

# OPERATIONAL PLAN NELSON MANDELA 2017/18



## **TABLE OF CONTENT**

Annexure D - Technical Indicator Definitions

Abbro	eviations and Acronyms	2
PAR	T A - STRATEGIC OVERVIEW	
I.	Introduction and Overview	4
2.	Core Functions of the Department	4
3.	Vision	4
4.	Mission	4
5.	Values	4
6.	Conceptual Framework and Strategic Goals	5
7.	Strategic Goals of the Eastern Cape Department of Health	6
8.	Overview of 2015/6 Budget and MTEF Estimates – 2016/17 to 2018/19	8
PAR	T B - PROGRAMME AND SUB-PROGRAMME PLANS	
I.	Programme I - Health Administration & Management	11
2.	Programme 2 - District Health Services	38
3.	Programme 3 - Emergency Medical Services	72
4.	Programme 4 - Provincial Hospital Services	76
5.	Programme 5 - Central & Tertiary Hospitals	94
6.	Programme 6 - Health Sciences and Training	110
7.	Programme 7 - Health Care Support Services	116
8.	Programme 8 - Health Facilities Management	122
ANN	NEXURES	

130

## **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 HIV & AIDS, STI and TB control **HAST 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

## I. INTRODUCTION AND OVERVIEW

## To be appropriated by Vote

Responsible MEC MEC for health

Administration Department Provincial Department of Health

Accounting Officer Head of Department

## 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

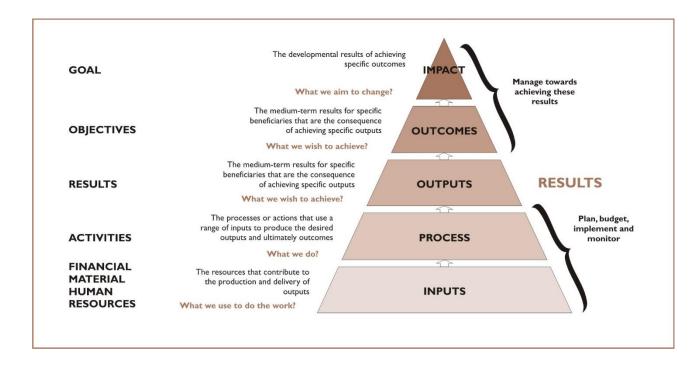
The department's activities will be anchored on the following values in the next five years and beyond:

- 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

1	Strategic Goal	Strategic Objectives	ECDOH Strategic Plan Expected Outcomes
<ul> <li>HIV &amp; AIDS and Tuberculosis prevented and successfully managed;</li> <li>Maternal, infant and child mortality reduced.</li> </ul>	Prevent and reduce the disease burden and promote health	<ul> <li>HIV infection rate reduced by 15% by 2019;</li> <li>TB death rate reduced by 30% in 2019;</li> <li>Child Mortality Reduced to less than 34 per 1000 population by 2019;</li> <li>Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019;</li> <li>40% of Quintile 1&amp;2 school screened by Integrated School Health (ISH) Teams in 2019</li> <li>Screening coverage of chronic illnesses increased to more than a</li> <li>million by 2019</li> </ul>	<ul> <li>Progressively ensure all HIV positive patients eligible for treatment are initiated on ART;</li> <li>Increase TB cure rate to 50%;</li> <li>Ensure 90% of children are vaccinated and monitored for growth;</li> <li>Reduce Maternal Mortality Ratio to 215 per 100 000 live births;</li> <li>Reduce hypertension and diabetes incidence;</li> <li>Ensure 100% of quintile 1&amp;2 schools are providing school health services</li> </ul>
Improved quality of health care	Improved quality of care	<ul> <li>Patient/Client satisfaction rate increased to more than 75% in health services by 2019;</li> <li>Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019;</li> </ul>	<ul> <li>Improved quality of health care</li> <li>Ensure all facilities are conditionally compliant (50%-75%) by 2017 and fully compliant (75%-100%) to National Core Standards</li> </ul>

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

Table 2: Expenditure Estimate

R thousand		Outcome		Main appro- priation	Adjusted appro- priation	Revised estimate	Medi	nates	% change from	
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
I. 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	Medi	um-term estin	nates	% change from
	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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	_	1	-	1	1	-	_	1	
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	_	1	ı	-	_	_	
Payments for financial assets	87,840	_	-	_	ı	ı	-	_	-	
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	-	-	-	1	1	-	-	-	
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 I is divided between sub-programme I.I – Health Administration (Office of the MEC) and Sub-Programme 1.2 - Health Management.

## I.I.I 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	Programme	Indicator Type	Estimate			2017/18 Targets		
objectives statement	Performance Indicator	& Frequency of Reporting	2016/17	2017/18	QI	Q2	Q3	Q4
Provide political and strategic	Strategic Object	<b>ive</b> : Strategic Leader	ship and accountabili	ty by 2019				
direction to the	Number of	Quarterly	Categorical	2	6 statutory	5 statutory	6 statutory	
	statutory			statutory	documents	documents	documents	
Department by	documents tabled			documents				
focusing on transformation	at Legislature							
and change	Negotiated	Quarterly	Report	3 NSDA reports	4 NSDA reports	4 NSDA reports	4 NSDA reports	
_	service delivery	-						
management.	agreement							
	(NSDA) Reports							

Table 5: Negotiated Service Delivery Agreement (NSDA)

Key Performance Area (KPA)	Output	Indicator
	Training of health professionals (including nurses)	No of trained health professionals
Development of health professionals and management	Improve functionality of Lilitha Nursing colleges	No of functional nursing colleges
management	Provisioning of bursaries for health professionals	No of bursary holders
	Increase Ward Based Outreach Teams (WBOTs) for increased health promotion	No of Ward Based Outreach Teams
	Increased outreach to communities	No of household visited
Expansion of the re-engineering of Primary health care services	HPV vaccination for Grade 4 learners (9 year olds) as part of the Integrated School Health Programme	HPV 1 <sup>st</sup> dose coverage
	Screening for learners in quintile 1&2 schools) for barriers to learning	School Grade I – learners screened
	Screening for learners in quintile 1&2 scribbis) for barriers to learning	School Grade 8 – learners screened
	TB client treatment success rate	TB new client success rate
	TB client lost to follow up rate	TB client lost to follow up rate
Expansion of HIV/AIDS treatment and TB	TB MDR and XDR confirmed treatment initiation rate	MDR treatment initiation rate
management	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
Reduced maternal and child mortality rate	Reduce maternal mortality by 5%	Maternal mortality rate
Provision of health infrastructure and	Construction of new clinics	No of clinics constructed
services	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
	Revamping of district hospitals	No of district hospital refurbished
Implementation of National Health	Expansion of 40 consulting rooms to existing clinics	No of additional consulting room completed
insurance	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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
FINANCE												
Clean audit opinion achieved by	Monitor the Integrated Audit	from Auditor- General	AGSA Audit report	Annually	Unqualified Audit Report	Unqualified Audit Report	Unqualified audit report	-	-	-	Unqualified audit report	
2019	Improvement Strategy (IAIS)	Audit Improvement Plan for Financial Performance Review		Quarterly	Qualified Audit	AIP Reviewed, improve- ments recorded	Finance AIP Implemented					
		Audit Improvement Plan for Performance Information Review		Quarterly	Qualified Audit	AIP Reviewed, improvement s recorded	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	•	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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarter	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
ICT												
2.2.2 Percentage of fixed PHC facilities with broadband access	Identification of sites per district Submission of prescribed forms	Percentage of Hospitals with broadband access	Internet rollout report	Quarterly	86.5%	26%	100%	28%	49.4%	74.1%	100%	
	Implementati on,	Numerator			77	6	89 (6New)	25 (INew)	44 (2 new)	66 (2 new)	89 (Inew)	
	commissionin g and monitoring	Denominator			89	23	89	89	89	89	89	
	Identification of sites per district Submission of prescribed	Percentage of PHC with broadband access	Internet rollout report	Quarterly	60.3%	28.5%	100%	91.7%	95%	98%	100%	
	forms Implementation, com-	Numerator			466	686 (220) new)	772 (86 new)	708 (22 new)	730 (22 new)	752 (22 new)	772 (20 new)	
	missioning and monitoring	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	telephone systems	Commissio- ning reports at individual sites Telkom account	Quarterly	New Indicator	44%	100%	56%	73.8%%	88%	100%	
	upgraded	Numerator				74	168	94 (20 new)	124 (30 new)	148 (24 new)	168 (20new)	
		Denominator				168	168	168	168	168	168	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarter	ly Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
HRM												
To facilitate effective human resources planning, development and management in order to	Ensure that all policies are in place and enforce the implementati on thereof		Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	Level 2	Human resources MPAT Level 3	Level 4	-	-	Level 4	-	
improve provision of health services	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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
To facilitate effective human resources planning,	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	
development and management in order to improve provision of health	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	
services	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,	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	
development and management	Conduct Job Evaluation	% of Job Evaluation conducted	Job evaluation report	Quarterly	-	50%	100%	25%	50%	85%	100%	
in order to improve provision of health services	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	Planned	Perfor- mance	Means of verify-	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	indicator	cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
		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 Administrativ e 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					
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	I planners forum hosted	2 planners forum hosted.	-	Provincial planners forum hosted	-	Provincial planners forum hosted	0

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Build and develop capacity in districts for effective and efficient health planning and effective	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 I.3.I)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	Level 3 (MPAT 1.3.1)	
	execution of departmental plans.	Monitoring – Evaluations (MPAT1.3.2)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPATI.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPAT1.3.2)	Level 3 (MPATI.3.2)	
	Build and develop capacity in districts for effective and efficient health planning and effective execution of departmental plans.	Monitoring – Planning of Implementati on Programmes (MPATI.3.3)	Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	Level 3 (MPATI.3.3)	Level 3 (MPATI.3.3)	Level 3 (MPAT1.3.3)	Level 3 (MPATI.3.3)	Level 3 (MPAT1.3.3)	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
		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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
		Ethics (Assessment of policies & systems to ensure professional ethics)	Performance Monitoring and Evaluation (MPAT) Performance	Quarterly	New Indicator	New Indicator	Level 3 (Assessment of policies & systems to ensure professional ethics)					
			Report Department of Performance Monitoring and Evaluation (MPAT) Performance Report	Quarterly	New Indicator	New Indicator	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. I	Level 3 2.5.1	Level 3 2.5. I	Level 3 2.5.1	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
		Risk	Department	Quarterly	New	New	Level 3	Level 3	Level 3	Level 3	Level 3	
		Management	of		Indicator	Indicator	2.6.1	2.6.1	2.6.1	2.6.1	2.6.1	
		2.6.1	Performance									
			Monitoring									
			and									
			Evaluation									
			(MPAT)									
			Performance									
			Report									
		Corporate	Department	Quarterly	New	New	Level 3	Level 3	Level 3	Level 3	Level 3	
		Governance	of		Indicator	Indicator	Corporate	Corporate	Corporate	Corporate	Corporate	
		of ICT. 2.8.1	Performance				Governance	Governance	Governance	Governance	Governance	
			Monitoring				of ICT. 2.8.1	of ICT. 2.8.1	of ICT. 2.8.1	of ICT. 2.8.1	of ICT. 2.8.1	
			and									
			Evaluation									
			(MPAT)									
			Performance									
			Report									

Strategic	Planned	Perfor- mance	Means of verify-	Frequency quarterly/	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	indicator	cation	annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
objective	Customize & Distribute the	Approved 3	Submission letter, Tabling letter	annually Quarterly	APP approved	APP approved	2017/18 Submission of APP 2017/18- 2019/20	Template	Submission of the Ist draft of the 2017/18- 2019/20 APP	Submission of the 2 <sup>nd</sup> draft of the 2017/18- 2019/20 APP	Submission of the Approved 2017/18- 2019/20 annual performance plan	
	Print summarised version of APP & distribute (districts & facilities)											

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Provide managers with the template for of the Operational Plan Consolidate inputs and revise quarterly targets	Approved Iyear Operational Plan	Tabling letter	Annual		OP approved and submitted	Submission	Template cleaning and circulation	Provide programme manager with the template	Development of the Operational Plan	Submission of the Approved 2017/18Oper ational plan	
	districts & do build capacity share	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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Facilitate the	Approved	Submission	Quarterly	2015/16-	16/17-18/19	Approved	-	Ist draft DHP	<sup>2nd</sup> draft	Final 2017/18-	
	review and	2017/18-	letter to		17/18 DHP s	DHP s for	17/18-19/20			2017/18-	2019/20 DHP	
	development	19/20 DHPs	NDOH.		for eight	eight districts	DHP s		NDOH by 30	2019/20 DHP	s developed	
	of District				districts	submitted to	submitted to		August 2017.	s developed	and submitted	
	Health Plans				submitted to	NDOH	NDH			by 30	to NDOH by	
					NDOH					November	30 March	
	Circulate									2017.	2018.	
	2017/18 -											
	19/120											
	Standardized											
	DHP											
	template to											
	all districts.											
	8 capacity											
	building											
	sessions for											
	all districts.											
	Assessment											
	report on											
	APP –DHP											
	alignment											

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Facilitate the review development of district operational plans.	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	-	-	-	Operational plans assessed for alignment to the APP.	
	Operational plans template developed and circulated to districts Ensure alignment to the DHP											
	Support the review of development of Service delivery improvement plan.  Process mapping of key services.	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.	
	Support development of Standard operating procedures.											

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	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 antipoverty 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	I Anti- poverty site report developed	I Anti- poverty site report developed	I Anti- poverty site report developed	I 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	I	I			I		
	Compile Annual report for the department	Annual report submitted	Reports	Annually	2	2	2	I draft report	I final report			
	Facilitate quarterly progress review	Quarterly review meetings held	Minutes of Review meeting	Quarterly	4	4	4	1	I	I	1	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
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		2	2	-		-	I	
	Coordinate the auditing of Pre- determined Objectives and Sector Audit	Auditor General meetings held	Reports	Annually		I	I	-	-	-	I	
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				-	-	-		

Strategic	Planned	Perfor-	Means of verify-	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
Support improvement of Management Systems	Facilitate the MPAT process Ensure all directorates score themselves and meet the deadline Facilitate review and improvement	ECDOH scoring above 3 in the MPAT	Annually	Annually				-		-	-	
	of Moderated scores											
	improvement plan	MPAT improvement plan	Annually	Annually	l	I	ı	-	-	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	I	-	-	-	I	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
effective planning, Monitoring and Evaluation process in order to improve the provision of health services.(DQI)	Health facilities that submitted DHIS, PPIP, ETR, Tier.Net data & ART Cohort data in compliance	Data Flow Policy target	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 (Completenes s as per rationalized 2013 NIDS document & data sets)	% Health Districts that submitted complete DHIS data elements (Completenes s)	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			Budget		
								QI	Q2	Q3	Q4	R'000
	Measure	% Health	Monthly data	Quarterly	71%	95%	100%	100%	100%	100%	100%	
	Health	Facilities that	quality index									
	facilities that	complied with	reports									
	complied with		·									
	absolute	validation										
	validation	rules										
	rules& ETR											
	data clean up											
	per District.											
	Do data											
	quality checks											
	, compile and											
	send feedback											
	Compile Pre-											
	submission											
	data											
	verification											
	report.											

Strategic objective	Planned	Perfor- mance indicator	Means of	- quarterly/		Estimate 2016/17	Annual target 2017/18		Budget			
	Activities		verify- cation					QI	Q2	Q3	Q4	R'000
To implement	Orientation	Functional	Attendance	Quarterly	8	8	8	8	8	8	8	
, maintain	on new	effective use	Register									
and support	developments											
systems and	in DHIS, ETR	information										
programmes	and Tier .Net	systems and										
		programmes										
	Communicati											
	on on new	and 2 Metros										
	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											
l	appropriate											
	Response to											
	data request											
	Give regular											
	feedback to											
	districts and											
	Programmes											

Strategic	Planned Activities	Perfor- mance indicator	Means of verify-cation	Frequency quarterly/ annually	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18		Budget			
objective								QI	Q2	Q3	Q4	R'000
To conduct Performance review of the districts through Quarterly meetings	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		Quarterly	3	4	4					
facilities from DHIS 1.4 to e Register and DHIS 2	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			Budget		
								QI	Q2	Q3	Q4	R'000
	Ensure T2	Number of	Facility Tier	Quarterly	269	119	119	29	30	30	30	
	Phase 0-5	Tier.Net 2	Progress	-								
	attain Phase 6	facilities phase	reports.									
	status	0-5attaining										
	Monitor	phase 6 status										
	sustainability	reduced										
	of T2											
	facilities											
	Ensure											
	eligible TI											
	facilities											
	implement T2											
	Monitor	Number of	Facility Tier	Quarterly	835	856	856	214	214	214	214	
	electronic	Art sites	Progress									
	Tier system	maintained on	reports.									
	(Tier.Net) on	Tier.Net										
	ART sites	systems										
		increased										

Strategic Planned		Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarter	ly Targets		Budget
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
To contribute	Manage and	Approved	Availability of	Annual	Approved	Approved	Approved	-	-	Approved	-	
towards	distribute RFI	Audit	Approved		Strategy	Strategy	Strategy			Strategy		
achievement	to relevant	intervention	Strategy									
of unqualified	facilities	strategy.										
audit opinion	(selected for											
oy 2016	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											

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**

### **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.

### 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.

### 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 communitybased 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 I.I 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	Planned	Perfor- mance	Means of Verifica-	Frequency quarterly/	Baseline	Estimate	Annual target 2017/18	Quarterly rangets				
objective	Activities	indicator	tion	annually	2015/16	2016/17		QI	Q2	Q3	Q4	
Health facilities assessed for compliance with National Core Standards increased to more than 60% by 2019	Implementati on of ICRM according to the approved business plan		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	Planned	Perfor- mance	Means of Verifica-	Frequency quarterly/	Baseline	Estimate	Annual target			Budget R'000		
objective	Activities	indicator	tion	annually	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	
experience of care rate increased to	Orientation of Districts on PEC survey	Patient Experience of Care Survey Rate (PHC)	List of facilities conducted PEC	Annually	66%	45%	70%	-	70%	-	-	
more than 75%	guidelines and	Numerator			509	351	540	-	540			
in health	implement-	Denominator			772	772	772	-	772			
services by 2019	tation	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	Conduct population screening. Identification of vulnerable households.	OHH registration visit coverage - in population	Registration forms	Quarterly	11.8%	8.6%	20%	10%	15%	18%	20%	
2019	To develop and effect the	Numerator			202 500	155 412	361 423	180 711	271 067 (90 356 new)	325 281 (54 214 new)	361 423 (36 142 new)	
and effect the community health plans as per screening outcomes Strengthen intergovernmental collaboration through the integrated service delivery model	Denominator			1 781 501	1 807 114	1 807 114	1 807 114	1 807 114	1 807 114	1 807 114		

Strategic	Planned	Perfor- mance		Frequency quarterly/	Baseline	Estimate	Annual target		Quarter	ly Targets		Budget R'000
objective	Activities	indicator	tion	annually	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	
100% District clinical specialist team (DCSTs) coverage for all Districts by 2019	strengthen the capacity of health professional at PHC level in delivering	Number of Districts with fully fledged District Clinical Specialist Teams (DCSTs)	Appointment Letters of the teams  per district	Annually	??	??	5	-	2	4 (2 new)	5 (I new)	
PHC utilisation rate increased to 3 visits per	Facilitate implementati on of Ideal clinics and national core	PHC utilisation rate	Stats SA, facility register, patient records	Quarterly	2.7	2.8	2.8	2.8	2.8	2.8	2.8	
person per	standards	Numerator			18 207 610	9 313 153	18 635 845	18 635 845	18 635 845	18 635 845	18 635 845	
year in all facilities by 2019	compliance	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	Strengthening implementati on of complaints	Complaints Resolution Rate	Complaints register, redress report	Quarterly	81%	86.6%	85%	85%	85%	85%	85%	
more than 75% in health services by 2019	management policy	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.	Fixed PHC facility supervision rate	DHIS Supervision reports	Quarterly	78%	78%	80%	80%	80%	80%	80%	
	Facilitate	Numerator					618	618	618	618	618	

 $<sup>^1\,\</sup>text{MTT}$  guidelines 2012: (team x1 family physician, x3 nurse specialist, x1 O&G/ Paediatrician )

Strategic	Planned	Perfor- mance	Means of Verifica-	Frequency quarterly/	Baseline	Estimate   ta	Annual target			Budget R'000		
objective	Activities	indicator	tion	annually	2015/16	2016/17	2017/18	QI	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.	% of functional clinic committees	Minutes Reports Attendance registers	Quarterly	60%	60%	70%	20%	40%	60%	70%	
		Numerator					540	154	308	463	540	
	appointment of clinic committees	Denominator					772	772	772	772	772	
Two districts piloting NHI implementati on by 2019	Monitor the implementati on 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	Planned	Perfor- mance	Means of	Frequency quarterly/	Baseline	Estimate	Annual target	Quarterly Targets			Budget R'000	
objective	Activities	indicator	verification	annually	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	
Screening	NCD	Clients 40	Facility	Quarterly	2 876 902	823 046	1 017 000	254 250	254 250	254 250	254 250	
coverage of	quarterly	years and	registers									
chronic	reviews	older										
illnesses		screened for										
increased to	Avail chronic	hypertension										
more than a	diseases	Clients 40	Facility	Quarterly	2 286 342	716 460	1 017 000	254 250	254 250	254 250	254 250	
million by	guidelines and	years and	registers									
2019	IEC material	older										
	and basic	screened for										
	equipment in	diabetes										
	Ideal clinics	Mental	Facility	Quarterly	399 911	165 742	4.5%	4.5%	4.5%	4.5%	4.5%	
		disorders	registers									
	Support	screening										
	training of	rate										
	chronic											
	conditions											
	guidelines											
	(diabetes											

Strategic	Planned	Perfor- mance	Means of	Frequency quarterly/	Baseline	Estimate	Annual target		Quarter	ly Targets		Budget R'000
objective	Activities	indicator	verification	annually	2015/16	2016/17	2017/18	QI	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		Clients treated for mental disorders - new Numerator	Facility registers	Quarterly	0.21%	0.22%	0.23%	0.23%	0.23%	0.23%	0.23%	
2019		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	

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

### 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	Planned	Performanc	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	e indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
100% Compliance with the Waste Management Act by 2019	Delegation of waste officers per hospital  Conduct situational analysis on medical waste management	Percentage of	Waste segregation audit tool, audit report	Quarterly	100%	100%	100%	100%	100%	100%	100%	
	in Hospitals  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	Planned	Performanc	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	e indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Training of	Numerator			120	150	170	50	80	20	170	
	EHPs on hazardous	Denominator			120	150	170	170	170	170	170	
	substances Act.											
	Audit 8	Number of	Reports	Quarterly	4	4	8	8	8	8	8	
	Municipalities	Municipality's										
	rendering	audited.										
	municipal											
	health											
	services											

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

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Facilitate scaling up and implementati on of the HAST District Implementati on Plans (DIP) to achieve 90-	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	
	90-90 targets 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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	data element			_								
	at facility											
	level											
	Conduct											
	support visits											
	to all districts											
	Conduct in-											
	service											
	trainings on											
	TB screening											
	and PHC											
	register											
	Facilitate use	TB client	ETR.Net,	Quarterly	83.7%	84.20%	85%	85%	85%	85%	85%	
	of laboratory	treatment	clinical									
	tracking	success rate	record,									
	system		facility									
	Conduct data		register,									
	mop up in all		patient									
	the districts		records									
	Facilitate	Numerator			18 400	14323	16 560	4140	4140	4140	4140	
	partnership with the	Denominator			21 990	17018	19 483	4 870	4 87 1	4 87 1	4 87 1	
	Eastern Cape AIDS Council											
	(ECAC)											
	community based											
	settings, , in											
	conducting education											
	campaigns on											
	adherence											
	counseling, in									1		

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarte	rly Targets		Budget
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	all the 25			_								
	Sub-districts											
	Facilitate use	TB client lost	Clinical	Quarterly	6.8%	7.30%	5%	5%	5%	5%	5%	
	of laboratory	to follow up	record,									
	tracking	rate	facility									
	system		register,									
	Conduct data		patient									
	mop up in all		records									
	the districts	Numerator			1 500	1250	2 689	672	673	672	672	
	Facilitate				21.000	17010	F2 774	12.444	12.444	12.442	12.442	
	early tracing	Denominator			21 990	17018	53 774	13 444	13 444	13 443	13 443	
	of											
	interrupters,											
	by Involving											
	supporting											
	partners,											
	WBOT,											
	ECAC and											
	community											
	leaders in											
	tracing of											
	interrupters.											
	Conduct	TB death rate	ETR.net,	Annually	5.2%	5.20%	5.5%	-	-	-	5.5%	
	routine		ТВ	<b>,</b>								
	facility based		register,									
	record audits		patient									
	through		records									
	implementati	Numerator			1 140	892	2 958				2 958	
	on of District	Dananiaati			21.000	17010	E2 774				E2 774	1
	Rapid	Denominator			21 990	17018	53 774				53 774	
	Appraisal											
	Tool (DRAT)											
	,											

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

### 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

**OPERATIONAL PLAN** 

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

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarte	rly Targets		Budget
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Coordinate integration of PMTCT services with MCWH, CCMT, TB, and PHC managers at Provincial, District and Sub District	indicator	Oil	amuany			2017/10					
	Monthly tracing of defaulters to ensure that	Immunisation coverage under I year	Facility registers, patient records	Quarterly	86.1%	76.0%	87%	87%	87%	87%	87%	_
	they receive all scheduled Vaccine before Iyear.	Numerator  Denominator			118 192	75 759 99 630	119 475	119 475	137 328	119 475	119 475	
	Engage CBO, Community Leaders & WBOT to	Measles 2nd dose coverage	Facility registers, patient records	Quarterly	81%	86%	87%	87%	87%	87%	87%	
	ensure that	Numerator	1000145		114 371	31 763	123 437	123 437	123 437	123 437	123 437	
	every eligible child receive their second dose within 2year of life.	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	Planned	Perfor-	Means of verification	Frequency	Baseline	Estimate	Annual		Quart	erly Targets		Budget
objective	Activities	mance indicator	on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Hexavalent(Is	Numerator			-15 041	-3 145	643	643	643	643	643	
	t,2nd & 3rd dose) before administering Measles first dose	Denominator			58 483	-25 320	128 697	128 697	128 697	128 697	128 697	
	Intensify Community based IMCI trainings for	Diarrhea case fatality rate	Facility registers, patient records	Quarterly	3.6%	3.30%	3.5%	3.5%	3.5%	3.5%	3.5%	
	WBOT, IYA	Numerator			256	142	246	246	246	246	246	
	and other community structures	Denominator			7 032	4312	7 032	7 032	7 032	7 032	7 032	
	Training of new professional nurses on	Pneumonia case fatality rate	Facility registers, patient records	Quarterly	3.7 %	3%	3.5%	3.5%	3.5%	3.5%	3.5%	
	IMCI to	Numerator			257	139	245	245	245	245	245	
	ensure 60% saturation.	Denominator			7 012	4877	7 012	7 012	7 012	7 012	7 012	
	To intensify community based interventions	Severe acute malnutrition case fatality rate	Facility registers, patient records	Quarterly	10.1%	9.9%	9%	9%	9%	9%	9%	
	for early	Numerator			284	166	254	254	254	254	254	
	identification e.g GMP ,supplementa tion	Denominator			2819	1677	2 819	2 819	2 819	2 819	2 819	
Quintile 1&2 school screened by ntegrated School Health (ISH)	Establish monitoring and evaluation teams that is inclusive of	School Grade I screening coverage	Learner profile form, Attendance register	Quarterly	40 531	29766	39 441	14 794	29 589	36 383	39 441	

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarte	rly Targets		Budget
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
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	Couple year protection rate	Facility registers, patient records	Quarterly	53.6%	55%	65%	65%	65%	65%	65%	
	methods of	Numerator			955 064	891 377	I 157 525	I 157 525	1 157 525	1 157 525	1 157 525	
c n g	contraceptio n and guidelines (this includes doctors)	Denominator			I 780 807	I 620 685	I 780 807	I 780 807	I 780 807	I 780 807	I 780 807	

Strategic	Planned	Perfor-	Means of	Frequency		Estimate	Annual	Quarterly Targets				
objective	Activities	mance indicator	verification on	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	Bu R
Screening coverage of chronic illnesses increased to 90 000 by	Training of professional nurses on taking of Pap smear and Guidelines	Cervical cancer screening coverage 30 years and older	Facility registers, patient records	Quarterly	57.6%	70.1%	65%	65%	65%	65%	65%	
2019	update.	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	
Mortality Reduced to less than 34 per 1000 schopopulation by 2019  Street the imponing on a hear straightful function of the imponing systems of the function of the imponing systems of the imponing	Contracting of nurses to increase the learner and	Human Papilloma Virus Vaccine I <sup>st</sup> dose	Facility registers, patient records	Annually	65 761	47 786	50 972	-	-	-	50 972	-
	school coverage Strengthen the implementati on of the e- health strategy through functionality mobile data capturing system	Human Papilloma Virus Vaccine 2nd dose	Facility registers, patient records	Annually	New Indicator	53 553	57 123	-	•	-	57 123	
	Community do mo	Vitamin A dose 12-59 months coverage	Facility registers, patient records		63.5%	57%	65%	65%	65%	65%	65%	
	e.g WBOT,	Numerator			741 185	164 522	759 266	759 266	759 266	759 266	759 266	
	ISHP	Denominator			1 168 102	1 149 812	1 168 102	1 168 102	1 168 102	1 168 102	1 168 102	

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

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

### 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 I: 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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Budget			
objective	Activities	mance indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
Health facilities assessed for compliance with National Core Standards increased to more than	Facilitate the implementati on 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%	
60% by 2019		Numerator					24	0	17	23	26	
by 2019		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	Facilitate the implementati on of PEC guidelines	2.4.2 Patient Experience of Care Survey Rate	List of facilities that conducted PEC	Annually	80.3%	38%	91%	-	91%	-	-	
services by 2019		Numerator			53	23	60	-	60	-	-	
2019		Denominator			66	60	66	-	66	-	-	
		Patient Experience of Care Satisfaction rate	System generated PEC results	Annually	0%	70%	70%	-	-	70%	-	
80% of hospitals	Strengthen clinical care	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	
meeting national efficiency	best practices	Inpatient Bed Utilisation Rate	Facility register	Quarterly	57.2%	56%	66%	66%	66%	66%	66%	
targets by		Numerator			1 264 514	612 438	1 160 949	1 160 949	1 160 949	1 160 949	1 160 949	

OPERATIONAL PLAN

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarter	ly Targets		Budget
objective	Activities	mance indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
2019		Denominator			2 209 313	I 093 294	1 759 014	1 759 014	1 759 014	1 759 014	1 759 014	
	Monitor cost drivers and ensure implementati on 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 atisfaction rate increased o more than 75% in health	Strengthen the implementati on of complaints	Complaint Resolution rate	Facility complaints registers, redress report	Quarterly	94%	94.2%	90%	90%	90%	90%	90%	
services by 2019	management policy	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

Outcome				Main Adjusted Revised appropri- appropri- estimate ation ation			Med	% change from 2016/17		
R thousand	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

2017/18

OPERATIONAL PLAN

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

R thousand		Outcome		Main appropri- ation	Adjusted appropri- ation	Revised estimate	Med	ium-term estima	ites	% change from 2016/17
K thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	170111 2010/17
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

OPERATIONAL PLAN

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### 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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Budget			
objective	Activities	mance indicator	verify- cation	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
of EMS response time	Deploy human and material resources closer to	EMS PI urban response under 15 minutes rate	Institutional EMS registers	Quarterly	55%	41.2%	70%	70%	70%	70%	70%	
5% by 2019	communities platform	Numerator			17 210	6 480						
,	Measure response times utilizing live tracking	Denominator			31 370	15 710						
	Deploy human and material resources closer to communities	EMS PI rural response under 40 minutes rate	Institutional EMS registers	Quarterly	47.3%	58%	70%	70%	70%	70%	70%	
		Numerator			38 951	28 591						
	Measure response times utilizing live tracking	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

		Outcome		Main appropri- ation	Adjusted appropri- ation	Revised estimate	Medium-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
I. 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

P thousand		Outcome		Main Adjusted appropri- appropri- ation ation		Revised estimate	Medi	% change from		
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	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

**OPERATIONAL PLAN** 

### **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	Planned	ties ance indicator	Means of verification	Frequency of reporting (quarterly / annual)	Baseline	Estimate	Annual target 2017/18	Quarterly targets				Budget
objective Health	Activities				2015/16	2016/17		QI	Q2	Q3	Q4	R'000
Health	Facilitate the	National Core	National core	Quarterly	100%	100%	100%	25%	50%	75%	100%	
facilities	conducting of	Standards self-	Standard									
assessed for	self-	assessment	assessment									
compliance	assessment at	rate	tool									
with National	facility level	Numerator			5	5	5	I	2(I new)	3(I new)	5(2 new)	
Core					-		-	-	-		_	
Standards		Denominator			5	5	5	5	5	5	5	
increased to	Facilitate	Quality	Quality	Quarterly	60%	100%	100%	100%	100%	100%	100%	
more than	development	improvement	Improvement									
60% by 2019	of quality	plan after self-	Plans									
	improvement	assessment										
	plan at facility	rate										

Strategic	Planned	Programme perform-	Means of	Frequency of	Baseline	Estimate	Annual		Quarte	erly targets		Budget
objective	Activities	ance indicator	indicator	reporting (quarterly / annual)	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	level after self-	Numerator			3	4	4	I	2(I new)	3(I new)	4(I new)	
	assessments	Denominator			5	4	4	4	4	4	4	
	& procure for health technology Facilitate conducting of Fire drills	Hospitals compliants with all extreme and vital measures of the national core	National core standard assessment report	Quarterly	0%	75%	75%	-	25%	50%	75%	
	(emergencie)	standards Numerator			0	3	3		I	2(I new)	3(I new)	
	Development of clinical risk							_		, ,	, ,	
	and protocols.	Denominator			5	4	4	-	4	4	4	
Patient satisfaction rate increased		Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	0%	20%	100%	25%	50%	75%	100%	
to more than	and field	Numerator			0	I	5	I	2(I new)	3(I new)	5(2 new)	
75% in health services by 2019	Monitor implementatio n of the tools for CSS	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 performance indicator	Means of verification	of reporting (quarterly / annual)	Baseline 2015/16	Estimate 2016/17	Annual target 2017/18	QI	Quarterl Q2	y targets	Q4	Budget R'000
	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,	Inpatient bed utilisation rate	Facility registers, patient registers	Quarterly	67.8%	66.2%	75%	75%	75%	75%	75%	
	guidelines and procedure	Numerator			404 65 1	266 736	120 874	120 874	120 874	120 874	120 874	
	manuals	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	1150/1000 000	200/ 1000 000	600/ 1000 000	800/ 1000 000	1150/ 1000	

Strategic	Planned	Programme perform-	Means of	Frequency of	Baseline 2015/16	Estimate	Annual			Budget		
objective	Activities	indicator		reporting (quarterly / annual)		2016/17	2017/18	QI	Q2	Q3	Q4	R'000
1.9 80% of hospitals meeting national efficiency targets by 2019	IYM and functionality of Cost Containment Committees	Expenditure per patient day equivalent (PDE)	BAS, facility registers	Quarterly	R1,705	R1,965	R1,937	R1,937	R1,937	R1,937	R1,937	
Patient satisfaction rate increased to more than 75% in health		Complaints resolution rate	Facility complaints registers, redress report	Quarterly	86.5%	92.7%	87%	87%	87%	87%	87%	
services by 2019	system	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		-	

### 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 Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual		Quarter	y targets		Budget
objective Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
Health facilities assessed for compliance with National Core  Conduct inservice training of Quality Assurance managers and	National Core Standards self- assessment rate	National core Standard assessment tool	Quarterly	100%	70%	100%	40%	70%	90%	100%	
Standards Nursing increased to service	Numerator			П	7	10	4	7( 3 new)	9(2 new)	10	
more than 60% by 2019  Managers, on, 7 Nationa 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	Denominator				10	10	10	10	10	10	

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

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
Patient satisfaction rate increased		Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	100%	70%	100%	20%	50%	70%	100%	
to more than 75% in health	surveys by all	Numerator			10	7	10	2	5 ( 3 more)	7(2 more)	10 ( 2 more)	
services by 2019	development of Quality improvement plans for client satisfaction	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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
	patients											
	according to											
	drug resistance											
	patterns.											
	Ensure	Inpatient Bed	Facility	Quarterly	62.2%	70%	71%	71%	71%	71%	71%	
	admission of	Utilisation	registers,	Quarterly	02.276	70%	7 1 70	7176	7170	/ 1/6	7 1 70	
	all MDR	Rate	patient									
	patients on		registers									
	Bed aquiline	Numerator	8		84 026	287426	291532	72 883	72 883	72 883	72 883	
	until culture											
	conversion.	Denominator			135 064	410 609	410 609	102 652	102 653	102 652	102 652	
	Facilitate	Denominator			133 004	410 607	410 607	102 632	102 653	102 632	102 632	
	admission of											
	all patients											
	abusing drugs											
	and alcohol,											
	in order to											
	give them											
	counselling											
	sessions on											
	adherence to treatment											
	Monitor	Expenditure	BAS, facility	Quarterly	R5 737	R1,700	R1,800	R1,800	R1,800	R1,800	R1,800	
	implementatio		registers	Quarterly	13 737	100	1(1,000	11,000	1(1,000	11,000	1(1,000	
	n of Drug	day equivalent										
	Resistance TB											
	policy in	( ' -/										
	prescribing											
	drugs for all											
	the patients											
	with											
	confirmed											
	MDR-TB.			1								

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
Patient satisfaction rate increased to more than 75% in health services by 2019	Complaints	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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
Health facilities assessed for compliance with National Core	Conduct self- assessments	National Core Standards self- assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	100%	-	-	-	
Standards increased to		Numerator			3	3	3	3				
more than		Denominator							-	-	-	
60% by 2019	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	-	

OPERATIONAL PLAN

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
Patient satisfaction rate increased	Conduct Patient Satisfaction	Patient Satisfaction Survey Rate	PSS forms, PSS report	Quarterly	75%	0%	75%	-			75%	
to more than 75% in health	Surveys (PSS)	Numerator			2	0	2	-			2(I new)	
services by		Denominator			3	3	3	-	-	-	3	
2019	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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
	Monitor availability of clinical policies, protocols, guidelines and procedure manuals											
	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	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%	
75% in health ervices by 2019	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

		Outcome		Main appropri- ation	Adjusted appropri-ation	Revised estimate	Medi	ım-term estim	ates	% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
I. 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

D thousand		Outcome		Main appropri- ation	Adjusted appropri- ation	Revised estimate	Medi	um-term estim	nates	% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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	

OPERATIONAL PLAN

#### 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

**OPERATIONAL PLAN** 

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	Planned	Programme perfor-		Frequency of reporting	f reporting Baseline E			Quarterly tar	gets			Budget
objective	Activities	mance indicator				2016/17	2017/18	QI	Q2	Q3	Q4	R'000
Health	Facilitate	National	National core	Quarterly	100%	100%	100%	100%	100%	100%	100%	
facilities	conducting of	Core	Standard									
assessed for	self-	Standards	assessment									
compliance	assessment at	self-	tool									
with National	facility level	assessment										
Core		rate										
Standards	Facilitate	Quality	Quality	Quarterly	100%	100%	100%	100%	100%	100%	100%	
increased to	development	improvement	Improvement									
more than	of quality	plan after self-	Plans									
60% by 2019	improvement	assessment										
	plan at facility	rate										
	level after											
	self-											
	assessments											

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual	Quarterly t	argets			Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Develop specifications and procure for health technology equipment Facilitate conduction of fire drills Develop Clinical Risk Management and protocols	Hospitals compliant with all extreme and vital measures of the national	National core standard assessment report	Quarterly	0%	80%	100%	100%	100%	100%	100%	
	Facilitate Training of	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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual	Quarterly	targets			Budget
objective	Activities	mance indicator	verification		2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
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%	
	Facilitate conducting of outreach and inreach  Monitor availability of clinical policies, protocols, guidelines and procedure manuals	Denominator			198703.4	120 463						

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

#### 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

OPERATIONAL PLAN

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: I Quarterly Activities for Tertiary Hospitals

Strategic objective	Planned Activities	Programme perfor-	_		Baseline 2015/16	Estimate 2016/17	Annual target		Quarterl	y targets		Budget R'000
objective	Activities	indicator	verilication	(quarterly / annual)	2015/10	2010/17	2017/18	QI	Q2	Q3	Q4	K 000
Health facilities assessed for compliance with National Core	Facilitate conducting of self- assessment at facility level	National Core Standards self- assessment rate	National core Standard assessment tool	Quarterly	100%	100%	100%	100%	-	-	-	
Standards increased to more than		Numerator				2	2	2	-	-	-	
60% by 2019		Denominator				2	2	2	-	-	-	
	Facilitate development of quality improvement plan at facility	plan after self-	Quality Improvement Plans	Quarterly	100%	100%	100%	-	100%	-	-	
	level after self- assessments	Numerator Denominator			2	2	2	-	2	-	-	

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget R'000
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	K*000
	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	2	2	-	-	1	-	
Patient satisfaction rate increased to more than 75% in health	Conduct Patient Satisfaction Surveys (PSS)	Denominator Patient Satisfaction Survey Rate	PSS forms, PSS report, patient satisfaction module	Quarterly	0%	0%	100%	50%	100%	-	-	
services by 2019		Numerator			2	2	2	I	2 (I new)	-	-	
2019		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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarte	erly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
	protocols, guidelines and procedure manuals											
	Facilitate recruitment of Health Professionals.	Inpatient bed utilisation rate	Facility registers, patient records	Quarterly	75.6%	76.2%	75%	75%	75%	75%	75%	
	Facilitate conducting of	Numerator			456 638	230 688	725 699	725 699	725 699	725 699	725 699	
	outreach and in reach. Monitor availability of clinical policies, protocols, guidelines and procedure manuals  IYM	Denominator  Expenditure per patient	BAS, expenditure	Quarterly	604 202 R3 412	302 618 R3,386	967599 R3,014	967599 R3,014	967599 R3,014	967599 R3,014	967599 R3,014	
	Monitor functionality of cost containment committees	day equivalent (PDE)	report									
	Facilitate training and implementatio n 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-	Means of	Frequency of reporting	Baseline 2015/16	Estimate 2016/17	Annual target		Quarter	y targets		Budget R'000
objective	Activities	mance indicator	verilication	(quarterly / annual)	2015/16	2010/17	2017/18	QI	Q2	Q3	Q4	K 000
	Facilitate	Complaint	Complaints	Quarterly	10%	100%	90%	90%	90%	90%	90%	
	training and	resolution	registers at									
	implementatio	within 25	facility,									
	n of	working days	redress									
	Complaints	rate	report									
	Management											
	Committee											

#### 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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	ly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
Health facilities assessed for compliance with National Core	Conduct self- assessments	National Core Standards self- assessment rate	National core Standard assessment tool	· /	New Indicator	100%	100%	100%	-	-	-	
Standards increased to more than 60% by 2019	Develop and implement Quality Improvement Plans (QIPs)	Quality improvement plan after self- assessment rate		Quarterly	New Indicator	100%	100%	-	100%	-	-	
	Plans (QIPs)	Percentage of Hospitals compliant with all extreme and vital measures of the national core standards	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	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarte	rly targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
80% of	Facilitate		Facility	Quarterly	New	85%	85%	85%	85%	85%	85%	
hospitals	recruitment	utilisation rate			Indicator							
meeting	of Health		patient									
national	Professionals		records									
efficiency							204 250	204.250	204.250	204.250	204.250	
targets by	Facilitate	Numerator					306 250	306 250	306 250	306 250	306 250	
2019	conducting of	Denominator					360 294	360 294	360 294	360 294	360 294	1
	outreach and	Benominator					300 27 1	300 271	300 27 1	300 271	300 27 1	
	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											
	IYM	Expenditure	BAS,	Quarterly	New	R1, 442	R1, 442	R1, 442	R1, 442	RI, 442	R1, 442	
		per patient	expenditure		Indicator	1, 1.12	1(1, 112	100, 112	111, 112	1,,,,,,,,,	1(1, 112	
		pe. patient	report		Indicacoi							

Strategic	Planned	Programme perfor-	Means of	Frequency of reporting	Baseline	Estimate	Annual target		Quarter	y targets		Budget
objective	Activities	mance indicator	verification	(quarterly / annual)	2015/16	2016/17	2017/18	QI	Q2	Q3	Q4	R'000
	Monitor functionality of cost containment committees	day equivalent (PDE)										
Patient satisfaction rate increased to more than 75% in health	Monthly monitoring of Complaints	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

	Outcome			Main appropri- ation	Adjusted appropriation	Revised estimate	Medium-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
I. 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	Medi	um-term estin	nates	% change from
K thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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

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

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

## RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS AND BUDGETS

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

			Main appropri- ation	Adjusted appropri-ation	Revised estimate	Medium-term estimates				
R thousand	2013/14	2014/15	2015/16	ucion	2016/17		2017/18	2018/19	2019/20	2016/17
I. 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	Medi	um-term estim	nates	% change from
n tilousaliu	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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

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#### 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	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
95% of	Procure	Percentage of	Facility	Quarterly	92.5%	51.6%	85%	25%	50%	60%	85%	
clients eligible	wheelchairs	eligible	register									
for assistive	Issue the	applicants										
devices	wheelchairs	supplied with										
provided with	to eligible	wheelchairs										
wheelchair s,	applicants	Numerator			8 061	I 633	1796	528	I 057	I 268	I 796	
hearing aids,		Denominator			8 715	3 163	2113	2113	2113	2113	2113	
prostheses		Denominator			6713	3 103			2113			
& orthoses	Order the	Percentage of	Facility	Quarterly	173%	105.7%	95%	25%	50%	75%	95%	
by 2019	hearing aid as	eligible	register									
	per	applicants										
	measurement	supplied with										
	Issue and Fit	hearing aids										
	the hearing	Numerator			5 405	I 283	267	70	141	211	267	
	aid to eligible	Denominator			3 130	1 213	281	281	281	281	281	
	applicants	Denominator			3 130	1 213	201	201	201	201	201	ı

OPERATIONAL PLAN

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarte	erly Targets		Budget
objective	Activities	mance indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Design the Prosthesis Fit and Issue the	Percentage of eligible applicants supplied with prostheses	OP Centres reports	Quarterly	73.3%	30.8%	70%	20%	40%	60%	70%	
	prosthesis to	Numerator			9 331	443	787	225	450	674	787	
	eligible applicants	Denominator			12 733	I 440	1 124	I 124	1 124	1 124	1 124	
	Design the orthoses Issue the orthoses to eligible	Percentage of eligible applicants supplied with orthoses	OP Centres reports	Quarterly	168%	100%	95%	60%	80%	95%	95%	
	applicants	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	
20% vailability of essential lrugs in all lealth acilities by	Maintain 3 month buffer stock within the depots Monitor availability of	Percentage of order fulfillment of essential drugs at the depots.	MEDSAS	Quarterly	84%	2%	85%	85%	85%	85%	85%	
019	essential	Numerator			366 124	3 856	489 629	489 629	489 629	489 629	489 629	
	drugs	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

	Outcome			Main appropriati on	Adjusted appropriati on	Revised estimate	Medium-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
I. 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

	Outcome			Main appropriati on	Adjusted appropriati on	Revised estimate	Medilim-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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

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

Strategic	Planned	Perfor-	Means of	Frequency	Baseline	Estimate	Annual		Quarterl	y Targets		Budget
objective	Activities	mance indicator	verification	quarterly/ annually	2015/16	2016/17	target 2017/18	QI	Q2	Q3	Q4	R'000
	Projects Site visit and inspections and month monitoring meetings with Implementing Agents	of health facilities that have undergone minor	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)	Completion Certificate, Invoice, Report Commissioning	Annually	New indicator	9 major	3 major	-		-	3 major	

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

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

NOTES	

### RECONCILING PERFORMANCE TARGETS WITH EXPENDITURE TRENDS

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

		Outcome			Adjusted appropriati on	Revised estimate	Medium-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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

	Outcome			Main appropriati on	Adjusted appropriati on	Revised estimate	Medium-term estimates			% change from
R thousand	2013/14	2014/15	2015/16		2016/17		2017/18	2018/19	2019/20	2016/17
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 I: 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	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 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

2017/18

OPERATIONAL PLAN

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	2.1.4 Audit Improvement Plan for Performance Information Review		The tool is used by the Presidency to monitor compliance by departments with the 4 management practice domains.	report	Method applicable	Not applicable	Indicator Output	Type Categorical	<b>Cycle</b> Quarterly	Yes Yes	Performance	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.		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.		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.		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 I Mbps 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

## I. PROGRAMME 2: DISTRICT HEALTH SERVICES (DHS)

# **SUB PROGRAMME 2.1,2.2 & 2.3: DISTRICT DEVELOPMENT**

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance		Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	
2.3 Health facilities	2.3.22 Ideal clinic status	Fixed clinics, CHCs and	Monitors whether PHC	Ideal Clinic review tools	Numerator: SUM([Ideal	The indicator measures self	Cumulative	Percentage	Quarterly	Yes	Higher	District Health Services and
assessed for	determinations	CDCs where	health	review tools	clinic status	or peer					percentage indicates	Quality
compliance with		Ideal clinic	establishments			assessment, and					greater level of	Assurance
National Core	Perfect	status	are measuring		conducted by	performance is					ideal clinic	Directorates
Standards	Permanent		their level of		PPTICRM])	reliant on					principles	Birectorates
increased to	Team for Ideal		compliance with			accuracy of					principies	
more than 60%	Clinic	by PPTICRM as	standards in		Denominator:	interpretation						
by 2019	Realisation and	a proportion	order to close		SUM([Fixed	of ideal clinic						
'	Maintenance		gaps in		PHC "	data elements						
	(PPTICRM) rate	plus fixed	preparation for		clinics/fixed							
	(fixed	CHCs/CDCs	an external		CHCs/CDCs])							
	clinic/CHC/CD		assessment by									
	C).		the Office of									
			Health									
			Standards									
			Compliance									
2.4 Patient	2.4. Patient	Fixed health	Monitors		Numerator:	Availability of	Quality	Percentage	Measured	Yes	Higher	District Health
experience of	Experience of	facilities that	whether public	Patient	SUM([Facility	the report			quarterly		percentage	Services and
care increased to	Care Survey		health	Experience of	Patient				(conducted		indicates	Quality
more than 75%	Rate	Patient	establishments	Care Survey	Experience of				once annually)		commitment of	Assurance
in health services			are conducting	forms from Clinics and	Care survey						facilities to	Directorates
by 2019		Care Surveys as a proportion of	experience of	DHIS	done])						conduct the	
-,		fixed health	•	מחט	Denominator:						survey	
		facilities	care surveys		SUM([Fixed							
		lacilities			PHC							
					clinics/fixed							
					CHCs/CDCs1							
					+ [public							
					hospitals])							
	2.4.10 Patient	Satisfied	Monitors	DHIS - Patient	Numerator:	Generalizability	Quality	Percentage	Annual	Yes	Higher	District Health
	Experience of	responses as a	patient	Satisfaction	SUM([Patient	depends on the		_			percentage	Services and
	Care	proportion of	satisfaction with	Module	Experience of	number of					indicates better	Quality
	Satisfaction rate	all responses	health services		Care satisfied	users					compliance to	Assurance
		from Patient			responses])	participating in					Batho pele	Directorates
		Experience of			Denominator:	the survey.					principles	
		Care survey			SUM([Patient							
		questionnaires			Experience of							
					Care total							
					responses])							

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
I.1 PHC utilisation rate increased to 3 visits per person per year in all facilities by 2019	I.I.I PHC utilisation rate	Average number of PHC visits per person per year in the population.	Monitors PHC access and utilisation.	DHIS	Numerator: PHC headcount total Denominator: Population total		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	Complaints Resolution Rate	Complaints resolved as a proportion of complaints received	Monitors public health system response to customer concerns	DHIS, complaints register,	Numerator: SUM([Complain t resolved]) Denominator: SUM([Complain t 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([Complain t resolved within 25 working days]) Denominator: SUM([Complain t 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
I.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		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	increasing the number of clients with diabetes detected and referred for	Comprehensive	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
	I.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	Comprehensive Tick Register	\ <u>-</u>	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%	2.5.1	This measure	To track	Waste disposal	Numerator:		Output	%	Quarterly	No	Compliance	GM: PHP
Compliance	Percentage of	health facilities	compliance of	management.	Number of	limitations	•		,		with waste	
with the Waste	health facilities	that dispose	health facilities		health facilities	anticipated					management for	
Management	complying with	waste in line	with SANS		(Hospitals) that						purposes of	
Act by 2019	SANS waste	with SANS	10248		dispose waste						infection	
	disposal	10248	regulation on		in line with						control and	
	requirements	regulation as a	waste		SANS 10248						sustaining a	
		proportion of	management.		regulation at a						healthy	
		the total health			given reporting						environment.	
		facilities.			period.							
					Denominator:							
					Number of							
					facilities							
					(Hospitals)							
					during same							
					time period.							

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

Strategic		Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
I.5 HIV infection rate reduced by 15% by 2019	I.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	/Importance Monitors the total clients remaining on lifelong ART at the month		Numerator: SUM([ART adult remain on ART end of period])+SUM([ART child under 15 years remain on ART end of period])	None None	Type of Indicator  Output	Туре	Cycle  Quarterly	no no	Performance Higher total	Responsibility HIV/AIDS Programme Manager
	I.5.2 TB/HIV co-infected client on ART rate	(TFO)] 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	Indicator	Short	Purpose		Calculation	Data	Type of	Calculation	Reporting	New	Desired	
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
					Denominator: Total number of registered HIV positive TB patients							
I.5 HIV infection rate reduced by I5% by 2019	I.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 retest]) + 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
	I.5.4 Male Condoms Distributed	Male condoms distributed from a primary distribution site to health facilities or points in the community (e.g. campaigns, nontraditional 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 the province	HIV/AIDS Cluster
	I.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

1.6.1 TB cleart restricted by save and older restrement as a proportion of active treatment as a proportion of ALL TB cleart successfully success rate (out off the suppression of a proportion of ALL TB cleart sarred on restrement completed as a proportion of ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement to complete day as a proportion of ALL TB cleart sarred on restrement. This applies to ALL TB cleart sarred on restrement to complete day as a proportion of the referror the clear target of the referror the cost to follow up rate (new off the restrement) as a proportion of the referror the clear target on the restrement of the referror the clear target on the restrement of the restrement of the referror the clear target on the restrement of the referror the clear target on the restrement of the restrement of the referror the clear target on the restrement of the referror the clear target on the restrement of the restre	Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
1.6.1 TB client   TB client   Syears and older start on treatment rate   Syears and older start on treatment for t	Objectives	name	Definition	/Importance	Source		Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
1.6.1 B cleath parts reduced by 5 years and older start on creatment arate   1.6.2 TB client success rate   1.6.2 TB client success rate   1.6.2 TB client success rate   1.6.2 TB client successfully success rate   1.6.2 TB client successfully success rate   1.6.2 TB client sand older test completed and treatment completed as a proportion of ALL TB clients stard on treatment completed as a proportion of ALT TB clients stard on treatment of clients stard on treatment oloss to follow up rate   1.6.3 TB client to flow up rate   1.6.3 TB client start on treatment oloss to follow up rate   1.6.3 TB client to flow up rate   1.6.3 TB client start on treatment oloss to follow up rate   1.6.3 TB client to flow up rate   1.6.3 TB client start on treatment of the retention in loss to follow up rate   1.6.3 TB client to flow up rate   1.6.3 TB client to f			performed			who are							
Lé TB client Trace reduced by 30% in 2019  I.6.2 TB client TB client S years and older start on or treatment a rate  I.6.2 TB client TB client S years and older start on or treatment a rate  I.6.2 TB client TB client S years and older start on or treatment a rate  I.6.2 TB client TB client S years and older start on or treatment a client S years and older start on or treatment a client S years and older start on or treatment a client S years and older tests of the client S years and older tests of the client S years and older start on or treatment to client S years and older start on treatment to client S years and older tests of the client S years and older tests of the client S years and older start on treatment to complete dy as a proportion of ALL TB clients started on treatment (both cured and treatment completed para a proportion of ALL TB clients started on treatment This applies to ALL TB clients started on treatment and treatment cloes to follow up rate  I.6.3 TB Client TB client S wards and older start on treatment and the started on treatment and treatment clients and the started on treatment and treatment clients would started on treatment and trea						circumcised							
1.6.1 TB client   TB client   Syears and older start on treatment a rate method by Syears and older start on of treatment at a proportion of TB symptomatic client Syears and older test positive   TB clients when the proportion of TB symptomatic client Syears and older test positive   TB clients when the proportion of ALT TB clients the otherwise started on treatment. This applies to ALL TB clients (New, Retreatment, Completed outpurate loss to follow up rate   TB clients when the prior of the client service with the prior of the client service with the prior of the retention in the client service with the prior of the retention in the client service with the prior of the retention in the client service with the prior of the retention in the prior of the prior of the prior of the retention in the prior of the retention in the prior of the prior of the clients would started on treatment. This applies to ALL TB clients when the prior of the p						under medical							
Section 2019   Sect						supervision])							
and older start on treatment at rate  In contract the sum of the start of the start of the start of the sum of the start of the sta	I.6 TB death	I.6.1 TB client	TB client 5	Monitors	PHC	Numerator:	- Accuracy	Process/	Rate	Quarterly	No	Screening will	TB Programme
and older start on treatment at rate  Item treatment success rate	rate reduced by	5 years	years and older	trends in early	Comprehensive	SUM([TB client	dependent on	Activity				enable early	Manager
rate a proportion of TB symptomatic client S years and older test positive  1.6.2 TB client treatment success rate completed and reatment completed and reatment and proportion of ALL TB clients started on treatment of the client spapiles to ALL TB clients (Part and pulmonary) and extra (Part and pulmonary) and extra (Part and pulmonary) up rate (Policow a completed up rate on the client would be up rate on the const to follow up rate on the construction of the c	30% in 2019	and older start	start on	identification of	Tick Register	5 years and	quality of data					identification of	
TB symptomatic client 5 years and older test positive  I.6.2 TB client success rate  Treatment success rate  TB client years and older tested positive  Treatment success rate  TB Register;  SUM(TB client successfully completed treatment for treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment of treatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment (New, Retreatment, Other, pulmonary) dimonary and extra  I.6.3 TB Client, loss to follow up rate  TB Register;  Numerator;  Numerator;  Numerator;  SUM(TB client successfully completed treatment)  Denominator  SUM(TB client successfully completed treatment)  TB Register;  Numerator;  SUM(TB client successfully completed treatment)  Denominator  SUM(TB client successfully completed treatment)  TER register;  TB Register;  Numerator;  SUM(TB client successfully completed treatment)  Teatment at least 6 monts, prior  TB Register;  TB Register;  Numerator;  SUM(TB client successfully completed treatment)  Teatment at least 6 monts, prior  TB Register;  TB		on treatment	treatment as	children with		older start on	from reporting					TB suspect in	
symptomatic client 5 years and older test positive positi		rate	a proportion of	TB symptoms		treatment])	facility					health facilities	
client 5 years and older test positive  I.6.2 TB client rearment rearment success rate  I.6.2 TB client 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  I.6.3 TB Client loss to follow up rate  I.6.3 TB Client (New, Retreatment, Other, pulmonary) and extra  I.6.3 TB Client (loss to follow up rate)  I.6.4 TB Client (loss to follow up rate)  I.6.5 TB Client (loss to follow up rate)  I.6.6 TB Client (loss to follow up rate)  I.6.7 TB Client (loss to follow up rate)  I.6.8 TB Client (loss to follow up rate)  II.6.9 TB Client (loss to follow up rate)  III.6.9 TB Client (loss to follow up rate)  I			ТВ	in health care		Denominator:	,						
client 5 years and older test positive  I.6.2 TB client rearment rearment success rate  I.6.2 TB client 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  I.6.3 TB Client loss to follow up rate  I.6.3 TB Client (New, Retreatment, Other, pulmonary) and extra  I.6.3 TB Client (loss to follow up rate)  I.6.4 TB Client (loss to follow up rate)  I.6.5 TB Client (loss to follow up rate)  I.6.6 TB Client (loss to follow up rate)  I.6.7 TB Client (loss to follow up rate)  I.6.8 TB Client (loss to follow up rate)  II.6.9 TB Client (loss to follow up rate)  III.6.9 TB Client (loss to follow up rate)  I			symptomatic	facilities		:SUM([TB							
I.6.2 TB client treatment successfully success rate   TB clients treatment completed of treatment completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary)			client 5 years										
older test positive  I.6.2 TB client treatment treatment success fully success rate  I.6.2 TB clients treatment treatment completed of 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)  I.6.3 TB Client TB Register; Cherch and Started on treatment, other of the discrete feet of the client start on treatment or treatment or treatment or treatment, other one of the client start on treatment or treatment or treatment or treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, other one of the client start on treatment or treatment, or the client start on treatment or the client start on treatment or the cli			and			client 5 years							
The completed completed completed or treatment completed or treatment completed or treatment to make the follow a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary) and extra pulmonary and extra loss to follow up rate   TB Register; TB Register; TB Register; TB Register; SUM([TB client successfully completed or treatment of successfully completed or treatment of the follows a proportion of ALL TB clients should sapplies to ALL TB clients (New, Retreatment, Other, pulmonary) and extra pulmonary and extra or treatment loss to follow up rate   TB Register; TB Register; SUM([TB client successfully completed treatment)   TB Register; SUM([TB client successfully completed treatment or successfully dependent or or treatment or successfully data from reporting facility and treatment or tr			older test										
The clients successfully successfully completed to reatment (both cured and treatment completed) as a proportion of ALL TB clients started on treatment. TB fill client started on treatment. Other, pulmonary and extra up rate (lother to the control of follow up rate (lother to the control of ALL TB clients started on the clients would extra pulmonary and extra on treatment loss to follow up rate (lother to the control of ALL TB clients to the clients would extra pulmonary and extra on treatment loss to follow up rate (lother to the control of the control			positive			tested							
treatment successfully success fall gramment for completed 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 and extra pulmonary and extra pulmonary and extra (or pulmonary) and extra (or pulmonary) are (or follow up rate (or follow up rate (or follow up rate (or follow are one) to follow are (or follow are one) to follow are therefore the (or follow are one) to follow are one of treatment) as a therefore the (or follow are one) to follow are one of treatment are treatment are for the retention in general treatment are treatment).  SUM([TB client successfully completed treatment]) to percentage dreatment) and epidement on quality of data from reporting facility.  Denominator SUM([New smear positive pulmonary TB client start on treatment]) to treatment at least 6 months prior (or follow up rate (o						positive])							
treatment successfully success fall gramment for completed 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 and extra pulmonary and extra pulmonary and extra (or pulmonary) and extra (or pulmonary) are (or follow up rate (or follow up rate (or follow up rate (or follow are one) to follow are (or follow are one) to follow are therefore the (or follow are one) to follow are one of treatment) as a therefore the (or follow are one) to follow are one of treatment are treatment are for the retention in general treatment are treatment).  SUM([TB client successfully completed treatment]) to percentage dreatment) and epidement on quality of data from reporting facility.  Denominator SUM([New smear positive pulmonary TB client start on treatment]) to treatment at least 6 months prior (or follow up rate (o		1.6.2 TB client	TB clients	Monitors	TB Register;	Numerator:	Accuracy	Outcome	Percentage	Quarterly	No	Higher	TB Programme
success rate completed treatment (both cured and 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)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up rate (follow up months or more of treatment)  1.6.3 TB Client TB clients would loss to follow up months or more of treatment at least 6 months or treatment at leas				success of TB	_		,			,		_	Manager
treatment (both cured and treatment completed) as a proportion of ALL TB clients would have been started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)  I.6.3 TB Client loss to follow up rate follows a cohort analysis therefore the first would have been started on treatment at least 6 months prior  I.6.3 TB Client follow up rate follows a cohort analysis therefore the feetiveness of the retention in care strategies. This follows a cohort analysis therefore the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and treatment success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and the success rate.  ITB Register; ETR.Net summerator. SUM([Ts]) and summerator. SUM([Ts])		success rate	,	treatment for		\ <b>L</b>							
(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)  I.6.3 TB Client loss to follow up rate  (In the contract of the retention in (missed two months or more of treatment) as a therefore the solor treatment at least 6 months or more of treatment) as a therefore the solor treatment at least 6 months or more of treatment) as a therefore the solor treatment at least 6 months or more of treatment) as a therefore the solor treatment at least 6 months or more of treatment) as a therefore the solor treatment at least 6 months or more of treatment at least 6 months or least 7 months 10 months							, ,						
and treatment completed) as a proportion of ALL TB clients whole tients would have been started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary) and extra pulmonary)  I.6.3 TB Client loss to follow up rate  I.6.3 TB Client (missed two months or more of treatment) as a whole of the retention in care strategies. This follows a cohort analysis therefore the clients would have been started on treatment at least 6 months prior  I.6.3 TB Client (missed two months or more of treatment) as a therefore the clients would have been started on treatment at least 6 months prior  I.6.3 TB Client (New, Retreatment, Other, pulmonary) and extra pulmonary)  I.6.3 TB Client (New, Retreatment, Other, pulmonary) follow up (missed two months or more of treatment) as a therefore the loss to follow up (missed two months or more of treatment) as a therefore the loss to follow up]  III RB Register;  II B Register;  II B Register;  SUM [TB () client lost to follow up (mup)  Denominator SUM([New smear positive pulmonary TB (client start on treatment))  Accuracy Outcome Percentage Quarterly No Lower levels of interruption reflect improved case holding, which is important for facility is important for facilitating													
completed) as a proportion of ALL TB clients started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary)  I.6.3 TB Client loss to follow up rate  In the complete of the complet							,						
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started on treatment. This applies to ALL TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)  I.6.3 TB Client loss to follow up rate (missed two months or more of treatment) as a cohort analysis therefore the color of the teresten on treatment)  have been started on treatment at least on treatment at least 6 months prior (Accuracy of the treatment) and the treatment of the trea													
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TB clients (New, Retreatment, Other, pulmonary and extra pulmonary)  I.6.3 TB Client loss to follow up rate (missed two months or more of treatment) as a least 6 months prior  I.6.3 TB Client not cohort analysis therefore the loss to follow up rate (streatment) as a least 6 months or the client loss to follow up rate (streatment) as a least 6 months or the prior least 6 months or the pulmonary prior least 6 months or the pulmonary and extra pulmonary)  I.6.3 TB Client rational pulmonary and extra pulmonary pulmonary and extra pulmonary and						a. saas.rej)							
(New, Retreatment, Other, pulmonary and extra pulmonary)  I.6.3 TB Client loss to follow up rate    Interpretation of the pulmonary and extra pulmonary													
Retreatment, Other, pulmonary and extra pulmonary)  I.6.3 TB Client loss to follow up rate    TB clients who are lost to follow up rate   TB clients who are strategies. months or more of treatment) as a therefore the   SUM [TB client   SUM [TB													
Other, pulmonary and extra pulmonary)  I.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 therefore the  TB Register; ETR.Net  TB Register; SUM [TB () client lost to follow up]  Denominator  SUM [TB client sum of cohort analysis therefore the service of the state of the care strategies. SUM [TB client sum of cohort analysis therefore the service of the state of the care strategies. SUM [TB client sum of cohort analysis therefore the service of the state of the care strategies. SUM [TB client sum of cohort analysis therefore the service of the state of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the care strategies of the care strategies. Sum [TB client sum of the care strategies of the ca			1	p									
Dulmonary and extra pulmonary			· · · · · · · · · · · · · · · · · · ·										
Extra pulmonary)   TB Client   TB clients who are lost to follow up rate   TB register; ETR.Net   TB Register; ETR.Net   SUM [TB () client lost to follow up more of cohort analysis treatment) as a   TB Register; ETR.Net   TB Register; ETR.Net   SUM [TB () client lost to follow up (missed two more of treatment) as a   TB Register; ETR.Net   SUM [TB () client lost to follow up (autive of data from reporting facility)   TB Client   TB Register; ETR.Net   TB Register; ETR.Net   SUM [TB () client lost to follow up (autive of data from reporting facility)   TB Client   TB Percentage   Quarterly   No   Lower levels of interruption reflect improved case holding, which is important for facilitating   TB Percentage   Percentage   Quarterly   No   Lower levels of interruption reflect improved case holding, which is important for facilitating   TB Percentage													
Denominator													
I.6.3 TB Client Swho are lost to loss to follow up rate  TB clients who are lost to effectiveness of follow up rate  TB Register;  ETR.Net  TB Register;  SUM [TB () dependent on quality of data from reporting months or more of treatment) as a therefore the  TB Clients who are lost to effectiveness of the retention in care strategies.  TB Register;  SUM [TB () dependent on quality of data from reporting facility  Outcome  Percentage  Outcome  Percentage  Outcome  Percentage  Outcome  Percentage  Outcome  FB Promainator  improved case holding, which is important for facilitating													
loss to follow up rate follow up (missed two months or more of treatment) as a lost to follow up are lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of treatment) as a lost to follow up (missed two more of the retention in client lost to follow up (missed two more of the retention in client lost to follow up (missed two more of the retention in client lost to follow up (missed two more of the retention in client lost to follow up (missed two more) and the retention in client lost to follow up (missed two more) are formed to make the retention in client lost to follow up (missed two more) are formed to make the retention in care strategies.  SUM [TB client lost to follow up (missed two more) are formed to make the retention in care strategies.  SUM [TB client lost to follow up (missed two more) are formed to make the retention in care strategies.  SUM [TB client lost to follow up (missed two more) are formed to more of the retention in care strategies.  SUM [TB client lost to follow up (missed two more) are formed to more of the m		L6.3 TR Client		Monitors the	TB Register	Numerator	Accuracy	Outcome	Percentage	Quarterly	No	Lower levels of	TB Programme
up rate follow up (missed two months or more of treatment) as a therefore the follow up (missed two more of treatment) as a follow up (missed two tare strategies. This follows a cohort analysis therefore the follow up (missed two follow up) (missed two follow up) (plant from reporting facility) (plant from reporting								Catconic	I si contage	Qual terry	1.13		Manager
(missed two months or months or treatment) as a care strategies.  (missed two care strategies.  This follows a cohort analysis therefore the cohort and provided as a cohort analysis therefore the cohort and provided as a cohort analysis therefore the cohort analysis the cohor							'					•	
months or more of cohort analysis treatment) as a months or treatment as a more of treatment as a more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of treatment as a cohort analysis therefore the more of the more of treatment as a cohort analysis therefore the more of t		ap race											
more of cohort analysis treatment) as a therefore the SUM [TB client substitution of the cohort analysis therefore the substitution of the cohort analysis therefore the substitution of the cohort analysis therefore the substitution of the cohort analysis the cohort				_								•	
treatment) as a therefore the SUM [TB client facilitating						·						<u> </u>	
				•		SUM ITR client							
I proportion of I clients would initiated on I successful TR			proportion of	clients would		initiated on						successful TB	

Strategic	Indicator	Short	Purpose	-	Calculation	Data	Type of	Calculation	Reporting	New	Desired	<b>5</b> """
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
		TB clients	have been		treatment]						treatment	
		started on	started on		-							
		treatment. This	treatment at									
		applies to ALL	least 6 months									
		TB clients	prior									
		(New,										
		Retreatment,										
		Other,										
		pulmonary and										
		extra-										
		pulmonary).										
	1.6.4 TB Client	TB clients who	Monitors death	TB Register;	Numerator:	Accuracy	Outcome	Percentage	Annually	Yes	Lower levels of	TB Programme
	death rate	died during	during TB	ETR.Net	SUM([TB client	dependent on					death desired	Manager
		treatment as a	treatment		death during	quality of data						
		proportion of	period. The		treatment])	from reporting						
		TB clients	cause of death			facility						
		started on	may not		Denominator:							
		treatment. This	necessarily be		SUM([TB client							
		applies to ALL	due to TB. This		initiated on							
		TB clients (New,	follows a cohort		treatment])							
		Retreatment,	analysis									
		Other,	therefore the									
		pulmonary and	clients would									
		extra	have been									
		pulmonary)	started on									
			treatment at									
			least 6 months									
			prior									
	I.6.6 TB MDR	TB MDR client	Monitors	TB Register;	Numerator:	Accuracy	Outcome	Percentage	Annually	Yes	Higher	TB Programme
	treatment	successfully		EDR Web	TB MDR client	dependent on					percentage	Manager
	success rate	completing	TB treatment		successfully	quality of data					indicates a	
		treatment as a			complete	submitted					better	
		proportion of			treatment	health facilities					treatment rate	
		TB MDR			Denominator							
		confirmed			SUM([TB MDR							
		clients started			confirmed							
		on treatment			client initiated							
					on treatment])							

## 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
I.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	I.7.I Antenatal Ist 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
I.8 Child Mortality Reduced to less than 34 per I 000 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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	псэропэнынсу
		tested around			Denominator							
		10 weeks			Infant PCR test							
					around 10							
		_			weeks		_	_				
	1.8.2	Percentage	Monitor the	Facility Register	Numerator:	Reliant on	Output	Percentage	Quarterly	No	Higher	EPI Programme
	Immunisation	children under	implementation		SUM([Immunise	under I		Annualised			percentage	manager
	coverage under	I year who	of Extended	Denominator:	d fully under I	population					indicate better	
	I year	completed their	J	Stats SA	year new])	estimates from					immunisation	
	(Annualised)	primary course	Immunisation			Stats SA, and					coverage	
		of immunisation	(EPI)		Denominator	accurate						
		The child			SUM([Female	recording of						
		should only be			under I year])	children under						
		counted ONCE as fully			+ SUM([Male	I year who are fully immunised						
		,			under I year])	at facilities						
		immunised										
		when receiving the last vaccine				(counted only ONCE when						
		in the course				last vaccine is						
		in the course				administered.)						
	1.8.3 Measles	Measles 2nd	Monitors	Facility Register	Numerator:	Accuracy	Output	Percentage	Quarterly	No	Higher	EPI
	2nd dose	dose coverage	protection of	racinty register	SUM([Measles	dependent on	Output	rercentage	Quarterly	110	coverage rate	LII
	coverage	dose coverage	children against	Denominator:	2nd dose])	quality of data					indicate greater	
	(annualised)		measles.	Stats SA	ziid dosej)	submitted					protection	
	(allitualiseu)		Because the 1st	Julis JA	Denominator:	health facilities					against measles	
			measles dose is		SUM([Female I	ileartii iaciities					against measies	
			only around		year]) +							
			85% effective		SUM([Male I							
			the 2nd dose is		year])							
			important as a		/ ca. ]/							
			booster.									
			Vaccines given									
			as part of mass									
			vaccination									
			campaigns									
			should not be									
			counted here									
	I.8.4 DTaP-	DTaP-IPV/	Monitors	Facility Register	Numerator:	Accuracy	Outcome	Percentage	Quarterly	No	Lower dropout	EPI
	IPV/Hib 3 -	Heb3 to	children who		SUM([DTaP-	dependent on					rate indicates	
	Measles 1st	Measles I st	drop out of the		IPV/Hib 3rd	quality of data					better vaccine	
	dose drop-out	dose drop-out	vaccination		dose]) -	submitted					coverage	
	rate		program after		SUM([Measles	health facilities						
			14 week		1st dose under							
			vaccination.		I year]) =							

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	<b>J</b> our cc	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	пезропзівшеў
					DTaP-IPV-Hib- HBV 3 to							
					Measles 1st							
					dose drop-out							
					dose di op-out							
					Denominator:							
					SUM(DTaP-							
					IPV-Hib-HBV							
					3rd dose])							
	1.8.5 Diarrhea	Diarrhea deaths	Monitors	ART Register	Numerator:	Reliant on	Impact	Percentage	Quarterly	No	Lower children	MNCWH
	case fatality	in children	treatment		SUM [Child	accuracy of					mortality rate is	Programme
	under 5 years	under 5 years	outcome for		under 5 years	diagnosis /					desired	manager
	rate	as a proportion	children under		with diarrhea	cause of death						
		of diarrhea	5 years who		death]	Accuracy						
		separations	were separated			dependent on						
		under 5 years in health	with diarrhea		Denominator:	quality of data submitted						
		facilities			SUM [Child under 5 years	health facilities						
		lacilities			with Diarrhea	Health lacilities						
					admitted]							
	1.8.6	Pneumonia	Monitors	Ward Register	Numerator:	Accuracy	Impact	Percentage	Quarterly	Yes	Lower children	MNCWH
	Pneumonia case	deaths in	treatment	Traine Register	SUM [Child	dependent on	Impace	T cr cerrage	Qual certy	1.03	mortality rate is	Programme
	fatality under 5	children under	outcome for		under 5 years	quality of data					desired	manager
	years rate	5 years as a	children under		with pneumonia	submitted						
		proportion of	5 years who		death]	health facilities						
		pneumonia	were separated									
		separations	with pneumonia		Denominator:							
		under 5 years			SUM [Child							
		in health			under 5 years							
		facilities			with pneumonia							
	1076-	C	Manitan	\\\\\d_{}\d_{}	admitted]	A	lana a sa	Damana	Oursets 1	V	1 121	MNICVA/LL
	1.8.7 Severe	Severe acute	Monitors	Ward register	Numerator:	Accuracy	Impact	Percentage	Quarterly	Yes	Lower children	MNCWH
	acute malnutrition	malnutrition deaths in	treatment outcome for		SUM [Child under 5 years	dependent on quality of data					mortality rate is desired	Programme manager
	case fatality	children under	children under		severe acute	submitted					desil ed	manager
	under 5 years	5 years as a	5 years who		malnutrition	health facilities						
	rate	proportion of	were separated		deaths]	incardi iacilides						
		severe acute	with Severe		Denominator:							
		malnutrition	acute		SUM [Children							
		(SAM) under 5	malnutrition		under 5 years							
		years in health	(SAM)		severe acute							
		facilities			malnutrition							
					admitted]							

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	•
3.4 40% of Quintile 1&2 school screened by Integrated School Health (ISH) Teams in 2019	3.4.2 School Grade I learners screened	Proportion of Grade I 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 I - 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
I.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
	I.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([Medrox yprogesterone injection]) / 4) + (SUM ([Norethistero ne 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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition pill cycles / 13)	/Importance	304.00	Method (SUM([Sterilisat	Limitations	Indicator	Туре	Cycle	Indicator	Performance	порелошне
		+			ion - male]) *							
		(Medroxyproge			10) +							
		sterone			(SUM([Sterilisat							
		injection / 4) + (Norethisteron			ion - female]) * 10) +							
		e enanthate			(SUM([Female							
		injection / 6) +			condoms							
		(IUCD x 4) +			distributed]) /							
		(SUM Female			120) +							
		condoms distributed/200)			(SUM([Sub-							
		+ (SUM Male			dermal implant inserted]) * 2.5)							
		condoms			[[]] 2.5)							
		distributed /			Denominator:							
		200) + (Male			SUM {[Female							
		sterilization x			15-44 years]} +							
		20) + (Female sterilization x			SUM{[Female 45-49 years]}							
		10)			TJ-T7 years];							
1.2 Screening	1.2.4 Cervical	Cervical	Monitors	Facility Register	Numerator:	Reliant on	Output	Percentage	Quarterly	No	Higher	MNCWH
coverage of	cancer	smears in	implementation		SUM([Cervical	population					percentage	Programme
chronic	screening	women 30	of policy on	Stats SA	cancer	estimates from					indicate better	Manager
illnesses increased to	coverage 20 years and older	years and older as a proportion	cervical screening		screening 30 years and	Stats SA, and Accuracy					cervical cancer coverage	
more than a	years and order	of 10% of the	Sci ceiling		older])	dependent on					coverage	
million by 2019		female			<b>1</b> /	quality of data						
		population 30			Denominator:	submitted						
		years and older.			(SUM([Female	health facilities						
					30-34 years]) + SUM([Female							
					35-39 years]) +							
					SUM([Female							
					40-44 years]) +							
					SUM([Female							
					45 years and							
					older])) / 10							
1.8 Child	1.8.10 Human	Girls 9 years	This indicator	HPV Campaign	SUM([Agg_Girl	None	Output	Number	Annually	No	Higher	MNCWH
Mortality	Papilloma Virus	and older that	will provide	Register –	09 yrs HPV 1st						percentage	Programme
Reduced to less	Vaccine 1st	received HPV	overall yearly	captured	<u>dose]) +</u>						indicate better	Manager
than 34 per 1000	dose coverage	1st dose	coverage value	electronically	SUM([Agg_Girl						coverage	
1000			which will	on HPV system	10 yrs HPV 1st							

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 lst dose]) + SUM([Agg_Girl 12 yrs HPV lst dose]) + SUM([Agg_Girl 13 yrs HPV lst dose]) + SUM([Agg_Girl 14 yrs HPV lst dose]) + SUM([Agg_Girl 15 yrs and older HPV lst dose])							
	1.8.11 Human Papilloma Virus Vaccine 2 <sup>nd</sup> 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	Register – captured electronically	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 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	Indicator	Short	Purpose	S	Calculation	Data	Type of	Calculation	Reporting	New	Desired	D
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
	I.8.8 Vitamin A dose I2-59 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 supplementatio n to children aged 12-59 months. The denominator is multiplied by 2 because each child should receive supplementatio	DHIS, facility registers, patient records	Numerator: Vitamin A dose		Output	Percentage	Quarterly	No	Higher proportion of children 12-29 months who received Vit. A will increase health	MNCWH Programme Manager
	I.8.12 Infant exclusively breastfed at HepB 3rd dose rate	Percentage of Infants exclusively breastfed at HepB 3rd dose rate	n twice a year  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
I.7 Maternal Mortality Ratio Reduced to less than 100 per 100 000 population by 2019	I.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										
I.8 Child Mortality Reduced to less than 34 per 1000 population by 2019	I.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	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 –	1.9.1	Measures	Tracks the	Death register	Numerator:	Depended on	Output	%	Quarterly	No	Improved and	GM: PHP
mortems	Percentage of	number of	turn-around		Number of cold	accuracy of					short turn-	
conducted	post-mortem	post-mortems	time for Post		bodies with	Forensic					around times	
within 72hrs	performed	performed by	Mortems.		post-mortem	Pathology					for post	
increased to	within 72 hours	Forensic			performed	services data					mortems.	
95% by 2019		<b>Pathologists</b>			within 72 hrs.	base.						
		within a period			of receipt of							
		of 3 days of			body							
		receiving the			Denominator:							
		body from the			Total number							
		SAPS as a			of cold bodies							
		percentage of			received from							
		the total			SAPS							
		number of			(expressed as							
		bodies received			percentage)							

2017/18

OPERATIONAL PLAN

## 2.10 SUB – PROGRAMME DISTRICT HOSPITALS

Strategic	Indicator	Short	Purpose	S	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Door oneihilite
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	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	annual National Core Standards	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 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	Indicator	Short	Purpose	Saures	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Bosnowsibilit
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	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.		DHIS, facility register & Admission	Numerator Inpatient days + I/2 Day	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	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	quality of care  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
	I 10.12 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	Track the expenditure per PDE in Hospitals in the province	Medical Scheme data, DHIS, facility registers,		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 I, 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										
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 PI urban response under 15 minutes rate	Proportion PI calls in urban locations with response times under 15 minutes	the norm for critically ill or	DHIS, institutional EMS registers OR DHIS, patient and vehicle report.	Numerator: EMS PI urban response under 15 minutes Denominator: EMS PI urban calls	Cumulative	Input	Rate per 10 000 population	Quarterly	No	Higher number of rostered ambulances may lead to faster response time.	EMS Manager
	3.6.2 EMS PI rural response under 40 minutes rate	Proportion PI calls in rural locations with response times under 40 minutes	compliance with	DHIS, institutional EMS registers Patient and vehicle report.	Numerator: EMS PI rural response under 40 minutes Denominator: EMS PI rural calls	Accuracy dependent on quality of data from reporting EMS station	Output	Percentage	Quarterly	No	Higher percentage indicate better response times in the rural areas	EMS Manager
	3.6.3 EMS interfacility transfer rate	Inter-facility (from one inpatient facility to another inpatient facility) transfers as proportion of total EMS patients transported	ambulances for inter-facility	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	establishments are conducting	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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance		Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	
	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
I.10 80% of Hospitals meeting national efficiency targets by 2019	I.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 + I/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
	I.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 + I/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	Indicator	Short	Purpose		Calculation	Data	Type of	Calculation	Reporting	New	Desired	
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
I.3 NCD coverage increased to I300/I000 000 through management of c hronic illnes	I.3.1 Cataract surgery rate	Clients who had cataract surgery per I 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 I Million	Quarterly	No	Higher levels reflect a good contribution to sight restoration, especially amongst the elderly population.	GM: Hospital Services
I.10 80% of Hospitals meeting national efficiency targets by 2019	I.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 I, 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	expenditure per PDE in district Hospitals in the province	BAS, Stats SA, Council for Medical Scheme data, DHIS, facility registers, patient records Admission, expenditure	district	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	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	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		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	Indicator	Short	Purpose	6	Calculation	Data	Type of	Calculation	Reporting	New	Desired	D
Objectives	name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
1.10 80% of Hospitals meeting national efficiency targets by 2019	I.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	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	DHIS, facility register & Admission	Numerator Sum ([Inpatient days total x 1])+([Day patient total x 0.5])  Denominator SUM([inpatient deathstotal])+([inpatient dischargestotal])+([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	specialties Inpatient bed days used as proportion of maximum Inpatient bed days (inpatient beds x days in period) available. Include all specialties	Inpatient beds Monitors effectiveness and efficiency of inpatient management	register	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
	I.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/Emergenc y 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	·	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 I, 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										
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	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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	Jource	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	
<b>2.3:</b> Health	2.3.4 Hospital	Hospitals that	Monitors		Numerator:	Reliability of	Quality	Percentage	Quarterly	No	Higher	Quality
facilities assessed	achieved 75%	achieved a	whether public	DHIS - NCS	Number of	data provided					assessment	assurance
for compliance	and more on	performance of	hospitals	Reports	Hospitals that						indicates	
with National	National Core	75% or more	establishments		conducted						commitment of	
Core Standards	Standards self -	on National	are measuring		National Core						facilities to	
increased to more	assessment rate	Core Standards	their own level		Standards self-						comply with	
than 60% by 2019		self -assessment	of compliance		assessment to						NCS	
			with standards		date in the							
			in order to		current financial							
			close gaps in		year							
			preparation for									
			an external		Denominator:							
			assessment by		Total number							
			the Office of		of Hospitals							
			Health									
			Standards									
			Compliance									
	2.3.18	Percentage of s	Monitors	NCS self-	Numerator:	None	Outcome	Percentage	Quarterly	No	Higher number	Quality
	Percentage of	health facilities	quality in health	assessment	Total number				•		indicates	Assurance
	health facilities	compliant to all	facilities	report,	of Hospitals						greater number	
	compliant with	Extreme and		•	that are						of facilities	
	all extreme and	vital Measures			compliant to all						compliant to all	
	vital measures	of National			extreme						extreme and	
	of the national	Core Standards			measures and at						vital measures	
	core standards				least 90% of						of National	
					vital measures						Core Standards	
					of national core							
					standards							
					Denominator:							
					Number of							
					Hospitals that							
					conducted							
					National Core							
					Standards self-							
					assessment to							
1					date in the							
					current financial							
					year							

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives  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	Definition 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	Method Numerator: SUM([Facility Patient Experience of Care survey done])  Denominator: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	Total number of Hospitals	Indicator Output	Type %	<b>Cycle</b> Quarterly	Indicator No	Performance 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
	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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	Jource	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
2.3 Health	2.3.5 Hospital	Hospitals that	Monitors	DHIS - National	Numerator:	Reliability of	Quality	Percentage	Quarterly	No	Higher	Quality
facilities assessed	achieved 75%	achieved a	whether public	Core Standard	Number of	data provided					assessment	assurance
for compliance	and more on	performance of	hospitals	review tools	Hospitals that						indicates	
with National	National Core	75% or more	establishments		conducted						commitment of	
Core Standards	Standards self -	on National	are measuring		National Core						facilities to	
increased to more	assessment rate	Core Standards	their own level		Standards self-						comply with	
than 60% by 2019		self -assessment	of compliance		assessment to						NCS	
			with standards		date in the							
			in order to		current financial							
			close gaps in		year							
			preparation for									
			an external		Denominator:							
			assessment by		Total number							
			the Office of		of Hospitals							
			Health									
			Standards									
			Compliance									
2.4 Patient	2.4. Patient	Fixed health	Monitors		Numerator:	Total number	Output	%	Quarterly	No	Higher	GM: DHS
Experience of	Experience of	facilities that	whether public	Patient	SUM([Facility	of Hospitals					percentage	
Care increased to	Care Survey	have conducted	health	Experience of	Patient						indicates better	
more than 75% in	Rate	Patient	establishments	Care Survey	Experience of						levels of	
health services by		Experience of	are conducting	forms from	Care survey						satisfaction in	
2019		Care Surveys as	patient	Clinics	done])						district.	
		a proportion of	experience of									
		fixed health	care surveys		Denominator:							
		facilities			SUM([Fixed							
					PHC							
					clinics/fixed							
					CHCs/CDCs]							
					+ [public							
					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
	2.4.15 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	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	I.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	1	in the current financial year  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	Patient days	Track the	DHIS, facility	Numerator:	Accurate	Efficiency	Percentage	Quarterly	No	Higher bed	District Health
	Inpatient Bed	during the	over/under	register	Inpatient days +	reporting sum					utilisation	Services
	Utilisation Rate	reporting	utilisation of	Admission	I/2 Day	of daily usable					indicates	
		period,	central Hospital		patients	beds					efficient use of	
		expressed as a	beds								bed utilisation	
		percentage of			Denominator:						and/or higher	
		the sum of the			Inpatient bed						burden of	
		daily number of			days (Inpatient						disease and/or	
		usable beds.			beds * 30.42)						better service	
					available						levels. Lower	
					a vanas is						bed utilization	
											rate indicates	
											inefficient	
											utilization of	
											the facility	
	1.10.16	Expenditure per	Tuesdothe	BAS, Stats SA,	Numerator:	Accurate	Efficiency	Number (Rand)	Ougustaulu	No		District Health
							Efficiency	Number (Kand)	Quarterly	INO	Lower rate	
	Expenditure per		expenditure per		Total	reporting sum					indicating	Services.
	patient day	which is a	PDE in district	Medical Scheme	•	of daily usable					efficient use of	
	equivalent	weighted	Hospitals in the	data, DHIS,	district	beds					financial	
	(PDE)	combination of	province	facility registers,	Hospitals						resources.	
		inpatient days,		patient records								
		day patient		Admission,	Denominator:							
		days, and		expenditure	Patient Day							
		OPD/Emergenc			Equivalent							
		y total			(PDE) as							
		headcount, with			defined above							
		inpatient days										
		multiplied by a										
		factor of I, day										
		patient										
		multiplied by a										
		factor of 0.5										
		and										
		OPD/Emergenc										
		y total										
		headcount										
		multiplied by a										
		factor of 0.33.										
		All Hospital										

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										
•	2.4.24 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**

Subjectives in a condition of the propertion of	Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
A Patient Experience of Care Surveys to more of bar services by 2019  2.4 Patient Experience of Care Surveys a reportion of Sarifscrion Rate  2.4.16 Patient Experience of Care Surveys a reportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys as a Rate  2.4.16 Patient Experience of Care Survey				•									•
assessed for compliance compliance with National Core Standards self- core Standards self- steel or Standards self- steel or session that self- assessment are assessment are assessment as their own level by 2019  24 Patient Experience of Care functased to more than 75% in health services by 2019  24.16 Patient Experience of Care Standards self- assessment or the Care functased to more than 75% in health facilities  24.16 Patient Experience of Care Standards self- assessment or the Care surveys  24.16 Patient Experience of Care Standards self- services by 2019  24.16 Patient Experience of Care functased to more than 75% in health facilities  24.16 Patient Experience of Care Surveys as a proportion of Satisfaction all responses for making the conducted of the services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional service of Care Surveys and Surveys as a functional services by 2019  24.16 Patient Experience of Care Surveys as a functional service of Care Surveys as								Quality	Percentage	Quarterly	No	_	-
Complance with National Core with National Core with National Core Standards self- assessment rate with National assessment rate with National assessment rate with National Core Standards self- with National Core of complance with National Core Standards self- assessment by National Core Standards self- with National Core Standards self- with National Core Standards self- assessment to date in the cyrent final core of public Height Height Core Incomplance National Core Standards self- assessment to date in the cyrent final core of public Height Height Core Incomplance National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards self- assessment to date in the cyrent final core of public Height Height National Core Standards to the cyrent final core of public Height Height National Cor				•			data provided						assurance
Sandards self- core Standards sincreased to more than 60% by 2019  2.4 Patient Experience of Care surveys 2.16 Patient Experience of Care Surveys as a proportion of fixed health facilities  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys a seasonment by Mumerator: SUM([Fixed pelath facilities  Denominator: Sumatoria  Denominator: SUM([Fixed pelath facilities  Denominator: Sumatoria  Denominato			1 .	•	review tools	•							
Core Standards increased to more than 60% by 2019  2.4.7 Patient Experience of Care increased to more than 61% health facilities  2.4.1 6 Patient Experience of Care surveys 2019  2.4.1 6 Patient Experience of Care assessment on the Experience of Care surveys 2019  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.1 6 Patient Experience of Care increased to more than 62% health facilities  2.4.2 6 Patient Experience of Care increased to more than 62% health facilities  2.4.3 6 Patient Experience of Care increased to more than 62% health facilities													
self - assessment with standards by 2019  2.4.7 Patient Experience of Care increased to more than 6% by 2019  2.4.16 Patient Experience of Care surveys 2019  2.4.16 Patient Experience of Care surveys 2019  2.4.16 Patient Experience of Care increased to more than 6% facilities  2.4.16 Patient Experience of Care surveys 2019  2.4.16 Patient Experience of Care survey													
assessment with standards in order to close gaps in preparation for an external assessment by the Office of Health Compliance  2.4.7 Patient Experience of Care Surveys and a proportion of fixed health facilities  2.4.16 Patient Experience of Care surveys 2019  2.4.16 Patient Experience of Care surveys 2019  2.4.16 Patient Experience of Care for Survey and a proportion of Satisfaction Rate Compliance  2.4.17 Patient Experience of Care Survey as a proportion of Satisfaction and Satisfaction with Hospital services by Care Survey should be survey.  3.2.4.16 Patient Experience of Care Surveys and Satisfaction Satisfaction and Satisfaction and Satisfaction and Satisfaction and Satisfaction and Satisfaction statisfaction with Hospital Services by Care Survey should be survey.  3.2.4.16 Patient Experience of Care Surveys (Satisfaction Satisfaction Satisfaction with Hospital Services Survey) (Satisfaction Survey) (S		assessment rate											
by 2019    Separation   Care Survey as a proportion of a proportion of fixed health services by 2019    2.4 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of fixed health facilities    2.4.1 Patient Experience of Care Survey as a proportion of a proportion of a proportion of all responses as			-									NCS	
close gaps in preparation for an external assessment by the Office of Health Standards Compliance  2.4. Patient Experience of Care increased to more than 75 % in health services by 2019  2.4. Patient Experience of Care survey and a proportion of fixed health facilities  2.4. Patient Experience of Care survey and a proportion of fixed health facilities  2.4. Patient Experience of Care survey and conducting care surveys and a proportion of fixed health facilities  2.4. 16 Patient Experience of Care survey and care surveys facilities  2.4. 16 Patient Experience of Care survey and care surveys facilities  2.4. 16 Patient Experience of Care surveys facilities  2.4. 16 Patient Experience of Care survey facilities  2.4. 16 Patient Experience of Care survey facilities  2.4. 16 Patient Experience of Care surveys facilities  2.4. 16 Patient Facilities  2.			assessment										
Persparation for an external assessment by the Office of Health Standards Compliance  2.4. Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Care Surveys as a proportion of Rixed health facilities  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Care surveys as a proportion of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Care surveys as a proportion of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion o	by 2019					current financial							
a nexternal assessment by the Office of Health Standards Compliance  2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Care survey factor in facilities  2.4.16 Patient Experience of Care survey forms from				close gaps in		year							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Gaze Survey and indicates better levels of Gaze from Patient Experience of Care surveys as a proportion of fixed health facilities  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction all responses as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care surveys Satisfaction with Health services from Patient Experience of Care survey Satisfaction with health services from Patient Experience of Care survey Satisfaction with Health services from Patient Experience of Care survey Satisfaction with Health services from Patient Experience of Care survey Satisfaction with Health services from Patient Experience of Care survey Satisfaction with Health services from Patient Experience of Care survey Satisfaction with Hospital Services. Services Services Services Services Services.				•									
the Office of Health Standards Compliance  2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Gare Survey and Services by 2019  2.4.16 Patient Experience of Gare increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Gare Survey and Services by 2019  2.4.16 Patient Experience of Gare Survey and Services by 2019  2.4.16 Patient Experience of Care Survey and Services from Patient Experience of Care Survey and Satisfaction of Satisfaction all responses as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.16 Patient Experience of Care Survey and Satisfaction with Hospital survey.  2.4.						Denominator:							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Care Survey and proportion of Satisfaction in Experience of Care Survey and the services by 2019  2.4.16 Patient Experience of Care Survey and the services of Care Survey and the service of Care Survey a				,									
2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.16 Patient Experience of Care Rate  2.4.16 Patient Experience of Care Rate  2.4.16 Patient Experience of Care Rate  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction Rate  2.4.16 Patient Experience of Care Surveys Availability of Care Survey done]  Availability of Care Survey done]  Availability of the report						of public							
2.4.7 Patient Experience of Care increased to more than 57% in health services by 2019  2.4.16 Patient Experience of Care Survey as a proportion of fixed health facilities  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction in Responses as a Care Care Satisfaction Rate from Patient Experience of Care Surveys Satisfaction of S						Hospitals							
2.4 Patient Experience of Care increased to more than 75% in health services by 2019  2.4.1 Patient Experience of Care Survey 2019  2.4.1 Patient Experience of				Standards									
Experience of Care increased to more than 15% in health services by 2019  Experience of Care increased to more than 25% in health services by 2019  Experience of Care Survey Rate  Experience of Care Survey Rate  Experience of Care Survey Sail patient Experience of fixed health facilities  Experience of Care Surveys as a proportion of fixed health facilities  Experience of Care Surveys as a proportion of fixed health facilities  Experience of Care Surveys as a patient experience of Care Surveys as a proportion of fixed health facilities  Experience of Care Survey Sail patient experience of Care Surveys Sailsfaction in district.  Experience of Care Survey Sails Action in Experience of Care Survey Sails Action all responses as a Care or Poportion of Satisfaction all responses Rate  Experience of Care Survey Sails Action Satisfaction Satisfaction Satisfaction all responses from Patient Experience of Care Survey Sails Action Satisfaction Satisfa				Compliance									
Care increased to more than 75% in health 57% in health 57	2.4 Patient	2.4.7 Patient	Fixed health	Monitors	Patient	Numerator:	Availability of	Output	%	Quarterly	No	Higher	GM: DHS
Rate Patient Experience of Care Surveys as a proportion of fixed health facilities  2.4.16 Patient Experience of Care Surveys as a proportion of Satisfaction attemption Patient Experience of Care Surveys  2.4.16 Patient Experience of Care Surveys  Annually  Annually  No Higher percentage indicates better levels of satisfaction with Hospital services.  No Summerator. SUM([Fixed PHC clinics/fixed CHCs/CDC3+ public hospitals])  No Superience of Care Surveys  Annually  No Higher percentage indicates better levels of satisfaction with Hospital services.	Experience of	Experience of	facilities that	whether public	Experience of	SUM([Facility	the report					percentage	
Experience of Care Surveys as a proportion of fixed health facilities  2.4.16 Patient Experience of Care Surveys as a patient experience of fixed health facilities  2.4.16 Patient Experience of Care Surveys as as a proportion of Satisfaction all responses Rate from Patient Experience of Care surveys    Satisfaction   Clinics   Care survey done]   Care survey done]   Clinics   Care survey done]   Care survey done]   Care survey done]   Clinics   Care survey done]   Care survey done]   Clinics   Care survey done]   Care survey done done done done done done done done	Care increased	Care Survey	have conducted	health	Care Survey	Patient						indicates better	
Services by 2019  Care Surveys as a proportion of fixed health facilities  Care Surveys as a proportion of fixed health facilities  Denominator: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  2.4.16 Patient Experience of Care proportion of Satisfaction Rate  Annually  No Higher percentage indicates better levels of satisfaction with health services  From Patient Experience of Care survey  Care Surveys as a patient experience of Care surveys  Denominator: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Satisfaction Surveys  Satisfaction with health services  Annually  No Higher percentage indicates better levels of satisfaction with Hospital services.	to more than	Rate	Patient	establishments	forms from	Experience of						levels of	
a proportion of fixed health facilities    Annually   No   Higher percentage indicates better levels of Satisfaction Rate   Satisfaction Rate   Satisfaction Rate   Satisfect of Care survey   Satisfaction Rate   Satisfect of Care survey   Satisfaction   Satisfac	75% in health		Experience of	are conducting	Clinics	Care survey						satisfaction in	
fixed health facilities    Denominator: SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])	services by		Care Surveys as	patient		done])						district.	
facilities  facilities  SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  2.4.16 Patient Experience of Care satisfaction Rate  Finom Patient Experience of Care survey  Substitute of Care survey  SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Numerator: SUM([Patient Experience of Care satisfied responses])  Monitors patient Satisfaction With health services  SUM([Patient Experience of Care satisfied responses])	2019		a proportion of	experience of									
facilities  facilities  SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  2.4.16 Patient Experience of Care satisfaction Rate  Find Patient Experience of Care survey  Substitute of Care survey  SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Numerator: SUM([Patient Experience of Care satisfied responses])  SUM([Fixed PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Numerator: SUM([Patient Experience of Care satisfied responses])  Substitute of Care satisfied responses as a proportion of satisfaction with health services  Find Patient Substitute of Care satisfied responses])  SUM([Patient Experience of Care satisfied responses])  SUM([Patient Experience of Care satisfied responses])  Substitute of Care satisfied responses]			fixed health	care surveys		Denominator:							
2.4.16 Patient Experience of Care Satisfaction all responses Rate from Patient Experience of Care survey  PHC clinics/fixed CHCs/CDCs] + [public hospitals])  PHC clinics/fixed CHCs/CDCs] + [public hospitals])  PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Numerator: Sum([Patient Experience of Care satisfaction with health services of Care satisfied responses])  Satisfaction Whodule Satisfaction with health services of Care satisfied responses])  PHC clinics/fixed CHCs/CDCs] + [public hospitals])  Output % Annually No Higher percentage indicates better levels of satisfaction with Hospital services.				,		SUM([Fixed							
2.4.16 Patient Experience of Care Statisfaction Rate From Patient Experience of Care survey  CHCs/CDCs] + [public hospitals])  DHIS - Patient Satisfaction Satisfaction With He survey.  CHCs/CDCs] + [public hospitals])  Numerator: SUM([Patient Experience of Care satisfied responses])  No Higher percentage indicates better levels of satisfaction with Hospital services.													
2.4.16 Patient Experience of Care Satisfaction Rate Rate Figure 1 Experience of Care survey Figure 2 Care Survey F						clinics/fixed							
2.4.16 Patient Experience of Care Satisfaction Rate Rate Figure 1 Experience of Care survey Figure 2 Care Survey F						CHCs/CDCs1							
2.4.16 Patient Experience of Care Satisfaction Rate From Patient Experience of Care survey    No													
Experience of Care proportion of all responses from Patient Experience of Care survey  Experience of Care survey  Satisfaction with health services from Patient Experience of Care survey  Satisfaction with health services from Patient Experience of Care survey  Satisfaction Module Experience of care satisfied responses])  SUM([Patient Experience of users participating in the survey.  SubM([Patient Experience of users participating in the survey.  Satisfaction with Hospital services.													
Experience of Care proportion of all responses from Patient Experience of Care survey  Experience of Care survey  Satisfaction with health services from Patient Experience of Care survey  Satisfaction with health services from Patient Experience of Care survey  Satisfaction Module Experience of care satisfied responses])  SUM([Patient Experience of users participating in the survey.  SubM([Patient Experience of users participating in the survey.  Satisfaction with Hospital services.		2.4.16 Patient	Satisfied	Monitors	DHIS - Patient		Generalizability	Output	%	Annually	No	Higher	GM: DHS
Care proportion of Satisfaction with Health services Rate from Patient Experience of Care survey Satisfaction with Experience of Care survey.  Module Experience of users participating in the survey.  Indicates better levels of satisfaction with Hospital services.		Experience of	responses as a	patient						,			
Satisfaction all responses from Patient Experience of Care survey    Satisfaction   All responses from Patient   Experience of Care survey   Care survey   Care satisfied   Users participating in the survey.   Care survey   Care survey   Care satisfied   Users participating in the survey.   Care survey   Care survey   Care survey   Care satisfied   Users participating in the survey.   Care satisfied   Users participating in				•		\ <u>-</u>	•						
Rate from Patient Experience of Care survey responses]) participating in the survey. satisfaction with Hospital services.			1			•	-						
Experience of Care survey the survey. Hospital services.													
Care survey services.		35											
												•	
			questionnaires									33. 11663.	

Strategic	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance	004100	Method Denominator:	Limitations	Indicator	Туре	Cycle	Indicator	Performance	псорологине
					SUM([Patient							
					Experience of							
					Care total							
1.10 80% of	1.10.5 Average	Average	To monitor the	DHIS, facility	responses]) Numerator:	High levels of	Efficiency	Days (number)	Quarterly	No	A low average	District Health
Hospitals	Length of Stay	number of	efficiency of the	register &	Inpatient days +	efficiency y	Linciency	Days (Hulliber)	Quarterly	140	length of stay	Services
meeting	,	patient days	tertiary	Admission	1/2 Day	could hide poor					reflects high	
national		that an	Hospital		patients	quality					levels of	
efficiency		admitted patient in the			Denominator:						efficiency. But	
targets by 2019		district Hospital			Inpatient						these high efficiency levels	
		before			Separations						might also	
		separation.			(Inpatient						compromise	
					deaths +						quality of	
					Inpatient discharges +						Hospital care. High ALOS	
					Inpatient						might reflect	
					transfers out						inefficient	
											quality of care	
	1.10.11	Patient days	Track the	DHIS, facility	Numerator:	Accurate	Efficiency	Percentage	Quarterly	No	Higher bed	District Health
	Inpatient Bed Utilisation Rate	during the reporting	over/under utilisation of	register Admission	Inpatient days + I/2 Day	reporting sum of daily usable					utilisation indicates	Services
	Othisation rate	period,	tertiary	/ (dimission	patients	beds					efficient use of	
		expressed as a	Hospital beds								bed utilisation	
		percentage of			Denominator:						and/or higher	
		the sum of the daily number of			Inpatient bed days (Inpatient						burden of disease and/or	
		usable beds.			beds * 30.42)						better service	
		4545.5 5 5 4 5 .			available						levels. Lower	
											bed utilization	
											rate indicates	
											inefficient utilization of	
											the facility	
	1.10.17	Expenditure per	Track the	BAS, Stats SA,	Numerator:	Accurate	Efficiency	Number (Rand)	Quarterly	No	Lower rate	District Health
	Expenditure per	•	expenditure per		Total	reporting sum					indicating	Services.
	patient day	which is a	PDE in tertiary	Medical Scheme data, DHIS,	Expenditure in district	of daily usable beds					efficient use of	
	equivalent (PDE)	weighted combination of	v Hospitals in the province	facility registers,		peds					financial resources.	
	(. 22)	inpatient days,	a.e province	patient records							. 20041 000.	
		day patient		Admission,								
		days, and		expenditure								

Strategic	Indicator	Short	Purpose		Calculation	Data	Type of	Calculation	Reporting	New	Desired	
	name	Definition	/Importance	Source	Method	Limitations	Indicator			Indicator	Performance	Responsibility
Objectives	name	OPD/Emergenc y total headcount, with inpatient days multiplied by a factor of I, 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		Source	Method  Denominator: Patient Day equivalent (PDE) as defined above	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
2.4 Patient Experience of Care increased to more than 75% in health services by 2019	2.4.25 Complaints Resolution Rate	one inpatient day  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	Indicator	Short	Purpose	Source	Calculation	Data	Type of	Calculation	Reporting	New	Desired	Responsibility
Objectives	name	Definition	/Importance		Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	. ,
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	75% or more on National Core Standards self -assessment	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	Patient Experience of Care Surveys as	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
	Resolution Rate	Proportion of all complaints received that are resolved	To monitor the response to complaints in Hospitals	complaints register,	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
	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,	Total number of complaints resolved within 25 days	Accuracy of information is dependent on the accuracy of time stamp for each complaint	Quality	Percentage	Quarterly	No	_	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	Responsibilit
2.6 First year	2.6.1 Number	Number of	Tracks the	Bursary	No	Data quality	Input	No.	Annual	no	Higher	Human
Health	of Bursaries	new medicine	numbers of	contracts	denominator	depends on					numbers of	Resources
professional	awarded for	students	medicine			good record					students	Development
students	first year	provided with	students			keeping by					provided with	Programme
receiving	medicine	bursaries by	sponsored by			both the					bursaries are	Manager
bursaries by	students	the provincial	the Province			Provincial DoH					desired, as this	
2019		department of	to undergo			and Health					has the	
		health	training as			Science					potential to	
			future health			Training					increase future	
			care providers			institutions					health care	
			•								providers	
	2.6.2 Number	Number of	Tracks the	SANC	No	Data quality	Input	No.	Annual	Yes	Higher	Human
	of Bursaries	basic nursing	numbers of	Registration	denominator	depends on	•				numbers of	Resources
	awarded for	students	medicine	form		good record					students	Development
	first year	enrolled in	students			keeping by					provided with	Programme
	nursing	nursing	sponsored by			both the					bursaries are	Manager
	students	colleges and	the Province			Provincial DoH					desired, as this	
		universities	to undergo			and Health					has the	
		and offered	training as			Science					potential to	
		bursaries by	future health			Training					increase future	
		the provincial	care providers			institutions					health care	
		department of	•								providers	
		health									•	

## PROGRAMME 7: PERFORMANCE INDICATORS FOR HEALTH CARE AND SUPPORT

Strategic	Indicator	Short	Purpose	C	Calculation	Data	Type of	Calculation	Reporting	New	Desired	B
Objectives	Name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
1.11 95% of	1.11.1	Clients supplied	Tracks the	DHIS, facility	Numerator:	Dependent on	Output with	Percentage	Quarterly	No	Higher	Clinical Support
clients eligible	Percentage of	with	degree to which	registers	Number of	accuracy of	special focus to				percentage	Manager
for assistive	eligible	wheelchairs as a			clients supplied	DHIS	access				reflects	
devices	applicants	proportion of	is meeting the		with						improved	
provided with		the total clients	need for		wheelchairs						service delivery	
wheelchairs,	wheelchairs	applying for	assistive devices		during a						and increased	
hearing aids,		wheelchairs	in the Province		reporting						access to	
prostheses &		expressed as a			period						wheelchairs	
orthoses by		percentage										
2019					Denominator:							
					Total clients							
					applied and on							
					waiting list to							
					receive							
					wheelchairs							
					during the same							
	1.11.2	Cl:	T. J. d.	DI IIC C 111	period	D 1 .	0	D	0	No	1.15.4	CI: : I C
	Percentage of	Clients supplied with hearing	Tracks the degree to which	DHIS, facility registers	Numerator: Number of	Dependent on accuracy of	Output with special focus to	Percentage	Quarterly	NO	Higher	Clinical Support Manager
		aids as a	the department	registers		DHIS	access				percentage reflects	Manager
	eligible applicants	proportion of	is meeting the		with hearing	DHIS	access				improved	
	supplied with	the total clients	need for		aids during a						service delivery	
	hearing aids	applying for	assistive devices		reporting						and increased	
	ricaring aids	hearing aids	in the Province		period						access to	
		expressed as a	iii die i i ovilice		period						hearing aids	
		percentage			Denominator:						rical ing aids	
		percentage			Total clients							
					applied and on							
					waiting list to							
					receive hearing							
					aids during the							
					same period							
	1.11.3	Clients supplied	Tracks the	DHIS, facility	Numerator:	Dependent on	Output with	Percentage	Quarterly	No	Higher	Clinical Support
	Percentage of	with prosthesis	degree to which		Number of	accuracy of	special focus to		,		percentage	Manager
	eligible		the department		clients supplied	DHIS	access				reflects	
	applicants	of the total	is meeting the		with prosthesis						improved	
	supplied with	clients applying	need for		during a						service delivery	
	prostheses	for prosthesis	assistive devices		reporting						and increased	[
		expressed as a	in the Province		period						access to	
		percentage									prosthesis	

Strategic Objectives	Indicator Name	Short Definition	Purpose /Importance	Source	Calculation Method Denominator: Total clients applied and on waiting list to receive prosthesis	Data Limitations	Type of Indicator	Calculation Type	Reporting Cycle	New Indicator	Desired Performance	Responsibility
	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	degree to which	DHIS, facility registers	during the same period  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
I.12 90% availability of essential drugs in all health facilities by 2019	Percentage of	Drug orders fulfilled completely	Ensure availability of essential drugs in all facilities	MEDSAS	Numerator: Number of order fulfilled completely  Denominator: Number of orders received × 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
	*	where Capital, Scheduled Maintenance, (Management Contract projects only) have been completed (excluding new and replacement	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
	have undergone minor refurbishment		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	Indicator	Short	Purpose		Calculation	Data	Type of	Calculation	Reporting	New	Desired	
Objectives	Name	Definition	/Importance	Source	Method	Limitations	Indicator	Туре	Cycle	Indicator	Performance	Responsibility
,	2.7.3 Number	Number of	Tracks overall	Practical	Number of	Accuracy	Input	Number	Annual	No	A higher	Chief Director:
	of health	existing health	improvement	Completion	health facilities	dependent on					number will	Infrastructure
	facilities that	facilities outside	and	Certificate	outside NHI	reliability of					indicate that	and Technical
	have undergone	NHI Pilot	maintenance of	Capital	Pilot District	information					more facilities	Management
	major	District where	existing	infrastructure	that have	captured on					were	
	refurbishment	Capital,	facilities.	project list,	undergone	project lists.					refurbished.	
	outside NHI	Scheduled		Scheduled	major							
	Pilot District	Maintenance,		Maintenance	refurbishment							
		(Management		project list, and								
		Contract		Contract								
		projects only)		projects).								
		have been										
		completed										
		(excluding new										
		and										
		replacement										
		facilities).										
	2.7.4 Number	Number of	Tracks overall	Job card /	Number of	Accuracy	Input	Number	Annual	No	A higher	Chief Director:
	of health	existing health	improvement	invoice,	health facilities	dependent on					number will	Infrastructure
	facilities that	facilities outside	and	Professional	outside NHI	reliability of					indicate that	and Technical
	have undergone	NHI Pilot	maintenance of	Day-to-day	Pilot District	information					more facilities	Management
	minor	District where	existing	Maintenance	that have	captured on					were	
	refurbishment	Professional	facilities.	project list	undergone	project lists.					refurbished.	
	outside NHI	Day-to-day		(only	minor							
	Pilot District	Maintenance		Management	refurbishment							
		projects		Contract								
		(Management		projects).								
		Contract										
		projects only)										
		have been										
		completed										
		(excluding new										
		and										
		replacement										
		facilities).						ĺ				

