



Province of the
EASTERN CAPE
HEALTH

OPERATIONAL PLAN



2016/17

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ABBREVIATIONS & ACRONYMS

AGSA	Auditor-General SA
APP	Annual Performance Plan
AIP	Audit Intervention Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BANC	Basic Antenatal Care
BAS	Basic Accounting System
CCMDD	Central Chronic Medicine Dispensing and Distribution
CFO	Chief Financial Officer
CoE	Compensation of Employees
CHCs	Community Health Centres
CIBD	Construction Industry Development Board
CHCWs	Community Health Care Workers
DCSTs	District Clinic Specialist Teams
DDG	Deputy Director General
DHIS	District Health Information System
DHMIS	District Health Management Information System
DHS	District Health Services
DOTS	Directly Observed Treatment Short-Course
DPC	Disease Prevention and Control
DPSA	Department of Public Service and Administration
DRPW	Department of Roads and Public works
DM	District Municipality
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECSECC	Eastern Cape Socio-Economic Council
ES	Equitable Share
ELHC	East London Hospital Complex
EMS	Emergency Medical Services
FMPPi	Framework for Managing Programme Performance
GHS	Information General Household Survey

GIAMA	Government Immovable Asset Management Act
HFRG	Health Facility Revitalization Grant
HST	Health Sciences and training
HAST	HIV & AIDS, STI and TB control
HCT	HIV Counseling and Testing
HCSS	Health Care Support Services
HFM	Health Facilities Management
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPV	Human Papilloma Virus
HPCSA	Health Professionals Council of South Africa
HPTD	Health Professionals Training and Development (Grant)
HRMIS	Human Resource Management Information Systems
HRM	Human Resource Management
HRD	Human Resource Development
HT	Health Technology
HRH	Human Resources for Health
ICMD	Integrated Chronic Diseases Management
ICT	Information and Communications Technology
IDMS	Infrastructure Delivery Management System
IMR	Infant mortality rate
IDIP	Infrastructure Delivery Improvement Programme
IRM	Infrastructure Reporting Model
ISH	Integrated School Health
ISHP	Integrated School Health Programme
IT	Information Technology
IPT	Isoniazid Preventive Therapy
MCWH	Maternal, Child and Women's Health and Nutrition
MDGs	Millennium Developmental Goals
MDR-TB	Multi-drug resistant TB
MEC	Member of the Executive Council
METROs	Medical Emergency Transport and Rescue Organizations
MMC	Medical Male Circumcision
MMR	Maternal Mortality Ratio
MTCT	Mother-To-Child-Transmission

MTEF	Medium Term Expenditure Framework
MOU	Maternal Obstetric Unit
MPAT	Management Performance Assessment Tool
MTSF	Medium Term Strategic Framework
NCDs	Non-Communicable Diseases
NCS	National Core Standards
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NDP	National Development Plan
NHI	National Health Insurance
NHLS	National Health Laboratory Services
NNMR	Neonatal Mortality Rate
NSDA	Negotiated Service Delivery Agreement
NTSG	National Tertiary Services Grant
NT	National Treasury
OD	Organisational Development
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OPD	Outpatient Department
OTP	Office of the Premier
OSD	Occupational Specific Dispensation
PCR	Polymerase Chain Reaction
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PDP	Provincial Development Plan
PERSAL	Personnel and Salaries
PFMA	Public Finance Management Act
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PMR	Perinatal Mortality Rate
PEPFAR	President's Emergency Plan For Aids Relief
PMTCT	Prevention of Mother-To-Child Transmission
PSS	Patient Satisfaction Surveys
PSA	Public Service Administration

PPPs	Public-Private Partnerships
RDQA	Routine Data Quality Assessment
RPHC	Revitalization of PHC
QA	Quality Assurance
RPHC	Re-engineering the Primary Health Care System
QIP	Quality Improvement Plan
SLA	Service level Agreement
SADHS	South Africa Demographic and Health Survey
SANTA	South African National Tuberculosis Association
SCM	Supply Chain Management
SITA	State Information Technology Agency
SDIP	Service Delivery Improvement Plan
SDG's	Sustainable Development Goals
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
SMME	Small Medium Micro Enterprise
STI	Sexually Transmitted Infection
SVS	Stock Visibility System
TB	Tuberculosis
THS	Traditional Health Services
TMC	Traditional Male Circumcision
TROA	Total Clients Remaining On ART
VPN	Virtual Private Network
WISN	Workload Indicators of Staffing Needs
WBOTs	Ward-Based Outreach Teams
XDR-TB	Extreme Drug Resistance Tuberculosis

PART A: STRATEGIC OVERVIEW

I. INTRODUCTION AND OVERVIEW

To be appropriated by Vote

Responsible MEC	MEC for health
Administration Department	Provincial Department of Health
Accounting Officer	Head of Department

I.1 Core functions of the Department

The core competency of the Provincial Department of Health is the provision of health services, in other words, promotive, preventative, curative and rehabilitative health services

I.2 VISION

A quality health service to the people of the Eastern Cape Province, promoting a better life for all.

I.3 MISSION

To provide and ensure accessible, comprehensive, integrated services in the Eastern Cape, emphasising the primary health care approach, optimally utilising all resources to enable all its present and future generations to enjoy health and quality of life.

I.4 VALUES

The department's activities will be anchored on the following values in the next five years and beyond:

- Equity of both distribution and quality of services
- Service excellence, including customer and patient satisfaction
- Fair labour practices
- Performance-driven organisation
- High degree of accountability
- Transparency

I.5 STRATEGIC GOALS

The department has three strategic goals, aligned to the strategic goals of the National Department of Health for implementation in the 2015/16-2019/20 term of government.

Table I: Strategic Goals

Strategic Goal	Expected Outcomes
Prevent and reduce the disease burden and promote health	• HIV infection rate reduced by 15% by 2019 • TB death rate reduced by 30% in 2019 • Child Mortality Reduced to less than 34 per 1000 population by 2019 • Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019 • Screening coverage of chronic illnesses increased to more than a million by 2019
Improved quality of care	• Patient satisfaction rate increased to more than 75% in health services by 2019 • compliance with National Core Standards increased to 60% by 2019 • Unqualified audit opinion achieved by 2019 • Number of Bursaries awarded for first year medicine students
Universal health coverage	• 100% Ward Based Outreach Teams (WBOT) coverage by 2019 • Two districts piloting NHI implementation by 2019

PART B:

PROGRAMME

AND

SUB-PROGRAMME PLANS

PROGRAMME I

HEALTH ADMINISTRATION & MANAGEMENT

The health administration and management programme comprises of two main components: the **ADMINISTRATION** component, which refers to the Executive Authority which lies with the Office of the Member of Executive Council (MEC); and the second component, which is the **MANAGEMENT** of the organisation and is primarily the function of the Office of the Superintendent General. Programme I has a total budget of R674,962,000. This divided between sub-programme I.1 – Health Administration (Office of the MEC) which is allocated R8,377,000, and Sub-Programme I.2 - Health Management R666,585,000.

Budget allocation: Programme I

Table ADMIN: I

BUDGET	R'000
Compensation of employees	452,150
Goods and services	215,598
Transfers	1,452
Capital assets	5,762
TOTAL BUDGET	674,962

SUB-PROGRAMME I.1 HEALTH ADMINISTRATION - OFFICE OF THE MEC

Programme Purpose: To provide political and strategic direction to the Department by focusing on transformation and change management.

Priorities:

- Give political and strategic direction to the Department;
- Engage all governance structures of the Department, i.e. Hospital boards, Clinic Committees, Provincial Health Council, and Lilitha Education Nursing Council.

SUB-PROGRAMME I.2 HEALTH MANAGEMENT

Programme Purpose:

To manage human, financial, information and infrastructure resources. This is where all of the Policies, with reference to strategic planning and development, coordination, monitoring and evaluation, including regulatory functions of head office, are located.

The management component under the Superintendent General's supervision is comprised of three branches with their sub-components (branches) as listed below:

Finance Branch

- Financial Management Services
- Integrated Budget Planning and Expenditure Review
- Supply Chain Management (SCM)

Corporate Services Branch

- Information, Communication and Technology (ICT)
- Human Resource Management (HRM)
- Human Resource Development (HRD)
- Corporate Services Management

Clinical Branch

- District Health Services
- Hospital Services
- Communicable Diseases

- Health Programmes
- Clinical Support Services

PRIORITIES

- To facilitate effective human resources planning development and management in order to improve provision of health services
- To implement corporate systems to support the service delivery imperatives of the department
- To achieve an unqualified regulatory audit opinion
- To review and develop of the three year Annual Performance Plan (APP) and one year Operational Plan of the Department and to ensure alignment to national and provincial priorities
- To review and assist the Central, Regional and Tertiary hospitals develop of their plans in line with the indicative MTSF
- To communicate the strategic imperatives of the department all employees of the department, especially at sub-district & facility levels
- To monitor the performance of health programs through the development and production of quarterly, mid-year and annual report
- To coordinate the auditing of Pre-determined Objectives and Sector Audit
- To support the improvement of management systems through the implementation of the MPAT process

I.1.3 QUARTERLY TARGETS FOR MANAGEMENT FOR PROGRAMME I

Table ADMIN 2: Quarterly Activities for management 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Unqualified audit opinion achieved by 2019	Monitor the Integrated Audit Improvement Strategy (IAIS)	Audit opinion from Auditor-General	AGSA Audit report	Annually	Qualified Audit Report	Unqualified Audit Report	Unqualified Audit Report	-	-	-	Unqualified audit report	
		2.1.2 Audit Improvement Plan for Financial Performance Review		Quarterly		Qualified Audit	AIP Reviewed, improvements recorded	AIP Reviewed	AIP Reviewed	AIP Reviewed	AIP Reviewed	
		2.1.3 Audit Improvement Plan for Performance Information Review		Quarterly		Qualified Audit	AIP Reviewed, improvements recorded	AIP Reviewed	AIP Reviewed	AIP Reviewed	AIP Reviewed	
2016/17	Facilitate review and development of the DHER by all districts. 2015/16 DHER template circulated to all districts DHER capacity building sessions conducted in all 08 districts	2015/16 DHER reports developed	Web based DHER report	Annually	8 District 2013/14 DHER reports available.	8 District 2014/15 DHER reports	8 District 2015/16 DHER reports submitted to NDOH.	-	08 DHER reports assessed and submitted to National office.	-	-	42

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Ensure level 3 MPAT	Ensure that all policies are in place and enforce the implementation thereof	2.1.4 MPAT Assessment Report	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Annually	Level 2	Level 3	Level 3 MPAT performance	-	-	-	Level 3 MPAT performance	
	Ensure that all policies are in place and enforce the implementation thereof	2.1.5 Strategic Management MPAT Level 3	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	Level 3	Strategic Management MPAT Level 3	Strategic Management MPAT Level 3	Strategic Management MPAT Level 3	-	Strategic Management MPAT Level 3	
	Ensure that all policies are in place and enforce the implementation thereof	2.1.6 Governance & accountability MPAT Level 3	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	Level 2	Governance & accountability MPAT Level 3	Governance & accountability MPAT Level 3	Governance & accountability MPAT Level 3		Governance & accountability MPAT Level 3	
	Ensure that all policies are in place and enforce the implementation thereof	2.1.7 Human resources MPAT Level 3	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	Level 2	Human resources MPAT Level 3	Human resources MPAT Improvement Plan Level 3	Human resources MPAT Level 3		Human resources MPAT Level 3	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		2.1.8 Financial Management MPAT Level 3	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	Level 3	Financial Management MPAT Level 3	Financial Management MPAT Level 3	Financial Management MPAT Level 3		Financial Management MPAT Level 3	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	Number of provincial planners, monitoring and evaluation fora hosted.	Planners and Monitoring & Evaluation forum Report	Bi annual.	2 planners forum hosted	1 planners forum hosted	2 planners forum hosted.	-	Provincial planners forum hosted	-	Provincial planners forum hosted	0
		Monitoring – Integration of Performance Monitoring and Strategic Management (MPAT 1.3.1)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		Monitoring – Evaluations (MPATI.3.2)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPATI.3.2)	Level 3 (MPATI.3.2)	Level 3 (MPATI.3.2)	Level 3 (MPATI.3.2)	Level 3 (MPATI.3.2)	
		Monitoring – Planning of Implementation Programmes (MPATI.3.3)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPATI.3.3)	Level 3 (MPATI.3.3)	Level 3 (MPATI.3.3)	Level 3 (MPATI.3.3)	Level 3 (MPATI.3.3)	
		Service Delivery Improvement (SD Charter, Standards, & SDIP) 2.1.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (SD Charter, Standards, & SDIP) 2.1.1	Level 3 (SD Charter, Standards, & SDIP) 2.1.1	Level 3 (SD Charter, Standards, & SDIP) 2.1.1	Level 3 (SD Charter, Standards, & SDIP) 2.1.1	Level 3 (SD Charter, Standards, & SDIP) 2.1.1	
		Management Structures (Functionality of Management Structures) 2.2.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (Functionality of Management Structures) 2.2.1	Level 3 (Functionality of Management Structures) 2.2.1	Level 3 (Functionality of Management Structures) 2.2.1	Level 3 (Functionality of Management Structures) 2.2.1	Level 3 (Functionality of Management Structures) 2.2.1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		Accountability (Assessment of accountability mechanisms – Audit Committee) 2.3.2	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (Assessment of accountability mechanisms – Audit Committee) 2.3.2	Level 3 (Assessment of accountability mechanisms – Audit Committee) 2.3.2	Level 3 (Assessment of accountability mechanisms – Audit Committee) 2.3.2	Level 3 (Assessment of accountability mechanisms – Audit Committee) 2.3.2	Level 3 (Assessment of accountability mechanisms – Audit Committee) 2.3.2	
16. OPERATIONAL PLAN 2016/17		Ethics (Assessment of policies & systems to ensure professional ethics)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (Assessment of policies & systems to ensure professional ethics)	Level 3 (Assessment of policies & systems to ensure professional ethics)	Level 3 (Assessment of policies & systems to ensure professional ethics)	Level 3 (Assessment of policies & systems to ensure professional ethics)	Level 3 (Assessment of policies & systems to ensure professional ethics)	
		Ethics (Fraud Prevention) 2.4.2	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (Fraud Prevention) 2.4.2	Level 3 (Fraud Prevention) 2.4.2	Level 3 (Fraud Prevention) 2.4.2	Level 3 (Fraud Prevention) 2.4.2	Level 3 (Fraud Prevention) 2.4.2	
		Internal Audit 2.5.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 2.5.1	Level 3 2.5.1	Level 3 2.5.1	Level 3 2.5.1	Level 3 2.5.1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		Risk Management 2.6.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 2.6.1	Level 3 2.6.1	Level 3 2.6.1	Level 3 2.6.1	Level 3 2.6.1	
		Corporate Governance of ICT. 2.8.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 Corporate Governance of ICT. 2.8.1	Level 3 Corporate Governance of ICT. 2.8.1	Level 3 Corporate Governance of ICT. 2.8.1	Level 3 Corporate Governance of ICT. 2.8.1	Level 3 Corporate Governance of ICT. 2.8.1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Customize & Distribute the template	Approved 3 year Annual Performance Plan	Submission letter, Tabling letter	Quarterly	APP approved and submitted	APP approved and submitted	Submission of APP 2017/18-2019/20	-	Submission of the 1 st draft of the 2017/18-2019/20 APP	Submission of the 2 nd draft of the 2017/18-2019/20 APP	Submission of the finalised 2017/18-2019/20 annual performance plan	
	Consolidate the inputs into the APP Conduct consultation session Prepare tender for final printing submit to the SG for Print summarised version of APP & distribute (districts & facilities)											
	Provide managers with the template for of the Operational Plan Consolidate inputs and revise quarterly targets	Approved 1 year Operational Plan	Tabling letter	Annual	OP approved and submitted	OP approved and submitted	Submission of OP 2017/18	-	Provide programme manager with the template	Development of the Operational Plan	Submission of the finalised 2017/18 Operational plan	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Support visits to sub – districts & do build capacity share government priorities and assist them in the development of their operational plans.	Number of sessions hosted to communicate the strategic imperatives	Reports	Quarterly			Four consolidated reports submitted	Develop a report on the communication session attended for NMM and BCM Sub - districts	Develop a report on the communication session attended for Joe Gqabi and Chris Hani Sub - districts	Develop a report on the communication session attended for Amathole and Sara Baartman Sub-districts	Develop a report on the communication session attended for OR Tambo and Alfred Nzo Sub - districts	
	Facilitate the review and development of District Health Plans Circulate 2017/18 - 19/20 Standardized DHP template to all districts. 8 capacity building sessions for all districts. Assessment report on APP –DHP alignment	2017/18-19/20 DHPs revised and submitted to NDOH.	Submission letter to NDOH.	Quarterly	2015/16-17/18 DHP s for eight districts submitted to NDOH	16/17-18/19 DHP s for eight districts submitted to NDOH	Approved 17/18-19/20 DHP s submitted to NDH	-	1 st draft DHP submitted to NDOH by 30 August 2016.	2 nd draft 2017/18-2019/20 DHP s developed by 30 November 2016.	Final 2017/18-2019/20 DHP s developed and submitted to NDOH by 30 March 2017.	90

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate the review development of district operational plans.	2017/18 Operational plans for districts assessed for alignment to DHP	Report on Operational plans alignment to APP and DHP	Annually	08 district operational plans assessed.	08 district Operational plans assessed	08 Operational plans assessed for alignment to APP and DHP.	-	-	-	08 Operational plans assessed for alignment to the APP.	5
	Operational plans template developed and circulated to districts											
	Support the review of development of Service delivery improvement plan.	2018/19 Service delivery improvement plan developed.	2018/19 SDIP	Annually	2015/16 – 17/18 SDIP	2015/16-17/18 SDIP	Draft 2018 /19 - 20/21 SDIP.	-	-	-	Draft 2018/19 -20/21 SDIP.	R5
	Process mapping of key services.											
	Support development of Standard operating procedures.											
	Coordinate the review of 16 Anti-poverty sites master plan and implementation reports.	Approved 3 year Anti-poverty site implementation plan reviewed.	Approved 3 year plan and quarterly reports.	Annual	Approved draft 3 year master plan on 16 anti-poverty sites.	Draft 3 year anti-poverty master plan	Reviewed master plan.	Approved 3 year master plan.	-	-	-	42

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Performance Monitoring and Improvement of Service Delivery at Provincial level	Finalize baseline information for the 16 sites.	Quarterly reports for anti-poverty site developed.	Quarterly reports developed and submitted	Quarterly	New Indicator	Quarter 3 antipoverty site developed	4 quarterly reports on antipoverty developed	1 Anti-poverty report developed	1 Anti-poverty report developed	1 Anti-poverty report developed	1 Anti-poverty site report developed	
	Compile Quarterly Performance Reports: 1 PQRS 2 Quarterly report	Quarterly reports submitted	Reports	Quarterly	8	8	8	2	2	2	2	
	Compile midyear report	Mid-Year report submitted	Reports	Annually	1	1	1			1		300 000
	Compile Annual report for the department	Annual report submitted	Reports	Annually	2	2	2	1 draft report	1 final report			
	Facilitate quarterly progress review	Quarterly review meetings held	Minutes of Review meeting	Quarterly	4	4	4	1	1	1	1	
	Evaluate performance and monitor trends	Trend analysis documents	Reports	Annually	1	2	4	1	1	1	1	
	Assist programmes to develop M&E plan for their units	Number of programmes with own M&E plans	M&E document	Bi-Annually	1	2	2		1		1	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Coordinate the auditing of Pre-determined Objectives and Sector Audit	Auditor General meetings held	Reports	Annually	1	1	1				1	
Support Performance Improvement at District level	Participate at performance review meetings at district level	Number of district review meetings attended	Report	Quarterly	4	4	8	2	2	2	2	
	Facilitate annual indicator review and training for district planners	1 of participants at the annual meeting	Attendance register	Annually	1	1	1	-	-	-	1	
Support Improvement of Management Systems	Facilitate the MPAT process Ensure all directorates score themselves and meet the deadline Facilitate review and improvement of Moderated scores	ECDOH scoring above 3 in the MPAT	Annually	Annually	1	1	1	-	1	-	-	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Develop MPAT Performance improvement plan	MPAT improvement plan	Annually	Annually	I	I	I	-	-	I	-	
Facilitate evaluation within the department	To establish Evaluation Priorities and participate in evaluation project.	I of evaluation studies conducted	Evaluation report	Annually	0	0	I				I	
To implement systems for effective planning, Monitoring and Evaluation process in order to improve the provision of health services. (DQI)	Measure Health facilities that submitted DHIS, PPIP, ETR, Tier.Net data & ART Cohort data in compliance with Routine Data Flow Policy timeliness. (Timeliness and Submission)	% Health Districts that submitted DHIS data in compliance with Routine Data Flow Policy target dates (Timeliness and Submission)	Monthly data quality index reports	Quarterly	87%	-	95%	95%	95%	95%	95%	0

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Measure Health facilities that submitted complete DHIS data elements on PHC, Hospital, EHS ,WBOT, ISHP, EMS, Monthly ART and ART Cohort (Completeness as per rationalized 2013 NIDS document & data sets)	% Health Districts that submitted complete DHIS data elements (Completeness)	Monthly data quality index reports	Quarterly	93%		90%	90%	90%	90%	90%	0

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Measure Health facilities that complied with absolute validation rules& ETR data clean up per District. Do data quality checks , compile and send feedback Compile Pre-submission data verification report.	% Health Facilities that complied with absolute validation rules	Monthly data quality index reports	Quarterly	71%		95%	95%	95%	95%	20	

Strategic objective	Planned Activities	Performanc e indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To implement , maintain and support systems and programmes	Orientation on new developments in DHIS, ETR and Tier .Net	Functional effective use of information systems and programmes in 6 districts and 2 Metros	Attendance Register	Quarterly	8	8	8	2	2	2	2	100
	Communicati on on new developments in DHIS, ETR and Tier .Net Ensure distribution of updated builds, data files, fixes and system upgraded versions for functionality to 6 Districts and 2 Metro's. Ensure timely and appropriate Response to data request Give regular feedback to districts and Programmes											

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To conduct Performance review of the districts through Quarterly meetings	Send Communication to relevant stakeholders Prepare and present Programme performance reports per target set. Assist with logistics for the meeting Compile Minutes of all the events before, during and after the Quarterly meeting.	Number of Quarterly meetings held in a year	Attendance Register	Quarterly	3	4	4	1	1	1	1	60
To facilitate migration of all health facilities from DHIS 1.4 to e Register and DHIS 2	Number of health facilities on DHIS 1.4	Number of health facilities on DHIS 2	List of the facilities capturing DHIS 2	Quarterly	7	5	50	12	12	13	13	300

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To promote facility integration of Tier and ETR.Net systems.	Identify eligible facilities for integration of Tier and ETR .Net	Number of facilities with Tier.Net & ETR module captured at facility level reduced	List of the facilities capturing on Tier.Net & ETR module	Quarterly	141	161	49	12	12	12	13	350
	Ensure T2 Phase 0-5 attain Phase 6 status Monitor sustainability of T2 facilities Ensure eligible T1 facilities implement T2	Number of Tier.Net 2 facilities phase 0-5attaining phase 6 status reduced	Facility Tier Progress reports.	Quarterly	177	269	119	29	30	30	30	
	Monitor electronic Tier system (Tier.Net) on ART sites	Number of Art sites maintained on Tier.Net systems increased	Facility Tier Progress reports.	Quarterly	855	835	856	214	214	214	214	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To contribute towards achievement of unqualified audit opinion by 2016	Manage and distribute RFI to relevant facilities (selected for auditing). Communicate , Support ,follow up and report all facilities selected for auditing Coordinate and share auditing findings to all districts 6 & 2 Metro's Monitor action plans developed based on audit findings for all 6 Districts and 2 Metro's	Approved Audit intervention strategy.	Availability of Approved Strategy	Annual	Approved Strategy	Approved Strategy	Approved Strategy	-	-	Approved Strategy	-	200

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		Promotion of Access to Information. 2.10.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 Promotion of Access to Information. 2.10.1	Level 3 Promotion of Access to Information. 2.10.1	Level 3 Promotion of Access to Information. 2.10.1	Level 3 Promotion of Access to Information. 2.10.1	Level 3 Promotion of Access to Information. 2.10.1	
		Promotion of Administrative Justice (Compliance with PAJA requirements) 2.11.1	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (Compliance with PAJA requirements) 2.11.1	Level 3 (Compliance with PAJA requirement s) 2.11.1	Level 3 (Compliance with PAJA requirement s) 2.11.1	Level 3 (Compliance with PAJA requirement s) 2.11.1	Level 3 (Compliance with PAJA requirements) 2.11.1	
	Facilitate & monitor the payment of creditors within 30 days	No of Valid invoice paid within 30 days	BAS + LOGIS and Invoice Register	Quarterly	162 731	179 004	196 905	29536	59072	59072	49226	
	Minimise under expenditure	Under expenditure (percentage)	BAS + IYM reports	Quarterly	R0	R0	0.5%	24,8	49,6	74,4	99,2	
	Improve revenue generation	Amount of revenue generated(rand value)	BAS and DELTA9	Quarterly	R181,8mil	R156,7mil	R165,5mil	R24,9mil	R54,3mil	R30,7mil	R55,6mil	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
50% of health facilities connected to web-based DHIS through broadband by FY2019	Procurement plans to be aligned with the budget	Percentage of procurement conducted in line with the procurement plans monitored	Procurement plan BAS LOGIS	Quarterly	New indicator	New indicator	80%	20%	20%	30%	10%	
	Identification of sites per district	Percentage of Hospitals with broadband access	Internet rollout report	Quarterly	New indicator	25%	51%	17%	26%	26%	30%	
	Submission of prescribed forms	Numerator				22	45 (23 New)	4	6	6	7	
	Implementation, commissioning and monitoring	Denominator				89	89	23	23	23	23	
	Identification of sites per district	Percentage of fixed PHC facilities with broadband access	Internet rollout report	Quarterly	New Indicator	24%	49.4%	25%	25%	25%	25%	
	Submission of prescribed forms	Numerator				182	382 (200 new)	50	50	50	50	
OPERATIONAL PLAN 2016/17	Implementation, commissioning and monitoring	Denominator				772	772	200	200	200	200	
	Management of office connectivity to Global Life and Bhisho Hospital	% of offices provided with network cables	Offices networked and cabled including upgrading of old sites	Quarterly	New indicator	New indicator	100%	50%	50%	-	100%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Implement the ICT Strategic Plan for Video Conferencing	% of centres with video conferencing installed		Quarterly	New indicator	New indicator	25%	23.5%	47%	70.6%	100%	
			Numerator				17	4	8 (4 new)	12 (4 new)	17 (5 new)	
			Denominator				17	17	17	17	17	
	Management of the ICT Security plan and submit monthly compliance monitoring report	IT policy approved	Signed policy	Quarterly	New indicator	New indicator	Approved policy	Draft	consultation	Approved	-	
	Completed											
To facilitate effective human resources planning, development and management in order to improve provision of health services	Communication and engagement on Employee Satisfaction Survey Report	Employee satisfaction rate	Employee satisfaction survey report	Annual	65%	65%	65%	-	-	-	65%	
	Employee Wellness Case Management Services	Employee wellness utilization rate	EW Statistics and Case Registers	Quarterly / annually	2%	2%	2%	1.5%	1.7%	1.8%	2%	
	Conduct health risk assessments for employees	No. of Health Risk Assessments sessions done	Health Risk Assessment report and attendance registers	Quarterly / annually	84	88	80	20	20	20	20	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
33. OPERATIONAL PLAN 2016/17	Submission of the HR Plan by Q2	Approved HR Plan	HR Plan signed by Executive Authority	Quarterly / annual	-	-	Approved plan	50%	50%	-	-	
	Finalise, approved organisational structures	Organogram Approved	Proof of approved organogram signed by the MEC.	Annually	Org. design 80% complete	Approval of org. design 90%	approved Organogram	Approved Organogram	-	-	-	
	Conduct Job Evaluation	Job Evaluation conducted	Job evaluation report	Quarterly	-	-	50%	10%	25%	40%	50%	
	Conduct diagnostic review of Employee Relations cases and write plan for corrective action and support	Employee relations utilization rate	Statistics and Case Database	Quarterly / Annual	-	-	100%	50%	50%	-	-	
	Develop interactive template of Employee Relations statistics with timelines for completion within deadlines	Percentage of employee relations cases finalized within 90 days.	Statistics	Quarterly / annual	-	-	100%	25%	50%	75%	100%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency / quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Re-train districts in the use of the HR MIS tool to manage exit benefits within the deadlines	Percentage of employees whose exit benefits are paid within 3 months.	Persal reports	Quarterly / annual	-	-	100%	100%	100%	100%	100%	

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PROGRAMME 2

DISTRICT HEALTH SERVICES (DHS)

PROGRAMME PURPOSE

To ensure the delivery of primary health care services through the implementation of the District Health System.

PROGRAMME DESCRIPTION

The District Health Service (DHS) programme is composed of nine sub-programmes, namely:

- 2.1 District Management
- 2.2 Community Health Clinics
- 2.3 Community Health Centres (CHCs)
- 2.4 Community-based Services
- 2.5 Other Community Services
- 2.6 HIV & AIDS, STI and TB (HAST) Control
- 2.7 Maternal, Child and Women's Health & Nutrition
- 2.8 Coroner Services
- 2.9 District Hospitals

PRIORITIES FOR THE NEXT THREE YEARS

- To implement the model for the delivery of health services in the Eastern Cape based on the re-engineering of primary health care (PHC) services
- To implement and strengthen NHI preparatory in the pilot district
- To prevent and reduce morbidity and mortality related to TB, HIV/AIDS and STIs
- To reduce perinatal, infant and child mortality and maternal mortality within the province
- To improve early detection and management of people with chronic conditions

SUB-PROGRAMMES 2.1 – 2.3 (DISTRICT MANAGEMENT, CLINICS AND COMMUNITY HEALTH CENTRES)

SUB-PROGRAMME PURPOSE

- **Sub-Programme 2.1 *District Management:***

The sub-programme manages the effectiveness and functionality as well as the coordination of health services, referrals, supervision, evaluation and reporting as per provincial and national policies and requirements.

- **Sub-Programme 2.2 *Clinics***

The sub-programme manages the provision of preventive, promotive, curative and rehabilitative care, including the implementation of priority health programmes through accessible fixed clinics and mobile services in 26 sub-districts.

- **Sub-Programme 2.3 *Community Health Centres (CHCs):***

The sub-programme renders 24-hour health services, maternal health at midwifery units and the provision of trauma services, as well as the integration of community-based mental health services within the down referral system.

STRATEGIC GOAL BEING ADDRESSED:

- Strategic goal 1 - Prevent and reduce the disease burden and promote health
- Strategic goal 2 - Improved quality of care
- Strategic goal 3 - Universal Health Coverage

QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES FOR 2.1 – 2.3

Budget allocation: Sub-programme 2.1 – 2.3

Table DMI: I

BUDGET	R'000
Compensation of employees	7,235,524
Goods and services	2,536,012
Transfers	77,318
Capital assets	119,561
TOTAL BUDGET	9,968,415

Budget	2.1 District Management	2.2 Community Health Clinics	2.3 Community Health Centres
Compensation of employees	572,766	1,421,671	820,238
Goods and services	105,217	405,326	195,594
Transfers	30,183	1,545	1,052
Capital assets	40801	11,100	5,070
TOTAL BUDGET	748,967	1,839,642	1,021,954

Table DM: 2 Quarterly targets for District Health Services for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Two districts piloting NHI implementation by 2019	Equip members of Ward Based Outreach Teams in at least two sub districts with Data Capturing Devices and a functional Computer Application	Number of districts piloting NHI interventions					2	-	-	-	2	
	Establish consultation fora in different categories of stakeholders	Establish NHI consulting FORA					Yes	Yes	Yes	Yes	Yes	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Implementation of ICRM according to the approved business plan.	Percentage of fixed PHC Facilities scoring above 70% on the ideal clinic dashboard.	Co standard compliance self-assessment tool, self-assessment report	Quarterly	New indicator	49%	10%	25%	25%	25%	25%	
		Numerator				378	24 (20 New)	5	5	5	5	
		Denominator				722	241	20	20	20	20	
Patient experience of care rate increased to	Facilitate implementation of the PSS	Client Satisfaction Survey Rate (PHC)	Patient satisfaction module, PSS forms	Quarterly	49.4%	49%	75%	6.5%	32.4%	58.3%	75%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
more than 75% in health services by 2019		Numerator			382	378	579	50	250 (200 new)	450 (200 new)	579 (129 new)	
		Denominator			772	772	772	772	772	772	772	
		Client Satisfaction rate (PHC)	Patient satisfaction module, PSS forms	Annually	New Indicator	65%	68%	-	-	-	68%	
100% Ward Based Outreach Teams (WBOT) coverage by 2019 ¹	Update database of OTLs and CHWs	OHV registration visit coverage - in population	Household registration visits registers, patient records	Quarterly	8.2%	22%	25%	8%	16%	20%	25%	
		Numerator			294 447	550 633	611 239	195 597	391 193	488 991	611 239	
		Denominator			3 581 565	2 444 957	2 444 957	2 444 957	2 444 957	2 444 957	2 444 957	
	Ensure availability of resources for WBOT implementation in districts. Facilitate training of OTLs and CHWs in districts	Number of ward-based outreach teams appointed	WBOT reports	Quarterly	484	383(20 new)	413 (30 new)	391 (8new)	399(8 new)	407(8 new)	413(6 new)	

¹ The target talks to full team, there are other teams but not fully fledged

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
100% District clinical specialist team (DCSTs) coverage for all Districts by 2019	Contracting of specialist doctors through PPP (Private Public partnership) Aggressive recruitment strategies to attract doctors : mass advert and head hunting	Number of Districts with fully fledged District Clinical Specialist Teams (DCSTs)	Appointment letters per district	Annually	5	4	8	-	-	-	8	
PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	Monitoring of PHC data collection and reporting	PHC utilisation rate	Stats SA, facility register, patient records	Quarterly	2.7	2.7	2.8	2.8	2.8	2.8	2.8	
		Numerator			17 906 952	4 465 210	18 739 851	18 739 851	18 739 851	18 739 851	18 739 851	
		Denominator			6 655 652	6 982 809	6 692 804	6 692 804	6 692 804	6 692 804	6 692 804	
		Complaints Resolution Rate	Complaints register, redress report	Quarterly	New indicator	94%	80%	80%	80%	80%	80%	
Patient experience of care rate increased to more than 75% in health services by 2019	Facilitate and monitor implementation of complaints management policy					4 801						
						5 081						
		Complaint resolution within 25 working days rate	Complaints register, redress report	Quarterly	96.4%	99%	80%	80%	80%	80%	80%	
Improve quality of care and efficiency.	Monitor supervision of PHC facility.					4 770						
						4 801						
		Fixed PHC facility supervision rate	DHIS Supervision reports	Quarterly	78	78	80	80	80	80	80	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Improve community participation		Numerator						617	617	617	617	
		Denominator						773	773	773	773	
	District Health council re-constitution following the Local Government election.	Number of District Health council established	Minutes Reports Attendance registers	bi annual	7	7	8	0	2	6 (4 new)	8 (2 new)	
	Establishment and orientation of Clinic CHC Committees on the new policy	% of clinic committees established	Minutes Reports Attendance registers	Quarterly			100%	30%	60%	80%	100%	
		Numerator					773	231	463	618	773	
		Denominator					773	773	773	773	773	

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SUB-PROGRAMME 2.4: COMMUNITY BASED SERVICES (including NON-COMMUNICABLE DISEASES)

PURPOSE

The Community-based Services sub-programme manages the implementation of the Community-based Health Services Framework. This includes:

- Implementation of disease-prevention strategies at a community level
- Promoting healthy lifestyles through health education and support
- Providing chronic and geriatric services including rehabilitation as a supportive service
- Providing oral health services at a community level (including schools and old age homes)
- Strengthening the prevention of mental disorders, substance, drug, and alcohol abuse to reduce unnatural deaths

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health

QUARTERLY TARGETS FOR COMMUNITY-BASED SERVICES

Budget allocation: Sub-programme 2.4

Table CBS: I

BUDGET	R'000
Compensation of employees	372,467
Goods and services	98,088
Transfers	5,284
Capital assets	2,093
TOTAL BUDGET	477,932

Table CBS: 2 Quarterly targets for Community-based Services for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Reduction of the traditional Male circumcision mortality to less than 10 by 2019	Conduct safe circumcision awareness campaigns Monitoring of initiates at initiation schools	Mortality rate among traditional male circumcision initiates (expressed per 1000 initiates)	Traditional male circumcision (TMC) database; Input summary sheets	Bi-annually	1.1 /1 000	0.02 / 1 000	0/1 000	0/1000	-	0/1000	-	
Increase to 80% PHC coverage by 2019	Provide budget for consumables for restoration within the district health system, Review and monitor quarterly performance	Tooth restoration rate	Facility registers	Quarterly	33:1	28:1	26:3	26:3	26:3	26:3	26:3	1,560
		Numerator			187 671	152 597	150 000	150 000	150 000	150 000	150 000	
		Denominator			5 687	5 432	5 695	5 695	5 695	5 695	5 695	
	Facilitate procurement of dental suite for selected CHC through infrastructure, Review and monitor quarterly performance	Percentage of CHCs providing oral health services	Facility registers	Quarterly	78.6%	78.6%	81%	81%	81%	81%	81%	300
		Numerator			33	33	34	34	34	34	34	
		Denominator			42	42	42	42	42	42	42	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Development of provincial integrated health promotion strategy, Consultations	Approved Provincial Health Promotion Strategy	Attendance Registers and Report	Annual	-	-	Approved Strategy	Draft	Draft	Draft	Approved	
	Facilitate Campaigns according to the Health calendar	Number of Health awareness campaigns conducted	Reports	Quarterly	-	-	12	3	3	3	3	

QUARTERLY TARGETS FOR Non-Communicable Diseases / DPC

Table DCP1: Quarterly targets for Non-communicable Diseases (Disease Prevention and Control) for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Screening coverage of chronic illnesses increased to 90 000 by 2019	Facilitate NCD quarterly information sessions, procure and provide chronic guidelines	Clients screened for hypertension	Facility registers	Quarterly	New indicator	749 200	800 000	200 000	200 000	200 000	200 000	798
		Clients screened for diabetes	Facility registers	Quarterly	New indicator	615 621	800 000	200 000	200 000	200 000	200 000	639
	Facilitate training of Health Professionals on NCD guidelines	Clients screened for Mental Health	Facility registers	Quarterly	New indicator	110 193	160 000	40 000	40 000	40 000	40 000	39
Mental health service platform increased to 55% of hospitals by 2019	Monitor utilization of chronic guidelines in selected Ideal clinics	Clients treated for mental disorders - new	Facility registers	Quarterly	New indicator	8.6%	10%	10%	10%	10%	10%	
		Numerator				9 484	16 161	16 161	16 161	16 161	16 161	
		Denominator				110 193	161 616	161 616	161 616	161 616	161 616	
Eradication of avoidable blindness	Monitor and support decentralization of chronic drugs in Ideal clinics	Number of District Mental Health Teams established		Annually	New Indicator	1	2	-	-	-	2	
	Monitor Screening for eye care problems (break down roles)	No of clients screened for eye care				10 016	16 400	4 100	4 100	4 100	4 100	
	Provide budget for procurement of reading glasses for clients with refractive errors	No of clients corrected refractive errors					2 210	552	552	552	552	200

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SUB-PROGRAMME 2.5: OTHER COMMUNITY SERVICES

PURPOSE

The Other Community Services sub-programme manages the devolution of municipal health service from the Department of Health to the district municipalities and metros, (health care waste management and other hazardous substances control), and implements a port health strategy to control the spread of communicable diseases through ports of entry into the province.

Strategic goals being addressed:

Strategic goal 2: Improved quality of care

QUARTERLY TARGETS FOR OTHER COMMUNITY SERVICES

Budget allocation: Sub-programme 2.5

Table OCS: I

BUDGET	R'000
Compensation of employees	42,377
Goods and services	13,855
Capital assets	2,178
TOTAL BUDGET	58,410

Table OCS: 2 Quarterly targets for Other Community Services for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
100% Compliance with the Waste Management Act by 2019	Provide consumables that will enable health facilities	Percentage of health facilities complying with SANS waste disposal requirements	Waste segregation audit tool, audit report	Quarterly	100%	79%	80%	80%	80%	80%	80%	
	Conduct training through the service provider	Numerator			91	70	71	71	71	71	71	
	targeting was generators and waste handlers	Denominator			91	89	89	89	89	89	89	
	Conduct segregation audits to selected facilities											
	Conduct training of health professionals on health care waste	Number of health professionals trained	Attendance register	Quarterly	Not measured		400	100	100	100	100	
		Numerator						100	100	100	100	
		Denominator						400	400	400	400	
	Collection of waste from the clinics to the central collection points	Percentage of clinics where waste has been collected	Waste collection document	Quarterly			100%	100%	100%	100%	100%	
		Numerator					772	772	772	772	772	
		Denominator					772	772	772	772	772	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000	
								Q1	Q2	Q3	Q4		
100% Compliance with the Waste Management Act by 2019	Develop and update the database	Number of premises on the database	Data base for premises selling hazardous substances	Quarterly			120	100	5	10	5		
		Numerator					120	100	5	10	5		
		Denominator					120	120	120	120	120		
	Monitor municipal health services rendered by DMs and Metros	Number of municipality's audited.	Reports	Quarterly			8	2	2	2	2		
	Monitor compliance on environmental health norms and standards												

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SUB-PROGRAMME 2.6 - HIV & AIDS, STI & TB (HAST) CONTROL

PURPOSE

To control the spread of HIV infection, reduce and manage the impact of the disease to those infected and affected in line with PGDP goals, and to control the spread of TB, manage individuals infected with the disease and reduce the impact of the disease in the communities.

Strategic goals being addressed:

- **Strategic goal 1** - Prevent and reduce the disease burden and promote health

QUARTERLY TARGETS FOR HIV & AIDS, STI AND TB CONTROL

Budget allocation: Sub-programme 2.6

Table HIV: 1

BUDGET	R'000
Compensation of employees	602,258
Goods and services	1,124,149
Transfers	21,125
Capital assets	27,853
TOTAL BUDGET	1,775,385

Table HIV: 2 Quarterly targets for HIV & AIDS, STI AND TB Control for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
HIV infection rate reduced by 50% by 2019	Facilitate scaling up and implementation of the HAST District Implementation plans (DIP) to achieve 90-90-90 targets	Adults remaining on ART – Total	Tier.net and the Adult clinical record	Quarterly	301 141	464 684	473 089	390 736	418 187 (27 451 new)	445 638 (27 451 new)	473 089 (27 451 new)	
	Facilitate scaling up and implementation of the HAST DIP to achieve 90-90-90 targets	Total Children (under 15 years) remaining on ART – Total	Tier.net and the Adult clinical record	Quarterly	18 434	24 565	24 786	21 736	22 754 (1 018 new)	23 770 (1 016 new)	24 786 (1 016 new)	183
	Conduct data management workshop	TB/HIV co-infected client on ART rate	Tier.net and the Adult clinical record	Quarterly	New indicator	New indicator	90%	90%	90%	90%	90%	
	Conduct TB /HIV program reviews	Num: Den:					19 440 21 600	4 860 5 400	4 860 5 400	4 860 5 400	4 860 5 400	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Client tested for HIV (incl. ANC)	Tier.net and the Adult clinical record	Quarterly	1 296 703	1 260 087	1 453 837	363 459	363 459	363 459	363 459	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Male condom distribution coverage	Patients records	Quarterly	New Indicator	55	50	50	50	50	50	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
TB death rate reduced by 50% in 2019	Facilitate partnership with the HOTL in conducting education campaigns for a boy child in and out of school by end 2016	Medical male circumcision performed - Total	Tier.net and the Adult clinical record	Quarterly	51 045	50 854	63 556	15 352	11 425	26 779	10 000	
	Provision of medical supplies in all health facilities in the province in order to scale up Male Medical Circumcision											
	Mobilize resources like TB screening tools for proper screening of presumptive patients in facilities	TB symptom 5yrs and older screened rate	Facility TB Screening tool, patient records	Quarterly	New Indicator	53%	70%	70%	70%	70%	70%	92,075
	Monitor and analyze reports from various districts on a quarterly basis.	Numerator				1 987 096	10 497 866	2 624 467	2 624 467	2 624 467	2 624 467	
		Denominator				3 749 238	14 996 952	3 749 238	3 749 238	3 749 238	3 749 238	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Conduct Programme reviews quarterly Develop Standard Operating Procedure (SOP) on patient & family education Distribute and conduct workshop on adherence strategy to the districts	TB client treatment success rate	ETR,Net, clinical record, facility register, patient records	Quarterly	81.1%	83%	83%	83%	83%	83%	83%	4,085
		Numerator			18 327	16 621	15 932	3 983	3 983	3 983	3 983	
		Denominator			22 404	20 123	19 195	4 798	4 799	4 799	4 799	
	Conduct support visits targeting districts with high lost to follow up Facilitate early tracing of interrupters, by Involving relevant stakeholders	TB client lost to follow up rate	Clinical record, facility register, patient records	Quarterly	7.6%	6.8%	7.2%	7.2%	7.2%	7.2%	7.2%	18,56
		Numerator			1 711	1 026	1382	346	346	345	345	
		Denominator			22 404	15 092	19 195	4 798	4 799	4 799	4 799	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Conduct mortality audits, community dialogues and quarterly reviews and for Sub-districts and districts affected	TB death rate	ETR.net, TB register, patient records	Annually	5.4%	5.8%	5.6%	-	-	-	5.6%	804
		Numerator			1 223	1 081	1 075	-	-	-	1 075	
		Denominator			22 475	18 362	19 195	-	-	-	19 195	
	Monitor implementation of Emocha system	TB MDR confirmed treatment initiation rate	EDR web, MDR-TB register, patient records	Annually	100%	90%	90%	-	-	-	90%	70,937
		Numerator			1779	2 250	2 700	-	-	-	2 700	
		Denominator			1779	2 500	3 000	-	-	-	3 000	
	Conduct MDR programme reviews and Provincial Clinical Review Committee meetings quarterly	TB MDR treatment success rate ²	EDR web, MDR-TB register, patient records	Annually	36%	42%	45%	-	-	-	45%	4,085
		Numerator				756	801	-	-	-	801	
		Denominator				1 800	1779	-	-	-	1779	

² MDR-TB patients are diagnosed by facilities and are sent to the MDR-TB hospitals for initiation of treatment. It is not possible to obtain this information for each district, and we are only able to get reports with this information from hospitals that are treating MDR-TB.

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
HIV infection rate reduced by 50% by 2019	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Adult with viral load completion (VLD) rate at 12 months	Facility Tier.net and the clinical record	Quarterly	55.9%	52.5%	>90%	>90%	>90%	>90%	>90%	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Adult with viral load suppressed (VLS) rate at 12 months	Facility Tier.net and clinical record	Quarterly	81.2%	79%	>90%	>90%	>90%	>90%	>90%	
HIV infection rate reduced by 50% by 2019	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	HIV test positive child 5-14 years	Facility HCT Registers, DHIS	Quarterly	New Indicator	1 605	3 384	846	846	846	846	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets											

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	Child under 1 year naïve started ART	Facility Tier.net, clinical record and DHIS	Quarterly	New Indicator	New Indicator	260	65	65	65	65	

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SUB PROGRAMME 2.7: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

PROGRAMME PURPOSE

To reduce mother, new born and child mortality through strengthened maternal and child as well as nutrition health services across the Eastern Cape Province

Strategic goals being addressed:

- **Strategic goal 1:** Prevent and reduce the disease burden and promote health

Budget allocation: Sub-programme 2.7

Table MCWH: 1

BUDGET	R'000
Compensation of employees	-
Goods and services	41,962
Capital assets	1,736
TOTAL BUDGET	43,698

Table MCWH: 2 Quarterly targets for Maternal, Child and Women's Health and Nutrition for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Improve early booking through Mass mobilization Increase Pregnancy Screening at house level. Implementation of BANC	Antenatal 1st visit before 20 weeks rate	Facility registers, patient records	Quarterly	48.8%	59%	65%	65%	65%	65%	65%	
		Numerator			62 574	62 807	83 390	20 847	20 847	20 847	20 847	
		Denominator			128 293	106 800	128 293	32 073	32 073	32 073	32 073	
	Mass mobilization Encourage postnatal visit through community education Strengthen WBOT functionality	Mother post-natal visit within 6 days rate	Facility registers, patient records	Quarterly	58.0%	58%	60%	60%	60%	60%	60%	
		Numerator				61 309	54 812	54 812	54 812	54 812	54 812	
		Denominator				106 434	91353	91353	91353	91353	91353	
	Facilitate increased access and initiation to life-long ART for HIV positive	Antenatal client initiated on ART rate	Facility registers, patient records	Annually	91.7%	94%	95%	-	-	-	95%	
		Numerator			21682	19 059	22 457				22 457	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Child Mortality Reduced to less than 34 per 1000 population by 2019	woman	Denominator			23639	20 253	23 639				23639	
	Trainings of health professionals and sub-district data capturers on Implementation of revised PMTCT guidelines											
	Facilitate and support ANC early booking and early initiation of ART on HIV positive pregnant women. Coordinate integration of PMTCT services with MCWH, CCMT, TB, and PHC managers at Provincial, District and Sub District level	Infant 1 st PCR test positive around 10 weeks rate.	Facility registers, patient records	Quarterly	New indicator	1.7%	<1.4%	<1.4%	<1.4%	<1.4%	<1.4%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate training of DCST's and MCWH managers on RED and DQS Monitoring of district performance and availability of vaccines monthly and conduct catch up drives to reach the hard to reach areas	Immunisation coverage under 1 year (annualised)	DHIS, facility registers, patient records	Quarterly	80.9%	84%	85%	82%	82%	82%	82%	
		Numerator			113 817	114 154	119 585	119 585	119 585	119 585	119 585	
		Denominator			140 689	137 307	140 689	140 689	140 689	140 689	140 689	
		Measles 2nd dose coverage (Annualised)	DHIS, facility registers, patient records	Quarterly	73.5	81%	85%	85%	85%	85%	85%	
		Numerator				110 747	120 585	30 146	30 146	30 146	30 147	
		Denominator				137 328	141 865	141 865	141 865	141 865	141 865	
	Facilitate training of DCST's and MCWH managers on RED and DQS	DTaP-IPV-Hib 3 Measles 1st dose drop-out rate	DHIS, facility registers, patient records	Quarterly	New Indicator	0.5	0.5	0.5	0.5	0.5	0.5	
		Numerator				687	664	664	664	664	664	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Monitoring of district performance and availability of vaccines monthly and conduct catch up drives to reach the hard to reach areas	Denominator				137 328	132 841	132 841	132 841	132 841		
	To attend district programme reviews											
	Conduct an audit of all MCWH trainer in the province. Facilitate	Child under 5 years diarrhea case fatality rate	DHIS, facility registers, patient records	Quarterly	5.2%	4%	5%	5%	5%	5%		
		Numerator			351	249	259	64	65	65	65	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	availability of TOT for each district for MCWH programme	Denominator			6 784	6 544	5186	1 296	1 297	1 297	1 296	
	Training of TOT's as course directors and facilitators for IMCI so that there can be continuous training of professional nurses in facilities											
	Training of CHWs on the Community Component of IMCI											
	Training of TOT's as course directors and facilitators for IMCI so that there can be continuous training of professional nurses in facilities	Child under 5 years pneumonia case fatality rate	DHIS, facility registers, patient records	Quarterly	4.2%	4%	3.8%	3.8%	3.8%	3.8%	3.8%	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Develop norms and standards and roll out/dissemination	Numerator			274	265	178	44	45	45	44	
		Denominator			6 513	7 043	4 706	1 177	1 176	1 176	1 177	
	Training of DCST's and INP managers as TOT's for Ten Steps for management of Severe Acute Malnutrition. Monthly monitoring of district and hospital performance for intervention and support through attendance of district quarterly reviews.	Child under 5 years severe acute malnutrition case fatality rate	DHIS, facility registers, patient records	Quarterly	12%	12%	8%	10%	9.5%	9%	8%	
		Numerator			339	295	171	42	43	43	43	
	To procure posters for SAM protocol	Denominator			2 867	2 563	2 142	535	536	536	535	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	Strengthen the functionality of RPHC Implementation task teams. Stakeholder engagement (intersect oral collaboration), DOH, DBE, DSD.	School Grade R screening coverage	DHIS, EMIS, Learner profile form	Quarterly	New Indicator	0.07%	10%	5%	7%	8%	10%	
		Numerator				207	7 631	3 815	5 342	6 105	7 631	
		Denominator				296 318	76308	76308	76308	76308	76308	
	Strengthen the functionality of RPHC Implementation task teams. Stakeholder engagement (intersect oral collaboration), DOH, DBE, DSD.	School Grade 1 screening coverage (Annualised)	DHIS, EMIS, Learner profile form	Quarterly	13.4%	23%	10%	5%	7%	8%	10%	
		Numerator			26 531	33 671	14 794	7 397	10 356	11 836	14 794	
		Denominator			197 378	147 944	147 944	147 944	147 944	147 944	147 944	
	Strengthen the functionality of RPHC Implementation task teams.	School Grade 8 screening coverage (Annualised)	DHIS, EMIS, learner profile form	Quarterly	6.8%	10%	10%	5%	7%	8%	10%	
		Numerator			9 247	10 300	10 205	5 103	7 144	8 164	10 205	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Stakeholder engagement (intersect oral collaboration), DOH, DBE, DSD.	Denominator			136 239	102 051	102 051	102 051	102 051	102 051	102 051	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Mass mobilization Increase access to health services in nodal areas (Outreach services)	Couple year protection rate (Annualised)	DHIS, facility registers, patient records	Annually	43%	41%	55%	-	-	-	55%	
		Numerator			699 800	722 920	891 377				891 377	
		Denominator				1 780 810	1 620 685				1 620 685	
Screening coverage of chronic illnesses increased to a million by 2019	Population screening of all clients in care : ART, Family Planning	Cervical cancer screening Coverage (Annualised)	DHIS, facility registers, patient records	Quarterly	56.3%	59%	60%	25%	25%	25%	25%	
		Numerator			81 869	65 220	1 047 097	261 774	261 775	261 774	261 774	
		Denominator			1 745 162	147 556	1 745 162	1 047 097	1 047 097	1 047 097	1 047 097	
	Capacity building amongst clinicians, to improve the skill for Testing.											

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Child Mortality Reduced to less than 34 per 1000 population by 2019	Strengthen the functionality of RPHC implementation task teams.	Human Papilloma Virus (HPV) Vaccine 1st dose coverage	DHIS, facility registers, patient records	Annually	88.3%	85%	75%	-	-	-	75%	
		Numerator			56 251	54 158	47 786				47 786	
		Denominator			71 404	63 715	63 715				63 715	
	Strengthen the functionality of RPHC implementation task teams.	Human Papilloma Virus (HPV) Vaccine 2 nd dose coverage	DHIS, facility registers, patient records	Annually		-	75%	-	-	-	75%	
		Vitamin A dose 12-59 months coverage (Annualised)	DHIS, facility registers, patient records	Quarterly	53%	62%	61%	61%	61%	61%	61%	
		Numerator			626 612	724 937	701 396	175 349	175 349	175 349	175 349	
		Denominator			1 185 824	1 168 094	1 149 832	287 458	287 458	287 458	287 458	
	To ensure continuous training of CHWs on Vitamin A supplementation	Monthly monitoring of district performance.										
		Facilitate training of TOT's on Infant and Young Child Feeding.										
		Infant exclusively breast fed at HepB 3 rd dose rate	DHIS, facility registers, patient records	Quarterly	New indicator	50%	50%	25%	25%	25%	25%	
		Facilitate internal										
		Numerator				31 266	61 611	15 402	15 402	15 402	15 402	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	and external assessments of facilities with maternity beds for Mother Baby Friendly status. Facilitate training workshop for EHO's on Regulation R991. Monitor the functioning of the 6 Human Milk Banks in the province.	Denominator				62 864	123 222	61 611	61 611	61 611	61 611	
	To procure length boards and height measures. To facilitate training of TOT's on Nutrition Assessment Counselling and support	Under 2years Underweight for age incidence(Annualised)	Facility Registers	Annually		17.2 per 1000	15 per 1000	-	-	-	15 per 1000	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Improve early booking through Increase Pregnancy Screening at house level. Implementation BANC Capacity building :Saturation ESMOE	Maternal mortality in facility ratio (Annualised)	DHIS, facility registers, patient records	Annually	148.3/100 000	137/100 000	120/100 000	-	-	-	120/100 000	
Child Mortality Reduced to less than 34 per 1000 population by 2019	All the above activities under Child Health contribute to the reduction of Child Mortality.	Inpatient early neonatal death rate	Facility registers, patient records	Annually	20.8/1000	13 / 1000	12 / 1000	-	-	-	12 / 1000	

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SUB-PROGRAMME 2.8: CORONER SERVICES

PROGRAMME PURPOSE

- To strengthen the capacity and functionality of forensic pathology institutions within the province and facilitate access to forensic pathology services at all material times.
- The Coroner Services sub-programme renders forensic pathology services in order to establish the circumstances and causes surrounding unnatural deaths.

Strategic goals being addressed:

- Strategic goal 1: Improved quality of care

Budget allocation: Sub-programme 2.8

Table CS: 1

BUDGET	R'000
Compensation of employees	66,373
Goods and services	15,234
Capital assets	5,499
TOTAL BUDGET	87,106

Table CS: 2 Quarterly targets for Coroner Services for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Post – mortems conducted within 72hrs increased to 90% by 2019	Integration with EMS	Percentage of post-mortem performed within 72 hours Numerator Denominator	Death register, forensic pathology database	Quarterly	79%	93%	85%	85%	85%	85%	85%	
	Procure new fridges, Refrigerated truck							2 527	2 528	2 528	2 528	
	and a LODOX Improve staffing complement							2 973	2 974	2 974	2 974	

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SUB-PROGRAMME 2.9 - DISTRICT HOSPITALS

PROGRAMME PURPOSE

To provide comprehensive and quality district hospital services to the people of the Eastern Cape Province.

Strategic goals being addressed:

- **Strategic goal 1:** Prevent and reduce the disease burden and promote health
- **Strategic goal 2:** Improved quality of care

Budget allocation: Sub-programme 2.9

Table DH: I

BUDGET	R'000
Compensation of employees	3,337,374
Goods and services	536,587
Transfers	18,129
Capital assets	23,231
TOTAL BUDGET	3,915,321

Table DH: 2 Quarterly targets for District Hospitals for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate implementation of National Core Standards assessments by hospitals	National Core Standards self - assessment rate	National core Standard assessment tool	Quarterly	New Indicator	83.3%	90.9%	-	-	-	-	
		Numerator				55	60	15	15	15	15	
	Ensure that facilities develop Quality Improvement Plans	Denominator				66	66	-	-	-	-	
		Quality improvement plan after self - assessment rate	Quality Improvement Plans	Quarterly	New Indicator	90.9%	100%	-	30%	30%	-	
	Improve Plans After self-assessments	Numerator				50	60	-	-	-	-	
		Denominator				55	60	-	-	-	-	
	Monitor And support The implementation of Quality Improvement Plans	Percentage of District Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	13.6%	0%	12%	-	-	-	-	
		Numerator			9	0	8	2%	2%	2%	2%	
		Denominator			66	66	66	-	-	-	-	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate the implementation of Patient Satisfaction Surveys	2.4.2 Client Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	New Indicator	68.2%	91%	-	-	-	-	
		Numerator				45	60	30	30	-	-	
		Denominator				66	66	66	66	-	-	
Patient satisfaction rate increased to more than 75% in health services by 2019	Analyze Patient Experience of Care	Client Satisfaction rate	PSS forms, PSS report	Annually	25.7%	-	70%	-	-	-	70%	
	Survey Results, Develop and Implement Service Delivery Improvement Plans											
80% of hospitals meeting national efficiency targets by 2019	Monitor patient flow and support implementation of patient flow improvement plans	Average Length of Stay	Facility register	Quarterly	5.3 days	5.2 days	4.9 days	4.9 days	4.9 days	4.9 days	4.9 days	
		Inpatient Bed Utilisation Rate	Facility register	Quarterly	65%	59%	65%	65%	65%	65%	65%	
	Ensure implementation of District Hospital Package of Service and Clinical Guidelines	Numerator			1 318 586	963 254	1 115 472	1 115 472	1 115 472	1 115 472	1 115 472	
		Denominator			2 234 106	1 654 270	1 716 112	1 716 112	1 716 112	1 716 112	1 716 112	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Monitor cost drivers and ensure implementation of cost control measures where deviations are noted	Expenditure per PDE (patient day equivalent)	BAS, Stats SA, Council for Medical Scheme data, facility registers, patient records	Quarterly	R1 909	R1,990	R2,382	R2,382	R2,382	R2,382	R2,382	
Patient satisfaction rate increased to more than 75% in health services by 2019	Strengthen implementation of Complaints Management Policy	Complaint Resolution rate	Facility complaints registers, redress report	Quarterly	New Indicator	94%	80%	80%	80%	80%	80%	
	Ensure analysis of complaints And implementation of Service Delivery Improvement Plans	Complaint Resolution within 25 working days rate	Facility complaints registers, redress report	Quarterly	98.2%	100%	80%	80%	80%	80%	80%	

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PROGRAMME 3

EMERGENCY MEDICAL SERVICES (EMS)

PROGRAMME PURPOSE

To render an efficient, effective and professional emergency medical services as well as planned patient transport services including disaster management services to the citizens of the Eastern Cape Province.

PRIORITIES FOR THE NEXT THREE YEARS

- Improve call taking and dispatching ability by rolling out the computerised call-taking and dispatching system initially to the Alfred Nzo and the Chris Hani EMS Centres.
- Increase the EMS fleet to include dedicated fleet for inter hospital , XDR /MDR and Maternity transfers

Strategic goals being addressed:

- Strategic goal 3: Universal Health Coverage

QUARTERLY TARGETS FOR PROGRAMME 3: EMS

Budget allocation: Programme

Table EMS: I

BUDGET	R'000
Compensation of employees	667,964
Goods and services	336,115
Transfers	4,159
Capital assets	101,957
TOTAL BUDGET	1,120,995

Table EMS: 2 Quarterly Activities for EMS for 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Proportion of EMS response time improved to 85% by 2019	Deploy human and material resources closer to communities	EMS PI urban response under 15 minutes rate	Institutional EMS registers	Quarterly	51.5%	58%	68%	68%	68%	68%	68%	
		Numerator			20 592	14 418	19 436	4 859	4 859	4 859	4 859	
		Denominator			39 971	24 848	28 583	7 145	7 145	7 145	7 145	
	Deploy human and material resources closer to communities	EMS PI rural response under 40 minutes rate	Institutional EMS registers	Quarterly	50.4%	46%	68%	68%	68%	68%	68%	
		Numerator			22,457	28 105	21 866	4 467	4 467	4 467	4 467	
		Denominator			44,529	61 055	32 156	8 039	8 039	8 039	8 039	
Establish a dedicated fleet for inter-facility transfers Monitor dedicated fleet utilization	Establish a dedicated fleet for inter-facility transfers	EMS inter-facility transfer rate	Institutional EMS registers	Quarterly	New Indicator	28.8%	70%	70%	70%	70%	70%	
		Numerator				137 489	304 216	76 053	76 053	76 053	76 053	
		Denominator				478 039	434 594	108 648	108 648	108 648	108 648	

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PROGRAMME 4

PROVINCIAL HOSPITAL SERVICES

(REGIONAL AND SPECIALISED)

PURPOSE

To provide cost-effective, good quality secondary hospital services and specialised services, which include psychiatry and TB hospital services.

SUB-PROGRAMMES

General (Regional) Hospital Services: Rendering of hospital services at general specialist level and providing a platform for research and the training of health workers

- Cecilia Makiwane
- Frontier
- St Elizabeth
- Dora Nginza
- Mthatha

TB Hospital Services: To convert current tuberculosis hospitals into strategically placed centres of excellence in which a small percentage of patients may undergo hospitalisation under conditions that allow for isolation during the intensive phase of treatment, as well as the application of the standard multi-drug resistant (MDR) protocols

- Jose Pearson
- Fort Grey
- Nkqubela
- Majorie Parish
- PZ Meyer
- Majorie Parks
- Winter Berg
- Osmond
- Khotsong
- Empilweni
- Themba

Psychiatric Mental Hospital Services: Rendering a specialist psychiatric hospital service for people with mental illness and intellectual disability and providing a platform for training of health workers and research

- Elizabeth Donkin Psychiatric Hospital
- Komani Psychiatric Hospital
- Tower Psychiatric Hospital – provide long-term
- Cecilia Makiwane Hospital acute psychiatric Unit
- Holy Cross Hospital acute psychiatric Unit
- St Barnabas Hospital acute psychiatric Unit
- Mthatha Regional Hospital acute psychiatric Unit
- Dora Nginza Hospital - 72 hour observation Unit plus

PRIORITIES FOR THE NEXT THREE YEARS

- To strengthen the capacity and functionality of regional hospitals within the province
- To improve mother and child health and contributing towards the achievement of MDGs
- To improve clinical management of TB patients
- To strengthen the functionality of psychiatric hospitals within the province in order to improve outcomes for clients through the use of effective treatments and rehabilitation programmes
- To implement the National Core Standards

QUARTELY TARGETS FOR REGIONAL HOSPITALS

Strategic goals being addressed:

Strategic goal 1: Prevent and reduce the disease burden and promote health

Strategic goal 2: Improved quality of care

PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR REGIONAL HOSPITALS

QUARTERLY TARGETS FOR REGIONAL HOPITALS FOR 4.I

Budget allocation: Programme 4.I

Table RH: I

BUDGET	R'000
Compensation of employees	1,881,083
Goods and services	372,243
Transfers	19,339
Capital assets	3,707
TOTAL BUDGET	2,276,372

Table RH: 2 Quarterly targets for Regional Hospitals in 2016/17

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate the conducting of self-assessment at facility level	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New Indicator	60%	80%	20%	40%	60%	80%	
		Numerator				3	4	1	2(1 new)	3(1 new)	4(1 new)	
		Denominator				5	5	5	5	5	5	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	60%	100%	100%	100%	100%	100%	
		Numerator				3	4	1	2(1 new)	3(1 new)	4(1 new)	
		Denominator				5	4	1	2	3	4	
	Develop specifications & procure for health technology	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	0%	0%	75%	-	25%	50%	75%	
		Numerator			0	0	3	-	1(1 new)	2(1 new)	3(1 new)	
		Denominator			0	5	4	-	4	4	4	
	Facilitate conducting of Fire drills (emergencies)	Development of clinical risk and protocols.										
Patient satisfaction rate increased to more than 75% in health services by 2019		Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	New Indicator	20%	80%	20%	40%	60%	80%	
		Numerator				1	4	1	2(1 new)	3(1 new)	4(1 new)	
	Denominator				5	5	5	5	5	5		
Monitor implementation of the tools for CSS												
	Facilitate training of committees and field workers	Patient Satisfaction rate	PSS forms, PSS report	Annually	60%	65%	70%	-	-	-	70%	
Monitor												

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	implementation of the tools for CSS											
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of specialists and Health Professionals	Average length of stay	Facility registers, patient registers	Quarterly	5.2 days	5.5 days	4.6 days	4.6 days	4.6 days	4.6 days	4.6 days	
	Facilitate conducting of out-reach and in-reach											
	Monitor availability of policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient registers	Quarterly	68.8%	68%	75%	75%	75%	75%	75%	
NCD coverage increased to 1300/1000 000 through management of chronic illnesses by 2019	Conduct formalized cataract outreach services	Numerator			533,168	404 651	120 874	120 874	120 874	120 874	120 874	
		Denominator			774,432	597 266	161 165	161 165	161 165	161 165	161 165	
		Cataract surgery rate (Uninsured Population) (Regional hospital)	Facility registers, patient registers	Quarterly	117.5/1000 000	565/ 1000 000	1100/ 1000 000	200/ 1000 000	600/ 1000 000	800/ 1000 000	1100/ 1000 000	
1.9 80% of hospitals meeting national efficiency targets by 2019	IYM and functionality of Cost Containment Committees	Expenditure per patient day equivalent (PDE)	BAS, facility registers	Quarterly	R4,461	R1,807	R2,243	R2,243	R2,243	R2,243	R2,243	
Patient satisfaction rate increased to more than 75% in health	Monitor implementation of Complaint management system	Complaints resolution rate	Facility complaints registers, redress report	Quarterly	New Indicator	86.5%	80%	80%	80%	80%	80%	
		Complaint resolution	Facility	Quarterly	100%	98.8%	80%	80%	80%	80%	80%	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
services by 2019		within 25 working days rate	registers, redress report									
	Monitor functionality of Hospital Boards Induction of Hospital Boards	No of hospitals with functional hospital boards	Facility registers, redress report	Quarterly	100%	98.8%	5	2	2	1	-	

SUB – PROGRAMME: SPECIALISED TB HOSPITALS

QUARTERLY TARGETS FOR SPECIALISED TB HOSPITALS

Budget allocation: Sub-programme 4.2

Table TBH: I

BUDGET	R'000
Compensation of employees	267,032
Goods and services	140,997
Transfers	2,186
Capital assets	6,932
TOTAL BUDGET	417,147

Table TBH: 2 Quarterly Activities for Specialised TB Hospitals for 2016/17

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct in-service training of Quality Assurance managers and Nursing service Managers, on, 7 National Core Standards including the 6 priority areas, for all the 11 TB hospitals Ensure provision of technical assistance by Quality Assurance unit, on the analysis of quality assurance assessment reports, for all the 11 TB hospitals	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	36.3%	63.6%	81.8%	100%	
		Numerator			11	11	11	4	7(3 new)	9(2 new)	11	
		Denominator			11	11	11	11	11	11	11	
	Facilitate development of the Quality improvement plans by all the TB hospitals Facilitate implementation of the quality improvement plans by all the TB hospitals	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	100%	100%	100%	36.3%	63.6%	81.8%	100%	
		Numerator			11	11	11	4	7(3 new)	9(2 new)	11(2 new)	
		Denominator			11	11	11	4	7	9	11	
	Support all TB hospitals on the implementation of policies that will assist them to be compliant with all the extreme measures	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	35%	0%	45.4%	25%	42.8%	44.4%	45.4%	
		Numerator				0	5	1	3(2	4(1 new)	5(1	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate improvement on infrastructure in order to improve ventilation in all TB hospitals.								new)		new)	
		Denominator				11	11	4	7	9	11	
	Facilitate implementation of satisfaction surveys by all 11 hospitals. Facilitate development of Quality improvement plans for client satisfaction	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	New indicator	100%	100%	18.1%	54.6%	81.8%	100%	
		Numerator				11	11	2	5 (3 New)	9 (4 new)	11	
80% of hospitals meeting national efficiency targets by 2019	Facilitate analysis of the quality Assessment reports. Facilitate development of Quality improvement plans	Denominator				11	11	11	11	11	11	
		Patient Satisfaction rate	PSS forms, PSS report	Annually	78%	70%	75.6%	-	-	-	75.6%	
	Facilitate development of MDR technical review committees in all the Sub-districts Facilitate improvement of infection prevention and control by isolating patients according to drug resistance patterns.	Average length of stay	Facility registers, patient registers	Quarterly	112.4 days	88.4 days	105days	105days	105days	105days	105days	
		Inpatient Bed Utilisation Rate	Facility registers, patient registers	Quarterly	64.6%	62.2%	70%	70%	70%	70%	70%	
Facilitate admission of all patients abusing drugs and alcohol , in order to give them	Facilitate admission of aquiline until culture conversion.	Numerator			353 768	84 026	287426	71 857	71 857	71 856	71 856	
		Denominator			547 499	135 064	410 609	102 652	102 652	102 652	102 652	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	counselling sessions on adherence to treatment											
	Monitor implementation of Drug Resistance TB policy in prescribing drugs for all the patients with confirmed MDR-TB.	Expenditure per patient day equivalent (PDE)	BAS, facility registers	Quarterly	R889	R3 375	R1,700	R1,700	R1,700	R1,700	R1,700	
Patient satisfaction rate increased to more than 75% in health services by 2019	Ensure availability and use of Complaints registers in all the 11 TB hospitals	Complaints resolution rate	Complaints registers at facilities	Quarterly	93%	97.8%	80%	80%	80%	80%	80%	
	Facilitate analysis of the Complaints register so as to resolve complaints within 25 days											
	Ensure availability and use of Complaints registers in all the 11 TB hospitals	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	97.1%	100%	100%	100%	100%	100%	100%	
	Facilitate analysis of the Complaints register so as to resolve complaints within 25 days											

SUB – PROGRAMME: SPECIALISED PSYCHIATRIC HOSPITALS

QUARTELY TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Budget allocation: Sub-programme 4.3

Table SPH: I

BUDGET	R'000
Compensation of employees	449,446
Goods and services	173,429
Transfers	1,150
Capital assets	2,780
TOTAL BUDGET	626,805

Table SPH: 2 Quarterly Activities for Specialised Psychiatric Hospitals

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct self-assessments	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New Indicator	0%	100%	100%	-	-	-	
		Numerator				0	4	4				
	Develop and implement Quality Improvement Plans (QIPs)	Denominator				4	4	4	-	-	-	
		Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	0%	100%	-	100%	100%	-	
		Numerator				0	4	-	4	4	-	
		Denominator				4	4	-	4	4	-	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct self-assessments	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	New Indicator	0%	50 %	-	-	100%	-	
		Numerator				0	2	-	-	2	-	
	Conduct Patient Satisfaction Surveys (PSS)	Denominator				4	4	-	-	2	-	
		Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	New Indicator	0 %	75%	-	25%	50%	75%	
		Numerator				0	3	-	1	2(1 new)	3(1 new)	
		Denominator				4	4	-	4	4	4	
80% of hospitals meeting national efficiency targets by 2019	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report	Annually	72%	0%	70%	-	-	-	70%	
	Facilitate recruitment of Health Professionals	Average length of stay	Facility registers, patient records	Quarterly	6.7days	8days	5.5days	5.5days	5.5days	5.5days	5.5days	
	Facilitate conducting of outreach and in											

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	reach Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
	Facilitate recruitment of Health Professionals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	91%	92.8%	75%	75%	75%	75%	75%	
		Numerator			174 609	137 344						
	Facilitate conducting of outreach and inreach	Denominator			192 346	147 993						
	Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
Patient satisfaction rate increased to more than 75% in health services by 2019	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3,322	R3,732	R3,266	R3,266	R3,266	R3,266	R3,266	
	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facilities	Quarterly	New Indicator	0%	80%	80%	80%	80%	80%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	100%	4%	80%	80%	80%	80%	80%	

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PROGRAMME 5

TERTIARY & CENTRAL HOSPITALS

PROGRAMME PURPOSE

To strengthen and continuously develop the modern tertiary services platform to adequate levels in order to be responsive to the demands of the specialist service needs of the community of the Eastern Cape Province. There are two Tertiary Hospitals and one Central Hospital in the Eastern Cape Province:

Central Hospital

- Nelson Mandela Academic Hospital

Tertiary Hospitals

- Livingstone Hospital
- Frere Hospital
- Fort England (specialised psychiatric hospital)

Specialised Psychiatric Hospital

- Fort England, partly funded through the NTSG.

PRIORITIES FOR THE NEXT THREE YEARS

- To strengthen oncology services
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

Strategic goals being addressed:

- **Strategic goal 1:** Prevent and reduce the disease burden and promote health
- **Strategic goal 2:** Improved quality of care

CENTRAL HOSPITALS

QUARTERLY TARGETS FOR CENTRAL & TERTIARY HOSPITALS FOR 2016/17

Budget allocation: Sub-programme 5.1

Table THS: I

BUDGET	R'000
Compensation of employees	1,954,725
Goods and services	762,348
transfers	24,285
Capital assets	97,432
TOTAL BUDGET	2,838,790

Table THS: 2 Quarterly Activities for Central Hospitals

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate conducting of self-assessment at facility level	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New Indicator	100%	80%	100%	100%	100%	100%	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	100%	80%	100%	100%	100%	100%	
	Develop specifications and procure for health technology equipment Facilitate	Percentage of Hospitals compliant with all extreme and vital measures of the national core	National core standard assessment report	Quarterly	0%	0%	80%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	conduction of fire drills Develop Clinical Risk Management and protocols	standards										
	Facilitate Training of Quality Assurance Committees Monitor implementation of the development tool	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	New Indicator	100%	80%	100%	100%	100%	100%	
	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report, patient satisfaction module	Annually	70%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and in reach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Average length of stay	Facility registers, patient records	Quarterly	6.7 days	8 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days	
	Facilitate recruitment of	Inpatient bed utilisation rate	Facility registers,	Quarterly	91%	93%	75%	75%	75%	75%	75%	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	Health Professionals	Numerator	patient records		174 609	137 344						
	Facilitate conducting of outreach and inreach	Denominator			192 346	147 993						
	Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3.322	R3.732	R3.266	R3.266	R3.266	R3.266	R3.266	
	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	New Indicator	98%	90%	60%	70%	80%	90%	
	Facilitate training and implementation of Complaints Management Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	100%	100%	80%	20%	40%	60%	80%	

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TERTIARY HOSPITALS

QUARTERLY TARGETS FOR TERTIARY HOSPITALS FOR 2016/17

Table THS: 1 Quarterly Activities for Tertiary Hospitals

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Facilitate conducting of self-assessment at facility level	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New Indicator	100%	100%	100%	-	-	-	
		Numerator				2	2	2	-	-	-	
		Denominator				2	2	2	-	-	-	
	Facilitate development of quality improvement plan at facility level after self-assessments	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	100%	100%	-	100%	-	-	
		Numerator				2	2	-	2	-	-	
		Denominator				2	2	-	2	-	-	
Patient satisfaction	Conduct self-assessments Develop and implement Quality Improvement Plans (QIPs)	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	0%	0%	50%	-	-	50%	-	
		Numerator			0	0	1	-	-	1	-	
		Denominator			2	2	2	-	-	2	-	
		Patient Satisfaction	PSS forms, PSS report,	Quarterly	New Indicator	80%	80%	80%	80%	80%	-	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
rate increased to more than 75% in health services by 2019	Satisfaction Surveys (PSS)	Survey Rate	patient satisfaction module									
		Numerator					2	1	2 (1 new)	-	-	
		Denominator					2	2	2	-	-	
80% of hospitals meeting national efficiency targets by 2019	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report, patient satisfaction module	Annually	77%	80%	70%	70%	70%	70%	70%	
		Average length of stay	Facility registers, patient records	Quarterly	5.7 days	5.9 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days	
		Facilitate recruitment of Health Professionals										
	Facilitate conducting of outreach and in reach											
		Monitor availability of clinical policies, protocols, guidelines and procedure manuals										
		Facilitate recruitment of Health Professionals. Facilitate										
	Facilitate recruitment of Health Professionals. Facilitate	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	79.3%	76.3%	75%	75%	75%	75%	75%	
		Numerator			467,127	345 414	725 699	725 699	725 699	725 699	725 699	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	conducting of outreach and in reach. Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Denominator			589,357	452 892	967599	967599	967599	967599	967599	
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R2,330	R3,610	R2,843	R2,843	R2,843	R2,843	R2,843	
	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	New Indicator	96.4%	85%	60%	70%	80%	85%	
	Facilitate training and implementation of Complaints Management Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	100%	100%	80%	20%	40%	60%	80%	

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SPECIALISED PSYCHIATRIC TERTIARY HOSPITALS

Purpose

To ensure the provision of specialist clinical and health services. Its other responsibility is to provide clinical and health leadership in ensuring that the hospital meets its targets

PRIORITIES FOR THE NEXT THREE YEARS

- To strengthen Mental Health Care Service
- To strengthen institutional capacity to deliver relevant and quality services at appropriate levels
- To improve institutional functionality and effectiveness by ensuring that efficiency indicators are fully achieved

Table SPH I: Quarterly Targets for Specialised Psychiatric Hospitals

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Conduct self-assessments	National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New Indicator	New Indicator	100%	100%	-	-	-	
	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	New Indicator	100%	-	100%	-	-	
	Conduct self-assessments Develop and implement Quality Improvement Plans (QIPs)	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	New Indicator	New Indicator	100%	100%	-	-	-	
Patient	Conduct	Patient	PSS forms, PSS	Quarterly	New	60 %	75%	-	60%	65%	75%	

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
satisfaction rate increased to more than 75% in health services by 2019	Patient Satisfaction Surveys (PSS)	Satisfaction Survey Rate	report, patient satisfaction module		Indicator							
	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report, patient satisfaction module	Annually	New Indicator	New Indicator	70%	-	-	-	70%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of Health Professionals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	New Indicator	New Indicator	85%	85%	85%	85%	85%	
	Facilitate conducting of outreach and in reach	Numerator					306 250	306 250	306 250	306 250	306 250	
	Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Denominator					360 294	360 294	360 294	360 294	360 294	
	Facilitate recruitment of Health Professionals											
	Facilitate conducting of outreach and inreach											
	Monitor availability of											

Strategic objective	Planned Activities	Programme performance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	clinical policies, protocols, guidelines and procedure manuals											
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	New Indicator	New Indicator	RI, 44I	RI 44I	RI 44I	RI 44I	RI 44I	
	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	New Indicator	New Indicator	90%	90%	90%	90%	90%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	New Indicator	New Indicator	95%	95%	95%	95%	95%	

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PROGRAMME 6

HEALTH SCIENCES AND TRAINING (HST)

PROGRAMME PURPOSE

To develop a capable health workforce for the Eastern Cape provincial health system as part of a quality people value stream.

PRIORITIES FOR THE NEXT THREE YEARS

- In-service learning for primary services (clinical, human resources and finance) by providing effective knowledge to practice programmes, short learning programmes and related skills development interventions
- Implement a comprehensive management development and leadership programme
- Facilitate the implementation of the learnership and internship (workplace experience) programmes
- Implement career management strategies through succession planning that underpin recruitment and retention of critical skills
- Establishment of an academic platform to enhance the supply of the critical health professions skills in line with the human resources for health plan

Strategic goals being addressed:

- Strategic goal 2: Improved quality of care

QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING

Budget allocation: Programme 6

TABLE HST: I

BUDGET	R'000
Compensation of employees	508,976
Goods and services	89,757
Transfers	177,024
Capital assets	23,710
TOTAL BUDGET	799,467

TABLE HST: 2 Quarterly Activities for Health Sciences and Training, 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Fifty (50) first year medical student receiving bursaries by 2019	Recruitment and payment of fees	Number of Bursaries awarded for first year medicine students	DoH bursary database	Annual	-	10	10	-	-	-	10	3 857 000: Equitable Share Intake 16/17
	Administering the signing of bursary contracts and safe keeping thereof											
Fifty (50) first year medical student receiving bursaries by 2019	Recruitment (advert), selection and first year registration if new nursing students across all nursing academic programmes	Number of Bursaries awarded for first year nursing students	DoH bursary database	Annual	New Indicator	950	550	-	-	-	550	18 560 Equitable 10 095 HWSET A
	Advertise, appoint and place Departmental and HWSETA Funded Interns	Number of interns on internship programme	Internship Programme Database	Annual	560	736	736	200	86	250	200	
To develop a responsive health workforce by ensuring adequate training and accountability are in place	Approved WSP 2015 and Implementation of Priority Training Needs	Number of employees utilizing Skills Levy	Training Attendance Registers NSDS III Report	Quarterly	10850	15000	12735	1300	2935	4890	3610	74 440 Equitable 6 6033 HWSET A

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To manage and monitor the performance of the employees of the department through work contracts	PMDS register compiled Capturing on persal	% of SMS members with signed Performance Agreements	Persal PMDS Reports	Annually			100%	100%	-	-	-	
		% of all Employees with signed Performance Agreements					80%	80%	-	-	-	

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PROGRAMME 7

HEALTH CARE SUPPORT SERVICES (HCSS)

PROGRAMME PURPOSE

To render quality, effective and efficient transversal health (orthotic & prosthetic, rehabilitation, laboratory, social work services and radiological services) and pharmaceutical services to the communities of the Eastern Cape. Health Care Support Services consist of two sub-programmes: Transversal Health Services and Pharmaceutical Services.

Transversal Health Services consists of:

- The orthotic & prosthetic (O&P) services sub-programme, which has three existing O&P centres that are at different levels of staffing and different level of functionality in terms of equipment and infrastructure. The centres are based within the three hospitals namely the PE Provincial Hospital, in East London at Frere Hospital, and in Mthatha at Bedford Orthopaedic Hospital. The prescriptions received from medical professionals and the referrals especially from the outreach programme determine the need for the service.
- Rehabilitation, laboratory, social work and radiological services are rendered at all hospitals and/or community health centres.

Pharmaceutical Services is responsible for:

- Coordination of the full spectrum of the Pharmaceutical Management Framework including drug selection, supply, distribution and utilization.
- Pharmaceutical standards development and monitoring for health facilities and the two medical depots are coordinated under this programme.

PRIORITIES FOR THE NEXT THREE YEARS

- To improve systems for the provision of assistive devices and rehabilitation equipment to persons with disabilities
- To strengthen systems to ensure uninterrupted availability of essential medicines at all levels

Strategic goals being addressed

- **Strategic goal 1:** Prevent and reduce the disease burden and promote health
- **Strategic goal 2:** Improve Quality of Care

QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

Budget allocation: Programme 7

Table HCSS: I

BUDGET	R'000
Compensation of employees	59,427
Goods and services	57,863
Transfers	
Capital assets	919
TOTAL BUDGET	118,609

Table HCSS: 2 Quarterly targets for Health Care Support Services, 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
95% of clients eligible for assistive devices provided with wheelchair	Procure wheelchairs Issue the wheelchairs to eligible applicants	Percentage of eligible applicants supplied with wheelchairs	Facility register	Quarterly	72%	85%	65%	25%	25%	25%	25%	
		Numerator						1 419	1 419	1 419	1 419	
	Order the hearing aid as per measurement Issue and Fit the hearing aid to eligible applicants	Denominator						5 676	5 676	5 676	5 676	
		Percentage of eligible applicants supplied with hearing aids						25%	25%	25%	25%	
s, hearing aids, prostheses & orthoses by 2019		Numerator	Facility register	Quarterly	108%	161%	85%	678	678	678	678	
		Denominator						7 713	7 713	7 713	7 713	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
90% availability of essential drugs in all health facilities by 2019	Design the Prosthesis Fit and Issue the prosthesis to eligible applicants	Percentage of eligible applicants supplied with prostheses	OP Centres reports	Quarterly	56%	67%	60%	25%	25%	25%	25%	
		Numerator			6961	8 570	7 792	1 948	1 948	1 948	1 948	
	Design the orthoses Issue the orthoses to eligible applicants	Denominator			12 484	12 733	12 987	7 792	7 792	7 792	7 792	
		Percentage of eligible applicants supplied with orthoses	OP Centres reports	Quarterly	203%	145%	95%	25%	25%	25%	25%	
		Numerator			23 274	24 244	16 060	4 015	4 015	4 015	4 015	
		Denominator			11 444	16 672	16 905	16 060	16 060	16 060	16 060	
	Maintain 3 month buffer stock within the depots Monitor availability of essential drugs	Percentage of order fulfillment of essential drugs at the depots.	MEDSAS	Quarterly	78%	87%	85%	85%	85%	85%	85%	
		Numerator			388 128	91 359	466 313					
		Denominator			497 600	105 062	548 604					

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PROGRAMME 8:

HEALTH FACILITIES MANAGEMENT (HFM)

PROGRAMME PURPOSE

To improve access to health care services through provision of new health facilities, upgrading and revitalisation, as well as maintenance of existing facilities, including the provision of appropriate health care equipment.

The programme consists of sub-programmes:

- Community Health Facilities
- Emergency Medical Services
- District Hospital Services
- Provincial Hospital services
- Other facilities

PRIORITIES FOR THE NEXT THREE YEARS

- To facilitate and provide infrastructural support in terms of the upgrading of the existing structures for health services delivery, as well as other organisational building requirements
- To facilitate general maintenance in all spheres of the organisation To facilitate the provision of essential equipment in health facilities
- To ensure the implementation of PGDP requirements by engaging SMME contractors in health facilities management projects

Strategic goals being addressed:

- **Strategic goal 2:** Improved quality of care

QUARTERLY TARGETS FOR HEALTH FACILITIES MANAGEMENT FOR 2016/17

Budget allocation: Programme 8

Table HFM: 1

BUDGET	R'000
Compensation of employees	25,000
Goods and services	347,304
Capital assets	1,030,472
TOTAL BUDGET	1,402,776

Table HFM: 2 Quarterly targets for Health Facilities Management 2016/17

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
(721) Health facilities refurbished to comply with the National norms and standards by 2019	Conduct onsite visits to closely monitor projects under refurbishment. Monthly Monitoring Meetings with both Agents (IA) to assess project and program management progress to date.	Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually (major)	New Indicator	19 major 120 minor	8 major 70 minor	- 17	- 17	- 17	8 19	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		Number of health facilities that have undergone major and minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)		Annually(major)	New Indicator		9 major 70 minor	- 17	- 17	- 17	9 17	
	Annual SLA review session to assess value for money on services rendered by both Implementing Agent.	Establish Service Level Agreements (SLAs) with Departments of Public Works (and any other implementing agent)	Signed and approved SLA	Annually	Yes	Yes	Yes	-	-	-	Yes	
	Consultation of relevant stakeholders to review User Asset Management Plan that is aligned to the Departmental Strategic Plan	Approved 2016/17 User Asset Management Plan (UAMP)	UAMP Signed and Approved document	Annually	Approved	Approved	Approved	-	-	Approved	-	No Financial implication

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Check Medical Equipment , Maintenance management, availability & condition assessment	Approved contract - Condition of Health Technology medical equipment at facilities	Signed and Approved Contract.	Annually	-	-	Approved Contract	-	-	-	Approved Contract	2,000
	Update Annual Implementation Plan (AIP) 2016/17 according to the revised budget and identified projects.	Approved Annual Infrastructure Plan (AIP)	Signed AIP	Annually	Approved Plan	Approved Plan	Approved Plan	Approved Plan	-	-	-	No Financial implication
	Update Infrastructure Program Management Plan (IPMP) in line with the AIP & B4.	Approved IPMP	Signed IPMP	Annually	Approved Plan	Approved Plan	Approved Plan	-	-	-	Approved Plan	No Financial implication

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2014/15	Estimate 2015/16	Annual target 2016/17	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Review Infrastructure Maintenance Strategy for Buildings, Fixed Plant, and Machinery & Equipment in line with infrastructure backlogs.	Approved Maintenance Strategy	Signed Maintenance Strategy	Annually	Approved Plan	Approved Plan	Approved Plan	-	-	-	Approved Plan	No Financial implication

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ANNEXURE

Technical Indicator Definitions

ANNEXURE B: TECHNICAL INDICATOR DESCRIPTIONS

PROGRAMME 1: HEALTH ADMINISTRATION & MANAGEMENT

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Number of statutory documents tabled at Legislature	Statutory documents submitted and tabled at the Provincial Legislature	Tracks the number of statutory documents submitted and tabled at the Provincial Legislature	Copies of the document	Not applicable	Unavailability of statutory documents	Output	Categorical	Annual	No	Compliance with legislative requirements	Office of the MEC
2.1.1 Audit opinion from Auditor General for	Audit opinion for Provincial Departments of Health for financial performance	To strengthen financial management monitoring and evaluation	Documented Evidence: Annual Report Auditor General's Report	Categorical	N/A	Outcome	N/A	Annual	No	Unqualified Audit Opinion from the Auditor General	Chief Financial Officers of Provincial Departments of Health Chief Financial Officer : National DoH
2.1.2 Audit Improvement Plan for Financial Performance Review					Not applicable		Categorical	Quarterly	Yes		Chief Financial Officer
2.1.3 Audit Improvement Plan for Performance Information Review					Not applicable		Categorical	Quarterly	Yes		DDG: Clinical Services

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.1.4 Level 4 MPAT	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	MPAT report	The tool has Structure Questionnaires	Minimal as there are controls	Output	Categorical	Annual	No	Level 4	GM: SOP
2.1.5 Strategic Management improvement plan (MPAT_IP improvement plan of health has performance review	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	Performance report	Not applicable	Minimal as there are controls	Output	Categorical	Quarterly	Yes	Level 3	GM: SOP
2.1.6 Governance & accountability MPAT improvement plan (MPAT_IP)	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	Performance report	Not applicable	Minimal as there are controls	Output	Categorical	Quarterly	Yes	Level 3	GM: SOP
2.1.7 Human resources management MPAT	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	Performance report	Not applicable	Minimal as there are controls	Output	Categorical	Quarterly	Yes	Level 3	GM: HR

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
improvement plan (MPAT_IP)	tool) that the department of health has to achieve.	compliance by departments with the 4 management practice domains.									
2.1.8 Financial Management MPAT improvement plan (MPAT_IP)	The level of compliance (out of 4 levels in the tool) that the department of health has to achieve.	The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	Performance report	Not applicable	Minimal as there are controls	Output	Categorical	Quarterly	Yes	Level 3	GM: Finance
2.2.1 Percentage of Hospitals with broadband access	Percentage of Hospitals with broadband access	To track broadband access to hospitals	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	Num: Total Number of hospitals with minimum 2 Mbps connectivity Den: Total Number of Hospitals	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity to ensure that South African health system can implement the eHealth Programme	ICT Directorate / Chief Directorate
2.2.2 Percentage of fixed PHC	Percentage of fixed PHC facilities	To ensure broadband access to PHC facilities	Network reports that confirm	Num: Total Number of fixed PHC	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is	ICT Directorate / Chief Directorate

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
facilities with broadband access	with broadband access		availability of broadband; OR Network rollout report for sites that are not yet live	facilities with minimum IMbps connectivity Den: Total Number of fixed PHC Facilities						more favorable for connectivity	

PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.22 Percentage of fixed PHC Facilities scoring above 70% on the ideal clinic dashboard.	Facilities that have implemented the ideal clinic and adhering to more than 70% of the elements as defined in the Ideal Clinic Dashboard (to be published during March 2016)	To track implementation of the ideal clinic principles	Reports from the Ideal Clinic Dashboard information system	Num: Number of fixed PHC Facilities scoring above 70% on the ideal clinic dashboard Den: Number of Fixed PHC facilities that conducted an assessment to date in the current financial year	The indicator measures self or peer assessment, and performance is reliant on accuracy of interpretation of ideal clinic data elements	Cumulative	Percentage	Quarterly	Yes	Higher percentage indicates greater level of ideal clinic principles	District Health Services and Quality Assurance Directorates
2.4.1 Client Satisfaction Survey Rate (PHC)	The percentage of fixed Primary Health Care facilities that conducted a Patient Satisfaction survey that were	Tracks the service satisfaction of the Primary Health Care users	Patient Satisfaction Survey forms from Clinics	Num: Total number of Fixed PHC Health facilities that conducted a Patient Satisfaction Survey to date in the current	Availability of the report	Quality	Percentage	Annually	Yes	Higher percentage indicates commitment of facilities to conduct the survey	District Health Services and Quality Assurance Directorates

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	satisfied with the services.			financial year Den: Total number of Fixed PHC facilities							
2.4.9 Client Satisfaction Rate (PHC)	The percentage of patients whom participated in the client satisfaction survey that were satisfied with the service.	To monitor satisfaction of patients using PHC facilities	DHIS - Patient Satisfaction Module	Num: Total number of patients satisfied with the service at PHC facilities Den: Total number of patients that took part in a Patient Satisfaction survey at PHC facilities	Generalizability depends on the number of users participating in the survey.	Quality	Percentage	Quarterly	Yes	Higher percentage indicates better compliance to Batho pele principles	District Health Services and Quality Assurance
3.1.1 OHH registration visit coverage (Annualised)	Proportion of households in the target wards covered by	Monitors implementation of the PHC re-engineering strategy	household registration visits registers, patient records	Num: OHH registration visit	Dependent on accuracy of OHH in population	Output	Percentage	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or	CBS programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	Ward Based Outreach Teams			Den OHH visit total						greater reliance on public health system.	
3.2.1 Number of Districts with fully fledged District Clinical Specialist Teams (DCSTs)	Number of Districts who have DCSTs functioning with all required members, as per the Ministerial Task Team (MTT) report	Track the availability of clinical specialists in the Districts	Appointment letters per district (and/or Reports outlining activities of DCSTs)	Sum of Districts with fully fledged DCSTs	There are multiple combinations of team members that qualifies to be a fully functional team. These combinations can change in year o reporting	Input	No	Quarterly	No	Higher number indicated greater availability of clinical specialists	DHS Cluster
1.1.1 PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	Stats SA, facility register, patient records	Num: PHC headcount total Den: Population total	Dependent on the accuracy of estimated total population from StatsSA	Output	Number	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system. A lower uptake may indicate underutilization of facility	Programme Manager
2.4.17 Complaints	Proportion of all complaints received	To monitor the response to complaints	complaints register, redress report	Num: Number	Accuracy of information is dependent on the	Quality	Percentage	Quarterly	No	Higher percentage suggest better management	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
Resolution Rate	that are resolved	in PHC facilities		complaints resolved Den: Total number of complaints received	accuracy of time stamp for each complaint					of complaints in PHC facilities	
2.4.25 Complaint resolution within 25 working days rate	Percentage of complaints of users of PHC facilities resolved within 25 days	To monitor the management of the complaints in PHC Facilities	complaints register, redress report	Num: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in PHC Facilities	Quality Assurance

SUB-PROGRAMME: COMMUNITY BASED SERVICES

NON-COMMUNICABLE DISEASES / DISEASE PREVENTION AND CONTROL (DPC)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator (Input etc.)	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.2.1 Clients screened for hypertension	Measure the number of people counseled and screened for high blood pressure as part of comprehensive health screening	Counseling and screening increases early detection and treatment before complications set in	Facility Register	Sum of Clients screened for hypertension	The new data collection tools may not exist all facilities	output	Sum	Quarterly	No	Greater number of people screened for high blood pressure	CD: health Programmes
1.2.2 Clients screened for diabetes	Measure the number of people counseled and screened for raised blood glucose levels as part of comprehensive health screening	Counseling and screening increases early detection and treatment before complications set in	Facility Register	Sum	The new data collection tools may not exist all facilities	output	Sum	Quarterly	No	Greater number of people screened for raised blood glucose levels	CD: health Programmes
1.2.3 Clients screened for Mental Health	Measures proportion of population screened for mental disorders	Monitored to increase early detection	Facility Register	PHC Client screened for mental disorders	The new data collection tools may not exist all facilities	Output	Percentage	Quarterly	No	Greater number of for mental disorders	CD: health Programmes
1.3.1 Cataract surgery rate (Annualised)	Clients who had cataract surgery per 1 million uninsured population. The population will be divided by 12 in the formula to make provision for annualisation	Monitors access to cataract surgery.	Facility registers, patient registers	Num: Cataract surgery total Den: Uninsured population	Accuracy dependent on quality of data from health facilities	Quality	Rate per 1 Million	Quarterly	No	Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population.	GM: Hospital Services

SUB-PROGRAMME: OTHER COMMUNITY SERVICES

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.5.1 Percentage of health facilities complying with SANS waste disposal requirements	This measure health facilities that dispose waste in line with SANS 10248 regulation as a proportion of the total health facilities.	To track compliance of health facilities with SANS 10248 regulation on waste management.	Waste disposal management.	Num: Number of health facilities (hospitals) that dispose waste in line with SANS 10248 regulation at a given reporting period. Den: Number of facilities (hospitals) during same time period.	No specific limitations anticipated	Output	%	Quarterly	No	Compliance with waste management for purposes of infection control and sustaining a healthy environment.	GM: PHP

SUB-PROGRAMME: HIV & AIDS, STI & TB (HAST) CONTROL

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.4.1 Adults remaining on ART- total	Adults remaining on ART	Track the number of adults on ARV Treatment	Facility Register	Num: SUM [Total adults remaining on ART at end of the reporting period] Den: SUM Clients remaining on ART equals [Naive (including PEP and PMTCT) + it Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out (TFO)]	None	Input	Cumulative total	Quarterly	Yes	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.4.2 Total children(under 15 years) remaining on ART	Total children (under 15 years) remaining on ART - total	Track the number of children on ARV Treatment	Facility Register	Num: SUM [Total children under 15 years remaining on ART at end of the reporting period] Den: SUM Clients remaining on ART equals [Naive (including PEP and PMTCT) + Experienced (Exp) + Transfer in (TI) + Restart] minus [Died (RIP) + Lost to follow-up (LTF) + Transfer out (TFO)]	None	Input	Cumulative total	Quarterly	Yes	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
1.4.3 TB/HIV co-infected client on ART rate	TB/HIV co-infected clients on ART as a proportion of HIV positive TB clients	All eligible co-infected clients must be on ART to reduce mortality. Monitor's ART initiation for TB clients	Facility Register	Num: Total number of registered HIV+TB patients on ART Den: Total number of registered HIV+TB patients	Availability of data in ETR.net, TB register, patient records	Outcome	Percentage	Quarterly	No	Higher proportion of TB/HIV co-infected on ART treatment will reduce co-infection rates	TB/HIV manager
1.4.4 Client tested for HIV (incl ANC)	HIV Tests (15 Years and older)	Monitors annual testing of persons 15 years and older	Facility Register	Sum of : HIV test child 19-59 months HIV test child 5-14 years HIV test client 15-49 years (excl ANC) HIV test client 50 years and older (excl ANC) Antenatal client HIV 1st test Antenatal client HIV re-test)	Dependent on the accuracy of facility register	Process	Percentage	Quarterly	No	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager
1.4.5 Male condom distribution Coverage	Total number of Male condoms supplied distributed	Tracks the supply of male condoms in the Province	Numerator: Facility Register Denominator:	Num: Total number of Male condoms distributed in the province Den: Male Population 15 years and older	None	Process	Number	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in the province	HIV/AIDS Cluster

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
			Stats SA								
1.4.6 Medical Male Circumcisions performed - total	Total number of Medical Male Circumcisions (MMCs) conducted	Tracks the number of the MMCs conducted	Facility Register	Total number of Medical Male Circumcisions (MMCs) conducted	None	Output	Sum	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager
1.5.1 TB symptom 5yrs and older screened rate	TB client 5 years and older screened at health facilities for TB symptoms rate	To determine whether all persons attending health facilities are screened for TB	Facility Register	Num: Patients over 5 screened for TB Den: Headcount of those over 5 not attending TB treatment	- Accuracy dependent on quality of data from reporting facility	Output	Rate	Annually	No	Higher	TB Programme Manager
1.5.2 TB client treatment success rate	Proportion TB patients (ALL types of TB) cured or those who completed treatment	Monitors success of TB treatment for ALL types of TB	Facility Register	Num: SUM [TB client cured OR completed treatment] Den: SUM [TB client (new pulmonary) initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	Yes	Higher percentage suggests better treatment success rate.	TB Programme Manager
1.5.3 TB Client loss to follow up rate	Percentage of smear positive PTB cases who interrupted (defaulted) treatment	Monitor patients defaulting on TB treatment	Facility Register	Num: SUM [TB (new pulmonary) treatment defaulter] Den: SUM [TB (new pulmonary) client initiated on treatment]	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Lower levels of interruption reflect improved case holding, which is important for facilitating successful TB treatment	TB Programme Manager
1.5.4 TB Client death rate	Proportion TB patients who died during treatment period	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB.	Facility Register	Num: SUM([TB client death during treatment]) Den: SUM([TB (new pulmonary) client initiated on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Annually	Yes	Lower levels of death desired	TB Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.5.5 TB MDR confirmed treatment initiation rate	B MDR confirmed clients started on treatment as a proportion of TB MDR confirmed clients	Monitor's initial loss to follow up and the effectiveness of linkage to TB care strategies	Facility Register	Num: TB MDR confirmed client start on treatment Den: TB MDR confirmed client	Accuracy dependent on quality of data from reporting facility	Output	Percentage	Annually	No	Higher proportion of TB MDR clients started improve health outcomes of TB MDR client	TB Programme Manager
1.5.6 TB MDR treatment success rate	TB MDR client successfully treated	Monitor's success of MDR TB treatment	NHLS and Facility Register	Num: SUM(TB MDR client successfully treated)) Den: SUM(TB MDR confirmed client initiated on treatment))	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Annually	Yes	Higher percentage indicates a better treatment rate	TB Programme Manager

SUB-PROGRAMME: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.6.1 Antenatal 1st visit before 20 weeks rate	Women who have a booking visit (first visit) before they are 20 weeks into their pregnancy as proportion of all antenatal 1st visits	Tracks proportion of pregnant women that presented at a health facility within the first 20 weeks of pregnancy	Facility Register	Num: Antenatal 1st visit before 20 weeks Den: Antenatal 1st visit total	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of ANC services	MNCWH programme manager
1.6.2 Mother postnatal visit within 6 days rate	Mothers who received postnatal care within 6 days after delivery as proportion of deliveries in health facilities	Tracks proportion of mothers that received postnatal care within 6 days from giving birth	Facility Register	Num: Mother postnatal visit within 6 days after delivery Den: Delivery in facility total	Accuracy dependent on quality of data submitted health facilities	Process	Percentage	Quarterly	No	Higher percentage indicates better uptake of postnatal services	MNCWH programme manager
1.6.3 Antenatal client initiated on ART rate	Percentage of HIV positive Antenatal clients placed on ART.	Tracks the HIV Treatment policy	Facility Register	Num: Antenatal client start on ART Den: Antenatal client eligible for ART initiation	Accuracy dependent on quality of data Reported by health facilities	Output	Percentage	Annually	No	Higher percentage indicates greater coverage of HIV positive clients on HIV Treatment	MNCWH programme manager
1.7.1 Infant 1st PCR test positive around 10 weeks rate	Infants PCR tested for the first time around 10 weeks after birth as proportion of live births to HIV positive women	This indicator is used to measure mother to child transmission rate	Facility Register	Num: SUM[Infant 1st PCR test positive around 10 weeks Den: SUM [Live birth to HIV positive woman]	Accuracy dependent on quality of data submitted health facilities	Output	Rate	Quarterly	No	Lower percentage indicates fewer infants received HIV from their mothers	PMTCT Programme
1.7.2 Immunisation coverage under 1 year (Annualised)	Percentage children under 1 year who completed their primary course of immunisation The child should only be	Monitor the implementation of Extended Programme in Immunisation (EPI)	Facility Register	Num: SUM([Immunised fully under 1 year new])	Reliant on under 1 population estimates from Stats SA, and accurate recording of	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator or	Desired Performance	Responsibility
	counted ONCE as fully immunised when receiving the last vaccine in the course (usually the 1st measles and PCV3 vaccines) AND if there is documented proof of all required vaccines (BCG, OPV1, DTaP-IPV/Hib 1, 2, 3, HepB 1, 2, 3, PCV 1,2,3, RV 1,2 and measles 1) on the Road to Health Card/Booklet AND the child is under 1 year old		Denominator: Stats SA	Den: SUM([Female under 1 year]) + SUM([Male under 1 year])	children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.)						

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.7.3 Measles 2nd dose coverage (annualised)	Measles 2nd dose coverage	Monitor's protection of children against measles. Because the 1st measles dose is only around 85% effective the 2nd dose is important as a booster. Vaccines given as part of mass vaccination campaigns should not be counted here	Facility Register Denominator: Stats SA	Num: SUM([Measles 2nd dose]) Den: SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percent	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI
1.7.4 DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	DTaP-IPV/ Hib3 to Measles 1st dose drop-out	Monitor's children who drop out of the vaccination program after 14 week vaccination.	Facility Register	Num: SUM([DTaP-IPV/Hib 3rd dose]) - SUM([Measles 1st dose under 1 year]) Den: SUM([DTaP-IPV/Hib 3rd dose])	Accuracy dependent on quality of data submitted health facilities	Outcome	Percent	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.7.1.1 Infant exclusively breastfed at HepB 3rd dose rate	Percentage of Infants exclusively breastfed at HepB 3rd dose rate	Monitor Exclusive breastfeeding	Facility Register	Num: SUM([Infants exclusively breastfed at HepB 3rd dose]) Den: SUM([HepB 3rd dose])	Reliant on honest response from mother; and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	Yes	Higher percentage indicate better exclusive breastfeeding rate	Cluster: Child Health
1.7.5 Child under 5 years diarrhoea case fatality rate	Proportion of children under 5 years admitted into any public health facility with diarrhoea who died	Monitor's treatment outcome for children under 5 years who were admitted with diarrhoea. Include under 1 year diarrhoea deaths	Facility Register	Num: SUM [Child under 5 years with diarrhoea death] Den: SUM [Child under 5 years with Diarrhoea admitted]	Reliant on accuracy of diagnosis / cause of death Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	No	Lower children mortality rate is desired	MNCWH Programme manager
1.7.6 Child under 5 years pneumonia case fatality rate	Proportion of children under 5 years admitted into any public health facility with pneumonia who died	Monitor's treatment outcome for children under 5 years who were admitted with pneumonia. Include under 1 year diarrhoea deaths	Facility Register	Num: SUM [Child under 5 years with pneumonia death] Den: SUM [Child under 5 years with pneumonia admitted]	Reliant on accuracy of diagnosis / cause of death; Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
1.7.7 Child under 5 years severe acute malnutrition case fatality rate	Proportion of children under 5 years admitted into any public health facility with severe	Monitor's treatment outcome for children under 5 years who were admitted with severe acute malnutrition.	Facility Register	Num: SUM [Child under 5 years severe acute malnutrition deaths]	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	acute malnutrition who died	Includes under 1 year severe acute malnutrition deaths as defined in the		Den: SUM [Children under 5 years severe acute malnutrition admitted]							
3.4.1 School Grade 1 screening coverage (annualised)	Proportion of Grade 1 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	Facility Register Report from Department of Basic Education	Num: SUM [School Grade 1 - learners screened] Den: SUM [School Grade 1 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
3.4.2 School Grade 8 screening coverage (annualised)	Proportion of Grade 8 learners screened by a nurse in line with the ISHP service package	Monitors implementation of the Integrated School Health Program (ISHP)	<u>Numerator:</u> Facility Register <u>Denominator:</u> Report from Department of Basic Education	Num: SUM [School Grade 8 - learners screened] Den: SUM [School Grade 1 - learners total]	None	Process	Percentage	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
1.6.4 Couple Year Protection Rate (annualised)	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of female population 15-44 year. Contraceptive years are the total of (Oral pill cycles /	Track the extent of the use of contraception (any method) amongst women of child bearing age	Facility Register <u>Denominator:</u> StatsSA	Num: (SUM([Oral pill cycle]) / 13) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4) + (SUM([Male condoms distributed]) / 200) + (SUM([Sterilization - male]) * 20) + (SUM([Sterilization -	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	Health Information, Epidemiology and Research Programme

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) + Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)s			female)) * 10) +Sub-dermal implants X3 Den: SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]}							MCWH&N Programme
1.2.4 Cervical cancer screening coverage (annualised)	Cervical smears in women 30 years and older as a proportion of 10% of the female population 30 years and older.	Monitors implementation of policy on cervical screening	Facility Register <u>Denominator:</u> Stats SA	Num: SUM{[(Cervical cancer screening 30 years and older)]} Den: (SUM{[Female 30-34 years]} + SUM{[Female 35-39 years]} + SUM{[Female 40-44 years]} + SUM{[Female 45 years and older]}) / 10	Reliant on population estimates from Stats SA, and Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher percentage indicate better cervical cancer coverage	MNCWH Programme Manager
1.7.9 Human Papilloma Virus Vaccine 1st dose coverage	Proportion of grade 4 girl learners ≥ 9 years vaccinated per year with the 1st dose of the HPV vaccine during 2016 Calendar year	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress and reflect the coverage so far	HPV Campaign Register – captured electronically on HPV system <u>Denominator:</u> Report from Department of Basic Education	Num: Girls 9 years and older that received HPV 1st dose Den: Grade 4 girl learners ≥ 9 years during 2016	None	Output	Percentage annualised	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager
1.7.10 Human Papilloma Virus Vaccine 2 nd dose coverage	Proportion of grade 4 girl learners ≥ 9 years vaccinated per year with the 2nd dose of the HPV vaccine during	This indicator will provide overall yearly coverage value which will aggregate as the campaign progress	HPV Campaign Register HPV system	Num: Girls 9 years and older that received HPV 2nd dose Den: Grade 4 girl learners ≥ 9 years	None	Output	Percentage annualised	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2016, and First round 2017	and reflect the coverage so far	Report from Department of Basic Education								
1.7.8 Vitamin A dose 12-59 months coverage (Annualised)	Proportion of children 12-59 months who received vitamin A 200,000 units, preferably every six months	Monitor's vitamin A supplementation to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementation twice a year	DHIS, facility registers, patient records	Num: Vitamin A dose 12-59 months Den: Population 12-59 months*2		Output	Percentage	Quarterly	No	Higher proportion of children 12-59 months who received Vit A will increase health	MNCWH Programme Manager
1.7.5 Maternal mortality in facility ratio (Annualised)	Women who died in hospital as a result of childbearing, during pregnancy or within 42 days of delivery or termination of pregnancy, per 100,000 live births in facility	This is a proxy for the population-based maternal mortality ratio, aimed at monitoring trends in health facilities between official surveys. Focuses on obstetric causes	DHIS, facility registers, patient records	Num: Maternal death in facility Den: Live birth in facility	Quality of reporting	Impact	Ratio per 1000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care	MNCWH Programme Manager
1.7.12 Inpatient early neonatal death rate	Proportion of children 28 days admitted/separated who died during their stay in the facility as a proportion of Live birth in facility	Monitor's treatment outcome for admitted children under 28 days	DHIS, facility registers, patient records	Num: Inpatient death early neonatal Den: Live birth in facility	Quality of reporting	Impact	Rate per 1000	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

2.8 SUB-PROGRAMME: CORONER SERVICES

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.8.1 Percentage of post-mortems performed within 72 hours	Measures number of post-mortems performed by Forensic Pathologists within a period of 3 days of receiving the body from the SAPS as a percentage of the total number of bodies received	Tracks the turn-around time for Post Mortems.	Death register	Num: Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body Den: Total number of cold bodies received	Depended on accuracy of Forensic Pathology services data base.	Output	%	Quarterly	No	Improved and short turn-around times for post mortems.	GM; PHP

2.9 SUB-PROGRAMME: DISTRICT HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.1 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.8 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.15 Percentage of hospitals compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.4.2 Client Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	assessment to date in the current financial year Nun: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.10 Client Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Nun: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.9.1 Average Length of Stay	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHIS, facility register & Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
1.9.5 Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHIS, facility register Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient bed days (inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services
1.9.9 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day	Track the expenditure per PDE in district	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records	Num: Total Expenditure in district hospitals	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	hospitals in the province	Admission, expenditure	Den: Patient Day Equivalent (PDE) as defined above							
2.4.18 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register;	Numer: Number complaints resolved Den: Number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.26 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register;	Numer: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
3.6.1 EMS PI urban response under 15 minutes rate	Proportion PI calls in urban locations with	Monitors compliance with the norm for critically ill or injured clients to receive EMS within	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Numer: EMS PI urban response under 15 minutes Den: EMS PI urban calls	Cumulative	Input	Rate per 10 000 population	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS Manager

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	response times under 15 minutes	15 minutes in urban areas									
3.6.2 EMS PI rural response under 40 minutes rate	Proportion PI calls in rural locations with response times under 40 minutes	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 40 minutes in rural areas	DHS, institutional EMS registers Patient and vehicle report.	Num: EMS PI rural response under 40 minutes Den: EMS PI rural calls	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
3.6.3 EMS inter-facility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	Monitors use of ambulances for inter-facility transfers as opposed to emergency responses	DHS, institutional EMS registers Patient and vehicle report.	Num: EMS inter-facility transfer Den: EMS clients total	Accuracy dependent on the reliability of data recorded on the Efficiency Report at EMS stations and emergency headcount reported from hospitals.	Output	Percentage	Quarterly	No	Lower percentage desired. The target is the CSP target of 10% (8.2) of acute patient contacts and measures whether capacity exists at the appropriate level of care.	EMS Manager

PROGRAMME 4

SUB-PROGRAMME 4.1: REGIONAL HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.2 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.9 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.16 Percentage of health facilities compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year							
2.4.3 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Nun: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.11 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Nun: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.9.2 Average Length of Stay	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHIS, facility register & Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
1.9.6 Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHIS, facility register Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services
1.9.10 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity	Track the expenditure per PDE in district hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Num: Total Expenditure in district hospitals Den: Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	expressed as a equivalent to one inpatient day										
2.4.19 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.27 Complaint resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Num: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 4.2: SPECIALISED TB HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.3 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitor's whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.10 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitor's whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.17 Percentage of health facilities compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitor's quality in health facilities	NCS self-assessment report,	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				assessment to date in the current financial year							
2.4.4 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Num: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.12 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Num: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS
2.4.20 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.28 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Num: Total number of complaints resolved within 25 days	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Den: Total number of complaints received							

SUB-PROGRAMME 4.3: SPECIALISED PSYCHIATRIC HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.4 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.11 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.18 Percentage of hospitals compliant with all extreme and vital measures	Percentage of health facilities compliant to all Extreme and vital	Monitors quality in health facilities	NCS self-assessment report,	Num: Total number of Hospitals that are compliant to all extreme	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
of the national core standards	Measures of National Core Standards			measures and at least 90% of vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year						measures of National Core Standards	
2.4.5 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Nun: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.13 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Nun: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.4.21 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.29 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Num: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

PROGRAMME 5

SUB-PROGRAMME 5.1: CENTRAL HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.5 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.12 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.19 Percentage of hospitals compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report;	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year						measures of National Core Standards	
2.4.6 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Num: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.14 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Num: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.9.3 Average Length of Stay	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHIS, facility register & Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out)	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
1.9.7 Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHIS, facility register Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services
1.9.11 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in district hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Num: Total Expenditure in district hospitals Den: Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
2.4.22 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved	Accuracy of information is dependent on the accuracy of time	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Den: Total number of complaints received	stamp for each complaint						
2.4.30 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Nun: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 5.2: TERTIARY HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.6 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Nun: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.13 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a	Monitors whether health establishments are developing a plan to close gaps	Quality Improvement Plans DHIS /NCS report	Nun: Number of Hospitals that developed a Quality improvement plan to date in the	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	proportion of fixed health facilities	identified after self-assessments		current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year							
2.3.70 Percentage of hospitals compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report;	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance
2.4.7 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Num: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.4.15 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Num: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM; DHS
1.9.4 Average Length of Stay	Average number of patient days that an admitted patient in the district hospital before separation.	To monitor the efficiency of the district hospital	DHS, facility register & Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient Separations (Inpatient deaths + Inpatient discharges + Inpatient transfers out	High levels of efficiency y could hide poor quality	Efficiency	Days (number)	Quarterly	No	A low average length of stay reflects high levels of efficiency. But these high efficiency levels might also compromise quality of hospital care. High ALOS might reflect inefficient quality of care	District Health Services
1.9.8 Inpatient Bed Utilisation Rate	Patient days during the reporting period, expressed as a percentage of the sum of the daily number of usable beds.	Track the over/under utilisation of district hospital beds	DHS, facility register Admission	Num: Inpatient days + 1/2 Day patients Den: Inpatient bed days (Inpatient beds * 30.42) available	Accurate reporting sum of daily usable beds	Efficiency	Percentage	Quarterly	No	Higher bed utilisation indicates efficient use of bed utilisation and/or higher burden of disease and/or better service levels. Lower bed utilization rate indicates inefficient utilization of the facility	District Health Services

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.9.12 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergency total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergency total headcount multiplied by a factor of 0.33. All hospital activity expressed as a equivalent to one inpatient day	Track the expenditure per PDE in district hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	Num: Total Expenditure in district hospitals Den: Patient Day equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Efficiency	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	District Health Services.
2.4.23 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.31 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Num: Total number of complaints resolved within 25 days Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

SUB-PROGRAMME 5.3: PSYCHIATRIC TERTIARY HOSPITALS

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.3.7 National Core Standards self - assessment rate	Fixed health facilities that have conducted annual National Core Standards self-assessment as a proportion of fixed health facilities.	Monitors whether health establishments are measuring their own level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	DHIS - NCS Reports	Num: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year Den: Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.14 Quality improvement plan after self - assessment rate	Fixed health facilities that have developed a quality improvement plan after self-assessment as a proportion of fixed health facilities	Monitors whether health establishments are developing a plan to close gaps identified after self-assessments	Quality Improvement Plans DHIS /NCS report	Num: Number of Hospitals that developed a Quality improvement plan to date in the current financial year Den: Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.3.21 Percentage of hospitals compliant with all extreme and vital measures of the national core standards	Percentage of health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	Num: Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards Den: Number of Hospitals that conducted National Core Standards self-assessment to date	None	Outcome	Percentage	Quarterly	No	Higher number indicates greater number of facilities compliant to all extreme and vital measures of National Core Standards	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.4.8 Patient Satisfaction Survey Rate	Fixed health facilities that have conducted Patient Satisfaction Surveys as a proportion of fixed health facilities. The target population will be divided by 12 in the formula to make provision for annualisation	To monitor the efficiency of the hospitals.	PSS forms, PSS report	Num: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year. Den: Total number of Hospitals	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
2.4.16 Patient Satisfaction rate	Average Patient Satisfaction score of all Hospitals that conducted the annual patient satisfaction survey.	Tracks the service satisfaction of the district hospital users.	PSS forms, PSS report	Num: Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year Den: Total number of Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year	Generalizability depends on the number of users participating in the survey.	Output	%	Annually	No	Higher percentage indicates better levels of satisfaction with hospital services.	GM: DHS
2.4.24 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	Num: Number complaints resolved Den: Total number of complaints received	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance
2.4.32 Complaints resolution within 25 working days rate	Percentage of complaints of users of Hospital Services resolved within 25 days	To monitor the management of the complaints in Hospitals	complaints register,	Num: Total number of complaints resolved within 25 days	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	Higher percentage suggest better management of complaints in Hospitals	Quality Assurance

Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
				Den: Total number of complaints received							

PROGRAMME 6: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.6.1 Number of Bursaries awarded for first year medicine students	Number of new medicine students provided with bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	Bursary contracts	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	no	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager
2.6.2 Number of Bursaries awarded for first year nursing students	Number of basic nursing students enrolled in nursing colleges and universities and offered bursaries by the provincial department of health	Tracks the numbers of medicine students sponsored by the Province to undergo training as future health care providers	SANC Registration form	No denominator	Data quality depends on good record keeping by both the Provincial DoH and Health Science Training institutions	Input	No.	Annual	Yes	Higher numbers of students provided with bursaries are desired, as this has the potential to increase future health care providers	Human Resources Development Programme Manager

PROGRAMME 7: PERFORMANCE INDICATORS FOR HEALTH CARE AND SUPPORT

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
I.10.1 Percentage of eligible applicants supplied with wheelchairs	Clients supplied with wheelchairs as a proportion of the total clients applying for wheelchairs expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Num: Number of clients supplied with wheelchairs during a reporting period Den: Total clients applied and on waiting list to receive wheelchairs during the same period	Dependant on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to wheelchairs	Clinical Support Manager
I.10.2 Percentage of eligible applicants supplied with hearing aids	Clients supplied with hearing aids as a proportion of the total clients applying for hearing aids expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Num: Number of clients supplied with hearing aids during a reporting period Den: Total clients applied and on waiting list to receive hearing aids during the same period	Dependant on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to hearing aids	Clinical Support Manager
I.10.3 Percentage of eligible applicants supplied with prostheses	Clients supplied with prosthesis as a proportion of the total clients applying for prosthesis expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Num: Number of clients supplied with prosthesis during a reporting period Den: Total clients applied and on waiting list to receive prosthesis during the same period	Dependant on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to prosthesis	Clinical Support Manager
I.10.4 Percentage of eligible applicants supplied with orthoses	Clients supplied with prosthesis as a proportion of the total clients applying for orthosis expressed as a percentage	Tracks the degree to which the department is meeting the need for assistive devices in the Province	DHIS, facility registers	Num: Number of clients supplied with orthosis during a reporting period Den: Total clients applied and on waiting list to receive orthosis during the same period	Dependant on accuracy of DHIS	Output with special focus to access	Percentage	Quarterly	No	Higher percentage reflects improved service delivery and increased access to orthosis	Clinical Support Manager

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.11.1 Percentage of order fulfillment of essential drugs at the depots.	Drug orders fulfilled completely	Ensure availability of essential drugs in all facilities	MEDSAS	Num: Number of order fulfilled completely Den: Number of orders received x 100	Poor maintenance of stock levels by the depot	Output	Percentage	Quarterly	No	Availability of essential drugs at all facilities	Pharmaceutical Services Manager
	Hospitals with drug stock out	Ensure availability of tracer drugs	Pharmaceutical asset register	Num: Supplies/drugs out of stock Den: All facilities reporting multiplied by the number	Poor maintenance of stock levels by the depot	Output	Percentage	Quarterly	No	Low stock out rates	Pharmaceutical Services Manager
	Depot supplies received from the suppliers	Ensure availability of drugs	MEDSAS	Num: Drug supplies received by the depot Den: Total number of drug supplies received x 100	Failure to adhere to contractual agreements by the supplier	Output	Percentage	Quarterly	No	Timely distribution of drugs from the supplier	Pharmaceutical Services Manager
	Drug supplies received by facilities within 5 days from the depot	Ensure availability of drugs	MEDSAS	Num: Drug supplies received by facilities Den: Total number of drug supplies received x 100	Unavailability of drugs and transport	Output	Percentage	Quarterly	No	Timely distribution of drugs from the depot	Pharmaceutical Services Manager

PROGRAMME 8: INFRASTRUCTURE NORMS AND STANDARDS

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.7.1 Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
2.7.2 Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, or Professional Day-to-day Maintenance projects (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate or equivalent, Capital infrastructure project list, Scheduled Maintenance project list, and Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities outside NHI Pilot District that have undergone major and minor refurbishment	Accuracy dependent on reliability of information captured on project lists.	Input	Number	Annual	No	A higher number will indicate that more facilities were refurbished.	Chief Director: Infrastructure and Technical Management
2.7.3 Establish Service Level Agreements (SLAs)	A service level agreement (SLA) / Service Delivery	To strengthen partnerships with Public Works (and	Service level agreement /	Service level agreement (SLA) / Service Delivery	Availability of documentation to prove a Service	Process	Compliance	Annual	No	A Service Level Agreement / Service Delivery Agreement	Chief Director: Infrastructure and

Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
with Departments of Public Works (and any other implementing agent)	Agreement (SDA) was established with Public Works (and any other Implementing Agent).	any other Implementing Agent) to accelerate infrastructure delivery by means of formalising an SLA (SDA) and ensuring accountability by all relevant role players.	Service Delivery Agreement	Agreement (SDA) established with WCG: Transport and Public Works (and any other Implementing Agent)	Level Agreement / Service Delivery Agreement has been established.					was established with WCG: Transport and Public Works (and any other Implementing Agent) which should lead to accelerated infrastructure delivery.	Technical Management



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