Province of the
EASTERN CAPE
HEALTH

OPERATIONAL PLAN

2017/18

Together, moving the health system forward

2030 NDP

TABLE OF CONTENT

ABBREVIATIONS & ACRONYMS

ACRONYMS

AGSA	Auditor-General SA
APP	Annual Performance Plan
AIP	Audit Intervention Plan
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BAC	Basic Accounting System
BANC	Basic Antenatal Care
CCMDD	Central Chronic Medicine Dispensing and Distribution
CFO	Chief Financial Officer
CoE	Compensation of Employees
CSSD	Central Sterile Supply Department
CIBD	Construction Industry Development Board
CHCs	Community Health Centres
CHCWs	Community Health Care Workers
DCSTs	District Clinic Specialist Teams
DDG	Deputy Director General
DHIS	District Health Information System
DHS	Demographic Health Survey
DOTS	Directly Observed Treatment Short-Course
DPC	Disease Prevention and Control
DPSA	Department of Public Service and Administration
DM	District Municipality
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ECSECC	Eastern Cape Socio-Economic Consultative Status
ELHC	East London Hospital Complex
EMS	Emergency Medical Services
GHS	General Household Survey
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
HPTD	Health Professionals Training and Development (Grant)
HRM	Human Resource Management
HRD	Human Resource Development
HRH	Human Resources for Health
ICT	Information and Communications Technology
IMR	Infant mortality rate
ISHP	Integrated School Health Programme
IT	Information Technology
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
MOU	Maternal Obstetric Unit
MTSF	Medium Term Strategic Framework
NCDs	Non-Communicable Diseases
NCS	National Core Standards
NDoH	National Department of Health
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
O&P	Orthotic and Prosthetic
OHH	Outreach Households
OPD	Outpatient Department
OSD	Occupational Specific Dispensation
PCV	Pneumococcal Vaccine
PDE	Patient Day Equivalent
PERSAL	Personnel and Salaries
PGDP	Provincial Growth and Development Plan
PHC	Primary Health Care
PMR	Perinatal Mortality Rate
PMTCT	Prevention of Mother-To-Child Transmission
PSS	Patient Satisfaction Surveys
PPPs	Public-Private Partnerships
RPHC	Revitalization of PHC
RPHC	Re-engineering the Primary Health Care System
SADHS	South Africa Demographic and Health Survey
SCM	Supply Chain Management
SDIP	Service Delivery Improvement Plan
SOP	Standard Operating Procedure
Stats SA	Statistics South Africa
STI	Sexually Transmitted Infection
TB	Tuberculosis
THS	Traditional Health Services
TROA	Total clients remaining On ART
WBOTs	Ward-Based Outreach Teams
XDR-TB	Extreme Drug Resistance Tuberculosis

PART A: STRATEGIC OVERVIEW

1. INTRODUCTION AND OVERVIEW

To be appropriated by Vote

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

2. 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

3. VISION

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

4. MISSION

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

5. VALUES

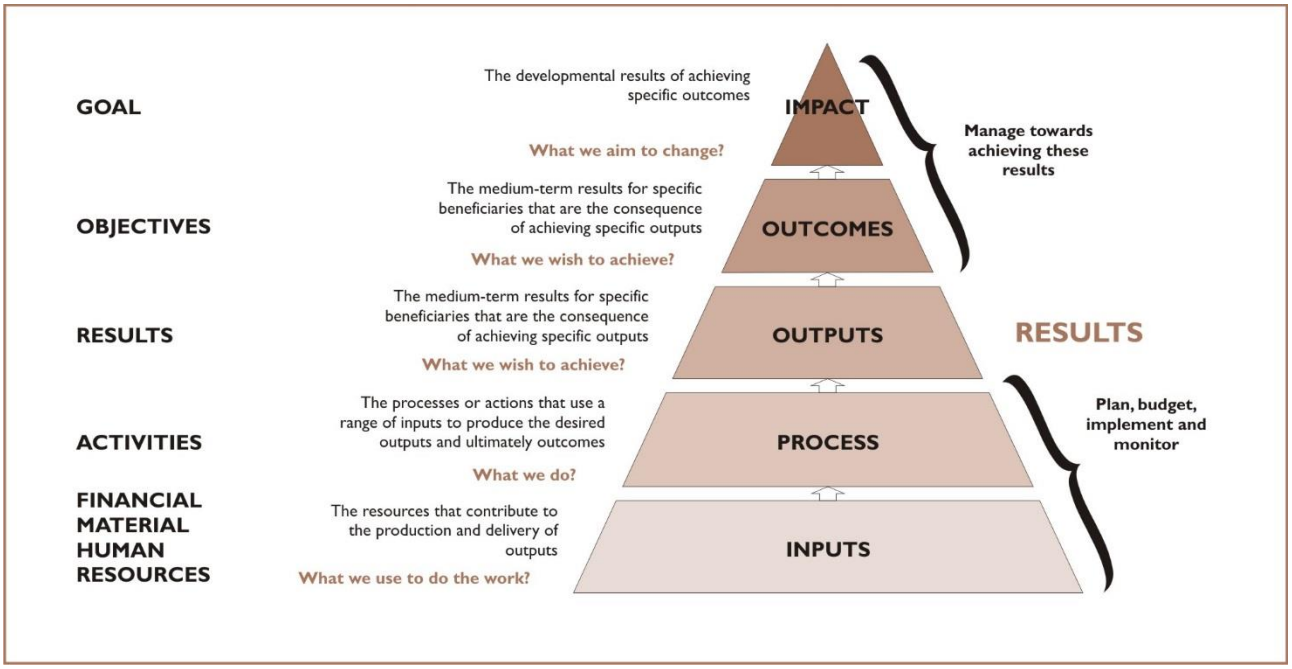
The department's activities will be anchored on the following values in the next five years and beyond:

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

6. CONCEPTUAL FRAMEWORK & STRATEGIC GOALS

The following Conceptual Framework outlines key guiding principles for ECDOH in the development of the Annual Performance Plan and the Strategic Plan.

Figure 1. Conceptual Framework



STRATEGIC GOALS OF THE EASTERN CAPE DEPARTMETN OF HEALTH 2020

The Five-year (2015/16 – 2019/20) Strategic Plan of the Department of Health has three strategic goals aligned to those of the National Department of Health, and will be implemented in the year 2017/18. The strategic objectives are linked to the Medium Term Strategic Framework (MTSF) and the National Health Council Priorities.

Table 1: ECDOH Strategic Plan Goals, Objectives, Outcomes and Linkage with the MTSF Expected Outcomes for 2014 - 2019

I	Strategic Goal	Strategic Objectives	ECDOH Strategic Plan Expected Outcomes
• HIV & AIDS and Tuberculosis prevented and successfully managed; • Maternal, infant and child mortality reduced.	• 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; • 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019 • Screening coverage of chronic illnesses increased to more than a • million by 2019	• Progressively ensure all HIV positive patients eligible for treatment are initiated on ART; • Increase TB cure rate to 50%; • Ensure 90% of children are vaccinated and monitored for growth; • Reduce Maternal Mortality Ratio to 215 per 100 000 live births; • Reduce hypertension and diabetes incidence; • Ensure 100% of quintile 1&2 schools are providing school health services
• Improved quality of health care	• Improved quality of care	• Patient/Client satisfaction rate increased to more than 75% in health services by 2019; • Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019;	• Improved quality of health care • Ensure all facilities are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards

I	Strategic Goal	Strategic Objectives	ECDOH Strategic Plan Expected Outcomes
• Efficient Health Management Information System for improved decision making	• Improved quality of care	• 100% of health facilities connected to web-based DHIS through broadband by 2019	• Efficient Health Management • Information System for improved decision making • Implement web based district health information system at 90% of all facilities
• Improved human resources for health	• Improved quality of care	• First year Health professional students receiving bursaries by 2019	• Improved human resources for Health • Increase enrollment of Medicine, Nursing and Pharmacy students annually by 10% per annum.
• Improved health management and leadership	• Improved quality of care	• Clean audit opinion achieved by 2019	• Improved health management and Leadership • Clean audit opinion from the Auditor General
• Improved health facility planning and infrastructure delivery	• Improved quality of care	• Health facilities refurbished to comply with the National norms and standards by 2019	• Improved health facility planning and infrastructure delivery • Compliance with Norms & Standards for all new Infrastructure Projects
• Universal Health coverage achieved through implementation of National Health Insurance; • Re-engineering of Primary Health Care	• Universal health coverage Improved quality of care	• 100% Ward Based Outreach Teams (WBOT) coverage by 2019	• Universal Health coverage achieved through implementation of National Health Insurance; • Re-engineering of Primary Health Care • Appoint Ward Based Outreach Teams (WBOTs) in 23 Rural Districts (as classified by the Dept. of Rural Development)

Table 2: Expenditure Estimate

R thousand	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20	
1. Administration	619,349	576,459	668,261	674,962	740,321	698,344	687,001	703,165	752,387	(1.6)
2. District Health Services	8,659,522	8,939,147	9,516,426	9,968,415	10,221,679	10,361,909	10,937,544	11,932,718	12,862,776	5.6
3. Emergency Medical Services	812,946	850,947	946,270	1,120,995	1,155,907	1,070,925	1,222,366	1,437,796	1,537,932	14.1
4. Provincial Hospitals Services	2,666,158	2,818,809	4,927,742	3,320,325	3,291,226	3,087,454	3,322,570	3,497,659	3,748,404	7.6
5. Central Hospital Services	2,412,192	2,444,026	823,221	2,838,790	2,925,588	3,101,991	3,108,963	3,270,499	3,529,464	0.2
6. Health Sciences & Training	650,152	726,252	769,372	799,467	791,986	769,442	853,145	891,625	954,341	10.9
7. Health Care Support Services	97,779	92,399	93,129	118,609	118,786	107,196	130,759	125,672	132,544	22.0
8. Health Facilities Management	1,130,157	1,101,815	1,199,522	1,402,776	1,402,776	1,346,510	1,444,817	1,505,595	1,573,298	7.3
Total payments and estimates	**17,048,255**	**17,549,854**	**18,943,943**	**20,244,339**	**20,648,269**	**20,543,771**	**21,707,165**	**23,364,729**	**25,091,146**	**5.7**

Table 3: Summary of Provincial expenditure estimates by economic classification

R thousand	Outcome			Main appro-priation	Adjusted appro-priation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16	2016/17			2017/18	2018/19	2019/20	
Current payments	**15,499,838**	**16,173,844**	**17,091,967**	**18,565,281**	**18,859,326**	**18,627,694**	**20,072,943**	**21,702,671**	**23,285,559**	**7.8**
Compensation of employees	10,698,249	11,576,336	12,562,282	13,511,327	13,504,099	13,457,197	14,415,656	15,372,271	16,459,115	7.1
Goods and services	4,797,006	4,595,259	4,522,995	5,053,954	5,355,227	5,168,268	5,657,287	6,330,400	6,826,444	9.5
Interest and rent on land	4,583	2,248	6,690	–	–	2,229	–	–	–	(100.0)
Transfers and subsidies to:	**387,171**	**355,268**	**571,824**	**284,872**	**390,967**	**558,974**	**290,342**	**325,999**	**344,255**	**(48.1)**
Provinces and municipalities	23,202	9,122	13,229	5,157	9,874	9,874	3,427	2,568	2,711	(65.3)
Departmental agencies and accounts	40,541	15,542	35,417	29,270	31,197	31,797	46,661	70,301	74,238	46.7
Higher education institutions	46,759	–	–	–	–	–	–	–	–	
Households	276,669	330,604	523,178	250,445	349,896	517,303	240,254	253,131	267,306	(53.6)
Payments for capital assets	**1,073,406**	**1,020,742**	**1,280,152**	**1,394,186**	**1,397,976**	**1,357,103**	**1,343,880**	**1,336,059**	**1,461,332**	**(1.0)**
Buildings and other fixed structures	554,097	672,696	881,906	744,096	751,161	720,321	727,420	724,394	846,803	1.0
Machinery and equipment	518,661	348,046	397,400	650,090	646,815	636,782	616,460	611,665	614,529	(3.2)
Software and other intangible assets	648	–	846	–	–	–	–	–	–	
Payments for financial assets	**87,840**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**17,048,255**	**17,549,854**	**18,943,943**	**20,244,339**	**20,648,269**	**20,543,771**	**21,707,165**	**23,364,729**	**25,091,146**	**5.7**
Payments for financial assets	**87,840**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**17,048,255**	**17,549,854**	**18,943,943**	**20,244,339**	**20,244,339**	**20,320,531**	**21,261,787**	**22,603,340**	**23,869,133**	**4.6**

PART B

PROGRAMME AND SUB-PROGRAMME PLANS

PART B: PROGRAMME AND SUB-PROGRAMME PLANS

1.1 OFFICE OF THE MEC

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 1 is divided between sub-programme 1.1 – Health Administration (Office of the MEC) and Sub-Programme 1.2 - Health Management.

1.1.1 PROGRAMME PURPOSE

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

1.1.2 PRIORITIES FOR THE NEXT THREE YEARS

- 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.

1.1.3 PROVINCIAL STRATEGIC OBJECTIVES AND ANNUAL TARGETS FOR OFFICE OF THE MEC

Strategic Goal(s) being addressed:
Strategic Goal 2: Improved quality of care

Table 4: ***Provincial Strategic Objectives and Annual Targets for Sub-Programme 1.1 - Office of the MEC***

Strategic objectives statement	Programme Performance Indicator	Indicator Type & Frequency of Reporting	Estimate 2016/17	2017/18 Targets				
				2017/18	Q1	Q2	Q3	Q4
Provide political and strategic direction to the Department by focusing on transformation and change management.	**Strategic Objective**: Strategic Leadership and accountability by 2019							
	Number of statutory documents tabled at Legislature	Quarterly	Categorical	2 statutory documents	6 statutory documents	5 statutory documents	6 statutory documents	
	Negotiated service delivery agreement (NSDA) Reports	Quarterly	Report	3 NSDA reports	4 NSDA reports	4 NSDA reports	4 NSDA reports	

Table 5: Negotiated Service Delivery Agreement (NSDA)

Key Performance Area (KPA)	Output	Indicator
Development of health professionals and management	Training of health professionals (including nurses)	No of trained health professionals
	Improve functionality of Lilitha Nursing colleges	No of functional nursing colleges
	Provisioning of bursaries for health professionals	No of bursary holders
Expansion of the re-engineering of Primary health care services	Increase Ward Based Outreach Teams (WBOTs) for increased health promotion	No of Ward Based Outreach Teams
	Increased outreach to communities	No of household visited
	HPV vaccination for Grade 4 learners (9 year olds) as part of the Integrated School Health Programme	HPV 1st dose coverage
	Screening for learners in quintile 1&2 schools) for barriers to learning	School Grade 1 – learners screened
		School Grade 8 – learners screened
Expansion of HIV/AIDS treatment and TB management	TB client treatment success rate	TB new client success rate
	TB client lost to follow up rate	TB client lost to follow up rate
	TB MDR and XDR confirmed treatment initiation rate	MDR treatment initiation rate
	Increase access to ART for patients	ART client remain on ART end of month - total
	Increase number of pregnant mothers on ART	ANC initiated on ART rate
	Provision of safe male circumcision	Safe male circumcision performed
Reduced maternal and child mortality rate	Reduce child mortality by 5%	Child mortality rate
	Reduce maternal mortality by 5%	Maternal mortality rate
Provision of health infrastructure and services	Construction of new clinics	No of clinics constructed
	Completion of Frontier Hospital casualty unit, paediatrics and outpatient departments	Refurbishment of Frontier hospital completed
	Completion of the 530 beds in Cecilia Makiwane	CMH Flagship project completed
Implementation of National Health insurance	Revamping of district hospitals	No of district hospital refurbished
	Expansion of 40 consulting rooms to existing clinics	No of additional consulting room completed
	Expand the Nelson Mandela Academic hospital training platform	No of additional doctors & Specialists appointed
	Establish Alfred Nzo District as the provincial NHI pilot site	No of NHI pilot site established

1.2 HEALTH ADMINISTRATION & MANAGEMENT

1.2.1 PROGRAMME PURPOSE

The purpose of the programme is to manage human, financial, information and infrastructure resources. This is where all the policy, strategic planning and development, coordination, monitoring and evaluation, including regulatory functions of head office, are located.

The management component of the administration under the Superintendent General's supervision is comprised of three clusters 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

Clinical Branch

- District Health Services
- Hospital Services
- Communicable Diseases
- Health Programmes
- Clinical Support Services

1.2.2 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 a clean 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

1.2.3 QUARTERLY TARGETS FOR MANAGEMENT FOR PROGRAMME 1.2

Table 6: Quarterly Activities for management 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
FINANCE												
Clean audit opinion achieved by 2019	Monitor the Integrated Audit Improvement Strategy (IAIS)	Audit opinion from Auditor-General	AGSA Audit report	Annually	Unqualified Audit Report	Unqualified Audit Report	Unqualified audit report	-	-	-	Unqualified audit report	
		Audit Improvement Plan for Financial Performance Review		Quarterly	Qualified Audit	AIP Reviewed, improve-ments recorded	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	
		Audit Improvement Plan for Performance Information Review		Quarterly	Qualified Audit	AIP Reviewed, improvement s recorded	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	Finance AIP Implemented	
	Facilitate payment of creditors within 30 days	No of Valid invoice paid within 30 days	BAS + LOGIS and Invoice Register	Quarterly	149 880 (invoices)	164 868 (Invoices)	196 905	295 35	590 72	590 72	492 26	
Ensure level 3 MPAT	Minimise unauthorised expenditure	Over expenditure(p ercentage)	BAS + IYM reports	Quarterly	0%	1%	1%	1%	1%	1%	1%	
	Improved revenue generation	Amount of revenue generated (rand value)	BAS and DELTA9	Quarterly	R 124, 4m	R 156,7m	R165,5mil	R24,9mil	R54,3mil	R30,7mil	R55,6mil	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
ICT												
2.2.2 Percentage of fixed PHC facilities with broadband access	Identification of sites per district Submission of prescribed forms Implementation, commissioning and monitoring	Percentage of Hospitals with broadband access	Internet rollout report	Quarterly	86.5%	26%	100%	28%	49.4%	74.1%	100%	
		Numerator			77	6	89 (6New)	25 (1New)	44 (2 new)	66 (2 new)	89 (1new)	
		Denominator			89	23	89	89	89	89	89	
	Identification of sites per district Submission of prescribed forms Implementa-tion, com-missioning and monitoring	Percentage of PHC with broadband access	Internet rollout report	Quarterly	60.3%	28.5%	100%	91.7%	95%	98%	100%	
		Numerator			466	686 (220) new)	772 (86 new)	708 (22 new)	730 (22 new)	752 (22 new)	772 (20 new)	
		Denominator			772	772	772	772	772	772	772	
Ensure good corporate governance	Identify sites by scrutinizing the Telkom account and extracting the sites to be upgraded	Percentage of upgraded telephone systems (PABX)	Commissio-ning reports at individual sites Telkom account	Quarterly	New Indicator	44%	100%	56%	73.8%%	88%	100%	
		Numerator				74	168	94 (20 new)	124 (30 new)	148 (24 new)	168 (20new)	
		Denominator				168	168	168	168	168	168	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
HRM												
To facilitate effective human resources planning, development and management in order to improve provision of health services	Ensure that all policies are in place and enforce the implementation thereof	2.1.7 Human resources MPAT Level 4	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	Level 2	Human resources MPAT Level 3	Level 4	-	-	Level 4	-	
	Conduct Provincial Employee Satisfaction Survey	Employee satisfaction rate	Employee satisfaction survey report	Annual	Not measured	65%	75%	-	-	-	75%	
	Annual review of Human Resource Plan	Approved HR Plan	HR Plan signed by Executive Authority	Quarterly / annual	HR Plan signed on	One approved HR Plan	Approved HR Plan	Consultation with stakeholders	Consolidate revision	One approved adjusted HR Plan	Review HR Plan	
	Attend to Employee Relations Cases	Employee wellness utilization rate	Statistics and Case Database	Quarterly / Annual	Not measured	3%	3%	2.5%	2.7%	2.8%	3%	
	Finalize Employee Relations cases within 90 days	Percentage of employee relations cases finalized within 90 days.	Statistics	Quarterly / annual	66% 57/87	90%	100%	25%	50%	75%	100%	
	Process the exit benefits of employees exiting the service within 3 months of termination	Percentage of employees whose exit benefits are paid within 3 months.	Persal reports	Quarterly / annual	Not measured	90%	100%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To facilitate effective human resources planning, development and management in order to improve provision of health services	Conduct Health Risk Assessments for employees	No. of Health Risk Assessments sessions done	Health Risk Assessment report and attendance registers	Quarterly / annual	84	80	90	20	25	20	25	
	Submission of the HR Plan by Q2	Approved District HR Plans	HR Plans signed by Executive Authority	Quarterly / annual	New indicator	New indicator	3 District HR plans Approved	Report on Annual monitoring of plans Situational analysis in 3 districts	Analysis of information	Draft plan	Final Approval of draft plan	
	Approved Employment Equity Plan	Approved EE plan	Quarterly / annual	New indicator	New indicator	Approved EE plan	Approved EE plan	Situational analysis in 3 districts	Analysis of information	Draft plan	Final approval of plan	
To facilitate effective human resources planning, development and management in order to improve provision of health services	Finalise, approved organisational structures	Organogram Approved	Proof of approved organogram signed by the MEC.	Annually	Approval of org. design 90%	Approved Organogram	Final approval of organogram	Analysis	Draft Organogram	Final draft of the Organogram	Approved Organogram	
	Conduct Job Evaluation	% of Job Evaluation conducted	Job evaluation report	Quarterly	-	50%	100%	25%	50%	85%	100%	
	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%	5%	4.5%	4.7%	4.8%	5%	
	Develop a Document Management Strategy	Document management strategy approved	Document Management Strategy signed by SG	Annual	Draft strategy	Approved Document management Strategy	Approved strategy	Analysis and stakeholder engagement	Draft plan developed	Final draft	Approved strategy	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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 requirements) 2.11.1	Level 3 (Compliance with PAJA requirements) 2.11.1	Level 3 (Compliance with PAJA requirements) 2.11.1	Level 3 (Compliance with PAJA requirements) 2.11.1	
STRATEGY												
	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

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	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)	
		Monitoring – Evaluations (MPAT1.3.2)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	Monitoring – Planning of Implementation Programmes (MPAT1.3.3)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPAT1.3.3)	Level 3 (MPAT1.3.3)	Level 3 (MPAT1.3.3)	Level 3 (MPAT1.3.3)	Level 3 (MPAT1.3.3)	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		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	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	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	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
		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	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	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	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Customize & Distribute the template 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)	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	Template circulation	Submission of the 1st draft of the 2017/18-2019/20 APP	Submission of the 2nd draft of the 2017/18-2019/20 APP	Submission of the Approved 2017/18-2019/20 annual performance plan	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Provide managers with the template for of the Operational Plan Consolidate inputs and revise quarterly targets	Approved 1year Operational Plan	Tabling letter	Annual	OP approved and submitted	OP approved and submitted	Submission of OP 2017/18	Template cleaning and circulation	Provide programme manager with the template	Development of the Operational Plan	Submission of the Approved 2017/18Operational plan	
	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	Not measured	Not measured	4 Sessions on imperatives hosted	Session for NMM and BCM Sub - districts	Session for Joe Gqabi and Chris Hani Sub -districts	Session for Amathole and Sara Baartman Sub- districts	Session for OR Tambo and Alfred Nzo Sub - districts	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate the review and development of District Health Plans Circulate 2017/18 - 19/120 Standardized DHP template to all districts. 8 capacity building sessions for all districts. Assessment report on APP –DHP alignment	Approved 2017/18-19/20 DHPs	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	-	1st draft DHP submitted to NDOH by 30 August 2017.	2nd draft 2017/18-2019/20 DHP s developed by 30 November 2017.	Final 2017/18-2019/20 DHP s developed and submitted to NDOH by 30 March 2018.	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate the review development of district operational plans. Operational plans template developed and circulated to districts Ensure alignment to the DHP	Approved 2017/18 Operational plans for districts assessed	Report on Operational plans alignment to APP and DHP	Annually	08 district operational plans assessed.	08 district Operational plans assessed	08 Operational plans assessed	-	-	-	08 Operational plans assessed for alignment to the APP.	
	Support the review of development of Service delivery improvement plan. Process mapping of key services. Support development of Standard operating procedures.	Approved 2018/19 Service delivery improvement plan	2018/19 SDIP	Annually	2015/16 – 17/18 SDIP	2015/16-17/18 SDIP	Draft 2018 /19 - 20/21SDIP.	-	-	-	Draft 2018/19 -20/21 SDIP.	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Coordinate the review of 16 Anti-poverty sites master plan and implementati on reports.	Approved 3 year Anti-poverty site implementati on 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.	-	-	-	
	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 site report developed	1 Anti-poverty site report developed	1 Anti-poverty site report developed	1 Anti-poverty site report developed	
Performance Monitoring and Improvement of Service Delivery at provincial level	Compile Quarterly Performance Reports PQRS ECDOH 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		
	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	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Performance Monitoring and Improvement of Service Delivery at provincial level	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	
	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	8	8	8	8	
	Facilitate annul indicator review and training for district planners	Number of participants at the annual meeting	Attendance register	Annually	1	1	1	-	-	-	1	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
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	-	-	
	Develop MPAT Performance improvement plan	MPAT improvement plan	Annually	Annually	1	1	1	-	-	1	-	
Facilitate evaluation within the department	To establish Evaluation Priorities and participate in evaluation project.	Number of evaluation studies conducted	Evaluation report	Annually	0	0	1	-	-	-	1	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
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 timelines. (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%	100%	100%	100%	100%	100%	
	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%	100%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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%	100%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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 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	Functional effective use of information systems and programmes in 6 districts and 2 Metros	Attendance Register	Quarterly	8	8	8	8	8	8	8	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
To conduct Performance review of the districts through Quarterly meetings	Send Communicati on 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	
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	5	50	50	12	12	13	13	
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	161	49	49	12	12	12	13	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	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	269	119	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	835	856	856	214	214	214	214	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	-	

NOTES

2. PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

2.1 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

2.1.2 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

2.2 SUB – PROGRAMMES 2.1 – 2.3 DISTRICT MANAGEMENT, CLINICS AND COMMUNITY HEALTH CENTRES

SUB – PROGRAMME PURPOSE

2.1 Sub-Programme 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.

2.2 Sub- Programme 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, outreach services (reengineering of PHC services) and mobile services in 26 sub-districts.

2.3 Sub – Programme 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 Care Coverage

STRATEGIC OBJECTIVES BEING ADDRESSED:
Strategic objective 1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019
Strategic objective 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic objective 2.4 Patient/Client satisfaction rate increased to more than 75% in health services by 2019
Strategic objective 3.2 100% Ward Based Outreach Teams (WBOT) coverage by 2019

Table 7: Budget allocation: Sub – programme 2.1,2.2 & 2.3 for 2017/18

Budget	District Management – R'000	Community Health Clinics - R'000	Community Health Centres - R'000
Compensation of employees	649,349	1,561,910	890,200
Goods and Services	123,946	580,106	179,936
Transfers	31,142	-	-
Capital Assets	42,841	14,355	5,323
Total Budget	**847,278**	**2,156,371**	**1,075,459**

2.2.3 QUARTERLY TARGETS FOR DISTRICT HEALTH SERVICES FOR 2.1 – 2.3

Table 8: Quarterly targets for District Management, Clinics and CHCs sub- programmes for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of Verifica-tion	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	Implementation of ICRM according to the approved business plan	Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Mainte-nance (PPTICRM) rate (fixed clinic/CHC/CDC)	Co standard compliance self-assessment tool, self-assessment report	Quarterly	6.2%	6%	20%	7.5%	11.6%	15.8%	20%	
		Numerator			15	15	48	18	28	38	48	
		Denominator			241	241	241	241	241	241	241	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of Verifica-tion	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient experience of care rate increased to more than 75% in health services by 2019	Orientation of Districts on PEC survey guidelines and implement-tation	Patient Experience of Care Survey Rate (PHC)	List of facilities conducted PEC	Annually	66%	45%	70%	-	70%	-	-	
		Numerator			509	351	540	-	540			
		Denominator			772	772	772	-	772			
		Patient Experience of Care Satisfaction rate (PHC)	System generated PEC results	Annually	60%	68%	69%	-	69%	-	-	
		Numerator					373	-	373	-	-	
		Denominator				540	540	-	540	-	-	
30% Ward Based Outreach Teams (WBOT) coverage by 2019 1	Conduct population screening. Identification of vulnerable households. To develop and effect the community health plans as per screening outcomes Strengthen inter-governmental collaboration through the integrated service delivery model	OHH registration visit coverage - in population	Registration forms	Quarterly	11.8%	8.6%	20%	10%	15%	18%	20%	
		Numerator			202 500	155 412	361 423	180 711	271 067 (90 356 new)	325 281 (54 214 new)	361 423 (36 142 new)	
		Denominator			1 781 501	1 807 114	1 807 114	1 807 114	1 807 114	1 807 114	1 807 114	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of Verifica-tion	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
100% District clinical specialist team (DCSTs) coverage for all Districts by 2019	To strengthen the capacity of health professional at PHC level in delivering quality health care services through improved clinical governance	Number of Districts with fully fledged District Clinical Specialist Teams (DCSTs)	Appointment Letters of the teams [1]per district	Annually	??	??	5	-	2	4 (2 new)	5 (1 new)	
PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	Facilitate implementation of Ideal clinics and national core standards compliance	PHC utilisation rate	Stats SA, facility register, patient records	Quarterly	2.7	2.8	2.8	2.8	2.8	2.8	2.8	
		Numerator			18 207 610	9 313 153	18 635 845	18 635 845	18 635 845	18 635 845	18 635 845	
		Denominator			6 692 804	6 731 178	6 655 659	6 655 659	6 655 659	6 655 659	6 655 659	
Patient experience of care rate increased to more than 75% in health services by 2019	Strengthening implementation of complaints management policy	Complaints Resolution Rate	Complaints register, redress report	Quarterly	81%	86.6%	85%	85%	85%	85%	85%	
		Complaint resolution within 25 working days rate	Complaints register, redress report	Quarterly	97%	98.9%	85%	85%	85%	85%	85%	
Improve quality of care and Efficiency.	Facilitate filling of PHC supervisor vacant post. Facilitate	Fixed PHC facility supervision rate	DHIS Supervision reports	Quarterly	78%	78%	80%	80%	80%	80%	80%	
		Numerator					618	618	618	618	618	

[1] MTT guidelines 2012: (team x1 family physician, x3 nurse specialist, x1 O&G/ Paediatrician)

Strategic objective	Planned Activities	Perfor-mance indicator	Means of Verifica-tion	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	provision of supervision transport. Training of PHC supervisors	Denominator					772	772	772	772	772	
Improve community participation	Facilitate the establishment of DHCs	Number of District Health council established	Minutes Reports Attendance registers	Annual	-	-	8	-	-	-	8	
	Training on revised clinic committee policy. Facilitate appointment of clinic committees	% of functional clinic committees	Minutes Reports Attendance registers	Quarterly	60%	60%	70%	20%	40%	60%	70%	
		Numerator					540	154	308	463	540	
		Denominator					772	772	772	772	772	
Two districts piloting NHI implementation by 2019	Monitor the implementation NHI business plan	Number of districts piloting NHI interventions	Business plan and Reports	Annually	2	2	2	-	-	-	2	

2.4 SUB-PROGRAMME: COMMUNITY BASED SERVICES – DISEASE PREVENTION AND CONTROL (NON COMMUNICABLE DISEASES)

2.4.1 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

Strategic goal 2: Improved quality of care

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objective 1.2 Screening coverage of chronic illnesses increased to more than a million by 2019

Table 9: Budget allocation for sub programme 2.4

BUDGET	R'000
Compensation of employees	401,131
Goods and services	122,646
Transfers	3,427
Capital assets	10,583
TOTAL BUDGET	**537,787**

2.4.4 QUARTERLY TARGETS FOR DPC

Table 10: Quarterly targets for Disease Prevention and Control sub- programme for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Screening coverage of chronic illnesses increased to more than a million by 2019	NCD quarterly reviews Avail chronic diseases guidelines and IEC material and basic equipment in Ideal clinics Support training of chronic conditions guidelines (diabetes	Clients 40 years and older screened for hypertension	Facility registers	Quarterly	2 876 902	823 046	1 017 000	254 250	254 250	254 250	254 250	
		Clients 40 years and older screened for diabetes	Facility registers	Quarterly	2 286 342	716 460	1 017 000	254 250	254 250	254 250	254 250	
		Mental disorders screening rate	Facility registers	Quarterly	399 911	165 742	4.5%	4.5%	4.5%	4.5%	4.5%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	hypertension and mental health) Support district in diabetes awareness (November), hypertension (May) and mental health (July) Support district in mental illness awareness											
Mental health service platform increased to 55% of hospitals by 2019		Clients treated for mental disorders - new	Facility registers	Quarterly	0.21%	0.22%	0.23%	0.23%	0.23%	0.23%	0.23%	
		Numerator			39 500	41 486	*45 634*	11 409	11 409	11 409	11 409	
		Denominator			18 207 610	19 117 991	20 073 890	5 018 473	5 018 473	5 018 473	5 018 473	
	Support district scheduled program quarterly reviews	Number of District Mental Health Teams established		Annually	No data	1	2	-	-	-	2	
Eradication of avoidable	Support training of	No of clients screened for	Facility registers	Quarterly	12 730	15 460	16 233	4 058	4 058	4 058	4 058	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
blindness	Primary eye Care for PHC nurses	eye care										
	Provide spectacles, eye care guidelines, basic eye care equipment, IEC material Training of districts on new National eye care policy Support districts in eye care management and awareness program	No of clients Identified with refractive errors	Facility registers	Quarterly	4 285	3 838	4 030	1 007	1 007	1 007	1 007	
		No of clients corrected refractive errors	Facility registers	Quarterly	2 726	1 7 42	1 829	457	457	457	457	

2.5 SUB-PROGRAMME: OTHER COMMUNITY SERVICES

2.5.1 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 1: Improved quality of care

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objective 2.5 100% Compliance with the Waste Management Act by 2019

Table 11: Budget allocation for sub programme 2.5

BUDGET	R'000
Compensation of employees	52,037
Goods and services	17,674
Transfers	-
Capital assets	5,062
TOTAL BUDGET	**74,773**

2.5.3 QUARTERLY TARGETS FOR PUBLIC HEALTH / OTHER COMMUNITY SERVICES

Table 12: Quarterly targets for Other Community Services sub – programme for 2017/18

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
100% Compliance with the Waste Management Act by 2019	Delegation of waste officers per hospital Conduct situational analysis on medical waste management in Hospitals	Percentage of health facilities complying with SANS waste disposal requirements	Waste segregation audit tool, audit report	Quarterly	100%	**100%**	100%	100%	100%	100%	100%	
	Training of waste collectors Provision of protective clothing to waste collectors	Number of health professionals trained	Attendance register	Quarterly	200	300	350	50	100	100	100	
	Monitor service providers collecting waste from the clinics in line with the SLA	Percentage of clinics where waste has been collected.	Waste collection document	Quarterly	80%	80%	100%	100%	100%	100%	100%	
	Registering of premises selling hazardous substances.	Number of premises on the database	Data base for premises selling hazardous substances	Quarterly	120	150	170	50	80	20	170	

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Training of EHPs on hazardous substances Act.	Numerator			120	150	170	50	80	20	170	
		Denominator			120	150	170	170	170	170	170	
	Audit 8 Municipalities rendering municipal health services	Number of Municipality's audited.	Reports	Quarterly	4	4	8	8	8	8	8	

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

2.6.1 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objectives 1.4 HIV infection rate reduced by 15% by 2019

Strategic objectives 1.5 TB death rate reduced by 30% in 2019

2.6.3 QUARTERLY TARGETS FOR HIV & AIDS, STI AND TB CONTROL

Table 13: Budget allocation for HAST Sub-programme 2.6

BUDGET	R'000
Compensation of employees	720,040
Goods and services	1,299,528
Transfers	9,711
Capital assets	11,175
TOTAL BUDGET	**2,040,454**

Table 14: Quarterly targets for HIV & AIDS, STI AND TB Control sub – programme for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
HIV infection rate reduced by 15% by 2019	Facilitate scaling up and implementation of the HAST District Implementation plans (DIP) to achieve 90-90-90 targets	ART client remain on ART end of month -total			361 166	394 840	560 531	501 32	520 865	540 698	560 531	
	Conduct data mop up Conduct support visits Conduct in-service trainings	TB/HIV co-infected client on ART rate	Tier.net and the Adult clinical record	Quarterly	New indicator	96.50%	97%	97%	97%	97%	97%	
		Num:				18181	24 068	6 017	6 017	6 017	6 017	
		Den:				18836	24 812	6 203	6 203	6 203	6 203	
	Facilitate scaling up and implementation of the HAST District Implementation Plans (DIP) to achieve 90-90-90 targets	HIV test done - total	Tier.net and the Adult clinical record	Quarterly	1 549 658	506 388	1 204 118	301 029	301 030	301 030	301 029	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	Male Condoms distributed	Patients records	Quarterly	54	92 509 778	101 052 989	25 263 247	25 263 247	25 263 247	25 263 247	
	Provision of medical supplies in all health facilities in the province in order to scale up Male Medical Circumcision	Medical male circumcision performed - Total	Tier.net and the Adult clinical record	Quarterly	10 029	38 601	31 822	-	12 729	19 093	-	
TB death rate reduced by 30% in 2019	Facilitate procurement and distribution of TB screening Tool (book form) in all the 25 Sub districts. Facilitate update of	TB client 5yrs and older start on treatment rate	Facility TB Screening tool, patient records	Quarterly	57%	46.5%	70%	70%	70%	70%	70%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	data element at facility level Conduct support visits to all districts Conduct in-service trainings on TB screening and PHC register											
	Facilitate use of laboratory tracking system Conduct data mop up in all the districts Facilitate partnership with the Eastern Cape AIDS Council (ECAC) community based settings, , in conducting education campaigns on adherence counseling, in	TB client treatment success rate	ETR.Net, clinical record, facility register, patient records	Quarterly	83.7%	84.20%	85%	85%	85%	85%	85%	
		Numerator			18 400	14323	16 560	4140	4140	4140	4140	
		Denominator			21 990	17018	19 483	4 870	4 871	4 871	4 871	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	all the 25 Sub-districts											
	Facilitate use of laboratory tracking system Conduct data mop up in all the districts Facilitate early tracing of interrupters, by Involving supporting partners, WBOT, ECAC and community leaders in tracing of interrupters.	TB client lost to follow up rate	Clinical record, facility register, patient records	Quarterly	6.8%	7.30%	5%	5%	5%	5%	5%	
		Numerator			1 500	1250	2 689	672	673	672	672	
		Denominator			21 990	17018	53 774	13 444	13 444	13 443	13 443	
	Conduct routine facility based record audits through implementation of District Rapid Appraisal Tool (DRAT)	TB death rate	ETR.net, TB register, patient records	Annually	5.2%	5.20%	5.5%	-	-	-	5.5%	
		Numerator			1 140	892	2 958				2 958	
		Denominator			21 990	17018	53 774				53 774	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Receive GeneXpert weekly alerts from NHLS, distribute them per district and follow up on all newly diagnosed clients started on treatment.	TB MDR confirmed treatment initiation rate	EDR web, ,MDR-TB register, patient records	Annually	91.6%	90%	94%	-	-	-	94%	
		Numerator			2 066	2 700	3102				3102	
		Denominator			2 255	3 000	3 300				3 300	
	Facilitate partnership with the Eastern Cape AIDS Council (ECAC) community based settings, , in conducting education campaigns on adherence counseling, in all the 25 Sub-districts	TB MDR treatment success rate[2]	EDR web, ,MDR-TB register, patient records	Annually	37%	37%	40%	-	-	-	40%	
		Numerator			725	169	1 200				1 200	
		Denominator			1 981	453	3 000				3 000	

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

2.7.1 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objectives 1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019
Strategic objectives 1.8 Child Mortality reduced to less than 34 per 1000 population by 2019
Strategic objectives 3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019
Strategic objectives 1.2 Screening coverage of chronic illnesses increased to 90 000 by 2019

Table 15: Budget allocation for MCWH&N Sub-programme 2.7

BUDGET	R'000
Compensation of employees	-
Goods and services	35,684
Transfers	-
Capital assets	12,815
TOTAL BUDGET	**48,499**

2.7.4 QUARTERLY TARGETS FOR MATERNAL, CHILD AND WOMENS HEALTH & NUTRITION

Table 16: Quarterly targets for Maternal, Child and Women's Health and Nutrition sub – programme for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Community mobilisation through campaigns and WBOT	Antenatal 1st visit before 20 weeks rate	Facility registers, patient records	Quarterly	59.7%	64%	65.1%	65%	65%	65%	65%	
		Numerator			65 053	33 332	16 784	17 695	17 696	17 696	17 695	
		Denominator			108 895	52 155	25 767	27 223	27 224	27 224	27 224	
	Strengthening of Mom Connect so that mothers get informed during pregnancy.	Mother post-natal visit within 6 days rate	Facility registers, patient records	Quarterly	58.2%	60%	62.8%	65%	65%	65%	65%	
		Numerator			61 800	30 449	14 204	19 920	19 920	19 920	19 920	
		Denominator			106 244	50 936	22 631	26 560	26 560	26 560	26 560	
	Facilitate increased access and initiation to life-long ART for HIV positive	Antenatal client initiated on ART rate	Facility registers, patient records	Annually	94%	65.1%	95%	-	-	-	95%	
		Numerator			19 122	16 784	19 759	-	-	-	19 759	
		Denominator			20 370	25 767	20 370	-	-	-	20 370	
Child Mortality Reduced to less than 34 per 1000 population by 2019	Facilitate and support ANC early booking and early initiation of ART on HIV positive pregnant women.	Infant 1st PCR test positive around 10 weeks rate	Facility registers, patient records	Quarterly	-	1.5%	<1.5%	<1.5%	<1.5%	<1.5%	<1.5%	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Coordinate integration of PMTCT services with MCWH, CCMT, TB, and PHC managers at Provincial, District and Sub District level											
	Monthly tracing of defaulters to ensure that they receive all scheduled Vaccine before 1year.	Immunisation coverage under 1 year	Facility registers, patient records	Quarterly	86.1%	76.0%	87%	87%	87%	87%	87%	
		Numerator			118 192	75 759	119 475	119 475	119 475	119 475	119 475	
		Denominator			137 328	99 630	137 328	137 328	137 328	137 328	137 328	
	Engage CBO, Community Leaders & WBOT to ensure that every eligible child receive their second dose within 2year of life.	Measles 2nd dose coverage	Facility registers, patient records	Quarterly	81%	86%	87%	87%	87%	87%	87%	
		Numerator			114 371	31 763	123 437	123 437	123 437	123 437	123 437	
		Denominator			141 882	138 315	141 882	141 882	141 882	141 882	141 882	
	Encourage Facility personnel to catch-up Missed doses of	DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	Facility registers, patient records	Quarterly	-117.9%	-12.4%	0.5%	0.5	0.5	0.5	0.5	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Hexavalent(1st,2nd & 3rd dose) before administering Measles first dose	Numerator			-15 041	-3 145	643	643	643	643	643	
		Denominator			58 483	-25 320	128 697	128 697	128 697	128 697	128 697	
	Intensify Community based IMCI trainings for WBOT, IYA and other community structures	Diarrhea case fatality rate	Facility registers, patient records	Quarterly	3.6%	3.30%	3.5%	3.5%	3.5%	3.5%	3.5%	
		Numerator			256	142	246	246	246	246	246	
		Denominator			7 032	4312	7 032	7 032	7 032	7 032	7 032	
	Training of new professional nurses on IMCI to ensure 60% saturation.	Pneumonia case fatality rate	Facility registers, patient records	Quarterly	3.7 %	3%	3.5%	3.5%	3.5%	3.5%	3.5%	
		Numerator			257	139	245	245	245	245	245	
		Denominator			7 012	4877	7 012	7 012	7 012	7 012	7 012	
	To intensify community based interventions for early identification e.g GMP ,supplementation	Severe acute malnutrition case fatality rate	Facility registers, patient records	Quarterly	10.1%	9.9%	9%	9%	9%	9%	9%	
		Numerator			284	166	254	254	254	254	254	
		Denominator			2 819	1677	2 819	2 819	2 819	2 819	2 819	
Quintile 1&2 school screened by Integrated School Health (ISH)	Establish monitoring and evaluation teams that is inclusive of	School Grade 1 screening coverage	Learner profile form, Attendance register	Quarterly	40 531	29766	39 441	14 794	29 589	36 383	39 441	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Teams in 2019	ECDoE and Soc Dev. Increase the number of school nurses to improve performance Implement: health promoting schools strategy	School Grade 8 screening coverage	Learner profile form, Attendance register	Quarterly	12 586	14387	20 502	8 164	15 308	18 368	20 502	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Training of health professionals on Adolescent and Youth Friendly services	Delivery in 10 to 19 years in facility rate	Facility registers, patient records	Quarterly	New Indicator	New Indicator	7.2%	7.2%	7.2%	7.2%	7.2%	
	Training of all health personnel on expanded methods of contraceptio n and guidelines (this includes doctors)	Couple year protection rate	Facility registers, patient records	Quarterly	53.6%	55%	65%	65%	65%	65%	65%	
		Numerator			955 064	891 377	1 157 525	1 157 525	1 157 525	1 157 525	1 157 525	
		Denominator			1 780 807	1 620 685	1 780 807	1 780 807	1 780 807	1 780 807	1 780 807	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Screening coverage of chronic illnesses increased to 90 000 by 2019	Training of professional nurses on taking of Pap smear and Guidelines update.	Cervical cancer screening coverage 30 years and older	Facility registers, patient records	Quarterly	57.6%	70.1%	65%	65%	65%	65%	65%	
		Numerator			85 017	26 316	95 911	95 911	95 911	95 911	95 911	
		Denominator			147 556	150 177	147 556	147 556	147 556	147 556	147 556	
Child Mortality Reduced to less than 34 per 1000 population by 2019	Contracting of nurses to increase the learner and school coverage Strengthen the implementation of the e-health strategy through functionality mobile data capturing system	Human Papilloma Virus Vaccine 1st dose	Facility registers, patient records	Annually	65 761	47 786	50 972	-	-	-	50 972	
		Human Papilloma Virus Vaccine 2nd dose	Facility registers, patient records	Annually	New Indicator	53 553	57 123	-	-	-	57 123	
	Strengthen Community Based Interventions e.g WBOT, ISHP	Vitamin A dose 12-59 months coverage	Facility registers, patient records		63.5%	57%	65%	65%	65%	65%	65%	
		Numerator			741 185	164 522	759 266	759 266	759 266	759 266	759 266	
		Denominator			1 168 102	1 149 812	1 168 102	1 168 102	1 168 102	1 168 102	1 168 102	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification on	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Increase number of MBFI facilities. Intensify community based awareness strategies e.g dialogues and campaigns	Infant exclusively breastfed at DTaP-IPV-Hib-HBV 3rd dose rate	Facility registers, patient records	Quarterly	29.4%	27.7%	40%	40%	40%	40%	40%	
		Numerator	Facility registers, patient records			14 795	69 405	69 405	69 405	69 405	69 405	
		Denominator				53 363	126 919	126 919	126 919	126 919	126 919	
Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Training of All health professionals on ESMOE BANC	Maternal mortality in facility ratio	Facility registers, patient records	Annually	135.2/100 000	120/100 000	115/100 000	-	-	-	115/100 000	
Child Mortality Reduced to less than 34 per 1000 population by 2019	Training of All health professionals on HBB MSSN Intra-partum care	Neonatal death in facility rate	Facility registers, patient records	Annually	12.8 / 1000	10 /1000	12 /1000	-	-	-	12 /1000	

2.8 SUB-PROGRAMME: CORONER SERVICES

2.8.1 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objective 1.9 Post – mortems conducted within 72hrs increased to 95% by 2019

2.8.2 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR CORONER SERVICES

2.8.3 QUARTERLY TARGETS FOR CORONER SERVICES

Table 17: Budget allocation for Coroner Services Sub-programme 2.8

BUDGET	R'000
Compensation of employees	74,572
Goods and services	19,654
Transfers	-
Capital assets	5,774
TOTAL BUDGET	**100,000**

Table 18: Quarterly targets for Coroner Services sub - programme for 2017/18

Strategic objective	Planned Activities	Performance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets			
								Q1	Q2	Q3	Q4
Post – mortems conducted within 72hrs increased to 90% by 2019	Integration with EMS Procure new fridges, Refrigerated truck and a LODOX Improve staffing complement	Percentage of post-mortem performed within 72 hours	Death register, forensic pathology database	Quarterly	93%	92.5%	95%	95%	95%	95%	95%
		Numerator			10 017	4252					
		Denominator			10 811	4 596					

2.9 PROVINCIAL STRATEGIC OBJECTIVES, INDICATORS AND ANNUAL TARGETS FOR DISTRICT HOSPITALS

2.9.1 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objectives 2.3 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019

Strategic objectives 2.4 Patient satisfaction rate increased to more than 75% in health services by 2019

Strategic objectives 1.10 80% of Hospitals meeting national efficiency targets by 2019

2.9.3 QUARTERLY TARGETS FOR DISTRICT HOSPITALS

Table 19: Budget allocation for District Hospitals Sub-programme 2.8

BUDGET	R'000
Compensation of employees	3,477,166
Goods and services	537,114
Transfers	10,000
Capital assets	32,643
TOTAL BUDGET	**4,056,923**

Table 20: Quarterly targets for District Hospital sub- programme for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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 implementation of National Core standard assessment	Hospital achieved 75% and more on National Core Standards self-assessment rate	National core Standard assessment tool	Quarterly	New indicator	New indicator	40%	0%	25.7%	34.8%	39.3%	
		Numerator					24	0	17	23	26	
		Denominator					66	66	66	66	66	
		Numerator			2	8	16	4	8	12	16	
		Denominator			64	60	60	60	60	60	60	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate the implementation of PEC guidelines	2.4.2 Patient Experience of Care Survey Rate	List of facilities that conducted PEC	Annually	80.3%	38%	91%	-	91%	-	-	
		Numerator			53	23	60	-	60	-	-	
		Denominator			66	60	66	-	66	-	-	
		Patient Experience of Care Satisfaction rate	System generated PEC results	Annually	0%	70%	70%	-	-	70%	-	
80% of hospitals meeting national efficiency targets by	Strengthen clinical care best practices	Average Length of Stay	Facility register	Quarterly	5.1 days	5 days	4.8 days	4.8 days	4.8 days	4.8 days	4.8 days	
		Inpatient Bed Utilisation Rate	Facility register	Quarterly	57.2%	56%	66%	66%	66%	66%	66%	
		Numerator			1 264 514	612 438	1 160 949	1 160 949	1 160 949	1 160 949	1 160 949	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
2019		Denominator			2 209 313	1 093 294	1 759 014	1 759 014	1 759 014	1 759 014	1 759 014	
	Monitor cost drivers and ensure implementation of cost control measures where deviations are noted	Expenditure per PDE (patient day equivalent)	BAS	Quarterly	R3,317	R2, 302	R2,620	R2,620	R2,620	R2,620	R2,620	
Patient satisfaction rate increased to more than 75% in health services by 2019	Strengthen the implementation of complaints management policy	Complaint Resolution rate	Facility complaints registers, redress report	Quarterly	94%	94.2%	90%	90%	90%	90%	90%	
		Complaint Resolution within 25 working days rate	Facility complaints registers, redress report	Quarterly	99.6%	98.5%	95%	95%	95%	95%	95%	

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 21: Expenditure Estimates: District Health Services

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. District Management	645,815	631,035	729,615	748,967	748,967	748,967	851,724	749,301	807,875	13.7
2. Community Health Clinics	1,761,055	1,866,101	1,874,174	1,839,642	1,839,642	1,839,642	1,972,290	2,258,139	2,384,594	7.2
3. Community Health Centres	1,082,402	1,151,200	904,933	1,021,954	1,021,954	1,021,954	1,289,538	1,373,644	1,450,568	26.2
4. Community Based Services	434,343	400,684	408,868	477,932	477,932	477,932	611,822	640,857	676,744	28.0
5. Other Community Services	111,153	94,295	39,613	58,410	58,410	58,410	127,259	130,205	137,500	117.9
6. Hiv/Aids	1,301,780	1,431,329	1,583,403	1,775,385	1,775,385	1,775,392	2,032,537	2,293,490	2,421,923	14.5
7. Nutrition	38,848	46,592	28,497	43,698	43,698	43,703	48,499	52,837	55,797	11.0
8. Coroner Services	79,817	75,809	80,783	87,106	87,106	87,106	99,041	104,937	110,816	13.7
9. District Hospitals	3,204,309	3,242,101	3,866,540	3,915,321	3,915,321	3,941,870	3,547,132	3,675,502	3,881,329	(10.0)
Total payments and estimates	**8,659,522**	**8,939,147**	**9,516,426**	**9,968,415**	**9,968,415**	**9,994,976**	**10,579,842**	**11,278,913**	**11,927,146**	**5.9**

Table 22: Summary of Provincial Expenditure Estimates by Economic Classification: District Health Services

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**8,337,559**	**8,758,735**	**9,245,513**	**9,771,536**	**9,771,536**	**9,771,541**	**10,403,042**	**11,098,273**	**11,736,391**	**6.5**
Compensation of employees	5,963,705	6,423,559	6,859,019	7,295,524	7,295,524	7,295,529	7,583,349	7,906,562	8,349,330	3.9
Goods and services	2,373,832	2,334,530	2,384,924	2,476,012	2,476,012	2,475,750	2,819,693	3,191,711	3,387,061	13.9
Interest and rent on land	22	646	1,570	–	–	262	–	–	–	(100.0)
Transfers and subsidies to:	**155,250**	**125,500**	**160,709**	**77,318**	**77,318**	**103,874**	**72,067**	**76,246**	**80,515**	**(30.6)**
Provinces and municipalities	23,202	9,122	13,229	5,157	5,157	5,157	2,427	2,568	2,711	(52.9)
Departmental agencies and accounts	34,210	15,542	17,302	21,125	21,125	21,125	28,497	30,150	31,838	34.9
Higher education institutions	46,759	–	–	–	–	–	–	–	–	
Households	51,079	100,836	130,178	51,036	51,036	77,592	41,143	43,528	45,966	(47.0)
Payments for capital assets	**124,802**	**54,912**	**110,204**	**119,561**	**119,561**	**119,561**	**104,733**	**104,394**	**110,240**	**(12.4)**
Buildings and other fixed structures	–	–	–	–	–	–	–	–	–	
Machinery and equipment	124,802	54,912	110,204	119,561	119,561	119,561	104,733	104,394	110,240	(12.4)
Payments for financial assets	**41,911**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**8,659,522**	**8,939,147**	**9,516,426**	**9,968,415**	**9,968,415**	**9,994,976**	**10,579,842**	**11,278,913**	**11,927,146**	**5.9**

NOTES

3. PROGRAMME 3: EMERGENCY MEDICAL SERVICES (EMS)

3.1 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.

3.2 PRIORITIES FOR THE NEXT THREE YEARS

- Improve call taking and dispatching ability by rolling out the computerised call-taking and dispatching system to the 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

3.3 QUARTERLY TARGETS FOR PROGRAMME 3: EMS

Table 23: Budget allocation for programme 3

BUDGET	R'000
Compensation of employees	763,840
Goods and services	367,134
Transfers	3,049
Capital assets	88,343
TOTAL BUDGET	**1,222,366**

Table 24: Quarterly Activities for EMS for 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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 platform Measure response times utilizing live tracking	EMS P1 urban response under 15 minutes rate	Institutional EMS registers	Quarterly	55%	41.2%	70%	70%	70%	70%	70%	
		Numerator			17 210	6 480						
		Denominator			31 370	15 710						
	Deploy human and material resources closer to communities Measure response times utilizing live tracking	EMS P1 rural response under 40 minutes rate	Institutional EMS registers	Quarterly	47.3%	58%	70%	70%	70%	70%	70%	
		Numerator			38 951	28 591						
		Denominator			82 294	49 285						
	Establish a dedicated fleet for inter-facility transfers Monitor dedicated fleet utilization	EMS inter-facility transfer rate	Institutional EMS registers	Quarterly	29.4%	34%	30%	30%	30%	30%	30%	
		Numerator			185 727	103 749	189 411	189 411	189 411	189 411	189 411	
		Denominator			631 369	305 334	631 369	631 369	631 369	631 369	631 369	

Table 25 : Summary of payments and estimates by sub programme: Emergency Medical Services

R thousand	Outcome 2013/14	2014/15	2015/16	Main appropri-ation	Adjusted appropri-ation 2016/17	Revised estimate	Medium-term estimates 2017/18	2018/19	2019/20	% change from 2016/17
1. Emergency Transport	784,898	816,345	880,349	1,025,367	1,000,919	879,025	1,116,698	1,319,942	1,412,224	27.0
2. Planned Patient Transport	28,048	34,602	65,921	95,628	154,988	191,900	105,668	117,855	125,708	(44.9)
Total payments and estimates	**812,946**	**850,947**	**946,270**	**1,120,995**	**1,155,907**	**1,070,925**	**1,222,366**	**1,437,796**	**1,537,932**	**14.1**

Table 26 : Summary payments and estimates by economic classification: Emergency Medical Services

R thousand	Outcome 2013/14	2014/15	2015/16	Main appropri-ation	Adjusted appropri-ation 2016/17	Revised estimate	Medium-term estimates 2017/18	2018/19	2019/20	% change from 2016/17
Current payments	**665,956**	**714,900**	**821,116**	**1,014,879**	**1,058,945**	**980,174**	**1,130,974**	**1,339,293**	**1,433,913**	**15.4**
Compensation of employees	461,400	506,480	639,431	677,964	710,324	719,756	763,840	812,429	877,544	**6.1**
Goods and services	204,556	208,420	181,662	336,915	348,621	260,418	367,134	526,865	556,369	**41.0**
Interest and rent on land	–	–	23	–	–	–	–	–	–	
Transfers and subsidies to:	**1,939**	**2,538**	**2,321**	**4,159**	**2,290**	**2,111**	**3,049**	**3,226**	**3,407**	**44.4**
Households	1,939	2,538	2,321	4,159	2,290	2,111	3,049	3,226	3,407	**44.4**
Payments for capital assets	**127,324**	**133,509**	**122,833**	**101,957**	**94,672**	**88,640**	**88,343**	**95,277**	**100,612**	**(0.3)**
Machinery and equipment	127,324	133,509	122,833	101,957	94,672	88,640	88,343	95,277	100,612	**(0.3)**
Payments for financial assets	**17,727**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**812,946**	**850,947**	**946,270**	**1,120,995**	**1,155,907**	**1,070,925**	**1,222,366**	**1,437,796**	**1,537,932**	**14.1**

NOTES

4. PROGRAMME 4: PROVINCIAL HOSPITAL SERVICES (REGIONAL AND SPECIALISED)

4.1 PURPOSE

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

SUB-PROGRAMME 4.1

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

SUB-PROGRAMME 4.2

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
- Nkqubela
- Majorie Parish
- PZ Meyer
- Majorie Parks
- Winter Berg
- Osmond
- Khotsong
- Empilweni
- Themba

SUB-PROGRAMME 4.3

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

4.1.1 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 engaging SMME contractors in health facilities management projects

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

4.1 QUARTERLY TARGETS FOR REGIONAL HOPITALS FOR 4.1

Budget allocation: Programme 4.1

Table 27: Budget allocation for sub - programme 4.1

BUDGET	R'000
Compensation of employees	1,987,032
Goods and services	272,662
Transfers	10,000
Capital assets	4,292
TOTAL BUDGET	**2,273,986**

Table 28: Quarterly targets for Regional Hospitals in 2017/18

Strategic objective	Planned Activities	Programme perform-ance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	100%	100%	100%	25%	50%	75%	100%	
		Numerator			5	5	5	1	2(1 new)	3(1 new)	5(2 new)	
		Denominator			5	5	5	5	5	5	5	
	Facilitate development of quality improvement plan at facility	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	60%	100%	100%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Programme perform-ance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	level after self-assessments	Numerator			3	4	4	1	2(1 new)	3(1 new)	4(1 new)	
		Denominator			5	4	4	4	4	4	4	
	Develop specifications & procure for health technology Facilitate conducting of Fire drills (emergencie) Development of clinical risk and protocols.	Percentage of Hospitals compliants with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	0%	75%	75%	-	25%	50%	75%	
		Numerator			0	3	3	-	1	2(1 new)	3(1 new)	
		Denominator			5	4	4	-	4	4	4	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training of committees and field workers Monitor implementation of the tools for CSS	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	0%	20%	100%	25%	50%	75%	100%	
		Numerator			0	1	5	1	2(1 new)	3(1 new)	5(2 new)	
		Denominator			5	5	5	5	5	5	5	
	Facilitate training of committees and field workers	Patient Experience of Care	PSS forms, PSS report	Annually	0%	70%	70%	-	-	-	70%	

Strategic objective	Planned Activities	Programme perform-ance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Monitor implementation of the tools for CSS											
80% of hospitals meeting national efficiency targets by 2019	Facilitate recruitment of specialists and Health Professionals Facilitate conducting of out-reach and in-reach	Average length of stay	Facility registers, patient registers	Quarterly	5.5 days	5.7days	4.6 days	4.6 days	4.6 days	4.6 days	4.6 days	
	Monitor availability of policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient registers	Quarterly	67.8%	66.2%	75%	75%	75%	75%	75%	
		Numerator			404 651	266 736	120 874	120 874	120 874	120 874	120 874	
		Denominator			597 266	403 217	161165	161 165	161 165	161 165	161 165	
NCD coverage increased to 1300/1000 000 through management of chronic illnesses by 2019	Conduct formalized cataract outreach services	Cataract surgery rate (Uninsured Population) (Regional hospital)	Facility registers, patient registers	Quarterly	565/ 1000 000	1100/ 1000 000	1150/ 1000 000	200/ 1000 000	600/ 1000 000	800/ 1000 000	1150/ 1000 000	

Strategic objective	Planned Activities	Programme perform-ance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
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	R1,705	R1,965	R1,937	R1,937	R1,937	R1,937	R1,937	
Patient satisfaction rate increased to more than 75% in health services by 2019	Monitor implementation of Complaint management system	Complaints resolution rate	Facility complaints registers, redress report	Quarterly	86.5%	92.7%	87%	87%	87%	87%	87%	
		Complaint resolution within 25 working days rate	Facility registers, redress report	Quarterly	19.2%	96.6%	95%	95%	95%	95%	95%	
	Monitor functionality of Hospital Boards Induction of Hospital Boards	No of hospitals with functional hospital boards	Facility registers, redress report	Quarterly	98.8%	5	5	2	2	1	-	

4.2 SUB – PROGRAMME: SPECIALISED TB HOSPITALS

Strategic goals being addressed:

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

Strategic goal 2: Improved quality of care

4.2.1 QUARTERLY TARGETS FOR SPECIALISED TB HOSPITALS

Budget allocation: Sub-programme 4.2

Table 29: Budget allocation for sub - programme 4.2

BUDGET	R'000
Compensation of employees	222,712
Goods and services	121,775
Transfers	1,149
Capital assets	7,278
TOTAL BUDGET	**352,915**

Table 30: Quarterly Activities for Specialised TB Hospitals for 2017/18

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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%	70%	100%	40%	70%	90%	100%	
		Numerator			11	7	10	4	7(3 new)	9(2 new)	10	
		Denominator			11	10	10	10	10	10	10	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	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%	30%	60%	80%	100%	
		Numerator			10	10	10	3	6	8	10	
		Denominator			10	10	10	10	10	10	10	
	Support all TB hospitals on the implementation of policies that will assist them to be compliant with all the extreme measures Facilitate improvement on infrastructure in order to improve ventilation in all TB hospitals.	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	0%	45.4%	60%	33.3%	50%	50%	60%	
		Numerator			0	5	6	1	3	4	6	
		Denominator			10	10	10	3	6	8	10	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	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	100%	70%	100%	20%	50%	70%	100%	
		Numerator			10	7	10	2	5 (3 more)	7(2 more)	10 (2 more)	
		Denominator			10	10	10	10	10	10	10	
	Facilitate analysis of the quality Assessment reports. Facilitate development of Quality improvement plans	Patient Satisfaction rate	PSS forms, PSS report	Annually	70%	75.6	79%	-	-	-	79%	
80% of hospitals meeting national efficiency targets by 2019	Facilitate development of MDR technical review committees in all the Sub-districts Facilitate improvement of infection prevention and control by isolating	Average length of stay	Facility registers, patient registers	Quarterly	94.2 days	92days	90 days	90 days	90 days	90 days	90 days	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	patients according to drug resistance patterns.											
	Ensure admission of all MDR patients on Bed aquiline until culture conversion. Facilitate admission of all patients abusing drugs and alcohol , in order to give them counselling sessions on adherence to treatment	Inpatient Bed Utilisation Rate	Facility registers, patient registers	Quarterly	62.2%	70%	71%	71%	71%	71%	71%	
		Numerator			84 026	287426	291532	72 883	72 883	72 883	72 883	
		Denominator			135 064	410 609	410 609	102 652	102 653	102 652	102 652	
	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	R5 737	R1,700	R1,800	R1,800	R1,800	R1,800	R1,800	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
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 Facilitate analysis of the Complaints register so as to resolve complaints within 25 days	Complaints resolution rate	Complaints registers at facilities	Quarterly	93.2%	98%	90%	90%	90%	90%	90%	
	Ensure availability and use of Complaints registers in all the 11 TB hospitals Facilitate analysis of the Complaints register so as to resolve complaints within 25 days	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	100%	96.8%	100%	100%	100%	100%	100%	

4.3 SUB – PROGRAMME: SPECIALISED PSYCHIATRIC HOSPITALS

Strategic goals being addressed:

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

Strategic goal 2: Improved quality of care

4.3.1 QUARTELY TARGETS FOR SPECIALISED PSYCHIATRIC HOSPITALS

Budget allocation: Sub-programme 4.3

Table 31:: Budget allocation for sub - programme 4.3

BUDGET	R'000
Compensation of employees	503,052
Goods and services	189,698
Transfers	-
Capital assets	2,919
TOTAL BUDGET	**695,669**

Table 32: Quarterly Activities for Specialised Psychiatric Hospitals for 2017/18

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	100%	100%	100%	100%	-	-	-	
		Numerator			3	3	3	3				
		Denominator			3	3	3	3	-	-	-	
	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	0%	100%	100%	-	100%	100%	-	
		Numerator			0	3	3	-	3	3	-	
		Denominator			3	3	3	-	3	3	-	
	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%	50 %	100%	-	-	100%	-	
		Numerator			0	1	3	-	-	3	-	
		Denominator			3	3	3	-	-	3	-	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	75%	0%	75%	-			75%	
		Numerator			2	0	2	-			2(1 new)	
		Denominator			3	3	3	-	-	-	3	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report	Annually	0%	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	6.7days	8days	5.5days	5.5days	5.5days	5.5days	5.5days	
	Facilitate recruitment of Health Professionals Facilitate conducting of outreach and inreach	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	92.8%	75%	75%	75%	75%	75%	75%	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	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	R3,732	R3,266	R3,266	R3,266	R3,266	R3,266	R3,266	
Patient satisfaction rate increased to more than 75% in health services by 2019	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facilities	Quarterly	100%	86%	88.5%	88.5%	88.5%	88.5%	88.5%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facilities	Quarterly	100%	96%	96%	96%	96%	96%	96%	

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 33: Summary of payments and estimates by sub programme: Provincial Hospital Services

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. General (Regional) Hospitals	1,774,416	1,912,464	4,002,196	2,276,373	2,243,513	2,173,051	2,273,986	2,410,334	2,582,054	4.6
2. Tb Hospitals	349,582	353,727	356,953	417,147	418,204	388,813	352,915	378,204	405,102	(9.2)
3. Psychiatric Mental Hospitals	542,160	552,618	568,593	626,805	629,509	525,590	695,669	709,121	761,248	32.4
Total payments and estimates	**2,666,158**	**2,818,809**	**4,927,742**	**3,320,325**	**3,291,226**	**3,087,454**	**3,322,570**	**3,497,659**	**3,748,404**	**5.9**

Table 34: Summary of payments and estimates by economic classification: Provincial Hospital Services

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**2,594,777**	**2,739,034**	**4,709,596**	**3,284,231**	**3,251,071**	**2,902,977**	**3,296,931**	**3,470,534**	**3,719,761**	**13.6**
Compensation of employees	2,083,478	2,273,524	3,912,037	2,537,561	2,505,201	2,151,935	2,712,796	2,871,628	3,087,315	26.1
Goods and services	510,346	464,660	793,466	746,670	745,870	750,201	584,135	598,906	632,446	(22.1)
Interest and rent on land	953	850	4,093	–	–	841	–	–	–	(100.0)
Transfers and subsidies to:	**33,623**	**58,519**	**194,337**	**22,675**	**22,050**	**164,246**	**11,149**	**11,796**	**12,456**	**(93.2)**
Households	33,623	58,519	194,337	22,675	22,050	164,246	11,149	11,796	12,456	(93.2)
Payments for capital assets	**24,051**	**21,256**	**23,809**	**13,419**	**18,105**	**20,231**	**14,489**	**15,330**	**16,187**	**(28.4)**
Machinery and equipment	23,891	21,256	23,809	13,419	18,105	20,231	14,489	15,330	16,187	(28.4)
Software and other intangible assets	160	–	–	–	–	–	–	–	–	
Payments for financial assets	**13,707**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**2,666,158**	**2,818,809**	**4,927,742**	**3,320,325**	**3,291,226**	**3,087,454**	**3,322,570**	**3,497,659**	**3,748,404**	**7.6**

NOTES

5. PROGRAMME 5: CENTRAL & TERTIARY HOSPITALS

5.1 PROGRAMME PURPOSE FOR CENTRAL HOSPITALS

To strengthen and continuously develop the modern central and 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:

SUB-PROGRAMMES

Central Hospital

- Nelson Mandela Academic Hospital

5.1.2 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
- Name of central Hospital: Nelson Mandela Academic Hospital

Strategic goals being addressed:
Strategic goal 1: Prevent and reduce the disease burden and promote health
Strategic goal 2: Improved quality of care

Strategic Objectives being addressed:
Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019
Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019

5.1.2 QUARTERLY TARGETS FOR CENTRAL HOSPITALS FOR 2017/18

Budget allocation: Sub-programme 5.1

Table 35:: Budget allocation for sub- programme 5.1

BUDGET	R'000
Compensation of employees	672,623
Goods and services	256,325
Transfers	25,109
Capital assets	6,820
TOTAL BUDGET	**960,877**

Table THS: 2 Quarterly Activities for Central Hospitals for 2017/18

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	100%	100%	100%	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	100%	100%	100%	100%	100%	100%	100%	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Develop specifications and procure for health technology equipment Facilitate conduction of fire drills Develop Clinical Risk Management and protocols	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	National core standard assessment report	Quarterly	0%	80%	100%	100%	100%	100%	100%	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate Training of Quality Assurance Committees Monitor implementation of the development tool	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	0%	100%	100%	100%	100%	100%	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report, patient satisfaction module	Annually	0%	70%	70%	-	-	-	70%	
80% of hospitals meeting national efficiency	Facilitate recruitment of Health Professionals	Average length of stay	Facility registers, patient records	Quarterly	8.2days	10.5days	5.5days	5.5days	5.5days	5.5days	5.5days	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
targets by 2019	Facilitate conducting of outreach and in 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	89.7%	87.5%	75%	75%	75%	75%	75%	
		Numerator			178278	105 471						
	Facilitate conducting of outreach and inreach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Denominator			198703.4	120 463						

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3 737	R3,659	R4,247	R4,247	R4,247	R4,247	R4,247	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	98.3%	99.6%	90%	90%	90%	90%	90%	
	Facilitate training and implementation of Complaints Management Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	99%	100%	98%	98%	98%	98%	98%	

5.2 PROGRAMME PURPOSE FOR TERTIARY HOSPITAL SERVICES

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 three Tertiary Hospitals in the Eastern Cape Province:

5.2.1 SUB-PROGRAMMES

Tertiary Hospitals

- Livingstone Hospital
- Frere Hospital
- Fort England

5.2.2 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

Strategic Objectives being addressed:
Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019
Strategic Objective 1.10: 80% of Hospitals meeting national efficiency targets by 2019

5.1.2 QUARTERLY TARGETS FOR TERTIARY HOSPITALS FOR 2017/18

Table 36: Budget allocation for sub- programme 5.2

BUDGET	R'000
Compensation of employees	1,429,140
Goods and services	624,019
Transfers	-
Capital assets	94,927
TOTAL BUDGET	**2,148,086**

Table THS: 1 Quarterly Activities for Tertiary Hospitals

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	100%	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	100%	100%	100%	-	100%	-	-	
		Numerator			2	2	2	-	2	-	-	
		Denominator			2	2	2	-	2	-	-	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	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%	50%	50%	-	-	50%	-	
		Numerator			0	1	1	-	-	1	-	
		Denominator			2	2	2	-	-	2	-	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	0%	100%	50%	100%	-	-	
		Numerator			2	2	2	1	2 (1 new)	-	-	
		Denominator			2	2	2	2	2	-	-	
	Analyse reports of the PSS	Patient Experience of Care Satisfaction Rate	PSS forms, PSS report, patient satisfaction module	Annually	80%	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,	Average length of stay	Facility registers, patient records	Quarterly	5.8 days	5.8 days	5.5 days	5.5 days	5.5 days	5.5 days	5.5 days	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	protocols, guidelines and procedure manuals											
	Facilitate recruitment of Health Professionals. Facilitate conducting of outreach and in reach. Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	75.6%	76.2%	75%	75%	75%	75%	75%	
		Numerator			456 638	230 688	725 699	725 699	725 699	725 699	725 699	
		Denominator			604 202	302 618	967599	967599	967599	967599	967599	
	IYM Monitor functionality of cost containment committees	Expenditure per patient day equivalent (PDE)	BAS, expenditure report	Quarterly	R3 412	R3,386	R3,014	R3,014	R3,014	R3,014	R3,014	
Patient satisfaction rate increased to more than 75% in health services by 2019	Facilitate training and implementation of Complaints Management Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	96.4%	94.9%	90%	90%	90%	90%	90%	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Facilitate training and implementation of Complaints Management Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	10%	100%	90%	90%	90%	90%	90%	

5.3 PROGRAMME PURPOSE FOR SPECIALISED TERTIARY HOSPITAL

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 is one Specialised Tertiary Hospital in the Eastern Cape Province:

5.3.1 SUB-PROGRAMMES

Specialised Tertiary Hospitals

- Fort England (specialised psychiatric Hospital)

5.3.2 PRIORITIES FOR THE NEXT THREE YEARS

- 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

Strategic Objectives being addressed:
Strategic Objective 2.3: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019
Strategic Objective 2.4: Patient satisfaction rate increased to more than 75% in health services by 2019

Table 37: Quarterly Targets for Specialised Psychiatric Hospitals

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	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	100%	100%	100%	-	-	-	
	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self-assessment rate	Quality Improvement Plans	Quarterly	New Indicator	100%	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	100%	100%	100%	-	-	-	
Patient satisfaction rate increased to more than 75% in health services by 2019	Conduct Patient Satisfaction Surveys (PSS)	Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	60 %	0%	75%	-	60%	65%	75%	
	Analyse reports of the PSS	Patient Satisfaction rate	PSS forms, PSS report, patient satisfaction module	Annually	New Indicator	70%	70%	-	-	-	70%	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
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 Facilitate recruitment of Health Professionals Facilitate conducting of outreach and inreach Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	New Indicator	85%	85%	85%	85%	85%	85%	
		Numerator					306 250	306 250	306 250	306 250	306 250	
		Denominator					360 294	360 294	360 294	360 294	360 294	
	IYM	Expenditure per patient	BAS, expenditure report	Quarterly	New Indicator	R1, 442	R1, 442	R1, 442	R1, 442	R1, 442	R1, 442	

Strategic objective	Planned Activities	Programme perfor-mance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Monitor functionality of cost containment committees	day equivalent (PDE)										
Patient satisfaction rate increased to more than 75% in health services by 2019	Monthly monitoring of Complaints Committee	Complaints resolution rate	Complaints registers at facility, redress report	Quarterly	New Indicator	64.5 %	80%	80%	80%	80%	80%	
	Monthly monitoring of Complaints Committee	Complaint resolution within 25 working days rate	Complaints registers at facility, redress report	Quarterly	New Indicator	100%	95%	95%	95%	95%	95%	

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 38: ***Summary of payments and estimates by sub-programme: Central & Tertiary Hospitals***

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. Central Hospital Services	774,264	758,650	262,945	910,426	938,263	994,837	960,877	1,014,472	1,067,277	(3.4)
2. Provincial Tertiary Services	1,637,928	1,685,376	560,276	1,928,364	1,987,325	2,107,154	2,148,086	2,256,028	2,462,187	1.9
Total payments and estimates	**2,412,192**	**2,444,026**	**823,221**	**2,838,790**	**2,925,588**	**3,101,991**	**3,108,963**	**3,270,499**	**3,529,464**	**0.2**

Table 39: Summary of payments and estimates by economic classification: Central & Tertiary Hospitals

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**2,246,198**	**2,365,937**	**721,876**	**2,716,119**	**2,781,238**	**2,956,585**	**2,982,108**	**3,136,285**	**3,387,734**	**0.9**
Compensation of employees	1,427,840	1,555,938	242,355	1,954,725	1,954,725	2,200,342	2,101,763	2,241,195	2,338,308	(4.5)
Goods and services	818,358	809,970	479,521	761,394	826,513	755,861	880,345	895,091	1,049,426	16.5
Interest and rent on land	–	29	–	–	–	382	–	–	–	(100.0)
Transfers and subsidies to:	**43,107**	**874**	**9**	**24,285**	**29,013**	**57,226**	**25,109**	**26,565**	**28,053**	**(56.1)**
Households	43,107	874	9	24,285	29,013	57,226	25,109	26,565	28,053	(56.1)
Payments for capital assets	**122,887**	**77,215**	**101,336**	**98,386**	**115,337**	**88,180**	**101,747**	**107,649**	**113,677**	**15.4**
Buildings and other fixed structures	858	3,180	2,461	–	–	–	–	–	–	
Machinery and equipment	122,029	74,035	98,875	98,386	115,337	88,180	101,747	107,649	113,677	15.4
Total economic classification	**2,412,192**	**2,444,026**	**823,221**	**2,838,790**	**2,925,588**	**3,101,991**	**3,108,963**	**3,270,499**	**3,529,464**	**0.2**

NOTES

6. PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

6.1 PROGRAMME PURPOSE

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

6.2 PRIORITIES FOR THE NEXT THREE YEARS

- Manage the bursary scheme effectively to ensure a flow of health professionals in to the Department
- 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

Strategic Objectives being addressed: 2.6 First year Health professional students receiving bursaries by 2019

6.2 QUARTERLY TARGETS FOR HEALTH SCIENCES AND TRAINING

Budget allocation: Programme 6

Table 40: Budget allocation for programme 6

BUDGET	R'000
Compensation of employees	497,484
Goods and services	139,306
Transfers	195,230
Capital assets	21,125
TOTAL BUDGET	**853,145**

TABLE 41: Quarterly Activities for Health Sciences and Training, 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
Fifty (50) first year medical student receiving bursaries by 2019	Recruitment and payment of fees Administering the signing of bursary contracts and safe keeping thereof	Number of Bursaries awarded for first year medicine students	DoH bursary database	Annual	20	10	10	-	-	-	10	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Recruitment (advert), selection and registration if new nursing students across all nursing academic programmes	Number of Bursaries awarded for first year nursing students	DoH bursary database	Annual	894	550	350	-	-	-	350	
Fifty (50) first year medical student receiving bursaries by 2019	Advertise, appoint and place Departmental and HWSETA Funded Interns	Number of interns on internship programme	Internship Programme Database	Annual	736	497	500	500	-	-	-	
To develop a responsive health workforce by ensuring adequate training and accountability are in place	Approved WSP 2017 and Implementation of Priority Training Needs	Number of employees utilizing Skills Levy	Training Attendance Registers NSDS III Report	Quarterly	15000	12735	17192	4397	5398	5398	2098	
To manage and monitor the performance of the	PMDS register compiled	% of SMS members with signed Performance Agreements	Persal PMDS Reports	Annually		100%	100%	100%	-	-	-	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
employees of the department through work contracts	Capturing on persal	% of all Employees with signed Performance Agreements			80%	80%	100%	100%	-	-	-	

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

Table 42: Summary of payments and estimates by sub-programme: Health Sciences & Training

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. Nursing Training Colleges	293,489	277,510	290,679	336,342	294,223	289,825	317,558	334,049	359,845	9.6
2. Ems Training College	4,872	9,910	13,574	15,611	12,608	12,368	15,018	17,364	18,493	21.4
3. Bursaries	86,631	170,799	198,856	152,901	191,101	180,016	177,594	175,700	185,540	(1.3)
4. Other Training	265,160	268,033	266,263	294,613	294,054	287,233	342,975	364,512	390,463	19.4
Total payments and estimates	**650,152**	**726,252**	**769,372**	**799,467**	**791,986**	**769,442**	**853,145**	**891,625**	**954,341**	**10.9**

Table 43: Summary of payments and estimates by economic classification: Health Science & Training

R thousand	Outcome			Main appropri-ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**506,834**	**551,940**	**550,018**	**621,174**	**570,013**	**562,610**	**636,790**	**662,721**	**712,617**	**13.2**
Compensation of employees	388,111	413,547	418,577	508,976	461,815	474,518	497,484	530,282	572,762	4.8
Goods and services	118,722	138,392	131,441	112,198	108,198	88,092	139,306	132,439	139,855	58.1
Interest and rent on land	1	1	–	–	–	–	–	–	–	
Transfers and subsidies to:	**123,173**	**165,118**	**211,519**	**154,583**	**198,263**	**186,933**	**195,230**	**206,553**	**218,121**	**4.4**
Departmental agencies and accounts	6,331	–	18,115	8,145	8,145	8,145	37,950	40,151	42,400	365.9
Households	116,842	165,118	193,404	146,438	190,118	178,788	157,280	166,402	175,721	(12.0)
Payments for capital assets	**10,019**	**9,194**	**7,835**	**23,710**	**23,710**	**19,899**	**21,125**	**22,350**	**23,603**	**6.2**
Machinery and equipment	10,019	9,194	7,835	23,710	23,710	19,899	21,125	22,350	23,603	6.2
Payments for financial assets	**10,126**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total economic classification	**650,152**	**726,252**	**769,372**	**799,467**	**791,986**	**769,442**	**853,145**	**891,625**	**954,341**	**10.9**

NOTES

7. PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

7.1 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.

7.2 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objective 1.11 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019
Strategic objective 1.12 90% availability of essential drugs in all health facilities by 2019

Table 44: Budget allocation for programme 7

BUDGET	R'000
Compensation of employees	59,207
Goods and services	71,007
Transfers	
Capital assets	545
TOTAL BUDGET	**130,759**

7.4 QUARTERLY TARGETS FOR HEALTH CARE SUPPORT SERVICES

TABLE 45: Quarterly Activities for Health Care Support Services, 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
95% of clients eligible for assistive devices provided with wheelchair s, hearing aids, prostheses & orthoses by 2019	Procure wheelchairs Issue the wheelchairs to eligible applicants	Percentage of eligible applicants supplied with wheelchairs	Facility register	Quarterly	92.5%	51.6%	85%	25%	50%	60%	85%	
		Numerator			8 061	1 633	1796	528	1 057	1 268	1 796	
		Denominator			8 715	3 163	2113	2113	2113	2113	2113	
	Order the hearing aid as per measurement Issue and Fit the hearing aid to eligible applicants	Percentage of eligible applicants supplied with hearing aids	Facility register	Quarterly	173%	105.7%	95%	25%	50%	75%	95%	
		Numerator			5 405	1 283	267	70	141	211	267	
		Denominator			3 130	1 213	281	281	281	281	281	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Design the Prosthesis Fit and Issue the prosthesis to eligible applicants	Percentage of eligible applicants supplied with prostheses	OP Centres reports	Quarterly	73.3%	30.8%	70%	20%	40%	60%	70%	
		Numerator			9 331	443	787	225	450	674	787	
		Denominator			12 733	1 440	1 124	1 124	1 124	1 124	1 124	
	Design the orthoses Issue the orthoses to eligible applicants	Percentage of eligible applicants supplied with orthoses	OP Centres reports	Quarterly	168%	100%	95%	60%	80%	95%	95%	
		Numerator			28 028	11 201	16 625	10 500	14 000	16 625	16 625	
		Denominator			16 672	11 201	17 500	17 500	17 500	17 500	17 500	
90% availability of essential drugs in all health facilities by 2019	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	84%	2%	85%	85%	85%	85%	85%	
		Numerator			366 124	3 856	489 629	489 629	489 629	489 629	489 629	
		Denominator			435 864	192 851	576 034	576 034	576 034	576 034	576 034	

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 46: Summary of payments and estimates by sub = programme: Health Care Support Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. Orthotic & Prosthetic Services	36,789	42,480	33,744	51,324	54,908	44,562	47,363	54,493	57,432	6.3
2. Medicine Trading Account	60,990	49,919	59,385	67,285	63,878	62,634	83,396	71,180	75,112	33.1
Total payments and estimates	**97,779**	**92,399**	**93,129**	**118,609**	**118,786**	**107,196**	**130,759**	**125,672**	**132,544**	**22.0**

Table 47 : Summary of payments and estimates by economic classification: Health Care Support Services

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**92,053**	**82,421**	**90,664**	**117,290**	**112,144**	**105,470**	**130,214**	**125,096**	**131,935**	**23.5**
Compensation of employees	39,358	40,703	50,586	59,427	55,081	56,574	59,207	64,762	68,218	4.7
Goods and services	52,694	41,718	40,078	57,863	57,063	48,896	71,007	60,334	63,717	45.2
Interest and rent on land	1	–	–	–	–	–	–	–	–	
Transfers and subsidies to:	**–**	**8**	**91**	**400**	**4,923**	**101**	**–**	**–**	**–**	**(100.0)**
Households	–	8	91	400	4,923	101	–	–	–	(100.0)
Payments for capital assets	**2,180**	**9,970**	**2,374**	**919**	**1,719**	**1,625**	**545**	**577**	**609**	**(66.5)**
Machinery and equipment	2,180	9,970	2,374	919	1,719	1,625	545	577	609	(66.5)
Payments for financial assets	**3,546**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Total payments and estimates	**97,779**	**92,399**	**93,129**	**118,609**	**118,786**	**107,196**	**130,759**	**125,672**	**132,544**	**22.0**

NOTES

8. PROGRAMME 8: HEALTH FACILITIES MANAGEMENT (HFM)

8.1 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 four sub-programmes and other facilities:

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

8.2 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

STRATEGIC OBJECTIVES BEING ADDRESSED:

Strategic objective 2.7 Health facilities refurbished to comply with the National norms and standards by 2019

8.4 QUARTERLY TARGETS FOR HEALTH FACILITIES MANAGEMENT

Table 48: Budget allocation for programme 8

BUDGET	R'000
Compensation of employees	35,000
Goods and services	438,806
Transfers	
Capital assets	971,011
TOTAL BUDGET	**1,444,817**

Table 49: Quarterly targets for Health Facilities Management 2017/18

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
2.7 Health facilities refurbished to comply with the National norms and standards by 2019	Projects Site visit and inspections and month monitoring meetings with Implementing Agents.	2.7.1 Number of health facilities that have undergone major refurbishment in NHI pilot district	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	9 major	8 major	7major	-	-	-	7major	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.2 Number of health facilities that have undergone minor refurbishment in NHI pilot district	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	320 minor	17 minor	4 minor	-	-	-	4 minor	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.3 Number of health facilities that have undergone major refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	New indicator	9 major	3 major	-	-	-	3 major	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	2.7.4 Number of health facilities that have undergone minor refurbishment outside NHI pilot District (excluding facilities in NHI Pilot District)	Practical Completion Certificate, Invoice, Report Commissioning Certificate	Annually	New indicator	22 minor	62 minor	-	-	-	62 minor	
	Bilateral meetings to discuss contents of changes / amendments made on the SLA with both Implementing Agents.	Establish Service Level Agreements (SLAs) with Departments of Public Works (and any other implementing agent)	Signed and approved SLA	Annually	2	2	2	-	-	-	2	

Strategic objective	Planned Activities	Perfor-mance indicator	Means of verification	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	Quarterly Targets				Budget R'000
								Q1	Q2	Q3	Q4	
	UAMP co-ordination meetings by Infrastructure Planning Unit with all other units to discuss inputs and consolidation of the main document.	2016/17 User Asset Management Plan (UAMP)	UAMP Signed and Approved document	Annually	1	1	1	-	-	-	1	

NOTES

RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

Table 50: Summary of payments and estimates by sub-programme: Health Facilities Management

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
1. Community Health Facilities	426,142	397,120	404,918	261,154	311,019	294,423	218,027	207,454	314,833	(25.9)
2. Emergency Medical Rescue Services	458	15	7	–	–	–	–	–	–	
3. District Hospital Services	339,461	149,633	310,025	433,372	458,414	390,923	750,465	907,984	990,525	92.0
4. Provincial Hospital Services	254,077	507,015	449,514	580,000	506,027	502,522	329,421	294,194	258,805	(34.4)
5. Other Facilities	110,019	48,032	35,058	128,250	127,316	158,642	146,904	95,963	9,135	(7.4)
Total payments and estimates	**1,130,157**	**1,101,815**	**1,199,522**	**1,402,776**	**1,402,776**	**1,346,510**	**1,444,817**	**1,505,595**	**1,573,298**	**7.3**

Table 51: Summary of payments and estimates by economic classification: Health Facilities Management

R thousand	Outcome			Main appropriation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from 2016/17
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	
Current payments	**502,412**	**405,881**	**301,392**	**372,304**	**386,948**	**351,038**	**473,806**	**532,149**	**505,668**	**35.0**
Compensation of employees	7,628	6,176	10,391	25,000	19,000	15,230	35,000	30,000	31,000	129.8
Goods and services	492,678	399,394	290,528	347,304	367,948	335,769	438,806	502,149	474,668	
Interest and rent on land	2,106	311	473	–	–	39	–	–	–	
Transfers and subsidies to:	**10,502**	**-2**	**–**	**–**	**–**	**–**	**–**	**–**	**–**	
Households	10,502	-2	–	–	–	–	–	–	–	
Payments for capital assets	**617,243**	**695,936**	**898,130**	**1,030,472**	**1,015,828**	**995,472**	**971,011**	**973,446**	**1,067,630**	
Buildings and other fixed structures	553,239	669,516	879,445	744,096	751,161	720,321	727,420	724,394	846,803	
Machinery and equipment	64,004	26,420	18,685	286,376	264,667	275,151	243,591	249,052	220,827	
Total economic classification	**1,130,157**	**1,101,815**	**1,199,522**	**1,402,776**	**1,402,776**	**1,346,510**	**1,444,817**	**1,505,595**	**1,573,298**	

ANNEXURE D: TECHNICAL INDICATOR DESCRIPTIONS

PROGRAMME 1: HEALTH ADMINISTRATION& MANAGEMENT

Strategic Objectives	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 a 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 Clean audit opinion achieved by 2019	2.1.1 Audit opinion from Auditor General	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	Clean Audit Opinion from the Auditor General	Chief Financial Officers of Provincial Departments of Health
	2.1.2 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
	2.1.3 Audit Improvement Plan for Financial 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	Not	Not applicable	Output	Categorical	Quarterly	Yes	Level 3	Chief Financial Officer

Strategic Objectives	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 Audit Improvement Plan for Performance Information 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.	report	applicable	Not applicable	Output	Categorical	Quarterly	Yes		DDG: Clinical Services
	2.1.5 Strategic Management improvement plan (MPAT_IP improvement plan 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 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: HR

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.1.8 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
2.2 100% of health facilities connected to web-based DHIS through broadband by 2019	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 facilities with broadband access	Percentage of fixed PHC facilities with broadband access	To ensure broadband access to PHC facilities	Network reports that confirm availability of broadband; OR Network rollout report for sites that are not yet live	**Num:** Total Number of fixed PHC facilities with minimum 1Mbps connectivity **Den:** Total Number of fixed PHC Facilities	NA	Output	Percentage	Quarterly	No	Higher Proportion of broadband access is more favorable for connectivity	ICT Directorate / Chief Directorate

1. PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

SUB PROGRAMME 2.1,2.2 & 2.3: DISTRICT DEVELOPMENT

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.22 Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC).	Fixed clinics, CHCs and CDCs where Ideal clinic status determinations are conducted by PPTICRM as a proportion Fixed clinics plus fixed CHCs/CDCs	Monitors whether PHC health establishments are measuring their level of compliance with standards in order to close gaps in preparation for an external assessment by the Office of Health Standards Compliance	Ideal Clinic review tools	**Numerator:** SUM([Ideal clinic status determinations conducted by PPTICRM]) **Denominator**: SUM([Fixed PHC clinics/fixed CHCs/CDCs])	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 Patient experience of care increased to more than 75% in health services by 2019	2.4. Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics and DHIS	**Numerator:** SUM([Facility Patient Experience of Care survey done]) **Denominator:** SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Availability of the report	Quality	Percentage	Measured quarterly (conducted once annually)	Yes	Higher percentage indicates commitment of facilities to conduct the survey	District Health Services and Quality Assurance Directorates
	2.4.10 Patient Experience of Care Satisfaction rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	**Numerator:** SUM([Patient Experience of Care satisfied responses]) **Denominator:** SUM([Patient Experience of Care total responses])	Generalizability depends on the number of users participating in the survey.	Quality	Percentage	Annual	Yes	Higher percentage indicates better compliance to Batho pele principles	District Health Services and Quality Assurance Directorates

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
3.2 100% Ward Based Outreach Teams (WBOT) coverage by 2019	3.2.1 OHH registration visit coverage	Outreach households registered by Ward Based Outreach Teams as a proportion of OHH in population	Monitors implementation of the PHC re-engineering strategy	DHIS, household registration visits registers, patient records	**Numerator:** SUM([OHH registration visit]) **Denominator:** Household mid-year estimate	Dependant on accuracy of OHH in population	Output	Percentage	Quarterly	No	Higher levels of uptake may indicate an increased burden of disease, or greater reliance on public health system.	CBS / Outreach Services programme manager
1.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	1.1.1 PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	facility register, DHIS Denominator: Stats SA,	**Numerator:** PHC headcount total **Denominator:** Population total	Dependant on the accuracy of estimated total population from Stats SA	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	DHS Manager
2.4 Patient/Client satisfaction rate increased to more than 75% in health services by 2019	2.4.19 Complaints Resolution Rate	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved]) **Denominator:** SUM([Complaint 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
	2.4.27 Complaint resolution within 25 working days rate	Complaints resolved within 25 working days as a proportion of all complaints resolved	Monitors the time frame in which the public health system responds to complaints	DHIS, complaints register,	**Numerator:** SUM([Complaint resolved within 25 working days]) **Denominator:** SUM([Complaint resolved])	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

2.4 SUB-PROGRAMME: COMMUNITY BASED SERVICES: DISEASE PREVENTION AND CONTROL (DPC)

Strategic Objectives	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 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.1 Clients 40 years and older screened for hypertension	Number of clients not on treatment for hypertension screened for hypertension in PHC clinics and OPD	This should assist with increasing the number of clients detected and referred for treatment	PHC Comprehensive Tick Register	SUM([Client 40 years and older screened for hypertension])	The new data collection tools may not exist all facilities	Process/Activity	Sum of Number	Quarterly	No	Greater number of people screened for high blood pressure	CD: health Programmes
	1.2.2 Clients 40 years and older screened for diabetes	Number of clients not diagnosed and not on treatment for diabetes screened for diabetes in PHC clinics and OPD	This should assist with increasing the number of clients with diabetes detected and referred for treatment	PHC Comprehensive Tick Register	SUM([Client 40 years and older screened for diabetes])	The new data collection tools may not exist all facilities	Process/Activity	Sum of Number	Quarterly	No	Greater number of people screened for raised blood glucose levels	NCD Programme Manager
	1.2.3 Mental disorders screening rate	Clients screened for mental disorders (depression, anxiety, dementia, psychosis, mania, suicide, developmental disorders, behavioral disorders and substance use disorders at PHC facilities	Monitors access to and quality of mental health services in PHC facilities	PHC Comprehensive Tick Register	**Numerator:** SUM([PHC client screened for mental disorders]) **Denominator:** SUM([PHC headcount under 5 years]) + SUM([PHC headcount 5 years and older])	The new data collection tools may not exist all facilities	Process/Activity	Percentage	Quarterly	No	Higher percentage of for mental disorders screening	NCD Programme Manager

2.5 SUB-PROGRAMME: OTHER COMMUNITY SERVICES

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
2.5 100% Compliance with the Waste Management Act by 2019	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.	**Numerator**: Number of health facilities (Hospitals) that dispose waste in line with SANS 10248 regulation at a given reporting period. **Denominator:** 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

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

Strategic Objectives	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 HIV infection rate reduced by 15% by 2019	1.5.1 ART client remain on ART end of month - total	Total clients remaining on ART (TROA) are the sum of the following: - Any client on treatment in the reporting month - Any client without an outcome reported in the reporting month Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]	Monitors the total clients remaining on life-long ART at the month	ART Register; TIER.Net; DHIS	**Numerator:** SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None	Output	Cumulative total	Quarterly	no	Higher total indicates a larger population on ART treatment	HIV/AIDS Programme Manager
	1.5.2 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. Monitors ART initiation for TB clients	TB register; ETR.Net;	**Numerator:** Total number of registered HIV+TB co-infected patients on ART	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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					Denominator : Total number of registered HIV positive TB patients							
1.5 HIV infection rate reduced by 15% by 2019	1.5.3 Client tested for HIV (incl. ANC)	Total number of HIV Tests done	Monitors HIV testing	Facility Register; DHIS	SUM([Antenatal client HIV 1st test]) + SUM([Antenatal client HIV re-test]) + SUM([HIV test 19-59 months]) + SUM([HIV test 5-14 years]) + SUM([HIV test 15 years and older (excl ANC)])	Dependent on the accuracy of facility register	Process	Number	Quarterly	No	Higher percentage indicate increased population knowing their HIV status.	HIV/AIDS Programme Manager
	1.5.4 Male Condoms Distributed	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, non-traditional outlets, etc.).	Monitors distribution of male condoms for prevention of HIV and other STIs, and for contraceptive purposes. Primary distribution sites (PDS) report to sub-districts on a monthly basis	Numerator: Stock/Bin card	SUM([Male condoms distributed])	None	Process	Percentage	Quarterly	No	Higher number indicated better distribution (and indirectly better uptake) of condoms in t he province	HIV/AIDS Cluster
	1.5.6 Medical male circumcision - total	Medical male circumcisions performed 15 years and older as a proportion of total medical male circumcisions	Monitors medical male circumcisions performed under supervision	Theatre Register/ PHC tick register, DHIS	SUM([Males 10 to 14 years who are circumcised under medical supervision])+([Males 15 years and older	Assumed that all MMCs reported on DHIS are conducted under supervision	Output	Rate	Quarterly	No	Higher number indicates greater availability of the service or greater uptake of the service	HIV/AIDS Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		performed			who are circumcised under medical supervision])							
1.6 TB death rate reduced by 30% in 2019	1.6.1 TB client 5 years and older start on treatment rate	TB client 5 years and older start on treatment as a proportion of TB symptomatic client 5 years and older test positive	Monitors trends in early identification of children with TB symptoms in health care facilities	PHC Comprehensive Tick Register	***Numerator***: SUM([TB client 5 years and older start on treatment]) ***Denominator***: :SUM([TB symptomatic client 5 years and older tested positive])	- Accuracy dependent on quality of data from reporting facility	Process/ Activity	Rate	Quarterly	No	Screening will enable early identification of TB suspect in health facilities	TB Programme Manager
	1.6.2 TB client treatment success rate	TB clients successfully completed treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors success of TB treatment for ALL types of TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	**Numerator**: SUM([TB client successfully completed treatment]) **Denominator** SUM([New smear positive pulmonary TB client start on treatment])	Accuracy dependent on quality of data from reporting facility	Outcome	Percentage	Quarterly	No	Higher percentage suggests better treatment success rate.	TB Programme Manager
	1.6.3 TB Client loss to follow up rate	TB clients who are lost to follow up (missed two months or more of treatment) as a proportion of	Monitors the effectiveness of the retention in care strategies. This follows a cohort analysis therefore the clients would	TB Register; ETR.Net	**Numerator:** SUM [TB () client lost to follow up] **Denominator** : SUM [TB client initiated on	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	TB Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra-pulmonary).	have been started on treatment at least 6 months prior		treatment]						treatment	
	1.6.4 TB Client death rate	TB clients who died during treatment as a proportion of TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)	Monitors death during TB treatment period. The cause of death may not necessarily be due to TB. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior	TB Register; ETR.Net	**Numerator:** SUM([TB client death during treatment]) **Denominator:** SUM([TB 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
	1.6.6 TB MDR treatment success rate	TB MDR client successfully completing treatment as a proportion of TB MDR confirmed clients started on treatment	Monitors success of MDR TB treatment	TB Register; EDR Web	**Numerator:** TB MDR client successfully complete treatment **Denominator** 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

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

Strategic Objectives	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 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.1 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	***Numerator:*** Antenatal 1st visit before 20 weeks ***Denominator*** 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
	1.7.2 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	***Numerator:*** Mother postnatal visit within 6 days after delive ***Denominator*** 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
	1.7.3 Antenatal client initiated on ART rate	Percentage of HIV positive Antenatal clients placed on ART.	Tracks the HIV Treatment policy	Facility Register	***Numerator:*** Antenatal client start on ART ***Denominator*** Antenatal client eligible (Antenatal client known HIV positive but NOT on ART at 1st visit) 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
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.1 Infant 1st PCR test positive around 10 weeks rate	Infants PCR tested positive for the first time around 10 weeks after birth as proportion of Infants PCR	This indicator monitors PCR positivity rate in HIV exposed infants around 10 weeks	Facility Register	***Numerator:*** SUM[Infant 1st PCR test positive around 10 weeks	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Lower percentage indicate fewer HIV transmissions from mother to child	PMTCT Programme

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		tested around 10 weeks			***Denominator*** Infant PCR test around 10 weeks							
	1.8.2 Immunisation coverage under 1 year (Annualised)	Percentage children under 1 year who completed their primary course of immunisation The child should only be counted ONCE as fully immunised when receiving the last vaccine in the course	Monitor the implementation of Extended Programme in Immunisation (EPI)	Facility Register Denominator: Stats SA	***Numerator:*** SUM([Immunised fully under 1 year new]) ***Denominator*** SUM([Female under 1 year]) + SUM([Male under 1 year])	Reliant on under 1 population estimates from Stats SA, and accurate recording of children under 1 year who are fully immunised at facilities (counted only ONCE when last vaccine is administered.)	Output	Percentage Annualised	Quarterly	No	Higher percentage indicate better immunisation coverage	EPI Programme manager
	1.8.3 Measles 2nd dose coverage (annualised)	Measles 2nd dose coverage	Monitors 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	***Numerator***: SUM([Measles 2nd dose]) ***Denominator:*** SUM([Female 1 year]) + SUM([Male 1 year])	Accuracy dependent on quality of data submitted health facilities	Output	Percentage	Quarterly	No	Higher coverage rate indicate greater protection against measles	EPI
	1.8.4 DTaP-IPV/Hib 3 - Measles 1st dose drop-out rate	DTaP-IPV/ Heb3 to Measles1st dose drop-out	Monitors children who drop out of the vaccination program after 14 week vaccination.	Facility Register	***Numerator:*** SUM([DTaP-IPV/Hib 3rd dose]) - SUM([Measles 1st dose under 1 year]) =	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Lower dropout rate indicates better vaccine coverage	EPI

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					DTaP-IPV-Hib-HBV 3 to Measles 1st dose drop-out ***Denominator:*** SUM(DTaP-IPV-Hib-HBV 3rd dose])							
	1.8.5 Diarrhea case fatality under 5 years rate	Diarrhea deaths in children under 5 years as a proportion of diarrhea separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with diarrhea	ART Register	***Numerator:*** SUM [Child under 5 years with diarrhea death] ***Denominator***: SUM [Child under 5 years with Diarrhea 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
	1.8.6 Pneumonia case fatality under 5 years rate	Pneumonia deaths in children under 5 years as a proportion of pneumonia separations under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with pneumonia	Ward Register	***Numerator:*** SUM [Child under 5 years with pneumonia death] ***Denominator:*** SUM [Child under 5 years with pneumonia admitted]	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager
	1.8.7 Severe acute malnutrition case fatality under 5 years rate	Severe acute malnutrition deaths in children under 5 years as a proportion of severe acute malnutrition (SAM) under 5 years in health facilities	Monitors treatment outcome for children under 5 years who were separated with Severe acute malnutrition (SAM)	Ward register	***Numerator:*** SUM [Child under 5 years severe acute malnutrition deaths] ***Denominator:*** SUM [Children under 5 years severe acute malnutrition admitted]	Accuracy dependent on quality of data submitted health facilities	Impact	Percentage	Quarterly	Yes	Lower children mortality rate is desired	MNCWH Programme manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	3.4.2 School Grade 1 learners screened	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)	School Health data collection forms	SUM [School Grade 1 - learners screened}	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
	3.4.3 School Grade 8 learners screened	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)	Numerator School Health data collection forms	SUM [School Grade 8 - learners screened]	None	Process	Number	Quarterly	Yes	Higher percentage indicates greater proportion of school children received health services at their school	School health services
1.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	Delivery in 10 to 19 years in facility rate	Deliveries to women under the age of 20 years as proportion of total deliveries in health facilities	Monitors the proportion of deliveries in facility by teenagers (young women under 20 years).	Health Facility Register, DHIS	***Numerator:*** SUM [Delivery 10–14 years in facility] + [Delivery 15–19 years in facility] ***Denominator***: SUM([Delivery in facility total])	None	Process	Percentage	Quarterly	Yes	Lower percentage indicates better family planning	HIV and Adolescent Health
	1.7.4 Couple Year Protection Rate (Int)	Women protected against pregnancy by using modern contraceptive methods, including sterilizations, as proportion of female population 15-49 year. Contraceptive years are the total of (Oral	Track the extent of the use of contraception (any method) amongst women of child bearing age	Facility Register	***Numerator*** (SUM([Oral pill cycle]) / 15) + (SUM([Medroxyprogesterone injection]) / 4) + (SUM ([Norethisterone enanthate injection]) / 6) + (SUM([IUCD inserted]) * 4.5) + (SUM([Male condoms distributed]) / 120) +	Accuracy dependent on quality of data submitted health facilities	Outcome	Percentage	Quarterly	No	Higher percentage indicates higher usage of contraceptive methods.	MCWH&N Programme

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		pill cycles / 13) + (Medroxyprogesterone injection / 4) + (Norethisterone enanthate injection / 6) + (IUCD x 4) + (SUM Female condoms distributed/200) + (SUM Male condoms distributed / 200) + (Male sterilization x 20) + (Female sterilization x 10)			(SUM([Sterilisation - male]) * 10) + (SUM([Sterilisation - female]) * 10) + (SUM([Female condoms distributed]) / 120) + (SUM([Sub-dermal implant inserted]) * 2.5) ***Denominator:*** SUM {[Female 15-44 years]} + SUM{[Female 45-49 years]}							
1.2 Screening coverage of chronic illnesses increased to more than a million by 2019	1.2.4 Cervical cancer screening coverage 20 years and older	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 Stats SA	***Numerator:*** SUM([Cervical cancer screening 30 years and older]) ***Denominator:*** (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
1.8 Child Mortality Reduced to less than 34 per 1000	1.8.10 Human Papilloma Virus Vaccine 1st dose coverage	Girls 9 years and older that received HPV 1st dose	This indicator will provide overall yearly coverage value which will	HPV Campaign Register – captured electronically on HPV system	SUM([Agg_Girl 09 yrs HPV 1st dose]) + SUM([Agg_Girl 10 yrs HPV 1st	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
population by 2019			aggregate as the campaign progress and reflect the coverage so far		dose]) + SUM([Agg_Girl 11 yrs HPV 1st dose]) + SUM([Agg_Girl 12 yrs HPV 1st dose]) + SUM([Agg_Girl 13 yrs HPV 1st dose]) + SUM([Agg_Girl 14 yrs HPV 1st dose]) + SUM([Agg_Girl 15 yrs and older HPV 1st dose])							
	1.8.11 Human Papilloma Virus Vaccine 2nd dose coverage	Girls 9yrs and older HPV 2nd dose	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	SUM([Agg_Girl 09 yrs HPV 2nd dose]) + SUM([Agg_Girl 10 yrs HPV 2nd dose]) + SUM([Agg_Girl 11 yrs HPV 2nd dose]) + SUM([Agg_Girl 12 yrs HPV 2nd dose]) + SUM([Agg_Girl 13 yrs HPV 2nd dose]) + SUM([Agg_Girl 14 yrs HPV 2nd dose]) + SUM([Agg_Girl 15 yrs and older HPV 2nd dose])	None	Output	Number	Annually	No	Higher percentage indicate better coverage	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	1.8.8 Vitamin A dose 12-59 months coverage (Annualised)	Children 12-59 months who received vitamin A 200,000 units, every six months as a proportion of population 12-59 months.	Monitors 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	***Numerator:*** Vitamin A dose 12-59 months ***Denominator:*** Population 12-59 months*2		Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit. A will increase health	MNCWH Programme Manager
	1.8.12 Infant exclusively breastfed at HepB 3rd dose rate	Percentage of Infants exclusively breastfed at HepB 3rd dose rate	Monitor Exclusive breastfeeding	Facility Register	***Numerator:*** SUM([Infants exclusively breastfed at HepB (DTaP-IPV-Hib-HBV) 3rd dose]) ***Denominator:*** 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 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	1.7.5 Maternal mortality in facility ratio	Maternal death is death occurring during pregnancy, childbirth and the puerperium of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of pregnancy and irrespective of the cause	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 (around 30% of all maternal mortality). Provides indication of health system	Maternal death register, Delivery Register	***Numerator:*** SUM([Maternal death in facility]) ***Denominator:*** SUM([Live birth in facility])+SUM([Born alive before arrival at facility])	Completeness of reporting	Impact	Ratio per 100 000 live births	Annually	No	Lower maternal mortality ratio in facilities indicate on better obstetric management practices and antenatal care	MNCWH Programme Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		of death (obstetric and non-obstetric) per 100,000 live births in facility	results in terms of prevention of unplanned pregnancies, antenatal care, delivery and postnatal services									
1.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	1.8.9 Neonatal death in facility rate	Neonatal 0-28 days who died during their stay in the facility as a proportion of live births in facility	Monitors treatment outcome for admitted children under 28 days	Delivery register, Midnight report	***Numerator:*** SUM([Inpatient death 0-7 days]) + SUM([Inpatient death 8-28 days]) ***Denominator***: SUM([Live birth in facility])	Quality of reporting	Impact	Percentage	Annually	No	Lower death rate in facilities indicate better obstetric management practices and antenatal and care	MNCWH Programme Manager

2.9 SUB-PROGRAMME: CORONER SERVICES

Strategic Objectives	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 Post – mortems conducted within 72hrs increased to 95% by 2019	1.9.1 Percentage of post-mortem 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	***Numerator:*** Number of cold bodies with post-mortem performed within 72 hrs. of receipt of body ***Denominator:*** Total number of cold bodies received from SAPS (expressed as percentage)	Depended on accuracy of Forensic Pathology services data base.	Output	%	Quarterly	No	Improved and short turn-around times for post mortems.	GM: PHP

2.10 SUB – PROGRAMME DISTRICT HOSPITALS

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.1 Hospital achieved 75% and more on National Core Standards (NCS) 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	***Numerator***: SUM([Hospital achieved 75% and more on National Core Standards self - assessment]) ***Denominator***: SUM([Hospitals conducted National Core Standards self - assessment])	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.4 Patient satisfaction rate increased to more than 75% in health services by 2019	2.4.2 Patient Experience of Care survey Rate	District Hospitals that have conducted Patient Experience of Care Surveys as a proportion of district hospitals	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Satisfaction Survey forms from district hospitals	***Numerator***: SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([District Hospitals])	Availability of the report	Quality	Percentage	Conducted Annually but measured quarterly (cumulatively)	No	Higher percentage indicates commitment of facilities to conduct the survey	District Health Services and Quality Assurance Directorates
	2.4.10 Patient Experience of Care Satisfaction rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator***: SUM([Patient Experience of Care satisfied responses]) ***Denominator***: SUM([Patient Experience of Care total responses])	Generalizability depends on the number of users participating in the survey.	Quality	Percentage	Annual	No	Higher percentage indicates better compliance to Batho pele principles	District Health Services and Quality Assurance

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.1 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	***Numerator*** Inpatient days + 1/2 Day patients ***Denominator*** 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
	1.10.6 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	***Numerator*:** Inpatient days + 1/2 Day patients ***Denominator*:** 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	Hospital Services Manager
	110.12 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	Track the expenditure per PDE in Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	***Numerator*** Total Expenditure ***Denominator*** Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		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										
2.4 Patient satisfaction rate increased to more than 75% in health services by 2019	2.4.18 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator*** Number complaints resolved ***Denominator*** 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
	2.4.26 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,	***Numerator*** Total number of complaints resolved within 25 days ***Denominator*** Total number of complaints resolved	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)

Strategic Objective	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: Proportion of EMS response time improved to 85% by 2019	3.6.1 EMS P1 urban response under 15 minutes rate	Proportion P1 calls in urban locations with response times under 15 minutes	Monitors compliance with the norm for critically ill or injured clients to receive EMS within 15 minutes in urban areas	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	***Numerator:*** EMS P1 urban response under 15 minutes ***Denominator:*** EMS P1 urban calls	Cumulative	Input	Rate per 10 000 population	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS Manager
	3.6.2 EMS P1 rural response under 40 minutes rate	Proportion P1 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	DHIS, institutional EMS registers Patient and vehicle report.	***Numerator:*** EMS P1 rural response under 40 minutes ***Denominator:*** EMS P1 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	DHIS, institutional EMS registers Patient and vehicle report.	***Numerator:*** EMS inter-facility transfer ***Denominator:*** 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

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.2 Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals 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 - National Core Standard review tools	***Numerator:*** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator:*** Total number of public Hospitals	Reliability of data provided	Output	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance	Monitors whether public hospitals 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
2.4 Patient satisfaction rate increased to more than 75% in health services by 2019	2.4.3 Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Availability of the report	Quality	Percentage	Quarterly	No	Higher percentage indicates commitment of facilities to conduct the survey	GM: DHS

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.4.12 Patient Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator:*** SUM([Patient Experience of Care satisfied responses]) ***Denominator***: SUM([Patient Experience of Care total responses])	Generalizability depends on the number of users participating in the survey.	Quality	Percentage	Annual	Yes	Higher percentage indicates better compliance to Batho pele priciples	District Health Services and Quality Assurance
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.2 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	***Numerator:*** Inpatient days + 1/2 Day patients ***Denominator:*** 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
	1.10.7 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	***Numerator:*** Inpatient days + 1/2 Day patients ***Denominator:*** 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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.3 NCD coverage increased to 1300/1000 000 through management of c hronic illnes	1.3.1 Cataract surgery rate	Clients who had cataract surgery per 1 million uninsured populations. The population will be divided by 12 in the formula to make provision for annualisation	Monitors access to cataract surgery.	Facility registers, patient registers	***Numerator*:** Cataract surgery total ***Denominator*** 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
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.13 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and OPD/Emergenc y total headcount, with inpatient days multiplied by a factor of 1, day patient multiplied by a factor of 0.5 and OPD/Emergenc y 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	***Numerator::*** Total Expenditure in district Hospitals ***Denominator*:** 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.

Strategic Objectives	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 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.21 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator***: Number complaints resolved ***Denominator***: 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 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,	***Numerator***: Total number of complaints resolved within 25 days ***Denominator***: 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

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.3 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals 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	***Numerator:*** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator*:** Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.4 Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Availability of the report	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
	2.4.13 Patient Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator:*** SUM([Patient Experience of Care satisfied responses]) ***Denominator*:** SUM([Patient Experience of Care total responses])	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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.3 Average length of stay	The average number of client days an admitted client spends in hospital before separation. Inpatient separation is the total of day clients, Inpatient discharges, Inpatient deaths and Inpatient transfers out. Include all specialties	Monitors effectiveness and efficiency of Inpatient management. Proxy indicator because ideally it should only include Inpatient days for those clients separated during the reporting month. Use in all hospitals and CHCs with Inpatient beds	DHIS, facility register & Admission	***Numerator*** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) ***Denominator*** SUM([inpatient deaths-total])+([inpatient discharges-total])+([inpatient transfers out-total])	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	GM:DHS
	1.10.8 Inpatient Bed Utilisation Rate	Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties	Monitors effectiveness and efficiency of inpatient management	DHIS, facility register Admission	***Numerator*:** Sum ([Inpatient days total x 1])+([Day patient total x 0.5]) ***Denominator*:** 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	Hospital Services Manager
	1.10.14 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	Track the expenditure per PDE in TB Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	***Numerator*** Total Expenditure ***Denominator*:** Patient Day Equivalent (PDE) as defined above	Accurate reporting sum of daily usable beds	Outcome	Number (Rand)	Quarterly	No	Lower rate indicating efficient use of financial resources.	Hospital Services Manager

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		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										
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.22 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator:*** Number complaints resolved ***Denominator:*** 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
	2.4.30 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,	***Numerator:*** Total number of complaints resolved within 25 days ***Denominator:*** 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 4.3: SPECIALISED PSYCHIATRIC HOSPITALS

Strategic Objectives	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: Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.4 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals 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	***Numerator*:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator*:** Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
	2.3.18 Percentage of health facilities compliant with all extreme and vital measures of the national core standards	Percentage of s health facilities compliant to all Extreme and vital Measures of National Core Standards	Monitors quality in health facilities	NCS self-assessment report,	***Numerator*:** Total number of Hospitals that are compliant to all extreme measures and at least 90% of vital measures of national core standards ***Denominator*:** 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

Strategic Objectives	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: Patient Experience of Care increased to more than 75% in health services by 2019	2.4.5 Patient Experience of Care 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	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) **Denominator**: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
	2.4.14 Patient Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator:*** Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year ***Denominator:*** 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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.4.23 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator*:** Number complaints resolved ***Denominator*:** 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 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,	***Numerator*:** Total number of complaints resolved within 25 days ***Denominator*:** 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

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.5 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals 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 - National Core Standard review tools	***Numerator:*** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator:*** Total number of Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4. Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS

Strategic Objectives	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 Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator*:** Sum of Patient Satisfaction Scores Hospitals that conducted a Patient Satisfaction Survey to date in the current financial year ***Denominator*:** 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
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.4 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 central Hospital	DHIS, facility register & Admission	***Numerator*:** Inpatient days + 1/2 Day patients ***Denominator*:** 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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	1.10.10 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 central Hospital beds	DHIS, facility register Admission	***Numerator*:** Inpatient days + 1/2 Day patients ***Denominator*:** 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
	1.10.16 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	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	***Numerator*:** Total Expenditure in district Hospitals ***Denominator*:** 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.

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		activity expressed as a equivalent to one inpatient day										
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.24 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator***: Number complaints resolved ***Denominator***: 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 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,	***Numerator***: Total number of complaints resolved within 25 days ***Denominator***: 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

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.6 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self - assessment	Monitors whether public hospitals 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 - National Core Standard review tools	***Numerator:*** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator:*** Total number of public Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.7 Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Availability of the report	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
	2.4.16 Patient Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	***Numerator***: SUM([Patient Experience of Care satisfied responses])	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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					Denominator: SUM([Patient Experience of Care total responses])							
1.10 80% of Hospitals meeting national efficiency targets by 2019	1.10.5 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 tertiary Hospital	DHIS, facility register & Admission	***Numerator*:** Inpatient days + 1/2 Day patients ***Denominator*:** 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
	1.10.11 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 tertiary Hospital beds	DHIS, facility register Admission	***Numerator*:** Inpatient days + 1/2 Day patients ***Denominator*:** 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
	1.10.17 Expenditure per patient day equivalent (PDE)	Expenditure per patient day which is a weighted combination of inpatient days, day patient days, and	Track the expenditure per PDE in tertiary v Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	***Numerator*:** 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.

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
		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			***Denominator*:** Patient Day equivalent (PDE) as defined above							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.25 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator*:** Number complaints resolved ***Denominator*:** 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
	2.4.33 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,	***Numerator*:** Total number of complaints resolved within 25 days ***Denominator*:** 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: PSCHIATRIC TERTIARY HOSPITALS

Strategic Objectives	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 Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	2.3.7 Hospital achieved 75% and more on National Core Standards self - assessment rate	Hospitals that achieved a performance of 75% or more on National Core Standards self -assessment	Monitors whether public hospitals 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 - National Core Standard review tools	***Numerator*:** Number of Hospitals that conducted National Core Standards self-assessment to date in the current financial year ***Denominator*:** Total number of public Hospitals	Reliability of data provided	Quality	Percentage	Quarterly	No	Higher assessment indicates commitment of facilities to comply with NCS	Quality assurance
2.4 Patient Experience of care increased to more than 75% in health services by 2019	2.4.8 Patient Experience of Care Survey Rate	Fixed health facilities that have conducted Patient Experience of Care Surveys as a proportion of fixed health facilities	Monitors whether public health establishments are conducting patient experience of care surveys	Patient Experience of Care Survey forms from Clinics	***Numerator:*** SUM([Facility Patient Experience of Care survey done]) ***Denominator***: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Total number of Hospitals	Output	%	Quarterly	No	Higher percentage indicates better levels of satisfaction in district.	GM: DHS
	2.4.17 Patient Experience of Care Satisfaction Rate	Satisfied responses as a proportion of all responses from Patient Experience of Care survey questionnaires	Monitors patient satisfaction with health services	DHIS - Patient Satisfaction Module	**Numerator:** SUM([Patient Experience of Care satisfied responses]) ***Denominator***: SUM([Patient Experience of Care total responses])	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

Strategic Objectives	Indicator name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.4.26 Complaints Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	***Numerator*:** Number complaints resolved ***Denominator*:** 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
	2.4.34 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,	***Numerator*:** Total number of complaints resolved within 25 days ***Denominator*** 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 6: PERFORMANCE INDICATORS FOR HEALTH SCIENCES AND TRAINING

Strategic Objectives	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 First year Health professional students receiving bursaries by 2019	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

Strategic Objectives	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 95% of clients eligible for assistive devices provided with wheelchairs, hearing aids, prostheses & orthoses by 2019	1.11.1 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	***Numerator*:** Number of clients supplied with wheelchairs during a reporting period ***Denominator*:** Total clients applied and on waiting list to receive wheelchairs during the same period	Dependent 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
	1.11.2 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	***Numerator*:** Number of clients supplied with hearing aids during a reporting period ***Denominator*:** Total clients applied and on waiting list to receive hearing aids during the same period	Dependent 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
	1.11.3 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	***Numerator*:** Number of clients supplied with prosthesis during a reporting period	Dependent 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

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
					Denominator: Total clients applied and on waiting list to receive prosthesis during the same period							
	1.11.4 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	***Numerator*:** Number of clients supplied with orthosis during a reporting period ***Denominator*:** Total clients applied and on waiting list to receive orthosis during the same period	Dependent 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
1.12 90% availability of essential drugs in all health facilities by 2019	1.12.1 Percentage of order fulfillment of essential drugs at the depots.	Drug orders fulfilled completely	Ensure availability of essential drugs in all facilities	MEDSAS	***Numerator*:** Number of order fulfilled completely ***Denominator*:** 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

PROGRAMME 8: HEALTH FACILITIES MANAGEMENT

Strategic Objectives	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 Health facilities refurbished to comply with the National norms and standards by 2019	2.7.1 Number of health facilities that have undergone major refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone major 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 minor refurbishment in NHI Pilot District	Number of existing health facilities in NHI Pilot District where 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.	Job card/ invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities in NHI Pilot District that have undergone 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

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	2.7.3 Number of health facilities that have undergone major refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement facilities).	Tracks overall improvement and maintenance of existing facilities.	Practical Completion Certificate Capital infrastructure project list, Scheduled Maintenance project list, and Contract projects).	Number of health facilities outside NHI Pilot District that have undergone major 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
	2.7.4 Number of health facilities that have undergone minor refurbishment outside NHI Pilot District	Number of existing health facilities outside NHI Pilot District where 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.	Job card / invoice, Professional Day-to-day Maintenance project list (only Management Contract projects).	Number of health facilities outside NHI Pilot District that have undergone 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

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