



PROVINCIAL GOVERNMENT WESTERN CAPE
DEPARTMENT OF HEALTH



ANNUAL PERFORMANCE PLAN

2009 / 10



Foreword by Minister Marius Llewellyn Fransman, MEC for Health

This Annual Performance Plan comes at a time that we complete 15 years of service delivery to the people of the Western Cape under our nascent democracy. The list of achievements, challenges and obstacles is undoubtedly endless. However, delivery was possible because of meticulous attention given by our government to policy formulation, implementation and performance management. The Western Cape Department of Health demonstrates what can be achieved especially in the context of the challenging economic times and the realities of fiscal discipline and limited resources.

Since our first democratic elections in 1994 we have had the benefit of deriving lessons from each successive year of delivery. It goes without saying therefore that Annual Performance Plans outline the roadmap to achieving our strategic and operational goals and set clearly defined targets for our success.

This year the Annual Performance Plan of the Western Cape Department of Health assumes added importance as health has been identified as a priority focus area for government. In the quest for improving the quality of life of our people it is vital that our day to day work in operationalising this APP reflects the priority and focus accorded to it.

In taking forward the agenda of providing access to quality health care throughout the Western Cape, we give expression and fulfillment to the Constitution and Bill of Rights through our vision for health, Healthcare 2010, which takes health care services and facilities closer to the patients and communities that we serve

Our success in the implementation of primary health care and the training of community-based carers is indeed commendable. These community based carers and the network of support around them give expression to our vision of equal access to quality health care for all. Furthermore, we need to continue doing all in our ability to reduce waiting times for patients, providing an environment at our health care facilities that is dignified and humane.

We have done much over the past year to highlight the quadruple burden of disease that confronts the Western Cape. Our programmes over the next period will seek to consolidate these achievements whilst we continue to strive for the implementation of world class strategies in the treatment of TB, non communicable diseases, injuries and HIV/AIDS.

Our government strives to deepen democracy and extend services in the areas of housing, sanitation, water, electricity and improving the quality of life of our people. Through our initiatives to create an enabling environment for the creation of decent work, skills and training and economic opportunity for all, we begin to eradicate the underlying causes that contribute towards the burden of disease.

I am indeed proud of the achievements of my department in the field of HIV/AIDS. Our programme has been acknowledged as the best in sub-Saharan Africa and this contributed immensely towards our selection as the launch site for the Chevron Global Aids Fund Partnership. The major measure of our achievement however is our success in eradicating the scourge of AIDS and providing adequate support for those suffering from this pandemic. We must diligently monitor the implementation of this APP in order to take us forward in this struggle.

The Western Cape is notoriously known as the TB capital of the world. This is a reputation which we must do our utmost to shake-off as it is written in the blood and lives of our people. We will continue to ensure that the implementation of the WHO DOTS strategy and other measures to overcome this disease continues unabated.

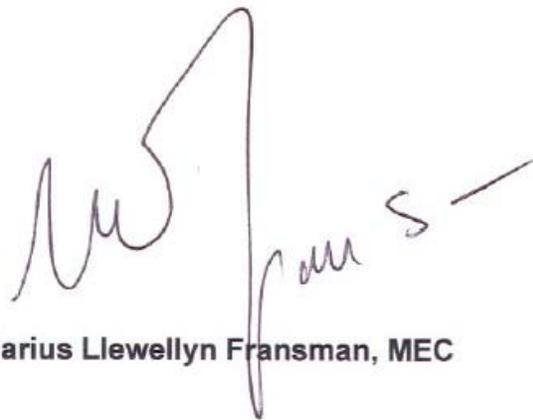
One of the key drivers of our National Health priority focus is mobilizing communities in support of the healthy lifestyles campaign. We are cognizant of the fact that unless communities are engaged and take ownership, we will not be able to achieve our strategic goals of building healthy communities with equal access to quality health care. Our success in the area of provision of quality health care is dependent upon individuals and groups making informed choices regarding their health and well-being.

Our commitment to deliver quality health care is carried by about 500 provincial health facilities and some 25 000 personnel across the province. This network of health care facilities is strengthened through the delivery of new health care facilities such as Khayelitsha and Mitchels Plain Hospitals that are now in construction phase as well as an ongoing programme of revitalization.

Our personnel and health care workers in particular form the backbone of our service. We are therefore delighted by the extension of the OSD to new areas and see this as a key development in retaining valuable expertise and experience within our health system. We will continue to support measures that facilitate the skills training and upliftment of health workers and professionals in order to ensure that they remain a valuable resource.

We will continue to address issues of equity through recruitment and the expansion of the training of community based and home based carers. In the same vein we must continue to deliver quality health care services whilst simultaneously addressing the imperatives of the BBBEE Act and engaging the transformation of the health sector.

Finally, our success over the next APP period and indeed the next five years of government requires that we muster our efforts and diligently apply the limited resources at our disposal. Through working with communities, health activists, NGOs and CBOs we will truly give expression to what it means to live in a democracy. More importantly, we will ensure that the provision of quality health care to all is a reality based on the fundamental assumption that working together, we can achieve more.



Marius Llewellyn Fransman, MEC



Message from the Head of Health Western Cape.

Professor Craig Househam

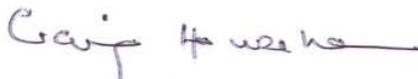
This Annual Performance Plan (APP) for the 2009/2010 financial year outlines departmental initiatives to ensure that the significant amount of resources that have been allocated to the Western Cape Department of Health are indeed utilized for the maximum benefit of the broader population of the province.

The need for health services continues to outstrip the available resources for health care in the Western Cape and will do so for the foreseeable future. Providing quality health services that satisfy the expectations of the people will at the best of times always be a challenge whether it be in the public or the private sector. The challenge to do this in the public sector is formidable when one considers the numbers of people that are dependent on the health services provided by the Western Cape Department of Health and the wide variety of health conditions with which they present to the clinics, community health centers and hospitals of the Department.

The key initiative for the Department during the 2009/2010 financial year will be the implementation of the Comprehensive Service Plan and as with the previous financial year these implementation steps outlined in detail in this APP will take the department closer to the goal of ensuring that patients are managed at the most appropriate level of care and thus that maximum cost efficiency is achieved.

Many challenges face the Department of which HIV and AIDS, multi-drug resistant Tuberculosis, chronic medical conditions and injuries of various types are but a few. This is exacerbated by a burgeoning population not fully matched by the budget allocation. A major challenge for the department during 2009, accepting budget constraints as a given, will be to address the issue of the quality of service provided. I am convinced the department must be honest with our clients in terms of what we can deliver. For example if a person attending a busy clinic, hospital casualty or pharmacy is expected to wait they should be informed how long they will have to wait and the period that they have to wait should be reasonable. If a person has to wait for several hours for service but is aware of the waiting time, is courteously treated by staff, receives the correct medical advice from a competent health professional and the medicine that he or she requires, the perception of the service will be different from when the same person waits fruitlessly in a queue for an interminable time and leaves without receiving the required advice and medicine. This is the challenge for all the staff in the Department of Health from the manager to the nurse and from the doctor to the admission clerk.

This Annual Performance Plan (APP) outlines in detail the full spectrum of services provided by the Department across the various programmes which include district health services, emergency medical services, forensic pathology services, specialized, provincial and central hospitals. Performance indicators outlined in the APP hold the Department accountable for the level of services to be provided and serve as the basis for the performance agreements of management. I trust that this public document will prove useful to members of the public, legislators and the staff of the Department and promote good governance within the public health sector in the Western Cape.



Professor Craig Househam

Head Health: Western Cape

February 2009

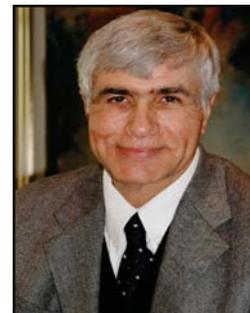


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STRATEGIC OVERVIEW

STRATEGIC OVERVIEW

1. OVERVIEW OF STRATEGIC PLAN

The vision, mission and values that guide the Western Cape Department of Health, support those of the National Department of Health and are:

Vision:

Equal access to quality health care.

Mission:

To improve the health of all people in the Western Cape and beyond, by ensuring the provision of a balanced health care system, in partnership with all stakeholders, within the context of optimal socio-economic development.

Values:

The core values that will be reflected in the way in which the vision and mission are achieved are:

- 1) Integrity;
- 2) Openness and transparency;
- 3) Honesty;
- 4) Respect for people; and
- 5) Commitment to high quality service.

Healthcare 2010 Comprehensive Service Plan

Healthcare 2010 sets out the strategic direction of the Western Cape Department of Health and supports the vision and mission of the National Department of Health. The Western Cape Health Department is a key role-player in support of the Provincial Growth and Development Strategy. The Department leads the key provincial interventions of Healthcare 2010 and Burden of Disease and contributes significantly to growth and development through ensuring and promoting a healthy community and workforce.

The Comprehensive Service Plan arising from Healthcare 2010 reshapes service delivery in the Department to ensure management of patients at a level of care that is most appropriate to their need, thereby maximising the provision of health services with the available resources. This strengthens Primary Health Care including community-based and preventive care. Regional hospitals are being strengthened to improve the accessibility to general specialist services to the communities. These services will be adequately supported with well-equipped and appropriately staffed secondary and highly specialised tertiary services.

2. SITUATION ANALYSIS

2.1 MAJOR DEMOGRAPHIC CHARACTERISTICS

All inclusive censuses were conducted by StatsSA in 1996 and 2001 and until recently the 2001 data has been used to project population growth. However, the Cabinet resolved to move away from a five-year to a ten-year census with the result that the next census is scheduled in 2011, created a gap in information and resulted in the decision that StatsSA conduct the Community Survey 2007.

The outcome of the survey is particularly significant for the Western Cape as it reflects a 16.7% increase in the Western Cape population between 2001 and 2007, i.e. increasing from 4 524 335 to 5 278 585 which is double that of the average national increase from 44 819 778 in 2001 to 48 502 063 in 2007.

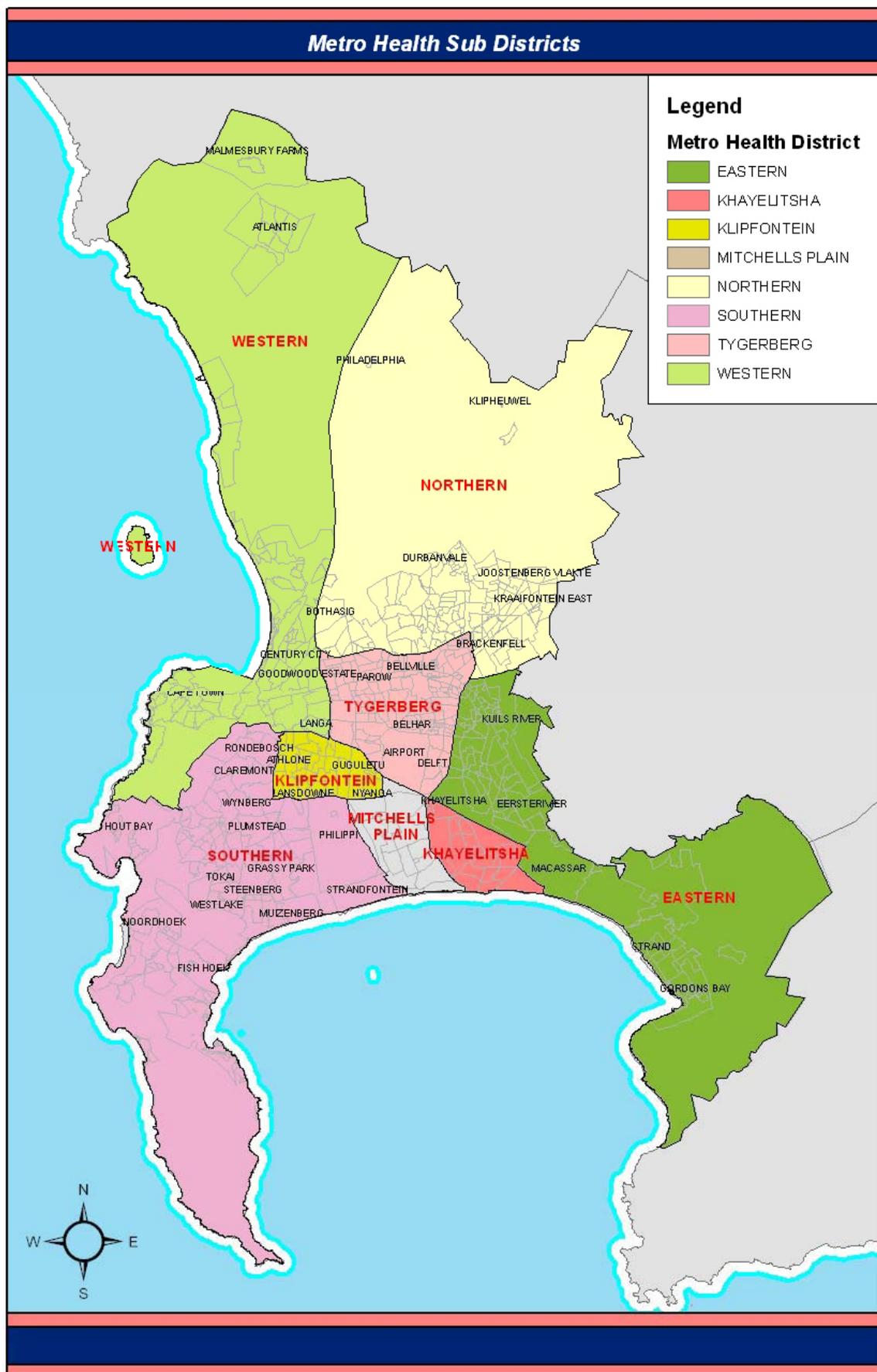
The Western Cape has a land surface of approximately 129 307 km² and based on the outcome of the Community Survey 2007 has a population density of approximately 40.8 persons per square kilometre. The Cape Town Metro district accommodates approximately 66% of the population and display higher density ratios, which is significant for planning purposes. The remainder of the population is distributed more sparsely, in approximately equal proportions between the other rural districts, i.e. Cape Winelands, Overberg, Eden, and West Coast, with the exception of the Central Karoo, which is very sparsely populated.

The land surface of the Western Cape represents 10.6% of the nation's total surface area and 10.9% of the total population and in 2004 the Western Cape's contribution to the national gross domestic product (GDP) was 14.56%. (Groenewald: 2008).

Table 1: Population estimates based on the 2008 mid-year estimates by StatsSA

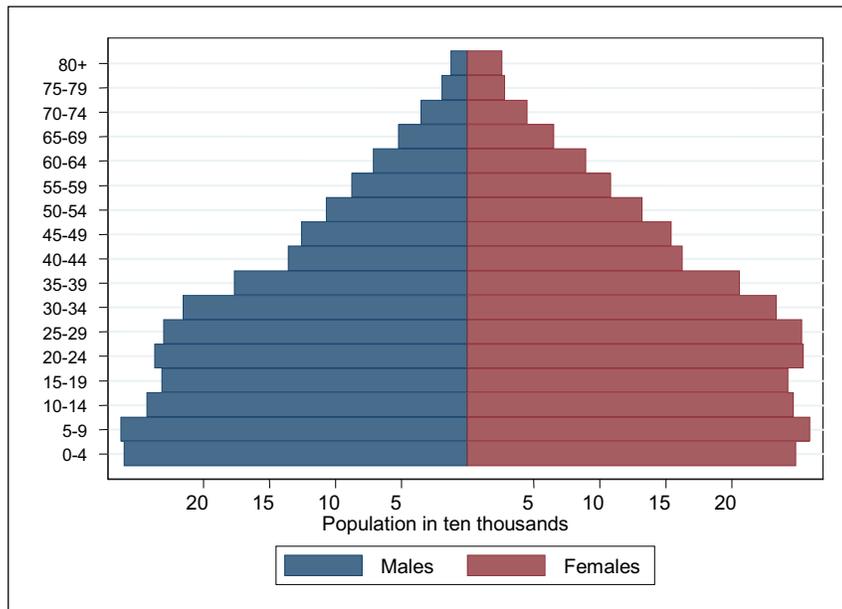
District	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2001-2004 % Uninsured
	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	
Cape Town	2 893 248	2 938 199	2 983 849	3 030 208	3 047 470	3 012 776	3 497 097	3 511 285	3 525 473	3 539 661	3 553 850	3 568 038	68.4%
West Coast	282 672	287 064	291 524	296 053	271 404	295 503	286 750	287 913	289 077	290 240	291 404	292 567	81.0%
Cape Winelands	629 490	639 270	649 202	659 289	627 110	656 455	712 413	715 303	718 194	721 084	723 974	726 865	80.0%
Overberg	203 517	206 679	209 890	213 151	194 698	213 580	212 787	213 650	214 514	215 377	216 240	217 104	83.0%
Eden	454 924	461 992	469 170	476 459	444 321	475 785	513 308	515 391	517 473	519 556	521 638	523 721	81.0%
Central Karoo	60 485	61 425	62 379	63 348	61 381	63 569	56 229	56 457	56 685	56 913	57 142	57 370	89.0%
Western Cape Province	4 524 336	4 594 629	4 666 014	4 738 508	4 646 384	4 717 668	5 278 584	5 300 000	5 321 416	5 342 832	5 364 248	5 385 663	73.0%
Uninsured Population													
District	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	
Cape Town	1 978 982	2 009 728	2 040 953	2 072 662	2 163 704	2 139 071	2 482 939	2 493 012	2 503 086	2 513 160	2 523 233	2 533 307	
West Coast	228 964	232 522	236 134	239 803	219 837	239 357	232 268	233 210	234 152	235 095	236 037	236 979	
Cape Winelands	503 592	511 416	519 362	527 431	501 688	525 164	569 930	572 243	574 555	576 867	579 180	581 492	
Overberg	168 919	171 544	174 209	176 915	161 599	177 271	176 613	177 330	178 046	178 763	179 479	180 196	
Eden	368 488	374 213	380 027	385 932	359 900	385 386	415 780	417 466	419 153	420 840	422 527	424 214	
Central Karoo	53 832	54 668	55 517	56 380	54 629	56 576	50 044	50 247	50 450	50 653	50 856	51 059	
Western Cape Province	3 302 777	3 354 091	3 406 202	3 459 123	3 461 357	3 522 826	3 927 574	3 943 508	3 959 443	3 975 377	3 991 312	4 007 247	

Source: Department of Health: Information Management



The Western Cape population pyramid in Figure 1 below exhibits a relatively large young population and smaller older population although less marked than in the rest of the country. The Western Cape under 15 year population is approximately 27% compared to 32% nationally and those more than 60 years account for 7.8% in the Western Cape compared to 7.32% in the rest of the country). Generally a population pyramid with over 30% of the people younger than 15 years and 6% aged 75 years and above is considered a "young population" and if those younger than 15 years are less than 30% and those 75 years and above are more than 6% then a population is considered an "aging population"¹ therefore the Western Cape falls somewhere in between these types. Figure 1 shows that the older population in the Western Cape is dominated by females.

Figure 1: Western Cape mid year population estimates for 2008 by age and sex

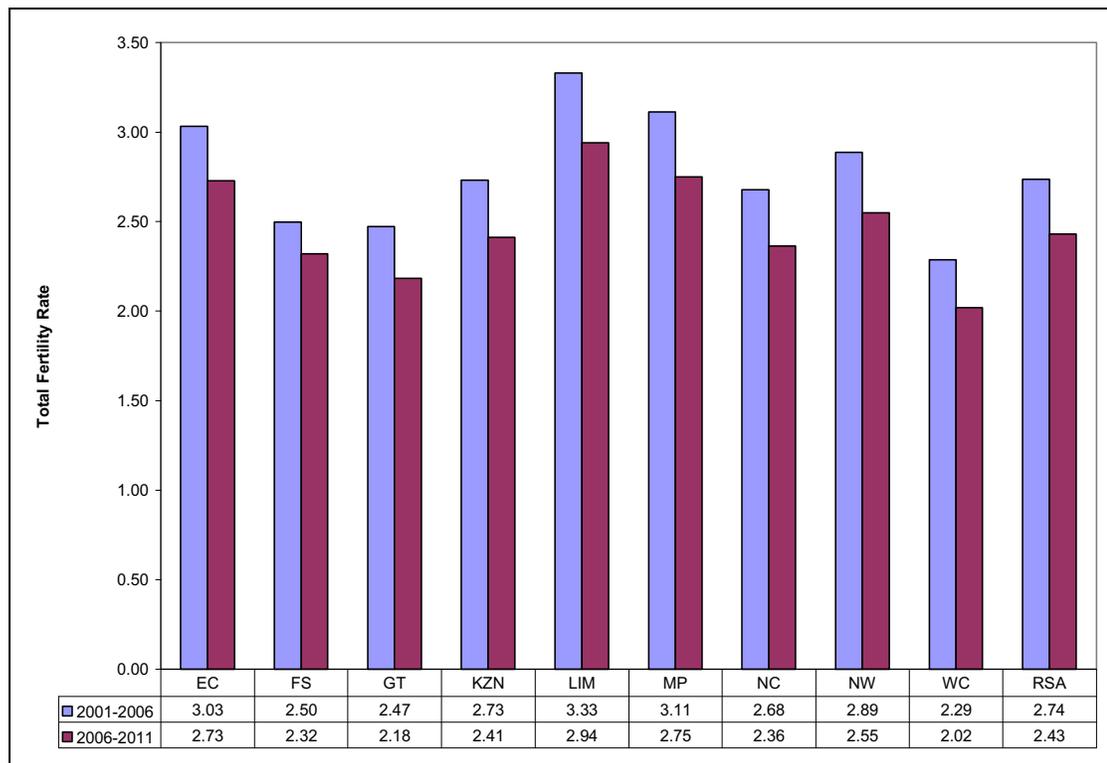


Source: Mid year population estimates, 2008. Statistical release 0302 StatsSA

Figure 2 overleaf shows that the province has the lowest average total fertility rates in the country. In the Western Cape a woman is expected to have on average 2.02 children in her lifetime compared to 2.43 children in South Africa for the period 2006-11. Globally the rate of 2.0 is considered to be the required replacement rate over the long term that would result in a stable population in the absence of migration. This indicator reflects that population growth in the Western Cape is driven by migration.

¹ http://en.wikipedia.org/wiki/Population_pyramid

Figure 2: Provincial average total fertility rates for the periods 2001–2006 and 2006–2011



Source: Mid year population estimates, 2008. Statistical release 0302 StatsSA

The Western Cape has an average access to basic amenities such as piped water and water-borne sewage that is higher than the national average. However, there are gross inequities between different health districts.

In 2001, StatsSA, the University of Oxford and the Human Science Research Council (HSRC) developed provincial indices for multiple deprivations where wards were rated according to five domains of deprivation namely: Income and Material Deprivation, Employment Deprivation, Health Deprivation, Education Deprivation, and Living Environment Deprivation.

Figure 3, shows that the most deprived wards in the Western Cape are within the City of Cape Town municipality particularly the townships on the Cape Flats alongside the N2 and the wards in the Little Karoo. Although the Karoo has the largest geographical area of multiple deprivation it has a very small population compared to the City of Cape Town. As shown in Table 1 the Central Karoo comprises 1% of the population versus 66% in the Metro. Therefore not only does the Metro have the largest population in the province, it also has the highest concentration of multiple deprivation.

The provincial indices of multiple deprivation indicate that about half of the 50 most deprived wards in the Western Cape are most deprived on four or more domains named above.

Table 2 outlines the poverty and socio-demographic data obtained from the General Household Survey of 2007.

Table 2: Poverty indicators as reported in the General Household Survey of 2007

		Western Cape	RSA Average
Percentage of households connected to the mains electricity supply	2002	88.0	76.1
	2003	88.5	77.6
	2004	92.7	80.4
	2005	92.2	80.1
	2006	93.5	80.2
Percentage of households that use paraffin or wood for cooking	2002	15.7	37.9
	2003	16.1	36.8
	2004	12.2	35.0
	2005	9.6	33.5
	2006	7.5	31.6
Percentage of households using a bucket toilet, or which have no toilet facility	2002	5.7	13.2
	2003	9.1	11.8
	2004	3.7	10.8
	2005	5.6	10.2
	2006	3.1	8.6
Percentage of households whose refuse is removed by the municipality	2002	83.4	55.0
	2003	84.8	56.8
	2004	87.7	57.1
	2005	91.3	60.1
	2006	91.9	60.6
Percentage of households with access to piped water in the dwelling or on site	2002	91.1	66.1
	2003	89.2	67.3
	2004	92.4	67.8
	2005	92.0	68.4
	2006	93.4	71.3

Source: General Household Survey, July 2007. StatsSA: P0318

Table 3: Socio-demographic characteristics of the population

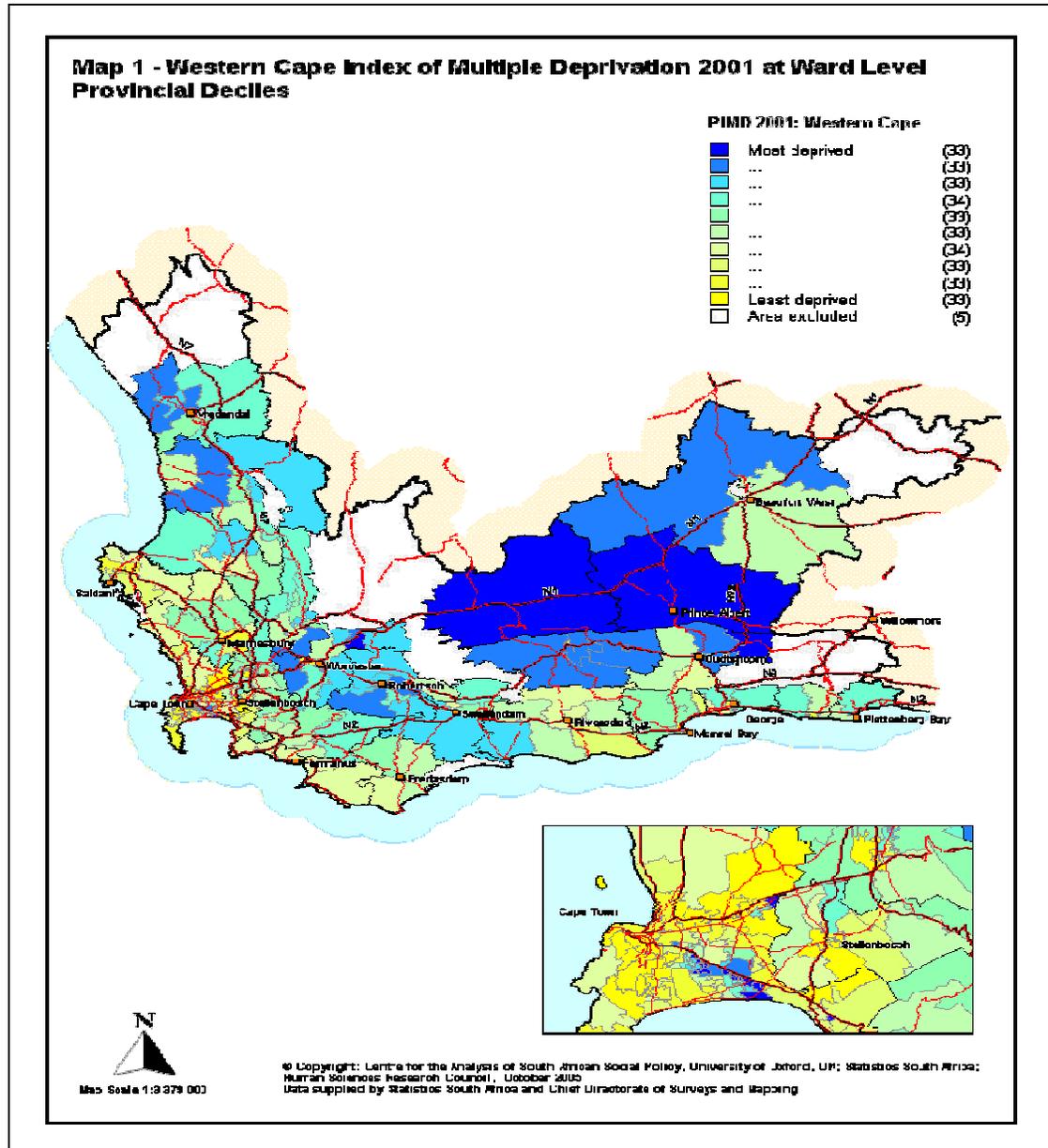
	% of total population	% < 15 yrs	% > 60 yrs	% Female	% Foreign born	% of population >20 years with no education	% of population 15-65 years who are unemployed
Western Cape	10.1	27.3	7.8	51.5	2.4	5.7	26.1
National	100	32%	7.32%	52.2	2.3	17.9	41.6

Source: Census 2001

The population of the Western Cape is relatively older in comparison with the national average and compares favourably with the national average for people over 20 years of age with no education and those between the ages of 15 – 64 years who are unemployed.

The General Household Survey (July 2006: 34) indicates that the unemployment in the Western Cape is 17.7% in comparison to the national figure of 28.6%.

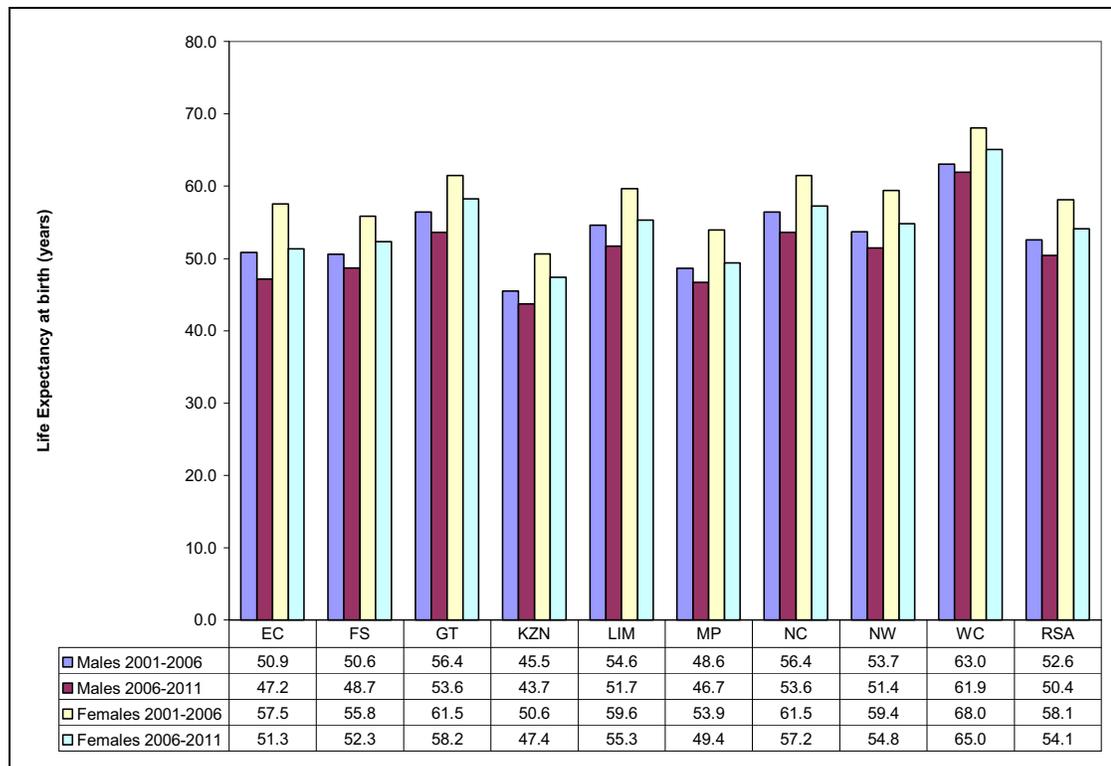
Figure 3: Map illustrating the Western Cape index of multiple deprivation



Source: Provincial Indices of Multiple of Deprivation

2.2 EPIDEMIOLOGICAL PROFILE

The StatsSA report on the mid year population estimates for 2008 indicates that on average, the population of the Western Cape is relatively better off than the rest of the country. Life expectancy at birth for both males and females remains the highest in the country. As with the rest of the country life expectancy at birth has been decreasing due to HIV and AIDS. In the Western Cape life expectancy for males is expected to decrease from 63 years in 2001 – 2006 to 61.9 years in 2006 – 2011 and for females from 68 years to 65 years for the same time periods.

Figure 4: Provincial average life expectancy at birth, 2001–2006 and 2006–2011

Source: Mid year population estimates, 2008. Statistical release 0302 StatsSA

Child mortality indicators are important because they are a reflection of the state of development of a population group and their access to basic services. The South African Demographic Health Survey 2003 reported the Infant Mortality Rate (IMR) for the Western Cape to be 45 per 1000 live births compared to 43 per 1000 live births nationally where as in 1998 it reported it to be 8.4 per 1000 live births. However, the SADHS 2003 report also says "...there is poor correlation between the provincial estimates for child mortality from 2003 SADHS with the 1998 SADHS ... Given the inconsistencies of findings of this survey with the 1998 SADHS and the context of the HIV epidemic with the impact that it has on child mortality, the estimates of the level of child mortality from this survey are not plausible." Furthermore the provincial mortality surveillance system of the Western Cape burden of disease project provides child mortality data for Cape Town, Cape Winelands East and Overberg districts which account for approximately 75% of the population in the province. From this data the IMR for Cape Town for 2006 was 21.4 per 1 000 live births, Cape Winelands East 28 per 1 000 live births and Overberg 26 per 1 000 live births (See Table 5). This is more in line with the projected data from ASSA 2003 which suggests that the IMR for Western Cape for 2006 is 26 per 1000 live births compared to 48.0 per 1000 live births in the country². In the absence of complete empirical data for the provincial mortality surveillance data, the Department will therefore use ASSA 2003 data for estimated child mortality for the province.

² **ASSA 2003:** ASSA2003 Model: Provincial Output. AIDS Committee of Actuarial Society of South Africa. <http://www.actuarialsociety.co.za/aids/>

Table 4: Trends in key provincial mortality indicators [A1]

Indicator	2000 (SAHR 2006: 386)		2006 ASSA 2003		National Target Health goals, objectives and indicators 2001 to 2005
	Western Cape	National	Western Cape	National	
Infant mortality (under 1)	31.7	59.1	26	48	45 per 1 000 live births by 2005
Child mortality (under 5)	46.3	94.7	39	73	59 per 1 000 live births by 2005
Maternal mortality ratio per 100,000 live births	Source: Saving Mothers: Third report on confidential enquiries into maternal deaths in South Africa 2002-2004, 2006: 34. Western Cape				100 per 100 000 live births by 2005
	2000	2002	2004		
	62.4	74.7	98.8		

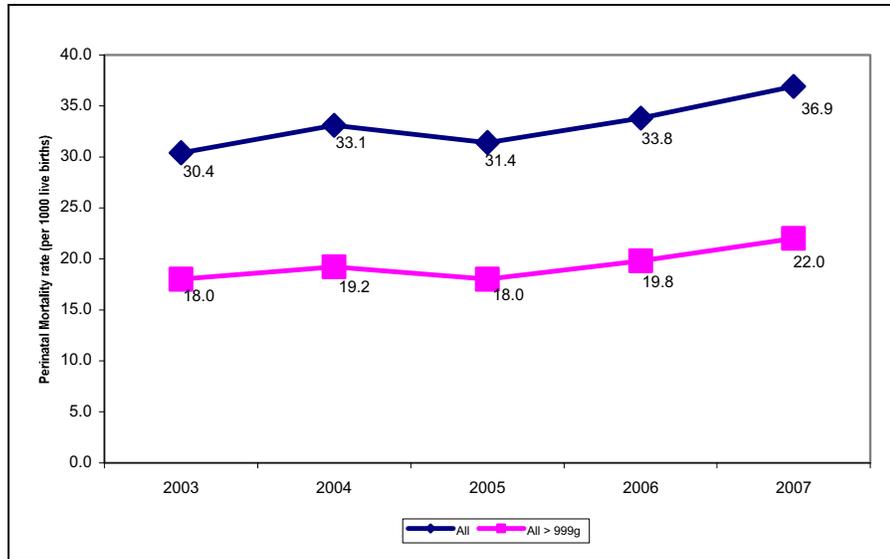
Table 5: Infant Mortality Rate (per 1 000 live births)

	2002 ¹	2003	2004	2005	2006	2007	Source	
South Africa	59	-	-	-	48		¹ South African Health Review 2005: 302	
Western Cape	30	-	-	-	26		² South African Health Review 2006: 386	
Cape Town Metro district	-	25.16	23.74	22.28	21.40	20.28	City of Cape Town	
Cape Town Metro Sub-districts	-							
Eastern	-	28.98	22.90	27.51	32.00	28.38		
Khayelitsha	-	42.11	36.61	34.72	31.33	30.16		
Klipfontein	-	28.65	28.79	27.41	24.65	24.74		
Mitchell's Plain	-	22.03	24.18	22.85	22.08	21.27		
Northern	-	24.55	20.80	22.88	20.62	21.08		
Southern	-	16.98	20.97	15.23	11.88	11.98		
Tygerberg	-	18.61	19.58	16.20	17.61	14.91		
Western	-	17.58	16.41	15.22	14.21	20.28		
Cape Winelands East				29	28			Groenewald et al. Cause of death and premature mortality in Boland Overberg Region, 2004-2006 (BOD Project)
Cape Winelands East Sub districts								
Breede River Winelands				28	24			
Breede Valley				21	23			
Witzenberg				42	45			
Overberg				35	26			
Overberg Subdistricts				29	28			
Cape Agulhas				35	23			
Overstrand				31	29			
Swellendam				11	23			
Theewaterskloof				31	26			

Note:

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

As discussed above, the Western Cape has very favourable developmental indicators such as life expectancy, total fertility rate and infant mortality rate when compared to the rest of the country. As shown in Figure 5, perinatal mortality rates (including and excluding babies born below 999g) calculated from the Perinatal Problem Identification Programme (PPIP) for public health facilities, have increased since 2005 although they are still lower than national estimates of 39.8 per 1000 for all births and 27.2 per 1000 for all births more than 999g. This is particularly important for the Department as it is a key marker of access to health care delivery during the antepartum, intrapartum and post partum period.

Figure 5: Perinatal Mortality Rate per 1 000 live births

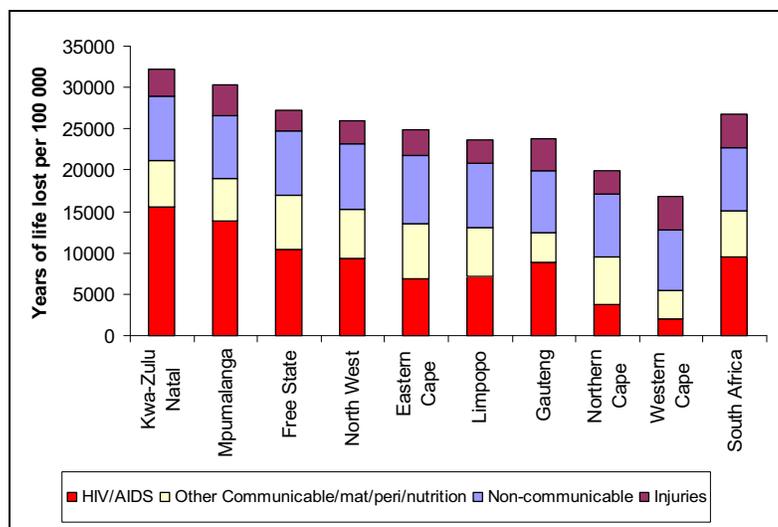
Source: Perinatal Problem Identification Programme, Western Cape Department of Health: Sub-directorate: Women's Health

Similarly maternal mortality reflects the quality of health services. Although maternal mortality in the Western Cape is one of the lowest in the country, it has been increasing over time. The maternal mortality rate per 100 000 live births has increased from 47.3 in 1998 to 98.8 in 2004 mostly due to non pregnancy related sepsis mainly due to HIV/AIDS³.

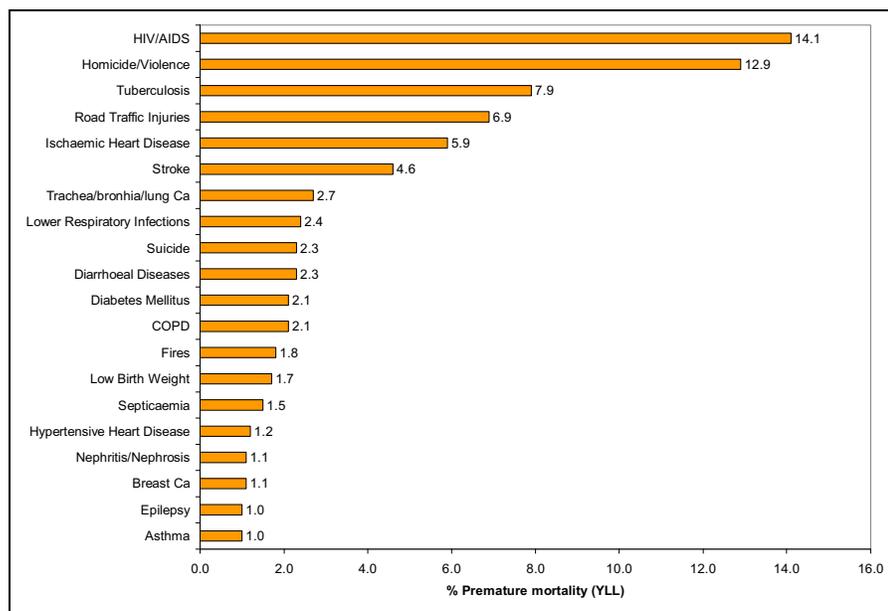
The Western Cape like the rest of the country suffers from a quadruple burden of disease albeit at lower levels, which consists of pre-transitional conditions related to under development, including TB, non-communicable diseases, injuries and HIV and AIDS.

Figure 6 overleaf shows that the Western Cape has the lowest rate of premature mortality at 16 764 YLL's per 100 000 population compared with 26 735 YLL's per 100 000 nationally. It also has the lowest premature mortality due to HIV and AIDS and other infectious disease which is consistent with its more developed status. However, it has the highest premature mortality due to injury (4 000 YLL per 100 000 population). The chronic disease burden is constant across provinces illustrating the point that this burden of disease component afflicts provincial populations equally irrespective of level of development, wealth or urban status.

³ Saving Mothers: Third report on confidential enquiries into maternal deaths in South Africa 2002-2004, 2006:

Figure 6: Premature mortality rate (Years of life lost) by broad causal group, 2000Source: Bradshaw et al 2005⁴

Analysis of the top 20 causes of premature mortality in the Western Cape in Figure 6 shows that injuries (homicide, road traffic incidents, suicide and fires) account for the largest contribution or almost a quarter (23.9%) of the Provincial burden of disease, followed closely by the major infectious diseases (HIV/AIDS and TB) approximately 22.0% of the burden. The mortality rate in the Western Cape due to injuries is 10 times higher for men and seven times higher for women than the global average⁵.

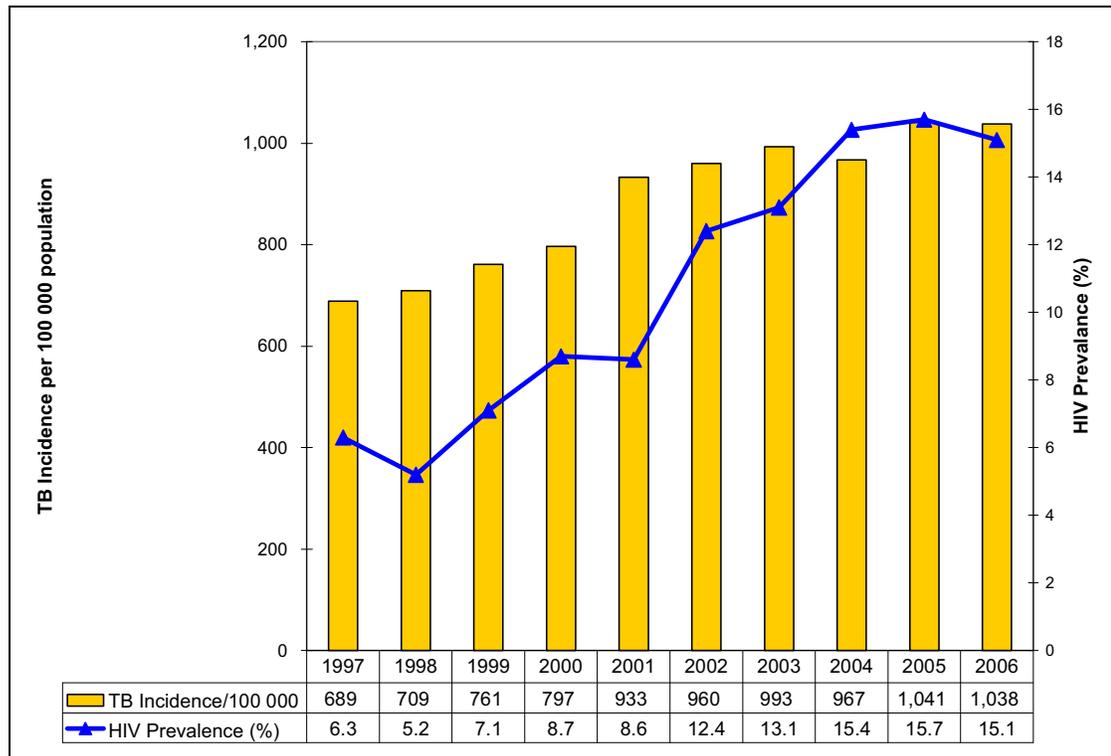
Figure 7: Top 20 causes of premature mortality (YLL) for Western Cape, 2000Source: Bradshaw et al 2003³

4 Bradshaw D, Nannan N, Groenewald P, Joubert J, Laubscher R, Nojilana B, Norman R, Pieterse D and Schneider M. Provincial mortality in South Africa, 2000: priority-setting for now and a benchmark for the future. *S Afr Med J* 2005; 95 (7): 496-503

5 Norman R, Matzopoulos R, Groenewald P, Bradshaw D. *The high burden of injuries in South Africa*. *WHO Bulletin* 2007; 85 (9), 649-732

HIV is the primary cause of the death in the province and in the country and as shown in Figure 8 below the HIV epidemic has fuelled the TB epidemic. The incidence of TB in the Western Cape has increased from 689/100 000 in 1997 to 1 038/100 000 in 2006 and has decreased marginally to 1 004/100 000 in 2007. This incidence is almost double the national TB incidence.

Figure 8: Incidence of TB and HIV prevalence in the Western Cape 1997 to 2006



Source: Western Cape Department of Health, HIV/AIDS and TB Directorate

Multiple Drug Resistant (MDR) and Extensive/Extreme Drug Resistant (XDR) TB are emerging problems. Between 2001 and 2007, the number of cases of MDR seen at Brooklyn Chest Hospital increased from 248 to 631; an increase of 154%. Between January 2007 and January 2009, 132 cases of XDR cases were identified of whom 69 died.

Mental illness contributes to the burden of disease through morbidity rather than through mortality. There is a paucity of data in this regard but substance abuse is a particular problem in the Western Cape. Apart from a small number of suicides, which only constitutes 2.3%, most people will not die from mental disorders. Nevertheless they present a significant burden on the health services and to communities at large. Prevalence data for mental disease are also very poor for the country as a whole. In one national study it is stated that in South Africa adults have a 30% lifetime prevalence for Mental Disease⁶ which must constitute a substantial burden. There are no comparable data for the Western Cape.

⁶ Stein DJ, Seedat S, Herman A Lifetime prevalence of psychiatric disorders in South Africa *The British Journal of Psychiatry*.2008; 192: 112-11

The role of the Department of Health is not only to manage disease; it is also to improve health status. However, the major determinants of health e.g. alcohol misuse are often beyond the reach of the health sector and include a range of socio-structural ('upstream') factors such as income inequality, poverty, access to basic services and social behavioural norms. This is very much in line with the concept of intersectoral action introduced at the Alma-Ata Conference on Primary Health Care (1978). This emphasises not only the need for health services but also takes into consideration economic conditions, socio-cultural and political determinants of health⁷. [WHO and UNICEF, 1978]

The Provincial Government of the Western Cape (PGWC) mandated the Western Cape Department of Health to lead an initiative to define the components of the burden of disease in the Province and to provide evidence-based recommendations as to how these can be reduced. In particular the aim is to focus on inter-sectoral collaboration that addresses the critical determinants, especially the upstream, of this burden in order to build and sustain health security.

To date mortality surveillance and injury surveillance has been institutionalised in the Department. Furthermore the Department participated extensively in the development of the Liquor Act, 2008 and in collaboration with Department of Social Development and Department of Community Safety in developing a documentary on alcohol to challenge and undermine pervasive norms, attitudes and beliefs about alcohol use to promote the decrease in misuse of alcohol in the Western Cape. This documentary will be completed by the end of March 2009 and will be shown in relevant settings such as schools, health clinics, places of work, prisons, to traffic offenders etc. accompanied by workshops discussing different aspects of the film and an evaluation process to evaluate behaviour change.

2.3 MAJOR HEALTH SERVICE CHALLENGES AND PROGRESS

The key challenge for the Department is the implementation of the Comprehensive Service Plan, which was formally approved for implementation by the provincial Minister of Health on 11 May 2007. The CSP identifies that the Department must be restructured to a more optimal configuration and that it is under funded to deliver the level of care prescribed by government policy. The initial steps to implement the Comprehensive Service Plan were taken during 2007 and progressed significantly during 2008.

The decision to assume full responsibility for Personal Primary Healthcare in the rural districts was announced by the Provincial Minister of Health on 11 March 2005 and the process has been implemented in three phases. The Department provided the funding for PPHC services in the rural districts from 1 April 2005 and this was followed by full assumption of managerial responsibility from 1 March 2006 and thereafter the transfer of all staff and assets used by local government to deliver PPHC services by July 2007. A challenge is that the physical infrastructure transferred from local government requires significant upgrading to meet the required standards and that no additional funding has been allocated for the maintenance and upgrading of these facilities. The Department has identified the areas of critical need and is addressing them as best possible within the available funding.

⁷ World Health Organisation and UNICEF. 1978. Declaration of Alma-Ata 1978. International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 found at http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf

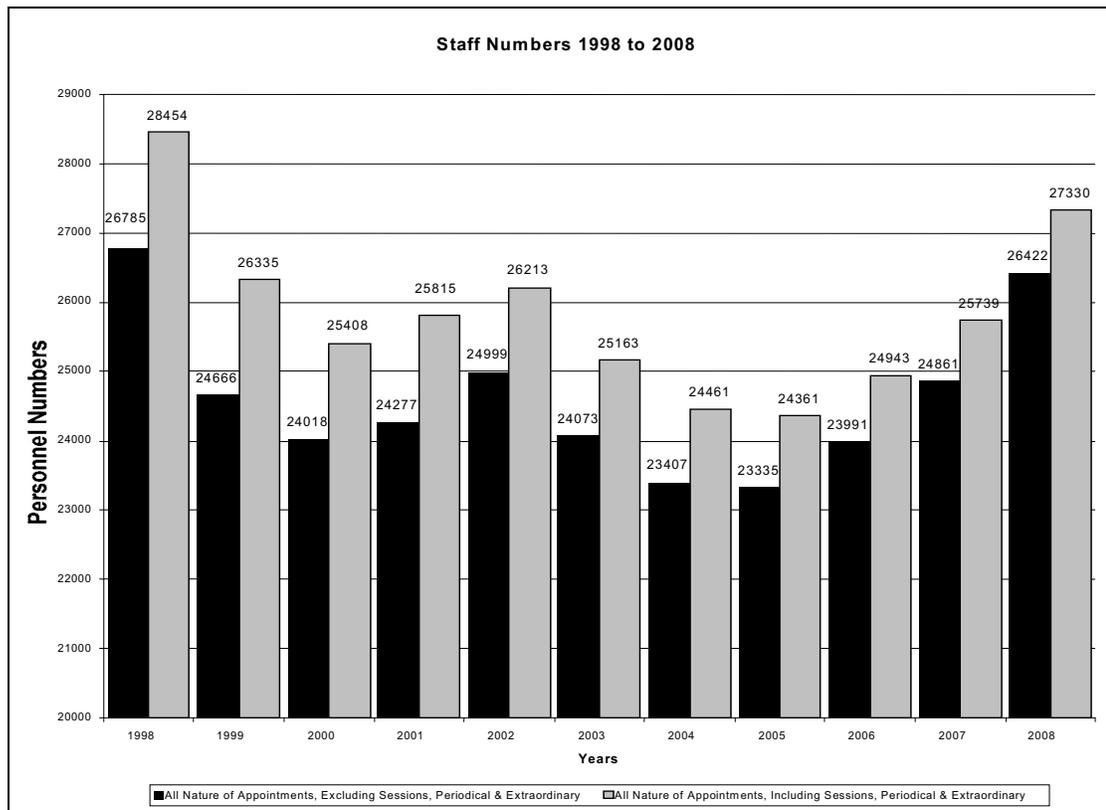
The assumption of responsibility for the remaining PPHC services within the Cape Town Metro district remains as a pending matter.

A major challenge for the health services is the quality of care. A centralised Quality Assurance Unit supports and co-ordinates the activities of the quality assurance managers at facility level and monitors the quality of care. Complaints and compliments, morbidity and mortality, client satisfaction surveys and evaluation of safety and security risks to patients and staff are regularly monitored. The challenge is to implement interventions that will address identified shortcomings.

The Department is focusing on improving clinical governance in the services by strengthening the family medicine and emergency medicine capacity and appointment of level two clinical heads.

Quality of care is adversely affected by the inability to recruit and retain experienced and quality health care professionals. The current shortage of nurses, especially nurses with specialist training, who are the backbone and key determinant of health services, presents a serious challenge. Figure 10 illustrates the number of personnel in the Department of Health between 1998 and 2007. The attrition rate of nurses is of particular concern, for professional nurses it was approximately 10% and for some specialist areas of nursing it was 16% for the period 1 April 2004 to 31 March 2007. The implementation of the occupational specific dispensation (OSD) for nurses during 2007 has already begun to show a reversal of this trend.

Figure 9: Personnel numbers in Provincial Health Facilities from 1998 to 2006



2.4 INTRA AND INTER PROVINCIAL EQUITY IN THE PROVISION OF SERVICES

In order to ensure equitable access for all to the full package of Primary Health Care Services the allocation of resources in the CSP is determined by the distribution of human settlement within each sub-district. The outcome of this approach shows that service delivery in sparsely populated areas is more expensive than in more densely populated areas. The table below shows the allocation of posts in full time equivalents (FTEs) per district in the CSP.

Table 6: Allocation of posts per full time equivalent per district in the CSP

Health District	FTEs per 100,000 population	Density: persons per sq km	Percentage of total population (WC)	Clinic service points	Population served per clinic
Cape Town Metro	112	1330	63.3%	102	32,734
Cape Winelands	122	32	14.2%	75	9,642
Overberg	146	20	4.7%	38	6,151
Eden	137	22	10.4%	73	7,159
Central Karoo	164	2	1.0%	18	3,861
West Coast	141	13	6.4%	70	4,638

In the Western Cape 7.52% of the total population live in sparsely populated areas, which constitute 74% of the total area of the province (Rural 2 and Deep Rural in the table below.) The relatively high cost of service delivery to these rural settlements is offset by efficiency gains in the more densely populated areas where 77.6% of the population occupies 7.7% of the total area of the province (Metropolitan and rural high density in the table below).

Table 7: Human settlement profile in the Western Cape

Human settlement profile in the Western Cape		% of Total Western Cape Population	% of Total Western Cape Area
Metropolitan: Cape Town		63.2%	1.9%
Rural High Density: e.g. Paarl, Worcester, George		14.4%	5.8%
Rural 1:	Max travel distance to clinic between 7-12 km	14.9%	18.3%
Rural 2:	Max travel distance to clinic between 13-24 km	5.83%	26.0%
Deep Rural:	Max travel distance to clinic more than 24 km	1.69%	48.0%
		100%	100%

In the CSP rural level 1 beds are weighted according to population density to compensate for the fact that beds are geographically less accessible due to the greater travelling distances, poorer road infrastructure, lack of public transport, etc. Level 2 beds are weighted according to the distance of the rural regional hospital from Cape Town. To further enhance equitable services delivery in all the districts, the following additional measures have been applied: Level 2 beds have been allocated to the larger rural district hospitals to provide for structured outreach and support from regional hospitals. It is generally accepted that there is a need to provide for the skills development and further training of medical officers in rural areas. Access to the specialists from the regional hospitals will have a significant impact in this regard. It also provides the opportunity to treat non-acute level 2 patients in district hospitals who otherwise have to be referred to a regional hospital. It is anticipated that this will have a favourable impact on the quality of care and the ability of the district hospitals to deliver the full package of services and consequently improve the utilisation and cost efficiency of rural district hospitals. The referral from district to regional hospitals is expected to decrease significantly.

2.5 RESOURCE TRENDS

Total receipts increase by R1 147 billion or 13.12 per cent from R8.746 billion in the revised estimates of 2008/09 to R9.893 billion in 2009/10.

The equitable share funding increases by R870.444 million or 15.09 per cent from R5 768 billion in the revised estimate of 2008/09 to R6 638 billion in 2009/10.

Conditional grant transfers increase by R288.711 million or 11.41 per cent from R2 530 billion in the revised estimate of 2008/09 to R2 819 billion in 2009/10.

Adjustments for the 2009 MTEF include updating the demographic and economic data used to populate the allocation formula such as the 2008 Mid-year population estimates, the 2008 Education Snap Survey, the 2007 General Household Survey, the 2006 Provincial GDP-R information and the 2005 Income and Expenditure Survey all conducted by StatsSA.

Table 8 below reflects the Department's budget for the MTEF period

Table 8: Health Department budget as a percentage of Provincial budget

	Audited 2005/06	Audited 2006/07	Audited 2007/08	Main appropriation 2008/09	Adjusted appropriation 2008/09	Revised estimate 2008/09	2009/10	2010/11	2011/12
	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Health	5 718 812	6 419 515	7 497 868	8 641 973	8 870 805	8 745 734	9 982 798	10 925 269	11 764 458
Provincial Total	16 731 315	18 831 640	21 504 963	24 888 574	26 202 478	25 835 221	29 009 013	30 999 328	33 452 685
Health budget as a percentage of Provincial Total	34.18%	34.09%	34.87%	34.72%	33.85%	33.85%	34.41%	35.24%	35.17%

Source: Western Cape Budget: 2009

The sources of the Department's funding are:

- The equitable share; which is the funding allocated to each province by National Treasury based on a formula which aims to promote national equity. The equitable share is then distributed by the Provincial Treasury between the respective provincial departments.
- Conditional grants are funds allocated by National Treasury for specific projects/performance levels.
- Retained revenue.

Detail regarding the allocations from the respective sources is reflected in Tables 9 and 10. In 2009/10 it is projected that the equitable share will account for 67.11% of the Department's funding and the conditional grants for 28.5% in contrast to the 66.24% and 29.08% respectively allocated in the revised estimate of the 2008/09 budget. The projected revenue for 2009/10 is 3.94% of the budget in comparison to the 4.68% in 2008/09.

Table 9: Funding sources of the Western Cape Health Department

	Audited 2005/06	Audited 2006/07	Audited 2007/08	Main appropriation 2008/09	Adjusted appropriation 2008/09	Revised estimate 2008/09	2009/10	2010/11	2011/12
Treasury Funding	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Equitable share	3 627 255	4 075 807	4 737 154	5 618 625	5 753 595	5 768 178	6 638 622	7 315 553	7 998 813
Conditional grants	1 814 939	2 011 991	2 262 868	2 633 668	2 670 035	2 530 381	2 819 092	3 232 463	3 449 105
Financing		27 657			37 656	37 656	44 924	50 000	
Total Treasury Funding	5 442 194	6 115 455	7 000 022	8 252 293	8 461 286	8 336 215	9 502 638	10 598 016	11 447 918
Departmental Receipts	276 618	304 060	497 846	389 680	409 519	409 519	390 160	327 253	316 540
TOTAL RECEIPTS	5 718 812	6 419 515	7 497 868	8 641 973	8 870 805	8 745 734	9 892 798	10 925 269	11 764 458

Source: Budget Statement 2009

Table 10: Conditional grant allocation for 2009/10

Conditional grant	Main appropriation 2009/10	Percentage of total Health budget for 2009/10
National Tertiary Services Grant (NTSG)	1 583 991	16.0%
Health Professions Training and Development (HPTDG)	362 935	3.7%
HIV and AIDS Grant	309 913	3.1%
Hospital Revitalisation Grant (HRP)	388 845	3.9%
Forensic Pathology Services	58 484	0.6%
Provincial Infrastructure Grant (PIG)	114 924	1.2%
TOTAL CONDITIONAL GRANT ALLOCATION	2 819 092	28.5%
TOTAL HEALTH BUDGET	9 892 798	

The CPIX inflation for 2008/09 is now estimated to be 9.5 per cent, and is expected to decrease to 4.5 per cent by 2011/12. CPIX inflation has an impact on input costs including salaries, construction and payment for goods and services. As indicated by National Treasury, a partial inflation adjustment will be made on critical budget items.

The CPIX multiplier used in the document are illustrated in Table 11.

Table 11: CPIX multiplier 2007/08 prices

YEAR	UPDATED CPIX MULTIPLIER APPLIED
2004/05	1.11
2005/06	1.07
2006/07	1.04
2007/08	1.00
2008/09	0.93
2009/10	0.89
2010/11	0.85
2011/12	0.83

Table 12: Trends in provincial service volumes [A2]

Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate
PHC headcount in PHC facilities	13 068 303	12 180 933	13 029 007	14 645 765
L1 OPD headcount in district hospitals	712 166	695 108	877 999	839 152
Separations: district hospitals	142 054	144 373	203 932	221 808
OPD headcount in regional and central hospitals	1 029 093	964 193	1 471 936	1 545 043
Separations: regional and central hospitals	310 815	324 575	253 700	258 613

Note:

Refer to the performance tables in the respective programmes for further detail regarding the shift of beds between levels and corresponding movement of outpatients.

Table 13: Public hospitals by hospital type [PHS1]

Hospital type	Number of hospitals	Number of beds	Provincial average number of beds per 1 000 Uninsured	Provincial average number of beds per 1 000 Total population
District hospitals	34	2 292	0.58	0.43
Regional hospital	6	1 379	0.35	0.26
Central hospitals	3	2 417	0.61	0.46
Sub-total acute hospitals	43	6 088	1.54	1.15
Tuberculosis hospitals	6	1 008	0.26	0.19
Psychiatric hospitals	4	1 924	0.49	0.36
Other Special hospitals	1	156	0.04	0.03
Sub-total chronic hospitals	11	3 088	0.78	0.58
Total public hospitals	54	9 176	2.33	1.73

Table 14: Public hospitals by level of care [PHS2]

Level of care	Number of Hospitals providing level of care*	Number of Beds	Provincial average number of beds per 1 000 uninsured
L1 Beds (District hospitals)	34	2 292	0.43
L2 Beds (Regional hospitals)	6	1 379	0.26
L3 Beds (Central hospitals)	3	2 417	0.46
All acute levels	43	6 088	1.14

Table 15: Division of budget between the respective financial programmes since 2005/06 and for the MTEF period

Programme	2005/06		2006/07		2007/08		2008/09		2009/10		2010/11		2011/12	
	R'000	%	R'000	%	R'000	%								
1. Administration	167 291	2.93%	162 125	2.53%	205 333	2.74%	275 250	3.15%	313 813	3.17%	345 909	3.17%	372 615	3.17%
2. District Health Services	1 629 951	28.50%	1 922 792	29.95%	2 707 578	36.11%	3 128 808	35.78%	3 503 630	35.42%	3 898 758	35.69%	4 185 738	35.58%
3. Emergency Medical Services	255 851	4.47%	277 844	4.33%	341 877	4.56%	407 318	4.66%	488 136	4.93%	538 061	4.92%	579 603	4.93%
4. Provincial Hospitals	1 295 905	22.66%	1 397 635	21.77%	1 306 027	17.42%	2 358 641	26.97%	2 621 311	26.50%	2 889 410	26.45%	3 112 495	26.46%
5. Central Hospitals	1 980 705	34.63%	2 123 000	33.07%	2 349 884	31.34%	1 859 539	21.26%	1 911 422	19.32%	2 106 917	19.28%	2 269 586	19.29%
6. Health Sciences and Training	79 009	1.38%	98 858	1.54%	133 706	1.78%	179 110	2.05%	191 334	1.93%	210 904	1.93%	227 187	1.93%
7. Health Care Support Services	93 075	1.63%	92 906	1.45%	81 785	1.09%	97 938	1.12%	177 978	1.80%	198 100	1.81%	199 605	1.70%
8. Health Facilities Management	217 025	3.79%	344 355	5.36%	371 678	4.96%	439 130	5.02%	685 174	6.93%	737 210	6.75%	817 629	6.95%
TOTAL	5 718 812	100%	6 419 515	100%	7 497 868	100%	8 745 734	100%	9 892 798	100%	10 925 269	100%	11 764 458	100%

Source: Budget Statement 2009.

Notes:

1. The funding for Programme 8 was transferred from the Department of Public Works from 1 April 2005
2. The funding for GF Jooste, Hottentots Holland, Karl Bremer and Nelspoort Hospitals was transferred from Programme 4 to Programme 2 during 2007/08.
3. The funding for the level 2 beds in the central hospitals was transferred from Programme 5 to Programme 4 from 2008/09.
4. The revised estimate was used for 2008/09.

2.6 POLICY CHANGES AND TRENDS

National Health Act, 2003 (Act No 61 of 2003)

The National Health Act has been developed to comply with the obligations imposed by the Constitution and establish a structured and uniform health system within the Republic.

This Act came into effect on 2 May 2005 with the exception of some sections i.e. chapter 6 (health establishments and relating to the certificate of need) and chapter 8 (control of use of blood, blood products, tissue and gametes in humans). The following regulations have been issued under this Act:

- Regulations regarding the rendering of Forensic Pathology Service (Government Gazette 30075, Notice Number: 636, Regulation: 8718).
- Regulations relating to the obtainment of information and the processes of determination and reference price list (Government Gazette: 30110, Notice Number: 681, Regulation: 8722).

3. BROAD POLICIES, PRIORITIES AND STRATEGIC GOALS

The policies, priorities and strategic goals of the Department are guided by the Millennium Development Goals and the priorities of the National Department of Health at a national level, the Provincial Growth and Development Strategy at a provincial level and Healthcare 2010 on a departmental level.

3.1 MILLENNIUM DEVELOPMENT GOALS (MDGS)

In September 2000 at the United Nations Millennium Summit South Africa was one of the 189 countries to commit to the Millennium Development Goals to reduce global poverty.

The goals are:

- 1) Eradicate extreme poverty and hunger;
- 2) Achieve universal primary education;
- 3) Promote gender equality and empower women;
- 4) Reduce child mortality;
- 5) Improve maternal health;
- 6) Combat HIV and AIDS, malaria and other diseases;
- 7) Ensure environmental sustainability; and
- 8) Develop a global partnership for development.

The following table summarises the goals, targets and indicators of the Millennium Development Goals. The health-related Millennium Development Goals against which the Department is required to report are numbers 1, 4, 5, 6, 7 and 8.

Table 16: Millennium development goals

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
1. Eradicate extreme poverty and hunger.	Halve, between 1990 and 2015, the proportion of people who suffer from hunger.	Prevalence of underweight children under 5 years of age.
		Proportion of the population below minimum level of dietary energy consumption.
2. Achieve universal primary education.	Ensure that by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.	Net enrolment ratio in primary education.
		Literacy rate of 15 – 24 year-olds.
3. Promote gender equality and empower women.	Eliminate gender disparity in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015.	Ratio of girls to boys in primary, secondary and tertiary education.
		Ratio of literate females to males of 15 – 24 year-olds.
4. Reduce child mortality.	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.	Under-5 mortality rate (U5MR).
		Infant mortality rate.
		Proportion of one-year old children immunised against measles.
5. Improve maternal health.	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.	Maternal mortality ratio.
		Proportion of births attended by skilled health personnel.
6. Combat HIV and AIDS, malaria and other diseases.	Have halted, by 2015, and begun to reverse the spread of HIV and AIDS, malaria and other diseases.	HIV prevalence among 15 – 24 year old pregnant women.
		Condom use rate of the contraceptive prevalence rate.
		Number of children orphaned by HIV and AIDS.
		Proportion of the population in malaria risk areas using effective malaria prevention and treatment measures. (Prevention to be measured by the % of under 5 year olds sleeping under insecticide treated bednets and treatment to be measured by % of under 5 year olds who are appropriately treated.)
		Prevalence and death rates associated with TB.
		Proportion of TB cases detected and cured under DOTS.

MILLENNIUM DEVELOPMENT GOAL	TARGET	INDICATORS
7. Ensure environmental sustainability.	Halve, by 2015, the proportion of people without sustainable access to safe drinking water.	Proportion of people with sustainable access to an improved water source.
	By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.	Proportion of urban population with access to improved sanitation.
8. Develop a global partnership for development.	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system.	Official development assistance.
	In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries.	Proportion of exports admitted free of duties and quotas. Proportion of population with access to affordable essential drugs on an established basis.

Table 17 shows the progress the province has made towards reaching the targets for MDG's.

- 1) Child mortality appears to be decreasing. The infant mortality rate has decreased by almost half (43%) since 2000 and under – 5 year mortality has decreased by about a third (31%). Since HIV and AIDS is the leading cause of death in those 1-4 years and the province seems to be improving its PMTCT rate (decreased from 6.1% in 2005/06 to 4.1% in 2007/08), it is quite likely that the trend for child mortality will remain in a downward trend though perhaps not reaching a target of a 75% decrease.
- 2) Maternal mortality is increasing and not decreasing and this is also due to HIV and AIDS related deaths.
- 3) The HIV incidence data is not readily available and therefore HIV prevalence in those 15–24 years can be used as a proxy of incidence. It is therefore encouraging that for both the age groups <20 years and 20-24years the HIV prevalence has been decreasing for the last four years.

TB incidence on the other hand has been increasing steadily over time with an increasing problem of MDR and XDR TB.

Table 17: The Western Cape progress on health related Millennium Development Goals 2000-2006

Millennium Development Goal	MDG objective	Indicator	2000	2001	2002	2003	2004	2005	2006	2007	2015 Target	Source	
Reduce Child Mortality.	Reduce <5 mortality by two thirds by 2015.	IMR/1000 live births	44 (1998)	-	-	43.5	-	-	26	25.3	15	SADHS 1998 and 2003 ASSA 2003	
		Child (<5y) Mortality Rate/ 1000 live births	56.6 (1998)	-	-	56.3	-	-	39.0	38.8	19	SADHS 1998 and 2003 ASSA 2003	
		Measles coverage under 1 year	-	82.5	84.9	78.1	91.7	90.7	93.7	102.8	>90	Departmental Annual Reports	
Improve Maternal Health.	Reduce maternal mortality by 75% by 2015.	Maternal Mortality Ratio/100 000 live births	62.4	54.5	74.7	85.7	98.8	-	-		15	Saving mothers, Third report on confidential enquiries into maternal deaths in South Africa 2002-2004.	
Combat HIV/AIDS & other diseases.	Halve new infections by 2015.	HIV Incidence	-	-	0.7% ly	-	0.9% ly	-	-			<0.35	SADH 1998 South African National HIV prevalence, incidence behavioural and communication survey 2005 (Empirical data)
		HIV Prevalence in age group <20years	4.9	6.3	7.3	8.7	8.1	7.2	5.6	4.3	2.45		Departmental Annual Antenatal Survey reports
		HIV Prevalence in age group 20 -24years	10.5	10.3	15.0	15.3	17.4	15.9	15.4	14.5	5.25		
		Condom distribution rate from public sector health facilities (per male >15years)	-	5.9	9.1	10.3	15.6	20.1	25.7	41.1	-		Departmental Annual Reports.
		Number of maternal HIV and AIDS orphans under 15 years	1 876	3 097	4 871	7 325	10 572	14 682	19 648	25 334	-		Dorrington et al, 2003 HIV/AIDS profile in the provinces of South Africa
		New Smear Positive Cure Rate for TB	-	72	68	72	68.3	69.3	71.9	77.4	-		Departmental Annual Reports.
		TB Incidence Rate per 100 000	797	933	960	993	967	1 041	1 038	1 004			Departmental Annual Reports.

Notes:

- Acceptable sanitation is flush, chemical and VIP toilets.
- Information is obtained from surveys and not routinely collected.

3.2 NATIONAL DEPARTMENT OF HEALTH FIVE-YEAR PRIORITIES

The National Department of Health has developed a set of priorities for the period 2004 – 2009, which are based on the assessment of the achievements of the past 10 years and the work that is required to strengthen the National Health System in South Africa. The following priorities were approved by the Health MINMEC, which was subsequently replaced by the National Health Council.

Table 18: National Department of Health five-year priorities

PRIORITY	ACTIVITY
1. Improve governance and management of the NHS.	<ul style="list-style-type: none"> Review and strengthen communication within and between health departments. Strengthen corporate identity, public relations and marketing of health policies and programmes. Strengthen governance and maintenance structures and systems. Strengthen oversight over public entities and other bodies. Adopt Health Industry Charter.
2. Promotes healthy lifestyles.	<ul style="list-style-type: none"> Initiate and maintain healthy lifestyles campaign. Strengthen health promoting schools initiative. Initiate and maintain diabetes movement. Develop and implement strategies to reduce chronic diseases of lifestyle. Implement activities and interventions to improve key family practices that impact on child health.

PRIORITY	ACTIVITY
3. Contribute towards human dignity by improving quality of care.	<ul style="list-style-type: none"> • Strengthen community participation at all levels. • Improve clinical management of care at all levels of the health care delivery system. • Strengthen hospital accreditation system in each province in line with national norms and standards.
4. Improve management of communicable diseases and non-communicable illnesses.	<ul style="list-style-type: none"> • Scale up epidemic preparedness and response. • Improve immunisation coverage. • Improve the management of all children under the age of 5 years presenting with illnesses such as pneumonia, diarrhoea, malaria and HIV. • Updated malaria guidelines, integrate malaria control into comprehensive communicable disease control programme and ensure reduction of cases. • Implement TB programme and review recommendations. • Accelerate implementation of the Comprehensive Plan for HIV/AIDS. • Strengthen free health care for people with disabilities. • Strengthen programmes on women and maternal health. • Strengthen programmes for survivors of sexual abuse and victim empowerment. • Improve risk assessment of non-communicable illnesses. • Improve mental health services.
5. Strengthen primary health care, EMS and hospital service delivery systems.	<ul style="list-style-type: none"> • Strengthen primary health care. • Implement provincial EMS plans. • Strengthen hospital services.
6. Strengthen support services.	<ul style="list-style-type: none"> • Strengthen NHLS. • Ensure availability of blood through South African National Blood Service. • Transfer forensic labs including mortuaries to provinces. • Implement health technology management system. • Strengthen radiation control. • Quality and affordability of medicines. • Establish an integrated disease surveillance system. • Integrate non natural mortality surveillance into overall mortality surveillance system. • Establish an integrated food control system.
7. Human resource planning, development and management.	<ul style="list-style-type: none"> • Implement plan to fast-track filling of posts. • Strengthen human resource management. • Implement national human resource plan. • Strengthen implementation of the CHW programme and expand mid level worker programme. • Strengthen programme of action to mainstream gender.
8. Planning, budgeting, monitoring and evaluation.	<ul style="list-style-type: none"> • Implement SHI proposals as adopted by Cabinet. • Strengthen health system planning and budgeting. • Strengthen use of health information system.
9. Prepare and implement legislation.	<ul style="list-style-type: none"> • Implement Mental Health Care Act. • Implement National Health Act. • Implement Provincial Health Acts. • Traditional healers, Nursing & Risk Equalisation Fund Bills implemented.
10. Strengthen international relations.	<ul style="list-style-type: none"> • Strengthen implementation of bi and multi-lateral agreements. • Strengthen donor co-ordination. • Strengthen implementation of NEPAD strategy and SADC.

3.2.1 **Highlights of the Western Cape Department of Health's contribution to the National Department of Health's priorities**

1) **Improve governance and management of the National Health System:**

- Governance and management of the District Health System are being strengthened through the development of district and sub-district management structures in the province and facility managers have been appointed at the major community health centers in the Metro. The responsibility for the provision of Personal Primary Health Care (PPHC) services that were previously provided by the rural municipalities has been transferred to the provincial Department of Health.
- The management structure has been strengthened by the appointment of a chief director and four directors in the Metro District and a director for each of the rural districts for the provision of Primary Health Care Services.
- The City of Cape Town continues to provide and partially fund PPHC services in the Cape Town Metro Health district until the services are transferred to the Provincial Government.

2) **Promote healthy lifestyles:**

- Primary health care contributes towards health education and counselling.
- Chronic lifestyle disease programme: through clubs for diabetes, hypertension, asthma and epilepsy these programmes provide lifestyle information that enables individuals and groups to make informed choices regarding their health and well being.
- Developing a documentary about alcohol which aims to empower young people to make responsible choices about drinking alcohol.

3) **Contribute towards human dignity by improving quality of care:**

- Community participation is facilitated by the facilities boards that have been appointed in all hospitals, in line with the Health Facility Boards Act.
- Community participation is promoted through the Provincial Health Council, in line with the National Health Act.
- Effective public relations are facilitated by means of communication with the public and internal communication, for example imbizo's/face-to-face meetings and media coverage.
- A provincial profile of complaints and compliments is compiled and reviewed on a quarterly basis.
- External client satisfaction surveys are conducted in accordance with a planned schedule.
- Generic and specific services standards have been developed.
- A provincial infection prevention and control policy has been developed and a provincial infection and control committee constituted to give strategic direction to the development of infection prevention and control strategies.
- Mortality and morbidity reviews are conducted at institutional level on a monthly basis.
- An adverse event incident reporting system with centralised data capture in order to create a provincial database of adverse clinical events which guide the proactive arm of the risk management programmes has been created.

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- Staff satisfaction surveys are conducted.
 - Waiting time surveys are conducted at selected sites, representative of level 1, 2 and 3 services.
 - Clinical governance will be strengthened through the employment of family physicians and level 2 clinical heads.
- 4) **Improve management of communicable diseases and non-communicable illnesses:**
- HIV and AIDS: The Western Cape has implemented the national comprehensive plan for the management, treatment and care of people living with HIV and AIDS. The province has achieved significant increase in anti-retroviral treatment access and universal coverage for the PMTCT intervention, through successful partnerships and multi-sectoral efforts.
 - The incidence of tuberculosis (TB) in the Western Cape continues to be amongst the highest in the world, exacerbated by the HIV and AIDS pandemic. The Department has made significant progress in the implementation of the WHO DOTS Strategy and is working towards the overall goal of achieving an 85% cure rate. However, the solution to this problem lies elsewhere in housing and socio-economic conditions.
 - The Department has implemented the Chronic Dispensing Unit (CDU) which dispenses pre-packed chronic medications to over 70 000 stable chronic patients in the Metro each month, which are then delivered to the respective facilities and therefore decreasing waiting times for patients at the dispensary. Similarly the rural districts have alternative dispensing methods for chronic stable patients whose medication is pre-packed by pharmacists at the community health centres.
- 5) **Strengthen primary health care, Emergency Medical Services and hospital delivery systems:**
- The strengthening of Personal Primary Health Care includes the assumption of responsibility for the provision of these services in the rural districts, the establishment of facility management, the computerisation of PHC services and the development of an infrastructure plan for PHC.
 - Emergency Medical Services have been strengthened with additional funding as well as restructuring of the service in line with the recommendations of an expert external review. Emergency services in hospitals are being enhanced by the appointment of emergency medicine specialists.
 - Hospital services, particularly regional hospital services providing level 2 services, are also being strengthened.
- 6) **Strengthen support services**
- The transfer of the Medico-Legal Mortuaries from the South African Police Services to the Provincial Department of Health was accomplished on 1 April 2006. A Directorate: Forensic Pathology has been established.
 - Medicines and pharmacy legislation is currently being implemented. Regional support is being provided to facilitate compliance.
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7) Human resource planning, development and management:

- A Human Resource Plan that is aligned to the Comprehensive Service Plan has been adopted.
- Nurse training at various levels is being strengthened within the Department.
- Training of additional categories of health workers will be extended through the Extended Public Works Programmes with learnerships in key areas.
- An Employment Equity Plan has been developed and implemented.
- An Affirmative Action Strategy has been implemented in consultation with the relevant stakeholders.

8) Planning, budgeting, monitoring and evaluation:

- The strategic planning of health services in the Western Cape is activity based and aligned with the allocated funding envelope.
- The Department participates in the quarterly reporting systems of the National Department of Health and Treasury in which non-financial performance is reported.
- Programme performance is monitored quarterly by an internal Monitoring and Evaluation Committee where Programme Managers report on the performance of the respective programmes against the set of indicators in the Annual Performance Plan. The Monitoring and Evaluation Committee is chaired by the Head of Department.
- Financial monitoring is done by means of the monthly in year monitoring and in addition quarterly evaluation in the Financial Monitoring Committee, chaired by the Head of Department.
- The Hospital Information System (HIS) has been implemented in the central hospitals and rolled out to several hospitals in the regions. Similarly the Primary Health Care Information System (PHCIS) is being implemented in the province. These initiatives are constrained by limited funding.

9) Prepare and implement legislation:

- Mental Health Act: The Mental Health Review Board has been is functioning well and has been a model for other provinces.
- National Health Act 61 of 2003: is being implemented and the governance requirements are being implemented with the Provincial Health Council which has been constituted in terms of the Act.
- The Medicines and Related Substances Act 101 of 1965 as amended and Pharmacy Act 53 of 1974 as amended: considerable preparatory work has been done to prepare for the implementation of this legislation.

- The following redundant provincial legislation has been repealed as part of the provincial government's Law Review Project:
 - 1) Ambulance Personnel Transfer and Pensions Ordinance, 1955 (Ordinance 11 of 1955);
 - 2) Hospitals Ordinance, 1946 (Ordinance 18 of 1946) and its subordinate legislation namely:
 - Regulations relating to Honorary Medical Staff of Provincial Hospitals, 1953. (PN 553 of 1953);
 - Regulations for the procurement by Provincial Hospitals and Associated Institutions, 1953 (PN 761 of 1953);
 - Regulations relating to the Payment of Transport Allowances to Members of Hospital Board, 1956 (PN 323 of 1956); and
 - Regulations relating to Election, Powers and Functions of Medical Committees, 1960 (PN 307 of 1960).
- The Western Cape Fees Act 5 of 2008 was promulgated which regulates the fees to be paid by the public for health care services rendered by the Department and repeals the Hospital Ordinance 18 of 1946. The repeal of the Hospital Ordinance is a landmark as it does away with the requirement that only certain medically qualified persons can be appointed as the head of a hospital. It means that the provincial Minister and the Department may now appoint a non-medically qualified manager as the head of hospital in terms of the Public Service Act.
- The Western Cape District Health Councils Bill which aims to regulate the functioning of district health councils has been published public for comment with permission of the provincial Cabinet.

10) **Strengthen international relations:**

- The Department has a number of co-operation agreements with various donor agencies, e.g. the European Union for community-based services and the Global Fund for TB and HIV and AIDS.

3.3 ANNUAL NATIONAL HEALTH PLAN FOR 2008/09

It is a requirement of the National Health Act of 2003 that the National Department of Health develops and submits to the National Health Council an Annual National Health Plan that consolidates the Annual Performance Plans of the national and provincial departments of health. The Annual National Health Plan (ANHP) must indicate the national priorities and the anticipated outputs.

The ANHP for 2008/09 is the third such plan that has been developed since the promulgation of the Act. For the 2008/09 financial year, the National Health Council adopted 8 priorities for the National Health System, which will be implemented by the national and provincial departments of health. These are:

- 1) Health programme priorities, focusing on communicable and non-communicable diseases;
- 2) Quality improvement through the development and implementation of Health Facility Improvement Plans;
- 3) Implementation of an integrated national health information system;

- 4) Health financing, including designing the national health insurance system and reducing the rate of increase of tariffs in the private health care sector.
- 5) Further reduction in the prices of pharmaceutical products;
- 6) Strengthening human resources for health;
- 7) Improving international health relations; and
- 8) Strengthening management and communication.

3.4 FEE STRUCTURES

3.4.1 National Department of Health: Free health services

In accordance with national policy the provincial Department of Health provides the following health services free of charge:

- 1) Family planning services;
- 2) Health advisory services,
- 3) Immunisations to combat notifiable infectious diseases, excluding vaccination for foreign travel;
- 4) Treatment of infectious, formidable and/or notifiable diseases, e.g. pulmonary tuberculosis, Leprosy, Meningococcal meningitis;
- 5) The preparation of medical reports required in cases with legal implications such as rape, assault, drunken driving, post mortems, etc.
- 6) Oral health services: the screening, preventive and promotive services offered at schools and also scholars classified according to a means test and referred by the school nursing services or oral health services;
- 7) Patients are transported free of charge in certain instances;
- 8) Involuntary (certified) mental health care users (MHCU);
- 9) School children referred by schools and classified (as H0 and H1 patients) according to a means test;
- 10) Children committed in terms of section 15 and 16 of the Child Care Act, Act 74 of 1983;
- 11) Children under the age of six years. This applies to children classified as H0, H1, H2 and H3 in terms of a means test;
- 12) Pregnant women classified as H0, H1, H2, and H3 patients;
- 13) Termination of pregnancy is free to hospital patients (H0, H1, and H2 patients) as well as full paying patients but excluding patients treated by their private doctors. The free service includes free ambulance and patient transport services.
- 14) Primary health care services are rendered free to permanent residents, including asylum seekers and refugees from neighbouring states, and who are classified as H0, H1 or H2 patients.

3.4.2 The Uniform Patient Fee Schedule (UPFS)

The regulations relating to the UPFS in terms of which patient fees are determined are amended annually by the provincial Minister of Health and published in the Provincial Gazette. In terms of the regulations published in the Provincial Gazette 6302 on 7 October 2005, the provincial Health Department provides free health services to the following categories of patients [subject to conditions specified in the Gazette], in addition to the free services outlined in Annexure C of Finance Instruction G50 of 2003, dated 23 December 2003, determined by the National Department of Health:

- Social grantees
- Formally unemployed

These patients are therefore classified as fully subsidised hospital patients (H0).

Recipients of the following types of grants are classified as social grantees:

- Old age pension;
- Child support grant;
- Veteran's pension;
- Care dependency grant;
- Foster care grant; and
- Disability grant;

Other patients are assessed according to a means test and categorised as H1, H2 or H3 patients and are subsidised accordingly.

Table 19: Tariff categories

Tariff category	Individual/single gross income per annum	Household/family unit gross income per annum	Level 1, 2 and 3 Tariffs
H1	Less than R36 000	Less than R50 000	As gazetted
H2	Equal to or more than R36 000 but less than R72 000	Equal to or more than R50 000 but less than R 100 000	As gazetted
H3 (Self-funded)	Equal to or more than R72 000	Equal to or more than R100 000	The full price of the UPFS
Private and externally funded	Not applicable	Not applicable	The full price of the UPFS

Meeting the commitment outlined above makes a significant contribution to providing accessible health care, addressing equity issues and the formation of Social Capital. However, this commitment also has a related impact on the limited available resources.

3.5 THE PROVINCIAL GROWTH AND DEVELOPMENT STRATEGY (PGDS)

The Provincial Growth and Development Strategy strengthens the growth and development agenda by addressing local imperatives and realities, promoting a shared initiative to achieve the vision of the Western Cape as a "Home for All."

The following strategies constitute the base of the PGDS as described in the Provincial Growth and Development Strategy which served as a green paper for the Western Cape, (Provincial Gazette Extraordinary: 6385: 4 October 2006):

First generation strategies:

Micro-economic Development Strategy (MEDS)
Strategic Infrastructure Plan (SIP)
Human Capital Development Strategy (HCDS)
Social Capital Formation Strategy (SCFS)
Provincial Spatial Development Strategy (PSDF)

Second generation strategies

Scarce Skills Strategy (SSS)
Human Settlement Strategy (HSS)
Integrated Law Reform Project (ILRP)
Sustainable Development Implementation
Plan (SDIP)

Each of these strategies is championed by a lead department and supported by other related departments. The Department of Health has been allocated the role of support department to the social capital formation and strategic infrastructure strategies. The lead departments are the Departments of Social Services and Poverty Relief and Transport and Public Works, respectively.

3.5.1 Department of Health contributions towards the social transformation projects in the 27 priority areas

The Provincial Government has identified focus areas to give effect to the Provincial Growth and Development Strategy (PGDS). Interventions (resources, collaboration with stakeholders and service delivery) to promote social regeneration will be focussed. The 27 communities targeted are those most vulnerable to poverty, crime and gangsterism.

3.5.1.1 Governance

The Department of Health appointed a dedicated Social Capital Manager, on contract, to coordinate Social Capital activities and represent the Department at the provincial Social Transformation Steering Committee and service delivery planning activities covering the following areas:

- 1) Establishment of community intermediary structures;
- 2) Establishment of inter-governmental teams in the 27 priority areas; and
- 3) Service delivery jamborees in 27 priority areas.

3.5.1.2 Service delivery

The Department provides on-site healthcare services in and around the priority areas as summarised in Table 21 below: The 21 priority areas have now been increased to 27 areas which include:

- Atlantis in Western sub-district
- Bonteheuwel – Langa in Western sub-district
- George sub-district in Eden
- Mossel Bay sub-district in Eden
- Heidelberg in Hessequa sub-district in Eden
- Worcester in Breede Valley sub-district in the Cape Winelands.

Table 20: Social Transformation Projects: Twenty-seven priority areas

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE	
					Home-based care	Social capital/ Prevention projects
METRO	SOUTHERN	MUIZENBERG	Victoria Hospital 90 beds False Bay Hospital: 40 beds Fish Hoek Clinic Redhill Mobile Clinic Simonstown Satellite Clinic Muizenberg Clinic Masiphumelele Clinic Ocean View CHC Ocean View Clinic	Cataract surgeries done ARV site ARV site ARV site Extended hours	Compassion in Action Living Hope covers all these areas for HBC as well as having a palliative care centre with 20 beds. Nutrition rehabilitation programme by Living hope	Physical Exercise group at Retreat CHC Chronic Disease support groups at Masipumelele by Living Hope
METRO	MITCHELL'S PLAIN	PHILLIPI	Lansdowne Clinic Hanover Park CHC & MOU Hanover Park Clinic Newfields Satellite Clinic Philippi Clinic Philippi CHC	Extended hours and maternity services	Athlone YMCA for HBC Infant feeding counsellors in Hanover Park. Ithembalabantu palliative care centre 10 beds	Exercise group at Athlone Hall Chronic disease support groups by Red Cross
		MITCHELL'S PLAIN	Crossroads CHC Crossroads 1 clinic Crossroads 2 clinic Brown's Farm CHC (Inzamezabantu) Mzamomhle clinic Pumlangi clinic Mandalay Satellite Clinic Lentegeur Clinic Tafelsig CHC Eastridge Clinic Mitchells Plain CHC & MOU Mitchells Plain Youth Health Centre Rocklands Clinic Weltevreden Valley Clinic Westridge Clinic	ARV site ARV site Extended hours & Maternity services and ARV site Reproductive Health services and various youth activities	Homebased care by Gods Kingdom and Arisen Women Arisen Women Gods Kingdom	Chronic disease support groups by Red Cross Eye screening project and mobility workers by SANC for the Blind Chronic Disease support groups by Arisen Women Breastfeeding club Social health workers by PPASA

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE		
					Home-based care	Social capital/ Prevention projects	
	KLIPFONTEIN	NYANGA	GF Jooste Hospital 180 beds	ARV site	Athlone YMCA	Sensible drinking/ Substance abuse workers	
			Manenberg Clinic				
			Guguletu CHC & MOU	Extended Hours & Maternity services and ARV site	St Lukes Hospice, Nokuthembeka, SACLA, SA Red Cross.	Exercise group by SACLA at Nyaga clinic and Guguletu Reproductive Health Clinic and Chronic disease support groups by Red Cross	
			Guguletu Clinic				
			Masincedane Clinic	ARV site	St Johns and Red Cross		
			Nyanga CHC				
			Nyanga Junction RHC	Dedicated Reproductive health services			
			Nyanga Clinic	Dedicated Reproductive health services			
			Uluntu RHC				
		GREATER ATHLONE	Dr Abdurahman clinic	ARV site	Athlone YMCA		
			Heideveld clinic				
			Awaiting New Mitchells Plain Hospital: 230 beds. Currently beds based at Lentegeur Hospital		St Lukes Hospice: 30 palliative/respice beds		
	TYGERBERG	BISHOP LAVIS	Bishop Lavis CHC/MOU	Extended hours and maternity services	Caring Network plus infant feeding peer counsellors by La leche League		
			Bishop Lavis Clinic				
			Netreg Clinic Valhalla Park Clinic				
		ELSIES RIVER	Adriaanse Clinic	Extended hours & Maternity services	Konoina Tehillah plus Elsie's River Lifecare centre for palliative care 20 beds.	Exercise group at Elsie's CHC	
			Elsies River CHC/MOU				
			Elsies River Clinic Leonsdale Satellite Clinic Matroosfontein Satellite Clinic				
		DELFT	Delft Clinic	Extended hours and ARV site	Ma Afrika Tikkon	Exercise group at Library	
			Delft CHC				
			Karl Bremer Hospital 175 beds Eerste River Hospital 30 beds				ARV site ARV site

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE		
					Home-based care	Social capital/ Prevention projects	
METRO	KHAYELITSHA	KHAYELITSHA	Khayelitsha Site B Youth Centre	Various youth services and activities	Caring network, SA Red Cross, Zanempilo, St Lukes, SACLA	Eye screening project and mobility workers by SANC for the blind. Chronic disease support groups, school health workers by PPASA Community IMC and door to door campaign. Seasonal diarrhoeal campaign Pjilani Nutrition rehabilitation projects at Mayibuye, Site B, Site C and Town 2	
			Khayelitsha Site B Clinic				
			Khayelitsha Site B CHC	Extended hours, ARV site			
			Khayelitsha Site B MOU	Maternity services			
			Zibonele Town 2 Clinic				
			Luvuyo Clinic				
			Matthew Goniwe CHC	ARV site			
			Mayenzeke Clinic				
			Nolungile Youth Centre	Various youth services and activities			Caring network, SA red cross, Zanempilo, St Lukes, SACLA plus Bapumelele Palliative care centre with 10 beds
			Nolungile Clinic				
			Nolungile CHC	Extended hours and ARV site			
			Michael Mapongwana CHC/MOU	Extended hours and maternity services and ARV site			
			Zakhele Clinic				
			Kuyasa Clinic	ARV site			
Awaiting New Khayelitsha Hospital: 230 beds.	90 beds currently housed at TBH						
Hilcrest Clinic		Eersteriver Bluedowns HIV, SA Home Bureau Infant feeding peer counsellors by La leche League Konoinia Ma Afrika Tikkun Eagles Rest palliative care centre with 10 beds					
Kleinvei Clinic							
Kleinvei CHC	Extended hours						
Blue Downs Clinic							
Russel's Rest Clinic							
Wesbank Clinic							
Mfuleni CHC	ARV site						
Mfuleni Clinic	ARV site						
Driftsands Satellite Clinic							
Helderberg Hospital 90 beds	ARV site						
Eerste River Hospital 60 beds	ARV site						
Vanguard CHC	ARV site		Red Cross Society				
Langa clinic							
ATLANTIS	Westfleur Hosp		ARV site	Catholic welfare development World vision			
	Mamre CHC						
	Protea Park clinic						
	Saxon Sea Clinic						
	Pella Satellite Clinic						

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE	
					Home-based care	Social capital/ Prevention projects
CAPE WINELANDS	DRAKENSTEIN	PAARL	Paarl Hospital: 250 beds and increasing to 327 beds Mbekweni Clinic Phola Park Clinic Dalvale Clinic Patriotplein Clinic JJ du Pre Le Roux Clinic Klein Nederburg Clinic Klein Drakenstein Clinic TC Newman CHC	 Because there is no District hospital, CHC is rendering District Hospital level functions ARV site	Caring Network Drakenstein Hospice, Wellington Society for the Aged and Saron Gemeenskapdiens plus Luthando palliative care centre with 12 beds	Exercise group at TC Newman Comm hall
CAPE WINELANDS	WITZENBERG SUB-DISTRICT	WITZENBERG SUB-DISTRICT	Ceres Hospital Ceres CHC Bella Vista Clinic Breërivier Clinic Nduli Clinic Op die Berg Clinic Prince Alfred Hamlet Clinic & mobile Tulbach Clinic Wolsely Clinic Karoo Mobile Koue Bokkeveld Mobile Skurweberg Mobile Warm Bokkeveld Mobile Tulbach Mobile Wolsely Mobile	ARV site Joint IDP planning with Municipality	Witzenberg Aids Action	
CAPE WINELANDS	BREDE VALLEY	WORCESTER	Worcester Hosp Worcester CHC Brewelskloof Hosp De Doorns Clinic Empilisweni clinic Maria Pieterse Clinic Rawsonville Clinic Sandhills Clinic Somerset Clinic Touwsriver Clinic	ARV site ARV site	Famsa Boland hospice Vukuhambe and rise and Shine for mental illness and APD for rehabilitation	
OVERBERG DISTRICT	THEEWATERS-KLOOF	THEEWATERS-KLOOF	Caledon Hospital Caledon CHC Grabouw CHC Grabouw CHC MOU Botrivier Clinic Genandendal Clinic Greyton Clinic	ARV site Extended hours and ARV site	Elgin Community college, Badisa Riviersonderend, Genadendal Legal Info	Theewaterskloof Health and Welfare Committee and Community IMCI project

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE	
					Home-based care	Social capital/ Prevention projects
			Riviersonderend Clinic Villiersdorp Clinic Caledon Mobile 1 Caledon Mobile 2 Caledon Mobile 3 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Villiersdorp Mobile 1 Villiersdorp Mobile 2 Villiersdorp Mobile 3			
EDEN	HESSEQUA	HEIDELBERG	Heidelberg CHC Riversdale Hosp Still Bay clinic Albertinia Van Wyksdorp Riversdale Clinic Slangriver Clinic	ARV site	Droom and Oasis Community project	Chronic Dispensing off site venues
EDEN	OUDTSHOORN	OUDTSHOORN	Oudtshoorn Hospital Bridgeton Regent Street Toekomsrus Bongoletu	ARV site	Coronation Memorial	Chronic Dispensing off site venues
EDEN	KANNALAND	KANNALAND	Zoar, Amalien Steyn Clinic Calitzdorp Clinic Van Wyksdorp Mobile Van Wyksdorp Satellite Clinic Ladismith Mobile Calitzdorp Mobile		Huis Isak van tonder, Oasis.	Chronic Dispensing off site venues
EDEN	GEORGE	GEORGE	George Hospital Harry Comay Bianco clinic Conville CHC George Civic centre Clinic Lawaaicamp Clinic Pacaltsdorp clinic Parkdene Clinic Rosemor Clinic Tembaletu Clinic Touwsranten sat clinic Wilderness mobile Kraaibos mobile Diepkloof & Geelhout boom mobile	ARV site ARV site	Huis JJ Watson CMR	Chronic Dispensing off site venues

DISTRICT	SUB-DISTRICT	PRIORITY AREA	CURRENT HEALTH FACILITIES	Types of services available at health facilities other than Child and Women's health and the normal hours of curative services. (VCT is offered in all fixed facilities)	COMMUNITY BASED HEALTH SERVICES AVAILABLE	
					Home-based care	Social capital/ Prevention projects
			Koekenaap Satellite Clinic Nuwerus Satellite Clinic Stofkraal Satellite Clinic Mosvlei Satellite Clinic Rietpoort Satellite Clinic Kliprand Satellite Clinic			
WEST COAST	CEDERBERG SUB-DISTRICT	CEDERBERG SUB-DISTRICT	Clanwilliam Hospital 30 beds Clanwilliam CHC Clanwilliam Mobile Graaffwater Mobile Graaffwater Clinic Wuppertal Clinic Citrusdal Hospital Citrusdal Clinic Citrusdal Mobile Robyn Lambertsbaai Clinic	ARV site	Diakonale Dienste Lambertsbay, Ons Huis, Sederhof Clanwilliam	Psycho-social rehabilitation group by Ons Huis, Exercise group by Ons Huis Chronic disease support group Chronic Disease support group by Sederhof Clanwilliam
WESTCOAST	SALDANHA	VREDENBURG	Vredenberg Clinic Louville Clinic Vredenburg Hospital: 56 beds and increasing to 80 beds	ARV site	Westcoast Community HIV/Aids Action, St Helena Sandvlei Hospice, Vital connection	Substance Abuse awareness Psychosocial rehabilitation group, Chronic disease support groups by Vital Connection

3.6 HEALTHCARE 2010

The Western Cape Strategic Transformation Plan, Healthcare 2010, originates from the restructuring plans that were commenced in 1994 and was approved by Provincial Cabinet on 26 March 2003.

The technical model is based on a set of inter-related variables such as population size, patient activities and the financial envelope. It was developed in order to substantially improve the quality of the health services and to restructure the Department to be financially sustainable. Healthcare 2010 identified that the Department is under funded by conservatively R500 million (2001 rands) if it is to deliver the level of service prescribed by government policy. This was confirmed with the further development of the Comprehensive Service Plan.

3.6.1 The underlying principles of Healthcare 2010 are:

- 1) Quality care at all levels;
- 2) Accessibility of care;
- 3) Efficiency;

- 4) Cost effectiveness;
- 5) Primary health care approach;
- 6) Collaboration between all levels of care; and
- 7) De-institutionalisation of chronic care.

3.6.2 Implementation of Healthcare 2010

The strategic goals of the Department are:

- 1) Provide an integrated and quality seamless healthcare service;
- 2) Ensure an appropriate and affordable staff establishment;
- 3) Ensure that there are appropriate facilities in the right places; and
- 4) An appropriate funding envelope.

The realisation of these goals requires the detailed development of four inter-related plans, each with a number of component projects, which form the pillars of Healthcare 2010, i.e.

- The Comprehensive Service Plan;
- The Human Resource Plan;
- The Infrastructure Plan; and
- The financial plan.

1) The Comprehensive Service Plan

The Comprehensive Service Plan (CSP) has been developed and provides the framework for the reshaping of the service at all levels of care to give effect to Healthcare 2010.

The Provincial Cabinet approved the CSP on 19 July 2006. Following a period of consultation with external stakeholders the Department it was approved for implementation by the Provincial Minister of Health on 11 May 2007 and confirmed the under funding identified in Healthcare 2010. The Department is vigorously engaged in the implementation process.

2) The Personnel (Human Resource) Plan

The primary cost driver in health is the personnel costs and therefore both the ability to operate within the allocated budget and most importantly the quality of the health service delivered is dependent on the personnel. A human resource plan has been developed to implement the staffing models recommended in the CSP.

3) The Infrastructure Plan

The infrastructure plan has been developed to provide health facilities ranging from clinics, community health centres and hospitals of the correct design and appropriate location.

4) The Financial Plan

The costing of the Comprehensive Service Plan and the appropriate allocation of resources across the service platform in an equitable manner will be set the in the financial plan for Healthcare 2010.

3.6.3 Key deliverables for 2009/10

- 1) **Implementation of the Comprehensive Service Plan to improve the quality of health care delivery, which includes:**
 - Fully functioning health districts.
 - Strengthening district health service delivery through outreach and support to district hospitals, community health centres and clinics.
 - Restructuring the service platform and implementation of services per level of care across the service platform.
 - Restructuring emergency medical services to achieve improved response times and begin to achieve response times closer to the national norms.
 - Expansion of community-based care services through the Expanded Public Works Programmes in Health to enable people to be managed in communities where they live.
 - Infrastructure:
 - Increase the percentage of total health budget allocated to maintenance
 - Commencement of the construction of the Khayelitsha and Mitchells Plain District Hospitals.
- 2) **Strengthened TB programmes with special focus on improved cure rates and the management of multi and extreme drug resistant TB.**
- 3) **Care and management of people living with HIV and AIDS with a greater focus on targeted prevention interventions and district health based treatment.**
- 4) **Implementation of the new Pneumococcal and Rotavirus vaccines and the replacement of the current DPT-Hib vaccines.**
- 5) **Address service pressures in mental health, obstetric and neonatal services, surgery and emergency care.**
- 6) **Strengthened mechanisms to assess the burden of disease and strategies developed with other departments to begin to reduce the burden of disease.**
- 7) **Strengthened human resource and financial management to improve performance**

4. DESCRIPTION OF THE STRATEGIC PLANNING PROCESS

Prior to commencing the planning process for 2009/10 at the beginning of June 2008, the Department embarked on an intensive process of internal reflection on its performance for the 2007/08 financial year. During this process each programme was analysed in terms of planned performance versus actual financial and non-financial performance within the context of the Comprehensive Service Plan. Valuable lessons were learned, for example regarding the definition of appropriate performance indicators and the setting of realistic targets, which were carried forward into the planning process.

This was followed by a planning process at Caledon in July 2008 where each programme assessed what the return on its financial investment it will deliver, i.e. value for money, during the 2008/09 financial year and therefore what services would be provided in 2009/10 within the projected available funding. Options were explored as to how savings could be realised by improved efficiencies and the 'savings' used to meet further demand for service, and four policy options were identified for submission to Treasury for the MTEC process.

The Department has developed a detailed plan for the implementation of the CSP across the key service delivery financial programme, i.e. Programmes 2, 4 and 5, and is outlined in the Executive Summary of Part B of this document. This will be implemented in line with available funds in the respective programmes.

From a technical perspective a concerted effort has been made to improve the documentation and monitoring of performance information. For the first time a comprehensive summary of all the performance indicators used in this document has been compiled and is attached as Annexure A. The sources of the component data elements of the indicators have also been specified. This is a dynamic process which will be reviewed and amended as appropriate. A further addition is a list of health facilities attached as Annexure B. The accuracy of this information is particularly important in the context of the denominators used to calculate performance information.

A number of indicators in the document are specified by the National Department of Health in collaboration with National Treasury. There are some instances where the Province has elected to include a related indicator to add value to the information provided. These indicators can be identified by the numbering of the indicators in the respective tables, e.g.

"1." 'Nationally prescribed indicator

"1.1" Additional related indicator provided by the Province for clarity and which should therefore be read in conjunction with the national indicator.

5. PAST EXPENDITURE TRENDS AND RECONCILIATION OF THE MTEF PROJECTIONS WITH PLAN

Table 21: Trends in provincial public health expenditure (R million) [A3]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	5 501 787 000	6 075 160 000	7 126 190 000	8 306 604 000	9 207 624 000	10 188 059 000	10 946 829 000
Total Capital	217 025 000	344 355 000	371 678 000	439 130 000	685 174 000	737 210 000	817 629 000
Grand Total	5 718 812 000	6 419 515 000	7 497 868 000	8 745 734 000	9 892 798 000	10 925 269 000	11 764 458 000
Total per person	1,212	1,216	1,415	1,643	1,852	2,037	2,184
Total per uninsured person	1,623	1,634	1,901	2,209	2,489	2,737	2,936
Constant 2007/08 prices							
Total excluding capital	5 893 499 990	6 288 906 833	7 126 190 000	7 750 488 863	8 159 902 394	8 708 192 457	9 092 598 241
Total Capital	232 476 618	356 470 696	371 678 000	409 730 881	607 209 087	630 126 559	679 134 753
Grand Total	6 125 976 608	6 645 377 529	7 497 868 000	8 160 219 743	8 767 111 481	9 338 319 016	9 771 732 994
Total per person	1,299	1,259	1,415	1,533	1,641	1,741	1,814
Total per uninsured person	1,739	1,692	1,901	2,061	2,205	2,340	2,439
% of Total spent on:-							
District Health Services	28.50%	29.95%	36.11%	35.78%	35.42%	35.69%	35.58%
Provincial Hospital Services ²	22.66%	21.77%	17.42%	26.97%	26.50%	26.45%	26.46%
Central Hospital Services	34.63%	33.07%	31.34%	21.26%	19.32%	19.28%	19.29%
Capital	3.79%	5.36%	4.96%	5.02%	6.93%	6.75%	6.95%
Health as % of total public expenditure (current prices)	34.15%	34.06%	34.88%	34.70%	34.57%	34.67%	34.67%



**BUDGET PROGRAMMES &
SUB-PROGRAMMES**

EXECUTIVE SUMMARY

1. INTRODUCTION

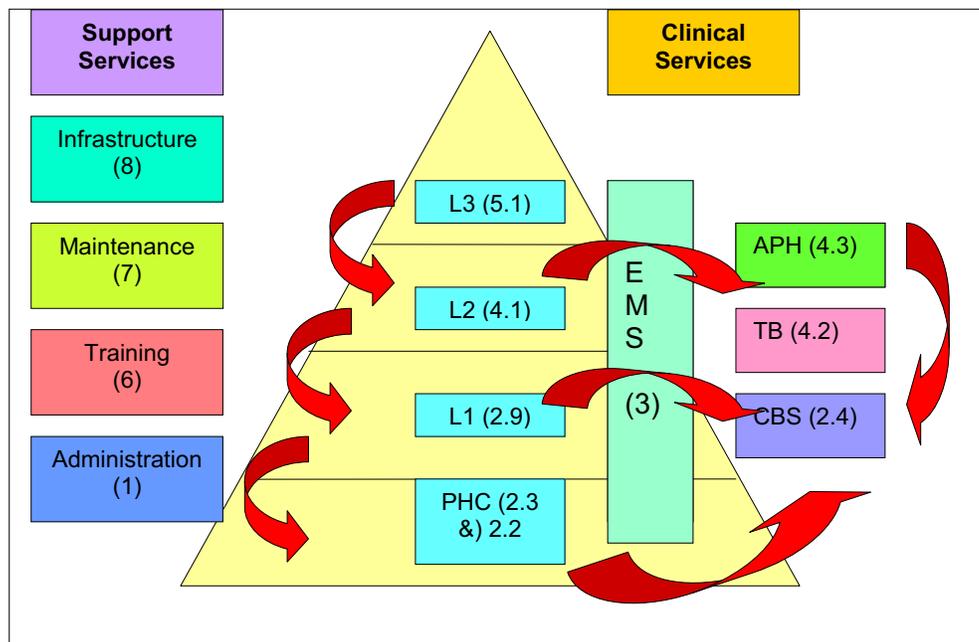
The executive summary of Part B highlights the key service delivery outputs to be achieved during the 2009/10 financial year as the Department continues with the progressive implementation of the Comprehensive Service Plan (CSP). The manner in which the current services are delivered is not yet fully consistent with the CSP. The Annual Performance Plan (APP) for 2008/09 articulated a series of performance targets to align the services with the APP targets and the 2009/10 will build on the foundation laid in 2008/09.

The Department has two clinical service divisions, namely District Health Services and Programmes, and Central, Regional and Associated Psychiatric Hospitals and Emergency Medical Services. The following inter-divisional key performance areas have been identified as the basis for integrated service delivery for 2009/10:

- 1) Acute services (including EMS and acute hospital services)
- 2) Ambulatory care (including Outreach & Support)
- 3) Infectious disease management
- 4) De-hospitalised care

The key deliverables to be achieved across the service platform in 2009/10 within each of the four priorities areas will be articulated as “service shifts” across the financial sub-programmes as illustrated in the following diagram:

Figure 1: The integrated clinical service delivery platform per financial sub-programme and the support services per financial programme



2. ACUTE SERVICES (INCLUDING EMERGENCY MEDICAL SERVICES AND ACUTE HOSPITAL SERVICES):

2.1 PRINCIPLES FOR THE TRANSFORMATION OF THE ACUTE SERVICES

The two service divisions agreed to the following principles for transformation of the acute services platform in 2009/10:

- 2.1.1 The packages of care for levels 1, 2 and 3 services were finalised during 2008/09. The development of standard case definitions and a point prevalence survey at different facilities across the various general specialities, allowed for the quantification of level 1, 2 and 3 activities across the acute hospital service platform and identified quantifiable service shifts to be implemented against realistic time-frames in the 2009/10 financial year and beyond.
- 2.1.2 The total number of usable acute beds will be quantified per financial sub-programme (5.1, 4.1 and 2.9). The number of acute beds has increased from 2007/08 to 2008/09 and it is assumed that there will be no major increase in the number of acute beds across the platform during 2009/10.
- 2.1.3 The separation of level 2 and level 3 services within the central hospitals is an important activity towards the restructuring of the service platform.
- 2.1.4 The appointment of the level 2 clinical heads remains a critical step to consolidate clinical governance for the general speciality disciplines.
- 2.1.5 Tygerberg and Groote Schuur Hospitals will explore alternative lodging arrangements for clients who require specific services over a period of time, but do not require active care while in hospital.
- 2.1.6 Specific performance targets for emergency centres, theatres and critical care areas the in regional and central hospitals will be actively managed during 2009/10.
- 2.1.7 The eight level 2 general specialities will be divided into 3 “service clusters”:
 - 1) **Cluster 1:** Emergency Medicine; Internal Medicine; Psychiatry;
 - 2) **Cluster 2:** Surgery, Orthopaedics; Anaesthetics
 - 3) **Cluster 3:** Obstetrics & Gynaecology; Paediatrics and Neonatology;
- 2.1.8 The approach for each cluster is to determine:
 - 1) The current reality for the Metro and the rural districts respectively, in terms of “distance from the CSP targets”;
 - 2) The projected achievements for March 2009 (as per 2008/09 APP), towards reaching CSP targets;
 - 3) The achievable deliverables for 2009/10, towards reaching CSP targets.

2.2 CLUSTER 1: EMERGENCY MEDICINE, INTERNAL MEDICINE AND PSYCHIATRY:

2.2.1 Emergency Medicine:

A key Departmental decision is the uniform and compulsory implementation of the various aspects of the Acute Emergency Case Load Policy (AECLP), as from 1 August 2008. The pilot for integrated emergency care service provision in the Cape Winelands District and the Khayelitsha/ Eastern sub-structure provides a model for geographic clinical governance for pre and in hospital emergency care, and will be systematically replicated across the province.

2.2.1.1 Metro:

The Eerste River Hospital emergency centre is expected to be operational in 2010/11, the Karl Bremer Hospital emergency centre in 2011/12, the Khayelitsha District Hospital emergency centre in 2011/12 and the Mitchells Plain Hospital emergency centre in 2012/13.

- **The projected achievements by March 2009 are:**

- Integrated emergency care services across the EMS services and all point of entry emergency services in the Eastern/ Khayelitsha sub-structure under the clinical governance of the Emergency Medicine Specialist;
- Fully functional Site B emergency centre acting as a point of entry emergency service for the Khayelitsha District Hospital (with the establishment of an “admissions unit” at Khayelitsha District Hospital);
- Two additional extended hours service points will be functional at Michael Mapongwane and Gustrouw CHCs;
- Progress to integrated Emergency Centres which will manage both Trauma and Medical emergencies.

- **The key deliverables for 2009/10 are:**

- Appointment of five additional Emergency Medical Specialists to manage prioritised emergency centres across the Metro and to provide clinical governance in Metro West and East respectively;
- Progress towards standardisation of emergency centre functionality and case management across all emergency centres (staffing, equipment, SOPs, “child friendly areas”, etc.) at all acute hospitals;
- Fast track the physical infrastructure projects at Eerste River, Karl Bremer and Victoria Hospitals;
- Clinical management oversight of the nine 24-hour emergency units in the Metro by the respective referral district hospitals;
- Establishment of an additional extended hours service point at the consolidated Albow Gardens City facility;
- Progress towards standardisation of pre-hospitalised case management (30 minute response time; clinical case management protocols, etc.).

2.2.1.2 Rural Districts:

The integrated emergency care pilot in the Cape Winelands has had significant positive impacts on the functioning of the various emergency centres at the acute hospitals in the area.

- **The projected achievements by March 2009 are:**
 - Integrated emergency care services, with standardised protocols across the EMS services and all point of entry emergency services in the Cape Winelands District, under the clinical governance of the Emergency Medicine Specialist;
 - An extended hours service point will be functional at the Grabouw CHC;
 - Established emergency care access in 50% of non-hospital towns with population of >5000 in all rural districts.

- **The key deliverables for 2009/10 are:**
 - Appointment of 3 additional Emergency Medical Specialists in the Paarl, Worcester and George service areas to manage prioritised emergency centres and to provide clinical governance across the 3 areas;
 - Progress towards standardisation of emergency centre functionality and case management across all emergency centres (staffing, equipment, SOPs, "child friendly areas", etc.) at all acute hospitals;
 - Mitigate peak periods (e.g. Easter and Christmas peak in Beaufort West) in specific towns;
 - Provide access to emergency care in 50% of non-hospital towns with population of >5000 people;
 - Extended hours services to be provided in a minimum of 5 sites (one town per rural district);
 - Progress towards standardisation of pre-hospital case management (30 minute response time; clinical case management protocols, etc.).

2.2.2 Internal medicine:

The key objective for 2008/09 was to finalise the packages of care for levels 1, 2 and 3, across the service platform, and the improvement in the system to move clients from acute beds to sub-acute beds, TB hospital beds and acute psychiatric beds.

2.2.2.1 Metro:

- Currently the main deviation from the CSP is:
 - 1) The lack of sufficient adult male and female beds for the Khayelitsha sub-district, resulting in the bulk of patients from Khayelitsha being managed at GF Jooste Hospital,
 - 2) Level 1 patients from half of the Klipfontein sub-district currently drain to Groote Schuur Hospital,
 - 3) Level 2 patients from Mitchells Plain sub-district currently drain to GF Jooste Hospital.

- The main projected achievement by March 2009 is:
 - 1) Tygerberg Hospital will provide level 2 clinical support for level 2 clients in Khayelitsha District Hospital wards;

-
- 2) Quantified patient care activities in acute beds across the platform in the Metro, with clear targets for service shifts between levels of care; and from acute beds to sub-acute beds, TB beds and psychiatric beds.

- **The key deliverables for 2009/10 are:**

- Consolidation of the level 2 services at Tygerberg Hospital with improved linkages with the level 2 service at Karl Bremer Hospital.
- Shift of level 2 services for the Mitchells Plain sub-district from GF Jooste Hospital to Groote Schuur Hospital;
- Implement appropriate case management in line with the packages of care policy framework, in collaboration with the Senior Family Physicians;
- Shift patients in acute beds to appropriate levels of care with particular reference to sub-acute beds, TB beds and mental health care facilities.

2.2.2.2 Rural Districts:

There is currently a strong outreach and support programme from the level 2 Internal Medicine Department to all district hospitals and CHCs in the Paarl service area. This has led to improved case management, with appropriate cases being referred to the level 2 Internal Medicine Department.

- **The key deliverables for 2009/10 are:**

- Uniform implementation of the outreach and support system in all 3 rural service areas;
- Implement appropriate case management in line with the packages of care policy framework, in collaboration with the Senior Family Physicians;
- Consolidate the staffing complement within the level 2 Internal Medicine Departments in all 3 complexes (preferably 3 specialists and appropriate medical officer capacity);
- Shift patients in acute beds to appropriate levels of care with particular reference to sub-acute beds, TB beds and mental health care facilities;

2.2.3 Psychiatry:

The acute mental illness caseload is stretching all resources. The key objective for 2008/09 was to manage the acute psychiatric caseload across the service platform, by shifting sub-acute and chronic mental health clients from the Associated Psychiatric Hospital (APH) beds into community-based service mental health care institutions, and creating additional acute mental health bed capacity in the system. This has provided relief to acute hospitals, where many acute psychiatric clients were presenting in the emergency units and remaining well beyond the 72-hour observation period. The quantification of level 1, 2 and 3 caseload, as well as “step-down cases” in acute beds was completed during 2008/09.

2.2.3.1 Metro:

- The main deviation from the CSP is the unavailability of 72-hour bed capacity in the district hospitals across the Metro, in the face of an increased acute caseload fuelled by the “substance abuse epidemic”.
- **The main projected achievements by March 2009 are:**
 - Increased capacity for acute clients at the three APH hospitals through access to 80 sub-acute beds (at William Slater and Stikland Hospitals);
 - A 20-bed capacity created for acute clients in Lentegeur Hospital using a ward vacated by the transfer of clients to the IDS residential care institutions;
 - A mental health nurse in place in each district and regional hospital;
 - Significant decrease in number of acute mental health clients remaining in acute hospitals beyond the 72-hour observation period.
- **The key deliverables for 2009/10 are:**
 - Consolidation of level 1 hospital mental health service, with designated medical officers per sub-district to do outreach to mental health clinics at PHC facilities, in addition to the appointment of one clinical psychologist per sub-structure;
 - Level 2 services:
 - One community psychiatrist per sub-structure (two sub-districts), with outreach specialist clinics per district hospital;
 - Capacity for 10 more acute beds created at the Associated Psychiatric Hospitals;
 - Additional specialist ambulatory services at the Associated Psychiatric Hospitals.

2.2.3.2 Rural districts:

- **The main projected achievements by March 2009 are:**
 - Worcester Hospital to have commissioned 8 beds in psychiatry;
 - George Hospital to have commissioned 10 beds in psychiatry;
 - Paarl Hospital to have commissioned 4 beds in psychiatry.
- **The key deliverables for 2009/10 are:**
 - Worcester Hospital to remain at 8 beds (to be increased to 28 beds in 2010/11);
 - George Hospital to remain at 10 beds (to be increased to 22 beds in 2010/11);
 - Paarl Hospital to remain at 4 psychiatry beds (to be increased to 22 beds in 2010/11);
 - Community psychiatrists need to be placed on the **establishment of regional hospitals** to participate in the psychiatric team (two psychiatrists per regional hospital) with outreach and support to the sub-districts;

- **Management of acute psychiatric patients at district hospitals:** There needs to be a clear standard operating procedure for the admission of clients to the appropriate APH institution (with the level 2 psychiatric units at the regional hospitals playing a vital role to manage the interface between the district hospitals and the appropriate APH units);
- **Ambulatory care of mental health clients:** Mental health nurse at each district hospital, MO at sub district level to do outreach with the support of the psychiatrist(s) from the regional hospital.

2.3 CLUSTER 2: SURGERY, ORTHOPAEDICS AND ANAESTHETICS:

2.3.1 Surgery:

The key strategies for 2008/09 were to increase the number of level 1 elective surgical procedures at selected district hospitals and to increase the number of day surgical procedures. The efficiency of theatres was improved through the uniform application of standardised definitions, performance targets and improved information systems.

2.3.1.1 Metro:

- The major current deviation from the CSP in Metro East is the lack of access to emergency level 1 surgery at Khayelitsha District Hospital, Eerste River and Karl Bremer Hospitals and the presence of level 2 and 3 elective surgical services at Karl Bremer Hospital.
- The major current deviation currently from the CSP in Metro West is the lack of surgical services in Mitchells Plain sub-district, and the relative lack of elective surgery services at GF Jooste Hospital.
- **The projected achievements by March 2009 are:**
 - Completion of an audit and analysis of theatre utilisation across the platform (to identify spare capacity and appropriate utilisation) as well as the point prevalence survey to determine appropriate utilisation of bed capacity;
 - Level 3 and part of level 2 surgical services will be relocated from Karl Bremer Hospital to Tygerberg Hospital;
 - Expanded capacity to perform level 1 elective procedures at Metro District Hospitals;
 - Finalisation of a list of procedures to be done as day surgical cases, and implementation of day surgical procedure programme.
- **The key deliverables for 2009/10:**
 - Complete level 2 surgical service shift from Karl Bremer Hospital to Tygerberg Hospital, with a quantum of level 2 outreach service maintained at Karl Bremer Hospital.
 - Level 2 elective surgical service shift for Mitchells Plain sub-district from GF Jooste Hospital to Groote Schuur Hospital;
 - Expand level 1 elective surgical services outputs at District Hospitals across the Metro (with appropriate outreach and support from referral level 2 hospitals);
 - Develop specific plans for ENT, ophthalmology, urology and surgery in children to level 1 hospitals, in Metro West and East.

2.3.1.2 Rural Districts:

The key issues in the rural complexes revolve around establishing good outreach and support systems in all three service areas, and achieving the appropriate skills levels at the district hospitals.

- **The key deliverables for 2009/10 are:**

- Uniform implementation of the outreach and support system in all three service areas (linked to some practical activities such as endoscopy services); with full-time MOs at District Hospitals for skills transfer (and maintenance);
- Consolidate skills building around elective procedures in line with the finalised level 1 package;
- Designate district hospitals where the competence to perform life-saving surgical procedures (e.g. open thoracotomy, torsion of testes, etc.) are needed, and implement targeted skills building programme;
- Develop specific plans for ENT, Ophthalmology, Urology and surgery in children to level 1 hospitals in each of the three rural service areas.

2.3.2 Orthopaedics:

The key strategies for 2008/09 were to agree on an orthopaedic surgery services plan in the Metro and to define how services would be distributed, recognising that the budget for level 2 services would be centralised at GSH and TBH for the Metro West and Metro East respectively. During 2008/09 the packages of care were finalised, and a point prevalence survey provided clarity about bed utilisation. Additional theatre lists were established in GSH as a leverage to consolidate level 2 services.

2.3.2.1 Metro:

- The major deviation in Metro East is the lack of level 1 orthopaedics at Khayelitsha District Hospital, Eerste River and Karl Bremer Hospitals;
- The major deviations in Metro West are the lack of level 1 orthopaedics in the Mitchells Plain sub-district, and the presence of level 2 orthopaedic services in GF Jooste, Victoria and New Somerset Hospitals.
- **The projected achievements by March 2009 are:**
 - Level 1 orthopaedics services established at Eerste River Hospital and Khayelitsha District Hospital (with skilled MOs to perform the procedures);
 - Quantification of the quantum of level 2 orthopaedic services at Victoria, GF Jooste and New Somerset Hospitals and an initiation of the relocation of the services to Groote Schuur Hospital;
 - Develop an operational plan for orthopaedic services/procedures across the Metro hospitals with specialist outreach and support and cost recovery.

- **The key deliverables for 2009/10 are:**

- Increase the quantum of level 1 orthopaedics in Khayelitsha District Hospital and Eerste River Hospital;
- Consolidate the level 2 orthopaedics service in Tygerberg Hospital, with appropriate outreach and support in Metro East;
- Establish functional level 2 orthopaedic beds at Groote Schuur Hospital (separate from level 3). Commence a process of relocation of the level 2 orthopaedics services from Victoria, GF Jooste and New Somerset Hospitals to Groote Schuur Hospital;
- Develop and strengthen outreach and support services from Groote Schuur Hospital level 2 orthopaedic service to Metro West acute hospitals.

2.3.2.2 Rural Districts:

The key issues in the rural service areas revolve around establishing good outreach and support systems in all three service areas, and achieving the appropriate skills levels at the district hospitals.

- **The key deliverables for 2009/10 are:**

- Uniform implementation of the outreach and support system in all three service areas (linked to performing specific procedures);
- Establish and strengthen an outreach and support service to designated hospitals;
- Consolidate skills building around elective procedures in line with the L1 package;
- Finalise the appropriate equipment requirements at district hospitals (e.g. C-arm availability).

2.3.3 Anaesthetics:

The key challenge for 2008/09 was to approve the anaesthetics services plan for the Metro and to appoint level 2 clinical heads to co-ordinate services across the platform. There is a need to implement the Metro Anaesthetics Plan (MAP) and to refine the rural anaesthetics services plan.

2.3.3.1 Metro:

- **The projected achievements by March 2009 are:**

- Level 2 clinical heads appointed for Metro East and West;
- Establishment of an outreach and support service to all district hospitals (with after hours specialist support).

- **The key deliverables for 2009/10 are:**

- Level 2 clinical skills consolidation and coordination of service delivery in the Metro West and East;
- Increase medical officer capacity to perform level 1 anaesthetic procedures in district hospitals.
- Achieve coverage of 1 specialist and 5 medical officers at New Somerset, Victoria and GF Jooste Hospitals to provide adequate cover for theatres as per Metro Anaesthetic Plan.

2.3.3.2 Rural Districts:

The key issues in the rural service areas revolve around establishing good outreach and support systems in all three service areas, and achieving the appropriate skills levels at the district hospitals.

- **The key deliverables for 2009/10 are:**
 - Finalise and implement an anaesthetics plan for the three rural service areas;
 - Additional sessional anaesthetic capacity at Worcester Hospital for outreach to Overberg District.

2.4 CLUSTER 3: OBSTETRICS, GYNAECOLOGY AND PAEDIATRICS (INCLUDING NEONATOLOGY):

2.4.1 Obstetrics and gynaecology:

2.4.1.1 Obstetrics

The key objectives for 2008/09 were to increase the quantum of acute obstetrics beds in the Metro (in the direction of the CSP) and the shift of level 1 and 2 obstetric services between Tygerberg and Karl Bremer Hospitals and Khayelitsha District Hospital (in line with the CSP), based on the quantification of level 1, 2 and 3 caseload across the service platform.

2.4.1.1.1 Metro:

- The main CSP deviations in Metro East are the absence of the obstetric beds in Eerste River Hospital, and the drainage of Grabouw to Helderberg Hospital;
- The main CSP deviations in Metro West are the lack of level 1 obstetric beds for the Klipfontein, Mitchells Plain and Southern sub-districts and the absence of MOUs in Du Noon in the Western sub-district and Crossroads in Mitchells Plain sub-district.
- **The projected achievements by March 2009 are:**
 - Fully functional 20-bed acute level 1 obstetric service in Khayelitsha District Hospital to provide level 1 referral service for the clients from Michael Mapongwane MOU in Khayelitsha sub-district;
 - Relocated level 1 obstetrics service from Tygerberg Hospital to Karl Bremer Hospital and relocated level 2 obstetrics service from Karl Bremer Hospital to Tygerberg Hospital;
 - Fully functional additional 20-bed acute level obstetric service in Mowbray Maternity Hospital to provide level 1 referral service for the clients from the Mitchells Plain the sub-district;
 - Established ultrasonography service in each of the eight Metro sub-districts;
 - MOUs transferred from Mowbray Maternity Hospital to MDHS;
 - Expanded MOU and basic ante-natal care (BANC) capacity within the eight Metro sub-districts.

- **The key deliverables for 2009/10 are:**
 - Consolidate the level 2 service in Tygerberg Hospital;
 - Shift level 1 and proportional level 2 service for the Southern sub-district from Groote Schuur Hospital to Mowbray Maternity Hospital (GSH to MMH), with increased labour ward and theatre capacity at MMH;
 - Increase MOU capacity in Tygerberg sub-district (for growing Delft area);
 - Increase BANC coverage in all sub-districts (especially in Western and Mitchells Plain sub-districts).

2.4.1.1.2 Rural Districts:

There is currently a strong outreach and support programme from the level 2 Obstetrics Department to all district hospitals in the Paarl service area. This has led to improved case management, with appropriate cases being referred to the level 2 Obstetrics Department.

- **The key deliverables for 2009/10 are:**
 - Strengthen and maintain BANC services in all three rural service areas;
 - To provide increased access to ultrasonography services in the rural districts (implement the Worcester service area model for sub-district ultrasonography service in the other two service areas);
 - Transfer responsibility for level 1 ambulatory antenatal care (level 1 high risk clinics) to the Family Medicine departments at the three regional hospitals;
 - Implement training modules for all staff involved with maternal care within each of the three service areas (using the standardised training kit).

2.4.1.2 Gynaecology

The definition of level 1, 2 and 3 packages of care has led to a clearer definition of a package of gynaecology services to be delivered at PHC facilities and level 1 hospitals.

2.4.1.2.1 Metro:

- **The key deliverables for 2009/10 are:**
 - Strengthen colposcopy and LETZ services at all level 2 hospitals by standardising protocols, improving equipment and monitoring and improving access;
 - Improve case management for gynaecological cases at CHCs and District Hospitals through improved clinical governance and outreach and support from level 2 services;
 - Provide increased TOP services at CHCs and district hospitals.

2.4.1.2.2 Rural Districts:

- 4) **The key deliverables for 2009/10 are:**
- Uniform implementation of the outreach and support system in all three rural service areas;
 - Provide colposcopy services at Swartland, Hermanus and Beaufort West hospitals;
 - Provide adequate access to TOP services at district hospitals in the three rural service areas;
 - Provide adequate access to clinical forensic services at district hospitals.

2.4.2 Paediatrics and Neonatology:

The key challenge identified is how to improve point of entry per sub-district for acute paediatric cases, especially in the Klipfontein, Mitchells Plain and Khayelitsha sub-districts, as all these cases currently impact on the point of entry services at Red Cross War Memorial Children's Hospital (RCWMCH). This is exacerbated during the diarrhoeal disease season. The relocation of level 1 and level 2 obstetric services has a knock-on effect on neonatal services. The appropriate distribution of level 2 and level 1 neonatal services (including kangaroo mother care) need to be implemented after the quantification of current services across the platform.

2.4.2.1 Metro:

- The key CSP deviations in Metro East are the lack of level 1 paediatric beds for the Khayelitsha sub-district (which impacts on RCWMCH), and the presence of level 2 paediatric services at Karl Bremer Hospital, and the lack of the level 2 paediatric beds at Helderberg Hospital;
- The key CSP deviations in Metro West are the lack of level 1 paediatric beds for the Mitchells Plain and Klipfontein sub-districts, and the presence of levels paediatric services at Groote Schuur Hospital, which all impacts on RCWMCH.
- **The projected achievements by March 2009 are:**
 - Direct admissions to the 18 level 1 beds at Khayelitsha District Hospital from the Site B CHC emergency unit, in line with protocols;
 - Direct admissions to the 12 level 1 beds at Mitchells Plain level 1 hospital from the Mitchells Plain CHC emergency unit, in line with protocols;
 - Level 2 and 3 shift of paediatrics from Groote Schuur Hospital to Red Cross Children's War Memorial Hospital completed;
 - Quantification of level 1 and 2 neonatal service shifts (including kangaroo mother care services) across service platform completed and relocation initiated;
- **The key deliverables for 2009/10 are:**
 - Improve point of entry for acute paediatrics in all sub-districts;
 - Level 2/ level 1 paediatric service shifts between Tygerberg, Karl Bremer and Helderberg Hospitals;

- Complete level 2/ level 1 neonatal service shifts across the service platform in the Metro (including improvement of KMC capacity);
- Provide additional level 2 neonatal capacity at TBH;
- Provide targeted training for midwives and medical officers on neonatal resuscitation;
- Institutionalise Child Health Problem Identification Program (CHIP);
- Reconfigure and retain four neonatal ICU beds into high care beds at New Somerset Hospital for ventilation according to the package of care and the remaining three ICU beds to move to Groote Schuur Hospital;
- Address PHC challenges around prevention of mother to child transmission (PMTCT), use of Road To Health Card (RTHC), management of paediatric TB, feeding practices and mixing and use of salt and sugar solution for diarrhoeal disease.

2.4.2.2 Rural districts:

The successful implementation of **continuous positive airway pressure (CPAP)** at Ceres Hospital has produced a model for roll-out to other district hospitals.

- **The key deliverables for 2009/10 are:**

- Roll-out **continuous positive airway pressure (CPAP)** to Swartland, Vredenburg, Caledon, Oudtshoorn and Beaufort West Hospitals;
- Provide targeted training for midwives and medical officers for neonatal resuscitation.
- Implement Child Health Problem Identification Program (CHIP) uniformly across the three rural service areas;
- Implement kangaroo mother care (KMC) in Stellenbosch sub-district;
- Address PHC challenges around PMTCT (prevention of mother to child transmission), use of Road To Health Card (RTHC), management of paediatric TB, feeding practices and mixing and use of salt and sugar solution for diarrhoeal disease.

3. AMBULATORY CARE:

The two service divisions agreed to the following approach for the transformation of the ambulatory services platform in 2009/10:

- Institutionalise the ambulatory services related to the three general speciality “service clusters” within the context of the outreach and support policy framework of the Department (the discipline specific activities are contained in the relevant parts of the acute services section (see section 2));
- Improve chronic disease management (CDM) through the appropriate relocation of stable CDM clients to PHC facilities:
- The objective for 2008/09 was to relocate 10 000 stable chronic disease management (CDM) clients attending for ambulatory care at the central hospitals, to attend CHCs for ambulatory care. The steps were:

- 1) To develop a standard case definition for stable adult and paediatric CDM;
- 2) To quantify the numbers of clients to be relocated per central hospital (according to the case definition) per geographic area;
- 3) Determine the capacity of the recipient CHC to absorb the referred clients;
- 4) To project manage the relocation of the clients to the destination CHC, per geographic area.

3.1 METRO:

The major deviations from the CSP is the excess number of outpatient visits at central hospitals as opposed to the lower number of total PHC headcount in the Metro, and the absence the formalised level 2 service platforms in Metro East and West.

- **The projected achievements by March 2009 are:**

- Numbers of stable CDM clients (as per case definition) quantified per central hospital per geographic area and initial relocation commenced (possibly 2 000 clients);
- Existing outreach and support arrangements between level 2 hospitals and district hospitals quantified for formalisation;

- **The key deliverables for 2009/10 are:**

- Relocate 10 000 stable adult and paediatric CDM clients from the central hospitals to CHCs (5.1. to 2.3. shift);
- Relocate stable CDM clients from the CHCs to clinics and into community based services (via CDU) (2.3. to 2.2. and 2.4. shift);
- Relocate stable psychiatric OPD clients from APH to PHC/ CHCs in a phased manner where capacity allows;
- Formalisation of the outreach and support contract between level 2 services and district hospitals and CHCs in the Metro.

3.2 RURAL DISTRICTS:

- **The key deliverable for 2009/10 are:**

- Formalisation of the outreach and support contract between L2 services and district hospitals and CHCs in the 3 service areas.

4. INFECTIOUS DISEASES

The two service divisions agreed to the following approach for the transformation of the infectious diseases platform in 2009/10:

4.1 STRATEGIC FOCUS AREAS FOR THE MANAGEMENT WITH CLIENTS WITH HIV AND AIDS, AND TB

The key strategic focus areas for the management of clients with HIV and AIDS and TB across the service platform are:

- HIV Prevention (to implement an integrated, combined prevention strategy);
- HIV treatment (enrol and manage clients at accredited ART sites; implement a nurse-led doctor supported model of care (STRETCH model));
- TB management (clinical governance model at TB hospitals; transfer of TB hospitals management to the district hospitals; shift stable TB clients to CBS; improve infection control);
- Infectious diseases service platform consolidation (consolidate platform from PHC to level 3 services).

4.2 METRO:

The major deviation from the CSP is the lack of a consolidated TB hospital for the Metro. The impact of the ART programme has not been fully factored in on the modelling for the PHC services. The physical infrastructure limitation at PHC facilities is the single biggest limiting factor to the relocation of stable ART clients.

The projected achievements at March 2009 are:

- Stable adult ART clients from Groote Schuur Hospital (170 patients) and Tygerberg Hospital (218 patients) relocated to PHC ART sites;
 - Stable paediatric ART patients down - referred from RCWMCH (114 patients) and Tygerberg Hospital (150 patients) to PHC ART sites;
 - The nurse-led ART model implemented at multiple sites across the Metro (STRETCH model to be implemented in Khayelitsha and Mitchell's Plain sub-districts);
 - Stable TB clients identified in Brooklyn Chest and DP Marais Hospitals and initial shifts to CBS and PHC services commenced;
 - Community-based pilot for MDR management established in Khayelitsha sub-district;
 - Finalisation of the ID platform management plan and approved for implementation by Inter-divisional executive committee.
- **The key deliverables for 2009/10 are:**
 - Develop and implement an integrated, combined prevention strategy for each sub-district through innovative local partnerships;
 - Manage 47 926 clients on daily ART at various sites across the Metro:

- Accredit six additional treatment sites in the Metro;
- A total of 740 stable ART clients (185 at GSH, 175 at RCCH, 380 at TBH) to be transferred from the central hospitals to PHC ART sites (dependent on successful skills transfer for the management of especially paediatric clients);
- Expansion of nurse-led doctor supported ART model to 9 additional PHC sites.
- Improve the management of TB clients across the service platform in the Metro:
 - Establish capacity at Brooklyn Chest Hospital to manage acute, complex (often co-infected) TB cases, with the appropriate clinical governance from level 2 internal medicine and paediatric units;
 - The line management of Brooklyn Chest and DP Marais TB hospitals will transfer to the Western/Eastern DHS sub-structure management team;
 - Decant stable TB clients into PHC and CBS care to create more capacity to admit TB clients occupying acute hospital beds (final decanting targets will be reflected in final APP in January 2009);
 - Develop and implement infection control plan in every hospital (to reduce risk of infection in staff members);
 - Consolidate community-based MDR pilot in Khayelitsha sub-district, with a view of roll-out to other sub-districts.
- Implement the approved Metro adult and paediatric ID platform consolidation plan (adult and paediatric ID specialists to provide outreach and support to level 2 internal medicine and paediatric units, with a view to support general MO-led services within the DHS).

4.3 RURAL DISTRICTS:

The major deviation from the CSP need for additional TB beds in the Paarl and George service areas. The impact of the ART programme has not been factored in on the modelling for the PHC services. The physical infrastructure limitation at PHC facilities is the single biggest limiting factor to the relocation of ART clients.

- **The projected achievements at March 2009 are:**
 - Due to the distances in rural districts many patients are initiated onto ART and then followed up by medical officers at PHC clinics rather than at the accredited ART site;
 - The nurse-led ART model (STRETCH) to be implemented in Eden district and Drakenstein sub-district;
 - Stable TB clients to be identified in Brewelskloof Hospital and initial shifts to CBS and PHC services commenced.
- **The key deliverables for 2009/10 are:**
 - Develop and implement an integrated, combined prevention strategy for prioritised sub-districts across the rural districts (through innovative local partnerships);

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- Manage 20 310 clients on daily ART at various sites across the rural districts:
 - Accredit seven additional treatment sites across the rural districts;
 - Expansion of nurse-led doctor supported ART model to thirty-one additional PHC sites across the rural districts;
 - Improve the management of TB clients across the service platform in the Metro:
 - Establish capacity at rural TB hospitals to manage acute, complex (often co-infected) TB cases, with the appropriate clinical governance from level 2 internal medicine and paediatric units;
 - The line management of rural TB hospitals will transfer to the West Coast, Cape Winelands and Eden District management teams;
 - Decant stable TB clients into PHC and CBS care to create more capacity to admit TB clients occupying acute hospital beds (final decanting targets will be reflected in final APP in January 2009);
 - Develop and implement infection control plan in every hospital (to reduce risk of infection in staff members);
 - Implement the approved Rural districts adult and paediatric ID platform consolidation plan (adult and paediatric ID specialists to provide outreach and support to level 2 internal medicine and paediatric units, with a view to support general MO-led services within the DHS)

5. DE-HOSPITALISED CARE

The two service divisions agreed to the following approach for the implementation of the de-hospitalised care strategy in 2009/10:

5.1 THE KEY STRATEGIC FOCUS AREAS FOR DE-HOSPITALISED CARE FOR 2009/10

- Expand access to Mental Health de-hospitalised care:
 - Providing a continuum of care for psychiatric clients (sub-acute care, group homes and psycho-social rehabilitation groups)
 - Providing a continuum of care for intellectually disabled (IDS) clients (residential care and day care centres);
- Expand access to sub-acute care:
 - Quantify via a point prevalence survey during November 2008 how many clients in need of “sub-acute care” are in all acute hospitals across the province;
 - Quantify existing sub-acute and palliative care capacity per “geographic service area” (Metro East & West and the three rural service areas);
 - Create increased sub-acute care capacity per “geographic service area” (quantify in final draft of APP in January 2009);

- Expand home based care:
 - Determine geographic areas with highest numbers of category 3 clients (as per above-mentioned point prevalence survey);
 - Expand the number of carers (200) in identified areas of greatest need;
 - Develop and implement integrated adherence model for HIV/TB;
 - Implement basic prevention/promotion package for all carers.

5.1.1 **Metro:**

The main deviations from the CSP are the lack of sufficient sub-acute care facilities in sub-districts of highest burden in the Metro. There are a number of inappropriate clients in acute hospital beds, in these geographic areas.

- **The projected achievements for March 2009 are:**
 - **Mental health de-hospitalised care:**
 - 80 sub-acute psychiatric beds (40 beds at William Slater and 40 beds at Stikland House), with equitable access for the three APH institutions;
 - 5 facilities providing 304 beds for residential care for people with profound and severe intellectual disability;
 - Consolidation of the community-based service residential care wards (Ward 1 and 2) for children with profound and severe intellectual disability with high care burden at Stikland Hospital;
 - 8 Psychiatric Group homes with 278 beds;
 - 26 PSR groups for community based psychiatric care;
 - 19 Special day care centres for 717 severe and profound intellectually disabled clients.
 - **Sub-acute care:**
 - Review completed of all clients in the 144 sub-acute beds in the Metro (Booth Memorial 84 adult beds and Sarah Fox 60 paediatric beds), and the 87 chronic care beds at St Joseph and 280 at Lifecare, with a view of de-institutionalising all inappropriately placed clients, in order to create more sub-acute capacity;
 - Quantification of all adult sub-acute care clients in all acute hospitals (using standard case definition) by mid-November 2008;
 - Map existing provision of sub-acute and palliative beds per geographic service area;
 - Identify key priority areas for expansion (for inclusion in final APP draft, using the “APH” principle of funds follow function).
 - **Homebased care:**
 - 1328 community based carers across the 8 sub-districts in the Metro;
 - Carer per population ratio per sub-district to measure equity.

- **The key deliverables for 2009/10 are:**
 - **Mental Health dehospitalised care:**
 - Maintain the 80 mental health sub-acute care beds and improve efficiencies.
 - Management of the sub-acute care bed resorts under APH with joint governance with the DHS, with a view of procuring the services of NPOs to manage these and a concomitant transfer of the responsibility to the DHS in 2010/11;
 - Devolve a total of an additional 40 clients from the APH to residential facilities for profound and severe Intellectual Disability;
 - Existing DHS community mental health services maintained with increase in NPO subsidy.
 - **Sub-acute care:**
 - Final number of beds for expansion to determined for January 2009;
 - Final number of additional sub-acute beds to be distributed equitably in areas of greatest need.
 - **Homebased care:**
 - Increase number of NPO employed carers by 100-200 (to be finalised in January 2009);
 - To allocate carers equitably across the sub-districts according to needs;
 - Expand the implementation of an integrated TB/HIV adherence model.

5.1.2 Rural districts:

- **The projected achievements for March 2009 are:**
 - **Mental Health dehospitalised care:**
 - 1 residential facility in West Coast providing 17 beds for people with profound and severe intellectual disability; 2 in Cape Winelands with 49 beds;
 - 1 Psychiatric Group home in Cape Winelands with 55 beds;
 - No funded PSR groups for community based psychiatric care
 - A total of 6 Special day care centres for profound and severe intellectually disabled clients in the rural districts - 3 in Cape Winelands with 75 clients and 3 in Eden with 70 clients.
 - **Sub-acute care:**
 - Review completed of all clients in the 12 palliative care beds in West Coast, the 50 beds in Cape Winelands, the 4 in Overberg and the 42 in Eden with the view to identify inappropriately placed clients in order to create more capacity for sub-acute care;
 - Quantification of all adult sub-acute care clients in all acute hospitals (using standard case definition) by mid-November 2008;

- The proposal to combine palliative care and sub-acute care in these facilities and planning also finalised for the Central Karoo 6 beds to be opened for both palliative care and sub-acute ;
 - **Homebased care**
 - 256 community based carers in West Coast, 234 in Cape Winelands, 290 in Eden, 197 in Overberg and 70 in Central Karoo.
- **The key deliverables for 2009/10 are:**
 - **Mental Health dehospitalised care:**
 - 10 additional clients with profound and severe intellectual disability to be dehospitalised from the Psychiatric Hospitals to Cape Winelands; (numbers for Eden to be added);
 - 1 Group home for psychiatric clients with 13 beds in the West Coast;
 - Planning for sub-acute mental health beds for 2010/11 in the three rural service areas linked to level 2 hospitals;
 - Increase DHS community mental health services in selected geographic areas, based on situational analysis, availability of resources and areas in greatest need.
 - **Sub-acute care:**
 - Existing palliative care facilities to start accommodating sub-acute care;
 - District Hospitals with bed capacity to convert this capacity to sub-acute beds: 12 beds in Vredendal Hospital and 5 beds in Lapa Munnik in West Coast;
 - Increase number of sub-acute care facilities in each of the 3 service areas.
 - **Homebased care:**
 - Increase number of NPO funded caregivers to 50 - 100 across the rural districts according to objective needs.

6. MONITORING AND EVALUATION

To ensure adequate and appropriate monitoring and evaluation:

- 1) A separate table of indicators will be developed to track the key service shifts as described in the executive summary;
- 2) Data will be used to measure the shifts using a combination of data derived from the routine data sources (on Sinjani) as well as six-monthly or annual audits;
- 3) The performance will be reviewed at the quarterly departmental monitoring and evaluation committee meeting;
- 4) Each Programme will capture more detailed performance parameters to monitor the implementation of the proposed steps towards the CSP, contained in this executive summary.

7. CONCLUSION

The executive summary forms the basis for integrated restructuring of the service delivery platform, in line with the CSP. All the financial sub-programmes will be aligned to contribute to the achievement of the activities articulated in the summary.

PROGRAMME 1: ADMINISTRATION

1. AIM

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

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 1.1: OFFICE OF THE MEC

Rendering of advisory, secretarial and office support services.

2.2 SUB-PROGRAMME 1.2: MANAGEMENT

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

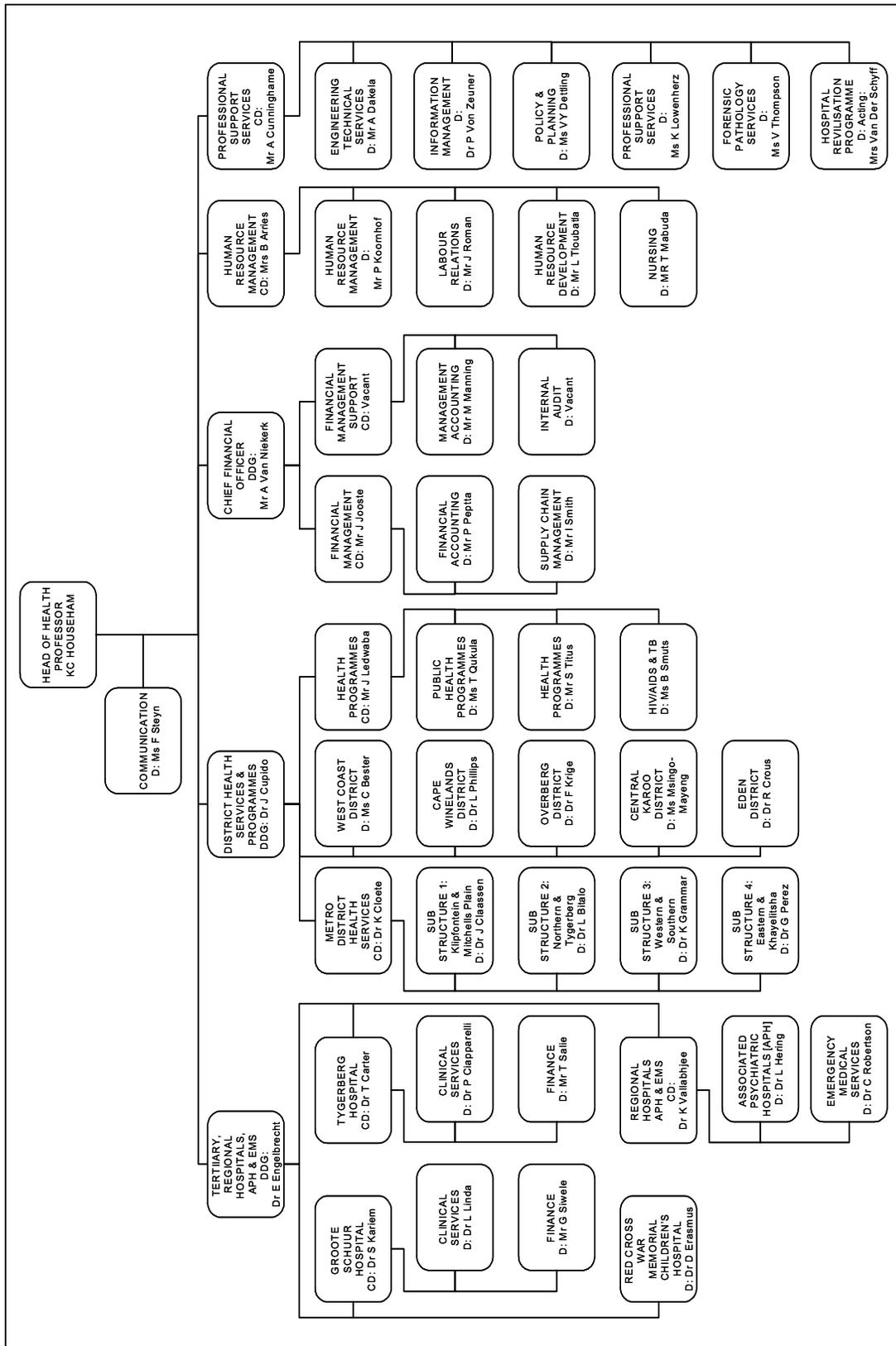
2.2.1 Sub-programme 1.2.1: Central management

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

2.2.2 Sub-programme 1.2.2: Decentralised management

Implementing policy and organising health regions, managing personnel and financial administration, determining work methods and procedures and exercising regional control.

ORGANOGRAM: SENIOR MANAGEMENT



3. ADMINISTRATION: PLANNING

3.1 SITUATION ANALYSIS

The Department of Health is managed by a combination of a central management component situated in the Head Office in Cape Town and decentralised district offices in Beaufort West, George, Worcester, Caledon, Malmesbury and sub-structure offices in the Metro District. Each sub-structure office of the Metro district manages two sub-districts and are located in Khayelitsha, Athlone, Mitchell's Plain and Retreat. Other important role-players are the institutional management at the respective facilities.

The strategy and operation of the Department is influenced by various international, national and provincial programmes and mandates, which include the Millennium Development Goals, the National Programme of Action, Accelerated Shared Growth Initiative of South Africa and the Provincial Growth and Development Strategy.

The Department is responsible for the provision and management of the provincial health services, which provide predominantly for the health care needs of the uninsured population of the Western Cape.

The Provincial Minister determines provincial policy and the central head office management gives effect to provincial and national policies ensuring that the Western Cape provincial health service is aligned with national, provincial and departmental strategy, policy and directives.

Human resources, professional support, supply chain and financial management policies and procedures are determined and co-ordinated at the central head office. The current organisational chart of the senior management of the Department and the incumbents is reflected on the previous page. It is envisaged that this structure will be amended during the 2009/10 financial year.

High levels of migration into the Western Cape remain a challenge, as although the province receives funding for a designated number of patients from other provinces for tertiary services, inadequate financial provision is made in terms of the provincial equitable share for the increased number of patients from other provinces who require primary and secondary level care. The in-migration to the Western Cape from neighbouring provinces, has been confirmed by the Community Survey 2007 published by Stats SA which indicates that in 2007 the population of the Western Cape had increased by 16.7% since 2001. The impact of migration from neighbouring countries is not reflected in a concomitant increase in the equitable share allocation to health.

The demand for services currently exceeds the quantum of service that can be provided from the available resources. The Comprehensive Service Plan, approved by the Provincial Minister and Cabinet, provides the blueprint for reshaping the health services to ensure that available resources are optimally utilised.

The shape of the health service requires a solid base for Primary Health Care (PHC) that is integrated with regional and central services to provide a seamless service experience for patients.

An Infrastructure Plan has been developed for the Department in support of the Comprehensive Service Plan, which will be implemented using all available funding for infrastructure either from the national conditional grants or provincial funding. The Department faces a significant challenge to

fund the necessary upgrading and construction of primary health care facilities from the available budget.

The Burden of Disease Report has been tabled and the findings accepted by the Department and the Provincial Cabinet. This forms the basis for provincial interventions to reduce the disease burden.

A Human Resources Plan has been developed in support of the implementation of the Comprehensive Service Plan. Human resource planning process has been established and is ongoing in the Department.

3.2 **POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES**

The Western Cape Department of Health's response to the National Department of Health's priorities is outlined in Part A: Strategic Overview.

The Comprehensive Service Plan (CSP) is the Western Cape's service transformation plan, which is one of the National Health System priorities, aiming to improve service delivery and provide equal access to quality health care. The CSP provides the framework for the Department's planning for the MTEF period and beyond.

The key events for 2009/10 to implement the Comprehensive Service Plan (CSP) have been integrated into the Annual Performance Plan and progress will be monitored via the quarterly monitoring and evaluation meeting chaired by the Head of Department.

The Department continues to make a concerted effort to improve patient billing and revenue collection and has entered into designated service provider agreements with medical schemes and other government departments. Revenue recovered from the Road Accident Fund (RAF) has increased substantially.

Communication with staff at all levels, as well as stakeholders and the media is a key objective. This is achieved through regular newsletters and staff meetings where management interact with staff across the province. The Department has developed and implemented a comprehensive communication strategy to keep all stakeholders informed regarding health matters.

The efficient rendering of health services by the Department is dependent on continuous and meaningful support from the human resources, communication, financial, information and professional support services, which are essential enablers.

The implementation of the Comprehensive Service Plan depends on meaningful and integrated support rendered to line managers by the structured Support Services Chief Directorates of the Department.

The Support Services are discussed individually describing their functions and addressing the constraints and measures planned to overcome them, with a description of planned quality improvement measures.

3.3 KEY COMPONENTS OF ADMINISTRATION: PLANNING:

3.3.1 Finance:

3.3.1.1 Situation analysis:

This Division is headed by the Chief Financial Officer and consists of two Chief Directorates, i.e. Financial Management and Budget Administration.

Financial Management has two directorates, responsible for financial management and supply chain management. A key function of financial management is the annual compilation of the audited financial statements and ongoing interaction with the Auditor-General. The excellent management and support of this component enabled the Department to maintain an unqualified audit for the 2008/09 financial year. Other key issues addressed by this Chief Directorate are:

- Supply chain management
- Transport management
- The Cape Medical Depot, which procures pharmaceuticals and medical and surgical sundries in bulk for the Department.
- Salary administration

The Management Accounting Directorate within the Chief Directorate: Budget Administration is responsible for revenue generation internal audit and the budgeting process of the Department. This includes the Financial Control System, Financial Management Committee (FMC) and the compilation of the required financial reports to Treasury.

3.3.1.2 Constraints and measures to overcome them:

A key constraint is the retention of skilled staff and the difficulty in recruiting appropriately skilled and experienced staff. A contributing factor is the competition between government departments for skilled staff from a relatively limited pool. Ongoing training and development of finance personnel is therefore a priority as is the training of non-financial managers in the correct finance and procurement procedures.

In order to address the short-comings identified by the Auditor-General it is planned to implement customised training programmes for institutional management to ensure that they are able to implement sound financial management.

3.3.2 Professional Support Services:

This Chief Directorate currently consists of the following Directorates:

- 1) Information Management
- 2) Professional Support Services
- 3) Policy and Planning
- 4) Engineering and Technical Services (Programme 7)
- 5) Hospital Revitalisation Programme (Programme 8)
- 6) Forensic Pathology Services (Sub-programme 7.3)

The span of control of this chief directorate has grown over time from the original four directorates to six directorates providing a very diverse range of services. An organisational development

investigation has been completed in which it is recommended that the chief directorate be split into two. There will therefore be a chief directorate to deal with all the infrastructure related issues, i.e. Engineering and Technical Support, Hospital Revitalisation and a new directorate for Facilities Management. The remaining directorates will be managed within another chief directorate.

3.3.2.1 Information Management:

The key activities of Information Management are information management, data collection, registry and messenger services, records management and Minimum Information Security Standards [MISS] providing support to the line managers.

The compilation of an accurate and reliable repository of data and information of performance information is critical for the effective planning, management and monitoring of the performance of the Department.

The following measures are planned:

- Improve the integrity of non-financial performance data.
- Create a central repository of all non-financial performance data.
- Refresh of information technology.
- The 'national data managers' project' which is an initiative of the National Department of Health to improve the PHC data in the provinces.

3.3.2.2 Professional Support Services:

This directorate has a varied range of responsibilities, which include:

- Pharmacy services to ensure an efficient and cost effective pharmaceutical service.
- Manage the contract with the service provider of Chronic Dispensing Unit to improve the delivery of chronic medication to patients.
- The co-ordination and control of the supply of laboratory services and blood products for the province.
- Co-ordinates and provides advisory support to the Department's radiographic services.
- Facilitates the licensing and inspection of healthcare establishments.
- Co-ordinates quality assurance for the Department.
- Provides medico-legal expertise and support to all matters with potential legal implications.

3.3.2.3 Policy and Planning:

This directorate has two main components, i.e. a legal component and a strategic planning component.

The strategic planning component was responsible for the development of Healthcare 2010 and subsequently the Comprehensive Service Plan. The directorate continues to support the refinement of the staff establishments in the restructuring process and the development of the Human Resource Plan. The directorate has a key responsibility for facilitating the departmental strategic planning

process and the co-ordination and compilation of the Annual Performance Plan and Budget Statement.

The legal component is responsible for facilitating and managing litigation matters in consultation with the Department of the Premier, the provision of legal opinions, drafting of contracts, drafting new legislation and general legal administration.

The key constraint in this directorate is the lack of appropriate capacity. It is planned to appoint appropriately skilled staff in order to develop the staff complement recommended by the recent organisational development investigation.

3.3.2.4 Other Professional Support Services directorates:

Information regarding the other Professional Support Services directorates is documented in the respective programmes as follows:

- Engineering and Technical Services (Programme 7)
- Hospital Revitalisation Programme (Programme 8)
- Forensic Pathology Services (Sub-programme 7.3)

3.3.3 Human Resource Management

Another key component of Programme 1 is the Chief Directorate: Human Resource Management which consists of the following directorates and components:

- 1) Human Resource Management (Further detail provided in Paragraph 4)
- 2) Labour Relations (Further detail provided in Paragraph 4)
- 3) Human Resource Development (Detail provided in Programme 6)
- 4) Nursing (Further detail provided in Paragraph 4)
- 5) The Transformation Unit (Further detail provided in Paragraph 4).

3.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 1.1: Provincial objectives and performance indicators for Administration [ADMIN1]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Sub-programme 1.2:	Management	Strategic Goal:	To conduct the strategic management and overall administration of the Department of Health						
To coordinate, integrate and provide health information to the department	Improve the Integrity of data	1. Data submission rate of prioritised data sets	-	-	-	This is a new indicator.	85% (11 760/ 13 836)	92% (12 729/ 13 836)	100% (13 836/ 13 836)
	Creating a central data repository for all performance / non-financial data.	2. Number of budget programmes whose core data has been incorporated into the central data repository	-	-	-	This is a new indicator.	8	8	8
	Implementation of HIS at all contracted hospitals	3. Percentage of hospitals where the HIS has been implemented	25% (6/41)	34% (14/41)	47% (19/41)	60% (24/41)	70% (28/41)	80% (32/41)	90% (36/41)
To formulate policy and provide overall management and administrative support to the Department and the respective districts and institutions within the Department	All hospitals with up to date asset register	4. Percentage of hospitals with up to date asset register	88% (36/41)	95% (39/41)	95% (39/41)	100% (41/41)	100% (41/41)	100% (41/41)	100% (41/41)
	All other components, excluding hospitals, with an up to date asset register.	5. Number of health districts with up to date PHC asset register (excluding hospitals)	See note	See note	5	9	9	9	9
	Reduce the number of stock outs at the CMD	6. Number of items on stock outs at the Central Medicine Depot (CMD)	<60	53	61	70	<50	<50	<50
To systematically monitor and evaluate the quality of service delivery.	Timeous resolution of complaints.	7. Percentage of complaints resolved within 25 days.	Not reported in the APP	Not reported in the APP	Not reported in the APP	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received

Note:

Indicator 4 and 5 are extracted from Programme 8, Table HFM7 and are reported and managed in Programme 1.

Indicator 5: Previously the Department reported on all institutions having an up to date asset register and not on health districts with up to date asset registers.

The basis of this indicator is the five rural districts and the four sub-structure offices in the Metro,

3.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

The allocation to Administration increases to 3.17 per cent of the vote in 2009/10 in comparison to the 3.15 per cent allocated in the revised estimate of 2008/09, which amounts to a nominal increase of R38.563 million or 14.01 per cent from the revised estimate for 2008/09.

Table 1.2: Trends in provincial public health expenditure for Administration [ADMIN2]

Expenditure	2005/06 (actual)	2006/07 (actual)	2007/08 (actual)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)	2011/12 (MTEF projection)
Current prices							
Total	167 291 000	162 125 000	205 333 000	275 250 000	313 813 000	345 909 000	372 615 000
Total per person	35.46	30.71	38.74	51.72	58.74	64.48	69.19
Total per uninsured person	47.49	41.28	52.07	69.52	78.94	86.67	92.99
Constant 2007/08 prices							
Total	179 201 686	167 829 163	205 333 000	256 822 410	278 104 693	295 663 987	309 499 536
Total per person	37.99	31.79	38.74	48.26	52.05	55.12	57.47
Total per uninsured person	50.87	42.73	52.07	64.86	69.96	74.08	77.23

4. ADMINISTRATION: HUMAN RESOURCES MANAGEMENT

The Department has in the order of 25 000 employees from salary levels 1-16. The human resource function is governed from the central office with decentralised management to districts and institutional facility levels. At the head Office the Chief Directorate consists of five main components, i.e. Human Resource Management, Human Resource Development, Labour Relations, Nursing and Transformation Sub-directorate.

4.1 SITUATION ANALYSIS

- 4.1.1 Currently the approved staff establishment is not aligned with the service needs of the Department as outlined in the new organisational and post structure that was developed in the Comprehensive Service Plan. This is being and will be addressed by the Human Resource Plan with the implementation of the CSP.
- 4.1.2 This process will result in the relocation of posts from institutions where they are not needed to areas where they can be appropriately deployed.
- 4.1.3 The shortage of nurses in the Department hampers service delivery in some service areas. The implementation of the Occupational Specific Dispensation (OSD) for nurses has improved the recruitment and retention of nurses and will continue to do so during the 2009/10 financial year and beyond.
- 4.1.4 The further development of OSD's for all other professional occupational groups in the Public Service will improve the recruitment and retention of these employees.
- 4.1.5 The implementation of the Policy and Procedure on Incapacity Leave and Ill-health (PILIR), which is a system to manage sick leave in the Public Service, has resulted in a decrease in the absenteeism rate. The average number of days sick leave per employee during 2004 was 11 days, 10 days in 2005, 8 days in 2006 and 10 days in 2007 which indicates a steady improvement in the management of sick leave.

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS.

The Chief Directorate directly supports the implementation of the strategic plan of the Department and the following objectives will play a direct role in the execution of the Annual Performance Plan during 2009/10:

- 4.2.1 Facilitate the organisational change process within the Department. This entails the development and maintenance of an approved departmental organisation and post structure to ensure the structured execution of the CSP.
- 4.2.2 Coordinate the HR Planning process within the Department as a whole as well as on directorate and institutional level. This process ensures that the correct number and type of posts for rendering a service are identified, created and maintained. This planning process informs the compilation of the personnel budget of the Department.

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- 4.2.3 Competency profiling as part of the Human Resource Plan (HRP).
 - 4.2.4 Consultation with all relevant stakeholders in the development and implementation of the HRP.
 - 4.2.5 Ensure that the PERSAL system is updated and maintained.
 - 4.2.6 Implement and maintain efficient recruitment and selection processes for the timeous appointment of employees to render health services.
 - 4.2.7 Formal HR and Labour Relations training to line managers with regard to national and provincial policy, measures and practices as well as collective agreements.
 - 4.2.8 Provide governance and strategic direction with regards to nursing across the Department.
 - 4.2.9 Identifying the training needs in collaboration with line managers and facilitate the process to procure the appropriate service providers.
 - 4.2.10 Ensure the application of the Employment Equity plan, which was approved on 1 June 2007, for the period 2007 to 2012. The plan spells out measures to improve recruitment of appropriate candidates from the designated groups and people living with disabilities.
 - 4.2.11 Implement the Occupation Specific Dispensation for health professionals, which will contribute to the retention of staff in these categories and reduce the attrition rate within the Department
 - 4.2.12 The Department has developed a nursing strategy, which will be implemented it over the next financial year. Satellite campuses will be established in the Boland and Southern Cape. The marketing and promotion of the nursing profession will be a key focus of the Directorate: Nursing.
 - 4.2.13 The effective management of staff with respect to issues such as performance, leave, discipline and employee assistance is key to creating a productive work force. This is critical for the implementation of the Comprehensive Service Plan and its aim of optimal utilisation of the available resources.
- 4.3 **CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM.**

Recruitment of appropriate numbers of certain key clinical personnel, such as pharmacists and specialty nurses, remains a challenge. In order to meet the demand and improve the production of health workers a study is being undertaken to quantify the skills gap by competency profiling as part of the Human Resource Plan of the Department.

Human resource offices across the Department have staff shortages and capacity constraints and the challenge is addressed by allocating additional funding for the appointment of more staff. At the same time staff capacity will be built by an audit team within the Chief Directorate.

4.4 PLANNED QUALITY IMPROVEMENT MEASURES

The service and human resource restructuring process that is in progress aims to provide an optimal bed and skill mix of personnel to meet the calculated service requirements.

Problems experienced with systems such as the PERSAL system, which needs to be updated and the Basic Accounting System (BAS) with slow response times continue to impact on efficiency. The Department continues to address this matter, which is a national competency with relevant departments. The Department has also implemented a project to update the PERSAL system.

Table 1.3: Public health personnel in 2007/08 [HR1]

Categories	Number employed	% of total employed	Number per 1 000 people	Number per 1 000 uninsured people	Vacancy Rate	% of total personnel budget	Annual cost per staff member
Medical Officers	1,774	6.69%	0.33	0.45	16.91%	15.72%	362,216
Medical Specialists	457	1.72%	0.09	0.12	22.15%	6.36%	569,079
Dentists	68	0.26%	0.01	0.02	20.00%	0.59%	353,906
Professional Nurse	4,744	17.88%	0.90	1.20	28.09%	25.55%	220,154
Enrolled Nurses	2,047	7.71%	0.39	0.52	21.27%	5.98%	119,477
Enrolled Nursing Auxiliaries	4,038	15.22%	0.76	1.02	14.09%	9.55%	96,660
Student Nurses	10	0.04%	0.00	0.00	0.00%	0.02%	68,760
Pharmacists	328	1.24%	0.06	0.08	42.76%	1.64%	204,917
Physiotherapists	119	0.45%	0.02	0.03	21.71%	0.46%	157,691
Occupational Therapists	103	0.39%	0.02	0.03	26.43%	0.41%	160,914
Clinical Psychologists	68	0.26%	0.01	0.02	27.66%	0.34%	204,004
Radiographers	403	1.52%	0.08	0.10	11.43%	1.70%	172,556
Emergency Medical Staff	1,341	5.05%	0.25	0.34	44.19%	4.39%	133,807
Dieticians	80	0.30%	0.02	0.02	20.79%	0.31%	158,803
Other allied health professionals and technicians	800	3.01%	0.15	0.20	27.07%	3.18%	162,294
Managers, Administrators & all other staff	10,155	38.27%	1.92	2.58	25.08%	23.81%	95,852
Grand Total	26,535	100%	5.01	6.73	24.80%	100%	154,061

Notes:

1. These vacancy rates are expressed as a percentage vacancy determined by the existing approved staff establishment. This is materially different from the envisaged staff establishment that will be derived from the Comprehensive Service Plan.
2. Professional nurses on salary levels 9-12 are included as managers.

Table 1.4: Situational analysis and projected performance for human resources (excluding health sciences and training) [HR3]

Strategic objective	Measurable objective	Performance Measure/Indicator	Type	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	National target 2007/08	
Sub-programme 1.2.1 Administration		Strategic goal:	The recruitment and retention of an appropriate workforce for the Department of Health.									
To have an effective and efficient and skilled workforce.	To provide sufficient staff with appropriate skills per occupational group.	1. Number of medical officers per 100,000 people	No	37	37	37	37	37	37	37	18.7	
		2. Number of medical officers per 100,000 people in rural districts	No	13	13	13	13	13	13	13	12.2	
		3. Number of professional nurses per 100,000 people	No	95	100	100	100	100	100	100	105	
		4. Number of professional nurses per 100,000 people in rural districts	No	60	70	80	80	80	80	80	92.5	
		5. Number of pharmacists per 100,000 people	No	8	10	15	15	15	15	15	34	
		6. Number of pharmacists per 100,000 people in rural districts	No	6	8	12	12	12	12	12	24	
		7. Vacancy rate for professional nurses	%	15%	15%	13%	13%	13%	13%	13%	15	
		8. Attrition rate for doctors	%	30%	25%	20%	20%	20%	20%	20%	25	
		9. Attrition rate for professional nurses	%	12%	12%	10%	10%	10%	10%	10%	25	
		10. Absenteeism for professional nurses	%	3%	3%	2.7%	2.7%	2.7%	2.7%	2.7%	5	
		11. Percentage of hospitals with employee satisfaction survey	%	45%	60%	65%	65%	65%	65%	65%	50	
		Efficiency										
		12. Nurse clinical workload (PHC)	No	35	35	32	35	27	28	35	40	
		13. Doctor clinical workload (PHC)	No	50	50	29	50	29	27	25	30	
Outcome												
14. Supernumerary staff as a percentage of establishment	%	0	0	0	0	0	0	0	0			

NOTES:

- Excludes Local Government personnel.
- Excludes sessions, periodical and extraordinary appointments.
- Absenteeism is calculated: $\text{Persons} \times 261 / \text{days sick leave} \times 100$
- Doctors = medical officers, specialists, registrars and medical superintendents
- Doctors as defined in Note 4 are used throughout the Table when reference is made to medical professionals, i.e. for Indicators 1, 2, 8 and 11
- The unfunded posts within the Department of Health were abolished or frozen since July 2004 and the information for indicators 11, 12 and 13 would not be a true reflection of the real service need in terms various occupational classes. Furthermore the information is not obtainable from PERSAL.
- The job evaluation benchmark for medical officers with effect from 1/12/2003 have only been implemented during 2004. There was previously no specific job title for community service doctors to differentiate from medical officers on the PERSAL system. The information for indicator 14 is only be available from the 2006/07 financial year.
- Although the current indicator for medical officers exceeds the national target, in the Western Cape's view there is not an over provision of personnel.
- The indicators regarding pharmacists confirm the shortage of this category of personnel in the Province.
- Attrition rate for doctors (Indicator 8) and professional nurses (Indicator 9) excludes with effect from 2007/08 terminations on contract. If the latter is included it inflates the attrition figure which does not reflect the true situation.

PROGRAMME 2: DISTRICT HEALTH SERVICES

1. PROGRAMME DESCRIPTION

To render Primary Health Care Services and District Hospital Services including preventive, promotive, curative and rehabilitation services. The foundation for the effective and efficient provision of these services is based on the integration of facility based services; community based and support services.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 2.1 DISTRICT MANAGEMENT

Planning and administration of services, managing personnel and financial administration and co-ordinating and the management of the Day Hospital Organisation and Community Health Services rendered by Local Authorities and Non-Governmental Organisations within the Metro and determining working methods and procedures and exercising district control.

2.2 SUB-PROGRAMME 2.2 COMMUNITY HEALTH CLINICS

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

2.3 SUB-PROGRAMME 2.3 COMMUNITY HEALTH CENTRES

Rendering a primary health service with full-time medical officers in respect of mother and child, health promotion, geriatrics, occupational therapy, physiotherapy, psychiatry, speech therapy, communicable diseases, mental health, etc.

2.4 SUB-PROGRAMME 2.4 COMMUNITY BASED SERVICES

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

2.5 SUB-PROGRAMME 2.5 OTHER COMMUNITY SERVICES

Rendering environmental and port health etc.

2.6 SUB-PROGRAMME 2.6 HIV AND AIDS

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

2.7 SUB-PROGRAMME 2.7 NUTRITION

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

2.8 SUB-PROGRAMME 2.8 CORONER SERVICES

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

2.9 SUB-PROGRAMME 2.9 DISTRICT HOSPITALS

Rendering of a hospital service at district level.

2.10 SUB-PROGRAMME 2.10 GLOBAL FUND

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

3. INTRODUCTION

The aim of Programme 2 is to render a full package of community-based services (Sub-programme 2.4) and facility-based services [clinics (Sub-programme 2.2), community health centre (Sub-programme 2.3) and district hospitals (Sub-programme 2.9)] within the District Health System (DHS).

Health services and programmatic interventions are developed and implemented in response to the burden of disease in the Western Cape along with guiding international, national and provincial strategic frameworks and policies. The eight 'Divisional Priorities' work cohesively to strengthen the vehicle to provide services i.e. strengthening the district health system, community-based services, chronic disease management and the efficient use of district hospitals whilst maintaining a focus on the priority health programmes to improve TB control, the diagnosis and treatment of HIV and AIDS, child health and women's health.

During 2009/10 the service delivery platform will continue to be transformed towards that envisaged in the Comprehensive Service Plan (CSP) via an integrated approach across the Department as articulated in the executive summary at the beginning of Part B of this document. The following Programme 2 priority areas will align to the departmental priority key performance areas (KPAs):

- 1) Acute services including Emergency Medical Services (EMS)
- 2) Chronic disease management - ambulatory care including outreach and support
- 3) HIV and AIDS and TB control - infectious disease management
- 4) Community-based services - de-hospitalised care.

In addition the programmatic focus on child health and woman's health will remain and two specific interventions to address burden of disease "midstream" and "upstream" risk factors will be implemented during 2009/10:

- 1) Water and sanitation interventions, especially in informal settlements as they relate to the prevalence of diarrhoeal disease via an effective inter-governmental mechanism to monitor the provision of basic services and Municipal health services;
- 2) Substance abuse, especially related to alcohol abuse and prevalence of Fetal Alcohol Syndrome (FAS).

4. DISTRICT HEALTH SERVICES

4.1 SITUATION ANALYSIS

4.1.1 Services within the District Health system

4.1.1.1 Management and governance

In line with the National Health Act (No 61 of 2003) and the Healthcare 2010 strategy the implementation of the District Health System is a key vehicle for delivering Primary Health Care and district hospital services. During the period 2005 to 2007 the Western Cape Provincial Department of Health transferred personal primary health care services, previously provided by rural municipalities to the province. The Department has successfully transferred 545 Local Government staff members to the provincial staff establishment in the 5 rural districts.

The Comprehensive Service Plan (CSP) was formally approved by the Provincial Cabinet and was officially released on 11th May 2007. The CSP provides a clear framework for the implementation of the District Health System in the Western Cape. This paved the way for the formalisation of the six district management structures (Cape Metro, West Coast, Cape Winelands, Overberg, Eden, Central Karoo) during the 2008/09 financial year. The appointment of District and Metro sub-structure managers during the 2008/09 financial year, in line with the establishment of districts and in compliance with the National Health Act of 2003 was a key deliverable for the implementation of the DHS.

4.1.1.2 Primary Health Care Services

The Primary Health Care Information System (PHCIS) has been established at 33 PHC facilities by March 2008. The system allows for each registered patient to have a unique identification number that is the same whether the patient is on a PHC platform in provincial or City of Cape Town managed services or any of the hospitals throughout the Province that are connected to the Health Information System (Clinicom). At the end of the October 2008 there were 2.19 million patients registered on the system on the PHC platform. This translates to 53% of the uninsured population in the province and in fact two million of these clients are in the Metro which translates to about 80% of the uninsured population in the Metro. Reports have also shown that the waiting time particularly at reception has significantly reduced in those facilities in which it was implemented. Furthermore the system allows for improved continuity of care with a single unique patient identifier across all platforms. It is projected that the system will be rolled out to a total of forty PHC facilities across the province by March 2009.

Access to emergency care is a constitutional right and it is imperative that trauma and emergency services are strengthened at all levels of care in the public health system. All community health centres with 24-hour emergency centres have implemented the uniform South African Triage System (SATS) to improve access to high quality emergency care. An integrated model for emergency care was implemented during the 2008/09 financial year in the Cape Winelands and Eastern sub-district of the Metro. It is also projected that 50% of non-hospital towns that have a population of 5 000 or more will have implemented a system of access to after-hours emergency care by March 2009.

In an attempt to further increase the accessibility of health care services in the Cape Metro, extended hours services were introduced at the nine Metro CHCs that also provide 24-hr trauma and emergency services. These services provide a limited nurse-based clinic package of services between the hours of 16:00 and 21:00 on weekdays, and 08:00 to 13:00 on Saturdays.

By end of September 2009, 75.9% of all fixed PHC facilities were supported by a doctor at least once a week. The registration of family medicine as a speciality by the Health Professions Council heralded an exciting new era and 2008 saw the first intake of twenty family medicine registrars. As trained specialists in family medicine, family physicians will increasingly perform a critical role in improving the quality of services at health facilities, through student training, morbidity and mortality reviews and regular clinical audits.

All sub-districts offer a full package of PHC services. In 2007/08 the province spent R313 per uninsured person on PPHC, and R122 per PHC visit. This increase from R273 per uninsured person and R72 per Head count in 2006/07 can be attributed primarily to the introduction of the Occupation Specific Dispensation for nursing personnel.

During 2007/08, 13.029 million people used primary health care services at 479 facilities throughout the Province, an increase of 8.1% from the previous year. The utilization rate rose from 3.1 in 2006/07 to 3.6 in 2007/08 visits per uninsured person. This can be attributed to increased visits due to anti-retroviral provision, expansion of basic antenatal care (BANC) and chronic medication dispensing from the chronic medicine dispensing units (1.4 millions prescriptions in 2007/08). The latter has significantly reduced patient waiting times.

4.1.1.3 District hospital services

There has been an overall increase in people using district hospital services as reflected in the numbers of separations, day cases and patient day equivalents. In 2007/08 those using out-patient services increased from 436,643 in 2006/07 to 515,501 and those using casualty increased from 258,465 in 2006/07 to 362,498. The Western Cape has thirty-three district hospitals including the Khayelitsha and Mitchell's Plain district Hospital hubs based at Tygerberg and Lentegeur Hospitals respectively. It is projected that construction will commence during the 2008/09 financial year on the Khayelitsha and Mitchell's Plain district hospitals. The re-classification of three Metro regional hospitals into district hospitals has increased the level 1 beds in the province from 1 541 beds in 2006/07 to 2 113 beds in 2007/08 which is progress towards the Comprehensive Service Plan target of 2 460.

More than two-thirds (80.1%) of district hospitals have operational hospital boards. Most (90%) district hospitals have a full time chief executive officer (CEO). Hospital expenditure per patient day equivalent increased in from R692.86 in 2006/07 to R893 in 2007/08 in line with the transformation of the hospital platform.

A case fatality rate of 1.05% was recorded for 2007/08, which is a 0.26 increase from 2006/07 (0.79%) and above the target of 0.7% for 2007/08. The addition of three Metro hospitals to the programme (GF Jooste, Karl Bremer and Helderberg), which performed a quantum of more complex level 2 work, in the 2007/08 figure and which were not part of the 2006/07 data, explains this trend. The caesarian section rate has increased in from 14.3% in 2006/07 to 20.6% in 2007/08, mainly because of the higher rates in Karl Bremer and Helderberg Hospitals because of the significant quantum of level 2 general specialist care in these hospitals. As at September 2008 this trend is continuing.

The key projected deliverables for 2008/09 to address the significant service pressures in the Metro were:

- 1) **Emergency (point of entry) care:** emergency units established at the Khayelitsha Site B and Mitchells Plain CHCs, for admission of appropriate level 1 cases into the level 1 beds at Khayelitsha and Mitchells Plain district hospital hubs;
- 2) **Obstetric pressures:** Forty additional level 1 obstetrics beds in the Metro (twenty beds at Khayelitsha District Hospital in Metro East, and twenty beds at Mowbray Maternity Hospital in Metro West);
- 3) **Mental Health:** a psychiatric nurse appointed at each district hospital in the province and low secure areas/ safe observation areas created;
- 4) **Surgical services:** increased level 1 elective surgical procedures performed at Khayelitsha District Hospital hub and Eerste River Hospital.

4.1.1.4 Community-based services

1) Community mental health care:

The CSP proposes a holistic and integrated approach to the delivery of mental health services. In addition, the key strategy for promoting community-based mental health services is to decongest the acute hospitals and concomitantly ensure that clients are treated and placed at the appropriate level of care. The foundation for these services should be strong and delivered as close to home as possible. This requires partnerships that span both government departments and non-governmental organizations with a balance of medical and non-medical approaches to service provision. Community Based Mental Health Services provide care to de-hospitalised clients and is a strategy to minimise unnecessary hospitalisation. Currently there are 1 681 clients in funded community mental health services in the province:

- In residential care facilities for people with profound and severe intellectual disabilities there are a total of 370 funded beds
- In special day care centres for people with profound and severe intellectual disabilities there are a total of 862 funded beds
- In groups homes for psychiatric clients there are a total of 333 funded beds
- There are also psychosocial Rehabilitation Groups which meet weekly

2) Integrated community home-based care services:

These services are provided to clients in their homes and communities. Integrated home-based care has three service delivery streams: Home-based care, community adherence support and prevention/promotion interventions. In 2007/08, 145 Non Profit Organisations (NPOs) were funded for home-based care and 1 343 carers. The funding comprises R14 million from the European Union and R28 million allocation from Expanded Public Works Programme (EPWP). In 2007/8, 16 823 clients were registered for the provision of home based care services. The Department has developed positive partnerships with Non Profit Organisations and has facilitated the strengthening of management processes, capacity development and the sharing of best practices. The Department has developed a NPO database and improved guidelines for NPO funding and monitoring and evaluation to ensure the maintenance of high service quality. The number of carers in 2008/09 has increased to 2 300.

Through the Expanded Public Works Programme (EPWP), the department has trained 1 000 carers on NQF level 1 and 420 on NQF level 2 in 2007/08. In 2008/09 there will be a group of 350 learners on NQF level 3. This programme enables carers to develop a career path as recognised community health workers. The National Department of Health is drafting a regulatory framework to support this.

4.1.1.5 Chronic disease management system

Approximately 10% of people die prematurely from cardiovascular diseases in the province and the management of chronic diseases places a significant burden on the health system. The management of the following chronic diseases have been prioritised: chronic lung disease especially asthma, diabetes, hypertension, cardiovascular diseases, epilepsy and mental health. The Provincial Chronic Disease Management Strategy will be completed before the end of 2008.

Patients with chronic disease require their treatment on a daily basis, therefore ensuring access to medication is important for both the clients and the health providers. The amount of 1 420 500 chronic disease medication prescriptions were issued through a variety of alternative systems in 2007/08.

Family Physicians are responsible for implementing appropriate clinical governance systems for the management of chronic diseases. Thirty-eight CHCs had institutionalised annual clinical audits for the monitoring of cardiovascular risk management practices at the end of 2007/08. An integrated audit tool to monitor the quality of services for the above mentioned prioritised chronic diseases has been developed and is currently being piloted at Vanguard CHC with the view of roll out in 2009/10.

Table 2.1: District health service facilities by health district [DHS1]

Health district	Facility type	Number	Population (Uninsured) 2008/09	Uninsured Population per fixed PHC facility	Per capita utilisation
WEST COAST	Non fixed clinics	42	234,152	9,006	-
	Fixed Clinics	26			
	CHCs	0			
	Sub-total clinics + CHCs	68			
	District hospitals	7			
CAPE WINELANDS	Non fixed clinics	33	574,555	11,266	-
	Fixed Clinics	51			
	CHCs	0			
	Sub-total clinics + CHCs	84			
	District hospitals	4			
OVERBERG	Non fixed clinics	25	178,047	8,093	-
	Fixed Clinics	22			
	CHCs	0			
	Sub-total clinics + CHCs	47			
	District hospitals	4			
EDEN	Non fixed clinics	39	419,153	13,972	-
	Fixed Clinics	30			
	CHCs	5			
	Sub-total clinics + CHCs	74			
	District hospitals	6			
CENTRAL KAROO (Rural development node)	Non fixed clinics	11	50,450	8,408	-
	Fixed Clinics	6			
	CHCs	1			
	Sub-total clinics + CHCs	18			
	District hospitals	4			
METROPOLE	Non fixed clinics	12	2,503,086	23,839	-
	Fixed Clinics	105			
	CHCs (including MOU's)	53			
	Sub-total clinics + CHCs	170			
	District hospitals (including Victoria Hospital and Khayelitsha and Mitchells Plain District Hospital hubs)	9			
PROVINCE	Non fixed clinics	180	3,959,443	16,498	-
	Fixed Clinics	240			
	CHCs (including MOU's)	59			
	Sub-total clinics + CHCs	479			
	District hospitals (including Victoria Hospital and Khayelitsha and Mitchells Plain District Hospital hubs)	34			

Notes:

1. Source: Directorate Information Management
2. Non fixed clinics are satellites and mobiles
3. PHC utilisation per capita and (uninsured persons) in brackets, based on PHC headcount as projected for 2008/09.

Table 2.2: Personnel in district health services by health district [DHS2]

Health district	Personnel category	Posts filled	Posts approved	Vacancy rate (%)	Total Personnel (incl. LG)	Number in post per 1000 uninsured people
West Coast	PHC facilities					
	Medical officers	2	2	0.0%	2	0.009
	Professional nurses	117	126	7.2%	117	0.501
	Pharmacists	9	9	0.0%	9	0.039
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
	District hospitals					
	Medical officers	10	13	23.1%	10	0.043
	Professional nurses	147	147	0.0%	147	0.630
	Pharmacists	6	8	25.0%	6	0.026
	Cape Winelands	PHC facilities				
Medical officers		13	16	19.2%	13	0.022
Professional nurses		294	292	-0.7%	294	0.513
Pharmacists		15	16	6.3%	15	0.026
Community health workers		Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
District hospitals						
Medical officers		14	16	12.5%	14	0.024
Professional nurses		132	136	2.9%	132	0.230
Pharmacists		3	3	0.0%	3	0.005
Overberg		PHC facilities				
	Medical officers	6	6	0.0%	6	0.034
	Professional nurses	101	102	0.6%	101	0.571
	Pharmacists	5	6	16.7%	5	0.028
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
	District hospitals					
	Medical officers	9	8	-12.5%	9	0.051
	Professional nurses	81	82	1.2%	81	0.457
	Pharmacists	3	3	0.0%	3	0.017
	Eden	PHC facilities				
Medical officers		16	19	15.8%	16	0.038
Professional nurses		175	179	2.2%	175	0.419
Pharmacists		16	16	0.0%	16	0.037
Community health workers		Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
District hospitals						
Medical officers		21	25	16.0%	21	0.050
Professional nurses		204	190	-7.4%	204	0.488
Pharmacists		9	12	25.0%	9	0.022
Central Karoo		PHC facilities				
	Medical officers	2	4	50.0%	2	0.040
	Professional nurses	26	28	7.1%	26	0.517
	Pharmacists	2	2	-23.1%	2	0.040
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
	District hospitals					
	Medical officers	4	4	0.0%	4	0.080
	Professional nurses	45	42	-7.1%	45	0.896
	Pharmacists	2	2	0.0%	2	0.040
	Metropole	PHC facilities				
Medical officers		114	139	18.0%	132	0.053
Professional nurses		709	743	4.5%	1,070	0.429
Pharmacists		72	75	4.0%	82	0.033
Community health workers		Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
District hospitals						
Medical officers		100	111	9.9%	100	0.040
Professional nurses		536	554	3.2%	536	0.215
Pharmacists		21	22	4.5%	21	0.008
Province		PHC facilities				
	Medical officers	152	185	17.8%	170	0.043
	Professional nurses	1,422	1,470	3.2%	1,783	0.452
	Pharmacists*	119	123	3.8%	129	0.033
	Community health workers	Not on establishment	Not on establishment	Not on establishment	Not on establishment	Not on establishment
	District hospitals					
	Medical officers	158	177	10.8%	158	0.040
	Professional nurses	1 145	1 151	0.5%	1 145	0.290
	Pharmacists	44	50	12.0%	44	0.011

Notes:

1. Source: WC Department of Health, CFO'S Office and City of Cape Town, City Health Department
2. Data as at 30 September 2008
3. Population figures: Information Management: Circular 5/2009.

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

Strategic Objectives	Measurable objectives	Performance Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Winelands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2003/04
Sub-programmes 2.1 - 2.3. Strategic goal:		Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services in all the districts of the Western Cape										
Deliver quality Primary Health Care (PHC) services in all 6 districts	Allocate sufficient funds per uninsured person to sustain an average utilisation rate of 3.87 per annum	1. Provincial PHC expenditure per uninsured person	R272	R259	R313	R306	R142	R356	R361	R475	R639	
		2. Total PHC headcount per annum	13 068 303	12 180 933	13 029 007	7 787 777	1 799 879	648 508	1 642 274	239 099	911 470	
		3. PHC utilisation rate per capita (total population)	2.77	2.31	2.41	2.2	2.5	3.0	3.1	4.3	3.2	2.3
		3.1 PHC utilisation rate per uninsured person	3.71	3.09	3.24	3.05	3.1	3.65	3.88	4.84	3.91	
		4. PHC utilisation rate - under 5 years	5.2	4.8	4.9	4.2	5.3	5.8	7.0	7.3	6.7	3.8
	5. Percentage of sub districts offering the full package of PHC services	80%	100%	100%	100%	100%	100%	100%	100%	100%	100%	60%
	Ensure the efficient and quality delivery of the full package of PHC services	6. Percentage fixed PHC facilities supported by a doctor at least once a week	Not available	Not available	73.4	92.7	72.6	89.3	36.5	8.3	62.0	31%
		7. Supervision rate (%)	73.34	71.76	43.8	43.40%	30.00%	28.90%	75.60%	59.70%	33.50%	78%
		8. Provincial PHC expenditure per headcount	R76	R86	R93	R 124	R 46	R 105	R 72	R 85	R 135	R99
9. Percentage of complaints resolved within 25 days		New indicator from 2009/10	-	-	-	-	-	-	-	-	-	

Note:

The above Strategic goal applies to Sub Programmes 2.1, 2.2 and 2.3

Table 2.4: Situation analysis indicators for district hospitals sub-programme [DHS4]

Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-lands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2003/04	
Strategic goal:	Transform the district hospital service platform to provide access to full package of quality Level 1 hospital services in all districts in the Western Cape												
Provide access to full district hospital package of care in all 6 districts	Provide sufficient theatre capacity and resources at district hospitals to perform caesarian sections at a rate of between 10 - 15%	1. Caesarean section rate for district hospitals	10.70%	14.30%	20.6	28.30%	18.70%	20.90%	18.40%	18.70%	11.3	12.50%	
		Provide sufficient resources for the rendering of out patient services at a target rate of one out patient per inpatient day by 2010	2. Number of patient day equivalents (PDEs) in district hospitals	643,244	661,655	956,181	441,492	95,961	74,501	176,005	40,092	128,130	
			3. OPD Total headcount in district hospitals	447 414	436 643	515 501	265 776	60 613	28 137	88 133	4 993	67 849	
			3.1 Casualty/ emergency/ trauma headcount in district hospitals	264 752	258 465	362 498	147 422	47 160	45 548	68 675	14 382	39 311	
			3.2 Comprehensive OPD headcount in district hospitals (Number of OPD headcount + Trauma/emergency casualty)	712,166	695,108	877,999	413,198	107,773	73,685	156,808	19,375	107,160	
	Implement quality assurance measures to minimise patient risk in district hospitals	4. Percentage of district hospitals with patient satisfaction survey using DoH template	46.0%	35.7%	25.7%	42.9%	25.0%	0.0%	33.3%	0.0%	42.9%	10%	
		5. Percentage of district hospitals with mortality and morbidity meetings every month	45%	21.40%	71.40%	100.0%	75.0%	50.0%	66.7%	14.3%	114.3%	36%	
		6. Percentage of district hospitals with clinical audit meetings every month	Not requested prior to 2007/08	Not requested prior to 2007/08	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
		7. Percentage of complaints resolved within 25 days in district hospitals	Not requested prior to 2007/08	Not requested prior to 2007/08	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	Not reported	
		8. Case fatality rate in district hospitals for surgery separations	0.70%	0.79%	1.05%	1.51%	0.75%	0.38%	0.64%	0.83%	0.35%	3.90%	
	Deliver district hospital services at optimal efficiency	Manage bed utilisation to achieve an average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals	9. Average length of stay in district hospitals	2.8	2.8	3.3	4.0	2.8	2.7	3.0	3.2	2.6	4.2
			10. Bed utilisation rate based on useable beds	71.00%	71.70%	79.30%	88.40%	61.80%	70.90%	81.10%	76.80%	71.50%	68%
11. Total separations in district hospitals			142,054	144,373	203,932	76,790	21,610	18,259	40,957	10,460	35,750		
Ensure the cost effective management of district hospitals at a target expenditure of approximately R950 per PDE by 2010		12. Expenditure per patient day equivalent in district hospitals	R698	R714	R894	R969	R938	R752	R787	R832	R851	R814 in 2003/04 prices	

Note:
Indicator 12: 2007/08 prices

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

4.2.1 Policy and strategic framework:

Programme 2 functions within a national, provincial and divisional strategic framework as illustrated in Table 2.6 below.

Table 2.5: Policy and strategic framework

National level	The Constitution National Health Act Public Finance Management Act Medium Term Strategic Framework National Spatial Development Framework Accelerated Shared Growth Initiative of South Africa Strategic Priorities for the National Health System (2004 –09)
Provincial level	IKapa eLihlumayo Provincial Growth and Development Strategy (PGDS) Healthcare 2010 Comprehensive Service Plan
Divisional level	EIGHT DIVISIONAL PRIORITIES: Implementation of the DHS: 1) Strengthening the District Health System 2) Community-based services 3) District Hospitals 4) Chronic disease management Priority Health Programmes: 5) TB 6) HIV and AIDS 7) Women's Health 8) Child Health

The Provincial Growth and Development Strategy (PGDS) recognises the upstream risk factors, or the so-called social determinants of the Burden of Disease, as a key developmental issue for the Provincial Government as a whole, and mandates the Department to implement the Healthcare 2010 strategy in order to contribute to the objective of “promoting liveable communities that foster and nurture the well-being of all residents”.

The Comprehensive Service Plan (CSP) describes a detailed service delivery model for District Health Services (DHS), acute hospitals (level 1, 2 and 3), specialised hospitals (TB, Rehabilitation and Psychiatric Services), Emergency Medical Services and Forensic Pathology Services.

The Department addressed the implementation of the CSP during the past two financial years. During 2009/10 the service delivery platform within the district health services will continue to be transformed towards that envisaged in the CSP via an integrated approach across the Department. As discussed above the Department has four inter-divisional key performance areas (KPA's) for integrated service delivery transformation for 2009/10 i.e.:

- 1) Acute services (including EMS)
- 2) Ambulatory care (including outreach and support)
- 3) Infectious disease management
- 4) De-hospitalised care

The key deliverables to be achieved across the service platform in 2009/10 within each of the four priorities areas will be articulated as “service shifts” across the financial sub-programmes as illustrated in Figure 1 in the Part B: Executive Summary.

In addition to articulating the service platform formulation within the DHS, the CSP provides a detailed outline of the configuration and functions of the DHS management structures. These district, sub-district and facility management structures will strengthen district-based planning, monitoring and evaluation and service delivery. It will also provide for functional inter-sectoral planning and implementation to address the key upstream drivers of the burden of disease.

4.2.2 **Priorities:**

4.2.2.1 **Strengthening the DHS**

1) **Management and governance:**

The priority is to comply with the National Health Act (no 63 of 2003) and systematically strengthen the district management structures via the six district offices and the four Metro sub-structure offices during 2009/10. The aim is to achieve significant efficiencies and improvements in patient care, through improved management and clinical governance. The Department appointed district managers at the level of a Director for Central Karoo (located in Beaufort West), and Cape Winelands (based in Worcester) as from 1 June 2008, in addition to the existing managers for Eden (based in George), West Coast (based in Malmesbury) and Overberg (moved to Caledon). The Cape Metro has a district manager at the level of a Chief Director. The Department appointed four sub-structure managers at the level of a Director for the Cape Metro as from 1 June 2008. The sub-structure managers will each manage all the PGWC health services in two sub-districts. These sub-structure offices will be based in the following geographic locations:

- Southern and Western sub districts based in Retreat;
- Northern and Tygerberg sub districts based in Parow;
- Mitchell's Plain and Klipfontein sub districts based in Mitchell's Plain;
- Khayelitsha and Eastern sub districts based in Khayelitsha.

2) **PHC services:**

The PHCIS which is a patient electronic record on the primary health care platform is projected to be rolled out to a total of forty PHC facilities across the province by March 2009. The objective is to roll it out to a total of seventy-three PHC facilities during 2009/10 pending the availability of connectivity infrastructure which is currently a challenge. This is being addressed with SITA and Department of the Premier, Information Technology department. Nonetheless the Department will consolidate the facilities with the PHCIS and ensure that there is full functionality of all the modules which include the registration, appointment and PHC visits. The ART clinical module will be also be rolled out to additional sites and a modified PHC JAC pharmacy module will be added to the functionality in two community health centres in 2009/10 as a pilot.

The integrated model for emergency care that is being piloted in Cape Winelands and the Eastern sub-district in the Metro will be institutionalised across all five rural districts and four Metro sub-structures during 2009/10, with the appointment of nine emergency care specialists who will be supporting clinical governance in emergency services in specified geographic areas.

The model for providing access to emergency care in non-hospital towns with population sizes of 5 000 or more will be rolled out to 50% of the towns in 2009/10.

The extended hours services were expanded to 12 sites during 2008/09 with the addition of services at Michael Mapongwane, Gustrouw and Grabouw CHCs. There will be an additional service point at Albow Gardens CHC, after the consolidation of the Goodhope CHC with the Albow Gardens clinic, in the Western sub-district of the Metro during 2009/10. Also if additional funding is available the following sites will also be added:

- In Overberg district, Hermanus;
- In West Coast district, Diazville in Saldanha Bay;
- In Cape Winelands district, Witzenburg
- In Central Karoo district Beaufort West and
- In Eden District George.

The clinical governance in the DHS will be consolidated and improved during 2009/10. The number of senior family physicians in the DHS will be increased from a projected fifteen by March 2009, to twenty-five by March 2010, and the number of family medicine registrars will increase from forty to sixty during 2010.

The PHC headcount increased from 13.029 million in 2007/08 to 14.496 million in 2008/09. The key strategy to provide bi-monthly chronic medication to stable clients will impact the headcount in a significant way and the decanting of stable ambulatory patients with chronic diseases from the central hospitals to PHC facilities will impact it minimally due to the numbers targeted.

It is difficult to estimate the impact of this but in 2009/10 there will be approximately 2.2 million prescriptions that patients will receive for chronic disease management. This can be estimated to be the number of visits for chronic disease medicine collection where patients come to the facility on a monthly basis. According to the South African Demographic Survey, 2003, 14.8% of men and 28.0% of women who have hypertension are on treatment and are controlled. If this is used as a proxy of control of chronic diseases in general and it is assumed that 20% of clients on chronic disease medication will be well controlled and good candidates for two monthly visits, it is then estimated that the PHC headcount would decrease by 220 000 visits.

However, the Department is also embarking on a process of clinical audits which will improve quality of care in chronic patients and thus increase the number of those who are controlled on medication. Furthermore the Department is improving its Information Management Systems and its ability to respond more generally to service pressures and needs. The assumption is that these interventions would decrease inefficiencies within the system and this could lead to either a PHC headcount drop or increase if there is unmet need that fills the capacity that is made available. There is limited information to predict the trend in PHC headcount going forward due to the transformatory processes occurring within the Department. With the improvement in information systems over the MTEF period the inability to predict such trends will be addressed. Thus the PHC headcount will be kept constant and over the next three years trends developed to enable more accurate projections going forward.

The cost per PHC headcount is projected to be limited to an increase from R103 for 2007/08 to R112 for 2009/10, in 2007/08 prices, if the PHC headcount does decrease by 220 000 headcounts as predicted.

4.2.2.2 District hospital services: acute services including EMS

Construction has commenced on the Khayelitsha District Hospital and Mitchell's Plain District Hospital will follow soon within the 2009/10 financial year. Victoria Hospital will be transferred to District Health Services in 2009/10 from Programme 4. The key priority is to increase the quantum of level 1 acute hospital services offered across the 2 300 beds in the thirty-four district hospitals in the province. The amended level 1 hospital package for the Western Cape was finalised in September 2008, and a quantification of level 1 care activities across the service platform completed in November 2008. There will be specific targets for level 1 and level 2 service shifts across the different general specialities across the service platform, in line with CSP targets that will be implemented in the 2009/10 financial year (see executive summary).

The major service platform shifts during 2008/09 was the level 1 and 2 shift of obstetric and neonatal services between Karl Bremer, Tygerberg and Khayelitsha district hospitals. The following are some of the intended shifts for 2009/10:

- 1) Levels 1 and 2 paediatric service shifts between Tygerberg, Karl Bremer and Helderberg Hospitals.
- 2) Improved kangaroo mother care across the service platform from level 2, level 1 and PHC level;
- 3) Level 1 elective surgical procedures for Klipfontein and Mitchells Plain sub-districts to be rendered at Khayelitsha District Hospital and Eerste River Hospital;
- 4) Increase the quantum of level 1 orthopaedics in Khayelitsha District Hospital and Eerste River Hospital;
- 5) Increase medical officer capacity to perform level 1 anaesthetic procedures in district hospitals.

Emergency services will be made more accessible, efficient and effective within the District Health System. Five clinical governance and training complexes for emergency medicine headed by emergency medicine specialists will be established. Emergency units in district hospitals will incrementally have Principal Medical Officers in charge and have the required competent nursing and medical staff employed such that the use of agency staff is minimised. Access to emergency care particularly in rural non hospital towns will also be improved.

There will be an overall increase in people using district hospital services in 2009/10, with the number of patient days increasing to 760,000 and the separations increasing to 227,174. The average length of stay will decrease to 3 days (from 3.56 days in 2007/08). The expenditure per patient day equivalent will be limited to an increase from R893 in 2007/08 to R905 in 2008/09 to R971 in 2009/10, in 2007/08 prices, by attaining significant internal efficiencies.

The caesarian section rate of 20.6% in 2007/08 is likely to remain constant in 2008/09 and 2009/10 as the services transform and ultimately the quantum of level 2 general specialist care in the district hospitals. It is proposed that the total mortality rate be monitored, and that specific targets be set once the baseline has been established. It is also proposed to develop a list of benchmarked "avoidable admissions" at level 2 and level 3 institutions, to track the effectiveness of level 1/PHC care, as a key marker of quality of care across the service platform.

4.2.2.3 Community based services

The Western Cape strategy of iKapa Elihlumayo and Social Capital Formation focus on building healthy communities through intensive collaboration between the public sector and civil society. Two of the key social capital links to the Department is the community participation structures and the employment of community-based workers via NPOs.

The number of carers will increase from 2 300 in 2008/09 to 2 500 in 2009/10, and the number of funded NPOs will increase from 150 to 155. An integrated community based adherence model for all chronic diseases will be developed and implemented.

A key focus priority for 2009/10 is to increase sub acute beds by sixty beds in the Metro (beds at Lifecare). The rural districts will also explore the use of some district hospital beds, which are under utilised for purposes of “de-hospitalisation” in order to increase access to services. The chronic care institutions of Lifecare and St Joseph will be re-configured as chronic care and sub-acute institutions in 2009/10, and the number of adult chronic care beds will be reduced from 280 to 220 beds. There is also a plan to decant TB inpatients who are inappropriately admitted to TB hospitals to the community-based service platform.

A priority for 2008/09 leading into 2009/10 was to ensure that mental health users who are inappropriately placed at acute psychiatric hospitals are transferred to alternative facilities, in order to improve access for acute psychiatric clients from across the service platform. The Department commissioned eighty mental health sub-acute care beds (forty at Stikland Hospital and forty at William Slater Hospital), and 100 beds for residential care for clients with intellectual disability at Zandvliet long term care facility during the 2008/09 financial year, with a view to identifying more community-based service capacity to absorb another fifty clients from psychiatric hospitals during 2009/10.

4.2.2.4 Chronic disease management system

A total of 1 420 500 chronic disease medication prescriptions were issued through a variety of alternative systems in 2007/08. This is projected to increase to 1.5 million scripts in 2008/09 and 2.2 million scripts in 2009/10.

It is projected that 2 000 stable chronic disease management (CDM) clients will be identified, as per standard case definition for the five prioritised conditions, in the central hospitals (against the APP target of 20 000), and be successfully transferred to CHCs for continued management during the 2008/09 financial year. This number will increase to 5 000 clients during 2009/10. The development of tools and processes for institutionalisation of annual clinical audits for the monitoring of priority chronic diseases will be completed by end of 2008/09. The roll out of this clinical audit system will be rolled out from 2009/10.

4.2.3 Strategic goals and objectives

In order to fulfil the vision of Healthcare 2010, District Health Services have the following Strategic Goal and objectives:

4.2.3.1 Strategic goals

- 1) Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services to the communities living in all districts in the Western Cape.

-
- 2) Transform the district hospital service platform to provide access to the full package of quality level 1 hospital services to the communities in all districts in the Western Cape.
 - 3) Establish an integrated community-based service (CBS) platform to render a full package of quality CBS services to the communities in all districts in the Western Cape.
 - 4) Provide a comprehensive package of quality services to all clients with chronic diseases in all districts in the Western Cape.

4.2.3.2 Strategic objectives for District Health Services

The following are the strategic objectives together with the measurable objectives to achieve goal 1:

- 1) Comply with the national Health Act (No 63 of 2003) prescripts on the establishment of the District Health System
- 2) Deliver efficient quality Primary Health Care (PHC) services in all 6 districts.

4.2.3.3 Strategic objectives for district hospitals

The following are the strategic objectives to achieve goal 2:

- 1) Comply with the South African Constitution with regards to universal access to emergency medical services.
- 2) Ensure accessible, effective and efficient district hospital services in all six districts.
- 3) Provide administrative support to PHC facilities in all six districts.

4.2.3.4 Strategic objectives for community-based services

The following are the strategic objectives to achieve goal 3:

- 1) Provide home-based care to prioritised clients in need in all six districts;
- 2) Deliver quality Home Community Based Services (HCBS) in all six districts
- 3) Provide in-patient palliative care to prioritised clients in need in all six districts;
- 4) Provide sub-acute care to prioritised clients in need in all six districts;
- 5) Provide chronic care to prioritised clients in need in all six districts;

4.2.3.5 Strategic objectives for chronic disease management systems

The following are the strategic objectives to achieve goal 4:

- 1) Provide optimal access to chronic medication for clients in all six districts;
- 2) Provide optimal clinical care for clients with chronic diseases.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.6: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
PRIMARY HEALTH CARE	<ul style="list-style-type: none"> Attrition of health workers Conditions of work for health workers 	<ul style="list-style-type: none"> Occupational specific dispensation for health professionals.
	<ul style="list-style-type: none"> Poorly maintained and inadequate infrastructure; particularly infrastructure taken over from municipalities 	<ul style="list-style-type: none"> The department is part of a national process to undertake an audit of current PHC infrastructure and submit a bid to National Treasury
	<ul style="list-style-type: none"> The current Metro district management structure needs to undergo a massive HR restructuring process 	<ul style="list-style-type: none"> Four sub-structure management offices has been created in the Metro; staff will be matched and placed in the new structure
	<ul style="list-style-type: none"> Poor data collection and collation processes and systems in Information Management 	<ul style="list-style-type: none"> SOPs to be developed and enforced; PHC Information System has been developed and is currently being rolled out in the Province
DISTRICT HOSPITALS	<ul style="list-style-type: none"> Recruitment of trained staff, especially skilled medical officers Conditions of work for health workers 	<ul style="list-style-type: none"> Occupational specific dispensation for health professionals Family Medicine registrar programme
	<ul style="list-style-type: none"> Providing a limited range of the full package of L1 hospital services at many district hospitals 	<ul style="list-style-type: none"> Recruiting and retaining skilled MOs; provide practical on-the-job skills training, especially in surgical and anaesthetic skills
	<ul style="list-style-type: none"> Level 2 services currently provided on a level 1 platform in the rural areas and driving the costs at level 1 hospitals 	<ul style="list-style-type: none"> Implementing the Departmental Outreach and Support policy particularly with regards to appropriate funding of activities per level of care.
COMMUNITY BASED SERVICES	<ul style="list-style-type: none"> Availability of appropriate physical infrastructure 	<ul style="list-style-type: none"> Infrastructure planning in progress; strategy to use under-utilised hospital infra-structure
	<ul style="list-style-type: none"> Chronic and sub-acute clients blocking acute beds, especially in psychiatry and internal medicine 	<ul style="list-style-type: none"> Coherent strategy for decanting of sub-acute and chronic mental health, TB and internal medicine clients being implemented
	<ul style="list-style-type: none"> Continued availability of donor funding for HBC; especially in light of the need to have an exit strategy for EU funded activities 	<ul style="list-style-type: none"> Implementation of the CSP and its related resources EPWP funding for NPOs as training platform for the carers
CHRONIC DISEASES MANAGEMENT	<ul style="list-style-type: none"> Regulations relating to coding and dispensing of medications 	<ul style="list-style-type: none"> Development of guidelines for the management of Chronic Diseases with PCC
	<ul style="list-style-type: none"> Availability of drugs 	<ul style="list-style-type: none"> Coherent strategy to overcome drug shortages

4.4 MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.7: Provincial objectives and performance indicators for District Health Services [DHS5]

Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Strategic goal: Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services in all the districts of the Western Cape									
Comply with the National Health Act (no 63 of 2003) prescripts on the establishment of the District Health System	Establish a fully functional DHS in each of the districts by 2010.	1. The number of District Health Plans formally approved by the District Health Council	0	0	0	0	5	6	6
Deliver efficient quality Primary Health Care (PHC) services in all 6 districts	Establish an integrated PHC information system (PHCIS) at all PHC facilities in all 6 districts.	2. The number of PHC facilities that have the required infrastructure and equipment to implement PHCIS	23	33	54	73	78	110	130
	Improve clinical governance and quality of District Health Services in all six districts by 2010.	3. The number of Principal Family Physicians and Family Physicians appointed in the District Health Service	0	0	9	2	17	30	32
		4. The number of Family Medicine registrars employed in the District Health Service	0	0	20	17	60	80	80
	Improve the access to Primary Health Care clinic services by extending the service hours CHCs	5. The number of CHCs and/or CDC's offering nurse based extended hours to 21h30 on weekdays and 8h00 to 12h00 on weekends	0	0	9	12	18	18	18
Comply with the South African Constitution with regards to universal access to emergency medical services	Improve access to efficient and effective emergency care within the District Health System	6. Percentage of non-hospital towns with populations of more than 5000 that have access to an emergency service on a 24-hour basis	N/A	N/A	N/A	50%	56%	61%	65%
Strategic goal: Provide a comprehensive package of quality services to all clients with chronic diseases in all districts in the Western Cape									
Provide optimal access to chronic medication for clients in all 6 districts	Increase number of CDM clients receiving medication at a reduced time.	7. Number of prescriptions dispensed through an alternative dispensing system.	688 222	700 000	1 420 500	730 000	1 500 000	1 600 000	1 650 000
Provide optimal clinical care for clients with chronic diseases	Implement a clinical audit system for chronic diseases	8. Number of sub-districts undertaking annual clinical audits for the management of chronic diseases using the integrated tool	N/A	N/A	Not required to report	N/A	8	20	32
Strategic goal: Establish an integrated community-based service (CBS) platform to render a full package of quality CBS services to the communities in all districts in the Western Cape.									
Provide home-based care to prioritised clients in need of care	Increase the number of clients receiving home community based services.	9. Total number of NPO appointed home carers.	933	1 100	1 343	2 300	2 500	2 600	2 700
	Increase number of home-based care (HBC) clients seen.	10. Total number of registered active HBC clients	10 222	11 000	16 823	23 000	29 000	30 000	31 000
Deliver quality Home Community Based Services (HCBS) in all 6 districts	Increase access to home community based services	11. Total CBS headcounts per annum (client visits)	N/A	N/A	N/A	New indicator	2 056 000	2 060 000	2 065 000
Provide inpatient palliative, sub acute and chronic care to prioritised clients in need of care	Ensure bed utilization to full capacity.	12. Number of palliative, sub acute and chronic care beds	807	792	807	780	783	783	803
		13. Bed utilisation rate in palliative, sub acute and chronic care beds	N/A	70%	71%	79%	85%	85%	85%
Strategic goal: Transform the district hospital service platform to provide access to full package of quality level 1 hospital services in all districts in the Western Cape									
Ensure accessible, effective and efficient District Hospital services in all 6 districts.	Provide the total CSP number of beds in district hospitals by 2010	14. Number of district hospital beds	1 546	1 570	2 292	2 255	2 413	2 460	2 460

Notes:

1. The transfer of GF Jooste, Helderberg, Karl Bremer Hospital has resulted in an increase in inpatient days in 2008/09
2. In 2009/10 Victoria Hospital will be transferred to Programme 2 thus 158 beds will be added in 2009/10. An additional 58 beds will come from KDH (18) & Mowbray Maternity Mowbray Hospital (20), Helderberg Hospital (20),

Table 2.8: Performance indicators for District Health Services [DHS6]

Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Sub-programmes 2.1 - 2.3:	Strategic goal:	Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services in all the districts of the Western Cape								
Deliver effective quality Primary Health Care (PHC) services in all 6 districts	Allocate sufficient funds per uninsured person to sustain an average utilisation rate of 3.87 per annum by 2010.	1. Provincial expenditure per uninsured person ¹ .	R272	R259	R313	R346	R388	R410	R428	
		2. Total PHC headcount per annum	13 068 303	12 180 933	13 029 007	14 645 765	14 645 765	14 645 765	14 645 765	
		3. PHC utilisation rate (per capita).	2.77	4. 2.31	2.41	3.7	2.76	2.74	2.73	
		3.1 PHC utilisation rate per uninsured person.	3.71	3.09	3.24	2.75	3.7	3.68	3.67	3.5
		4. PHC utilisation rate - under 5 years.	5.2	4.8	4.9	5	5	5	5	5
	5. Percentage of sub districts offering the full package of PHC services.	80%	100%	100%	100%	100%	100%	100%	100%	100%
	Ensure the efficient and quality delivery of the full package of PHC services.	6. Percentage fixed PHC facilities supported by a doctor at least once a week.	Not available	Not available	73.40%	100%	80%	85%	90%	
		7. Supervision rate.	73.34%	71.76%	43.80%	100%	100%	100%	100%	100%
		8. Provincial PHC expenditure per headcount	R76	R87	R93	R105	R112	R117	R117	R78
Implement quality assurance measures to minimise patient risk and improve clinical outcomes	9. Percentage of complaints resolved within 25 days	New indicator from 2009/10	-	-	-	25%	30%	40%	100%	

Notes:

The above Strategic goal covers Financial sub programmes 2.1, 2.2 and 2.3

Indicators 1, 3 and 4 for 2009/10 onwards preliminary Community Survey 2007 estimates from Information Management Directorate were used

Indicator 3: Uninsured population is 74.52% of total population.

Indicator 6: Fixed PHC facilities means fixed clinics plus community health centres.

Indicator 8: 2007/08 prices

Table 2.9: Performance indicators for District Hospitals [DHS7]

Strategic goal: Transform the district hospital service platform to provide access to full package of quality level 1 hospital services in all districts in the Western Cape										
Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Ensure accessible, effective and efficient District Hospital services in all 6 districts	Provide sufficient theatre capacity and resources at district hospitals to perform caesarian sections at 20%	1. Caesarian section rate for district hospitals	10.70%	14.30%	20.60	20.6%	20%	20%	20%	11%
	Provide sufficient resources for the rendering of out patient services at a target rate of one outpatient per inpatient day.	2. Number of patient day equivalents (PDEs) in district hospitals	643 244	661 655	956 181	992 617	1 187 327	1 234 821	1 284 213	
		3. OPD total headcounts in district hospitals	447 414	436 643	515 501	533 732	691 042	725 594	761 874	
		3.1 Casualty/emergency/trauma headcount	264 752	258 465	362 498	305 420	376 091	394 896	414 640	
		3.2 Comprehensive OPD headcount in district hospitals (OPD + Casualty/emergency/trauma)	712 166	695 108	877 999	839 152	1 067 133	1 120 490	1 176 514	
	Implement quality assurance measures to minimise patient risk and improve clinical outcomes.	4. Percentage of district hospitals with patient satisfaction survey using DoH template	46.00%	35.70%	25.70%	100%	100%	100%	100%	100%
		5. Percentage of district hospitals with mortality and morbidity meetings every month	45.00%	21.40%	71.40	70%	75%	80%	85%	100%
		6. Percentage of district hospitals with clinical audit meetings every month	Not requested prior to 2007/08	Not requested prior to 2007/08	N/A	31%	35%	40%	45%	100%
		7. Percentage complaints resolved within 25 days in district hospitals	Not requested prior to 2007/08	Not requested prior to 2007/08	N/A	45%	50%	60%	70%	100%
	8. Case fatality rate in district hospitals for surgery separations	0.70%	0.79%	1.05%	1.0%	1.0%	1.0%	1.0%	1.0%	3.50%
	Manage bed utilisation to achieve an average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals.	9. Average length of stay in district hospitals	2.8 days	2.8days	3.3 days	3.2 days	3.2 days	3 days	3 days	3.2 days
		10. Bed utilisation rate (based on useable beds) in district hospitals	71.0%	71.7%	79.3%	85.1%	86%	85%	85%	72%
11. Total separations in district hospitals		142 054	144 373	203 932	221 808	267 246	277 936	289 053		
Ensure the cost effective management of district hospitals at a target expenditure of approximately R950 per PDE by 2010	12. Expenditure per patient day equivalent in district hospitals	R698	R714	R894	R954	R930	R950	R957	R814	

Notes:

All indicators: The planned outputs and expenditure for 2009/10 includes the impact of Victoria Hospital which shifts from Programme 4 to Sub-programme 2.9 from 2009/10

Indicator 12: 2007/08 rands

4.5 SERVICE LEVEL AGREEMENTS AND TRANSFERS TO MUNICIPALITIES AND NON-GOVERNMENT ORGANISATIONS

The table below reflects the transfer payments to municipalities and non-government organisations

4.5.1 Service level agreements and transfers to municipalities and non-government organisations

Table 2.10: Transfers to municipalities and non-governmental organisations (R'000) [DHS8]

Entities R'000	Outcome			Main appropriation 2008/09	Adjusted appropriation 2008/09	Revised estimate 2008/09	Medium-term estimate			% Change from Revised estimate 2008/09
	Audited 2005/06	Audited 2006/07	Audited 2007/08				2009/10	2010/11	2011/12	
Universities										
Metro										
Stellenbosch	22 437									
Western Cape	9 835									
Cape Town	18 996									
Cape Peninsula University of Technology	3 161	1 275	1 400	1 567	1 567	1 567	1 708	1 883	2 028	9.00
Cape Medical Depot Trading Account	7 316	4 044	1 411	1 573	1 573	1 573	1 715	1 890	2 036	9.03
SETA	1 947	2 045	2 169	2 801	2 801	2 801	2 997	3 304	3 559	7.00
Provincial Aided Hospitals										
St Joseph	5 483	5 757	6 045	6 591	6 591	6 591	7 184	7 902	8 535	9.00
Sarah Fox	3 842	4 034	4 644	4 618	4 618	4 618	5 034	5 537	5 980	9.01
Maitland Cottage	4 376	4 595	4 825	5 919	5 919	5 919	7 232	7 972	8 587	22.18
Booth Memorial	7 138	7 796	8 570	8 924	8 924	8 924	9 727	10 700	11 556	9.00
Clanwilliam	6 793	7 029	3 787							
Radie Kotze	3 850	4 043	4 503	4 612	4 612	4 612	5 027	5 541	5 969	9.00
Murraysburg	2 177	2 360	2 478	2 620	826	826				(100.00)
Prince Albert	3 380	3 500								
Uniondale	2 595	2 850	2 993	3 185	749	749				(100.00)
Laingsburg	2 905									
SA Red Cross Air Mercy	11 835	16 053	18 873	21 000	21 000	21 000	22 890	25 231	27 179	9.00
Conradie Care Centre	25 744	27 008	28 439	30 952	30 952	30 952	33 738	37 111	40 081	9.00
Tuberculosis (Contract Hospitals)										
DP Marais	8 291	5 330								
Harry Comay										
Non Government Organisations										
HIV/Aids	31 103	34 245	47 601	53 337	52 788	52 788	51 542	61 542	67 696	(2.36)
Nutrition	1 622	1 374	1 721	1 636	1 636	1 636	1 722	1 898	2 045	5.26
NGO (APH)			1 021	1 115	1 115	1 115				(100.00)
HCW: NGO's	451	486								
Santa Guidance	17	81	98							
Global Fund	16 730	18 451	19 649	18 397	22 726	22 726	8 713	1 326		(61.66)
Expanded Public Works Programme			12 000	19 732	28 000	28 000	30 000	33 068	35 621	7.14
TB							1 400	1 540	1 663	
Health Committees, Mental Health, Social Capital	13 811	19 533	24 157	29 750	29 750	29 750	33 680	37 256	39 956	13.21
Total departmental transfers to development corporations	215 835	171 889	196 384	218 329	226 147	226 147	224 309	243 701	262 491	(0.81)

4.5.2 Transfers to municipalities (R'000) [DHS8]

Table 2.11: Total departmental transfers and grants [DHS8]

Municipalities R'000	Outcome			Main appro- pria- tion 2008/09	Adjusted appro- pria- tion 2008/09	Revised estimate 2008/09	Medium term estimate			% Change from Revised estimate 2008/09
	Audited	Audited	Audited				2009/10	2010/11	2011/12	
	2005/06	2006/07	2007/08				2008/09	2008/09	2008/09	
Total departmental transfers/grants										
Category A	104 662	129 915	142 740	155 838	167 241	167 241	189 663	213 212	230 466	13.41
City of Cape Town	104 662	129 915	142 740	155 838	167 241	167 241	189 663	213 212	230 466	13.41
Category B	58 284									
Beaufort West	1 463									
Bergrivier										
Bitou	3 510									
Breede River/Winelands	850									
Breede Valley	3 997									
Cape Agulhas										
Cederberg	707									
Drakenstein	7 699									
George	11 981									
Kannaland										
Knysna	3 738									
Laingsburg										
Hessequa	1 040									
Matzikama	749									
Mossel Bay	3 766									
Oudtshoorn	1 362									
Overstrand	1 230									
Prince Albert	335									
Saldanha Bay	4 000									
Stellenbosch	6 570									
Swartland	2 829									
Swellendam										
Theewaterskloof	2 112									
Witzenberg	346									
Unallocated										
Category C	54 481	9 318	8 184	7 673	7 673	7 673	1 894			(75.32)
Cape Winelands	17 140	1 311								
Central Karoo	4 910	1 369	1 622	1 306	1 306	1 306	323			(75.27)
Eden	13 641	2 540	2 707	2 612	2 612	2 612	645			(75.31)
Overberg	7 921	1 684	2 165	1 687	1 687	1 687	416			(75.34)
West Coast	10 869	2 414	1 690	2 068	2 068	2 068	510			(75.34)
Unallocated										
Total transfers to local government	217 427	139 233	150 924	163 511	174 914	174 914	191 557	213 212	230 466	9.51

Table 2.12: Transfers to municipalities and non-government organisations (R'000) for Personal Primary Health Care Services [DHS8]

Municipalities R'000	Outcome						Medium-term estimate			% Change from Revised estimate
	Audited	Audited	Audited	Main appro- p-riation	Adjusted appro- p-riation	Revised estimate				
	2005/06	2006/07	2007/08	2008/09	2008/09	2008/09	2009/10	2010/11	2011/12	
Personal Primary Health Care Services	206 214	112 758	118 623	128 232	130 113	130 113	158 246	174 431	187 898	21.62
Category A	97 589	112 638	118 623	128 232	130 113	130 113	158 246	174 431	187 898	21.62
City of Cape Town	97 589	112 638	118 623	128 232	130 113	130 113	158 246	174 431	187 898	21.62
Category B	57 863									
Beaufort West	1 463									
Bergrivier										
Bitou	3 510									
Breede River/Winelands	850									
Breede Valley	3 997									
Cape Agulhas										
Cederberg	707									
Drakenstein	7 699									
George	11 981									
Kannaland										
Knysna	3 738									
Laiingsburg										
Hessequa	1 040									
Matzikama	749									
Mossel Bay	3 766									
Oudtshoorn	1 362									
Overstrand	1 230									
Prince Albert	335									
Saldanha Bay	3 839									
Stellenbosch	6 355									
Swartland	2 784									
Swellendam										
Theewaterskloof	2 112									
Witzenberg	346									
Unallocated										
Category C	50 762	120								
Cape Winelands	16 545									
Central Karoo	4 465									
Eden	12 538									
Overberg	7 165	120								
West Coast	10 049									
Unallocated										

Table 2.13: Transfers to municipalities and non-government organisations (R'000) for Integrated Nutrition [DHS8]

Municipalities R'000	Outcome			Main appro- priation	Adjusted appro- priation	Revised estimate	Medium-term estimate			% Change from Revised estimate 2008/09
	Audited 2005/06	Audited 2006/07	Audited 2007/08				2009/10	2010/11	2011/12	
	Integrated Nutrition	2 997	2 973				3 150	3 308	3 308	
Category A	2 997	2 973	3 150	3 308	3 308	3 308	3 604	3 973	4 279	8.95
City of Cape Town	2 997	2 973	3 150	3 308	3 308	3 308	3 604	3 973	4 279	8.95
Category B										
Beaufort West										
Bergivier										
Bitou										
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein										
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay										
Stellenbosch										
Swartland										
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C										
Cape Winelands										
Central Karoo										
Eden										
Overberg										
West Coast										
Unallocated										

Note:

Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

Table 2.14: Transfers to municipalities and non-government organisations (R'000) for the Global Fund [DHS8]

Municipalities R'000	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimate			% Change from Revised estimate 2008/09
	Audited	Audited	Audited				2009/10	2010/11	2011/12	
	2005/06	2006/07	2007/08							
Global Fund	7 296	12 645	11 403	11 705	21 227	21 227	2 894			(86.37)
Category A	3 773	3 447	3 609	4 032	13 554	13 554	1 000			(92.62)
City of Cape Town	3 773	3 447	3 609	4 032	13 554	13 554	1 000			(92.62)
Category B										
Beaufort West										
Bergrivier										
Bitou										
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein										
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay										
Stellenbosch										
Swartland										
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C	3 523	9 198	7 794	7 673	7 673	7 673	1 894			(75.32)
Cape Winelands	595	1 311								
Central Karoo	363	1 369	1 232	1 306	1 306	1 306	323			(75.27)
Eden	1 103	2 540	2 707	2 612	2 612	2 612	645			(75.31)
Overberg	756	1 564	2 165	1 687	1 687	1 687	416			(75.34)
West Coast	706	2 414	1 690	2 068	2 068	2 068	510			(75.34)
Unallocated										

Note:

Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

Table 2.15: Transfers to municipalities and non-government organisations (R'000) for the HIV and AIDS [DHS8]

Municipalities R'000	Outcome			Main appro- priation	Adjusted appro- priation	Revised estimate	Medium term estimate			% Change from Revised estimate 2008/09
	Audited	Audited	Audited				2009/10	2010/11	2011/12	
	2005/06	2006/07	2007/08							
HIV and Aids	920	10 857	17 748	20 266	20 266	20 266	26 813	34 808	38 289	32.31
Category A	303	10 857	17 358	20 266	20 266	20 266	26 813	34 808	38 289	32.31
City of Cape Town	303	10 857	17 358	20 266	20 266	20 266	26 813	34 808	38 289	32.31
Category B	421									
Beaufort West										
Bergivier										
Bitou										
Breede River/Winelands										
Breede Valley										
Cape Agulhas										
Cederberg										
Drakenstein										
George										
Kannaland										
Knysna										
Laingsburg										
Hessequa										
Matzikama										
Mossel Bay										
Oudtshoorn										
Overstrand										
Prince Albert										
Saldanha Bay	161									
Stellenbosch	215									
Swartland	45									
Swellendam										
Theewaterskloof										
Witzenberg										
Unallocated										
Category C	196		390							
Cape Winelands										
Central Karoo	82		390							
Eden										
Overberg										
West Coast	114									
Unallocated										

Note: Excludes regional services council levy. Due to structural changes comparative figures cannot be submitted.

4.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH THE PLAN

Sub-programmes 2.1 – 2.5 are allocated a nominal increase of R269.477 million or 16.98 per cent in 2009/10 in comparison to the revised estimate of 2008/09.

Table 2.16: Trends in provincial public health expenditure for District Health Services [DHS9] for Sub-programmes 2.1 – 2.5

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection)	2011/12 MTEF projection)
Current prices							
Total excluding capital	1 022 808 000	1 149 888 000	1 389 473 000	1 586 601 000	1 856 078 000	2 045 912 000	2 203 872 000
Total Capital	13 126 000	31 249 000	28 400 000	28 922 000	46 550 000	98 991 000	95 944 000
Grand Total	1 035 934 000	1 181 137 000	1 417 873 000	1 615 523 000	1 902 628 000	2 144 903 000	2 299 816 000
Total per person	219.59	223.76	267.52	303.59	356.11	399.85	427.03
Total per uninsured person	294.06	300.73	359.55	408.02	478.60	537.39	573.91
Constant 2007/08 prices							
Total excluding capital	1 095 629 282	1 190 345 357	1 389 473 000	1 480 380 355	1 644 877 692	1 748 733 046	1 830 568 713
Total Capital	14 060 537	32 348 457	28 400 000	26 985 714	41 253 146	84 612 062	79 692 507
Grand Total	1 109 689 819	1 222 693 814	1 417 873 000	1 507 366 069	1 686 130 838	1 833 345 108	1 910 261 220
Total per person	235.22	231.63	267.52	283.26	315.59	341.77	354.69
Total per uninsured person	315.00	311.31	359.55	380.70	424.14	459.33	476.70

Table 2.17: Trends in provincial public health expenditure for District Hospitals [DHS9]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	419 084 000	456 673 000	854 454 000	1 014 888 000	1 245 566 000	1 372 959 000	1 478 961 000
Total Capital	27 639 000	58 649 000	55 281 000	141 809 000	294 619 000	359 114 000	520 240 000
Grand Total	446 723 000	515 322 000	909 735 000	1 156 697 000	1 540 185 000	1 732 073 000	1 999 201 000
Total per person	94.69	97.63	171.65	217.37	288.27	322.89	371.21
Total per uninsured person	126.81	131.21	230.69	292.14	387.43	433.96	498.90
Constant 2007/08 prices							
Total excluding capital	448 921 696	472 740 463	854 454 000	946 942 715	1 103 834 929	1 173 529 836	1 228 446 903
Total Capital	29 606 825	60 712 491	55 281 000	132 315 092	261 094 750	306 950 895	432 119 046
Grand Total	478 528 521	533 452 954	909 735 000	1 079 257 807	1 364 929 679	1 480 480 731	1 660 565 950
Total per person	101.43	101.06	171.65	202.81	255.47	275.99	308.33
Total per uninsured person	135.84	135.82	230.69	272.58	343.35	370.93	414.39

5. HIV & AIDS, STI AND TB CONTROL

5.1 SITUATION ANALYSIS

5.1.1 Overview

The annual antenatal HIV prevalence in 2006 was 15.1%. Although the HIV prevalence in the Province as a whole remains lower than the prevalence nationally, there is a disproportionate prevalence across the Province, with some districts having a much higher burden of disease.

The HIV epidemic has also fuelled the TB epidemic. There has been a dramatic increase in the number of TB cases in the Western Cape over the past seven years and the number of TB cases has been disproportionately higher in geographic areas with higher HIV prevalence. However, in 2007, the number of TB cases decreased slightly. The reason for this levelling off is unclear and it may indicate that active case finding needs to be increased. There were 48 672 TB cases registered in 2007. This translates to a TB incidence of 1004.4 cases per 100 000 population for all TB cases and 518.2 per 100 000 population for new TB cases.

The Department has implemented the 'Comprehensive HIV and AIDS Care, Management and Treatment Plan' adopted by the National Cabinet in November 2003 and is committed to integrating the HIV and AIDS programme into the general health services in such a way that the additional resources lead to strengthening the general health system rather than creating a vertical HIV and AIDS service delivery model. The Department has developed a Provincial Strategic Plan, which moves towards addressing the issues arising from the National Strategic Plan (NSP) for HIV and AIDS for 2007 – 2011 at a provincial level.

5.1.2 HIV prevention programmes

HIV prevalence amongst antenatal clinic attendees in the Western Cape has highlighted that certain areas within the Province such as Khayelitsha, Guguletu/Nyanga and Knysna/Plettenberg Bay continue to show high levels of HIV infection. This poses a serious challenge in terms of the delivery of health services, social services, as well as for other sectors. It is therefore critical that the prevention strategy is successfully implemented in conjunction with treatment and care interventions in order to avert the long-term impact of the epidemic in this Province.

5.1.2.1 Community mobilisation

There are 33 multi-sectoral action teams throughout the Province that bring relevant role-players [government departments, local government and non-governmental organisations and civil society organisations] together at sub-district level to initiate local responses to the epidemic. Five hundred and fifty eight projects are funded through community based organisations. Targeted interventions in thirty-five sites are undertaken in high transmission areas. These interventions are aimed at commercial sex workers and truckers, older men, refugees and youth in faith based organizations.

A specific intervention with men aged 18-62 years in the high HIV prevalence sub-district of Khayelitsha was implemented during 2008, based on research undertaken in 2006/7.

A provincial HIV prevention communication campaign was compiled after consultation with NGOs involved in peer education programmes targeting men and the youth. The campaign is focusing on messaging and assistance from other role players in this field was obtained. The communication task team then recommended the use of the 'Scrutinize' series and 'Beat it' TV commercials that are

currently flighted on SATV. These TV commercials are accompanied by manuals for use at community level. A TV commercial addressing delaying sexual debut has been commissioned as part of the series. The campaign was launched in Guguletu on 26 September 2008 in order to coincide with the Schools' AIDS Month. Peer educators from the high school programme, men's organizations, guilders from FBOs and refugee community attended the launch.

The provincial World AIDS Day and STI/Condom Week events will be key events in the HIV prevention communication campaign. Future events will take a different format in that they will have the Scrutinize 'Risk Game' that engages participants directly. Each event will be preceded by a week long building up run by trained volunteers from the local area thus there will be no 'parachuting' in and out of areas.

The main challenge has been the relatively high capital outlay for starting the campaign with all necessary resources. The campaign will move to the non-metro areas and then regional specificities, such as language preferences will have to be included in the strategy.

5.1.2.2 Life skills and peer education

Peer education is one of the critical programmes for HIV prevention to ensure "an HIV free generation". There is a peer education programme in 131 secondary schools in the high burden areas of the Metro, Paarl, Wellington, George and Plettenberg Bay, with 13 068 badged peer educators in the Province. 'LoveLife' programmes are also aimed at selected secondary schools. There are 16 455 'LoveLife' leaders at 139 schools.

5.1.2.3 Voluntary counselling and testing (VCT)

People in the Western Cape can access voluntary counselling and HIV testing services at all fixed PHC facilities in the Province, as well as at fifty-two non-medical sites. There are twenty-three NGOs which employ 499 lay counsellors, who provide the bulk of the pre- and post-test counselling services. The annualised VCT coverage in those fifteen years and older was 14% for 2007/08, translating to 266 682 people (276 331 VCT and 94 637 antenatal care clients) 15 to 49 years old. In 2008/09 the department is projecting to test approximately 333 139 people 15 to 49 years old. This equates to approximately 12% of the adult population. The targets from 2009/10 onwards are adjusted to reflect VCT excluding antenatal care clients.

5.1.2.4 Prevention of mother-to-child transmission (PMTCT)

The PMTCT Programme is a flagship HIV prevention programmes of the Western Cape. The programme is available at PHC facilities providing an antenatal care service.

The Department projects that there will be 110 000 first antenatal clients of those 104 500 (95%) will be tested for HIV and 15 570 are projected to be HIV positive. The estimated 14.9% HIV prevalence during this period compares well with the Antenatal Surveillance survey data. The Nevirapine uptake rate among babies born to women with HIV remains high, at 101.6%.¹ in 2007/08. The transmission rate for the programme for those who test at six weeks is 5.2%.

¹ Nevirapine coverage rate is 72%. Nevirapine coverage rate among babies born to women with HIV calculates the number of babies who received Nevirapine compared to those who would be expected to receive it according to estimates derived from HIV antenatal survey results.

5.1.2.5 Sexually transmitted infections (STIs)

An effective programme to address sexually transmitted infections (STIs) is an important component of any HIV prevention strategy. This programme remains a challenge for the department. There is a further decrease in the incidence of STIs in the first six months of 2008/2009 by 0.5% per 1 000 compared to the same period in 2007/08. However, the partner treatment rate remains below target at 19 to 20% during 2008/09. For the public sector services, the provincial strategic plan proposes measures to mobilise male partners to come forward for treatment thus permitting incremental expansion of this programme.

5.1.2.6 Condoms

The Province has an extensive condom distribution network that includes public sector and non-traditional non public sector sites. From 1 April 2007 to 31 March 2008 there were 71 292 064 male condoms distributed, which translates to 41.1 condoms per adult male over fifteen years of age per year. In 2008/09 the Department projects that it will distribute 86 million male condoms. Actual male condoms distributed in the first six months 2008/09 were 33 608 416, which translated to 19.4 condoms per adult male. The set target of fifty per adult male has not been met. The Department for 2009/10 projects that it will distribute 78 million male condoms, which translates to 19.5 condoms per adult male.

In 2007/08, access to female condoms increased across the Province, with 562 725 female condoms distributed. In the first six months of 2008/09 there is a 65% further increase in female condom distribution (375 960) compared to the same period in 2007/08 (244 906). Generally, there is an increasing awareness and demand for female condoms among women. Currently the challenge is limited availability of female condoms from the National Department of Health where supply is not meeting the provincial demand.

5.1.2.7 Post exposure prophylaxis (PEP)

Post exposure prophylaxis for occupational exposure to HIV is offered in all hospitals. The Department has a PEP programme for victims of sexual assault where PEP is available at designated sites. The HAST Directorate is making concerted efforts to integrate with Women's Health and other key related programmes thus ensuring that PEP is provided within the context of a seamless Clinical Forensic Services across the healthcare delivery service platform.

5.1.3 Treatment Programme:

5.1.3.1 Care of HIV infected persons

All community health centres and clinics provide first contact ambulatory care for HIV positive clients including CD4 testing to manage the HIV patient and to assess readiness for ART. Those eligible for ART are referred to ART care centres when required. Treatment for opportunistic infections and nutritional support is available at primary health care facilities.

5.1.3.2 Antiretroviral treatment (ART)

The National Strategic Plan 2007-2011 has set a target that at least 80% of patients defined as WHO Stage 4 must be put onto treatment by 2011 in order for the Province to help curb the impact of the HIV epidemic on health services due to debilitation and opportunistic infections. By 30th September 2008, there were sixty-five accredited ART sites Province-wide providing ART to 46 053 patients. This is 12% greater than the target for this time period.

In the first six months of the 2008/2009 financial year 9 745 patients have been started on ART. This translates to a coverage rate of 62% of patients who require treatment, as defined as those reaching WHO stage 4 with the total number in need estimated by the Actuarial Society of South Africa (ASSA) model. It must be emphasised that this does not take into account all the patients in this and previous years who entered into WHO stage 4 or those with a CD4 < 200 who have not yet accessed ART. This is known as the treatment backlog. It is difficult to calculate the true coverage rate in need of treatment due to the unknown extent of the treatment backlog. Using the definition of WHO stage 4 and with the current patient numbers of 46 053 it is estimated that a coverage rate of 75% of patients needing treatment who have accessed treatment could have been achieved, but due to the incompleteness of the definition coverage is over estimated and therefore assume the coverage rate is deemed less than 75%.

In June 2008 the roll-out of the nurse-driven doctor supported services in the Eden District and the Drakenstein and Breede Valley sub-districts of the Cape Winelands district was approved as well as in the two high-burden sub-districts in the Metro (Khayelitsha and Mitchell's Plain). In total twenty sites across the Province have been identified for implementation of the service model.

The province has contracted the services of the Knowledge Translation Unit at UCT (KTU) to train nurses to take over the management of stable HIV and AIDS clients on ART, using the Streamlining Tasks and Roles to Expand Treatment and Care for HIV (STRETCH) model, which builds on PALS Plus training. PALS stands for Practical Approach to Lung health in South Africa. It's a flip-chart guide plus a package of training for nurses. It provides step-by-step training on the management of various clinical presentations, with a focus on TB and asthma. PALS-plus refers to the addition of HIV/ART to the training package.

To date (end September 2008) gaps with PALS Plus training have been identified, necessary training completed and STRETCH training of the "trainers" is underway in the selected sub-districts.

5.1.3.3 Diflucan partnership

A national donor partnership programme was started in 2001 for the treatment of oesophageal candidiasis and cryptococcal meningitis. In 2007/2008, 179 328 Diflucan tablets were used to treat 7 531 patients (4 793 oesophageal candidiasis and 2 738 cryptococcal meningitis, respectively 8% and 55% increase from the reported number the previous financial year). In the same period, 117 bottles of Diflucan paediatric oral solution were used to treat 111 patients (107 oesophageal candidiasis and 4 for cryptococcal meningitis).

5.1.4 Tuberculosis

5.1.4.1 Introduction

Tuberculosis (TB), a preventable and curable disease, remains one of the Western Cape's most serious public health problems. This is placing an extraordinary burden on those afflicted by the disease, their families and the health budget. TB control urgently requires augmentation due to the emergence of multi drug-resistant TB (MDR-TB) and extensively drug-resistant TB (XDR-TB). The Department will continue to accelerate provincial TB control in the 2009/10 financial year.

5.1.4.2 Overview of the epidemic

In 2007, the Province had a caseload of 48 672 TB cases and an incidence of 1004.4 cases/ 100 000 population for all TB cases and 518.2/100 000 population for new smear positive TB cases. Newly diagnosed TB cases comprised 71.6% and 28.4 % had previously been treated for TB. Pulmonary TB Cases made up 88.6% of the caseload and extra pulmonary TB cases made up 11.4%. The proportion of infectious smear positive TB cases were 58.3% and 22.1% were smear negative. Children under the age of seven years made up 14.2% of cases.

5.1.4.3 Progress in 2007/08 financial year

The “Enhanced TB Strategy” continued to be implemented during the 2007/08 financial year. The focus was on 22 high burden TB/HIV health facilities in eleven sub-districts to ensure that these facilities have the resources they require to improve TB control. This resulted in an excellent improvement in the overall performance of the TB programme in the Province. The TB cure rate for new smear positive cases showed a significant increase from 72,2% in the previous financial year to 77.3 % in 2007/08. This cure rate is well above the national cure rate of 62 % for the same period. A TB treatment success rate of 81,9% was achieved which is well on its way to achieve the national and global target of >85% for 2011. The TB defaulter rate also decreased from the previous year from 11.1% to 9.7%, which is an excellent achievement, although much more effort will be required to achieve the national and global target of below 5% for 2011.

5.1.4.4 MDR and XDR-TB

The emergence of multi-drug resistant (MDR) and extreme drug resistance (XDR) is potentially the most serious aspect of the TB epidemic in the Province, given the large burden of disease, the late presentation of cases, high interruption rates and high proportion of previously treated patients. The spread of MDR-TB and XDR-TB to vulnerable populations such as HIV co-infected individuals can have devastating consequences. Apart from a much reduced possibility of cure, HIV infected patients who contract MDR-TB or XDR-TB have an extremely high risk of dying, often before the diagnosis of drug resistance has been confirmed.

This underlines the importance of sustaining and strengthening the general TB DOTS strategy implementation to prevent MDR/XDR-TB tuberculosis generation.

The Department implemented drug resistant TB registers for the first time in the Province and commence monitoring drug resistance in a more meaningful manner in the future. A total of 861 new MDR-TB cases were registered and 96 XDR-TB cases have been identified since testing for XDR-TB was introduced early in 2007. The death rate for XDR-TB patients at over 40%, is a cause for concern.

In June 2008 the Department completed the Demonstration Project conducted in conjunction with the “Foundation for Innovative New Diagnostics” (FIND), the MRC, and NHLS to demonstrate the use of the HAIN line probe assay for rapid MDR-TB diagnosis under field conditions. The trial produced evidence for the reliability and feasibility of using rapid line probe assays under routine conditions and has resulted in the WHO making an announcement that the WHO now recommended "line probe assays" for rapid MDR-TB diagnosis worldwide. This will result in a much faster diagnosis of MDR-TB of 7 days instead of 4-6 weeks. The Department has offered to pilot the roll out of implementing these rapid tests as part of routine TB care as soon as the National TB Control Programme and NHLS completes the algorithm and logistics for the use of this test.

5.2 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.18: Situation analysis for HIV and AIDS, STIs and TB control [HIV1]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-lands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2007/08
Strategic Goal:		Decrease the number of new infections in the age group 15-24 years										
Implement an effective prevention strategy.	Provide PMTCT services to all pregnant women at 1 st Antenatal booking visit	1. Percentage fixed PHC facilities offering PMTCT	74%	74%	84.4%	22%	86%	86%	100%	100%	93%	50
	Provide VCT services at all fixed PHC facilities in the Province	2. Percentage fixed PHC facilities offering VCT to non-antenatal clients	100%	100%	89.1%	100	88.1	92.9	100	100	52	90
	Provide PEP for occupational exposure at all hospitals in the Province	3. Percentage hospitals offering PEP for occupational HIV exposure	100%	100%	100%	100%	100%	100%	100%	100%	100%	100
	Provide PEP for sexual assault at all hospitals in the Province	4. Percentage hospitals offering PEP for sexual abuse	89.70%	100.00%	100%	100%	100%	100%	100%	100%	100%	100
	Distribute Male Condoms from all PHC Facilities and non PHC facilities to all adult males 15years and above	5. Male condom distribution rate from public sector health facilities	19.9	34.9	41.1	56.2	8.6	16.7	12.9	14	14.4	11
	Issue of STI partner notification slips to all STI clients treated new	6. STI partner treatment rate	18.5	19.75	18.9	18.6	18.8	20	20.7	18	18.2	40%
	Administer Nevirapine to babies of mothers who accepted PMTCT intervention	7. Nevirapine newborn uptake rate	97%	98.0%	101.6	114.90%	99.30%	95.90%	100.00%	100%	100%	20
	Administer Nevirapine to HIV positive women in labour who accepted PMTCT intervention	8. Nevirapine uptake-antenatal clients	75.40%	89.80%	73.5%	72.4%	72.6%	77.5%	80%	100%	82%	
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities	9. Clients HIV pre-test counselled rate in fixed PHC facilities	1.3%	2.5%	2.7%	2.5%	2.4%	2.8%	2.3%	1.5%	2.5%	80
	Determine acceptability of HIV testing in those pre test counselled	10. HIV testing rate (excluding antenatal)	92.5%	97.2%	95.1%	91.3%	95.8%	96%	95.1%	96.3%	96.1%	90
Strategic Goal:		Reduce morbidity and mortality amongst HIV affected persons										
Provide ART to patients in need	Accredit facilities to provide ART	11. ART service points registered	43	50	62	37	8	4	7	2	4	
	Increase number of patients on ART	12. ART patients- Total registered	16 343	26 111	37 435	28 452	3,699	850	3 261	303	880	
	Improve quality of ART service provision	13. Percentage of fixed facilities with any ARV drug stock out	Not reported	0	0	0	0	0	0	0	0	0
	Accredit facilities to provide ART	14. Percentage of fixed facilities referring patients to ARV sites for assessment	Not reported	100%	100%	100%	100%	100%	100%	100%	100%	N/A
	Monitor turn around times and engage NHLS as needed	15. CD4 test at ARV treatment service points with turnaround time > 6 days	Not reported	Not reported	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	Not collected	N/A
	Monitor expenditure on a monthly basis and variances	16. Percentage of dedicated HIV/AIDS budget spent	101%	103.00%	100%	100%	100%	100%	100%	100%	100%	

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-lands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2007/08
Strategic Goal:		Reduce morbidity and mortality due to TB										
Strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme	17. Percentage of TB cases with a DOT supporter	93%	86%	85%	91%	71%	91%	91%	88%	82%	100%
	Ensure that TB patients remain in care	18. TB treatment interruption rate (%)	11.9%	11.1%	9.6%	9.9%	9.4%	8.2%	8.3%	11.7%	10.2	10%
	Monitor turn around times and engage NHLS as needed	19. Percentage of TB sputa specimens with turnaround time less than 48 hours	72%	67%	65%	65%	57%	69%	72%	68%	80%	80%
	Ensure a regular and uninterrupted TB drug supply	20. Percentage of new smear positive PTB cases cured at first attempt	69.3%	71.9%	77.5%	76.6 %	77.8%	83.1%	80.6%	69.0%	76.3%	60%
Address TB/HIV, MDR and XDR-TB to ensure the adequate treatment and management of these patients	Ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the (X)DR-TB Programme	21. New MDR TB cases reported- % annual change	Not reported	Not available	3.20%	Not available	Not available	Not available	Not available	Not available	Not available	
		22. New MDR TB cases reported- % annual change ¹	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	

Note:

Indicators 21 and 22: It is estimated that there were 861 MDR cases in the Province in 2007. The rate of annual change in these statistics will be collected next year when there are two years worth of provincial data.

5.3 POLICIES, PRIORITIES AND STRATEGIC GOALS

The provincial Department of Health has committed itself to a comprehensive HIV and AIDS, and TB programme that, via all relevant departments of the provincial government and all sectors of society, addresses all aspects of the HIV and AIDS and TB dual epidemics.

5.3.1 HIV and AIDS and Sexually Transmitted Infections (STI)

The provincial strategy draws from the National HIV and AIDS and STI Strategic Plan (NSP) for South Africa, 2007 – 2011. The NSP 2007 – 2011 has two primary aims:

- 1) Reduce the number of new infections by 50% by 2011
- 2) Reduce the impact of HIV and AIDS on individuals, families and society by expanding access to an appropriate package of treatment, care and support to 80% of all people diagnosed with HIV.

The National Department of Health has identified overall targets and the financial implications for implementing the NSP, which focuses on:

- Prevention
 - Social mobilization for social and behavioural change.
 - Interventions such as PMTCT, VCT, female condoms.
- Decreasing morbidity and mortality of HIV and AIDS of which ART is one of the components.

The provincial programme is co-ordinated by the Provincial AIDS Council, which has representation from all relevant stakeholders in the Province and is chaired by the provincial Minister of Health. The Provincial AIDS Council has officially endorsed the Provincial Strategic Plan 2007–2011. The

strategy provides a roadmap for increased effort and commitment to contain the spread of HIV, with ambitious targets, aligned with the National Strategic Plan.

The Provincial Inter-Departmental AIDS Committee (PIDAC), co-ordinates the provincial government sector response, and is convened by the provincial Department of Health.

In addition to its co-ordinating and leadership role in the provincial programme, the Department of Health is responsible for the development and implementation of policies, strategies and activities within the Department to curb and manage the HIV and TB epidemics. The programme relates to the three broad strategic goals.

Table 2.19: The three broad strategic goals of the HIV & AIDS/STI programme

Decrease the number of new infections in the age group 15-24 years	Reduce morbidity and mortality amongst HIV affected persons	Implement Care & support programmes for people living with HIV & AIDS
Community mobilisation	Anti-retroviral treatment (ART)	Home-based care / community ARV adherence support. (See section on disease prevention and control)
Lifeskills and peer education (Education Department)	Ongoing management of HIV positive clients not on ART.	Palliative hospice care (See section on disease prevention and control)
Voluntary counselling and testing (VCT)	In-patient management of HIV and AIDS disease.	Social support (Department of Social Services)
Sexually transmitted infections (STI) management Condom/barrier methods Post exposure prophylaxis (PEP) Prevention of mother-to-child transmission (PMTCT)		Orphans/ vulnerable children (Department of Social Services)

The implementation of the various strategies has been incremental over the last five years. There is a closer integration with the Women's Health programme regarding PMTCT and PEP for sexual assault. The Nutrition Sub-directorate and the HIV and AIDS Directorate are jointly addressing the infant feeding aspects of the PMTCT programme as well as the provision of nutritional support to HIV positive clients.

The adoption of the 'Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa' by the National Cabinet in 2003 resulted in the provision of anti-retroviral treatment (ART) for HIV infected individuals. The advent of this large-scale treatment programme has had major implications for the health care delivery system in the country and this Province. The impact of HIV and AIDS on levels of care has been increasing steadily as the prevalence of HIV has increased in the Western Cape over the past eight years.

5.3.2 Tuberculosis

In response to the TB epidemic, the provincial strategy draws from the Draft National Tuberculosis Strategic Plan 2007 – 2011 to reduce morbidity and mortality due to TB. The strategic objectives to achieve TB control in the country are:

- To strengthen the implementation of the DOTS strategy
- To address TB and HIV, MDR and XDR-TB
- To contribute to health systems strengthening
- To work collaboratively with all care providers; to empower people with TB as well as communities

- To coordinate and implement TB research
- To strengthen infection control.

5.3.2.1 Departmental Strategy for TB for 2009/10

The goal of the Department is to reduce morbidity and mortality due to TB through the following strategic objectives:

- 1) Strengthen the implementation of the DOTS Strategy through expansion and enhancement of high quality DOTS in high TB burden sub-districts and health facilities.

The focus will remain on strengthening TB services in 11 high TB burden sub-districts which are Khayelitsha, Cape Town Eastern, Klipfontein, Drakenstein, Breede Valley, Mitchell's Plain, Cape Town Northern, Cape Town Western, Tygerberg, George and Mossel Bay. Key actions to improve the DOT strategy will include the following:

- Improve TB case detection and monitor laboratory turn-around times of TB specimens;
 - Sustain and improve TB treatment outcomes
 - Strengthen adherence to TB treatment and support of patients; and
 - Continue to implement a standardised TB reporting and recording system and conduct quarterly analysis of data
- 2) Address HIV positive TB, MDR and XDR-TB to ensure the adequate treatment and management of these patients.

TB and HIV

Ensuring functional integration of TB and HIV activities at facility level is key to providing patient centred comprehensive care. Key action to achieve this will include:

- Ensure early diagnosis of HIV in TB patients through provider initiated testing and counselling
- Conduct CD4 testing, Cotrimoxazole therapy and ART (to those who qualify) for all co-infected TB patients
- TB and HIV integrated audits will be conducted to monitor implementation.

MDR and XDR-TB

Key activities to ensure adequate management of MDR and XDR TB will include:

- Implement and adhere to revised M(X)DR-TB policy guidelines;
- Early detection through routine culture and DST for all high risk groups;
- Admission and isolation to M(X)DR-TB referral centres; and
- Strengthen infection control;
- Implementation of a pilot project in Khayelitsha to pilot providing MDR-TB treatment and care at primary health care and community level.

Advocacy, Communication and Social Mobilisation (ACSM)

Critical to the success of any efforts to control TB is the development and the implementation of a comprehensive ACSM plan. Close partnerships will be forged with relevant partners such as TB Free and the Communication's Directorate to expand TB ACSM activities in 2008. Activities will include quarterly door-to-door awareness campaigns, a taxi branding campaign, erection of bill boards, developing, printing and distribution of IEC materials and conducting activities to commemorate World TB Day.

5.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.20: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
HIV and AIDS and TB	<ul style="list-style-type: none"> Demand for services exceeds the capacity of the government to provide services in prevention, care and support and treatment 	<ul style="list-style-type: none"> The Department has developed a comprehensive prevention strategy, which will help decrease new infections. Besides such interventions as VCT, PMTCT and STI services being provided, non-government organisations (NGO's) working with women, children and vulnerable groups will be further engaged to assist with targeted prevention interventions. The Department will implement a strategy for the Provincial Interdepartmental AIDS Committee (PIDAC), which will commit other government departments to implement appropriate targeted actions aimed at the downstream and upstream factors associated with the HIV and TB epidemics Decanting of stable ART patients from level 3 and level 2 to PHC level is in progress. A nurse-led, doctor supported service will be implemented at 20 sites An integrated HIV/TB treatment adherence strategy will be implemented to decant stable patients from facility based care to community based care
	<ul style="list-style-type: none"> Recruiting and retaining the appropriate human resources 	<ul style="list-style-type: none"> Human resources employed through the HIV and AIDS program will be integrated into health services to strengthen services generally
	<ul style="list-style-type: none"> Adequate infrastructure 	<ul style="list-style-type: none"> To address the infrastructure problem, through Global Funding, six PHC infrastructure projects are in progress
	<ul style="list-style-type: none"> The Department's ability to take over the activities currently funded by Global Fund into the equitable share in a phased manner thus not overburdening the state. 	<ul style="list-style-type: none"> The Department has a structured exit strategy from Global fund to slowly take over the Global Fund financial commitments over a four-year period from 2006 to 2010.

5.5 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.21: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control [HIV2]

Strategic Objective	Measurable Objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Strategic Goal: Reduce morbidity and mortality amongst HIV affected persons									
Provide ART to patients in need	Increase number of clients in need of ART starting treatment to 99,526 by 2011	1. Number of new ART patients	11 078	12 529	13 928	8 321	22 480	15 994	15 296
Strategic Goal: Decrease the number of new infections in the age group 15-24 years									
Implement an effective prevention strategy.	Increase number of clients tested for HIV to 380,000 by 2011	2. Number of persons tested for HIV, excluding antenatal	181 476	245 271	276 331	289 065	323 000	361 000	380 000
	Distribute 650, 000 female Condoms through Public Health Care (PHC) and non PHC sites in the Province by 2011	3. Number of female condoms distributed from public health facilities	Data not collected through DHIS. Non DHIS distribution 49 722	254 426	562 725	548 050	550 000	600 000	650 000
	Decrease mother to child HIV transmission to 4% by 2011	4. PMTCT transmission rate	6.10% 444/ 7 099	5.40% 429/ 7 961	5.20%	4.51%	4.00%	4.00%	4.00%
Strategic Goal: Reduce morbidity and mortality due to TB									
Strengthen the implementation of the DOTS Strategy	Increase routine sputum collection in all TB patients at 2 months to 80% by 2011	5. Smear conversion rate at 2 months for new smear positive PTB cases	62.3%	69.6%	71.9%	72%	73%	74%	75%

Table 2.22: Performance indicators for HIV & AIDS, STI and TB control [HIV3]

Strategic Objective	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (actual)	Province wide value 2008/09 (estimate)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)	Province wide value 2011/12 (target)	National target 2007/08
Strategic Goal: Decrease the number of new infections in the age group 15-24 years										
Implement an effective prevention strategy.	Provide PMTCT services to all pregnant women at 1 st Antenatal booking visit	1. Percentage fixed PHC facilities offering PMTCT (PMTCT facility rate)	74% 213/288	74% 213/288	84.4% 242/288	80% 230/288	82% 245/299	87% 259/299	88% 262/299	100%
	Provide VCT services at all fixed PHC facilities in the Province	2. Percentage fixed PHC facilities offering VCT to non-antenatal clients (VCT facility rate)	100% 290/290	100% 290/290	89% 258/290	100% 290/290	97% 290/299	99% 295/299	100% 299/299	100%
	Provide PEP for occupational exposure at all hospitals in the Province	3. Percentage of hospitals offering PEP for occupational HIV exposure	100% 40/40	100% 40/40	100% 40/40	100% 40/40	100% 41/41	100% 41/41	100% 41/41	100%
	Provide PEP for sexual assault at all hospitals in the Province	4. Percentage of hospitals offering PEP for sexual abuse	89.7% 35/39	100.0% 40/40	87.0% 35/40	100% 40/40	100% 41/41	100% 41/41	100% 41/41	100%
	Distribute Male Condoms from all PHC Facilities and non PHC facilities to all adult males 15 years and above	5. Male condom distribution rate from public sector health facilities	19.9	34.9	41.1	39.2 67 957 263/ 1 734 277	39.2 74 752 989/ 1 906 624	43.0 82 228 288/ 1 914 297	47.1 90 451 117/ 1 921 970	11
	Issue of STI partner notification slips to all STI clients treated new	6. STI partner treatment rate (%)	18.5%	19.75%	18.9%	20.3%	20.5%	21%	22%	40%

Strategic Objective	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (actual)	Province wide value 2008/09 estimate	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)	Province wide value 2011/12 (target)	National target 2007/08	
	Administer Nevirapine to babies of mothers who accepted PMTCT intervention	7. Nevirapine newborn uptake rate	97% 9261/ 9 534	98% 10 519/ 10 701	101.6%	95%	95%	95%	95%	70%	
	Administer Nevirapine to HIV positive women in labour who accepted PMTCT intervention	8. Nevirapine uptake- antenatal clients ⁵	75.4% 7 798/ 10 342	89.8% 8 558/ 9 520	73.5%	90.0%	90.0%	90.0%	90.0%		
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities	9. Clients HIV pre-test counselled rate in fixed PHC facilities (%)	1.3% 196 120/ 13 068 303	2.5% 304 523/ 12 180 933	2.7% 320 325/ 11 863 906	3% 360 000/ 12 338 462	3.8% 340 000	4.0% 380 000	4.0% 400 000	100%	
	Determine acceptability of HIV testing in those pre test counselled	10. HIV testing rate (excluding antenatal)	92.5%	97.2%	95.1%	90.0%	95.0%	95.0%	95.0%	90.0%	
Strategic Goal: Reduce morbidity and mortality amongst HIV affected persons											
Provide ART to patients in need	Accredit facilities to provide ART	11. ART service points registered	43	50	62	70	76	84	90		
	Increase number of patients on ART	12. ART patients- Total registered	16 343	26 111	37 435	45 756	68 236	84 230	99 526		
	Improve quality of ART service provision	13. Percentage of fixed facilities with any ARV drug stock out	Not reported	0	0	0	0	0	0	0	
	Accredit facilities to provide ART	14. Percentage of fixed facilities referring patients to ARV sites for assessment	Not reported	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	100% 290/290	
	Monitor turn around times and engage NHLS as needed ⁴	15. CD4 test at ARV treatment service points with turnaround time > 6 days	Not reported	Not reported	Not collected	Not available	Not available	Not available	Not available	Not available	0
	Monitor expenditure on a monthly basis and variances	16. Percentage of dedicated HIV/AIDS budget spent	101%	103%	100%	100%	100%	100%	100%	100%	100%
Strategic Goal: Reduce morbidity and mortality due to TB											
Strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme	17. Percentage of TB cases with a DOT supporter	93%	86%	85%	90%	91%	92%	93%	10%	
	Ensure that TB patients remain in care	18. TB treatment interruption rate	11.9%	11.1%	9.6%	9%	9%	9%	8%	4%	
	Monitor turn around times and engage NHLS as needed	19. Percentage of TB sputa specimens with turnaround time less than 48 hours	72%	67%	65%	68%	72%	73%	75%	80%	
	Increase the number of people cured for PTB at first attempt	20. Percentage of new smear positive PTB cases cured at first attempt	69.3%	71.9%	77.5%	78%	78%	79%	80%	60%	
Ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	Ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	21. New MDR TB cases reported- annual percentage change	Not reported	Not available	3.20%	Not available	Not available	Not available	Not available		
		22. New XDR TB cases reported – annual percentage change	Not reported	Not available							

Notes:

Indicator 5: Rate: Number of male condoms per male 15 years and older per year.

Indicators 7 & 8: Until 2006/07, the Nevirapine administration rate was reported. As from 2006/07 NVP coverage rate was reported. The denominator for the coverage rate for 2006/07 is based on the provincial and region specific sero-prevalance, derived from the 2006 HIV Antenatal Survey; namely Western Cape 15.7%, Metropole 18.2%, Cape Winelands 12.6%, Overberg 14.1%, Eden 13%, Central Karoo 6.5%, West Coast 9.1%

In 2003/04 the Nevirapine administration rate to women was calculated as follows
(Self administered Nevirapine + NVP in labour) / deliveries on PMTCT programme.

In 2004/05 due to change in protocol, the Nevirapine Administration Rate changed to NVP administered in Labour/ PMTCT deliveries- Transfer-in during deliveries

Indicator 15: This is in the process of being addressed

Indicator 21: Data was systematically collected from 1 January 2007. This indicator will there only be available from 1 January 2008 It is estimated that there were 696 MDR cases in the Province in 2007. The rate of annual change in these statistics will be collected next year when there are two years' worth of provincial data and thus would be better able to predict the rate of annual change

Indicator 22: As for Indicator 21, the rate of annual change in these statistics will be collected next year when there are two years' worth of provincial data and thus would be better able to predict the rate of annual change.

5.6 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 2.23: Trends in provincial public health expenditure for HIV and AIDS [HIV4]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total	122 655 000	168 579 000	239 899 000	276 467 000	309 913 000	448 834 000	480 994 000
Total per person	26.00	31.94	45.26	51.95	58.01	83.67	89.31
Total per uninsured person	34.82	42.92	60.83	69.82	77.96	112.45	120.03
Constant 2007/08 prices							
Total	131 387 718	174 510 239	239 899 000	257 957 934	274 648 469	383 638 616	399 520 738
Total per person	27.85	33.06	45.26	48.48	51.41	71.52	74.18
Total per uninsured person	37.30	44.43	60.83	65.15	69.09	96.12	99.70

Table 2.24: Trends in provincial public health expenditure on HIV and AIDS and Global Fund (Sub-programmes 2.6 and 2.10 [HIV4])

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total	172 355 000	249 129 000	324 575 000	423 471 000	383 533 000	459 547 000	480 994 000
Total per person	36.53	47.20	61.24	79.58	71.78	85.67	89.31
Total per uninsured person	48.93	63.43	82.31	106.95	96.48	115.14	120.03
Constant 2007/08 prices							
Total	184 626 230	257 894 289	324 575 000	395 120 228	339 891 360	392 795 499	399 520 738
Total per person	39.14	48.86	61.24	74.25	63.62	73.22	74.18
Total per uninsured person	52.41	65.66	82.31	99.79	85.50	98.41	99.70

6. MATERNAL CHILD AND WOMEN'S HEALTH, AND NUTRITION

6.1 SITUATION ANALYSIS

6.1.1 Women's Health

Women's health has been on the agenda of global health organizations for the last 20 – 30 years. The importance of women's health is echoed in the United Nation's Millennium Goals 3 and 5, which emphasise the need to promote gender equality and empower women as well as to improve maternal health. In response, the country has introduced the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD) whose main focus is to analyse maternal deaths and recommend strategies to improve maternal health care, thereby reducing maternal mortality. The Province has women's health as one of the eight divisional priorities in which departmental resources are channeled in order to respond and advance the progress towards achievement of the MDGs

According to the Burden of Diseases study (2007) non-pregnancy related sepsis, mostly HIV and AIDS, remain the most common cause of maternal death, followed by hypertensive disorders and obstetric haemorrhage. The MDGs together with the departmental goals will be achieved through prevention of diseases, health promotion, curative and rehabilitative services in the context of the Comprehensive Service Plan (CSP).

6.1.1.1 Antenatal Care

Research has demonstrated that the earlier the pregnant woman books at the antenatal clinic (ANC) the better the outcome for both mother and unborn child, hence the emphasis by the National and Provincial Department of Health on the importance of booking earlier than 20 weeks. In 2007/08, less than 40% of women in the Province attended antenatal care before 20 weeks.

The Province has a high coverage of antenatal visits, over 90% of women attended antenatal care services before they gave birth. The biggest challenge however is to ensure that women attend antenatal care services before 20 weeks gestation. Booking before 20 weeks of gestation assists in early problem identification. For 2009/10 the Province will develop an enhanced strategy which will amongst other things focus on improving client awareness regarding the importance of early booking especially in areas with low booking rates.

Basic Antenatal Care (BANC) is a national quality improvement programme, which was introduced in 2006. This programme focuses on early identification of pregnant women at risk and early referral to the appropriate level of care. Basic Antenatal Care has to date been rolled out to 51.9% of the facilities within the Province and during 2009/10 BANC will be rolled out to 80% of the facilities.

6.1.1.2 Maternal Health

The Province has 51 birthing units, i.e. facilities where deliveries take place, which include midwife obstetric units (MOUs), district, regional and central hospitals. Most of these birthing units are in the Cape Town Metro District with the obstetric bed capacity of 455 maternity beds (2004/05). The Comprehensive Service plan (CSP) proposes two new district hospitals for the Khayelitsha and Mitchells Plain sub-districts, with sixty level 1 obstetric beds each to strengthen maternal services in the Metro. Due to the increase in service pressures, the Metro District Health Services (MDHS) commissioned forty additional level 1 obstetric beds (twenty in the Khayelitsha district hospital hub

and twenty beds in Mowbray Maternity Hospital), and increased the capacity of MOU and BANC coverage in the sub-districts, during 2008/09.

For the last decade Western Cape's MMR was estimated to 54/100 000 per year on average. The NCCEMD enquiry has identified the following top five conditions causing mortality amongst pregnant women in the Western Cape and the country.

The top 5 conditions causing maternal deaths are;

- 1) Non pregnancy related infections including HIV/AIDS
- 2) Hypertensive disorders
- 3) Obstetric haemorrhage
- 4) Sepsis
- 5) Pre existing medical disorders

Despite a relatively small number of maternal deaths, the Province is faced with similar challenges as the rest of the country. For 2009/10 the Province will enhance intrapartum and postpartum care. The percentage of birthing facilities implementing 8 or more of the 10 "Saving Mothers Report III" recommendations will be increased to 90%.

It is estimated that the Western Cape Province has one of the highest incidence of Foetal Alcohol Syndrome (FAS) with over 7.5% of children in socio-economically disadvantaged areas being affected (National Department of Health: 2001). For 2009/10 the Province will strengthen the available services by developing and implementing the FAS policy with special emphasis on the prevention of FAS by providing services a part of the integrated PHC services.

6.1.1.3 Neonatal Health Services

According to the Western Cape Perinatal Problem Identification Programme report (2007) the Province has an average perinatal mortality rate of 33.1/1000 for the period from 2003 to 2007, which is lower than the national average figure of 39.8/1000 for the same period. The top three primary obstetric causes of perinatal death are; unexplained intrauterine deaths (3.4%), spontaneous preterm birth (2%) and intrapartum asphyxia (2.3%) (WC PPIP report 2007). For 2009/10 the Province will roll out Continuous Positive Airway Pressure (CPAP) and ambulatory Kangaroo Mother Care (KMC) as targeted interventions for the reduction of perinatal mortality.

6.1.2 Reproductive Health

6.1.2.1 Contraceptive Services

Contraceptive utilization is influenced by various factors such as the client's knowledge and attitude to contraception, socio-economic development, urban-rural residence, educational status and culture. In order to accommodate the varying needs and preferences of clients, a variety of contraceptive methods are offered.

Women Year Protection Rate is the indicator that provides information on how many women are protected against pregnancy through the use of modern contraceptive methods. This indicator has increased from 28% (2006/07) to 31% (2007/08). For 2009/10 the target is 36%. The measures to attract new users and retain the existing ones will be explored for implementation.

6.1.2.2 Cervical and Breast Cancer Screening Services

Cervical cancer is one of the few cancers that can be prevented by early diagnosis of the pre cancerous lesion through a very inexpensive investigation, the Pap smear, which examines the cervical histology. Cervical cancer screening programme is a national programme aimed at reducing morbidity and mortality as result of cancer of the cervix. Women aged 30 years and above, during their lifetime, are entitled to three free pap smears at intervals of 10 years. Over the past few years the Province did not meet the targets set for this service. In 2006/07 the target was 7%, but the Province only managed to achieve 6.3%. For the financial year 2007/08 the Province achieved 5.1% against the target of 7.5%. The target for 2009/10 is 8.5%. Programme enhancement strategies such as campaigns that include community-based mobilisation, will be implemented to ensure that the target is achieved. Quality of cervical smears as well as management of those with abnormal smears will be closely monitored. Access to colposcopy services will be improved by rolling out this service to more district hospitals in order to provide further services to women who screen positive for the pre cancerous lesions.

According to the Western Cape Burden of Disease study (2007), breast cancer accounted for 3% of premature mortality in women aged 15 and above in Cape Town in 2004. This was also observed in Boland Overberg in 2005. The current breast cancer services will be strengthened following a detailed report on the proposed pilot sites as well as finalisation of the provincial policy on these services.

6.1.2.3 Termination of pregnancy (TOP) services

The 'Choice on Termination of Pregnancy Act' prescribes that termination of pregnancy services should be accessible to women of all ages. In 2007/08 the Province had 29 out of 40 hospitals, and 3 out of 59 CHC's offering TOP services. Research evidence shows that strengthening of contraceptive services has a potential to reduce TOP's. In 2009/10, the Province will be enhancing the contraceptive services through community based mobilisation and youth involvement.

6.1.3 Child Health

6.1.3.1 Introduction

One of the Millennium Development Goals is to reduce childhood mortality by two thirds by 2015. According to the Medical Research Council, Burden of Disease studies of 2000, the majority of child deaths occur in infancy (under one year of age) and in the young child (1-4 years of age) age group. In fact the under five deaths account for a significant percentage of all deaths in children.

HIV and AIDS, diarrhoea, lower respiratory tract infections (LRTIs), under nutrition and perinatal problems (low birth weight, neonatal infections, perinatal asphyxia and birth trauma) account for almost 50% of under-5 deaths in the Western Cape. In addition to deaths directly attributable to under nutrition, malnutrition plays an important synergistic role in diarrhoea and respiratory

infections. There are however indications that the PMTCT programme are having a positive impact on Infant mortality Rates.

6.1.3.2 Immunisation

The Expanded Programme on Immunisation (EPI) is a national programme to prevent vaccine preventable diseases. Nationally, the immunisation coverage target for fully immunised children under 1 year is 90%. This Province has exceeded this target according to the routine monitoring record (RMR) statistics. However, there are four sub-districts that did not achieve the target of 80% and these sub districts are targeted for the implementation of RED strategy. The Province, in line with National Department of Health has identified the following interventions to improve vaccine coverage:

- Implementation of RED strategy in low coverage areas
- Implementation of monitoring charts at facilities where children are being immunised
- To raise awareness in communities
- To ensure that data are validated at all levels

New and existing vaccines

In 2008/09 the Province introduced Tetanus and Diphtheria (Td) vaccine which is given at 6 and 12 years to prevent tetanus and diphtheria. The National Department of Health announced the intention to introduce the rotavirus and pneumococcal vaccines for 2009/10. The EPI vaccine budget for the Province will increase significantly i.e. from R18 million to R88 million.

Rotavirus vaccine is administered to children at 10 and 14 weeks of age while the pneumococcal vaccine is administered at 6 weeks, 14 weeks and 9 months.

Currently, DPT-HIB and polio vaccines are being administered separately. However, in future they will be given together as Pentaxim, which will have budget implications. The rotavirus and pneumococcal vaccines will be implemented from 1 April 2009.

6.1.3.3 Screening for Developmental Disabilities

The screening for developmental disabilities is important for detecting developmental disabilities at 6 weeks, 9 months and 18 months to ensure early intervention. This screening is done simultaneously when children are vaccinated at PHC facilities within the Province. This programme needs to be strengthened by ensuring that there are clearly defined indicators that will assist in measuring its success. Although the indicator that will measure this programme will be the number of children assessed under 1 year of age, the screening of children at 18 months will continue.

6.1.3.4 Integrated Management of Childhood Illnesses

The 'Integrated Management of Childhood illnesses' (IMCI) is a critical clinical management intervention to ensure good quality care for children accessing the PHC platform in particular. In IMCI in addition to the clinical management intervention, audits are done to evaluate the quality of care. IMCI was introduced in 2000, however, the impact of this programme has not been measured and in 2009/10 the Province will explore the possibility of a study to evaluate its impact. The

Province will strengthen the integration of the Household Community Component (HHCC) of IMCI into community-based services in 2009/10.

6.1.3.5 **School Health**

Phase 1 of The National School Health Policy is aimed at screening grade 1/R pupils to identify problems and manage appropriately via assessments for hearing, eye, gross motor and anthropometrics (weight and height). Since July 2007 all districts in the Province are implementing Phase 1 and 2 of the National School Health Policy.

6.1.3.6 **Child Problem Identification Programme (CHPIP)**

The Child Problem Identification Programme is a childhood morbidity and mortality assessment system in a hospital setting. The main objective of CHPIP is to assess the quality of care provided to children and to identify modifiable causes of child mortality so that targeted interventions can be introduced. The Province will be rolling this programme to all hospitals on an incremental basis. The success of the PPIP programme will be used to promote programme expansion.

Currently there are ten facilities implementing CHPIP in the province, the implementation of which varies in the facilities. Surgical and ICU deaths are however not assessed according to this programme. The objective for 2009/10 is that the existing facilities will roll out CHPIP to all departments within the facilities.

6.1.3.7 **Priority disease: Infantile diarrhoea.**

The Province experiences a significant peak in infantile diarrhoeal disease during the summer months. A diarrhoeal task team comprising members from communication, health promotion, health programmes and the City of Cape Town have addressed the resulting service pressures through a six-pronged strategy namely:

- 1) Problem identification – identification of ‘hotspots’ in all districts;
- 2) Community based services;
 - Improved water and sanitation
 - Community Awareness/education
 - Social mobilisation and inter –sectoral coordination
- 3) Improve PHC management and referral;
- 4) Improve management and transportation of the critically ill children through Emergency Medical Services;
- 5) Improve management of hospital provision; and
- 6) Research, monitoring and evaluation.

6.1.4 Integrated Nutrition Programme (INP)

The problems of poverty and underdevelopment in the Western Cape Province are often hidden behind an image of relative affluence as portrayed in comparative studies between the Provinces. The health status of the children appears to be better than elsewhere in the country. However, disparities exist in the Province, these include certain areas where up to 80% of the population live in informal housing, have no medical aid and live below the household subsistence level where the children's health status is poor. These disparities are reflected by infant mortality rates, which between sub districts range from 13 per 1000 live births to 56 per 1000 live births with an overall Provincial IMR of 35 per 1000 live births. Nutrition services are available at all levels of care in PHC facilities and Hospitals. Community based nutrition services are delivered at schools, crèches, and old age homes.

6.1.4.1 Malnutrition

There is good evidence that malnutrition increases the likelihood of mortality from a number of different diseases and may be associated with over half of all childhood mortality. Conversely, due to the "nutritional transition" which the Province is undergoing, the Province has higher prevalence of obesity for both men and women. This is further exemplified by the relatively high proportion of deaths due to cardiovascular diseases compared to the rest of the country.

The table below shows that even though the Province has favourable indicators with regards to under nutrition when compared to the national average. It is, however, concerning that the prevalence of obesity is 8% more than the national average for women aged 16 – 35 years of age.

Table 2.25: National and Provincial Nutrition Status Indicators

Indicator	National Status	Provincial Status	Interpretation
Stunting (1- 9yr)	18%	12%	Low height for age, (Stunting - Height for age less than the international reference value of 2 standard deviations) High percentage is an indication of bad environmental conditions and chronic malnutrition
Wasting (1- 9yr)	4.5%	11.5%	Low weight for height (weight for height that is less than the international reference value by more than 2 standard deviations) Reflects current under nutrition and disease
Underweight (1 – 9 years): Moderate Severe	9.3% 1.0%	8.2% 0.5%	Low weight for age (Weight for age that is less than the international reference value by more than 2 standard deviations) Poverty and poor dietary intake and current under nutrition
Vitamin A Deficiency (10 – 19.9ug/dL) (1 – 9 years)	49.9	41.2	Vitamin A on the basis of serum concentration 10 – 19.9 ug/dL indicates low(marginal vitamin A status)
Obesity in women 16 – 35 years	24.9%	32.7%	BMI of above 30 Increased risk for Chronic diseases of lifestyle.
Overweight in women 16 – 35 years	26.6%	26%	BMI above 25, Increased risk for Chronic diseases of lifestyle.

Source: National Food consumption survey: Fortification Baseline 2005

The results of the South African Youth behaviour risk survey 2002 amongst learners' grades 8 – 11, confirms the need for emphasis on prevention and management of obesity. This age group in the Province shows a higher prevalence of obesity for both women and men as compared to the national average. The role of nutrition in reducing the burden of disease specifically in the management of healthy lifestyles is becoming increasingly important.

Obesity is associated with an increased risk of cardiovascular diseases of 2.8% in men and 3.4% in women (Willet and Dietz 1999), hypertension and certain type of cancers of the reproductive system in women and with rectum, colon and prostate cancers in men. A study in children in the Western Cape showed that current levels of obesity were associated with inactivity as measured by television time, lower fitness levels and lower intake of daily fruit and vegetables. (Lambert et al 2000).

6.1.4.2 **Micronutrient supplementation – Vitamin A**

The vitamin A supplementation programme is implemented to protect immunity, prevent blindness and reduce the risk of children dying from the common childhood illnesses. The vitamin A coverage has increased in children and post partum women. The coverage under 1 year for 2007/08 was 91.6% and 63.6% in post partum women for the province. Ongoing awareness, training and monitoring will be done to ensure that this good coverage is maintained. Mini campaigns (using RED strategy) will be introduced to improve the vitamin A coverage in low coverage areas.

6.1.4.3 **Infant and Young Child Feeding**

The 'Baby Friendly Hospital Initiative' (BFHI) is one of the key strategies for child survival. Facilities are accredited to become baby friendly against a stringent set of criteria by external assessors on an annual basis. All facilities have to undergo first time assessment and receive accreditation. Accredited facilities are reassessed after a period of three years to determine if they have maintained their BFHI status. The number of facilities declared 'baby friendly' have increased from eleven facilities (including two private facilities) in 2005/06 to sixteen facilities in December 2007. The Department accredited an additional three facilities in 2008/09. It is the intention of the department to increase the number of new facilities by three new facilities per year. A further challenge is the maintenance of the Baby Friendly status in those hospitals already accredited.

An infant and young child feeding policy was approved nationally in December 2007. The aim of the policy is to improve the nutritional status, growth and development of infants and young children. This is done through the protection, promotion and support of safe infant feeding practices. Implementation of this policy has commenced in the Western Cape in 2008 and will be further strengthened in 2009/10.

6.1.4.4 **Growth Monitoring and Promotion**

Routine growth monitoring and promotion are done at PHC facilities. The Road to health Chart (RTHC) is used as a primary tool to assess the growth of children. Challenges exist with the quality of data collected on the RMR in order to reflect the nutritional status of children attending facilities. Growth monitoring should be performed at every child visit to the health establishment. A new 'Road to Health' card will be implemented in 2009/10 to improve growth monitoring.

6.1.4.5 Food service management

Food service management is often an under emphasised aspect of health care. The provincial food service management policy was approved in March 2005 and included the development of a monitoring tool with evaluation criteria for food services. Monitoring of the implementation is ongoing in the Province. The results of a food service audit undertaken during 2007 indicated that the food service policy has been implemented and 23 out of a total of 38 facilities (60%) scored above 75% on the food service monitoring tool.

6.1.4.6 Community Based Nutrition programmes

Community-based nutrition programmes are a direct means of improving nutrition. The Western Cape has implemented projects ranging from nutrition rehabilitation of malnourished children, linkages with community IMCI and multidisciplinary crèche-based projects. A national framework for community based nutrition programming has been drafted and interventions will be implemented and expanded in future plans.

Table 2.26: Situation analysis indicators for MCWH & Nutrition [MCWH1]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-lands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2003/04
Strategic goal: Reduce child and neonatal morbidity and mortality												
Reduce Morbidity and Mortality from Vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised	1. Percentage of fixed PHC facilities with DTP-Hib vaccine stock out	Not available	Not available	0.67%	0.1%	1.7%	0	0.1%	0	2.2%	
		2. Full Immunisation coverage under 1 year	91.3%	92.9%	100.5%	98.4%	103.1%	90.7%	118.6%	89.4%	102.1%	90%
		3. Measles coverage under 1 year	90.7%	93.7%	102.8%	101.7%	102.2%	91.1%	120.1%	93.2%	102.4%	90%
Improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1 year to at least 90%	4. Vitamin A coverage under 1 year	26.5%	68.6%	91.6%	84%	107.5%	89.8%	117.7%	88.3%	109.2%	80%
		5. Percentage of facilities certified as Baby friendly to at least 35%	14.8% (11/74)	18.9% (14/74)	21.6% (16/74)	34.29% (12/35)	11.11% (1/9)	0% (0/6)	22.2% (2/9)	0 (0/6)	11.11% (1/9)	30%
Improve prevention and management of common childhood illnesses	Facilities implementing IMCI	6. Percentage of fixed PHC facilities implementing IMCI	81%	82%	88%	76.1%	42.4%	89.3%	98.1%	100%	100%	70%
Improve access of health services to youth	Ensure that health services are certified as youth friendly	7. Percentage of fixed PHC facilities certified as youth friendly	Not available	Not available	20%	14.8%	28.8%	60.7%	17.3%	0%	6%	30%
Strategic goal: Improve women's Health and Decrease Morbidity and Mortality during pregnancy, birth and post delivery												
To reduce morbidity and mortality in women at risk of cervical cancer	Increase cervical cancer screening coverage in women aged 30 years and over to be at least 8%	8. Cervical cancer screening coverage	5.5%	6.3%	5.1%	4.1%	6.5%	5.9%	8.1%	7.0%	7.9%	15%
Strategic goal: Decrease morbidity and mortality during pregnancy, birth and post delivery.												
To reduce morbidity and mortality in women as a result of abortions	Improve access to TOP services to 100% of all acute hospitals	9. Percentage of hospitals offering TOP services	92%	85%	78%	100%	150%	100%	42.9%	25%	57.1%	100%
		10. Percentage of CHC's offering TOP services	80%	5%	5.7%	4.80%	25%	0	0	0	0	80%

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-lands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2003/04
Decrease morbidity and mortality during pregnancy, birth and post delivery	Increase access to safe delivery services	11. Number of total deliveries in facilities	90 393	95 289	97 404	60 848	16 894	3 115	10 434	1 164	4 949	
		12. Facility delivery rate (Percentage)	New Indicator	New Indicator	New Indicator							
	Decrease teenage deliveries to <10% of all deliveries	13. Institutional delivery rate for women under 18 years (Percentage)	10.1%	10.1%	7.5%	7.8%	5.1%	8.9%	8.1%	9.7%	8.9%	

6.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

Policies, priorities and strategic goals function within a national, provincial and divisional strategic framework as illustrated in Table below.

Table 2.27: Policy and strategic framework applicable to the Directorate: Comprehensive Health Programmes

National level	National Health Act Public Finance Management Act Medium Term Strategic Framework National Spatial Development Framework Accelerated Shared Growth Initiative of South Africa Strategic Priorities for the National Health System (2004 –09) Sexual Offences Act 23 of 1957 Choice of Termination of pregnancy Sterilisation Act INP Broad Guidelines for Implementation Strategic priorities Integrated Nutrition programme 2009
Provincial level	IKapa eihlumayo (PGDS) Healthcare 2010 Standardised maternal Guidelines Management of survivors of rape and sexual assault
Divisional level	EIGHT DIVISIONAL PRIORITIES: Implementation of the DHS: 1) Strengthening the District Health System 2) Community-based services 3) District Hospitals 4) Chronic disease management Priority Health Programmes 5) TB 6) HIV and AIDS 7) Women's Health 8) Child Health

The purpose of the Comprehensive Health Programs (CHP) Directorate is to coordinate, develop, monitor and evaluate the maternal, child, women's health and nutrition programmes, policies and guidelines.

During the financial year 2008/09 Comprehensive Health Programmes will focus on the following priority programmes namely:

- Cervical cancer screening
- Expanded programme of immunization (fully immunized children < 1 year)
- Basic Antenatal Care (BANC)
- Saving Mothers Report III (recommendations)

- Screening for Developmental Disabilities
- Food Service Management
- Nutrition Supplementation Programme (ARV sites)
- Diarrhoeal Disease in children < 5 years (peak season)

Furthermore, CHP will strengthen intersectoral liaison and cooperation e.g. Education, Social Development, Agriculture, Local Government in managing these programmes.

6.2.1 Strategic Goals and Objectives

6.2.2.1 Women's Health

Strategic goal: Improve women's health and decrease morbidity and mortality during pregnancy, birth and post delivery

Strategic objectives

- 1) Improve early antenatal booking rate (below 20 weeks of gestation)
- 2) Implement the Saving Mothers(SM) Report III recommendations
- 3) Reduce morbidity and mortality in women as a result of abortions
- 4) Reduce morbidity and mortality in women at risk of cervical cancer.
- 5) Increase utilisation of contraceptives.
- 6) Increase access to safe delivery services

6.2.2.2 Child Health

Strategic goal: Reduce child and neonatal morbidity and mortality.

Strategic objective

- 1) Improve resistance to disease in children <1 year
- 2) Improve access to developmental screening
- 3) Improve prevention and management of common childhood problems.
- 4) Improve Perinatal Care to reduce neonatal morbidity and mortality
- 5) Assess the health status of learners grade 1
- 6) Reduce Morbidity and Mortality from Vaccine preventable diseases
- 7) Increase the number of Baby Friendly Hospital Initiative (BFHI) facilities

6.2.2.3 Nutrition

Strategic goal: Improve the nutritional status people in the province

Strategic objectives

- 1) Improve the nutritional status of prioritised groups

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.28: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
Human resources	<ul style="list-style-type: none"> Inadequate organisational capacity for nutrition services. Inadequate organisational capacity for Expanded programme on Immunisation, youth and adolescent health. 	<ul style="list-style-type: none"> Develop and implement a HR plan for nutrition services i.e. dieticians in line with the CSP. Increase organisational capacity for expanded programme on immunisation, youth and adolescent health.
Nutrition Supplementation	<ul style="list-style-type: none"> Increased pressures on services arising from emerging chronic diseases of lifestyles. 	<ul style="list-style-type: none"> Review resource allocation and management of chronic diseases in accordance with BOD findings.
Resource management	<ul style="list-style-type: none"> No identified budget for child and women's health programmes in districts. 	<ul style="list-style-type: none"> Create specific budgets with financial responsibilities and objectives.
Monitoring and Evaluation	<ul style="list-style-type: none"> Flow, accuracy, timeliness and completeness of data for all programmes. 	<ul style="list-style-type: none"> Integrated planning and management of data/information with the Directorate: Health Information Management.

6.4 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.29: Provincial objectives and performance indicators for MCWH and Nutrition [MCWH2]

7 Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Strategic goal: Improve women's Health and decrease Morbidity and Mortality during pregnancy, birth and post delivery									
Improve early antenatal booking rate (below 20 weeks of gestation)	Increase antenatal booking rate below 20 weeks to at least 65% by 2011.	1. Percentage of women making antenatal bookings before 20 weeks	Not applicable	37%	39%	44.20%	60%	65%	70%
	Implement BANC at 100% fixed and non fixed PHC facilities to by 2011	2. Percentage of fixed and non fixed PHC facilities offering BANC	Not measured	3% (9/290)	52% (99/290)	65% (254/391)	58% (265/460)	62% (285/460)	66% (305/460)
Increase utilisation of contraceptives	Increase women year contraceptive protection rate	3. Women year contraceptive protection rate	-	-	-	New indicator	36%	38%	40%
Strategic goal: Reduce child and neonatal morbidity and mortality									
Improve access to developmental screening	Percentage of children under 1 year screened for developmental disabilities	4. Developmental screening rate in children under 1 year of age	-	-	-	New indicator	1.2	1.4	1.6
Improve Perinatal Care to reduce neonatal morbidity and mortality	Monitor early neonatal death rate (ENNDR) for babies >1000g	5. Early neonatal death rate (ENNDR) for babies >1000g at PPIP sites	4	4.6	4.6	4.4	4.2	4.0	3.8
Strategic goal: Improve the nutritional status of people in the province									
Improve the nutritional status of children	Improve identification of children with malnutrition	6. Percentage of underweight children under 5 years	0.57%	0.89%	0.78	New	0.78	0.78	0.78

Note:

Indicator 2: From 2009/10 the definitions of PHC facilities have changed according to national policy and which accommodated and hence the difference in the numbers.

Table 2.30: Performance indicators for Maternal Child and Women's Health and Nutrition [MCWH 3]

Strategic objective	Measurable Objective	Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Strategic goal: Reduce child and neonatal morbidity and mortality										
Reduce Morbidity and Mortality from Vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised	1. Percentage of fixed PHC facilities with DTP-Hib vaccine stock out	Not available	Not available	0.67%	<2%	<2%	<2%	<2%	0
		2. Full Immunisation coverage under 1 year	91.3%	92.9%	100.5%	93%	95%	95%	95%	90%
		3. Measles coverage under 1 year	90.7%	93.7%	102.8%	93%	93%	93%	93%	90%
Improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1 year to at least 90%	4. Vitamin A coverage under 1 year	26.5%	68.6%	91.6%	89%	92%	93%	93%	80%
Improve prevention and management of common childhood problems.	Facilities implementing IMCI	5. Percentage of fixed PHC facilities implementing IMCI	81%	82%	88%	84%	85%	90%	95%	70%
Improve access of health services to youth.	Ensure that at least X% of health services are certified as youth friendly	6. Percentage of fixed PHC facilities certified as youth friendly	Not available	Not available	20%	14%	18%	18%	18%	30
Strategic goal: Improve women's Health										
To reduce morbidity and mortality in women at risk of cervical cancer.	Increase cervical cancer screening coverage in women aged 30 years and over to be at least 8%	7. Cervical cancer screening coverage	5.5%	6.3%	5.1%	6.3%	8.0%	8.5%	9%	10%
Strategic goal: Decrease morbidity and mortality during pregnancy, birth and post delivery										
Reduce morbidity and mortality in women as a result of abortions	Improve access to TOP services by increasing TOP facilities to 100% of all acute hospitals and 8.5% of CHC	8. Percentage of hospitals offering TOP services	92%	85%	78%	75%	77%	80%	83%	100%
		9. Percentage of CHC's offering TOP services	80.0%	5.0%	5.7%	5.7%	5.7%	6.8%	7.0%	80%
Increase the number of BFHI facilities	Increase facilities certified as Baby friendly to at least 35%	10. Percentage of facilities certified as baby friendly	14.8% (11/74)	18.9% (14/74)	21.6% (16/74)	25.6% (19/74)	29.7% (22/74)	33.7% (25/74)	37.8% (28/74)	30%
Increase access to safe delivery services	Improve facility delivery rate to 95%	11. Total deliveries in facilities	90 393	95 289	97 404	91 359	92 000	92 500	93 000	
		12. Facility Delivery rate	New Indicator	New Indicator	Data unavailable	96.9%	97%	97%	97%	
	Decrease teenage pregnancy to <10% of all deliveries	13. Institutional delivery rate for women under 18 years	10.1%	10.1%	7.5%	7.9%	7.5%	7.5%	7.5%	13%

Notes:

Indicator 8: Prior to 2007/08 the denominator was the hospitals designated to provide TOP services not all acute hospitals and specialised hospitals.

6.5 EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 2.31: Trends in provincial public health expenditure for INP [MCWH4]

Expenditure	2005/06 (actual)	2006/07 (actual)	2007/08 (actual)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)	2011/12 (MTEF projection)
Current prices							
Total	13 700 000	15 136 000	16 810 000	17 868 000	18 452 000	20 339 000	21 910 000
Total per person	2.90	2.87	3.17	3.36	3.45	3.79	4.07
Total per uninsured person	3.89	3.85	4.26	4.51	4.64	5.10	5.47
Constant 2007/08 prices							
Total	14 675 405	15 668 541	16 810 000	16 671 763	16 352 375	17 384 658	18 198 770
Total per person	3.11	2.97	3.17	3.13	3.06	3.24	3.38
Total per uninsured person	4.17	3.99	4.26	4.21	4.11	4.36	4.54

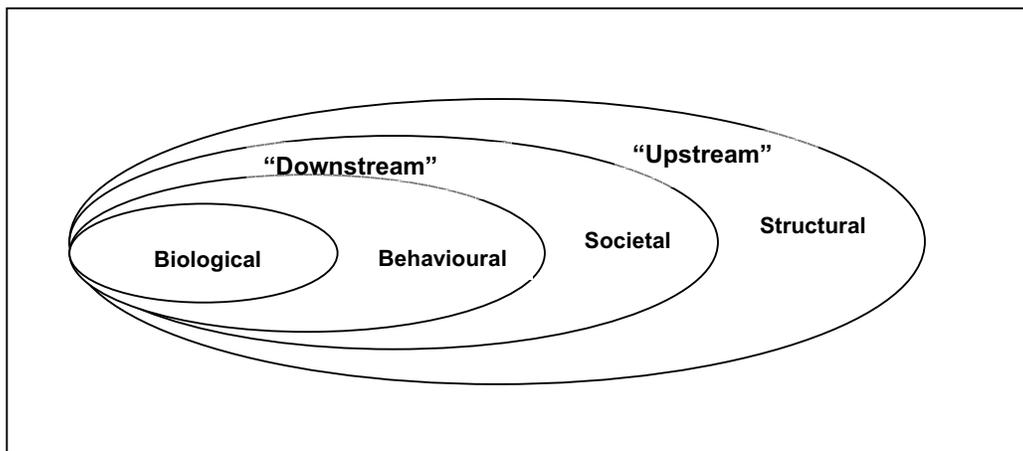
7. DISEASE PREVENTION AND CONTROL

7.1 SITUATION ANALYSIS

7.1.1 Burden of Disease

The major determinants of health are often beyond the reach of the health sector and include a range of socio-structural ('upstream') factors such as income inequality, poverty, access to basic services and social behavioural norms. This is shown in figure 2.8 below as societal and structural factors. The Provincial Government of the Western Cape (PGWC) mandated the Western Cape Department of Health to lead an initiative to define the components of the Burden of Disease (BoD) in the Province and to provide evidence-based recommendations as to how these can be reduced. In particular the aim is to focus on inter-sectoral collaboration that addresses the critical determinants, especially the upstream determinants, of this burden in order to build and sustain health security.

Figure 2.1: Determinants of disease



The Burden of Disease reduction project resulted in collaboration between a wide range of stakeholders. The five prevention workgroups provided comprehensive reviews of the evidence and identified several factors which could reduce the burden of disease dramatically:

- 1) **Reduction of alcohol and drug abuse** (by addressing both demand and supply factors)
- 2) **Improving early childhood development outcomes** (by addressing nutrition, parenting skills, access to pre-school and maternal mental health)
- 3) **Adolescent Development programmes** (including recreational and physical activities, mentoring, health lifestyle development and life skills training)
- 4) **Creating healthy social norms related to health** (including reducing gender imbalances, improving adherence to chronic medication, promoting safe sex, promoting breastfeeding and challenging the norms related to alcohol use)
- 5) **Reducing multiple deprivation** (ensuring access to quality housing, water and sanitation; improving road and personal safety and increasing access to social grants)

- 6) **Health system interventions** (health service interventions ranging from health promotion to secondary prevention were highlighted by all five groups, in particular for Mental Health, HIV and TB and Child Health).

In the case of mental health and major infectious diseases, health sector level interventions could have potentially substantial impact at population level. The reason for this is that more downstream health sector interventions targeting individuals can have important secondary or recursive prevention effects in reducing the burden of disease at the population level by interrupting the transmission of infectious agents or the propagation of psychological trauma within family units.

7.1.2 Environmental and Port Health

Maintaining environmental health is vital in disease prevention, as demonstrated by the annual diarrhoeal disease outbreaks in densely populated informal settlements in the Cape Metro. The monitoring of the provision of clean water and basic hygiene and sanitation services is therefore an essential task for the Provincial Health Department.

Port Health Services at the three major harbours in the Western Cape i.e. Cape Town, Saldanha and Mossel Bay and at the Cape Town International Airport has reverted to the Provincial Department of Health in terms of the National Health Act, 2003 (Act 61 of 2003). The number of ships assessed on average for a clearance certificate monthly has risen from 65 to 90.

In terms of the National Health Act, the co-ordination of environmental health services is a provincial function. In planning for the 2010 World Cup the province is compiling an Environmental Health and a Port Health Plan. This process is ongoing and updated on a regular basis

The National Department has developed indicators for Municipal Health Services to be implemented on DHIS in 2008.

7.1.3 Alcohol Harm

As discussed in Part A of this document, the role of the Department of Health is not only to address disease by providing health services, but also to improving health status. However, the major determinants of health are often beyond the reach of the health sector and include a range of socio-structural ('upstream') factors such as income inequality, poverty, access to basic services and social behavioural norms.

In a recent publication from the Medical Research Council², alcohol harm ranks third as a risk factor contributing to the national burden of disease, after unsafe sex and interpersonal violence. In the National Injury Mortality Surveillance System (NIMSS) of the four major towns in South Africa, Cape Town recorded the highest percentage of alcohol positive deaths. Approximately half all homicides and road traffic deaths in 2004 tested positive for blood alcohol concentration³.

Furthermore the Western Cape has a particular problem of Foetal Alcohol Syndrome (FAS), which is a preventable cause mental retardation. South Africa has reported some of the highest prevalence rates of FAS in the world ranging between 46 and 103 per 1000⁴. According to the prevalence study

² R Norman, D Bradshaw, M Schneider, J Joubert, P Groenewald, S Lewin, K Steyn, T Vos, R Laubscher, N Nannan, B Nojilana, D Pieterse and South African Comparative Risk Assessment Collaboration Grou. *A comparative risk assessment for South Africa in 2000: Towards promoting health and preventing disease* SAMJ 2007;97(8):637-641.

³ Matzopoulos, R 2005, 'Editorial. Alcohol and injuries – a clear link', Southern African Journal of Epidemiology and Infection, vol. 20, pp. 114-115

⁴ Fact Sheet from foundation of Alcohol Related Research (FARR) found at http://www.farr.org.za/PDF/Fact_file.pdf

done in 2001 in Wellington the Western Cape, 88 per 1000 Grade 1 pupils in this town had FAS⁵, while the rate of FAS in America children is 0.05 to 2.0 per 1000 births⁶.

More broadly, alcohol misuse undermines families and the wider social fabric through its effects on interpersonal relationships, child abuse, teenage pregnancy, school drop-outs, crime and violence. It exacerbates and in some instances causes poverty and exacts an enormous cost to the economy through lost productivity. As such the Department is focusing on alcohol as an upstream risk factor to be addressed.

7.1.4 Oral Health

The prevalence of dental caries (decayed teeth) in early childhood, referred to as early childhood caries (ECC) varies between 1% to 12% in developed countries while in developing countries, it is as high as 70%. The South African National Children's Oral Health Survey of 2003 revealed that early childhood caries in the Western Cape is very high. The primary dentition (milk teeth) is more severely affected with 6 decayed teeth per 6-year-old child. In this age group, 82% had ECC in the Western Cape compared to the 60% average National weighted mean. The 'decayed, missing and filled teeth' (DMFT) percentage for 5 and 6 year olds in the Western Cape is almost double that of the National mean. Older children are also at risk, with caries in the permanent dentition of 12 and 15 year olds in the Western Cape at 62% and 81% respectively, compared to 37% and 51% for the National weighted mean. The DMFT in the Western Cape for 12 and 15 year olds is double that for the National weighted means.

Other oral health problems encountered in the Western Cape are periodontal disease, malocclusion (30 - 40% of 12 year olds need orthodontic treatment) and edentulousness (37% of the adult population is edentulous).

The Department has developed an Oral Health Plan in line with Healthcare 2010 which includes the Oral Health Centre at the University of the Western Cape. Services are rendered in 111 PHC facilities. In addition, services are provided at certain prisons and within specialised institutions.

Oral health services provided are both facility-based (clinical services) and community-based. Community-based services focus on oral health promotion and prevention. The primary focus is primary school children but also includes mothers and babies at ante-and post-natal health facilities.

The preventive programmes at primary schools include oral health education and teaching children the correct tooth brushing technique in order to improve their oral health status. Oral hygienists play a vital role in oral health promotion and prevention. This is mostly a community-based service whereby the oral hygienists visit pre-schools and primary schools in the area where they are based. In 2007, 28 oral hygienists visited a total of 520 pre-schools and 1 331 primary schools. A total of 94 495 learners were reached for oral health education and a total of 33 409 were placed on a brushing programme. The community-based service is mainly available in the Metro as this is the only district that still has the means to transport children from schools for the fissure sealant programme. Transport issues affect those in rural areas particularly, as parents struggle to bring their children for this preventative procedure.

⁵ Direct Communication with Leana Olivier National Manager for FARR

⁶ May PA, Gossage JP. Estimating the prevalence of fetal alcohol syndrome: a summary. *Alcohol Res Health*. 2001;25:159-167.

7.1.5 Prevention of Blindness

To be in line with the National Vision 2020 Plan, the Province has developed an Eye Care Plan that addresses the following areas:

- Ensuring that eye care screening is integrated as part of the PHC package and school health services.
- Training of Ophthalmic Nurses. This has however been a challenge as this qualification is not part of the occupation specific dispensation (OSD) and no nurses have shown interest in doing the training.
- Ensuring District Eye Care Services including a high volume cataract surgery site, refraction services, low vision and community based services. Besides the other tertiary hospitals that are also doing cataract surgery, Eerste River Hospital has been identified as the high volume cataract surgery site.

7.1.6 Social Transformation

In the State of the Province Address (SOPA) 2007, the Premier highlighted focus areas for the year 2007/2008 to give effect to the Provincial Growth and Development Strategy (PGDS). Twenty-one priority areas were identified where the Provincial Government of the Western Cape (PGWC) will focus its interventions (resources, collaboration with stakeholders and service delivery) on facilitating social regeneration initiatives. In the SOPA of 2008, 6 additional areas were added.

The 27 areas are:

- | | |
|------------------------|---------------------|
| 1) Manenberg | 2) Mitchells Plain |
| 3) Khayelitsha | 4) Hanover Park |
| 5) Nyanga | 6) Elsies River |
| 7) Bishop Lavis | 8) Delft |
| 9) Kleinvlei | 10) Gugulethu |
| 11) Philippi | 12) Muizenberg |
| 13) Vredenburg | 14) Paarl |
| 15) Oudtshoorn | 16) Matzikama |
| 17) Theewaterskloof | 18) Kannaland |
| 19) Cedarberg | 20) Central Karoo |
| 21) Witzenberg | 22) Mossel Bay |
| 23) Worcester | 24) Atlantis |
| 25) Bonteheuwel- Langa | 26) Greater Athlone |
| 27) George | |

Community mobilisation jamborees are run in all the priority areas by the various PGWC departments. Health's contribution is to run screening services for chronic diseases, awareness programmes and marketing of departmental community-based services. Furthermore various interactions with communities were done in an effort to assist them to establish coordinating structures.

7.1.7 Health Promotion

The priorities for health promotion are guided by the recommendations of the provincial Burden of Disease Study (2007) as well as the need for health promotion interventions indicated by the eight divisional goals.

Over the year the programme has provided integral support to the Child Health (diarrhoeal disease, immunization), Women's Health (cervical screening, early access to ante-natal services), Mental Health (substance abuse) and to Chronic Care (capacity-building for healthy lifestyle promotion through support groups)

The healthy lifestyles programme which is integrated as part of the chronic diseases support groups, addresses the key risk factors for chronic disease - nutrition, safe sexual behaviour, alcohol / tobacco / substance abuse, and physical activity. Among youth in particular these factors correlate and overlap with other risk behaviours currently identified as reaching critical proportions in the province, specifically substance abuse, crime and inter-personal violence. The healthy lifestyle components are included in all health promotion events and activities, most notably through collaboration with other departments through the Social Transformation Programme and inter-divisional departmental events coordination.

Health Promoting Schools remains a priority for comprehensive and inter-sectoral health promotion among children and school-going youth, addressing environmental concerns (hygiene & sanitation, school safety) together with risk behaviours. Health Promotion continues to provide a provincial resource centre for IEC materials and information.

Table 2.32: Situation analysis indicators for non-communicable disease control [PREV1]

Strategic Objectives	Measurable objectives	Performance measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Metro District 2007/08	Cape Wine-land District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2007/08	
Strategic goal: To ensure the delivery of a good quality Disease control programme in all the districts of the Western Cape													
Provide capacity to render disease control services	Ensure that all districts have at least one trauma centre for victims of violence	1. Number of trauma centres for victims of violence	41	41	41	13	6	4	7	4	7	1 per district	
	Ensure all districts have a health care waste management plan	2. Number of health districts with health care waste management plan implemented	6	6	5	1	1	1	1	1	1	All districts	
Provide programmes for the prevention of occupational diseases	Increase the % of hospitals providing occupational health programme to 100%	3. Percentage of hospitals providing occupational health programmes	35	77	84.4	100	75	100	100	100	100	100	
Ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools programme	4. Percentage of schools implementing Health Promoting Schools Programme (HPSP)	Not planned	11.8	20.4	33.1	0	0	15.7	0	0	50	
Preparations for the dealing with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan	5. Integrated epidemic preparedness and response plans implemented	Y	Y	Y	Y	Y	Y	Y	Y	Y	Yes	
	Ensure adequate outbreak response in line to Provincial Guidelines	6. Outbreak responded to within 24 hours (Days)	New indicator	New indicator								1 day	
		7. Malaria fatality rate	Not available	No malaria	0	0	0	0	0	0	0	0	0.25
		8. Cholera fatality rate	Not available	No cholera	0	0	0	0	0	0	0	0	0.5
To improve the vision of people with cataracts	Increase the cataract surgery rate to be in line with the national target of 2,000/1million by 2010	9. Cataract surgery rate (Number/ million population)	1 276	1 287	1 033				N/A	N/A		1 000	
		9.1 Number of cataract operations.	5 928	6 030	5 718	4 557	563	80	487	31	0		

7.2 PRIORITIES AND BROAD STRATEGIC OBJECTIVES

7.2.1 Burden of Disease

In line with the burden of disease findings, the following projects were planned for 2008 and will run into 2009/10:

- Roll-out of mortality surveillance across all districts in the Western Cape.
- Collaboration with the Department of Social Development and Department of Community Safety around the reduction of substance abuse: A documentary film challenging underlying norms and beliefs around alcohol is envisaged, broadcast locally (on Cape Town Community Television) and may be used to build a substance abuse programme for scholars, drunk drivers and other substance users.
- Collaboration with the Department of Community Safety to address motor vehicle accident injury prevention. Once again the intention is to focus strategies in high prevalence areas.
- In collaboration with the Department of Local Government and Housing and the City of Cape Town, where Burden of Disease data on tuberculosis and diarrhoea will be used to provide additional information to improve prioritisation of the allocation of housing in the metropolitan areas of Cape Town. The feasibility of this is being piloted.
- The Western Cape Department of Health has undertaken to initiate a perinatal mental service in the metropolitan areas of Cape Town located in each Maternal Obstetric Unit. The department will train health care providers in primary health care, general medical and trauma settings on how to screen for substance abuse and how to conduct a brief intervention for those abusing substances.

7.2.2 Environmental Health

The strategic goal for Environmental Health is to improve the co-ordination and monitoring of Municipal Health Services (MHS). The objectives for 2009/2010 will be:

- Refine the monitoring and evaluation for municipal health services. The National indicators were finalized, integrated onto Sinjani and implemented as from 1st January 2008.
- Continue with the monitoring of the MHS of local authorities in the Province.
- Ensure that the necessary facilities at all 2010 FIFA World Cup events, Fan Park venues and tourist facilities comply with relevant legislation and standards.

Render all Port Health services as determined by the International Health Regulations Act and expand the service in order to align it with 2010 requirements.

7.2.3 Alcohol Harm

Interventions to address alcohol misuse need to address both the supply and demand issues. An example of an upstream intervention is that of legislation. The tobacco legislation in South Africa has shown successes in decreasing the prevalence of tobacco use in South Africa. The Department has been very active in the development of the Western Cape Liquor Bill driven by the Department of Finance, Economic Development and Tourism in the Economic cluster. This Bill seeks to decrease access to alcohol by regulating “where and when” alcohol can be sold and in particular bringing into the regulated framework the high number of illegal shebeens in communities.

Due to the inputs provided by the Burden of Disease project representing the Social Cluster interests, the Social cluster will be part of the Liquor Board and the Board will have a legislated Monitoring, Evaluation and Research sub committee which will drive evidence based planning monitoring and evaluation of alcohol harms. In 2009/10 pending the enactment of the Bill into law, the department will be actively participating in the setting up this sub committee. The collaboration will be premised on the existing Burden of Disease surveillance system which has been focusing on mortality surveillance and will be expanding to include morbidity surveillance of injuries in particular. The Bill also provides increased powers to the South African Police Service for enforcement.

This intervention will help to address the supply side of the equation of alcohol misuse. On the demand side, the Department in collaboration the Department of Social Development and Community Safety is developing a documentary with the aim of challenging and undermining pervasive norms, attitudes and beliefs about alcohol use and in so doing decrease the use and misuse of alcohol in the Western Cape. The target audience will be people living in the Western Cape aged 15-35 years because alcohol misuse is common in this group and they are typically the target market of alcohol advertisers. Furthermore this group is of reproductive age, thus interventions targeting this age group are most likely to influence the next generation's attitudes to alcohol use.

The intended distribution of the film would be through the National Broadcaster. The Provincial Government of the Western Cape could also show this film in relevant settings (schools, health clinics, places of work, prisons, to traffic offenders as mandatory education punishments etc.).

7.2.4 **Oral Health**

The key primary prevention strategies in dentistry are usually considered to be oral health promotion and education, community water fluoridation and pit and fissure sealants. These have been proven to be the most cost-effective strategies.

Fluoridation of the community drinking water supply is probably the best single measure and most cost effective means of caries prevention. However, due to problems in implementation of this strategy, alternate methods of fluoridating the oral environment have been considered. School based brushing programmes with fluoridated toothpaste will be implemented. This programme will also inculcate the habit of brushing the teeth at an early age, establishing a sound oral hygiene practice from childhood age. Grade R, 1 and 2 learners would be targeted.

An aggressive and appropriate programme to create knowledge and awareness, which empower people in terms of self-care, need to be implemented. This would be achieved simultaneously with the implementation of brushing programmes at schools. This strategy will also be integrated with the mother and child health programmes as a means to address early childhood caries (ECC). This would include education at neonatal and postnatal clinics involving the mothers. Infant feeding involving the practice of sugary fluids in baby bottles will be addressed.

7.2.5 **Prevention of blindness**

The key strategic objectives for 2009/10 are:

- Eerste River Hospital will continue as a high volume cataract surgery centre in the province. In implementing the CSP, clients who are not appropriately placed on the cataract surgery waiting

list of tertiary hospitals will be identified and transferred for their surgery at Eerste River Hospital.

- Training of staff on visual acuity in order to be able to pick up cases to be referred.
- To establish refraction services in the Province, especially in the Metropole.

Two refraction sites have been established in the Metropole. Bonang, the social service arm of the South African Optometric Association, will service the Northern Metropole and Cape Peninsula University of Technology School of Optical Dispensing will service the Southern Metropole on a preferred service bid provider contract.

- To expand the training and establishment of a community based eye screening service.

7.2.6 Social Transformation

The Department of Health has been allocated the responsibility of coordinating the social transformation interventions of George, Kleinvlei, Delft and Hanover Park communities.

Three strategies are utilised to address the needs of these communities:

- 1) Community mobilisation
- 2) Mobilisation of inter-departmental and inter-governmental teams within these communities
- 3) Service delivery jamborees.

The process of community mobilisation will be linked to the interventions that are in line with the Divisional priorities. The implementation of these strategies is done through consultative processes within these communities which include community empowerment and training.

7.2.7 Health Promotion

The direction for Health Promotion in the Province is informed by the findings of the Burden of Disease study, with particular attention to the relatively high chronic disease burden in the province as well as to the exceptionally high levels of intentional and unintentional injury. It is further informed by the eight divisional goals emphasising children and women.

The strategic plan for Health Promotion aligns its response to the current strategic framework of the National Department of Health, in particular:

- 1) The promotion of healthy lifestyles
- 2) Improved quality of care through community participation
- 3) Strengthening of primary health care services through collaboration with the programmes responsible for mental health, child health, women's health, nutrition and chronic disease management as well as the Social Capital / Social Transformation programmes.

The Department is embarking on a consultative process with the view to determine needs, human resources and infrastructure requirements in line with the national mid level workers framework. The implementation of this will be supported over the MTEF by the development of the norms, standards, reviewing the EPWP Health promotion related unit standards and facilitation of training to meet requirements.

The campaign to promote healthy lifestyles addresses the key behavioural factors for protection of long-term health in the population, in particular: sexual decision-making; the abuse of tobacco, alcohol and drugs; nutrition; regular physical activity. Recognising the underlying social and environmental determinants of risk-taking behaviour, and the impact of poor mental health on the capacity of individuals to make healthy choices, the campaign collaborates with the provincial Social Capital and Social Transformation Programmes for the integration of health knowledge and action across sectors, as well as strengthening the capacity of the health sector to promote healthy living through facility- and community-based services.

The expected adoption of the amended Tobacco Legislation in 2008 will provide the platform for intensified dissemination, monitoring of compliance and public complaints. A Provincial Tobacco Control Team has been established for the purpose of monitoring, education and research. A compliance survey is proposed to evaluate progress in all provincial government departments.

The emphasis of programme support for the provincial diarrhoeal disease seasonal focus has been on the promotion of the use of the Salt Sugar Solution. This will be sustained and improved through a consolidation of work with households and crèches. It is intended that substantially increased attention will be given to hand-washing and hygiene through a high-profile campaign to extend this promotion across population groups and settings.

Health Events: The programme is broadly responsible for the organisation of many health programme related events on the departmental calendar. The establishment of the Departmental Events Oversight Committee and operational framework will improve coordination of these events with other departmental and provincial role-players. The integration of events with the Jamboree process provides a further opportunity for economical use of resources, improved inter-departmental functioning and engagement with client communities.

7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Table 2.33: Analysis of constraints and measures to overcome them

	CONSTRAINTS	MEASURES TO OVERCOME THEM
HEALTH PROMOTION	<ul style="list-style-type: none"> Inadequate staffing 	<ul style="list-style-type: none"> Implementation of the Comprehensive Service Plan
ENVIRONMENTAL HEALTH	<ul style="list-style-type: none"> Grey areas in National Health Act, 2003 No line function over Las who render municipal health services. Minimum guidance from National Department regarding Municipal Services excluding food control. 	<ul style="list-style-type: none"> Clarity to be sought from National Department Constant liaison with EH and Municipal managers Attend National Meetings
MENTAL HEALTH (SUBSTANCE ABUSE)	<ul style="list-style-type: none"> Linkages between Health, Social Development and the other Departments 	<ul style="list-style-type: none"> An active substance abuse forum with clear roles

7.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 2.34: Provincial objectives and performance indicators for non-communicable disease control [PREV 2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Strategic Goal:	Ensure adequate disease prevention and control								
The implementation of the National Health Act provisions dealing with Environmental health	Monitor municipal environmental health services	1. Percentage of bacteriological water samples taken from water services authorities conforming to standards	N/A	N/A	New indicator	92%	92.5%	93%	94%
		2. Percentage of chemical water samples taken from water services authorities conforming to standards	N/A	N/A	New indicator	96%	96%	96.5%	97%
		3. Percentage of households with access to potable water within 200m	N/A	N/A	New indicator	96%	96%	96.5%	97%
		4. Percentage of sewage effluent samples complying to requirements	55%	60%	69%	70%	71%	72%	72%

Table 2.35: Performance indicators for disease prevention and control [PREV 3]

Strategic goal: To ensure the delivery of a good quality Disease control programme in all the districts of the Western Cape										
Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Provide capacity to render disease control services	Ensure that all districts have at least one trauma centre for victims of violence	1. Number of trauma centres for victims of violence	41	41	41	41	42	42	42	1 per district
	Ensure all districts have a health care waste management plan	2. Number of health districts with health care waste management plan implemented	6	6	5	6	6	6	6	All districts
Provide programmes for the prevention of occupational diseases (see above note)	Increase the % of hospitals providing occupational health programme to 100%	3. Percentage of hospitals providing occupational health programmes	35%	77%	84%	90%	90%	90%	95%	100%
Ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools programme	4. Percentage of schools implementing Health Promoting Schools Programme (HPSP)	Not planned	11.8%	20.4%	7%	20%	25%	30%	30%
Preparations for the dealing with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan	5. Integrated epidemic preparedness and response plans implemented	Y	Y	Y	Y	Y	Y	Y	Yes
	Ensure adequate outbreak response in line to Provincial Guidelines	6. Outbreaks responded to within 24 hours.	New indicator	New indicator	0	95%	95%	95%	95%	
		7. Malaria fatality rate	Not available	No malaria	0	0	0	0	0	0
		8. Cholera fatality rate	Not available	No cholera	0	0	0	0	0	0
To improve the vision of people with cataracts	Increase the cataract surgery rate to be in line with the national target of 1400/1million	9. Cataract surgery rate (Number/ million population)	1 276	1 287	1 033	1 600	1 800	2 000	2 200	1 000
		9.1 Number of cataract operations.	5 928	6 030	5 718	5 790	7 400	7 700	8 000	

7.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

A priority allocation of R8.981 million for M(X)DR TB has been allocated in 2009/10.

A priority allocation of R35.926 million has been allocated to reducing infant and child mortality.

Programme 2 is allocated 35.42 per cent of the total vote in 2009/10 in comparison to the 35.78 per cent that was allocated in the revised estimate for 2008/09. This translates into a nominal increase of R347.822 million or 11.98 per cent. Forensic Pathology Services have been reallocated from Sub-programme 2.8 to Sub-programme 7.3. and Victoria Hospital has shifted from Sub-programme 4.1 to Sub-programme 2.9.

Table 2.36: Trends in public health expenditure in District Health Services: Total Programme 2 [DHS9]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate)	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	1 629 951 000	1 922 792 000	2 707 578 000	3 128 808 000	3 503 630 000	3 898 758 000	4 185 738 000
Total Capital	40 765 000	89 898 000	83 681 000	170 731 000	341 169 000	458 105 000	616 184 000
Grand Total	1 670 716 000	2 012 690 000	2 791 259 000	3 299 539 000	3 844 799 000	4 356 863 000	4 801 922 000
Total per person	354.14	381.29	526.65	620.05	719.62	812.20	891.61
Total per uninsured person	474.25	512.45	707.81	833.33	967.15	1091.59	1198.31
Constant 2007/08 prices							
Total excluding capital	1 745 999 291	1 990 443 009	2 707 578 000	2 919 338 825	3 104 957 242	3 332 443 894	3 476 735 955
Total Capital	43 667 362	93 060 948	83 681 000	159 300 806	302 347 896	391 562 957	511 811 553
Grand Total	1 789 666 654	2 083 503 956	2 791 259 000	3 078 639 631	3 407 305 138	3 724 006 851	3 988 547 508
Total per person	379.35	394.71	526.65	578.54	637.73	694.23	740.59
Total per uninsured person	508.02	530.48	707.81	777.54	857.10	933.03	995.33

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

1. AIM

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

The Clinical Governance and Co-ordination of Emergency Medicine within the Provincial Health Department.

The co-ordination for the Department of Health of preparation for the FIFA 2010 World Cup Soccer Tournament.

2. PROGRAMME STRUCTURE

2.1 SUB-PROGRAMME 3.1: EMERGENCY TRANSPORT

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

Emergency Medicine and the FIFA 2010 World Cup are reflected as two separate objectives within Sub-programme 3.1: Emergency Medical Services

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

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

3. SUB PROGRAMME 3.1: EMERGENCY TRANSPORT

3.1 SITUATIONAL ANALYSIS

3.1.1 Introduction

The Western Cape EMS have an established foundation for Emergency Medical Services having taken a systems approach to developing an emergency medical system rather than just an ambulance service.

The burden of disease study has established that trauma and violence in the Western Cape carry the greatest risk for death and that prevention strategies for trauma and violence transversally across all departments should be a priority in order to address the upstream factors that result in the high rate of injury and death. Trauma and violence are the biggest burden of disease in the Western Cape, accounting for 21% of deaths and up to 40% of hospital admissions with an estimated R5 billion cost to society.

The Western Cape Department of Health treats almost two million emergency patients per year and 400 000 of these are transported by ambulance, i.e. approximately 20% of the patients are transferred using 4% of the budget. The demand for the service is growing at 10% per annum as evidenced by the incidents recorded on the Computer Aided Dispatch System.

3.1.2 Services

Emergency Medical Services has an established Communications System with six call taking and dispatch centers managed collaboratively with the Local Authority District Government and Provincial Local Government Disaster Management. The centers have established computer aided dispatch systems, vehicle tracking and radio communications networks which provide a platform for operational management of resources and management information.

Emergency Medical Services is represented in 50 towns in the Western Cape and achieves response time performance of 60% priority 1 urban responses within 15 minutes in towns where there are stations and 75% priority 1 responses within 40 minutes in rural (farms) areas or towns where there are no stations.

In the Cape Town Metro, EMS experiences a 30% inefficiency rate where no patient is found at the scene. This is the result of poor response times which are caused by a combination of insufficient operational and staffed ambulances; and appropriate co-ordination and control of these resources.

Medical Rescue is provided in twenty-eight centers and there are forty hydraulic rescue tools (jaws of life) distributed throughout the Province and on all the national roads (N1, N2, N7). Currently medical rescue is provided as an over and above function by ambulance staff.

The aero-medical service is contracted to the Red Cross Air Mercy Service who through two helicopters and a fixed wing aircraft transfers most long distance transfer patients from rural locations into metropolitan hospitals thereby retaining ambulances in rural towns to service local emergency calls. The service transfers 1 200 patients per year and provides an essential medical rescue platform rescuing patients from the sea and wilderness areas in the Western Cape.

Emergency Medical Services has an Emergency Medicine Division which provides both undergraduate and postgraduate training in emergency medicine in collaboration with the University of Stellenbosch and the University of Cape Town and provides a coordinating and clinical governance service to the acute services emergency centre environment. The service has taken responsibility for ambulance and rescue training and development. Emergency Medical Services has recruited emergency medicine consultants and in cooperation with District Health Services and hospital services is exploring models for delivering emergency care in rural and metropolitan districts with the emergency medicine specialist as the lead.

3.1.3 **Infrastructure**

Emergency Medical Services is delivered from fifty locations (stations) each with a physical facility and 30% of the facilities are purpose built and appropriate to the function. Progress is being made in building new stations. The expansion of the function has exceeded the space available for training and administration within the organization.

New stations have recently been constructed in Hermanus, Caledon, Atlantis and Riversdal.

3.1.4 **Finance**

Emergency Medical Services has benefited from a consistently progressive funding model towards achieving the Comprehensive Service Plan. The major contributor to projected cost is personnel and the capacity to train and recruit personnel is a limiting factor.

National business plans indicate that the Western Cape EMS budget should be R432 million before inflation in 2009/10 in order to begin a steady incremental progression towards achieving the required personnel establishment to approach response time targets.

3.1.5 **Human resource management**

Emergency Medical Services currently has a 34% vacancy rate against the Organizational Study 43/2006 performed in line with the Western Cape Comprehensive Service Plan.

The Western Cape has responded by recruiting student Emergency Care Practitioners to be trained and deployed because there are insufficient trained personnel to recruit. A training solution is being explored to produce the number of quality emergency service providers required.

Emergency communications presents a further human resource challenge. The communication centre represents the most critical link in effective service delivery. This applies not only to EMS but to all aspects of health services as it often represents the first point of entry accessed by patients. The post structures, job classification and organizational structure for communications center personnel are currently unresolved and are being addressed with urgency.

Table 3.1: Situation analysis indicators for EMS and Patient Transport [EMS1]

Strategic Objectives	Measurable objectives	Performance Measure / Indicator	Province wide value 2005/06	Province wide value 2006/07	Province wide value 2007/08	Metro District 2007/08	Cape Winelands District 2007/08	Overberg District 2007/08	Eden District 2007/08	Central Karoo District 2007/08	West Coast District 2007/08	National target 2007/08	
Strategic goal:		To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape											
Ensure the provision of sufficient resources for the rendering of an effective and efficient emergency and patient transport service	Provide target number of ambulances and patient transporters by 2010	1. Total number of rostered ambulances	197	205	222	89	41	24	28	14	26		
		2. Rostered ambulances per 1 000 people	0.041	0.039	0.041	0.025	0.055	0.103	0.052	0.208	0.081	0.3	
		3. Percentage of hospitals with patient transporters	5.00	0	0	0	0	0	0	0	0	0	100%
		4. Average kilometers travelled per ambulance (per annum)	58 231	71 433	60 597	39 971	66 637	67 701	94 647	59 242	79 178		
		5. Total kilometers travelled by all ambulances	11 471 507	13 439 511	13 452 597	3 557 451	2 732 114	1 624 834	2 650 188	829 386	2 058 624		
	Provide target number of appropriately trained operational emergency staff	6. Percentage of locally based staff with training in BAA	48%	46%	47%	46%	44%	36%	56%	50%	50%	100%	
		7. Percentage of locally based staff with training in AEA	38%	45%	44%	44%	47%	60%	37%	37%	42%		
		8. Percentage of locally based staff with training in ALS (Paramedics)	8%	9%	9%	10%	9%	5%	7%	7%	8%		
	Achieve normative response times in metro and urban areas	9. Percentage of P1 calls with a response time of < 15 minutes in an urban area	30.0%	37.6%	48%	37%	62%	91%	71%	68%	83%	100%	
		10. Percentage of P1 calls with a response time of < 40 minutes in a rural area	70.0%	64.4%	70%	Not Recorded	58.2%	82.3%	70%	49%	73.4%	100%	
		11. Percentage of all calls with a response time within 60 minutes	Not Available	61 721	75% (241 952/ 321 000)	Available for 40 min target only	100%						
	Adherence to the prescribed staffing of ambulances	12. Percentage of operational rostered ambulances with single person crews.	0%	0%	0%	0%	0%	0%	0%	0%	0%		
	Ensure the effective and efficient utilisation of resources	13. Percentage of ambulance trips used for inter-hospital transfers	20.0%	15.0%	21%	43.6%	8.6%	5%	5.5%	3.6%	8.1%	30%	
		14. Percentage of green code patients transported by ambulance	29.0%	34.8%	34.8%	12.6%	34.2%	44.2%	44.3%	39.2	39.4%		
		15. Cost per patient transported by ambulance	715	709	829	See note below							
		16. Percentage of ambulances with less than 200 000 kilometers on the odometer.	-	49%	67%	60%	41%	83%	75%	86%	73%	100%	
		17. Number of EMS emergency cases- Total (Patients)	374 485	392 395	387 438	159 305	73 867	31 253	62 641	21 899	38 473		
	18. EMS referral cases	Definition to be clarified											

Notes:

Indicator 11: If total calls denominator used = 64% (251 952/ 393 731)

Indicators 9 and 10: These figures are target achieved for March 2008.

Indicator 15: No formula exists for the calculation of per patient costs at a District Level.

3.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The Comprehensive Service Plan for EMS outlines and models the essential components of EMS including;

- Emergency Ambulance Services
- Medical Rescue Services
- Communications Services
- Patient Transport Services
- Aeromedical Services
- Emergency Medicine Structure
- Management and Administration

The current focus and priority will be training, communication systems and motivating for increasing the personnel complement.

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

3.3.1 Finance

Emergency Medical Services has a solid foundation and structure.

The projected budget necessary for EMS in 2009/10 based on the National Business plans is R432 million before inflation. The budget available to EMS for 2009/10 is earmarked from National Health to the function.

Expected funding made available through the FIFA 2010 Soccer World Cup process will address additional vehicle procurement, equipment and the operationalization of the event.

3.3.2 Human Resources

Emergency Medical Services has a 34% vacancy rate against the CSP aligned establishment and limited human resources are the principal constraint to performance. The skills mix of EMS personnel with 46% having training in basic life support (BLS), 43% in intermediate life support (ILS) and 11% in advanced life support (ALS) does not approach the national targets, with training capacity the limiting factor.

Management development is a challenge.

These human resource challenges are also experienced in the communication centres where current staffing and supervisory models need to be reviewed. The absence of a formal qualification in emergency medical dispatch is a factor that inhibits the development of communications centre personnel and retards the efficiency of the communications system.

The calculated personnel gap in EMS is 595 personnel (2008) based on an activity and population based model to meet response time targets (CSP). The model assumes 100% efficiency, which places a very significant management challenge to the EMS.

Table 3.2: Distribution of the operational staff during 2008/09 and the projected model staff numbers required to meet performance targets.

DISTRICT	NUMBER OF PERSONNEL IN 2006	NUMBER OF PERSONNEL IN 2008	MODEL 2010
Centria Karoo	48	43	80
Eden	139	134	209
WestCoast	126	113	154
Cape Winelands	142	166	225
Overberg	115	110	121
Total rural areas	570	566	789
Metro	369	766	669
TOTAL PERSONNEL	939	1 332	1 458

Note:

The model excludes the 232 rescue personnel required.
This table excludes supervisors or managers.

International recruitment of Western Cape EMS staff is a challenge to achieving targets and more recently Fire Services have started recruiting paramedics at higher local authority salaries further draining skills out of EMS.

Emergency Medical Services will replace staff lost to normal attrition and appoint further personnel with funding made available through the FIFA Office in which case current students will be employed as basic life support staff in the metropolitan area and a new batch of students recruited.

Emergency Medical Services employs drivers as opposed to basic life support (BLS) personnel to staff HealthNET although HealthNET is used as an entry portal for emergency ambulance services and many recruited drivers do in fact possess BLS qualification.

3.3.3 Support and Information Systems

The EMS mobile Data Terminal Project (MDT or on board computer) is still in a pilot phase with development examining the front end ambulance dispatch and navigation, the electronic patient record, the stability of hardware, vehicle tracking, the connectivity between ambulance MDTs and communications centres and hospitals. If the pilot proves successful then the plan is to lease MDTs within the scope of the operational budget with gradual progression to supply the entire ambulance fleet.

The 'Fika Msinya' (Arrive Quickly) project has demonstrated that efficient coordinated dispatch and control is a key to achieving response times. To achieve the required efficiency greater investment in human resources is required within the communication centres and this will be a key priority in all operational plans.

The data input of the GIS coordinates of emergency calls through the 112 Emergency Number System will provide essential data in the future on which to built response. The 112 Centres should become operational during 2009.

The trunking radio network will be extended into the Cape Winelands District and the new metropolitan paging system will be implemented.

HealthNET will use the existing CAD GEMC system to coordinate the management of vehicles.

3.3.4 **Services**

Response time performance in the Western Cape is showing incremental improvement with time, however, the metropolitan area lags behind the rest because of a higher vacancy rate and the challenge of coordinating larger resource numbers.

Mission time, i.e. the time to complete one entire ambulance mission from the time the emergency call is received to the time the ambulance is available after completing at the hospital, is used as a staff performance measure because the more EMS can reduce the mission time the more ambulances will be available to service calls.

The Flying Squad Ambulance service in the metropolitan area has been reconfigured at an intermediate life support level because mothers require low levels of care but rapid transit to obstetric centers.

In the rural areas the normal ambulance service responds to mothers in labor.

The Flying Squad in the metropolitan area, Red Cross AMS and Ambulance Service all perform acute incubator transfers between midwife obstetric units, hospitals and referral centres.

Emergency Medical Services will implement an incubator transfer module in each of the nine districts which has neonatal transfer equipment appropriate to the task i.e. incubator, vital signs monitor, temperature monitor, ventilator and consumables.

3.3.5 **Infrastructure**

New EMS stations are planned to replace the existing stations at Bonnievale, De Doorns, Vredendal, Leeu Gamka and Ceres. The Worcester station and communications centre should be completed in the 2009/10 financial year.

District hubs at ambulance stations in Beaufort West, Worcester, Caledon, Grabouw, Malmesbury, Riversdal and George will be modified to include transit facilities, i.e. waiting room and toilets, for outpatients and the design of all EMS stations will be adapted to accommodate HealthNET transit passengers.

Government Motor Transport continues to replace ambulances through their fleet management system and the EMS fleet has benefited from this system. Emergency Medical Services continues to get good support from GMT although accelerating costs are cause for closer analysis.

Fourteen new ambulances will be procured with the object to get to a fleet of 260 ambulances by utilizing FIFA funding.

3.3.6 **Corporate Governance**

In order to improve corporate governance the COMMUNICATIONS CENTER STRUCTURE will be subjected to an organizational development review with specific reference to the career structure, jobs and qualifications of communications personnel.

Emergency Medicine, the Training College and HealthNET will also be subject to organizational structure review.

4. EMERGENCY MEDICINE

4.1 SITUATIONAL ANALYSIS

The Comprehensive Service Plan did not specifically address the structure of emergency medicine and emergency centers, however, agreement has been reached that clinical governance and coordination will be driven transversally through hospitals and that hospitals will have single emergency centers instead of separate trauma and emergency units.

A geographic model will be applied to the clinical governance and structure of emergency medicine with the completion of the pilots and the roll out appointment of emergency medicine specialists in George, Worcester, Paarl, East Metropole and West Metropole. Emergency medicine specialists will also be appointed in secondary level hospitals in emergency centers.

4.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

4.2.1 Strategic Priorities

Emergency medicine will focus on facility based emergency medicine and the links between institutions and will expand its pilot District Health Service projects into all rural and metropolitan districts.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.3.1 Finance

Emergency medicine will continue to be funded through the EMS budget which will fund additional emergency medicine consultants, South African Triage Score (SATS) coordinator, quality care agents, researchers, bed bureau officers and the required information systems.

4.3.2 Human Resources

Emergency medicine will finalize an organizational structure appropriate to delivering clinical services, research, clinical teaching and training and quality management.

An emergency centre model including infrastructure and equipment will be presented to guide hospitals.

Strategic management of emergency medicine will be through a provincial Strategic Management Team (SMT) consisting of the Chief Director District Health Services, Chief Director Hospital Services, Director EMS and the Head of Emergency Medicine.

Each of the nine health substructures in the Province will develop an operational management team (OMT) in respect of emergency medicine.

Emergency medicine will facilitate the establishment emergency centers as single functional units (medicine and trauma under one line manager) within hospitals and propose organizational, governance and infrastructural models for implementation.

A provincial structure to deal with transversal clinical services, clinical training and teaching, research and quality management will be established.

4.3.3 **Services**

Operational management teams and emergency centre teams will use the Acute Emergency Case Load Management Policy (AECLMP) to drive the flow of emergency patients.

The AECLMP will be used as a strategic tool to drive the flow of emergency patients to appropriate levels of care and quality.

The AECLMP outlines steps necessary to ensuring the flow of emergency patients to appropriate levels of care. Essential to the AECLMP are the following;

- Standardization of the decision making process with respect to patient referral in EMS communication centers
- Standardization and improvement in the information system to monitor emergency center capacity and bed status
- Standardization of the communication from the EMS communication center with respect to hospital diversions
- Standardization of the management of increased patient numbers at receiving institutions
- Standardized management of emergency clients in emergency centers
- Standardized management of the throughput of emergency clients into wards and with respect to discharge
- Increased bed capacity across the platform to deal with seasonal disease burden increases
- Improved point of care service capacity in Mitchells Plain and Khayelitsha and direct referral to level 1 hospitals.

4.3.4 **Clinical Governance**

Emergency medicine will develop a provincial structure to deal with transversal clinical services, training and teaching, research and quality management all of which deal with clinical governance across the platform of pre-hospital emergency care and emergency center emergency medicine.

4.3.5 **Corporate Governance**

The following elements of Emergency Medicine will be addressed in order to improve corporate governance;

- The emergency medicine structure including the EMS training structure will be subjected to an Organizational Development exercise

- A South African Triage Score co-ordinator function will be created to drive SATS across the province
- The model for emergency center management and staffing will be developed and implemented.

5. FIFA 2010 HEALTH UNIT

5.1 SITUATIONAL ANALYSIS

The Health Planning for the FIFA World Cup has been completed.

5.1.1 Functions of the FIFA Health Unit

The Department of Health is tasked with a complex and wide scope with regards to its responsibilities. These responsibilities may be broken down broadly as follows:

- **Health Command and Control**
- **Health Services** which includes Hospital Preparedness, Forensic Pathology Services and Environmental (Port Health)
- **Emergency Medical Services** – inclusive of Aero-Medical, Disaster Medicine and Bio-Chemical Response capability
- **Establishment of a Medical Facility at the 2010 stadium** – inclusive of staffing and equipping this facility
- **Health Promotion**

The function of the FIFA Word Cup unit is to coordinate all health planning and preparation for the tournament.

5.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

The FIFA Unit is responsible for coordinating the following health related activities with respect to the tournament:

- Emergency Medical Services
- Forensic Pathology Services
- Medical Disaster and Mass Casualty
- Health Promotion
- Environmental and Port Health
- Aeromedical Services

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.3.1 Finance

The administrative costs of the FIFA office have been provided in the 2009/10 budget and the respective components are funding the necessary planning.

An additional amount of R44 million has been provided by Provincial Treasury to ensure funding towards operationalization of the event.

5.3.2 Human Resources

The core of the FIFA Unit has been appointed.

5.3.3 Services

Funding provided for the FIFA World Cup will be used to procure ambulances to perform Public Viewing Area, VIP and Stadium Standby's, procurement of emergency medical equipment including that for the Green Point Stadium and training on incident management.

Funding for operational personnel costs for the event is budgeted for in the next cycle.

6. SUB PROGRAMME 3.2: PLANNED PATIENT TRANSPORT (PPT OR HEALTH NON EMERGENCY TRANSPORT - HEALTHNET)

6.1 SITUATIONAL ANALYSIS

HealthNET (Non Emergency Transport) services are provided equitably across all the rural and metropolitan areas. A HealthNET hub has been established in each rural district with conveniences at the hub for transit patients. In the metropolitan area a rural hub is established at Tygerberg Hospital to coordinate patients accessing and leaving metropolitan hospitals.

HealthNET performs intra-district, inter-district and metropolitan transport and the focus for 2009/10 will be on intra-district transport within the five rural districts. HealthNET has expanded to deliver on patient transport within districts and between districts to ensure the access of all health clients to health institutions.

6.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

HealthNET in the metropolitan area has the strategic aim of relieving the Emergency Ambulance Service by transporting walking patients.

In the rural areas the focus is moving to intra-district transport to support District Health Services.

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

6.3.1 Finance:

Finance for HealthNET is provided as part of the EMS budget.

6.3.2 Human resources:

Emergency Medical Services employs drivers as opposed to basic life support personnel to staff HealthNET although HealthNET is used as an entry portal for Emergency Ambulance Services and many recruited drivers do in fact possess BLS qualification.

6.3.3 Support systems:

HealthNET will use the existing booking system to coordinate the management and scheduling of patient transfers. The GEMC System is used to capture operational statistics.

6.3.4 Information systems:

Research and analysis into the out patient transfers within the province will be completed in order to determine whether patients are being appropriately referred to consults in referral hospitals. Preliminary research at Tertiary Hospitals indicates that many outpatients are returning inappropriately to these hospitals thereby incurring unnecessary HealthNET costs.

6.3.5 Facilities

District hubs at ambulance stations in Beaufort West, Worcester, Caledon, Grabouw, Malmesbury, Riversdal and George will be modified to include transit facilities (waiting room and toilets) for outpatients.

7. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 3.3: Provincial objectives and performance indicators for EMS and patient transport services [EMS2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Target	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape									
Improve response times to emergency scenes in areas.	Increase the number of all responses in less than 30 minutes.	1. Percentage of all emergency responses in less than 30 minutes.	New Indicator	54% (217 869/ 397 002)	56.7% (181 886/ 321 000)	50% (200 000/ 400 000)	60% (CAD Data) (252 000/ 420 000)	65% (CAD Data) (273 000/ 420 000)	70% (CAD Data) (294 000/ 420 000)
	Increase the percentage of telephone calls answered within 12 seconds to 70% by 2010.	2. Percentage of telephone calls answered within 12 seconds.	New Indicator	-	76.5% (Metro Only 151 759/ 198 395)	50% (150 000/ 300 000)	80% (240 000/ 300 000)	90% (270 000/ 300 000)	90% (270 000/ 300 000)
Strategic goal: To facilitate clinical governance and coordination of Emergency Medicine within the Emergency Departments of all health institutions.									
Improved quality of care in Emergency Departments.	To appoint emergency medicine consultants in key emergency departments and EMS.	3. The number of emergency medicine consultants appointed.	New Indicator	-	4	9	12	12	12
Strategic goal: To render effective and efficient pre-hospital emergency services during the FIFA World Cup									
Strengthen EMS services in order to meet FIFA 2010 requirements and standards.	Procure Ambulances for the FIFA World Cup	4. Number of ambulances procured	New Indicator	-	0	0	10	0	0
	The procurement of base station trunking radios for 10 Hospital Emergency Departments by 2010	5. The percentage of metropolitan hospitals with trunking radios in their emergency centres.	New Indicator	-	0 (0/10)	50% (5/10)	100% (10/10)	100% (10/10)	100% (10/10)

Note:

Indicator 1: The Computer Aided Dispatch System classifies Urban Areas as ALL non farming areas and therefore all towns as urban areas which is a departure from the definition of urban areas previously used. This will affect targets going forward because EMS does not have services in many Western Cape towns.

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

Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape										
Ensure the provision of sufficient resources for the rendering of an effective and efficient emergency and patient transport service	Provide target number of ambulances and patient transporters by 2010	1. Total number of rostered ambulances	197	205	222	240	250	250	230	
		2. Rostered ambulances per 1000 people	0.041	0.039	0.042 (222/ 5 278)	0.05 (240/ 5 425)	0.05 (250/ 5 342)	0.05 (250/ 5 364)	0.04 (230/ 5 385)	
		3. Percentage of hospitals with patient transporters	5%	0%	0%	0%	0%	0%	0%	
		4. Average kilometers travelled per ambulance (per annum).	58 231	71 433	60 597 (13 452 527/ 222)	69 000 (14 400 000/ 240)	62 400 (15 600 000/ 250)	62 400 (15 600 000/ 250)	60 000 (13 800 000/ 230)	
		5. Total kilometers travelled by all ambulances.	11 471 507	13 439 511	13 452 527	13 152 528	15 600 000	15 600 000	13 800 000	
	Provide target number of appropriately trained operational emergency staff	6. Percentage locally based staff with training in BAA.	48%	46%	47% (445/942)	52.6% (700/1 332)	45% (600/ 1 332)	38% (5 06/ 1 332)	32% (426/ 1 332)	
		7. Percentage locally based staff with training in AEA.	38%	45%	44% (414/942)	38.7% (515/1 332)	45% (600/ 1 332)	50% (666/ 1 332)	54.5% (726/ 1 332)	
		8. Percentage locally based staff with training in ALS (Paramedics).	8%	9%	9% (80/ 942)	8.8% (117/ 1 332)	10% (133/ 1 332)	12% (160/ 1 332)	13.5% (180/ 1 332)	
	Achieve normative response times in metro and urban areas	9. Percentage of P1 calls with a response time of < 15 minutes in an urban area	30.0%	37.6%	48% (3 661/ 7 626)	42% (3 7182/ 88 686)	30% (CAD Data Change over) (28 350/ 94 500)	35% (CAD Data) (33 075/ 94 500)	40% (37 800/ 94 500)	
		10. Percentage P1 calls with a response time of < 40 minutes in a rural area	70.0%	64.4%	70% (1 023/ 1 472)	70% (9 072/ 12 918)	70% (CAD Data Change over) (22 050/ 31 500)	75% (CAD/Data) (23 625 31 500)	80% (25 200/ 31 500)	
		11. Percentage of all calls with a response time within 60 minutes	Not Available	61,721	75% (241 952/ 321 000)	69% (297 522/ 431 118)	65% (CAD Data Change over) (273 000/ 420 000)	70% (CAD Data) (294 000/ 420 000)	75% (315 000/ 420 000)	
	Adhere to the prescribed staffing of ambulances	12. Percentage of operational rostered ambulances with single person crews.	0%	0%	0%	0%	0%	0%	0%	
	Ensure the effective and efficient utilisation of resources	13. Percentage of ambulance trips used for inter-hospital transfers	20.0%	15.0%	21% (82 761/ 387 438)	21% (87 498/ 418 578)	20% (84 000/ 420 000)	20% (84 000/ 420 000)	20% (84 000/ 420 000)	
		14. Percentage of green code patients transported by ambulance	29.0%	34.8%	34.8% (102 930/ 398 029)	29% (123 246/ 418 578)	30% (126 000/ 420 000)	30% (126 000/ 420 000)	30% (126 000/ 420 000)	
		15. Cost per patient transported by ambulance	R715	R709	R829	R852	R970	R1 031	R1 080	
		16. Percentage ambulances with less than 200 000 kilometers on the odometer		49%	67% (142/ 222)	67% (143/ 213)	60% (156/ 260)	60% (156/ 260)	60% (138/230)	
		17. Number of EMS emergency cases-Total	374 485	392 395	387 438	418 578	420 000	420 000	420 000	
		18. EMS referral cases	Definition to be clarified							

Notes:

Indicator 1: EMS has consistently reflected its total fleet of ambulances in this indicator because it is very difficult to measure the rostered fleet because of fluctuation with each shift

Indicator 9: This indicator prior to 2008 was measured as all urban calls not as P1 urban calls because manual data collection was used.

Indicator 10: This indicator prior to 2008 was measured as all rural calls not P1 rural calls.

Indicator 11: This indicator uses total calls (urban and rural) as the denominator.

Indicator 13: Cases represented here are the patient numbers transferred

Indicator 17: This indicator reflects patient numbers.

8. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

In 2009/10 Emergency Medical Services is allocated 4.93 per cent of the vote in comparison to the 4.66 per cent that was allocated in the revised budget of 2008/09. This amounts to a nominal increase of R80.818 million or 19.84 per cent.

The following minimum amounts are earmarked for Emergency Medical Services: R495.611 million in 2009/10; R546.301 million in 2010/11 and R588.479 million in 2011/12. The earmarked amounts include funding for Programme 3: Emergency Medical Services and Sub-programme 6.2: Emergency Medical Services Training Colleges

The objectives of the funding are to:

- Ensure the provision of sufficient resources for the rendering of an effective and efficient emergency and patient transport service.
- Train appropriate numbers of emergency medical care personnel to meet the quantitative and qualitative needs of Emergency Medical Services.
- Maintain and improve standards of emergency medical care through the continuous development of Emergency Medical Care.

Table 3.5: Trends in provincial public health expenditure for EMS and patient transport [EMS4]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	255 851 000	277 844 000	341 877 000	407 318 000	488 136 000	538 061 000	579 603 000
Total Capital	213 000	9 093 000	18 706 000	13 013 000	27 120 000	17 850 000	10 730 000
Grand Total	256 064 000	286 937 000	360 583 000	420 331 000	515 256 000	555 911 000	590 333 000
Total per person	54.28	54.36	68.03	78.99	96.44	103.63	109.61
Total per uninsured person	72.69	73.06	91.44	106.16	129.61	139.28	147.32
Constant 2007/08 prices							
Total excluding capital	274 066 929	287 619 590	341 877 000	380 048 648	432 591 743	459 904 948	481 426 833
Total Capital	228 165	9 412 926	18 706 000	12 141 798	24 034 056	15 257 198	8 912 497
Grand Total	274 295 094	297 032 516	360 583 000	392 190 447	456 625 799	475 162 146	490 339 330
Total per person	58.14	56.27	68.03	73.70	85.47	88.58	91.05
Total per uninsured person	77.86	75.63	91.44	99.05	114.86	119.05	122.36

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES**1. AIM**

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

2. PROGRAMME STRUCTURE**2.1 SUB-PROGRAMME 4.1: GENERAL (REGIONAL) HOSPITALS**

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

2.2 SUB-PROGRAMME 4.2: TUBERCULOSIS HOSPITALS

To convert present Tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions, which allows for isolation during the intensive phase of treatment, as well as the application of the standardised multi-drug resistant (MDR) protocols.

2.3 SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

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

2.4 SUB-PROGRAMME 4.4: REHABILITATION SERVICES

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

2.5 SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

Rendering an affordable and comprehensive oral health service and training, based on the primary health care approach.

3. SUB-PROGRAMME 4.1 GENERAL (REGIONAL) HOSPITALS0

The key deliverables for sub-programme 4.1 in the 2008/09-financial year were:

- Transfer of level 2 services within the central hospitals to the Programme 4-budget structure.
- Separation of level 2 and 3 management services in the central hospitals.
- Appointment of heads for level 2 services in each major discipline within the Metro East and Metro West drainage areas.
- Expansion of level 2 beds by 144 and level 1 by 20 beds. The 20 level 1 beds have been opened within Mowbray Maternity Hospital to address the current service pressures until such time that Mitchell's Plain District Hospital has been built. These beds are funded from Programme 2, but the level 1 functionality is currently in a Programme 4 hospital .
- The appointment of specialists for obstetric, anaesthetic and ENT services.
- The transfer of midwife obstetric units to District Health Services.
- Increasing theatre time and day surgery capacity.
- Phased commissioning of services in the Hospital Revitalisation Programme (HRP) hospitals.

3.1 SITUATIONAL ANALYSIS

3.1.1 General overview

- With effect from the 2008/09 financial year, this sub-programme included funding for the regional hospital (level 2) services situated in Tygerberg, Groote Schuur and Red Cross War Memorial Children's Hospitals.
- The key challenge for this sub-programme is the implementation of the CSP. Service reconfiguration has commenced across the various specialist disciplines and level 2 beds have been designated accordingly within the central hospitals.
- Social factors and broader behavioural patterns of unhealthy lifestyles have a major impact on health resources. This is reflected in trauma and emergency statistics that include motor vehicle accident injuries; victims of crime such as rape, gangster violence, drug and alcohol abuse and medical emergencies owing to diseases of lifestyle.
- Once patients engage in substance abuse they may develop a medical disorder accompanied by brain changes which requires medical treatment. Similarly, once psychological trauma has occurred, patients with post traumatic stress disorder (PTSD) require medical treatment. The impact of substance abuse and other stress factors within society on mental health is being increasingly felt within the facilities. This disease burden adds to the existing demand on acute, chronic and trauma services.
- Seasonal burden of disease pressures such as diarrhoeal disease during the summer months (January to May) result in high bed occupancy rates in the rehydration wards of over 100%. This is evident from the statistics at Red Cross War Memorial Children's Hospital and Somerset Hospital in the Metro.
- Further pressure on the acute services results from migration to the Western Cape.

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- The increased severity of disease, especially from the HIV and AIDS, and TB epidemic and other aspects of the changing disease burden is evident at health facilities.
 - Ensuring quality of care, monitoring the activities such as complaints and compliments, morbidity and mortality, client satisfaction surveys and the implementation of interventions, is a key focus area in ensuring that optimal health services are delivered in terms of the defined packages of care.
 - The impact of the occupation specific dispensation for nurses must be assessed and evaluated. It would appear that this has provided stability within the workforce, although it still remains a challenge to recruit experienced nursing staff in areas such as trauma, mental health, midwifery and theatres. The recruitment and retention of other professional health staff also remains a serious challenge.

3.1.2 Challenges addressed in the 2008/09 financial year:

- Service reconfiguration.
- Realistic target setting and monitoring the outcomes.
- Impact of social factors as reflected in the trauma and emergency statistics.
- The disease burden added to the existing demand on acute, chronic and trauma services.
- The hospital revitalization projects and long-term financial impact on the Department.
- Increased patient load resulting in a significant escalation in the cost of medical supplies, medication, blood and blood products and laboratory costs.
- Agency expenditure, which remained high due to the unavailability of sufficient, experienced health professional staff.

3.1.3 Response to challenges:

- The reconfiguration of services by major service discipline across the health platform within the regional hospitals is still in process. The provision of level 1 and level 2 services within these hospitals has been defined.
- The designation of level 2 beds within the central hospitals and the reclassification of inpatient and outpatient services are far advanced. The next step is for these beds to function at level 2.
- Level 2 inpatient wards, outpatient clinics and cost centres have been defined to facilitate management and reporting the clinical outputs and costs/ expenses in line with the separation of level 2 and 3 services into Sub-programme 4.1 and 5.1 respectively for the 2008/09 financial year.
- Setting targets for the level 2 services within the regional and central hospitals and reporting a combined outcome has been a serious challenge. The current information systems will have to be enhanced to ensure that the outcomes for level 2 services are correctly reflected.
- Additional level 2 beds were opened for the Metro and rural regional hospitals.
- The high care beds at Worcester Hospital have been opened.

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- The upgrading of the 3 rural regional hospitals continues. The construction schedules remain challenging and the Department of Transport and Public Works is assisting with the management of timelines. The provision of resources in line with commissioning plans is important to ensure that all services are commissioned as planned at the completed HRP hospitals.
 - Cost containment measures and protocols for ordering laboratory tests have been implemented.
 - Special efforts were made to recruit permanent staff and hospitals have received management budgets for agency services to ensure effective use of limited financial resources.

3.1.4 Acute Hospital Services:

- The acute services provided by the regional hospitals in this programme continued to operate under pressure as evidenced by the hospital performance statistics as well as the pressure on budgets.
- Geographic separation of identified level 2 wards has been completed for the central hospitals.
- The emergency centres in the central hospitals (trauma and medical emergencies) were designated as level 2 services.
- The draft service packages for level 2 services were finalised in August 2008. This assisted in the development of case definitions that formed part of the criteria to conduct folder audits and point prevalence surveys in various disciplines and institutions. This assists in the planning of services towards alignment of the CSP.
- Level 2 clinical heads were appointed during the 2008/09 financial year. This was a key enabler for strengthening clinical governance for the general speciality disciplines.
- Hospital admissions have increased and bed occupancy rates generally remain high. Rigorous analysis of patient data as well as engagement with clinicians has been undertaken to better understand the service pressures.
- The opening of twenty level 1 beds in Mowbray Maternity hospital, but funded by District Health Services, and 144 level 2 beds across the platform in 2008/09 relieved the service pressures within all drainage areas across the service platform.
- Beds designated as level 2 beds have been further defined and become operational at this level within Tygerberg, Groote Schuur and Red Cross War Memorial Children's Hospitals and the separation of level 2 and 3 services within the central hospitals remains a key activity towards restructuring of the service platform.
- The eight level two general specialities were divided into three service clusters:
 - Cluster 1: Emergency Medicine, Internal Medicine, Psychiatry
 - Cluster 2: Surgery, Orthopaedics, Anaesthetics and
 - Cluster 3: Obstetrics and Gynaecology, Paediatrics and Neonatology

3.1.4.1 Cluster 1: Emergency medicine, internal medicine and psychiatry

1) Emergency Medicine and Trauma:

- Trauma and emergency services in particular continued to be under severe strain with high volumes and more seriously ill patients being seen. This has caused the waiting time for elective surgery to increase.
- The integrated management of emergency care services, with standardised protocols across the emergency medicine services, has been launched as a pilot project in the Cape Winelands district and the Eastern Sub-district in the Metro. Emergency medicine specialists have been appointed to play a central role in these pilot projects. The intention is to roll out this approach to all districts during 2009/10.
- Progressive implementation of the Acute Emergency Case Load Policy (AECLP) from August 2008 is intended to improve the triage and flow of patients, including admissions, across the system.
- Proposals have been developed for appropriate staffing of emergency centres and will be incrementally implemented over the MTEF period.
- There has been an increased need for intensive care unit (ICU) services.

2) Internal Medicine:

- Finalisation of the level 2 package of care and standard case definitions by October 2008 was the key objective for 2008/09. The main projected achievement within Metro East and Metro West by March 2009 is quantified patient care activities in acute beds across the platform, with clear targets for service shifts between levels of care; and from acute beds to sub-acute beds, TB beds and psychiatric beds.
- In the rural regions there are strong outreach and support programmes from the level 2 internal medicine departments to all district hospitals and community health centres. This has led to improved case management, with appropriate cases being referred to the level 2 internal medicine departments.

3) Psychiatry

Refer to Sub-Programme 4.3

3.1.4.2 Cluster 2: Surgery, orthopaedics and anaesthetics:

- A key strategy for 2008/09 was to increase the quantum of surgical procedures which include day cases.
- The theatre audit was done to identify spare capacity and promote appropriate utilisation of theatres as well as point prevalence studies to determine current utilisation of bed capacity.
- Some of the level 2 surgical services were relocated from Karl Bremer Hospital to Tygerberg Hospital.
- Two adult postoperative high care beds and an additional emergency theatre list were commissioned within Tygerberg Hospital in 2008/09 to manage the high trauma and emergency surgery load. The two adult postoperative high care beds improved the performance of level 2 elective and emergency surgery.

- Finalisation of the list of procedures to be performed as day surgery cases as well as the implementation of a day surgical procedure programme has been completed.
- The key strategies for orthopaedic services were:
 - The consolidation of the level 2 services in the Metro West at Groote Schuur Hospital,
 - The finalisation of the packages of care and quantification of the level 2 orthopaedic services at Victoria, GF Jooste and Somerset Hospitals; and
 - Capacitating medical officers with the necessary skills to perform level 1 procedures at Victoria and Somerset Hospitals.
- A Metro anaesthetics plan has been developed.
 - The key challenge for 2008/09 was to appoint level 2 clinical heads to coordinate services across the platform. The Metro Anaesthetics Plan (MAP) is being incrementally implemented.
 - The level 2 clinical heads for anaesthetics in the Metro East and West were appointed.
 - Second specialists in the rural regional hospitals were appointed.

3.1.4.3 Cluster 3: Obstetrics, gynaecology and paediatrics (including neonatology)

1) Obstetric and gynaecology services:

- There has been a significant increase in deliveries at some hospitals over the last few years. In the absence of the Khayelitsha and Mitchell's Plain Hospitals the service pressures were addressed by opening 20 additional level 1 beds at Mowbray Maternity Hospital.
- The decreased utilization of family planning and sterilizations and migration as contributory factors to this increase in deliveries requires additional research.
- Shortage of staff with respect to trained midwives and medical officers continued.
- Pressure on gynaecology services was exacerbated by the lack of appropriate skills, available theatre time and defined referral pathways within the system. A work group consisting of clinicians and managers are identifying the key interventions required to strengthen this service.
- Level 1 and 2 packages of care for gynaecology services have been defined. This will ensure a clearer definition of the gynaecology services to be rendered across the platform.
- Termination of pregnancy remains a further pressure area within the regional hospitals. The capacity to do first trimester termination of pregnancies at district hospitals and community health centres will be addressed as a priority for 2009/10.
- Level 2 obstetric services were successfully shifted from Karl Bremer Hospital to Tygerberg Hospital and level 1 service from Tygerberg Hospital to Karl Bremer Hospital. The level 2 service shifts are now reflected in the Programme 4 budget and reporting structure.
- Two (2) high care obstetric beds and twelve (12) level 2 obstetric beds have been commissioned in Tygerberg Hospital to address service pressures.
- The shift of management responsibility for the midwife obstetrics units (MOUs) from Mowbray Maternity Hospital to the District Health Service was finalized during the 2008/09 financial year.

- The appointment of an additional specialist at Mowbray Maternity Hospital ensured outreach and support to level 1 services and intensified training of interns, medical officers and family physicians.
- The medical officer staffing at Mowbray Maternity Hospital has been increased as the existing service was inadequate.
- Currently, Victoria Hospital does not have the appropriate infrastructure to render obstetric services. Thus Mowbray Maternity Hospital will absorb its obstetric load and Victoria Hospital will continue to render level 2 gynaecology services.

2) Paediatrics and Neonatology:

The relocation of level 2 obstetric services impacts on neonatal services.

- The distribution of level 2 neonatal services in the Metro East was implemented after quantification of the existing services across the platform and relocation will be initiated during 2009/10.
- Two paediatric high care beds and 30 level 2 neonatal beds were commissioned in Tygerberg Hospital during 2008 to address the service pressures.
- The shift of level 2 paediatric services from Groote Schuur Hospital to Red Cross War Memorial Children's Hospital was finalized during the 2008/09 financial year.
- The quantification of the level 2 neonatal service shifts will follow the obstetric shifts from Groote Schuur Hospital to Mowbray Maternity Hospital.

3.1.5 Infectious diseases: HIV and AIDS, and TB:

- In line with the national key strategies the rollout of HIV and AIDS management and treatment protocols has been implemented at all regional hospitals.
- The HIV and AIDS pandemic contributes significantly to the load on the services. The impact is felt at all acute, TB and chronic medical hospitals.
- Tuberculosis rates remain high and co-infection of TB and HIV has resulted in uncommon forms of presentation and late diagnosis of the disease. The increase in the severity of TB will be addressed in Sub-programme 4.2 TB Hospitals. There are constantly a significant number of TB patients in acute medicine beds within the general hospitals.
- Stable TB patients were shifted from TB in-patient care facilities into primary health care facilities and community based services in order to create more bed capacity to admit TB patients occupying acute hospital beds.

3.1.6 Clinical governance:

3.1.6.1 Appointment of level 2 heads:

- The appointed level 2 heads in the Metro East and Metro West will be responsible for clinical governance for the level 2 platform of each relevant service discipline.

3.1.6.2 Outreach and support:

- A policy for outreach and support by clinical staff to other institutions and the rural areas has been formalised.
- Agreements between institutions seek to confirm the service needs to be addressed by the clinicians, the logistical and financial arrangements.
- Specialists appointed in the rural regional hospitals provide outreach and support in the rural regions and play a vital role in ensuring appropriate referrals to secondary and tertiary hospitals.
- Training and retraining staff at level 1 and 2, through outreach and support, is vital to the success of the Comprehensive Service Plan in ensuring that patients are treated appropriately at the correct level of care.
- Over the past two years, the ENT services in the province have been strengthened by a team consisting of a specialist and experienced medical officer who have visited different facilities to provide a surgical and outpatient service. Approximately 1 200 procedures were performed in each year, which made a significant contribution to reducing waiting lists for ENT procedures such as tonsillectomy. A provincial strategy is being defined to map the way for ENT services within the Western Cape.

3.1.7 Corporate Governance:**3.1.7.1 Human resource management:**

- In the 2008/09 financial year there has been a net gain of 29 filled posts in this sub-programme and although it was planned to fill more posts, it appears that the newly filled posts have offset the number of staff lost through attrition. The total staff complement continues to be supplemented by the recruitment of staff via agency services.
- The recruitment of scarce nursing skills in the areas of theatre and midwifery is vital to sustain service delivery.
- The lack of key staff is a limiting factor to the optimal provision of health services. The range of strategies adopted both nationally and provincially will to some extent improve the ability to recruit and retain staff, especially professional nurses and medical officers. The impact of the OSD for nurses and the reduction in the leave for nurses must still be evaluated.
- Increasing the number of professional health workers remains a priority.

3.1.7.2 Hospital Revitalisation Project:

- The revitalization of George, Worcester and Paarl Hospitals continues.
- At George Hospital, the focus area has been the completion of infrastructure. Health technology implementation, quality assurance, organizational development and monitoring and evaluation are areas being addressed in parallel. Funding the full commissioning of the infrastructure within the current budget envelope remains a challenge. A range of strategies have been developed towards the phased implementation of the final commissioning of service areas.
- The correction of the staff establishments in line with the expansion of services and the Comprehensive Service Plan continues to be addressed.

- At Worcester Hospital, the infrastructure is at various stages of completion. The new theatre, day theatre, OPD and acute psychiatric unit were completed in October 2008. Monitoring and evaluation processes have been established to ensure progress towards further revitalization goals. The Department of Transport and Public Works is assisting to ensure timeous delivery.
- Paarl Hospital has commenced with the infrastructure projects and the Specialist OPD was commissioned in October 2008. Addressing staff capacity will form part of the 2009/10 strategies.

Table 4.1: Situation analysis indicators for General (Regional) hospitals [PHS3]

Strategic objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National target 2003/04
Strategic goal	To provide appropriate and accessible regional hospital services for acute patients in the Western Cape.					
Provide sufficient bed and clinical capacity to render quality general specialist services in regional hospitals.	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarian section rate of 33%	1. Caesarian section rate for regional hospitals	32%	33%	33.1%	22%
	Provide sufficient resources for the rendering of comprehensive out patient services at a target rate of approximately 1:1 out patients per inpatient day	2. Number of patient day equivalents (PDE) in regional hospitals	924 692	942 460	636 992	
		3. OPD total headcounts in regional hospitals	439 865	487 959	362 960	
		3.1 Casualty/emergency/trauma headcount	314 825	319 385	201 009	
		3.2 Comprehensive OPD headcount in regional hospitals (OPD + Casualty/emergency/trauma)	754 690	807 344	563 969	
	Implement quality assurance measures to minimise patient risk in regional hospitals.	4. Percentage of regional hospitals with patient satisfaction survey using DoH template	80%	100%	100%	20%
		5. Percentage of regional hospitals with mortality and morbidity meetings every month	80%	100%	100%	90%
		6. Percentage of regional hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
		7. Percentage of complaints resolved within 25 days in regional hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
	8. Case fatality rate in regional hospitals for surgery separations	1.74%	1.70%	1.70%		
Ensure the effective and efficient rendering of sustainable regional hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals.	9. Average length of stay in regional hospitals	3.6 days	3.4	3.4	4.8
		10. Bed utilisation rate, based on useable beds, in regional hospitals	98%	99%	91%	72%
		11. Total separations in regional hospitals	188 166	196 904	130 205	
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1500 per PDE	12. Expenditure per patient day equivalent in regional hospitals	R921	R999	R1 127	R1 128

Notes:

1. From 2008/09 the values for the indicators reflect 9 hospitals.
2. Prior to 2008/09 level 2 and level 3 services were not separated in the central hospitals.
3. Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided. Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.
4. Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
5. Indicator 11: Per definition day cases are included in separations and therefore included in total patient days.
6. Indicator 12: Costs in 2007/08 prices

3.2 POLICIES, PRIORITIES AND STRATEGIC GOALS FOR 2009/10

The priorities for 2009/2010 are addressed in an integrated approach to service delivery across the health platform. The Programme 4 strategies are categorized in terms of **Service Priorities, Clinical Governance and Corporate Governance**.

3.2.1 Strategic goal:

To provide appropriate and accessible regional hospital services for acute patients in the Western Cape.

3.2.2 Strategic objectives for service delivery:

- 1) Ensure the effective and efficient rendering of sustainable regional hospital services.
- 2) Provide sufficient bed and clinical capacity to render quality general specialist services in regional hospitals.

The main focus areas to address the service delivery strategic objectives for the hospitals in this sub-programme are:

- 1) Service reconfiguration in terms of the CSP
- 2) Acute hospital services
- 3) Ambulatory Care
- 4) Infectious disease management
- 5) De-Hospitalized care

3.2.2.1 Service reconfiguration in terms of the Comprehensive Service Plan per discipline:

The key priorities are:

- 1) Improving the quality of patient care by ensuring the greatest efficiency and effectiveness in clinical activities.
- 2) Appropriate accessibility to health services.
- 3) Enhancing clinical efficiencies to ensure affordability and redirect savings to meet population demands.

Activities:

- 1) Improving services in line with set targets is the root of the transformation process.
- 2) In line with Comprehensive Service Plan, the major objectives in this sub-programme include the reconfiguration of services within these hospitals and the expansion and strengthening of rural regional hospitals. Service reconfiguration per discipline is being undertaken to enhance optimal health care provision and improve efficiencies.

- 3) In line with the Comprehensive Service Plan, the majority of level 2 services within the Cape Metro district will be provided within the central hospitals. This will require the reclassification of existing inpatient and out patient services and the reconfiguration of services according to the package of care provided. Level 2 services in central hospitals are now funded from the provincial equitable share in Programme 4, Sub-programme 4.1.
- 4) Management structures have been reconfigured to co-ordinate the delivery of services and will continue to assess the transformation process to ensure that the right patient care is delivered in the right place at the right time.
- 5) Appointment of heads of level 2 clinical services for each major discipline to co-ordinate clinical services across the platform in each of the drainage areas which will ensure that level 2 services are appropriately consolidated.
- 6) Victoria Hospital is classified as a district hospital in terms of the CSP and will be shifted to Programme 2, District Hospital Services, as from 1 April 2009.

3.2.2.2 Acute hospital services:

The appointment of twelve level 2 heads is a key element towards reconfiguration of services and improved clinical governance. Transformation of the services are managed across the Metro in a holistic manner and divided organizationally into Metro East and Metro West. The main focus areas of transformation are in the following service disciplines:

- Cluster 1: Emergency medicine, internal medicine and psychiatry;
- Cluster 2: Surgery, orthopaedics and anaesthetics;
- Cluster 3: Obstetrics and gynaecology, paediatrics and neonatology.

The focus for 2009/10 is the Metro while reconfiguration in the rural regional hospitals will be undertaken in a phased manner.

Cluster 1: Emergency medicine, internal medicine and psychiatry

1) Emergency medicine:

The key priorities are:

- The implementation of the AECLM policy and improving the triage policy.
- Progress towards standardization of emergency centre functionality and case management across all emergency centres (including staff appointments, equipment, standard operating procedures, child friendly areas, etc).
- Clinical management oversight of the Vanguard 24-hour emergency unit by Somerset Hospital and Retreat 24-hour emergency unit by Victoria Hospital.
- The regional hospitals are to play a central role in the clinical governance of emergency medicine across the districts.
- Improvement in case management at the point of entry services, in accordance with standardized protocols.

- Progressing to integrated emergency centres, which will manage both trauma, and medical emergencies.
- Progressive implementation towards child friendly emergency centres.

Activities:

- The current emergency unit at Victoria Hospital must be enlarged to absorb the increased emergency load in the metro west area until such time that a new hospital has been built. The planning and tender process for this project will be commenced in the 2009/10 financial year. Reporting on this process will be reflected in Programme 2 as from 1 April 2009.
- Strengthening nurse capacity in medical emergencies and establishing a 24-hour professional nurse-driven management, with medical officer support, of non-emergency visits to the emergency center in Red Cross War Memorial Children's hospital (RCWMCH) and all regional hospitals.
- Attend to approximately 35 000 children with medical emergencies and injuries at RCWMCH.
- A consolidated emergency center will operate as a single portal of entry for the acutely ill patients referred to Tygerberg Hospital. This will significantly improve the efficiency and patient flow at Tygerberg Hospital. Patients will be appropriately admitted to either level 2 or level 3 inpatient beds.
- Appointment of emergency medical specialists in the Metro, Paarl, Worcester and George Hospitals for overall clinical governance across all emergency centres in the geographic areas, which will be funded from Programme 3.
- Improving the client throughput in acute beds by appointing bed managers in Paarl, Worcester, George and Somerset Hospitals.
- Strengthening the emergency units at the regional hospitals amounts to R15.3 million.
- An extended hours service is to be introduced in the towns where the three regional hospitals are located.
- A process will be implemented to establish indicators for monitoring and evaluation of the AECLMP policy which will include an annual survey to establish whether the critical, implementable areas of the policy are in place; the 6-hourly bed status and the monthly triage profile.

2) Internal medicine:

The key priorities are:

- Reconfiguration of functional beds in the Metro East and West.
- Shifting sub-acute and psychiatric patients from acute medicine beds to sub-acute beds, TB beds and acute psychiatric beds.
- The uniform implementation of the outreach and support system in all three of the rural regional areas.

Activities:

- The reconfiguration of the platform for internal medicine in the Metro has been finalized per drainage area. A workgroup has been convened to co-ordinate the service shifts, resolve the issues related to the final drainage areas, agree on the points of service entry and enhance the sub-acute plans per institution.
- Dedicated level 2 specialists will manage the secondary internal medicine services within the central hospitals.
- Level 2 services for internal medicine in the Metro East will be consolidated at Tygerberg Hospital with improved linkages with the level 2 services at Karl Bremer Hospital.
- Level 2 services in Metro West for the Mitchell's Plain area will be shifted from GF Jooste Hospital to Groote Schuur Hospital.
- The appointed head of level 2 medical services will co-ordinate clinical services across the platform in each of the drainage areas.
- Reconfiguration of 90 functional level 1 beds within Somerset Hospital. Medical officers from level 2 services will be relocated to the level 1-service areas and a family physician will be appointed.
- 90 Level 1 beds to be reconfigured at Victoria Hospital and staff to be placed appropriately.
- Consolidate the staffing complement within all the level 2 disciplines in the three rural regional centres with specialist and appropriate medical officer capacity amounting to R2, 3 million.

3) Psychiatric services:

Refer to Sub-Programme 4.3 for specific information regarding the psychiatric hospitals.

The key priority is:

- Strengthening the level 2 services in regional hospitals by appointing one community psychiatrist per sub-structure, with specialist clinics per district hospital; creating capacity for ten more acute beds within the Associated Psychiatric Hospitals and additional specialist ambulatory services.

Activities:

- 72-hour observation units have been opened and clinical management of psychiatric patients within regional hospitals will be strengthened further.
- Worcester Hospital to have 8 beds.
- George Hospital to remain at 10 beds.
- Paarl Hospital to remain at 4 beds.
- Adult and child-and-adolescent psychiatric patients will be separated within Tygerberg Hospital and the infrastructure requirements will be concluded in 2009/10.
- Community psychiatrists will be placed on the establishment of rural regional hospitals with outreach and support to the districts. Capacity at the regional hospitals (Paarl and Worcester) will be two psychiatrists at salary level 12, one for inpatient care and one for community outreach.

- The level 2 psychiatric units at the regional hospitals will play a vital role to manage the interface between the district hospitals and the appropriate psychiatric hospitals.
- A new 25-bed 72-hour observation service is to be commissioned at Groote Schuur Hospital to accommodate patients from the GF Jooste Hospital drainage area at a cost of R5 million.

Cluster 2: Surgery, orthopaedics and anaesthetics

4) Surgery:

The key priorities are:

- Reconfigure level 2 services.
- Increase day surgery capacity.
- Strengthen capacity in rural regional hospitals.

Activities:

- The appointed head of level 2 surgical services will co-ordinate clinical services across the platform in each of the drainage areas.
- Training and retraining of specific staff components will be done to address the shortage in specific operating skills.
- The clinical coordinator for surgery will define which minor surgical procedures can be performed at level 1 and provide clear guidelines and protocols.
- Theatre time, space and staff will need to be more efficiently used to address the bottlenecks in the system.
- Level 2 surgical services in Metro East will shift from Karl Bremer Hospital to Tygerberg Hospital. A quantum of level 2 outreach services will be maintained at Karl Bremer Hospital.
- The increased day surgery capacity at Groote Schuur Hospital will continue to relieve bed pressures and improve efficiencies in Metro West.
- The level 2 surgical services in Metro West will shift from GF Jooste hospital to Groote Schuur hospital for the Mitchells Plain sub-district.
- Somerset Hospital to provide outreach to Wesfleur Hospital.
- A plan to increase the availability of anaesthetics capacity to enable surgery to be performed is being finalised and will be incrementally implemented.
- Referral protocols are being developed by a core team to address referrals across the service platform.
- The capacity within rural regional hospitals will be increased by fully commissioning the day surgery units at Worcester and George Hospitals and uniform implementation of outreach and support systems are to be established in all three rural regions, linked to some practical activities such as endoscopy services. A medical officer for skills transfer will be identified at district hospitals.
- Develop specific plans for ENT, ophthalmology and urology outreach by the three rural regional hospitals to the districts.

- Rural regional centres will develop specific plans for surgical skills maintenance.
- A process will be initiated to implement indicators for monitoring and evaluation of theatre efficiencies, which will include cancellation rate for elective procedures.

5) Orthopaedic services:

The key priorities are:

- Consolidation of level 2 orthopaedic services in the Metro West.
- Consolidation of level 2 orthopaedic services in the Metro East.
- Identifying the procedures that can be shifted to day care surgery and level 1 hospitals.

Activities:

- The services to be provided at levels 1 and 2 are being defined by a dedicated workgroup under the chairmanship of the coordinating clinician for orthopaedic services.
- The appointed clinical head of orthopedic services will manage the level 2 services across each of the drainage areas in the Metro.
- Level 2 services in Metro East will be consolidated in Tygerberg Hospital and outreach and support from Tygerberg Hospital will be provided across the orthopaedic platform. The planned appointment of a specialist performing outreach at Tygerberg Hospital as well as the purchasing of appropriate equipment will assist in achieving the objective.
- In the Metro West and in accordance with the CSP, level 2 orthopaedic services will be relocated ultimately from GF Jooste, Somerset and Victoria Hospitals to Groote Schuur Hospital, but some appropriate level 2 orthopaedic services will remain at GF Jooste, Victoria and Somerset Hospitals. However, significant level 1 orthopaedic capacity (increasing medical officer cover) must be further developed at these hospitals to avoid inappropriate referrals and provide accessible first level hospital care.
- Additional theatre capacity, including day surgery, will be a key enabler for the reorganization of these services according to the CSP. Increased day surgery is planned at Groote Schuur Hospital with developed and strengthened outreach and support orthopaedic services across the platform for Metro West.
- The bulk purchase and standardized use of orthopaedic implants will be investigated to maximize value for money.
- The key deliverable for the three rural regional hospitals is the uniform implementation of the outreach and support system linked to performing specific procedures.

6) Anaesthetic services:

The key priorities are:

- Implementing the Metro anaesthetic plan, provision of outreach and support and after hour specialist support.

- Level 2 clinical skills consolidation and coordination of service delivery in Metro East and West.
- Strengthening capacity in the rural regional hospitals with additional sessional anaesthetic capacity at Worcester Hospital for outreach to the Overberg district.

Activities:

- A plan has been developed to strengthen the anaesthetic services within the Metro. This includes the appointment of additional specialists at regional hospitals with an outreach, support and service responsibility within district hospitals and ensuring adequate numbers of trained medical officers at district hospitals.
- A second specialist anaesthetist will be appointed at the rural regional hospitals to strengthen these services as well as the capacity to perform outreach and support to district hospitals.
- The implementation of a pre-operative anaesthetic clinic at Tygerberg Hospital will improve efficiency and reduce cancellations.
- The strengthening of anaesthetic capacity is a key enabler to expand and strengthen surgical, obstetric, gynaecology, orthopaedic, ENT and other services.

Cluster 3: Obstetrics and gynaecology, paediatrics and neonatology**7) Obstetric and gynaecology services:****The key priorities are:**

- Consolidation of level 2 services in the Metro East and West.
- Shifting level 1 obstetric services from Groote Schuur Hospital to Mowbray Maternity Hospital.
- Training and development of staff who can be transferred with the future relocation of services.
- Strengthening the colposcopy service at level 2 hospitals.
- Provision of specialist outreach services from level 2 gynaecology services.

Activities:

- A cross-programme approach involving programmes 2, 4 and 5 has been developed to address the increased workload in obstetric services within the Metro. This will allow a co-coordinated approach across the obstetric platform in line with the Comprehensive Service Plan. The total package of obstetric services has been reviewed and funding provided in 2008/09 to alleviate some of the service pressures.
- Treatment protocols and the establishment of clear referral pathways across levels of care will be implemented.
- The appointed head of level 2 obstetric and gynecology services will co-ordinate clinical services across the platform in each of the drainage areas.
- Level 2 beds in the Metro East to be consolidated within Tygerberg Hospital.

- Shift level 1 and proportional level 2 services in the Metro West for the Southern sub-district from Groote Schuur Hospital to Mowbray Maternity Hospital, with increased labour ward and theatre capacity at Mowbray Maternity hospital. The possible change in referral pathways of Khayelitsha patients from Mowbray Maternity hospital to Tygerberg hospital will also be investigated.
- Training and development of staff for future redeployment with the service shifts.
- Level 2 specialists will undertake a specific training program for interns, midwives and medical officers in improving obstetric skills using the national Essential Steps in the Management of Obstetric Emergencies (ESMOE) package and training material.
- The key deliverables in the rural regions are to strengthen and maintain basic ante-natal care (BANC) services in the rural regions, to provide access to ultrasonography services and to transfer responsibility for level 1 ambulatory antenatal care to the family medicine departments at the three regional hospitals.

8) Paediatric and neonatal services:

The key priorities are:

- Complete the level 2 paediatric and neonatal service shifts in the Metro East and West.
- Align paediatric and neonatology beds in line with the CSP.
- Developing additional level 2 neonatal capacities in line with the priorities identified in the neonatal/ kangaroo mother care (KMC) plan.
- Improve KMC care in the rural regions.
- Strengthen the responsiveness to the diarrhoeal season.

Activities:

Paediatrics:

- The expansion of the level 1 service is vital to address the seasonal service pressures within paediatrics and to decrease the referrals to levels 2 and 3.
- Extending the hours for primary health care services for children at certain clinics will reduce the service pressures at Red Cross War Memorial Children's Hospital.
- Level 2 paediatric service shifts in the Metro East between Tygerberg and Karl Bremer Hospitals will be completed.
- The appointed head of level 2 paediatrics and neonatal services will co-ordinate clinical services across the platform in each of the drainage areas.

Neonatal Services:

- Reconfiguration of four neonatal ICU beds into high care beds at Somerset Hospital for 24-hour ventilation, whilst three ICU beds are to be shifted to Groote Schuur Hospital.
- The level 2 neonatal service shifts will be completed in the Metro West, following the obstetric service shifts from Groote Schuur Hospital to Mowbray Maternity Hospital.

- Paarl Hospital will increase their KMC beds from 6 to 16, if funding allows this expansion, which will help to alleviate pressure at Tygerberg Hospital.
- Provision of additional level 2 neonatal capacity at Tygerberg Hospital.
- The skills and competency of level 1 clinicians, the role of specialists rendering outreach and support and the role of the family physicians are the key drivers in improving this service.
- Level 2 specialists will undertake a significant training program for midwives and medical officers in neonatal resuscitation as 25% of neonatal deaths occur during the first hour of birth.

9) **Other services:**

- **High Care Beds:**

- Fully commissioning the high care beds within the rural regional hospitals.
- Additional staff appointments at Worcester and Paarl Hospitals to strengthen the high care bed units will cost approximately R1 122 065 and R3 120 951 respectively.
- Commission and operate eight extra high care beds (four at Tygerberg and four at Groote Schuur Hospitals).

- **Ear, nose and throat (ENT) services:**

- The appointed specialist ENT surgeons (20 sessions) at Somerset and George Hospitals with a further specialist shared between Paarl and Worcester Hospitals will continue with their responsibility to provide a service at the regional hospitals and through outreach and support build the services at level 1 facilities. This will build on the momentum developed by the project over the last two years.
- Further strengthening of the provincial ENT plan will map out the requirements for audiologist services in the metro and rural hospitals.

Table 4.2: Number of level 2 beds in central hospitals

Hospital	2007/08	2008/09	2009/10 Target
Groote Schuur Hospital	172	190	278
Red Cross Children's Hospital	61	63	55
Tygerberg Hospital	724	772	702
Total	957	1 025	1 035

3.2.2.3 **Ambulatory care:**

The key priorities are:

- To identify and quantify the number of patients visiting the outpatients departments that can be devolved to lower levels of care.
- Relocation of first trimester termination of pregnancies.
- **Activities:**
- Appropriate devolution of outpatient activities to primary health care.

- Planning the devolution of patients at RCWMCH visiting the outpatients department to the appropriate level of care within the relevant sub-districts in accordance with the identified clinical conditions of asthma, epilepsy and dermatology.
- Planned relocation of first trimester termination of pregnancies at Victoria Hospital to Lady Michaelis in line with the CSP.

3.2.2.4 Infectious Disease Management:

The key priorities are:

- Decanting stable ARV patients in regional hospitals to community health centres (CHC's).
- Improve HIV and AIDS management.
- Develop and implement infection control measures within general hospitals to reduce the risk of infection in staff members.

Activities:

- Pending the finalization of the ART decanting plan, the planning process has commenced to decant stable ART patients from regional hospitals to the CHC's in the Metro West area.
- Implementation of TB control measures in general hospitals will aim at prevention of intra-hospital spread of TB with a particular focus on the management of the occupational health risks posed to staff and other patients by patients with TB. This will require extraction fans and ensuring adequate ventilation in identified areas. The policy in respect of the use of N97 masks will be enforced and MDR and XDR patients will be appropriately isolated.

3.2.2.5 De-hospitalised Care:

The key priority is:

- Quantification of patients that fit the case definition that can be managed at sub-acute care level (including orthopaedics).

3.2.3 Improving health services through clinical governance:

The key priorities are:

- The completion of outreach and support agreements between institutions to formalize and enhance outreach and support arrangements.
- Revised quality assurance plans per institution to improve service delivery.
- Improved clinical governance at all levels of care.
- Improved client satisfaction.

Activities:

- Improve patient flow and bed management.
- Improve the triage patient system to prioritize emergencies appropriately.
- Monitor outreach and support within the different disciplines.

-
- Manage the patient referral system optimally to ensure that the right patient is treated at the right level of care.
 - Apply clinical guidelines and clinical governance to improve the quality of care. This will include regular morbidity and mortality monitoring and clinical audit processes.
 - Participation in the Child Health Problem Identification Program (CHIP).
 - Clinical audit parameters to be determined across the platform.
 - Manage infection and prevention control processes with specific focus on TB management in general hospitals.
 - Hand washing survey conducted.
 - Strengthen hospital facility boards at each institution to promote ownership of facilities by communities and increase accountability of institutional management to communities.
 - Improve patient satisfaction by:
 - Conducting at least one comprehensive client satisfaction survey and implement action plans to address specific client concerns and recommendations;
 - Assessment of the implementation of the Patient's Rights Charter;
 - Refinement of the patient complaints and compliments procedure
 - Monitoring of safety and security risks
 - Specific focus on clean bathroom and toilet management.
 - Enhance the Health Department as employer of choice by ensuring, amongst others, the following:
 - Assessment of staff satisfaction surveys;
 - EAP to support staff working in a stressful environment; and
 - Improvement of the physical working environment.

3.2.4 **Improve health services through corporate governance:**

The key priorities are:

1) **Achieving financial balance by effecting:**

- Alignment of reporting systems in line with the CSP implementation in central hospitals.
- Establishing cost centre management in central hospitals and commence process in other regional hospitals.
- Improvement of cost containment measures.
- Improved contract management.
- Improved asset management.
- Ensure an unqualified Auditor-General report.

2) Governance of level 2 services by:

- Strengthening human resource management and capacity building amongst workforce in regional hospitals.
- Strengthening of nurse capacity in all areas.
- Managing organisational change, including communication with role players and project management to ensure implementation of the CSP.
- Improved information management (ICD 10 coding, etc)
- Ongoing interaction with other stakeholders on the health services reform within the Department (Health Facility Boards, etc).

Activities:

- 1) Regional hospitals to support CHC's and clinics with supply chain management functions. Victoria and Somerset Hospitals to commence the planning process for providing supply chain management support. Infrastructure requirements to be determined in terms of the quantified support to be provided to Metro District Health Services.
- 2) Progressive commissioning of the completed building areas at Paarl, Worcester and George Hospitals. Staff components are to be strengthened in the main kitchens, admission points, specialist clinics, medical records, and other areas in a phased manner within the funding envelope.
- 3) Strengthening human resource management and financial management within rural regional hospitals and appoint staff within those sections.

3.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**3.3.1 Services**

- 1) Significant reconfiguration of services in line with the Comprehensive Service Plan will ensure improved practices and redeployment of staff. Effective communication, change management and due labour strategies will be required at all levels. Patients will, however, be treated optimally at the appropriate level of service.
- 2) The availability of services within a revised service platform will be communicated to the general public.
- 3) The key service challenges for 2009/10 were identified as dealing with the increased demand for health services as signified in the disease patterns. There is also a need to engage other role players in influencing upstream factors such as healthy lifestyles, safe sex and responsible drinking and safe driving.
- 4) The pressure on theatre services will continue and strategies will be further strengthened to improve theatre efficiencies.

3.3.2 Finance and financial management

- 1) Reporting mechanisms for the different levels of care and cost differentiation within the central hospitals remains a challenge as does the final operationalisation and enhanced management of the cost centres. As staff becomes more acquainted with the differentiated levels of care and standard operating procedures of new systems, the reporting efficiencies will improve.

- 2) Improving on audit findings will continue and strengthening financial capacity within finance and supply chain management units within hospitals will remain a priority. Training of the first line managers have been prioritised within 2009.
- 3) The patient load and disease profile result in a significant increase in the cost of medical consumables, blood and blood products, laboratory tests and medicine. These cost drivers are monitored and protocols on the use of blood and laboratory tests for patients have been implemented.
- 4) Recruitment of staff via agency services remains a challenge due to the failure to recruit and retain permanent staff. The cost for agency services is high and hospitals may only employ agency personnel equivalent to the number of vacant and funded posts.

3.3.3 Human resources

- 1) Recruiting and retaining experienced health professionals, professional nurses and doctors, anaesthetists, and other staff categories such as financial support staff remains a challenge. The range of strategies adopted by the Department will to some extent improve the ability to recruit and retain staff.
- 2) Nursing skill challenges are largely experienced in theatre, critical care, emergency, maternity and psychiatric services. Nurse training has been the main objective to address the skills and competencies.
- 3) The Occupational Specific Dispensation (OSD) for nurses which has been implemented will assist to retain nursing staff.
- 4) Finalisation of the organisational development structure and matching and placing of staff will reduce the personal anxieties of staff within the change management process of the Comprehensive Service Plan.
- 5) Chief operating officers (COOs) will be appointed at hospitals to strengthen management at institutional level.

3.3.4 Support systems and Information

- 1) Staff recruitment and retention challenges to support systems remain problematic in areas such as finance, human resources, maintenance and information management.
- 2) The information technology systems must be strengthened to improve the operating and reliability of systems such as BAS, LOGIS, Clinicom and Delta 9.
- 3) Improved data and information systems must ultimately be linked to the budget process to ensure equitable budget allocations based on measurable deliverables.
- 4) The monitoring and evaluation processes within the sub-programme are to be strengthened to improve planning and implementation of objectives.

3.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Please note the following regarding Table 4.4: Provincial objectives and performance indicators for general (regional) hospitals [PHS4] below and Table 4.5: Performance indicators for general regional hospitals [PHS5] overleaf:

- From 2008/09 the funding for level 2 services in central hospitals was allocated from Programme 4 and not from Programme 5 as was previously the case.
- Therefore the historical data for the period 2005/06 to 2007/08 is not presented in these tables as it is not directly comparable with the information for 2008/09 going forward. The information for 2005/06 to 2007/08 information can be obtained from Table 4.2.
- The indicators in Table 4.5 are determined by the National Department of Health, however, additional information has been provided for each indicator reflecting the performance as follows, e.g.:
 - Number of patient day equivalents in regional hospitals – Total:
This is the information required by the National Department of Health and includes the level 2 services in both central and regional hospitals.
 - Number of patient day equivalents in regional hospitals – Regional:
This is additional provincial information and reflects the performance of level 2 services in regional hospitals.
 - Number of patient day equivalents in regional hospitals – Central:
This is additional provincial information and reflects the performance of level 2 services in central hospitals.
- Note that from 2009/10 Victoria Hospital shifts from Programme 4 to Sub-programme 2.9.

Table 4.3: Provincial objectives and performance indicators for general (regional) hospitals [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Strategic goal:	To provide appropriate and accessible regional hospital services for acute patients in the Western Cape.								
Provide sufficient bed and clinical capacity to render quality general specialist services in regional hospitals.	Provide a total of 2 400 beds in regional hospitals by 2010.	1. Number of beds in regional hospitals- Total	1 856	1 943	1 379	2 490	2 342	2 400	2 400
		1.1 Number of beds in regional hospitals – Regional	1 856	1 943	1 379	1 465	1 307	1 316	1 316
		1.2 Number of beds in regional hospitals - Central	Not reported	Not reported	Not reported	1 025	1 035	1 084	1 084
		2. Total number of patient days in regional hospitals - Total	673 128	697 602	449 545	768 670	723 126	769 663	769 663
		2.1 Total number of patient days in regional hospitals - Regional	673 128	697 602	449 545	471 073	400 412	431 670	431 670
		2.2 Total number of patient days in regional hospitals - Central	Not reported	Not reported	Not reported	307 812	321 155	337 993	337 993

Notes:

1. The figures include 6 regional hospitals until 200/09 and thereafter 5 and the level 2 services in the 3 central hospitals.
2. Victoria Hospital shifts to Programme 2 in the 2009/2010 financial year.
3. Indicator 2: Total number of patient days includes day cases (Day case: - 1 separation - 0.5 in patient day).

Table 4.4: Performance indicators for general (regional) hospital for 2008/09 to 2010/11 [PHS5]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	
Strategic goal:	To render a comprehensive package of general specialist hospital services to the population of the Western Cape									
Provide sufficient capacity to render quality general specialist services in regional hospitals	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarian section rate of 33%	1. Caesarian section rate for regional hospitals – Total	Refer to Table 4.2 for the information for 2005/06 to 2007/08 which is not directly comparable with the successive years as it did not include the level 2 beds in central hospitals.			33%	35%	33%	33%	
		1.1 Caesarian section rate for regional hospitals – Regional	Level 2 beds in central hospitals are only included from 2008/09.			33%	33%	33%	33%	
		1.2 Caesarian section rate for regional hospitals – Central				0%	38%	33%	33%	
	Provide sufficient resources for the rendering of comprehensive 1 out patient services at a target rate of approximately 1:1 out patients per inpatient day	2. Number of patient day equivalents in regional hospitals Total				1 094 151	1 002 926	1 042 713	1 042 713	
		2.1 Number of patient day equivalents in regional hospitals Regional				649 139	551 768	570 196	570 196	
		2.2 Number of patient day equivalents in regional hospitals Central				445 012	451 158	472 517	472 517	
	Provide sufficient resources to cater for emergency care in regional hospitals.	3. OPD total headcounts in regional hospitals - Total				678 377	592 349	592 349	592 349	
		3.1 OPD total headcounts in regional hospitals - Regional				346 502	271 241	271 241	271 241	
		3.2 OPD total headcounts in regional hospitals - Central				331 875	321 108	321 108	321 108	
		3.3 Casualty/emergency/trauma headcount - Total				311 572	283 729	283 729	283 729	
		3.4 Casualty/emergency/trauma headcount - Regional				181955	153 729	153 729	153 729	
		3.5 Casualty/emergency/trauma headcount - Central				129 617	130 000	130 000	130 000	
		3.6 Comprehensive OPD total headcount in regional hospitals (OPD + casualty/emergency/trauma) - Total				989 949	876 078	876 078	876 078	
		3.7 OPD total headcount in regional hospitals - (OPD + casualty/emergency/trauma) - Regional				528 457	424 970	424 970	424 970	
		3.8 OPD total headcount in regional hospitals (OPD + casualty/emergency/trauma) - Central				461 492	451 108	451 108	451 108	
		Implement quality assurance measures to minimise patient risk in regional hospitals	4. Percentage of regional hospitals with patient satisfaction survey using DoH template - Total				100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]
			4.1 Percentage of regional hospitals with patient satisfaction survey using DoH template - Regional				100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]
			4.2 Percentage of regional hospitals with patient satisfaction survey using DoH template - Central				100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]
	5. Percentage of regional hospitals with mortality and morbidity meetings every month – Total					100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]	
	5.1 Percentage of regional hospitals with mortality and morbidity meetings every month – Regional					100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]	
	5.2 Percentage of regional hospitals with mortality and morbidity meetings every month – Central					100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	
	6. Percentage of regional hospital with clinical audit meetings every month - Total					100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]	
	6.1 Percentage of regional hospitals with clinical audit meetings every month - Regional					100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]	
	6.2 Percentage of regional hospitals with clinical audit meetings every month – Central					100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target
		7. Percentage of complaints resolved within 25 days in regional hospitals – Total				100%	100%	100%	100%
		7.1 Percentage of complaints resolved within 25 days in regional hospitals - Regional				100%	100%	100%	100%
		7.2 Percentage of complaints resolved within 25 days in regional hospitals – Central				100%	100%	100%	100%
		8. Case fatality rate in regional hospitals for surgery separations - Total				1.70%	3.85%	3.85%	3.85%
		8.1 Case fatality rate in regional hospitals for surgery separations - Regional				1.7%	1.7%	1.8%	1.8%
		8.2 Case fatality rate in regional hospitals for surgery separations - Central				6%	6%	6%	6%
Ensure the effective and efficient rendering of sustainable regional hospital services	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals	9. Average length of stay in regional hospitals - Total				4 days	4.5 days	4.5 days	4.5 days
		9.1 Average length of stay in regional hospitals - Regional				3.6 days	4 days	4 days	4 days
		9.2 Average length of stay in regional hospitals - Central				5 days	5 days	5 days	5 days
		10. Bed utilisation rate based on usable beds in regional hospitals - Total				91%	88%	85%	85%
		10.1 Bed utilisation rate based on usable beds in regional hospitals - Regional				91%	90%	85%	85%
		10.2 Bed utilisation rate based on usable beds in regional hospitals - Central				91%	85%	85%	85%
		11. Total separations in regional hospitals - Total				212 318	175 867	195 838	195 838
		11.1 Total separations in regional hospitals - Regional				130 970	111 324	128 239	128 239
	11.2 Total separations in regional hospitals - Central				62 581	64 543	67 599	67 599	
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1 500 per PDE	12. Expenditure per patient day equivalent in regional hospitals- Total				R1 567	R1 630	R1 667	R1 745
		12.1 Expenditure per patient day equivalent in regional hospitals- Regional				R1 300	R1 313	R1 351	R1 414
		12.2 Expenditure per patient day equivalent in regional hospitals- Central				R1 827	R2 019	R2 049	R2 145

Note:

- From 2008/09 the values for the indicators reflect 9 hospitals.
- Prior to 2008/09 level 2 and level 3 services were not separated in the central hospitals.
- Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided. Comprehensive outpatient services therefore includes the headcount of casualty/emergency and trauma units.
- Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
- Indicator 11: Per definition day cases are included in separations and therefore included in total patient days.
- Indicator 12: Costs in 2007/08 prices
- Given the transformation of the service that is currently in progress and the lack of historical data on which to base valid performance projections the projections have been pegged at the 2009/10 level and will be reviewed and amended during the 2010/11 budget process.

3.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 4 is allocated 26.5 per cent of the vote during 2009/10 in comparison to the 26.97 per cent that was allocated in the 2008/09 revised budget. This amounts to a nominal increase of R262.670 million or 11.14 per cent. Funding for Victoria Hospital has been shifted from Sub-programme 4.1 to Sub-programme 2.9 from 2009/10.

There is a nominal increase of R180.089 million or 10.82 per cent in 2009/10 in Sub-programme 4.1 in comparison to the revised estimate of 2008/09. Note that the budget for level 2 services in the central hospitals is included in Sub-programme 4.1 from 2008/09.

Table 4.5: Trends in provincial public health expenditure for general (regional) hospitals [PHS6]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	795 425 000	909 634 000	718 190 000	1 665 148 000	1 845 237 000	2 033 962 000	2 190 999 000
Total Capital	134 037 000	191 900 000	201 568 000	188 081 000	203 210 000	155 117 000	76 495 000
Grand Total	929 462 000	1 101 534 000	919 758 000	1 853 229 000	2 048 447 000	2 189 079 000	2 267 494 000
Total per person	197.02	208.68	173.54	348.26	383.40	408.09	421.02
Total per uninsured person	263.84	280.46	233.23	468.05	515.28	548.46	565.85
Constant 2007/08 prices							
Total excluding capital	852 057 201	941 638 324	718 190 000	1 553 668 747	1 635 270 273	1 738 518 843	1 819 876 208
Total Capital	143 580 087	198 651 759	201 568 000	175 489 249	180 087 041	132 585 480	63 537 880
Grand Total	995 637 288	1 140 290 083	919 758 000	1 729 157 996	1 815 357 315	1 871 104 323	1 883 414 088
Total per person	211.04	216.02	173.54	324.94	339.77	348.81	349.71
Total per uninsured person	282.62	290.33	233.23	436.72	456.65	468.79	470.00

4. SUB - PROGRAMME 4.2 TUBERCULOSIS HOSPITALS

The key deliverables for sub-programme 4.2 in the 2008/2009 financial year were:

- Management of TB services across programmes 2 and 4 in a holistic manner.
- Collaboration between the HIV and AIDS and TB programmes.
- Upgrading Harry Comay, Sonstraal, ID and DP Marais Hospitals progressively for more acute ill patients.
- Planning the opening of 90 beds at Brooklyn, DP Marais, and ID and Harry Comay Hospitals.
- Increase recreational facilities, strengthen infection control, enhance psychosocial interventions and improve occupational health safety for staff.

4.1 SITUATIONAL ANALYSIS

4.1.1 General Overview:

- Sub-programme 4.2 consists of 6 hospitals: Brooklyn Chest and DP Marais Hospitals in Cape Town, Sonstraal TB Hospital in Paarl, and Malmesbury Infectious Diseases Hospital in Malmesbury, Brewelskloof Hospital in Worcester and Harry Comay Hospital in George.

- All the TB hospitals are now provincial hospitals.
- The management of the TB hospitals in the rural areas is currently the responsibility of the regional hospital managers within the relevant rural areas.
- The Organizational Development (OD) exercise made recommendations on a management structure for TB Hospitals. The line management of TB hospitals will be transferred to Programme 2 in 2009/10, but the budget structure will remain a Programme 4 responsibility to remain within the national programme structure.
- Various challenging areas are still being addressed to ensure that the TB hospitals transferred to the province conform to the standards of the Department of Health. These include service standards and protocols, staff establishments, infrastructure and integrating these hospitals into the various systems of the department.

4.1.2 **Challenges addressed in the 2008/09 financial year:**

- ARV treatment of patients at TB hospitals and accreditation of Brooklyn Chest Hospital as an ARV treatment site.
- Access to MDR and XDR treatment in the Metro.
- Reducing waiting lists.
- Strengthening outreach and support services.
- Strengthening the referral system.
- Infrastructure and building maintenance.
- Improving the staffing capacity.

4.1.3 **Responses to challenges:**

- TB patients requiring ARV treatment are receiving their treatment at TB hospitals.
- Brooklyn Chest Hospital appointed a Principal Medical Officer in 2008 to coordinate and manage the ARV treatment of patients in Brooklyn Chest hospital. Changes have been made to the existing OPD clinic to accommodate a separate ARV outpatient clinic.
- Brooklyn Chest Hospital was accredited as an ARV site on 14 September 2008.
- The accreditation process at DP Marais Hospital commenced in June 2008.
- The management of MDR TB patients and access to treatment has been changed to support reliable medicine distribution and access.
- There are no waiting lists for M(X)DR patients, but the waiting list for non-drug resistant TB patients requiring hospitalization remains a challenge.
- The need for psychiatric outreach and support in the management of substance abuse was identified and a plan is developed to address this matter. Outreach and support from Groote Schuur Hospital commenced in November 2008.
- Due to the fact that there are only two TB hospitals in the Metro, the drainage areas will have to be redefined for patients to be referred from these two hospitals to other acute hospitals. A work group is addressing this matter.

- Site meetings have been held at Malmesbury ID, Sonstraal and Brooklyn Chest Hospitals to determine provisional costing for projects on the works maintenance list. The major projects are the opening of the 90 additional beds across the TB platform, the upgrading of the kitchen at Brooklyn Chest Hospital, the renovation and repair of ID Malmesbury Hospital and replacement of the electric wiring at Sonstraal Hospital. The planning process has commenced for these projects during 2008/2009, for continuation in 2009/10.
- R7 million was allocated in the 2008/09 financial year to TB hospitals for strengthening the staff capacity at all TB hospitals.

4.1.4 TB Hospitals and Clinical Services:

- Despite efforts to strengthen TB control in the Western Cape, the burden of disease from TB continues to rise. TB in the Western Cape has dramatically increased over the past 7 years. The incidence of TB in the Western Cape has increased from 689/100 00 in 1997 to 1 158/100 00 in 2006.
- Approximately 862 new MDR patients have been diagnosed in the Western Cape during the period 1 January 2008 to 31 December 2008.
- A further development has been the identification of cases of extremely drug resistant Tuberculosis (XDR-TB) in the Western Cape, with 123 identified to date of whom 59 have died.
- Approximately thirty percent of TB patients in the Western Cape are co-infected with HIV resulting in high morbidity and mortality rates in this group and an increase in the average length of stay of patients.
- Improving patient turnover remains a major challenge within TB hospitals.
- The revised MDR DOTS Plus strategy, which requires admission for six months, as well as the increase in the number and acuity of absolute cases, will increase the pressure on hospital beds.
- Patients who can be managed through the home-based care system are being discharged to make way for more acutely ill patients.
- The table below reflects the planned opening of additional TB beds in 2008/09. The final commissioning date of these beds will be dependant on the tendering processes within the Department of Transport and Public Works and it is estimated that the beds will be commissioned early 2009. A monitoring and evaluation process between the two Departments has been established.
- The acuity of patients being managed in TB hospitals has increased. The clinical capacity and management of the TB hospitals needs to be strengthened to address the increasing service pressures. This has required more intensive medical and nursing care, an increase in the drug and laboratory budget and an increase in staffing levels. A plan to formalize specialist support to TB hospitals is being developed and with specific support and this has commenced at Brooklyn Chest Hospital.
- The number of extra-pulmonary TB cases has increased by 66 % in the Metro over the last 3 years (from 12 % to 16% of all TB cases), which is in all likelihood a reflection of the impact of the HIV epidemic.

Table 4.6: Increase in TB beds in 2008/09

HOSPITAL	BEDS IN 2007/08	PLANNED BEDS 2008/09	FINAL INCREASE IN BEDS
Brooklyn Chest Hospital	327	367	40
DP Marais Hospital	260	300	40
ID Malmesbury	41	51	10
TOTAL	628	718	90

Table 4.7: Breakdown of TB beds in 2008/09

BREAKDOWN OF TB BEDS IN 2008/2009	NUMBER OF BEDS
Drug sensitive TB	603
MDR TB	236
XDR TB	67
Paediatric Sensitive TB	106
Paediatric MDR TB	16
TOTAL	1 030

4.1.4.1 DP Marais Hospital:

- DP Marais Hospital has 260 available beds and bed occupancy rates have remained stable over the past few years at approximately 85%.
- DP Marais Hospital caters for adult ambulatory TB patients, requiring daily-observed therapy, who are unable to handle treatment in an out-patient/community setting. Fifty-four (54) beds have been converted to MDR male beds.

4.1.4.2 Brooklyn Chest Hospital:

- Brooklyn Chest Hospital caters for complicated TB cases requiring admission and specialized care and is a designated multi-drug resistant (MDR) and extreme drug resistant (XDR) specialist centre.
- Due to the high TB and HIV co-infection rates of patients admitted to Brooklyn Chest Hospital, the severity of the disease in patients is significantly higher than in the past. This has resulted in increased length of stay and increased patient mortality.
- Two wards [90 beds] at Brooklyn Chest Hospital have been converted to isolation facilities for MDR patients. Beds for patients with non-resistant TB have been decreased to accommodate the beds earmarked for MDR patients, which has a consequence in terms of beds allocated for the management of non-resistant TB patients in hospitals.
- These wards are equipped with germicidal ultraviolet lights and central ventilation. The opening of these isolation wards has not been sufficient to deal with the demand for beds for MDR patients. A further challenge is the management of patients with XDR TB and partial XDR TB. Sixty-seven (67) beds for XDR TB patients have been opened.
- A specialist OPD clinic for the management and initiation of treatment of newly diagnosed M(X)DR TB patients, ensures appropriate treatment and counseling.

- The hospital increasingly has to manage patients with chronic or terminal MDR TB and the option of building a step-down/palliative care facility for these patients is being considered. It is planned to rebuild a large 721-bed hospital for TB on the site of the Brooklyn Chest Hospital for the Metro that will incorporate DP Marais and Brooklyn Chest Hospitals. The business case that has been submitted to the National Department of Health in terms of the Hospital Revitalisation Programme and has been approved but the funding has not been allocated for the project.
- An increasing number of dually infected patients also qualify for ARV treatment. The average co-infection at this hospital is 50%. Brooklyn Chest Hospital was accredited as an ARV site on 14 September 2008.
- Additional and separate facilities are to be commissioned at Brooklyn Chest Hospital, following the identification of several patients with extreme resistance to treatment.
- Staff houses converted to sub acute facilities will become functional in 2008 with each accommodating 8 MDR TB patients. A housekeeper and a nurse will supervise these patients.
- Two prefabricated buildings to be used as recreational facilities for M(X)DR TB patients were erected in 2008.

4.1.4.3 **Brewelskloof Hospital:**

- Brewelskloof Hospital has 206 beds in use for TB patients with 34 beds utilized by the BCG Research Unit of the School for Child and Adolescent Health, UCT.
- The hospital is a designated multi-drug resistant (MDR) specialist centre and is responsible for the management of all MDR patients in the current Cape Winelands and Overberg districts.
- Eight (8) paediatric beds have been opened and the MDR female beds have been increased by five.
- Ultra-violet germicidal irrigation units for the MDR wards have been implemented to minimize infection at a cost of R625 000.
- Brewelskloof Hospital provides TB outreach services to 21 clinics in the region. Medical officers carry out monthly visits and the hospital also provides TB drugs to all other hospitals and clinics within the region.
- The current pharmacy is very small and inadequate and plans are in progress to move the pharmacy to larger premises.
- The average co-infection of Tuberculosis and HIV at this hospital is 16%.
- The average bed occupancy rate is 82% and has been affected by shortage of both medical and nursing staff.
- The hospital has been accredited as an ARV site.
- Brewelskloof Hospital accommodates a school with an average of 10 pupils. The school has moved from the hospital to an old staff house on the premises where it is functioning well.

4.1.4.4 **Harry Comay Hospital:**

- Priority is given to the admission of patients from deep rural areas requiring streptomycin injections.

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- The hospital was provincialised as from 1 June 2005.
 - The current hospital infrastructure is generally of poor quality and inadequate for the type of services that need to be delivered. Consideration will be given to replace the hospital with improved facilities in the medium to long term.
 - The hospital also manages MDR TB cases for the Eden and Central Karoo districts and currently makes provision for eighteen patients.
 - A twenty bed ward has been converted to a MDR/XDR ward and will become operational once the necessary staff has been recruited. It is currently used for decanting of patients to allow for further renovation of the hospital.

4.1.4.5 **Sonstraal Hospital:**

- Sonstraal Hospital in Paarl has been provincialised.
- It currently has ninety beds. Patients are referred to the hospital from primary health care clinics and hospitals in the area.
- Thirty-three beds are used for MDR patients.
- Forty-five patients were decanted from Sonstraal Hospital as part of the strategy to increase bed capacity for more stable MDR patients from Brooklyn Chest Hospital. This was a temporary measure to accommodate the waiting list of MDR patients. The MDR patients are being reconsolidated at Brooklyn Chest and DP Marais Hospitals.
- Acutely ill patients are first stabilized at Paarl Hospital.
- Multi-drug resistant patients with more serious illness are referred to Brooklyn Chest Hospital in Cape Town.

4.1.4.6 **The Infectious Diseases (ID) Hospital in Malmesbury:**

- The hospital has forty-one beds and a personnel component of nineteen.
- The hospital infrastructure is in a poor state and the hospital is inadequately staffed at present.
- More optimal utilization and management of this hospital is being planned.

4.1.5 **Clinical Governance of Multi-Drug Resistant TB:**

- The emergence of multi-drug resistance (MDR) is potentially the most serious aspect of the TB epidemic and refers to TB, which is resistant to the first line, TB drugs.
- Multi-drug resistant TB is difficult and expensive to treat, with cure rates of 50% at best.
- Since 1990, MDR TB in the Metro has largely been managed at Brooklyn Chest Hospital.
- The DOTS Plus survey conducted by the Medical Research Council, confirmed that the Western Cape has the lowest MDR rate in the country. The reported rates were 1% for new cases, and 4% for re-treatment cases. These rates were the same as those reported in a survey conducted in 1995. However, the absolute number of MDR cases has significantly increased and places huge pressure on the hospital bed platform, as these patients have to be admitted for a period of 6 months.

- The emergence of resistance to second line drugs (XDR) has further deepened the challenges in managing the epidemic. Sixty seven (67) beds have been converted at Brooklyn Chest Hospital to accommodate XDR patients. These patients are more difficult to treat, the drug options are limited, the side effects severe, they require longer hospitalization, take longer to sputum convert and are more costly to treat with a significantly poorer prognosis.

Table 4.8: Situation analysis indicators for TB hospitals [PHS3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National Target 2003/04
Strategic goal:	To render comprehensive TB hospital services to the population of the Western Cape.					
Provide sufficient capacity to render quality TB hospital services	Provide sufficient resources for the rendering of inpatient and out patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010	1. Number of patient Day Equivalents in TB hospitals	293,059	306,287	300,307	
		2. OPD total headcount in TB hospitals	3,784	3,839	2,942	
	Implement quality assurance measures to minimise patient risk in TB hospitals.	3. Percentage of TB hospitals with patient satisfaction survey using DoH template	0%	31%	33%	
		4. Percentage of TB hospitals with mortality and morbidity meetings every month	0%	44%	50%	
		5. Percentage of TB hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
		6. Percentage of complaints resolved within 25 days in TB hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
Ensure the effective and efficient rendering of sustainable TB hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 100 days and an optimum bed occupancy rate of 90% in TB hospitals by 2010.	7. Average length of stay in TB hospitals	75.5	76	80	
		8. Bed utilisation rate based on useable beds in TB hospitals	79%	83%	83	
		9. Total separations in TB hospitals	3,340	4,006	3,759	
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R350 per PDE	10. Expenditure per patient day equivalent in TB hospitals	R242	R258	R339	

Notes:

- The National Department of Health did not provide national targets for TB hospitals.
- Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
- Indicator 10: 2007/08 prices.

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS FOR 2009/2010:**4.2.1 Strategic Goals:**

- To provide accessible care for TB patients requiring hospitalization.
- To render comprehensive TB hospital services to the population of the Western Cape.
- Provide sufficient infrastructure for the rendering of TB hospital services.

4.2.2 Service Delivery Strategic Objectives:

To ensure the allocation of sufficient resources to TB hospitals in the Western Cape to effectively manage the treatment of TB and in particular M(X)DR TB.

The main focus areas to address the strategic objectives and priorities for the hospitals in this sub-programme include:

- Service reconfiguration in terms of the objectives within the Comprehensive Service Plan (CSP).
- Further strengthening the management, staffing and development capacity of TB services.
- Tuberculosis hospitals will remain programmatically in Sub-programme 4.2, but the managerial responsibility for these hospitals will move to Programme 2 from 1 April 2009. Whilst it would have been ideal to move these hospitals from a programme perspective into Programme 2, this is not possible due to the nationally accepted financial programme structure. The Division District Health Services and Health Programmes will assume full managerial responsibility for all TB hospitals, but the Programme Manager of Programme 4 will retain financial governance and monitoring and evaluation oversight of Sub-programme 4.2.
- Increase paediatric TB beds.
- Strengthen OPD services.
- Coordinated and improved service delivery and governance of service towards improved quality of care with improved patient flow. Improved management of M(X)DR TB.
- To improve the psychosocial element of care for patients within TB Hospitals.
- Improve the infection control strategy for the prevention of transmission of tuberculosis in health care facilities.
- Strengthen the occupational health and safety programme within TB hospitals to protect and care for staff.
- Improved infrastructure and equipment in terms of the upgrading plan for TB hospitals.
- Embark upon a pilot project for the decentralized ambulatory and step down management of TB within the Khayelitsha sub-district.

4.2.2.1 Service Reconfiguration priorities for 2009/10 towards achieving the objectives in the Comprehensive Service Plan:

The key priorities are:

1) Improved access to TB hospital beds:

- Sub-acute patients to be shifted from acute beds in general hospitals to TB beds in TB hospitals.
- Increase paediatric TB beds.

Activities:

- Brooklyn Chest Hospital will become a center of excellence for MDR, XDR and complicated TB patients.
- The acuity of patients to be accommodated within DP Marais Hospital will also be changed given the pressure for acute TB beds. A ward will be converted to an acute ward for MDR patients. Equipment requirements to be addressed include oxygen points, suction units, etc.

- MDR beds to be consolidated across the platform at Brooklyn Chest, DP Marais, Brewelskloof and Harry Comay Hospitals.
- Provision has been made for an increase of 300 beds across the province over time in terms of the CSP. From 2009/10 this will be done in a phased manner in terms of the completion of the infrastructure plan.
- Twenty paediatric beds are to be commissioned at Harry Comay Hospital. The ward is already available, but is currently used for decanting patients.
- Specialist outreach and support needs to be systematically strengthened to TB hospitals in the light of the increasing acuity and co-morbidity of patients. The internal medicine departments of regional hospitals will assume responsibility for the clinical governance within TB hospitals.

2) **Ambulatory Care:**

- A soundproof audio booth will be purchased and installed at Brooklyn Chest Hospital to expand the audiology service and to also serve DP Marais Hospital and the West Coast district. This is necessary as the drugs used for the treatment of TB are potentially ototoxic.
- A soundproof audio booth will also be purchased and installed at Harry Comay Hospital.
- Outreach and support from Brooklyn Chest Hospital to include the Khayelitsha district.
- Establish pharmaceutical services at Sonstraal Hospital. The appointed pharmacist at Paarl Hospital will be utilized towards establishment of this service at Sonstraal Hospital.
- Pharmaceutical services to be strengthened at Brooklyn Chest Hospital by appointing an additional pharmacist. The workload in terms of the ARV services, extended OPD, increased M(X) DR patient load and the increased control of MDR drugs within the Metro by Brooklyn Chest Hospital has necessitated additional capacity.

3) **Improved management of infectious diseases:**

- To ensure an efficient mechanism to shift stable TB patients from TB in-patient care facilities into primary health care (PHC) and community-based services (CBS) care in order to create more capacity.
- To pilot a community-based model for MDR TB management in the Khayelitsha sub-district.
- All remaining TB hospitals to be accredited for ART.

Activities:

- An expert review panel on MDR/ XDR TB, which includes clinicians, has been appointed by the Head of Department. The panel makes recommendations on the clinical management of difficult patients such as chronic defaulters and others that have a very poor prognosis.
- Establish capacity at Brooklyn Chest Hospital to manage acute, complex and often co-infected TB cases, with the appropriate clinical governance from level 2 internal medicine and paediatric units.

- Establishment of ARV services at and the accreditation of DP Marais, Sonstraal, ID and Harry Comay Hospitals. Additional staff to be appointed includes medical officers and nurses.
- An ambulatory service and sub acute facility has been established in the Khayelitsha sub-district in partnership with the community care centers and an identified NPO. Brooklyn Chest Hospital will be responsible for the overall clinical governance of this project.
- A mechanism between the acute hospitals, PHC facilities and the TB hospitals will be created to ensure the efficient flow of TB patients into and out of TB hospitals.

4) **De-hospitalized care:**

- Implement an integrated TB/ HIV adherence model.

Activities:

- The collaboration between the HIV/AIDS and TB programmes within the Department has been strengthened to address effective treatment across the service platform.

4.2.3 **Clinical Governance of TB services:**

4.2.3.1 **Improving Clinical Governance towards improved quality of care:**

- The approach to better manage chronic defaulters will be reviewed.
- Admission and discharge criteria of patients into TB hospitals will be reviewed.
- The outreach and support programme from TB hospitals to PHC facilities will be significantly enhanced to strengthen the clinical management at these facilities.
- Expansion of outreach and support to clinics in the Drakenstein and Stellenbosch districts are planned. Staff will be appointed at Brewelskloof Hospital to address this priority.
- The general approach to improving quality of care mentioned under Sub program 4.1: General Hospitals, will also apply to TB Hospitals.

4.2.3.2 **Improving the psychosocial element of care for patients within TB Hospitals:**

- Additional counselors will be employed at all the MDR TB centers.
- Recreational facilities will be established at all M(X)DR TB centers.
- A register with detailed incident reporting of all patients who absconded will be implemented and an appropriate response ensured. A holistic approach, including psychosocial rehabilitation, to reduce the number of patients absconding from TB hospitals will be further strengthened.

4.2.3.3 **Improving the infection control strategy for the prevention of transmission of tuberculosis in health care facilities:**

- Strengthen infection control measures in all hospitals through improved ventilation systems.
- All hospitals to have a designated infection control officer trained on TB infection control and prevention and monitoring of the implementation of the infection control plans.
- All hospitals to have infection control plans.

4.2.3.4 **Strengthen the occupational health and safety programme within TB hospitals to protect and care for staff:**

- Increased measures to protect staff and patients from contracting TB and MDR TB will be put in place.
- A security system will be installed at Harry Comay Hospital.
- A medical surveillance system to be in place at each TB Hospital to monitor the hospital staff contracting TB within our institutions.

4.2.4 **Corporate Governance in TB hospitals:**

4.2.4.1 **Strengthening the management, staffing and development capacity:**

- A senior executive management structure representing both Programmes 2 and 4 has been created to oversee the urgent implementation of steps to address the pressures in TB hospitals as well as to better coordinate efforts across the programmes.
- The capacity of all the TB hospitals to collect and manage information is being addressed by means of appointing information officers, implementing technical systems where manual data is still collected and ensuring that routine data collected is reported as accurately as possible.
- The TB communication strategy will continue to be strengthened.
- An organizational development exercise has been concluded to ratify the minimum staffing requirements at all TB Hospitals in the medium to long term as per the CSP. The current staff will be matched and placed accordingly. Further posts will be filled in line with the OD reports
- In collaboration with a NGO the counseling service at Brooklyn Chest Hospital has been strengthened. Counselors will also be appointed at all TB hospitals in 2009 with improved outputs planned.
- Human resource management to be strengthened at Brewelskloof Hospital by creating and filling a senior administration officer post.
- Financial management capacity to be strengthened at Brewelskloof hospital by creating and appointing an administration officer for supply chain management.

4.2.4.2 **Infrastructure and equipment**

1) **Brooklyn Chest Hospital:**

- The health facilities infrastructure plan for the province provides for the upgrading of Brooklyn Chest Hospital and the possible move of DP Marais Hospital from the current Princess Alice Orthopaedic Hospital site to the Brooklyn Chest Hospital site. This plan has been approved and forms part of the Departmental infrastructure plan (Refer to Programme 8). This is planned for the medium to long term.
- Infrastructure funding within Programme 8 will be directed towards Brooklyn Chest Hospital in 2009/10 to address the interim planned outputs, which will enhance patient care. One dilapidated ward will be renovated and repaired and will be commissioned as a 20-bed ward; the staff houses will be renovated and repaired to be used as step down facilities. The kitchen will be upgraded and additional offices will be constructed at the occupational therapy department for the commissioning of the audiology department. This work started in 2008/09 and will be completed in 2009/10.

- Ablution facilities will be upgraded which will enhance quality of care and a fire alarm system will be installed.

2) DP Marais Hospital

- The former education/ occupational therapy building at DP Marais Hospital will be converted into a ward, which can accommodate 45 TB drug sensitive patients. This will cost an estimated R3.880 million. The Department of Transport and Public Works is managing this process and commissioning is planned for 2009/10.

3) ID Hospital Malmesbury

- Commission an empty ward to accommodate ten TB drug sensitive patients.
- Further renovations of the hospital will be done in an incremental manner.

4) Harry Comay Hospital

- Purchase and erect two prefabricated buildings to be used as recreational facilities.
- Renovate and repair two additional wards.

5) Brewelskloof Hospital

- The reconstruction of the fire escape to the educational facility.

6) Sonstraal Hospital

- Electrical rewiring is planned for this hospital.

4.3 ANALYSIS OF CONSTRAINTS AND PLANNED MEASURES TO OVERCOME THEM

4.3.1 Services

- 1) The impact of the HIV epidemic on the management of TB clients will have to be managed effectively.
- 2) A major challenge will be the protection of health workers against occupational exposure of TB, especially MDR TB. All the TB hospitals are high-risk settings that need significant protective measures to safeguard their staff.
- 3) Client satisfaction surveys will be performed and norms around patient care and discharge plans, especially for MDR clients, will be further strengthened.
- 4) Improving the clinical skills at Primary Health Care level to diagnose TB in a HIV positive patient, who is sputum negative, will be further strengthened.

4.3.2 Finance and financial management

- 1) Additional TB funding was received in the 2008/09 financial year and used towards strengthening TB hospitals by appointing additional staff, improving the quality of care, building maintenance and increased spending on medication for high-risk TB patients. The projects commenced in 2008/09 will continue in the 2009/10 financial year to further strengthen these hospitals.
- 2) The budgets for medication will be increased for treating the increasing number in MDR/XDR patients.

4.3.3 Human resources

- 1) The general skills and competencies of clinicians to deal with patients with complex clinical presentations at all levels of care will have to be enhanced.
- 2) The organizational design for TB hospitals will be implemented in a phased manner in line with the affordable budget envelope to address the staff shortages.

4.3.4 Support systems and Information

- 1) Staff recruitment and retention challenges to support developing systems in TB hospitals remain problematic in areas such as finance, human resources, maintenance and information management and as these hospitals have been recently provincialised; increased efforts are being made to ensure that these hospitals are brought to the standard of other provincial hospitals in the Western Cape.
- 2) The information technology systems must be strengthened and the standard information and technical systems are systematically implemented.
- 3) The monitoring and evaluation processes within the sub-programme are to be strengthened to improve planning and implementation of objectives.

4.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.9: Provincial objectives and performance indicators for TB hospitals [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Strategic goal: Provide sufficient infrastructure for the rendering TB hospital services.									
Provide sufficient bed capacity to render quality TB hospital services	Provide a total of 1 287 beds in TB hospitals by 2010	1. Number of beds in TB hospitals	1 008	1 008	1 008	1 030	1 120	1 287	1 287
		2. Total number of patient days in TB hospitals	291 798	305 008	299 342	305 328	311 435	355 036	404 740

Note:

Indicator 2: Total number of patient days includes day cases (Day case = 1 separation – 0.5 in patient day)

Table 4.10: Performance indicators for TB hospitals [PHS5]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08
Strategic goal:	To render comprehensive TB hospital services to the population of the Western Cape									
Provide sufficient capacity to render quality TB hospital services	Provide sufficient resources for the rendering of inpatient and out patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010	1. Number of patient day equivalents [PDE] in TB hospitals	293 059	306 287	300 307	342 608	349 460	424 380	424 380	
		2. OPD total headcount in TB hospitals	3 784	3 839	2 942	2 016	2 076	2 117	2 117	
	Implement quality assurance measures to minimise patient risk in TB hospitals	3. Percentage of TB hospitals with patient satisfaction survey using DoH template	0%	31%	33%	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	
		4. Percentage of TB hospitals with mortality and morbidity meetings every month	0%	44%	50%	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	
		5. Percentage of TB hospitals with clinical audit meetings every month	Not requested prior to 20008/09	Not requested prior to 20008/09	Not requested prior to 20008/09	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	
		6. Percentage of complaints resolved within 25 days in TB hospitals	Not requested prior to 20008/09	Not requested prior to 20008/09	Not requested prior to 20008/09	100%]	100%	100%	100%	
Ensure the effective and efficient rendering of sustainable TB hospital services	Manage bed utilisation to achieve an average length of stay of approximately 90 days and a bed occupancy rate of 90% in TB hospitals	7. Average length of stay in TB hospitals	75.5 days	76 days	80 days	85 days	85 days	85 days	85 days	
		8. Bed utilisation rate, based on useable beds, in TB hospitals	79%	83%	83%	85%	85%	90%	90%	
		9. Total separations in TB hospitals	3 340	4 006	3 759	3 834	3 911	4 974	4 974	
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R350 per PDE	10. Expenditure per patient day equivalent in TB hospitals	R242	R258	R339	R366	R395	R345	R362	

Notes:

1. The National Department of Health did not provide national targets for TB hospitals.
2. Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
3. Indicators 7 and 8: Note regarding the 2008/09 target: The number of TB beds will increase. Due to the increase in M(X)DR TB patients it is assumed that the average length of stay and bed utilization rate will also increase.
4. Indicator 10: 2007/08 prices.

4.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS

Sub-programme 4.2 received a nominal increase of R21.046 million or 15.64 per cent in 2009/10 comparison to the revised estimate of 2008/09.

Table 4.11: Trends in provincial public health expenditure for TB hospitals [PHS3]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	66 116 000	76 379 000	101 671 000	134 575 000	155 621 000	171 537 000	184 781 000
Total Capital							
Grand Total	66 116 000	76 379 000	101 671 000	134 575 000	155 621 000	171 537 000	184 781 000
Total per person	14.01	14.47	19.18	25.29	29.13	31.98	34.31
Total per uninsured person	18.77	19.45	25.78	33.99	39.15	42.98	46.11
Constant 2007/08 prices							
Total excluding capital	70 823 288	79 066 299	101 671 000	125 565 398	137 913 122	146 620 393	153 481 834
Total Capital							
Grand Total	70 823 288	79 066 299	101 671 000	125 565 398	137 913 122	146 620 393	153 481 834
Total per person	15.01	14.98	19.18	23.60	25.81	27.33	28.50
Total per uninsured person	20.10	20.13	25.78	31.71	34.69	36.73	38.30

5. SUB-PROGRAMME 4.3: PSYCHIATRIC HOSPITALS

The key deliverables for sub-programme 4.3 in the 2008/2009 financial year were:

- Opening 90 step down beds.
- Appointment of community specialist for Eastern and Khayelitsha sub-districts.
- Strengthening the interface between acute and psychiatric hospitals to cope with the TIK epidemic.
- Training nurses in advanced psychiatry. (Refer to Programme 6)

5.1 SITUATIONAL ANALYSIS

5.1.1 General Overview:

- This sub-programme consists of the four specialist psychiatric hospitals, namely Alexandra, Lentegour, Stikland and Valkenberg Hospitals collectively known as the Associated Psychiatric Hospitals (APH).
- Together these hospitals provide the bulk of the specialist in-patient psychiatric services.
- Remaining specialist in-patient services are provided in the central hospitals and the rural regional hospitals.

5.1.2 Challenges addressed in the 2008/09 financial year:

- Community based mental health care service delivery.
- Acute hospital and clinical services.

- Hospital estate management and physical infrastructure.
- Human resource management.
- Alignment of services in terms of the Comprehensive Service Plan.

5.1.3 Responses to Challenges:

5.1.3.1 Community Based Mental Health Care Service Delivery:

- In line with the World Health Organisation recommendations, the Mental Health Care Act 17 of 2002 and the Comprehensive Service Plan, mental health care services are being integrated into all levels of general care.
- The intention is for the specialist services to grow smaller and provide services only for acutely ill people with severe and enduring mental illnesses.
- The strengthening of district health care services, the increase in community-based care options and the establishment of regional hospital psychiatric services are all essential for this to be realised.
- There is an active collaboration with district health services to discharge the remaining 400 to 500 long term patients who are predominantly in the intellectual disability services (IDS) to appropriate community based settings. This shift follows the principle of funds following the service. In 2008/09, approximately 100 patients were transferred to NPO run facilities within the community.

5.1.3.2 Acute Hospital and Clinical Services:

- The burden of mental illness has been growing with large numbers of patients entering the district hospitals' emergency services, despite their challenges in terms of available infrastructure and clinical competency.
- This has resulted in rapid turnover of patients within the psychiatric hospitals to make way for more acutely ill patients and waiting lists for acute psychiatric beds.
- Various strategies have been employed to improve patient flow and provide options for improved care for specific groups of patients.
- An innovative strategy of assertive community teams (ACT) for the three adult psychiatric hospitals was introduced in January 2007. This is an intensive specialist support service for the patients identified to be unstable, high frequency service users.
- The results of this intervention indicate a dramatic reduction in hospitalisation for these patients. For example over a 12-month period they are hospitalised 10% of the time compared to the preceding 12 months. During the past year readmission rates for the APH overall declined from 13% to 11% despite the rapid discharge of patients in a pressurised service.
- Linked to the ACT service, has been the identification of the need for a sub acute facility where certain patients who require more intensive psychosocial rehabilitation can be afforded the opportunity. In conjunction with Metro District Health Services, two facilities were commissioned at William Slater (Metro West) and Stikland House (Metro East) and each will have a maximum of 42 places and will serve the three psychiatric hospitals. These services opened in September 2008. A joint governance structure has been setup between DHS and the psychiatric hospitals.

Valkenberg and Stikland Hospitals render the day-to-day operational support. These services are being commissioned in such a way as to be transferable to an NPO in two years time.

- Further measures to relieve pressure, have been the active management of acute beds with daily bed status monitored against patients awaiting admission, by senior clinicians and managers at the hospitals; the urgent opening of 20 additional acute beds at Valkenberg Hospital in December/January 2007/08 and active support and outreach from specialists to district hospitals to more effectively manage patients at district level and to facilitate the transfer of skills.
- Trends indicated a declining waiting list for Valkenberg Hospital and a manageable one for Stikland Hospital. Lentegeur Hospital continued to have an unacceptably long waiting list despite having the highest number of available acute beds. A 20-bed medium term unit was commissioned in November 2008 at Lentegeur Hospital to alleviate pressures. This unit was funded from the savings generated through the dehospitalization of IDS patients to a NPO run facility.

5.1.3.3 Hospital estate management and physical infrastructure:

- For the remaining service alignment in accordance with the CSP to take place, chronic wards have to be decommissioned once patients are discharged to alternative care and the vacated units customised for a completely different category of patient.
- Currently the lead-time from decommissioning to renovation to commissioning is a minimum of two years and is a significant rate-limiting factor to progress.
- The major changes still required to take place are in the two intellectual disability services at Lentegeur and Alexandra Hospitals.

5.1.3.4 Human resource management:

- Implementation of the newly approved CSP aligned establishment for the psychiatric hospitals commenced during 2008.

5.1.3.5 Alignment of services towards the Comprehensive Service Plan (CSP):

1) Alexandra Hospital:

In patient services:

- Currently managing 380 beds with reduction to 240 beds planned.
- Within these beds, the service shifts from long term to acute, and medium term for people with specialised needs.

Out patient services:

- Relocation of outpatients into more suitable accommodation to manage the expanded service.
- Establishment of an Assertive Community Team and a structured support and outreach programme negotiated with district health services.

2) Lenteguur Hospital:**Psychiatric services:**

- The current inpatient configuration is close to CSP target.
- Currently there are 205 acute and 60 chronic beds. It is planned to have 225 acute and no chronic beds.
- On 1 March 2007 the first Public Private Partnership (PPP) in the Department of Health was implemented at Lenteguur hospital and Western Cape Rehabilitation sites. The first contractual year, of the 12-year contract, has been successfully completed. At Lenteguur Hospital, the private party provides soft facility management services, which include catering, cleaning and security.

Forensic services:

- The key service still to be commissioned is two 20-bed medium secure units for juveniles and intellectually disabled people.
- The commissioning is dependant on the decommissioning of wards for re-commissioning as secure units, subject to successful discharge of chronic patients, followed by an infrastructure commissioning process.

Intellectual Disability Service:**In patient services:**

- Currently there are 500 operational beds while in terms of the CSP there should be 240 beds.
- Within these beds, the service shifts from long term to acute, and medium term for people with specialised needs.

Out patient services:

- Establishment of an Assertive Community Team and a structured support and outreach programme negotiated with district health services.

3) Stikland Hospital:

- The current configuration is close to the CSP target.
- There are currently 346 beds, which will be reduced to 318 beds, with the final discharge of remaining chronic patients, including the transfer of a 30-bed unit for people with profound and severe intellectual disabilities to district health services or non-profit organizations.

4) Valkenberg Hospital:

- The current 340 beds will increase to 400 beds with the HRP when the Forensic service is expanded.

Table 4.12: Situation analysis indicators for psychiatric hospitals [PHS3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National Target 2003/04
Strategic Goal:	To render specialist psychiatric hospital services to the population of the Western Cape.					
Provide sufficient capacity to render comprehensive specialist psychiatric hospital services	Provide sufficient resources for the rendering of comprehensive specialist psychiatric hospital services to in patients and out patients amounting to approximately 584 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents (PDEs) in psychiatric hospitals	649 818	647 315	641 220	
		2. OPD total headcount in psychiatric hospitals And	19 238	20 573	21 403	
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services	3. Percentage of psychiatric hospitals with patient satisfaction survey using DoH template	100%	100%	100%	
		4. Percentage of psychiatric hospitals with mortality and morbidity meetings every month	100%	100%	100%	
		5. Percentage of psychiatric hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
		6. Percentage of complaints resolved within 25 days in psychiatric hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
Ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 90% by 2010	7. Average length of stay in psychiatric hospitals	125.1 days	129.74 days	139 days	
		8. Bed utilisation rate, based on useable beds, in psychiatric hospitals	82.8%	85.5%	90.4%	
		9. Total separations in psychiatric hospitals and	5 145	4 907	4 560	
	Ensure the cost effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE	10. Expenditure per patient day equivalent in psychiatric hospitals	R460	R481	R537	

Notes:

1. The National Department of Health did not provide national targets for specialist psychiatric hospitals.
2. Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
3. Indicator 10: 2007/08 prices.

5.2 POLICIES, PRIORITIES AND STRATEGIC GOALS FOR 2009/2010:**5.2.1 Strategic Goal:**

Provide specialized psychiatric hospital services for acute and chronic patients.

Provide sufficient infrastructure for the rendering of specialist psychiatric hospital services.

5.2.2 Service Delivery Strategic Objectives:

To align the services in terms of the CSP and the Mental Health Care Act 17 of 2002 to provide the appropriate acute specialist support for a sustainable community based service.

Provide sufficient capacity to render comprehensive specialist psychiatric hospital services.

The key priorities are:

- Strengthening psychiatric services
- De-hospitalization of Intellectual disability patients

5.2.2.1 Acute hospital services:

- Support general regional hospitals to continue with the commissioning of level 2 beds in line with the CSP.
- Integrate assertive community team services into acute adult services and ensure sustainability.

5.2.2.2 Ambulatory Care:

- Strengthen ambulatory services, identifying the full package of specialist ambulatory services, which would support district health services.
- Focus on psychosocial rehabilitation aspects of the service and involvement of the full multidisciplinary team.
- Establish day care centres at each psychiatric facility which provides specialist rehabilitation services for identified vulnerable groups.
 - As part of a first episode psychosis service.
 - For people with dual diagnosis of mental illness and substance abuse.
 - These would need to be goal directed services with active roles for the full multidisciplinary team and would not be confused with pure activity based day centres of the past.
- Continue to strengthen outreach and support to district hospitals. In the Metro, the responsibility is primarily that of the psychiatric hospitals, with contributions from Tygerberg and Groote Schuur Hospitals. In the rural regions, this is part of the level 2 regional services responsibility together with the community psychiatrists. This involves both skills transfer as well as establishing specialist outpatient's clinics.
- At district service level, strengthening of the ambulatory mental health services will be achieved by appointing a designated senior medical officer and a clinical psychologist per sub district and mental health nurses at PHC and district hospitals.
- Mechanisms for effective task shifting will be part of the mental health service team's agenda, with specific reference to mid level workers, particularly home based carers.

5.2.2.3 De hospitalised Care:

- Continue with the dehospitalisation of chronic patients and the closure of chronic intellectual disability beds with a target of 100 patient discharges for the 2009/10 year and the shifting of funds with patients to create more community based residential places.
- Using the same principles, fund level 3 (24-hour supervision) group home placements for people requiring an exit plan from the sub acute facility. Without this, people who have successfully progressed in the step down programme could face readmission to a bed in the psychiatric hospitals.

- Consolidate and stabilise the two new sub acute facilities at William Slater and Stikland House at an estimated R6 million for operational costs.
- District health services continue to improve funding to community based service providers to levels that build sustainability.
- Expand psycho social rehabilitation groups.
- Training of home-based carers in mental health.
- Expand perinatal mental health services at MOU's.

5.2.3 **Clinical governance of psychiatric/mental health services:**

5.2.3.1 **Organizational management:**

- Improving the quality of care remains central to all activities.
- Regular, integrated feedback reports on performance are shared widely on a quarterly basis, which provides an opportunity for all components to participate in robust discussions to improve the quality of information and patient care. This initiative will be continued.
- Structures have been put into place to better co-ordinate and manage services across institutions, levels of care and geographical areas. These include a Chief Directorate six-monthly forum, a monthly meeting between the mental health programmes and the psychiatric hospitals, a Strategic Management Team (SMT) at Chief Directorate level across the divisions and the appointment of a coordinating clinician for mental health services.

5.2.3.2 **Quality of care:**

- Continue to strengthen and maintain quality of care initiatives in line with hospital improvement plans.
- Ensure that monitoring and evaluation is actively used by all clinicians and managers to inform and improve all aspects of care and service delivery within the psychiatric hospitals.

5.2.4 **Corporate Governance of Psychiatric/Mental Health Services:**

5.2.4.1 **Human resource management:**

- Align staff establishments to CSP targets and use all opportunities to acquire and develop the capacity and skills required for the predominantly acute service envisaged in the CSP.
- Recruiting and retaining competent and skilled staff in critical clinical, financial and human resource positions requires ongoing attention and effort, particularly against the background of a highly upwardly mobile workforce.
- The senior clinicians and managers must pay attention to improving local working conditions as well as mentoring junior staff.

5.2.4.2 **Human resource development: (Refer to Programme 6)**

- Continue to provide practical short courses in psychiatry related topics for a range of health professionals with planned expansion of the current programme.
- Provide appropriate continuing professional development for mental health care practitioners.

5.2.4.3 Physical infrastructure:

- Ensure that the long-term plan for the four hospital estates is aligned to the service requirements and any funds available for upgrades are used judiciously to address priorities in service realignment.
- Continue to participate in the HRP process for Valkenberg Hospital and ensure the organisational change management processes compliment this initiative.

5.2.4.4 Strengthen information management:

- Information management plays a central role in providing comprehensive and accurate monitoring and evaluation reports.
- Develop information management skills at hospitals and implement a retention strategy for information officers to improve the quality of data from institutions.

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

5.3.1 Services

- 1) Continue the development and improvement of standards for the acute services.
- 2) Improved management of patient prescriptions with the finalisation of legal prescription charts for all hospitals. The challenge is to provide records, which make practical provision for long patient stays.
- 3) Complaints and compliments will be monitored in accordance with the departmental policy. Hospital and district level trends are to be monitored and each complaint used to improve services and identify risks.
- 4) Morbidity and mortality committees are in place at all hospitals. Quarterly reporting in accordance with provincial policy has been established and will continue. The reviews will be used to improve service delivery within a multidisciplinary team context.
- 5) Adverse incident and safety and security monitoring systems are in place. Reports are submitted quarterly to the Provincial Quality Assurance Coordinator. The results are internalised within the institution and used to change practises locally.
- 6) The mental health service drug and therapeutic forum meets quarterly and represents the psychiatric services across the provincial platform and the chairman represents psychiatric services at the Provincial Coding Committee.
- 7) Treatment protocols for mental health problems at regional and district hospital level have been published and are reviewed annually.
- 8) Regular reports in accordance with the Mental Health Care Act of 2002 are submitted to the Mental Health Review Board.

5.3.2 Finance and financial management

- 1) Improving on audit findings will continue and strengthening financial capacity within Finance and Supply Chain Management units within these hospitals will remain a priority. Training of the first line managers has been prioritised within 2009.
- 2) Increased cost in psychiatric medication in line with the treatment protocols will be carefully managed.

5.3.3 Human resources

- 1) Staff establishments will be aligned to CSP targets and all opportunities will be used to acquire and develop the capacity and skills required for the predominantly acute service envisaged in the CSP.
- 2) Continue with the professional development for mental health care practitioners.
- 3) Continue with the provision of courses in psychiatry for nurses and psychiatry related topics for a range of health professionals.
- 4) Recruiting and retaining competent and skilled staff in critical clinical, financial and human resources positions requires ongoing efforts.

5.3.4 Support systems and Information

- 1) Strengthening information management will continue as it plays a central role in providing comprehensive and accurate monitoring and evaluation reports.
- 2) Continue with the appointment of information officers at all hospitals as an essential means of improving the quality of data from institutions.
- 3) Manage the ageing physical infrastructure on the large estates. This impacts on the daily stressful work experience of staff, which has negative implications for the retention of staff.

5.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.13: Provincial objectives and performance indicators for psychiatric hospitals [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Strategic goal:	Provide sufficient infrastructure for the rendering of specialist psychiatric hospital services								
Provide sufficient bed capacity to render quality specialist psychiatric hospital services.	Provide a total of 1 763 beds in specialist psychiatric hospitals by 2010	1. Number of beds in specialist psychiatric hospitals	2 096	2 015	1 924	1 893	1 796	1 796	1 796
		2. Total number of patient days	643 405	639 948	634 917	621 851	557 209	568 580	580 184
Provide a range of stepdown services to support de-institutionalised care.	Provide a total of 125 stepdown beds for people with mental illness of intellectual disability.	3. Number of stepdown beds	-	-	-	New indicator	125	125	125
		4. Bed utilisation rate of stepdown beds	-	-	-	New indicator	85%	85%	85%
		5. Total number of patient days in stepdown beds	-	-	-	New indicator	38 781	38 781	38 781

Notes:

Indicator 2: Total number of patient days includes Day cases (Day case – 1 separation – 0.5 in patient day).

Table 4.14: Performance indicators for specialist psychiatric hospitals [PHS5]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08	
Strategic goal	To render specialist psychiatric hospital services to the population of the Western Cape										
Provide sufficient capacity to render comprehensive specialist psychiatric hospital services	Provide sufficient resources for the rendering of comprehensive specialist psychiatric hospital services to in patients and out patients amounting to approximately 600 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents [PDEs] in psychiatric hospitals	649 818	647 315	641 220	627 405	580 141	607 725	607 725		
		2. OPD total headcount in psychiatric hospitals	19 238	20 573	21 403	16 664	22 932	22 932	22 932		
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services	3. Percentage of psychiatric hospitals with patient satisfaction survey using DoH template	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	
		4. Percentage of psychiatric hospitals with mortality and morbidity meetings every month	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	
		5. Percentage of psychiatric hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	
		6. Percentage of complaints resolved within 25 days in psychiatric hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	100%	100%	100%	100%		
Ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 85% by 2010	7. Average length of stay in psychiatric hospitals	125.1 days	29.74 days	139 days	130 days	100 days	100 days	100 days		
		8. Bed utilisation rate, based on useable beds, in psychiatric hospitals	82.8%	85.5%	90.4%	90%	85%	85%	85%		
		9. Total separations in psychiatric hospitals	5 145	4 907	4 560	4 783	4 628	4 455	4 455		
	Ensure the cost effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE	10. Expenditure per patient day equivalent in psychiatric hospitals	R460	R481	R537	R578	R657	R667	R698		

Notes:

1. The National Department of Health did not provide national targets for psychiatric hospitals.
2. Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
3. Indicator 10: 2007/08 prices

5.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Sub-programme 4.3 was allocated a nominal increase of R41.648 million or 10.72 per cent in 2009/10 in comparison to the revised estimate of 2008/09.

Table 4.15: Trends in provincial public health expenditure for psychiatric hospitals [PHS6]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	279 060 000	300 496 000	344 390 000	388 523 000	430 171 000	474 168 000	510 777 000
Total Capital							
Grand Total	279 060 000	300 496 000	344 390 000	388 523 000	430 171 000	474 168 000	510 777 000
Total per person	59.15	56.93	64.98	73.01	80.51	88.39	94.84
Total per uninsured person	79.21	76.51	87.33	98.13	108.21	118.80	127.46
Constant 2007/08 prices							
Total excluding capital	298 928 350	311 068 572	344 390 000	362 511 946	381 222 493	405 292 726	424 258 939
Total Capital							
Grand Total	298 928 350	311 068 572	344 390 000	362 511 946	381 222 493	405 292 726	424 258 939
Total per person	63.36	58.93	64.98	68.12	71.35	75.55	78.78
Total per uninsured person	84.85	79.20	87.33	91.56	95.90	101.54	105.87

6. SUB-PROGRAMME 4.4: REHABILITATION SERVICES

The key deliverables for sub-programme 4.4 in the 2008/ 2009 financial year were:

- Facilitate the development of rehabilitation capacity at all service levels through the provision of rehabilitation-related training in various fields such as specialized wheelchair and buggy seating, neuro-rehabilitation, etc.
- Training of trainers in specialized seating from African Partner countries.
- Continue with nurse training initiatives (R2 176, R2 175 and R683 bridging programmes) for nursing staff from the Metro hospitals. The hospital-based nursing schools will operate as campuses under the Western Cape College of Nursing.
- Align the Provincial Mobility Assistive Devices Advisory Committee under the WCRC. Establish a similar advisory committee for speech-/ language- and hearing assistive devices.
- Transfer the management of Orthotic and Prosthetic Centre (OPC) services to Western Cape Rehabilitation Centre (WCRC and reduce the OPC waiting list).
- Continued stringent management of the public private partnership (PPP) contract and completion of outstanding remedial works to ensure appropriate risk transfer to the private party.

6.1 SITUATIONAL ANALYSIS

6.1.1 General Overview:

- Only the Western Cape Rehabilitation Centre (WCRC), for persons with physical disabilities, and the Orthotic and Prosthetic Centre (OPC) remain in this sub-programme. For this reason the sub-programme was designated Rehabilitation Services.
- Both WCRC and OPC provide services to the entire Western Cape Province, although OPC services in the Southern Cape are outsourced.
- Services provided by the WCRC and OPC are closely interlinked and transversal in nature.
- These rehabilitative services are a key enabler for the implementation of the CSP, as they improve the ability of clients to access health services at the appropriate levels, provided that they have access to the necessary mobility-and other assistive devices and assistive technology.

6.1.1.1 The Western Cape Rehabilitation Centre

- The Western Cape Rehabilitation Centre is a 156-bed provincial specialized facility providing physical rehabilitation services to persons with activity limitations and participation restrictions, resulting from a wide variety of impairments such as spinal cord afflictions, head injury, amputation, stroke, complications of TB/HIV and AIDS, amongst others.
- The WCRC provides essential specialized in-and outpatient rehabilitation services to persons from the Western Cape and neighboring provinces, and plays a key role in reducing the impact of disabling conditions on individuals, their families and the broader community.
- Community re-integration, a return to productive activity and an improved quality of life are key outcomes.
- The in-patient services of the WCRC maintained average bed occupancy of 85%, but only during core working hours, i.e. Monday to Friday. The majority of clients continued to be discharged home over weekends as part of the strategy to facilitate their future reintegration back into the community, and into their families. This was reflected in a “drop” in PDE’s following the implementation of Clinicom in mid-September 2008.
- Service efficiencies remained extremely difficult to improve due to excessive workloads for health therapists. Recruitment of nursing staff remained problematic.
- The specialist outreach seating clinics to community-based mental health programmes, special schools and care centers were again outsourced in 2008/09. Annually, 80 outreach clinics are provided to approximately 1 000 high-risk clients, most of whom are children.

6.1.1.2 Orthotic and Prosthetic Centre

- In mid 2008/09 the management of the Orthotic and Prosthetic Centre was shifted from Programme 7 to Sub-programme 4.4 to resort under the WCRC. Improving service efficiencies, technical expertise and replacement of obsolete equipment were identified as priority areas to be addressed in 2009/10.

- Improved warehousing services and the appointment of much-needed administrative- and stores staff was also identified as key areas to be addressed. The recruitment and retention of qualified orthotists/prosthetists remains a challenge.
- The continued outsourcing of services in the Southern Cape/ Karoo region provided relief to the OPC whose staff continues to experience service pressures.
- The provision of orthotics and prosthetics are essential elements of rehabilitation programmes for persons with physical disabilities. The rehabilitation process is accelerated by the early supply of a well-fitting device. Conversely an incorrectly manufactured or ill- fitting device delays rehabilitation and results in poorer outcomes for clients.

6.1.1.3 Public Private Partnership

- On 1 March 2007 the first Public Private Partnership (PPP) in the Department of Health was implemented at the WCRC and greater Lentegeur sites. The first contractual year, of the 12-year contract, has been successfully completed.
- The PPP provides for risk transfer from the Department of Health to the private party, of all moveable and immovable assets for planned-, preventative- and reactive maintenance, as well as upgrading and refurbishment where indicated.
- “Hard” and “soft” facilities management services were provided in eleven service areas (including medical- and therapeutic equipment, cleaning, catering, linen and laundry, gardens and grounds, security, estate maintenance, waste management, pest control, utilities management and provision of a 24-hour helpdesk) at an additional cost per PDE of R290.
- The implementation of the PPP has allowed clinical staff to focus on core business i.e. rendering rehabilitation services to clients, as all facility management and equipment issues are logged through the helpdesk.
- In the first year of the PPP contract period a total of 2 749 calls, mostly for estate maintenance and medical equipment, were logged. A total of 121 calls exceeded the stipulated rectification period, resulting in penalty deductions of R259 083.
- The successful implementation of the PPP is due to strong support provided by the Department of Health PPP contract manager and two contract supervisors who assist the heads of the institutions in stringently managing the PPP. They ensure that penalties are deducted where necessary and that the sub-contractors achieve the deliverables in terms of the output specifications and service standards. The objective is for the Department to receive the expected value for money.
- The benefits of the PPP in ensuring the ongoing and long-term maintenance of the WCRC facility completed in 2004 at a cost of R100 million are clearly evident. In 2008/09 the buildings still remain neat, clean and in an excellent state of repair. The adequate maintenance of state assets is in line with the Infrastructure Plan for Healthcare 2010.
- At the WCRC, the PPP also makes provision for the acquisition, maintenance and refurbishment of all medical and therapeutic equipment, over the 12-year period, and in 2008/09 a substantial number of obsolete pieces of equipment were replaced by the private party (ECG’s, defibrillators, tilt tables, posture wheelchairs etc)

6.1.2 Challenges addressed in the 2008/09 financial year:

- The very slow pace of development of rehabilitation services at community-based level, as well as increased bed pressures at acute tertiary facilities (90% of all WCRC referrals) which impacted negatively on the ability of the Bed Management Team to expedite admissions and reduce length of stay.
- Co-morbidity, particularly the development of pressure sores in persons with spinal cord afflictions admitted to acute hospital facilities, resulted in excessive delays in the implementation of rehabilitation programmes for many clients and increased expenditure to the Department for the management of these preventable complications.
- A further challenge is to fund the most effective and efficient solution to address the needs of long term, ventilator dependent spinal cord injured patients referred from the Acute Spinal Cord Injury Unit at Groote Schuur Hospital.
- There are increasing requests for senior (supervisory) WCRC clinical staff to provide technical expertise to other divisions and programmes within the Provincial Department as well as at National Health level, to African Partner countries and the WHO in Geneva as part of the Motivation Project.
- Acceptable nursing staff to patient ratios, eradicating a PN ratio of 1:79 beds at night.
- Recruitment and retention of medical staff to the WCRC and qualified orthotists / prosthetists to the OPC.
- The re-alignment of the OPC under “Health” services as opposed to “Engineering” services necessitating an altered mind-set to service delivery and the implementation of change management strategies.
- Implementation of Clinicom and the concomitant increased administrative workload on already over-burdened clinical staff.
- Dual statistical systems to be integrated where possible in order to provide useful and accurate information for management.
- An appropriate organizational structure aligned with real service demands following commissioning of the WCRC in 2004, and which not only provides career progression for therapists but which also reflects the specialized and developmental nature of the services provided by the WCRC.
- Under-utilization of certain infrastructure such as the hydro pool and gym area.

Responses to challenges:

- Ongoing provision of technical expertise to DHS, participation on various DHS Task Teams and expansion of the Bed Management Team (BMT) to include the two Nursing Assistant Managers (Area Managers).
- In the WHO Guidelines on the Provision of Manual Wheelchairs in less resourced settings, the WCRC is listed as one of six accredited training sites world-wide, and in 2008/09, the WCRC continued to develop rehabilitation capacity at all service levels through the presentation of training modules on wheelchair- and buggy seating. Courses (such as the 3-week basic and 1-week advanced courses in neurological rehabilitation) were also presented.

- Obtaining USAID Funding (through Motivation, UK) to pay for “replacement” (locum) staff, while WCRC staff is involved in development and training initiatives.
- Facilitating the development and implementation of minimum standards, in line with the newly released World Health Organization guidelines on a national basis, has been prioritized for 2009/10.
- Utilization of sub acute facilities such as Conradie Care Centre / Booth for wound management of patients with pressure sores until such time as clients can be admitted for rehabilitation, as well as ongoing awareness-raising on the prevention of pressure sores.
- Development of a business proposal for the commissioning of 3-4 beds at WCRC for the management of long-term ventilated patients.
- Appointment of permanent nursing staff to reduce agency expenditure and bridging/ upgrading of own staff through own nurse training initiatives.
- The process of change management was initiated at the OPC along with an investigation of staffing options and solutions, efficient working methods and the utilization of available human resources.
- Identified obsolete equipment at OPC and prioritized replacement in 2009/10, explored options of developing OPC as a national training site and revised skills development priorities for staff.
- Investigated the implementation, application and shortcomings of the HIS programme, to support and incorporate the WCRC data coding system, so as to provide useful statistics for quality assurance improvements and performance management.
- Submitted various requests for an organizational development investigation to address the range of staff capacity matters.
- Development of a Health and Wellness Centre proposal in collaboration with the Facility Board and Mitchells Plain- and Khayelitsha Disability Forums, to optimize the utilization of infrastructural resources at WCRC.

Table 4.16: Situation analysis indicators for specialised rehabilitation services [PHS3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National Target 2003/04
Strategic goal:	To provide comprehensive interdisciplinary specialised rehabilitation services for persons with physical disabilities, inclusive of the provision of mobility and other assistive devices, orthotics and prosthetics.					
Provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources for the rendering of high intensity rehabilitation services to in patients and out patients amounting to approximately 53 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents in rehabilitation hospitals (PDEs)	277 907	47 130	50 654	
		2. OPD total headcount in rehabilitation hospitals	4 740	5 206	5 856	
	Implement quality assurance measures to minimise patient risk in the WCRC	3. Percentage of rehabilitation hospitals with patient satisfaction survey using DoH template	12%	100%	100%	
		4. Percentage of rehabilitation hospitals with a mortality and morbidity meetings every month	0%	100%	100%	
		5. Percentage of rehabilitation hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
		6. Percentage of complaints resolved within 25 days in rehabilitation hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	
Ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 40 days and a bed occupancy rate of 90% by 2010	7. Average length of stay in rehabilitation hospitals	54.6 days	43.3 days	51.6 days	
		8. Bed utilisation rate, based on useable beds, in rehabilitation hospitals	73%	80%	87%	
		9. Total separations in rehabilitation hospitals	5 059	1 049	958	
	Ensure the cost effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1,800 per PDE	10. Expenditure per patient day equivalent in rehabilitation hospitals	R372	R1 212	R1 577	

Notes:

1. The National Department of Health did not provide national targets for specialized rehabilitation hospitals.
2. Indicator 1: The decrease in beds between 2005 and 2006 reflects the mainly acute services from the old Conradie Hospital site that were absorbed by other facilities in the Metro
From 2006/07 the budget for the provincially aided hospitals previously funded by Programme 4.4 moved Sub-programme 2.4 (St Joseph's Hospital and Sara Fox) and Sub-programme 5.1 (Maitland Cottage Hospital)
3. Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
4. Indicator 9: The decrease in separations and PDEs in 2006/07 was the result of the shift of hospitals from this programme to other sub-programmes.
5. Indicator 10: 2007/08 prices.

6.2 POLICIES, PRIORITIES AND STRATEGIC GOALS FOR 2009/2010:

6.2.1 Strategic Goal:

To provide comprehensive interdisciplinary specialized rehabilitation services for persons with physical disabilities, inclusive of the provision of mobility- and other assistive devices, orthotics and prosthetics.

6.2.2 Service Delivery Strategic Objectives:

- To further develop the WCRC as a centre of excellence for rehabilitation services.
- To facilitate the development of quality rehabilitation services for persons with physical disabilities, at all levels of health care within the Department.
- Provide sufficient capacity to render comprehensive high intensity rehabilitation services.
- Render an orthotic and prosthetic service for the province.
- Provide quality orthotic and prosthetic services.
- Provide a responsive orthotic and prosthetic service.

Key priorities:

- 1) Enhancing rehabilitation services in terms of the objectives within the Comprehensive Service Plan (CSP), including implementation of an appropriate service solution for long-term ventilated patients and continued provision of capacity-building training and research.
- 2) Improved ambulatory care: (The priorities below are transversal across the platform)
 - Centralized co-ordination of mobility and speech/language and hearing assistive devices for the Western Cape.
 - Strengthen the integration of the orthotic and prosthetic services with WCRC as a provincial service.
- 3) Commissioning of the Health and Wellness Centre Project for persons living with a disability in the communities of Mitchells Plain and Khayelitsha.
- 4) Provision of support to the adjacent district hospital and CHC's.
- 5) Organizational development to align WCRC and OPC structures with the CSP and service realities.
- 6) To establish accreditation requirements to get WCRC accredited as a training venue for occupational therapy- and physiotherapy technicians and to compile the business case.

6.2.2.1 Enhancing rehabilitation services in terms of the objectives within the Comprehensive Service Plan (CSP):

- The prevalence and incidence of disability continues to increase annually as acute hospitals and EMS services increase their efficiencies and effectiveness in response to an increasing disease burden and caseload.

- The development of rehabilitation services at primary level (facility and community based) in accordance with the CSP rehabilitation strategy is slow, resulting in increasing length of stay at the WCRC and continued outpatient attendances at tertiary and secondary hospitals. For this reason, the WCRC will continue to provide technical expertise to District Health Services to facilitate the development of community-based rehabilitation.
- Assistance continues to be rendered to the District Health Services regarding the service reconfiguration.
- In 2009/10, and as one of six listed WHO Training Providers, the WCRC will continue to develop rehabilitation capacity at all levels through the presentation of basic-, Intermediate and advanced training modules on wheelchair-and buggy seating. The internationally accredited 3-week basic and 1-week advanced courses on neurological rehabilitation will also continue to be provided at WCRC.
- The WCRC will continue to provide International Classification of Functioning, Disability and Health (ICF) training to health therapists in South Africa as requested by the National Department of Health.
- The implementation of minimum standards, in line with WHO guidelines, for the provision of mobility assistive devices in lesser-resourced settings, will continue to be a priority. The WCRC, through the Provincial Mobility Assistive Devices Advisory Committee, and in partnership with Motivation, will continue to play a catalytic and advocacy role in ensuring the adoption of the WHO Guidelines in the whole of South Africa.
- Addressing the provincial backlog on mobility-, hearing-, prosthetic- and orthotic assistive devices remains problematic. Efforts will be made to continue to find innovative ways of dealing with the increased demand for such devices by people living with disabilities.
- Addressing the quality and lifespan of mobility assistive devices to enhance the quality of life of wheelchair users will continue through research and development. The partnership with Motivation, an NGO from the United Kingdom is supported in this regard.

6.2.2.2 Ambulatory care:

1) **Centralized management of mobility assistive devices for the Western Cape:**

- The functions of the Provincial Mobility Assistive Devices Committee resort under the WCRC management and will be further developed
- A similar Advisory Committee for Speech- / Language- and Hearing assistive devices will be established to provide consolidated information to top management structures and to advocate for strategies to reduce backlogs.
- The provision of dedicated, ring-fenced funding to facilitate the eradication of the existing waiting lists for mobility- and other assistive devices will be investigated

2) **Management of the Orthotic and Prosthetic Services:**

- The plan developed in 2008/09 will be incrementally implemented with a specific focus in 2009/10 on reducing the waiting times for appliances and improving the quality of the orthotic and prosthetic services.

- Orthotic and prosthetic services remain problematic with long waiting lists, staff shortages and very outdated technology, equipment and technical expertise. Service reconfiguration options to reduce waiting lists build capacity and improve service quality and efficiencies will continue to be explored.
- Equipment requirements for the centre will be prioritized and purchased in terms of the available funding allocations to this sub-programme and from the Central Equipment Capital Expenditure Fund.
- Occupational Health and Safety concerns identified at the OPC will be addressed in collaboration with Engineering Services.
- Implementation of HIS / Clinicom is scheduled for early 2009/10 to facilitate the move away from an “engineering / manufacturing” mind-set, to a “patient-focused service delivery” mind-set. More accurate patient-related statistical data will also become available.

6.2.2.3 Commissioning of the Health and Wellness Centre Project for persons living with a disability in the communities of Mitchells Plain and Khayelitsha

- Equipment- and human resource requirements to commission the project will be identified. Alternative funding streams (private sector-, interdepartmental- and other alternatives) will be further explored.
- Relationship-building with the Disability Forums and other key stakeholders will continue.

6.2.2.4 Provision of support to the Mitchells Plain District Hospital and Sub-District CHC's

- Implementation of the JAC Pharmacy Dispensing system (HIS Module) as part of the continued pharmaceutical support provided to the Mitchells Plain District hospital (satellite wards on the Lentegour site) is scheduled for early in 2009/10.
- Strategies to improve efficiencies in the warehousing support provided to the Mitchells Plain District Hospital and CHC's in the Sub-District will continue to be investigated and the service level agreements adapted accordingly.

6.2.3 Corporate Governance:

6.2.3.1 Management of the Public Private Partnership contract:

- Implementation of the public private partnership necessitates ongoing vigilance and stringent financial controls to ensure compliance with the Department's contractual obligations and obtaining best value for money.
- Clinical staff are able to focus on their core business of service delivery, although administration and management of the PPP adds to the workload of the hospital manager and administrative staff.
- The reporting lines and governance mechanisms of this project are being reviewed.

6.2.3.2 Improved human resource management and development

- The utilization of agency nursing staff has decreased to the minimum through the judicious utilization of overtime contracts and the appointment of permanent nursing staff.

- A new Skills Development strategy for OPC staff will be developed and implemented, in line with the technological upgrade of equipment at the OPC.
- The outputs of the Nurse Training School at WCRC are addressed in Programme 6.
- Incorporation of the WCRC Nursing School as a sub-campus of the WCCN will continue to be investigated.

6.2.3.3 Improved information management and monitoring and evaluation systems:

- Standard operating procedures and generic rehabilitation standards have been developed. Compliance to improve quality of care and efficiencies in patient management will be monitored on an ongoing basis.
- The Code of Behaviour (COB) strategy for patients and visitors developed and implemented at WCRC will continue to be monitored on a quarterly basis.

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

6.3.1 Finance and financial management

- 1) Implementation of the public-private partnership necessitates ongoing vigilance and stringent financial controls to ensure compliance with the Department's contractual obligations and obtaining best value for money without compromising or impacting negatively on the core business.
- 2) Revenue generation remains challenging given the national policy on free health care for the disabled.
- 3) Additional cost recovery from the Departments of Education and Social Development will be done, given the number of outreach services rendered to these sites, e.g. special schools, care centres, workshops, old age homes, etc.

6.3.2 Human resources

- 1) Despite ongoing nursing vacancy rates, the use of agency staff has decreased through the use of overtime contracts and ensuring that vacant posts are filled as soon as possible.
- 2) Training nurses at the WCRC Nursing School will further address the nursing shortages.

6.3.3 Support systems and Information

- 1) Implementation of the HIS / Clinicom patient information system is scheduled for early 2009/10.
- 2) The rehabilitation-specific information-management system, which was developed to provide realistic epidemiological information and accurate management information per diagnosis, is unique to this specialized referral rehabilitation facility. Performance targets are being developed as the database increases. The need for this system to become part of a local area network (LAN) at the WCRC will continue to be pursued. It unfortunately cannot be absorbed into Clinicom, which makes the need to continue with dual information systems a necessity.

6.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.17: Provincial performance objectives and performance indicators for rehabilitation services [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Sub-programme 4.4: Rehabilitation services	Strategic goal:	To provide comprehensive interdisciplinary specialised rehabilitation services for persons with physical disabilities, inclusive of the provision of mobility and other assistive devices, orthotics and prosthetics.							
Provide sufficient bed capacity at the WCRC to render high intensity rehabilitation services.	Provide a total of 156 beds in the WCRC by 2010.	1. Number of beds in WCRC	911	156	156	156	156	156	156
		2. Total number of patient days	276 144	45 395	48 743	49 552	49 600	51 246	51 246
Render an Orthotic and Prosthetic service for the Province	Manage a combination of in-house and out-sourced services	3. Number of orthotic and prosthetic devices manufactured.	4 616	4 467	5 250	5 500	5 610	6 910	6 910
Provide quality Orthotic and Prosthetic devices	Training and liaison with Physiotherapists and Occupational Therapists	4. Percentage of orthotic and prosthetic devices requiring remanufacture.	3%	2%	2%	2%	2%	2%	2%
			(138/ 4 616)	(89/ 4 467)	(105/ 5 250)	(110/ 5 500)	(112/ 5 610)	(138/ 6 910)	(138/ 6 910)
Provide a responsive Orthotic and Prosthetic service	Increase productivity and outsourcing where cost effective	5. Number of patients on waiting list for orthotic and prosthetic services for over 6 months.	527	758	441	450	420	220	220

Notes:

- Indicator 1: The decrease in beds between 2005 and 2006 reflects the mainly acute services from the old Conradie Hospital site that were absorbed by other facilities in the Metro . From 2006/07 the budget for the provincially aided hospitals previously funded by Programme 4.4 moved Sub-programme 2.4 (St Joseph's Hospital and Sara Fox) and Sub-programme 5.1 (Maitland Cottage Hospital)
- Indicator 2: Total number of patient days includes Day cases (Day case = 1 separation – 0.5 in patient day)

Table 4.18: Performance indicators for rehabilitation services [PHS5]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2005/06 Actual	Province wide value 2006/07 Actual	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Province wide value 2010/11 Target	Province wide value 2011/12 Target	National target 2007/08	
Strategic goal:	To provide high intensity specialised rehabilitation services for persons with physical disabilities.										
Provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources for the rendering of high intensity rehabilitation services to in patients and out patients amounting to approximately 53 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents in rehabilitation hospitals	277 907	47 130	50 654	50 788	51 804	53 079	53 079		
		2. OPD total headcount in rehabilitation hospitals	4 740	5 206	5 856	6 137	6 137	6 200	6 200		
	Implement quality assurance measures to minimise patient risk in the WCRC	3. Percentage of rehabilitation hospitals with patient satisfaction survey using DoH template	12%	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	
		4. Percentage of rehabilitation hospitals with mortality and morbidity meetings every month	0%	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	
		5. Percentage of rehabilitation hospitals with clinical audit meetings every month	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	
		6. Percentage of complaints resolved within 25 days in rehabilitation hospitals	Not requested prior to 2008/09	Not requested prior to 2008/09	Not requested prior to 2008/09	100%	100%	100%	100%		
Ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 45 days and a bed occupancy rate of 90% by 2010	7. Average length of stay in rehabilitation hospitals	54.6 days	43.3 days	51.6 days	51 days	50 days	47 days	45 days		
		8. Bed utilisation rate, based on useable beds, in rehabilitation hospitals	73%	80%	87%	85%	85%	90%	90%		
		9. Total separations in rehabilitation hospitals	5 059	1 049	958	1 139	1 004	1 139	1 139		
	Ensure the cost effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1800 per PDE	10. Expenditure per patient day equivalent in rehabilitation hospitals	R372	R1 212	R1 577	R1 843	R1 909	R1 981	R2 074		

Notes:

- The National Department of Health has not provided national targets for rehabilitation services.
- Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.
- Indicator 8: A 75% bed utilization rate is the limit set in the PPP contract. PDEs exceeding this result in additional expenditure to the Department.
- Indicator 10: 2007/08 prices.

6.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Sub-programme 4.4 was allocated a nominal increase of R11.301 million or 11.27 per cent in 2009/10 in comparison to the revised estimate of 2009/10.

Table 4.19: Trends in provincial public health expenditure in rehabilitation services [PHS6]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	96 569 000	55 202 000	79 888 000	100 299 000	111 600 000	123 014 000	132 512 000
Total Capital							
Grand Total	96 569 000	55 202 000	79 888 000	100 299 000	111 600 000	123 014 000	132 512 000
Total per person	20.47	10.46	15.07	18.85	20.89	22.93	24.60
Total per uninsured person	27.41	14.05	20.26	25.33	28.07	30.82	33.07
Constant 2007/08 prices							
Total excluding capital	103 444 463	57 144 213	79 888 000	93 584 127	98 901 205	105 145 601	110 066 429
Total Capital							
Grand Total	103 444 463	57 144 213	79 888 000	93 584 127	98 901 205	105 145 601	110 066 429
Total per person	21.93	10.83	15.07	17.59	18.51	19.60	20.44
Total per uninsured person	29.36	14.55	20.26	23.64	24.88	26.34	27.47

7. SUB-PROGRAMME 4.5: DENTAL TRAINING HOSPITALS

The key deliverables for sub-programme 4.5 in the 2008/09 financial year were:

- Training of dental health professionals.
- Phased implementation of the Oral Health Plan.

7.1 SITUATIONAL ANALYSIS:

7.1.1 General Overview:

- The University of the Western Cape Oral Health Teaching platform (OHTP) comprises of the Tygerberg Oral Health Centre (OHC), Mitchells Plain OHC, Red Cross Children's Hospital dental clinic, Groote Schuur Hospital maxillo-facial unit and satellite centres at Mitchells Plain CHC, Guguletu dental clinic, Bottelary clinic and its mobile dental services, including services provided on the Phelophepa Health Care Train.
- The operational service plan for oral health has been approved and implementation has commenced in a phased manner.

7.1.2 Challenges addressed in the 2008/09 financial year:

- Implementation of the approved operational service plan for oral health.
- Addressing expensive dental equipment requirements and maintaining them within an improved infrastructure for dental services.
- Training and development of oral health professionals.
- Oral health services at Correctional Services facilities.

7.1.3 Response to challenges:

- The implementation of the approved Oral Health Plan is being done in a phased manner within the existing funding envelope.
- Equipment needs and infrastructure requirements were addressed.
- Training and development, especially of oral hygienists and a new programme to train dental therapists (as midlevel) were negotiated between the National Health Department and Department of Education in terms of the National Health Human Resource Plan.
- The process has been commenced for the consideration of an exit strategy for oral health services delivered at Correctional Services facilities. It was recommended that Correctional Services provide their own primary health care and only tertiary and quaternary services be provided by the provincial Department of Health at a cost to Correctional Services.

7.1.4 Population characteristics and equity:

- 1) **The projected increase in public oral health services demand was based on four factors:**
 - Census figures indicating the Western Cape is experiencing a high growth rate especially in the urban areas.
 - Increased poverty in the communities that need services the most.
 - The medical aid policy of allocating oral health financing to the saving account increased the public sector workload as non-primary dental procedures are generally high expense items.
 - An increase in referrals from both the private and public sector PHC facilities to the OHTP, due to the expertise available at these sites.
- 2) **Health needs as assessed by the South African National Children's Oral Health survey of 2003 highlighted the following with the highest prevalence rate and incidence in the Western Cape.**
 - Caries: 82% of children < 6 years have tooth decay.
 - Dentures: 37% of adults are edentulous.
 - Impact of trauma, motor vehicle accidents and violence on maxillo-facial surgery.
 - The pattern of dental problems is in the main preventable by educational programmes and water fluoridation and the majority of oral diseases can be treated at primary care facilities.

- The increase in referral of tertiary and quaternary services, especially for craniofacial deformities has placed an additional burden on complex treatment protocols and prolonged theatre time.

7.1.5 Service facilities:

- As a service facility, the OHTP has become the de facto referral centre for more complex patients. The OHTP package of care consists of primary, secondary, tertiary and quaternary services.
- The Tygerberg OHC and Mitchells Plain OHC and the satellite clinics of the OHTP at the Mitchell's Plain CHC and the Red Cross Children's Hospital are the only specialized children's clinics offering comprehensive oral health services for children and children with special needs. It is also the screening site for children that require treatment under general anaesthetic and conscious sedation.
- The OHTP provides specialised dental treatment for medically compromised and maxillofacial services at the Red Cross Children's Hospital, Tygerberg and Groote Schuur OHC's.
- The outreach programme of the OHTP at Guguletu is serviced by staff and students from the OHTP on a rotational basis and takes comprehensive oral health care to primary health care. This outreach programme sees in excess of 18 000 patients per year.
- Patients from all over the province, as well as neighbouring provinces and countries, seek treatment at the OHTP. The majority of them are referred from the public sector oral health service clinics for tertiary and quaternary services.
- The demand for adult dentures creates long waiting lists and places a significant burden on the operational budget and dental laboratory services of the OHTP.
- The high referral rates for extraction of wisdom teeth under general anaesthetics resulted in long waiting times and constrain service delivery for other maxillofacial services.
- The referrals of orthodontics from both public and private sector for patients aged 6-17 years resulted in a heavy load on the specialist orthodontic service.
- There was a need to increase prioritisation and focus of the services due to the demand being beyond the resources available. The level of service utilisation is high and is being reflected in the number of visits to the OHTP.
- A strengthened PHC service would also reduce the service delivery burden on the OHTP.

7.1.6 Cost efficiency:

- Cost of personnel is high due to the fact that supervision of students is labour intensive.
- All dental specialist posts are consolidated at the OHTP for the provision of specialized services and the training of registrars.
- It is of note that a significant part of the services are rendered by postgraduate students especially registrars in the four clinical specialities, e.g. the average patient load of 100 patients for an orthodontics registrar is equivalent to R1.3 million worth of specialised services per registrar per year.

- In general the cost of preventive measures, infection control and sterilization, has increased due to the HIV and AIDS epidemic. The specific treatment cost has also significantly increased due to laboratory costs and drug therapy for opportunistic infection.

7.1.7 Oral health training:

- At undergraduate level, dentists and oral hygienists are being trained at the UWC OHTP.
- At post-graduate level specialists in the following disciplines are being trained:
 - Maxillo-facial and oral surgery
 - Orthodontics
 - Prosthodontics
 - Community dentistry
 - Oral medicine and periodontics
 - Oral pathology
- The OHTP and the University of the Western Cape is committed to produce on average per year for the next MTEF period the following oral health professionals:
 - Ninety-four dentists
 - Twenty-two oral hygienists (diploma level)
 - Three oral hygienists (degree level)
 - Six registrars per year
 - Twenty M.Science (Dent) students in the four clinical disciplines
 - Twenty-three Diploma in Conscious Sedation and Pain graduates comprising of medical officers and dentists to reduce the burden of services under general anaesthesia.
 - Fifty-seven Diploma in Advanced Dentistry.
- In addition the OHTP will provide Continuing Professional Development courses for both public and private sector oral health professionals. The OHTP provides the facilities for teaching and practical training for radiographers and dental assistants at the two training centres for the students of the Cape Peninsula University of Technology.

7.2 POLICIES, PRIORITIES AND STRATEGIC OBJECTIVES FOR 2009/2010:

The oral health plan will be implemented in phases over time within the available resources. While most of the elements will rightly fall under Programme 2, the plan has been described in this section for completeness and because the OHTP will be providing technical support with the implementation of the plan and the evaluation of services.

7.2.1 Strategic Goals:

- To provide accessible and quality dental services for the Western Cape population.
- To provide for the training of oral health personnel at different levels for the PGWC and the country.

7.2.2 Strategic Objectives:

- To provide dental services efficiently and effectively within the available resources.
- To conduct research primarily for public health programmes.
- To facilitate and support the monitoring and evaluation of public sector services at a district level.

7.2.3 Phased implementation of the Comprehensive Oral Health Service Plan (COHSP):

The key priorities are:

7.2.3.1 Fluoridating the oral environment:**1) Water fluoridation**

It is unlikely that progress will be made with widespread water fluoridation in the Western Cape in the short to medium term.

2) School fluoride rinsing and/ or both brushing programme

In view of the delay in implementing water fluoridation, a programme of rinsing with fluoride was considered. However, due to the need to establish a sound oral hygiene practice at an early age it was decided that the brushing programme would be more appropriate.

7.2.3.2 Selective pit and fissure sealant programme

Implementation of a pit and fissure sealant programme targeting first and second permanent molar teeth. Sealing first permanent molars of grade 1 children in four schools with an estimated 400 children. The schools selected would be two in the Ravensmead area and two in Mitchells Plain. The estimated cost for this additional service for sealant material is R96 000.

7.2.3.3 Primary oral care treatment package

- 1) Early diagnosis and treatment of grade 1 learners which includes:
 - Annual screening of grade 1 learners.
 - Basic conservative care for permanent dentition and emergency care (extractions and Atraumatic Restorative Technique) for primary dentition.
- 2) Contingency care: second to sixth primary school years:
 - Basic conservative care on demand for permanent dentition and emergency care (extractions and Atraumatic Restorative Technique) for primary dentition.
- 3) Screening and conservative care for permanent dentition in final primary school year.
- 4) High school and adults includes:
 - Contingency care: emergency care (extractions) and basic conservative care on demand.
 - Screening of children in well baby clinics at the Mitchells Plain Day Hospital for the prevention of early childhood caries.

7.2.3.4 Oral health promotion and education

The above will be supported with an aggressive oral health education and promotion programme, which will focus on mother and childcare in order to address the profound problem of early childhood caries (ECC).

7.2.3.5 Service priorities

Table 4.20: Service priorities for the oral health programme

PRIORITY	SERVICE	STAFF CATEGORY
1. Primary prevention	Water fluoridation Dental health education Fluoride rinsing/brushing programmes	Oral hygienists Dental assistants Dental therapists Dentists Speech therapists Dieticians, etc
2. Basic treatment package [clinical procedures]	Examination Intra-oral X-rays Simple fillings Emergency pain relief and treatment of sepsis Dentures	Oral hygienists Dental therapists Dentists Dental technicians

7.2.3.6 The service platform

- The proposed service platform deviates from the national model. Primary oral health services in the Western Cape are only rendered in district hospitals where no suitable accommodation is available within a clinic or community health centre.
- Theatre facilities and anaesthetists will be made available at district hospitals for treatments requiring general anaesthesia. Children under 6 years of age present an overwhelming demand for dental treatment under general anaesthetics. Service delivery in the Mitchell's Plain and Khayelitsha catchment's areas is to be improved. This will require the appointment of additional staff including theatre-nursing staff. For 2009/10 a theatre nurse will be appointed. This would allow the establishment of a general anaesthetic service for dentistry in the Mitchells Plain catchment area through a public private partnership.
- General anaesthetics access for medically compromised child patients at Red Cross War Memorial Children's hospital to be improved.

7.2.3.7 Service package

The package of care to be provided at primary health care facilities will be in line with the national policy. The package of care will therefore consist of promotive and primary preventative services as well as basic treatment services. School children and pre-school children will be the priority patient groups.

The distribution of workload across the levels of care will be as follows:

- 90% primary care
- 8% secondary care
- Tertiary and quaternary care will account for 2% of services provided

7.2.3.8 Denture provision:

- The demand for dentures remains a critical service delivery problem. The Western Cape Peninsula (including Metropole) has the highest edentulous population in South Africa. The adult population largely affected is in the lower and lower to middle class who depend on the Provincial Government Health Services. It is not possible to meet the demand and therefore the current levels of denture provision will be continued.
- This will ensure the provision of about 1 500 denture units per year.
- To increase this service by an additional 100 denture units, an additional R300 000 would be required.

7.2.4 Corporate Governance of Dental Services:**7.2.4.1 Strengthening Human Resources**

Staffing required was determined based on a utilization-based approach. From the level of utilization the required staff numbers per category of staff was calculated and compared to the CSP staffing model.

There was not a significant difference in the estimated staff costs between the CSP staffing and the numbers derived from the modelling. In order to contain costs, the CSP staffing model was accepted.

Provision was also made for additional posts as well as oral health manager posts at district level.

7.2.4.2 Support systems

Role of the UWC OHTP:

It is envisaged that the OHTP would be engaged at the following levels:

- 1) Treating referred patients for the following:
 - Maxillo-facial surgery
 - Oncology
 - Oral pathology
 - Orthodontics
 - Advanced restorative
 - Advanced paediatric dental services
 - Management of medically compromised patients requiring hospital care.

- 2) Human resource development:

Improving the skills of oral health professionals as follows:

- Extended skills of oral hygienists – in service training
- Dentist:
 - Interceptive orthodontics, e.g. orthodontic skills development of clinicians at designated clinics in the province in order to facilitate interceptive treatment and concomitant

prevention of minor malocclusions. This would entail dental technicians to provide services for removal appliances.

- Minor oral surgery, e.g. fracture immobilisation under local anaesthetic, impacted molars
 - Dental assistants: in service training in terms of requirements for registration with the Health Professions Council.
- 3) Support to the regions:
- Registrar (maxillo-facial surgeon) rotation e.g. Paarl Hospital
 - Orthodontic expertise can be established in various regions. More advanced cases can be managed in consultation with a full-time service rendering orthodontist at the OHTP which is available to the Provincial Oral Health Services.
 - Development of minor oral surgery skills of clinicians at designated clinics and regions to facilitate local treatment of simple fractures, impacted 3rd molars.
 - General specialist consultation service to the regions as required from time to time.

7.2.4.3 Infrastructure:

- Oral health infrastructure requirements are addressed in the departmental infrastructure planning processes.

7.2.5 Clinical Governance of Dental Services:

- To incrementally implement the Provincial Quality of Care policy.
- The three components to be addressed are:

7.2.5.1 Patient Satisfaction

- The development of a client based survey to assess the satisfaction with services rendered at the OHC.
- Complaints mechanism in place (PALS) and follow up on recommendations.
- The Hospital Board in line with the Facilities Boards Bill will be making the OHC accessible to the community and facilitate community participation in decision-making.
- Reduction of waiting lists through the transfer of skills and services to the other levels of care, general improved efficiency and PPI (dentures and orthodontics).

7.2.5.2 Care for the Carer

- Staff support unit established (EAP) and encourage staff utilization of the support that can be provided.
- Employee satisfaction survey to be done and recommendations to be addressed.

7.2.5.3 Clinical Quality

- To develop management tools by clinicians to measure quality assurance of services per department. To use monitoring indices to measure impact of the services on quality of life indicators.
- Develop evidence-based treatment protocols that are accepted by all stakeholders.
- Multi -disciplinary quality assurance team to evaluate adverse events and services as a peer review mechanism.
- To measure prevalence and incidence rates to assist in quality of care for HIV/AIDS, TB and special categories of ill patients.

7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

7.3.1 Services

- 1) A client based survey will be further developed to assess the level of satisfaction with services rendered.
- 2) The complaints mechanism will be used to ensure corrective measures are implemented to improve patient care.

7.3.2 Finance and financial management

- 1) The Western Cape COHSP will be implemented in a phased manner within the available funding envelope.
- 2) Procurement of non-contract items and small capital equipments to be streamlined.
- 3) Standardisation of dental consumables.

7.3.3 Human resources

- 1) The Oral Health HR requirements will be addressed as part of the broader Departmental HR plan.
- 2) In-service training to be strengthened for oral health professionals.

7.3.4 Support systems

- 1) Oral health infrastructure requirements will be addressed in the Departmental infrastructure planning processes.

7.3.5 Information

- 1) Routine collection of Oral health indicator information to be improved with clear indicators, targets, data verification and data assessment.

7.4 SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 4.21: Situation analysis and performance indicators: Academic Dental Services [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	National target 2007/08 ¹
Strategic goal:	To establish an effective and efficient dental service delivery platform with sufficient resources for the teaching and training of dental hospitals.						
Provide sufficient capacity to render quality dental services.	Provide sufficient resources for the rendering of inpatient and out patient dental hospital services.	1. Number of patient visits per annum	181 141	195 203	176 991	193 800	
		2. Number of theatre cases per annum	1 363	1 563	1 016	1 200	
		3. Number of patients provided with dentures per annum	2 282	1 335	1 205	1 400	
Provide sufficient resources for the teaching and training of dental professionals	Optimise the number of students trained on the platform per annum	4. Number of students graduating per annum	174	107	198	220	

Note:

- The National Department of Health did not provide national targets for dental hospitals.
- 2008/2009 reduction in service due to refurbishment of the two theatres at Tygerberg Oral Health Centre and reduction of operating slates at Grootte Schuur Hospital.

Table 4.22: Performance indicators: Academic Dental Services [PHS4]

Strategic goal	To establish an effective and efficient dental service delivery platform with sufficient resources for the teaching and training of dental hospitals.								
Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2010/12 Target
Provide sufficient capacity to render quality dental services.	Provide sufficient resources for the rendering of inpatient and out patient dental hospital services.	1. Number of patient visits per annum	181 141	195 203	176 991	193 800	197 676	198 000	198 000
		2. Number of theatre cases per annum	1 363	1 563	1 016	1 400	1 300	1 300	1 300
		3. Number of patients provided with dentures per annum	2 282	1 335	1 205	1 300	1 500	1 500	1 500
Provide sufficient resources for the teaching and training of dental professionals	Optimise the number of students trained on the platform per annum	4. Number of students graduating per annum	174	107	198	200	240	240	240

Note:

- The National Department of Health did not provide national targets for dental hospitals.

7.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Sub-programme 4.5 is allocated a nominal increase of R8.586 million or 12.25 per cent in 2009/10 in comparison to the revised estimate of 2008/09.

Table 4.23: Trends in provincial health expenditure for dental training hospitals [PHS6]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total excluding capital	58 735 000	55 924 000	61 888 000	70 096 000	78 682 000	86 729 000	93 426 000
Total Capital							
Grand Total	58 735 000	55 924 000	61 888 000	70 096 000	78 682 000	86 729 000	93 426 000
Total per person	12.45	10.59	11.68	13.17	14.73	16.17	17.35
Total per uninsured person	16.67	14.24	15.69	17.70	19.79	21.73	23.31
Constant 2007/08 prices							
Total excluding capital	62 916 780	57 891 615	61 888 000	65 403 174	69 728 894	74 131 179	77 601 019
Total Capital							
Grand Total	62 916 780	57 891 615	61 888 000	65 403 174	69 728 894	74 131 179	77 601 019
Total per person	13.34	10.97	11.68	12.29	13.05	13.82	14.41
Total per uninsured person	17.86	14.74	15.69	16.52	17.54	18.57	19.37

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALISED)

1. AIM

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

2. PROGRAMME STRUCTURE

Sub-programme 5.1. Central hospital services

Rendering of only highly specialised tertiary and quaternary services on a national basis, and a platform for the training of health workers and research.

The three central hospitals, Tygerberg Hospital, Groote Schuur Hospital and Red Cross War Memorial Children's Hospital, provide both highly specialised health services to the people of the Western Cape, as well as patients from beyond provincial and national boundaries, as part of their total services.

3. SITUATION ANALYSIS

3.1 CONTEXT OF CENTRAL HOSPITAL SERVICES:

In line with the strategic direction of the Department of Health, as outlined by the Comprehensive Service Plan, the Central Hospitals provide both highly specialized and general specialist services within the facilities. These highly specialised services are grouped into level 3 and 4 or tertiary and quaternary services), and general specialist or secondary services level 2 services, represented by programme 5.1 and programme 4.1 respectively. Table 5.1 below indicates the beds in these hospitals according to the level of care. Beds refer largely to the inpatient service, while there is also a significant outpatient service.

Table 5.1: Number of beds operated in central hospitals by level of care [2008/09] [CHS1]

Central Hospital	Level 3 and 4 beds	Level 2 beds	Total beds
Groote Schuur Hospital [GSH]	685	190	875
Tygerberg Hospital [TBH]	538	772	1310
Red Cross War Memorial Children's Hospital [RCWMCH]	237	63	300
TOTAL	1460	1025	2485

3.2 SERVICES

3.2.1 Range of services provided

A comprehensive range of highly specialised services was provided within the 1 460 tertiary (level 3 and 4) bed platform. The various services provided are reflected in Table 5.2 overleaf.

Highly specialised services represent 2% of all patient contacts. Highly specialised services are provided by sub-specialists who focus on particular aspects of a general specialty area. These services often require expensive and advanced equipment and health technology, as well as a multidisciplinary approach, whereby specialists from more than one discipline participate in the management of patients with complex illnesses. This is reflected in the cost of patient care at tertiary level of care (R2 923 per patient day equivalent)¹ compared to that at secondary level (R1 229 per patient day equivalent)¹. A strong focus was placed on strengthening the health system to ensure the correct and appropriate referral of patients for highly specialised care.

Table 5.2: Range of services in central hospitals during 2008

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

¹ Costs as on 1 October 2008

3.2.2 Service organisation

3.2.2.1 Tygerberg Hospital

Tygerberg Hospital provides a full spectrum of tertiary services as part of the Western Cape Tertiary Service Platform, apart from services such as paediatric cardiac surgery, heart, liver and bone marrow transplantation that are centralised at GSH and RCWMCH. Tygerberg Hospital highly specialised services receive referrals from Metro East level 2 services, the Worcester and Paarl level 2 geographical areas, as well as direct emergency referrals according to the referral guidelines from West Coast District, Cape Winelands District, the Overberg District and the Central Karoo District.

Tygerberg Hospital provides certain provincially unique services:

- Twenty-two bed adult Burns Unit (recently refurbished), which includes critical care beds.
- Cochlear implantation.
- Dedicated academic infection prevention and control unit.
- Craniofacial surgical unit.

3.2.2.2 Red Cross War Memorial Children's Hospital

Red Cross War Memorial Children's Hospital provides tertiary and quaternary paediatric services as well as regional hospital paediatric services (reported on in Programme 4.1) to its immediate drainage area. The Red Cross War Memorial Children's Hospital receives patients from the Klipfontein corridor, Metro West and George. Currently no other paediatric beds exist in the Klipfontein corridor. The Red Cross War Memorial Children's Hospital is an important provincial, national and international clinical and academic resource in child health care. It is a national referral centre for:

- Paediatric liver and kidney transplants.
- The separation of conjoined twins.
- It is the provincial centre for paediatric cardiac surgery.
- It is the only dedicated specialised burns unit for children in the Province.

The Red Cross War Memorial Children's Hospital plays a vital role in clinical governance of child health services in the province.

3.2.2.3 Groote Schuur Hospital

Groote Schuur Hospital, which celebrated its 70th anniversary during 2008/09, drains patients from the Metro West as well as George for adult and neonatal services. Groote Schuur Hospital provides unique services such as:

- Heart, liver and bone marrow transplants.
- Cardiac electrophysiology.
- Neurosurgical coiling.
- Neuronavigational surgery.
- Neuropsychiatry with special focus on HIV related psychiatric problems.
- Ocular oncology services

All three central hospitals receive referrals for highly specialised care from the whole of South Africa, as well as SADC countries.

3.2.2.4 Restructuring of the services within the central hospitals

Key changes to the central hospitals in the restructuring process to implement the Comprehensive Service Plan are:

- 1) Differentiating tertiary and secondary services within each central hospital, both for inpatients and outpatients.
- 2) Establishing a Unitary Western Cape Tertiary Service with a shared vision across the highly specialised services.
- 3) Ensuring equitable access to highly specialised services for all citizens of the Western Cape.
- 4) Ensuring appropriate organisational alignment to enable the management by level of care.

The steps taken to restructure the services in 2008/2009 were as follows:

- 1) Differentiating tertiary and secondary services within each central hospital, both for inpatients and outpatients.
 - Designation of beds and wards as either level 2 or level 3 and ensuring that patient management is within the respective packages of care. Checklists and guidelines were established for laboratory investigations, use of blood products, a range of medications, imaging modalities and staffing ratios per level of care.
 - The shift of ten paediatric tertiary service beds (six endocrine beds and four neurosurgery beds) from GSH to RCWMCH was initiated in the last quarter of 2008/2009 and final consolidation of these services will take place in the 2009/10 year.
 - Identifying the respective levels of service and systematically moving patients to level 1 services where appropriate and simultaneously accommodating level 2 and 3 patients who have been inappropriately managed in level 1 services.
 - Outpatient activities were differentiated by level of care.
 - Reporting mechanisms were established to record patient activity and expenditure by level of care.
- 2) Establishing a Unitary Western Cape Tertiary Service with a shared vision across the highly specialised services.
 - A level 3 package of care was finalised following wide consultation.
 - The level 3 bed distribution across the central hospitals was finalised with input from clinicians and relevant Institutions of Higher Education.
 - Ensuring a seamless interface between level 2 and level 3, especially between the level 2 heads per discipline in the Metro West and the Metro East and the level 3 heads and academic Heads of Department.
 - Establishing a clear clinical governance framework for a Unitary Western Cape Tertiary Service.
 - Ensuring cooperation across the platform.

3) Ensuring equitable access to highly specialised services.

As a result of a clinical governance initiative, steps were taken to ensure equitable access to highly specialised services a process has been implemented to facilitate the referral by speciality and sub-speciality from the five level 2 geographic areas to the unitary Western Cape Tertiary Service. The five level 2 geographic areas are Metro West, Metro East, George, Paarl and Worcester regional hospital geographical service areas. It has been agreed that there should be a single waiting list for the unitary Western Cape Tertiary Service and initial steps have been taken to implement this, for example a single waiting list has been established for paediatric cardiac care and for transplant services.

4) Ensuring an appropriate organisational design to enable the management by level of care.

- The organisational design investigations have been applied to all three central hospitals and will be finalised during 2009/2010.
- Particular areas of technical design work were required with regard to areas such as critical care, theatre needs and modernised management principles.

3.2.3 Service activities and performance for 2008/09

The 2008/09 financial year was the first year where Programme 5 reported only on the highly specialised services of the central hospitals. Target setting has been a challenge given the lack of separate historic trends for the highly specialised services and reporting mechanisms had to be adjusted and bolstered to report separately on the highly specialised services.

The secondary services provided in the central hospitals are reflected separately in Programme 4.1. During 2008/09 the tertiary service outputs in the central hospitals have been more closely aligned with the CSP targets which are based on optimal efficiency.

The key service indicators for the central hospitals are reflected in Tables 5.3 to 5.6.

The tables below reflect some of the unique tertiary and quaternary services delivered in 2008/2009.

Table 5.3: Red Cross War Memorial Children's Hospital

Key tertiary service outputs	Red Cross War Memorial Children's Hospital
Total number of operations performed ¹	8 400
Number of open heart operations performed	240
Number of children admitted and treated for burns	2 600
Number of complex spinal operations performed	8
Number of liver and kidney transplants total	12
Number of ICU beds operated	20
ICD Inpatient coding rate ²	88%

Notes:

1. The target in 2008/2009 was 750 cases per month. The achievement was for an average of 700 operations per month. The target was set based on past trends, which included a supplementary ENT list of short surgical procedures which has moved to another facility. Whilst the number is less than the target, theatre performance was maintained during 2008/2009.
2. The ICD-10 coding system is a diagnosis coding standard developed by the World Health Organisation (WHO) and was adopted by the Department of Health. This system indicates the type of pathology/disease or diagnosis of a patient.

Table 5.4: Groote Schuur Hospital

Key tertiary service outputs	Groote Schuur Hospital	
Number of heart valve replacements	100	
Transplants (liver and kidney)	50 renal; 4 heart transplants; 7 liver transplants	
Renal dialysis stations operated for chronic patients with chronic renal failure	23 dialysis stations	
Number of hip and/or knee replacements performed	150 total	
Catheter laboratory activities (These activities are provided by cardiologists and frequently require anaesthetic interventions as well)	Pericardial aspirations ¹	50
	Valve screens ²	28
	Electrophysiological studies ³	76
	Cardiac ablations ⁴	52
	Intracardiac defibrillations ⁵	911
	Intra aortic balloon pumps inserted ⁶	12
Vitreoretinal surgical cases performed	120	
Endovascular aortic repair procedures performed	15	
Bone marrow transplants performed	14	
ICD 10 Inpatient coding rate	85%	

Notes: Explanations of catheter laboratory activities:

1. Pericardial aspirations: withdrawal of excess fluid from the lining of the heart, the fluid prevents the heart from functioning normally.
2. Valve screens: x-ray screening of metal valves to evaluate valve function.
3. Electrophysiological studies: highly specialised studies done to assess the electrical functioning of the heart in patients with suspected cardiac conduction disturbances and abnormal heart rhythms.
4. Cardiac ablation: Surgical cautery of an abnormal electrical circuit in the heart which is causing a problem with the function of the heart
5. Intracardiac defibrillations: a special pacemaker inserted into to the heart that can deliver a shock the patient if the heart has an abnormal rhythm to
6. Intra aortic balloon pumps: a balloon placed in the aorta to assist cardiac function in patients with abnormal valves or problems with the arteries

Table 5.5: Tygerberg Hospital

Key tertiary service outputs	Tygerberg Hospital
Transplants	40 renal transplants
Renal dialysis stations operated for chronic patients with chronic renal failure	Operated 21 dialysis stations and purchased services through a PPI agreement equivalent to three stations
Number of cochlear implants performed	6
Number of hip and/or knee replacements	200 total
Number of cardiac stents inserted	325
Number of pacemakers inserted	100 new, 25 replacements
Vitreoretinal surgical cases done	80
ICD 10 Inpatient coding rate	70%

Maitland Cottage Home

Maitland Cottage Home, a provincially aided hospital, operates as an extension of RCWMCH and renders specialist orthopaedic surgery, post-operative care and rehabilitation for children with orthopaedic conditions. Maitland Cottage Home has 85 beds, and had 900 admissions, and performed 420 operations during the financial year 2008/2009.

Table 5.6: Situation analysis indicators for central hospitals [CHS2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Actual 2005/06	Actual 2006/07	Actual 2007/08	National target 2007/08
Strategic goal	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant					
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarian section rate for central hospitals	36%	35%	36.6%	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents in central hospitals	1 092 450	1 117 316	1 090 957	Not available
		3. OPD total headcount in central hospitals	886 778	964 193	957 339	Not available
		3.1 Casualty/emergency/trauma headcount in central hospitals	142 315	154 652	151 637	Not available
		3.2 Comprehensive OPD total headcount in central hospitals (OPD + casualty/emergency/trauma) (3.2 = 3 + 3.1)	1 029 093	1 118 845	1 108 976	Not available
		4. Percentage of central hospitals with a patient satisfaction survey using DoH template	100% [3/3]	100% [3/3]	100% [3/3]	100%
		5. Percentage of central hospitals with mortality and morbidity meetings at least once a month	100% [3/3]	100% [3/3]	100% [3/3]	100%
		6. Percentage of central hospitals with clinical audit meetings at least once a month	100% [3/3]	100% [3/3]	100% [3/3]	Not available
		7. Percentage of central hospitals with complaints resolved within 25 days	Not requested prior to 2007/08	Not requested prior to 2007/08	100% [3/3]	100%
		8. Case fatality rate in central hospitals for surgery separations	3.10%	2.97%	3.80%	3.00%
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay in central hospitals	5.6 days	5.4 days	5.8 days	5.3 days
		10. Bed utilisation rate, based on useable beds, in central hospitals	81.80%	83.00%	80.90%	75.00%
		11. Total separations in central hospitals	122 649	127 671	123 495	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE	12. Expenditure per patient day equivalent in central hospitals	R1 876	R1 900	R 2 150	R1 877

Notes:

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided. Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units. However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation= 0.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.7: Situation analysis indicators for Grootte Schuur Hospital [CHS2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National target 2007/08	
Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant						
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarian section rate for Grootte Schuur Hospital	Data not requested per hospital	43.%	46.7%	25%	
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents in Grootte Schuur Hospital			436 967	424 173	Not available
		3. OPD total headcount in Grootte Schuur Hospital			417 801	418 466	Not available
		3.1 Casualty/emergency/trauma headcount in Grootte Schuur Hospital			Not reported previously in the APP	42 269	Not available
		3.2 Comprehensive OPD total headcount in Grootte Schuur Hospital (OPD + casualty/emergency/trauma) (3.2 = 3 + 3.1)			Not reported previously in the APP	460 735	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Grootte Schuur Hospital has a patient satisfaction survey using DoH template			Yes	Yes	Yes
		5. Grootte Schuur Hospital has mortality and morbidity meetings at least once a month			Yes	Yes	100%
		6. Grootte Schuur Hospital has clinical audit meetings at least once a month			Yes	Yes	Not available
		7. Percentage of complaints resolved at Grootte Schuur Hospital within 25 days			Not requested prior to 2007/08	100%	100%
		8. Case fatality rate in Grootte Schuur Hospital for surgery separations			4.1%	4.4%	3.00%
	Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay in Grootte Schuur Hospital		6.1days	6.26 days	5.3 days
			10. Bed utilisation rate, based on useable beds, in Grootte Schuur Hospital		82%	81.8%	75.00%
11. Total separations in Grootte Schuur Hospital				45,089	42,977	Not available	
Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE		12. Expenditure per patient day equivalent in Grootte Schuur Hospital		R 2,079	R 2,355	R1 877	

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Data for 2007/08 for the individual separate hospitals has been updated from Sinjani subsequent to the finalisation of the data for the collective central hospital as reported in the 2007/08 Annual Report.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation=0.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.8: Situational analysis indicators for Tygerberg Hospital [CHS2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Actual 2005/06	Actual 2006/07	Actual 2007/08	National target 2007/08	
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarian section rate for Tygerberg Hospital	Data not requested per hospital	28%	30%	25%	
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents in Tygerberg Hospital			536 918	518 130	Not available
		3. OPD total headcount in Tygerberg Hospital			395 928	370 123	Not available
		3.1 Casualty/emergency/trauma headcount in Tygerberg Hospital			Not previously reported separately in APP	66 584	Not available
		3.2 Comprehensive OPD total headcount in Tygerberg Hospital (OPD + casualty/emergency/trauma) (3.2 = 3 + 3.1)			Not previously reported separately in APP	436 707	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Tygerberg Hospital has a patient satisfaction survey using DoH template			Yes	Yes	Yes
		5. Tygerberg Hospital has mortality and morbidity meetings at least once a month			Yes	Yes	Yes
		6. Tygerberg Hospital has clinical audit meetings at least once a month			Yes	Yes	Not available
		7. Percentage of complaints resolved within 25 days at Tygerberg Hospital			Not requested prior to 2007/08	100%	100%
		8. Case fatality rate in Tygerberg Hospital for surgery separations			4.5%	4.9%	3.00%
	Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay in Tygerberg Hospital		6.25 days	6.2 days	5.3 days
			10. Bed utilisation rate, based on useable beds, in Tygerberg Hospital		81%	80.3%	75.00%
11. Total separations in Tygerberg Hospital				60 751	59 237	Not available	
Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE		12. Expenditure per patient day equivalent in Tygerberg Hospital		R 1 754	R 1 995	R1 877	

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Data for 2007/08 for the individual separate hospitals has been updated from Sinjani subsequent to the finalisation of the data for the collective central hospital as reported in the 2007/08 Annual Report.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation= 0.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.9: Situational analysis indicators for Red Cross War Memorial Children's Hospital [CHS2]

Strategic Objectives	Measurable objectives	Measure / Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	National target 2007/08	
Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant						
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarian section rate for Red Cross War Memorial Children's Hospital	Data not requested per hospital	Not applicable	Not applicable	Not applicable	
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of one out patient per inpatient day ¹	2. Number of patient day equivalents in Red Cross War Memorial Children's Hospital			143,431	148,654	Not available
		3. OPD total headcount in Red Cross War Memorial Children's Hospital			150,464	145 639	Not available
		3.1 Casualty/emergency/trauma headcount in Red Cross War Memorial Children's Hospital			Not reported previously in the APP	41 637	Not available
		3.2 Comprehensive OPD total headcount in Red Cross War Memorial Children's Hospital (OPD + casualty/emergency/trauma) (3.2 = 3 + 3.1)			Not reported previously in the APP	187 276	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Red Cross War Memorial Children's Hospital has a patient satisfaction survey using DoH template			Yes	Yes	Yes
		5. Red Cross War Memorial Children's Hospital has mortality and morbidity meetings at least once a month			Yes	Yes	Yes
		6. Red Cross War Memorial Children's Hospital has clinical audit meetings at least once a month			Yes	Yes	Not available
		7. Percentage of complaints resolved within 25 days at Red Cross War Memorial Children's Hospital			Not requested prior to 2007/08	100%	100%
		8. Case fatality rate in Red Cross War Memorial Children's Hospital for surgery separations			0.44%	0.3%	3.00%
	Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay in Red Cross War Memorial Children's Hospital		3.9 days	4 days	5.3 days
			10. Bed utilisation rate, based on useable beds, in Red Cross War Memorial Children's Hospital		84.00%	81.70%	75.00%
11. Total separations in Red Cross War Memorial Children's Hospital				21 831	21 281	Not available	
Ensure the cost effective management of central hospitals at a target expenditure of approximately R2,800 per PDE		12. Expenditure per patient day equivalent in Red Cross War Memorial Children's Hospital		R 1 845	R 2 155	R1 877	

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Data for 2007/08 for the individual separate hospitals has been updated from Sinjani subsequent to the finalisation of the data for the collective central hospital as reported in the 2007/08 Annual Report.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total patient days (Day cases=1 separation= 0.5 in patient day.)

Indicator 12: 2007/08 prices

3.2.4 Case load in Central Hospitals

The delivery of acute hospital services remains a key activity in the central hospitals and particular emphasis has been placed on emergency centres, theatres and critical care areas. Emergency surgery represents up to 40% of the total surgical outputs.

Service trends by admissions have not changed significantly over the last five years. Significant service pressures remained in obstetrics, neonatal and orthopaedic surgery services as well as intensive or high care services. The number of deliveries at Groote Schuur Hospital increased by 8% compared to 2007/08 and Tygerberg Hospital by 7% with a related increase in neonatal services. The commissioning of extra level 2 obstetric beds and shifting of services to the appropriate level of care together with the bolstering level 1 and midwife obstetric unit (MOU) capacity provided some relief in managing the obstetric service pressures.

Surgical disciplines, over time, experienced a reduction in theatre time largely due to nursing shortages and several vacant anaesthetist posts. These relate to the recruitment and retention of skilled nursing staff to function in the theatre environment and a provincial wide challenge in terms of recruiting and retaining anaesthetists. Key priorities that have been identified are to increase operating theatre time and efficiencies and to reduce the cancellation rate of operations. During 2008/09 both Groote Schuur and Tygerberg Hospitals provided an extra theatre list for urgent surgical procedures and increased efficient day surgical activities to relieve some pressure on theatres. A theatre efficiency task team was established and a range of surveys and operational policies developed to support the whole province in this strategic undertaking. A theatre priority setting project was launched to assist clinicians and managers in the need to prioritise cases for surgery.

The seasonal burden of disease especially for paediatric burns, respiratory infections and diarrhoeal disease acutely escalates resource requirements. Diarrhoeal disease remains a seasonal occurrence from January to May each year, resulting in bed high occupancy rates well over 100 percent in RCWMCH. Without early identification and treatment some diarrhoeal cases progress and eventually require higher levels of care. The diarrhoeal season was dealt with in a collaborative fashion by means of an integrated diarrhoeal season management plan. Similarly, during the winter months paediatric burns admissions increased to almost double the baseline in the summer months.

Similar seasonal pressures in psychiatric and medical conditions, especially respiratory, required responsive resource allocation strategies.

Provision of renal services and especially dialysis services remained a key service priority for both Tygerberg and Groote Schuur Hospitals. Groote Schuur Hospital commissioned three additional renal dialysis stations to deal with the increasing service requirements. Tygerberg Hospital utilised earmarked funding to open three stations in a public private initiative with a private provider in Paarl to expand delivery capacity by 1 000 dialysis sessions a year.

The implementation of the Acute Emergency Case Load Management Policy was audited and monitored to ensure an appropriate response to major service pressures. There was a specific focus on assessing discharge management strategies and more efficient bed management.

During 2008/09, Groote Schuur Hospital developed lodging facility proposal focusing on medically stable patients requiring no provincial hospital care. Such a lodging facility will allow the hospital to use acute beds to admit acutely ill patients, whilst still completing the care of patients who are ambulatory and require follow-up on a daily basis until the treatment plan is complete. Examples are

radiation therapy for cancer, and ophthalmic care. It is envisaged that such lodging facilities could be operated by NGO's.

3.2.5 **Ambulatory care (outpatient services, outreach and support)**

Due to the number of outpatient headcounts exceeding the CSP targets, in 2008/09 it was imperative to critically assess whether outpatient visits were appropriate. These assessments commenced in paediatrics and medicine with particular emphasis on chronic conditions which formed part of a Chronic Disease Management project in the Department that spans various levels of care (programmes 5, 4 and 2). The initial focus was on epilepsy, diabetes mellitus, hypertension, asthma and dermatology. Through this process, stable patients who could be treated at other appropriate levels of care were identified. These patients were referred for management to facilities closer to their homes with outreach and support from the referral hospital.

Outreach and support to less specialised levels of care forms part of the key responsibilities of each specialised level of care as to assist in strengthening the health system. Level 3 services predominantly reach out to level 2 services. The CEO's of the central hospitals formalised outreach and support activities and initiated new arrangements with facilities providing lower levels of care as identified by co-ordinating clinicians or needs analyses.

3.2.6 **De-hospitalised care**

Co-ordinating clinicians, jointly with hospital clinicians and managers, conducted point prevalence studies so as to ascertain a profile of patients who might be treated at more appropriate, less specialised levels. Systems re-engineering was required to move patients and re-direct referral systems where required. Patients who could be managed in de-hospitalised care settings were identified and together with District Health Services these patients have been discharged from the central hospital setting.

3.2.7 **Infectious disease management**

In collaboration with other health programmes, highly specialised experts in central hospitals assisted in the drafting of the Provincial Infectious Diseases Plan. A strategic objective of this plan is to relocate stable patients on anti retroviral treatment (ART) to the correct level of care, according to patient needs.

Infection prevention and control remains a specific priority in central hospitals. High-risk areas are areas in which the average length of stay is relatively long, e.g. critical care areas, or where there is congestion of patients, e.g. in emergency centres and neonatal wards. Hand washing was particularly promoted together with the rational use of antibiotics. The risk of transmission of Tuberculosis in the institutions as a particular focus area and strategies to address this problem are discussed under priorities for the 2009/10 year.

3.3 **CLINICAL GOVERNANCE:**

3.3.1 **Defining Clinical Governance**

Clinical Governance has been defined as a system through which health service organisations are responsible and accountable for:

- Continuously improving the quality of their services;
- Safeguarding high standards of care;
- Ensuring the best clinical outcomes for patient care, given resource limitations;
- Creating an environment in which excellence in clinical care will flourish.

Clinical Governance focuses on the following pillars:

- Clinical effectiveness
- Clinical risk management
- Quality assurance
- Sustainability

In 2008/09 the service adopted this framework and largely through the co-ordinating clinicians systematically facilitated closer interaction between managers and clinicians towards continuously improving clinical governance and quality of care.

As part of this commitment several key policies, governance and clinical guideline documents were drafted and implemented to strengthen clinical governance in 2008/09. Some of these policies and guidelines are:

- Clinical governance framework for a Unitary Western Cape Tertiary Service Platform
- Packages of care by discipline.
- Guidelines on renal dialysis.
- Guidelines to management and referral of cardiac disease.
- Mental health guidelines.
- Drug use in anaesthesia.
- Outreach and support agreements.
- Several theatre operational policies to improve theatre efficiencies and patient safety.
- Head injury management guidelines.
- Paediatric surgery versus surgery in children; a position paper.
- Emergency medicine guidelines.

3.3.2 **System of Co-ordinating Clinicians**

The system of coordinating clinicians, funded from Programme 5, has been operational for the past three years. These six co-ordinating clinicians, appointed from current staff for each major general discipline, spend fifty percent of their time functioning across all levels of care and the province. The

co-ordinating clinicians play a major role in coordinating their specific discipline as well as the clinical governance within the Department. The coordinating clinicians were instrumental *inter alia* in the following:

- Defining and documenting packages of care together with case definitions for each level of care. This forms the basis for the reorganisation of services and the implementation of the CSP towards the treatment of the right patient at the right level of care.
- Developing referral guidelines for each discipline.
- Conducting point prevalence surveys to quantify patient shifts and facilitating the shift of patients to appropriate levels of care.
- Service quality improvement and developing uniform clinical guidelines and operational policies as well as promoting seamless patient care across all levels of care.
- Continuous support to clinicians in the rural settings, together with facilitated interaction to ensure a seamless experience to patients.
- Providing valuable input to facilitate enhancement of skills in the District Health Services, such as Basic Antenatal Care (BANC) and skills development programs such as iMocomp and family physicians specialist training programme.
- Advising on equipment and consumable usage requirements, as well as on matters to improve for example theatre efficiency.
- Developing clinical guidelines according to pressing clinical management priorities.

3.3.3 Quality of care

As part of a comprehensive approach to improve quality of care to patients and staff several strategies and interventions were pursued during 2008/09. Some focused actions included:

- Each hospital conducted staff and patient satisfaction surveys and responded to the key findings of these surveys.
- Adopting and implementing the standardised electronic adverse event reporting system.
- Regular clinical department morbidity and mortality reviews were held in all clinical departments.
- Led by the coordinating clinicians the following specialised monitoring tools were established/strengthened:
 - Child Health Problem Identification Program (CHIP), which has been implemented at Red Cross Children's War Memorial Hospital and Tygerberg Hospital,
 - Perinatal Problem Identification Program (PPIP)
 - Anaesthetic and Surgical Problem Identification Program (ASPIP).
- Concluding and responding to findings of a waiting time survey done at all the central hospitals.
- At a strategic level clinical outcome trends were monitored with specific reference to mortality trends. Case fatality indicators for the central hospitals have remained unchanged from previous years demonstrating the commitment of clinicians and managers to quality patient care, notwithstanding the increased service pressure and resource limitations. Neonatal mortality showed a marginal increase and emphasised the need to establish additional neonatal care

beds in TBH and reduce the load on the nursery at GSH. Assistance was provided to District Health Services to establish and roll-out of continuous positive airway pressure (CPAP) in neonates, and to strengthen ante natal care.

- Promoting infection prevention and control at the central hospitals with a focus on hand washing campaigns and prevention of hospital acquired infections especially Tuberculosis.
- Monitoring of complaints and compliments.

3.3.4 **Priority Setting**

As part of the clinical governance strategy the Department, with the support of a bio-ethicist, adopted the Accountability for Reasonableness (A4R) framework as a guiding tool for priority setting. This approach is required to explicitly determine how resources should be prioritised sustainably due to the fact that needs outstrip the resources available. The A4R approach follows four basic steps in priority setting. These steps are defined as:

- Stakeholder engagement
- Publicity
- Responsiveness
- Leadership

Priority setting and A4R also forms part of three parallel processes that deal with resource management:

- Continued motivation and justification (with valid and substantial facts and arguments) to obtain more resources to address health needs.
- Increasing efficiency and better utilisation of current resources
- Priority setting to ensure accountable allocation and application of scarce resources at macro, meta and micro levels.

The process of priority setting commenced in 2006 and progressed during 2008/09 with particular support to projects in for example eye surgery, renal dialysis, paediatric intensive care access, oncology services and theatre cases

As highly specialised services consume significant resources it is anticipated that priority setting will remain a key issue particularly in the highly specialised service environment.

3.3.5 **Enhancing operating theatre performance**

Operating theatre time continued to be a scarce resource in central hospitals. Approximately sixty-five percent of inpatient services are dependant on a well functioning theatre system. The operating theatre system is a complex service environment where various professionals and a range of support systems must function effectively together. The goal is to ensure optimum operating time and ensure that the available operating time is utilised in the most appropriate way, for patients who would benefit the most.

A Theatre Efficiency Task Team was established in 2008/09. The team prioritised the improvement of theatre information and performance monitoring and developed a range of operational policies, patient safety guidelines and theatre management practices. These projects will continue into 2009/10.

A range of strategies was developed to enhance the availability of nursing staff in the theatres. Each of the central hospitals appointed a nurse mentor in the theatre environment, overseeing nurse training and development as well as providing general support to junior staff.

3.4 CORPORATE GOVERNANCE

3.4.1 Management

Each central hospital has a chief executive officer (CEO) with extensive financial and human resource delegations to operate the facilities autonomously. The CEO is responsible for the providing level 2 and level 3 services within the hospital and receives support from financial, human resource and support service managers. Currently, both GSH and TBH, have a chief operating officer (COO) for the hospital, coordinating all the clinical services. In future there will be a COO for level 2 and one for level 3 services. The CEO's meet regularly with clinicians, managers and Institutes of Higher Education, and support the Health Facility Boards. The Deputy Director General for Secondary, Tertiary and Emergency care oversees the performance, transversal management and strategic solutions across the Central and Regional Hospital Services and Emergency Care. Together, the team aims to lead a dynamic, reliable organisation and service with clinical and managerial accountability, and be an employer of choice.

3.4.2 Funding

The funding sources for the MTEF period 2006/2007 to 2008/2009 are indicated in Table 5.10.

Table 5.10: Funding sources for Programme 5 (Nominal amounts)

Fund	2006/7 Audited	2007/08 Audited	2008/9 Adjustment estimate
	R'000	R'000	R'000
National Tertiary Services Grant	1 272 640	1 335 544	1 500 193
Health Professions Training and Development Grant	199 677	210 144	196 028
Modernisation of Tertiary Services (MTS)	13 173	51, 06	30 434
Equitable Share	637 510	804 196	132 884
TOTAL	2 123 000	2 349 884	1 859 539
Capital funding allocated in Programme 8	41 092	65 819	58 819
TOTAL including Capital	2 164 092	2 415 703	1 918 358
Share of Departmental Budget	34%	32%	22%
Total Departmental budget	6 419 515	7 515 406	8 870 805

Notes:

The equitable share allocation to Programme 5 in 2008/09 was transitional pending an appropriate NTSG allocation.

The reduction of the equitable share allocation from 2007/08 from Programme 5 to 08/09 reflects the shift of level 2 services from Programme 5 to Programme 4.1.

3.4.2.1 Conditional Grants: NTSG and HPTDG

The National Tertiary Service Grant (NTSG) is insufficient to fund all the tertiary activities which therefore need to be supplemented with equitable share funding. Compared to 2007/08 the NTSG increased by R164 510 649. This represented a 12.3% increase compared to 2007/2008. With the inflation benchmarked for 2008/2009 by National Treasury at 3.7% the real increase in the NTSG was 8.6%. This growth assisted the province to increase the bed numbers from 2007/08 and reduce the dependency on the equitable share.

The Health Professional Training and Developmental Grant (HPTDG) aims to fund the service costs related to training and having health science students on the service platform. The HPTDG to the Western Cape increased from R339 442 000 for the 2007/2008 year to R356 414 000 in 2008/2009 year. This represents an increase of R16.9 million or 5% growth. Of the total HPTDG, 55% was allocated to Programme 5 and is in keeping with the findings of the student rotation survey, founded on the principle that funding follows students.

The HPTDG allocation and trend must be viewed against the backdrop of the Western Cape receiving only 10% of the HPTDG, but training 30% of all medical officers and 45% of all dentists in the country. This mismatch in the national requirement to train more doctors and health workers for the country on the one hand and the funding based on the Western Cape population, leads to a strain on the capacity to provide a service platform to accommodate all the training needs. This in turn leads to unnecessary strain in the relationship between the Western Cape Department of Health and the Institutes of Higher Education.

Table 5.11 below shows the total cumulative shortfall in the funding from these two grants, considering only inflation since 2001/02. It amounts to R344 million for the NTSG and R300 million for the HPTDG.

Table 5.11: Accumulative reduction in the NTSG and the HPTDG

Year	2000/01	2001/02	2002/03	2003/04	2004/5	2005/6	2006/7	2007/8
NATIONAL TERTIARY SERVICES GRANT (NTSG)								
Total grant allocated	962	1 011	1 047	1 077	1 104	1 215	1 173	1 336
Amount required to match inflation		1 013	1 071	1 170	1 238	1 255	1 298	1 359
Cumulative reduction		(2.5)	(26.7)	(120)	(254)	(295)	(320)	(344)
HEALTH PROFESSIONS TRAINING AND DEVELOPMENT GRANT (HPTDG)								
Total grant allocated	292	309	316	315	327	323	323	339
Amount required to match inflation		307 786	325 311	355 239	375 834	381 105	394 306	412 584
Cumulative reduction		1.2	8.1	(48.3)	(97.1)	(155.2)	(226.3)	(300)

A costing study concluded in 2007/08, indicated that the cost to the Department for training health science students amounts to R791 million in comparison to the HPTDG allocation of R339 million in 2007/08, reflecting a shortfall of R452 million.

The programme recognises the support by the Provincial Government in cushioning the reduction of funding in real terms allocated to Programme 5. The reduction in the NTSG especially over time limits the quantum of highly specialised services that is affordable by the Western Cape Department of Health.

3.4.3 Equipment and health technology

3.4.3.1 Modernisation of tertiary services (MTS)

The amount of R30 434 000 for health technology in the MTS conditional allocation was fully spent in 2008/09. These funds were earmarked for health technology in radiation medicine and medical imaging.

The MTS funds were primarily allocated to pilot the installation of a digital picture archiving and communication system (PACS) at Tygerberg Hospital as a pilot before rolling out to the rest of the province. This system enables images to be viewed on a digital screen and paper copies to be printed as required. Once fully established, all medical imaging services in the whole province will be linked through a provincial wide PACS/RIS system with telemedicine capacity. The PACS/RIS system requires support from a well functioning IT system, a strategic matter dealt with under Programme 1. Other key strategic purchases from the MTS funding will improve service delivery and quality of care, are listed in Table 5.12.

Table 5.12: Key equipment purchased from MTS funding

Institutions	Equipment description	Costs	Service impacts
Groote Shuur Hospital	CT scanner	R5 million	Improved access to CT scanning especially trauma patients
Tygerberg Hospital	PACS/RIS	R20.5million	Improve capturing and distribution of radiological images
Tygerberg Hospital	Linear Accelerator	R5 million	Enhanced ability to manage cancer patients

3.4.3.2 Earmarked Provincial Equipment Fund

The earmarked provincial equipment funding (R15 million allocated to the central hospitals) was used to make key strategic purchases to improve patient safety, quality of care, efficiency and the working environment of staff. Key items purchased in 2008/09 relate specifically to the theatre environment (theatre tables, anaesthetic machines and monitors), radiological screening systems and intensive care environment (new monitoring stations), other highly specialised equipment like haemodialysis machines and key equipment utilised in the kitchens.

3.4.4 Monitoring and evaluation systems

The programme established a systematic approach to the monitoring and evaluation of service activities and resources. Monthly meetings were held at the each of the central hospitals while combined quarterly meetings were held across programmes. Timeous reporting in terms of the Division of Revenue Act (DORA) requirements for the NTSG, HPTDG and MTS occurred throughout the year.

3.4.5 Information management and reporting systems

A significant challenge experienced during 2008/09, was the separation of the financial administration system to report financial and clinical outputs for both Programme 4.1 and Programme 5 separately. This process was concluded in 2008/09 and the reporting structures will be further strengthened to report by clinical cost centres.

An additional information management post was filled at each of the central hospitals to assist in the information system and reporting capacity, especially in the light of separate reporting requirements for Programme 4.1 and programme 5.1 from 1 April 2008.

3.4.6 **Infrastructure and maintenance**

3.4.6.1 **Tygerberg Hospital**

The business case for the revitalisation of Tygerberg Hospital was approved by the National Department of Health, pending the availability of funding for this urgent mega project. Maintenance will continue until such time that a new structure has been built.

Tygerberg Hospital undertook the following:

- The first phase of a comprehensive infrastructure plan to improve the flow of patients through the Emergency Centre, inclusive of a resuscitation unit.
- Child-and-adolescent psychiatry services were separated from adult psychiatry services to provide a safe environment for these vulnerable patients.
- The hospital also upgraded the burns unit and ablution facilities for patients and staff.
- Infrastructure changes to improve security.

3.4.6.2 **Red Cross War Memorial Children's Hospital**

The Red Cross Children's War Memorial Children's Hospital infrastructure program included the following:

- The completion and commissioning of phase one of the new theatre complex recognising the superb contribution by the Children's Hospital Trust in raising funds.
- The completion and commissioning of an upgraded surgical ward.
- The completion and commissioning of the new security gatehouse at the entrance to the Hospital.
- The commissioning of the new Magnetic Resonance Imager (MRI) for children.
- A new CSSD was constructed as part of the new theatre complex building programme.

3.4.6.3 **Groote Schuur Hospital**

Groote Schuur Hospital continued routine maintenance work such as painting and the repair of the buildings. Other activities included:

- The improvement of security measures at the hospital as well as the entrance area.
- Upgrading the pharmacy store security and air conditioning.
- Replacing the fire detection system.

3.4.7 **Human resources**

The following human resource matters during 2008/09 are notable:

- The Organisational Development Investigation (ODI) commenced and will be concluded in 2009/10.

- A joint effort by the Institutes of Higher Education particular focussed on the management of remunerative work outside the public service (RWOPS) in the Central Hospitals.
- The finalisation and implementation of the Occupational Specific Dispensation (OSD) for nurses in 2007/08 was concluded in 2008/09.
- The recruitment and retention of anaesthetic staff presented as a major challenge during the 2008/09 financial year, which influenced surgical outputs.
- At RCWMCH the strengthening of critical care staffing (nursing and anaesthetic) in 2008/09 resulted in an increase in the availability of paediatric intensive care beds for elective surgery. This impacted positively in particular on cardiac surgery and spinal surgery with outputs for the former reaching a projected 240 cardiac operations and the latter reaching a projected 8 complex spinal operations in the 2008/09 financial year.

3.4.8 **Audit compliance**

Despite being very complex organisations and handling a large number of transactions on a daily basis the central hospitals received an unqualified audit from the Auditor General in 2008/09. This was the result of focus and implementation of action plans to remedy issues identified in the 2007/08 Auditor General Report. The programme has identified particular areas of focus for sustained strategies into 2009/10 with support from the Chief Directorate expenditure control and the internal audit committee. During 2008/09 specific emphasis was placed on ensuring audit compliance with regard to following the limited bidding process and the approval of preference point allocations.

4. **POLICIES, PRIORITIES, STRATEGIC GOALS**

The Key Performance Areas for 2009/2010 are as follows:

- 1) Improving Services.
- 2) Clinical governance.
- 3) Corporate governance.

4.1 **KEY PERFORMANCE AREA: IMPROVING SERVICES**

The service priorities for 2009/2010 for the Department are:

- 1) Acute Hospital Services.
- 2) Ambulatory care.
- 3) Infectious diseases management.
- 4) De-hospitalised care.

4.1.1 **Service priority area: Acute Hospital Services**

The main strategies for 2009/10 are as follows:

- 1) To improve the level 3 functionality by ensuring that the services are rendered in keeping with the level 3 package of care and performance parameters.
- 2) Improve efficiencies to respond to service pressures, especially in emergency care, obstetrics and neonatal care, critical care and increasing theatre time and performance.
- 3) Continue to assess patient profiles in level 3 service areas to ensure these are appropriate for level 3 and the redirection of patients with system strengthening along lines of referral.

- 4) The emphasis in child health will continue, emphasising the commitment in the progressive realisation of the Rights of Children.
- 5) Establish lodging facilities for selected patients who need to attend highly specialised services on a daily basis to complete their treatment programme, but who do not need care in-between such treatment sessions.

Service specific priorities are outlined below:

4.1.1.1 Emergency medical care

- **Objective:** Improve bed management in the central hospitals.
 - Actions:
 - Compliance with the Acute Emergency Case Load management Policy (AECLMP) with specific reference to bed and discharge management, improving throughput in the emergency centre to definitive care.
 - Measure:
 - Each central hospital to have explicit discharge strategies and patient specific discharge plans.
 - Defined measurement according to the completed waiting time surveys completed.
 - Clear evidence of the implementation of the AECLMP by means of sampled audits, bed status reports as required and the routine availability of triage profiles.

4.1.1.2 Neonatal/paediatric services

- **Objective:** Improve access to neonatal critical care.
 - Action:
 - Strengthen neonatal ICU services at Groote Schuur and Tygerberg Hospitals with the consolidation of ICU beds from Somerset Hospital at Groote Schuur Hospital
 - Perform 240 cardiac operations at Red Cross War Memorial Children's Hospital
 - Measure:
 - Appropriate neonatal care provided in Groote Schuur Hospital and Somerset Hospital.
 - 240 Cardiac operations performed at Red Cross War Memorial Children's Hospital.

4.1.1.3 Surgery and Anaesthetics

- **Objective:** Improve theatre efficiencies.
 - Action:
 - Implement guidelines for theatre management.
 - Improve theatre nursing availability.
 - Improve anaesthetic staffing availability.
 - Improve stock control and supplies to theatres, as well as the cleaning and preparation of fine instruments.
 - Ensure punctual theatre starting times where the surgical preparation commences by 08:00 and on the scheduled time for afternoon slates.
 - Strengthen post anaesthetic high care capacity.
 - Monitoring of theatre utilisation by means of cancellation rate for elective surgery.
 - Measure:
 - Guidelines and operational polices developed.
 - The variance from the start of surgical preparation for morning (scheduled from 08h00) and afternoon slates commences and on the scheduled starting time for afternoon lists.
 - Cancellation rates for elective surgical cases.

4.1.1.4 Critical care

- **Objective:** Improve access to critical care.
 - Action:
 - Increase critical nursing staff through training of community service nurses in critical care (six month training program) towards assisting with critical care service delivery and recruitment into critical care nursing in the long term.
 - Establish a provincial critical care forum to oversee and monitor the appropriate use of critical care resources.
 - Measure:
 - Operate twenty-two paediatric intensive care beds at Red Cross War Memorial Children's Hospital and eight at Tygerberg Hospital.
 - Monthly critical care activity reports submitted and analysed.
 - A functional critical care forum established to govern access and performance of critical care services.

4.1.2 Priority area: Ambulatory care

- **Objective:** Ensure appropriate Out Patient Department (OPD) services at level 3.
 - Actions:
 - Identify and discharge patients, not requiring further care by a specialist, as part of the collaborative chronic disease management project, focusing on epilepsy, diabetes mellitus, asthma and hypertension in adult services.
 - Consolidate and transfer some adolescent outpatient services, currently provided at Red Cross War Memorial Children's Hospital, to Groote Schuur Hospital.
 - Transfer selected paediatric OPD services as a pilot project in identified geographic areas in the DHS. (Focussing on dermatology, epilepsy, asthma, and general paediatrics).
 - Measures:
 - Achieve the CSP target of 1.1 OPD headcount for each inpatient day.
 - The follow up OPD visits in medicine are reduced by 5 000 for Groote Schuur and Tygerberg Hospitals respectively.
 - Identified adolescent OPD services transferred from Red Cross War Memorial Children's Hospital to Groote Schuur Hospital with continued support.

4.1.3 Service priority area: De-hospitalised care

- **Objective:** Improve patient throughput in acute hospital beds and manage long term conditions in children on a decentralised basis.
 - Action:
 - Create sixty lodging beds possibly operated by a NGO. The focus will be on radiation oncology, ophthalmology and medicine services.
 - Perform patient audits to define and quantify the number of patients to be accommodated in these beds. Tygerberg Hospital to accommodate thirty of these beds for Metro East and Groote Schuur Hospital to accommodate thirty beds for the Metro West
 - Undertake a pilot project in defined geographical areas to manage children with long-term health conditions appropriately within defined geographical areas.

- Measure:
 - Sixty lodging beds established: Thirty in Metro West and Metro East respectively
 - At Red Cross War Memorial Children's Hospital the paediatric follow up visits for chronic conditions will reduce by a total of 1 500 visits for the year.

4.2 KEY PERFORMANCE AREA: CLINICAL GOVERNANCE

The key strategies in terms of clinical governance for 2009/10 are:

- 1) Implement formal outreach and support.
- 2) Improve infection prevention and control.
- 3) Establish a Unitary Western Cape Tertiary Service.

4.2.1 Implement formal outreach and support

- **Objective:** Implement formal outreach and support agreements.
 - Actions:
 - Formalise the outreach and support services in programmes in accordance with circular H83 of 2008.
 - Measure:
 - Outreach and support agreements implemented and monitored and providing meaningful support to less specialised levels of care.

4.2.2 Improved infection and prevention control mechanisms

- **Objective:** Improved infection and prevention control mechanisms.
 - Actions:
 - Reduce the transmission of Tuberculosis (TB) in hospitals by means of upgrading infrastructure and ensuring protection to prevent transmission.
 - Hospitals to strengthen infection prevention and control strategies.
 - Each hospital to conduct a hand washing survey and develop responses.
 - Each hospital to develop a stratified infection prevention and control plan.
 - Measure:
 - Prioritised Infrastructure upgraded to ensure appropriate, ventilation and extraction.
 - Protective masks distributed as required.
 - Annual hand washing survey conducted and responded to.
 - Infection prevention and Control (IPC) Plan available at each central hospital.

4.2.3 Establish clinical governance mechanisms in the unitary Western Cape Tertiary Service

- **Objective:** Establish clinical governance mechanisms in the Unitary Western Cape Tertiary Service.
 - Action:
 - Conclude and implement a Western Cape Tertiary Services Governance framework.
 - Ensure functionality of unitary paediatric cardiac care, nuclear medicine and child and adolescent psychiatry services.
 - Ensure equal access for patients by means of single waiting lists for identified disciplines.

- Measures:
 - Western Cape Tertiary Services Governance framework is implemented with established governance structures as agreed.
 - Functional single waiting lists for the following specialities:
 - 1) Paediatric cardiac surgery
 - 2) Transplant surgery
- **Objective:** Have functional level 3 inpatient services.
 - Action:
 - Implement the final level 3 bed plan and align service provision accordingly.
 - Level 3 packages of care implemented and functional service delivery cognisant of priority setting.
 - Measures:
 - Services established in line with the level 3 bed plan.
 - Output parameters for inpatients aligned to modelled parameters in the CSP, as contained in this APP.
- **Objective:** Implement the outcome of the review of the co-ordinating clinician system.
 - Action:
 - Conclude the review on the co-ordinating clinician system.
 - Ensure provincial and system wide discipline coordination monitoring and management.
 - Ensure discipline specific clinical governance.
 - Measure:
 - Recommendations of the coordinating clinician system review implemented.

4.3 KEY PERFORMANCE AREA: CORPORATE GOVERNANCE

The key strategies in Corporate Governance for 2009/10 are:

- 1) Implementation of the recommendations of the Organisational Development Investigation (ODI).
- 2) Establish functional business units/ cost centres to decentralise responsibility and accountability for resources and services.
- 3) Ensure the availability of essential equipment to render efficient tertiary services.
- 4) Ensure an unqualified Audit Report
- 5) Have institutional specific annual operational and business plans.

4.3.1 Implementation of the Organisational Development investigation recommendations

- **Objective:** Implementation of the recommendations of the Organisational Development Investigation (ODI) at each Central Hospital.
 - Action:
 - Develop and implement action plans to operationalise ODI recommendations.
 - Measures:
 - The ODI recommendations are fully implemented for each central hospital.

4.3.2 Establish functional business units/ cost centres to decentralise responsibility and accountability for resources and services

- **Objective:** Establish functional business units/ cost centres to decentralise responsibility and accountability for resources and services.

- Action:
 - Establish functional business units/ cost centres with decentralised responsibility assigned to specific managers and clinicians.
- Measures:
 - Functional business units /cost centres established with assigned responsibilities to identified managers and clinicians.

4.3.3 Ensure the availability of essential equipment to render efficient tertiary services

- **Objective:** Ensure the availability of essential equipment to render efficient tertiary services.
 - Action:
 - Complete the installation of the Picture Archiving and Communications System (PACS) and the Regional Information System (RIS) in Tygerberg Hospital (R16.5 million).
 - Red Cross War Memorial Children's Hospital to install and commission a new CT scanner (R8 million).
 - Supply and install the prioritised and authorised equipment to be purchased from the Modernisation of Tertiary Services funding as advised during the fourth quarter of 2008/09.
 - Measure:
 - The PACS and RIS system functional in Tygerberg Hospital.
 - The new CT Scanner delivered and installed at Red Cross War Memorial Children's Hospital.
 - The prioritised and approved equipment delivered and installed for each of the institutions.

4.3.4 Ensure an unqualified Audit Report

- **Objective:** Ensure an unqualified Audit Report
 - Action:
 - Provincial Supply Chain Management Chief Directorate invited to facilitate a training workshop on contract management.
 - Each central hospital to have specific strategies to further improve contract management.
 - Measure:
 - Ensure compliance with Auditor General Report with regards to contract management towards improved skills in this field.
 - Achieve an unqualified audit in 2009/10.

4.3.5 All central hospitals to have institutional specific annual operation plans

- **Objective:** All central hospitals to have institutional specific annual operation plans.
 - Action:
 - Each central hospital to submit annual operational plans by discipline and sub discipline.
 - Measure:
 - Annual operational plans concluded and approved by 1 April 2009 forming the basis of the CEO Performance Agreement.

5. ANALYSIS OF MAIN CHALLENGES AND CONSTRAINTS

The main challenges and measures to overcome them in 2009/10 are as follows:

5.1 FINANCE, FINANCIAL AND INFORMATION MANAGEMENT

- 1) The Department in 2007 concluded a costing study to quantify the funding shortage and several submissions in this regards have been made to the National Department of Health without positive response. The Programme continued to improve efficiencies and find creative ways to render additional and better quality care within the funding available.
- 2) Reporting mechanism in terms of stratified levels of care and cost centres remains a challenge for the central hospitals. The final operationalisation and enhanced management of the cost centres remains a challenge, yet will be particular focus in 09/10. . Increase efficiency and capacity deepening will occur as staff becomes more acquainted with the stratified levels of care and standard operating procedures of the new systems.
- 3) The annual audit of the central hospitals and ensuring judicious responses to audit findings together with the development and implementation of action plans to address audit findings, will continue.
- 4) Ongoing institutional monthly and combined quarterly meetings will take place to continue the monitoring of financial and clinical indicators and respond to matters identified during these meetings.

5.2 HUMAN RESOURCES

- 1) Recruiting and retaining appropriately qualified and experienced health professionals, especially nurses and key medical professions, as well as financial support staff, remains a challenge. The nursing skill challenges are largely experienced in theatre, critical care, emergency, maternity and psychiatric services. Formal and in-house training will be used to further bolster nursing skills and competencies. Upskilling of nursing staff often requires release from service to fully engage with an academic program, which in turn exacerbates the nursing shortage at an operational level. The Occupational Specific Dispensation (OSD) for nurses implemented in 2007/08 assisted to retain nursing staff. The OSD for doctors, pharmacists and social workers that was implemented in 2008/09, should further assist in the recruitment and retention of these skilled staff categories.
- 2) The recruitment and retention of anaesthetists remains a significant challenge and the co-ordinating clinician in anaesthetics, together with the two Heads of Department for the University of Stellenbosch and University of Cape Town assisted in this regard. A focus area was on the creation of an enabling working environment for female anaesthetists with children.
- 3) Concluding new Joint Agreements, which will regulate the relationship between the Department and four Institutions of Higher Education (HEI), would facilitate improved relationships between the Provincial Department of Health and the HEI's.

- 4) The management of the RWOPS system will be strengthened following technical work done with the HEI's during 2008/09.
- 5) Improved mechanisms of accommodating supernumerary registrars in the system have been developed.

5.3 SUPPORT SYSTEMS

- 1) Staff recruitment and retention challenges pose a significant challenge to support systems. Newly appointed officials often require to be retrained in specific duties when vacancies are filled. Financial, human resources, maintenance, clinical technology and information support staff pose a specific challenge in this regard. To this end the programme has motivated for the creation of student artisan, clinical engineering and clinical technology posts to bolster the sustainable supply of staff in these categories.
- 2) There is a great need to improve the IT platform, which became evident with the implementation of the Picture Archiving and Communications System (PACS) and the Regional Information System (RIS) system. A strengthened IT system would be needed to improve the operating speed and reliability of several electronic activities ranging from financial information systems like Basic Accounting System to clinical information systems like Clinicom.

5.4 SERVICES

- 1) The key service challenges for 2009/10 were identified as dealing with the increased service load as well as changes in disease and caseload patterns. These were marked in critical care, obstetric, neonatal and psychiatric services and chronic conditions. The orthopaedic service load remains high and the largest proportion of theatre time is allocated to orthopaedic surgery.
- 2) Significant pressure on theatre services will continue in 2009/10. Strategies to improve theatre efficiency, management systems and the management of demand for operating time will be further strengthened.

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Prior to 2008/09 level 2 and level 3 services were not reported separately in central hospitals.

Table 5.14 [“Provincial indicators”]:

Separate tables are provided to illustrate the performance targets from 2008/09 where the performance relates only to the tertiary activities that are funded by Programme 5 in comparison to Table 5.13 which reflects all beds in central hospitals until 2007/08.

Tables 5.15 to 5.18: [“National indicators”]:

The performance data for the period 2005/06 to 2007/08 is not comparable with the data for the period 2008/09 to 2011/12 as 2005/06 to 2007/08 refers to the performance of all levels of care activities whereas the performance data for 2008/09 to 2011/12 only refers to performance data related to level 3 services funded by Programme 5. For the 2005/06 to 2007/08 data please refer to the respective situation analysis tables, Tables 5.6 – 5.9.

Table 5.13: Provincial objectives and performance indicators for central hospitals for 2005/06 to 2007/08 [CHS3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Strategic goal:		Provide sufficient infrastructure for the rendering of highly specialised hospital services.							
Central hospitals						Refer to Table 5.14			
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1460 level 3 beds in central hospitals by 2010	1. Number of beds in central hospitals	2 472	2 479	2 417				
		2. Total number of patient days in Central hospitals	778 816	740 321	715 384				
Groote Schuur Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 607 level 3 beds in Groote Schuur Hospital by 2010	3. Number of beds in Groote Schuur Hospital	-	919	867				
		4. Total number of patient days in Groote Schuur Hospital ¹	-	275 342	269 030				
Tygerberg Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 598 level 3 beds in Tygerberg hospital by 2010	5. Number of beds in Tygerberg hospital	-	1 283	1 262				
		6. Total number of patient days in Tygerberg Hospital	-	379 770	367 031				
Red Cross War Memorial Children's Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 255 level 3 beds in Red Cross Children's Hospital by 2010.	7. Number of beds in Red Cross Children's Hospital.	-	277	288				
		8. Total number of patient days in Red Cross Children's Hospital	-	85 210	85 237				

Notes:

Indicators 2, 4, 6, & 8: Total number of patient days includes day cases (Day case = 1 separation = 0.5 in patient day)

Table 5.14: Provincial objectives and performance indicators for central hospitals for 2008/09 to 2011/12 [CHS3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Strategic Goal:		Provide sufficient infrastructure for the rendering of highly specialised hospital services.							
Central hospitals									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1460 level 3 beds in central hospitals by 2010	1. Number of L3 beds in central hospitals	Refer to Table 5.13			1 460	1 460	1 460	1 460
		2. Total number of patient days in central hospitals ¹				425 584	444 519	444 519	444 519
Groote Schuur Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 607 level 3 beds in Groote Schuur Hospital by 2010	3. Number of L3 beds in Groote Schuur Hospital				685	607	607	607
		4. Total number of patient days in Groote Schuur Hospital ¹				211 162	184 810	184 810	184 810
Tygerberg Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 598 level 3 beds in Tygerberg hospital by 2010	5. Number of L3 beds in Tygerberg hospital				538	608	598	598
		6. Total number of patient days in Tygerberg Hospital				145 804	185 115	182 070	182 070
Red Cross War Memorial Children's Hospital									
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 255 level 3 beds in Red Cross Children's Hospital by 2010.	7. Number of L3 beds in Red Cross Children's Hospital.				237	245	255	255
		8. Total number of patient days in Red Cross Children's Hospital				68 618	74 594	77 639	77 639

Notes:

Indicators 2, 4, 6, & 8: Total number of patient days includes day cases (Day case = 1 separation = 0.5 in patient day)

Table 5.15: Performance indicators for central hospitals for 2008/09 to 2011/12 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National target ¹ 2007/08
Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target section rate of 36%	1. Caesarean section rate for central hospitals	Refer to data in Table 5.6			44%	44%	44%	44%	25%
		2. Number of patient day equivalents in central hospitals	604 486	606 698	606 698	606 698	Not available			
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	3. OPD Total headcount at central hospitals	555 094	486 538	486 538	486 538	Not available			
		Implement quality assurance measures to minimise patient risk in central hospitals	4. Percentage of central hospitals with a patient satisfaction survey using DoH template	100%	100%	100%	100%	100%		
	5. Percentage of central hospitals with mortality and morbidity meetings at least once a month		100%	100%	100%	100%	100%			
	6. Percentage of central hospitals with clinical audit meetings at least once a month		100%	100%	100%	100%	100%			
	7. Percentage of complaints resolved within 25 days at central hospitals		100%	100%	100%	100%	100%			
	Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	8. Case fatality rate in central hospitals for surgery separations	2.3%	3.5%	3.5%	3.5%	3%		
9. Average length of stay in central hospitals			6.6 days	6.5 days	6.5 days	6.5 days	5.3 days			
10. Bed utilisation rate, based on useable beds, in central hospitals			83.00%	83.00%	83.00%	83.00%	75.00%			
Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 870 per PDE by 2010.		11. Total separations in central hospitals	64 094	68 387	68 387	68 387	Not available			
12. Expenditure per patient day equivalent in central hospitals	R2 851	R2 700	R2 870	R3 004	R 1 877					

Notes:

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total inpatient days (Day cases=1 separation=.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.16: Performance indicators for Groote Schuur Hospital for 2008/09 to 2011/12 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National target ¹ 2007/08
Strategic goal	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarean section rate at Groote Schuur Hospital	Refer to Table 5.7.			49.8%	49%	49%	49%	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Groote Schuur Hospital		299 219	252 237	252 237	252 237	252 237	Not available	
		3. OPD Total headcount in Groote Schuur Hospital		264 172	202 280	202 280	202 280	202 280	Not available	
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Groote Schuur Hospital has a patient satisfaction survey using DoH template		Yes	Yes	Yes	Yes	Yes	Yes	
		5. Groote Schuur Hospital has mortality and morbidity meetings at least once a month		Yes	Yes	Yes	Yes	Yes	Yes	
		6. Groote Schuur Hospital has clinical audit meetings at least once a month		Yes	Yes	Yes	Yes	Yes	Not available	
		7. Percentage of complaints resolved within 25 days		100%	80%	80%	80%	80%	100%	
		8. Case fatality rate in Groote Schuur Hospital for surgery separations		3%	3.5%	3.5%	3.5%	3.5%	3%	
	Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Groote Schuur Hospital	6.3 days	6.5 days	6.5 days	6.5 days	6.5 days	5.3 days	
			10. Bed utilisation rate, based on useable beds, at Groote Schuur Hospital	83%	83%	83%	83%	83%	75%	
			11. Total separations at Groote Schuur Hospital	33 459	28 432	28 432	28 432	28 432	Not available	
		Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R3 290 per PDE by 2010.	12. Expenditure per patient day equivalent at Groote Schuur Hospital	R2 645	R3 095	R3 290	R3 444	R3 444	R1 877	

Notes:

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total inpatient days (Day cases=1 separation=.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.17: Performance indicators for Tygerberg Hospital for 2008/09 to 2011/12 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National target* 2007/08
Strategic goal	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarean section rate at Tygerberg Hospital	Refer to Table 5.7.			40%	39%	39%	39%	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Tygerberg Hospital	215,411	252,652	248,497	248,497	Not available			
		3. OPD total headcount at Tygerberg Hospital	208,822	202,613	199,281	199,281	Not available			
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Tygerberg Hospital has a patient satisfaction survey using DoH template	Yes	Yes	Yes	Yes	Yes			
		5. Tygerberg Hospital has mortality and morbidity meetings at least once a month	Yes	Yes	Yes	Yes	Yes			
		6. Tygerberg Hospital has clinical audit meetings at least once a month	Yes	Yes	Yes	Yes	Not available			
		7. Percentage of complaints resolved within 25 days at Tygerberg Hospital	100%	100%	100%	100%	100%			
	8. Case fatality rate in Tygerberg Hospital for surgery separations	3%	3.5%	3.5%	3.5%	3%				
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Tygerberg Hospital	7.2 days	6.5 days	6.5 days	6.5 days	5.3days			
		10. Bed utilisation rate, based on useable beds, at Tygerberg Hospital	74%	83.00%	83.00%	83.00%	75 %			
		11. Total separations at Tygerberg Hospital	20,311	28,479	28,011	28,011	Not available			
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2 439per PDE by 2010	12. Expenditure per patient day equivalent at Tygerberg Hospital	R3 094	R2 256	R2 439	R2 553	R 1,877			

Note:

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total inpatient days (Day cases=1 separation=.5 in patient day.)

Indicator 12: 2007/08 prices

Table 5.18: Performance indicators for Red Cross Children's Hospital for 2008/09 to 2011/2012 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National target* 2007/08
Strategic goal:	To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarean section rate of 36%	1. Caesarean section rate at Red Cross War Memorial Children's Hospital	Data not requested per hospital	Refer to Table 5.9		Not applicable	Not applicable	Not applicable	Not applicable	25%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Red Cross War Memorial Children's Hospital				95 985	101 809	105 964	105 964	Not available
		3. OPD Total headcount at Red Cross War Memorial Children's Hospital				82 100	81 645	84 977	84 977	Not available
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Red Cross War Memorial Children's Hospital has a patient satisfaction survey using DoH template				Yes	Yes	Yes	Yes	Yes
		5. Red Cross War Memorial Children's Hospital has mortality and morbidity meetings at least once a month				Yes	Yes	Yes	Yes	Yes
		6. Red Cross War Memorial Children's Hospital has clinical audit meetings at least once a month				Yes	Yes	Yes	Yes	Not available
		7. Percentage of complaints resolved within 25 days at Red Cross War Memorial Children's Hospital				100%	100%	100%	100%	100%
		8. Case fatality rate for surgery separations at Red Cross War Memorial Children's Hospital				0.40%	0.40%	0.40%	0.40%	3
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Red Cross War Memorial Children's Hospital				6.7 days	6.5 days	6.5 days	6.5 days	5.3 days
		10. Bed utilisation rate, based on useable beds at Red Cross War Memorial Children's Hospital				82.6%	83%	83%	83%	75 %
		11. Total separations at Red Cross War Memorial Children's Hospital				10 279	11 476	11 944	11 944	Not available
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 882 per PDE by 2010.	12. Expenditure per patient day equivalent at Red Cross War Memorial Children's Hospital				R2 764	R2 821	R2 882	R3 017	R1 877

Notes:

All indicators: The central hospitals were only reported as separate hospitals in the APP from 2006/07.

Please note that prior to 2008/09 L2 and L3 services were not separated in central hospitals.

Indicator 3: The required indicator only refers to OPD total headcount. However, as this does not provide a comprehensive overview of the outpatient workload, additional information regarding the casualty/emergency/trauma workload is also provided.

Comprehensive out patient services therefore includes the headcount of casualty/emergency and trauma units.

However, the CSP does not provide for trauma and emergency units at L3 and as the funding for level 2 services in central hospitals was allocated to Programme 4.1 from 2008/09, no casualty/emergency/trauma is reported in Programme 5 from 2008/09.

Indicator 6: In the absence of the national clinical audit tool the Western Cape interpretation of this indicator is reflected in the indicator definitions in Annexure A.

Indicator 11: Per definition Day cases are included in separations and therefore included in total inpatient days (Day cases=1 separation=.5 in patient day.)

Indicator 12: 2007/08 prices

7. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTION WITH PLAN

The central hospital services are allocated 19.32 per cent of the vote in 2009/10 in comparison to the 21.26 per cent of the vote that was allocated in the revised budget of 2008/09. This amounts to a nominal increase of R51.883 million or 2.79 per cent. This refers only to the funding for level 3 services. In addition to this the central hospitals receive equitable share funding which is allocated in Programme 4.

A priority allocation of R31.804 million is made for the Modernisation of Tertiary Services for 2009/10.

Table 5.19: Trends in provincial public health expenditure for central hospitals [CHS5]

Expenditure	2005/06 (actual)	2006/07 (actual)	2007/08 (actual)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)	2011/12 (MTEF projection)
Current prices							
Total excluding capital	1 980 705 000	2 123 000 000	2 349 884 000	1 859 539 000	1 911 422 000	2 106 917 000	2 269 586 000
Total Capital	36 131 000	41 092 000	52 320 000	55 115 000	100 375 000	93 638 000	101 720 000
Grand Total	2 016 836 000	2 164 092 000	2 402 204 000	1 914 654 000	2 011 797 000	2 200 555 000	2 371 306 000
Total per person	427.51	409.98	453.25	359.80	376.54	410.23	440.30
Total per uninsured person	572.51	551.00	609.15	483.57	506.06	551.34	591.75
Constant 2007/08 prices							
Total excluding capital	2 121 726 068	2 197 695 074	2 349 884 000	1 735 045 550	1 693 924 182	1 800 876 764	1 885 151 734
Total Capital	38 703 434	42 537 770	52 320 000	51 425 130	88 953 481	80 036 612	84 490 138
Grand Total	2 160 429 502	2 240 232 844	2 402 204 000	1 786 470 681	1 782 877 663	1 880 913 376	1 969 641 872
Total per person	457.94	424.40	453.25	335.71	333.70	350.64	365.72
Total per uninsured person	613.27	570.39	609.15	451.19	448.48	471.25	491.52

Table 5.20: Analysis of the budget for central hospitals

Budget*	Audited 2005/6	Audited 2006/7	Audited 2007/8	2008/9 Revised	2009/10	2010/11	2011/12
	R'000	R'000	R'000	R'000	R'000	R'000	R'000
Office DDG	22 644	2 057	3 172	6 808	56 038	61 769	66 538
Programme 5							
Groote Schuur	838 628	910 050	996 525	1 126 151	1 221 965	1 346 944	1 450 938
Programme 4				277 931	341 185	376 080	405 117
Programme 5	838 628	910 050	996 525	848 220	880 780	970 864	1 045 821
Red Cross	245 946	265 999	312 876	359 120	384 056	423 336	456 021
Programme 4				74 771	59 936	66 066	71 167
Programme 5	245 946	265 999	312 876	284 349	324 120	357 270	384 854
Maitland Cottage	0	4 595	4 825	5 919	7 232	7 972	8 587
Programme 5							
Tygerberg	873 487	940 299	1 032 487	1 190 684	1 269 812	1 399 685	1 507 751
Programme 4				476 441	626 560	690 643	743 965
Programme 5	873 487	940 299	1 032 487	714 243	643 252	709 042	763 785
Total	1 980 705	2 123 000	2 349 884	2 688 682	2 939 103	3 239 706	3 489 835
Programme 4				829 143	1 027 681	1 132 789	1 220 249
Programme 5	1 980 705	2 123 000	2 349 884	1 859 539	1 911 422	2 106 917	2 269 586
Sum 3 hospitals	1 958 061	2 116 348	2 341 887	2 675 955	2 875 833	3 169 965	3 414 709
Programme 4				829 143	1 027 681	1 132 789	1 220 249
Cost of level 3 beds as % of total cost of central					64.26%	64.26%	64.26%

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

1. AIM

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

2. PROGRAMME STRUCTURE

2.1 SUB PROGRAMME 6.1: NURSE TRAINING

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

2.2 SUB PROGRAMME 6.2: EMERGENCY MEDICAL SERVICES (EMS) TRAINING

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

2.3 SUB PROGRAMME 6.3: BURSARIES

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

2.4 SUB PROGRAMME 6.4: PRIMARY HEALTH CARE (PHC) TRAINING

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

2.5 SUB PROGRAMME 6.5: TRAINING OTHER

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

3. PROGRAMME OVERVIEW

Adequate numbers of personnel need to be trained to address the competencies and service delivery needs as identified in the Comprehensive Service Plan (CSP).

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

To increase the numbers of competent nurses the Department invests substantially in nursing education, training and development, marketing, recruitment and retention strategies.

The Expanded Public Works Programme (EPWP) is a short to medium term government initiative aimed at the provision of work opportunities coupled with training, with particular focus on communities with high levels of unemployment.

The EPWP strengthens the sustainability of community-based services at primary care level through the training of Community Care Givers (CCGs) toward formal qualifications in ancillary health care and community health work. It contributes to creating employment opportunities and alleviating poverty through stipended work opportunities and training of relief workers who are recruited from the community. The relief workers create a reservoir of qualified replacements necessary due to the turnover and attrition of CCGs employed by NGO's who advance into other employment opportunities.

Programme 6 implements following learnership programmes for unemployed persons within nursing and the pharmaceutical services.

These learners are eligible for employment by the Department on completion of their learning programmes.

The approach to training of personnel is based on the current number of personnel across the service platform and what skills mix is required to meet service needs and ensure that the gap between these is filled.

A comprehensive Human Resource Development Strategy (HRDS) and an annual implementation plan will flow from the Human Resource Plan (HRP) that was developed during 2008.

The HRDS will provide a framework to internal and external stakeholders on the implementation of the Public Service Human Resource Development Strategy Vision 2015 developed by the Department of Public Service and Administration. (DPSA)

3.1.1 Competency profile assessment

A competency profile assessment will be conducted in a phased approach from 1 August 2008 to 31 March 2010 to address the human resource development requirements arising from the CSP and the HR Plan.

3.1.2 Strategic focus

The strategic focus will be to:

- Research the current priority competencies that are available within the Department.
- Identify the competencies per selected occupational categories that are critical for effective service delivery at primary, secondary and tertiary levels of care.
- Profile the current competencies within the Department against the required competencies identified and to identify critical education, training and development strategies.

Ongoing analysis of education, training and development requirements for specific priority occupational groups will be informed by the annual Workplace Skills Plan and the HWSETA and the PSETA Sector Skills Plans. These analyses are done in collaboration with relevant service personnel and higher education institutions. Information will be supplemented by the outcomes of the competency profile assessment.

Education, training and development needs of health and support professionals in the Department are indicated through the continued engagement with all the appropriate Higher Education Institutions (HEIs) in South Africa.

Strengthen current relationships with professional bodies in relation to:

- Formal training of professionals (health and support)
- Exit strategies for community-based workers
- Mid-level categories within professions.

4. SUB-PROGRAMME 6.1: NURSE TRAINING

4.1 SITUATIONAL ANALYSIS

4.1.1 General Overview:

The shortage of nurses is a global phenomenon affecting both the developed and the developing countries. However, in developing countries this is exacerbated by continued recruitment of nurses by the developed nations such as the United Kingdom, United State of America, the Middle East, New Zealand and Australia. South Africa, as any other developing country, is also facing a shortage of health human resources, in particular the registered nurses. The shortage of nurses continuously threatens the provision of high quality care as nurses are part of the core health service delivery and in most instances provide up to 80% of health services. In addition the socio- economic and political reforms, changes in disease burden and medical technology and escalating cost of medical insurance result in increased demands from communities so that the need for skilled professionals in the public service becomes more urgent.

The Department has in recent years experienced a shortage of registered nurses in both general and specialty areas of nursing. As at the 16 May 2008 the Department had on its establishment 10,824 nurses.

A more radical approach is required to create a sustained improvement of nursing shortage. The development of the National Nursing Strategy, the implementation of Occupational Specific Dispensation which is aimed at addressing the recruitment and retention of nurses was designed to mitigate these challenges.

The Department has adopted a Provincial Nursing Strategy (March 2007) and a formal Nurse Training Framework which enhances an Integrated Nursing Education and Training and a Coordinated Clinical Placement Systems in line with the National Nursing Strategy.

Table 6.1: Number of expected nursing graduates

Final year nursing students	Financial year						
	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Registered Nurses (R425 and R683)	208	258	299	266	324	361	434

Note:

The information above reflects the number of final year nursing students (R425 and R683 respectively) from WCCN, UWC and Departmental Nursing Schools

4.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

4.2.1 Strategic Priorities

- 1) Develop an integrated Nursing Education and Training Model in line with the South African Nursing Council amended qualification structure that will address the current nursing shortages by maximizing the current training opportunities and available resources.
- 2) Coordinate formal nurse training programs and initiatives within the Department ensuring that nurse training is addressing the CSP needs and strategic focus of the Department and complies with nursing and education legislation.

The main focus areas to address the strategic objectives for the Directorate: Nursing Services in this sub-programme include:

- An approved Integrated Nursing Education and Training Model including infrastructure and equipment
- Develop, implement and monitor a Nurse Education and Training Plan for basic qualifications as well as post basic qualifications with specific reference to specialty areas based on service needs.

4.3 PLANNED QUALITY IMPROVEMENTS IMPACT ON SERVICE DELIVERY

4.3.1 Long term planning

It takes a nurse four years of training, before registered nurses graduate and are available to be recruited to the services. Graduates require an additional one year for a post basic qualification within a specialty area. For this reason it is critical that an investment in nurse training yields graduates who meet the requirements of the health services.

4.3.2 Sustainable levels of nurses for quality of care

4.3.2.1 Balancing supply and demand

Staff attrition is a reality for any organisation. However, there must be matching plan to ensure that vacant posts are filled. Training a critical mass of health science workers will assist to balance supply and demand. However, if a balance between supply and demand is not kept service delivery will be compromised, with the implications of higher levels of patient mortality and morbidity.

4.3.2.2 Scarce skills

If nurse training levels do not keep pace with CSP targets, the situation will lead to a wider gap in the skills mix needed with a compromise to the quality of health care.

4.3.2.3 Quality of care

The correct mix of nursing skills is required to improve the quality of care by ensuring that not only nurses are trained, but the full spectrum of the multidisciplinary team who render health care services. Reduced training levels will compromise this.

4.4 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

4.4.1 Restructuring of the Departmental (public) nurse training platform

The current training of nurses is fragmented, therefore if the province is to deal with the current nursing crisis effectively a holistic, integrated approach has to be implemented. This will call for a new radical approach and strategy towards nursing education and training, thus doing “business unusual”.

The proposed model seeks to establish the nursing schools as the satellite campuses of the college, in order to ensure that nurse training is coordinated and integrated at all levels.

4.4.2 Midwifery Training (basic program): Diploma in Midwifery for Registration as a Midwife, Government Notice No. R. 254 of 14 Feb 1975 as amended.

The Western Cape College is accredited with SANC and will therefore be offering the course as from the 2009 academic year. The approved curriculum will be used by the Campuses and nursing schools (satellite campuses) of the WCCN. It is envisaged that the first intake at the main campus will be in June 2009.

4.4.3 Psychiatric nursing training (basic program): Diploma in Psychiatric Nursing for Registration as a Psychiatric Nurse, Government Notice No. R. 880 of 2 May 1975 as amended.

There is a great shortage of registered nurses with psychiatric nursing training. The only registered nurses available to staff the psychiatric facilities are from R425 program from the universities and colleges where the output is insufficient. The South African Nursing Council (SANC) has approved the one year psychiatric nursing science diploma and the Associated Psychiatric Hospital nursing campus started with program in July 2008 with 12 students.

4.4.4 **Nursing schools**

Although the nursing schools are well positioned as training institutions for nurses the training programmes are fragmented and not well co-ordinated and in most instances do not address the strategic needs of the Department.

Each nursing school has its own selection criteria with the result that some nurses, especially those from Primary Health Care, are not accommodated on the courses and therefore they seek other options, such as training opportunities offered by the private sector within the province or training providers in other provinces. Another issue is that some of the training schools in the Department train less than ten students at a time which is not cost effective.

The above situation is complicated by the fact that only three nursing schools within the province offer the bridging course, namely the Western Cape Rehabilitation Centre, George and Worcester Hospitals Nursing schools. The majority of public nursing schools train Enrolled Nurses (EN) or Enrolled Nursing Auxiliary (ENA). In terms of the CSP the Department should train more registered nurses than enrolled nursing auxiliaries and should also bridge more enrolled nursing auxiliaries to enrolled nurses. The Province has an oversupply of 1 088 enrolled nursing auxiliaries, while the CSP requires additional 584 enrolled nurses and 1 399 registered nurses respectively. Therefore the provincial nursing schools should reduce the number of enrolled nursing auxiliaries that they train and start bridging the available enrolled nurses to registered nurses to facilitate meeting the need of the required number of registered nurses.

4.4.5 **Western Cape College of (WCCN)**

The WCCN offers a four year diploma nursing program: Nurse (General, Psychiatric and Community) and Midwife: Government Notice No R. 425 of 22 February 1985 as amended and 1 year post basic diploma programs in Government Notice No R 212 of 19 February 1993 as amended: Medical Surgical Nursing Science: Trauma and Emergency; Medical and Surgical Nursing Science: Critical Care Nursing; Medical and Surgical Nursing Science: Operating Theatre.

The number of nurses doing post basic courses at the college is fairly low and it is envisaged that if the college capacity to train post basic courses were to be fully utilized, the shortage of nurses who are qualified in ICU, Theatre and Trauma nursing could be alleviated within a short time. The Province has a rich clinical learning environment which if properly and fully utilized and clinical placement between the private and public nursing students were fully coordinated could yield better results and maximum output.

5. SUB PROGRAMME 6.2: EMERGENCY MEDICAL SERVICES (EMS) TRAINING COLLEGE

5.1 SITUATIONAL ANALYSIS

The Emergency Medical Service delivery needs emanating from Healthcare 2010 as reflected in the Comprehensive Service Plan (CSP) require that sufficient competent personnel be trained to meet these needs. Filling the staffing gap has to be achieved through training as there is a countrywide shortage and staff are not available to be recruited.

Emergency Medical Services personnel are largely operating as emergency care practitioners, as well as rescue workers, and communication staff.

There are three categories of Emergency Care practitioners:

- Basic Life Support (BLS).
- Intermediate Life Support (ILS).
- Advanced Life Support, also known as paramedics (ALS).

The required division of BLS, ILS and ALS staff is:

- BLS: 30%
- ILS: 50%
- ALS: 20%

The attrition rate for BLS, ILS and ALS staff is:

- BLS: 3%
- ILS: 3%
- ALS: 10%

The current Emergency Care Practitioner staff, which includes communication (call taking and dispatch) and control room staff as well as rescue staff, gap, compared with the CSP is as follows:

Table 6.2: The PGWC Staff Establishment as at end 2008

Category	Filled	Vacant Funded	Total
Basic Life Support (BLS)	569	0	569
Intermediate Life Support (ILS)	504	2	506
Advanced Life Support (ALS)	115	0	115
Total	1201	2	1201

Table 6.3: The required PGWC Staff Establishment and gap analysis:

Category	Current	CSP Need	CSP Need with Attrition	Needed to Train	Qualifications
Basic Life Support (BLS)	569	510	541	87	BAA
Intermediate Life Support (ILS)	506	852	903	397	AEA, ECT
Advanced Life Support (ALS)	115	340	411	296	N.Dip, CCA
Total	1201	1702	1855	780	

During 2008/09 the EMS management trained 161 learners (school leavers) up to BLS level, and commenced training a further 135 so as to have a rolling increase in the numbers. The funding for these students is in Programme 3.1 but remains an ongoing challenge.

Training of Emergency Care Practitioners

The current academic capacity includes the training staff in EMS, and the training staff in the Cape Peninsula University of Technology (CPUT), with whom the Department has a Memorandum of Understanding to train students.

Medical Rescue

There are currently 12 medical rescue modules that are recognised by the Professional Board. Training on these 12 modules is currently being undertaken under the auspices of the College. The future training mandate is still being finalised by the HPCSA.

Training to fill the staffing gap

A detailed plan was formulated in May 2007 mapping out the strategies to fill the staffing gap through training.

Basic life support (BLS):

The additional BLS personnel to be trained by 2010 are the current 135 students who form the feeder group for future ILS and ECT training.

Intermediate Life Support (ILS)

The additional ILS personnel required, including accumulative attrition numbers, by 2010 is an additional 388 ILS personnel.

Advanced Life Support [ALS]

The additional ALS personnel required, including accumulative attrition numbers, is an additional 294 ALS personnel. These personnel can only be trained in one of two ways: N.Dip (3 years) or CCA (9 months). While the intake into the N.Dip could increase in 2008, the bulk of these personnel ought to be trained within the CCA qualification. This would imply an amendment to the current accreditation and would require two courses to be run in parallel.

Medical Rescue:

Emergency Medical Service personnel with medical rescue capabilities are urgently required. In spite of the fact that the official qualification has not been established it is strongly advised that, in addition to those staff with medical rescue competencies and completed models the following are required over the next 3 years:

- Advanced Medical rescue: 40/year, to a total of 120
- Intermediate Medical Rescue: 30/year, to a total of 90
- Basic Medical rescue: 100/year, to a total of 300

5.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

5.2.1 Priorities for 2009/10

The priorities for 2009/10 are as follows:

Achieve the following training numbers in Operational Emergency Care Personnel:

1) National Diploma EMC	25
2) Paramedic (Critical Care Assistant) – 10 month Course	18
3) AEA (Ambulance Emergency Assistant) - 15- week Course	82
4) BAA (Basic Ambulance Assistant) - 6- Week Course	120
5) Medical Rescue Training	90
6) CME (Continuous Medical Education)- 1 to 2 Days per Course)	480
7) Emergency Communications Training	44
8) National Certificate in Communications (Boston College)	30

5.2.2 Strategic Priorities

The key strategic priorities to be addressed within the Comprehensive Service Plan context include the following:

- **Addressing the shortfall of Emergency Care Personnel being trained in order to meet current and future EMS patient care requirements by:**
 - Re-establishing a formal Emergency Medical Care College
 - Increasing the critical mass of Emergency Care Personnel within the Emergency Medical Services based on operational requirements
 - Increasing the critical mass of specific qualification groups within the Emergency Medical Services including; Basic Life Support, Intermediate Life Support, Advanced Life Support, Emergency Care Technicians, Communication Personnel and Rescue Technicians
 - Increasing the number of qualified Emergency Care personnel in the recruitment pool through the Emergency Care Practitioner – Student Programme (18.2)
 - Improving the quality of care through continuous medical education needs
 - Providing access to bursaries to both 18.1 and 18.2 learners for the Emergency Care Technician and professional degree programmes
- **Ensuring a broader availability of Emergency Care Education by:**
 - Entering into collaborative agreements with other public health care institutions
 - Entering into agreements with NGO's in establishing community emergency care initiatives
 - Promoting access web-based education to Emergency Care personnel in the Western Cape
 - Providing access to members of the public on careers in the Emergency Medical Services

- **Promoting formal career pathing to previously informal categories of personnel within the Emergency Medical Services by:**
 - Formalizing emergency communications training
 - Formalizing medical rescue training
- **Building management/ leadership capacity in support services crucial to the provision of Emergency Medical Care within the Western Cape by:**
 - The provision of formal management training through an accredited Higher Education Institution
 - The provision of specialized skills training such as infection control, human resource management, labour relations. Financial management and information technology

The training strategy will include educational interventions in the following key areas:

- Basic life support (18.2 learners)
- Intermediate life support
- Advanced life support
- Medical rescue
- Non-accredited continuous medical education
- Emergency communications
- Management/leadership
- Generic skills building programmes
- Specialized functional training programmes

Collective Agreements

- Public Service Co-ordinating Bargaining Council (PSCBC) Collective Agreements
- Provincial Service Bargaining Council Agreements

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The constraints and the measures to overcome them are listed below:

- **Inadequate budget to support increased need for Emergency Care Training**
 - Programme 6 currently only “part-funds” Emergency Medical Services Training. The staff complement required to present HPCSA accredited training programmes exceeds the total budget for Sub-Programme 6.2. The bulk of the training personnel component of the budget is thus borne by Programme 3.
 - Besides the staff complement needed, there is a wealth of equipment and vehicle needs to attain accreditation from HPCSA. This would need to be funded also under this program.
 - In addition, the policy directive by the Health Professions Council of South Africa to introduce continuous professional development as a registration determinant has dramatically increased the need for continuous medical education. The current Sub-Programme 6.2 budget does not make provision for these additional training needs and its costs are also borne by Programme 3.

Measures to overcome constraints

- Adequate funding for training is required with Sub-programme 6.2 for the increased personnel and equipment costs currently borne by Programme 3.
- Strict expenditure monitoring is enforced to reduce operational costs, thereby making additional funding available for continuous medical education programmes

6. SUB PROGRAMME 6.3: BURSARIES**6.1 SITUATION ANALYSIS**

In terms of Chapter 1, part IX, section E3 of the Public Service Regulations (PSR) 2001, bursaries are granted for higher education to both serving and prospective employees as a specific recruitment tool. It is used to recruit and retain scarce skills for the Department. Bursaries awarded in 2008 / 2009 were in line with the needs of the department as indicated in the Comprehensive Service Plan and the Workplace Skills Plan 2008 / 2009.

Table 6.3: Bursaries awarded in 2008/09

Category	New	Maintenance
Nurse Training	695	910
Primary Health Care Nurse Training	100	16
Health Science Training	155	166
Support Services	153	100

6.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

Planning across Programme 6 is underway to identify additional categories for awarding bursaries in 2009 /2010 and the capacity of the relevant HEI's to provide the required education and training.

Categories for expansion include

- Clinical technologists
- Medical physicists
- Industrial technicians
- Medical orthotists and prosthetists
- Artisans
- Mid-level workers in priority categories
- Health leadership and management.

6.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

6.3.1 Non-availability of posts for graduate bursars

- The non-availability of posts ring-fenced to recruit graduate bursars into the Department impacts not only on the capacity of the services to attain much-needed competencies but also increases the financial risk to the Department with the potential increase in the value of irrecoverable debt.
- A policy framework and placement plan is to be developed in line with the Departmental recruitment policy to manage and guide the recruitment of all graduate bursars into the department.

6.3.2 Lack of effective HRD Information System

- The continued absence of an effective HRD Information System hampers the effective management of bursaries as information necessary for the proper planning, implementation and monitoring of bursaries in the department are not readily available when required.
- The Programme is engaging E-innovation to come up with effective system.

7. SUB PROGRAMME 6.4: PRIMARY HEALTH CARE (PHC): IMPROVEMENT AND MAINTENANCE OF COMPETENCE PROJECT (IMOCOMP)

7.1 SITUATION ANALYSIS

The improvement and maintenance of competence of health professionals in the district health services of the public sector strives to strengthen effective and efficient service delivery to the public through the continual improved capacity of healthcare professionals of evidence-based interventions

The greatest challenge is the maintenance of skills and knowledge levels amongst academically isolated health professionals in peri-urban and rural areas. A knowledge and skills-gap analysis conducted amongst medical practitioners at primary health care level identified significant gaps that hamper effective service delivery.

The current focus is on service delivery personnel in level 1 and primary health care services at community health centres and clinics.

7.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

A policy on the improvement and maintenance of competence of health professionals in the district health services (iMOCOMP) reflects the following specific aims:

- To improve knowledge and skills of health care professionals
- To improve job satisfaction and reduce staff turn-over
- To improve the quality of health care service delivered

The iMOCOMP (Improvement of the Maintenance of Competencies) project is based on an internal partnership with District Health Service and an external partnership between the Department and all four Western Cape HEIs.

7.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

- **Strengthening relationships with all HEIs**
 - Development of a more integrated approach across all HEIs
- **Strengthening the integrated planning of iMOCOMP interventions**
 - Coordinate planning of iMOCOMP interventions
- **Strengthening coordination of iMOCOMP strategies at Levels 2 and 3**
 - Extension of Service to levels 2 and 3

8. SUB PROGRAMME 6. 5: TRAINING OTHER

8.1 SITUATION ANALYSIS

The priorities that are reflected in the Workplace Skills Plan flowing from the education, training and development needs identified in the Comprehensive Service Plan form the context of training and development for all categories of personnel.

Formal relationships with all the Higher Education Institutions in the Province have been extended through interactions with regards to the development of courses for leadership and management development (University of the Western Cape Schools of Management and Public Health, University of Cape Town Graduate School of Business (GSB), University of Stellenbosch, School of Public Management).

The Provincial Training Academy provides generic and management courses, as well as links to the Department of Public Service Administration (DPSA) and the Public Service Education and Training Authority (PSETA).

8.1.1 Planning and research

Initiatives are being undertaken to ensure that planning of Education, Training and Development is research based e.g. clinical technologists, engineers, artisans, health professionals, pharmacists and pharmacist assistants, mid-level workers and new categories of community-based workers.

8.1.2 2009/2010 Planned interventions

- Batho Pele training for levels 1 -5
- Induction of new employees
- Generic and Health Department-specific Management and Leadership Programmes for all categories of managers

8.1.3 Expanded Public Works Programme

Community Care Givers

The strategy is two pronged

- Provide training to Home / Community Care Givers (HCBCs) employed by NGOs to deliver community based services extending the services from facilities directly into the homes.
- Provide stipend work opportunities and/ or training to relief workers who are recruited from the community.
- Relief workers will provide a continuous pool of available carers to combat attrition of workers who advance into other career paths (better paid employment, study opportunities, bursaries).

8.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

The HRDS will provide a framework to internal and external stakeholders on the implementation of the Public Service Human Resource Development Strategy Vision 2015 developed by the Department of Public Service and Administration. (DPSA). The Comprehensive Service Plan and Workplace Skills Plan provide the overarching strategic direction on which all education, training and development interventions are based.

8.2.1 Competency Profile Assessment

As part of the HR Plan, an assessment of competencies focusing on the priority occupational categories will be undertaken.

Research to establish capacity of training institutions in line with the needs of the HR Plan.

8.2.2 Priorities

Based on the Comprehensive Service Plan and Workplace Skills Plan, the following priorities have been identified for this sub-programme:

- Deepening implementation of the HRD Strategy through research and analysis.
- Developing a plan to integrate bursar and community service placements as part of comprehensive clinical placement policy.
- Extension of the induction programme.
- Management and Leadership programmes: Project Khaedu, Health Leadership Programme (HLP), Financial Management, Health Leadership and Management Diploma Programme (University of the Western Cape).
- Training programmes for the improvement and maintenance of competences (iMOCOMP).
- Training programmes for Mid-level workers.
- Marketing the importance of PMDS as the basis of the WSP and other planning initiatives.

8.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

Human Resource Capacity Constraints

- Expansion of the HRD strategic agenda requires additional resources to establish of research, planning, and policy capacity
- Effectively assess the impact of education, training and development interventions to related funding.

Measures to overcome the constraints

- Review of HRD organisational structure
- Implementation of Database will enhance quantitative reporting and analysis. Return on investment studies and research will reflect the qualitative impact of education, training and development interventions.

9. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 6.4: Provincial objectives and performance indicators for human resource development [HR2]

Strategic objective	Measurable objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Programme 6: Health Sciences and training	Strategic Goal:	Rendering of education, training and development opportunities for serving and prospective employees of the Department of Health to enhance service delivery.							
Sub-programme 6.1: Nurse training									
To provide formal nurse education and training programme to address the Departmental needs	Provision of nursing education and training based on the Departmental Plan	Nursing College: Number of nursing students in training:							
		1. Number of Registered Nurses in training at WCCN (Post Basic [Advanced] Diploma R212)	31	28	30	35	90	105	200
		2. Number of Registered Nurses in training at WCCN (Post Basic Diploma R48)	-	-	-	-	30	160	190
		3. Number of Registered Nurses in training at WCCN (Diploma R254)	-	23	-	-	30	50	50
		4. Number of Registered Nurses in training at WCCN (Diploma R880)	-	-	-	12	25	50	50
		5. Number of Student Nurses in training at WCCN (Basic Diploma R425)	502	568	613	798	1 185	1 448	1 687
		6. Total number of nurses in training at the WCCN	533	619	643	845	1 360	1 813	2 177
		Nursing Schools: Number of nursing students in training							
		7. Number of Registered Nurses in training at the nursing schools (Bridging i.e. R683)	0	40	40	32	70	150	150
		8. Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2175)	151	197	229	239	265	265	275
		9. Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2176)-	87	95	183	77	70	70	70
10. Total number of nurses in training in the Nursing Schools	238	332	452	348	405	485	495		
11. Total number of nursing students in training	771	951	1 095	1 193	1 765	2 298	2 672		

Strategic objective	Measurable objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target		
Sub-programme 6.2: EMS Training College											
<p>To train appropriate numbers of Emergency Medical Care Personnel to meet the quantitative and qualitative needs of the Emergency Medical Services. To maintain and improve the standards of emergency medical care through the continuous clinical development of Emergency Medical Care Personnel in the Western Cape</p>	<p>Provision of Primary and continuous Medical and Rescue Education to meet the service demands of the Emergency Medical Services</p>	Number of intake of students									
		12. Number of student intake for the National Diploma EMC	123	141	161	30	25	30	30		
		13. Number of student intake for the Critical Care Assistant (CCA) (Paramedic) course	14	0	24	12	18	12	12		
		14. Number of student intake for the Ambulance Emergency Assistant (AEA) (5- months course)	83	0	0	92	82	72	72		
		15. Number of student intake for the Basic Ambulance Assistant (BAA) (5- week course)	36	0	24	144	120	144	144		
		16. Number of student intake for the Medical Rescue Training course	-	-	-	60	90	100	100		
		17. Number of student intake for emergency service continuous medical training (CME Training) (1 or 2 day courses)	359	350	400	400	480	500	500		
		18. Number of student intake for Emergency Communications	-	-	-	32	44	48	48		
		19. Number of student intake for the National Certificate in Communications				-	30	40	50		
		Number of graduates per programme									
		20. Number of graduates from the National Diploma: EMC	13	15	15	15	25	25	25		
		21. Number of graduates from the Critical Care Assistant (CCA) Paramedic course	11	0	20	10	10	20	20		
		22. Number of graduates from the Ambulance Emergency Assistant (AEA) course (5-months course)	32	0	0	88	65	65	65		
		23. Number of graduates from the Basic Ambulance Assistant (BAA) course (5-week course)	29	0	20	122	122	122	122		
		24. Number of graduates from the Medical Rescue Training course				55	90	90	90		
		25. Number of graduates from the emergency Continuous Medical Education (CME) Training (1 or 2 day courses)	359	340	380	380	480	480	480		
		26. Number of graduates from the Emergency Communications Training				32	44	44	44		
		27. Number of graduates from the National Certificate in Communications					40	50	60		
		GRAND TOTAL:					702	836	876	876	
				28. Number of learners to complete programmes per year.							
		Sub-programme 6.3: Bursaries									
		<p>To Plan, and Fund the Formal Education and Training interventions</p>	<p>Funding the training of professionals (including health professionals and Support Services) through a bursary scheme</p>	Number of students with bursaries							
				29. Number of nursing professionals with bursaries	1 254	1 568	1 570	2 060	2 210	2 340	2 574
				30. Number of health professionals with bursaries	262	259	319	308	394	419	461
				31. Number of other professionals with bursaries				10	11	12	13
				32. Number of support services personnel with bursaries	117	505	228	470	440	569	626
				Number of graduating bursars							
				33. Number of graduating nursing professional bursars	-	-	-	285	314	346	381
34. Number of graduating health professional bursars	-			-	-	39	43	47	52		
35. Number of graduating other professional bursars	-			-	-	5	6	6	6		
36. Number of graduating support services bursars	-			-	-	320	352	387	426		

Strategic objective	Measurable objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Sub-Programme 6.4: Primary Health Care (PHC) iMOCOMP									
To plan, coordinate and implement Training and Development Interventions	iMOCOMP The provision of training for the improvement & maintenance of competence project (iMOCOMP)	37. Number of people trained through iMOCOMP	0	0	0	300	2 200	3 000	3 300
Sub-programme 6.5 Training Other									
	Levy to HWSETA	38. Administrative levy payable to HWSETA in terms of skills development legislation.	R 1,942 m	R 2,045 m	R 2,169 m	R 2,280 m	R 2,394 m	R 2,514 m	R 2,640 m
6.5.2 Expanded Public Works Programme									
To provide training opportunities for unemployed persons to facilitate access to employment.	Funding training opportunities for Community Care Givers employed by NGOs	39. Number of Community Care Givers (CCGs) learners	0	1 009	1 805	1 840	2 000	2 400	2 600
		40. Number of graduating Community Care Givers (CCGs)	0	0	0	1 408	1 800	2 160	2 340
	Funding training opportunities and stipends for data capturer interns	41. Number of data capturers interns	0	0	0	172	108	120	-

Notes:

Indicators 16, 18, 21, 31, 32, 33, 34: are new indicators from the 2009/10 financial year. No data exists for the previous financial years.

Indicator 36: Administrative levy payable to HWSETA in terms of skills development legislation

Indicator 39: Funding for the data capturer project is available for 3 years.

Table 6.5: Situational analysis and projected performance for health sciences and training [HR4]

Strategic objective	Measurable objective	Performance measure/ Indicator	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12
Programme 6: Health sciences and training		Strategic goal: Rendering of education, training and development opportunities for serving and prospective employees of the Department of Health to enhance service delivery.							
Rendering of education, training and development opportunities for serving and prospective employees of the Department of Health.	Provide a sufficient pool of prospective employees	1. Intake of medical students (Number)	1 611	1 704	1 678	1 713	1 780	1 869	1 869
		2. Intake of nurse students (Number)	763	871	992	1 192	1 236	1 557	1 557
		3. Number of students with bursaries from the province	1 633	2 332	2 117	2 848	3 055	3 340	3 340
		4. Attrition rates in first year of medical school (Percentage)	4%	2.7%	4%	4%	4%	4%	4%
		5. Attrition rates in first year of nursing school (Percentage)	15%	15%	15%	10%	10%	10%	10%
		6. Number of basic medical students graduating	407	440	289	298	320	402	402
		7. Number of basic nurse students graduating.	114	133	285	304	299	400	400
		8. Number of medical registrars graduating.	39	47	43	44	44	44	44
		9. Number of advanced nurse students graduating.	202	198	199	199	199	199	199
		10. Average training cost per basic nursing graduate (Rand)	R39 214	R10 450	R11 500	R12 650	R14 000	R15 300	R15 300
		11. Development component of HPT & D grant spent	0%	0%	0%	0%	0%	0%	0%

Notes:

- Information received from University of Cape Town reflects from years 2002/03 to 2007/08. Information received from University of Stellenbosch reflects from 2001/02 to 2004/05. Information from University of the Western Cape has not been received.
- Indicator 10: For the 2001/02 financial year nurse students were in salaried posts. The bursary system for nurse training was introduced during the 2002/03 financial year. From the 2006/07 financial year the variance in the average training cost is due to the phasing out of salaries students and the funding of bursary students only.

10. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 6 is allocated 1.93 per cent of the vote in 2009/10 in comparison to the 2.05 per cent allocated in the revised estimate of 2008/09. This amounts to a nominal increase of R12.224 million or 6.82 per cent.

There is also an earmarked allocation of R7.475 million in 2009/10 to the Emergency Medicine Training College.

There is a priority allocation of R77.376 million in 2009/10, R82.018 million in 2011/12 and R86.939 million in 2011/12 for the Expanded Public Works Programme.

Table 6.6: Trends in provincial public health expenditure on Health Sciences and Training [HR5]

Expenditure	2005/06 (actual)	2006/07 (actual)	2007/08 (actual)	2008/09 (MTEF projection)	2009/10 (MTEF projection)	2010/11 (MTEF projection)	2011/12 (MTEF projection)
Current prices							
Total	79 009 000	98 858 000	133 706 000	179 110 000	191 334 000	210 904 000	227 187 000
Total per person	16.75	18.73	25.23	33.66	35.81	39.32	42.18
Total per uninsured person	22.43	25.17	33.91	45.24	48.13	52.84	56.69
Constant 2007/08 prices							
Total	84 634 236	102 336 194	133 706 000	167 118 844	169 562 394	180 269 139	188 704 886
Total per person	17.94	19.39	25.23	31.40	31.74	33.61	35.04
Total per uninsured person	24.02	26.06	33.91	42.21	42.65	45.17	47.09

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

1. AIM

To render support services required by the Department to realise its aims.

2. PROGRAMME STRUCTURE

2.1 PROGRAMME 7.1: LAUNDRY SERVICES

Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities.

2.2 PROGRAMME 7.2: ENGINEERING SERVICES

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

2.3 PROGRAMME 7.3: FORENSIC SERVICES

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

This service is now transferred from programme 2.

2.4 PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Rendering specialised orthotic and prosthetic services.

This service is now transferred to Sub-programme 4.4.

2.5 PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.

3. SUB-PROGRAMME 7.1: LAUNDRY SERVICES

3.1 SITUATION ANALYSIS

Linen and laundry services are provided by large central laundries located at Tygerberg, Lentegour and George Hospitals. Several rural hospitals have small in-house laundries. A large portion of the service is outsourced which has proved cost effective and ensured availability of linen. In addition outsourcing has resulted in a reduction in overtime worked at in-house laundries.

Twenty million linen items are processed annually of which in-house laundries process fourteen million pieces per annum and out-sourced private sector laundries process six million pieces per annum. Tygerberg Laundry is processing eight million pieces per annum; George and Lentegour Laundries combined process a further six million pieces per annum. Tygerberg Laundry has 163 staff, Lentegour Laundry has 67 staff and George Laundry has 31 staff. All laundry personnel are multi-skilled.

3.2 POLICIES, PRIORITIES AND OBJECTIVES

In order to provide a cost effective service with minimum risk, there is a combination of in-house and outsourced laundry services. The priority has been to increase the efficiency of in-house services. Large volumes of work are imperative for the strategic laundries to be cost-competitive with the private sector. Recent productivity gains in the in-house laundries have led to a shift of work from the private sector to the in-house laundries. This was necessary to ensure that personnel resources are fully utilised.

3.3 CONSTRAINTS AND PLANNED MEASURES TO OVERCOME THEM

The relatively high level of salaries of in-house laundry personnel compared with the private sector is a significant constraint to making these laundries completely cost competitive. A gradual reduction in staff coupled with morale building and training has significantly improved productivity. The challenge facing the laundry service is aging high cost equipment that must be replaced.

Ideally a greater proportion of the work should be outsourced to reduce expenditure, however, there is unfortunately insufficient reliable capacity in the private sector at present to achieve this.

3.4 PLANNED QUALITY IMPROVEMENT MEASURES

The infrastructure of the provincial laundries has been significantly upgraded in the last two financial years. The systematic replacement of equipment will continue during the 2009/10 financial year. Replacement of this equipment increases both cost effective operations and efficiency of the laundries.

It is planned to upgrade the Lentegour Laundry as part of the new Mitchell's Plain Hospital Revitalisation Project, which will include the purchase of new equipment.

3.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.1

Table 7.1: Provincial objectives and performance indicators for Laundry services [SUP1]

Sub-programme 7.1: Laundry Services		Strategic goal: To render laundry services to hospitals, care and rehabilitation centres and certain local authorities.							
Strategic Objective	Measurable Objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Provide a laundry service to all provincial hospitals	Manage the pieces/linen laundered by a combination of strategic in-house and out-sourced laundries.	1. Total number of pieces of linen laundered:	20m	20m	20.06m	20.5m	20.5m	20.5m	21m
	Manage the number of pieces laundered by in-house laundries.	2. Number of pieces of linen laundered: in-house laundries.	14m	14m	14.8m	15m	15m	15m	15.5m
	Manage the number of pieces laundered by private sector.	3. Number of pieces of linen laundered: outsourced services.	6m	6m	5.26m	5.5m	5.5m	5.5m	5.5m
Provide cost effective in-house laundry service	Ensure that in-house laundries produce cost effective laundry services.	4. Average cost per item laundered in in-house laundries.	R1.74	R1.74	R1.91	R1.80	R1.90	R1.95	R2.00
Provide cost effective out-sourced laundry service	Ensure that service providers produce cost effective laundry services.	5. Average cost per item laundered in out-sourced laundries.	R1.48	R1.47	R1.61	R1.46	R1.70	R1.70	R1.80

Note:

In-house laundry costs **exclude** cost of capital for buildings and equipment

Outsourced costs **include** cost of capital, profit and VAT (all of which are **not** included in the in-house cost).

4. SUB-PROGRAMME 7.2 ENGINEERING SERVICES

4.1 SITUATION ANALYSIS

The Directorate: Engineering and Technical Support is responsible for hospital equipment repairs and maintenance, clinical engineering, engineering services repairs and maintenance, operation of plant and machinery, in-house building repairs and maintenance, in-house minor building projects, and continuous refinement of systems and processes.

Responsibility for day-to-day maintenance of health facilities, including hospitals, primary healthcare facilities, ambulance stations and forensic mortuaries, lies with the individual institutions. Capital repair and rehabilitation requirements are identified by the facility and the Directorate: Engineering and Technical Support and is normally undertaken by the Department of Transport and Public Works.

Based on the present cost of construction the replacement value of the buildings is estimated at R13, 5 billion. Assuming a norm of 4% of replacement cost as an appropriate annual maintenance budget, the estimated expenditure on the maintenance of buildings should be in the region of R540 million per annum. The 2008/09 Programme 8 maintenance budget for buildings was R85 million. The 2009/10 Programme 8 maintenance budget is R113 million showing an increase of 26%. However, there is still a significant backlog of maintenance, repair and rehabilitation work that is estimated to be in the region of R800 million.

In 2007 the Department of Health appointed the CSIR to carry out a situational analysis and make recommendations to substantially improve the maintenance of both buildings and equipment. The CSIR confirmed that the Department has a serious backlog in respect of maintenance work, which confirmed the need for additional funding. They also concluded that there is a serious lack of capacity to effectively manage the maintenance function. In the absence of significant increases in the maintenance budget four recommendations to improve maintenance management were made. A list of actions that could lead to "quick wins" was recommended. An additional R10 million was allocated to the Programme 7.2 budget in 2008/09, a portion of which was aimed at implementing the "quick wins".

During the 2008/09 financial year Recommendation 1 of the CSIR for a clear and uniform set of maintenance terms and definitions was developed in consultation with the Department of Transport and Public Works, and Treasury.

Recommendations 2, 3 and 4 of the CSIR relate to the creation of an Immovable Asset Register and Condition Assessment. These are issues that are currently being dealt with also as part of the Infrastructure Development Improvement Programme (IDIP) process. The requirement for a comprehensive Immovable Asset Register and Condition Assessment will become mandatory in terms of the Government Immovable Assets Management Act (GIAMA) and the Department of Transport and Public Works will in all likelihood be appointed as the custodian of all provincial property (see 4.3).

The following have been addressed in terms of the “quick wins” identified by the CSIR.

- The Engineering organogram has been reviewed and was forwarded to HRM Directorate in October 2008 for further attention. An organisational development investigation will follow.
- The maintenance management framework document (MMF) was aligned according to the maintenance policy requirements. The maintenance policy is now 90% complete.
- All available equipment operation and maintenance manuals have been distributed to hospital maintenance staff.
- The procedures for appropriate cost allocation of maintenance work for 2009/10 have been documented and will be finalised with all the role players early in 2009.
- The maintenance budget has been ring-fenced to prevent misappropriation of maintenance funds. Treasury has decreed that maintenance funding is “earmarked” and is subject to quarterly reporting.
- District office managers were given maintenance protocols defining the levels of maintenance and budgeting for maintenance.
- Comprehensive maintenance management systems have been set up at the George and Worcester Hospitals. However, these systems may be too costly for full roll out to all hospitals in the Province.
- A basic condition and suitability assessment of rural clinics was completed in 2008. The Provincial Government has assumed responsibility for the service rendered by these clinics and the property is being transferred into the name of the Provincial Government. The assessment will inform maintenance budgeting and prioritisation.
- An Engineering and Technical Support Services Maintenance web page will be available on the existing provincial network to consolidate all relevant documentation (policy, guidelines, manuals, etc.) in a version controlled environment.

The Department of Health is implementing the Infrastructure Development Improvement Programme (IDIP). National Treasury are currently funding IDIP and a technical assistant has been attached to the Western Cape Department of Health (WCDH). He has been assisting the Department, along with his other duties, to implement the CSIR recommendations.

One of the first assignments for the Health Technical Assistant (HTA) was to carry out an organisational review of infrastructure delivery within the Department. The review proposed that a new Infrastructure Management Unit was required and ratification is now awaited from Provincial Cabinet for a new Chief Directorate of Infrastructure Management to be created. A Maintenance Policy has been drafted and the technical assistant is currently involved with the Department’s GIAMA responsibilities and asset management system.

4.2 POLICIES, PRIORITIES AND OBJECTIVES

A successful maintenance programme requires the following six key interlinking needs. These are:

- 1) A clear, unambiguous and structured approach, including policies and procedures, to maintenance and immovable asset management;
- 2) A management information system to enable effective maintenance planning, budgeting and decision making;
- 3) Current, quality information on existing assets;
- 4) Sufficient funding;
- 5) Sufficient capacity at all levels, and
- 6) Clearly defined processes and allocated responsibilities for maintenance related functions.

The above is based on the conviction that hospital maintenance is an integral part of health service delivery.

The CSIR Report provides details of interventions necessary to provide the above key needs. The implementation of the IDIP and GIAMA will make several of the key recommendations of the CSIR Report mandatory.

4.3 ANALYSIS OF CONSTRAINTS AND MEASURES TO OVERCOME THEM

The key recommendations made by the CSIR and which are currently being addressed are:

- 1) **Maintenance terms and definitions** have been developed which will be applied to ensure uniformity of approach to maintenance.
- 2) **Immovable Asset Register (IAR):**
 - Currently there is no up-to-date immovable asset register of the Department of Health's estate; without which it is difficult to plan, manage and maintain health facilities in a fully co-ordinated manner.
 - IDIP is assisting the Department to update the WCDH IAR which will comply with the legislative requirements and guidelines laid down by National Treasury, the National Department of Health and GIAMA. The IDIP technical assistant is assisting Department to prepare their User Asset Management Plan (U-AMP), a GIAMA requirement.
 - Also in terms of GIAMA the Department of Transport and Public Works have to prepare a Custodian Asset Management Plan (C-AMP) – assuming they are indeed appointed to be the custodian of immovable property.
- 3) **Condition assessment:**
 - The last formal assessment of the condition of the Department of Health's estate was undertaken in 1995/6. The property portfolio has not been kept up to date by the Department of Works and IDIP will need to work with the Department of Transport and Public Works and the Department of Health to ensure new condition surveys are undertaken. Without these it is not possible to accurately:
 - Plan maintenance proactively
 - Motivate for an acceptable level of funding for planned and backlog maintenance.

- It is the intention that following the development of the updated IAR, a condition assessment be undertaken by DTPW, using the structured process recommended by the National Department of Health, so that the requirements of GIAMA can be fully addressed. In addition DTPW have to value each facility in terms of GIAMA.

4) **Funding estimates:**

- Using the IAR and the condition assessment the funding required for normal maintenance and backlog maintenance will be determined.
- A strategy will be determined to proactively address the backlog.
- This plan will be consolidated into an approach to National Treasury for special funding in consultation with the Department of Transport and Public Works and Treasury.

In the absence of adequate maintenance funding the intention is to improve the management of the existing maintenance capability in the Department. The immediate focus is thus on the “quick wins” as determined by the CSIR and reported on under paragraph 4.1.

Maintenance budgets are also allocated to individual facilities, in addition to the funding in Programme 7.2 and Programme 8. Capacity will be created in 2009/10 to better monitor all maintenance expenditure.

Table 7.2: Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading ¹	*Estimated grading 2008	Outline of major rehabilitation projects since last audit
DISTRICT HOSPITALS			
Beaufort West	4	4	Painted inside of hospital, Helipad provided.
Caledon	4	3	Major upgrade in progress.
Ceres	5	4	New routine maintenance; and internal & external repairs and renovations.
Citrusdal	4	4	Routine maintenance only.
Clanwilliam	N/A	4	Routine maintenance only.
Eerste River	N/A	4	Upgrade of casualty and OPD. Installation of bulk liquid oxygen storage tank. Routine maintenance only. Ward E repairs and renovations.
False Bay	4	4	Routine maintenance only.
GF Jooste	4	3	Routine maintenance. Ward 3 repairs and renovations
Helderberg	3	2	New ward and OPD under construction.
Hermanus	4	2	Internal and external repairs and renovations; new Admin. office, store, district nurses accommodation and routine maintenance. Major upgrade in planning.
Karl Bremer	4	4	In process of installing new generator. Repairs and renovations of prefabs on site. Routine maintenance.
Knysna	4	2	Repairs & renovations including routine maintenance.
Ladismith	4	4	Routine maintenance only. Busy with helipad. New fence.
Laingsburg	N/A	4	Internal painting and repairs. Routine maintenance.
LAPA Munnik	4	4	Routine maintenance only.
Montagu	2/3	4	Internal and external renovations and painting.
Mossel Bay	4	2	Partial internal and external renovations and painting. Water tanks installed. New theatre air conditioning system.
Murraysburg	N/A	3	OPD added. X-ray and kitchen upgraded. New helipad being installed.
Otto du Plessis	3/4	4	Routine maintenance and minor upgrades.
Oudtshoorn	4	4	Routine maintenance and minor upgrades. New bulk pharmacy store. New generator.
Prince Albert	N/A	3	New street lights. Routine maintenance.
Radie Kotze	N/A	4	Routine maintenance only.

Hospitals by type	Average 1996 NHFA condition grading ¹	*Estimated grading 2008	Outline of major rehabilitation projects since last audit
Riversdale	4	3	Major upgrade in progress.
Robertson	4	3	Routine maintenance only.
Stellenbosch	4	3	Routine maintenance. Parking area for government garage vehicles.
Swartland	4	3	Boiler replaced. Routine maintenance.
Swellendam	4	3	Renovations in progress. New clinic on site.
Uniondale	N/A	3	Routine maintenance only.
Vredenburg	3	2	Comprehensive revitalisation in progress
Vredendal	4	4	Upgrade of CSSD, X-ray and theatres in progress.
Wesfleur	2	3	Routine maintenance only.
PROVINCIAL HOSPITALS			
George	4	5	Comprehensive revitalisation in progress.
Mowbray Maternity	3	5	Routine maintenance only.
Paarl	3	2	Routine maintenance. Revitalisation in progress
Somerset	4	2	North Block has been painted both externally and internally. Changes to accommodate road in progress.
Victoria	2	3	Routine maintenance. New generator has been installed.
Worcester	4	3	Comprehensive revitalisation in progress.
CENTRAL HOSPITALS			
Groote Schuur	5	4	Major renovations and improvements to maternity block and OPD.
Red Cross	4	4	New specialist OPD added. Prefab buildings replaced with permanent structures. Day theatre extensively upgraded. External renovation of main hospital building. Renovation of nurses home. Central steam installation converted to point of use electrical heating. New Trauma Unit added. New oncology ward built.
Tygerberg	3	2	Pharmacy upgraded. Several wards renovated.
TUBERCULOSIS HOSPITALS			
Brewelskloof	4	4	Routine maintenance only.
Brooklyn Chest	4	2	Ongoing internal and external renovation of wards. Installation of UV lights in progress.
DP Marais	4	4	Extraction fans installed. Nurses home upgraded for new Sub-Regional Offices..
Harry Comay	1	2	Ward 1 was renovated, ward 2 was painted and admin section was upgraded. Installed a new generator and heat pump and calorifier. Extraction fans were installed at Ward 1, 5 & 6.
Malmesbury	N/A	1	Repairs & renovations in tender stage.
Sonstraal	N/A	3	Repairs and renovations in tender stage
PSYCHIATRIC HOSPITALS			
Alexandra	3	3	Repairs and renovations of Wards 3 & 4 in progress.
Lentegeur	4	4	Renovation of ward blocks in progress.
Nelspoort	3	3	Repairs and renovations of Alpha Ward are completed. New fence. Busy with kitchen and clinic upgrade.
Stikland	4	3	Several ward blocks renovated.
Valkenberg	3	2	Routine maintenance. Repairs and renovations are in tender stage.
PROVINCIALY AIDED CHRONIC MEDICAL AND OTHER SPECIALISED HOSPITALS			
Booth Memorial	N/A		Routine maintenance.
Die Wieg	N/A		Internal and external renovations and painting.
Maitland Cottage	N/A		Routine maintenance only.
Sarah Fox	N/A		Routine maintenance only
St Josephs	N/A		Routine maintenance only.
Conradie Care	N/A		Routine maintenance only.

* The estimated 2008 grading is based on routine inspections by the Engineering personnel and the requirements of Healthcare 2010.

HFA Grading

Category	Description
5	As new; appropriate (purpose designed) for proposed use; requires almost no attention; annual maintenance allowance should be 1% of budget; zero backlog maintenance
4	Good condition; generally suitable for use; needs normal maintenance, or minor repairs or alterations to remain in use; annual maintenance allowance should be 3% of budget; zero backlog maintenance
3	Poor condition; requires major repairs and/or is unsuitable for its proposed use, but rehabilitation or alterations will not exceed 65% of replacement cost; annual maintenance allowance should be 8% of budget; average cost of refurbishment 50% of replacement cost
2	Replace; requires major repairs or is unsuitable for its current function, such that renovation costs would exceed 70% of replacement cost; annual maintenance allowance should be at least 8% of budget, but may not be worthwhile unless no replacement will be available
1	Condemn; should be demolished and replaced; effectively no useful value

4.4 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.2:**Table 7.3 Provincial objectives and performance indicators for Engineering services [SUP1]**

Sub-programme 7.2 Engineering Services		Strategic goal: Rendering a maintenance service to equipment, engineering installations, and repairs and renovations to buildings.							
Strategic Objective	Measurable Objectives	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Effective maintenance of buildings and engineering installations Efficient engineering installations Safe working environment (Buildings, machinery and equipment)	A combination of in-house and out-sourced maintenance in co-operation with Works	1. Maintenance backlog as % of replacement value	8% 1.2bn/ 13bn	7% 900m/ 13bn	7% 900m/ 13bn	6% 800m/ 13bn	6% 800m/ 13bn	6% 800m/ 13bn	5% 700m/ 13bn
	Monitoring of plant efficiency and modification or renewal as necessary	2. Cost of utilities per bed	R6 500	R6 112	R6 912	R7 300	R7 300	R7 300	R7 500
	Arrange training of staff in the Occupational Health and Safety Act	3. Number of reportable incidents in terms of Occupational Health and Safety Act	300	300	183	180	160	160	150
Cost effective maintenance of medical equipment	Manage a combination of in-house and out-sourced maintenance	4. Number of maintenance jobs completed both in-house and outsourced	9 463	13 011	11 234	12 092	13 000	13 100	13 200

5. SUB-PROGRAMME 7.3 FORENSIC PATHOLOGY SERVICES

5.1 SITUATIONAL ANALYSIS

After the transfer of the “Medico-legal Mortuaries” from the South African Police Service to Provincial Departments of Health on 1 April 2006 the Department of Health, Provincial Government Western Cape established a new Forensic Pathology Service (FPS) in the Province. This service is rendered via eighteen facilities, which include two M6 Academic Forensic Pathology Laboratories in the Metro, three Referral FPS Laboratories and smaller FPS Laboratories and Holding Centres in the West Coast, Cape Winelands, Overberg, Eden and Central Karoo Districts.

The Western Cape FPS is managed through a central unit that is responsible for the management and coordination of the service. The FPS is being developed as a new service with sufficient Human Resource and Infrastructure capacity to improve the service delivery.

5.2 POLICIES, PRIORITIES AND STRATEGIC GOALS

In terms of section 25(2) of the Health Act 2003, the provincial Departments of Health is responsible for implementation of the entire Forensic Pathology Service, excluding Forensic Laboratories (which is a national responsibility), in compliance with national policies and law. This is a culmination of a cabinet decision on 29 April 1998 to transfer the medico-legal mortuaries from SAPS to Health. The priorities for the Forensic pathology Service in the Western Cape are the following:

- 1) Implementing the Forensic Pathology Service as per policy, statutory and legal requirements (Code).
- 2) Implement the **human resource plan as per implementation plan**
- 3) Training and orientation of personnel as per human resource development plan.
- 4) Determining the equipment needs and procure the required equipment as per supply chain prescripts.
- 5) Determining the vehicle needs and procure as per Government Motor Transport fleet management prescripts.
- 6) Develop a **facilities plan** and develop a schedule for the renovation and construction of facilities.
- 7) Develop, pilot and implement a Forensic Pathology Information management system.

Strategic objectives for Forensic Pathology Services

To provide a Forensic Pathology Service in the Province in accordance with the provisions of the following Acts: Inquest Act, National Health Act, Human Tissue Act, Births & Death Registration Act, Prisons Act, and the Medical, Health Professions Act as well as the Forensic Pathology Services Code of Guidelines.

The Forensic Pathology Service (FPS) aims to render a standardised, objective, impartial and scientifically accurate service, following national protocols and procedures, for the medico-legal investigation of death that serves the judicial process in the Provincial Government of the Western Cape. The priority is to retain the necessary medical expertise to ensure a uniform, high standard of medico-legal autopsy in cases of unnatural death or unattended/ non-ascertained natural deaths.

The strategic focus areas for the Forensic Pathology Services are the following:

- 1) Human Resource Management
 - Adequate staffing through the recruitment of personnel as per the Human Resource Plan.
 - Retention of staff through a supportive and safe work environment with appropriate staff wellness interventions.
- 2) Human Resource Development
 - Implementation of orientation and training programmes to ensure adequately trained personnel.
 - Enrolment of identified Forensic Pathology Personnel on the Forensic Pathology Support Diploma.
 - Training of general practitioners in the performance of autopsies.
 - Provision of undergraduate and postgraduate training as well as research in the pursuit of service excellence by the two Departments of Forensic Medicine.
- 3) Infrastructure
 - Ensure adequate infrastructure by the upgrading of existing and construction of new Forensic Pathology Laboratories throughout the Province.
- 4) Stakeholder relationship
 - Ensure improved stakeholder relationship by structured interaction with Stakeholders, including but not limited to SAPS, Home Affairs, Private Hospital Organisations, Undertakers and the Department of Justice,
- 5) Disaster preparedness
 - Implementation of a disaster plan to equip the Forensic Pathology Service to respond to any foreseeable disaster.
- 6) Improvement of the public perception of the Forensic Pathology Service

Currently, 10,000 medico-legal post-mortems (PM) are performed annually in the Western Cape in order to establish the cause of death in cases as defined in The Inquest Act. This amounts to 2.06 post-mortems per 100 000 population. Of these 5 996 medico-legal post-mortems are performed in the Metropolitan area and 4 011 in the rural districts.

There is still concern that a substantial number of medico-legal cases are under-reported. As a result of this the Provincial Department of Health has identified the need to improve the Forensic Pathology support in the rural regions, thus the organisational structure for the Forensic Pathology Service make provision for specialist forensic pathologist support in the rural districts. As an indicator of the quality of service being rendered the Department is measuring the number of autopsies being performed.

Improvement to the physical infrastructure remains a priority. Two new Forensic Pathology Laboratories were commissioned during 2008/09 financial year and a further three are under construction. Planning has commenced with regard to four new projects i.e.:

- The relocation of the Salt River (M6 academic) facility onto the Groote Schuur Hospital premises and construction of a new facility to deal with a caseload exceeding 3 000 cases per annum.
- The expansion of the Tygerberg (M6 academic) facility to adequately deal with the caseload and also to act as the disaster response centre for the Metro district.
- The construction of a new facility in Beaufort West (M1) to ensure adequate facilities to deal with the caseload and also to act as disaster response centre for the Karoo district.
- The construction of a new facility to replace the current facility in Stellenbosch (M3), which is inadequate to deal with the caseload.

These construction projects can only proceed if additional funding is secured.

5.3 ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM:

The high workload and related stress continues to impact on the ability to recruit and retain personnel to the Forensic Pathology Service. This needs to be addressed by providing additional specialist posts of suitable grading as provided in the proposed human resource plan for the FPS, ensuring adequate grading of Forensic Pathology Support posts as well as ensuring dedicated employee wellness programmes within the Forensic Pathology Service. The National Strategic Plan for FPS, (linked to that the Healthcare 2010 Plan) proposes 123 Forensic Pathologists (FP's) for South Africa (SA). There are approximately thirty registered and practising Forensic Pathologists in SA at present. There are eight university training centres in South Africa, of which only six train post-graduate students. The average output of these centres is not even one qualified student (Forensic Pathologist) per year.

To expedite full implementation, the Forensic Pathology academic training centres must be resourced and supported in the short to medium term, to enable the training of registrars; whilst continuing optimum, competent service delivery. In an effort to deal with the lack of Forensic Pathologists, the Province has increased the number of registrar posts. This is, however, linked to the number of specialists available to provide the mentoring and supervision as required by the Health Professions Council of South Africa.

A high percentage of staff in the new Forensic Pathology Service is new to the Department of Health and the Forensic Pathology Service and ongoing orientation of these staff as well as comprehensive basic training is required.

The Human Resource plan for the service will be implemented with an increase in personnel to 261 filled posts out of an establishment of 306 in 2009/2010 financial year. Incident response time will be decreased by ensuring sixty-one vehicles in active service on the road.

Finalisation of post-mortem reports are affected by the backlogs being experienced by the National and South African Police Service Forensic Laboratories and the time taken to process and report on toxicology and DNA results.

Building and infrastructure can only be upgraded as per the infrastructure plan if additional funding is secured. Infrastructure funding to implement the infrastructure plan is limited and business cases will be submitted to secure funding for the construction of a new M6 Academic facility in the Metro, as well as the upgrading of Tygerberg FPL to accommodate the caseload and to ensure disaster preparedness.

5.4 MEASUREABLE OBJECTIVES AND PERFORMANCE INDICATORS FOR SUB-PROGRAMME 7.4 [SUP1]

Table 7.4: Provincial objectives and performance indicators for Forensic Pathology Services [SUP1]

Sub-programme 7.4: Forensic Pathology Services		Strategic goal: The establishment of a Forensic Pathology Service for the Province that is designed to contribute positively to ensure the development of a just South African Society, to assist with the fight against and prevention of crime, to assist with the prevention of unnatural death, to establish the independence of the medical and related scientists and to ensure an equitable, efficient and cost effective service.							
Strategic Objectives	Measurable objectives	Performance measure/ Indicator	Province wide value 2005/06 (actual)	Province wide value 2006/07 (actual)	Province wide value 2007/08 (actual)	Province wide value 2008/09 (estimate)	Province wide value 2009/10 (target)	Province wide value 2010/11 (target)	Province wide value 2011/12 (target)
Provision of an effective and efficient forensic pathology service in accordance with the statutory requirements.	Adequate staffing through the recruitment of personnel as per the Human Resource Plan.	1. Percentage of Forensic Pathology Service posts filled according to Human Resource Plan.	Not reported	98%	92%	85%	92%	92%	92%
	Improved quality of service.	2. Percentage of autopsies performed.	New indicator implemented during 2007/8 Financial Year	New indicator implemented during 2007/8 Financial Year	New indicator implemented during 2007/8 Financial Year	70%	80%	85%	85%
			Baseline not yet available	Baseline not yet available	Baseline not yet available	7 000/ 10 000	8 000/ 10 000	8 500/ 10 000	8 500/ 10 000
	Improved response time.	3. Average Forensic Pathology Service response time (From receipt of call to arrival on scene).	Service still with SAPS	New indicator implemented during 2007/8 Financial Year Baseline not yet available	54 minutes	40 minutes	38 minutes	38 minutes	38 minutes
Improved quality of service.	4. Percentage of Forensic Pathology Service personnel budget spent on training.			4.9% 638 813 / 13 037 000	8.64% 2 562 495 / 29 658 504	2% 677 480/ 33 874 000	1.5% 679 350/ 45 290 000	1.5% 757 920/ 50 528 000	1.5% 818 550/ 54 570 000

5.5 PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Table 7.5: Trends in public health expenditure for Sub-programme 7.4: Forensic Pathology Services [SUP2]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices¹							
Total	2 004 000	51 966 000	122 266 000	85 980 000	69 176 000	78 037 000	70 226 000
Total per person	0.42	9.84	23.07	16.16	12.95	14.55	13.04
Total per uninsured person	0.57	13.23	31.00	21.72	17.40	19.55	17.52
Constant 2007/08 prices							
Total	2 146 680	53 794 358	122 266 000	80 223 763	61 304 568	66 701 735	58 330 755
Total per person	0.46	10.19	23.07	15.08	11.47	12.43	10.83
Total per uninsured person	0.61	13.70	31.00	20.26	15.42	16.71	14.56

6. SUB-PROGRAMME 7.4 – ORTHOTIC AND PROSTHETIC SERVICES

Funding and managerial responsibility for Orthotic and Prosthetic Services has been transferred to Sub-programme 4.4.

7. SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

7.1 SITUATION ANALYSIS

The Cape Medical Depot (CMD), operating on a trading account, is responsible for the purchasing, warehousing and distribution of pharmaceuticals and medical sundries.

In order to provide this service, Working Capital is required to purchase stock. The Working Capital must be augmented from time to time in line with inflation and increasing demands.

7.2 POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

Adequate funding is required to sustain purchases against the Working Capital Account.

7.3 CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

The Working Capital has not been augmented adequately resulting in the inability to purchase adequate stock to service current demands. Representation is made on an annual basis to at least augment capital in line with inflation.

7.4 PLANNED QUALITY IMPROVEMENT MEASURES

On going efforts to promote quality improvement will include:

- Adequately funded Capital Account
- Purchasing of adequate stock
- Improved service delivery

7.5 MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS: SUB-PROGRAMME 7.5

Table 7.6: Provincial objectives and performance indicators for the MEDPAS trading account [SUP1]

Sub-programme 7.5: Medicine trading account		Strategic goal: Managing the supply of pharmaceuticals and medical sundries to hospitals, community health centres and local authorities.							
Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Sufficient working capital to support adequate stock-holding.	Increase working capital in line with projected inflator.	1. Working capital in the medicine trading account.	R41.3 m	R43.8 m	R50.0 m	R54.0 m	R58.3 m	R62.9 m	R68.0 m

8. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 7 is allocated 1.80 per cent of the vote in 2009/10 in comparison to the 1.12 per cent allocated in the 2008/09 adjusted budget. This amounts to a nominal increase of R80.040 million or 81.73 per cent., which is largely the result of the shift of Forensic Pathology Services from Sub-programme 2.8 to Sub-programme 7.3 from 2009/10 and the earmarked allocation of R58.088 million for maintenance in 2009/10, R64.163 million in 2010/11 and R69.163 million in 2011/12.

Table 7.7: Trends in Health Care Support Services expenditure [SUP2]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total	93 075 000	92 906 000	81 785 000	97 938 000	177 978 000	198 100 000	199 605 000
Total per person	19.73	17.60	15.43	18.40	33.31	36.93	37.06
Total per uninsured person	26.42	23.65	20.74	24.74	44.77	49.63	49.81
Constant 2007/08 prices							
Total	99 701 699	96 174 780	81 785 000	91 381 192	157 726 153	169 324 984	165 794 868
Total per person	21.13	18.22	15.43	17.17	29.52	31.57	30.78
Total per uninsured person	28.30	24.49	20.74	23.08	39.68	42.42	41.37

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

1. AIM

To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Provincial Infrastructure Grant.

2. PROGRAMME STRUCTURE

- 2.2 **SUB-PROGRAMME 8.1: COMMUNITY HEALTH FACILITIES**
- 2.3 **SUB-PROGRAMME 8.2: EMERGENCY MEDICAL RESCUE**
- 2.4 **SUB-PROGRAMME 8.3: DISTRICT HOSPITAL SERVICES**
- 2.5 **SUB-PROGRAMME 8.4: PROVINCIAL HOSPITAL SERVICES**
- 2.6 **SUB-PROGRAMME 8.5: CENTRAL HOSPITAL SERVICES**
- 2.7 **SUB-PROGRAMME 8.6: OTHER FACILITIES**

3. SITUATION ANALYSIS

3.1 COMMUNITY HEALTH FACILITIES

On 1 March 2006 the Department of Health assumed responsibility for personal primary health care (PPHC) in the rural districts. The rural Local Authority clinics infrastructure is in the process of being transferred to the Provincial Government by the Department of Transport and Public Works. An assessment of the condition and suitability of this infrastructure to deliver services in accordance with the Comprehensive Service Plan has been completed. The assessment includes a basic gap analysis that will be used to inform the prioritisation of infrastructure need. The prioritisation of community health service projects focuses on communities where services are either non-existent or seriously deficient (over-loaded).

The personal primary health care facilities currently operated by the City of Cape Town in the Metro will continue to be operated by the City pending the resolution of the funding and transfer of the services to the Provincial Government.

In the past 3 years new CHC's have been constructed in Swellendam, Montagu, Simondium and Wellington. New clinics have been constructed in Browns Farm and Stanford.

3.2 EMERGENCY MEDICAL SERVICES (EMS)

The ambulance service was previously rendered by local authorities and was largely accommodated inappropriately in buildings originally designed for other purposes and that were neglected over the years. Since provincialisation the Department has undertaken a programme to construct new purpose-built ambulance stations. In the past three years new ambulance stations have been constructed in Hermanus, Riversdale, Atlantis, Beaufort West and Caledon. The ambulance stations at Bredasdorp, Lenteguur, Oudtshoorn, and Stellenbosch have been upgraded.

3.3 DISTRICT HOSPITAL SERVICES

Many of the district hospitals require significant upgrading to render the services as defined in the Comprehensive Service Plan. Phase 1 of the comprehensive upgrade of the Riversdale Hospital was completed in 2007 and Phase 2 is now in progress. Phase 1 of the comprehensive upgrading of the Caledon Hospital is in progress.

Phase 1 of the revitalisation of the Vredenburg Hospital is complete and phase 2 is now in planning.

3.4 PROVINCIAL HOSPITAL SERVICES

The strengthening of the rural regional hospitals was identified as a priority for the implementation of the Comprehensive Service Plan. The revitalised George Hospital was formally opened in June 2006, although a final phase of construction is required to complete the project. Construction work on the revitalisation of the Paarl Hospital is progressing well and is due to be completed by the end of 2009. The final phase of the revitalisation of the Worcester Hospital will commence in 2009 for completion in 2011.

The campaign to prevent the spread of TB and to provide adequate treatment for those infected requires a significant improvement of the physical infrastructure. A major concern is infection control to prevent cross infection between patients and to protect the hospital personnel. Interim measures are being applied using maintenance funding. An additional earmarked sum of R10 million was provided in 2008/09 and a similar amount will be provided in 2009/10. There is an urgent need for new purpose-built facilities. Brooklyn Chest Hospital has been accepted into the Hospital Revitalisation Programme but funding has as yet not been approved.

The number of beds at the psychiatric hospitals has been substantially reduced over the past ten years. The upgrading of psychiatric hospitals has been prioritised by the National Department of Health. Valkenberg Hospital has been accepted into the Hospital Revitalisation Programme and planning for a replacement hospital is in progress. Stikland Hospital has been identified for replacement in terms of a possible property transaction involving the sale of excess land.

3.5 CENTRAL HOSPITAL SERVICES

The CSIR has completed a report on the condition and suitability of the physical infrastructure at Tygerberg Hospital. The recommendation is that it will be more economical to construct a new hospital than to upgrade and renovate the existing hospital. Tygerberg Hospital has been accepted into the Hospital Revitalisation Programme but has yet to be funded. The Department intends registering the project as a mega project with National Treasury. Consideration will be given to funding the project through a public private partnership (PPP).

The renovation and upgrading of the Red Cross War Memorial Children's Hospital continues. The work is being funded by the Children's Hospital Trust with financial and technical assistance from the Provincial Government. The construction of the new operating theatres and CSSD is complete. Ward D2 was upgraded in 2008.

Table 8.1: Historic and planned capital expenditure by type [HFM1]

R'000s	2005/06 Actual	2006/07 Actual	2007/8 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Major capital (Health)	18 000	33 486	15 936	21 000	68 000	29 800	31 384
Major capital (HRP)	103 445	174 337	192 159	238 992	388 845	440 554	485 501
Major capital (IPG)	55 229	64 056	79 429	94 643	114 924	128 879	155 614
Major capital (Other)			43 956	34 291	27 050	0	0
Major capital (Donor RCCH)	16 000	0	25 000	25 000	0	0	0
Maintenance and minor capital	48 538	72 478	84 155	85 197	113 405	137 977	145 130
Equipment	114 436	116 000	120 000	124 000	124 000	124 000	124 000
Equipment (Donor RCCH)	0	0	0	0	0	0	
Equipment maintenance	58 665	64 056	67 758	71 145	74 702	78 437	82 359
Total capital	414 313	524 413	628 393	694 268	910 926	939 647	1 023 988

Notes:

1. "Maintenance and minor capital" is the "maintenance" expenditure by Public Works.
2. "Equipment maintenance" excludes the personnel costs of Hospital and Clinical Engineering workshop personnel.
3. "Major Capital (Other)" refers to the upgrade of the forensic and pathology service

Table 8.2: Summary of sources of funding for capital expenditure [HFM2]

R'000s	2005/06 Actual	2006/07 Actual	2007/8 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Equitable share	239 639	286 020	287 849	301 342	380 107	370 214	382 873
Revitalisation grant ¹	103 445	174 337	192 159	238 992	388 845	440 554	485 501
Infrastructure grant	55 229	64 056	79 429	94 643	114 924	128 879	155 614
Donor funding (RCCH)	16 000		25 000	25 000	-	-	-
Other			43 956	34 291	27 050	-	-
Total capital	414 313	524 413	628 393	694 268	910 926	939 647	1 023 988

Table 8.3: Historic and planned major project completions by type [HFM3]

R'000s	2005/06 Actual	2006/07 Actual	2007/8 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
New hospitals	0	0	0	0	0	0	1
New clinics / CHC's	0	2	3	1	1	5	2
Upgraded hospitals	2	5	5	7	7	8	4
Upgraded clinics / CHC's	2	0	1	0	1	0	0

Table 8.4: Total projected long-term capital demand for health facilities management (R'000) [HFM4]

Programme	Province wide total R1,000's	Planning horizon (years)	Province total annualised ⁴ R1,000's
Programme 1			
MECs office and Administration ¹	-	-	-
Programme 2	0		0
Clinics and CHC's	300 000	15	20 000
Mortuaries	75 000	3	25 000
District hospitals	2 000 000	10	200 000
Programme 3	0		0
EMS infrastructure ¹	85 000	5	17 000
Programme 4	0		0
Regional Hospitals	390 000	5	78 000
Psychiatric hospitals ¹	910 000	7	130 000
TB hospitals ¹	550 000	10	55 000
Other specialised hospitals ¹	30 000	6	5 000
Programme 5	0		0
Provincial tertiary and national tertiary hospitals ¹	1 400 000	10	140 000
Other programmes^{1,3}	0		0
Compliance with Pharmacy Act.	96 000	10	9 600
Total all programmes	5 836 000		679 600

Note on table 8.4 [HFM 4]

1. The above figures are for building work only and specifically exclude equipment and furniture.
2. The planning horizon is based on expected available cash flows. The assumption is that the HRP projects will be fully funded. The horizon could shorten substantially if additional funding is available from conditional grants, donors or the sale of surplus property.
3. The above estimates are based on the 2004 Hospital Infrastructure Plan and will be revised during 2009.
4. The budget for clinic's and CHC's is largely based on existing provincial services. The projection could vary substantially as the full implication of the provincialisation of personal primary health care is determined.
5. Figures for individual districts will only be available when capacity is created in terms of the IDIP process.

Table 8.5: Situation analysis indicators for health facilities management [HFM5]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Province wide value 2005/6	Province wide value 2006/7	Province wide value 2007/8	National Target 2003/04
Programme 8: Health Facilities Management		Strategic goal: To provide new health facilities and to provide for the upgrading and maintenance existing health facilities.				
Maintain and improve health infrastructure	Provide funding from equitable share to fund capital projects	1. Equitable share capital programme as % of total health expenditure	0.39%	0.52%	0.21%	1.5
	To increase the number of hospitals on the Hospital Revitalisation Programme	2. Hospitals funded on the Revitalisation programme %	8%	12%	12%	17
	Provide adequate funding for infrastructure maintenance	3. Expenditure on facility maintenance as % of total health expenditure	0.70%	1.13%	1.12	2.5
Keep existing equipment in good condition	Provide adequate funding for equipment maintenance	4. Expenditure on equipment maintenance as % of total health expenditure	1.03%	1.00%	0.90%	2
To safeguard assets	Up to date asset register	5. Hospitals with up to date asset register.	Reported in Programme 1			100
	Up to date asset register	6. Health districts with up to date PHC asset register (excluding hospitals)	Reported in Programme 1			All
To provide appropriate PHC infrastructure	Provide facilities with piped water supply	7. Fixed PHC facilities with access to piped water	100%	100%	100%	100
	Provide facilities with mains electricity supply	8. Fixed PHC facilities with access to mains electricity	100%	100%	100%	100
	Provide facilities with telephone service	9. Fixed PHC facilities with access to fixed line telephone	100%	100%	100%	100
	Reduce backlog in service platform	10. Average backlog of service platform in fixed PHC facilities	R270 million	R265 million	R265 million	30
To provide appropriate hospital infrastructure	Reduce backlog in service platform	11. Average backlog of service platform in district hospitals	R1 285 million	R1 285 million	R1 285 million	30
		12. Average backlog of service platform in regional hospitals	R660 million	R600 million	R600 million	30
		13. Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R2 043 million	R2 039 million	R2 039 million	30
		14. Average backlog of service platform in tertiary and central hospitals	R1 400 million	R1 400 million	R1 400 million	30
		15. Average backlog of service platform in provincially aided hospitals	R13 million	R13 million	R13 million	30
Efficient delivery of infrastructure	Timeous completion of projects	16. Projects completed on time %	See note below	-	-	
	Projects completed within budget	17. Project budget over run %	See note below	-	-	
To improve the accessibility of health care facilities of the appropriate level of care	Adequate number of beds	18. District hospital beds per 1000 uninsured population	0,50	0,53	0,53	100
	Adequate number of beds	19. Regional Hospital beds per 1000 uninsured population	0,58	0,61	0,61	65
	Distance to PHC facility	20. Percentage of population within 5km of fixed PHC facility	94%	94%	94%	85

Notes

- Indicators 5 and 6: Reported in Programme 1
- Indicators 16 and 17: The Health Department does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process.
- Indicators 10 to 15: Average backlog of service platform is for building work only and specifically excludes equipment and furniture. Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable – hence the escalation in cost of district, regional and central hospitals.

4. POLICIES, PRIORITIES AND STRATEGIC GOALS

4.1 COMMUNITY HEALTH FACILITIES

The community health facilities are to be upgraded to facilitate the shift of healthcare to the lowest appropriate level. In the MTEF period the priority will be to provide new CHC's and clinics in line with the requirements of the Comprehensive Service Plan.

During the MTEF period new CHC's are planned for, Knysna (Witlokasie), Plettenberg Bay (Kwanakuthula), Malmesbury (Wesbank), Du Noon, and Mitchells Plain. New clinics are planned for Grassy Park and Friemersheim.

4.2 EMERGENCY MEDICAL SERVICE (EMS)

The substantial improvement of the Emergency Medical Service has been identified as a priority for the Department of Health. In support of this policy the intention is to relocate all ambulance stations to purpose built accommodation at appropriate hospital premises.

The construction of a new ambulance station in Worcester is in progress. The construction of new ambulance stations for Ceres, Vredendal, Leeu Gamka, Vredenburg, Plettenberg Bay, De Doorns and Khayelitsha are planned during the MTEF period.

4.3 DISTRICT HOSPITAL SERVICES

The provision of adequate level 1 (district) beds in the Metro is a priority for the Department of Health. The two most urgently needed district hospitals are the Khayelitsha and Mitchell's Plain Hospitals. A tender for the construction of the new district hospital for Khayelitsha has been awarded. It is anticipated that the tender for the construction of the Mitchells Plain Hospital will be awarded in February 2009. Completion of both hospitals is scheduled for 2012.

Hospital Revitalisation Programme funding has been requested for new district hospitals to replace the Helderberg and Mossel Bay Hospitals. Business cases for both of these hospitals have been approved.

Funding has been budgeted in the MTEF for essential extensions to the Hermanus Hospital.

4.4 PROVINCIAL HOSPITAL SERVICES

Regional hospitals are being strengthened to improve level 2 services and will expand the accessibility of general specialist services to the communities that need them most. The business case for the revitalisation of Victoria Hospital has been approved by the National Department of Health.

The planned replacement of the Somerset Hospital as part of the redevelopment of the precinct will not materialise before the 2010 soccer World Cup. Interim measures have been planned to prevent the existing hospital becoming dysfunctional as a result of development of the immediate vicinity for the soccer World Cup. The Provincial Cabinet has approved additional funding for this work. The planned interim measures are listed in the addendum to Schedule 1.

All of the TB Hospitals are now provincial hospitals. These hospitals will require urgent and significant upgrading and this work has been accommodated in the outer year of the MTEF and the year beyond. The business case for the revitalisation of the Brooklyn Chest Hospital has been approved but is currently not funded.

4.5 **CENTRAL HOSPITAL SERVICES**

The replacement of the Tygerberg Hospital will be undertaken as part of the Hospital Revitalisation Programme as soon as funding is approved by National Treasury. The possibility of funding this project through a public private partnership (PPP) is being investigated.

The renovation and upgrading of the operating theatres and wards at the Red Cross War Memorial Children's Hospital is a priority that will be funded by the Children's Hospital Trust. The existing operating theatre suite will be upgraded during 2009. The upgrading of the wards is ongoing.

Smaller, but essential upgrading projects at Groote Schuur Hospital will be funded from the Infrastructure Grant to Provinces.

4.6 **MAINTENANCE BACKLOG**

As stated in Programme 7 there is a serious backlog of maintenance work. The construction of new hospitals under the Hospital Revitalisation Programme to replace the most dilapidated infrastructure will substantially reduce the hospital maintenance backlog. Similarly the upgrading of facilities using Provincial Infrastructure Grant funding will reduce the backlog.

5. **ANALYSIS OF CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM**

5.1 **THE NEED FOR FLEXIBILITY TO ADDRESS URGENT UNFORESEEN PRIORITIES**

The lead times that are essential to ensure that projects are executed in the most effective, economical and efficient manner make it difficult to accommodate urgent unforeseen priorities. The delay in constructing the new Somerset Hospital and the rapid increase of the population in Delft are two examples of events that have given rise to the need for urgent unforeseen projects. Both projects are currently under technical investigation to determine scope and cost. The scheduling of projects must have a measure of flexibility to accommodate these and unforeseen priorities early in the MTEF period.

5.2 **PLANNING, DESIGN, CONSTRUCTION AND COMMISSIONING**

The limited capacity in respect of experienced technical and professional personnel both in the Departments of Health and of Transport and Public Works continues to hamper infrastructure delivery. This problem was exacerbated during the 2008/09 year by under-performing consultants and contractors. It is the intention to address this during the MTEF period as part of the IDIP process.

Overly optimistic cash flow projections coupled with under-performing consultants and contractors have particularly affected the Hospital Revitalisation Programme. The programme is projecting an under-expenditure of R 78.19 million in addition to the planned roll-over of R86.76 million in the 2008/09 financial year. A concerted effort has been made to expedite the completion of planning during the latter part of 2008 and it is predicted that the full HRP budget, including the roll-overs from 2008/9 will be spent in 2009/10 and 2010/11.

5.3 **PROGRAMME MANAGEMENT AND ACCOUNTABILITY**

The management of this programme, and in particular financial administration and accountability, poses a challenge. The accounting officer of Health is accountable for all expenditure and the programme performance, while having no direct jurisdiction over the actions that lead to such expenditure.

The management of the Programme is being addressed as part of the IDIP process. In line with the IDIP Business Plan a new organisational structure is being created to manage the programme as required in terms of the Division of Revenue Act (DORA). The new structure will also provide capacity to fulfil the requirements of the Government Immovable Assets Management Act (GIAMA). It was the intention to commence the filling of posts in the new structure during 2008. However, the process of creating the new structure still has to be finalised and the filling of posts is only likely to commence in 2009. The plan provides for the establishing of programme management capacity in Health.

6. SPECIFICATION OF MEASURABLE OBJECTIVES AND PERFORMANCE INDICATORS

Table 8.6: Provincial objectives and performance indicators for health facilities management [HFM6]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target
Programme 8	Health Facilities Management	Strategic Goal :	To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities						
Programme 8.1 Improve Community Health physical infrastructure	Provide Community Health infrastructure that is fit for purpose	1. Total infrastructure expenditure on community health facilities as a percentage of backlog (R300 million)	4.9%	8.9%	9.4%	9.8%	15.5%	33.0%	32.0%
Programme 8.2 Improve EMS physical infrastructure	Improve ambulance stations	2. Percentage of ambulance stations built for purpose (50 ambulance stations)	42%	47%	60%	66%	75%	80%	82%
Programme 8.3 Improve District Hospital physical infrastructure	Provide district hospital infrastructure that is fit for purpose	3. Total infrastructure expenditure on district hospitals as a percentage of backlog (R2 billion)	2.3%	5.9%	2.8%	11.2%	14.7%	18.0%	26.0%
Programme 8.4 Improve Provincial Hospital physical infrastructure	Provide provincial hospitals with the physical infrastructure that is fit for purpose	4. Total infrastructure expenditure on provincial hospitals as a percentage of backlog (R1,85 billion)	5.2%	6.7%	10.9%	14.4%	11.0%	8.4%	4.1%
Programme 8.5 Improve Central Hospital physical infrastructure	Provide central hospitals with the physical infrastructure that is fit for purpose	5. Total infrastructure expenditure on central hospitals as a percentage of backlog (R1,4 billion)	2.6%	2.4%	3.7%	4.3%	7.2%	6.7%	7.3%

Table 8.7: National Performance indicators for health facilities management [HFM7]

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National Target 2007/08
Programme 8: Health Facilities Management	Strategic Goal : To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities									
Maintain and improve health infrastructure	Provide funding from equitable share to fund capital projects	1. Equitable share capital programme as % of total health expenditure	0.39%	0.52%	0.21%	0.32%	0.69%	0.27%	0.27%	2.5
	To increase the number of hospitals on the Hospital Revitalisation Programme	2. Hospitals funded on the Revitalisation programme %	8%	12%	12%	12%	14%	14%	18%	25
	Provide adequate funding for infrastructure maintenance	3. Expenditure on facility maintenance as % of total health expenditure	0.70%	1.12%	1.12%	1.03%	1.14%	1.26%	1.23%	4
Keep existing equipment in good condition	Provide adequate funding for equipment maintenance	4. Expenditure on equipment maintenance as % of total health expenditure	1.03%	1.00%	0.90%	0.82%	0.75%	0.72%	0.70%	4

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 Target	2010/11 Target	2011/12 Target	National Target 2007/08
To safeguard assets	Up to date asset register	5. Hospitals with up to date asset register.	Reported in Programme 1							
	Up to date asset register	6. Health districts with up to date PHC asset register (excluding hospitals)	Reported in Programme 1							All
To provide appropriate PHC infrastructure	Provide facilities with piped water supply	7. Fixed PHC facilities with access to piped water	100%	100%	100%	100%	100%	100%	100%	100
	Provide facilities with mains electricity supply	8. Fixed PHC facilities with access to mains electricity supply	100%	100%	100%	100%	100%	100%	100%	100
	Provide facilities with telephone service	9. Fixed PHC facilities with access to fixed line telephone	100%	100%	100%	100%	100%	100%	100%	100
	Reduce backlog in service platform	10. Average backlog of service platform in fixed PHC facilities	R270 million	R265 million	R265 million	R255 million	R240 million	R240 million	R240 million	15
To provide appropriate hospital infrastructure	Reduce backlog in service platform	11. Average backlog of service platform in district hospitals	R1 285 million	R1 285 million	R1 285 million	R2 000 million	R2 000 million	R2 000 million	R2 000 million	15
		12. Average backlog of service platform in regional hospitals	R660 million	R600 million	R600 million	R250 million	R150 million	R100 million	R100 million	15
		13. Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R2 043 million	R2 039 million	R2 039 million	R2 030 million	R2 030 million	R2 030 million	R2 030 million	15
		14. Average backlog of service platform in tertiary and central hospitals	R1 400 million	R1 400 million	R1 400 million	R1 400 million	R1 400 million	R1 400 million	R1 400 million	15
		15. Average backlog of service platform in provincially aided hospitals	R13 million	R13 million	R13 million	R13 million	R13 million	R13 million	R13 million	15
Efficient delivery of infrastructure	Timeous completion of projects	16. Projects completed on time %	See note below	-	-	-	-	-	-	
	Projects completed within budget	17. Project budget over run %	See note below	-	-	-	-	-	-	
To improve the accessibility of health care facilities of the appropriate level of care	Adequate number of beds	18. District hospital beds per 1000 uninsured population	0,50	0,53	0,53	0,55	0,59	0,59	0,59	90
	Adequate number of beds	19. Regional Hospital beds per 1000 uninsured population	0,58	0,61	0,61	0,61	0,63	0,63	0,63	60
	Distance to PHC facility	20. Percentage of population within 5km of fixed PHC facility	94%	94%	94%	95%	95%	95%	95%	95%

Notes

- Indicators 5 and 6: Reported in Programme 1
- Indicators 16 and 17: The Health Department does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process.
- Indicators 10 to 15: Average backlog of service platform is for building work only and specifically excludes equipment and furniture. Figures updated to reflect current building costs and backlog in terms of HRP criteria where applicable – hence the escalation in cost of district, regional and central hospitals.

7. PAST EXPENDITURE TRENDS AND RECONCILIATION OF MTEF PROJECTIONS WITH PLAN

Programme 8 is allocated 6.93 per cent of the vote in 2009/10 in comparison to the 5.02 per cent that was allocated in the 2008/09 revised estimate. This translates into a nominal increase of R246.044 million or 56.03 per cent. There is an earmarked allocation of R113.405 million for maintenance for 2009/10 with a carry through to the outer years of the MTEF. There is a once-off priority allocation of R40 million for the casualty at Somerset Hospital.

Table 8.8: Trends in provincial public health expenditure for health facilities management [HFM8]

Expenditure	2005/06 Actual	2006/07 Actual	2007/08 Actual	2008/09 Estimate	2009/10 MTEF projection	2010/11 MTEF projection	2011/12 MTEF projection
Current prices							
Total	217 025 000	344 355 000	371 678 000	439 130 000	685 174 000	737 210 000	817 629 000
Total per person	46.00	65.24	70.13	82.52	128.24	137.43	151.82
Total per uninsured person	61.61	87.68	94.25	110.91	172.35	184.70	204.04
Constant 2007/08 prices							
Total	232 476 618	356 470 696	371 678 000	409 730 881	607 209 087	630 126 559	679 134 753
Total per person	49.28	67.53	70.13	77.00	113.65	117.47	126.10
Total per uninsured person	65.99	90.76	94.25	103.48	152.74	157.87	169.48

Table 8.9: Provisional priorities for hospital revitalisation

Priority	Hospital	2010 Classification	2004 Beds	2010 Beds	ESTIMATE R' million	Start	End
1	George (completion)	Provincial	202	265	95	2003	2010
2	Eben Donges	Provincial	213	307	294	2003	2010
3	Vredenburg (phase 2)	District	56	80	180	2003	2010
4	Paarl	Provincial	250	327	427	2005	2009
5	Khayelitsha	District	0	210	509	2008	2012
6	Mitchells Plain	District	0	210	509	2008	2012
7	Valkenberg **	Psychiatric	385	400	618	2009	2014
8	Brooklyn Chest *	TB	305	721	452	2010	2015
9	Tygerberg *	Central	1273	1199	1 998	2011	2016
10	Helderberg *	District	121	120	336	2012	2015
11	Victoria *	District	159	180	462	2013	2016
12	Mossel Bay *	District	90	90	176	2013	2016
13	Hermanus *	District	37	60	120	2014	2016
14	Harry Comay *	TB	90	169	150	2014	2016
15	Stikland *	Psychiatric	371	298	360	2015	2018
16	Swartland (+TB Hospital) *	District	85	147	210	2015	2018

Notes on table 8.10:

- In the absence of realistic norms the cost estimates are based on cost per bed of hospitals currently under construction. This is well above the IHPF norm but below Public Works estimates. No escalation has been included.
- The projects marked with an * are not yet funded for planning in 2009/10. Those marked with an ** are not yet funded for construction.
- The start dates for projects that are not yet funded are based on what is considered a realistic date given the projected availability of funding in the Hospital Revitalisation Programme.

8. CAPITAL INFRASTRUCTURE PROGRAMME

8.1 DELIVERABLES

The tables that follow indicate the deliverables in the capital infrastructure programme.

8.2 DEFINITIONS

Inception:	Health is detailing the need and is drafting a brief for Public Works
Planning:	Public Works have received the brief from Health and are proceeding with the design.
Tender:	Public Works have completed the documentation to tender readiness.
Construction:	Project is under construction.
Start date:	Date of letter of acceptance of tender
Completion date:	Date of practical completion
Duration:	Time from Start to Completion.

Schedule 1: Capital Projects Funding

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
1	8.1	Montagu	New CHC	Complete	15	2006	2007	2 835	2 075	760				
2	8.1	Simondium	New Clinic	Complete	16	2006	2007	6 914	6 464	450				
3	8.1	Swellendam	New CHC	Complete	48	2003	2007	187		187				
4	8.1	Wellington	New CHC	Complete	22	2006	2008	20 500	9 251	10 249	1 000			
5	8.2	Atlantis/Wesfleur ambulance station	Ambulance station	Complete	12	2006	2007	2 347	1 663	684				
6	8.2	Bonnievale Ambulance station	Ambulance station	Inception	12	2012	2013	3 350				350	2 750	250
7	8.2	De Doorns Ambulance station	Ambulance station	Inception	12	2010	2011	3 000			200	2 600	200	
8	8.2	Heidelberg Ambulance station	Ambulance station	Inception	12	2012	2013	3 050				250	2 800	
9	8.2	Leeu Gamka Ambulance Station	Ambulance station	Inception	12	2009	2010	8 500		120	5 100	3 000	280	
10	8.2	Malmesbury Hospital Ambulance station	Ambulance station	Inception	12	2011	2012	6 000				1 300	4 500	200
11	8.2	Moorreesburg Ambulance station	Ambulance station	Inception	12	2012	2013	-						6 050
12	8.2	Piketberg Ambulance station	Ambulance station	Inception	12	2010	2011	-						3 000
13	8.2	Swellendam Hospital Ambulance station	Ambulance station	Inception	12	2011	2012	-						
14	8.2	Tulbagh Ambulance station	Ambulance station	Inception	12	2010	2011	3 200			250	2 800	150	
15	8.2	Vredendal Hospital Ambulance station	Ambulance station	Inception	12	2009	2010	8 050		500	6 050	1 500	-	
16	8.4	Beweliskloof TB Hospital	Fire Escape	Construction	3	2008	2008	450		450				
17	8.4	Brooklyn Chest TB hospital	Repair & renovations	Planning	10	2009	2010	6 200		1 550	4 915	285		
18	8.4	Harry Comay TB Hospital	Repair & renovations	Planning	11	2008	2009	1 400		500	800	100		
19	8.4	Malmesbury TB Hospital	Repair & renovations	Planning	11	2009	2009	1 000		1 000				
20	8.4	Sonstraal TB hospital	Electrical upgrade	Planning	9	2008	2009	6 000		950	4 950	100		
21	8.4	Unallocated TB Infrastructure	Improvement to TB facilities					19 334		0	-	9 195	11 704	
22	8.5	Red Cross Hospital	CSSD relocation (Managed by Trust)	Construction	16	2007	2008	3 600		3 600				
	8.5	Red Cross Hospital	Ward upgrades	Planning	12	2009	2010	24 320			4 735	8 320	9 000	4 500
		TOTALS						16 434	28 000	28 000	29 800	31 384	18 000	18 000

Additional funding for interim measures at Somerset Hospital

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
24	8.4	Somerset Hospital	Casualty upgrade	Inception	12	2009	2010	20 000		1 000				
25	8.4	Somerset Hospital	Renovation of Blumberg NH	Inception	6	2009	2009	2 000		200				
26	8.4	Somerset Hospital	New public entrance	Inception	6	2009	2009	1 500		500				
27	8.4	Somerset Hospital	Demolition of vacant buildings	Inception	8	2009	2010	12 000		200				
28	8.4	Somerset Hospital	Relocation of SCM to Shipley	Planning	9	2009	2009	4 000		100	3 900			
30	8.4	Somerset Hospital	Enabling work for FIFA 2010 World Cup	Planning	12	2009	2010	38 000			36 100			
		Total - Somerset Hospital								2 000	40 000			

Schedule 2: Infrastructure Grant to Provinces

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
1	8.1	Beaufort West	New clinic	Inception	12	2012	2013	8 000					1 000	6 000
2	8.1	Du Noon CHC	New CHC	Inception	18	2010	2012	25 000			500	6 000	18 000	500
3	8.1	Friemersheim	New satellite clinic	Inception	12	2011	2011	2 000			0	50	1 900	50
4	8.1	Grassy Park	New clinic	Planning	10	2009	2010	12 500		750	8 400	2 850	500	
5	8.1	Hermanus	New CHC	Inception	18	2011	2013	20 000				300	5 200	12 000
6	8.1	Khayelitsha	New Clinic	Inception	18	2011	2012	12 000				300	5 200	6 000
7	8.1	Krystna - Witlokasie	New CHC	Inception	22	2010	2011	21 000			1 800	8 491	10 344	1 000
8	8.1	Maitland	New CHC	Inception	14	2012	2013	18 000			0	0	2 500	12 000
9	8.1	Malmesbury - Wesbank	New CHC	Planning	15	2009	2010	25 000		1 235	6 250	15 000	2 500	
10	8.1	Mitchell's Plain	New CHC	Inception	14	2012	2013	25 000			0	300	6 200	15 000
11	8.1	Mitchell's Plain CHC	Trauma and Pharmacy Upgrade	Planning	18	2009	2010	37 875		3 600		20 000	1 200	
12	8.1	Plettenberg Bay, Kwanokuthula	New CHC	Planning	12	2009	2011	20 000		1 500	6 400	10 000	900	
13	8.1	Rawsonville	New clinic	Inception	12	2011	2012	12 000				200	7 000	4 000
14	8.1	Robbie Nurock	New CHC	Inception	22	2011	2013	22 000				500	6 500	14 000
15	8.1	Stanford Clinic	New Clinic	Complete	11	2006	2007	2 060	1 960	300				
16	8.2	Beaufort West	New ambulance station and DMC	Complete	15	2006	2007	11 250	6 450	0				
17	8.2	Bredasdorp	Ambulance station and road upgrade	Complete	18	2007	2007	875	860	15				
18	8.2	Ceres	New Ambulance Station	Planning	12	2009	2010	10 500		1 000	6 500	3 400		
19	8.2	Hermanus	Ambulance station	Complete	9	2006	2006	4 142	3 362	780				
20	8.2	Lamberts Bay	Ambulance station upgrade	Planning	7	2009	2009	1 622		240	1420	100		
21	8.2	Lentegeur	Ambulance station upgrade	Planning	8	2006	2007	4 900		86				
22	8.2	Oudtshoorn	Ambulance station upgrade	Complete	8	2006	2007	1 400	1 000					
23	8.2	Plettenberg Bay, Kwanokuthula	New ambulance station	Planning	12	2009	2010	6 000		500	3 100	2 150	50	
24	8.2	Stellenbosch	Ambulance station upgrade	Complete	8	2006	2007	1 200		152				
25	8.3	Beaufort West Hospital	New store	Planning	7	2009	2009	3 500		2 100	2 650	100		
26	8.3	Bredasdorp Hospital	Addition and alteration to hospital entrance and store	Planning	5	2008	2009	800		800				
27	8.3	Caledon hospital	Upgrading of electrical supply	Construction	4	2008	2008	2 400		1 900	225			
28	8.3	Caledon Hospital	New wards and ambulance station	construction	8	2007	2009	22 500	7 040	15 000	550			
29	8.3	Caledon Hospital	Upgrade - phase 2	Planning	16	2010	2011	8 000			1 250	3 750	3 000	
30	8.3	Eerste River Hospital	New casualty	Construction	18	2008	2010	27 500		9 370	19 800	2 900	600	
31	8.3	Helderberg Hospital	New OPD & wards	Construction	15	2007	2008	17 300	5 660	15 000	280			
32	8.3	Hermanus Hospital	New ward, OPD & Admin	Inception	27	2010	2012	41 000		1 000	3 000	15 000	21 000	1 000

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost R000's	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
33	8.3	Karl Bremer Hospital	Trauma upgrade	Planning	24	2011	2013	28 000			0	500	15 000	12 000
34	8.3	Krystna Hospital	Upgrade casualty & new OPD	Inception	18	2010	2012	16 000			929	8 600	6 000	400
35	8.3	Riversdale Hospital	Phase 1 upgrade.	Complete	10	2007	2008	5 000	4 735	300				
36	8.3	Riversdale Hospital	Phase 2 upgrade.	Construction	17	2008	2009	17 000		12 000	5 300			
37	8.3	Riversdale Hospital	Resurface roads	Planning	3	2009	2009	1 500		1 000	500			
38	8.3	Robertson Hospital	Maternity ward	Inception	9	2010	2010	3 000			430	2 570		
39	8.3	Stellenbosch Hospital	Casualty upgrade	Inception	10	2011	2013	7 000				500	5 500	1 000
40	8.3	Swellendam Hospital	New casualty and admin. Offices	Inception	12	2011	2012	13 000					2 000	10 000
41	8.3	Vredendal Hospital	X Ray and CSSD upgrade	Construction	30	2006	2009	6 650	3 998	2 250				
42	8.4	Brooklyn Crest TB Hospital	New XDR Wards	Inception	24	2013	2015	40 000					3 000	20 000
43	8.4	Malmesbury - ID Hospital replacement	New TB wards	Inception	20	2012	2014	30 000						2 000
44	8.4	Mowbray Maternity Hospital	Hospital upgrading	Complete	30	2004	2007	56 000	3 652	4 907				
45	8.4	Paarl - TB Hospital	Upgrade	Inception	22	2012	2014	20 000					1 800	20 000
46	8.5	Groote Schuur Hospital	Interim improvements	Inception	12			21 019			0	0	0	
47	8.5	Groote Schuur Hospital	E-Floor upgrade	Planning	22	2011	2013	7 500	20		0	200	4 500	
48	8.5	Groote Schuur Hospital	Security upgrade	Inception	12	2009	2010	6 000		400	3 900	1 650	550	
49	8.5	Groote Schuur Hospital	Linear accelerator installation	Complete	6	2006	2007	2 004	1 904		0	0	0	
50	8.5	Groote Schuur Hospital	NEW MAIN BUILDING fire detection phase 1	Construction	18	2006	2008	12 000	8 100	4 500	100	0	0	
51	8.5	Groote Schuur Hospital	NEW MAIN BUILDING fire detection phase 2	Planning	24	2011	2012	3 500			0	50	3 000	
52	8.5	Groote Schuur Hospital	J Bolck fire safety	Planning	9	2009	2009	2 100		700	1 300	100	0	
53	8.5	Groote Schuur Hospital	Upgrade pharmacy store	Planning	7	2009	2009	2 000		200	1 800	200	0	
54	8.5	Groote Schuur Hospital	Upgrade D23 department anaesthesia	Planning	7	2009	2009	1 640		150	1 440	50	0	
55	8.5	Groote Schuur Hospital	Lift upgrading	Complete	10	2007	2007	2 526	1 926	600	0	0	0	
56	8.5	Groote Schuur Hospital	Upgrade trauma security	Inception	8	2009	2010	2 000			0	0	0	2 000
57	8.5	Groote Schuur Hospital	Out patient department upgrading	Planning	9			2 000			0	0	0	10 000
58	8.5	Groote Schuur Hospital	Masterplan for place utilisation	Planning	10	2009	2010	1 500		1 500	2 000			
59	8.5	Groote Schuur Hospital	Alterations to Clarendon & Carinus Nurse Home	Planning	36	2010	2013	2 500			0	100	2 000	
60	8.5	Groote Schuur Hospital	Alterations to TB patient areas	Planning	36	2010	2013	5 000			200	1 500	2 800	
61	8.5	Groote Schuur Hospital	Building management system upgrade	Planning	12	2013	2014	4 500			0	0	1 500	
62	8.5	Groote Schuur Hospital	Improved parking facilities for Oncology & Psychiatry	Planning	12	2012	2013	500			0	0	500	
63	8.5	Groote Schuur Hospital	Old Main Building alterations & upgrade	Planning	24	2013	2015	7 000			0	0	1 000	
64	8.5	Groote Schuur Hospital	Provision of airconditioning in certain areas of New Main Building	Planning	14	2013	2014	700					1 000	
65	8.5	Groote Schuur Hospital	Relocation of Child Care Centre	Planning	8	2010	2011	2 500				700	1 800	

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
66	8.5	Groote Schuur Hospital	Relocation of Engineering Workshop	Planning	6	2009	2010	6 000			3 000	2 800	77	
67	8.5	Groote Schuur Hospital	Survey for space utilisation	Planning	19	2008	2009	3 200			2 700			
68	8.5	Groote Schuur Hospital	Upgrading of fencing, roads & entrances	Planning	12	2012	2013	4 500				200	3 700	
69	8.5	Tygerberg Hospital	A5 Bronco Theatre and Pulmonology ICU upgrade	Inception	12	2012	2013	3 000					600	
70	8.5	Tygerberg Hospital	Fire door upgrade phase 1	Complete	14	2006	2007	731	531	300	0	0	0	
71	8.5	Tygerberg Hospital	Fire door upgrade phase 2	Construction	16	2008	2009	4 000		2 200	1800	0	0	
72	8.5	Tygerberg Hospital	Psychiatric Ward upgrade	Planning	12	2010	2011	4 000		100	0	1 918	2 082	
73	8.5	Tygerberg Hospital	Kitchen upgrade	Planning	12	2009	2010	12 000		200	4 000	7 000	820	
74	8.5	Tygerberg Hospital	Helipad	Planning	5	2009	2009	700		500	500	0	0	
75	8.5	Tygerberg Hospital	Lift upgrading: Blocks 21, 22, 53	Planning	12	2008	2009	8 000		3 958	7 100	150	0	
76	8.5	Tygerberg Hospital	Medical Record Upgrade	Inception	12	2012	2013	4 000					741	
77	8.5	Tygerberg Hospital	New main entrance and reception area	Inception	12	2012	2013	2 750					600	
78	8.5	Tygerberg Hospital	Upgrade Lift Bank	Inception	20	2012	2013	10 000					1 150	
79	8.5	Tygerberg Hospital	Upgrade casualty	Planning	12	2010	2011	13 200		312	4 500	8 300	300	
80	8.5	Tygerberg hospital	Security fence - Electric Fence East side	Inception	6	2009	2009	8 000		3 005	3 700	200		
81	8.5	Tygerberg hospital	Security fence - East Side	Inception				4 000			7 600	200		
82	8.5	Tygerberg hospital	Interim upgrades	Inception				38 000						22 000
83	8.6	Cape Medical Depot	Upgrade	Complete	14	2006	2007	4 816	3 866	0				
84	8.6	Oudtshoorn Medical depot	Relocation of the Medical Depot	Complete	9	2006	2007	4 700	3 200	233				
		TOTAL							80 262	94 643	114 924	128 879	155 614	170 950

Schedule 3: Hospital Revitalisation

No	Sub Prog.	Facility	Type of Infrastructure	Current Project Stage	Project Duration Months	Start Target Date	Complete Target Date	Estimated Total cost	2007/08 R000's	2008/09 R000's	2009/10 R000's	2010/11 R000's	2011/12 R000's	2012/13 R000's
1	8.4	Brooklyn Chest	Hospital	Inception	48	2010	2014	900,000					1 000	20 000
2	8.4	George Hosp -Phase 3	Hospital	Planning	24	2009	2011	65,000	10 691	8 687	29 000	29 000	4 000	
3	8.3	Khayelitsha Hosp Main	Hospital	Planning	36	2009	2012	536,000	5 000	31 704	139 699	217 140	130 000	48 000
4	8.3	Khayelitsha Hosp Infra	Hospital		8	2008	2009	14,300			4 000			
5	8.3	Mitchells Plain	Hospital	Planning	36	2009	2012	553,000	2 462	20 987	73 758	158 360	130 500	128 000
6	8.4	Paarl Hospital - Main	Hospital	Construction	44	2006	2009	370,000	101 516	100 292	100 000	12 000		
7	8.4	Paarl Hospital - Admin block	Hospital		20	2009	2011	20,000			6 500	12 500		
8	8.1	Paarl TC Newman CHC	CHC	Planning	24	2009	2011	13,000		771		10 000	2 000	
9	8.4	Valkenberg - upgrade	Hospital	Inception	78	2008	2015	1,400,000	2 990	6 807	3 040	6 000	6 201	50 000
10	8.4	Valkenberg - Admin Repair	Hospital	Planning	12	2009	2010	10,000			7 700	1 800		
11	8.3	Vredenburg - phase 1B	Hospital	Planning	9	2008	2009	4,050	11 984	16 390	3 300			
12	8.3	Vredenburg - phase 2A	Hospital	Planning	15	2009	2010	39,000			26 000	11 000		
13	8.3	Vredenburg - phase 2B	Hospital	Planning	35	2010	2012	150,000			12 000	50 000	60 000	30 000
14	8.4	Worcester Hospital - Phase 3	Hospital	Construction	67	2003	2008	266,000	53 535	33 855	4 000			
15	8.4	Worcester Hospital - Phase 4	Hospital	Planning	20	2009	2011	45,000		3 550	16 500	25 500	1000	
16	8.2	Worcester DMC	DMC	Construction	10	2006	2009	16,400	3 537	8 949	4 500	400		
17	8.3	Helderberg	Hospital	Envisaged				525,830						
18	8.3	Mosselbay	Hospital	Envisaged				480,000						
19	8.3	Robertson	Hospital	Envisaged				480,000						
20	8.3	HRP under and over spend							82 477				25 300	209 501
21	8.4	HRP under and over spend							82 477					
22	8.6	HRP Head Office							4 000	7 000	7 000	5 500	5 500	
23	8.1	HT, OD and QA									1 000	0	0	
24	8.3	HT, OD and QA									20 000	48 000	102 000	
25	8.4	HT, OD and QA									61 500	32 000	18 000	
26		TOTALS							195 715	400 388	519 497	619 200	485 501	485 501
27	8.3	Unauthorised Expenditure									-50 652	-178 646		
28	8.4	Unauthorised Expenditure									-80 000			
		Grand Total							195 715	400 388	388 845	440 554	485 501	485 501

Notes on Schedule 3

- The Mitchell's Plain and Khayelitsha Hospitals have been approved.
- The above table reflects the MTEF budget.
- An amount of R 160 million will be requested for roll over into 2009/10 to help support the shortfall in that year.
- The amounts shown for 2011/12 and 2012/13 are estimates only.

The following table indicates predicted Hospital Revitalisation funding roll-overs and shortfalls

	2009/10 R'000	2010/11 R'000	2011/12 R'000	2012/13 R'000
HRP Total	519 497	619 200	460 201	276 000
MTEF Budget	388 845	440 554	485 501	485 501
Difference	130 652	178 646	-25 300	-209 501
Shift from previous year	160 000	29 348	0	0
Shortfall	(29 348)	149 298	(25 300)	(209 501)

The shortfall in 2009/10 is covered by the planned roll-over of funding from 2008/09. The shortfall for 2010/11 and 2011/12 must be addressed by borrowing forward funding from the 2012/13 year, or by an additional funding allocation.
Note that with the completion of major projects in 2011/12, there will be a significant drop in the funding requirement in 2012/13.

Schedule 4: Upgrade of the forensic and pathology service

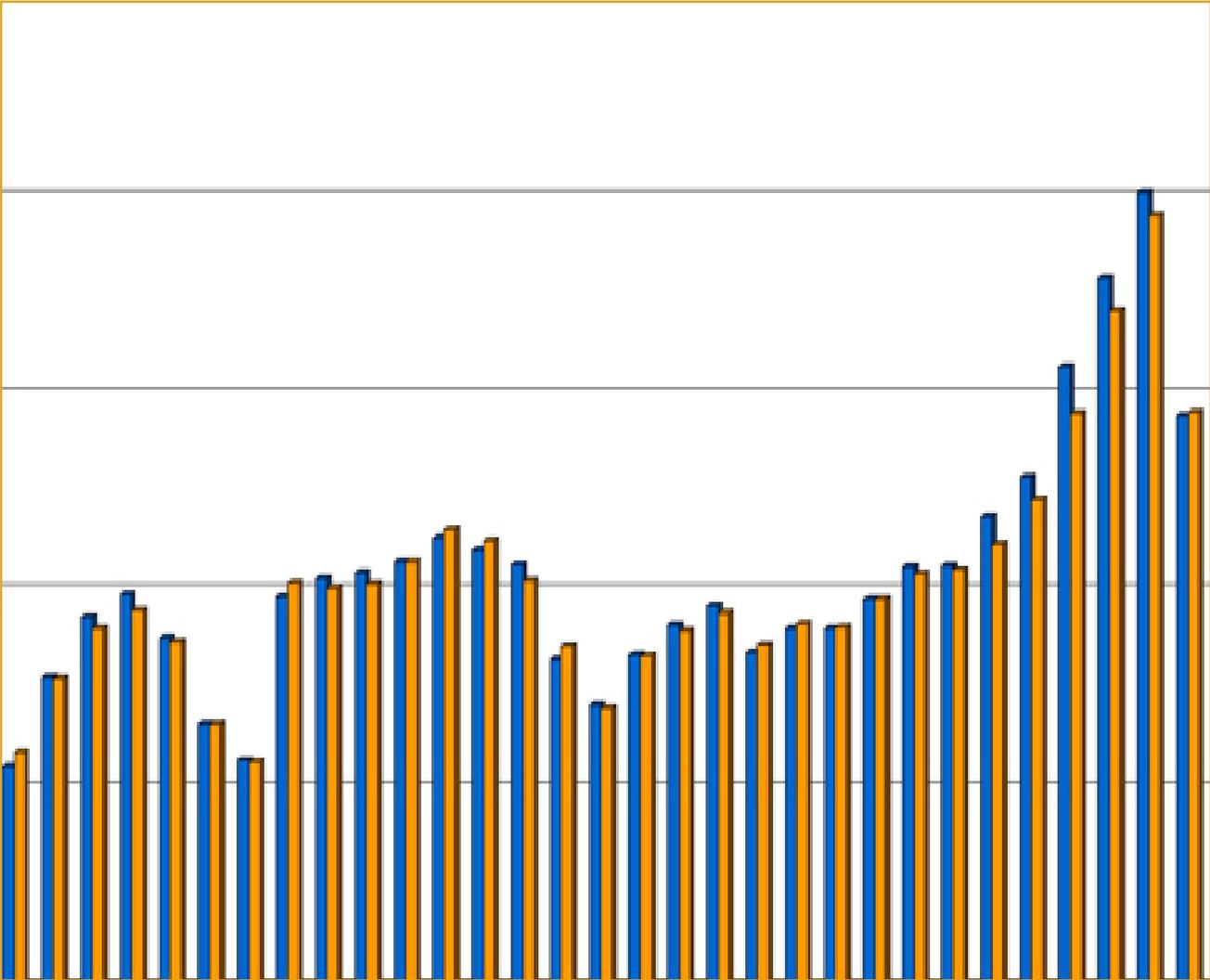
No	Priority	Name of the Project	Type of infrastructure	Current project stage	Project duration months	Start target date	Completion target date	Estimated Total cost	Actual 2007/08 R'000	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000
1		George - New FPL (M3)	FPS Laboratory	Construction	21	Jan-07	Sep-08	17 258	9 309	6 532			
2		Hermanus - New FPL (M2)	FPS Laboratory	Construction	19	Jan-07	Sep-08	12 920	6 218	5 930			
3		Malmesbury - New FPL (M1)	FPS Laboratory	Construction	13	Sep-07	Sep-08	12 522	5 251	7 278			
4		Paarl TC Newman - New FPL (M3)	FPS Laboratory	Construction	21	Mar-07	Dec-08	14 905	8 235	5 899			
5		Worcester - New FPL	FPS Laboratory	Construction	21	Mar-07	Dec-08	15 289	8 835	6 552			
6	1	Beaufort West New FPL (M1)	FPS Laboratory	Inception	18	Apr-08	Sep-09	7 500	81	389			
7	1	Cape Town Metro - Salt River replacement FPL (M6A)	FPS Laboratory	Inception	36	Apr-08	Mar-11	70 000	197	60			
8	1	Cape Town Metro - Upgrade of Tygerberg FPL (M6A)	FPS Laboratory	Inception	36	Apr-08	Mar-11	70 000		15			
9	1	Stellenbosch - New FPL (M3)	FPS Laboratory	Inception	18	Sep-08	Apr-10	14 000		300			
10	2	Vredenburg - New FPL (M1)	FPS Laboratory	Inception	12	Apr-09	Mar-10	9 260		150			
11	2	Riversdale New FPL (M1)	FPS Laboratory	Inception	24	Apr-08	Mar-10	5 000	65	17			
12	3	Swellendam - New FPL (M1)	FPS Laboratory	Inception	12	Apr-10	Mar-11	8 989		0			
13	3	Messel Bay New FPL (M2)	FPS Laboratory	Inception	18	Apr-10	Aug-11	11 000	54	719			
14	3	Wolseley - New FPL (M1)	FPS Laboratory	Inception	12	Apr-10	Mar-11	8 989		0			
15	3	Laingsburg - New FPL (M1)	FPS Laboratory	Inception	12	Apr-11	Mar-12	4 840	79	0			
16	4	Vredendal - Upgrade FPL (M1)	FPS Laboratory	Construction	6	Oct-11	Mar-12	2 000	14	0			
17	4	Krystna - New FPL (M1)	FPS Laboratory	Inception	18	Apr-11	Aug-12	12 800	43	450			
18	4	Oudishoorn New FPL (M3)	FPS Laboratory	Inception	12	Apr-11	Mar-12	14 641		0			
19		Head Office - NPW claim	FPS Laboratories	RAMP		Mar-06	May-08	5 628	5 555	0			
		Total - new construction							43 956	34 291			

Notes:

- No planning can proceed if additional funding is not secured for the MTEF period.

Schedule 5: Recurrent Maintenance

Name of the project/Programme	Type of infrastructure	Brief need/ proposed outcome	2008/09 R'000	2009/10 R'000	2010/11 R'000	2011/12 R'000
Vote 6 : Health	Community Health facilities	Maintain Serviceability	9 678	21 200	25 000	25 000
	District Hospitals	Maintain Serviceability	11 000	12 600	19 340	19 340
	Provincial Hospitals	Maintain Serviceability	21 725	23 305	26 637	29 790
	Central Hospitals	Maintain Serviceability	37 794	50 000	60 000	64 000
	Other Facilities	Maintain Serviceability	5 000	6 300	7 000	7 000
TOTAL			85 197	113 405	137 977	145 130



**ANNUAL PERFORMANCE PLAN
OF YEAR ONE**

PROGRAMME 1: ADMINISTRATION**Table C1.1: Administration**

Strategic Objective	Measurable Objective	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programme 1.2:	Management	Strategic Goal: To conduct the strategic management and overall administration of the Department of Health							
To coordinate, integrate and provide health information to the department	Improve the Integrity of data	1. Data submission rate of prioritised data sets	-	This is a new indicator.	85% (11 760/ 13 836)	76% (2 628 / 3 459)	79% (2 732 / 3 459)	82% (2 836 / 3 459)	85% (2 940 / 3 459)
	Creating a central data repository for all performance / non-financial data.	2. Number of budget programmes whose core data has been incorporated into the central data repository	-	This is a new indicator.	8	2	4	6	8
	Implementation of HIS at all contracted hospitals	3. Percentage of hospitals where the HIS has been implemented	47% (19/41)	60% (24/41)	70% (28/41)	61% (25/41)	63% (26/41)	66% (27/41)	70% (28/41)
To formulate policy and provide overall management and administrative support to the Department and the respective districts and institutions within the Department	All hospitals with up to date asset register	4. Percentage of hospitals with up to date asset register	95% (39/41)	100% (41/41)	100% (41/41)	100% (41/41)	100% (41/41)	100% (41/41)	100% (41/41)
	All other components, excluding hospitals, with an up to date asset register.	5. Number of health districts with up to date PHC asset register (excluding hospitals)	5	9	9	9	9	9	9
	Reduce the number of dues out (stock outs) at the CMD	6. Number of items on dues out (stock outs) at the Central Medicine Depot (CMD)	61	70	<50	<50	<50	<50	<50
To systematically monitor and evaluate the quality of service delivery.	Timeous resolution of complaints.	7. Percentage of complaints resolved within 25 days.	Not reported in the APP	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received	75% of complaints received

Table C1.2: Situational analysis and projected performance for human resources (excluding health sciences and training) [HR3]

Sub-programme 1.2.1 Administration		Strategic goal:		The recruitment and retention of an appropriate workforce for the Department of Health.							
Strategic Objective	Measurable objective	Performance Measure/Indicator	Type	2007/08 Actual	2008/09 Estimate	2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	National target 2007/08
To have an effective and efficient and skilled workforce.	To provide sufficient staff with appropriate skills per occupational group.	1. Number of medical officers per 100,000 people	No	37	37	37	Targets reported annually				18.7
		2. Number of medical officers per 100,000 people in rural districts	No	13	13	13					12.2
		3. Number of professional nurses per 100,000 people	No	100	100	100					105
		4. Number of professional nurses per 100,000 people in rural districts	No	80	80	80					92.5
		5. Number of pharmacists per 100,000 people	No	15	15	15					34
		6. Number of pharmacists per 100,000 people in rural districts	No	12	12	12					24
		7. Vacancy rate for professional nurses	%	13%	13%	13%					15
		8. Attrition rate for doctors	%	20%	20%	20%					25
		9. Attrition rate for professional nurses	%	10%	10%	10%					25
		10. Absenteeism rate for professional nurses	%	2.7%	2.7%	2.7%					5
		11. Percentage of hospitals with employee satisfaction survey	%	65%	65%	65%					50
		12. Nurse clinical workload (PHC)	No	32	35	27	27	27	27	27	40
		13. Doctor clinical workload (PHC)	No	29	50	29	29	29	29	29	30
		14. Supernumerary staff as a percentage of establishment	%	0	0	0	Targets reported annually				

PROGRAMME 2: DISTRICT HEALTH SERVICES

Table C2.1: Provincial objectives and performance indicators for District Health Services [DHS5]

Strategic Objectives	Measurable objectives	Measure/Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services in all the districts of the Western Cape									
Comply with the National Health Act (no 63 of 2003) prescripts on the establishment of the District Health System	Establish a fully functional DHS in each of the districts by 2010.	1. The number of District Health Plans formally approved by the District Health Council	0	0	5	Annual Target	Annual Target	Annual Target	Annual Target
Deliver efficient quality Primary Health Care (PHC) services in all 6 districts	Establish an integrated PHC information system (PHCIS) at all PHC facilities in all 6 districts.	2. The number of PHC facilities that have the required infrastructure and equipment to implement PHCIS	54	73	78	Annual Target	Annual Target	Annual Target	Annual Target
		3. The number of Principal Family Physicians and Family Physicians appointed in the District Health Service	9	2	17	Annual Target	Annual Target	Annual Target	Annual Target
	Improve clinical governance and quality of District Health Services in all six districts by 2010.	4. The number of Family Medicine registrars employed in the District Health Service	20	17	60	Annual Target	Annual Target	Annual Target	Annual Target
		5. The number of CHCs and/or CDC's offering nurse based extended hours to 21h30 on weekdays and 8h00 to 12h00 on weekends	9	12	18	Annual Target	Annual Target	Annual Target	Annual Target
Comply with the South African Constitution with regards to universal access to emergency medical services	Improve access to efficient and effective emergency care within the District Health System	6. Percentage of non-hospital towns with populations of more than 5000 that have access to an emergency service on a 24-hour basis	N/A	50%	56%	Annual Target	Annual Target	Annual Target	Annual Target
Strategic goal: Provide a comprehensive package of quality services to all clients with chronic diseases in all districts in the Western Cape									
Provide optimal access to chronic medication for clients in all 6 districts	Increase number of CDM clients receiving medication at a reduced time.	7. Number of prescriptions dispensed through an alternative dispensing system.	1 420 500	730 000	1 500 000	375,000	375,000	375,000	375,000
Provide optimal clinical care for clients with chronic diseases	Implement a clinical audit system for chronic diseases	8. Number of sub-districts undertaking annual clinical audits for the management of chronic diseases using the integrated tool	Not required to report	N/A	8	Annual target	Annual target	Annual target	Annual target
Establish an integrated community-based service (CBS) platform to render a full package of quality CBS services to the communities in all districts in the Western Cape.									
Provide home-based care to prioritised clients in need of care	Increase the number of clients receiving home community based services.	9. Total number of NPO appointed home carers.	1 343	2 300	2 500	Annual target	Annual target	Annual target	Annual target
	Increase number of home-based care (HBC) clients seen.	10. Total number of registered active HBC clients	16 823	23 000	29 000	Annual target	Annual target	Annual target	Annual target
Deliver quality Home Community Based Services (HCBS) in all 6 districts	Increase access to home community based services	11. Total CBS headcounts per annum (client visits)	N/A	New indicator	2 056 000	514 000	514 000	514 000	514 000
Provide inpatient palliative, sub acute and chronic care to prioritised clients in need of care	Ensure bed utilization to full capacity.	12. Number of palliative, sub acute and chronic care beds	807	780	783	783	783	783	783
		13. Bed utilisation rate in palliative, sub acute and chronic care beds	71%	79%	85%	85%	85%	85%	85%
Strategic goal: Transform the district hospital service platform to provide access to full package of quality level 1 hospital services in all districts in the Western Cape									
Ensure accessible, effective and efficient District Hospital services in all 6 districts.	Provide the total CSP number of beds in district hospitals by 2010	14. Number of district hospital beds	2 292	2 255	2 413	2 413	2 413	2 413	2 413

Table C2.2: Performance indicators for District Health Services [DHS6]

Strategic Objectives	Measurable objectives	Measure/Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programmes 2.1 - 2.3:	Strategic goal: Establish the District Health System (DHS) in line with the CSP to deliver the full package of quality DHS services in all the districts of the Western Cape								
Deliver effective quality Primary Health Care (PHC) services in all 6 districts	Allocate sufficient funds per uninsured person to sustain an average utilisation rate of 3.87 per annum by 2010.	1. Provincial expenditure per uninsured person ¹ .	R313	R346	R388	R388	R388	R388	R388
		2. Total PHC headcount per annum	13 029 007	14 645 765	14 645 765	3 661 441	3 661 441	3 661 441	3 661 441
		3. PHC utilisation rate (per capita).	2.41	2.63	2.76	2.76	2.76	2.76	2.76
		3.1 PHC utilisation rate per uninsured person.	3.24	3.52	3.7	3.7	3.7	3.7	3.7
		3. PHC utilisation rate - under 5 years.	4.9	5	5	5	5	5	5
		4. Percentage of sub districts offering the full package of PHC services.	100%	100%	100%	100% (32/32)	100% (32/32)	100% (32/32)	100% (32/32)
	Ensure the efficient and quality delivery of the full package of PHC services.	5. Percentage fixed PHC facilities supported by a doctor at least once a week.	73.40%	100%	80% (298/374)	Annual Target	Annual Target	Annual Target	Annual Target
		6. Supervision rate.	43.80%	100%	100%	100% (373/373)	100% (373/373)	100% (373/373)	100% (373/373)
		4. Provincial PHC expenditure per headcount	R93	R105	R112	R112	R112	R112	R112
		5. Percentage of complaints resolved within 25 days	-	-	25%	25%	25%	25%	25%

Table C2.3: Performance indicators for District Hospitals [DHS 7]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Ensure accessible, effective and efficient District Hospital services in all 6 districts	Provide sufficient theatre capacity and resources at district hospitals to perform caesarian sections at 20%	1. Caesarian section rate for district hospitals	20.6%	20%	20%	20%	20%	20%	20%
	Provide sufficient resources for the rendering of out patient services at a target rate of one outpatient per inpatient day .	2. Number of patient day equivalents (PDEs) in district hospitals	956 181	992 617	1 187 327	296 832	296 832	296 832	296 832
		3. OPD total headcounts in district hospitals	515 501	533 732	691 042	172 761	172 761	172 761	172 761
		3.1 Casualty/emergency/ trauma headcount	362 498	305 420	376 091	94 023	94 023	94 023	94 023
		4. Comprehensive OPD headcount in district hospitals (OPD + casualty/ emergency / trauma)	877 999	839 152	1 067 133	266 783	266 783	266 783	266 783
	Implement quality assurance measures to minimise patient risk and improve clinical outcomes.	5. Percentage of district hospitals with patient satisfaction survey using DoH template	25.7	100% (33/33)	100% (34/34)	Annual target	Annual target	Annual target	Annual target
		6. Percentage of district hospitals with mortality and morbidity meetings every month	71.4	70% (23/33)	75% (26/34)	Annual target	Annual target	Annual target	Annual target
		7. Percentage of district hospitals with clinical audit meetings every month	N/A	31%	35%	Annual target	Annual target	Annual target	Annual target
		8. Percentage complaints resolved within 25 days within district hospitals	N/A	45%	50%	50%	50%	50%	50%
		9. Case fatality rate in district hospitals for surgery separations	1.05%	1.0%	1.00%	1.00%	1.00%	1.00%	1.00%
	Manage bed utilisation to achieve an average length of stay of approximately 3 days and a bed occupancy rate of 85% in district hospitals.	10. Average length of stay in district hospitals	3.3 days	3.2 days	3.2 days	3.2 days	3.2 days	3.2 days	3.2 days
		11. Bed utilisation rate, based on useable beds, in district hospitals	79.30%	85.1%	86%	86%	86%	86%	86%
		12. Total separations in district hospitals	203 932	221 808	267 246	66 811	66 811	66 812	66 812
Ensure the cost effective management of district hospitals at a target expenditure of approximately Rxx per PDE by 2010	13. Expenditure per patient day equivalent ¹	R894	R954	R930	R930	R930	R930	R930	

Table C2.4: Provincial objectives and performance indicators for HIV and AIDS, STI and TB control [HIV2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic Goal: Reduce morbidity and mortality amongst HIV affected persons									
Provide ART to patients in need	Increase number of clients in need of ART starting treatment to 99,526 by 2011	1. Number of new ART patients	13 928	8 321	22 480	Annual target	Annual target	Annual target	Annual target
Strategic Goal: Decrease the number of new infections in the age group 15-24 years									
Implement an effective prevention strategy.	Increase number of clients tested for HIV to 380,000 by 2011	2. Number of persons tested for HIV, excluding antenatal	276 331	289 065	323 000	80 750	80 750	80 750	80 750
	Distribute 650, 000 female Condoms through Public Health Care (PHC) and non PHC sites in the Province by 2011	3. Number of female condoms distributed from public health facilities	562 725	548 050	550 000	137 500	137 500	137 500	137 500
	Decrease mother to child HIV transmission to 4% by 2011	4. PMTCT transmission rate	5.20%	4.51%	4.00%	4.00%	4.00%	4.00%	4.00%
Strategic Goal: Reduce morbidity and mortality due to TB									
Strengthen the implementation of the DOTS Strategy	Increase routine sputum collection in all TB patients at 2 months to 80% by 2011	5. Smear conversion rate at 2 months for new smear positive PTB cases	71.9%	72%	73%	73%	73%	73%	73%

Table C2.5: Performance indicators for HIV and AIDS, STI and TB control [HIV3]

Strategic objective	Measurable objective	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic Goal: Decrease the number of new infections in the age group 15-24 years									
Implement an effective prevention strategy.	Provide PMTCT services to all pregnant women at 1 st Antenatal booking visit	1. Percentage fixed PHC facilities offering PMTCT (PMTCT facility rate)	84.4%	80%	82%	82%	82%	82%	82%
			242/288	230/288	245/299	245/299	245/299	245/299	245/299
	Provide VCT services at all fixed PHC facilities in the Province	2. Percentage fixed PHC facilities offering VCT(VCT facility rate)	89%	100%	97%	97%	97%	97%	97%
			258/290	290/290	290/299	290/299	290/299	290/299	290/299
	Provide PEP for occupational exposure at all hospitals in the Province	3. Percentage of hospitals offering PEP for occupational HIV exposure	100%	100%	100%	100%	100%	100%	100%
			40/40	40/40	41/41	41/41	41/41	41/41	41/41
	Provide PEP for sexual assault at all hospitals in the Province	4. Percentage of hospitals offering PEP for sexual abuse	87.00%	100%	100%	100%	100%	100%	100%
			35/40	40/40	41/41	41/41	41/41	41/41	41/41
Distribute Male Condoms from all PHC Facilities and non PHC facilities to all adult males 15 years and above	5. Male condom distribution rate from public sector health facilities 1 (rate)	41.1	39.2 67 957 263/ 1 734 277	39.2 74 752 989/ 1 906 624	39.2 18 688 247/ 476 656	39.2 18 688 247/ 476 656	39.2 18 688 247/ 476 656	39.2 18 688 247/ 476 656	
Issue of STI partner notification slips to all STI clients treated new	6. STI partner treatment rate (%)	18.9%	20.3%	20.5%	20.5%	20.5%	20.5%	20.5%	
Administer Nevirapine to babies of mothers who accepted PMTCT intervention	7. Nevirapine newborn uptake rate	101.60%	95%	95%	95%	95%	95%	95%	
Administer Nevirapine to HIV positive women in labour who accepted PMTCT intervention	8. Nevirapine uptake-antenatal clients	73.5%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	

Strategic objective	Measurable objective	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Provide HIV pre-test and post-test counselling services in fixed PHC facilities	9. Clients HIV pre-test counseled rate in fixed PHC facilities (%)	2.7% 320 325 11 863 906	3% 360 000/ 12 338 462	3.80% 340 000	3.80%	3.80%	3.80%	3.80%
	Determine acceptability of HIV testing in those pre test counselled	10. HIV testing rate (excluding antenatal)	95.1%	90.00%	95.00%	95.00%	95.00%	95.00%	95.00%
Strategic Goal: Reduce morbidity and mortality amongst HIV affected persons									
Provide ART to patients in need	Accredit facilities to provide ART	11. ART service points registered	62	70	76	Annual target	Annual target	Annual target	Annual target
	Increase number of patients on ART	12. ART patients- Total registered	37,435	45,756	68,236	Annual target	Annual target	Annual target	Annual target
	Improve quality of ART service provision	13. Percentage of fixed facilities with any ARV drug stock out	0	0	0	0	0	0	0
	Accredit facilities to provide ART	14. Percentage of fixed facilities referring patients to ARV sites for assessment	100% 290/290	100% 290/290	100% 299/299	100% 299/299	100% 299/299	100% 299/299	100% 299/299
	Monitor turn around times and engage NHLS as needed	15. CD4 test at ARV treatment service points with turnaround time > 6 days	Not collected	Not available	Not available				
	Monitor expenditure on a monthly basis and variances	16. Percentage of dedicated HIV/AIDS budget spent	100%	100%	100%	100%	100%	100%	100%
Strategic Goal: Reduce morbidity and mortality due to TB									
Strengthen the implementation of the DOTS strategy	Strengthen the TB community DOT Programme	17. Percentage of TB cases with a DOT supporter	85%	90%	91%	91%	91%	91%	91%
	Ensure that TB patients remain in care	18. TB treatment interruption rate	9.60%	9%	9%	9%	9%	9%	9%
	Monitor turn around times and engage NHLS as needed	19. Percentage of TB sputa specimens with turnaround time less than 48 hours	65%	68%	72%	72%	72%	72%	72%
	Increase the number of people cured for PTB at first attempt	20. Percentage of new smear positive PTB cases cured at first attempt	77.5%	78%	78%	78%	78%	78%	78%
Ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	Ensure a standardized TB Drug resistant recording and reporting system to monitor progress in the implementation of the M(X)DR-TB Programme	21. New MDR TB cases reported- % annual change	3.20%	Not available	Not available				
		22. New XDR TB cases reported- % annual change	Not available	Not available	Not available				

Notes:

Indicator 5 : Rate: Number of male condoms per male 15 years and older per year.

Indicators 7 & 8 : Until 2006/07, the Nevirapine administration rate was reported. As from 2006/07 NVP coverage rate was reported. The denominator for the coverage rate for 2006/07 is based on the provincial and region specific sero-prevalance, derived from the 2006 HIV Antenatal Survey, namely Western Cape 15.7%, Metropole 18.2%, Cape Winelands 12.6%, Overberg 14.1%, Eden 13%, Central Karoo 6.5%, West Coast 9.1%

In 2003/04 the Nevirapine administration rate to women was calculated as follows (Self administered Nevirapine + NVP in labour) deliveries on PMTCT programme.

In 2004/05 due to change in protocol, the Nevirapine Administration Rate changed to NVP administered in Labour/ PMTCT deliveries- Transfer-in during deliveries

Indicator 15 : This is in the process of being addressed

Indicator 21 : Data was systematically collected from 1 January 2007. This indicator will there only be available from 1 January 2008 It is estimated that there were 696 MDR cases in the Province in 2007. The rate of annual change in these statistics will be collected next year when there are two years' worth of provincial data and thus would be better able to predict the rate of annual change

Indicator 22 : As for Indicator 21, the rate of annual change in these statistics will be collected next year when there are two years' worth of provincial data and thus would be better able to predict the rate of annual change.

Table C2.6: Provincial objectives and performance indicators for MCWH and N [MCWH2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: Improve women's Health and decrease Morbidity and Mortality during pregnancy, birth and post delivery									
Improve antenatal care	Increase antenatal booking rate below 20 weeks to at least 65% by 2011.	1. Percentage of women making antenatal bookings before 20 weeks	39%	44.20%	60%	60%	60%	60%	60%
	Implement BANC at PHC Clinics/ facilities to 70% by 2011	2. Percentage of fixed and non-fixed PHC facilities offering BANC	52% (178/343)	65% (254/391)	58% (265/460)	Annual target	Annual target	Annual target	Annual target
Increase utilisation of contraceptives	Increase women year contraceptive rate	3. Women year contraceptive protection rate	-	New indicator	36%	36%	36%	36%	36%
Strategic goal: Reduce child and neonatal morbidity and mortality									
Improve access to developmental screening	Percentage of children under 1 year screened for developmental disabilities	4. Developmental Screening Rate in children under 1 year of age	-	New indicator	1.2	1.2	1.2	1.2	1.2
Improve Perinatal Care to reduce neonatal morbidity and mortality	Monitor Early Neonatal Mortality Rate for babies >1000g	5. Early neonatal mortality rate of babies >1000g at PPIP sites	4.6	4.4	4.2	4.2	4.2	4.2	4.2
Strategic goal: Improve the nutritional status of prioritised groups of people in the province									
Improve the nutritional status of prioritised groups	Improve identification of children with malnutrition	6. Percentage of Underweight Children under 5 years	0.78	New indicator	0.78	0.78	0.78	0.78	0.78

Table C2.7: Performance indicators for MCWH and N [MCWH3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter3	Quarter 4
Strategic goal: Reduce child and neonatal morbidity and mortality									
Reduce Morbidity and Mortality from Vaccine preventable diseases	Improve child Immunisation status such that at least 90% of all children under one year are fully immunised	1. Percentage of fixed PHC facilities with DTP-Hib vaccine stock out	0.67%	<2%	<2%	<2%	<2%	<2%	<2%
		2. Full Immunisation coverage under 1 year	100.50%	93%	95%	95%	95%	95%	95%
		3. Measles coverage under 1 year	102.8%	93%	93%	93%	93%	93%	93%
Improve resistance to disease in children <1 year	Increase vitamin A supplementation coverage in children <1 year to at least 90%	4. Vitamin A coverage under 1 year	91.6%	89%	92%	92%	92%	92%	92%
Improve prevention and management of common childhood problems.	Facilities implementing IMCI	5. Percentage of fixed PHC facilities implementing IMCI	88% 302/343	84% 313/371	85% 254/299	85% 254/299	85% 254/299	85% 254/299	85% 254/299
Improve access of health services to youth.	Ensure that at least X% of health services are certified as youth friendly	6. Fixed PHC facilities certified as youth friendly	20% 69/377	22% 53/377	18% 53/299	Annual target	Annual target	Annual target	Annual target
Strategic goal: Improve women's Health									
To reduce morbidity and mortality in women at risk of cervical cancer.	Increase cervical cancer screening coverage in women aged 30 years and over to be at least 8%	7. Cervical cancer screening coverage (%)	5.10%	6.3%	8.0%	8.0%	8.0%	8.0%	8.0%
Strategic goal: Decrease morbidity and mortality during pregnancy, birth and post delivery									
To reduce morbidity and mortality in women as a result of abortions	Improve access to TOP services by increasing TOP facilities to 100% of all acute hospitals and 8.5% of CHC	8. Percentage of hospitals offering TOP services ¹	78%	75%	77% 37/48	Annual target	Annual target	Annual target	Annual target
		9. Percentage of CHC's offering TOP services	5.70%	5.70%	5.70% 3/59	5.70%	5.70%	5.70%	5.70%
Increase the number of BFHI facilities	Increased facilities certified as Baby friendly to at least 35%	10. Percentage of facilities certified as baby friendly	21.60% 16/74	25.60% 19/74	29.70% 22/74	Annual target	Annual target	Annual target	Annual target
Increase access to safe delivery services	Improve facility delivery rate to 95%	11. Total deliveries in facilities	97 404	91 359	92 000	23 000	23 000	23 000	23 000
		12. Facility Delivery rate	Data unavailable	96.9%	97%	97%	97%	97%	97%
	Decrease teenage pregnancy to <10% of all deliveries	13. Institutional delivery rate for women under 18 years	7.5%	7.9%	7.5%	7.5%	7.5%	7.5%	7.5%

Table C2.8: Provincial objectives and performance indicators for diseases prevention and control [PREV2]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 (actual)	Province wide value 2008/09 (target)	Province wide value 2009/10 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic Goal: Ensure adequate disease prevention and control									
The implementation of the National Health Act provisions dealing with Environmental health	Monitor municipal environmental health services	1. % Of bacteriological water samples taken from water services authorities conforming to standards	New indicator	92%	92.5%	92.5%	92.5%	92.5%	92.5%
		2. % Of chemical water samples taken from water services authorities conforming to standards	New indicator	96%	96%	96%	96%	96%	96%
		3. % Of households with access to portable water within 200m	New indicator	96%	96%	96%	96%	96%	96%
		4. % Sewage effluent samples complying to requirements	69%	70%	71%	71%	71%	71%	71%

Table C2.9: Performance indicators for disease prevention and control [PREV3]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To ensure the delivery of a good quality Disease control programme in all the districts of the Western Cape									
Provide capacity to render disease control services	Ensure that all districts have at least one trauma centre for victims of violence	1. Number of trauma centres for victims of violence	41	41	42	42	42	42	42
	Ensure all districts have a health care waste management plan	2. Number of health districts with health care waste management plan implemented	5	6	6	6	6	6	6
Provide programmes for the prevention of occupational diseases (see above note)	Increase the percentage of hospitals providing occupational health programme to 100%	3. Percentage of hospitals providing occupational health programmes	84%	90% 30/33	90% 31/34	90% 31/34	90% 31/34	90% 31/34	90% 31/34
Ensure the involvement of schools in promoting health	Increase the number of schools implementing Health Promoting Schools programme	4. Percentage of schools implementing Health Promoting Schools Programme (HPSP) (Percentage)	20.40%	7% 42/591	20% 118/591	20% 118/591	20% 118/591	20% 118/591	20% 118/591
Preparations for the dealing with epidemics and disasters	Ensure all districts have an integrated epidemic preparedness and response plan	5. Integrated epidemic preparedness and response plans implemented	Y	Y	Y	Y	Y	Y	Y
	Ensure adequate outbreak response in line to Provincial Guidelines	6. Outbreaks responded to within 24 hours.	0	95%	95%	95%	95%	95%	95%
		7. Malaria fatality rate	0	0	0	0	0	0	0
	8. Cholera fatality rate	0	0	0	0	0	0	0	
To improve the vision of people with cataracts	Increase the cataract surgery rate to be in line with the national target of 1400/1million	9. Cataract surgery rate (Number per million population) Population annualised per quarter	1 033	1 600	1 800	1 800	1 800	1 800	1 800
		9.1 Number of cataract operations.	5 718	5 790	7 400	1 850	1 850	1 850	1 850

PROGRAMME 3: EMERGENCY MEDICAL SERVICES**Table C3.1: Provincial objectives and performance indicators for EMS and patient transport services [EMS2]**

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Target	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape									
Improve response times to emergency scenes in areas.	Increase the number of all responses in less than 30 minutes.	1. Percentage of all emergency responses in less than 30 minutes.	56.7% (181 886/ 321 000)	50% (200 000/ 400 000)	60% (CAD Data) (252 000/ 420 000)	60% (63 000/ 105 000)	60% (63 000/ 105 000)	60% (63 000/ 105 000)	60% (63 000/ 105 000)
	Increase the percentage of telephone calls answered within 12 seconds to 70% by 2010.	2. Percentage of telephone calls answered within 12 seconds.	76.5% (Metro Only 151 759/ 198 395)	50% (150 000/ 300 000)	80% (240 000/ 300 000)	80% (96 000/ 120 000)	80% (96 000/ 120 000)	80% (96 000/ 120 000)	80% (96 000/ 120 000)
Strategic goal: To facilitate clinical governance and coordination of Emergency Medicine within the Emergency Departments of all health institutions.									
Improved quality of care in Emergency Departments.	To appoint emergency medicine consultants in key emergency departments and EMS.	3. The number of emergency medicine consultants appointed.	4	9	12	9	10	11	12
Strategic goal: To render effective and efficient pre-hospital emergency services during the FIFA World Cup									
Strengthen EMS services in order to meet FIFA 2010 requirements and standards.	Procure Ambulances for the FIFA World Cup	4. Number of ambulances procured	0	0	10	0	0	0	10
	The procurement of base station trunking radios for 10 Hospital Emergency Departments by 2010	5. The percentage of metropolitan hospitals with trunking radios in their emergency centres.	0 (0/10)	50% (5/10)	100% (10/10)	100% (10/10)	100% (10/10)	100% (10/10)	100% (10/10)

Table C3.2: Performance indicators for EMS and patient transport services [EMS3]

Strategic Objectives	Measurable objectives	Measure / Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To render effective and efficient pre-hospital emergency services including inter-hospital transfers and patient transport in the Western Cape									
Ensure the provision of sufficient resources for the rendering of an effective and efficient emergency and patient transport service	Provide target number of ambulances and patient transporters by 2010	1. Total number of rostered ambulances	222	240	250	240	240	240	250
		2. Rostered ambulances per 1000 people	0.042 (222/ 5 278)	0.05 (240/ 5 425)	0.05 (250/ 5 342)	0.045 (245/ 5 342)	0.045 (245/ 5 342)	0.045 (245/ 5 342)	0.05 (250/ 5 342)
		3. Percentage of hospitals with patient transporters	0%	0%	0%	0%	0%	0%	0%
		4. Average kilometers travelled per ambulance (per annum).	60 597 (13 452 527/ 222)	69 000 (14 400 000/ 240)	62 400 (15 600 000/ 250)	15 600	15 600	15 600	15 600
		5. Total kilometers travelled by all ambulances.	13 452 527	13 152 528	15 600 000	3 900 000	3 900 000	3 900 000	3 900 000
	Provide target number of appropriately trained operational emergency staff	6. Percentage locally based staff with training in BAA.	47% (445/942)	52.6% (700/1 332)	45% (600/ 1 332)	52.6% (700/1 332)	50.7% (675/1 332)	48.8% (650/1332)	45% (600/1 332)
		7. Percentage locally based staff with training in AEA.	44% (414/942)	38.7% (515/1 332)	45% (600/ 1 332)	38.7% (515/1 332)	40.5% (540/1 332)	42.4% (565/1 332)	45% (600/1 332)
		8. Percentage locally based staff with training in ALS (Paramedics).	9% (80/ 942)	8.8% (117/1 332)	10% (133/ 1 332)	8% (117/1 332)	8% (117/1 332)	8% (117/ 1332)	10% (132/1 332)
	Achieve normative response times in metro and urban areas	9. Percentage P1 calls with a response time of < 15 minutes in an urban area	48% (3 661/ 7 626)	42% (37 182/ 88 686)	30% (CAD Data Change over) (28 350/ 94 500)	20% (4 500/ 22 599)	22% (4 950/ 22 599)	25% (5 625/ 22 599)	30% (6 750/ 22 599)
		10. Percentage P1 calls with a response time of < 40 minutes in a rural area	70% (1 023/ 1 472)	70% (9 072/ 12 918)	70% (CAD Data Change over) (22 050/ 31 500)	70% (5 513/ 7 875)			
		11. Percentage of all calls with a response time within 60 minutes	75% (241 952/ 321 000)	69% (297 522/ 431 118)	65% (CAD Data Change over) (273 000/ 420 000)	60% (63 000/ 105 000)	61% (64 050/ 105 000)	62% (65 100/ 105 000)	65% (68 250/ 105 000)
	Adhere to the prescribed staffing of ambulances	12. Percentage of operational rostered ambulances with single person crews.	0%	0%	0%	0%	0%	0%	0%
	Ensure the effective and efficient utilisation of resources	13. Percentage of ambulance trips used for inter-hospital transfers	21% (82 761/ 387 438)	21% (87 498/ 418 578)	20% (84 000/ 420 000)	20% (21 000/ 105 000)	20% (21 000/ 105 000)	20% (21 000/ 105 000)	20% (21 000/ 105 000)
		14. Percentage of green code patients transported by ambulance	34.8% (102 930/ 398 029)	29% (123 246/ 418 578)	30% (126 000/ 420 000)	30% (31 500/ 105 000)	30% (31 500/ 105 000)	30% (31 500/ 105 000)	30% (31 500/ 105 000)
		15. Cost per patient transported by ambulance	R829	R852	R970	R970	R970	R970	R970
		16. Percentage ambulances with less than 200 000 kilometers on the odometer	67% (142/ 222)	67% (143/ 213)	60% (156/ 260)	50% (120/240)	50% (120/240)	50% (120/240)	60% (150/250)
		17. Number of EMS emergency cases-Total	387 438	418 578	420 000	100 000	200 000	300 000	420 000
		18. EMS referral cases	Definition to be clarified						

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

The indicators in the table below are determined by the National Department of Health, however, additional information has been provided for each indicator reflecting the performance as follows, e.g.:

- Number of patient day equivalents in regional hospitals – Total:
This is the information required by the National Department of Health and includes the level 2 services in both central and regional hospitals.
- Number of patient day equivalents in regional hospitals – Regional:
This is additional provincial information and reflects the performance of level 2 services in regional hospitals.
- Number of patient day equivalents in regional hospitals – Central:
This is additional provincial information and reflects the performance of level 2 services in central hospitals.

Note that from 2009/10 Victoria Hospital shifts from Programme 4 to Sub-programme 2.9.

Table C4.1: Sub-programme 4.1: General Hospitals

Strategic Objectives	Measurable objectives	Performance Measure/Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	To render a comprehensive package of general specialist hospital services to the population of the Western Cape								
Provide sufficient capacity to render quality general specialist services in regional hospitals	Provide sufficient theatre capacity in regional hospitals for the performance of specialist surgical procedures including a target caesarian section rate of 33%	1. Caesarian section rate for regional hospitals Total	33%	33%	35%	35%	35%	35%	35%
		1.1 Caesarian section rate for regional hospitals- Regional	33.1%	33%	33%	33%	33%	33%	33%
		1.2 Caesarian section rate for regional hospitals - Central	Not reported	0%	38%	38%	38%	38%	38%
	Provide sufficient resources for the rendering of comprehensive out patient services at a target rate of approximately 1:1 out patients per inpatient day Provide sufficient resources to cater for emergency care in regional hospitals.	2. Number of patient day equivalents in regional hospitals - Total	636 992	1 094 151	1 002 926	250 731	250 731	250 732	250 732
		2.1 Number of patient day equivalents in regional hospitals - Regional	Not reported	649 139	551 768	137 942	137 942	137 942	137 942
		2.2 Number of patient day equivalents in regional hospitals - Central	Not reported	445 012	451 158	112 789	112 789	112 790	112 790
		3. OPD total headcounts in regional hospitals - Total	362 960	678 377	592 349	148 087	148 087	148 087	148 088
		3.1 OPD total headcounts in regional hospitals - Regional	362 960	346 502	271 241	67 810	67 810	67 810	67 811
		3.2 OPD total headcounts in regional hospitals - Central	Not reported	331 875	321 108	80 277	80 277	80 277	80 277
		3.3 Casualty/emergency/trauma headcount - Total	201 009	311 572	283 729	70 932	70 932	70 932	70 933
		3.4 Casualty/emergency/trauma headcount - Regional	201 009	181 955	153 729	38 432	38 432	38 432	38 433

Strategic Objectives	Measurable objectives	Performance Measure/Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
		3.5 Casualty/emergency/trauma headcount - Central	Not reported	129 617	130 000	32 500	32 500	32 500	32 500	
		3.6 Comprehensive OPD total headcount in regional hospitals (OPD + casualty/ emergency/trauma) - Total	563 969	989 949	876 078	219 019	219 019	219 020	219 020	
		3.7 OPD total headcount in regional hospitals - (OPD + casualty/ emergency/trauma) - Regional	563 969	528 457	424 970	106 242	106 242	106 243	106 243	
		3.8 OPD total headcount tin regional hospitals (OPD + casualty/ emergency/trauma) - Central	Not reported	461 492	451 108	112 777	112 777	112 777	112 777	
	Implement quality assurance measures to minimise patient risk in regional hospitals	4. Percentage of regional hospitals with patient satisfaction survey using DoH template - Total	100% [6/6]	100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]
		4.1 Percentage of regional hospitals with patient satisfaction survey using DoH template - Regional	100% [6/6]	100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]
		4.2 Percentage of regional hospitals with patient satisfaction survey using DoH template - Central	Not reported	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]
		5. Percentage of regional hospitals with mortality and morbidity meetings every month - Total	100% [6/6]	100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]
		5.1 Percentage of regional hospitals with mortality and morbidity meetings every month - Regional	100% [6/6]	100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]
		5.2 Percentage of regional hospitals with mortality and morbidity meetings every month - Central	Not reported	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]
		6. Percentage of regional hospitals with clinical audit meetings every month - Total	0%	100% [9/9]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]	100% [8/8]
		6.1 Percentage of regional hospitals with clinical audit meetings every month - Regional	Not reported	100% [6/6]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]	100% [5/5]
		6.2 Percentage of regional hospitals with clinical audit meetings every month - Central	Not reported	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]	100% [3/3]
		7. Percentage of complaints resolved within 25 days in regional hospitals - Total	0%	100%	100%	100%	100%	100%	100%	100%
		7.1 Percentage of complaints resolved within 25 days in regional hospitals - Regional	Not reported	100%	100%	100%	100%	100%	100%	100%
		7.2 Percentage of complaints resolved within 25 days in regional hospitals - Central	Not reported	100%	100%	100%	100%	100%	100%	100%
		8. Case fatality rate in regional hospitals for surgery separations - Total	1.70%	1.70%	3.85%	3.85%	3.85%	3.85%	3.85%	3.85%
		8.1 Case fatality rate in regional hospitals for surgery separations - Regional	Not reported	1.7%	1.7%	1.7%	1.7%	1.7%	1.7%	1.7%
		8.2 Case fatality rate in regional hospitals for surgery separations - Central	Not reported	6%	6%	6%	6%	6%	6%	6%

Strategic Objectives	Measurable objectives	Performance Measure/Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Ensure the effective and efficient rendering of sustainable regional hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 4 days and a bed occupancy rate of 85% in regional hospitals.	9. Average length of stay in regional hospitals - Total	3.4 days	4 days	4.5 days	4.5 days	4.5 days	4.5 days	4.5 days	
		9.1 Average length of stay in regional hospitals - Regional	Not reported	3.6 days	4 days	4 days	4 days	4 days	4 days	
		9.2 Average length of stay in regional hospitals - Central	Not reported	5 days	5 days	5 days	5 days	5 days	5 days	
		10. Bed utilisation rate, based on useable beds in regional hospitals – Total	91%	91%	88%	88%	88%	88%	88%	
		10.1 Bed utilisation rate, based on useable beds in regional hospitals – Regional	Not reported	91%	90%	90%	90%	90%	90%	
		10.2 Bed utilisation rate, based on useable beds in regional hospitals – Central	Not reported	91%	85%	85%	85%	85%	85%	
		11. Total separations in regional hospitals - Total	130 205	212 318	175 867	43 966	43 967	43 967	43 967	
		11.1 Total separations in regional hospitals - Regional	Not reported	130 970	111 324	27 831	27 831	27 831	27 831	
		11.2 Total separations in regional hospitals - Central	Not reported	62 581	64 543	16 135	16 136	16 136	16 136	
	Ensure the cost effective management of regional hospitals at a target expenditure of approximately R1500 per PDE.	12. Expenditure per patient day equivalent in regional hospitals - Total	R1 128	R1 567	R1 630	R1 630	R1 630	R1 630	R1 630	
		12.1 Expenditure per patient day equivalent in regional hospitals- Regional	Not reported	R1 300	R1 313	R1 313	R1 313	R1 313	R1 313	
		12.2 Expenditure per patient day equivalent in regional hospitals - Central	Not reported	R1 827	R2 019	R2 019	R2 019	R2 019	R2 019	
	Provide sufficient bed capacity to render quality general specialist services in regional hospitals.	Provide a total of 2503 beds in regional hospitals by 2010.	13. Number of beds in regional hospitals- Total	1 379	2 490	2 342	2 342	2 342	2 342	2 342
			13.1 Number of beds in regional hospitals- Regional	Not reported	1 465	1 307	1307	1307	1307	1307
			13.2 Number of beds in regional hospitals- Central	Not reported	1 025	1 035	1 035	1 035	1 035	1 035
14. Total number of patient days in regional hospitals - Total			449 545	768 670	723 126	180 781	180 781	180 782	180 782	
14.1 Total number of patient days in regional hospitals - Regional			Not reported	471 073	400 412	100 103	100 103	100 103	100 103	
14.2 Total number of patient days in regional hospitals - Central			Not reported	307 812	321 155	80 289	80 289	80 289	80 289	

Table C4.2: Sub-programme 4.2: TB Hospitals

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Strategic goal:	To render comprehensive TB hospital services to the population of the Western Cape									
Provide sufficient capacity to render quality TB hospital services.	Provide sufficient resources for the rendering of inpatient and out patient TB hospital services amounting to approximately 424 000 patient day equivalents (PDE) by 2010.	1. Number of patient day equivalents in TB hospitals	300 307	342 608	349 460	87 365	87 365	87 365	87 365	
		2. OPD total headcount in TB hospitals	2 942	2 016	2 076	519	519	519	519	
	Implement quality assurance measures to minimise patient risk in TB hospitals.	3. Percentage of TB hospitals with patient satisfaction survey using DoH template	33.00%	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]
		4. Percentage of TB hospitals with mortality and morbidity meetings every month	50%	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]
		5. Percentage of TB hospitals with clinical audit meetings every month	Not requested prior to 2008/09	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]
		6. Percentage of complaints resolved within 25 days in TB hospitals	Not requested prior to 2008/09	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]	100% [6/6]
Ensure the effective and efficient rendering of sustainable TB hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 90 days and a bed occupancy rate of 90% in TB hospitals.	7. Average length of stay in TB hospitals	80 days	85 days	85 days	85 days	85 days	85 days	85 days	
		8. Bed utilisation rate, based on useable beds, in TB hospitals	83%	85%	85%	85%	85%	85%	85%	
		9. Total separations in TB hospitals	3 759	3 834	3 911	978	978	978	978	
	Ensure the cost effective management of TB hospitals at a target expenditure of approximately R320 per PDE.	10. Expenditure per patient day equivalent in TB hospitals	R339	R366	R395	R395	R395	R395	R395	
Provide sufficient bed capacity to render quality general specialist services in TB hospitals.	Provide a total of 1 120 beds in regional hospitals by 2010.	11. Number of beds in TB hospitals	1 008	1 030	1 120	1 120	1 120	1 120	1 120	
		12. Total number of patient days in TB hospitals.	299 342	305 328	311 435	77 859	77 859	77 859	77 859	

Table C4.3: Sub-Programme 4.3: Psychiatric hospitals

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Strategic goal:	To render specialist psychiatric hospital services to the population of the Western Cape									
Provide sufficient capacity to render comprehensive specialist psychiatric hospital services.	Provide sufficient resources for the rendering of comprehensive specialist psychiatric hospital services to in patients and out patients amounting to approximately 584 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents in psychiatric hospitals	641 220	627 405	580 141	145 035	145 035	145 035	145 035	
		2. OPD Total headcount in psychiatric hospitals	21 403	16 664	22 932	5 733	5 733	5 733	5 733	
	Implement quality assurance measures to minimise patient risk in specialist psychiatric hospital services	3. Percentage of psychiatric hospitals with patient satisfaction survey using DoH template	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]
		4. Percentage of psychiatric hospitals with mortality and morbidity meetings every month	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]
		5. Percentage of psychiatric hospitals with clinical audit meetings every month	Not requested prior to 2008/09	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]
		6. Percentage of complaints resolved within 25 days in psychiatric hospitals	Not requested prior to 2008/09	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]	100% [4/4]
Ensure the effective and efficient rendering of sustainable specialist psychiatric hospital services.	Manage bed utilisation to achieve an average length of stay of approximately 130 days and a bed occupancy rate of 90% by 2010	7. Average length of stay in psychiatric hospitals	139 days	130 days	100 days	100 days	100 days	100 days	100 days	
		8. Bed utilisation rate, based on useable beds in psychiatric beds	90% 90.4%	90%	85%	85%	85%	85%	85%	85%
		9. Total separations in psychiatric hospitals	4 560	4 783	4 628	1 157	1 157	1 157	1 157	
	Ensure the cost effective management of specialist psychiatric hospitals at a target expenditure of approximately R600 per PDE	10. Expenditure per patient day equivalent in psychiatric hospitals	R537	R578	R657	R657	R657	R657	R657	
Provide sufficient bed capacity to render quality specialist psychiatric hospital services.	Provide a total of 1 763 beds in specialist psychiatric hospitals by 2010.	11. Number of beds in psychiatric hospitals	1 924	1 893	1 796	1 796	1 796	1 796	1 796	
		12. Total number of patient days in psychiatric hospitals	634 917	621 851	557 209	139 302	139 302	139 302	139 302	
Provide a range of Step Down Services to Support dehospitalised care	Provide a Total of 125 step down beds for people with mental illness or Intellectual Disability	13. Number of step down beds	-	New indicator	125	125	125	125	125	
		14. Bed utilisation rate in step down beds	-	New indicator	85%	85%	85%	85%	85%	
		15. Total number of patient days in step down beds	-	New indicator	38 781	9 695	9 695	9 695	9 695	

Table C4.4: Sub-programme 4.4: Rehabilitation services

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Western Cape Rehabilitation Centre (WCRC)		Strategic goal: To provide high intensity specialised rehabilitation services for persons with physical disabilities.							
Provide sufficient capacity to render comprehensive high intensity rehabilitation services	Provide sufficient resources for the rendering of high intensity rehabilitation services to in patients and out patients amounting to approximately 53 000 patient day equivalents per annum by 2010	1. Number of patient day equivalents (PDE) in rehabilitation hospitals	50 654	50 788	51 804	12 951	12 951	12 951	12 951
		2. OPD Total headcount in rehabilitation hospitals	5,856	6 137	6,137	1,534	1,534	1,534	1,535
Implement quality assurance measures to minimise patient risk in the WCRC		3. Percentage of rehabilitation hospitals with patient satisfaction survey using DoH template	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]
		4. Percentage of rehabilitation hospitals with mortality and morbidity meetings every month	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]
		5. Percentage of rehabilitation hospitals with clinical audit meetings every month	0% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]
		6. Percentage of complaints resolved within 25 days in rehabilitation hospitals	0% [1/1]	0% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]	100% [1/1]
Ensure the effective and efficient rendering of sustainable high intensity rehabilitation services.	Manage bed utilisation to achieve an average length of stay of approximately 45 days and a bed occupancy rate of 90% by 2010.	7. Average length of stay in rehabilitation hospital	51.6 days	51 days	50 days	50 days	50 days	50 days	50 days
		8. Bed utilisation rate, based on useable beds in rehabilitation hospitals	87%	85%	85%	85%	85%	85%	85%
		9. Total separations in rehabilitation hospitals	958	1 139	1 004	251	251	251	251
	Ensure the cost effective management of the Western Cape Rehabilitation Centre at a target expenditure of approximately R1800 per PDE	10. Expenditure per patient day equivalent in rehabilitation hospitals	R1 577	R1 843	R1 909	R1 909	R1 909	R1 909	R1 909
Provide sufficient bed capacity at the WCRC to render high intensity rehabilitation services.	Provide a total of 156 beds in the WCRC by 2010.	11. Number of beds in rehabilitation hospital [WCRC]	156	156	156	156	156	156	156
		12. Total number of patient days in rehabilitation hospitals	48 743	49 552	49 600	12 400	12 400	12 400	12 400
Orthotic and Prosthetic Services		Strategic goal:							
Render an Orthotic and Prosthetic service for the Province	Manage a combination of in-house and out-sourced services	13. Number of orthotic and prosthetic devices manufactured.	5 250	5 500	5 610	1 403	1 403	1 403	1 403
Provide quality Orthotic and Prosthetic devices	Training and liaison with Physiotherapists and Occupational Therapists	14. Percentage of orthotic and prosthetic devices requiring remanufacture.	2% (105/ 5 250)	2% (110/ 5 500)	2% (112/ 5 610)	2% (138/ 6,910)	2% (138/ 6,910)	2% (138/ 6,910)	2% (138/ 6,910)
Provide a responsive Orthotic and Prosthetic service	Increase productivity and outsourcing where cost effective	15. Number of patients on waiting list for orthotic and prosthetic services for over 6 months.	441	450	420	445	440	430	420

Table C4.5: Sub-programme 4.5: Dental Training Hospitals [PHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal:	To establish an effective and efficient dental service delivery platform with sufficient resources for the teaching and training of dental professionals								
Provide sufficient capacity to render quality dental services.	Provide sufficient resources for the rendering of inpatient and out patient dental hospital services.	1. Number of patient visits per annum	176 991	193 800	197 676	49 419	49 419	49 419	49 419
		2. Number of theatre cases per annum	1 016	1 400	1 300	325	325	325	325
		3. Number of patients provided with dentures per annum	1 205	1 300	1 500	375	375	375	375
Provide sufficient resources for the teaching and training of dental professionals	Optimise the number of students trained on the platform per annum	4. Number of students graduating per annum	198	200	240	0	0	0	240

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALISED)**Table C5.1: Provincial objectives and performance indicators for central hospitals 2007/08 to 2009/10 [CHS3]**

Central hospitals	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
Strategic goal: Provide sufficient infrastructure for the rendering of highly specialised hospital services.										
Provide sufficient bed capacity to render quality highly specialised services in central hospitals	Provide a total of 1460 level 3 beds in central hospitals by 2010	1. Number of beds in central hospitals	2 417	1 460	1 460	1 460	1,460	1,460	1,460	
		2. Total number of patient days in central hospitals	715 384	425 584	444 519	111 130	111 130	111 130	111 130	
	Groote Schuur Hospital									
	Provide a total of 607 level 3 beds in Groote Schuur Hospital by 2010	3. Number of beds in Groote Schuur Hospital	867	685	607	607	607	607	607	
		4. Total number of patient days in Groote Schuur Hospital	269 030	211 162	184 810	46 203	46 203	46 203	46 203	
	Tygerberg Hospital									
	Provide a total of 608 level 3 beds in Tygerberg hospital by 2010	5. Number of beds in Tygerberg hospital	1 262	538	608	608	608	608	608	
		6. Total number of patient days ¹	367 031	145 804	185 115	46 279	46 279	46 279	46 279	
	Red Cross Children's Hospital									
	Provide a total of 245 level 3 beds in Red Cross Children's Hospital by 2010.	7. Number of beds in Red Cross Children's Hospital.	288	237	245	237	237	237	245	
8. Total number of patient days		85 237	68 618	74 594	18 649	18 649	18 649	18 649		

Table C5.2: Performance indicators for central hospitals for 2007/08 to 2009/10 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarian section rate of 36%	1. Caesarian section rate for central hospitals	36.6%	44%	44%	44%	44%	44%	44%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents in central hospitals	1 090 957	604 486	606 698	151 675	151 675	151 675	151 675
		3. OPD Total headcount at central hospitals	957 339	555 094	486 538	121 635	121 635	121 635	121 635
	Implement quality assurance measures to minimise patient risk in central hospitals.	4. Percentage of central hospitals with a patient satisfaction survey using DoH template	100%	100%	100%	0%	0%	0%	100%
		5. Percentage of central hospitals with mortality and morbidity meetings at least once a month	100%	100%	100%	100%	100%	100%	100%
		6. Percentage of central hospitals with clinical audit meetings at least once a month	100%	100%	100%	100%	100%	100%	100%
		7. Percentage of complaints resolved within 25 days at central hospitals	0%	100%	100%	100%	100%	100%	100%
		8. Case fatality rate in central hospitals for surgery separations	3.8%	2.3%	3.50%	3.50%	3.50%	3.50%	3.50%
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay in central hospitals	5.80 days	6.6 days	6.5 days	6.5 days	6.5 days	6.5 days	6.5 days
		10. Bed utilisation rate, based on useable beds, in central hospitals	80.9%	83%	83%	83%	83%	83%	83%
		11. Total separations in central hospitals	123 495	64 094	68 387	17 097	17 097	17 097	17 097
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2 800 per PDE	12. Expenditure per patient day equivalent in central hospitals	R2 154	R2 851	R2 700	R2 700	R2 700	R2 700	R2 700

Table C5.3: Performance indicators for Grootte Schuur Hospital for 2007/08 to 2009/10 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 (actual)	Province wide value 2008/09 (estimate)	Province wide value 2009/10 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarian section rate of 46%	1. Caesarian section rate at Grootte Schuur Hospital	47%	49.8%	49%	49%	49%	49%	49%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Grootte Schuur Hospital	424 173	299 219	252 237	63 059	63 059	63 059	63 059
		3. OPD Total headcount in Grootte Schuur Hospital	418 466	264 172	202 280	50 570	50 570	50 570	50 570
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Grootte Schuur Hospital has a patient satisfaction survey using DoH template	Yes	Yes	Yes	No	No	No	Yes
		5. Grootte Schuur Hospital has mortality and morbidity meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		6. Grootte Schuur Hospital has clinical audit meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		7. Percentage of complaints resolved within 25 days	100%	100%	80%	80%	80%	80%	80%
		8. Case fatality rate in Grootte Schuur Hospital for surgery separations	4.4%	3%	3.50%	3.50%	3.50%	3.50%	3.50%
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Grootte Schuur Hospital	6.26 days	6.3 days	6.5 days	6.5 days	6.5 days	6.5 days	6.5 days
		10. Bed utilisation rate , based on useable beds, at Grootte Schuur Hospital	82%	83%	83%	83%	83%	83%	83%
		11. Total separations at Grootte Schuur Hospital	42 977	33 459	28 432	7 108	7 108	7 108	7 108
	Ensure the cost effective management of Grootte Schuur Hospital at a target expenditure of approximately R2,800 per PDE	12. Expenditure per patient day equivalent at Grootte Schuur Hospital	R2 355	R2 645	R3 095	R3 095	R3 095	R3 095	R3 095

Table C5.4: Performance indicators for Tygerberg Hospital for 2007/08 to 2009/10 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 (actual)	Province wide value 2008/09 (estimate)	Province wide value 2009/10 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarian section rate of 46%	1. Caesarian section rate at Tygerberg Hospital	30%	40%	39%	39%	39%	39%	39%
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Tygerberg Hospital	518 130	215,411	252,652	63,163	63,163	63,163	63,163
		3. OPD total headcount at Tygerberg Hospital	370 123	208,822	202,613	50,653	50,653	50,653	50,653
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Tygerberg Hospital has a patient satisfaction survey using DoH template	Yes	Yes	Yes	No	No	No	Yes
		5. Tygerberg Hospital has mortality and morbidity meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		6. Tygerberg Hospital has clinical audit meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		7. Percentage of complaints resolved within 25 days at Tygerberg Hospital	100%	100%	100%	100%	100%	100%	100%
		8. Case fatality rate in Tygerberg Hospital for surgery separations	4.9%	3%	3.50%	3.50%	3.50%	3.50%	3.50%
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Tygerberg Hospital	6.2 days	7.2 days	6.5 days	6.5 days	6.5 days	6.5 days	
		10. Bed utilisation rate, based on useable beds, at Tygerberg Hospital	80%	74%	83%	83%	83%	83%	83%
		11. Total separations at Tygerberg Hospital	59 237	20 311	28 479	7 120	7 120	7 120	7 120
	Ensure the cost effective management of Groote Schuur Hospital at a target expenditure of approximately R2 800 per PDE	12. Expenditure per patient day equivalent at Tygerberg Hospital	R1 995	R3 094	R2 256	R2 256	R2 256	R2 256	R2 256

Table C5.5: Performance indicators for Red Cross War Memorial Children's Hospital for 2007/08 to 2009/10 [CHS4]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Strategic goal: To provide highly specialised hospital services in accordance with the specifications of the National Tertiary Services Grant									
Provide sufficient capacity to render quality highly specialised services in central hospitals for the uninsured population of the Western Cape and other provinces	Provide sufficient theatre capacity in central hospitals for the performance of highly specialised surgical procedures including a target caesarian section rate of 36%	1. Caesarian section rate at Red Cross War Memorial Children's Hospital	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
	Provide sufficient resources for the rendering of comprehensive highly specialised out patient services at a target rate of 1.1 out patient per inpatient day ¹	2. Number of patient day equivalents at Red Cross War Memorial Children's Hospital	148 654	95,985	101,809	25,452	25,452	25,452	25,452
		3. OPD Total headcount at Red Cross War Memorial Children's Hospital	145 639	82,100	81,645	20,411	20,411	20,411	20,411
	Implement quality assurance measures to minimise patient risk in central hospitals	4. Red Cross War Memorial Children's Hospital has a patient satisfaction survey using DoH template	Yes	Yes	Yes	No	No	No	Yes
		5. Red Cross War Memorial Children's Hospital has mortality and morbidity meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		6. Red Cross War Memorial Children's Hospital has clinical audit meetings at least once a month	Yes	Yes	Yes	Yes	Yes	Yes	Yes
		7. Percentage of complaints resolved within 25 days at Red Cross War Memorial Children's Hospital	100%	100%	100%	100%	100%	100%	100%
		8. Case fatality rate for surgery separations at Red Cross War Memorial Children's Hospital	0.3%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
Ensure the effective and efficient rendering of sustainable central hospital services	Manage bed utilisation to achieve an average length of stay of approximately 6 days and a bed occupancy rate of 85% in central hospitals	9. Average length of stay at Red Cross War Memorial Children's Hospital	4 days	6.7 days	6.5 days	6.5 days	6.5 days	6.5 days	6.5 days
		10. Bed utilisation rate, based on useable beds at Red Cross War Memorial Children's Hospital	81.7%	82.6%	83%	83%	83%	83%	83%
		11. Total separations at Red Cross War Memorial Children's Hospital	21 281	10 279	11 476	2 869	2 869	2 869	2 869
	Ensure the cost effective management of central hospitals at a target expenditure of approximately R2,800 per PDE	12. Expenditure per patient day equivalent at Red Cross War Memorial Children's Hospital	R 2 155	R2 764	R2 821	R2 821	R2 821	R2 821	R2 821

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Please note that this table reflects annual training targets.

Table C6.1: Provincial objectives and performance indicators for human resource development [HR2]

Strategic objective	Measurable objective	Performance Measure/ Indicator	2007/08 Actual	2008/09 Estimate	2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Programme 6: Health Sciences and training		Rendering of education, training and development opportunities for serving and prospective employees of the Department of Health to enhance service delivery.							
Strategic Goal:									
Sub-programme 6.1: Nurse training									
To provide formal nurse education and training programme to address the Departmental needs	Provision of nursing education and training based on the Departmental Plan	Nursing College: Number of nursing students in training:							
		1. Number of Registered Nurses in training at WCCN (Post Basic [Advanced] Diploma R212)	30	35	90	90	-	-	-
		2. Number of Registered Nurses in training at WCCN (Post Basic Diploma R48)	-	-	30	30	-	-	-
		3. Number of Registered Nurses in training at WCCN (Diploma R254)	-	-	30	30	-	-	-
		4. Number of Registered Nurses in training at WCCN (Diploma R880)	-	12	25	25	-	-	-
		5. Number of Student Nurses in training at WCCN (Basic Diploma R425)	613	798	1 185	1 185	-	-	-
		6. Total number of nurses in training at the WCCN	643	845	1 360	1 360	-	-	-
		Nursing Schools: Number of nursing students in training							
		7. Number of Registered Nurses in training at the nursing schools (Bridging i.e. R683)	40	32	70	70	-	-	-
		8. Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2175)	229	239	265	265	-	-	-
		9. Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2176)-	183	77	70	70	-	-	-
10. Total number of nurses in training in the Nursing Schools	452	348	405	405	-	-	-		
11. Total number of nursing students in training	1 095	1 193	1 765	1 765	-	-	-		
Sub-programme 6.2: EMS Training									
To train appropriate numbers of Emergency Medical Care Personnel to meet the quantitative and qualitative needs of the Emergency Medical Services. To maintain and improve the standards of emergency medical care through the continuous clinical development of Emergency Medical Care Personnel in the Western Cape	Provision of Primary and continuous Medical and Rescue Education to meet the service demands of the Emergency Medical Services	Number of intake of students							
		12. Number of student intake for the National Diploma EMC	161	30	25	-	-	-	25
		13. Number of student intake for the Critical Care Assistant (CCA) (Paramedic) course	24	12	18	18	-	-	-
		14. Number of student intake for the Ambulance Emergency Assistant (AEA) (5- months course)	0	92	82	21	40	-	21
		15. Number of student intake for the Basic Ambulance Assistant (BAA) (5- week course)	24	144	120	40	20	40	20
		16. Number of student intake for the Medical Rescue Training course	-	60	90	20	25	25	20
		17. Number of student intake for emergency service continuous medical training (CME Training) (1 or 2 day courses)	400	400	480	140	100	140	100
		18. Number of student intake for Emergency Communications	-	32	44	11	11	11	11

Strategic objective	Measurable objective	Performance Measure/ Indicator	2007/08 Actual	2008/09 Estimate	2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
		19. Number of student intake for the National Certificate in Communications		-	30				30
		Number of graduates per programme							
		20. Number of graduates from the National Diploma: EMC	15	15	25	-	-	25	-
		21. Number of graduates from the Critical Care Assistant (CCA) Paramedic course	20	10	10	-	-	-	10
		22. Number of graduates from the Ambulance Emergency Assistant (AEA) course (5-months course)	0	88	65	18	18	29	-
		23. Number of graduates from the Basic Ambulance Assistant (BAA) course (5-week course)	20	122	122	40	20	42	20
		24. Number of graduates from the Medical Rescue Training course	-	55	90	23	22	22	23
		25. Number of graduates from the emergency Continuous Medical Education (CME) Training (1 or 2 day courses)	380	380	480	144	96	144	96
		26. Number of graduates from the Emergency Communications Training	-	32	44	11	11	11	11
		27. Number of graduates from the National Certificate in Communications			40				40
		GRAND TOTAL:	435	702	836	236	167	273	160
		28. Number of learners to complete programmes per year.							
Sub-programme 6.3: Education : Bursaries									
To Plan, and Fund the Formal Education and Training interventions	Funding the training of professionals (including health professionals and Support Services) through a bursary scheme	Number of students with bursaries							
		29. Number of nursing professionals with bursaries	1 570	2 060	2 210	2160	0	50	0
		30. Number of health professionals with bursaries	319	308	394	394	0	0	0
		31. Number of other professionals with bursaries	-	10	11	11	-	-	-
		32. Number of support services personnel with bursaries	228	470	440	430	0	10	0
		Number of graduating bursars							
		33. Number of graduating nursing professional bursars	-	285	314	-	-	-	314
		34. Number of graduating health professional bursars	-	39	43	-	-	-	43
		35. Number of graduating other professional bursars	-	5	6	-	-	-	6
		36. Number of graduating support services bursars	-	320	352	-	-	-	352
Sub-Programme 6.4: Primary Health Care (PHC) iMOCOMP									
To plan, coordinate and implement Training and Development interventions	iMOCOMP The provision of training for the improvement & maintenance of competence project (iMOCOMP)	37. Number of people trained through iMOCOMP	0	300	2 200	600	700	400	500

Strategic objective	Measurable objective	Performance Measure/ Indicator	2007/08 Actual	2008/09 Estimate	2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programme 6.5 Training and Development									
	Levy to HWSETA	38. Administrative levy payable to HWSETA in terms of skills development legislation.	R 2 169 m	R 2 280 m	R 2 394 m	R2 394 m			
6.5.2 Expanded Public Works Programme									
To provide training opportunities for unemployed persons to facilitate access to employment.	Funding training opportunities for Community Care Givers employed by NGOs	39. Number of Community Care Givers (CCGs) learners	1 805	1 840	2 000	1 000	0	1 000	0
		40. Number of graduating Community Care Givers (CCGs)	0	1 408	1 800	0	900	0	900
	Funding training opportunities and stipends for data capturer interns	41. Number of data capturers interns	0	172	108	108	0	0	0

Notes:

Indicator 38: Administrative levy payable to HWSETA in terms of skills development legislation.

Where no figures reflected in 2007 / 08 and 2008 / 09 financial years, data for these indicators was not collected in the format used in the table.

Table C6.2: Situational analysis and projected performance for health sciences and training [HR4]

This table is not repeated in Part C as all the indicators are reported annually.

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

Table C7.1: Provincial objectives and performance indicators for Laundry services

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Sub-programme 7.1: Laundry Services		Strategic Goal: To render laundry services to hospitals, care and rehabilitation centres and certain local authorities							
Provide a laundry service to all provincial hospitals	Manage the pieces/linen laundered by a combination of strategic in-house and out-sourced laundries.	1. Total number of pieces of linen laundered:	20.06m	20.5m	20.5m	4.75m	4.7m	5.53m	5.5m
	Manage the number of pieces laundered by in-house laundries.	2. Number of pieces of linen laundered: in-house laundries.	14.8m	15m	15m	3.3m	3.1m	4.3m	4.3m
	Manage the number of pieces laundered by private sector.	3. Number of pieces of linen laundered: outsourced services.	5.26m	5.5m	5.5m	1.45m	1.6m	1.23m	1.23m
Provide cost effective in-house laundry service	Ensure that in-house laundries produce cost effective laundry services.	4. Average cost per item laundered in in-house laundries.	R1.91	R1.80	R1.90	R1.82	R1.80	R1.79	R1.90
Provide cost effective out-sourced laundry service	Ensure that service providers produce cost effective laundry services.	5. Average cost per item laundered in out-sourced laundries.	R1.61	R1.46	R1.70	R1.47	R1.46	R1.46	R1.70
Sub-programme 7.2: Engineering Services		Strategic Goal: Rendering a maintenance service to equipment, engineering installations, and repairs & renovations to buildings.							
Effective maintenance of buildings and engineering installations	A combination of in-house and out-sourced maintenance in co-operation with Works	1. Maintenance backlog as % of replacement value	7% 900m/ 13bn	6% 800m/ 13bn	6% 800m/ 13bn	6%	6%	6%	6%
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	2. Cost of utilities per bed	R6 912	R7 300	R7 300	R7 300	R7 300	R7 300	R7 300
Safe working environment (Buildings, machinery and equipment)	Arrange training of staff in the Occupational Health and Safety Act	3. Number of reportable incidents in terms of Occupational Health and Safety Act	183	180	160	54	23	41	42
Cost effective maintenance of medical equipment	Manage a combination of in-house and out-sourced maintenance	4. Number of maintenance jobs completed both in-house and outsourced	11 234	12 092	13 000	3 250	3 250	3 250	3 250
Sub-programme 7.3: Forensic Pathology Services		Strategic goal: The establishment of a Forensic Pathology Service for the Province that is designed to contribute positively to ensure the development of a just South African Society, to assist with the fight against and prevention of crime, to assist with the prevention of unnatural death, to establish the independence of the medical and related scientists and to ensure an equitable, efficient and cost effective service.							
Provision of an effective and efficient forensic pathology service in accordance with the statutory requirements.	Adequate staffing through the recruitment of personnel as per the Human Resource Plan.	1. Percentage of Forensic Pathology Service posts filled according to Human Resource Plan.	92% 213/231	90% (275/306)	92% (282/306)	78% 239/306	81% 249/306	85% 261/306	92% 281/306

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 Actual	Province wide value 2008/09 Estimate	Province wide value 2009/10 Target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
	Improved quality of service	2. Percentage of autopsies performed.	Baseline not available	70% 7 000/ 10 000	80% 8 000/ 10 000	80% 2000/ 2500	80% 2000/ 2500	80% 2000/ 2500	80% 2000/ 2500
	Improved response time	3. Average Forensic Pathology Service response time (From receipt of call to arrival on scene).	54 minutes	40 minutes	38 minutes	38 minutes	38 minutes	38 minutes	38 minutes
	Improved quality of service	4. Percentage of Forensic Pathology Service personnel budget spent on training.	8.64%	2%	2% 905 800 / 45 290 000	2% 226 450 / 11 322 500			
Sub-programme 7.4: Orthotic and prosthetic services		Please refer to Sub-programme 4.4							
Sub-programme 7.5: Medicine Trading Account		Strategic Goal: Managing the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centres and local authorities.							
Sufficient working capital to support adequate stock-holding.	Increase working capital in line with projected inflator.	1. Working capital in the medicine trading account.	R50.0 m	R54.0 m	R58.3 m	R58.3 m	R58.3 m	R58.3 m	R58.3 m

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT**Table C8.1 Provincial objectives and performance indicators for health facilities management [HFM6]**

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 (actual)	Province wide value 2008/09 (estimate)	Province wide value 2009/10 (target)	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Programme 8 Health Facilities Management		To provide for new health facilities, upgrading and maintenance of existing facilities, including the Hospital Revitalisation Programme and the Provincial Infrastructure Grant							
Programme 8.1 Improve Community Health physical infrastructure	Provide Community Health infrastructure that is fit for purpose	1. Total infrastructure expenditure on community health facilities as a percentage of backlog (R300 million)	9.40%	9.80%	15.50%	See note below			
Programme 8.2 Improve EMS physical infrastructure	Improve ambulance stations	2. Percentage of ambulance stations built for purpose (50 ambulance stations)	60%	66%	75%	75%	75%	75%	75%
Programme 8.3 Improve District Hospital physical infrastructure	Provide district hospital infrastructure that is fit for purpose	3. Total infrastructure expenditure on district hospitals as a percentage of backlog (R2 billion)	2.80%	11.20%	14.70%	See note below	-	-	-
Programme 8.4 Improve Provincial Hospital physical infrastructure	Provide provincial hospitals with the physical infrastructure that is fit for purpose	4. Total infrastructure expenditure on provincial hospitals as a percentage of backlog (R1,85 billion)	10.90%	14.4%	11.0%	See note below See note below	-	-	-
Programme 8.5 Improve Central Hospital physical infrastructure	Provide central hospitals with the physical infrastructure that is fit for purpose	5. Total infrastructure expenditure on central hospitals as a percentage of backlog (R1,4 billion)	3.70%	4.30%	7.20%		-	-	-

Notes:

- These indicators cannot be reported on meaningfully on quarterly basis. The programme is focussed on balancing annual expenditure with the budget. Furthermore they are based on an annual estimate of the backlog

Table C8.2 Performance indicators for health facilities management [HFM6]

Strategic Objectives	Measurable objectives	Performance Measure/ Indicator	Province wide value 2007/08 actual	Province wide value 2008/09 estimate	Province wide value 2009/10 target	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Health Facilities Management		Strategic goal: To provide new health facilities and to provide for the upgrading and maintenance of existing health facilities.							
Maintain and improve health infrastructure	Provide funding from equitable share to fund capital projects	1. Equitable share capital programme as percentage of total health expenditure	0.21%	0.32%	0.69%	See note below	-	-	-
	To increase the number of hospitals on the Hospital Revitalisation Programme	2. Hospitals funded on the Revitalisation Programme as a percentage of the total number of provincial hospitals.	12.00%	12.00%	14.00%	14%	14%	14%	14%
	Provide adequate funding for infrastructure maintenance	3. Expenditure on facility maintenance as percentage of total health expenditure	1.12%	1.03%	1.14%	See note below	-	-	-
Keep existing equipment in good condition	Provide adequate funding for equipment maintenance	4. Expenditure on equipment maintenance as percentage of total health expenditure	0.90%	0.82%	0.75%	See note below	-	-	-
To safeguard assets	Up to date asset register	5. Hospitals with up to date asset register.	Reported in Programme 1						
	Up to date asset register	6. Health districts with up to date PHC asset register (excluding hospitals)	Reported in Programme 1						
To provide appropriate PHC infrastructure	Provide facilities with piped water supply	7. Fixed PHC facilities with access to piped water	100%	100%	100%	100%	100%	100%	100%
	Provide facilities with mains electricity supply	8. Fixed PHC facilities with access to mains electricity	100%	100%	100%	100%	100%	100%	100%
	Provide facilities with telephone service	9. Fixed PHC facilities with access to fixed line telephone	100%	100%	100%	100%	100%	100%	100%
	Reduce backlog in service platform	10. Average backlog of service platform in fixed PHC facilities	R265 million	R255 million	R240 million	See note below	-	-	-
To provide appropriate hospital infrastructure	Reduce backlog in service platform	11. Average backlog of service platform in district hospitals	R1 285 million	R2 000 million	R2 000 million	See note below	-	-	-
		12. Average backlog of service platform in regional hospitals	R600 million	R250 million	R150 million	See note below	-	-	-
		13. Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	R2 039 million	R2 030 million	R2 030 million	See note below	-	-	-
		14. Average backlog of service platform in tertiary and central hospitals	R1 400 million	R1 400 million	R1 400 million	See note below	-	-	-
		15. Average backlog of service platform in provincially aided hospitals	R13 million	R13 million	R13 million	See note below	-	-	-
Efficient delivery of infrastructure	Timeous completion of projects	16. Projects completed on time %	See note below	See note below	See note below	See note below	-	-	-
	Projects completed within budget	17. Project budget over run %	See note below	See note below	See note below	See note below	-	-	-
To improve the accessibility of health care facilities of the appropriate level of care	Adequate number of beds	18. District hospital beds per 1000 uninsured population	0.53	0.55	0.59	0.59	0.59	0.59	0.59
	Adequate number of beds	19. Regional Hospital beds per 1000 uninsured population	0.61	0.61	0.63	0.63	0.63	0.63	0.63
	Distance to PHC facility	20. % Population within 5km of fixed PHC facility	94%	95%	0.95	95%	95%	95%	95%

Notes:

Indicators 1, 3 and 4 : These indicators cannot be reported on a quarterly basis due to capacity constraints which will hopefully be resolved with the implementation of IDIP.

Indicators 10 – 15 : These indicators cannot be reported on quarterly. They are based on an annual estimate of the backlog.

Indicators 16 and 17 : The Department of Health does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process

ANNEXURE A

PERFORMANCE INDICATOR DEFINITIONS

NOTE:

The Department is in the process of incorporating all performance information into a central repository housed at the Directorate: Information Management. As a result some data sources may change during the course of the 2009/10 financial year.

PROGRAMME 1: ADMINISTRATION

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 1.1: Provincial objectives and performance indicators for Administration [ADMIN1]									
1.	Data submission rate of prioritised data sets	Percentage of Routine Monthly Reports (RMR), Hospital Throughput Forms and HIV Counselling and Testing Register Reports that have been submitted to the provincial office according to the Western Cape Department of Health Data Flow Policy.	Primary Health Care Forms (RMR) submitted	Primary Health Care Forms (i.e. RMR's) that have been submitted on SINJANI according to the Western Cape Department of Health Data Flow Policy. A form has been submitted if data is entered against a particular reporting unit in a particular reporting period. Exclude private facilities.	Missing Data Report for the Primary Health Care Form (SINJANI)	Expected number of Primary Health Care Forms = 536	The expected number of Primary Health Care Forms (i.e. RMR's). The expected number of forms is derived from the number of reporting units listed on the Missing Data Report, i.e. the reporting units that are supposed to submit a form. Exclude private facilities.	Missing Data Report for the Primary Health Care Form (SINJANI)	100 (%)
			Hospital Throughput Forms submitted	Hospital Throughput Forms that have been submitted on SINJANI according to the Western Cape Department of Health Data Flow Policy. A form has been submitted if data is entered against a particular reporting unit in a particular reporting period. Exclude private hospitals, provincially aided hospitals and step down facilities.	Missing Data Report for the Hospital Throughput Form (SINJANI)	Expected number of Hospital Throughput Forms = 52	The expected number of Hospital Throughput Forms. The expected number of forms is derived from the number of hospitals listed on the Missing Data Report, i.e. the hospitals that are supposed to submit a form. Exclude private hospitals, provincially aided hospitals and step down facilities.	Missing Data Report for the Hospital Throughput Form (SINJANI)	
			HIV Counselling and Testing forms submitted	HIV Counselling and Testing Forms that have been submitted on SINJANI according to the Western Cape Department of Health Data Flow Policy. A form has been submitted if data is entered against a particular reporting unit in a particular reporting period. Include private facilities.	Missing Data Report for the HIV Counselling and Testing Register Reports (SINJANI)	Expected number of HIV Counselling and Testing Register Forms = 565	The expected number of HIV Counselling and Testing Register Forms. The expected number of forms is derived from the number of reporting units listed on the Missing Data Report, i.e. the reporting units that are supposed to submit a form. Include private facilities.	Missing Data Report for the HIV Counselling and Testing Register Reports (SINJANI)	
2.	Number of budget programmes whose core data has been incorporated into the central data repository	The number of budget programmes whose APP and Annual Report data are incorporated into the central repository via the Data Take-On project.	Budget programmes whose core data are incorporated in the central data repository	The number of budget programmes whose APP and Annual Report data are incorporated into the central data repository.	Data Take-on Project Reports	None	None	None	None (No)
3.	Percentage of hospitals where the HIS has been implemented	Percentage of provincial health hospitals where the HIS (Hospital Information System) has been implemented.	Hospitals where the HIS has been implemented	Provincial health hospitals where the HIS (Hospital Information System) has been implemented. The "go live" date signifies the implementation date.	HIS Roll-out Project Plan	Hospitals on the HIS contract = 41	Provincial health hospitals specified as part of the HIS roll-out plan. The hospitals are specified in the contract with the vendor - HST (Health Systems Technologies).	Contract with HST	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
4.	Percentage of hospitals with up to date asset register	Percentage of provincial health non-specialist hospitals with an up to date asset register according to the prescripts from National Treasury.	Non-specialist hospitals with an up to date asset register	Provincial health non-specialist hospitals with an up to date asset register according to the prescripts from National Treasury.	SYSPRO (for 3 central hospitals); LOGIS (all other hospitals)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Number of health districts with up to date PHC asset register (excluding hospitals)	Number of health districts with an up to date PHC asset register according to the prescripts from National Treasury. Exclude asset registers from hospitals. There are 4 districts in the Metro and 5 rural districts in the Western Cape (9 in total).	Health districts with an up to date asset register	Health districts with an up to date PHC asset register according to the prescripts from National Treasury. Exclude asset registers from hospitals. There are 4 districts in the Metro and 5 rural districts in the Western Cape (9 in total).	LOGIS	None	None	None	None (No)
6.	Number of items on stock out at the CMD	Number of items on stock out at the Cape Medical Depot (CMD).	Items on stock out at the CMD	Number of items on stock out at the Cape Medical Depot (CMD).	Stock Master (MEDSAS)	None	None	None	None (No)
7.	Percentage of complaints resolved within 25 days	Percentage of all complaints resolved within 25 days. Include complaints received by all provincial health hospitals as well as PHC facilities.	Complaint resolved within 25 days	The number of formal complaints received and registered during the reporting period that was resolved within 25 days. Include complaints received by all provincial health hospitals as well as PHC facilities.	Excel spreadsheet (Complaints and Compliments - Facility.xls)*	Complaints received	The number of formal complaints received and registered by health facilities during the reporting period. Complaints for which the 25-day period has not elapsed are included. Include complaints received by all provincial health hospitals as well as PHC facilities.	Excel spreadsheet (Complaints and Compliment s-Facility.xls)*	100 (%)

* Dataset will be incorporated into the provincial database (SINJANI) during the course of the financial year.

No	Measure / Indicator	Definition	Numerator/(s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	Denominator source	Factor (Type)
Table 1.6: Situational analysis and projected performance for human resources (excluding health sciences and training) [HR3]									
1.	Medical officers per 100,000 people	Medical officers in post per 100,000 people	Medical officers in post	Medical officers in post	PERSAL	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)
2.	Medical officers per 100,000 people in rural districts	Medical officers in post per 100,000 people in rural districts	Medical officers in post in rural districts	Medical officers in post in rural districts	PERSAL	Population in rural districts	Total population in the rural districts in the Western Cape, i.e. Cape Winelands, Central Karoo, Eden, Overberg and West Coast. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)

No	Measure / Indicator	Definition	Numerator(s)	Numerator definition	Numerator source	Denominator(s)	Denominator definition	Denominator source	Factor (Type)
3.	Professional nurses per 100,000 people	Professional nurses in post per 100,000 people.	Professional nurses in post	Professional nurses in post	PERSAL	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)
4.	Professional nurses per 100,000 people in rural districts	Professional nurses in post per 100,000 people in rural districts.	Professional nurses in post in rural districts	Professional nurses in post in rural districts	PERSAL	Population in rural districts	Total population in the rural districts in the Western Cape, i.e. Cape Winelands, Central Karoo, Eden, Overberg and West Coast. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)
5.	Pharmacists per 100,000 people	Pharmacists in post per 100,000 people	Pharmacists in post	Pharmacists in post	PERSAL	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)
6.	Pharmacists per 100,000 people in rural districts	Pharmacists in post per 100,000 people in rural districts	Pharmacists in post in rural districts	Pharmacists in post in rural districts	PERSAL	Population in rural districts	Total population in the rural districts in the Western Cape, i.e. Cape Winelands, Central Karoo, Eden, Overberg and West Coast. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100,000 (No)
7.	Vacancy rate for professional nurses	Percentage of professional nursing posts in the establishment that are vacant and funded.	Professional nursing posts that are vacant and funded	Professional nursing posts that are vacant and funded	PERSAL	Funded professional nursing posts	Funded professional nursing posts	PERSAL	100 (%)
8.	Attrition rate for doctors	Percentage of medical officers and specialists in post at the start of the period who leave the province during the period.	Medical officers in posts who leave the province during the reporting period	Medical officers in post at the start of the period who leave the province during the period.	PERSAL	Medical officers in posts at the start of the reporting period	Medical officers in post at the start of the period.	PERSAL	100 (%)
			Medical specialists in posts who leave the province during the reporting period	Medical specialists in post at the start of the period who leave the province during the period.	PERSAL	Medical specialist in posts at the start of the reporting period	Medical specialists in post at the start of the period.	PERSAL	
9.	Attrition rate for professional nurses	Percentage of professional nurses in post at the start of the period who leave the province during the period.	Professional nurses in posts who leave the province during the reporting period	Professional nurses in post at the start of the period who leave the province during the period.	PERSAL	Professional nurses in posts at the start of the reporting period	Professional nurses in post at the start of the period.	PERSAL	100 (%)
10.	Absenteeism for professional nurses	Percentage of working days lost through sickness by professional nurses.	Sick days for professional nurses	Days lost to sick leave by professional nurses. Maternity leave is excluded.	PERSAL	Working days	Working days during the period. Public holidays and weekends are excluded.	PERSAL	100 (%)

No	Measure / Indicator	Definition	Numerator(s)	Numerator definition	Numerator source	Denominator(s)	Denominator definition	Denominator source	Factor (Type)
11.	Hospitals with employee satisfaction survey	Percentage of hospitals with employee satisfaction survey.	Hospitals with an employee satisfaction survey	Provincial health hospitals with a current employee satisfaction survey.	Employee satisfaction survey reports (hard copies)	Provincial health hospitals = 51	Number of provincial health hospitals. This excludes private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)
12.	Nurse clinical workload (PHC)	Average number of PHC headcounts seen by a nurse in PHC facilities per clinical work day.	PHC total headcount	PHC patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	Professional Nurse clinical work days	Actual work days by Professional Nurses, irrespective of rank, used to perform clinical services in the facility during the reporting period. One actual work day is normally equivalent to an 8-hour shift.	Routine Monthly Report (SINJANI)	1 (No)
						Enrolled Nurse clinical work days	Actual work days by Enrolled Nurses, irrespective of rank, used to perform clinical services in the facility during the period. One actual work day is normally equivalent to an 8-hour shift.	Routine Monthly Report (SINJANI)	
						Nursing Assistant clinical work days	Actual work days by Nursing Assistants used to perform clinical services in the facility during the period. One actual work day is normally equivalent to an 8-hour shift.	Routine Monthly Report (SINJANI)	
13.	Doctor clinical workload (PHC)	Average number of PHC cases seen by a doctor in PHC facilities per clinical work day	PHC cases seen by doctor – not referred	A patient seen by a doctor for a PHC curative service (diagnosis and treatment), where the patient was not seen by a Professional Nurse or a Clinical Nurse Practitioner first and subsequently referred to a doctor.	Routine Monthly Report (SINJANI)	Doctor clinical workdays (PHC)	Actual clinical work days put in by doctor(s) at a Primary Health Care facility. Include ONLY clinical work (i.e. handling patients/clients).	Routine Monthly Report (SINJANI)	1 (No)
			PHC cases seen by doctor - referred	A patient seen by a doctor for a PHC curative service (diagnosis and treatment), after the patient/client had been seen by a Professional Nurse or a Clinical Nurse Practitioner and subsequently referred to a doctor. This referral may be due to diagnostic difficulties or due to the treatment required. The referral might be from a nurse in the same facility or in another facility.	Routine Monthly Report (SINJANI)				
14.	Supernumerary staff as a percentage of establishment	Percentage of the staff establishment identified as supernumerary, i.e. who are in excess due to restructuring.	Supernumerary staff	Posts on the staff establishment that are identified as supernumerary, i.e. that are in excess due to restructuring.	PERSAL	Staff establishment	Posts on the staff establishment.	PERSAL	100 (%)

PROGRAMME 2: DISTRICT HEALTH SERVICES

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 2.7: Provincial objectives and performance indicators for District Health Services [DHS5]									
1.	The number of District Health Plans formally approved by the District Health Council	The number of District Health Plans formally approved by the District Health Council.	District Health Plans formally approved by the District Health Council	The number of District Health Plans formally approved by the District Health Council.	District Health Council Meeting Minutes	None	None	None	None (No)
2.	The number of PHC facilities that have the required infrastructure and equipment to implement PHCIS	The cumulative number of PHC facilities with access to the Primary Health Care Information System (PHCIS).	PHC facilities with access to the Primary Health Care Information System (PHCIS)	The cumulative number of PHC facilities with access to the Primary Health Care Information System (PHCIS).	PHCIS Patient Master Index Reports (PHCIS)	None	None	None	None (No)
3.	The number of Principal Family Physicians and Family Physicians appointed in the District Health Service	The number of filled Principal Family Physicians and Family Physicians posts within the District Health system at the end of the reporting period.	Filled Principal Family Physician and Family Physician posts	The number of filled Principal Family Physicians and Family Physicians posts within the District Health system at the end of the reporting period.	PERSAL	None	None	None	None (No)
4.	The number of Family Medicine registrars employed in the District Health Service	The number of filled Family Medicine Registrars in the District Health Services (DHS) at the end of the reporting period.	Filled Family Medicine registrar posts	The number of filled Family Medicine Registrars in the District Health Services (DHS) at the end of the reporting period.	PERSAL	None	None	None	None (No)
5.	The number of CHCs and/or CDC's offering nurse based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends	The cumulative number of CHCs offering nurse based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends at the end of the reporting period.	CHCs offering nurse based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends	The cumulative number of CHCs offering nurse based extended hours to 21h30 weekdays and 8h00 to 12h00 on weekends at the end of the reporting period.	Facility Managers Report (SINJANI)	None	None	None	None (No)
6.	Percentage of non-hospital towns with populations of more than 5000 that have access to an emergency service on a 24-hour basis	Percentage of towns with a population of more than 5 000 that do not have a hospital within their boundary and has access to an emergency service on a 24 hour basis. Access to an emergency service refers to access to an ambulance that has response times that are in line with national norms and standards or 24 hour access to a health service that has either a clinical nurse practitioner or a professional nurse or a doctor within a 3-4km radius.	Non-hospital towns with populations of more than 5000 that have access to an emergency service on a 24hr basis	The number of towns with a population of more than 5 000 that do not have a hospital within their boundary and has access to an emergency service on a 24 hour basis. Access to an emergency service refers to access to an ambulance that has response times that are in line with national norms and standards or 24 hour access to a health service that has either a clinical nurse practitioner or a professional nurse or a doctor within a 3-4km radius.	Sub-district Managers Report (SINJANI)	Number of non-hospital towns with populations of more than 5000	Towns as defined by STATS SA who have population of more than 5000.	STATS SA	100 (%)
7.	Number of prescriptions dispensed through an alternative dispensing system	The number of prescriptions evaluated, labeled and packed for patient use through an alternative supply system during the period under review. An alternative supply system is any system where medication is prepared at one site but issued to the patient at another site. It includes the number of prescriptions evaluated, labeled and packed at a central dispensing site or pharmacy.	Prescriptions dispensed through an alternative dispensing system	The number of prescriptions evaluated, labeled and packed for patient use through an alternative supply system during the period under review. An alternative supply system is any system where medication is prepared at one site but issued to the patient at another site. It includes the number of prescriptions evaluated, labeled and packed at a central dispensing site or pharmacy.	Pharmacy Statistical Return (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
8.	Number of sub-districts undertaking annual clinical audits for the management of chronic diseases using the integrated tool	The number of sub-districts that have undertaken an annual clinical audit for the management of chronic diseases using the departmental integrated tool.	Sub-districts undertaking annual clinical audits for the management of chronic diseases using the integrated tool	The number of sub-districts that have undertaken an annual clinical audit for the management of chronic diseases using the departmental integrated tool.	Chronic disease management audit reports	None	None	None	None (No)
9.	Total number of NPO appointed home carers	Number of home carers (i.e. caregivers) appointed by non-profit organisations (NPO's). This number should correspond with the number of caregivers funded by the Department as specified in the Service Level Agreement between the Department and the NPO.	NPO appointed caregivers	Number of home carers (i.e. caregivers) appointed by non-profit organisations (NPO's). This number should correspond with the number of caregivers funded by the Department as specified in the Service Level Agreement between the Department and the NPO.	NPO reports to District Offices	None	None	None	None (No)
10.	Total number of registered active HBC clients	Total number of clients registered for home-based care (HBC) services in the Province.	Clients registered for home-based care services	Total number of clients registered for home-based care (HBC) services in the Province. This is obtained from the sum of male and female clients registered according to the HCBC (Home Community Based Care) register.	HCBC (Home Community Based Care) Register	None	None	None	None (No)
11.	Total CBS headcounts per annum (client visits)	The total number of all home based care (HBC) clients seen (i.e. headcount). Services rendered to HBC clients include CIMCI (community integrated management of childhood illnesses) TB DOTS (directly observed treatment) and ART adherence, chronic disease support groups, defaulter tracing including the number of family members in a household of a registered patient seen and to whom health promotion is given by the care giver.	Clients provided with a Home Community Based Care service	The total number of all home based care (HBC) clients seen (i.e. headcount). Services rendered to HBC clients include CIMCI (community integrated management of childhood illnesses) TB DOTS (directly observed treatment) and ART adherence, chronic disease support groups, defaulter tracing including the number of family members in a household of a registered patient seen and to whom health promotion is given by the care giver.	HCBC (Home Community Based Care) Register	None	None	None	None (No)
12.	Number of palliative, sub acute and chronic care beds	Useable beds in community based service (CBS) inpatient care facilities for palliative, sub-acute and chronic care. CBS inpatient care is provided by non-profit organisations (NPO's). Useable beds in CBS inpatient care facilities are beds funded by the Department that are actually available for use within the facility. Clients with a mental illness are excluded since these clients are accommodated in various types of group homes.	Useable beds in CBS inpatient care facilities	Useable beds in community based service (CBS) inpatient care facilities for palliative, sub-acute and chronic care. CBS inpatient care is provided by non-profit organisations (NPO's). Useable beds in CBS inpatient care facilities are beds funded by the Department that are actually available for use within the facility. Clients with a mental illness are excluded since these clients are accommodated in various types of group homes.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
13.	Bed utilisation rate in palliative, sub acute and chronic care beds	Patient days in community based service (CBS) inpatient care facilities for palliative, sub-acute and chronic care during the reporting period, expressed as a percentage of the sum of the daily number of useable beds funded by the Provincial Department of Health in CBS inpatient care facilities for palliative, sub-acute and chronic care.	Inpatient days in CBS inpatient care facilities	Total days spent in CBS inpatient care facilities for palliative, sub-acute and chronic care for all inpatients during the reporting period. Include patient days for beds funded by the Provincial Department of Health only. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable beds in CBS inpatient care facilities	Useable beds in community based service (CBS) inpatient care facilities for palliative, sub-acute and chronic care. CBS inpatient care is provided by non-profit organisations (NPO's). Useable beds in CBS inpatient care facilities are beds funded by the Department that are actually available for use within the facility (regardless of whether they are occupied by a patient or lodger). Clients with a mental illness are excluded since these clients are accommodated in various types of group homes.	Hospital Throughput Form (SINJANI)	100 (%)
14.	Number of district hospital beds	Usable beds in district hospitals are beds actually available for use within district hospitals (regardless of whether they are occupied by a patient or lodger).	Useable beds in district hospitals	Usable beds in district hospitals are beds actually available for use within district hospitals (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
Table 2.8: Performance indicators for District Health Services [DHS6]									
1.	Provincial expenditure per uninsured person	Expenditure on primary health care (PHC) by provincial Department of Health per uninsured person.	Expenditure on PHC by provincial DoH	Expenditure on PHC by provincial Department of Health, i.e. expenditure on sub-programmes 2.1, 2.2 and 2.3	BAS	Uninsured population	Estimated uninsured population of the Western Cape Province, i.e. the proportion of the total provincial population who are dependant on the state for health services. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009 and % uninsured as reported in the APP	1 (R)
2.	Total PHC headcount per annum	Total headcount for provincial and local government PHC facilities. The number of patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	PHC total headcount	Total headcount for provincial and local government PHC facilities. The number of patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	None	None	None	None (No)
3.	PHC utilisation rate (per capita)	Rate at which services are utilised by the target population, represented as the average number of visits per person per period in the target population.	PHC total headcount	Total headcount for provincial and local government PHC facilities, i.e. the number of patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	1 (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.1	PHC utilisation rate (per uninsured person)	Rate at which services are utilised by the target uninsured population, represented as the average number of visits per uninsured person per period in the target uninsured population.	PHC total headcount	Total headcount for provincial and local government PHC facilities, i.e. the number of patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	Uninsured population	Estimated uninsured population of the Western Cape Province, i.e. the proportion of the total provincial population who are dependant on the state for health services. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009 and % uninsured as reported in the APP	1 (No)
4.	PHC utilisation rate - under 5 years	Rate at which services are utilised by the target population under 5 years, represented as the average number of visits per person per period in the target population.	PHC headcount under 5 years	Total headcount under 5 years for provincial and local government PHC facilities, i.e. the number of patients under 5 years seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	Population under 5 years	The population under 5 years in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	1 (No)
5.	Percentage of sub-districts offering the full package of PHC services	Percentage of health sub-districts offering the full package of PHC services.	Health sub-districts offering full package of PHC services	Health sub-districts offering the full package of PHC services as defined by the National PHC package of care norms and standards document. The full package does not have to be provided in every clinic, but each component must be offered in at least one clinic in the sub-district.	PHC Managers Report (SINJANI)	Health sub-districts = 32	Number of provincial health sub-districts.	Departmental structure	100 (%)
6.	Percentage fixed PHC facilities supported by a doctor at least once a week	Percentage of fixed PHC facilities supported by a doctor at least once a week. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Fixed PHC facilities supported by a doctor at least once a week	Fixed PHC clinics supported by a doctor at least once a week during the period. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility Managers Report (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
7.	Supervision rate	Percentage of fixed PHC facilities that were visited by a supervisor at least once every month (official supervisor report completed). A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Supervisor visit this month	Visits to the facility by a dedicated clinic supervisor, who performs a visit according to the policy on clinic supervision and using the red flag or regular review tools. Each visit should normally be documented in writing. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Routine Monthly Report (SINJANI)	Fixed PHC facilities (299) MULTIPLIED BY the number of reporting periods (i.e. 12 reporting periods in a year)	The number of fixed PHC facilities multiplied by the number of reporting periods or months, i.e. 12 reporting periods in a year or 3 reporting periods in a quarter. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
8.	Provincial PHC expenditure per headcount	Expenditure on primary health care (PHC) by the provincial Department of Health per PHC headcount at provincial PHC facilities.	Expenditure on PHC by provincial DoH	Expenditure on PHC by provincial Department of Health, i.e. expenditure on sub-programmes 2.1, 2.2 and 2.3.	BAS	PHC total headcount at provincial DoH PHC facilities	Patients seen in any provincial Department of Health PHC facility during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	1 (R)
9.	Percentage of complaints resolved within 25 days	Percentage of complaints resolved within 25 days in central hospitals.	Complaints resolved within 25 days in central hospitals	The number of formal complaints received and registered in central hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments - Facility.xls)*	Complaints received in central hospitals	The number of formal complaints received and registered by central hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
Table 2.9: Performance indicators for District Hospitals [DHS7]									
1.	Caesarean section rate for district hospitals	Caesarean section deliveries in district hospitals expressed as a percentage of all deliveries in district hospitals.	Caesarean sections in district hospitals	Caesarean sections in district hospitals. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls.	Hospital Throughput Form (SINJANI)	Total deliveries in district hospitals	Total number of women who delivered in district hospitals. Calculated from the number of normal deliveries in district hospitals, assisted deliveries in district hospitals and caesarean sections in district hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
2.	Number of patient day equivalents (PDEs) in district hospitals	The total number of patient day equivalents in district hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in district hospitals.	Inpatient days in district hospitals	Total days spent in district hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in district hospitals	A patient who is admitted and separated from district hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
			1/3 OPD headcount in district hospitals	Headcount of all outpatients attending an outpatient clinic in a district hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/ emergency/ trauma headcount in district hospitals	Headcount of all patients attending a casualty/ emergency/ trauma unit in a district hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				
3.	OPD total headcounts in district hospitals	Headcount of all outpatients attending an outpatient clinic in a district hospital.	OPD headcount in district hospitals	Headcount of all outpatients attending an outpatient clinic in a district hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.1	Casualty/ emergency/ trauma headcount in district hospitals	Headcount of all patients attending a casualty/ emergency/ trauma unit in a district hospital with conditions requiring emergency treatment.	Casualty/ emergency/ trauma headcount in district hospitals	Headcount of all patients attending a casualty/ emergency/ trauma unit in a district hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.2	Comprehensive OPD headcount in district hospitals (OPD + casualty/ emergency/ trauma)	Sum of all outpatients attending an outpatient clinic in district hospital and all patients attending the casualty/ emergency/ trauma unit in a district hospital with conditions requiring emergency treatment.	OPD headcount in district hospitals Casualty/ emergency/ trauma headcount in district hospitals	Headcount of all outpatients attending an outpatient clinic in a district hospital. Headcount of all patients attending a casualty/ emergency/ trauma unit in a district hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	None	None	None	None (No)
4.	Percentage of district hospitals with a patient satisfaction survey using the DoH template	Percentage of district hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	District hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	District hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of district hospitals = 32	The number of provincial health district hospitals. Exclude provincially aided hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of district hospitals with mortality and morbidity meetings at least once a month / every month	Percentage of district hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	District hospitals with mortality and morbidity (M&M) meetings at least once a month / every month	District hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of district hospitals = 32	The number of provincial health district hospitals. Exclude provincially aided hospitals.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of district hospitals with clinical audit meetings at least once a month	Percentage of district hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	District hospitals with clinical audit meetings at least once a month / every month	District hospitals with clinical audit meetings at least once a month/ every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of district hospitals = 32	The number of provincial health district hospitals. Exclude provincially aided hospitals.	Facility list (Annexure to APP)	100 (%)
7.	Percentage of complaints resolved within 25 days in district hospitals	Percentage of complaints resolved within 25 days in district hospitals.	Complaints resolved within 25 days in district hospitals	The number of formal complaints received and registered in district hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments - Facility.xls)*	Complaints received in central hospitals	The number of formal complaints received and registered by central hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments - Facility.xls)*	100 (%)
8.	Case fatality rate in district hospitals for surgery separations	Percentage of surgery separations in district hospitals that died.	Inpatient death - surgery in district hospitals	A death recorded against an inpatient admitted to a district hospital surgery ward. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery in district hospitals	Separation for surgery in a district hospital is the administrative process by which a district hospital records the completion of treatment and/or the accommodation of a patient in a surgery ward. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Average length of stay in district hospitals	Average number of patient days that an admitted patient spends in a district hospital before separation.	Inpatient days in district hospitals	Total days spent in district hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in district hospitals	Separation is the administrative process by which a district hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in district hospitals	A patient who is admitted and separated from a district hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
10.	Bed utilisation rate (based on useable beds) in district hospitals	Patient days during the reporting period in district hospitals, expressed as a percentage of the sum of the daily number of district hospital usable beds.	Inpatient days in district hospitals	Total days spent in district hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Usable bed days in district hospitals in the year	Sum of the daily number of useable beds in district hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in district hospitals	A patient who is admitted and separated from a district hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
11.	Total separations in district hospitals	Separation is the administrative process by which a district hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Day patients in district hospitals	A patient who is admitted and separated from a district hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in district hospitals	A death recorded against an inpatient admitted to a district hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in district hospitals	Any admitted patients who complete their stay in a district hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in district hospitals	An admitted patient in a district hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
12.	Expenditure per patient day equivalent in district hospitals	The average cost per patient day equivalent in district hospitals with patient day equivalent calculated as inpatient days in district hospitals + ½ day patients in district hospitals + 1/3 OPD headcount in district hospitals + 1/3 casualty/ emergency/ trauma headcount in district hospitals.	Expenditure for district hospitals	Total district hospital expenditure, i.e. total expenditure for sub-programme 2.9	BAS	Patient day equivalents (PDEs) in district hospitals	The total number of patient day equivalents in district hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in district hospitals.	Hospital Throughput Form (SINJANI)	1 (R)

Table 2.21: Provincial objectives and performance indicators for HIV & AIDS, STI and TB control [HIV2]

1.	Number of new ART patients	Number of patients who have been enrolled on the ART programme for the first time. Exclude patients who were transferred in from another site.	New ART patients	Number of patients who have been enrolled on the ART programme for the first time. Exclude patients who were transferred in from another site.	ART register (PGWC HIV DB.mdb)	None	None	None	None (No)
2.	Number of persons tested for HIV, excluding antenatal	All clients or patients who were tested for HIV during the reporting period, excluding antenatal clients.	Clients tested for HIV (excluding antenatal)	All clients or patients who were tested for HIV during the reporting period, excluding antenatal clients.	HIV Counselling and Testing Register (SINJANI)	None	None	None	None (No)
3.	Number of female condoms distributed from public health facilities	The number of female condoms distributed to clients at public health facilities.	Number of female condoms distributed from public health facilities	The number of female condoms distributed to clients at public health facilities.	Routine Monthly Report (SINJANI)	None	None	None	None (No)
4.	PMTCT transmission rate	The proportion of babies on the prevention of mother-to-child transmission (PMTCT) programme who tested HIV positive.	PMTCT baby tested positive for HIV	Babies on the PMTCT programme who were tested for HIV for the first time according to the PMTCT testing protocols and had a positive test result.	PMTCT Baby Follow-up Register (SINJANI)	PMTCT baby tested for HIV	Babies on the PMTCT programme who were tested for HIV for the first time according to the PMTCT testing protocols.	PMTCT Baby Follow-up Register (SINJANI)	100 (%)
5.	Smear conversion rate at 2 months for new smear positive PTB cases	Percentage of new smear positive pulmonary tuberculosis (PTB) clients who converted to smear negative after being on TB treatment for 2 months.	New smear positive cases that converted at 2 months	Number of new smear positive pulmonary tuberculosis (PTB) clients who converted from smear positive to smear negative after receiving TB treatment for 2 months.	TB Register (ETR.net)	New smear positive PTB cases	Number of clients diagnosed with new smear positive pulmonary tuberculosis (PTB).	TB Register (ETR.net)	100 (%)

Table 2.22: Performance indicators for HIV & AIDS, STI and TB control [HIV3]

1.	Percentage fixed PHC facilities offering PMTCT (PMTCT facility rate)	Percentage of fixed PHC facilities offering PMTCT. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Fixed PHC facilities offering PMTCT	Fixed PHC facilities offering PMTCT. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility Managers Report (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
2.	Percentage fixed PHC facilities offering VCT to non-antenatal clients (VCT facility rate)	Percentage of fixed PHC facilities providing VCT to non-antenatal patients. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Fixed PHC facilities offering VCT to non-antenatal patients	Fixed PHC facilities offering VCT to non-antenatal clients. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility Managers Report (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	Percentage hospitals offering PEP for occupational HIV exposure	Percentage of public hospitals offering post exposure prophylaxis (PEP) for occupational HIV exposure.	Hospitals offering PEP for occupational HIV exposure	Provincial health hospitals offering post exposure prophylaxis (PEP) for occupational HIV exposure.	Facility Managers Report (SINJANI)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)
4.	Percentage hospitals offering PEP for sexual abuse	Percentage of public hospitals offering post exposure prophylaxis (PEP) for sexual abuse.	Hospitals offering PEP for sexual abuse	Provincial health hospitals offering post exposure prophylaxis (PEP) for sexual abuse.	Facility Managers Report (SINJANI)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Male condom distribution rate from public sector health facilities	Number of male condoms distributed to clients by the facility per male population 15 years and older.	Male condoms distributed	Male condoms from the stock of the facility which were given out to clients at distribution points at the facility or elsewhere in the community (i.e. campaigns, non-traditional outlets etc.). Male condoms distributed to other public sector health facilities for further distribution through these facilities should not be counted.	Routine Monthly Report (SINJANI)	Male population 15 years and older	Male population aged 15 years and older in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	1 (No)
6.	STI partner treatment rate (%)	Percentage of clients diagnosed with a sexually transmitted infection (STI) whose partner(s) received treatment.	STI partner treated - new	Clients who presented with a notification for sexually transmitted infection (STI) treatment and who received treatment for a suspected or confirmed STI. Only the first visit after a notification is counted.	Routine Monthly Report (SINJANI)	STI treated new episode	New episodes of symptomatic sexually transmitted infection (STI) treated according to the Syndromic Approach. One patient can have more than one new episode at the same time.	Routine Monthly Report (SINJANI)	100 (%)
7.	Nevirapine newborn uptake rate	Percentage of new born babies, born from HIV positive women, who received Nevirapine within 72 hours after birth.	Nevirapine dose to baby born to woman with HIV	New born babies, born from HIV positive women, who received Nevirapine suspension within 72 hours after birth.	PMTCT Labour Ward Register (SINJANI)	Babies born to woman with HIV	Babies (live births including BBA's) born from HIV positive women.	PMTCT Labour Ward Register (SINJANI)	100 (%)
8.	Nevirapine uptake-antenatal clients	Proportion of HIV positive pregnant women who received Nevirapine.	Nevirapine dose to woman at antenatal or labour	Nevirapine doses given to HIV positive pregnant women during labour in accordance with the PMTCT programme protocol.	PMTCT Labour Ward Register (SINJANI)	Antenatal client tested HIV positive - new	A pregnant woman who tested positive for HIV during an antenatal visit.	HIV Counseling and Testing Register (SINJANI)	100 (%)
9.	Clients HIV pre-test counseled rate in fixed PHC facilities (%)	Percentage of clients attending PHC facilities that are offered HIV pre-test counseling, excluding antenatal clients.	HIV pre-test counseled (excluding antenatal)	Clients receiving HIV pre-test counseling in PHC facilities, excluding antenatal clients and clients in labour. A couple who receives counseling is counted as 2 since two clients were counseled. Otherwise, group sessions are not counted since it is regarded as education rather than counseling.	HIV Counseling and Testing Register (SINJANI)	PHC total headcount	Total headcount for provincial and local government PHC facilities. The number of patients seen during the period. Each patient is counted once for each day they appear at the facility, regardless of the number of services provided on the day(s) they were seen.	Routine Monthly Report (SINJANI)	100 (%)
10.	HIV testing rate (excluding antenatal)	Percentage of clients who are tested for HIV after receiving HIV counseling, excluding antenatal clients.	HIV client tested (excluding antenatal)	Any client tested for HIV after receiving HIV counseling, excluding antenatal clients.	HIV Counseling and Testing Register (SINJANI)	HIV pre-test counseled (excluding antenatal)	Clients receiving HIV pre-test counseling in PHC facilities, excluding antenatal clients and clients in labour. A couple who receives counseling is counted as 2 since two clients were counseled. Otherwise, group sessions are not counted since it is regarded as education rather than counseling.	HIV Counseling and Testing Register (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
11.	ART service points registered	Facilities accredited to render anti-retroviral treatment (ART) services.	ART service points registered	Facilities accredited to render anti-retroviral treatment (ART) services.	ART register (PGWC HIV DB.mdb)	None	None	None	None (No)
12.	ART patients- Total registered	Patients on an anti-retroviral (ARV) regimen. This is the cumulative number of patients registered at accredited ART service points who are currently on treatment. ART patients who have died, were transferred out or became lost to follow up are therefore not counted.	ART patients registered	Patients on an anti-retroviral (ARV) regimen. This is the cumulative number of patients registered at accredited ART service points who are currently on treatment. ART patients who have died, were transferred out or became lost to follow up are therefore not counted.	ART register (PGWC HIV DB.mdb)	None	None	None	None (No)
13.	Percentage of fixed facilities with any ARV drug stock out	Percentage of all fixed facilities that reported a stock-out of any ARV drug during the reporting period. A facility can be counted as "out of stock" only once during the reporting period, irrespective of the time the facility was out of stock.	Fixed PHC facilities with any ARV drug stock out	Fixed PHC facilities with a stock out during the period of any ARV drug. A facility can be counted as "out of stock" only once during the reporting period, irrespective of the time the facility was out of stock. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Indicator Drugs (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
			Non-specialised hospitals with any ARV drug stock out	Non-specialised hospitals with a stock out during the period of any ARV drug. A facility can be counted as "out of stock" only once during the reporting period, irrespective of the time the facility was out of stock. Non-specialised hospitals are the sum of district, regional, tertiary and central hospitals.	Indicator Drugs (SINJANI)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	
14.	Percentage of fixed facilities referring patients to ARV sites for assessment	Percentage of fixed facilities referring HIV positive clients to an anti-retroviral treatment (ART) service point for an ART assessment (medical eligibility and/or treatment readiness) for the first time.	Fixed PHC facilities referring to ART service point for assessment	Fixed PHC clinics referring HIV positive clients to an anti-retroviral treatment (ART) service point for an ART assessment (medical eligibility and/or treatment readiness) for the first time. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility Managers Report (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			Non-specialist hospitals referring to ART service point for assessment	Non-specialised hospitals referring HIV positive clients to an anti-retroviral treatment (ART) service point for an ART assessment (medical eligibility and/or treatment readiness) for the first time. Non-specialised hospitals are the sum of district, regional, tertiary and central hospitals.	Facility Managers Report (SINJANI)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	
15.	CD4 test at ARV treatment service points with turnaround time > 6 days	Data not collected.							
16.	Percentage of dedicated HIV and AIDS budget spent	Percentage of dedicated HIV and AIDS budget spent.	Dedicated HIV and AIDS budget spent	Expenditure on HIV and AIDS by the Province, i.e. the expenditure for sub-programmes 2.6 and 2.10	BAS	Dedicated HIV and AIDS budget	Budget for HIV and AIDS for the Province, i.e. the budget for sub-programmes 2.6 and 2.10	BAS	100 (%)
17.	Percentage of TB cases with a DOT supporter	Percentage of TB cases who have a directly observed treatment (DOT) supporter.	TB cases with a DOT supporter	Patients registered for TB treatment who have a directly observed treatment (DOT) supporter. This refers to all patients on TB treatment who are supported by the facility or community, including community health workers, home based carers, DOT supporters, informed relatives, traditional healers, schools, crèches, or the workplace. Children are included.	DOTS Report (Provincial DOTS.xls)	TB cases on treatment	Patients registered for TB treatment.	TB Register (ETR.net)	100 (%)
18.	TB treatment interruption rate	Percentage of new smear positive pulmonary tuberculosis (PTB) cases who interrupt (default) from their TB treatment.	New smear positive PTB cases that defaulted	New smear positive PTB patients who were registered for TB treatment in the corresponding period in the previous year and who defaulted from their TB treatment.	TB Register (ETR.net)	All new smear positive PTB cases	New smear positive PTB patients who were registered for TB treatment in the corresponding period in the previous year.	TB Register (ETR.net)	100 (%)
19.	Percentage of TB sputa specimens with turnaround time less than 48 hours	Percentage of TB sputa test results received within 48 hours.	TB sputa results received within 48 hours	TB sputa specimens sent for testing with a recorded turnaround time (normally recorded as the time collected from the facility by the laboratory transport system to the time delivered back at the facility) of less than 48 hours.	Routine Monthly Report (SINJANI)	All sputum samples sent	All sputum samples sent to the laboratory. Include all samples, whether they are samples from suspected cases or samples from patients already on treatment.	Routine Monthly Report (SINJANI)	100 (%)
20.	Percentage of new smear positive PTB cases cured at first attempt	Percentage of new smear positive pulmonary tuberculosis (PTB) cases cured at first attempt.	New smear positive PTB cases - cured	New smear positive PTB patients, who were registered for TB treatment in the corresponding period in the previous year, with a treatment course outcome of cured.	TB Register (ETR.net)	All new smear positive PTB cases	New smear positive PTB patients who were registered for TB treatment in the corresponding period in the previous year.	TB Register (ETR.net)	100 (%)
21.	New MDR TB cases reported- annual percentage change	Percentage annual change in the number of new multi-drug resistant (MDR) TB cases reported.	New MDR cases reported in the current period	New MDR cases reported in the period.	MDR register (Quarterly Report on drug resistant TB.xls)	New MDR cases reported in the previous period	New MDR cases reported in the corresponding period in the previous year period.	MDR register (Quarterly Report on drug resistant	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			MINUS new MDR cases reported in the previous period	New MDR cases reported in the corresponding period in the previous year.	MDR register (Quarterly Report on drug resistant TB.xls)			TB.xls)	
22.	New XDR TB cases reported- annual percentage change	Percentage annual change in the number of new extreme drug resistant (XDR) TB cases reported.	New XDR cases reported in the current period MINUS new XDR cases reported in the previous period	New XDR cases reported in the period. New XDR cases reported in the corresponding period in the previous year.	MDR register (Quarterly Report on drug resistant TB.xls) MDR register (Quarterly Report on drug resistant TB.xls)	New XDR cases reported in the previous period	New XDR cases reported in the corresponding period in the previous year.	MDR register (Quarterly Report on drug resistant TB.xls)	100 (%)

Table 2.29: Provincial objectives and performance indicators for MCWH and Nutrition [MCWH2]

1.	Percentage of women making antenatal bookings before 20 weeks	Percentage of pregnant women who visit a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occur before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counseling / health promotion (the latter often done in groups).	Antenatal 1 st visit before 20 weeks	A pregnant woman who visits a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit', that occurs before 20 weeks after conception. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counseling / health promotion (the latter often done in groups).	Routine Monthly Report (SINJANI)	Antenatal 1 st visit	A pregnant woman who visits a health facility for the primary purpose of receiving antenatal care, often referred to as a 'booking visit'. The actual protocol followed during the visit might vary, but it should include relevant screening procedures, laboratory tests (e.g. for syphilis), and counseling / health promotion (the latter often done in groups). Sum of antenatal 1 st visits before and after 20 weeks.	Routine Monthly Report (SINJANI)	100 (%)
2.	Percentage of fixed and non-fixed PHC facilities offering BANC	Percentage of all fixed and non-fixed PHC facilities with staff trained in basic antenatal care (BANC) and using a standardised BANC checklist when rendering antenatal care during the booking and follow-up antenatal visits. Fixed PHC facilities include CHC's, CDC's, MOU's and clinics while non-fixed PHC facilities include satellite clinics and mobiles.	PHC facilities offering BANC	Number of all fixed and non-fixed PHC facilities with staff trained in basic antenatal care (BANC) and using a standardised BANC checklist when rendering antenatal care during the booking and follow-up antenatal visits. Fixed PHC facilities include CHC's, CDC's, MOU's and clinics while non-fixed PHC facilities include satellite clinics and mobiles.	Facility Managers Report (SINJANI)	PHC facilities = 461	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres (CHC's), community day centres (CDC's) and clinics. Non-fixed facilities are not open for 8 hours a day or are not open for 5 days a week and include satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	Women year contraceptive protection rate	Proportion of women protected by family planning services during a 1-year period based upon the volume of contraceptives issued during said period. All contraceptive methods issued, excluding condoms and emergency contraceptives, are multiplied/divided by their respective conversion factor to determine the number of women who were protected for a year.	Oral pill cycles DIVIDED by 15	A packet (cycle) of oral contraceptives issued to women each containing pills for one cycle (28 days). For every 15 oral pill packets dispensed it is considered that one woman is fully protected against pregnancy for a year.	Routine Monthly Report (SINJANI)	Total female population aged 15 – 44years	Total female population aged between 15 – 44 years in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
			Medroxyprogesterone injection DIVIDED by 4	Medroxyprogesterone acetate (Depo provera / Petogen) injections issued to women. This injection provides contraceptive protection for 3 months. A woman requires 4 medroxyprogesterone injections to be fully protected against pregnancy for one year.	Routine Monthly Report (SINJANI)				
			Norethisterone enanthate injection DIVIDED by 6	Norethisterone enanthate (Nuristerate) injections issued to women. This injection provides contraceptive protection for 2 months. A woman requires 6 norethisterone enanthate injections to be fully protected against pregnancy for one year.	Routine Monthly Report (SINJANI)				
			IUCD inserted MULTIPLIED by 3.5	Intra Uterine Contraceptive Devices (IUCD) inserted into women. It is considered that an IUCD will protect a woman for approximately 3.5 years against pregnancy.	Routine Monthly Report (SINJANI)				
			Interval sterilisation MULTIPLIED by 10	The number of interval sterilisations carried out. The sterilisation can be performed by means of a mini-laparotomy or Laparoscopic procedure. It excludes sterilisations done within 72 hours of a delivery. Each sterilisation is on average equivalent to 10 years of being fully protected against pregnancy.	Hospital Throughput Form (SINJANI)				
			Post-partum sterilisation MULTIPLIED by 10	The number of post-partum sterilisations carried out, i.e. where the sterilisation is performed within 72 hours of a delivery. The sterilisation can be performed by means of a mini-laparotomy, Laparoscopic procedure or a Caesarean section operation. Each sterilisation is on average equivalent to 10 years of being fully protected against pregnancy.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
4.	Developmental screening rate in children under 1 year of age	Proportion of children under 1 year who were screened for developmental problems in line with the departmental policy. Children are screened at 6 weeks and 9 months respectively.	Baby examined 1 st time before 6 weeks	Babies examined and assessed for the first time in a public health service facility (apart from the place of birth) up to and including 6 weeks.	Routine Monthly Report (SINJANI)	Total population under 1 year	The total population under 1 year in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
			Children screened at 9 months of age	Children who are screened for developmental problems in line with the departmental policy at the age of 9 months.	Routine Monthly Report (SINJANI)				
5.	Early neonatal death rate (ENNDR) for babies > 1 000g at PPIP sites	The death rate in babies who weigh more than 1 000g at birth and who were born at a PPIP (perinatal problem identification programme) site. A PPIP site is a birthing unit that records all births and perinatal deaths and identify the causes of deaths at regular mortality and morbidity meetings. Management change and policies are implemented based on these findings.	Early neonatal death in babies weighing more than 1 000g at PPIP sites	The number of early neonatal deaths in babies weighing more than 1 000g at birth in PPIP sites. An early neonatal death is a death to a live born baby within 7 completed days after birth.	PPIP Data Capturing Form (DCF) (PPIP)	Live births weighing more than 1 000g at PPIP sites	The number of live births weighing more than 1 000g at PPIP sites. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life.	PPIP Data Capturing Form (DCF) (PPIP)	100 (%)
6.	Percentage of underweight children under 5 years	The proportion of children under 5 years identified as being below the third centile but equal to or over 60% of the Expected Weight for Age (EWA) on the Road-to-Health chart. Each episode is counted once. Expressed per 1 000 children under 5 years in the catchment population.	Underweight for age under 5 years – new cases	A child under 5 years identified as being below the third centile but equal to or over 60% of the Expected Weight for Age (EWA) on the Road-to-Health chart. Include any such child irrespective of the reason for the underweight - malnourishment, premature birth, genetic disorders etc. Each episode is counted once.	Routine Monthly Report (SINJANI)	Total population under 5 years	The total population under 5 year in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
Table 2. 30: Performance indicators for Maternal Child and Women's Health and Nutrition [MCWH 3]									
1.	Percentage of fixed PHC facilities with DTP-Hib vaccine stock out	Percentage of fixed PHC facilities that reported a stock out of DTP-Hib vaccines any time during the reporting period. A facility can be counted as "out of stock" only once during the reporting period, irrespective of the time the facility was out of stock.	Fixed PHC facilities out of stock of DTP-Hib vaccine	Fixed PHC facilities with a stock out during the period of DTP-Hib vaccine. A facility can be counted as "out of stock" only once during the reporting period, irrespective of the time the facility was out of stock. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Indicator Drugs (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
2.	Full immunisation coverage under 1 year	Percentage of all children in the target population under one year who complete their primary course of immunisation. A primary course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles at 9 months.	Immunised fully under 1 year - new cases	All children under one year who completed their primary course of immunisation. A primary course includes BCG, OPV 1,2 & 3, DTP-Hib 1,2 & 3, HepB 1,2 & 3, and 1st measles at 9 months.	Routine Monthly Report (SINJANI)	Total population under 1 year	The total population under 1 year in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	Measles coverage under 1 year	Percentage of children under 1 year who received their measles vaccine at 9 months.	Measles 1st dose before 1 year	Measles vaccines 1st dose given to a child under one year of age (preferably at 9 months after birth).	Routine Monthly Report (SINJANI)	Total population under 1 year	The total population under 1 year in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
4.	Vitamin A coverage under 1 year	Percentage of children under 1 year who received a Vitamin A supplement at 6 months (but before 12 months).	Vitamin A supplement to 6-12 months infant	Doses of Vitamin A, 100,000 units, given once to infants aged at least 6 months and not yet 12 months of age.	Routine Monthly Report (SINJANI)	Total population under 1 year	The total population under 1 year in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
5.	Percentage of fixed PHC facilities implementing IMCI	Percentage of fixed PHC facilities implementing integrated management of childhood illnesses (IMCI).	Fixed PHC facilities implementing IMCI	Fixed PHC facilities that have at least one staff member who is IMCI trained is considered to be implementing IMCI. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility Managers Report (SINJANI)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of fixed PHC facilities certified as youth friendly	Percentage of fixed PHC facilities certified as youth friendly.	Fixed PHC facilities certified as youth friendly	Fixed PHC facilities certified as youth friendly according to the accreditation list from NAFSA (Association of International Educators) as distributed by the National Department of Health. A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	NAFSA list from the National Department of Health (external data source)	Fixed PHC facilities = 299	A fixed PHC facility is a facility that is open for at least 8 hours a day for 5 days a week. It includes, community health centres, community day centres and clinics, but excludes satellite clinics and mobiles.	Facility list (Annexure to APP)	100 (%)
7.	Cervical cancer screening coverage	Percentage of women aged 30 years and older who were screened for cervical cancer.	Cervical smear in woman aged 30 years and older screened for cervical cancer	A cervical (pap) smear done for women older than 30 years for screening purposes according to the national policy of screening all women in this age category every 10 years. Diagnostic smears or repeat smears are not included.	Routine Monthly Report (SINJANI)	Total female population aged 30 years and older	Total female population 30 years and older in the Western Cape Province. The population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
8.	Percentage of hospitals offering TOP services	Percentage of non-specialist provincial health hospitals offering termination of pregnancy (TOP) services.	Hospitals offering TOP services	Non-specialist provincial health hospitals offering termination of pregnancy (TOP) services.	Facility Managers Report (SINJANI)	Provincial health non-specialist hospitals = 41	Provincial health non-specialist hospitals, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Percentage of CHC's offering TOP services	Percentage of CHCs offering termination of pregnancy (TOP) services.	CHCs offering TOP services	CHCs offering termination of pregnancy (TOP) services.	Facility Managers Report (SINJANI)	CHCs = 59	Community health centres, i.e. facilities that are open 24 hours a day, 7 days a week, at which a broad range of primary health care services are provided. It also offers accident and midwifery services, but not surgery under general anaesthesia.	Facility list (Annexure to APP)	100 (%)
10.	Percentage of facilities certified as baby friendly	Percentage of birthing units certified as baby friendly.	Birthing units certified as baby friendly	Birthing units certified as baby friendly according to National baby friendly hospital initiative (BFHI) guidelines.	Provincial BFHI Report	Birthing units = 74	Sum of non-specialist hospitals, MOUs and CHCs (i.e. birthing units) that render delivery services.	Facility list (Annexure to APP)	100 (%)
11.	Total deliveries in facilities	Women who delivered in a public health facility under the supervision of trained medical/nursing staff. Exclude deliveries taking place before arrival at the facility (BBAs) or home deliveries. Sum of normal deliveries, assisted deliveries and caesarean sections.	Delivery in facility	Women who delivered in a public health facility under the supervision of trained medical/nursing staff. Exclude deliveries taking place before arrival at the facility (BBAs) or home deliveries. Sum of normal deliveries, assisted deliveries and caesarean sections.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
12.	Facility delivery rate	Percentage of women who delivered in a public health facility under the supervision of trained medical/nursing staff. Exclude deliveries taking place before arrival at the facility (BBAs) or home deliveries. Sum of normal deliveries, assisted deliveries and caesarean sections in the facility.	Delivery in facility	Women who delivered in a public health facility under the supervision of trained medical/nursing staff. Exclude deliveries taking place before arrival at the facility (BBAs) or home deliveries. Sum of normal deliveries, assisted deliveries and caesarean sections.	Hospital Throughput Form (SINJANI)	Population under 1 year x 1.03	All expected deliveries. The population under 1 year x 1.03 is used as a proxy for all expected deliveries. The total population under 1 year in the Western Cape Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)
13.	Institutional delivery rate for women under 18 years	Proportion of deliveries where the mother is under 18 years on the day of delivery.	Deliveries in facility to women under 18 years	Deliveries in the facility where the mother is under 18 years on the day of delivery.	Hospital Throughput Form (SINJANI)	Deliveries in facility	Women who delivered in a public health facility under the supervision of trained medical/nursing staff. Exclude deliveries taking place before arrival at the facility (BBAs) or home deliveries. Sum of normal deliveries, assisted deliveries and caesarean sections.	Hospital Throughput Form (SINJANI)	100 (%)

Table 2.34: Provisional objectives and performance indicators for non-communicable disease control [PREV 2]

1.	Percentage of bacteriological water samples taken from water service authorities conforming to standards	Percentage of domestic bacteriological water samples taken from water service authorities that conform to the standards set out in SANS 241. Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Domestic bacteriological water samples from Water Service Authority - compliant	Domestic bacteriological water samples taken from a water service authority supply (local authority) that conform to the standards set out in SANS 241. Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Monthly summary of municipal health services (SINJANI)	Domestic bacteriological water samples from Water Service Authority - analysed	Domestic bacteriological water samples taken from a water service authority supply (local authority). Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Monthly summary of municipal health services (SINJANI)	100 (%)
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No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
2.	Percentage of chemical water samples taken from water service authorities conforming to standards	Percentage of domestic chemical water samples taken from water service authorities that conform to the standards set out in SANS 241. Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Domestic chemical water sample from Water Service Authority - compliant	Domestic chemical water samples taken from a water service authority supply (local authority), that conform to the standards set out in SANS 241. Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Monthly summary of municipal health services (SINJANI)	Domestic chemical water sample from Water Service Authority - analysed	Domestic chemical water samples taken from a water service authority supply (local authority). Include routine normal water sampling schedule and points, but exclude samples collected in outbreaks and for other specific purposes.	Monthly summary of municipal health services (SINJANI)	100 (%)
3.	Percentage of households with access to potable water within 200m	The percentage of households (defined as any structure in which people live) with access to a safe (i.e. fit for human consumption) water supply that is within 200 metres from the dwelling.	Households with access to potable water supply within 200m	Number of households (defined as any structure in which people live) with access to a safe (i.e. fit for human consumption) water supply that is within 200 metres from the dwelling.	Annual summary of municipal health services (SINJANI)	Households	Formal and informal households (premises, not units) in the reporting area (structures in which people live).	Environment Health Annual Semi-permanent Survey (SINJANI)	100 (%)
4.	Percentage of sewage effluent samples complying to requirements	Percentage sewage effluent samples that conform to the standards for health safe disposal of treated sewage effluent - provincial guideline for the permissible utilisation and disposal of treated sewage effluent and National Health Act.	Sewage effluent samples compliant - Municipal	Sewage effluent samples taken from municipal sewage purification facilities that conformed to the standards for health safe disposal of treated sewage effluent.	Monthly summary of municipal health services (SINJANI)	Sewage effluent samples analysed - Municipal	Sewage effluent samples taken from municipal sewage purification facilities.	Monthly summary of municipal health services (SINJANI)	100 (%)
			Sewage effluent samples compliant - Government	Sewage effluent samples taken from government institution sewage purification facilities that conformed to the standards for health safe disposal of treated sewage effluent.	Monthly summary of municipal health services (SINJANI)	Sewage effluent samples analysed - Government	Sewage effluent samples taken from government institution sewage purification facilities.	Monthly summary of municipal health services (SINJANI)	
			Sewage effluent samples compliant - Private	Sewage effluent samples taken from private sewage purification facilities that conformed to the standards for health safe disposal of treated sewage effluent.	Monthly summary of municipal health services (SINJANI)	Sewage effluent samples analysed - Private	Sewage effluent samples taken from private sewage purification facilities.	Monthly summary of municipal health services (SINJANI)	
Table 2. 35: Performance indicators for Disease Prevention and Control [PREV 3]									
1.	Number of trauma centres for victims of violence	Operational trauma centres for victims of violence. This refers to Trauma Centres in the health facilities where there is a designated room/specific area where investigative processes are applied to determine the cause and manner of injuries to victims of violence or crime.	Trauma centres for victims of violence	Operational trauma centres for victims of violence. This refers to Trauma Centres in the health facilities where there is a designated room/specific area where investigative processes are applied to determine the cause and manner of injuries to victims of violence or crime.	Facility Managers Report (SINJANI)	None	None	None	None (No)
2.	Number of health districts with health care waste management plan implemented	Health districts with current health care waste management plan.	Health districts with health care waste management plan implemented	Health districts with a current health care waste management plan.	Contracts between the District and the Waste Collector	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	Percentage of hospitals providing occupational health programmes	Percentage of hospitals providing occupational health programmes.	Hospitals providing occupational health programmes	Provincial health hospitals providing occupational health programmes, i.e. who have a qualified occupational health practitioner providing an occupational health service to staff and/or the public. An occupational health service is a health service in and/or near a workplace that provides a preventive and promotive health service related to the workplace. Only facilities with a qualified occupational health practitioner that can be verified on PERSAL must be counted.	PERSAL	Provincial health hospitals = 51	Number of provincial health hospitals. This excludes private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals. Khayelitsha Hospital situated at Tygerberg Hospital is excluded.	Facility list (Annexure to APP)	100 (%)
4.	Percentage of schools implementing Health Promoting Schools Programme (HPSP)	Percentage of public schools implementing the Health Promoting Schools Programme (HPSP).	Schools implementing HPSP	Public schools implementing Health Promotion in Schools Programme (HPSP).	Department of Education (external source)	Schools	Public schools in the Western Cape Province.	Department of Education (external source)	100 (%)
5.	Integrated epidemic preparedness and response plans implemented	Integrated epidemic preparedness and response plans implemented.	Integrated epidemic preparedness and response plans implemented	The integrated epidemic preparedness and response plans are implemented.	Integrated epidemic preparedness and response plans	None	None	None	(Yes/No)
6.	Outbreaks responded to within 24 hours	Percentage of outbreaks responded to within 24 hours after declaration.	Outbreaks responded to within 24 hours	Number of outbreaks responded to within 24 hours after declaration.	To be confirmed	Outbreaks - total	Number of outbreaks reported in the Province during the reporting period.	To be confirmed	100 (%)
7.	Malaria fatality rate	Deaths from malaria as a percentage of the number of cases reported.	Deaths from malaria	The number of notified deaths from malaria.	Notifiable Medical Conditions notification form	Malaria cases reported	Notified malaria cases reported.	Notifiable Medical Conditions notification form	100 (%)
8.	Cholera fatality rate	Deaths from cholera as a percentage of the number of cases reported.	Deaths from cholera	The number of notified deaths from cholera.	Notifiable Medical Conditions notification form	Cholera cases reported	Notified cholera cases reported.	Notifiable Medical Conditions notification form	100 (%)
9.	Cataract surgery rate (Number / million population)	Cataract operations completed per 1,000,000 population.	Cataract operations performed	Number of cataract operations completed.	Hospital Throughput Form (SINJANI)	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	1,000,000 (No)
9.1	Number of cataract operations	Number of cataract operations completed.	Cataract operations performed	Number of cataract operations completed.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

PROGRAMME 3: EMERGENCY MEDICAL SERVICES

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 3.3: Provincial objectives and performance indicators for EMS and patient transport services [EMS2]									
1.	Percentage of all emergency responses in less than 30 minutes	The percentage of all emergency ambulance responses with a response time of less than 30 minutes. Response time is the time that elapsed from the call for assistance was first received by the emergency call-taker until the time the ambulance arrived on the scene of the emergency.	All ambulance responses with response time less than 30 minutes	The total number of ambulance responses with a response time of less than 30 minutes. Response time is the time that elapsed from the call for assistance was first received by the emergency call-taker until the time the ambulance arrived on the scene of the emergency.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Total ambulance responses	The total number of emergency ambulance responses, urban and rural, regardless of the number of patients transported. This excludes inter-hospital transfers by patient transporters (bus).	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
2.	Percentage of telephone calls answered within 12 seconds	The percentage of emergency telephone calls received from the public or any other emergency service agency on the 10177 number at the emergency communication centre that was answered within 12 seconds of the first ring.	Emergency telephone calls answered within 12 seconds	The number of emergency telephone calls received from the public or any other emergency service agency on the 10177 number at the emergency communication centre that was answered within 12 seconds of the first ring.	Calls recorded electronically (Symposium electronic telephone exchange system)	All emergency telephone calls answered	The total number of emergency telephone calls received on the 10177 emergency number at the communication centre.	Calls recorded electronically (Symposium electronic telephone exchange system)	100 (%)
3.	The number of emergency medicine consultants appointed	The number of Emergency Medicine Consultants appointed within Emergency Medicine.	Emergency medicine consultants appointed	The number of Emergency Medicine Consultants appointed within Emergency Medicine.	PERSAL	None	None	None	None (No)
4.	Number of ambulances procured	The number of new ambulances procured in preparation for the FIFA World Cup.	New road ambulances procured	The number of new ambulances procured in preparation for the FIFA World Cup.	GMT / Government Motor Transport (FLEET-MAN)	None	None	None	None (No)
5.	The percentage of metropolitan hospitals with trunking radios	The percentage of non-specialist metropolitan hospitals with trunking radios in the emergency / casualty/ trauma department.	Metropolitan non-specialist hospitals with trunking radios	Non-specialist hospitals in the metropole with trunking radios installed and functional in the emergency / casualty/ trauma department.	Radio inventory (LOGIS)	Number of non-specialist hospitals in the metropole = 10	Provincial health non-specialist hospitals in Cape Town, i.e. the sum of district, regional, tertiary and central hospitals.	Facility list (Annexure to APP)	100 (%)
Table 3.4: Performance indicators for EMS and patient transport [EMS3]									
1.	Total number of rostered ambulances	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Road ambulances in the EMS fleet	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	None	None	None	None (No)
2.	Rostered ambulances per 1000 people	The number of rostered ambulances per 1,000 population in the geographic area.	Road ambulances in the EMS fleet (Number of rostered ambulances)	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular HS/2009	1,000 (No)
3.	Percentage hospitals with patient transporters	The percentage of provincial health hospitals operating an outpatient transport system to transport outpatients independently of EMS and HealthNET. The Western Cape does not render this service and therefore the percentage will always be 0.	Hospitals with an outpatient transport system	The percentage of provincial health hospitals operating an outpatient transport system to transport outpatients independently of EMS and HealthNET. The Western Cape does not render this service and therefore the percentage will always be 0.	Not applicable	Provincial health hospitals = 51	Number of provincial health hospitals. This excludes private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals. Khayelitsha Hospital situated at Tygerberg Hospital is excluded.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
4.	Average kilometres travelled per ambulance (per annum)	Average kilometres travelled per ambulances during the year. Calculated from the total distance travelled by all ambulances for emergency trips divided by the number of rostered ambulances.	EMS ambulance kilometres travelled	The distance travelled by all ambulances for emergency trips.	GMT / Government Motor Transport (FLEET-MAN)	Road ambulances in the EMS fleet (Number of rostered ambulances)	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	1 (km)
5.	Total kilometres travelled by all ambulances	The distance travelled by all ambulances for emergency trips.	EMS ambulance kilometres travelled	The distance travelled by all ambulances for emergency trips.	GMT / Government Motor Transport (FLEET-MAN)	None	None	None	None (No)
6.	Percentage locally based staff with training in BAA	Percentage of all operational ambulance staff that have a Basic Life Support (BLS) qualification and are registered as a Basic Ambulance Assistant (BAA) with the Health Professional Council of South Africa (HPCSA).	Operational basic ambulance assistants	Number of all operational ambulance staff that holds a Basic Life Support (BLS) qualification and are registered as a Basic Ambulance Assistant (BAA) with the Health Professional Council of South Africa (HPCSA). This excludes training, administrative, communication centre and management staff.	PERSAL	EMS operational staff	The total number of EMS operational ambulances staff. This excludes training, administrative, communication centre and management staff.	PERSAL	100 (%)
7.	Percentage locally based staff with training in AEA	Percentage of all operational ambulance staff that have an Intermediate Life Support (ILS) qualification and are registered as an Ambulance Emergency Assistant (AEA) with the Health Professional Council of South Africa (HPCSA).	Operational ambulance emergency assistants	Number of all operational ambulance staff that have an Intermediate Life Support (ILS) qualification and are registered as an Ambulance Emergency Assistant (AEA) with the Health Professional Council of South Africa (HPCSA). This excludes training, administrative, communication centre and management staff.	PERSAL	EMS operational staff	The total number of EMS operational ambulances staff. This excludes training, administrative, communication centre and management staff.	PERSAL	100 (%)
8.	Percentage locally based staff with training in ALS (Paramedics)	Percentage of all operational ambulance staff that have an Advanced Life Support (ALS) qualification (Paramedic) and are registered as either an Ambulance Emergency Technician (AET/ANT) or an Emergency Care Practitioner (ECP) with the Health Professional Council of South Africa (HPCSA).	Operational advanced life support staff	Number of all operational ambulance staff that have an Advanced Life Support (ALS) qualification (Paramedic) and are registered as either an Ambulance Emergency Technician (AET/ANT) or an Emergency Care Practitioner (ECP) with the Health Professional Council of South Africa (HPCSA). This excludes training, administrative, communication centre and management staff.	PERSAL	EMS operational staff	The total number of EMS operational ambulances staff. This excludes training, administrative, communication centre and management staff.	PERSAL	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Percentage P1 calls with a response time of < 15 minutes in an urban area	Percentage of urban priority 1 ambulance responses where the response time was less than 15 minutes. Response time is the time it takes an ambulance to reach an emergency medical scene, from the time of the first call to the control room up to the time of arrival on the scene. An urban area is a built up area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Priority 1 ambulance responses with response under 15 minutes - urban	Priority 1 ambulance responses in urban areas where the response time was under 15 minutes. Response time is the time it takes an ambulance to reach an emergency medical scene, from the time of the first call to the control room up to the time of arrival on the scene. An urban area is a built up area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Priority 1 ambulance responses - urban	Priority one ambulance responses that occurred in urban areas within the reporting period. An urban area is a built up area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
10.	Percentage P1 calls with a response time of < 40 minutes in a rural area	Percentage of rural priority 1 ambulance responses where the response time was less than 40 minutes. Response time is the time it takes an ambulance to reach an emergency medical scene, from the time of the first call to the control room up to the time of arrival on the scene. A rural area is a farming or agricultural area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Priority 1 ambulance responses with response under 40 minutes - rural	Priority 1 ambulance responses in rural areas where the response time was under 40 minutes. Response time is the time it takes an ambulance to reach an emergency medical scene, from the time of the first call to the control room up to the time of arrival on the scene. A rural area is a farming or agricultural area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Priority 1 ambulance responses - rural	Priority one ambulance responses that occurred in rural areas within the reporting period. A rural area is a farming or agricultural area as defined in the Computer Aided Dispatch (CAD) geographic information system (GIS). A priority one ambulance response is an incident classified by the dispatcher as requiring an immediate response.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
11.	Percentage of all calls with a response time within 60 minutes	Percentage of all rural and urban ambulance responses irrespective of their priority where the response time was less than 60 minutes. Response time is the time it takes an ambulance to reach an emergency medical scene, from the time of the first call to the control room up to the time of arrival on the scene.	All ambulance responses with response under 60 minutes	The number of ambulance responses, urban and rural irrespective of the priority, where the response time was less than 60 minutes. Emergency ambulance trips, regardless of the number of patients transported. This excludes inter-hospital transfers by patient transporters (bus).	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Total ambulance responses	The total number of emergency ambulance responses, urban and rural, regardless of the number of patients transported. This excludes inter-hospital transfers by patient transporters (bus).	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
12.	Percentage of operational rostered ambulances with single person crews	Percentage of operational road ambulances in the EMS fleet with a single person crew. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Road ambulances in the EMS fleet with a single-person crew	The number of road ambulances in the EMS fleet during the reporting period, that had only a single-person crew. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Road ambulances in the EMS fleet (Number of rostered ambulances)	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
13.	Percentage of ambulance trips used for inter-hospital transfers	Percentage of ambulance responses to clinics and hospitals to transfer emergencies. The number of inter-hospital transfer trips is counted, regardless of the number of patients in the ambulance.	EMS referral trips – total	Ambulance responses to clinics and hospitals to transfer emergencies. The number of inter-hospital transfer trips is counted, regardless of the number of patients in the ambulance.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	Total ambulance responses	The total number of emergency ambulance responses, urban and rural, regardless of the number of patients transported. This excludes inter-hospital transfers by patient transporters (bus).	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
14.	Percentage green code patients transported by ambulance	Percentage of patients transported classified as green code according to the EMS patient triage coding system. A green code patient has normal vital signs and is ambulatory (able to walk).	Patients transported classified as green code	Patients transported classified as green code according to the EMS patient triage coding system. A green code patient has normal vital signs and is ambulatory (able to walk).	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	EMS emergency patients transported	The total number of emergency patients transported by ambulance.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
15.	Cost per patient transported by ambulance	Average cost per patient transported by ambulance. Calculated as the total expenditure for sub-programme 3.1 divided by the total number of emergency patients transported.	EMS expenditure – total	The total expenditure for emergency patient transport, i.e. sub-programme 3.1.	BAS	EMS emergency patients transported	The total number of emergency patients transported by ambulance.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	100 (%)
16.	Percentage ambulances with less than 200 000 kilometers on the odometer	Percentage of all ambulances in the EMS fleet with less than 200,000 km in vehicle mileage at the end of the reporting period. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	EMS ambulances under 200000 km	The number of ambulance in the EMS fleet with less than 200,000 km in overall mileage measured at the end of the reporting period. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	Road ambulances in the EMS fleet (Number of rostered ambulances)	The total number of road ambulances in the EMS fleet. Other rescue or primary response vehicles as well as HealthNET patient transporters and aircraft are excluded.	GMT / Government Motor Transport (FLEET-MAN)	100 (%)
17.	Number of EMS emergency cases – Total	The total number of EMS emergency patients transported by ambulance over the reporting period.	EMS emergency patients transported	The total number of emergency patients transported by ambulance.	Ambulance responses logged electronically (Computer Aided Dispatch (CAD) System Data Warehouse)	None	None	None	None (No)
18.	EMS referral cases	National Department of Health to provide a definition for this indicator.							

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 4.4: Provincial objectives and performance indicators for general (regional) hospitals [PHS4]									
PLEASE NOTE: REGIONAL HOSPITALS INCLUDE LEVEL 2 SERVICES RENDERED AT CENTRAL HOSPITALS									
1.	Number of beds in regional hospitals - Total	The total number of useable beds in regional hospitals consists of the useable beds in regional hospitals as well as the designated level 2 beds in central hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Useable beds in regional hospitals (total)	The total number of useable beds in regional hospitals consists of the useable beds in regional hospitals as well as the designated level 2 beds in central hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
1.1	Number of beds in regional hospitals - Regional	The number of useable beds in regional hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Useable beds in regional hospitals (regional hospitals)	Useable beds in regional hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
1.2	Number of beds in regional hospitals - Central	Designated number of level 2 useable beds in central hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Useable beds in regional hospitals (central hospitals)	Designated number of level 2 useable beds in central hospitals. Useable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in regional hospitals - Total	The total number of patient days in regional hospitals is a weighted combination of inpatient days in regional and designated level 2 wards in central hospitals and day patients in regional and designated level 2 wards in central hospitals.	Inpatient days in regional hospitals (total)	Total days spent in regional hospitals and designated level 2 wards in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (total)	A patient who is admitted and separated from a regional hospital or a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
2.1	Total number of patient days in regional hospitals - Regional	Patient days in regional hospitals are a weighted combination of inpatient days in regional hospitals and day patients in regional hospitals.	Inpatient days in regional hospitals (regional hospitals)	Total days spent in a regional hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (regional hospitals)	A patient who is admitted and separated from a regional hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
2.2	Total number of patient days in regional hospitals - Central	Patient days in designated level 2 wards in central hospitals are a weighted combination of inpatient days in designated level 2 wards in central hospitals and day patients in designated level 2 wards in central hospitals.	Inpatient days in regional hospitals (central hospitals)	Total days spent in a designated level 2 ward in a central hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (central hospitals)	A patient who is admitted and separated from a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				

Table 4.5: Performance indicators for general (regional) hospital for 2008/09 to 2010/11 [PHS5]

1.	Caesarean section rate for regional hospitals - Total	Caesarean section deliveries in regional hospitals and designated level 2 wards in central hospitals expressed as a percentage of all deliveries in regional hospitals and designated level 2 wards in central hospitals.	Caesarean sections in regional hospitals (total)	Caesarean sections in regional hospitals and designated level 2 wards in central hospitals. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls.	Hospital Throughput Form (SINJANI)	Total deliveries in regional hospitals	Total number of women who delivered in regional hospitals and designated level 2 wards in central hospitals. Calculated from the number of normal deliveries, assisted deliveries and caesarean sections in regional hospitals and designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
1.1	Caesarean section rate for regional hospitals - Regional	Caesarean section deliveries in regional hospitals, expressed as a percentage of all deliveries in regional hospitals.	Caesarean sections in regional hospitals (regional hospitals)	Caesarean sections in regional hospitals. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls.	Hospital Throughput Form (SINJANI)	Total deliveries in regional hospitals	Total number of women who delivered in regional hospitals. Calculated from the number of normal deliveries, assisted deliveries and caesarean sections in regional hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
1.2	Caesarean section rate for regional hospitals - Central	Caesarean section deliveries in regional hospitals, expressed as a percentage of all deliveries in regional hospitals.	Caesarean sections in regional hospitals (central hospitals)	Caesarean sections in designated level 2 wards in central hospitals. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls.	Hospital Throughput Form (SINJANI)	Total deliveries in regional hospitals	Total number of women who delivered in designated level 2 wards in central hospitals. Calculated from the number of normal deliveries, assisted deliveries and caesarean sections in designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
2.	Number of patient day equivalents in regional hospitals - Total	The total number of patient day equivalents in regional hospitals and designated level 2 wards in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in regional hospitals and designated level 2 wards in central hospitals.	Inpatient days in regional hospitals (total)	Total days spent in regional hospitals and designated level 2 wards in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (total)	A patient who is admitted and separated from a regional hospital or a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			1/3 OPD headcount in regional hospitals (total)	Headcount of all outpatients attending an outpatient clinic in a regional hospital and a designated level 2 outpatient clinic in a central hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/emergency/trauma headcount in regional hospitals (total)	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital and a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				
2.1	Number of patient day equivalents in regional hospitals - Regional	The total number of patient day equivalents in regional hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in regional hospitals.	Inpatient days in regional hospitals (regional hospitals)	Total days spent in a regional hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (regional hospitals)	A patient who is admitted and separated from a regional hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
			1/3OPD headcount in regional hospitals (regional hospitals)	Headcount of all outpatients attending an outpatient clinic in a regional hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/emergency/trauma headcount in regional hospitals (regional hospitals)	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				
2.2	Number of patient day equivalents in regional hospitals - Central	The total number of patient day equivalents in designated level 2 wards in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for designated level 2 OPD and casualty/ emergency/ trauma services in central hospitals.	Inpatient days in regional hospitals (central hospitals)	Total days spent in a designated level 2 ward in a central hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in regional hospitals (central hospitals)	A patient who is admitted and separated from a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
			1/3 OPD headcount in regional hospitals (central hospitals)	Headcount of all outpatients attending a designated level 2 outpatient clinic in a central hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/emergency/trauma headcount in regional hospitals (central hospitals)	Headcount of all patients attending a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	OPD total headcounts in regional hospitals - Total	Headcount of all outpatients attending an outpatient clinic in a regional hospital and a designated level 2 outpatient clinic in a central hospital.	OPD headcount in regional hospitals (total)	Headcount of all outpatients attending an outpatient clinic in a regional hospital and a designated level 2 outpatient clinic in a central hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.1	OPD total headcounts in regional hospitals - Regional	Headcount of all outpatients attending an outpatient clinic in a regional hospital.	OPD headcount in regional hospitals (regional hospitals)	Headcount of all outpatients attending an outpatient clinic in a regional hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.2	OPD total headcounts in regional hospitals - Central	Headcount of all outpatients attending a designated level 2 outpatient clinic in a central hospital.	OPD headcount in regional hospitals (central hospitals)	Headcount of all outpatients attending a designated level 2 outpatient clinic in a central hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.3	Casualty/ emergency/ trauma headcount - Total	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital and a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Casualty/ emergency/ trauma headcount in regional hospitals (total)	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital and a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.4	Casualty/ emergency/ trauma headcount - Regional	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital with conditions requiring emergency treatment.	Casualty/ emergency/ trauma headcount in regional hospitals (regional hospitals)	Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.5	Casualty/ emergency/ trauma headcount - Central	Headcount of all patients attending a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Casualty/ emergency/ trauma headcount in regional hospitals (central hospitals)	Headcount of all patients attending a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.6	Comprehensive OPD total headcount in regional hospitals (OPD + casualty/ emergency/ trauma) - Total	Sum of all outpatients attending an outpatient clinic in a regional hospital and a designated level 2 outpatient clinic in a central hospital, and all patients attending the casualty/ emergency/ trauma unit in a regional hospital and a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	OPD headcount in regional hospitals (total) Casualty/ emergency/ trauma headcount in regional hospitals (total)	Headcount of all outpatients attending an outpatient clinic in a regional hospital and a designated level 2 outpatient clinic in a central hospital. Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital and a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.7	Comprehensive OPD total headcount in regional hospitals (OPD + casualty/ emergency/ trauma) - Regional	Sum of all outpatients attending an outpatient clinic in a regional hospital and all patients attending the casualty/ emergency/ trauma unit in a regional hospital with conditions requiring emergency treatment.	OPD headcount in regional hospitals (regional hospitals) Casualty/ emergency/ trauma headcount in regional hospitals (regional hospitals)	Headcount of all outpatients attending an outpatient clinic in a regional hospital. Headcount of all patients attending a casualty/ emergency/ trauma unit in a regional hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.8	Comprehensive OPD total headcount in regional hospitals (OPD + casualty/ emergency/ trauma) - Central	Sum of all outpatients attending a designated level 2 outpatient clinic in a central hospital and all patients attending a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	OPD headcount in regional hospitals (central hospitals)	Headcount of all outpatients attending a designated level 2 outpatient clinic in a central hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Casualty/ emergency/ trauma headcount in regional hospitals (central hospitals)	Headcount of all patients attending a designated level 2 casualty/ emergency/ trauma unit in a central hospital with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				
4.	Percentage of regional hospitals with a patient satisfaction survey using the DoH template - Total	Percentage of regional hospitals and central hospitals with designated level 2 services with a published nationally mandated patient satisfaction survey in the last 12 months.	Regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months (total)	Regional hospitals and central hospitals with designated level 2 services with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of regional hospitals (total) = 8	The number of provincial health regional hospitals and central hospitals with designated level 2 service.	Facility list (Annexure to APP)	100 (%)
4.1	Percentage of regional hospitals with a patient satisfaction survey using the DoH template - Regional	Percentage of regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	Regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months (regional hospitals)	Regional hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of regional hospitals = 5	The number of provincial health regional hospitals.	Facility list (Annexure to APP)	100 (%)
4.2	Percentage of regional hospitals with a patient satisfaction survey using the DoH template - Central	Percentage of central hospitals with designated level 2 services with a published nationally mandated patient satisfaction survey in the last 12 months.	Regional hospitals with a published nationally mandated patient satisfaction survey in the last 12 months (central hospitals)	Central hospitals with designated level 2 services with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of central hospitals with designated level 2 services = 3	The number of provincial health central hospitals with designated level 2 services.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of regional hospitals with mortality and morbidity meetings at least once a month / every month - Total	Percentage of regional hospitals and central hospitals with designated level 2 services with mortality and morbidity (M&M) meetings at least once a month / every month.	Regional hospitals with mortality and morbidity meetings at least once a month / every month (total)	Regional hospitals and central hospitals with designated level 2 services with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of regional hospitals (total) = 8	The number of provincial health regional hospitals and central hospitals with designated level 2 service.	Facility list (Annexure to APP)	100 (%)
5.1	Percentage of regional hospitals with mortality and morbidity meetings at least once a month / every month - Regional	Percentage of regional hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Regional hospitals with mortality and morbidity meetings at least once a month / every month (regional hospitals)	Regional hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of regional hospitals = 5	The number of provincial health regional hospitals.	Facility list (Annexure to APP)	100 (%)
5.2	Percentage of regional hospitals with mortality and morbidity meetings at least once a month / every month - Central	Percentage of central hospitals with designated level 2 services with mortality and morbidity (M&M) meetings at least once a month / every month.	Regional hospitals with mortality and morbidity meetings at least once a month / every month (central hospitals)	Central hospitals with designated level 2 services with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of central hospitals with designated level 2 services = 3	The number of provincial health central hospitals with designated level 2 services.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
6.	Percentage of regional hospitals with clinical audit meetings at least once a month / every month - Total	Percentage of regional hospitals and central hospitals with designated level 2 services with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Regional hospitals with clinical audit meetings at least once a month / every month (total)	Regional hospitals and central hospitals with designated level 2 services with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of regional hospitals (total) = 8	The number of provincial health regional hospitals and central hospitals with designated level 2 service.	Facility list (Annexure to APP)	100 (%)
6.1	Percentage of regional hospitals with clinical audit meetings at least once a month / every month - Regional	Percentage of regional hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Regional hospitals with clinical audit meetings at least once a month / every month (regional hospitals)	Regional hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of regional hospitals = 5	The number of provincial health regional hospitals.	Facility list (Annexure to APP)	100 (%)
6.2	Percentage of regional hospitals with clinical audit meetings at least once a month / every month - Central	Percentage of central hospitals with designated level 2 services with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Regional hospitals with clinical audit meetings at least once a month / every month (central hospitals)	Central hospitals with designated level 2 services with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of central hospitals with designated level 2 services = 3	The number of provincial health central hospitals with designated level 2 services.	Facility list (Annexure to APP)	100 (%)
7.	Percentage of complaints resolved within 25 days in regional hospitals - Total	Percentage of complaints resolved within 25 days in regional hospitals and central hospitals with designated level 2 services.	Complaints resolved within 25 days in regional hospitals (total)	The number of formal complaints received and registered in regional hospitals and central hospitals with designated level 2 services during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received in regional hospitals (total)	The number of formal complaints received and registered by regional hospitals and central hospitals with designated level 2 services during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
7.1	Percentage of complaints resolved within 25 days in regional hospitals - Regional	Percentage of complaints resolved within 25 days in regional hospitals.	Complaints resolved within 25 days in regional hospitals (regional hospitals)	The number of formal complaints received and registered in regional hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received in regional hospitals (regional hospitals)	The number of formal complaints received and registered by regional hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
7.2	Percentage of complaints resolved within 25 days in regional hospitals - Central	Percentage of complaints resolved within 25 days in central hospitals with designated level 2 services.	Complaints resolved within 25 days in regional hospitals (central hospitals)	The number of formal complaints received and registered in central hospitals with designated level 2 services during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received in regional hospitals (central hospitals)	The number of formal complaints received and registered by central hospitals with designated level 2 services during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
8.	Case fatality rate in regional hospitals for surgery separations - Total	Percentage of surgery separations in regional hospitals and designated level 2 wards in central hospitals that died.	Inpatient death – surgery in regional hospitals (total)	A death recorded against an inpatient admitted to a regional hospital surgery ward or a designated level 2 surgery ward in a central hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery in regional hospitals (total)	Separation for surgery from a regional hospital or a designated level 2 ward in a central hospital is the administrative process by which the hospital records the completion of treatment and/or the accommodation of a patient in a surgery ward. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)
8.1	Case fatality rate in regional hospitals for surgery separations - Regional	Percentage of surgery separations in regional hospitals that died.	Inpatient death – surgery in regional hospitals (regional hospitals)	A death recorded against an inpatient admitted to a regional hospital surgery ward. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery in regional hospitals (regional hospitals)	Separation for surgery from a regional hospital is the administrative process by which a regional hospital records the completion of treatment and/or the accommodation of a patient in a surgery ward. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)
8.2	Case fatality rate in regional hospitals for surgery separations - Central	Percentage of surgery separations in designated level 2 wards in central hospitals that died.	Inpatient death – surgery in regional hospitals (central hospitals)	A death recorded against an inpatient admitted to a designated level 2 surgery ward in a central hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery in regional hospitals (central hospitals)	Separation for surgery from a designated level 2 ward in a central hospital is the administrative process by which the hospital records the completion of treatment and/or the accommodation of a patient in a designated level 2 surgery ward. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Average length of stay in regional hospitals - Total	Average number of patient days that an admitted patient spends in a regional hospital or a designated level 2 ward in a central hospital before separation.	Inpatient days in regional hospitals (total)	Total days spent in regional hospitals and designated level 2 wards in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in regional hospitals (total)	Separation is the administrative process by which a regional hospital or designated level 2 ward in a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in regional hospitals (total)	A patient who is admitted and separated from a regional hospital or a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
9.1	Average length of stay in regional hospitals - Regional	Average number of patient days that an admitted patient spends in a regional hospital before separation.	Inpatient days in regional hospitals (regional hospitals)	Total days spent in a regional hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in regional hospitals (regional hospitals)	Separation is the administrative process by which a regional hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in regional hospitals (regional hospitals)	A patient who is admitted and separated from a regional hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
9.2	Average length of stay in regional hospitals - Central	Average number of patient days that an admitted patient spends in a designated level 2 ward in a central hospital before separation.	Inpatient days in regional hospitals (central hospitals)	Total days spent in a designated level 2 ward in a central hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in regional hospitals (central hospitals)	Separation is the administrative process by which a designated level 2 ward in a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in regional hospitals (central hospitals)	A patient who is admitted and separated from a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
10.	Bed utilisation rate based on useable beds in regional hospitals - Total	Patient days during the reporting period in regional hospitals and designated level 2 wards in central hospitals, expressed as a percentage of the sum of the daily number of useable beds in regional hospitals and designated level 2 wards in central hospitals.	Inpatient days in regional hospitals (total)	Total days spent in regional hospitals and designated level 2 wards in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in regional hospitals (total)	Sum of the daily number of useable beds in regional hospitals and designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in regional hospitals (total)	A patient who is admitted and separated from a regional hospital or a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
10.1	Bed utilisation rate based on useable beds in regional hospitals - Regional	Patient days during the reporting period in regional hospitals, expressed as a percentage of the sum of the daily number of useable beds in regional hospitals.	Inpatient days in regional hospitals (regional hospitals)	Total days spent in a regional hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in regional hospitals (regional hospitals)	Sum of the daily number of useable beds in regional hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in regional hospitals (regional hospitals)	A patient who is admitted and separated from a regional hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
10.2	Bed utilisation rate based on useable beds in regional hospitals - Central	Patient days during the reporting period in designated level 2 wards in central hospitals, expressed as a percentage of the sum of the daily number of useable beds in designated level 2 wards in central hospitals.	Inpatient days in regional hospitals (central hospitals)	Total days spent in a designated level 2 ward in a central hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in regional hospitals (central hospitals)	Sum of the daily number of useable beds in designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in regional hospitals (central hospitals)	A patient who is admitted and separated from a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
11.	Total separations in regional hospitals - Total	Separation is the administrative process by which a regional hospital or designated level 2 ward in a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Day patients in regional hospitals (total)	A patient who is admitted and separated from a regional hospital or a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in regional hospitals (total)	A death recorded against an inpatient admitted to a regional hospital or a designated level 2 ward in a central hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in regional hospitals (total)	Any admitted patients who complete their stay in a regional hospital or a designated level 2 ward in a central hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			Inpatient transfer out in regional hospitals (total)	An admitted patient in a regional hospital or a designated level 2 ward in a central hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
11.1	Total separations in regional hospitals - Regional	Separation is the administrative process by which a regional hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution AND day cases.	Day patients in regional hospitals (regional hospitals)	A patient who is admitted and separated from a regional hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in regional hospitals (regional hospitals)	A death recorded against an inpatient admitted to a regional hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in regional hospitals (regional hospitals)	Any admitted patients who complete their stay in a regional hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in regional hospitals (regional hospitals)	An admitted patient in a regional hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
11.2	Total separations in regional hospitals - Central	Separation is the administrative process by which a designated level 2 ward in a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died,	Day patients in regional hospitals (central hospitals)	A patient who is admitted and separated from a designated level 2 ward in a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
		or who were transferred to another hospital or institution AND day cases.	Inpatient death in regional hospitals (central hospitals)	A death recorded against an inpatient admitted to a designated level 2 ward in a central hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in regional hospitals (central hospitals)	Any admitted patients who complete their stay in a designated level 2 ward in a central hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in regional hospitals (central hospitals)	An admitted patient in a designated level 2 ward in a central hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
12.	Expenditure per patient day equivalent in regional hospitals - Total	The average cost per patient day equivalent in regional hospitals and designated level 2 wards in central hospitals with patient day equivalent calculated as inpatient + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in regional hospitals and designated level 2 wards in central hospitals.	Expenditure for regional hospitals (total)	Total regional hospital and level 2 services in central hospital expenditure, i.e. total expenditure for sub-programme 4.1	BAS	Patient day equivalents in regional hospitals (total)	The total number of patient day equivalents in regional hospitals and designated level 2 wards in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in regional hospitals and designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	1 (R)
12.1	Expenditure per patient day equivalent in regional hospitals - Regional	The average cost per patient day equivalent in regional hospitals with patient day equivalent calculated as inpatient + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in regional hospitals.	Expenditure for regional hospitals (regional hospitals)	Total expenditure for regional hospitals only in sub-programme 4.1	BAS	Patient day equivalents in regional hospitals (regional hospitals)	The total number of patient day equivalents in regional hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in regional hospitals.	Hospital Throughput Form (SINJANI)	1 (R)
12.2	Expenditure per patient day equivalent in regional hospitals - Central	The average cost per patient day equivalent in designated level 2 wards in central hospitals with patient day equivalent calculated as inpatient + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in designated level 2 wards in central hospitals.	Expenditure for regional hospitals (central hospitals)	Total expenditure for designated level 2 services in central hospitals in sub-programme 4.1	BAS	Patient day equivalents in regional hospitals (central hospitals)	The total number of patient day equivalents in designated level 2 wards in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in designated level 2 wards in central hospitals.	Hospital Throughput Form (SINJANI)	1 (R)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 4.10: Provincial objectives and performance indicators for TB hospitals [PHS4]									
1.	Number of beds in TB hospitals	Useable beds in TB hospitals are beds actually available for use within TB hospitals (regardless of whether they are occupied by a patient or lodger).	Useable beds in TB hospitals	Useable beds in TB hospitals are beds actually available for use within TB hospitals (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in TB hospitals	Patient days in TB hospitals are a weighted combination of inpatient days and day patients in TB hospitals.	Inpatient days in TB hospitals	Total days spent in a TB hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in TB hospitals	A patient who is admitted and separated from a TB hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Day patients are not normally admitted in TB hospitals.	Hospital Throughput Form (SINJANI)				
Table 4.11 : Performance indicators for TB hospitals [PHS5]									
1.	Number of patient day equivalents in TB hospitals	The total number of patient day equivalents in TB hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in TB hospitals.	Inpatient days in TB hospitals	Total days spent in TB hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in TB hospitals	A patient who is admitted and separated from a TB hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Day patients are not normally admitted in TB hospitals.	Hospital Throughput Form (SINJANI)				
			1/3 OPD headcount in TB hospitals	Headcount of all outpatients attending an outpatient clinic in a TB hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/emergency/trauma headcount in TB hospitals	Headcount of all patients attending a TB hospital casualty/emergency/trauma unit with conditions requiring emergency treatment. These services are not rendered at TB hospitals and this count should always be 0.	Hospital Throughput Form (SINJANI)				
2.	OPD total headcount in TB hospitals	Headcount of all outpatients attending an outpatient clinic in a TB hospital.	OPD headcount in TB hospitals	Headcount of all outpatients attending an outpatient clinic in a TB hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.	Percentage of TB hospitals with a patient satisfaction survey using DoH template	Percentage of TB hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	TB hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	TB hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of TB hospitals = 6	The number of provincial TB hospitals.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
4.	Percentage of TB hospitals with mortality and morbidity meetings at least once a month / every month	Percentage of TB hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	TB hospitals with mortality and morbidity (M&M) meetings at least once a month / every month	TB hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of TB hospitals = 6	The number of provincial TB hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of TB hospitals with clinical audit meetings at least once a month / every month	Percentage of TB hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	TB hospitals with clinical audit meetings every month	TB hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of TB hospitals = 6	The number of provincial TB hospitals.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of complaints resolved within 25 days in TB hospitals	Percentage of complaints resolved within 25 days in TB hospitals.	Complaints resolved within 25 days in TB hospitals.	The number of formal complaints received and registered in TB hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Number of TB hospitals = 6	The number of formal complaints received and registered by TB hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
7.	Average length of stay in TB hospitals	Average number of patient days that an admitted patient spends in a TB hospital before separation.	Inpatient days in TB hospitals ½ day patients in TB hospitals	Total days spent in TB hospitals for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a TB hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Day patients are not normally admitted in TB hospitals.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	Separations in TB hospitals	Separation in a TB hospital is the administrative process by which a TB hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Hospital Throughput Form (SINJANI)	1 (No)
8.	Bed utilisation rate based on useable beds in TB hospitals	Patient days in TB hospitals during the reporting period, expressed as a percentage of the sum of the daily number of useable TB beds.	Inpatient days in TB hospitals ½ day patients in TB hospitals	Total days spent in TB hospitals for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a TB hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Day patients are not normally admitted in TB hospitals.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	Useable bed days in TB hospitals in the year	Sum of the daily number of useable TB beds.	Hospital Throughput Form (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Total separations in TB hospitals	Separation in a TB hospital is the administrative process by which a TB hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Day patients in TB hospitals	A patient who is admitted and separated from a TB hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Day patients are not normally admitted in TB hospitals.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in TB hospitals	A death recorded against an inpatient admitted to a TB hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in TB hospitals	Any admitted patient in a TB hospital who completes their stay in hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in TB hospitals	An admitted patient in a TB hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
10.	Expenditure per patient day equivalent in TB hospitals	The average cost per patient day equivalent in TB hospitals with patient day equivalent calculated as inpatient days + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in TB hospitals.	Expenditure in TB hospitals	Total TB hospital expenditure, i.e. total expenditure for sub-programme 4.2	BAS	Patient day equivalents in TB hospitals	The total number of patient day equivalents in TB hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in TB hospitals.	Hospital Throughput Form (SINJANI)	1 (R)
Table 4.14: Provincial objectives and performance indicators for psychiatric hospitals [PHS4]									
1.	Number of beds in psychiatric hospitals	Useable beds in psychiatric hospitals are beds actually available for use within psychiatric hospitals (regardless of whether they are occupied by a patient or lodger).	Useable beds in psychiatric hospitals	Useable beds in psychiatric hospitals are beds actually available for use within psychiatric hospitals (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in psychiatric hospitals	Patient days in psychiatric hospitals is a weighted combination of inpatient days and day patients in	Inpatient days in psychiatric hospitals	Total days spent in a psychiatric hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
		psychiatric hospitals.	½ day patients in psychiatric hospitals	A patient who is admitted and separated from a psychiatric hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
3.	Number of step-down beds	Useable beds in psychiatric step-down facilities are beds actually available for use within psychiatric step-down facilities (regardless of whether they are occupied by a patient or lodger). Psychiatric step-down facilities are located at William Slater and Stikland Hospitals.	Useable beds in psychiatric step-down facilities	Useable beds in psychiatric step-down facilities are beds actually available for use within psychiatric step-down facilities (regardless of whether they are occupied by a patient or lodger). Psychiatric step-down facilities are located at William Slater and Stikland Hospitals.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
4.	Bed utilisation rate, based on useable beds, for step-down beds	Patient days in psychiatric step-down facilities during the reporting period, expressed as a percentage of the sum of the daily number of useable psychiatric step-down beds. Psychiatric step-down facilities are located at William Slater and Stikland Hospitals.	Inpatient days in psychiatric step-down facilities ½ day patients in psychiatric step-down facilities	Total days spent in psychiatric step-down facilities for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a psychiatric step-down facility on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	Useable bed days in psychiatric step-down facilities in the year	Sum of the daily number of useable psychiatric beds. Psychiatric step-down facilities are located at William Slater and Stikland Hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
5.	Total number of patient days in step-down beds	Patient days in psychiatric step-down facilities are a weighted combination of inpatient days and day patients in psychiatric step-down facilities. Psychiatric step-down facilities are located at William Slater and Stikland Hospitals.	Inpatient days in psychiatric step-down facilities ½ day patients in psychiatric step-down facilities	Total days spent in a psychiatric step-down facility for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a psychiatric step-down facility on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	None	None	None	None (No)

Table 4.15: Performance indicators for psychiatric hospitals [PHS5]

1.	Number of patient day equivalents in psychiatric hospitals	The total number of patient day equivalents in psychiatric hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in psychiatric hospitals.	Inpatient days in psychiatric hospitals ½ day patients in psychiatric hospitals 1/3 OPD headcount in psychiatric hospitals	Total days spent in psychiatric hospitals for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a psychiatric hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Headcount of all outpatients attending an outpatient clinic in a psychiatric hospital.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	None	None	None	None (No)
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No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			1/3 casualty/ emergency/ trauma headcount in psychiatric hospitals	Headcount of all patients attending a psychiatric hospital casualty/ emergency/ trauma unit with conditions requiring emergency treatment. These services are not rendered at psychiatric hospitals and this count should always be 0.	Hospital Throughput Form (SINJANI)				
2.	OPD total headcount in psychiatric hospitals	Headcount of all outpatients attending an outpatient clinic in a psychiatric hospital.	OPD headcount in psychiatric hospitals	Headcount of all outpatients attending an outpatient clinic in a psychiatric hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.	Percentage of psychiatric hospitals with a patient satisfaction survey using DoH template	Percentage of psychiatric hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	Psychiatric hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	Psychiatric hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of psychiatric hospitals = 4	The number of provincial psychiatric hospitals.	Facility list (Annexure to APP)	100 (%)
4.	Percentage of psychiatric hospitals with morbidity and mortality meetings at least once a month / every month	Percentage of psychiatric hospitals with Morbidity and Mortality (M&M) meetings at least once a month / every month.	Psychiatric hospitals with Morbidity and Mortality (M&M) meetings at least once a month / every month	Psychiatric hospitals with Morbidity and Mortality (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of psychiatric hospitals = 4	The number of provincial psychiatric hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of psychiatric hospitals with clinical audit meetings at least once a month / every month	Percentage of psychiatric hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Psychiatric hospitals with clinical audit meetings every month	Psychiatric hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of psychiatric hospitals = 4	The number of provincial psychiatric hospitals.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of complaints resolved within 25 days in psychiatric hospitals	Percentage of complaints resolved within 25 days in psychiatric hospitals.	Complaints resolved within 25 days in psychiatric hospitals	The number of formal complaints received and registered in psychiatric hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments - Facility.xls)*	Complaints received in psychiatric hospitals	The number of formal complaints received and registered by psychiatric hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments - Facility.xls)*	100 (%)
7.	Average length of stay in psychiatric hospitals	Average number of patient days that an admitted patient spends in a psychiatric hospital before separation.	Inpatient days in psychiatric hospitals ½ day patients in psychiatric hospitals	Total days spent in psychiatric hospitals for all inpatients during the reporting period. Based on the midnight census. A patient who is admitted and separated from a psychiatric hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI) Hospital Throughput Form (SINJANI)	Separations in psychiatric hospitals	Separation in a psychiatric hospital is the administrative process by which a psychiatric hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Hospital Throughput Form (SINJANI)	1 (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
8.	Bed utilisation rate based on useable beds in psychiatric hospitals	Patient days in psychiatric hospitals during the reporting period, expressed as a percentage of the sum of the daily number of useable psychiatric beds.	Inpatient days in psychiatric hospitals	Total days spent in psychiatric hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in psychiatric hospitals in the year	Sum of the daily number of useable psychiatric beds.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in psychiatric hospitals	A patient who is admitted and separated from a psychiatric hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
9.	Total separations in psychiatric hospitals	Separation in a psychiatric hospital is the administrative process by which a psychiatric hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Day patients in psychiatric hospitals	A patient who is admitted and separated from a psychiatric hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in psychiatric hospitals	A death recorded against an inpatient admitted to a psychiatric hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in psychiatric hospitals	Any admitted patient in a psychiatric hospital who completes their stay in hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in psychiatric hospitals	An admitted patient in a psychiatric hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
10.	Expenditure per patient day equivalent in psychiatric hospitals	The average cost per patient day equivalent in psychiatric hospitals with patient day equivalent calculated as inpatient days + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in psychiatric hospitals.	Expenditure in psychiatric hospitals	Total psychiatric hospital expenditure, i.e. total expenditure for sub-programme 4.3	BAS	Patient day equivalents in psychiatric hospitals	The total number of patient day equivalents in psychiatric hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in psychiatric hospitals.	Hospital Throughput Form (SINJANI)	1 (R)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 4.18: Provincial performance objectives and performance indicators for rehabilitation services [PHS4]									
WCRC = Western Cape Rehabilitation Centre									
1.	Number of beds in WCRC	Useable beds in rehabilitation hospitals are beds actually available for use within rehabilitation hospitals (regardless of whether they are occupied by a patient or lodger).	Useable beds in rehabilitation hospitals	Useable beds in rehabilitation hospitals are beds actually available for use within rehabilitation hospitals (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days	Patient days in rehabilitation hospitals are a weighted combination of inpatient days and day patients in rehabilitation hospitals.	Inpatient days in rehabilitation hospitals	Total days spent in rehabilitation hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in rehabilitation hospitals	A patient who is admitted and separated from a rehabilitation hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Normally patients are not admitted to a rehabilitation hospital for one day only and this count will therefore be 0.	Hospital Throughput Form (SINJANI)				
3.	Number of orthotic and prosthetic devices manufactured	Number of orthotic and prosthetic devices manufactured that were issued to and received by the client.	Orthotic and prosthetic devices issued	Number of orthotic and prosthetic devices manufactured that were issued to and received by the client.	Orthotic and prosthetic register	None	None	None	None (No)
4.	Percentage of orthotic and prosthetic devices requiring remanufacture	Orthotic and prosthetic devices that require remanufacture due to poor or incorrect fitting and do not improve the client's function.	Orthotic and prosthetic devices requiring remanufacture	Orthotic and prosthetic devices that require remanufacture due to poor or incorrect fitting and do not improve the client's function.	Orthotic and prosthetic register	Orthotic and prosthetic devices manufactured	The total number of orthotic and prosthetic devices that were manufactured.	Orthotic and prosthetic register	100 (%)
5.	Number of patients on waiting list for orthotic or prosthetic device for over 6 months	Number of patients that have been waiting for their orthotic and / or prosthetic device for more than 6 months.	Patients on waiting list for over 6 months	Number of patients that have been waiting for their orthotic and / or prosthetic device for more than 6 months.	Orthotic and prosthetic register	None	None	None	None (No)
Table 4.19: Performance indicators for rehabilitation services [PHS5]									
1.	Number of patient day equivalents in rehabilitation hospitals	The total number of patient day equivalents in rehabilitation hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in rehabilitation hospitals.	Inpatient days in rehabilitation hospitals	Total days spent in rehabilitation hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in rehabilitation hospitals	A patient who is admitted and separated from a rehabilitation hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Normally patients are not admitted to a rehabilitation hospital for one day only and this count will therefore be 0.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			1/3 OPD headcount in rehabilitation hospitals	Headcount of all outpatients attending an outpatient clinic in rehabilitation hospitals.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/ emergency/ trauma headcount in rehabilitation hospitals	Headcount of all patients attending a casualty/ emergency/ trauma unit in a rehabilitation hospital with conditions requiring emergency treatment. These services are not rendered at rehabilitation hospitals and this count should always be 0.	Hospital Throughput Form (SINJANI)				
2.	OPD total headcount in rehabilitation hospitals	Headcount of all outpatients attending an outpatient clinic in rehabilitation hospitals.	OPD headcount in rehabilitation hospitals	Headcount of all outpatients attending an outpatient clinic in rehabilitation hospitals.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
3.	Percentage of rehabilitation hospitals with a patient satisfaction survey using the DoH template	Percentage of rehabilitation hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	Rehabilitation hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	Rehabilitation hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of rehabilitation hospitals = 1	The number of provincial health rehabilitation hospitals.	Facility list (Annexure to APP)	100 (%)
4.	Percentage of rehabilitation hospitals with mortality and morbidity meetings at least once a month / every month	Percentage of rehabilitation hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Rehabilitation hospitals with mortality and morbidity (M&M) meetings at least once a month / every month	Rehabilitation hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of rehabilitation hospitals = 1	The number of provincial health rehabilitation hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of rehabilitation hospitals with clinical audit meetings at least once a month / every month	Percentage of rehabilitation hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Rehabilitation hospitals with clinical audit meetings every month	Rehabilitation hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of rehabilitation hospitals = 1	The number of provincial health rehabilitation hospitals.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of complaints resolved within 25 days in rehabilitation hospitals	Percentage of complaints resolved within 25 days in rehabilitation hospitals.	Complaints resolved within 25 days in rehabilitation hospitals	The number of formal complaints received and registered in rehabilitation hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received in rehabilitation hospitals	The number of formal complaints received and registered by rehabilitation hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
7.	Average length of stay in rehabilitation hospitals	Average number of patient days that an admitted patient spends in rehabilitation hospitals before separation.	Inpatient days in rehabilitation hospitals	Total days spent in rehabilitation hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in rehabilitation hospitals	Separation in rehabilitation hospitals is the administrative process by which rehabilitation hospitals records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in rehabilitation hospitals	A patient who is admitted and separated from a rehabilitation hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Normally patients are not admitted to a rehabilitation hospital for one day only and this count will therefore be 0.	Hospital Throughput Form (SINJANI)				
8.	Bed utilisation rate based on useable beds in rehabilitation hospitals	Patient days in rehabilitation hospitals during the reporting period, expressed as a percentage of the sum of the daily number of useable beds in rehabilitation hospitals.	Inpatient days in rehabilitation hospitals	Total days spent in rehabilitation hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in rehabilitation hospitals	Sum of the daily number of useable beds in rehabilitation hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in rehabilitation hospitals	A patient who is admitted and separated from a rehabilitation hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Normally patients are not admitted to a rehabilitation hospital for one day only and this count will therefore be 0.	Hospital Throughput Form (SINJANI)				
9.	Total separations in rehabilitation hospitals	Separation in rehabilitation hospitals is the administrative process by which rehabilitation hospitals records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution, and day cases.	Day patients in rehabilitation hospitals	A patient who is admitted and separated from a rehabilitation hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay. Normally patients are not admitted to a rehabilitation hospital for one day only and this count will therefore be 0.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in rehabilitation hospitals	A death recorded against an inpatient admitted to a rehabilitation hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			Inpatient discharge in rehabilitation hospitals	Any admitted patient in a rehabilitation hospital who completes their stay in hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in rehabilitation hospitals	An admitted patient in a rehabilitation hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
10.	Expenditure per patient day equivalent in rehabilitation hospitals	The average cost per patient day equivalent in rehabilitation hospitals with patient day equivalent calculated as inpatient days + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in rehabilitation hospitals.	Expenditure in rehabilitation hospitals	Total expenditure for rehabilitation hospitals, i.e. total expenditure for sub-programme 4.4	BAS	Patient day equivalents in rehabilitation hospitals	The total number of patient day equivalents in rehabilitation hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services in rehabilitation hospitals.	Hospital Throughput Form (SINJANI)	1 (R)

Table 4.22: Performance indicators: Academic Dental Services [PHS4]

1.	Number of patient visits per annum	The total number of patients (i.e. headcount) attending the Oral Health Centres and outreach services rendered by the Oral Health Centres.	Total headcount for Oral Health Centres	The total number of patients (i.e. headcount) attending the Oral Health Centres and outreach services rendered by the Oral Health Centres.	Attendance registers	None	None	None	None (No)
2.	Number of theatre cases per annum	Number of oral health clients treated under general anaesthetic in theatre. Include referrals from outlying clinics. Theatre cases are divided into theatre times of 0 – 30 minutes, 30 – 60 minutes, 60 – 90 minutes and above 90 minutes.	Oral Health theatre cases	Number of oral health clients treated under general anaesthetic in theatre. Include referrals from outlying clinics. Theatre cases are divided into theatre times of 0 – 30 minutes, 30 – 60 minutes, 60 – 90 minutes and above 90 minutes.	Theatre log book	None	None	None	None (No)
3.	Number of patients provided with dentures per annum	The total number of patients (i.e. headcount) receiving a dental prosthesis manufactured by the Oral Health Centres.	Patients provided with dentures	The total number of patients (i.e. headcount) receiving a dental prosthesis manufactured by the Oral Health Centres.	Dental laboratory records	None	None	None	None (No)
4.	Number of students graduating per annum	The total number of Oral Health students who graduate during the academic year. Include oral hygienists, dentists, specialists and post-graduate diplomas qualifying from the Oral Health Centre training platform.	Oral Health students graduating	The total number of Oral Health students who graduate during the academic year. Include oral hygienists, dentists, specialists and post-graduate diplomas qualifying from the Oral Health Centre training platform.	UWC graduation list (external source)	None	None	None	None (No)

PROGRAMME 5: CENTRAL HOSPITAL SERVICES (HIGHLY SPECIALISED)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 5.14: Provincial objectives and performance indicators for central hospitals for 2008/09 to 2011/12 [CHS3]									
PLEASE NOTE: CENTRAL HOSPITALS REFER TO THE SERVICES RENDERED IN DESIGNATED LEVEL 3 WARDS AT CENTRAL HOSPITALS									
Central hospitals									
1.	Number of L3 beds in central hospitals	Useable beds in designated level 3 wards in central hospitals. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Level 3 useable beds in central hospitals	Useable beds in designated level 3 wards in central hospitals. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in central hospitals	Patient days in central hospitals are a weighted combination of inpatient days in central hospitals and day patients in central hospitals.	Inpatient days in central hospitals	Total days spent in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in central hospitals	A patient who is admitted and separated from a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
Groote Schuur Hospital									
1.	Number of L3 beds in Groote Schuur Hospital	Useable beds in designated level 3 wards in Groote Schuur Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Level 3 useable beds in Groote Schuur Hospital	Useable beds in designated level 3 wards in Groote Schuur Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in Groote Schuur Hospital	Patient days in Groote Schuur Hospital are a weighted combination of inpatient days in Groote Schuur Hospital and day patients in Groote Schuur Hospital.	Inpatient days in Groote Schuur Hospital	Total days spent in Groote Schuur Hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in Groote Schuur Hospital	A patient who is admitted and separated from Groote Schuur Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
Tygerberg Hospital									
1.	Number of L3 beds in Tygerberg Hospital	Useable beds in designated level 3 wards in Tygerberg Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Level 3 useable beds in Tygerberg Hospital	Useable beds in designated level 3 wards in Tygerberg Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
2.	Total number of patient days in Tygerberg Hospital	Patient days in Tygerberg Hospital are a weighted combination of inpatient days in Tygerberg Hospital and day patients in Tygerberg Hospital.	Inpatient days in Tygerberg Hospital	Total days spent in Tygerberg Hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in Tygerberg Hospital	A patient who is admitted and separated from Tygerberg Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
Red Cross War Memorial Children's Hospital									
1.	Number of L3 beds in Red Cross War Memorial Children's Hospital	Useable beds in designated level 3 wards in Red Cross War Memorial Children's Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Level 3 useable beds in Red Cross War Memorial Children's Hospital	Useable beds in designated level 3 wards in Red Cross War Memorial Children's Hospital. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
2.	Total number of patient days in Red Cross War Memorial Children's Hospital	Patient days in Red Cross War Memorial Children's Hospital are a weighted combination of inpatient days in Red Cross War Memorial Children's Hospital and day patients in Red Cross War Memorial Children's Hospital.	Inpatient days in Red Cross War Memorial Children's Hospital	Total days spent Red Cross War Memorial Children's Hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in Red Cross War Memorial Children's Hospital	A patient who is admitted and separated from Red Cross War Memorial Children's Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
Table 5.15: Performance indicators for central hospitals for 2008/09 to 2011/12 [CHS4]									
PLEASE NOTE: CENTRAL HOSPITALS REFER TO THE SERVICES RENDERED IN DESIGNATED LEVEL 3 WARDS AT CENTRAL HOSPITALS									
1.	Caesarean section rate for central hospitals	Caesarean section deliveries in central hospitals, expressed as a percentage of all deliveries in central hospitals.	Caesarean sections in central hospitals	Caesarean sections in central hospitals. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls.	Hospital Throughput Form (SINJANI)	Total deliveries in central hospitals	Total number of women who delivered in central hospitals. Calculated from the number of normal deliveries in central hospitals, assisted deliveries in central hospitals and caesarean sections in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
2.	Number of patient day equivalents in central hospitals	The total number of patient day equivalents in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in central hospitals.	Inpatient days in central hospitals	Total days spent in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients in central hospitals	A patient who is admitted and separated from a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			1/3 OPD headcount in central hospitals	Headcount of all outpatients attending a level 3 outpatient clinic in central hospitals.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/ emergency/ trauma headcount in central hospitals	Headcount of all patients attending a casualty/ emergency/ trauma unit in central hospitals with conditions requiring emergency treatment.	Hospital Throughput Form (SINJANI)				
3.	OPD total headcount at central hospitals	Headcount of all outpatients attending a level 3 outpatient clinic in central hospitals.	OPD headcount in central hospitals	Headcount of all outpatients attending a level 3 outpatient clinic in central hospitals.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
4.	Percentage of central hospitals with a patient satisfaction survey using DoH template	Percentage of central hospitals with a published nationally mandated patient satisfaction survey in the last 12 months.	Central hospitals with a published nationally mandated patient satisfaction survey in the last 12 months	Central hospitals with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	Number of central hospitals = 3	The number of provincial health central hospitals.	Facility list (Annexure to APP)	100 (%)
5.	Percentage of central hospitals with mortality and morbidity meetings at least once a month / every month	Percentage of central hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Central hospitals with mortality and morbidity (M&M) meetings at least once a month / every month	Central hospitals with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	Number of central hospitals = 3	The number of provincial health central hospitals.	Facility list (Annexure to APP)	100 (%)
6.	Percentage of central hospitals with clinical audit meetings at least once a month / every month	Percentage of central hospitals with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Central hospitals with clinical audit meetings at least once a month / every month	Central hospitals with clinical audit meetings at least once a month/ every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	Number of central hospitals = 3	The number of provincial health central hospitals.	Facility list (Annexure to APP)	100 (%)
7.	Percentage of complaints resolved within 25 days at central hospitals	Percentage of complaints resolved within 25 days in central hospitals.	Complaints resolved within 25 days in central hospitals	The number of formal complaints received and registered in central hospitals during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received in central hospitals	The number of formal complaints received and registered by central hospitals during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
8.	Case fatality rate in central hospitals for surgery separations	Percentage of surgery separations in central hospitals that died.	Inpatient death – surgery in central hospitals	A death recorded against an inpatient admitted to a central hospital surgery ward. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the speciality of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery in central hospitals	Separation for surgery in a central hospital is the administrative process by which a central hospital records the completion of treatment and/or the accommodation of a patient in a surgery ward. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Average length of stay in central hospitals	Average number of patient days that an admitted patient spends in a central hospital before separation.	Inpatient days in central hospitals	Total days spent in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations in central hospitals	Separation is the administrative process by which a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients in central hospitals	A patient who is admitted and separated from a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
10.	Bed utilisation rate based on useable beds in central hospitals	Patient days during the reporting period in central hospitals, expressed as a percentage of the sum of the daily number of central hospitals useable beds.	Inpatient days in central hospitals	Total days spent in central hospitals for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Useable bed days in central hospitals	Sum of the daily number of useable beds in central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients in central hospitals	A patient who is admitted and separated from a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
11.	Total separations in central hospitals	Separation is the administrative process by which a central hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Day patients in central hospitals	A patient who is admitted and separated from a central hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death in central hospitals	A death recorded against an inpatient admitted to a central hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the specialty of the ward.	Hospital Throughput Form (SINJANI)				
			Inpatient discharge in central hospitals	Any admitted patient who completes their stay in a central hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out in central hospitals	An admitted patient in a central hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
12.	Expenditure per patient day equivalent in central hospitals	The average cost per patient day equivalent in central hospitals with patient day equivalent calculated as inpatient days + ½ day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount in central hospitals.	Expenditure for central hospitals	Total central hospital expenditure, i.e. total expenditure for sub-programme 5.1	BAS	Patient day equivalents in central hospitals	The total number of patient day equivalents in central hospitals, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty/ emergency/ trauma services in central hospitals.	Hospital Throughput Form (SINJANI)	1 (R)
Table 5.16: Performance indicators for Grootte Schuur Hospital for 2008/09 to 2011/12 [CHS4]									
Table 5.17: Performance indicators for Tygerberg Hospital for 2008/09 to 2011/12 [CHS4]									
Table 5.18: Performance indicators for Red Cross Children's Hospital for 2008/09 to 2011/2012 [CHS4]									
PLEASE NOTE: CENTRAL HOSPITALS REFER TO THE SERVICES RENDERED IN DESIGNATED LEVEL 3 WARDS AT CENTRAL HOSPITALS									
1.	Caesarean section rate at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Caesarean section deliveries at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital, expressed as a percentage of all deliveries at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital. No deliveries take place at Red Cross War Memorial Children's Hospital.	Caesarean sections at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Caesarean sections at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital. A caesarean section is the removal of the foetus, placenta and membranes by means of an incision through the abdominal and uterine walls. No deliveries take place at Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)	Total deliveries at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Total number of women who delivered at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital. Calculated from the number of normal deliveries, assisted deliveries and caesarean sections per individual central hospital. No deliveries take place at Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)	100 (%)
2.	Number of patient day equivalents at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	The total number of patient day equivalents at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital, calculated using inpatient days, ½ day patients and 1/3 factors for OPD and casualty services at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Inpatient days at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Total days spent in Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital for all inpatients during the reporting period. Based on the midnight census.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			½ day patients at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A patient who is admitted and separated from Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
			1/3 OPD headcount at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Headcount of all outpatients attending an outpatient clinic at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)				
			1/3 casualty/ emergency/ trauma headcount at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Headcount of all patients attending a casualty/ emergency/ trauma unit with conditions requiring emergency treatment at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)				
3.	OPD total headcount in Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Headcount of all outpatients attending an outpatient clinic at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	OPD headcount at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Headcount of all outpatients attending an outpatient clinic at Grootte Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
4.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital has a patient satisfaction survey using DoH template	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with a published patient satisfaction survey in the last 12 months using the national DoH template.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with a published nationally mandated patient satisfaction survey in the last 12 months	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with a published patient satisfaction survey in the last 12 months using the national DoH template.	Client Satisfaction Survey Report (QA Initiatives-Facility.xls)*	None	None	None	(Yes/No)
5.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital has mortality and morbidity meetings at least once a month / every month	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with mortality and morbidity (M&M) meetings at least once a month / every month.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with mortality and morbidity (M&M) meetings at least once a month / every month	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with mortality and morbidity (M&M) meetings at least once a month / every month.	Minutes of M & M meetings (QA Initiatives-Facility.xls)*	None	None	None	(Yes/No)
6.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital has clinical audit meetings at least once a month / every month	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with clinical audit meetings at least once a month / every month. Clinical audit meetings are defined as meetings where peer review and/or discussion of clinical findings take place, inclusive, but not limited to, audits of prescription charts, compliance with clinical guidelines and protocols, patient records, adverse incidents (all categories) and including audit of mortality and morbidity meeting findings.	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with clinical audit meetings at least once a month / every month	Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with clinical audit meetings at least once a month / every month.	Minutes of clinical audit meetings (QA Initiatives-Facility.xls)*	None	None	None	(Yes/No)
7.	Percentage of complaints resolved within 25 days in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Percentage of complaints resolved within 25 at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Complaints resolved within 25 days at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	The number of formal complaints received and registered at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital during the reporting period that was resolved within 25 days.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	Complaints received at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	The number of formal complaints received and registered by Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital during the reporting period. Complaints for which the 25-day period has not elapsed are included.	Complaints and Compliments Register (Complaints and Compliments-Facility.xls)*	100 (%)
8.	Case fatality rate in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital for surgery separations	Percentage of surgery separations that at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Inpatient death –surgery at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A death recorded against an inpatient admitted to a surgery ward at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the speciality of the ward.	Hospital Throughput Form (SINJANI)	Separation – surgery at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Separation for surgery is the administrative process by which Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
9.	Average length of stay at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Average number of patient days that an admitted patient spends in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital before separation.	Inpatient days at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Total days spent in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital for all inpatients during the reporting. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Separations at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Separation is the administrative process by which Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Hospital Throughput Form (SINJANI)	1 (No)
			½ day patients at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A patient who is admitted and separated from Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
10.	Bed utilisation rate based on useable beds at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Patient days during the reporting period at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital, expressed as a percentage of the sum of the daily number of useable at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Inpatient days at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Total days spent in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital for all inpatients during the reporting. Based on the midnight census.	Hospital Throughput Form (SINJANI)	Usable bed at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Sum of the daily number of useable beds at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)	100 (%)
			½ day patients at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A patient who is admitted and separated from Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)				
11.	Total separations at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Separation is the administrative process by which Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital records the completion of treatment and/or the accommodation of a patient. Include inpatients who were discharged, who died, or who were transferred to another hospital or institution as well as day cases.	Day at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A patient who is admitted and separated from Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital on the same date. Exclude patients who died, or patients who were transferred to another hospital on the first day of their stay.	Hospital Throughput Form (SINJANI)	None	None	None	None (No)
			Inpatient death at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	A death recorded against an inpatient admitted to Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital. Include any death of an inpatient, even if the cause of death does not directly relate to the cause of admission or the speciality of the ward.	Hospital Throughput Form (SINJANI)				

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
			Inpatient discharge at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Any admitted patient who completes their stay in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital and are discharged to their usual residence. Exclude deaths and transfers to other hospitals and step-down facilities.	Hospital Throughput Form (SINJANI)				
			Inpatient transfer out at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	An admitted patient in Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital who is directed or physically transferred to another hospital for immediate admission there. Exclude patients referred to a primary health care facility or referred to other hospitals for a specialist OPD visit and similar.	Hospital Throughput Form (SINJANI)				
12.	Expenditure per patient day equivalent at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	The average cost per patient day equivalent at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital with patient day equivalent calculated as inpatient days + 1/2 day patients + 1/3 OPD headcount + 1/3 casualty/ emergency/ trauma headcount at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Expenditure at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	Total expenditure at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	BAS	Patient day equivalents at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital	The total number of patient day equivalents at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital, calculated using inpatient days, 1/2 day patients and 1/3 factors for OPD and casualty services at Groote Schuur / Tygerberg / Red Cross War Memorial Children's Hospital.	Hospital Throughput Form (SINJANI)	1 (R)

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 6.4: Provincial objectives and performance indicators for human resource development [HR2]									
Sub-programme 6.1 Nurse Training									
Nursing College: Number of nursing students in training:									
1.	Number of Registered Nurses in training at WCCN (Post Basic [Advanced] Diploma R212)	Number of students registered at the Western Cape College of Nursing for the post basic (advanced) nursing diploma R212 for the academic year.	Students registered for the R212 diploma in Clinical Nursing Science (Medical and Surgical Nursing Science) at the WCCN	Number of students registered at the Western Cape College of Nursing for the post basic (advanced) nursing diploma R212 for the academic year.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
2.	Number of Registered Nurses in training at WCCN (Post Basic Diploma R48)	Number of students registered at the Western Cape College of Nursing for the post basic nursing diploma R48 for the academic year.	Students registered for the R48 diploma in Clinical Nursing Science, Health Assessment, Treatment and Care at the WCCN	Number of students registered at the Western Cape College of Nursing for the post basic nursing diploma R48 for the academic year.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
3.	Number of Registered Nurses in training at WCCN (Diploma R254)	Number of students registered at the Western Cape College of Nursing for the post-registration nursing diploma R254 in midwifery for the academic year.	Students registered for the R254 Diploma in Midwifery at the WCCN	Number of students registered at the Western Cape College of Nursing for the post-registration nursing diploma R254 in midwifery for the academic year.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
4.	Number of Registered Nurses in training at WCCN (Diploma R880)	Number of students registered at the Western Cape College of Nursing for the post-registration nursing diploma R880 in psychiatry for the academic year.	Students registered for the R880 Diploma in Psychiatric Nursing at the WCCN	Number of students registered at the Western Cape College of Nursing for the post-registration nursing diploma R880 in psychiatry for the academic year.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
5.	Number of Student Nurses in training at WCCN (Basic Diploma R425)	Number of students registered at the Western Cape College of Nursing for the basic nursing diploma R425 for the academic year.	Students registered for the R425 Diploma in Nursing (General, Psychiatric and Community) and Midwifery WCCN	Number of students registered at the Western Cape College of Nursing for the basic nursing diploma R425 for the academic year.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
6.	Total number of nurses in training at the WCCN	The number of students registered at the Western Cape College of Nursing for post basic (advanced) and basic nurse training for the academic year. The sum of indicators 1 – 5.	Students registered for nurse training at the WCCN	The number of students registered at the Western Cape College of Nursing for post basic (advanced) and basic nurse training for the academic year. The sum of indicators 1 – 5.	Student registration form from WCCN (Excel spreadsheet)	None	None	None	None (No)
Nursing schools: Number of nursing students in training:									
7.	Number of Registered Nurses in training at the nursing schools (Bridging i.e. R683)	Number of students registered at Nursing Schools in the Western Cape for bridging courses for the academic year. The bridging course for enrolled nurse leading to registration as general nurse or psychiatric nurse was proclaimed in SANC Government notice No. R683 of 14 April 1989 as amended.	Students registered for the R683 bridging course at Nursing Schools	Number of students registered at Nursing Schools in the Western Cape for bridging courses for the academic year. The bridging course for enrolled nurse leading to registration as general nurse or psychiatric nurse was proclaimed in SANC Government notice No. R683 of 14 April 1989 as amended.	Student registration form from nursing schools (Excel spreadsheet)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
8.	Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2175)	Number of students registered at Nursing Schools in the Western Cape for the course leading to a nurse (sub-categories for mid-level workers) for the academic year. The course leading to enrolment as a nurse was proclaimed in SANC Government notice No. R2175 of 19 November 1993 as amended.	Students registered for the R2175 course at Nursing Schools	Number of students registered at Nursing Schools in the Western Cape for the course leading to a nurse (sub-categories for mid-level workers) for the academic year. The course leading to enrolment as a nurse was proclaimed in SANC Government notice No. R2175 of 19 November 1993 as amended.	Student registration form from nursing schools (Excel spreadsheet)	None	None	None	None (No)
9.	Number of sub-categories of nurses in training at the nursing schools (Mid-level workers i.e. R2176)	Number of students registered at Nursing Schools in the Western Cape for the course leading to a nurse (sub-categories for mid-level workers) for the academic year. The course leading to enrolment as a nursing auxiliary was proclaimed in SANC Government notice No. R2176 of 19 November 1993 as amended.	Students registered for the R2176 course at Nursing Schools	Number of students registered at Nursing Schools in the Western Cape for the course leading to a nurse (sub-categories for mid-level workers) for the academic year. The course leading to enrolment as a nursing auxiliary was proclaimed in SANC Government notice No. R2176 of 19 November 1993 as amended.	Student registration form from nursing schools (Excel spreadsheet)	None	None	None	None (No)
10.	Total number of nurses in training at the Nursing Schools	The number of students registered at Nursing Schools in the Western Cape for the academic year. The sum of indicators 7 – 9.	Students registered for training at Nursing Schools	The number of students registered at Nursing Schools in the Western Cape for the academic year. The sum of indicators 7 – 9.	Student registration form from nursing schools (Excel spreadsheet)	None	None	None	None (No)
11.	Total number of nursing students in training	The total number of nursing students in training as reflected by the Enrolment Register of the Western Cape College of Nursing (WCCN) and Nursing Schools in the Western Cape for the academic year. The sum of indicators 6 and 11.	Students registered for training at the WCCN and Nursing Schools	The total number of nursing students in training as reflected by the Enrolment Register of the Western Cape College of Nursing (WCCN) and Nursing Schools in the Western Cape for the academic year. The sum of indicators 6 and 11.	Student registration form from WCCN and nursing schools (Excel spreadsheet)	None	None	None	None (No)
Sub-programme 6.2: EMS training									
Number of intake of students									
12.	Number of student intake for the National Diploma EMC	The student intake at the Cape Peninsula University of Technology (CPUT) for the National Diploma in Emergency Medical Care during the current academic year. The National Diploma is conducted over a 3-year period and the exit level for this course is Advanced Life Support.	Student intake for National Diploma EMC	The student intake at the Cape Peninsula University of Technology (CPUT) for the National Diploma in Emergency Medical Care during the current academic year. The National Diploma is conducted over a 3-year period and the exit level for this course is Advanced Life Support.	Student registration form from CPUT (external data source)	None	None	None	None (No)
13.	Number of student intake for the Critical Care Assistant (CAA) (Paramedic) course	The student intake at the Western Cape College of Emergency Care for the Critical Care Assistant (Paramedic) course conducted over a 10-month period. The exit level for this course is Advanced Life Support.	Student intake for CAA (Paramedic) Course	The student intake at the Western Cape College of Emergency Care for the Critical Care Assistant (Paramedic) course conducted over a 10-month period. The exit level for this course is Advanced Life Support.	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
14.	Number of student intake for the Ambulance Emergency Assistant (AEA) (5-months course)	The student intake at the Western Cape College of Emergency Care for the Ambulance Emergency Assistant (AEA) course conducted over four and a half months. The exit level for this course is Intermediate Life Support.	Student intake for AEA 5-month course	The student intake at the Western Cape College of Emergency Care for the Ambulance Emergency Assistant (AEA) course conducted over four and a half months. The exit level for this course is Intermediate Life Support.	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)
15.	Number of student intake for the Basic Ambulance Assistant (BAA) (5-week course)	The student intake at the Western Cape College of Emergency Care for the Basic Ambulance Assistant (BAA) course conducted over a 7-week period. The exit level for this course is Basic Life Support.	Student intake for BAA 7-week course	The student intake at the Western Cape College of Emergency Care for the Basic Ambulance Assistant (BAA) course conducted over 7-week period. The exit level for this course is Basic Life Support.	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)
16.	Number of student intake for the Medical Rescue Training course	The student intake at the Western Cape College of Emergency Care for the Medical Rescue course. The programmes range from 1 – 3 weeks.	Student intake for Medical Rescue training	The student intake at the Western Cape College of Emergency Care for the Medical Rescue course. The programmes range from 1 – 3 weeks.	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)
17.	Number of student intake for emergency service continuous medical training (CME Training) (1 or 2 day courses)	The student intake at the Western Cape College of Emergency Care for the Continuous Medical Education (CME) programmes. Programmes range from 1 - 5 days. The 1 – 5 day CPD (Continuous Professional Development) programmes are formally accredited by the HPCSA (Health Professions Council of South Africa).	Student intake for CME training	The student intake at the Western Cape College of Emergency Care for the Continuous Medical Education (CME) programmes. Programmes range from 1 - 5 days. The 1 – 5 day CPD (Continuous Professional Development) programmes are formally accredited by the HPCSA (Health Professions Council of South Africa).	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)
18.	Number of student intake for Emergency Communications	The student intake at the Western Cape College of Emergency Care for the Emergency Communication programme conducted over an 8-week period. The programme is aimed at personnel working at the Emergency Communication Centre's in EMS (Emergency Medical Services).	Student intake for Emergency Communication training	The student intake at the Western Cape College of Emergency Care for the Emergency Communication programme conducted over an 8-week period. The programme is aimed at personnel working at the Emergency Communication Centre's in EMS (Emergency Medical Services).	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)	None	None	None	None (No)
19.	Number of student intake for the National Certificate in Communications	The student intake at the Cape Peninsula University of Technology (CPUT) and the Western Cape College of Emergency Care for the Emergency Care Technician national higher certificate for	Student intake for National Certificate in Communications at CPUT	The student intake at the Cape Peninsula University of Technology (CPUT) for the Emergency Care Technician national higher certificate for the current academic year.	Student registration form from CPUT (external data source)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
		the current academic year. The national higher certificate is conducted over a 2 year period and the exit level for this course is Mid-level worker Emergency Care Technician.	Student intake for National Certificate in Communications at EMS College	The student intake at the Western Cape College of Emergency Care for the Emergency Care Technician national higher certificate for the current academic year.	Student registration form from Western Cape College of Emergency Care (Excel spreadsheet)				
Number of graduates per programme									
20.	Number of graduates from the National Diploma: EMC	The number of students graduating from the Cape Peninsula University of Technology (CPUT) in the National Diploma in Emergency Medical Care during the current academic year. The National Diploma is conducted over a 3-year period and the exit level for this course is Advanced Life Support.	Students graduating from National Diploma EMC	The number of students graduating from the Cape Peninsula University of Technology (CPUT) in the National Diploma in Emergency Medical Care during the current academic year. The National Diploma is conducted over a 3-year period and the exit level for this course is Advanced Life Support.	Graduation list from CPUT (external data source)	None	None	None	None (No)
21.	Number of graduates from the Critical Care Assistant (CCA) Paramedic course	The number of students graduating from the Western Cape College of Emergency Care in the Critical Care Assistant (CAA) (Paramedic) course conducted over a 10-month period. The exit level for this course is Advanced Life Support.	Students graduating from CAA (Paramedic) course	The number of students graduating from the Western Cape College of Emergency Care in the Critical Care Assistant (CAA) (Paramedic) course conducted over a 10-month period. The exit level for this course is Advanced Life Support.	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
22.	Number of graduates from the Ambulance Emergency Assistant (AEA) course (5-months course)	The number of students graduating from the Western Cape College of Emergency Care in the Ambulance Emergency Assistant (AEA) course conducted over four and a half months. The exit level for this course is Intermediate Life Support.	Students graduating from AEA 5-month course	The number of students graduating from the Western Cape College of Emergency Care in the Ambulance Emergency Assistant (AEA) course conducted over four and a half months. The exit level for this course is Intermediate Life Support.	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
23.	Number of graduates from the Basic Ambulance Assistant (BAA) course (5-week course)	The number of students graduating from the Western Cape College of Emergency Care in the Basic Ambulance Assistant (BAA) course conducted over a 7-week period. The exit level for this course is Basic Life Support.	Students graduating from BAA 7-week course	The number of students graduating from the Western Cape College of Emergency Care in the Basic Ambulance Assistant (BAA) course conducted over a 7-week period. The exit level for this course is Basic Life Support.	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
24.	Number of graduates from the Medical Rescue Training course	The number of students graduating from the Western Cape College of Emergency Care in the Medical Rescue course. The programmes range from 1 – 3 weeks.	Students graduating from Medical Rescue training	The number of students graduating from the Western Cape College of Emergency Care in the Medical Rescue course. The programmes range from 1 – 3 weeks.	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
25.	Number of graduates from the emergency Continuous Medical Education (CME) Training (1 or 2 day courses)	The number of students graduating from the Western Cape College of Emergency Care in Continuous Medical Education (CME) programmes. Programmes range from 1 - 5 days. The 1 – 5 day CPD (Continuous Professional Development) programmes are formally accredited by the HPCSA (Health Professions Council of South Africa).	Students graduating from CME training	The number of students graduating from the Western Cape College of Emergency Care in Continuous Medical Education (CME) programmes. Programmes range from 1 - 5 days. The 1 – 5 day CPD (Continuous Professional Development) programmes are formally accredited by the HPCSA (Health Professions Council of South Africa).	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
26.	Number of graduates from the Emergency Communications Training	The number of students graduating from the Western Cape College of Emergency Care in the Emergency Communication programme conducted over an 8-week period. The programme is aimed at personnel working at the Emergency Communication Centre's in EMS (Emergency Medical Services).	Students graduating from Emergency Communication training	The number of students graduating from the Western Cape College of Emergency Care in the Emergency Communication programme conducted over an 8-week period. The programme is aimed at personnel working at the Emergency Communication Centre's in EMS (Emergency Medical Services).	Graduation list from Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
27.	Number of graduates from the National Certificate in Communications	The number of students graduating from the Cape Peninsula University of Technology (CPUT) and the Western Cape College of Emergency Care in the Emergency Care Technician national higher certificate for the current academic year. The national higher certificate is conducted over a 2 year period and the exit level for this course is Mid-level worker Emergency Care Technician.	Students graduating from National Certificate in Communications at CPUT	The number of students graduating from the Cape Peninsula University of Technology (CPUT) in the Emergency Care Technician national higher certificate for the current academic year.	Graduation list from CPUT (paper-based)	None	None	None	None (No)
			Students graduating from National Certificate in Communications at Western Cape College of Emergency Care	The number of students graduating from the Western Cape College of Emergency Care for the Emergency Care Technician national higher certificate for the current academic year.	Graduation list from Western Cape College of Emergency Care (paper-based)				
28.	GRAND TOTAL: Number of learners to complete programmes per year	Total number of learners/ students to successfully complete training programmes in emergency medical care during the year as reflected in the Graduation Registers of both the Western Cape College of Emergency Care and Cape Peninsula University of Technology (CPUT). The sum of indicators 20 – 27.	Students graduating from EMS College and CPUT training programmes in emergency medical care	Total number of learners/ students to successfully complete training programmes in emergency medical care during the year as reflected in the Graduation Registers of both the Western Cape College of Emergency Care and Cape Peninsula University of Technology (CPUT). The sum of indicators 20 – 27.	Graduation list from CPUT and Western Cape College of Emergency Care (paper-based)	None	None	None	None (No)
Sub-programme 6.3: Education: Bursaries									
Number of students with bursaries									
29.	Number of nursing professionals with bursaries	Nursing professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year.	Nursing professionals with full-time bursaries	Nursing professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year.	Approved bursary applications (Full Time Bursary Database. mdb)	None	None	None	None (No)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
30.	Number of health professionals with bursaries	Health professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year. Health professionals are all health professionals excluding nursing professionals, e.g. medical officers, pharmacists, etc.	Health professionals with full-time bursaries	Health professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year. Health professionals are all health professionals excluding nursing professionals, e.g. medical officers, pharmacists, etc.	Approved bursary applications (Full Time Bursary Database. mdb)	None	None	None	None (No)
31.	Number of other professionals with bursaries	Other professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year, e.g. clinical engineering.	Other professionals with full-time bursaries	Other professionals awarded full-time bursaries from the Provincial Department of Health for the current academic year, e.g. clinical engineering.	Approved bursary applications (Full Time Bursary Database. mdb)	None	None	None	None (No)
32.	Number of support services personnel with bursaries	Support services personnel awarded part-time bursaries from the Provincial Department of Health for the current academic year. Support services include Human Resources and Finance.	Support services personnel with part-time bursaries	Support services personnel awarded part-time bursaries from the Provincial Department of Health for the current academic year. Support services include Human Resources and Finance.	Approved bursary applications (Part Time Bursary Database. mdb)	None	None	None	None (No)
Number of graduating bursars									
33.	Number of graduating nursing professional bursars	Nursing professionals with full-time bursaries from the Provincial Department of Health who graduated during the current academic year.	Nursing professionals with full-time bursaries who graduated	Nursing professionals with full-time bursaries from the Provincial Department of Health who graduated during the current academic year.	Proof of academic records (Full Time Bursary Database. mdb)	None	None	None	None (No)
34.	Number of graduating health professional bursars	Health professionals with full-time bursaries from the Provincial Department of Health who graduated during the current academic year. Health professionals are all health professionals excluding nursing professionals, e.g. medical officers, pharmacists, etc.	Health professionals with full-time bursaries who graduated	Health professionals with full-time bursaries from the Provincial Department of Health who graduated during the current academic year. Health professionals are all health professionals excluding nursing professionals, e.g. medical officers, pharmacists, etc.	Proof of academic records (Full Time Bursary Database. mdb)	None	None	None	None (No)
35.	Number of graduating other professional bursars	Other professional bursars with full-time bursaries from the Provincial Department of Health who graduated during the current academic year, e.g. clinical engineering.	Other professionals with full-time bursaries who graduated	Other professional bursars with full-time bursaries from the Provincial Department of Health who graduated during the current academic year, e.g. clinical engineering.	Proof of academic records (Full Time Bursary Database. mdb)	None	None	None	None (No)
36.	Number of graduating support services bursars	Support service bursars with part-time bursaries from the Provincial Department of Health who graduated during the current academic year. Support services include Human Resources and Finance.	Support services personnel with part-time bursaries who graduated	Support service bursars who graduated during the current academic year. Support services include Human Resources and Finance.	Proof of academic records (Full Time Bursary Database. mdb)	None	None	None	None (No)
6.4 Primary Health Care (PHC) iMOCOMP									

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
37.	Number of people trained through iMOCOMP	Number of people trained through iMOCOMP (Improvement of Competencies Programme) at district level.	Students trained through iMOCOMP	Number of people trained through iMOCOMP (Improvement of Competencies Programme) at district level.	Quarterly Training Report (Combined QTR.xls)	None	None	None	None (No)
6.5 Training and Development									
38.	Administrative levy payable to HWSETA in terms of skills development legislation	Administrative levy payable to the Health and Welfare Sector Education and Training Authority (HWSETA) in terms of the skills development legislation.	HWSETA payment	Administrative levy payable to the Health and Welfare Sector Education and Training Authority (HWSETA) in terms of the skills development legislation.	BAS	None	None	None	None (No)
39.	Number of Community Care Giver (CCG) learners	Number of community based health learners that are part of the Expanded Public Works Programme (EPWP).	CCG learners	Number of community based health learners that are part of the Expanded Public Works Programme (EPWP).	Registration form (EPWP Learners on Quarterly Basis.xls)	None	None	None	None (No)
40.	Number of graduating Community Care Givers (CCGs)	Number of community based health workers graduating from the Expanded Public Works Programme (EPWP).	CCG learners who graduated	Number of community based health workers graduating from the Expanded Public Works Programme (EPWP).	Training provider graduation list (EPWP Learners on Quarterly Basis.xls)	None	None	None	None (No)
41.	Number of data capturers interns	Number of data capturers graduating from the Expanded Public Works Programme (EPWP).	Data capturers who graduated	Number of data capturers graduating from the Expanded Public Works Programme (EPWP).	Training provider graduation list (EPWP Learners on Quarterly Basis.xls)	None	None	None	None (No)

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 7.1: Provincial objectives and performance indicators for Laundry services [SUP1]									
1.	Total number of pieces of linen laundered	The actual number of linen pieces processed or laundered by both in-house and outsourced laundries.	Items laundered in-house	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	Laundry linen count (Linen counting spreadsheet. xls)	None	None	None	None (No)
			Items laundered outsourced	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector.	Private contractor accounts (Linen counting spreadsheet. xls)				
2.	Number of pieces of linen laundered: in-house laundries	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	Items laundered in-house	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	Laundry linen count (Linen counting spreadsheet. xls)	None	None	None	None (No)
3.	Number of pieces of linen laundered: outsourced services	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector.	Items laundered outsourced	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector.	Private contractor accounts (Linen counting spreadsheet. xls)	None	None	None	None (No)
4.	Average cost per item laundered in in-house laundries	The average cost per linen item processed or laundered in-house at Tygerberg, Lentegeur and George Hospitals. The in-house laundry costs include the cost for electricity, water, coal, fuel, and salaries and wages. The expenditure on capital for buildings and equipment is excluded.	Expenditure on in-house laundries excluding capital	Expenditure on in-house laundries situated at Tygerberg, Lentegeur and George Hospitals. The expenditure on electricity, water, coal, fuel, and salaries and wages are included. The expenditure on condemning of linen and capital assets that are more than R5,000 are excluded.	BAS	Items laundered in-house	The actual number of linen pieces processed or laundered by large central in-house laundries located at Tygerberg, Lentegeur and George Hospitals.	Laundry linen count (Linen counting spreadsheet. xls)	1 (R)
5.	Average cost per item laundered in outsourced laundries	The average cost per linen item processed or laundered by outsourced laundries. The outsourced laundry costs include the cost of capital, profit and VAT (all of which are not included in the in-house cost).	Expenditure on outsourced laundry services	Expenditure on outsourced laundry services. The expenditure on capital, profit and VAT are included (all of which are excluded from the in-house laundry costs).	BAS	Items laundered outsourced	The actual number of linen pieces processed or laundered by outsourced laundries in the private sector.	Private contractor accounts (Linen counting spreadsheet. xls)	1 (R)
Table 7.3: Provincial objectives and performance indicators for Engineering services [SUP1]									
1.	Maintenance backlog as % of replacement value	Expenditure required for maintenance, repairs and renovations to provincial health hospital buildings and equipment to reach an accepted standard (i.e. NHRA 4 that promotes safety, efficiency and reliability) expressed as a percentage of the replacement cost for provincial health hospitals. The maintenance, repairs and renovations for PHC facilities are excluded.	Expenditure required for hospitals and equipment to reach maintenance standard	Expenditure required for maintenance, repairs and renovations to provincial health hospital buildings and equipment to reach an accepted standard (i.e. NHRA 4 that promotes safety, efficiency and reliability). The maintenance, repairs and renovations for PHC facilities are excluded.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for hospitals	The total cost in rand of entirely replacing the existing provincial health hospital infrastructure. Provincial health hospitals exclude private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
2.	Cost of utilities per bed	The average expenditure on utilities per useable bed in provincial health hospitals. Utilities include expenditure on electricity and water as based on municipal and Eskom accounts.	Expenditure on utilities	The average expenditure on utilities per useable bed in provincial health hospitals. Utilities include expenditure on electricity and water as based on municipal and Eskom accounts.	Municipal and Eskom accounts (LOGIS)	Useable beds in provincial health hospitals	Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger). Provincial health hospitals exclude private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals.	Hospital Throughput Form (SINJANI)	100 (%)
3.	Number of reportable incidents in terms of the Occupational Health and Safety Act	The number of reportable incidents related to safe working environments in terms of the Occupational Health and Safety Act. These incidents require an incident investigation and prevention plan.	Health and Safety incidents reported	The number of reportable incidents related to safe working environments in terms of the Occupational Health and Safety Act. These incidents require an incident investigation and prevention plan.	Health and Safety Incident Reports (HR incident report system.xls)	None	None	None	None (No)
4.	Number of maintenance jobs completed both in-house and outsourced	The number of jobs completed by clinical engineering or hospital engineering workshops as well as outside contractors. Jobs include repairs, renovations, upgrades, etc.	Maintenance jobs completed	The number of jobs completed by clinical engineering or hospital engineering workshops as well as outside contractors. Jobs include repairs, renovations, upgrades, etc.	Engineering workshop requisitions (Job card system.xls)	None	None	None	None (No)

Table 7.4: Provincial objectives and performance indicators for Forensic Pathology Services [SUP1]

1.	Percentage of Forensic Pathology Service posts filled according to Human Resource Plan	Percentage of Forensic Pathology Service posts filled according to organisational structure.	Number of Forensic Pathology Service filled posts	Number of filled Forensic Pathology Service posts including contract appointments.	PERSAL	Forensic Pathology Service staff establishment	Total number of Forensic Pathology Service posts as per organisational structure.	Forensic Pathology Service organogram	100 (%)
2.	Percentage of autopsies performed	Percentage of autopsies performed of the total number of forensic pathology cases.	Number of autopsies performed	Number of autopsies performed.	Monthly summary of Forensic Pathology Services (FPS software)	Total number of forensic pathology cases	Total number of forensic pathology cases.	Monthly summary of Forensic Pathology Services	100 (%)
3.	Average Forensic Pathology Service response time (From receipt of call to arrival on scene)	Average Forensic Pathology Service response time from receipt of call to arrival on scene.	Forensic Pathology Service response time per case	Forensic Pathology Service response time for each case from receipt of call to arrival on scene.	Index Register (FPS software)	Total number of forensic pathology cases	Total number of forensic pathology cases.	FPS system	1 (No)
4.	Percentage of Forensic Pathology Service personnel budget spent on training	Percentage of Forensic Pathology Service personnel expenditure spent on training. NOTE: The indicator name refers to the personnel budget, but it is actually the personnel expenditure that is being monitored. The indicator name will be corrected in future APP's.	Forensic Pathology Service expenditure on training	Forensic Pathology Service (i.e. sub-programme 7.4) expenditure on training. This includes training provider costs, accommodation and meals, travel and subsistence.	BAS	Forensic Pathology personnel expenditure (Total compensation of employee expenditure)	Personnel expenditure for Forensic Pathology Services. This consists of the total expenditure on compensation of employees.	BAS	100 (%)

Table 7.5: Provincial objectives and performance indicators for the MEDPAS trading account [SUP1]

1.	Working capital in the medicine trading account	The working capital available to support adequate stock-holding at the Cape Medical Depot.	Working capital for CMD	The working capital available to support adequate stock-holding at the Cape Medical Depot.	Cape Medical Depot Capital Account (MEDSAS)	None	None	None	None (R)
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PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
Table 8.6: Provincial objectives and performance indicators for health facilities management [HFM6]									
1.	Total infrastructure expenditure on community health facilities as a % of backlog (R300 million)	Infrastructure expenditure on community health facilities as a percentage of the estimated infrastructure backlog.	Expenditure on community health facility infrastructure	Expenditure on community health facility infrastructure, i.e. expenditure on sub-programme 8.1	BAS	Estimated infrastructure backlog = R300 million	Estimated cost of addressing the infrastructure backlog for community health facilities. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations.xls)	100 (%)
2.	Percentage of ambulance stations built for purpose (50 ambulance stations)	Ambulance stations with accommodation and facilities that are suitable for purpose as a percentage of the total number of ambulance stations.	Ambulance stations built for purpose at the beginning of the financial year	Ambulance stations with accommodation and facilities that are suitable for purpose at the beginning of the financial year.	EMS Infrastructure Plan	Ambulance stations = 50	Total number of ambulance stations.	EMS Infrastructure Plan	100 (%)
			Ambulance stations built for purpose during the reporting period.	Ambulance stations with accommodation and facilities that are suitable for purpose completed during the course of the financial year.	Public Works RPM (Rational Program Manager) database				
3.	Total infrastructure expenditure on district hospitals as a percentage of backlog (R2 billion)	Infrastructure expenditure on district hospitals as a percentage of the estimated infrastructure backlog.	Expenditure on district hospital infrastructure	Expenditure on district hospital infrastructure, i.e. total expenditure on sub-programme 8.3	BAS	Estimated infrastructure backlog = R2 billion	Estimated cost of addressing the infrastructure backlog for district hospitals. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations.xls)	100 (%)
4.	Total infrastructure expenditure on provincial hospitals as a percentage of backlog (R1,85 billion)	Infrastructure expenditure on provincial hospitals as a percentage of the estimated infrastructure backlog.	Expenditure on provincial hospital infrastructure	Expenditure on provincial hospital infrastructure, i.e. total expenditure on sub-programme 8.4	BAS	Estimated infrastructure backlog = R1,85 billion	Estimated cost of addressing the infrastructure backlog for provincial hospitals. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations.xls)	100 (%)
5.	Total infrastructure expenditure on central hospitals as a percentage of backlog (R1,4 billion)	Infrastructure expenditure on central hospitals as a % of the estimated infrastructure backlog.	Expenditure on central hospital infrastructure	Expenditure on central hospital infrastructure, i.e. total expenditure on sub-programme 8.5	BAS	Estimated infrastructure backlog = R1,4 billion	Estimated cost of addressing the infrastructure backlog for central hospitals. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations.xls)	100 (%)
Table 8.7: National Performance indicators for health facilities management [HFM7]									
1.	Equitable share capital programme as percentage of total health expenditure	Expenditure on buildings upgrade renovation and construction, including equipment and maintenance, from the provincial equitable share allocation (i.e. excluding conditional grants) as a percentage of total provincial health expenditure.	Expenditure on buildings upgrade renovation and construction	Expenditure on buildings upgrade renovation and construction, including equipment and maintenance, from the provincial equitable share allocation (i.e. excluding conditional grants). (i.e. BAS items 2415791, 2416791, 2418791, 2421791, 1906791, 1910791, 1911791, 2810791, 2848791)	BAS	Expenditure by provincial DoH	Total expenditure by the Provincial Department of Health.	BAS	100 (%)
2.	Hospitals funded on the Revitalisation programme percentage	Percentage of provincial health hospitals approved and funded by the hospital revitalisation grant from 2003.	Hospitals with funding from the Revitalisation Grant from 2003	Provincial health hospitals that have funding allocated in the Division of Revenue Act from 2003 onwards. Only include approved hospitals that received funding during the period 2003 until the current financial year.	HRP (Hospital Revitalisation Programme) IPIP (Initial Programme Implementation Plan)	Provincial health hospitals = 51	Number of provincial health hospitals. This excludes private hospitals and/or provincial aided hospitals but includes specialist, district, regional, tertiary and central hospitals. Khayelitsha Hospital situated at Tygerberg Hospital is excluded.	Facility list (Annexure to APP)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
3.	Expenditure on facility maintenance as percentage of total health expenditure	Expenditure on health buildings maintenance in the Province as a percentage of total provincial health expenditure.	Buildings maintenance expenditure	Expenditure on buildings maintenance in the Province. Only Programme 8 expenditure is included. (Specifically BAS items 2415791, 2416791, 2418791, 2421791, 1906791, 1910791, 1911791, 2848791, 10005791, 1845791, 1000679)	BAS	Expenditure by provincial DoH	Total expenditure by the Provincial Department of Health.	BAS	100 (%)
4.	Expenditure on equipment maintenance as percentage of total health expenditure	Expenditure on health equipment maintenance in the Province as a percentage of total provincial health expenditure.	Equipment maintenance expenditure	Expenditure on equipment maintenance in the Province. (Specifically BAS items 1845791, 2812791)	BAS	Expenditure by provincial DoH	Total expenditure by the Provincial Department of Health.	BAS	100 (%)
5.	Hospitals with up to date asset register	Reported in Programme 1.							
6.	Health districts with up to date PHC asset register (excluding hospitals)	Reported in Programme 1.							
7.	Fixed PHC facilities with access to piped water	Percentage of fixed PHC facilities that have access to piped water. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Fixed PHC facilities with access to piped water	Fixed PHC facilities with access to piped water. Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Infrastructure Plans	Fixed PHC facilities = 299	PHC facilities with permanent physical infrastructure. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Facility list (Annexure to APP)	100 (%)
8.	Fixed PHC facilities with access to mains electricity	Percentage of fixed clinics, visiting points and CHC's that have access to mains electricity. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Fixed PHC facilities with access to mains electricity	Fixed clinics with access to mains electricity. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Infrastructure Plans	Fixed PHC facilities = 299	PHC facilities with permanent physical infrastructure. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Facility list (Annexure to APP)	100 (%)
9.	Fixed PHC facilities with access to fixed line telephone	Percentage of fixed clinics and CHCs that have access to fixed line (land line or DEC) telephone. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Fixed PHC facilities with access to fixed line telephone	Fixed clinics with access to a fixed telephone line. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Infrastructure Plans	Fixed PHC facilities = 299	PHC facilities with permanent physical infrastructure. . Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Facility list (Annexure to APP)	100 (%)
10.	Average backlog of service platform in fixed PHC facilities	Expenditure required to bring all fixed provincial health facilities up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total replacement value of those facilities.	Expenditure for fixed PHC facilities to reach maintenance standard	Expenditure required to bring all fixed provincial health facilities up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all PHC facilities	The total cost in rand of entirely replacing the fixed PHC facility infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
11.	Average backlog of service platform in district hospitals	Expenditure required to bring district hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total replacement value of those facilities.	Expenditure for district hospitals to reach maintenance standard	Expenditure required to bring all fixed provincial district hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all district hospitals	The total cost in rand of entirely replacing the district hospital infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)
12.	Average backlog of service platform in regional hospitals	Expenditure required to bring regional hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total replacement value of those facilities.	Expenditure for regional hospitals to reach maintenance standard	Expenditure required to bring all fixed provincial regional hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all regional hospitals	The total cost in rand of entirely replacing the regional hospital infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)
13.	Average backlog of service platform in specialised hospitals (including TB & psychiatric hospitals)	Expenditure required to bring all provincial health psychiatric, TB, chronic and other specialist hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total replacement value of those facilities.	Expenditure for specialist hospitals to reach maintenance standard	Expenditure required to bring all provincial psychiatric, TB, chronic and other specialised hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all specialist hospitals	The total cost in rand of entirely replacing the provincial specialist hospital infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)
14.	Average backlog of service platform in tertiary and central hospitals	Expenditure required to bring all provincial tertiary and central hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a proportion of total replacement value of those facilities.	Expenditure for tertiary and central hospitals to reach maintenance standard	Expenditure required to bring all fixed provincial tertiary and central hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all tertiary and central hospitals	The total cost in rand of entirely replacing the provincial tertiary and central hospital infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)
15.	Average backlog of service platform in provincially aided hospitals	Expenditure required to bring all provincially aided hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose) as a percentage of total replacement value of those facilities.	Expenditure for aided hospitals to reach maintenance standard	Expenditure required to bring all provincially aided hospitals up to a standard requiring routine maintenance (NHFA condition 4 - that is all systems and components fully operational and fit for purpose). Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	Replacement cost for all provincially aided hospitals	The total cost in rand of entirely replacing the provincially aided hospital infrastructure. Estimate by Health Facilities Planners based on CSP and Infrastructure Plans.	Estimate by Health Facilities Planners (APP Facilities calculations. xls)	100 (%)
16.	Projects completed on time	Percentage of building upgrade or new projects of R1 million or more completed within the original contract period.	Projects of over R1 million value completed on time	Number of building upgrade or new projects of over R1 million value completed on time.	Information not available*	Projects of over R1 million in value	Number of building upgrade or new projects of over R1 million in value.	Information not available*	100 (%)

No	Measure / Indicator	Definition	Numerator/ (s)	Numerator definition	Numerator source	Denominator/ (s)	Denominator definition	De-nominator source	Factor (Type)
17.	Project budget over run	Contract expenditure increases on projects of R1 million or more expressed as a proportion of the original contract values.	Contract expenditure increase in all projects of over R1 million	The total rand value of contract expenditure increases in the period on all building projects of over R1 million in value.	Information not available*	Original contract value of all projects of over R1 million in value	The sum of the original contract values of all projects of over R1 million in value.	Information not available*	100 (%)
			Original contract value of all projects of over R1 million in value	The sum of the original contract values of all projects of over R1 million in value.	Information not available*				
18.	District hospital beds per 1000 uninsured population	Number of district hospital beds per 1000 uninsured persons in the Western Cape Province.	Useable beds in district hospitals	Useable beds in district hospitals. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	Uninsured population	Estimated uninsured population of the Western Cape Province, i.e. the proportion of the total provincial population who are dependant on the state for health services. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009 and % uninsured as reported in the APP	1,000 (No)
19.	Regional hospital beds per 1000 uninsured population	Number of regional hospital beds per 1000 uninsured persons in the Western Cape Province.	Useable beds in regional hospitals	Useable beds in regional hospitals. Usable beds are beds actually available for use within the facility (regardless of whether they are occupied by a patient or lodger).	Hospital Throughput Form (SINJANI)	Uninsured population	Estimated uninsured population of the Western Cape Province, i.e. the proportion of the total provincial population who are dependant on the state for health services. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009 and % uninsured as reported in the APP	1,000 (No)
20.	Population within 5km of fixed PHC facility	Percentage of the total population that has to travel no further than 5 kms to reach a fixed PHC facility. Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Provincial population within 5kms of a fixed PHC facility	Estimated population within 5kms of a fixed PHC facility. Fixed PHC facilities include clinics, CDC's and CHCs. Satellite clinics and mobiles are excluded.	Infrastructure plans	Total population	Total population of the Western Cape Province. The total population for the Province is an estimation based on the figures published in the 2007 Community Survey and Mid-year Estimates (from StatsSA).	Western Cape Department of Health Circular H5/2009	100 (%)

* The Health Department does not have the capacity to provide this information. It is planned to create the capacity as part of the IDIP process.

ANNEXURE B

LIST OF FACILITIES

LIST OF FIXED FACILITIES

1. PRIMARY HEALTH CARE FACILITIES

1.1 West Coast District

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
None	Citrusdal Clinic Clanwilliam Clinic Darling Clinic Diazville Clinic Graafwater Clinic Hanna Coetzee Clinic Klawer Clinic Laingville Clinic Lalie Cleophas Clinic Lamberts Bay CDC Langebaan Clinic Louvville Clinic Lutzville Clinic Moorreesburg CDC Piketberg Clinic Porterville Clinic Redelingshuys Clinic Riebeeck Kasteel Clinic Riebeeck West Clinic Saldanha Clinic Sandy Point Clinic Van Rhynsdorp Clinic Velddrif Clinic Vredenburg Clinic Vredendal North Clinic Wesbank (Malmesbury) Clinic	Abbotsdale Satellite Clinic Aurora Satellite Clinic Chatsworth Satellite Clinic Doringbaai/Strandfontein Satellite Clinic Ebenhaezer Satellite Clinic Eendekuil Satellite Clinic Elandsbaai Satellite Clinic Goedverwacht Satellite Clinic Kalbaskraal Satellite Clinic Kliprand Satellite Clinic Koekenaap Satellite Clinic Koringberg Satellite Clinic Malmesbury Satellite Clinic Molsvlei Satellite Clinic Nuwerus Satellite Clinic Paternoster Satellite Clinic Rietpoort Satellite Clinic Riverlands Satellite Clinic Stofkraal Satellite Clinic Vredenburg Satellite Clinic (Chempos) Vredendal Central Satellite Clinic Wittewater Satellite Clinic Yzerfontein Satellite Clinic	Citrusdal Mobile 1 Clanwilliam Mobile Darling Mobile Graafwater Mobile Hopefield Mobile Klawer Mobile Leipoldville Mobile Lutzville Mobile Malmesbury Mobile 1 Malmesbury Mobile 2 Moorreesburg Mobile Piketberg Mobile 1 Piketberg Mobile 2 Piketberg Mobile 5 Porterville Mobile Van Rhynsdorp Mobile Vredenburg Mobile Vredendal Mobile Wuppertal Mobile
0	26	23	19

1.2 Cape Winelands District

Community Health Centres (CHCs)	Clinics (continued)	Satellite Clinics	Mobiles
None Clinics Aan-het-Pad Clinic Annie Brown Clinic Bella Vista Clinic Bergsig Clinic Bird Street Clinic Bonnievale Main Street Clinic Breerivier Clinic Ceres Hospital PHC Clinic Cloetesville CDC Cogmanskloof Clinic Dalevale Clinic De Doorns Clinic Dirkie Uys Street Clinic Don and Pat Bilton Clinic Empilisweni (Worcester) Clinic Groendal Clinic Happy Valley Clinic Hospital Street Clinic Idas Valley Clinic JJ Du Pre Clinic Kayamandi Clinic Klapmuts Clinic Klein Drakenstein Clinic	Klein Nederburg Clinic Kylemore Clinic Mbekweni Clinic McGregor Clinic Montagu Clinic Nduli Clinic Newton Clinic Nieuwedrift Clinic Nkqubela Clinic Op die Berg Clinic Orchard Clinic Paarl TC Newman CDC Patriot Plein Clinic Phola Park Clinic Prince Alfred Hamlet Clinic Rawsonville Clinic Sandhills Clinic Saron Clinic Simondium Clinic Soetendal/Hermon Clinic Touws River Clinic Tulbagh Clinic Victoria Street Clinic Wellington Clinic Windmeul Clinic Wolseley Clinic Worcester CDC Zolani Clinic	De Wet Satellite Clinic Gouda Satellite Clinic Hexberg Satellite Clinic Maria Pieterse Satellite Clinic Overhex Satellite Clinic Rhodes Fruit Farm Satellite Clinic Somerset Street Satellite Clinic Stellenbosch Student Health Satellite Clinic Non-medical Sites Agape (Paarl) Non-medical Site Breede River/Winelands Non-medical Site Breede Valley Non-medical Site Corobric Non-medical Site Witzenberg Non-medical Site	Bonnievale Mobile Bossieveld Mobile Botha/Brandwacht Mobile Dal / E de Waal Mobile Devon Valley Mobile Franschhoek Mobile Groot Drakenstein Mobile Karoo Mobile Koelenhof Mobile Koue Bokkeveld Mobile Montagu Mobile 1 Montagu Mobile 2 Robertson Mobile 1 Robertson Mobile 2 Skurweberg Mobile Slanghoek Mobile Strand Road Mobile Tulbagh Mobile Warm Bokkeveld Mobile Wolseley Mobile
23	28	8 + 5	20

1.3 Overberg District

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
None	Barrydale Clinic Botrivier Clinic Bredasdorp Clinic Buffeljagsrivier Clinic Caledon Clinic Gansbaai Clinic Genadendal Clinic Grabouw CDC Greyton Clinic Hawston Clinic Hermanus Clinic Hermanus Hospital PHC Clinic Kleinmond Clinic Mount Pleasant Clinic Napier Clinic Railton Clinic Riviersonderend Clinic Stanford Clinic Suurbraak Clinic Swellendam Hospital PHC Clinic Willa Clinic Zwelihle Clinic	Baardskeerdersbos Satellite Clinic Bereaville Satellite Clinic Betty's Bay Satellite Clinic Elim Satellite Clinic Malgas Satellite Clinic Onrus Satellite Clinic Pearly Beach Satellite Clinic Prottem Satellite Clinic Struisbaai Satellite Clinic Voorstekraal Satellite Clinic Waenhuiskrans Satellite Clinic	Barrydale Mobile 3 Bredasdorp Mobile 1 Bredasdorp Mobile 2 Caledon Mobile 1 Caledon Mobile 2 Caledon Mobile 3 Caledon/Hermanus/Stanford Mobile 4 Grabouw Mobile 1 Grabouw Mobile 2 Grabouw Mobile 3 Ruens Mobile 5 Swellendam Mobile 4 Villiersdorp Mobile 1 Villiersdorp Mobile 2
0	22	11	14

1.4 Eden District

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Alma CHC Bridgeton CHC Convulle CHC Plettenberg Bay CHC Thembalethu CHC	Albertinia Clinic Blanco Clinic Bongoletu Clinic Calitzdorp (Bergsig) Clinic Craggs Clinic D'Almeida Clinic De Rust (Blommenek) Clinic Dysselsdorp Clinic Eyethu Clinic George ARV Clinic George Civic Centre Clinic Great Brak River Clinic Heidelberg Clinic Hornlee Clinic Khayelethu Clinic Knysna Town Clinic Kranshoek Clinic Kwanokathula Clinic Ladismith (Nissenville) Clinic Lawaaikamp Clinic New Horizon Clinic Pacaltsdorp Clinic Parkdene Clinic Regent Street Clinic Riversdale Clinic Rosemoor Clinic Toekomsrus Clinic Uniondale (Lyonsville) Clinic Wit Lokasie Clinic Zoar Clinic	Brandwacht Satellite Clinic Friemersheim Satellite Clinic George Road Satellite Clinic Haarlem Satellite Clinic Hartenbos Satellite Clinic Herbertsdale Satellite Clinic Herold Satellite Clinic and Mobile Keurhoek Satellite Clinic Sedgefield Satellite Clinic Slangrivier Satellite Clinic Still Bay Satellite Clinic Touwsrante Satellite Clinic Van Wyksdorp Satellite Clinic Wittedrif Satellite Clinic Non-medical Sites Bitou Non-medical Site Hessequa Non-medical Site	Albertinia Mobile Calitzdorp Mobile Dana Bay Mobile De Rust Mobile Diepkloof and Geelhoutboom Mobile Haarlem Mobile Heidelberg Mobile Keurhoek Mobile Knysna District Municipality Mobile Kraabos Mobile Ladismith Mobile Mossel Bay Mobile 1 Mossel Bay Mobile 2 Mossel Bay Mobile 4 Mossel Bay Municipality Mobile Oudtshoorn Mobile 1 Oudtshoorn Mobile 3 Plettenberg Bay Mobile Riversdale Mobile Sedgefield Mobile Uniondale Mobile Van Wyksdorp Mobile Wilderness Mobile
5	30	16	23

1.5 Central Karoo District

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Beaufort West Hospital CHC	Beaufort West Constitution Street Clinic Kwamandlenkosi Clinic Laingsburg Clinic Murraysburg Clinic Nieuvelpark Clinic Prince Albert Municipality Clinic	Klaarstroom Satellite Clinic Leeu-Gamka Satellite Clinic and Mobile Matjiesfontein Satellite Clinic Merweville Satellite Clinic Nelspoort Satellite Clinic and Mobile	Beaufort West Mobile 1 Beaufort West Mobile 2 Laingsburg Mobile Merweville Mobile Murraysburg Mobile Prince Albert Mobile
1	6	5	6

1.6 Cape Town District

1.6.1 Eastern and Khayelitsha Sub-districts

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Boland Bank CHC Gustrouw CHC Khayelitsha (Site B) CHC Kleinvele CHC Macassar CHC Mfuleni CHC Michael Mapongwana CHC Nolungile CHC Midwife Obstetric Unit Khayelitsha (Site B) MOU Macassar MOU Michael Mapongwana MOU	Blue Downs Clinic Fagan Street Clinic Gordon's Bay Clinic Hillcrest (Kuils River) Clinic Ikwezi Clinic Khayelitsha (Site B) Clinic Khayelitsha Male Clinic Kleinvele Clinic Kuilsriver (Carinus Street) Clinic Kuyasa Clinic Luvuyo Clinic Macassar Clinic Matthew Goniwe Clinic Mayenzeke Clinic Mfuleni Clinic Nolungile Clinic Russel's Rest Clinic Sarepta Clinic Sir Lowry's Pass Clinic Site B Youth Clinic Site C Youth Clinic Somerset West Clinic Town 2 Clinic Wesbank (Oostenberg) Clinic Zakhele Clinic	Driftsands Satellite Clinic	Macassar Mobile
8 + 3	25	1	1

1.6.2 Klipfontein and Mitchells Plain Sub-districts

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Brown's Farm (Imzame Zabantu) CHC Crossroads CHC Dr Abdurahman CHC Guguletu CHC Hanover Park CHC Heideveld CHC Mitchells Plain CHC Nyanga CHC Midwife Obstetric Unit Guguletu MOU Hanover Park MOU Mitchells Plain MOU	Crossroads 1 Clinic Crossroads 2 Clinic Eastridge Clinic Guguletu Clinic Hanover Park Clinic Hazendal Clinic Heideveld Clinic Honeyside Clinic Lansdowne Clinic Lentegeur Clinic Manenberg Clinic Masincedane Clinic Mzamomhle Clinic Newfields Estate Clinic Nyanga Clinic Phumlani Clinic Rocklands Clinic Silvertown Clinic Tafelsig Clinic Vuyani Clinic Weltevreden Valley Clinic Westridge Clinic	Mandalay Satellite Clinic	
8 + 3	22	1	0

1.6.3 Northern and Tygerberg Sub-districts

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Bellville South CHC Bishop Lavis CHC Delft CHC Dirkie Uys CHC Durbanville CHC Kraaifontein CHC Elsies River CHC Parow CHC Ravensmead CHC Reed Street CHC Ruyterwacht CHC Scottsdene CHC St Vincent CHC Midwife Obstetric Unit Bishop Lavis MOU Elsies River MOU Kraaifontein MOU	Adriaanse Clinic Bishop Lavis Clinic Bloekompos Clinic Bothasig Clinic Brackenfell Clinic Brighton Clinic Chestnut Clinic Delft South Clinic Dirkie Uys Clinic Durbanville Clinic Elsies River Clinic Groenvallei Clinic Harmonie Clinic Kasselsvlei Clinic Leonsdale Clinic Matroosfontein Clinic Netreg Clinic Northpine Clinic Parow Clinic Ravensmead Clinic Scottsdene Clinic St Vincent Clinic Uitsig Clinic Valhalla Park Clinic Wallacedene Clinic		Oostenberg Mobile
13 + 3	25	0	1

1.6.4 Southern and Western Sub-districts

Community Health Centres (CHCs)	Clinics	Satellite Clinics	Mobiles
Good Hope CHC Grassy Park CHC Green Point CHC Hout Bay Harbour CHC Kensington CHC Lady Michaelis CHC Lotus River CHC Maitland CHC Mamre CHC Retreat CHC Robbie Nurock CHC Vanguard CHC Woodstock CHC Midwife Obstetric Unit Retreat MOU Vanguard MOU	Albow Gardens Clinic Alphen Clinic Chapel Street Clinic Civic Centre Clinic Claremont Clinic Diep River Clinic Du Noon Clinic Facticeon Clinic Fish Hoek Clinic Grassy Park Civic Centre Clinic Green Point Clinic Hout Bay Main Road Clinic Kensington Clinic Klip Road Clinic Langa Clinic Lavender Hill Clinic Lotus River Clinic Maitland Clinic Masiphumelele Clinic Melkbosstrand Clinic Muizenberg Clinic Ocean View Clinic Parkwood Clinic Philippi Clinic Protea Park Clinic Retreat Clinic Saxon Sea Clinic Seawind Clinic Spencer Road Clinic Strandfontein Clinic Table View Clinic Westlake Clinic Wynberg Clinic	Pelican Park Satellite Clinic Simon's Town Satellite Clinic Pella Satellite Clinic Pinelands Satellite Clinic Schotscheskloof Satellite Clinic	Redhill Mobile Melkbosstrand Mobile Witsand Mobile
13 + 2	33	5	3

2. HOSPITALS

2.1 Acute hospitals

Hospital type	West Coast	Cape Winelands	Overberg	Eden	Central Karoo	Metro	Total
District	Citrusdal Clanwilliam LAPA Munnik Swartland Vredenburg Vredendal Radie Kotze (PAH)	Ceres Montagu Robertson Stellenbosch	Caledon Hermanus Otto du Plessis Swellendam	Knysna Ladismith (Alan Blyth) Mossel Bay Oudtshoorn Riversdale Uniondale	Beaufort West Laingsburg Murraysburg Prince Albert	Eerste Rivier False Bay GF Jooste Helderberg Karl Bremer Khayelitsha Mitchells Plain Victoria Wesfleur	
Total	6 + 1	4	4	6	4	9	34
Regional	-	Paarl Worcester	-	George	-	Mowbray Maternity Somerset	
Total	0	2	0	1	0	2	5
Tuberculosis	Malmesbury ID	Brewelskloof Sonstraal	-	Harry Comay	-	Brooklyn Chest DP Marais	
Total	1	2	0	1	0	2	6
Psychiatric	-	-	-	-	-	Alexandra Lentegeur Stikland Valkenberg	
Total	0	0	0	0	0	4	4
Rehabilitation	-	-	-	-	-	Western Cape Rehab Centre	
Total	0	0	0	0	0	1	1
Central	-	-	-	-	-	Groote Schuur Red Cross War Memorial Children's Hospital Tygerberg	
Total	0	0	0	0	0	3	3

2.2 Palliative, sub-acute and chronic care

Type	West Coast	Cape Winelands	Overberg	Eden	Central Karoo	Metro	Total
Palliative	Siyabonga	Boland Hospice Braam Care Luthando Stellenbosch Hospice	-	Bethesda Knysna Hospice	Beaufort West Hospice	St Luke's Hospice Bapumelele Eagle's Rest Elsies Special Lifecare Helderberg Hospice Ithembalabantu Living Hope Tembacare	
	1	4	0	2	1	8	16
Sub-acute	-	-	-	-	-	Booth Memorial Sarah Fox	
	0	0	0	0	0	2	2
Chronic	-	-	-	-	Nelspoort	St Joseph's Home Conradie Care Centre	
	0	0	0	0	1	2	2
Other specialised	-	-	-	-	-	Maitland Cottage	
	0	0	0	0	0	1	1

ABBREVIATIONS

A4R	Accountability for reasonableness
ACT	Assertive community teams
ACVV	Afrikaanse Christelike Vroue Vereniging
ACSM	Advocacy, Communication and Social Mobilisation
AEA	Ambulance emergency assistant, same as Intermediate life support (ILS)
AECL(M)P	Acute emergency case load (management) policy
AIDS	Acquired immune deficiency syndrome
ALS	Advanced life support
AMS	Air Mercy Service
ANC	Antenatal clinic
ANHP	Annual National Health Plan
APD	Association for the Physically Disabled
APH	Associated psychiatric hospitals
APP	Annual performance plan
ART	Antiretroviral treatment
ARV	Antiretroviral
ASPIP	Anaesthetic and surgical problem identification program
ASSA	Actuarial Society of South Africa
BAA	Basic ambulance assistant
BANC	Basic antenatal care
BAS	Basic Accounting System
BFHI	Baby friendly hospital initiative
BLS	Basic life support
BMI	Body mass index
BMT	Bed management team
BoD	Burden of disease
C-AMP	Custodian asset management plan
CAD	Computer aided dispatch
CBS	Community-based services
CCA	Critical care assistant
CCG	Community care giver
CD	Chief Director
CD4	Cluster of Differentiation 4 (lymphocyte)
CDC	Community day centre
CDM	Chronic disease management
CDU	Chronic dispensing unit
CEO	Chief executive officer
CHC	Community health centre
CHIP /CHPIP	Child health problem identification program
CHP	Comprehensive health programme
CHW	Community health worker
CMD	Cape medical depot / Central Medicine Depot
CME	Continuous medical training
COB	Code of behaviour
COHSP	Comprehensive oral health service plan

COO	Chief operating officer
CPAP	Continuous positive airway pressure
CPD	Continuing professional development
CPIX	Consumer price index
CPUT	Cape Peninsula University of Technology
CSIR	Council for Scientific and Industrial Research
CSP	Comprehensive Service Plan
CSSD	Central Sterile Supply Department
CT	Computed tomography
D	Director
DDG	Deputy Director General
DHIS	District health information system
DHS	District health system
DNA	Deoxyribonucleic acid
DMC	Disaster management centre
DMFT	Decayed, missing and filled teeth
DoH	Department of Health
DORA	Division of Revenue Act
DOT	Directly observed treatment
DOTS	Directly observed treatment short course
DPSA	Department of Public Service and Administration
DPT-Hib	Diphtheria, Pertussis, Tetanus and Haemophilus influenza type B
DTPW	Department of Transport and Public Works
EAP	Employee assistance programme
ECC	Early childhood caries
ECG	Electrocardiogram
ECT	Emergency care technician
EH	Environmental health
EMC	Emergency medical care
EMS	Emergency medical services
EN	Enrolled nurse
ENA	Enrolled nursing auxiliary
ENNDR	Early neonatal death rate
ENT	Ear, nose and throat
EPI	Expanded programme on immunisation
EPWP	Expanded public works programme
ESMOE	Essential steps in the management of obstetric emergencies
EU	European Union
FARR	Foundation of Alcohol Related Research
FAS	Fetal alcohol syndrome
FBO	Faith-based organisations
FIFA	Fédération Internationale de Football
FIND	Foundation for Innovative New Diagnostics
FMC	Financial management committee
FP	Forensic pathologist
FPL	Forensic pathology laboratory
FPS	Forensic pathology services

FTE	Full time equivalent
GDP-R	Gross domestic product (rand)
GEMC	P152
GIAMA	Government Immovable Asset Management Act
GSB	Graduate School of Business
GSH	Groote Schuur Hospital
HAIN	P104
HAST	HIV and AIDS, STI and Tuberculosis
HBC	Home-based care
HCBC	Home community based services
HCDS	Human capital development strategy
HCW	Health care worker
HEI	Institutes of higher education
HH	Helderberg Hospital
HHCC	Household community component
HIS	Hospital Information System
HIV	Human immunodeficiency virus
HLP	Health leadership programme
HPCSA	Health Professions Council of South Africa
HPSP	Health promoting schools programme
HPTDG / HPT & D grant	Health professions training and development grant
HR	Human resources
HRD	Human resource development
HRDS	Human resource development strategy
HRP	Hospital revitalisation programme
HRP	Human Resource Plan
HSRC	Human Science Research Council
HSS	Human settlement strategy
HT	Pr8
HTA	Health technical assistant
HWSETA	Health and Welfare Sector Education and Training Authority
IAR	Immovable asset register
ICD10	International classification of disease coding
ICF	International classification of functioning, disability and health
ICU	Intensive care unit
ID	Infectious diseases
IDP	Part A
IDIP	Infrastructure delivery improvement programme
IDS	Intellectual disability service
IEC	P108
ILRP	Integrated law reform project
ILS	Intermediate life support
IMC	Part A
IMCI	Integrated management childhood illness
IMOCOMP	Improvement and maintenance of competence project
IMR	Infant mortality rate
INP	Integrated nutrition programme

IPC	Infection prevention and control
IPG	Pr8
IT	Information technology
JAC	Pr4, 5.2.2.4
KBH	Karl Bremer Hospital
KDH	Khayelitsha District Hospital
KMC	Kangaroo mother care
KPA	Key performance area
KTU	Knowledge translation unit
L1	Level 1
L2	Level 2
L3	Level 3
LA	Local authority
LAN	Local area network
LETZ	Loop excision of transitional zone
LOGIS	Logistic Information Management System
LRTI	Lower respiratory tract infection
MAP	Metro anaesthetics plan
MDG	Millennium development goal
MDHS	Metro District Health Services
MDR	Multi-drug resistant
MDT	Mobile data terminal
MEDS	Micro-economic development strategy
MHCU	Mental health care user
MHS	Municipal health services
MISS	Minimum information security standards
MMF	Maintenance management framework
MMH	Mowbray Maternity Hospital
MMR	Maternal mortality rate
MO	Medical officer
MOUs	Midwife obstetric units
MRC	Medical Research Council
MRI	Magnetic resonance imaging
MTEC	Medium-term expenditure committee
MTEF	Medium-term expenditure framework
MTS	Modernisation of tertiary services
NCCEMD	National Committee on Confidential Enquiry into Maternal Deaths
N.Dip	National diploma
NEPAD	New Partnership for Africa's Development
NHLS	National Health Laboratory Services
NHS	National health system
NIMSS	National injury mortality surveillance system
NPO	Non-profit organisation
NQF	National Qualifications Framework
NSP	National Strategic Plan
NTSG	National tertiary services grant
NVP	Nevirapine

OD	Organisation development
ODI	Organisational development investigation
OHC	Oral health centre
OHTP	Oral health teaching platform
OMT	Operational management team
OPC	Orthotic and Prosthetic Centre
OPD	Out-patient department
OSD	Occupational specific dispensation
P1	Priority 1
PACS	Picture archiving and communication system
PALS	Patient advice and liaison services
PALSA	Practical approach to lung health in South Africa
PCC	Provincial Coding Committee
PDE	Patient day equivalent
PEP	Post-exposure prophylaxis
PERSAL	Personnel Salary and Administration System
PGDS	Provincial growth and development strategy
PGWC	Provincial Government Western Cape
PHC	Primary health care
PHCIS	Primary Health Care Information System
PIDAC	Provincial Inter-Departmental AIDS Committee
PIG	Provincial infrastructure grant
PILIR	Policy and procedure on incapacity leave and ill-health
PMDS	Performance management development system
PMTCT	Prevention of mother-to-child transmission
PN	Professional nurse
PPASA	Planned Parenthood Association of South Africa
PPHC	Personal primary health care
PPI	Public-private interaction
PIIP	Perinatal problem identification programme
PPP	Public-private partnership
PPT	Planned patient transport
PSCBC	Public Service Co-ordinating Bargaining Council
PSDF	Provincial spatial development strategy
PSETA	Public Service Education and Training Authority
PSR	Public service regulations
PTB	Pulmonary tuberculosis
PTSD	Post traumatic stress disorder
QA	Quality assurance
RAF	Road Accident Fund
RCCH	Red Cross Children's Hospital
RCWMCH	Red Cross War Memorial Children's Hospital
RED	Reach every district
RHC	Reproductive Health Clinic
RIS	Regional information system
RMR	Routine monthly report / routine monitoring record
RTHC	Road to health card/chart

RWOPS	Remunerative work outside the public service
SA	South Africa
SACLA	South African Computer Lecturer's Association
SADC	South African Development Community
SADHS	South African Demographic and Health Survey
SANC	South African Nursing Council
SAPS	South African Police Service
SATS	South African Triage System
SATV	South African television
SCFS	Social capital formation strategy
SCM	Supply chain management
SDIP	Sustainable development implementation plan
SETA	Sector Education and Training
SHI	Social health insurance
SIP	Strategic infrastructure plan
SITA	State Information Technology Agency
SM	Saving mothers
SMT	Strategic management team
SOPA	State of the province address
SOPs	Standard operating procedures
SSS	Scarce skills strategy
STI	Sexually transmitted infections
STRETCH	Streamlining Tasks and Roles to Expand Treatment and Care for HIV
TB	Tuberculosis
TBH	Tygerberg Hospital
Td	Tetanus and Diphtheria
TOP	Termination of pregnancy
TV	Television
U-AMP	User asset management plan
U5MR	Under 5 mortality rate
UCT	University of Cape Town
UK	United Kingdom
UNICEF	United Nations Children's Fund
UPFS	Uniform patient fee schedule
USAID	United Nations Aid Agency
UV	Ultra-violet
UWC	University of the Western Cape
VAT	Value added tax
VCT	Voluntary counselling and testing
WC	Western Cape
WCCN	Western Cape College of Nursing
WCDH	Western Cape Department of Health
WCRC	Western Cape Rehabilitation Centre
WHO	World Health Organisation
WSP	Workplace skills plan
XDR	Extreme drug resistant
YLL	Years of Life Lost

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Contact Details

Department of Health
Western Cape
P.O. Box 2060
Cape Town, 8000

Room 20-08, 4 Dorp Street, Cape Town

Tel: 021 483 3245
Fax: 021 483 6169

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