Provincial Gazette

Free State Province

Published by Authority

Provinsiale Koerant

Provinsie Vrystaat

Uitgegee op Gesag

No. 68 FRIDAY, 15 September 2017 | No. 68 VRYDAG, 15 September 2017

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PROVINCIAL NOTICE

PROVINCIAL NOTICE

[No. 181 of 2017]

PRIVATE HEALTH ESTABLISHMENT AMENDMENT REGULATIONS, 2017

I, B Komphela, Member of the Executive Council responsible for Health in the Province, in terms of section 16(1)(i) of the Free State Hospital Act, 1996 (Act No. 13 of 1996), hereby publish the Amendment Regulations as set out in the Schedule.

SCHEDULE

GENERAL EXPLANATORY NOTE:

[ ] Words in bold type in square brackets indicate omissions from existing regulations.

___ Words underlined with a solid line indicate insertions in existing regulations.

Amendment of regulation 1

1. Regulation 1 of the Private Health Establishment Regulations, 2014 (hereinafter referred to as the "Regulations") is amended by the insertion of the definition of "**services**" after the definition of "**rehabilitation facility**":

" '**services**' means healthcare package in accordance with licence applied for and subsequently issued;".

Amendment of regulation 2

2. Regulation 2 of the Regulations is amended by –

(a) the substitution of subregulation (1) of the following subregulation:

"(1) Subject to regulation **[31]** 3(1) **[and subregulation (2)]**, these Regulations apply to all private health establishments in the Free State."; and

(b) the insertion of subregulation (4) after subregulation (3):

"(4) When considering whether good grounds exist in terms of subregulation (2), the MEC must take into account the following:

(a) the nature and purpose of the provision or provisions in the regulations that the private health establishment is seeking exemption from;

(b) the circumstances of the private health establishment including –

(i) the financial position of the private health establishment to comply with the provisions in question; and

(ii) the implications on the ability of the private health establishment to provide health services.".

Amendment of regulation 3

3. Regulation 3 of the Regulations is amended by the substitution for the proviso of subregulation (1) of the following proviso:

"unless, such person's application in terms of subregulations (a), (b) or (c) has been approved and registered in the Register for Private Health Establishments as contemplated in regulations 16(4) and 17(7) [**and a licence has been issued in terms of regulation 21(3)**].".

Amendment of regulation 4

4. Regulation 4 of the Regulations is amended by –

(a) the substitution for the heading of the following heading:

"**Application for registration [of licence]**"; and

(b) the substitution for subregulation (1) of the following subregulation:

"(1) A person who wishes to obtain the registration of a private health establishment [**and the concomitant licence**] or the amendment thereof contemplated by regulation 3, must submit to the Head of Department an application on the appropriate form prescribed in Annexure "A" together with the prescribed supporting documents.".

Amendment of regulation 6

5. Regulation 6 of the Regulations is amended by the substitution for subregulation (1) of the following subregulation –

"(1) The applicant must within 30 days prior to submission [**of an**] its application for [**a license**] registration, publish notification in a section of a daily newspaper circulating in the area where the service exists or is to be provided or the project exists or is to be located.".

Amendment of regulation 14

6. Regulation 14 of the Regulations is amended by the substitution for the introductory sentence in subregulation (1) of the following introductory sentence:

"(1) When considering an application for registration, variation of a licence or alteration to a health establishment [**in order**] to determine whether there is a need for the proposed private health establishment, the committee may take into account the following;".

Amendment of Annexure A

7. Annexure A of the Regulations is amended by the substitution for Annexure A of the attached Annexure A.

Amendment of Annexure C

8. Annexure C of the Regulations is amended by the substitution for Annexure C of the attached Annexure C.

Short title

9. These Regulations are called the Private Health Establishment Amendment Regulations, 2017.

health
Department of Health
FREE STATE PROVINCE

ANNEXURE A

DEPARTMENT OF HEALTH: PROVINCE OF THE FREE STATE

APPLICATION FOR REGISTRATION / VARIATION OF LICENCE /CHANGE OF SITE OF PRIVATE HEALTH ESTABLISHMENT IN TERMS OF PRIVATE FACILITIES LICENCING REGULATION OF 2014

THE HEAD OF DEPARTMENT
PO BOX 227
BLOEMFONTEIN
9300

Application is hereby made for registration of the following private health establishment, details of which are supplied below for the year ending 31 December 20.....

FORM 1

PART A

APPLICATIONS FOR:
- NEW ACUTE AND SUB- ACUTE PRIVATE HEALTH ESTABLISHMENTS
- VARIATION OF A LICENCE
-CHANGE OF SITE OF ACUTE AND SUB-ACUTE PRIVATE HEALTH ESTABLISHMENT

(This section is compulsory and must be completed by all applicants)

1. Name of proposed private health establishment / health establishment applying for variation or change of site

_____

2. In which area will the private health establishment be built (Town and Suburb)?

_____

3. Has the site already been acquired for the said establishment (Provide Erf Number)?

If a site has not been acquired, full details of the site must be provided to the Department immediately when such a site is acquired.

4 Will there be any other buildings and/or activities on the site other than the private health establishment? If so, provide details.

5 PPP Venture

Is the applicant willing to enter into partnership with the Department for future ventures?

6 List of Board of Directors and B-BBEE status

7. Provide applicable details of applicant.

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

8. How many other private health establishment registrations do you or CC's/Trusts/Company/entity to whom you are affiliated hold nationally? Provide details of other registered establishment, such as (a) when the registration / licence was granted, (b) when the registration / license expires, (c) composition of licenses e.g. number of beds and theatres etc . (d) location.

(Use separate sheet if necessary)

9. Name, address and contact details of developer.

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

10. Registration number of company / close corporation / trust

_____

11. Name, address and contact details of service provider (if different to applicant).

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

12. What are the clinical disciplines to be practised in the health establishment?

_____

_____

_____

(Use separate sheet if necessary)

FORM 1

PART B

ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for an Acute Establishment Registration / Variation of Licence / change of site)

13 Number of beds/treatment stations applied /licenced for.

Adult:	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Maternity:	i).	Obstetrics	_____
	ii).	Babies	_____
Intensive care:	i).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
High Care:	i).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
Paediatric	i).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Isolation beds:	i).	Adult	_____
	ii).	Pediatric	_____
	iii)	Neonatal	_____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

14 Number of theatres/treatment rooms applied for.

Minor theatre	_____
Major theatre	_____
Cardiac Theatre	_____
Cardiac Catheterization Laboratory	_____

General Procedure room/s _____

First stage rooms _____

Delivery rooms _____

Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc)

Unit Name:

(1) _____ Room Name: _____ Total: _____

(2) _____ Room Name: _____ Total: _____

(3) _____ Room Name: _____ Total: _____

(4) _____ Room Name: _____ Total: _____

(5) _____ Room Name: _____ Total: _____

(6) _____ Room Name: _____ Total: _____

(7) _____ Room Name: _____ Total: _____

(8) _____ Room Name: _____ Total: _____

(9) _____ Room Name: _____ Total: _____

(10) _____ Room Name: _____ Total: _____

15. Number of medical staff to be employed.

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

16. Number of nursing staff employed.

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

17. Other full-time registered staff employed. If any, specify.

_____

_____

_____

18 Other part-time registered staff employed If any, specify

19 Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e g. SANC, HPC etc)

20 Supplementary health services personnel

i). Administrative personnel
ii). Management
iii). General assistant/s
iv) Maintenance staff

21 Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

22 Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

23 Provide detailed reasons in accordance with the criteria as set out in Regulation 14(1) (i) to (x) as to why this application should be approved

(Use separate sheet and attach as addendum to this application)

24. Any other information deemed necessary for this application.

_____

_____

_____

_____

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____

Signature

FORM 1

PART C

SUB-ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for a Sub-Acute Establishment Registration / variation of licence / change of site)

25 State what type of establishment is applied for / registered / or licenced for (i.e step-down, sub-acute, rehabilitation, long-term, hospice, convalescent)

_____

_____

_____

26. Do you belong to a quality assurance group? If so, provide details

_____

_____

_____

27. Do you have any managed care or similar arrangement with any health funder/employer?

_____

_____

_____

28. Number of beds/treatment stations applied for / varied / will be relocated.

Adult:	I).	Medical	_____
	ii).	Surgical	_____
	iii).	Day	_____
Paediatric	I).	Medical	_____
	ii)	Surgical	_____
	iii).	Day	_____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____

TOTAL BEDS APPLIED / LICENCED FOR

_____

29. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

30. Will you provide any outpatient services?

_____

_____

31. Number of medical staff to be employed.

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

32. Number of nursing staff employed

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

33. Other full-time registered staff employed. If any, specify

_____

_____

_____

34. Other part-time registered staff employed. If any, specify

_____

_____

_____

35. Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g. SANC, HPC etc.)

_____

36. Supplementary health services personnel

i). Administrative personnel _____
ii). Management _____
iii). General assistant/s _____
iv) Maintenance staff _____

37. Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

38. Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this

_____

_____

_____

39 Provide detailed reasons in accordance with the criteria as set out in Regulation 14 (1) (i) to (x) as to why this application should be approved

(Use separate sheet and attach as addendum to this application)

40. Any other information deemed necessary for this application.

_____

_____

_____

(Use separate sheet if necessary)

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____
Signature

FORM 2

PART B

APPLICATIONS FOR VARIATION OR EXTENSIONS TO EXISTING ACUTE AND SUB-ACUTE PRIVATE HEALTH ESTABLISHMENTS

(To be completed by applicants applying for variation to their registered private health establishment)

1. Name of private health establishment

_____

2. **Physical address**

_____

_____

_____

_____

3 Erf no: _____

4. **Provide applicable details of applicant.**

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

5. Registration number of company or close corporation.

_____

6 Applicable details of service provider

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

FORM 2

PART B

ACUTE PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for a variation / extension to an Acute Establishment Registration)

7. Attach a copy of the existing licenses certificate as an addendum to this application:

Number of beds/treatment stations applied for:

Type of beds, theatres, units, rooms	Existing services	New services	Variance
Adult medical beds			
Adult surgical beds			
Obstetric beds			
Adult ICU beds			
Neonatal ICU beds			
Adult High Care beds			
Pediatric beds			
Day beds			
TOTAL NUMBER OF BEDS			
Minor theatres			
Major theatres			
First stage rooms			
Delivery rooms			
Emergency units			
Resuscitation rooms			
Lazer units			
Cath labs			
Haemodialysis unit			
Procedure rooms			

8. Number of theatres/treatment rooms applied for

Minor theatre _____

Major theatre _____

Cardiac Theatre _____

Cardiac Catheterization Laboratory _____

General Procedure room/s _____

First stage rooms _____

Delivery rooms _____

Other Specialized Units/Suites:
(i.e. Emergency, Endoscopy etc.)

Unit Name

(1) _____ Room Name _____ Total _____

(2) _____ Room Name _____ Total _____

(3) _____ Room Name _____ Total: _____

(4) _____ Room Name: _____ Total: _____

(5) _____ Room Name: _____ Total: _____

(6) _____ Room Name: _____ Total: _____

(7) _____ Room Name: _____ Total: _____

(8) _____ Room Name _____ Total: _____

(9) _____ Room Name: _____ Total: _____

(10) _____ Room Name: _____ Total: _____

9. Provide detailed reasons in accordance with the criteria as set out in Regulation 14 (1) (i) to (x) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

10. Have there been any structural and/or functional changes in patient accommodation during the current year?

(Use separate sheet if required and attach as addendum to this application)

_____

_____

11. Number of nursing staff employed at the date of application.

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

12 Number of medical practitioners employed at the time of application

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

13 Other existing full-time registered staff employed, if any specify.

_____

_____

14 Other part-time registered staff employed, if any specify

_____

_____

I hereby certify that the above particulars are true and correct.

Place _____

Date _____

Office/Position held _____

_____

Signature

FORM 2

PART C

SUB- ACUTE EXISTING PRIVATE HEALTH ESTABLISHMENTS
(This section must only be completed by applicants applying for variation / extensions to Sub -Acute Establishment Registration)

15. State what **service you wish to vary/extend** (i.e step-down, sub-acute, rehabilitation, long- term, hospice, convalescent)

_____

_____

16. Do you belong to a quality assurance group? If so, provide details

_____

_____

17. Do you have any managed care or similar arrangement with any health funder/employer?

_____

_____

18. Number of beds/treatment stations applied for

Adult:	i)	Medical	_____
	ii)	Surgical	_____
	iii)	Day	_____
Paediatric	i)	Medical	_____
	ii)	Surgical	_____
	iii)	Day	_____
Other Specialized Beds:	_____		_____
	_____		_____
	_____		_____
	_____		_____
	_____		_____
TOTAL BEDS APPLIED FOR			_____

19. Number of treatment rooms applied for:

General Procedure room/s _____

Emergency Room/ Resuscitation Room _____

19. Will you provide any outpatient services?

_____

_____

20. Number of medical staff to be employed

	MEDICAL	DENTAL	SPECIALISTS (Specify area of speciality)
FULL TIME			
PART TIME			

22. Number of nursing staff employed

	Registered	Student	Enrolled	Enrolled pupil	Enrolled assistant	Enrolled pupil assistant
FULL TIME						
PART TIME						

23 Other full-time registered staff employed If any specify

_____

_____

24 Other part-time registered staff employed. If any specify

_____

_____

25 Do you intend to do nursing training in basic and post basic courses? If yes, specify details of professional organization accreditation (e.g SANC. HPC etc)

_____

_____

26 Supplementary health services personnel

i). Administrative personnel _____
ii). Management _____
iii). General assistant/s _____
iv). Maintenance staff _____

27 Provide a map indicating the drainage area as well as an indication of all other health care establishments (public and private) in the drainage area.

(Use separate sheet and attach as addendum to this application)

28 Provide a copy of your feasibility study. If a copy has not been provided, give reasons for this.

_____

_____

29 Provide detailed reasons in accordance with the criteria as set out in Regulation 14 (1) (i) to (x) (2) as to why this application should be approved.

(Use separate sheet and attach as addendum to this application)

30. What was the average bed occupancy rate and average length of stay for the previous calendar year?

_____

_____

31 What proportion (%) of patients were discharged from the establishment in the last calendar year?

i)	Less than one week	_____
ii).	More than three days but less than one week	_____
iii).	One to three months	_____
iv).	More than three months	_____
v).	No potential for discharge	_____

32 What proportion (%) of admissions were re admissions within:

(a)	3 months	_____
(b)	6 months	_____
(c)	1-year	_____

33. What proportion (%) of patients admitted over the last calendar year were.

i).	Post-surgical (requiring traction, drainage, or wound care?)	_____
ii).	Post-medical illness (e.g. stroke) or requiring low-grade medical interventions (rehydration, IV, antibiotics, oxygen)	_____
iii).	Chronically disabled (mental, physical – e.g. Dementia, hemiplegic)	_____
iv).	Terminally ill (end stage)	_____
v).	For respite care	_____
vi).	Other general rehabilitation	_____
vii).	Patients admitted instead of acute hospitalisation for an acute illness, injury or	

exacerbation of a disease process _____

viii). Patients requiring nursing care of low intensity who are likely to remain for a long period of time _____

ix). Other _____

34. Of patients discharged over the last calendar year, what proportion (%) were discharged: (not to be filled in by hospices)

i). Directly home _____
ii). Other community-based facility _____
iii). To a hospice _____
(iv) Other _____

35. Number of full-time and part-time nurses at the establishment at the time of application.

Category of staff	No. of personnel	Full-time	Part-time
(a) Professional Nurse			
(b) ENA			
(c) Enrolled nurses			
(d) Care workers			

*Care workers are workers who deliver basic support and assistance and who assist with activities of daily living and who are not registered with the SANC.

36. Does the establishment provide services rendered by other professionals?

Mark F/T, P/T, SESSIONAL

Doctors (specify)	
Physiotherapists	
Occupational therapists	
Speech and hearing therapists	
X-Ray Services (specify)	
Arrangements for a laboratory services for pathology services (specify)	
Medical specialists (e.g. orthopaedic surgeon, psychiatrists)	
Social Worker	
Pharmacist	
Dietician	
Others (specify)	

37 On average how often are your patients assessed?
(Tick the most appropriate category)

Half hourly	
Hourly	
Between 1 and 4 hourly	
Between 4 and 8 hourly	
Between 8 and 24 hourly	
Once daily	
Between once daily and once weekly	
Less than once weekly	

38 Are the following treatments provided at the establishments?

	Y/N
Oral antibiotics on prescription	
Intravenous medication	
Urinary catherisation	
Blood pressure monitoring	
Oxygen supply and suction	
Ambubag	
Electrocardiograph	
Intubation	
Defibrillation	
Naso-gastric feeding	

39 Of your last 100 admissions, what % were referred by

A private hospital	
A private medical practitioner	
A private practitioner other than a private medical practitioner	
A public hospital	
A residential facility such as an old age home	
A welfare institution other than a residential facility	
A traditional healer	
Directly by the family	
Referred by self	
Case manager (e.g. QA Care)	
Others (specify)	

40. Do you provide any out- patient services?

_____

_____

Place _____

Date _____

Office/Position held _____

_____

Signature

ANNEXURE A

FORM 3

CHECK-LIST OF DOCUMENTS THAT SHOULD BE SUBMITTED WITH THE APPLICATION FORMS

DOCUMENTS	TICKS
Motivational letter	
Proof of payment	
Proof that the applicant has advertised in the relevant local paper the intention to build the private facility	
Proof of community endorsement of the project	
A letter from the Municipality stating that the desired land has been granted and is suitable for the intended business	
Feasibility study	
Business Plan	
Proof of financial viability	
Human resource recruitment plan	
B-BBEE certificate and list of shareholders	
Community Involvement/social responsibility plan	

FORM 2

PART D

ACUTE AND SUB- ACUTE EXISTING PRIVATE HEALTH ESTABLISHMENTS

(This section must only be completed by applicants applying for alterations/refurbishment to Acute and Sub-Acute Establishment Licenses)

1 Name of private health establishment

_____

2. Physical address

_____

_____

_____

3 Erf no: _____

4 Provide applicable details of applicant

Title: _____ **Initials:** _____ **Surname:** _____

Company: _____ **Trust/CC:** _____

Postal Address: _____

_____

_____

Office Phone: _____ **Fax:** _____

E-mail: _____ **Emergency Phone:** _____

5. Is the facility currently licensed with DOH: Yes ____ No____

6. If yes, provide current license number: _____

7. Describe the proposal to alter/refurbish the building

_____

_____

_____

_____

_____

_____

8 State what **area you wish to alter/ refurbish** (i.e. inside, outside, roof, floor, and lifts)

_____

_____

9. Indicate with X units/departments that require alterations/refurbishment.

i. Medical _____
ii. Surgical _____
iii. Paediatric _____
iv. Maternity _____
v. Theatre _____
vi. ICU _____
vii. Casualty _____
viii. Pharmacy _____
ix. Kitchen _____
x. Laundry _____
xi. Others _____

I hereby certify that the above particulars are true and correct

Place_____

Date_____

_____ _____

Name **Signature**

ANNEXURE A

FORM 4

DEPARTMENT OF HEALTH: PROVINCE OF THE FREE STATE

APPLICATION FOR REGISTRATION AS A PRIVATE HEALTH ESTABLISHMENT IN TERMS OF PROVINCIAL PRIVATE FACILITIES LICENCING REGULATION OF 2014

The Head of Health
Private Bag 227
BLOEMFONTEIN
9300

Application is hereby made for the registration of the following *private hospital / unattached Operating-theatre unit, details of which are supplied below for the year ending 31 December .....

(d) Name of private hospital/unattached operating-theatre unit.....

.....

2. Situation of premises (street, locality, town) .....

.....

3. Name and postal address of registered owner of the property (premises) .....

.....

4. Name and address of proprietor (in the case of a company or association, its nominee) who will be conducting the *private hospital/unattached operating-theatre unit.....

.....

5. Name and address of the medical practitioner or registered nurse and midwife who will be in charge .....

6. If a medical practitioner will be in charge, name and qualifications of the registered nurse and midwife who will be in charge of the nursing services.....

.....

7. Name and allocation of beds available for patients (see notes below).....

.....

	General		Maternity		Infectious diseases	Others (specify)	Total
White.....							
Non-white.....							

8. Number of.

(e) Operating theatres.....

(b) Delivery rooms.....

9. Changes in the patient accommodation/beds available during the current year, if any (specify) .....

10. Numbers of registered staff *employed at date of application/to be employed at date of new registration applied for:

		Practitioners		Nurses	
		Medical	Dental	Registered	Student
Full-time	White				
	Non-white				
Part-time	White				
	Non-white				

(f) Number of full-time enrolled nurses *employed at the date of application / to be employed at date of new registration applied for:

		Enrolled Nurses	Enrolled student nurses	Enrolled nursing assistants	Enrolled pupil nursing assistants
Full-time	White				
	Nonwhite				

(g) Other full-time registered staff employed (if any) (specify)

.....

13 Other part-time registered staff employed (if any) (specify) .....

14 If the hospital is ecognized by the South African Nursing Council as an approved training school for nurses, midwives or enrolled nurses or enrolled nursing assistants (a)

General nurses	Midwives	Enrolled nurses	Enrolled nursing assistants

(b) If the hospital is ecognized as an approved training school for one or more of the categories of nursing staff referred to in subsection (a), the following information should also be given:

Category	Number of registration or enrolment certificate issued by the SANC	Date of issue
(i) Student general nurses		
(ii) Student midwives		
(iii) Pupil nurses		
(iv) Pupil nursing		

assistants.....	

Registration with the SA Nursing Council (specify):

	Number of original certificate	Date of issue	Annual registration	
			Receipt number	Date

I Other trained staff, excluding person in control:
(i) Registered nurses/midwives:

Name	Qualifications	Number of original certificate	Date of issue	Annual registration	
				Receipt number	Date

(ii) Enrolled nurses .....

Total .....

(iii) Enrolled nursing assistant .....

Total .....

15. Arrangements for the training and teaching of each of the following categories, as applicable:

(h) Student nurses .....

(ii) Student midwives .....

(iii) Pupil nurses .....

(iv) Pupil nursing assistants .....

I hereby certify that the above particulars are true and correct

Place.....

Date..... .....

Signature of proprietor

N.B -If available space is insufficient, attached separate schedule.
Notes:

(a) *Words designated by an asterisk to be deleted if not applicable
(b) This form is to be used for the first and every subsequent application for registration
I Item 7: The numbers of beds, cribs/cots actually available for accommodating patients are to be stated, but these exclude –

- all trolleys.
- all waiting, preparation, first stage and labour room beds and cots in maternity units;
- the recovery trolleys and recovery beds of an operating-theatre unit of a private hospital, but not those of an unattached operating-theatre unit.

ANNEXURE A

FORM 5

CHECK-LIST OF DOCUMENTS THAT SHOULD BE SUBMITTED WITH THE APPLICATION FORMS FOR RENEWAL OF LICENSES

DOCUMENTS	TICKS
Proof of payment for renewal of license	
Spreadsheet of monthly bed occupancy and theatre utilization (time) data of previous financial year	
Proof of Registration with relevant statutory bodies for all health care professionals employed by the hospital i.e. nurses, pharmacists and therapists	
Proof of registration with relevant statutory bodies for health care professionals not employed by the hospital i.e. doctors and therapists	
B-BBEE Cerrificate	
Liability Insurance	

Annexure C Assessment tool

Criteria	Sub criteria	Sub criteria score	Sub criteria weight	Adjudication score	Criteria weight	Total score for criteria	Explanatory notes on weighting	Adjudication notes
1: Contribute to equitable distribution of health s	1.1 Accessible to the disadvantage communities and changes to promote more equitable societies through addressing racial, gender, economic and geographic based health inequalities	2	5	10			4= Beds < norm in province and district 3= Beds < norm in province only 2= Beds > norm in the province but < norm in district & Town 1= Beds > norm in province & District but < norm in town 0=Beds > norm in province, district & town	Assess to what extent services are available against the provincial affordable plan with wieghts towards peripheral distribution - Use total beds in line with NHI approach
	1.2 Relative area development and growth potential	2	5	10			5= IDP approved and implemented, 3= IDP approved and in the process of being implemented, 2= IDP available but not implemented, 0= IDP not available	Evaluate the potential of area to support private facilities by looking at the approved Intergrated Development Plan (IDP)
	1.3 Target populations to be served (age, composition, gender, socioeconomic conditions	2	5	10			5= applied beds <norm in the province for adults, children and maternity, 3 Applied beds < norm for either adults,children or maternity, 0= Applied beds > norm for adults, children or maternity	Ensure sufficient acute beds for adults, children and pregnant women as well as beds for TB, mental health rehab and old age available
	1.4 Cater to underserved health needs in the area	3	5	15			5= Plan to create access 0= no plan to create access	Applicant should show how will they create access for the catchment population
				45	3	135		
2. Promote balanced distribution of hospital types in planned areas	2.1 An appropriate mix of public and private health care services.	1	5	5			5= private beds < 20%, 4 = private beds < 25% 3 private beds < 30%, 2= private beds <35%, 1= private beds < 40%, 0 private beds > 40%	Ensure an appropriate mix of beds for insured and uninsured polulation with emphasis on providing equity to access of services
	2.2 Promote optimal use of spare capacity in provincial health establishment	2	5	10			5= Total public & private beds per hospital type < provincial norm 4= total public & private in the district < provincial norm 3 = total public & private beds in sub-district < provincial norm 0= total public & private beds in subdistrict > provincial norm	Evaluate if proposal would allow for sufficient services by using the total beds available in the province/district
	2.3 Promote the appropriate or optimal mix of beds distribution.	1	5	5			5= Facility type in geographic area according DOH health plan 3= Facility type lacking in the district, 0= sufficient facility type in the district	Fair distribution of the proposed facility in relation to existing same hospital group or another hospital (public/Private). - Envisaged facility at the area where there is need for more facilities according to the DOH plan, applicant must score maximum point of 5
	2.4 Fair distribution of the proposed facility in relation to existing same hospital group or another hospital.	1	5	5			5= 100 km or more, 4= 60-99km, 3=20-60km, 2=15-20 km, 1= 10-15km, 0= Less than 10 km	Higher weighting to proposed facilities in the more remote areas- have to balance against service demand and efficiency
				25	2	50		
3: Service (s) demand	3.1 Burden of disease (epidemiological) & demographic characteristics of the population to be served	2	5	10			5= applied service gap exist in district 3= Applied service gap exist in province 0= No service gap for applied service	Measure if proposal will close an existing service gap

	3.2 Current beds and the utilisation of beds in the catchment population.	2	5	10			5= Average Bed utilisation rate of existing public & private facilities > 80%, 3= Average BUR of existing public & private facilities 10-80%, 0= Average BUR in public & private facilities <70%	Over utilisation in a population indicate demand for beds wher under utilisation indicate that there is a over supply of beds
	3.3 Morbidity and mortality plan of the population in the catchment area	1	5	5			5= applied services will assist in reduction of national priority mortality rates 3= Applied services will assist in reduction of local identified priority mortality rates 0= applied services will not decrease mortality rates	Application must also address mortality and morbidity rate in the catchment area
				25	1	25		
4: Promote high quality services which are accessible, cost effective and safe	4.1 Service delivery values	2	5	10			5= District admission rate >50% less than provincial norm 4= District admission rate >20% less than provincial norm 3= district admission rate < provincial norm 2= district admission rate less than 10% higher than provincial norm 0 district admission are > 10% higher than provincial norm	Impact of application on existing population admission rates.
	4.2 Is there a clinical governance plan	1	5	5			5= comprehensive plan including trends analysis, patient saefty management and quality with proposed clinical governance structure	Ensure that there is an anticipated governance plan
	4.3 Information management plan	1	5	5			monthly data to DHIS 0= no information system plan	Ensure that there is a system of supplying information the the DHIS
	4.4 Comprehensive plan to comply with National core standards	1	5	5			5= comprehensive plan attached how to comply with National core standards 0=No plan how to comply with National core standards	A proactive plan how the anticipated facility would comply with norms and standards by the DHSC
				25	1	25		
5: Bed-to population ratios and public-to-private bed ratios in establishments feeder areas and in the surrounding health district, region and province	5.1 A public-private partnership (PPP) venture	1	5	5			5 plan included to partner to provide service to under served areas, 0= No plan to address underserviced areas	Assess preparedness of facility to partner with DOH in providing care to the community
	5.2 Application will address Bed to population ratio in the province	3	5	15			if 5.1 score 0, the weight in this category = 0. If not, score 5= Provincial and district beds < provincial norm, 4= Provincial beds < 10% above rpovincial norms and District bed < provincial norm, 3=Provincial and District beds within 10% of provincial norms, 0= Provincial and District beds > 10% above provincial norms	Ensure that there is sufficient capacity to manage health needs in line with the NHI or as an interim measure to assist the DOH to provide care required of communities
	5.3 Application will address bed to population gap in private sector	2	5	10			5= provincial insured beds < provincial norm 4= District insured beds < provincial norm, 3 District insured bed < 10% above provincial norm 2= Provincial insured beds > 20% above provincial norm 0= provincial insured bed > 30% above provincial norm	Ensure that the bed need of insured patients are met within the province/ district with promtion of district distribution
				30	5	150		

6: Transformation goals to promote of advance persons or categories of persons designated in terms of Employment Equity Act, Broad Based economic empowerment and other transformation policies	6.1 Shareholding based on previously disadvantaged (PDI) group	1	5	5			5= >50%, 3= 10-15% 0=<10%	-Application will be scored according to the instrument in terms of Employment Equity.
	6.2 representation of PDI in the senior and middle management						5= >50%, 3 - 10-15% 0=<10%	
	6.3 new entrant into the market			5	2	10	5= New entry , 0=existing	
7: Contribution towards National/Provincial priorities	7.1 Training, research and development with a view to the improvement of health service delivery	1	5	5			5= structured ongoing accredited health worker training 4= Planned training for proposed HR plan 3=planned HR in-service training plan 0= no training plan	-Application must indicate a broader strategy in Human Resource Health (HRH) plan and development.
	7.2 research and development with a view to the improvement of health service delivery	1	5	5			5= Planned research unit/laboratory 3= Planned assistance to research 0= no anticipated research	-Application must indicate collaboration with tertiary institution in research and development.
	7.3 Social responsibility/Community Projects (Proof of planned projects to support the community)	1	5	5			5= Planned social responsibility/community activities in line with national/provincial priorities 3= Planned social responsibility /community activities other than national priorities 0 = no planned social responsibility/ community activities	Planned projects must be in line with national/provincial priorities
				15	1	15		
8: Demonstration of availability of human resources and training of health personnel	8.1 Clear skills recruitment plan for health professionals	2	5	10			5= recruitment plan provided 0=No recruitment plan	-Application must provide a clear recruitment, retention and skills development plan
	8.2 List of doctors/specialists and other independent health practitioners	1	5	5			5= List provided 0=No list provided	-List of doctors/specialist should be submitted
	8.3 Memorandum of understanding not to appoint health workers form the geographic areas working in the public sector within 2 years from issued a licence to practice	2	5	10			5= MOU provided 0=No MOU	Applicant must not actively recruit personnel from public facilities within two years period of being licensed.
				25	1	25		

9. Financial sustainability		2	5	10			5= audit report of business plan submitted 0= No audit report submitted	**Audited business plan from an accredited company would assist in ensuring that the proposed project is feasable and sustainable.**
				10	1	10		
	TOTAL ADJUDICATION SCORE			(Maximum 400)		445		

400

Subminimum rejections	Criteria 1 <36		360		
	criteria 5 < 90				
	Total score <300				

Scores 300-360 requires strong motivation by advisory committee to the Head of Department

REQUIRED INFORMATION

Population per town, subdistrict and district	Stats SA Population census midyear adjustments
Approved provincial health care norms	Provincial service transformation plan
Insured populations per town, subdistrict, district	Stats SA Population census midyear adjustments
Beds distribution by type and service	Provincial facility database
Distance from facilities	Application form
Inpatient admissions by service/beds	District health information system*
Bed utilisation	District health information system*
B BBEEE status	B BBEEE status certificate
Other information	As per application

* All public & private facilities must provide monthly information as prescribed by the provincial head: Health