PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

AIM: To render a general and specialised hospital service.

SUB-PROGRAMME 4.1 GENERAL HOSPITALS: REGIONAL

AIM: delivery of hospital services on a population needs- based model which delivers accessible, appropriate, effective general specialist services, as well as a platform for training of health workers and research.

Situation analysis

Historically based inequities have caused disparities in the location of health facilities within the Province. Specialist services have been concentrated in the Metropole with a concomitant shortage of these services in the rural and peri-urban areas. In the Metropole the high number of Level 3 (highly specialised services) has caused a shortage in the number of Level 1 in-patient facilities. This effect is exacerbated by the high degree of fragmentation of the L2 (Regional Specialist services). Nowhere in the Metropole are the L2 services consolidated, but instead they are dotted around the Peninsula, often in inappropriate facilities. The problem is further compounded by the fact that many of what should be District (or L1) beds are funded and run as L2 beds, often at great cost to the Department.

In the Rural areas the problem is made worse by the fact that in the sub-districts, where the Regional Hospitals have been created, the Regional Hospital has insufficient beds to function as a facility providing specialised (L2) as well as District Hospital (L1) services. As in most of the country, the service is further hamstrung by a chronic shortage of trained specialists, as well as trained nursing personnel. Financial constraints in the Public Sector have led to the deterioration in the physical condition of the Hospitals .

Table: Current and expected values of key General Hospital indicators

2002/3 real terms	2010	2000/01	2001/02	2002/03	2003/04
Budget	824,356,362	598,913,106	596,906,658	603,856,000	581,346,008
Cost per PDE	891	629.82	705.73	720	738
Bed Occ	0.85	0.929	0.85	0.85	0.87
ALOS	4.22	5.13	4.45	4.4	4.3
Beds	2,230	2,036	2,136	2,136	2,136
OutPat/Inpat day	1.01	1.13	0.83	0.80	0.48
Outpatients	700,942	781,650	549,336	528,545	328,861
Inpatient Days	691,858	690,377	662,694	662,694	678,287
PDE's	925,505	950,927	845,806	838,876	787,907
Admissions	163,947	134,576	148,820	150,612	157,741

Table: Analysis of current composite staffing profile of General Hospitals: 2002/03*

Functional Category	Filled Posts	% of Total Staff	% of Total Salaries
ADMIN	464	11.4%	10.0%
DOMEST.SERV	1041	25.5%	12.8%
HEALTH MANAGERS	19	0.5%	1.4%
HEALTH TECHNICIANS	0	0.0%	0.0%
LIFE SCIENCES	7	0.2%	0.5%
MAINTENANCE WORKERS	2	0.0%	0.1%
Junior MO	61	1.5%	
MO	170	4.2%	
Registrars	7	0.2%	
Specialists	49	1.2%	
MEDICAL PROFESSIONALS	287	7.0%	18.0%
NATURAL SCIENCES	0	0.0%	0.0%
Prof Nurse	773	19.0%	26.4%
Staff Nurse	427	10.5%	9.6%
Assistants	730	17.9%	12.7%
NURSING	1930	47.3%	48.8%
OPERATORS	54	1.3%	0.8%
SEN MANAGERS	0	0.0%	0.0%
SOCIAL SCIENCES	18	0.4%	0.7%
THERAPISTS	198	4.9%	5.0%
TRADE WORKERS	26	0.6%	0.8%
TOTAL	4078	100.0%	100.0%

*Excluding Provincial Aided Hospitals

**See Annexure A for details of posts in each functional category

Policies, priorities and broad strategic objectives

- Healthcare 2010 forms the cornerstone for the Department's development over the next eight years.
- It essentially calls for the upgrading and expansion of Level 2 services so that 8% of all contacts within W. Cape health care system are managed at the Regional (or L2) Hospitals.
- Strengthening of the Rural Regional Hospitals in order to avoid inappropriate referrals to the Tertiary level and to render support to District Health Services.
- New and acute challenges like the HIV pandemic and the shifting disease profile have necessitated the manner in which health service planning is conducted. In order to deal with both HIV/AIDS pandemic, as well as the massive health burden brought about by trauma, significant emphasis also has to be given to preventive and promotive strategies. With resources being both finite and limited, this inevitably also impinges on service provision in the Hospitals. If successful, these strategies can have a positive outcome for the Health Service as a whole and the Hospital services in particular.

Constraints and measures planned to overcome them

Human Resource Constraints: relocation of staff within the Department so that staff deployment is congruent with the needs of the clients. *Infrastructural shortcomings:* including both the maintenance and upgrading of facilities have

led to backlogs in the maintenance and upgrading of buildings. All rural Regional Hospitals have been earmarked for funding by the Hospitals Revitalization Programme, for which the National Department of Health is providing separate funding through a conditional grant.
To alleviate the financial pressures, various strategies will be implemented, *inter alia* through revenue generation projects, public-private partnerships and outsourcing of non-core activities where appropriate. All these projects will aim at reducing the hospitals' net cost.
In order to achieve the stated objectives, a Human Resource Management plan is being developed in order to facilitate the optimal staffing.

Planned quality improvement measures
The provision of adequately trained clinical personnel, in particular specialised nurses, as well as medical specialists.
General improvements in the Hospital environments are to be achieved through the Revitalization Programme. These will in turn impact positively on the working conditions, which in turn will positively promote staff attitudes towards their work and their patients.
Quality Improvement programmes as well as Clinical Audits are currently being piloted in the District as well as Regional Hospitals.
The Facilities Boards Bill makes provision for the creation of community-based Hospital Boards that will be more representative of the communities they serve. These Boards will also give communities a greater share of ownership in the overall strategic direction of the facilities.

Table: Performance indicators for General Hospitals

Indicator	Province wide value	Hospital range	National target
Input			
1. Expenditure on hospital staff as percentage of total hospital expenditure (Excluding transfer payments)	72.8%		
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	9.4%		
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	1.9%		
4. Useable beds per 1000 people*	.48		
5. Useable beds per 1000 uninsured people*	.67		
6. Hospital expenditure per person*	142		
7. Hospital expenditure per uninsured person*	197		
Process			
8. Percentage of hospitals with operational hospital board	90%		
9. Percentage of hospitals with appointed (not acting) CEO in place	82%		
10. Percentage of hospitals with business plan agreed with provincial health department	100%		
11. Percentage of hospitals with up to date asset register	65%		
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level			
Output			
13. Separations per 1000 people*	31.9		
14. Separations per 1000 uninsured people*	44.4		
15. Patient day equivalents per 1000 people*	226		
16. Patient day equivalents per 1000 uninsured people*	313		
17. Patient fee income per separation			
Quality			
18. Percentage of hospitals in facility audit condition 4 or 5	50%		
19. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	0%		
20. Percentage of hospitals with designated official responsible for coordinating quality management	20%		
21. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	40%		
Efficiency			
22. Average length of stay	5.13		
23. Bed utilisation rate (based on useable beds)	93%		
24. Expenditure per patient day equivalent	629.82		
Outcome			
25. Case fatality rate for surgery separations	✓	✓	

* Not to be filled in for individual central hospitals.

PROGRAMME 4.1: EVOLUTION OF GENERAL HOSPITAL PERFORMANCE INDICATORS

Amounts in 2002/03 real terms

OBJECTIVE	INDICATOR	SPS TARGET 2010	Expenditure 2000/01	Expenditure 2001/02	Adjustment Budget 2002/03	Original Budget 2003/04	Budget Estimate 2004/05	Budget Estimate 2005/06
INPUT								
Provide sufficient funds for non- Personnel expenditure	Expenditure on staff as % of total expenditure (Excluding transfer paym)	66.92%	72.8%	72.6%	72.9%	72.6%	72.0%	70.0%
	Expenditure on drugs as % of total expenditure	9.3%	9.4%	9.90%	9.80%	9.8%	9.7%	9.7%
	Expenditure on maintenance as % total expenditure	5.86%	1.9%	0.9%	1%	0.9%	1.0%	1.5%
Provide Regional hospital Infrastructure in line with SPS	Useable beds per 1000 total population	0.49	0.48	0.50	0.50	0.49	0.49	0.48
	Useable beds per 1000 uninsured population	0.68	0.67	0.70	0.69	0.68	0.68	0.67
Provide sufficient funding to ensure an efficient regional hospital Service	Hospital expenditure per capita (total population)	181	142	140	140	134	135	136
	Hospital expenditure per capita (uninsured population)	252	197	195	195	186	188	189
Provide services that adequately address the needs of patients	Outpatients per inpatient day ratio	1.01	1.13	0.83	0.80	0.48	0.53	0.47
Increase specialist services in Regional Hospitals	Percentage specialist services in Regional Hospitals	80%	65%	65%	65%	70%	70%	70%
PROCESS								
Facilitate representative Management	Percentage of hospitals with operational hospital board	100%	90%	90%	90%	100%	100%	100%

Facilitate decentralised Management and Accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	82%	82%	86%	86%	100%	100%
	Percentage of hospitals with business plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%
	Percentage of hospitals with up to date asset register	100%	65%	65%	65%	80%	90%	100%
OUTPUT								
Ensure accessible regional	Separations per 1000 total population	36.0	31.9	34.9	35.0	36.3	36.0	35.7
Hospital services to the	Separations per 1000 uninsured population	50.0	44.4	48.5	48.6	50.4	50.0	49.5
Population of the western Cape	Patient day equivalents per 1000 total population	203	226	199	195	181	178	173
	Patient day equivalents per 1000 uninsured population	282	313	276	271	252	247	241
QUALITY								
Ensure adequate infrastructure	Percentage of hospitals in facility audit condition 4 or 5	100%	50%	50%	50%	60%	70%	70%
Ensure quality patient care	Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	100%	0%	11%	0%	36%	100%	100%
	Percentage of hospitals with designated official responsible for co-ordinating quality management	100%	20%	20%	30%	100%	100%	100%
	Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%	40%	40%	50%	85%	100%	100%
EFFICIENCY								
Ensure efficient and cost effective utilisation of resources	Average length of stay	4.2	5.13	4.45	4.40	4.30	4.20	4.20
	Bed utilisation: based on useable beds	85%	93%	85%	85%	87%	85%	85%

	Expenditure per patient day equivalent	890.71	629.82	705.73	719.84	737.84	759.97	782.77
	Expenditure per patient day equivalent on drugs	83.00	59.00	69.87	70.54	72.31	73.72	75.93
	Cost of non-clinical services as % of total expenditure Administration Excluded. Out sourced services: Laundries & Security	16.85%	17.5%	17.1%	17.0%	16.9%	16.9%	16.9%

Table: Evolution of expenditure by budget sub-programme in current prices (R million)[1]

Sub-programme:4.1	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
General Hospitals	530,160	562,059	603,856	611,576	644,500	671,457
Total programme	**855,444**	**909,382**	**966,546**	**999,067**	**1,052,851**	**1,096,888**

Table: Evolution of expenditure of budget sub-programme in constant 2002/03 prices (R million)[1]

Expenditure: Prog 4.1	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	**966,381**	**965,764**	**966,546**	**0.01%**	**951,967**
Total per person[4]	142.16	140.09	140.20	-0.7%	133.80
Total per uninsured person[5]	197.44	194.57	194.73	-0.7%	185.83

Conversion Factors:
2002/03 Rands

1999/00	1.16
2000/01	1.13
2001/02	1.06
2002/03	1.00
2003/04	0.95
2004/05	0.92
2005/06	0.89

SUB - PROGRAMME 4. 2: TUBERCULOSIS HOSPITALS

AIM: To convert present Tuberculosis sanitaria into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions which allow for isolation during the intensive phase of treatment, as well as the application of the standardized multi-drug resistant protocols.

Situational Analysis
South Africa ranks 9th among the 22 highest TB burden countries accounting for 80% of Tuberculosis worldwide. The Western Cape has one of the highest incidences of TB in the World, and the highest in South Africa. Lately the Western Cape has been overtaken in the numbers of actual New TB Cases by other Provinces who have lower incidences, higher populations, and a much more severe HIV Epidemic.

In 2001 estimated incidence was as follows:

All TB Cases:	823 / 100,000
All Smear Positives:	504 / 100,000
New Smear Positives:	352 / 100,000

TB Services are clinic / nurse based, and are delivered via the various components of the Internationally recognised DOTS Strategy.

Multi-Drug Resistant TB
Multi-drug Resistant TB (MDR TB) from a survey conducted in 2000-01 indicates a ± 1% MDR rate in new smear positive clients, and ± 4% in re-treatment smear positives. While 1% and 4% for new and re-treatment of infectious cases respectively are encouraging, care must be taken that the rates do not increase rapidly due to inefficient TB Control, and/ or the HIV Epidemic. Ineffective TB control leads to increasing demand for TB beds.

Plans, Policies, Broad Strategic Objectives

- An accessible efficient laboratory network based on quality assurance providing early passive case finding.
- Adequate supply of Laboratory Materials
- Uninterrupted TB Drug Supply.
- Accessible client friendly diagnosis, and treatment services using Directly Observed Short Course Treatment, where pills are seen to be swallowed by a trained health or community worker. Treatment to be observed for duration of treatment in all cases but certainly for full duration of intensive phase.
- Regular high quality support, and supervision by Provincial District TB Co-ordinators with District Co-ordinators visiting each clinic in their district once per month.

Presence of staff in clinics who are trained in TB Guidelines, management of clients, reporting, recording as mandated by guidelines, and policy. (One

member of staff in each treatment point responsible for maintenance of register, records, submitting quarterly reports, problem identification / solving)

- Provide hospitalisation for MDR and complicated TB cases under proper standards (isolating, protection in intensive phase, 4 months)
- Strategically placed centres of excellence for MDR
- Apply standardised MDR Treatment and management
- Introduce Standardised MDR Management, and Treatment as per New updated National MDR Guidelines
- Align Provincial MDR Management, and Treatment Practice to conform to expert International consensus, and best practice
- Apply standardized diagnosis, management to all non-MDR TB clients as for per National treatment guidelines to align Province with National and International best practice, consensus and up to date research/operational research.
- Provide limited number of beds at district level (L1) for TB clients on re-treatment requiring Streptomycin injections.

PROGRAMME 4.2: EVOLUTION OF TB HOSPITALS PERFORMANCE INDICATORS **Amounts in 2002/03 real terms**

OBJECTIVE	INDICATOR	SPS TARGET 2010	Expenditure 2000/01	Expenditure 2001/02	Adjustment Budget 2002/03	Original Budget 2003/04	Budget Estimate 2004/05	Budget Estimate 2005/06
INPUT								
Provide TB hospital infrastructure in line with SPS	Useable beds per 1000 total population	0.17	0.26	0.23	0.23	0.18	0.18	0.18
	Useable beds per 1000 uninsured population	0.24	0.36	0.31	0.32	0.25	0.25	0.25
Provide sufficient funding to ensure an efficient TB hospital service for the population	Hospital expenditure per capita (total population)	14	13	12	13	11	12	12
	Hospital expenditure per capita (uninsured population)	20	18	17	18	15	17	17
OUTPUT								
Ensure accessible TB hospital services to the population of the western Cape	Separations per 1000 total population	0.7	1.1	0.9	0.9	0.8	0.8	0.8
	Separations per 1000 uninsured population	1.0	1.5	1.3	1.3	1.1	1.2	1.2
	Patient day equivalents per 1000 total population	57	75	66	68	54	61	59
	Patient day equivalents per 1000 uninsured population	79	104	92	94	75	84	82
EFFICIENCY								
Ensure efficient and cost effective utilisation of resources	Average length of stay	80.0	70.00	70.00	70.00	70.00	70.00	70.00
	Bed utilisation rate based on useable beds	90%	78%	80%	79%	80%	89%	90%
	Expenditure per patient day equivalent	253.14	176.00	185.00	190.00	195.00	202.41	210.00
	Expenditure per patient day equivalent on drugs	83.00	59.00	18.32	18.62	19.11	19.63	20.37

SUB-PROGRAMME 4.3 PSYCHIATRIC /MENTAL HOSPITALS

AIM Rendering a specialist hospital service for psychiatric and intellectually challenged patients and creating a platform for training health workers and research.

Situational Analysis
The process now contained in the SPS planning started in the intellectual disability services in 1997, with the first round of serious downsizing. Whilst the process then was forced to accelerate due to severe financial limitations, there was a changed world view and approach to the care of mentally ill and intellectual disabled people that was already adopted by these services, albeit at a more reasonable pace that viewed institutional long term care as the last resort and not the best option for the client.

Policies, Priorities and Broad Strategic Objectives

- Mental Health Care Act.
- Sterilization Act.

To develop Acute Service delivery model:
- An affordable bed plan for the Province in line with the service shape.
- Open ward Q at Stikland.
- Open second ward for intellectually disabled patients at Alexandra**.**
- Review 24 hour service at Alexandra

Substance Abuse Service
- Provincial Policy for Substance Abuse for the Provincial Department of Health.
- Protocols for the management of overdose and withdrawal accepted and implemented at regional hospitals.
- Support to Regions
- Establish psychiatric service at De Nova
- Open ward for adolescents with mental illness & Intellectual disability at Alexandra .
- Participate in C&A forum.

When a level 2 service is offered in a specialist hospital as opposed to a general regional hospital and two clear issues, which may help in this definition , are:

- The ALOS required for the specific service e.g. 5 to 7 days in a general hospital versus 21 to 28 days in specialist hospital .
- Degree of containment required.
- Intercurrent physical problems associated with physical disabilities and immobility e.g. respiratory and bladder infections and epilepsy- related problems as well as the need for pressure care and special feeding. If there are not sufficient district level beds in the Metro a decision to run such support beds from two intellectual Disability Services sites could be considered with the appropriate funding adjustments.

- At Lentegeur the bulk of the current excess ward accommodation will now be used for the physical rehabilitation services.
- Ward transformed from long term to acute service provision need to reduce the number of beds, the wards are in 30 bed allocations.
- Long term patients should live the remainder of their lives in their only known home.
- Psychiatric hospitals services will also reduce bed numbers in the chronic and marginally in acute services , but this is expected to follow the reduction in need due to the development of services in Regional Hospitals.
- Current admission policies will result in this service growing smaller by natural attrition. However reorganising services within the facilities bed numbers will not reduce much further in the next three –year period.
- APH service providers have to provide appropriate outreach and support services which match departmental policy and plan teaching, research and service delivery.

4. Planned Quality Improvement measures.

Purpose:

- Patient safety
- Efficiency
- Medico legal
- Education Shared.

A Develop a file audit checklist

i. Introduce a random file audit on monthly basis at each hospital.

B Exit interviews

ii. Conduct at all hospitals.

PROGRAMME 4.3: EVOLUTION OF PSYCHIATRIC HOSPITAL PERFORMANCE INDICATORS

Amounts in 2002/03 real terms

INDICATOR	SPS TARGET 2010	Expenditure 2000/01	Expenditure 2001/02	Adjustment Budget 2002/03	Original Budget 2003/04	Budget Estimate 2004/05	Budget Estimate 2005/06
Expenditure on staff as % of total expenditure	75.00%	82.0%	82.8%	81.5%	81.3%	80.0%	80.0%
Expenditure on maintenance as % total expenditure	5.28%	0.8%	0.3%	0.5%	0.3%	0.5%	0.8%
Useable beds per 1000 total population	0.29	0.55	0.54	0.52	0.51	0.48	0.45
Useable beds per 1000 uninsured population	0.40	0.76	0.75	0.73	0.70	0.66	0.63
Hospital expenditure per capita (total population)	44	54	54	52	52	52	53
Hospital expenditure per capita (uninsured population)	62	75	75	73	72	73	73
Separations per 1000 total population	0.9	1.8	1.4	1.3	1.5	1.5	1.4
Separations per 1000 uninsured population	1.2	2.5	1.9	1.9	2.1	2.0	1.9
Patient day equivalents per 1000 total population	96	166	168	162	158	155	150
Patient day equivalents per 1000 uninsured population	133	230	234	225	219	215	208
Average length of stay	106.0	90.50	120.00	120.00	106.00	106.00	106.00
Bed utilisation rate based on useable beds	90%	82%	84%	84%	85%	88%	90%
Expenditure per patient day equivalent	463.71	326.00	320.27	323.00	329.00	338.87	352.09

SUBPROGRAMME 4.4 CHRONIC HOSPITALS

AIM: These Hospitals serve as centres of long term care for bed-ridden patients who require a minimum degree of active clinical care, either because of the specific nature of their illness or because their socio-economic circumstances do not allow for them to be cared for at home. Often the patient is not able to access ambulatory services, either because they live in an isolated environment or do not have access to transport.

SITUATION ANALYSIS

A number of smaller hospitals, mainly in the Metropole, serve as step-down facilities for acute hospitals. These facilities offer long term care at a much reduced cost. They also constitute a more conducive atmosphere for long term rehabilitative care. The level of nursing care is generally of a less intensive nature than that required in acute Hospitals.

POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

These Hospitals form an integral part in dealing with the expected flood of HIV patients. Although it is envisaged that many of these patients will be managed through the home based care system presently being developed, a significant number will require ongoing clinical management, for which these facilities can form an indispensable link. Presently the Province (Dept. Health & Social Services) is looking at the management of long term chronically ill elderly people who are mainly to be found in the Old-age Homes, even though by rights they should be managed in facilities in which a higher level of clinical care exists.

SUB-PROGRAMME 4.4 CHRONIC MEDICAL HOPITALS

PROGRAMME 4.4: EVOLUTION OF CHRONIC HOSPITAL PERFORMANCE INDICATORS								
OBJECTIVE	**INDICATOR**	**SPS TARGET 2010**	**Expenditure 2000/01**	**Expenditure 2001/02**	**Adjustment Budget 2002/03**	**Original Budget 2003/04**	**Budget Estimate 2004/05**	**Budget Estimate 2005/06**
INPUT								
Provide sufficient funds for non-staff	Expenditure on staff as % of total expenditure	75.00%	82.0%	82.8%	81.5%	81.3%	80.0%	80.0%
Expenditure	Expenditure on maintenance as % total expenditure	5.28%	0.8%	0.3%	0.5%	0.3%	0.5%	0.8%
Provide chronic hospital	Useable beds per 1000 total population	0.15	0.18	0.18	0.16	0.16	0.16	0.16
infrastructure in line with SPS	Useable beds per 1000 uninsured population	0.21	0.25	0.25	0.22	0.22	0.22	0.22
Provide sufficient funding to ensure	Hospital expenditure per capita (total population)	19	10	10	10	11	11	11
an efficient chronic hospital service for the population	Hospital expenditure per capita (uninsured population)	26	14	14	13	15	15	15
OUTPUT								
Ensure accessible chronic	Separations per 1000 total population	1.4	1.0	1.1	1.2	1.2	1.3	1.3
hospital services to the	Separations per 1000 uninsured population	2.0	1.4	1.5	1.6	1.7	1.8	1.9
population of the western Cape	Patient day equivalents per 1000 total population	51	53	53	47	50	49	47
	Patient day equivalents per 1000 uninsured population	71	73	73	65	69	67	66
EFFICIENCY								
Ensure efficient and cost effective	Average length of stay	35.0	50.20	48.00	40.00	40.00	38.00	35.00
Utilisation of resources	Bed utilisation rate based on useable beds	90%	78%	80%	80%	84%	83%	82%
	Expenditure per patient day equivalent	372.23	185.18	197.00	205.00	212.00	219.00	226.00

SUB-PROGRAMME 4.5 DENTAL TRAINING HOSPITALS

AIM:

Rendering a comprehensive oral health service and a platform for training oral health workers and conducting research.

SITUATION ANALYSIS

A. Mitchell's Plain Oral Health Centre

The Oral Health Centre (OHC) in Mitchells Plain is located in one of the most needy areas in the Province, i.e. in the Town Centre in Mitchells Plain with Khayelitsha, Gugulethu and Mitchells Plain as the catchment areas. Historically prior to the relocation of the OHC to Mitchells Plain the community only received a basic oral health service in the form of relief of pain and sepsis and very basic restorative care. Since the establishment of the OHC in 1992 the community has been offered a comprehensive oral health service encompassing primary, secondary and tertiary care at the OHC treating well in excess of 60 000 patients per year.

The OHC has become the "de facto" nucleus of the referral system for the Oral Health clinics of the Metropole region situated in Cape Town East (Cross Roads, Gugulethu) Cape Town South (Lentegeur, Westridge) South Peninsula (False Bay) Lotus River, Retreat, Tygerberg East (Delft, Mfuleni) Tygerberg South (Khayelitsha, Michael Mapongwana) Tygerberg West (Bishop Lavis, Elsies River) and the clinics at Eros school for cerebral palsy and Lentegeur Hospital.

The satellite clinic of the OHC situated at the Mitchells Plain Day Hospital is the only specialized children's clinic offering comprehensive oral health service for children. It has become the referral center for all "difficult to treat" children and children with special needs. It is also the screening site for children that require treatment under general anaesthetic. It sees in excess of 25 000 children per year.

The outreach programme of the OHC at Gugulethu is serviced by staff and students from the OHC on a rotational basis and takes comprehensive oral health care to the lower level of service. This outreach programme sees in excess of 30 000 patients per year.

B. Tygerberg Oral Health Centre

The Tygerberg Oral Health Centre is situated between the Tygerberg Hospital and the Stellenbosch University medical school. It is part of the Faculty Of Health Sciences of Stellenbosch University where Oral Hygienists, Dentists and Specialists are trained. Patients from all over the province, as well as neighbouring provinces and countries, attend for treatment, many of them referred from the public oral health service clinics.

All services are rendered on site (theatres included). However, there are regular outreach programmes to local communities as well as to rural areas over weekends and holidays.

POLICIES, PRIORITIES AND BROAD STRATEGIC OBJECTIVES

- To deliver the highest quality patient care within affordable and available resources, measured against international standards.

- To formalize the District Oral Health System with the OHC as the nucleus of a referral system for the Oral Health Clinics in the Metropole region.

- To become the referral centre for oral HIV/AIDS cases in the Western Cape.

- To establish a conscious sedation clinic.

- To expand training of dentists and extended duties of Oral Hygienists from the Metropole clinics so that services other than just primary health care are taken away from the OHC and the specialized children's clinic.

- To expand the preventive and promotive strategies such that over a period of time there is a positive outcome for oral health services as a whole and for services at the OHC in particular.

- To develop a public-private partnership for the provision of dentures for the uninsured in the community. The region has the highest rate of edentulousness in the country. Reduce the waiting list for their service.

- To develop a business plan for the provision of cost-effective orthodontic treatment for the uninsured in the region.

- To develop a strategy for the provision of implants and implant supported prosthesis to the community in consultation with implant suppliers and private laboratory technicians.

- To develop a protocol for the provision of services for children under general anaesthetic for members of funds such as Clothing Workers and Municipal Workers Unions in a public-private partnership.

- To provide tertiary and quaternary dental services for patients at Tygerberg, Red Cross Children's Hospital and Groote Schuur Hospital.

- To increase the capacity to train Registrars in the disciplines for which there is a need in the other provinces.

- To be recognised as a world-class teaching, education, research and development centre

- To create cost centres, managed on business principles, within the framework of current legislation.

- To replace ageing equipment (especially dental chairs) within a three year period

- To collaborate with other health service providers health-sciences faculties, other tertiary institutions as well as other university faculties.

- To increase service delivery

CONSTRAINTS AND MEASURES PLANNED TO OVERCOME THEM

HUMAN RESOURCE CONSTRAINTS

The filling of vacant, funded posts on the establishment within budgetary limits. This will enable the deployment of staff to take services to the lower level. Essential non-clinical posts must be included in this category since optimal support will result in cost-effective services.

On-going training and upgrading of skills are essential to optimise support services at the OHC.

INFRASTRUCTURAL SHORTCOMINGS

Due to the deficiency in the capital budget over the years the equipment has aged in some cases beyond repair. The dental chairs can no longer be maintained due to the non-availability of spares. Hopefully the OHC will be included in the Hospitals Revitalization Programme of the National Department Of Health.

The hand pieces, which are essential in the provision of comprehensive oral health care, have a finite life span and have over the years been inadequately replaced due to an insufficient operational budget, will also need to be upgraded.

To relieve the financial pressures various strategies will be implemented through:

- The development of revenue generation projects such as the orthodontic clinic.

- The development of the public-private partnership where private laboratories are contracted to provide a denture service for the uninsured.

- The development of a cost-centre approach where the metrople is appropriately billed for primary health care services rendered at its clinics by the OHC staff and students.

- To explore with treasury the concept of operational rental for a capital regeneration programme for the equipment development

PLANNED QUALITY IMPROVEMENT MEASURES

- The development of a client based survey to assess the satisfaction with services rendered at the OHC.

- The establishment of the Hospital Board in line with the Facilities Boards Bill thereby making the OHC acceptable to the community.

- The upgrading of facilities and infrastructure at the OHC and the satellite clinics with grants from the Revitalization programme. This should improve staff moral and attitudes towards their work and their patients with ultimately improving quality of care.

- With the formalization of the District Health system the improvement in referral time from the primary level to the OHC for specialized care.

- With the transfer of skills and services to the lower level of care the reduction in waiting times at the OHC for specialized care.

- The reduction in the waiting lists for dentures and orthodontic with the establishment of the public-private partnership.

- To develop management tools to measure quality assurance of services.

- To use monitoring indices to measure impact of the services on quality of life indicators.

- To measure prevalence and incidence rates to assist in quality of care for HIV/AIDS and chronically ill patients.

PERFORMANCE INDICATORS: ACADEMIC DENTAL SERVICES

Objective	Strategy	Output	Performance measure/ indicator	System used to monitor progress	KMO	Numerator	Denominator	Source	Data Available
Optimise Student training as agreed to by Committee of Dental Deans	Maintain a fully functional academic and training platform	Dental graduates, post-graduates and oral hygienists	Graduating students	University records	No. of graduates per year	No. of graduates	1 (year)	University records	Yes
Increase service rendering	Maintain a fully functional training and service platform	Patients treated	Increase in the number of patients treated	Dental Information System (Exact)	No. of patients treated	No. of patients treated	1 (year)	Exact system	Not yet
Reduce time patients spend on waiting lists	Increase service rendering, ensure appropriate level of service, sanitise waiting lists	Number of patients on waiting lists, and time spent on waiting lists	Number of patients on waiting lists for more than 1 year	Dental Information System (Exact)	Time patients spend on waiting lists	Number of patients on waiting lists for more than 1 year	1 (year)	Exact system / manual waiting lists / departmental records	Yes
Increase patient revenue	Actively follow-up on debtors	Accounts accrued	Percentage of accrued accounts received	Dental Information System (Exact)	Extent of outstanding accounts	Percentage of amount of accrued accounts received	Total accounts accrued	Exact system	Yes
Establish revenue generation initiatives	Draft business plans and implement projects	Business plans revenue systems in place	Number of projects implemented	Management advisory committee	No. of business plans implemented	No. of business plans implemented	1 (year)	Treasury records	Yes
Improved efficiency	Integrate theatres, administrative functions, etc.	Turnover time in theatres, waiting times for ordered items in stores	Theatre stats.	Theatre committee	Cases per theatre	Theatre cases	1 (year)	Theatre book	Yes

Evolution of performance indicators: Dental Training Hospitals							
Objective	**Performance measure/ indicator**	**2010 Target**	**2001/02 Actual**	**2002/03 (estimate)**	**2003/04 (target)**	**2004/05 (target)**	**2005/06 (target)**
Optimise Student training as agreed to by Committee of Dental Deans	Graduating students	80	69	64	129 *	97 *	80
Increase service rendering	Increase in the number of patients treated	250 000	±200 000	210 000	220 000	230 000	240 000
Reduce time patients spend on waiting lists	Number of patients on waiting lists for more than 1 year	100	2500	3500	2000	1000	500
Increase patient revenue	Percentage of accrued accounts received	80%	20%	20%	40%	60%	80%
Establish revenue generation initiatives	Number of projects implemented	6	1	2	3	4	5
Improved efficiency	Theatre stats.	1500	1137	1293	1300	1400	1500

* = 3 graduating classes per year due to implementation of new curriculum

PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES

Table: Evolution of expenditure by budget programme and sub-programme in current prices (R million)[1]

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
4.1 General Hospitals	530,160	562,059	603,856	611,576	644,500	671,457
4.2 TB Hospitals	49,277	49,062	54,106	55,641	58,636	61,089
4.3 Psychiatric Hospitals	201,602	216,064	224,882	237,451	250,234	260,700
4.4 Chronic medical hospitals	36,301	41,542	41,166	48,197	50,792	52,916
4.5 Dental training hospitals	38,104	40,655	42,536	46,202	48,689	50,726
Total programme	**855,444**	**909,382**	**966,546**	**999,067**	**1,052,851**	**1,096,888**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	966,381	965,764	966,546	0.01%	951,967
Total per person[4]	229.38	226.66	224.41	-1.1%	219.10
Total per uninsured person[5]	318.58	314.80	311.68	-1.1%	304.30

Conversion Factors: 2002/03 Rands

1999/00	1.16
2000/01	1.13
2001/02	1.06
2002/03	1.00
2003/04	0.95
2004/05	0.92
2005/06	0.89

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PROGRAMME 5: CENTRAL HOSPITAL SERVICES

5.1 CENTRAL HOSPITALS

Aim: To render highly specialised services to the inhabitants of the Western Cape as well as for the provinces for which the Western Cape is committed to render these services. To provide a high quality teaching platform where students at both under- and postgraduate levels can develop the requisite skills which will enable them to deal with the problems facing this country both at clinical and research level.

Situational Analysis

The province has three Central Hospitals; Tygerberg, Groote Schuur and Red Cross Children's Hospital. Tygerberg Hospital is linked to the University of Stellenbosch and Groote Schuur and Red Cross to the University of Cape Town. All three hospitals have applied stringent fiscal controls to curtail over-expenditure. **They are not sustainable in their present configuration**. The primary cause is duplication of expensive services, but the poor condition and extent of the physical infrastructure is a major contributor. The increasing cost of equipment has resulted in backlogs in the acquisition and maintenance of equipment.

The solution lies in co-operation between the Universities and the Province to reduce duplicated services and to rationalise the infrastructural requirement. Recent discussions with the Universities aimed at reducing duplication have indicated considerable goodwill.

Table: Current and expected values of Key Indicators for Central hospitals

Calculations in 2002/03 prices

	2010 Target	2000/01	2001/02	2002/03	2003/04	2004/05
Budget	1,343,598,111	1,441,075,352	1,430,218,764	1,455,120,000	1,412,458,175	1,459,640,034
Target cost per PDE	1,572	1,375	1,415	1,483	1,482	1,527
Bed Occupancy	0.85	0.782	0.84	0.84	0.85	0.85
ALOS	6.11	6.25	6.02	6.18	6.23	6.12
Beds	1,885	2,662	2,588	2,630	2,360	2,250
OutPat/Inpat day	1.38	1.14	0.81	0.64	0.90	1.11
Outpatients	809,655	864,594	643,656	514,722	662,180	773,162
Inpatient Days	584,821	759,815	795,850	809,800	732,190	698,063
PDE's	854,706	1,048,013	1,010,402	981,374	952,917	955,783
Admissions	95,715	121,667	132,148	131,014	117,543	114,129

Analysis of the Associated Academic Hospitals staffing Profile: 2002/03

Functional Category	Filled Posts	% of Total Staff	% of Total Salaries
ADMIN	1183	13.0%	10.5%
DOMESTIC SERVICES	1946	21.4%	9.8%
HEALTH MANAGERS	51	0.6%	1.5%
HEALTH TECHNICIANS	119	1.3%	1.5%
LIFE SCIENCES	45	0.5%	1.3%
MAINTENANCE WORKERS	31	0.3%	0.5%
Junior MO	115	1.3%	
MO	240	2.6%	
Registrars	275	3.0%	
Specialists	384	4.2%	
MEDICAL PROFESSIONALS	1015	11.2%	28.3%
NATURAL SCIENCES	3	0.0%	0.0%
Prof Nurse	1450	16.0%	19.6%
Staff Nurse	714	7.9%	6.3%
Assistants	1575	17.4%	10.9%
NURSING	3739	41.2%	36.9%
OPERATORS	24	0.3%	0.1%
PHARMACISTS	59	0.7%	0.9%
SEN MANAGERS	4	0.0%	0.2%
SOCIAL SCIENCES	60	0.7%	0.8%
THERAPISTS	731	8.1%	6.9%
TRADE WORKERS	63	0.7%	0.8%
TOTAL	9073	100.0%	100.0%

Policies, Strategies Broad Strategic Objectives

Healthcare 2010 indicates the need for a reduction of Level 3 beds in the province. At the same time it indicates the need for more appropriate staffing and a significant improvement in the general resourcing of the central hospitals, particularly in respect of equipment.

The immediate need is to eliminate fragmentation and duplication of tertiary services wherever possible. The quantum of tertiary services must be adjusted in accordance with the reduction in the National Tertiary Services Grant. **Healthcare 2010** indicates the need to separate the Level 3 and Level 2 services to prevent costly level creep to the higher level of care.

The re-deployment of general specialist services to rural regions will strengthen the rural Regional Hospitals, which in turn will have the effect of reducing inappropriate referrals to the Central Hospitals. This is a fundamental principle of **Healthcare 2010** that will ensure the sustainability of the Central Hospitals.

The overall strategic objective is to rationalise the Central Hospitals in such a way that their value as a national asset is preserved and yet they become affordable and sustainable.

Constraints and Measures taken to overcome them

The move towards appropriate staffing will necessitate the relocation of personnel to where they are most urgently needed. An example is the re-deployment of specialists to rural regional Hospitals. The high ratio of non-clinical staff per bed is also unsustainable and a reduction is an urgent necessity. The Human Resources Plan that is part of **Healthcare 2010** will address these issues.

The operational and maintenance costs of the massive and rapidly deteriorating physical infrastructure of the Central Hospitals, is a major constraint. The Infrastructure Plan that is part of **Healthcare 2010** will address these issues. It is envisaged that under-utilised infrastructure will become the subject of PPP's to promote sustainability of these hospitals physical infrastructure.

Quality Improvement Measures

- Risk management programme
- Management Review Process
- Patient Complaints Monitoring Mechanism
- Structured system for Mortality and Morbidity monitoring
- Structured Clinical Audit system
- Employee Assistance Programme

Table: Performance indicators for Central Hospitals

Indicator	Province wide value	Hospital range	National target
Input			
1. Expenditure on hospital staff as percentage of total hospital expenditure	73.2%		
2. Expenditure on drugs for hospital use as percentage of total hospital expenditure	5.4%		
3. Expenditure on hospital maintenance as percentage of total hospital expenditure	1.7%		
4. Useable beds per 1000 people*	.63		
5. Useable beds per 1000 uninsured people*	.88		
6. Hospital expenditure per person*	342		
7. Hospital expenditure per uninsured person*	475		
Process			
8. Percentage of hospitals with operational hospital board	100%		
9. Percentage of hospitals with appointed (not acting) CEO in place	100%		
10. Percentage of hospitals with business plan agreed with provincial health department	100%		
11. Percentage of hospitals with up to date asset register			
12. Maximum permitted value of procurement at discretion of hospital CEO without reference to provincial level			
Output			
13. Separations per 1000 people*	28.9		
14. Separations per 1000 uninsured people*	40.1		
15. Patient day equivalents per 1000 people*	249		
16. Patient day equivalents per 1000 uninsured people*	345		
17. Patient fee income per separation			
Quality			
18. Percentage of hospitals in facility audit condition 4 or 5	67%		
19. Percentage of hospitals that have conducted and published a patient satisfaction survey in last 12 months	0%		
20. Percentage of hospitals with designated official responsible for coordinating quality management	100%		
21. Percentage of hospitals with clinical audit (M&M) meetings at least once a month	100%		
Efficiency			
22. Average length of stay	6.25		
23. Bed utilisation rate (based on useable beds)	78%		
24. Expenditure per patient day equivalent	1375		
Outcome			
25. Case fatality rate for surgery separations			

PROGRAMME 5.1: EVOLUTION OF CENTRAL HOSPITAL PERFORMANCE INDICATORS

Amounts in 2002/03 real terms

OBJECTIVE	INDICATOR	SPS TARGET 2010	Expenditure 2000/01	Expenditure 2001/02	Adjustment Budget 2002/03	Original Budget 2003/04	Budget Estimate 2004/05	Budget Estimate 2005/06
INPUT								
Provide sufficient funds for non- Personnel expenditure in Central Hospitals	Expenditure on staff as % of total expenditure	63.80%	73.2%	72.8%	72.3%	71.2%	71.2%	71.2%
	Expenditure on drugs as % of total expenditure	8.0%	5.4%	5.33%	7.40%	7.4%	7.5%	7.5%
	Expenditure on maintenance as % total expenditure	6.81%	1.7%	1.9%	0.9%	1.6%	1.6%	1.6%
Provide Central Hospital Infrastructure in line with SPS	Useable beds per 1000 total population	0.41	0.63	0.61	0.61	0.54	0.52	0.51
	Useable beds per 1000 uninsured population	0.58	0.88	0.84	0.85	0.75	0.72	0.71
Provide sufficient funding to ensure an efficient Central Hospital Service for the population	Hospital expenditure per capita (total population)	295	342	336	338	325	328	330
	Hospital expenditure per capita (uninsured population)	410	475	466	469	452	456	458
Provide adequate human resources	Total staff to bed ratio	2.43	1.72	1.78	1.77	2.34	2.34	2.34
Provide services that adequately address the needs of inpatients and out patients	Outpatients per inpatient day ratio	1.38	1.14	0.81	0.64	0.90	1.06	1.11
	Trauma as % of total outpatient headcounts	31%	44%					
Protect highly specialised services in Central Hospitals	Percentage highly specialised services in Central hospitals	80%	65%	65%	65%	70%	70%	70%

PROCESS								
Facilitate representative Management	Percentage of hospitals with operational hospital board	100%	100%	100%	100%	100%	100%	100%
Facilitate decentralised Management and Accountability	Percentage of hospitals with appointed CEO in place (or Medical Superintendents)	100%	100%	100%	100%	100%	100%	100%
	Percentage of hospitals with business plan agreed with provincial health department	100%	100%	100%	100%	100%	100%	100%
	Percentage of hospitals with up to date asset register	100%						
OUTPUT								
Ensure accessible Central Hospital services to the Population of the western Cape and the rest of the country	Separations per 1000 total population	21.0	28.9	31.0	30.4	27.1	26.4	25.8
	Separations per 1000 uninsured population	29.2	40.1	43.1	42.2	37.6	36.7	35.8
	Patient day equivalents per 1000 total population	188	249	237	228	219	218	216
	Patient day equivalents per 1000 uninsured population	261	345	329	316	305	303	300
Facilitate revenue generation	Patient fee income per separation							
QUALITY								
Ensure adequate infrastructure	Percentage of hospitals in facility audit condition 4 or 5	100%	66%	66%	66%	66%	66%	66%
Ensure quality patient care	Percentage of hospitals that have conducted and	100%	0%	0%	0%	36%	100%	100%
	published a patient satisfaction survey in last 12 months							
	Percentage of hospitals with designated official	100%	20%	20%	30%	100%	100%	100%
	responsible for co-ordinating quality management							

	Percentage of hospitals with clinical audit (M&M)	100%	100%	100%	100%	100%	100%	100%
	meetings at least once a month							
EFFICIENCY								
Ensure efficient and cost effective	Average length of stay	6.1	6.25	6.02	6.18	6.23	6.10	6.12
Utilisation of resources	Bed utilisation rate based on useable beds	85%	78%	84%	84%	85%	85%	85%
	Expenditure per patient day equivalent	1,572.00	1,375.05	1,415.49	1,482.74	1,482.25	1,501.65	1,527.17
	Expenditure per patient day equivalent on drugs	125.76	74.25	75.46	109.72	109.69	112.62	114.54
	Cost of non-clinical services as % of total expenditure Administration Excluded	16.85%	17.5%	17.1%	17.0%	16.9%	16.9%	16.9%
	Out-sourced services: Laundries & Security							
OUTCOME								
Ensure desired clinical outcomes	Case fatility rate for surgery separations							

PROGRAMME 5: CENTRAL HOSPITAL SERVICES

Table: Evolution of expenditure by budget sub-programme in current prices (R million)[1]

Sub-programme:5.1	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
Central Hospitals	1,275,645	1,346,722	1,455,120	1,485,906	1,565,898	1,631,395
Total programme	**1,275,645**	**1,346,722**	**1,455,120**	**1,485,906**	**1,565,898**	**1,631,395**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)[1]

Expenditure: Prog 5	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total[3]	**1,441,075**	**1,430,219**	**1,455,120**	**0.5%**	**1,412,458**
Total per person[4]	342.05	335.66	337.85	-0.6%	325.08
Total per uninsured person[5]	475.07	466.19	469.23	-0.6%	451.50

Conversion Factors:
2002/03 Rands

1999/00	1.16
2000/01	1.13
2001/02	1.06
2002/03	1.00
2003/04	0.95
2004/05	0.92
2005/06	0.89

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

AIM: To provide training of all personnel within the Department of Health

PROGRAMME DESCRIPTION:

Nursing training college:
training of nursing personnel

Emergency medical services training college:
training of rescue and ambulance personnel

Bursaries:
to provide bursaries for nursing-, medical personnel and allied health workers to graduate at tertiary institutions

Primary health care training:
to train health workers to provide an efficient primary health care service

Training other:
to develop the knowledge, skills and attitudes of personnel in all occupational categories

1. Situational Analysis

Policies and strategies informing human resource development in province

ACTS
- Skills Development Act, 1998 (No 97 of 1998)
- Skills Development Levies Act, 1999 (Act No 9 of 1999)
- Learnerships Act (Act No. of 2001)
- South African Qualifications Authority Act, 1995
- National Education Policy Act (Act 27 or 1996)
- Further Education and Training Act (Act No. 98 of 1998)
- Higher Education and Training Act (Act No. 101 of 1997)
- Adult Basic Education and Training Act (Act No. 52 of 2000)

WHITE PAPERS
- The White Paper on the Transformation of the Public Service, 1995
- The White Paper on Transforming Service Delivery (Batho Pele), 1997
- The White Paper on Human Resource Management, 1997
- The White Paper for the Transformation of the Health System in South Africa, 1997

PLANS AND PRIORITIES
- Western Cape Provincial Health Plan (1995)

- Strategic and Service Delivery Improvement Plan (SSDIP) - Western Cape Provincial Department of Health (2001)
- Sector Skills Plan – Health and Welfare Sector Training Education Authority (HWSETA) (2001)
- Strategic Position statement (2002)
- Healthcare 2010 (2002)

COLLECTIVE AGREEMENTS

- Public Service Co-ordinating Bargaining Council (PSCBC) collective agreements
- Provincial Service Bargaining Council: Western Cape collective agreements
- Public Health and Welfare Sectoral Bargaining Council (PHWSBC) collective agreements

1.2 Training needs assessment and gap analysis; consultation process used to inform the needs assessment

- Determining Actual Numbers of Bursaries per Study Field per Service Delivery Needs, September 2002 (Directorate HRD)
- Management Training Needs Survey, March 2001 (Source: Directorate HRD)
- Training Needs Assessment per Occupational Category, May 2000 (Directorate HRD)
  Chief Professional Nurse
  Chief SASO: Gas Sterilizing, CSSD

1.2.1 Regional and institutional management communicated the need for the above project to all personnel including the unions at the local IMLC (Institutional Management and Labour Caucus).

1.2.2 Draft of Regional and Institutional Workplace Skills Plans which include training needs assessment and gap analysis are consulted within the Workplace Skills Development Committees at Regional and institutional level comprising all stakeholders including unions/ labour organisations.

1.3 Numbers and types of HEI Education and Training Providers for health professional education in province, including institutions of higher learning for basic, post-basic and post-graduate programmes (full time, part time or distance learning); main categories of personnel trained; availability of appropriate faculty staff

Table 1: Numbers and types of HEI Education and Training Providers for health professional education in the province

Institutions of higher learning for health professional education in province	Basic	Post-basic	Post-graduate	Main categories of personnel trained	Full-time/ Part-time/ Distance learning
University of Cape Town	✔	✔	✔	Medicine Physiotherapy Occupational Therapy Pharmacy Speech Therapy Nursing (R425 Degree and Diploma) Optometry Social Work (medical) Radiography Clinical Psychology Radiography Clinical Psychology Medical Technology Clinical Technology Medical Physics Dietetics Environmental Health	Full-time Part-time
University of Stellenbosch	✔	✔	✔	Medicine Dentistry Physiotherapy Occupational Therapy Pharmacy Speech Therapy Nursing (R425 Degree and Diploma) Optometry Social Work (medical) Radiography Clinical Psychology Medical Technology Clinical Technology Medical Physics Dietetics Environmental Health	Full-time Part-time
University of the Western Cape	✔	✔	✔	Nursing (R425 Degree and Diploma) Dentistry Physiotherapy Occupational Therapy Pharmacy Speech Therapy Optometry Social Work (medical) Radiography Clinical Psychology	Full-time Part-time

Institutions of higher learning for health professional education in province	Basic	Post-basic	Post-graduate	Main categories of personnel trained	Full-time/ Part-time/ Distance learning
				Medical Technology Clinical Technology Medical Physics Dietetics Environmental Health	
Cape Technikon		✔	✔	Nursing courses Medical Technology Clinical Technology Dietetics Oral Hygienist	Full-time Part-time
Peninsula Technikon		✔	✔	Nursing courses Radiography	Full-time Part-time
Netcare Training Academy	✔	✔		Nursing Bridging Courses Nursing courses (post basic)	Full-time Part-time
Western Cape College of Nursing	✔	✔		Nursing (R425 Degree and Diploma) Nursing courses (post basic)	Full-time Part-time
Technikon SA	✔			Nursing Bridging Courses	Distance Learning
University of Natal	✔			Nursing Bridging Courses	Distance Learning

1.4 Appraisal of training programmes during past year (including numbers trained by main category and attrition rates by year of courses)

Refer Annexure A (Appraisal of training programmes during past year)

1.5 Main areas of health research, including health systems research

- Healthcare 2010 – HRD planning and multi-year projections with regard to HR requirements in terms of HRD multiyear planning and projections for education, training and development

1.6 Key challenges over the strategic plan period

- Bursary system to meet health service delivery needs guided by an increased emphasis on Primary Health Care
- Increase in numbers of personnel trained to meet health care needs guided by an increased emphasis on Primary Health Care. Additional doctors,

nurses, nursing assistants and mid level heath workers required at District and secondary level hospitals.

- Employee Assistance Programme for personnel within the Department.
- Orientation and awareness to HIV/ AIDS prevention.
- Learnerships for non-employees (18.2 Learnerships of Skills Development Act, 1998)

2. Policies, priorities and broad strategic objectives

These should follow from the situation analysis. Issues to be covered should include:

2.1 Training programmes for primary health care nurses; duration of reorientation programmes for primary health care

Curative skills for Primary Health Care for Registered Nurses
Integrated Management of Childhood illnesses (Responsibility of Directorate: HIV/ AIDS)
Home-based care (Responsibility of Directorate: Programme Development)
Health Education and Health Promotion in schools (Responsibility of Directorate: Programme Development)
Community Health Nursing Science course
Primary Health Care

2.2 Training programmes for mid-level workers (e.g. in nursing, pharmacy, dentistry, radiography, physiotherapy, occupational therapy)

Learnerships: Pharmacist Assistants
Learnerships: Enrolled Nurse Assistant

2.3 Skills development and other training programmes (e.g. in management, integrated management of childhood illnesses, counselling, home based care, ABET, learnerships)

2.4 Structured in-service education/continuing professional development programmes (These programmes are based on the dynamic needs of the organisation and its workforce)

3. Analysis of constraints and measures planned to overcome them

3.1 Finance

- Limited allocation of funding. Allocation does not meet projected needs for training programmes. Programmes to be adapted to meet financial constraints. Performance targets based on health service needs will be compromised if funding is not in accordance with cost centre estimates.

3.2 Personnel

- Limited capacity of HRD personnel. Continuous professional development of, and support to HRD managers/ training co-ordinators.

3.3 Organisation and management

3.4 Physical infrastructure.

3.5 Availability of relevant and appropriate education and training courses

3.6 Availability of appropriate training providers

3.7 Lack of accredited (SAQA) unit standards and appropriate SGB (Standards Generating Bodies) to inform training curricula.

3.8 Policies. Inadequate coherence of legislation/ policies related to HRD e.g. Public Service Act favours employees trained at HEIs only whereas the Skills Development Act favours programmes by providers in HEI and providers external to HEI sector.

4. Specification of key measurable objectives and key performance indicators

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
1. Provide for the cost-effective training of nurses to meet the service needs of the Department Strategy: Identify formal training needs for nurse training, at basic and post basic levels; Quantify the numbers and categories of nurses to be trained annually, based on service delivery needs and priorities. A combination of in-house training at the Western Cape College of Nursing (WCCN) and sponsorship of university training provided through bursaries through bursary based financial assistance. Monitor and evaluate the nurse training programmes. Report on EE criteria	**Input:** Numbers: intake of students (basic and post-basic nursing) admitted to nurse training **NURSE TRAINING** 1. **Bridging Nurse Training** (ENA To EN and EN To RN) 2. **Basic Nurse Training** (R425 Diploma / Degree) 3. **Post Basic Nurse Training** (Professional Category i.e. RN) **Process:** Improved representation of PDI (EEA) students in intake **Output**: Numbers of graduates: basic Numbers of graduates: post-basic **Quality:** Attrition rates per year of formal training courses Percentage of first year entrants who graduate from formal training courses **Efficiency:** Average training cost per graduate 1. **Bridging Nurse Training** (ENA To EN and EN To RN)	**390** 12 * 300 78	**491** 74 270 147 R6,600	**750** 120 450 180 R7,500	**1330** 150 1000 180 R8,000	**1880** 200 1500 180 R8,500

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
	2. **Basic Nurse Training** (R425 Diploma / Degree)	#R43,500	R22,000	R22,000	R24,000	R24,000
	3. **Post Basic Nurse Training** (Professional Category i.e. RN		R5,400	R6,500	R8,000	R8,000
	Outcome: Percentage of graduate nurses in a Public Service post within 3 months of successful completion of basic nurse training programmes					
2. Ensure appropriate development of human resources to support health service delivery Strategy: Identify formal training needs for health professional training, at basic and post basic levels; Quantify the numbers and categories of health professionals to be trained annually, based on service needs. Health Science Professional fields include but are not limited to the following: Assess skills gaps by comparing skills required with skills available. Provide training, bursaries and learnerships to address skills gaps, needs and priorities Monitor and evaluate the training and allocation of bursaries and learnerships. Report on EE criteria.	**Input:** Numbers in intake of students Higher Education Institutions (HEIs): **1. Full-time study** **2. Part-time study** **Process:** Improved representation of PDI students in intake **Output**: Numbers of health science graduates **Quality:** Attrition rates per year of health science formal training courses Percentage of graduates per year of formal training courses **Efficiency:** Average bursary cost per graduate **1. Full-time study** **2. Part-time study** **Outcome:**	**134** 55 79 R20,000 R3,100	**196** 107 89 R20,000 R4,300	**178** 78 100 R20,000 R5,800	**228** 78 150 R24,000 R6,500	**280** 80 200 R26,000 R8,000

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
	Percentage of graduating health professionals in a Public Service post within 3 months of graduation		90%	90%	90%	90%
	Percentage of graduating doctors in a Public Service post within 3 months of graduation		90%	90%	90%	90%
2.2 Facilitate, co-ordinate, support, guide and monitor the implementation of the Departmental Workplace Skills Plan for the training and development of personnel within the Department.	**Input:** Numbers of training opportunities for personnel	5000	8000	10000	10000	12000
Identify functional training needs for health personnel and quantify the numbers and categories of health personnel to be trained annually, based on service needs.	**Process:** Improved representation of PDIs in intake **Output**: Numbers of personnel trained	4573	8000	8000	8000	8000
Compare skills required with skills available.	**Efficiency:** Average training cost per individual					
Provide training to address functional skills needs and priorities.	Outcome:					
Monitor and evaluate the functional training programmes.	Target population of personnel requiring training as at 2002 year	*	*	*	*	*
*Costs are borne by CAA for training and Department of Health for S & T.	Number of personnel trained % of need	20%	33%	40%	40%	50%
*Depends on individual salary of learner per occupational group						
2.3 Identify management training needs for health management at senior, middle and lower levels; quantify the numbers and categories of health management to be trained annually, based on service needs and priorities.	**Input:** Numbers of opportunities for managers	581	600	800	800	800
	Process: Improved representation of PDIs in intake					
Compare skills required with skills available.						
Provide training to address management skills needs	**Output**: Numbers of managers trained					
Monitor and evaluate the management training	**Efficiency:**					

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
programmes. 2.4 Identify Adult Basic Education and Training (ABET) training needs for all categories of health personnel to be trained annually, based on service needs. Provide ABET training to address ABET needs Monitor and evaluate the ABET program.	Average training cost per manager Outcome: Target population of personnel requiring management training as at 2002 year Number of managers trained % of need **Input:** Numbers of ABET training interventions for personnel **Process:** Improved representation of PDIs in intake **Output**: Numbers of personnel trained **Efficiency:** Average training cost per individual **Outcome:** Target population of personnel requiring ABET as at 2002 year Number of personnel trained in ABET % of need	581 90 90	800 200 200 R1000	800 800 800 R1000 2 400	800 800 800 R1000	800 800 800 R1000
3. **Provide an Employee Assistance Programme** Strategy: Develop policies and implementation strategy Establish EAP Monitor and evaluate the departmental EAP program.	**Input:** Number of personnel accessing EAP services **Process:** Personnel assisted by EAP services **Output**: Number of personnel who have accessed the EAP service **Efficiency:** Average cost per individual receiving EAP service **Outcome:**			600	1200	1500

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
	Number of personnel who have accessed EAP service Total workforce % of personnel who have access to EAP % of personnel who have accessed EAP					

1. An objective may have one indicator or more than one indicator of the same or different types.
2. Where data is available.

FOOTNOTES:

* Student Posts on Western Cape College of Nursing establishment

Allocation according to service delivery needs (To be revised as service delivery needs change)

#Salary per annum + 30% (employment benefits)

Bursary system implemented for nurses

PROGRAMME 6: HEALTH SCIENCES AND TRAINING

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
6.1 Nursing College	47,766	52,673	54,978	56,043	59,060	61,530
6.2 EMS training college	413	790	2,340	3,324	3,503	3,649
6.3 Bursaries			7,318	17,653	18,603	19,381
6.4 Primary Health Care Training			-	-	-	-
6.5 SETA		2,367	2,280	3,562	3,754	3,911
Total programme	**48,179**	**55,830**	**66,916**	**80,582**	**84,920**	**88,472**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total	**54,427**	**59,291**	**66,916**	**10.9%**	**76,599**
Total per person	12.92	13.92	15.54	9.7%	17.63
Total per uninsured person	17.94	19.33	21.58	9.7%	24.49

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PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

AIM: To render support services required by the Department to realise its aims

SUB-PROGRAMME 7.1 LAUNDRY SERVICES

Rendering a laundry service to hospitals, care and rehabilitation centres and certain local authorities

Situation analysis
Laundry services are provided by large central laundries at Tygerberg, Lentegeur and George. Several rural hospitals have small in-house laundries. In the past 5 years much of the laundry service has been successfully outsourced resulting in significantly reduced costs.

Policies, priorities and broad strategic objectives
In order to provide a cost effective service with minimum risk, a combination of in-house and outsourced laundry services has been instituted. The immediate priority is to increase the efficiency of in-house services to make these cost competitive with the private sector. Where this is not possible additional outsourcing will be implemented.

Constraints and measure planned to overcome them
Relatively high salaries of in-house laundry personnel coupled with low productivity are a major constraint to making these laundries cost competitive. A gradual reduction in staff coupled with morale building and incentivisation will hopefully improve the situation.

Planned quality improvement measures
Additional out-sourcing is envisaged to reduce costs.
A pilot scheme has been implemented at Groote Schuur Hospital to out-source linen control. The pilot scheme has successfully increased the availability of linen and it is envisaged that the scheme will be extended to Tygerberg Hospital in 2003/4.

PROGRAMME 7.1 LAUNDRY SERVICES

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Provide a laundry service to all provincial hospitals	A combination of strategic in-house and out-sourced services	Clean and disinfected linen	Number of pieces laundered **Target:** 22 million pieces per annum	Production records	Number of pieces laundered	Number of pieces laundered	1 (year)	DD: Laundry Services	Yes
Provide cost effective in-house laundry service	Personnel productivity, production cost control and increased volumes	Average cost per item processed competitive with out-sourced service	Average cost per item **Target:** R1-50 per item	Production records and financial statements	Average cost per item	Total cost of in-house laundries	Total number of items laundered in-house	DD: Laundry Services and Institutions	Yes
Provide cost effective out-sourced laundry service	Competitive tendering process	Lowest average cost per item processed	Average cost per item **Target:** R1-10 per item	Production records and financial statements	Average cost per item	Total cost of out-sourced laundry service	Total number of items laundered by out-sourced laundry service	DD: Laundry Services and contractors	Yes

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Provide a laundry service to all provincial hospitals	Total number of pieces laundered:	21,000,000	21,000,000	22,000,000	22,000,000	23,000,000
Provide a laundry service to all provincial hospitals	Number of pieces laundered: in-house laundries	16,413,945	16,413,945	17,000,000	17,000,000	17,500,000
Provide a laundry service to all provincial hospitals	Number of pieces laundered: outsourced services	4,586,055	4,586,055	5,000,000	5,000,000	5,500,000
Provide cost effective in-house laundry service	Average cost per item	R1-69	R1-50	R1-50	R1-50	R1-50
Provide cost effective out-sourced laundry service	Average cost per item	R0-06	R1-10	R1-10	R1-10	R1-10

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).

SUB-PROGRAMME 7.2 ENGINEERING SERVICES

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

Situation analysis
Each hospital has its own engineering workshop to provide routine day-to-day maintenance. A minimal staff complement is provided to render this service. Two general engineering workshops (at Zwaanswyk and Bellville) and one clinical engineering workshop (at Vrijzee) provide support to the hospitals. The Bellville, Vrijzee and Zwaanswyk workshops employ engineers, technicians and artisans that are able to assist hospitals with larger and more complex maintenance and repair work. These three workshops are part of the Directorate: Engineering and Technical Support.

Policies, priorities and broad strategic objectives
All hospital equipment maintenance and repair work is done by the hospital workshop personnel and the Directorate: Engineering and Technical Support.
Maintenance of buildings is a joint venture with Public Works. The latter undertake all major construction, repair and maintenance work at hospitals. The Directorate: Engineering and Technical Support is responsible for prioritising and defining the work to be done by Public Works.
The most urgent priority is to address the backlog of maintenance and rehabilitation of hospital infrastructure. The backlog is currently estimated at over R500 million. The strategy is to maximise the available resources through a combination of in-house and outsourced work. Work is focussed on schemes that will lead to the realisation of the strategic plan of the Department.

Constraints and measure planned to overcome them
Inadequate funding for maintenance and rehabilitation has been a problem for many years. Coupled to this is inadequate funding for new or replacement medical equipment. The result is that the hospital engineering personnel have to resort to innovative measures to keep outdated and obsolete equipment operational. In respect of buildings the focus is largely on safety and minimum functionality rather than rehabilitation and upgrading.

Planned quality improvement measures
The increasing availability of conditional grant funding in the form of the Provincial Infrastructure Grant (PIG) and the Revitalisation Grant will enable hospitals to be systematically upgraded.

Physical condition of hospital network

Hospitals by type	Average 1996 NHFA condition grading[1]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
District Hospitals			
Beaufort West	4		Routine maintenance only.
Caledon	4		Routine maintenance only.
Ceres	5		Routine maintenance only.
Citrusdal	4		Internal and external renovations and painting.
False Bay	4		Internal and external renovations and upgrading in progress.
Hermanus	4		Routine maintenance only.
Knysna	4		Internal and external renovations and painting.
Ladismith	4		Routine maintenance only.
LAPA Munnik	4		Routine maintenance only.
Montagu	2/3		Internal and external renovations and painting.
Mossel Bay	4		Partial internal and external renovations and painting.
Otto du Plessis	3/4		Routine maintenance only.
Oudtshoorn	4		Routine maintenance only.
Riversdale	4		External renovations and painting.
Robertson	4		Routine maintenance only.
Stellenbosch	4		Roof replaced.
Swartland	4		Roof replaced and kitchen upgraded.
Swellendam	4		Routine maintenance only.
Vredenburg	3		None – High priority for Revitalisation Programme
Vredendal	4		Casualty upgraded.
Wesfleur	2		Extensive internal and external repairs and renovations
Provincially Aided District Hospitals			
Clanwilliam			Ward upgraded for “private” patients.
Laignsburg			One wing converted for use as a clinic.
Murraysburg			OPD added.
Prnce Albert			OPD added.
Radie Kotze			Ward upgraded for “private” patients.
Uniondale			Routine maintenance only.
General Hospitals			
Conradie	1		None – hospital in process of closing.
Eben Donges	4		New CHC to replace general OPD New 90 bed ward block added. Pharmacy upgraded Hospital identified for priority Revitalisation.
GF Jooste	4		Casualty upgraded OPD and staff amenities block added
George	4		New Administration block and nurses home added. New patient reception and specialist OPD added. Several wards upgraded. Hospital identified for priority Revitalisation.
Hottentots Holland	3		Maternity wing upgraded.
Karl Bremer	4		Central steam installation converted to point of use electrical heating. Wards and reception upgraded for “private” and hospital patients.
Paarl	3		Casualty upgraded. Central steam installation converted to point of use electrical heating. Hospital identified for priority Revitalisation.
Somerset	4		Central steam installation converted to point of use electrical heating.
Victoria	2		Substantial external renovation of buildings
Central			
Groote Schuur	5		Major renovations and improvements to maternity block and OPD.

Red Cross	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.
Tygerberg	3		Pharmacy upgraded.

Hospitals by type	Average 1996 NHFA condition grading[1]	Any later provincial audit grading (with date)	Outline of major rehabilitation projects since last audit
Tuberculosis			
Brewelskloof	4		Extensive internal and external repairs and renovations
Brooklyn Chest	4		Ongoing internal and external renovation of wards.
Provincially Aided TB Hospitals			
DP Marais SANTA	4		Ablutions upgraded.
Harry Comay SANTA	1		None.
Psychiatric			Routine maintenance only.
Alexandra	3		Administration and teaching/clinic blocks upgraded.
Lentegeur	4		Renovation of ward blocks in progress.
Nelspoort	3		Central steam installation converted to point of use electrical heating.
Stikland	4		Several ward blocks renovated.
Valkenberg	3		None – hospital being scaled down from 1039 to 200 beds.
Chronic medical and other specialised			
KBH Rehabilitation			None – to be relocated to Lentegeur
Mowbray Maternity	3		Portion of nurses home converted to active birthing unit and ward for “private” patients.
Provincially Aided Chronic medical and other specialised			
Booth Memorial			One wing renovated.
Die Wieg			Internal and external renovations and painting.
Maitland Cottage Home			Routine maintenance only.
Sarah Fox			
St Josephs Home			Routine maintenance only.
Conradie - Lifecare			Wards upgraded for use by Lifecare

SUB-PROGRAMME 7.2 ENGINEERING SERVICES

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Effective maintenance of buildings and engineering installations	A combination of in-house and out-sourced maintenance in co-operation with Works	Health facilities that are maintained safe, presentable and fit for purpose	Maintenance backlog as % of replacement value **Target:** <4%	Routine inspections and cost estimates	Maintenance backlog as % of replacement value	Estimated maintenance backlog	Total replacement cost of buildings and engineering installations	Hospital Engineering Services and Works	Yes
Efficient engineering installations	Monitoring of plant efficiency and modification or renewal as necessary	Minimised cost of utilities and operation	Cost of utilities per bed **Target:** R3600 p.a.	Inspections, measurements and bench-marking	Cost of utilities per bed	Cost of utilities	Number of beds	Institutions and Information Management	Not immediately & Yes
Safe working environment (Buildings, machinery and equipment)	Training of personnel. Statutory inspections and tests. Designing for safety.	Eliminate injury resulting from un-safe practices, poor maintenance and deficient design	Number of reportable incidents **Target:** No reportable incidents.	Routine and statutory inspections. Safety Committee reports. Incident reports.	Number of reportable incidents	Number of reportable incidents	1 (year)	Institutions	?
Cost effective maintenance of medical equipment	A combination of in-house and out-sourced maintenance	Extended economic life of equipment and increased safety	Average cost per repair **Target:** R800	Routine inspections and records kept by Technicians	Average cost per repair	Total budget of Clinical Engineering Departments	Total number of jobs completed	Clinical Engineering Departments	Yes

Objective	Indicator[1]	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Effective maintenance of buildings and engineering installations	Maintenance backlog as % of replacement value	10,2%	10,2%	9%	8%	7%
Efficient engineering installations	Cost of utilities per bed	n/a	R3613	R3600	R3550	R3500
Safe working environment (Buildings, machinery and equipment)	Number of reportable incidents	405	300	300	300	300
Cost effective maintenance of medical equipment	Average cost per repair	R1238	R728	R800	R800	R800

SUB-PROGRAMME 7.3 FORENSIC SERVICES

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

Situation analysis
Forensic Services are delivered from two components – one at the UCT Medical School and the other at the University of Stellenbosch.

Policies, priorities and broad strategic objectives
To provide a forensic pathology service to the Metropole Region and a medico-legal support service to the other regions in accordance with the provisions of the Inquest Act and the National Health Bill.
The priority is to retain the necessary medical expertise to ensure a uniform, high standard of medico-legal autopsy in cases of unnatural death.
A strategic objective is to provide training of medical and non-professional staff that is sufficient to ensure that forensic pathology services in the province, and beyond, are adequately resourced.

Constraints and measure planned to overcome them
High turnover of medical specialists due to scarcity of senior posts and high stress levels associated with the performing of approximately 7000 medico-legal autopsies per annum. This can be addressed by providing additional specialist posts of suitable grading.
A present constraint is lack of employment opportunities for the specialists who are trained. This is in spite on a need for these specialists in rural areas. The problem will be addressed when the medico-legal services are transferred to the Department from the SAPS.

Planned quality improvement measures
Reduction of delays in performing medico-legal autopsies, particularly for the deceased of the Muslim faith. This can also be addressed by more adequate staffing to provide extended hours of services once the service is transferred form the SAPS to Health.

SUB-PROGRAMME 7.3 FORENSIC SERVICES

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Render a forensic pathology service to the Metropole region in accordance with the prevailing statutory requirements	Provision of medico-legal services to Salt River- and Tygerberg, South African Police Services mortuaries	Post-mortem examinations, submission of medico-legal reports and attendance at inquests	Number of post-mortem examinations performed and documented **Target:** 7500	Annual Reports to The Head of Forensic Services, and (National) Department of Health	Number of post mortem examinations	Number of post mortem examinations	1 (year)	Forensic services at GSH and TBH	Yes
Render a cost effective forensic service in the Metropole	Productivity and cost control	Cost effective service	Average cost per examination **Target:** R600-00	FMS and annual reports	Average cost per examination	Total budget	Number of examinations	Forensic services at GSH and TBH	Yes

Objective	Indicator[1]	2001/02 (actual)[2]	2002/03 (estimate)[2]	2003/04 (target)	2004/05 (target)	2005/06 (target)
Render a forensic pathology service to the Metropole region in accordance with the prevailing statutory requirements	Number of post mortem examinations	7500	7500	7500	7500	7500
Render a cost effective forensic service in the Metropole	Average cost per examination	R550	R600	R650	R700	R750

SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Rendering specialised orthotic and prosthetic services.

Situation analysis
The Orthotic and Prosthetic (O&P) Service is rendered from a provincial centre adjacent to Conradie Hospital. Orthotist/Prosthetists attend orthopaedic clinics throughout the province. The service in the Southern Cape/Karoo has been successfully outsourced.

Policies, priorities and broad strategic objectives
The policy is to render an effective, efficient and sustainable service through a combination of in-house and outsourced services. The immediate priority is to recruit, train and retain personnel to sustain the in-house service. The broader strategic objective is to ensure continuity of service delivery through an optimum mix of in-house and outsourced services.

Constraints and measure planned to overcome them
A major constraint is our inability to attract and retain suitably skilled and experienced personnel. This can be attributed to a shortage of qualified Orthotist/Prosthetists and surgical boot-makers, coupled with uncompetitive salaries. The shortage is being addressed by in-house training programmes. The uncompetitive salaries are a much greater problem that is part of a much bigger problem of uncompetitive salaries of registered health support personnel.

Planned quality improvement measures
Quality improvement focuses on two areas:
1. The reduction of waiting times. This is being addressed by recruiting additional personnel and outsourcing selected services.
2. Working with other professionals in the rehabilitation field to improve the quality of appliances.

SUB-PROGRAMME 7.4 ORTHOTIC AND PROSTHETIC SERVICES

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Render an Orthotic and Prosthetic service for the Province	A combination of in-house and out-sourced services	Orthotic and Prosthetic devices	Number of patients registered and number of devices manufactured **Targets:** 4500 patient registrations. 3500 completed devices	Patient data-base	Number of devices manufactured	Number of devices manufactured	1 (year)	O&P patient data base	Yes
Provide quality devices	Training and liaison with Physiotherapists and Occupational Therapists	Devices that meet patient needs first time	% of devices requiring remanufacture **Target:** <5%	Production records	% of devices requiring remanufacture	Number of devices requiring remanufacture	Total devices manufactured	O&P production data base	Yes
Provide a responsive service	Increase productivity and outsourcing where cost effective	More devices for same cost. Reduced waiting time	Number of patients waiting over 6months **Target:** <600	Patient data-base	Number of patients waiting over 6 months	Number of patients waiting over 6 months	1 (year)	O&P patient data base	Yes

Objective	Indicator[1]	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Render an Orthotic and Prosthetic service for the Province	Number of devices manufactured	4548	4500	4550	4600	4650
Provide quality Orthotic and Prosthetic devices	% of devices requiring remanufacture	5%	5%	3%	3%	2%
Provide a responsive Orthotic and Prosthetic service	Number of patients on waiting list waiting over 2 months	1744	600	600	600	600

SUB-PROGRAMME 7.5 MEDICINE TRADING ACCOUNT

Rendering the supply of pharmaceuticals and medical sundries to hospitals, Community Health Centers and local authorities

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. Orders are supplied in bulk to larger hospitals or as smaller one-off items to smaller institutions. The academic hospitals generally buy directly from manufacturers and tend to use the CMD as a top-up service, which adversely affects other institutions.

The CMD is also responsible for pharmaceutical quality control. This is achieved by means of a Quality Control Laboratory (QCL) situated at the Cape Technikon. The Pre-pack Unit currently situated at the Metro Regional Office is responsible for preparing patient ready packs.

Policies, priorities and broad strategic objectives

In order to render an effective service, the CMD needs sufficient working capital to maintain adequate stock levels in the face of poor supplier performance, erratic deliveries and erratic demands. The immediate priority is to obtain the abolition of the interest levied on working capital employed which is the major constraint to efficient performance. Once this has been obtained it is feasible for the CMD to increase stockholding with no financial penalty. This will enable the CMD to meet demands currently procured external to the CMD. This will result in increasingly reliable estimates for consumables, which in turn will tend to smooth out supply side fluctuations.

Constraints and measure planned to overcome them

The immediate priority is to negotiate the abolition interest on capital of the interest levied on working capital employed, which is the major constraint to efficient performance.

Motivations have been made annually to augment the working capital in line with the inflationary price increase percentage for pharmaceuticals, taking into account the annual turnover of the CMD. It is hoped that an additional R10 million will be obtained through the adjustment budget in 2003/4.

Planned quality improvement measures

It is planned to relocate the pre-pack unit to the CMD premises from Karl Bremer Hospital. This will shorten turnaround time for pre-packs, allow greater planning flexibility, increase security and decrease costs.

It is planned to implement a wide range of security options including CCTV cameras, and greater physical security, to ensure that stock is not misappropriated.

Institute warrants and entitlements are planned to smooth out irregular demand patterns, and to permit capping of consumable budgets on an institution, item or province wide basis.

SUB-PROGRAMME 7.5 MEDPAS TRADING ACCOUNT

Objective	Strategy	Output	Performance: Measure/ Indicator/ Target	System used to monitor progress	KMO	Numerator	Denominator	Source	Data available
Ensure availability of essential drugs	Monitor stock levels in terms of demand and supplier performance	Dues out below 60	Dues out below 60 items **Target:** <60	Dues out reports	No of items on dues	No of items with Nil balance	1	Medsas	Yes
Efficient utilisation of working capital	Monitor low turnover items and put on DDV's	Stock turnover 8 or more times per year	Stock turnover **Target:** >8	Medsas report	Stock turnover	Stock issued	Working capital	Medsas	Yes
Adequate working capital to support adequate stockholding	Increase working capital in line with projected inflator	Adequate working capital	Sufficient working capital to keep stock turnover below 12	Increased Working capital	Stock turnover	Stock issued	Working capital	Medsas	Yes
Sufficient stock available at end-user level	Number of demands to be satisfies within 48 Hours	Service level above 85%	Service level Target: >85%	Medsas reports	Service level	No of demands satisfied	Total no of demands	Medsas	Yes

Objective	Indicator	2001/02 (actual)	2002/03 (estimate)	2003/04 (target)	2004/05 (target)	2005/06 (target)
Ensure availability of essential drugs	No of items on dues	54	140	60	60	60
Efficient utilisation of working capital	Stock turnover	12	14	10	9	9
Adequate working capital to support adequate stockholding	Stock turnover	22.257 million	30 million	40 million	46 million	53 million
Sufficient stock available at end-user level	Service level	82%	82%	> 85%	> 85%	> 85%

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES

AIM: To render support services required by the Department to realise its aims

Sub-programme	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	2003/04 (budget)	2004/05 (MTEF projection)	2005/06 (MTEF projection)
7.1 Laundry services	32,073	28,970	33,898	34,903	36,872	38,320
7.2 Engineering services	16,052	17,362	19,156	27,757	29,251	30,475
7.3 Forensic services	4,045	4,490	5,193	6,099	6,427	6,696
7.4 Orthotic & prosthetic services	6,655	7,359	8,425	8,578	69,040	9,418
7.5 Medpas Trading Account	1	7,743	1	2,001	2,109	2,197
Total programme	**3,366,689**	**3,581,017**	**3,871,636**	**4,194,599**	**4,420,411**	**6,605,303**

Table: Evolution of expenditure of budget programme in constant 2002/03 prices (R million)

Expenditure	2000/01 (actual)	2001/02 (actual)	2002/03 (estimate)	Average annual change (%)	2003/04 (budget)[2]
Total	66,454	70,011	66,672	0,3%	75,416
Total per person	15,77	16,43	15,48	-0,8%	17,36
Total per uninsured person	21,91	22,82	21,50	-0,8%	24,11