**3. REPORT OF THE PORTFOLIO COMMITTEE ON HEALTH ON OVERSIGHT VISIT TO LIMPOPO PROVINCE FROM 21 TO 24 JULY 2015, DATED 24 FEBRUARY 2016**

The Portfolio Committee on Health having undertaken an oversight visit to the Limpopo Province from 21 to 24 July 2015 reports as follows:

1. **Objectives**

One of the functions of the Portfolio Committee on Health is to conduct oversight over the Department of Health and its entities. The Committee conducted its oversight visit in Limpopo Province from 21 to 24 July 2015.

The purpose of the oversight visit was to assess the following:

* Primary health care (PHC) services;
* Spending patterns of the province and of the different institutions;
* Human resources;
* Infrastructure in the public health institutions;
* Balance between clinical and administration services;
* Health service delivery;
* Security in public health facilities; and
* Drug stock outs.

1. **Delegation**

The delegation comprised of the following Members of Parliament:

Ms ML Dunjwa (ANC, Chairperson of the Committee)

Mr AF Mahlalela (ANC)

Dr P Maesela (ANC)

Mr I Mosala (ANC)

Ms CN Ncube-Ndaba (ANC)

Dr WG James (DA)

Dr HC Volmink (DA)

The following officials accompanied the delegation:

Ms Vuyokazi Majalamba (Committee Secretary)

Ms Nombali Magubane (Committee Assistant)

Mr Zubair Rahim (Committee Researcher)

Mr Moses Mncwabe (Committee Researcher)

Ms Lindokuhle Ngomane (Content Advisor)

1. **Member of the Provincial Legislature in attendance**

Mr WG Mtileni (Portfolio Chairperson)

1. **Public health facilities visited**

The Committee visited the following facilities; Messina Hospital, Madombidzha Clinic, George Masebe Hospital, Mapela Clinic, Mokopane Hospital and Letaba Hospital.

1. **Meeting with the Member of the Executive (MEC), Head of Department (HOD) and the Provincial Departmental officials**

Before undertaking its oversight visit to the different public facilities, the Committee met with the MEC, HOD and the departmental officials.

The Committee met with the following delegation at the office of the MEC:

Dr Phophi Ramathuba (MEC for Health in Limpopo Province); Dr S Kabane (HOD); Mr Jimmy Ledwaba (Senior General Manager, National Health Insurance); Dr M Nkadimeng (Senior General Manager); Mr NI Maphaha (Committee Coordinator, Limpopo Legislature); Ms PM Ramashilo (Researcher, Limpopo Legislature); Mr JT Mankhe (Parliamentary Officer); Dr RS Maponya (General Manager, Health Services); Mr TB Seate (Acting General Manager, Tertiary and Academic Services); and Mrs N Matshivhe (Senior Manager, MEC’s Office).

The MEC for Health in the province, Dr Ramathuba delivered her welcoming statement. The Head of Department, Dr Kabane, gave an overview of the current status of health services delivery in the province in line with the purpose of the oversight visit.

Dr Kabane pointed out that the province has of 5.54 million, characterised by high poverty and illiteracy rates. The province is comprised of five districts namely; Capricorn, Mopani, Waterberg, Vhembe and Sekhukhune. There are 42 hospitals of which 30 are district hospitals, six regional hospitals, two tertiary and four specialised hospitals. There are 444 clinics and community health centres which are spread through the five districts. Limpopo is ranked 3rd lowest prevalence of HIV and 2nd lowest prevalence of tuberculosis (TB).

The strategic priorities of the province are drawn from the manifesto, MTSF, outcomes and mandated outputs. The MTSF strategic priority five is to improve the health profile of all South Africans and the outcome is “long and healthy life for all South Africans”. The mandated outputs are as follows:

Output 1: Increasing Life Expectancy

Output 2: Decreasing Maternal and Child Mortality

Output 3: Combating HIV and AIDS and decreasing the burden of disease form TB

Output 4: Strengthening Health System Effectiveness

Dr Kabane also indicated that the strategic priorities are also influenced by the National Development Plan (NDP) with its nine pillars that relates to health as follows:

* Average male and female life expectancy increased to 70 years;
* Tuberculosis prevention ad cure rates progressively improved;
* Maternal and child mortality rates reduced;
* Prevalence of chronic non-communicable diseases reduced by 28%;
* Injury, accidents and violence reduced by 50% from 2010 levels;
* Heath systems reforms completed;
* Primary Health Care teams deployed to provide care to families and communities;
* Universal Health Coverage achieved; and
* Posts filled with skilled, committed and competent individuals.

On primary health care, Dr Kabane highlighted that to restore the image of PHC facilities, the province will follow the social franchising model for Ideal clinics. The approach will be based on qualification, commitment, support and maintenance. Firstly, a clinic will be certified as an Ideal clinic after achieving a score of 80% on the Office of Health Standards Compliance (OHSC) audit. Secondly, clinics must sign a partnership agreement with the National Department of Health (NDOH) and the province to maintain their status until the next audit (including signage, uniform and training courses). Thirdly, the NDOH and the province must commit to provide ongoing support to the clinics via delivery units. And lastly, quality assurance and performance monitoring include site inspections (2 years) and self-assessments (1 year) will be undertaken.

Dr Kabane highlighted the following prerequisites for an Ideal clinic:

* Have the required administrative processes to ensure efficiency and effectiveness.
* Have good infrastructure (buildings in good form, adequate space, essential equipment and information and communication network and tools) to provide the required services.
* Ensure continuity of care through an effective patient information system.
* Integrate the services and functions of the district clinical specialist teams (DCSTs), school health teams and municipal ward-based primary health care outreach teams (WBPHCOT) to improve population health outcomes.
* Provide integrated chronic disease management (ICDM) to deliver integrated patient centered care to patients with chronic diseases, encompassing the full value chain of continuum of care and support through the application and use of up-to-date clinical guidelines and protocols.
* Have the required medicines, supplies and laboratory support.
* Have adequate staff who have the required skills and uphold high standards of professional etiquette.
* Have a doctor available for the required sessions per week.
* Co-operate with stakeholders in the community to ensure quality comprehensive PHC services.
* Have the required district health support systems available to it.

Progress made by the province in relation to the Ideal clinics includes the following: provincial team having attended the six weeks lab; provincial workshop on ideal clinical was held; each district has developed a plan with prioritised clinics; and active support of development partners.

On National Health Insurance (NHI) and PHC re-engineering, the HOD mentioned that Vhembe District was selected as one of the districts to pilot NHI. The NHI pilot in Limpopo was formally launched by the Minister of Health, Dr Motsoaledi, on 17 April 2012, followed by three days of stakeholder consultative workshops. NHI activities in the district are funded from the NHI conditional grant on the basis of an approved business plan.

Dr Kabane further noted that a strong PHC service delivery platform is the heartbeat of the implementation of NHI. The health sector has developed and begun implementing a PHC re-engineering model, which consists of four streams as follows:

* Creation and deployment of ward-based PHC outreach teams;
* Establishment of district clinical specialist teams;
* Strengthening of integrated School Health Services; and
* Contracting of private health practitioners.

On finances, the HOD indicated that the budget for the provincial department of Health in Limpopo is R14.75 billion. The bulk of the budget goes to District Health Services. In this current financial year, the department is experiencing budget pressures under the health facilities management programme, spending is at 81.8% as of 30 June 2015. Overspending is anticipated under goods and services and households. In terms of conditional grants, there is slow spending on the National Health Insurance grant. On audit outcomes, the department received disclaimers as from the years 2010/11 financial year to 2012/13 and received a qualified audit opinion in 2013/14.

On human resources, the HOD highlighted that the vacancy rate was highest for medical specialists at 49% followed by professional nurses community service (44.1%), medical officers (31.6%) and medical officers community services at 20.0%. The department has experienced a high number of terminations (1832 as of the end of March 2015) from core personnel due to the new pension legislation.

The HOD indicated that the province has inherited an aged and inappropriate health infrastructure. The infrastructure budget has been steeply declining over the past three years (from 2010/11) which led to the province almost stopping the procurement of new infrastructure and limited maintenance of the existing one. Infrastructure challenges have therefore been responsible for a number of clinical incidents and medico-legal claims.

Dr Kabane noted that all security services in the province are provided through a central contract managed at provincial Treasury and all security services in the provincial department of Health are outsourced. There is a sector process of insourcing and the department has an operational plan which addresses the process. The department has experienced service provider challenges in different facilities, but these have been addressed jointly with provincial Treasury.

One of the six ministerial priority areas is availability of basics medicines and supplies. At the time of the oversight visit, clinics and hospitals were at 71.95% and 76.07% respectively. The medical depot medicines and surgical sundries was at 72%. The province is also experiencing a shortage of the BCG vaccine as it is a country-wide challenge.

The HOD highlighted that the province has since improved in some areas which include the accelerated implementation of programmes that will lead to the realisation of Universal Health Coverage through the National Health Insurance. There has been a focus on maintenance of infrastructure in the short to medium term. There has been improvement in life expectancy and reduced burden of disease such as HIV and AIDS, TB, malaria and non-communicable diseases.

Having indicated the areas that have improved in the province, the HOD noted that there were areas that needs to be improved which included amongst others, to fully revitalise the provincial health information system; implementation electronic patient records system; implementation of a system that will improve data collection; security; analysis, usage and storage; maintain high levels of medicines and consumables availability at all levels of facilities including the medical depot; and maintain and improve on the audit outcomes.

## Messina Hospital

On the 21 July 2015, the Committee conducted its oversight visit at Messina Hospital. The Committee met the following delegation at the hospital:

Ms F Mabuza (Chief Executive Officer, Messina Hospital); Dr IM Malatji (Chief Executive Officer, Louis Trichardt Hospital); Mrs Mojapelo Mouchi Johanna (Corporate Services); Mr Mathule Nniritsheni (Manager, Physical Facilities); Dr Magombo Mollen (Acting Clinical Manager); Mr TH Hlungwani (Communications Coordinator); Mr MP Morkee (Director, Infrastructure Planning); Mr MP Thobokgale (Coordinator); Ms LU Rathanga (Acting Senior Manager, Healthcare Support); Ms EM Lajuschaer (Manager, Pharmaceuticals); Ms MM Mashapo (Deputy Manager, Nursing Services); Ms FS Tshikovhi (Manager, National Health Insurance); Mr AE Muyanalo (Quality Assurance Coordinator); Mr J Ledwaba (Supply Chain Management); Mr Phamphe Phamel (Acting Senior Manager); Ms MP Malumane (Pharmacy Manager, Louis Trichardt Memorial Hospital); Mr Sigidi Kutelani (Deputy Manager, Communications, Louis Trichardt Memorial Hospital); Mr James I Mangkge (Parliamentary Officer); Mr NI Maphaha (Committee Coordinator); and Ms PM Ramashilo (Researcher).

Ms F Mabuza, the CEO of Messina Hospital briefed the Committee and highlighted that Messina Hospital is a small district hospital with 80 beds situated 90 km from Makhado town and 12 km from Beitbridge bordering Zimbabwe. The hospital is servicing a catchment population of 73 582 with 93.6% uninsured including foreigners.

Services rendered in the hospital includes amongst others trauma and emergency, mental health care, ophthalmic care, pharmaceutical services, paediatric services, infection control and health promotion services. Additional services include Thuthuzela Care Centre which is rendering trauma care and victim empowerment, Home Affairs registration of new babies and road accident fund services.

On the workforce profile of the hospital, there is a high vacancy rate (50.65% overall). Staff shortages is on all staff categories from medical officers, nursing personnel, allied personnel, administrative personnel to general personnel.

The budget for the hospital for 2015/16 is R90.9 million. The bulk of the budget goes to compensation of employees (90.98%) with households allocated R100 000 and machinery and equipment receiving R200 000. The CEO reported that the hospital has incurred over-expenditure on compensation of employees, goods and services, household and machinery and equipment.

The over-expenditure on compensation of employees is due to the general increment, grading of nurses and being under-funded. The over-expenditure on goods and services relate to accruals of last financial year and key accounts invoices that are expensive. The over-expenditure on machinery and equipment is due to commitment amounting to R460 101 for 2014/15. To address the over-expenditure, management will submit budget pressures to the provincial office through the district office.

On drug availability, the CEO noted that Messina Hospital was at 92% for tracer drugs and 86% for essential drugs. The hospital has experienced stock outs on disposable thermometers, N95 masks, Aluminium hydroxide liquid (Myogel).

Status of the standby generator was reported as being functioning with a 600 litre capacity attached to it and a separate storage tank of 2000 litres. The generator takes approximately five seconds to kick-up during power failure or load shedding. There are processes in place to relocate the old mobile standby generator from Tshilidzini Hospital to Messina Hospital.

The Committee concluded its meeting and took a walkabout in the hospital and visited the pharmacy, kitchen, laundry, paediatric ward, general ward, medical ward, maternity ward, X-ray room, theatre and outpatient department.

**Achievements**

The CEO highlighted the following achievements:

* Improved appointment of doctors from two to nine in 2014/15
* Received two autoclaves from National Department of Health in 2013 from the National Health Insurance programme
* Procured new anaesthetic machines and a new ironing machine in 2015
* Change of all patient’s mattress

**Challenges**

Infrastructure challenges:

* Causality is not easily accessible to ambulances.
* Old and inappropriate infrastructure and general shortage of space on-site.
* Limited working space at causality ward and outpatient department and it is not easily accessible to ambulances.
* Utilization of prefabricated structure in the outpatient department and tuberculosis unit.
* Allied health services are rendered in old mine houses.
* Limited staff accommodation.
* Need for the development of a replacement hospital which was approved in 2005/06.

Medical equipment challenges:

* The X-ray room is non-compliant with norms and standards of radiation control.
* Theatre emergency light is old.

Non-medical equipment challenges:

* Laundry machines and kitchen are old.

Referral system challenges:

* There is a poor referral system. The hospital experiences walk in patients without referral letters.

**Findings and observations**

* The Committee noted with great concern that a decision was taken in 2006 to demolish the existing Messina Hospital and rebuild it but no progress has been made to date.
* Medicine is stored in an office because the space is not enough at the drug storeroom.
* Medication is not properly labelled.
* There were ice packs in the passage at the pharmacy and not properly kept.
* Cleaning material and crockery were kept in one storeroom because of lack of space at the kitchen.
* The laundry at Messina was dirty with dysfunctional equipment.
* Soap used at the laundry was not of good quality that damages garments.
* There is no spin dryer at the laundry and clothes were hung in the sun to dry which sometimes poses a challenge especially during rainy seasons
* There is a high vacancy rate at the hospital and there is no commitment or timeframes given of when the posts will be filled.
* There is no paediatrician at the hospital and they refer their patients to Thohoyandou which is 138 km away from Messina.
* There is no orthopaedic surgeon at the hospital and patients are referred to Polokwane and some are sent back home due to the lack of beds.
* The hospital has already overspent by 61% on its budget in the first quarter.
* There has been a decline on the budget for goods and services which makes it difficult to procure new equipment or even maintain the existing one.
* The paediatric ward has no isolation. The hospital has no onsite paediatric doctor, a paediatrician visits the hospital once a month.
* Maternity ward is small with two neonatal cubicles.
* Patients with TB are accommodated in the same ward as general patients as there is no TB ward.
* The general ward is a mud bricks structure with its roof leaking.
* The X-ray room is near the maternity ward with a wooden door. This is an occupational hazard. X-ray machine is a more than 37 years old analogue machine which is always broken.
* The chronic ward has old and rusty sinks.
* Lack of disposable supplies such as N95 masks, paper towels and hand disinfectants.
* In theatre, linen is a challenge, it is not enough; only one operating table; and the air conditioners are not functioning.
* The outpatient department (OPD) is a small prefabricated structure with two consultation rooms.

1. **Madombidzha Clinic**

Ms Munonde (Operational Manager, Madombidzha Clinic) did the presentation and noted that Madombidzha Clinic is situated in the Makhado Health Sub-District of the Vhembe District Municipality. It is 16 km from Makhado town and Louis Trichardt Memorial Hospital.

The new clinic facility was officially opened on the 18th March 2014. The clinic renders 24 hour services on a call system basis. The current population served by the facility is 21 000 and villages served are Magau 1, 2 and 3, Madombidzha 1, 2 and 3, Tshiozwi 1 and 2, Rathidili 1 and 2, Brambos and neighbouring farms.

The primary health care package offered at the clinic include maternal services (antenatal care and deliveries), child health, reproductive health, prevention-of-mother-child transmission (PMTCT), mental health, chronic diseases like hypertension, diabetes mellitus, asthma, arthritis, epilepsy, HIV, youth friendly services, ward-based outreach and home-based care.

The headcount in 2014/15 was 57 538 clients. This contributes 6.8% to the 846 371 district headcount of the 123 PHC facilities in Vhembe district. The monthly headcount ranges from 5000 to 6000 clients and deliveries ranges from 25 to 30 per month. Drug availability was reported at 89.1% with tracer drugs at 84% and stock outs at 16%.

**Successes reported were as follows:**

* There is a soccer team for the elderly called Madombidzha Vhaaluwa Soccer FC. The team has started a fresh vegetable garden project inside the facility premises which is supported by the Department of Agriculture.
* There is an NHI doctor who comes to the facility from Mondays to Fridays weekly.
* The clinic has good working relationship with the Clinic Committee, Traditional leaders, local councillors and the community in general.
* The Makhado Municipality has provided the clinic with eight big waste bins.
* There are two doctors that have been contracted through primary health care re-engineering project.
* There is a functional facility improvement team towards NHI preparedness.

**Challenges highlighted were as follows:**

* Shortage of staff to provide a 24-hour service on night shift.
* There is no administration clerk and pharmacy assistant.
* The posts of a cleaner and a groundsman are vacant.
* The dispensary is small.
* The facility does not have a standby generator.
* Shortage of ambulances to transfer patients.

The Committee had a walkabout in the clinic.

**Findings and observations**

* The facility is affected by load shedding with staff resorting to using candles.
* The facility has no back-up plan for medicines that needs to be refrigerated, such as vaccines.
* The budget allocated to the clinic is located in the district.
* There is no midwife obstetrics unit and emergency room for patients awaiting transfer to the hospital.
* The pharmacy is secured and lockable.
* There is no pharmacist at the clinic, medication is dispensed by nurses.
* There is no groundsman.
* The clinic is operating on a 24-hour call system.
* There is a shortage of ambulances. Response time can be up to two hours.

1. **George Masebe Hospital**

The Committee conducted its oversight at George Masebe Hospital on the 22 July 2015 and met with the following delegation:

Ms RS Mokonyana (Chief Executive Officer, George Masebe Hospital); Mrs Maleka M Edith (Acting Senior Manager, Hospital Services); Mr Maxabane (Division Senior Manager, Financial Management); Mr MM Lamola (Senior Manager); Ms M Masemola (Emergency Services); Mr Stephen Mosimege (Senior Manager, Health Special Programmes); Mr Morobi Godly Malahji (Communications Manager); Mr SG van Zyl (Infrastructure Manager); Ms MM Langa (Assistant Area Manager); Ms MR Malatji (Assistant Area Manager); Ms MS Mokoma (Acting Allied Manager); Mr MF Malatji (Chief Artisan); Mr MS Makota (Deputy Manager Finance); Ms LJ Lesabane (Deputy Manager Nursing); Mr CC Mojem (Deputy Manager); Mr MP Seko (Communication Officer); Mr MA Maphoto (Senior Provisioning Administration Officer); Mr T Nkozele (Acting Manager); Mr TN Dhlamini (Chief Quantity Surveyor); Dr BC Okorie (Senior Clinical Manager); Mr D Phago (Operational Manager); Mrs SM Diase (Assistant Manager); and Ms M Mailula (Assistant Manager).

The CEO gave the overview of the hospital. The hospital is named after the late Kgoshi George Langa of the Bakenberg Tribal Authority. The hospital was built in 1968 and was under the administration of Dutch Reformed Missionaries and by then it was called Mogalakwena Hospital.

George Masebe is a district hospital providing level one care services. It is situated 60 kilometres west of Mokopane Town and serving a population of 139 393 under Mogalakwena Municipality in the Bakenberg local area. The hospital supports 14 feeder clinics and one community health centre.

Services rendered at the hospital are trauma and emergency, mental health care, ophthalmic care, obstetrics and gynaecology, dental/oral health, HIV and TB clinic, surgical, paediatric, mother and child, infection control, occupational health and safety, health promotion and oncology. Other services include those of Home Affairs, Emergency Services and Gateway clinic operating at an 8-hour system.

Drug availability was at 95% at the time of the visit. Pharmacy stock outs were reported on Vaccine BCG 20 Dose Vial + Diluent.

There are 21 security services, seven work day shift, seven night duty and seven for relief. They are posted at maternity ward, paediatric ward, main gate and also patrolling in the hospital premises from paediatric outpatient department to adult outpatient department.

**Achievements**

* The hospital has made improvements in compliance to the National Core Standards.
* The number of doctors has increased from seven in 2013 to 16 permanent and three sessional in 2015.
* A new chiller plant in the theatre has been installed.
* The vinyl flooring in the dental section, theatre 1 and 2 and in the female ward was completed.
* The paediatric ward has been renovated.
* The general ward and outpatient has been repainted.

**Challenges**

Infrastructure challenges:

* Ageing and inappropriate infrastructure which is not fit for purpose.
* Delayed completion of the maternity unit.
* Flooding of the hospital during rainy season.
* Unreliable water supply.
* Bad road to access boreholes.
* Theft of electrical cables and water related equipment.
* Budget limitations delays the complete refurbishment of the laundry.
* Steam and condensate lines are in bad condition and need replacement.
* The use of gas on trolleys need to be replaced with a gas line.
* Internal communication in the facility is a challenge because of poor cellular reception.

Human resources challenges:

* The vacancy rate for professional staff is at 39.23% and support staff vacancy at 60%.

The Committee took walkabout in the hospital and visited the pharmacy, paediatric, maternity, labour ward, allied health support services and kitchen.

**Findings and observations**

* The hospital has already reported an over expenditure in this budget when still in the first term of the financial year and they still need to fill vacant positions.
* There is no proper planning in the hospital as they could not even fill positions of the personnel that has retired.
* Budget allocated to the hospital has declined in all areas.
* Budget constraints prevent the complete refurbishment of the laundry and completion of maternity unit.
* There are staff shortages at the hospital at all levels.
* The hospital is outsourcing its laundry services and there is currently no plans to insource.
* There are delays in completing the maternity ward.
* There is unreliable water supply.
* Equipment are used more than their life span.
* There is no proper way of managing equipment that needs to be repaired or disposed of.
* Dental: two autoclaves are broken, dentists use microwave to sterilize equipment which is also used for warming up food. X-ray machine is not working. Electrical wiring is a problem.
* Occupational therapy: not enough equipment due to budget constraints.
* Pharmacy: Waiting time is about 10 minutes. Drug availability is at 94%.
* Kitchen: Dietician is responsible for the menu. Post for kitchen supervisor is vacant and staff acting on the position for years and not being compensated. Meat was found to have expired more than three months ago.

1. **Mapela Clinic**

The Committee conducted its oversight visit at Mapela Clinic on the 22 July 2015 and met with the following delegation:

Mrs SM Diase (Assistant Manager, Mapela Clinic); Mr Daniel Phago (Operational Manager, Mapela Clinic); RS Mokonyana (Chief Executive Officer, George Masebe Hospital); Mrs Maleka M Edith (Acting Senior Manager, Hospital Services); Mr Maxabane (Division Senior Manager, Financial Management); Mr MM Lamola (Senior Manager); Ms M Masemola (Emergency Services); Mr Stephen Mosimege (Senior Manager, Health Special Programmes); Mr Morobi Godly Malahji (Communications Manager); Mr SG van Zyl (Infrastructure Manager); Ms MM Langa (Assistant Area Manager); Ms MR Malatji (Assistant Area Manager); Ms MS Mokoma (Acting Allied Manager); Mr MF Malatji (Chief Artisan); Mr MS Makota (Deputy Manager, Finance); Ms LJ Lesabane (Deputy Manager Nursing); Mr CC Mojem (Deputy Manager); Mr MP Seko (Communication Officer); Mr MA Maphoto (Senior Provisioning Administration Officer); Mr T Nkozele (Acting Manager); Mr TN Dhlamini (Chief Quantity Surveyor); Dr BC Okorie (Senior Clinical Manager); and Mr D Phago (Operational Manager).

The Assistant Manager, Mrs Diase made the presentation on behalf of the clinic. The clinic was commissioned approximately 90 years ago as a two room facility. The catchment population that the clinic is servicing is 11 072 and 11 villages. The burden of disease is diabetes, hypertension, TB and HIV.

Services provided at the facility are women’s reproductive health, deliveries, management and prevention of genetic disorders and birth defects, integrated management of childhood illness, management of chronic illnesses like asthma, HIV and AIDS, diabetes and hypertension, adolescent and youth health, oral health and other primary health care services.

**Challenges**

* The allocated budget for the facility is centralised.
* Number of Male Medical Circumcision (MMC) booked exceeds the clinic capacity. There is limited space and lack of privacy for circumcisions.
* The efficiency of water pipes has been compromised due to hard water which results in leakages and blockages.
* There are transport shortages which limit the outreach services. The facility has three mobile clinic vehicles and two of these are over their lifespan and frequently in for repairs causing interruptions to visits.
* There is insufficient medical waste storage which compromises infection control.
* A doctor from Mokopane Hospital visits the clinic weekly. The waiting time to see a doctor is three hours.
* Staff accommodation is of poor quality and insufficient.

1. **Mokopane Hospital**

The Committee conducted an unannounced oversight visit at Mokopane Hospital. The Committee conducted a walk about led by the CEO of the Hospital and visited causality, new female and male wards, high care and paediatric ward. The Committee commended the cleanliness of the hospital and noted the platinum accreditation for providing excellent newborn care.

**Findings and observations**

* The causality lacks proper infrastructure and there is no privacy for patients.
* The hospital has 59 doctors including community service doctors.
* There is only high care unit at the hospital and no ICU.
* Broken equipment takes time to be repaired. E.g. incubators that were taken for repairs in 2014 have not been returned.
* There is a shortage of linen. Available linen is torn and not well kept.
* Budget for equipment is only R750 000 since 2010 which poses a challenge in procuring new equipment.
* Security is insufficient in the wards.
* The hospital experiences a high volume of illegal immigrants.
* Water reticulation is a challenge, this is due to hard water corroding plumbing.

1. **Letaba Hospital**

On the 23 July 2015, the Committee visited Letaba Hospital and met with the following delegation:

The Acting CEO, briefed the Committee and noted that the allocated beds for the hospital are 400 but only 214 are usable. Services are offered within normal working hours and emergency services are offered for 24 hours. The hospital provides level one and two services due to service demands from the dense population in close proximity to the hospital.

The hospital is undertaking various infrastructure interventions, some of these are:

* Maternity building, neonatal wards and victim empowerment centre are nearing completion with electrical work and internal finishing underway. Estimated completion date is October 2015.
* An additional generator will be provided for the maternity building, neonatal wards and victim empowerment centre and estimated completion is in October 2015.
* Work has started on the psychiatric ward and estimated completion is in July 2015.
* Renovations and alterations to the psychiatric ward is currently undergoing and estimated to be completed in July 2016.
* Work on the Orthotic-prosthetic centre is about to be completed, with flooring, seating and electrical fittings are outstanding.

The hospital’s budget for the 2015/16 financial year is R320.6 million. The hospital is overspending by 25% in this current financial year. Budget pressures are on goods and services, households and machinery and equipment. Maintenance budget has been cut from R3 million in the last financial year to R2.5 million in the current financial year. Household budget has been cut from R550 000 to R100 000 and already overspent by R468 000.

The hospital has high vacancy rates from senior management, medical specialists to administrative personnel. Vacancy rate for medical specialists is at 80.95%, operational manager (94.73%) and 81.2% for administration clerks.

**Challenges**

Infrastructure challenges:

* Delays in the completion of maternity ward and victim empowerment centre.
* The psychiatric ward has been closed due to underground water.
* There are delays in the completion of flooring and back-up water capacity.
* There is inadequate storage for medical records.
* There is a need for a back-up generator for newly maternity, neonatal unit and victim empowerment centre.
* The hospital does not render own laundry services.

Human resource challenges:

* Lack of specialists to provide level two services.
* Managerial posts not being filled leading to the lack of accountability and capacity (e.g. senior clinical manager, operational manager, pharmacy manager, etc.).
* Lack of support staff (e.g. ward clerks, patient admin, etc.).

Patients’ safety challenges:

* Security officials are not enough per shift (only 11 per shift).
* No security officials for residential area, pharmacy and kitchen.

Drug availability challenges:

* Many items are not on tender and they are sourced through quotation by provincial depot.
* There are no active pharmaceutical ingredients at the manufacturer level.

Referral system challenges:

* Lack of referral policy. There is a need for a gateway clinic.

The committee delegation visited both clinical services and support services.

**Findings and observations**

* Pharmacy: Drug availability is at 92% with enough stock of BCG. Storeroom where ARVs are kept has no light since 2014. Hospital pharmacy is able to supply ten surrounding clinics. The hospital does not adhere to norms and standards of drug storage as drugs were not properly labelled.
* Kitchen: Catering contractor staff not being provided with protective clothing. Some food items provided by the contractor were found to have reached expiry date (e.g. eggs).
* There is insufficient budget for equipment and maintenance.
* Human resources: There is severe staff shortages at all levels. Acting staff is not compensated for a number years. Approved grade progression for allied health workers has not been implemented. There is no specialist to provide level 2 services.
* A patient died at ICU during load shedding and the generator did not have fuel.
* There is a lack of back up of water supply at the hospital.
* There is no proper storage system for medical records.
* There is no proper system of storing unused equipment. There is lack of medical equipment.
* The Committee observed that the hospital is clean even during renovations.
* Psychiatric patients are accommodated with other general patients in one ward.

1. **Overall findings and observations made by the Committee**

The Committee made the following findings and observations:

1. **Human resources**

The provincial department suffers from critical staff shortages with critical posts not being filled. Funded vacancies takes time to be filled. There is overspending on compensation of employees. Conditions of employment observed by the Committee includes; personnel grade progression, poor performance management development systems leading to low staff morale and discontentment and a number of acting positions without compensation.

1. **Finances**

Budget on machinery and equipment is a concern. Most equipment are old and broken down and cannot be fixed or replaced due to limited budget. There is a decline in budget for goods and services.

1. **Infrastructure**

Most services are outsourced, such as security services, laundry, laboratory and medical waste. Where laundry services are rendered the machines are old and cannot clean the linen properly. The budget cuts on infrastructure is a concern, from R900 million to R300 million. Messina Hospital was prioritised almost ten years to be re-built, however issues of site to build has impeded the process.

1. **Procurement**

There is a poor contract management, contracts expire and hospitals goes on quotation or extended basis. For example, the catering contract in Letaba Hospital, the contractor cannot provide protective clothing to staff or conduct quality assurance of stock.

1. **Governance structures**

Governance structures do not exist in most facilities. The challenge is that members refuse to attend meetings as they are not offered stipend or sitting allowance.

1. **PHC re-engineering**

There is uneven roll-out of WBOTs and school health services due to the lack of human resources. Most facilities use already limited staff.

1. **Emergency Medical Services**

There is a shortage of ambulances. Response time can be up to four hours.

1. **Mobile clinics**

Mobile service provision is inconsistent, in some districts the vehicles are old or not in good condition.

1. **Recommendations**

In response to the findings and observations, the Committee recommends that the provincial department should:

* Address the issue of staff shortages urgently, as they were identified in all health facilities visited.
* Come up with a recruitment and retention strategy for health professionals and fill all critical posts.
* Ensure that a budget need assessment is carried out and budget anomalies looked into to ensure that health facilities have sufficient budget allocations.
* Prioritise infrastructure funding to ensure that all infrastructure development challenges are addressed.
* Prioritise the re-building of Messina Hospital as it is well overdue.
* Put systems in place to ensure that all health facilities place their orders for stock on time and they order enough stock. This will ensure that stock is always available at facilities.
* Ensure that health facilities conduct proper stock taking and quality assurance to avoid the use of expired products.
* Attend to contract management and ensure that all projects are completed within agreed timeframes.
* Ensure that health facilities never run out of consumables. This will also assist in curbing the spread of infections.
* Ensure that health facilities have relevant equipment and equipment maintenance plans in place.
* Ensure improved contract management in terms of service level agreements.
* Ensure improved record keeping in health facilities.
* Ensure that hospitals and clinics in the province have governance structures in the form of Hospital Boards and Clinic Committees that are functional to increase local accountability and power.
* Address the issue of insufficient ambulances and improve response times.
* Ensure improved provision of mobile services.
* Ensure resourcing of primary health care programmes to improve roll-out and prioritisation of WBOTs and school health services.

**Report to be considered.**