ANNUAL PERFORMANCE FOR FY 2017/2018							
Department of Health							
Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
1. Administration	7	7	0	0	100	0	0
2. District Health Services	44	29	14	1	66	32	2
3. Emergency Medical Services	5	2	3	0	40	60	0
4. Provincial Hospital Services	36	33	3	0	92	8	0
5. Central Hospital Services	32	30	2	0	94	6	0
6. Health Sciences and Training	11	9	2	0	82	18	0
7. Health Care Support Services	10	9	1	0	90	10	0
8. Health Facilities Management	5	2	2	1	40	40	20
Total	150	121	27	2	81	18	1

Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
Quarter 1	128	96	27	5	75	21	4
Quarter 2	119	92	24	3	77	20	3
Quarter 3	119	96	18	5	81	15	4
Quarter 4	141	105	33	3	74	23	2
ANNUAL	150	121	27	2	81	18	1

Q1 PERFORMANCE FOR FY 2017/2018							
Department of Health							
Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
1. Administration	2	2	0	0	100	0	0
2. District Health Services	44	26	15	3	59	34	7
3. Emergency Medical Services	4	2	2	0	50	50	0
4. Provincial Hospital Services	31	26	5	0	84	16	0
5. Central Hospital Services	28	26	2	0	93	7	0
6. Health Sciences and Training	9	7	2	0	78	22	0
7. Health Care Support Services	7	6	0	1	86	0	14
8. Health Facilities Management	3	1	1	1	33	33	33
Total	128	96	27	5	75	21	4

Q2 PERFORMANCE FOR FY 2017/2018							
Department of Health							
Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
1. Administration	2	2	0	0	100	0	0
2. District Health Services	44	28	14	2	64	32	5
3. Emergency Medical Services	4	2	2	0	50	50	0
4. Provincial Hospital Services	31	25	6	0	81	19	0
5. Central Hospital Services	28	27	1	0	96	4	0
6. Health Sciences and Training	0	0	0	0			
7. Health Care Support Services	7	7	0	0	100	0	0
8. Health Facilities Management	3	1	1	1	33	33	33
Total	119	92	24	3	77	20	3

Q3 PERFORMANCE FOR FY 2017/2018							
Department of Health							
Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
1. Administration	2	2	0	0	100	0	0
2. District Health Services	44	32	9	3	73	20	7
3. Emergency Medical Services	4	1	3	0	25	75	0
4. Provincial Hospital Services	31	29	2	0	94	6	0
5. Central Hospital Services	28	25	3	0	89	11	0
6. Health Sciences and Training							
7. Health Care Support Services	7	6	0	1	86	0	14
8. Health Facilities Management	3	1	1	1	33	33	33
Total	119	96	18	5	81	15	4

Q4 PERFORMANCE FOR FY 2017/2018							
Department of Health							
Programme/ Sub-programmes	Number of Performance Indicator	Number Achieved	Number Partially Achieved	Number Not Achieved	% of Targets Achieved	% of Targets Partially Achieved	% of Targets Not Achieved
1. Administration	7	7	0	0	100	0	0
2. District Health Services	44	29	13	2	66	30	5
3. Emergency Medical Services	5	2	3	0	40	60	0
4. Provincial Hospital Services	36	32	4	0	89	11	0
5. Central Hospital Services	32	23	9	0	72	28	0
6. Health Sciences and Training	2	2	0	0	100	0	0
7. Health Care Support Services	10	8	2	0	80	20	0
8. Health Facilities Management	5	2	2	1	40	40	20
Total	141	105	33	3	74	23	2

Monitoring and Evaluation Report
PROGRAMME 1: Administration

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target			Q2 Target			Q3 Target			Q4 Target			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Annual Target	ACTUAL YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Administration																		
	Percentage of the annual equitable share budget allocation spent	99.6%	100.0%	Annual target	100.6%	Annual target	Annual target	99.9%	Annual target	Annual target	99.7%	Annual target	100.0%	99.1%	99.1%	100.0%	99.1%	99.1%
	Numerator: Annual expenditure on equitable share budget	14,831,612,000	15,559,048,000	Annual target	16,287,059,000	-	Annual target	16,185,661,000	-	Annual target	16,151,192,000	-	15,559,048,000	16,048,977,000	-	15,559,048,000	16,048,977,000	-
	Denominator: Total BAS annual equitable share budget allocation	14,897,973,000	15,559,048,000	Annual target	16,194,330,000	-	Annual target	16,201,006,000	-	Annual target	16,201,006,000	-	15,559,048,000	16,201,006,000	-	15,559,048,000	16,201,006,000	-
1.1.1	**COMMENT**			Annual indicator. Not required to report on in Q1, merely for information purposes. Above calculations are based on May 2017 IYM and adjusted budget not yet taken into consideration.			Annual indicator. Not required to report on in Q2, merely for information purposes. Above calculations are based on August 2017 IYM.			Annual indicator. Not required to report on in Q3, merely for information purposes.			Based on the February 2018 IYM, current projections indicate a marginal deviation of 0.3% from the target. The performance is however closely monitored by the CFO's office.			This is a demand/service driven indicator which means it is not possible for the Department to predict performance with 100% accuracy. The marginal deviation from the performance target is considered by the Department as acceptable and is therefore considered as having achieved the target.		
	ACTION PLAN			No action required. Annual target/performance on track.			No action required. Annual target/performance on track.						None required.			None required.		
	Timeous submission of a Human Resource Plan for 2015 - 2019 to DPSA	Yes	Yes	Yes	Yes	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	Yes	Yes	100%	Yes	Yes	100%
2.1.1	**COMMENT**			Annual Indicator. There were however no changes made to the current HR Plan for 2015-2019 and the Annual HR Planning Implementation Report was submitted on 17 May 2017 to DoTP.			Annual Indicator. There were however no changes made to the current HR Plan for 2015-2019 and the Annual HR Planning Implementation Report was submitted in Q1 to DoTP.						Target achieved. There were no changes made to the current HR Plan for 2015-2019 and the Annual HR Planning Implementation Report was submitted in Quarter 1 to the Department of the Premier.			Target achieved.		
	ACTION PLAN			No action required. Western Cape Government Health is compliant for FY 2017/2018.			No action required. Western Cape Government Health is compliant for FY 2017/2018.						None required.			None required.		
	Cultural entropy level for WCG:Health	Not required to report	20.0%	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	20.0%	17.9%	112.0%	20.0%	17.9%	112.0%
	Numerator: Votes for potentially limiting values (PL) in current culture	-	15,000	-	-	-	-	-	-	-	-	-	15,000	12568	-	15,000	12568	-
	Denominator: Participants in the survey X 10 possible values	-	75,000	-	-	-	-	-	-	-	-	-	75,000	70380	-	75,000	70380	-
3.1.1	**COMMENT**			Annual indicator. The Western Cape Government Health will be conducting the Barrett Values Survey (BVS) during Quarter 2 of the financial year. As per Circular H101/2017, the BVS is to occur over the period 24 July - 21 August 2017. Reporting anticipated in Q3/Q4 once the BVS Report is published.			Annual indicator. Reporting anticipated in Q3 once Barrett Values Survey (BVS) results (report) are made available. BVS conducted in Q2.						The Cultural Entropy score equates to the percentage of votes for potentially limiting values, which can stem from internal or external factors, or from the fear-based actions and behaviours of leaders, managers and supervisors. A Cultural Entropy score of 10% or lower is healthy. Although a Cultural Entropy score of 18% reflects issues requiring cultural or structural adjustment, the Department performed better than anticipated, as the target was set at 20%. The over performance is considered acceptable and to the benefit of the organisation.			Target exceeded. The Department could not predict performance with 100% accuracy, as it is not within their full control. Targets were set based on previous baseline data and surveys conducted in the past. The lower than anticipated cultural entropy level is considered a positive outcome for the organisation and the Department deems the performance outcome as having achieved the target. Possible factors contributing to the target being exceeded include visible and accessible leadership, focus on values, the Management Efficiency and Alignment Project (MEAP), better communication via corporate communication flash messages with employees and leadership training of managers.		
	ACTION PLAN			No action required.			No action required.						The Directorate Change Management is to utilise the Barrett Values Survey (BVS) results to address the issues of cultural / structural adjustment, going forward.			None required.		
	Number of value matches in the Barrett survey	Not required to report	4	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	4	5	125.0%	4	5	125.0%
3.1.2	**COMMENT**			Annual indicator. The Western Cape Government Health will be conducting the Barrett Values Survey (BVS) during Quarter 2 of the financial year. As per Circular H101/2017, the BVS is to occur over the period 24 July - 21 August 2017. Reporting anticipated in Q3/Q4 once the BVS Report is published.			Annual indicator. Reporting anticipated in Quarter 3 once Barrett Values Survey (BVS) results (report) are made available. BVS conducted in Quarter 2.						The following 5 value matches (target was 4 value matches) were identified in the Barrett Values Survey (BVS), in terms of personal, current and desired values: accountability, respect, caring, honesty and responsibility. The higher than anticipated value matching results is considered as a benefit to the organisation.			Target exceeded. The Department could not predict performance with 100% accuracy, and targets were set based on previous baseline data. The cultural value matches highlight the relationship between personal values, current and desired organisational values. The higher than anticipated value matching result is considered a positive outcome for the organisation and the Department deems the performance		
	ACTION PLAN			No action required.			No action required.						None required.			None required.		
	Audit opinion from Auditor-General of South A	Unqualified	Unqualified	Annual target	-	Annual target	Annual target	Unqualified	Annual target	Annual target	-	Annual target	Unqualified	Unqualified	100%	Unqualified	Unqualified	100%
1	**COMMENT**			Annual indicator. Auditor-General of South Africa (AGSA) is currently still in the process of conducting audits. Receipt of AGSA report anticipated in Q2/Q3, after which the Audit Action Plan for the Department will be drafted.			Annual Indicator. Auditor-General South Africa (AGSA) Management report received.						Target achieved.			Target achieved.		
	ACTION PLAN			No action required.			No action required.						None required.			None required.		
	Percentage of hospitals with broadband access	69.2%	100.0%	81.1%	77.4%	95.3%	86.8%	88.7%	102.2%	92.5%	96.2%	104.1%	100.0%	96.2%	96.2%	100.0%	96.2%	96.2%
	Numerator: Hospitals with minimum 2 Mbps connectivity	37	53	43	41	-	46	47	-	49	51	-	53	51	-	53	51	
	Denominator: Number of hospitals	54	53	53	53	-	53	53	-	53	53	-	53	53	-	53	53	
2	**COMMENT**			Based on current projections, the number of hospitals planned to be rolled out with broadband connectivity seems to be on track.			Discrepancies in hospital naming conventions possible cause of inaccurate reporting, but require further investigation. Reconciliation of Sinjani hospitals list and Centre for e-Innovation (CeI) Sintrex list of broadband connectivity commenced.						Due to the delay in renovations at Radie Kotze Hospital and infrastructure challenges at Murraysburg Hospital, minimum broadband connection of 2 Mbps could not be implemented. The slight under-performance of 3.8% below the target is however deemed acceptable by the Department, as broadband roll outs are not 100% within their control, and is reliant on external departmental role players and services providers.			Due to the delay in renovations at Radie Kotze Hospital and infrastructure challenges at Murraysburg Hospital, minimum broadband connection of 2 Mbps could not be implemented at all Hospitals. The slight deviation from the performance target is considered by the Department as acceptable and is therefore considered as having achieved the target.		
	ACTION PLAN			Await final data sign offs for validated data to assess if any intervention(s) are required.			Directorate Information Management to reconcile necessary lists and liaise with CeI for sign off.						None required.			None required.		

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target			Q2 Target			Q3 Target			Q4 Target			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Annual Target	ACTUAL YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
3	**Percentage of fixed PHC facilities with broadband access**	84.2%	95.2%	89.7%	88.4%	98.5%	91.6%	91.0%	99.4%	93.4%	91.0%	97.5%	95.2%	91.8%	96.4%	95.2%	91.8%	96.4%
	Numerator: Fixed PHC facilities with minimum 1 Mps connectivity	230	260	245	236	-	250	243	-	255	244	-	260	246	-	260	246	
	Denominator: Number of fixed PHC facilities	273	273	273	267	-	273	267	-	273	268	-	273	268	-	273	268	
	COMMENT			WCGH = 161 of 185 + COCT = 75 of 82 = Total of 236			Western Cape Government Health (WCGH) = 167 of 185 and City of Cape Town (COCT) = 77 of 82 = Total of 244 fixed Primary Health Care (PHC) facilities.			Due to the mid year adjustments to the Annual Performance Plan, the minimum standard of 512 Kbps was increased to the National standard of 1 Mbps broadband connectivity/access. This however impacted on the reporting of the previous quarters, specifically on the number of fixed PHC facilities for the City of Cape Town(CoCT). CoCT originally reported 71 fixed PHC facilities with minimum 512 Kbps during the financial year. However, the number of CoCT fixed PHC facilities meeting the minimum broadband access of 1 Mbps is only 64 of 82. It is however important to note that all CoCT PHC facilities have internet access (e.g. 3G), but not necessarily broadband access. The Western Cape Government Health fixed PHC facilities meeting the minimum broadband access of 1 Mbps is 180 of 186 facilities. The slight under-performance of 4.2% below target is considered by the Department as acceptable as broadband roll outs are not 100% within their control, and is reliant on external role players and service providers.			Due to the mid year adjustments to the Annual Performance Plan, the minimum standard of 512 Kbps was increased to the National standard of 1 Mbps broadband connectivity/access. This however impacted on the reporting of the previous quarters, specifically on the number of fixed PHC facilities for the City of Cape Town(CoCT). CoCT originally reported 71 fixed PHC facilities with minimum 512 Kbps during the financial year. However, the number of CoCT fixed PHC facilities meeting the "new" minimum broadband access of 1 Mbps is only 64 of 82 facilities. It is however important to note that all CoCT PHC facilities have internet access (e.g. 3G), but not necessarily broadband access. The Western Cape Government Health fixed PHC facilities meeting the "new" minimum broadband access of 1 Mbps remain as is, at 180 of 186 facilities. The slight under-performance of 4.2% below target is considered by the Department as acceptable as broadband roll outs are not 100% within their control, and is reliant on external departmental role players and service providers.			Broadband access of 512 Kbps was reported on prior to the 2017/18 financial year. The 2017/18 target was set for 512 Kbps but this was amended during the mid-year adjustments budget process and actual achievement in 2017/18 is therefore for facilities with a minimum of 1 Mbps broadband access.		
	ACTION PLAN			Await final data sign offs for validated data to assess if any intervention(s) are required.			Directorate Information Management to reconcile fixed PHC lists (naming conventions) in collaboration with Centre of e-Innovation (CeI) and City of Cape Town (CoCT) for sign off.			None required.			None required.			None required.		

Monitoring and Evaluation Report
PROGRAMME 2: District Health Services

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
District Health Services																	
1	Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed	New indicator	0.0%	0.0%	100%	63.2%	994.7%	1574.0%	63.7%	24.2%	38.0%	100.0%	15.4%	15.4%	81.0%	89.2%	110%
	Ideal clinic status determinations conducted by Perfect Permanent Team for Ideal Clinic Realisation and Maintenance (PPTICRM) rate (fixed clinic/CHC/CDC)	New indicator	0	0	100%	12	189	1575%	79	30	38%	130	20	15%	221	239	108%
	Calculated field: Fixed PHC facilities	New indicator	0	0	100%	19	19	100%	124	124	100%	130	130	100%	273	268	98%
	COMMENT		Only self determinations conducted this quarter			Facilities have conducted assessments ahead of the schedule by which targets were set in the APP			238 facilities have had an Ideal clinic status determination by PPTICRM to date			The majority of PPITCRM assessments were conducted in previous quarters. Annual target exceeded.			Active involvement by facility managers in the Ideal Clinic programme has led to a better than expected performance particularly amongst rural clinics.		
	ACTION PLAN														Managers will actively support ongoing participation in Ideal Clinic assessments		
2	OHH registration visit coverage (annualised)	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape
	Numerator	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape
	Denominator	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape	Not applicable	Not applicable in Western Cape	Not applicable in Western Cape
	COMMENT																
	ACTION PLAN																
3	PHC utilisation rate - Total	2.3	2.3	2.2	96%	2.3	2.3	98%	2.2	2.2	96%	2.2	2.2	98%	2.3	2.2	96%
	PHC total headcount	14,413,350	3,672,120	3,530,725	96%	3,672,955	3,633,886	99%	3,604,834	3,455,539	96%	3,590,027	3,519,896	98%	14,539,936	14,140,046	97%
	Total population	6,362,257	1,619,717	1,604,518	99%	1,619,718	1,604,518	99%	1,604,518	1,604,518	100%	1,604,518	1,604,518	100%	6,418,073	6,418,069	100%
	COMMENT **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population breakdown**		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.												This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
4	Complaint resolution rate (PHC)	98.1%	95.5%	98.2%	103%	95.3%	98.3%	103%	95.6%	96.7%	101%	95.8%	93.3%	97%	95.6%	96.7%	101%
	Complaints resolved (PHC facilities)	3,220	725	700	96%	737	584	79%	754	647	86%	740	583	79%	2,958	2,514	85%
	Complaints received (PHC facilities)	3,383	760	713	94%	774	594	77%	789	669	85%	773	625	81%	3,095	2,601	84%
	COMMENT		Each complaint is unique and time to resolve is dependant on the complexity of the complaint.									There was a slight underperformance on this target which is not seen as significant. Overall performance for the year is on track.			A positive performance as a result of effective quality assurance processes through the year. The complexity of the complaint determines the time taken to resolve it and therefore cannot be forecast with 100% accuracy.		
	ACTION PLAN											None needed.					
5	Complaint resolution within 25 working days rate (PHC)	95.6%	95.3%	94.0%	99%	95.1%	95.0%	100%	95.0%	95.4%	100%	94.7%	91.8%	97%	95.0%	94.1%	99%
	Complaints resolved within 25 workings days (PHC facilities)	3,175	690	658	95%	701	555	79%	717	617	86%	701	535	76%	2,810	2,365	84%
	Complaints resolved (PHC facilities)	3,320	724	700	97%	737	584	79%	755	647	86%	740	583	79%	2,958	2,514	85%
	COMMENT		Each complaint is unique and time to resolve is dependant on the complexity of the complaint.									Each complaint is unique and time to resolve is dependant on the complexity of the complaint.			A marginal deviation from the performance target is considered by the department as having achieved the target. The complexity of the complaint determines the time taken to resolve it and therefore cannot be forecast with 100% accuracy.		
	ACTION PLAN																

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
District Hospitals																	
	Hospital achieved 75% and more on National Core Standards self assessment rate (District Hospitals)	New indicator	75.0%	0.0%	0%	100.0%	0.0%	0%	47.6%	0.0%	0%	0.0%	79.4%	100%	63.6%	79.4%	125%
	Hospitals that achieved at least 75% compliance with the national core standards (district hospitals)	New indicator	3	0	0%	8	0	0%	10	0	0%	0	27	100%	21	27	129%
	Hospitals that conducted a national core standards self-assessment during the financial year (district hospitals)	New indicator	4	0	0%	8	0	0%	21	0	0%	0	34	100%	33	34	103%
1	COMMENT		Assessments are still in progress or being signed-off, expected to change with final data.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports			We are able to report on this indicator in Q4 as the development work was required on NCS DHIS 2 system. Assessment were conducted earlier in the year but data could only be catpured and reports generated following the development work.			Active involvement by facility managers to improve on national core standards has led to a better than expected performance on this indicator, particularly by rural hospitals.		
	ACTION PLAN														Managers will support ongoing attempts to improve performance on national core standards assessments		
	Average length of stay (district hospitals)	3.2	3.3	3.3	100%	3.2	3.3	96%	3.2	3.3	98%	3.2	3.3	98%	3.2	3.3	97%
	Calculated field: Patient days in district hospitals	909,891	236,453	233,866	101%	230,192	243,195	95%	223,378	233,201	96%	226,079	230,430	98%	916,103	940,690	97%
	Calculated field: Inpatient separations in district hospitals	280,580	72,047	70,821	98%	70,971	73,171	103%	69,678	71,147	102%	70,006	70,797	101%	282,702	285,936	101%
2	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Slight deviation from target as this is a demand driven indicator and cannot be planned with 100% accuracy			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	Inpatient bed utilisation rate (district hospitals)	84.8%	87.5%	88.1%	101%	85.20%	91.5%	107%	82.6%	87.4%	106%	83.6%	86.3%	103%	84.7%	88.3%	104%
	Calculated field: Patient days in district hospitals	909,891	236,453	233,866	101%	230,192	243,195	95%	223,378	233,201	96%	226,079	230,430	98%	916,103	940,690	97%
	Inpatient bed days available (district hospitals) Usable beds total x 30.42	1,072,731	270,311	265,536	98%	270,311	265,780	98%	270,312	266,692	99%	270,313	266,936	99%	1,081,248	1,064,943	98%
3	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Slight deviation from target as this is a demand driven indicator and cannot be planned with 100% accuracy			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	Expenditure per (PDE) (district hospitals)	R 2,139	R 2,264	R 2,221	102%	R 2,272	R 2,253	101%	R 2,262	R 2,356	96%	R 2,257.44	R 2,490	91%	R 2,264	R 2,329	97%
	Expenditure in district hospitals (sub-programme 2.9)	2,923,677,427	784,525,500	762,823,762	103%	784,525,500	801,938,001	98%	784,525,500	813,543,542	96%	784,525,500	850,731,001	92%	3,138,102,000	3,229,036,306	97%
	Calculated field: Patient day equivalent (PDE) (district hospitals)	1,366,830	346,557	343,466.2	101%	345,269	355,919.8	97%	346,856	345,300.8	100%	347,528	341,716.167	102%	1,386,210	1,386,403	100%
4	COMMENT		Historically expenditure lower in first quarter however expenditure even lower than planned, may improve with finalised data.									Slight over expenditure as hopsitals ensure budget for the year is met			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	Complaint resolution rate (district hospitals)	99.4%	93.0%	99.3%	107%	93.9%	100.0%	106%	93.1%	98.4%	106%	93.0%	96.6%	104%	93.3%	98.6%	106%
	Complaints resolved (district hospitals)	1,661	411	397	97%	441	346	78%	418	306	73%	423	316	75%	1,695	1,365	81%
	Complaints received (district hospitals)	1,671	442	400	90%	470	346	74%	449	311	69%	455	327	72%	1,817	1,384	76%
5	COMMENT		Each complaint is unique and time to resolve is dependant on the complexity of the complaint.									Overperformance as more complaints resolved than planned			In line with National Core Standards, the focus on quality assurance has improved the complaint resolution rate. The complexity of the complaint determines the time taken to resolve it and therefore cannot be forecast with 100% accuracy.		
	ACTION PLAN														Managers will support ongoing improvements in the complaints resolution rate		
	Complaint resolution with 25 working days rate (district hospitals)	94.4%	90.4%	91.4%	101%	89.6%	88.4%	99%	90.3%	93.5%	104%	89.9%	91.5%	102%	90.0%	91.1%	101%
	Complaints resolved within 25 working days (district hospitals)	1,501	372	363	98%	396	306	77%	378	286	76%	381	289	76%	1,526	1,244	82%
	Complaints resolved (district hospitals)	1,661	411	397	97%	441	346	78%	418	306	73%	423	316	75%	1,695	1,365	81%
6	COMMENT		Each complaint is unique and time to resolve is dependant on the complexity of the complaint.									Overperformance as more complaints resolved within 25 days than planned			In line with National Core Standards, the focus on quality assurance has improved the complaint resolution rate. The complexity of the complaint determines the time taken to resolve it and therefore cannot be forecast with 100% accuracy.		
	ACTION PLAN														Managers will support ongoing improvements in the complaints resolution rate		

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
HIV and AIDS, STIs and TB																	
	TB programme success rate	80.4%	81.0%	80.6%	99%	81.3%	80.9%	99%	81.3%	79.2%	97%	80.8%	80.3%	99%	81.1%	80.2%	99%
	All TB cases treatment success (outcome Cohort)	34,651	8,650	8,324	96%	8,674	8,114	94%	8,680	9,083	105%	8,619	8,173	95%	34,612	33,694	97%
	All TB cases (outcome Cohort)	43,099	10,676	10,326	97%	10,666	10,033	94%	10,677	11,468	107%	10,670	10,182	95%	42,685	42,009	98%
1.1.1	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.												This is a service driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	ART Retention in care after 12 months	72.2%	70.8%	62.7%	88%	70.9%	62.6%	88%	70.9%	60.6%	86%	75.2%	59.5%	79%	72.3%	61.4%	85%
	ART clients retained in care after 12 months	33,307	7,896	7,283	92%	7,899	7,749	98%	7,891	6,899	87%	12,155	6,977	57%	35,842	28,908	81%
	ART clients initiated on treatment (12 month Cohort)	46,120	11,146	11,623	104%	11,136	12,373	111%	11,124	11,380	102%	16,163	11,721	73%	49,569	47,097	95%
2.1.1	COMMENT		Some facilities experience connectivity challenges, for example Gugulethu CHC which has a large patient population on ARVs.			Poor performance largely due to data capture backlogs						Targets set for Quarter 4 inappropriately higher than previous quarters. This has been addressed in the APP FY2018/19			Successful treatment requires lifelong adherence by the patient to treatment, unfortunately there are significant challenges faced by those delivering this service to try and retain clients. Some clients are not permanent or long term residents or do not provide accurate contact information to allow for follow-up. Social conditions and economic influences on the more vulnerable population also have an impact on retention in care. The Department continues to be committed to improve the number of clients retain in care.		
	ACTION PLAN		Ongoing monitoring of outcomes and resource allocation			Managers to investigate ways of reducing data capture backlogs			Managers to investigate ways of reducing data capture backlogs			Currently there is no functionality to identify patients who have truly defaulted from those who are receiving treatment elsewhere but did not inform the facility, who can only identify the patient as not returning to care. The Province is exploring solutions to help identify patients moving within the Province but those who leave the Province cannot at this time be identified.			Managers are to investigate ways of better retaining patients on ART in care		
	ART Retention in care after 48 months	60.7%	59.8%	50.2%	84%	59.9%	51.3%	86%	60.0%	49.2%	82%	66.0%	47.5%	72%	61.8%	49.5%	80%
	ART clients retained in care after 48 months	19,700	5,178	3,748	72%	5,187	4,040	78%	5,192	3,886	75%	8,141	4,414	54%	23,697	16,088	68%
	ART clients initiated on treatment (48 months Cohort)	32,455	8,659	7,466	86%	8,660	7,868	91%	8,650	7,894	91%	12,344	9,291	75%	38,314	32,519	85%
	COMMENT		Some facilities experience connectivity challenges, for example Gugulethu CHC which has a large patient population on ARVs.			Poor performance largely due to data capture backlogs						Targets set for Quarter 4 inappropriately higher than previous quarters. This has been addressed in the APP FY2018/19			Successful treatment requires lifelong adherence by the patient to treatment, unfortunately there are significant challenges faced by those delivering this service to try		
2.1.2	ACTION PLAN		Ongoing monitoring of outcomes and resource allocation			Managers to investigate ways of reducing data capture backlogs			Managers to investigate ways of reducing data capture backlogs			Currently there is no functionality to identify patients who have truly defaulted from those who are receiving treatment elsewhere but did not inform the facility, who can only identify the patient as not returning to care. The Province is exploring solutions to help identify patients moving within the Province but those who leave the Province cannot at this time be identified.			Managers are to investigate ways of better retaining patients on ART in care		
	ART client remain on ART end of month - total *Total clients on treatment minus Lost to follow-up minus died minus transferred out*	222,876	224,672	239,457	107%	228,971	240,293	105%	232,494	245,548	106%	237,504	256,821	108%	237,504	256,821	108%
1	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Overperformance as more patients remaining in care			A positive outcome for this indicator. As it is a demand driven indicator it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	TB/HIV co-infected client on ART rate	89.6%	87.8%	90.8%	103%	87.9%	90.4%	103%	87.8%	89.3%	102%	87.9%	90.8%	103%	87.8%	90.3%	103%
	Total number of registered HIV and TB co-infected patients on ART	14902	3,658	3,468	95%	3,635	3,471	95%	3,666	4,049	110%	3,647	3,596	99%	14,606	14,584	100%
	Total number of registered HIV and TB co-infected patients	16673	4,165	3,818	109%	4,137	3,841	108%	4,178	4,533	92%	4,152	3,960	105%	16,630	16,152	103%
2	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Overperformance as more co-infected patients on treatment			A positive outcome for this indicator, as it is a demand driven indicator it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.		
	ACTION PLAN																
	HIV test done - Total (Antenatal client HIV fist test + Antenatal clients HIV retest +HIV test 19-59 months + HIV test 5-14 years + HIV test 15 years and older (excluding ANC)	1,379,375	340,325	333,969	98%	343,968	367,279	107%	343,858	357,554	104%	345,464	377,240	109%	1,373,615	1,436,042	105%
3	COMMENT								Positive performance on demand driven indicator, possibly influenced by raised awareness due to World Aids Day						More tests done than planned which is a positive outcome. Performance is reliant on client uptake therefore the Department cannot predict with 100% accuracy, and a marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
	Male condom distributed	113913868	27,861,440	29,610,800	106%	27,965,586	24516600	88%	27,960,653	29504000	106%	27986919	30764800.0	110%	111,774,598	114,396,200	102%
4	COMMENT					The PUSH System quantities were re-evaluated due to the decentralisation of the Condoms Budget. There was a time period where no condoms could be distributed. This resulted in a large drop in August and thus projected performance.			Higher than usual performance due to condom distribution for World AIDS day			There was a change in the reporting source from last year, data is provided by the primary distribution sites rather than facility level. Targets were based on the previous reporting mechanism. As delivery is based on orders placed through the year, this results in fluctuations between quarters - thus this quarter was above target whereas a previous quarter was under target.			A positive outcome for this indicator. As it is a demand driven indicator it is not possible for the Department to predict with 100% accuracy and the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN					The future performance of this indicator needs to be						As a new reporting source the data will be interrogated					

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
5	Medical male circumcision - total	11,687	5,388	3,749	70%	5,699	5,571	98%	5,497	3,316	60%	5,457	3,908	72%	22,040	16,544	75%
	COMMENT		Operational challenges being addressed with NPOs, and when resolved expected to improve performance.						Engagement between Programmes and contracted NPOs and reasons for under performance ongoing			Although still below target, performance overall for the year has been much better than in previous years due to the assistance of NPOs			Client uptake of this service unfortunately remains low due to societal influences and stigma, however performance overall has been much better than in previous years due to the assistance of Non-Profit Organisations. These partnerships will be ongoing.		
	ACTION PLAN		Work in progress - mutually agreed work plans between services and agreed NPOs in their respective districts						Programmes has engaged with NPO's and awaiting written feedback from providers this week			There will be ongoing partnership with NPO's to improve performance.			There will be ongoing partnership with NPO's to improve performance.		
6	TB symptoms (client) 5 years and older start on treatment rate	New indicator	94.5%	90.0%	95%	94.8%	91.2%	96%	94.7%	88.6%	94%	94.5%	87.7%	93%	94.6%	89.4%	94%
	Sum (TB client 5 years and older start on treatment)	New indicator	5,201	4,685	90%	5,289	5,794	110%	5,312	5,345	101%	5,251	5,369	102%	21,054	21,193	101%
	Sum (TB symptomatic client 5 years and older tested positive)	New indicator	5,505	5,203	106%	5,581	6,350	88%	5,612	6,030	93%	5,558	6,125	91%	22,255	23,708	94%
	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Underperformance again this quarter specifically in the Metro district requires further investigation whether this is a service or data related issue.			As a result of this underperformance an investigation by Metro Health Services into the data collection process and patient care pathway was initiated. This is a challenging indicator to track accurately as the facility where people screen positive for TB symptoms are not always the same facility where they started on TB treatment. The implementation of electronic patient systems is expected to aid this.		
	ACTION PLAN											District Health Services to review data collection and reporting processes to identify whether the underperformance is due to a gap in reporting or in services.			There will be a plan to implement digital capture of TB data at facility level which can be used to better track patients who are daignosed with TB and who start treatment.		
7	TB client treatment success rate	83.5%	81.0%	80.6%	99%	81.3%	80.9%	99%	81.3%	79.2%	97%	80.8%	80.3%	99%	81.1%	80.2%	99%
	TB client successfully completed treatment	10,393	8,650	8,324	96%	8,674	8,114	94%	8,680	9,083	105%	8,619	8,173	95%	34,612	33,694	97%
	All TB clients	12,452	10,676	10,326	97%	10,666	10,033	94%	10,677	11,468	107%	10,670	10,182	95%	42,685	42,009	98%
	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.												This is a service driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
8	TB client lost to follow up rate	9.6%	9.6%	11.0%	87%	9.5%	10.5%	91%	9.5%	11.8%	81%	9.6%	11.2%	86%	8.4%	11.1%	75%
	Sum (TB client lost to follow-up)	1,195	895	1,132	79%	887	1,050	84%	893	1,350	66%	896	1,142	78%	3,571	4,674	76%
	All TB clients	12,452	9,361	10,326	91%	9,353	10,033	93%	9,365	11,468	82%	9,361	10,182	92%	37,440	42,009	89%
	COMMENT		Suspected factors contributing to lost to follow up includes declining socio-economic circumstances and increasing substance abuse. Community Based Service staff who are tasked to track down defaulters are unable to do so due to persistent crime or gang violence in communities.			Suspected factors contributing to lost to follow up includes declining socio-economic circumstances and increasing substance abuse. Community Based Service staff who are tasked to track down defaulters are unable to do so due to persistent crime or gang violence in communities.			Retention of patients is affected by socio-economic status and substance abuse. More reactive electronic tools need to be developed to assist services to identify and engage with patients as soon as they identified as at risk.			Retention of patients is affected by socio-economic status and substance abuse. More reactive electronic tools will be developed to assist services to identify and engage with patients as soon as they identified as at risk.			Retention of patients is affected by socio-economic status and substance abuse. More responsive electronic tools will be developed to assist services to identify and engage with patients as soon as they are identified as being at risk.		
	ACTION PLAN		District Health Services (DHS) Exco has mandated a situational analysis of factors to develop a comprehensive approach. TB staff are also encouraged to utilise electronic methods for tracking defaulters such as system reports			System improvements are being investigated but it is expected that changes will take time to implement			System improvements are being investigated but it is expected that changes will take time to implement			Service area improvements and electronic tools to be developed. Operational Executive Committee tasked to develop a plan.			Service area improvements and electronic tools to be developed to reduce loss to follow up. The Operational Executive Committee has been tasked to develop a plan on this.		
9	TB client death rate	3.0%	3.8%	3.9%	96%	3.8%	4.0%	94%	3.8%	3.8%	100%	3.8%	3.5%	108%	3.3%	3.8%	86%
	Sum (TB client died during treatment)	368	354	407	87%	354	404	88%	355	437	81%	356	357	100%	1,419	1,605	88%
	All TB clients	12,452	9,361	10,326	91%	9,353	10,033	93%	9,365	11,468	82%	9,361	10,182	92%	37,440	42,009	89%
	COMMENT					An increased death rate is reflective of problems with TB programme performance.									Approximately one third of TB patients are HIV positive, which places them at much higher risk of death due to TB, even if on ART. In addition, patients are affected by socio-economic status and substance abuse.		
	ACTION PLAN					System improvements are being investigated but it is expected that changes will take time to implement									Health services will investigate this underperformance and implement any improvements that are required.		
10	TB MDR treatment success rate	44.6%	41.8%	35.6%	85%	41.4%	43.8%	106%	44.0%	45.5%	103%	43.8%	50.1%	114%	42.8%	43.4%	101.5%
	TB MDR client successfully completed treatment	738	174	140	81%	176	166	94%	193	170	88%	192	170	89%	733	611	83%
	TB MDR confirmed client start on treatment	1,653	415	393	95%	424	379	89%	437	374	86%	437	339	78%	1,713	1,407	82%
	COMMENT		The Loss to follow-up rate is significantly higher than the previous quarters, especially in the Cape Metro who has the bulk of the patients which is 70%. This is especially significant amongst the patients who were previously treated on 1st or 2nd line TB treatment.									The improved performance could be attributed to clinics becoming more capacitated to initiate MDR treatment which allows patients to be initiated quicker and not have to be referred to a TB hospital for treatment, however this will continue to be monitored.			The positive performance could be attributed to clinics becoming more capacitated to initiate MDR treatment which allows patients to be initiated quicker and not have to be referred to a TB hospital for treatment. This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN		We are currently trying to put improvement measures in									Ongoing monitoring of performance.					

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Maternal, Child and Women's Health and Nutrition																	
1	Antenatal 1st visit before 20 weeks rate	69.6%	67.2%	68.2%	101%	68.8%	70.3%	102%	70.5%	71.0%	101%	70.3%	69.2%	98%	69.2%	69.7%	101%
	Antenatal 1st visit before 20 weeks	63,901	14,952	15,587	104%	15,910	17,439	110%	15,316	16,594	108%	15,855	17,672	111%	62,033	67,292	108%
	Antenatal 1st visit Sum of:	91,849	22,264	22,868	103%	23,139	24,804	107%	21,732	23,362	108%	22,545	25,529	113%	89,679	96,563	108%
	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.									Slight deviation from target, this is a service driven indicator which cannot be planned for with 100% accuracy			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
2	Mother postnatal visit within 6 days rate	60.0%	62.0%	58.1%	94%	63.9%	59.3%	93%	64.1%	61.7%	96%	63.7%	60.1%	94%	63.4%	59.8%	94%
	Mother postnatal visit within 6 days after delivery	54,816	14,321	13,248	93%	14,724	13,889	94%	14,706	14,428	98%	14,609	13,967	96%	58,358	55,532	95%
	Delivery in facility total	91,322	23,114	22,810	99%	23,047	23,402	102%	22,933	23,371	102%	22,924	23,236	101%	92,017	92,819	101%
	COMMENT		A marginal deviation from the performance target is considered by the Department as having achieved the target									Slight deviation from target, this is a service driven indicator which cannot be planned for with 100% accuracy			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
3	Antenatal client start on ART rate	90.8%	85.7%	93.4%	109%	86.1%	95.0%	110%	86.0%	96.2%	112%	85.9%	84.1%	98%	85.9%	92.1%	107%
	Antenatal client start on ART	7,009	1,676	1,663	99%	1,668	1,715	103%	1,664	1,557	94%	1,672	1,485	89%	6,682	6,420	96%
	Antenatal client known HIV positive + Antenatal client first test positive + Antenatal client HIV retest positive	7,715	1,956	1,780	91%	1,938	1,805	93%	1,934	1,618	84%	1,947	1,765	91%	7,777	6,968	90%
	COMMENT		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service									Slight underperformance this quarter expected to improve with finalised data, however annual performance is within target.			A positive outcome for this indicator. The success of the "test and treat" policy has resulted in more rapid initiation of ART care for pregnant women		
	ACTION PLAN																
4	Infant 1st PCR test positive around 10 weeks rate	0.8%	0.9%	0.4%	208%	0.9%	0.6%	139%	0.9%	0.4%	229%	0.9%	0.4%	204%	0.9%	0.5%	187%
	Infant PCR test positive around 10 weeks	95	28	15	188%	29	23	126%	28	14	200%	27	15	180%	113	67	169%
	Infant PCR test around 10 weeks	12,013	3,058	3,387	111%	3,089	3,558	115%	3,057	3,566	117%	3,034	3,401	112%	12,239	13,912	114%
	COMMENT **Birth PCR tests are now performed routinely for high-risk children and those testing positive from the birth PCR tests are not included in the numerator here, resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks**		Birth PCR tests are now performed routinely for high-risk children and those testing positive from the birth PCR tests are **not** included in the numerator here, resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks *(Infant birth PCR test positive rate 1%)*			Birth PCR tests are now performed routinely for high-risk children and those testing positive from the birth PCR tests are not included in the numerator here, resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks *(Infant birth PCR test positive rate 1%)*			Birth PCR tests are now performed routinely for high-risk children and those testing positive from the birth PCR tests are not included in the numerator here, resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks *(Infant birth PCR test positive rate 1%)*			Birth PCR tests are now performed routinely for high-risk children and those testing positive from the birth PCR tests are not included in the numerator here, resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks *(Infant birth PCR test positive rate 1%)*			An expansion on existing Programme interventions has resulted in an increased number of birth PCR tests being performed routinely for high-risk children. Those that are tested positive are initiated on treatment therefore resulting in a better than expected reported performance for this indicator which only measures positive PCRs at 10 weeks. Target setting has been addressed in the Annual Performance Plan (APP) FY2018/19.		
	ACTION PLAN																
5	Immunisation under 1 year coverage	79.9%	90.9%	79.4%	87%	91.0%	82.5%	91%	83.3%	81.2%	98%	84.0%	81.8%	97%	83.8%	81.2%	96.9%
	Immunised fully under 1 year new	78,933	22,134	20,969	95%	22,163	21,789	98%	22,004	21,459	98%	22,187	21,605	97%	88,487	85,822	97.0%
	Population under 1 year	98,837	24,360	26,414	108%	24,360	26,414	108%	26,414	26,414	100%	26,414	26,414	100%	105,655	105,653	100%
	COMMENT **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population**		The measles vaccine cannot be provided with other vaccines, therefore may delay the provision of later vaccines in the schedule till the child is older than 1 year. This has been influenced by the Measles Campaign. The reported period is also affected by the			Suspect that slightly lower than expected performance due to influence of ad hoc immunisations campaigns on in-facility immunisations. Campaign data is not included in routine data.						Slight deviation from target, this is a service driven indicator which cannot be planned for with 100% accuracy			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN					Continue to monitor											
6	Measles 2nd dose coverage	91.1%	78.2%	79.2%	101%	78.9%	81.0%	103%	74.4%	75.1%	101%	76.7%	77.8%	101%	74.5%	78.3%	105%
	Measles 2nd dose	92,898	19,731	21,353	108%	19,913	21,845	110%	20,060	20,246	101%	20,673	20,993	102%	80,377	84,437	105%
	Population aged 1 year	101,918	25,239	26,971	107%	26,971	26,971	100%	26,971	26,971	100%	26,971	26,971	100%	107,885	107,885	100%
	COMMENT **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population breakdown**		The measles campaign conducted in February/ March impacted routine immunisations in facilities as children were being immunised in the community. The catch-up effect on routine measles vaccine in April and May suspected due to low routine numbers in March – we expect these trends to be corrected with more routine data.									Overperformance as more children immunised than planned. This is a service driven indicator which cannot be planned for with 100% accuracy			An over-performance reported for this indicator. This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN		To be monitored														
7	DTaP-IPV-HepB-Hib 3rd Dose - Measles 1st dose drop-out rate	-13.8%	4.7%	5.3%	89%	4.7%	-5.1%	-92%	4.6%	2.0%	233%	4.5%	2.2%	207%	4.6%	1.1%	427%
	DTaP-IPV-HepB-Hib 3rd Dose Minus Measles 1st dose under 1 year	-11,506	1,056	1,304	81%	1,062	-1,262	-84%	1,055	484	218%	1,042	537	194%	4,215	1,063	397%
	DTaP-IPV-HepB-Hib 3rd Dose	83,132	22,579	24,674	109%	22,618	24,725	109%	22,981	24,472	106%	23,167	24,722	107%	91,346	98,593	108%
	COMMENT		The measles campaign conducted in February/ March impacted routine immunisations in facilities as children were being immunised in the community. The catch-up effect on routine measles vaccine in April and May			This performance reflects the fact that more measles vaccines were administered than expected. It is presumed that this is due to catch-up efforts conducted in the PHC facilities after the measles campaign.			**REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT**			**REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT**			REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT		
	ACTION PLAN		To be monitored			Performance to be monitored											
8	Diarrhoea case fatality rate	0.3%	0.2%	0.4%	56%	0.3%	0.6%	51%	0.2%	0.1%	317%	0.3%	0.4%	69%	0.3%	0.4%	82%
	Child under 5 years diarrhoea death	19	5	8	61%	7	5	140%	5	1	500%	6	10	60%	23	24	96%
	Diarrhoea separation under 5 years	6,992	1,996	1,833	109%	2,111	848	249%	2,100	1,586	132%	2,239	2,298	97%	8,446	6,565	129%
	COMMENT		There was a higher than expected number of diarrhoea deaths in the rural areas			Fewer deaths than target however fewer admissions also reported.						More deaths reported than target, which cannot be foreseen especially during the Paediatric Surge Season (November to May). It should also be noted that March is forecast so may reduce with actual data. Still on track for annual target.			One more death occurred than planned. Due to the nature of this indicator this cannot be predicted with 100% accuracy and may be affected by the paediatric surge season. The decline in number of separations should also be noted, as a positive outcome.		
	ACTION PLAN		Rural diarrhoea deaths being investigated			Investigation still ongoing									An investigation is to be conducted to determine the		

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
9	Pneumonia case fatality rate	0.4%	0.5%	0.6%	83%	0.5%	0.8%	60%	0.3%	0.8%	39%	0.3%	0.4%	81%	0.4%	0.7%	61%
	Pneumonia death under 5 years	35	10	11	91%	13	19	68%	5	10	50%	5	5	100%	33	45	73%
	Pneumonia separation under 5 years	7,943	2,140	1,958	109%	2,391	2,261	106%	1,903	1,284	148%	1,952	1,356	144%	8,386	6,859	122%
	COMMENT		Influenced by seasonal changes, expected to worsen in winter quarters. Smaller numbers therefore greater impact on performance when deviate.						The 6 deaths in the Metro are based on 4 pneumonia deaths at Tygerberg Hospital projected for 3 months, therefore finalised data may produce fewer deaths.						Due to the nature of this indicator the number of deaths cannot be predicted with 100% accuracy and may be affected by the paediatric surge season. The decline in number of separations should also be noted, as a positive outcome.		
	ACTION PLAN								The reported deaths are being confirmed with facilities.						An investigation is to be conducted to determine the cause of the increased case fatality rate		
10	Severe acute malnutrition case fatality rate	60.0%	0.7%	2.6%	27%	0.9%	2.7%	34%	0.0%	2.2%	100%	0.4%	1.4%	29%	0.5%	2.2%	23%
	Severe acute malnutrition (SAM) death in facility under 5 years	5	2	4	50%	2	2	100%	0	2	100%	1	2	50%	5	10	50%
	Severe acute malnutrition (SAM) separation under 5 years	841	279	152	183%	228	75	304%	220	92	239%	230	143	161%	956	462	207%
	COMMENT		Small numbers therefore minor deviations have greater impact. Fatality is hard to predict exactly.			This is an in-hospital measure and the high rates reflect the low number of total malnutrition admissions. The details of these cases are still being investigated			Deaths occurred in rural districts and are being investigated by the Rural District Health services.			No deaths recorded in this quarter at this time.			Due to the nature of this indicator the number of deaths cannot be predicted with 100% accuracy and may be affected by the paediatric surge season. The decline in number of separations should also be noted, as a positive outcome.		
	ACTION PLAN		Ongoing data collection process monitored			Under investigation by Programme and District Health Services									An investigation is to be conducted to determine the cause of the increased case fatality rate		
11	School Grade 1 learners screened	55171	16,588	19174	116%	14055	9131	65%	14422	13642	94.6%	13701	6942	51%	58765	48889	83%
	COMMENT		Metro District has not set targets for this indicator due to planned changed in the operational model of the school health service, however this has not yet been implemented and in the interim data is being collected as per last year.			There was an underperformance on this indicator possibly due to the July school holidays			December data forecasted based on October and November performance therefore expected to be lower with finalised data due to end of academic year.			There was a lower than expected performance on this indicator			The school health teams were diverted by ad hoc campaigns through the year. This resulted in an underperformance on this indicator.		
	ACTION PLAN					Performance expected to improve with finalised data.						Under performance to be investigated			Managers will investigate how best to resource the HPV		
12	School Grade 8 learners screened	9364	2,631	3001	114%	2056	3521	171%	2179	2150	99%	1996	2729	137%	8860	11401	129%
	COMMENT		Metro District has not set targets for this indicator due to planned changed in the operational model of the school health service, however this has not yet been implemented and in the interim data is being collected as per last year.			School health teams were able to include more Grade 8 learner screenings than planned.						There was a higher than expected performance on this indicator			School health teams managed to screen more Grade 8 learners than planned, therefore there was a higher than expected performance on this indicator.		
	ACTION PLAN											The reason for this over performance to be investigated			Improved target setting will be implemented in future plans.		
13	Delivery in 10 to 19 years in facility rate	New indicator	8.7%	10.4%	83%	8.7%	11.9%	73%	8.8%	11.2%	79%	8.8%	11.2%	79%	8.7%	11.2%	78%
	Delivery 10 - 19 years in facility	New indicator	2,004	2,370	85%	2,007	2,786	72%	2,009	2,610	77%	2,006	2,603	130%	8027	10,369	129%
	Delivery in facility total	New indicator	23,117	22,810	101%	23,050	23,402	98%	22,933	23,371	98%	22,918	23,236	101%	92017	92,819	101%
	COMMENT		New indicator for 2017_18, targets were therefore estimated			New indicator for 2017_18. Baseline data was not known therefore targets were under-estimated			New indicator for 2017_18. Baseline data was not known therefore targets were under-estimated			New indicator for 2017_18. Baseline data was not			A new indicator for this financial year therefore targets were modestly set.		
	ACTION PLAN		Monitor progress through year			Monitor progress			Monitor progress								
14	Couple year protection rate (Int)	57.2%	76.2%	81.5%	107%	76.2%	74.5%	98%	77.0%	83.5%	109%	77.0%	85.5%	111%	77.0%	81.3%	106%
	Sum Of : *Male sterilisation x10 Female sterilisation x10* *Medroxyprogesterone ÷4 Norethisterone enathate ÷6* *Oral pill cycles ÷15 IUCD inserted x4.5*	1,008,848	341,460	361,927	106%	341,427	330,899	97%	341,940	371,023	109%	341,986	379,651	111%	1,367,721	1,443,501	106%
	Female population 15-49 years	1,762,676	447,919	444,128	99%	447,919	444,128	99%	444,128	444,128	100%	444,128	444,128	100%	1,776,513	1,776,519	100%
	COMMENT		A new method of reporting on male and female condoms is being used, based on distribution from primary distribution sites rather than from facilities. It should also be noted the change in weightings to each of the contributing contraceptive methods in the new financial year.			Underperformance affected by the new method of reporting condom distribution. The PUSH System quantities were re-evaluated due to the decentralisation of the condoms budget. The distribution of condoms was restricted during a reconciliation period this quarter. Will continue to monitor going forward.			Due to a significant increase in condoms for World AIDS day as described above			Overperformance possibly attributed to new method of reporting condom distribution this year. This is being monitored on an ongoing basis.			This is a demand driven indicator and it is not possible for the Department to predict with 100% accuracy, the marginal deviation is considered as having achieved the planned target. A minor correction was made to the annual target to align with the Male Condom Distribution Rate target (see the below section Changes to Planned Targets).		
	ACTION PLAN					Monitor progress through year									These increases in certain family planning methods will be encouraged.		
15	Cervical cancer screening coverage (annualised)	54.9%	54.4%	53.9%	99%	58.6%	62.6%	107%	57.0%	54.8%	96%	54.1%	60.0%	111%	56.5%	57.8%	102%
	Cervical cancer screening in women 30 years and older	90,454	23,018	22,478	98%	24,813	26,121	105%	23,775	22,864	96%	22,576	25,006	111%	94,183	96,469	102%
	Female population 30 years and older ÷ 10	164,764	42,332	41,703	99%	41,703	41,703	100%	41,703	41,703	100%	41,703	41,703	100%	166,812	166,812	100%
	COMMENT **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population breakdown**		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.						The effect of the change in the definition (NIDS 2017/18) to include diagnostic smears may have influenced performance. District Health Service are investigating.			The effect of the change in the national indicator definition (NIDS 2017/18) to include diagnostic smears, whereas previously it was only population smears, has influenced performance.			This is a demand driven indicator and it is not possible for the Department to predict with 100%, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
16	HPV 1st dose (Girls 9 years and older that received HPV 1st dose)	36182	36,155	32356	89%	0	0.0%	100%	0	0.0%	100%	0	0	100%	36155	32,356	89%
	COMMENT		Performance was influenced by the measles campaign which took place over the same period as the HPV Campaign Round 1, eg: KESS did not take part as there was insufficient capacity to conduct both campaigns												Performance was influenced by the ad hoc measles campaign which took place over the same period as the HPV Campaign Round 1, therefore some sub structures did not take part in the HPV campaign as there was insufficient capacity to conduct both		
	ACTION PLAN														No action required as no campaigns are planned for the next financial year.		

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	Actual	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
17	HPV 2nd dose (Girls 9 years and older that received HPV2nd dose)	34941	0	0	100%	34117	34397	101%	0	0.0%	100%	0	0	100%	34117	34,397	101%
	COMMENT														This is a demand driven indicator and it is not possible for the Department to predict with 100%, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN																
18	Vitamin A 12 – 59 months coverage	50.7%	51.0%	47.6%	93%	52.0%	47.9%	92%	49.3%	48.8%	99%	50.1%	51.5%	103%	49.5%	48.9%	99%
	Vitamin A 12 – 59 months	525,757	106,603	104,035	98%	108,638	104,783	96%	107,660	106,599	99%	109,425	112,461	103%	432,324	427,878	99%
	Population 12-59 months x2	839,779	208,993	218,554	105%	218,554	218,555	100%	218,555	218,555	100%	218,555	218,555	100%	874,218	874,217	100%
	COMMENT **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population breakdown**		This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.			Marginal underperformance however District Health Services will raise awareness									This is a demand driven indicator and it is not possible for the Department to predict with 100%, the marginal deviation is considered as having achieved the planned target.		
	ACTION PLAN					Managers to be asked to improve performance											
19	Infant exclusively breastfed at DTaP-IPV-HepB-Hib 3rd Dose rate	31.7%	34.3%	30.0%	87%	34.2%	32.9%	96%	34.2%	37.9%	111%	34.3%	36.8%	107%	34.3%	34.4%	100%
	Infant exclusively breastfed at DTaP-IPV-HepB-Hib 3rd Dose	25,972	7,799	7,392	95%	7,870	8,127	103%	7,869	9,287	118%	7,761	9,089	117%	31,297	33,895	108%
	Total infants who received DTaP-IPV-HepB-Hib 3rd Dose	81,884	22,745	24,674	108%	22,990	24,725	108%	23,006	24,472	106%	22,604	24,722	109%	91,346	98,593	108%
	COMMENT								**REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT**			**REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT**			**REMOVED FROM REPORTING IN MID YEAR ADJUSTMENT**		
	ACTION PLAN																
20	Maternal Mortality in facility ratio	59 / 100000	54.1	80	67%	58.3	78	74%	54.1	37	146%	79.5	33	238%	61.5	57	107%
	Maternal death in facility	54	13	19	67%	14	19	74%	13	9	144%	19	8	238%	58	55	105%
	Live birth in facility + baby born alive before arrival at facility	0.918	0.236	0.236	100%	0.236	0.242	97%	0.236	0.242	97%	0.236	0.240	98%	0.943	0.961	98%
	COMMENT: Ratio per 100 000 live births		Small numbers therefore minor deviations have greater impact. Fatality is hard to predict exactly. Also influenced by late notifications from facilities.			Late submission of death notifications by facilities, particularly in metro						Fewer deaths than target however this may be due to a delay in reporting by facilities.			Due to the nature of this indicator, the number of deaths cannot be predicted with 100% accuracy. Various programme initiatives to improve maternal health have also positively influenced the outcome of		
	ACTION PLAN											Maternal health programme to follow up with Districts					
21	Neonatal death in facility rate	New indicator	5.5	10	53%	5.6	8	66%	5.6	9	60%	5.7	9	64%	5.6	9.3	60%
	Inpatient death 0-7 days + Inpatient death 8-28 days	New indicator	128	238	54%	129	198	65%	129	217	59%	131	207	63%	518	860	60%
	Live birth in facility	New indicator	23.142	22.681	102%	23.140	23.318	99%	23.140	23.254	100%	23.14	23.086	100%	92.57	92.34	100%
	COMMENT: Ratio per 1 000 live births		In the previous year this indicator measured early neonatal death only (0-7 days), this has now been extended to 0-28 days. This years numerator target was based on the assumption that this indicator would remain consistent, however it was changed as part of the NIDS revision and now includes all neonatal deaths. We therefore foresee this problem persisting through the year.			In the previous year this indicator measured early neonatal death only (0-7 days), this has now been extended to 0-28 days. This years numerator target was based on the assumption that the definition would remain consistent, however it was changed as part of the NIDS revision and now includes all neonatal deaths. We therefore foresee this problem persisting through the year.			In the previous year this indicator measured early neonatal death only (0-7 days), this has now been extended to 0-28 days. This years numerator target was based on the assumption that the definition would remain consistent, however it was changed as part of the NIDS revision and now includes all neonatal deaths. We therefore foresee this problem persisting through the year.			In the previous year this indicator measured early neonatal death only (0-7 days), this has now been extended to 0-28 days. This years numerator target was based on the assumption that the definition would remain consistent, however it was changed as part of the NIDS revision and now includes all neonatal deaths.			In the previous year early neonatal death (0-7 days) was reported. This was extended to early and late neonatal deaths (0-28 days) as part of the National Indicator Dataset (NIDS) revision and now includes all neonatal deaths. This year's numerator target was based on the assumption that the indicator would remain consistent resulting in a disparity between target and reporting.		
	ACTION PLAN		Child health co-ordinators to be consulted to determine whether the reporting process is reliable, and to determine whether additional action to current protocol is required to address this.			Child health co-ordinators to be consulted to determine whether the reporting process is reliable, and to determine whether additional action to current protocol is required to address this.			Child health co-ordinators to be consulted to determine whether the reporting process is reliable, and to determine whether additional action to current protocol is required to address this.			Targets adjusted accordingly for the new financial year FY2018/19			Targets adjusted accordingly for the new financial year FY2018/19		
Disease Prevention and Control																	
1	Cataract surgery rate	1,692	1,763	1,558	88%	1736	1,572	91%	1,880	1,517	81%	1,661	1,497.6	90%	1,760	1,540	88%
	Cataract surgery total	8,050	2,136	1,887	88%	2,103	1,904	91%	2,278	1,838	81%	2,012	1,814	90%	8,528	7,443	87%
	Uninsured population	4.759	1.211	1.211	100%	1.211	1.211	100%	1.211	1.211	100%	1.211	1.211	100%	4.845	4.833	100%
	COMMENT Rate per 1 000 000 population **Annual population figures were changed at a late stage in the APP compilation process. Unfortunately, in error, quarterly targets were not adjusted at the same time resulting in a misalignment between quarterly and annual targets Performance reported on correct quarterly population**		Performance in April lower than expected likely due to leave arrangements around public holidays and equipment shortages.			Staff shortages affected number of surgeries and types of surgeries performed			A decline in surgeries during December due to the holiday season			Performance expected to improve with finalised data.			The underperformance is attributed to equipment shortages and staff shortages at certain points during the year. Services to review plans to address this.		
	ACTION PLAN		Relevant managers are addressing equipment shortages.												Managers to address equipment and staff shortages during the year and to limit its impact.		
2	Malaria case fatality rate	0.7%	0.0%	1.9%	-100%	2.60%	0.0%	100%	0.0%	0.0%	100%	1.9%	0.0%	100%	1.2%	0.5%	100%
	Deaths from Malaria	1	0	1	100%	1	0	100%	0	0	100%	1	0	100%	2	1	100%
	Total number of Malaria cases reported	139	39	54	71%	39	38	103%	39	34	115%	53	60	88%	168	186	90%
	COMMENT		Fatality rate hard to predict and influenced by migratory population. The reported death occurred in Cape Winelands.			No deaths recorded in this quarter at this time.			No deaths recorded in this quarter at this time.			No deaths recorded in this quarter at this time.			Malaria is not endemic to the province and therefore cannot be predicted with 100% accuracy. A marginal deviation is considered by the Department as having achieved target.		
	ACTION PLAN																

PROGRAMME 3: Emergency Medical Services

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
EMS																	
	Number of WCG: Health Operational ambulances registered and licensed	248	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	248	247	100%	248	247	100%
	Number of WCG: Health operational ambulances registered and licensed	237	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	248	247	100%	248	247	100%
1.1.1	COMMENT					Annual Target			Annual Target			Dynamic EMS usage impacted vehicle availibity for inspections. Inpsectorate only has 2 people dedicated to EMS inspections which impacted the number of vehicles inspected. Withdrawn and written of vehicles replaced as per GMT schedule and not according to inspections to be done.			Dynamic EMS usage impacted vehicle availibity for inspections. Inpsectorate only has 2 people dedicated to EMS inspections which impacted the number of vehicles inspected. Withdrawn and written off vehicles replaced as per GMT schedule and not according to inspections to be done.		
	ACTION PLAN		No action			Annual Target			Annual Target			Vehicle inpsection schedule to be communicated with Inspectorate for improved availability.			Vehicle inpsection schedule to be communicated with Inspectorate for improved availability.		
	EMS P1 urban response under 15 minutes rate	58.2%	65.0%	62.1%	96%	65.0%	62.6%	96.27%	65.0%	59.0%	90.81%	65.0%	53.2%	81.92%	65.0%	59.5%	91.5%
	Numerator: EMS P1 urban response under	122645	19,477	21,322	109%	19,477	22,456	115%	19,477	19,582	101%	19,477	15,771	81%	77,908	79,131	102%
	Denominator: EMS P1 urban calls	210,688	29,965	34,339	115%	29,965	35,887	120%	29,965	33,175	111%	29,964	29,618	99%	119,859	133,019	111%
1	COMMENT		Despite higher P1 incident count, performance is on target. Target was reduced to account for resource limitations and Red Zone areas causing delays in response. A significant number of personnel are on sick leave due to Post Traumatic Stress Disorder, which impacts the ability to roster ambulances and negatively affects the operational ambulance fleet. It should also be noted that definitional changes in NIDS have resulted in Emergency Cases being split from IFT cases, with Obstetric cases being reported separately, and thus excluded. This will result in a difference in numerator and demonitator targets from previous years.			Priority 1 (P1 - Life Threatening) cases are once again higher than anticipated and higher than the previous quarter. Whilst attacks on staff still occur, safety initiatives and management of Red Zones appear to have allowed a plateau of these cases, although ad hoc violence, such as stoning of vehicles is still occurring. Red Zones remain a challenge in terms of their effect on prolonging call times whilst waiting for SAPS escorts, which results in a relative decrease in vehicle availability to service calls within the metropole. IN addition, health facilities have closed from time to time, which requires transportation to facilities further from the incident, again prolonging incident times. A high number of staff still remain in therapy for PTSD and related stress issues, which limits rostering of			A drop in performance is noted, which is attributable to a lower availability of resources (Post-Traumatic Stress Disorder (PTSD)-25 staff members not operational due to PTSD or related conditions. Volume of cases is lower than previous quarter with a slight increase in call volume of rural areas (holiday locations). Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes			A total of 14 vehicles (on average) are unable to be rostered due to prolonged ill health, including Post Traumatic Stress Disorder. In addition, 13% of our incidents occur in red zones, which adds additional burdeon on the service due to prolonged mission times (and hence decreased relative availabilty) as ambulances must wait for availability of South African Police Services for escorts. This has placed extreme pressure on the service to respond adequately to demand. Increasing areas of unrest have also resulted in "permanent red zones" in these areas. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes.			A total of 14 vehicles (on average) are unable to be rostered due to prolonged ill health, including Post Traumatic Stress Disorder. In addition, 13% of our incidents occur in red zones, which adds additional burdeon on the service due to prolonged mission times (and hence decreased relative availabilty) as ambulances must wait for availability of South African Police Services for escorts. This has placed extreme pressure on the service to respond adequately to demand. Increasing areas of unrest have also resulted in "permanent red zones" in these areas. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes.		
	ACTION PLAN		Continue performance initiatives. Focus on better identification of defined Red Zone areas to improve performance in these areas.			Continue initiatives. Actively manage stress and burnout cases. Continue collaboration with SAPS and Community Safety. Increase use of Emergency First Responder program			Continue initiatives. Actively manage stress and burnout cases. Continue collaboration with South African Police Service and Community Safety. Increase use of Emergency First Responder program			A significant redesign of interfacility transfer services is aimed for launch in April/May - this should improve response to transfers and free up more resources to service emergency calls. Actively manage stress and burnout cases. Continue collaboration with South African Police Service and Community Safety. Increase use of Emergency First Responder program			A significant redesign of interfacility transfer services is aimed for launch in April/May - this should improve response to transfers and free up more resources to service emergency calls. Actively manage stress and burnout cases. Continue collaboration with South African Police Service and Community Safety. Increase use of Emergency First Responder program		
	EMS P1 rural response under 40 minutes rate	79.4%	79.0%	80.6%	102%	79.0%	80.1%	101%	79.0%	78.8%	100%	79.0%	77.5%	98%	79.0%	79.3%	100%
	EMS P1 rural response under 40 minutes	14,118	2,575	2,268	88%	2,575	2,590	101%	2,575	2,611	101%	2,573	2,186	85%	10,298	9,655	94%
	EMS P1 rural calls (responses)	17,780	3,259	2,814	86%	3,259	3,232	99%	3,259	3,312	102%	3,259	2,822	87%	13,036	12,180	93%
2	COMMENT		Whilst essentially on target. The volume of cases now excludes maternity cases, as per new NIDS definitions. The migration to electronic PCR unfortunately resulted in exclusion of manual cases counts on Sinjani. This process has been corrected and will be included in Sinjani updates.			Performance is similar to previous quarter. Exclusion of Obstetric and Ift cases remains resulting in lower overall volume reflected.			Performance is similar to previous quarter, with an upward trend in call volume which may be attributed to the festive season migration to rural holiday locations. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes			Small volume changes in the rural areas results in realtively large changes in this indicator. Challenges meeting crew mandates due to low paramedic availability in these areas has resulted in pressure on performance.			Target Achieved		
	ACTION PLAN		Ensure data integration to Sinjani is corrected.			Continue performance initiatives with a focus on improving access to under represented geographic areas.			Continue performance initiatives with a focus on improving access to under represented geographic areas.			Continue performance initiatives with a focus on improving access to under represented geographic areas.					
	EMS inter-facility transfer rate	38.5%	38.1%	31.5%	83%	38.1%	31.4%	82.33%	38.1%	31.2%	81.77%	38.1%	32.2%	84.52%	38.12%	31.6%	83%
	EMS inter-facility transfer	203,306	50,827	38,556	76%	50,827	39,009	76.75%	50,827	38,859	76.45%	50,825	38,949	76.63%	203,306	155,373	76%
	EMS clients total	528,044	133,331	122,258	92%	133,331	124,366	93.28%	133,331	124,725	93.55%	133,331	120,954	90.72%	533,324	492,303	92%
3	COMMENT		Whilst essentially on target. The volume of cases now excludes maternity cases, as per new NIDS definitions.			Performance similar to previous quarter although increased volume is noted. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes, due to exclusions			Inter Facility Transfers showed a slight decrease during the quarter, but remained relatively flat compared to preceeding quarters. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes, due to exclusions above.			A slight increase in Inter Facility Transfer rate with their concomitant increased mission times places additional pressure on the ability to respond to community emergencies.			A slight increase in Inter Facility Transfer rate with their concomitant increased mission times places additional pressure on the ability to respond to community emergencies.		
	ACTION PLAN		Ensure data integration to Sinjani is corrected.			No action required.			No action required			A redesign of theInter Facility Transfer service should see improved service whilst also freeing up resources for community emergencies.			A redesign of theInter Facility Transfer service should see improved service whilst also freeing up resources for community emergencies.		

	Performance measure/ Indicator	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
4	**Total number of EMS emergency cases**	528,044	133,331	122258	92%	133,331	124366	93%	133,331	124725	94%	133,331	120954	91%	533,324	492303	92%
	COMMENT		Volume is significantly lower than expected as this now looks at patient counts, not incidents. Due to the discrepancy in Sinjani not including manual patient counts, this will need to be corrected to give an accurate reflection of patient volume.			Slight increase in volume from previous quarter. Total volume affected by definition change now reflecting cases transported to hospital only (not all cases attended to by EMS).			Total volume lower than targeted, but this reflects a change in definition to cases transported to hospital, and not all cases attended to by EMS. Overall trend is flat from Q1 to Q3. Higher call volume due to seasonal influx with a flat trend accros the quarters. Definitional change from National DoH occurred post setting of targets, and hence volume targets are higher than actual volumes			Total volume lower than targeted, but this reflects a change in definition to cases transported to hospital, and not all cases attended to by EMS.			Total volume lower than targeted, but this reflects a change in definition to cases transported to hospital, and not all cases attended to by EMS.		
	ACTION PLAN		Ensure data integration to Sinjani is corrected.			No Action required.			No action required			Active engagement with NDOH to assist with National Indicator data set and indicator definitions prior to Annual Performance Plan drafting					

PROGRAMME 4: Provincial Hospital Services

No.	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1 Target	Quarter 1 Actual Performance	Quarter 1 Actual % Achieved	Quarter 2 Target	Quarter 2 Actual Performance	Quarter 2 Actual % Achieved	Quarter 3 Target	Quarter 3 Actual Performance	Quarter 3 Actual % Achieved	Quarter 4 Target	Quarter 4 Actual Performance	Quarter 4 Actual % Achieved	Annual Target Total	Annual YTD Performance	Annual YTD % Achieved
General (regional) hospitals													General (regional) hospitals					
1.1.1	**Number of usable regional hospital beds**	**Actual (usable) beds (regional hospitals)**	1393	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	1,393	1,413	101%	1,393	1,413	101%
	COMMENT			No change in the number of usable regional hospital beds.			Paarl beds increased from 311 to 331 officially from June 2017 (additional 16 for Maternity and 4 for Psychiatry - these are Swartland Hospital beds). No changes in bed totals at other Regional Hospitals. Total beds for Regional Hospitals = 1413.			Paarl beds increased from 311 to 331 officially from June 2017 (additional 16 for Maternity and 4 for Psychiatry - these are Swartland Hospital beds). No changes in bed totals at other Regional Hospitals. Total beds for Regional Hospitals = 1413.			Paarl beds increased from 311 to 331 officially from June 2017 (additional 16 for Maternity and 4 for Psychiatry - these are Swartland Hospital beds). No changes in bed totals at other Regional Hospitals. Total beds for Regional Hospitals = 1413.			Paarl Hospital beds increased from 311 to 331 (additional 16 for Maternity and 4 for Psychiatry). These are Swartland Hospital beds. The target was set prior to the bed transfer being approved in terms of the departmental policy on bed changes.		
	ACTION PLAN			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.					
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (Regional hospitals)**		New Indicator	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100%
	Numerator	Hospitals that achieved at least 75% compliance with the national core standard (regional hospitals)	0	0	0	100%	0	0	100%	0	0	100%	5	5	100%	5	5	100%
	Denominator	Hospital that conducted a national core standard self-assessment during the financial year (regional hospital)	5	5	0	0%	5	0	0%	5	0	0%	5	5	100%	5	5	100%
	COMMENT			No hospitals conducted NCS assessments yet. Annual target.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			Target achieved – no deviation.			Target achieved – no deviation.		
	ACTION PLAN			Planned to start in Q2, reporting in Q3 and Q4.			Planned to start in Q2, reporting in Q3 and Q4.			Planned to conduct in Q4 when the National Core Standard (NCS) system enhancements are done, then hospitals will report in Q4.								
2	**Average length of stay (Regional Hospitals)**		3.9	3.9	3.9	99.3%	3.9	4.0	98.53%	3.8	3.98	95.5%	3.9	3.96	98.5%	3.9	3.96	98%
	Numerator	Patient days (inpatient days +1/2 day patients) (regional hospitals)	452,521	113,945	114,943	99%	113,904	113,871	100.03%	110,845	113,578	97.6%	113,856	112,942	100.8%	452,550	455,333	100.6%
	Denominator	Inpatient separations (Regional hospitals)	116,500	29,017	29,268	99%	28,937	28,769	100.58%	29,539	28,543	103.5%	29,056	28,519	101.9%	116,550	115,099	101%
	COMMENT			(2016/17 Q1 performance = 3.98 days). In line with previous year's performance. Increased efficiencies. Slight increase in Patient Days (Paarl, and Worcester) compared with same period last year.			(2016/17 Q2 performance = 3.94 days). In line with previous year's performance. Increased efficiencies.			This is a demand driven indicator.(2016/17 Q3 performance = 4.0 days). In line with previous year's performance. Increased efficiencies. Slight increase in Inpatient Days (George, and New Somerset). **Average length for GRH=3.1, MMH=4.2, NSH=4.4, PAH=3.2 & WOC=2.8**			(2016/17 Q4 performance = 3.9 days). In line with previous year's performance. Increased efficiencies.			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.		
3	**Inpatient bed utilization rate (Regional Hospitals)**		89.0%	89.6%	90.1%	101%	89.6%	88.7%	98.95%	87.2%	88.2%	101.1%	89.6%	87.6%	97.8%	89.0%	88.6%	100%
	Numerator	Patient days (inpatient days +1/2 day patients) (regional hospitals)	452,521	113,945	114,943	101%	113,904	113,871	99.97%	110,845	113,578	102.5%	113,856	112,942	99.2%	452,550	455,333	101%
	Denominator	Inpatient bed days available (Useable beds total X30.42)(Regional Hospital)	508,501	127,125	127,551	100%	127,125	128,433	101.03%	127,125	128,798	101.3%	127,125	128,950	101.4%	508,501	513,733	101%
	COMMENT			(2016/17 Q1 performance = 89.6%). In line with previous year's performance. Increased efficiencies. Slight increase in Patient Days (Paarl and Worcester) compared with same period last year. Paarl increase, 67% for Psychiatry, 15% for Maternity, 10% for Gynaecology. Worcester increase, 18% for Maternity, 17% for Paediatrics.			(2016/17 Q2 performance = 88.2%). In line with previous year's performance. Increased efficiencies. Facility deemed full at 85% bed occupancy rate.			(2016/17 Q3 performance=90.7%) Performance higher than anticipated due to increase workload thus the increased inpatient days resulted in the higher bed utilization rate (**NSH=100.5%, GRH=83.9%, MMH=88.5%, PAH=88.7% & WOC=79%**. Facility deemed full at 85% bed occupancy rate.			(2016/17 Q4 performance = 88.6%). Lower bed utilization due to decrease in patient-days - February has 28 days and March projected. Performance will be in line with target with actual figures for March. Facility deemed full at 85% bed occupancy rate.			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.					

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
4	**Expenditure PDE (Regional Hospital)**		R 2,927	R 2,744	R 2,889	94.99%	R 2,752	R 3,125	88.1%	R 2,798	R 3,146	88.9%	R 4,171	R 3,263	127.8%	R 3,119	R 3,106	100%
	Numerator	Expenditure in regional hospitals	1,729,622,000	407,183,500	427,423,178	95.3%	407,183,500	464,129,327	88%	407,183,500	465,586,881	87.5%	621,995,500	484,434,694	128.4%	1,843,546,000	1,841,574,080	100%
	Denominator	Patient Day Equivalent (PDE) (regional Hospitals)	590,924	148,387	147,959	100.3%	147,950	148,529	100%	145,514	147,995	98.3%	149,137	148,452	100.5%	590,987	592,935	100%
	COMMENT			(2016/17 Q1 performance = R2,753.23). The expenditure is slightly more than the target as the APL for Regional hospitals is filled at a higher than expected percentage plus the accruals paid in April now influences the projected June expenditure.			(2016/17 Q2 performance = R3,000). In Q2, the notch increments were paid and Paarl Hospital expenditure increased due to absorbing the Swartland Hospital patient load.			(2016/17 Q3 performance = R2,836). Expenditure is higher than target. The projected December data impacts on the current performance and this figure will be adjusted once the final data has been submitted.			(2016/17 Q4 performance = R3,116). Expenditure is lower than target due to March projected figures. Increased payments will be made in March due to late deliveries on equipment and increased efforts made to follow up on invoices before financial year-end. Very expensive post also not filled in Approved Post List, therefore hospitals will underspend.			Patient day equivalents (PDE) is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The expenditure per PDE was marginally less than anticipated..		
	ACTION PLAN			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.					
5	**Complaint Resolution rate (regional hospitals)**		99.3%	98.9%	100.0%	101%	98.9%	100.0%	101.1%	100.0%	100.0%	100%	100.0%	98.6%	99%	99.4%	99.6%	100%
	Numerator	Complaints resolved (Regional Hospitals)	303	92	87	95%	93	61	65.6%	62	51	82%	61	71	116%	308	270	88%
	Denominator	Complaints Received (regional Hospitals)	305	93	87	94%	94	61	64.9%	62	51	82%	61	72	118%	310	271	87%
	COMMENT			2016/17 Q1 performance = 53 complaints received, 100% resolved) Improvement due to better management of complaints process. More complaints received with 100% resolution rate.			(2016/17 Q2 performance = 87 complaints received, 100% resolved). Performance for Q2 = 59 (100.0% resolved): George Hospital = 10 (100.0%), Mowbray Maternity Hospital = 7 (100.0%), New Somerset Hospital = 14 (100.0%), Paarl Hospital = 17 (100.0%), Worcester Hospital = 11 (100.0%). Less complaints received from Mowbray Maternity Hospital this quarter.			(2016/17 Q3 performance = 92 complaints received, 100% resolved). Better management of complaints. Performance for Q3=33 complaints lodged and 50 complaints projected, **GRH= 4 (100%), NSH=8 (100%), PAH=11 (100%), WOC=9 (100%) , MMH=1(100%)**. All hospitals compliant.			(2016/17 Q4 performance = 71 complaints received, 100% resolved). Performance for Q4 = 63 (100.0% resolved):			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
6	**Complaint resolution within 25 working days rate (regional hospitals)**		97.7%	98.9%	99%	100%	98.9%	97%	98%	96.8%	100%	103%	100.0%	1.0	97%	99.0%	98.1%	99%
	Numerator	Complaints resolved within 25 working days (regional hospitals)	298	91	86	95%	92	59	64%	60	51	85%	61	69	113%	305	265	87%
	Denominator	Complaints resolved (Regional Hospitals)	305	92	87	95%	93	61	66%	62	51	82%	61	71	116%	308	270	88%
	COMMENT			(Q1 2016/17 performance = 53 complaints resolved, 96.2% resolved within 25 days) Improvement due to better management of complaints process. More complaints received with 100% resolved within 25 days.			(Q1 2016/17 performance = 87 complaints resolved, 97.7% resolved within 25 days). Performance for Q2 = 59 (96.6% resolved within 25 days), George Hospital = 10 (100.0%), Mowbray Maternity Hospital = 7 (100.0%), New Somerset Hospital = 14 (100.0%), Paarl Hospital = 17 (88.2%), Worcester Hospital = 11 (100.0%). Paarl Hospital had 2 complex complaints not resolved within 25 days.			(2016/17 Q3 performance = 92 complaints received, 100% resolved). Better management of complaints. Performance for Q3=33 complaints lodged and 50 complaints projected, **GRH= 4 (100%), NSH=8 (100%), PAH=11 (100%), WOC=9 (100%) , MMH=1(100%)**. All hospitals compliant.			(2016/17 Q4 performance = 71 complaints resolved, 98.6% resolved within 25 days). Performance for Q4 = 63 (100.0% resolved within 25 days):			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
7	**Mortality and morbidity review rate (regional hospitals)**		83.3%	84.3%	129.4%	153.51%	84.3%	121.6%	144.2%	84.3%	109.8%	130.25%	80.4%	64.7%	80.5%	83.3%	106.4%	128%
	Numerator	Mortality and morbidity review conducted per discipline (regional hospitals)	170	43	66	153.5%	43	62	144.2%	43	56	130.23%	41	33	80.5%	170	217	128%
	Denominator	Possible mortality and morbidity reviews (regional hospitals) x number of disciplines within regional hospitals	204	51	51	100.0%	51	51	100.0%	51	51	100.00%	51	51	100.0%	204	204	100%
	COMMENT			Monthly target = 14: Performance for April =14, May=16. M&M's conducted as planned, resulting in improved clinical governance and enhancing the quality of patient care. From April 2017, Paarl Hospital implemented monthly reporting of all their departmental M&M's - previously only reporting one joint hospital M&M per month. Number of monthly M&M's expected to increase from June 2017.			Monthly target = 17: Performance for July=12, August=13, September=13 (Projected). M&M reviews not conducted as planned or HOD's not submitting evidence. Paarl Hospital reported 1 M&M review per month (HOD's not submitting evidence that meetings are held), George Hospital reported 4 less reviews than previous period - excluded M&M reviews conducted by Specialist Outreach & Support teams at district hospitals. GENSES IM unit investigating possible duplication as some of the M&M reviews reported by Outreach and Support specialists were held at district hospitals - George and Worcester Hospitals affected.			Morbidity & Mortality Performance for October=21, November=15, & December=18 (Projected). **GRH =4, WOC=9, MMH=1, PAH=11 & NSH=8.**			(2016/17 Q4 performance = 39). Morbidity & Mortality reviews for Q4 = 30: George Hospital=8, Worcester Hospital=10, Mowbray Maternity Hospital=3, Paarl Hospital=1 & New Somerset Hospital=8. Not all specialities conducted M&M's at George and New Somerset Hospitals. HOD's not submitting evidence that Morbidity & Mortality reviews were conducted at Paarl Hospital.			More meetings were conducted than planned in terms of the target set, resulting in improved clinical governance and enhancing the overall quality of patient care. Over-performance mainly due to individual clinical units holding separate meetings – indicator target set by speciality groups.		
	ACTION PLAN			Performance discussed at management meetings, will closely monitor the overall performance.			Performance discussed at management meetings, will closely monitor the overall performance.			Performance discussed at management meetings, will closely monitor the overall performance.			Performance discussed at management meetings, will closely monitor the overall performance.					

Performance measure/ Indicator	Element		2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
	Specialised hospitals												**Specialised hospitals**			**Specialised hospitals**		
1.1.1	Number of usable specialised hospital beds	Actual (usable) beds (Specialised Hospitals)	2882	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	2882	2,882	100%	2882	2,882	100%
	COMMENT																	
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (Specialised**		New Indicator	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	72.7%	100.0%	138%	72.7%	100.0%	138%
	Numerator	Hospitals that achieved at least 75% compliance with the national core standard (Specialised hospitals)	4	0	0	100%	0	0	100%	0	0	100%	8	11	138%	8	11	138%
	Denominator	Hospital that conducted a national core standard self-assessment during the financial year (Specialised hospitals)	10	11	0	0%	11	0	0%	11	0	0%	11	11	100%	11	11	100%
	COMMENT																	
	ACTION PLAN																	
2	**Average length of stay (Specialised Hospitals)**		79.1	76.9	78.0	99%	76.0	78.8	96%	79.0	74.4	106%	85.7	76.5	112%	79.2	76.9	103%
	Numerator	Patient days (inpatient days +1/2 day patients) (Specialised hospitals)	887,679	221915	215,463	103%	226401	219,300	103%	222284	215,971	103%	223805	212,000	106%	894405	862,733	104%
	Denominator	Inpatient separations (Specialised hospitals)	11,221	2886	2,762	104%	2979	2,783	107%	2813	2,901	97%	2611	2,773	94%	11289	11,219	101%
	COMMENT																	
	ACTION PLAN																	
3	**Inpatient bed utilization rate (Specialised hospitals)**		84%	84.4%	81.9%	97%	86.1%	83.4%	97%	84.5%	82.1%	97%	85.1%	80.6%	94.7%	85.0%	82.0%	96%
	Numerator	Patient days (inpatient days +1/2 day patients) (Specialised hospitals)	887,679	221915	215,463	97%	226401	219,300	97%	222284	215,971	97%	223805	212,000	94.7%	894405	862,733	96%
	Denominator	Inpatient bed days available (Useable beds total X30.42)(Specialised hospitals)	1,052,045	263012	263,011	100%	263012	263,011	100%	263012	263,011	100%	263009	263,011	100.0%	1052045	1,052,045	100%
	COMMENT																	
	ACTION PLAN																	
4	**Expenditure PDE (Specialised hospitals)**		R 1,395	R 1,499	R 1,469	102%	R 1,481	R 1,487	100%	R 1,491	R 1,490	100%	R 1,475	R 1,618	91%	R 1,486	R 1,515	98%
	Numerator	Expenditure in(Specialised hospitals)	1,264,507,000	338,852,250	319,087,143	106%	338,852,250	332,653,249	102%	338,852,250	335,955,534	101%	338,852,250	343,538,208	99%	1,355,409,000	1,331,234,134	102%
	Denominator	Patient Day Equivalent (PDE)(Specialised hospitals)	906,173	226,029	217,284	104%	228,858	223,754	102%	227,265	225,449	101%	229,701	212,380	108%	911,852	878,867	104%
	COMMENT																	
	ACTION PLAN																	
5	**Complaint Resolution rate (Specialised hospitals)**		99.5%	97.9%	100.0%	102%	100.0%	100.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100%	99.5%	100.0%	101%
	Numerator	Complaints resolved (Specialised hospitals)	198	46	53	115%	54	56	104%	48	61	127%	51	53	104%	199	223	112%
	Denominator	Complaints Received (Specialised hospitals)	199	47	53	113%	54	56	104%	48	61	127%	51	53	104%	200	223	112%
	COMMENT																	
	ACTION PLAN																	
6	**Complaint resolution within 25 working days rate (Specialised hospitals)**		96.5%	93.6%	100.0%	107%	96.3%	100.0%	104%	95.8%	98.4%	103%	100%	98.1%	98%	96.5%	99.1%	103%
	Numerator	Complaints resolved within 25 working days (Specialised hospitals)	192	44	53	120%	52	56	108%	46	60	130%	51	52	102%	193	221	115%
	Denominator	Complaints resolved (Specialised hospitals)	199	47	53	113%	54	56	104%	48	61	127%	51	53	104%	199	223	112%
	COMMENT																	
	ACTION PLAN																	

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
7	**Mortality and morbidity review rate (Specialised hospitals)**		90.9%	100.0%	97.0%	97%	100.0%	97.0%	97%	78.8%	84.8%	108%	84.8%	90.9%	107%	90.9%	92.4%	102%
	Numerator	Mortality and morbidity review conducted per discipline (Specialised hospitals)	120	33	32	97%	33	32	97%	26	28	108%	28	30	107%	120	122	102%
	Denominator	Possible mortality and morbidity reviews (Specialised hospitals) x number of disciplines within(Specialised hospitals)	132	33	33	100%	33	33	100%	33	33	100%	33	33	100%	132	132	100%
	COMMENT																	
	ACTION PLAN																	
Tuberculosis hospitals																		
1.1.1	**Number of usable TB hospital beds**	**Actual (usable) beds (TB hospitals)**	1,026	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	1,026	1,026	100%	1,026	1,026	100%
	COMMENT																	
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (TB hospitals)**		New Indicator	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	66.7%	100.0%	150%	66.7%	100.0%	150%
	Numerator	Hospitals that achieved at least 75% compliance with the national core standard (regional hospitals)	4	0	0	100%	0	0	100%	0	0	100%	4	6	150%	4	6	150%
	Denominator	hospital that conducted a national core standard self-assessment during the financial year (TB hospitals)	5	6	0	0%	6	0	0%	6	0	0%	6	6	100%	6	6	100%
	COMMENT						We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports			Ongoing attention to improving performance on national core standards has resulted in all TB hospitals reaching the 75% mark and a better than expected performance.			Ongoing attention to improving performance on national core standards has resulted in all TB hospitals reaching the 75% mark and a better than expected performance.		
	ACTION PLAN																	
2	**Average length of stay (TB Hospitals)**		72.1	70.1	65.3	107%	66.1	67.1	99%	71.3	58.0	122.8%	83.0	59.8	138.8%	72.1	62.4	116%
	Numerator	Patient days (inpatient days +1/2 day patients) (TB hospitals)	281,165	70757	67,243	105%	73,107	67,701	108%	70,403	67,389	104%	72,521	63,675	113.9%	286,788	266,007	93%
	Denominator	Inpatient separations (TB hospitals)	3,900	1010	1,029	98%	1,106	1,009	110%	988	1,161	85%	874	1,065	82.1%	3,978	4,264	107%
	COMMENT			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service.						An increase in separations during November at the majority of TB hospitals requires further investigation.						Overall decrease due to the decrease in in-patient days. This is caused by Brooklyn Chest Hospital, Sonstraal and Harry Comay. This is a result of the policy of decentralisation of TB management and has resulted in patients having shorter admissions to hospital.		
	ACTION PLAN									Hospitals have been contacted for feedback.								
3	**Inpatient bed utilization rate (TB Hospitals)**		75.1%	75.6%	72.3%	95.6%	78.1%	72.8%	93.16%	75.2%	72.4%	96.3%	77.5%	68.5%	88.3%	76.6%	71.0%	93%
	Numerator	Patient days (inpatient days +1/2 day patients) (TB hospitals)	281,165	70,757	67,658	95.6%	73,107	68,127	93.19%	70,403	67,814	96%	72,521	64,102	88.4%	286,788	266,007	93%
	Denominator	Inpatient bed days available (Useable beds total X30.42)(TB Hospital)	374,531	93,633	93,633	100.0%	93,633	93,633	100.00%	93,633	93,633	100%	93,632	93,633	100.0%	374,531	374,531	100%
	COMMENT			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. Expected to improve with finalised data.			Lower than expected patient days, requiring further investigation.			This is a demand driven indicator						Overall decrease due to the decrease in in-patient days. This is caused by Brooklyn Chest Hospital, Sonstraal and Harry Comay. This is a result of the policy of decentralisation of TB management and has resulted in patients having shorter admissions to hospital.		
	ACTION PLAN																	

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
4	**Expenditure PDE (TB Hospital)**		R1021	R 1,071	R 1,096	97.7%	R 1,036	R 1,088	95.18%	R 1,076	R 1,092	98.57%	R 1,044	R 1,229	84.9%	R 1,056	R 1,125	93.9%
	Numerator	Expenditure in TB hospitals	289,300,000	76,342,000	74,143,333	103.0%	76,342,000	74,151,203	102.95%	76,342,000	74,026,909	103%	76,342,000	78,807,613	96.9%	305,368,000	301,129,058	98.6%
	Denominator	Patient Day Equivalent (PDE) (TB Hospitals)	283,380	71,314	67,658	105.4%	73,683	68,127	108.15%	70,958	67,814	105%	73,092	64,102	114.0%	289,047	267,701	92.6%
	COMMENT			A marginal deviation from the performance target is considered by the Department as having achieved the target			Expenditure on track, however lower than expected patients require further investigation.			This is a demand driven indicator						Much of expenditure is in fixed costs (eg staff), regardless of the number of admissions or how long patients stay inhospital. So while actual expenditure was less than target, because patients were admitted for shorter stays than expected, the cost per patient day equivalent (patient day spent in hospital) was higher than the target		
	ACTION PLAN																	
5	**Complaint Resolution rate (TB hospitals)**		100.0%	100.0%	100.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100.0%	100.0%	100.0%	100%
	Numerator	Complaints resolved (TB Hospitals)	54	11	9	82%	17	11	65%	11	16	145%	15	5	33.3%	54	41	76%
	Denominator	Complaints Received (TB Hospitals)	54	11	9	82%	17	11	65%	11	16	145%	15	5	33.3%	54	41	76%
	COMMENT																	
	ACTION PLAN																	
6	**Complaint resolution within 25 working days rate (TB hospitals)**		94.4%	90.9%	100%	110%	94.1%	100%	106%	90.9%	100%	110%	100.0%	1.0	100.00%	94.4%	100%	106%
	Numerator	Complaints resolved within 25 working days (TB hospitals)	51	10	9	90%	16	11	69%	10	16	160%	15	5	33.33%	51	41	80%
	Denominator	Complaints resolved (TB Hospitals)	54	11	9	82%	17	11	65%	11	16	145%	15	5	33.33%	54	41	76%
	COMMENT			A positive performance with more complaints sourced and addressed. Smaller numbers have greater impact on performance.						This is a demand driven indicator						Target achieved		
	ACTION PLAN																	
7	**Mortality and morbidity review rate (TB hospitals)**		88.9%	100.0%	94%	94%	100.0%	100.0%	100%	72.2%	83.3%	115%	83.3%	94.4%	113.38%	88.9%	93.1%	105%
	Numerator	Mortality and morbidity review conducted per discipline (TB hospitals)	64	18	17	94%	18	18	100%	13	15	115%	15	17	113.33%	64	67	105%
	Denominator	Possible mortality and morbidity reviews (TB hospitals) x number of disciplines within TB hospitals	72	18	18	100%	18	18	100%	18	18	100%	18	18	100.00%	72	72	100%
	COMMENT									Facilities were able to conduct more reviews than planned.						A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN																	
Psychiatric hospitals																		
1.1.1	**Number of usable psychiatric hospital beds**	**Actual (usable) beds (psychiatric hospitals)**	1,700	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	1,700	1,700	100.00%	1,700	1,700	100%
	COMMENT			No change in the number of usable psychiatric hospital beds.			No change in the number of usable psychiatric hospital beds.			No change in the number of usable psychiatric hospital beds.			No change in the number of usable psychiatric hospital beds.			Target achieved, zero deviation.		
	ACTION PLAN			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.					
1.1.2	**Number of usable beds (step-down facilities)**	**Actual (usable) beds (step-down facilities)**	150	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	150	150	100.00%	150	150	100%
	COMMENT			No change in the number of usable step-down facilities			No change in the number of usable step-down facilities.			No change in the number of usable step-down facilities.			No change in the number of usable step-down facilities: New Beginnings = 105, William Slater = 25, Lentegeur Intermediate = 20.			Target achieved, zero deviation.		
	ACTION PLAN			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.					

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (Psychiatric**		Not Required to report	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100%
	Numerator	Hospitals that achieved at least 75% compliance with the national core standard (Psychiatric Hospitals)	0	0	0	100%	0	0	100%	0	0	100%	4	4	100%	4	4	100%
	Denominator	hospital that conducted a national core standard self-assessment during the financial year (Psychiatric hospitals)	4	4	0	0%	4	0	0%	4	0	0%	4	4	100%	4	4	100%
	COMMENT			No hospitals conducted NCS assessments yet.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.						Target achieved, zero deviation.		
	ACTION PLAN			Planned to start in Q2, reporting in Q3 and Q4.			Planned to start in Q2, reporting in Q3 and Q4.			Planned to conduct in Q4 when the National Core Standard (NCS) system enhancements are done, then hospitals will report in Q4.								
2	**Average length of stay (Psychiatric Hospitals)**		86.5	83.87260766	89.4	93.8%	84.96280744	89.1	95.4%	85.4	89.0	104.2%	91.8	91.7	100.1%	86.4	89.8	96.2%
	Numerator	Patient days (inpatient days +1/2 day patients) (Psychiatric Hospitals)	563,319	140,235	137,796	101.8%	141,633	140,523	101%	141,056	138,038	102%	140,396	137,719	101.9%	563,320	554,075	98%
	Denominator	Inpatient separations (Psychiatric Hospitals)	6,516	1,672	1,541	108.5%	1,667	1,578	106%	1,652	1,551	107%	1,529	1,502	101.8%	6,520	6,172	106%
	COMMENT			(2016/17 Q1 performance = 84.3%). Higher ALOS caused by decrease in separations compared to same period last year. From February 2017, Alexandra Hospital discontinued admission of respite patients (IDS patients admitted to give family a break during holidays, etc.). Lentegeur Hospital currently renovating their child and adolescent ward - selectively admitting half the normal patient intake. Valkenberg Hospital struggled with discharging a number of acute patients due to poor family support and limited community based accommodation.			(2016/17 Q2 performance = 87.6%). Higher ALOS caused by decrease in separations compared to same period last year - placement issues for discharged patients. From February 2017, Alexandra Hospital discontinued admission of respite patients (Intellectual Disability patients admitted to give family a break during holidays, etc.). Lentegeur Hospital separations on a lowering trend, mostly Forensic speciality - hospital not administratively admitting forensic patients placed on LOA (Leave of Absence) coming in for periodic psych. assessments and repeat meds (outpatient service). Previously, the hospital was administratively admitting LOA patients that overnighted at			This is a demand driven indicator.(2016/17 Q3 performance = 90.0%). Higher ALOS caused by decrease in separations specifically from LGH and SLH compared to same period last year. From February 2017, Alexandra Hospital discontinued admission of respite patients (Intellectual Disability patients admitted to give family a break during holidays, etc.). Lentegeur Hospital separations on a lowering trend, mostly Forensic speciality.			(2016/17 Q4 performance = 90.1%). Higher ALOS caused by decrease in separations compared to same period last year. From February 2017, Alexandra Hospital discontinued admission of respite patients (Intellectual Disability patients admitted to give family a break during holidays, etc.).			On average patients stayed longer than anticipated due to the acuity of mental illness. Psychiatric hospitals have been experiencing placement issues and challenges with discharging some acute patients due to poor family support and limited community based accommodation in some cases. A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical governance meetings. The programme will closely monitor the overall performance. At Clinical Governance meeting in March 2017, a proposal was made for the CEO's of Psych and Rehab hospitals to consolidate the issues around Placement Problems for long staying patients and setup meeting with Dr. Kariem, so that it can be taken up with Dr. Keith Cloete for Inter-governmental collaboration improvement with Social Development,			Performance discussed at Clinical governance meetings. The programme will closely monitor the overall performance. Placement Problems for long staying patients referred to top management for Inter-governmental collaboration improvement with Social Development, etc.			Performance to be discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corportate governance meetings. The programme will closely monitor the overall performance. Placement Problems for long staying patients referred to top management for Inter-governmental collaboration improvement with Social Development, etc.					
3	**Inpatient bed utilisation rate (Psychiatric Hospitals)**		90.8%	90.4%	88.8%	98.3%	91.3%	90.6%	99.2%	90.9%	89.0%	97.9%	90.5%	88.8%	98.1%	90.8%	89.3%	98%
	Numerator	Patient days (inpatient days +1/2 day patients) (Psychiatric Hospitals)	563,319	140,235	137,796	98.3%	141,633	140,523	99%	141,056	138,038	98%	140,396	137,719	98%	563,320	554,075	98%
	Denominator	Inpatient bed days available (Usuable beds total X30.42)(Psychiatric Hospitals)	620,568	155,142	155,142	100.0%	155,142	155,142	100%	155,142	155,142	100%	155,142	155,142	100%	620,568	620,568	100%
	COMMENT			(2016/17 Q1 performance = 90.4%). In line with last year's performance. Slight drop in performance due to loss in Patient days (weekend/holiday leave). Easter fell in March 2016 (not affecting 2016/17 Q1) and fell in April 2017 this year (affecting 2017/18 Q1 data).			(2016/17 Q2 performance = 90.7%). In line with last year's performance. Effective bed management.			(2016/17 Q3 performance = 90.8%). In line with last year's performance. Effective bed management. Minimal patient fluctuation			(2016/17 Q4 performance = 88.3%). In line with last year's performance. Effective bed management. Minimal patient fluctuation			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Clinical governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate governance meetings. The programme will closely monitor the overall performance.					
4	**Expediture PDE (Psychiatric Hospital)**		R 1,479	R 1,601	R 1,525	105.0%	R 1,596	R 1,564	102.0%	R 1,583	R 1,621	97.65%	R 1,580	R 1,653	95.6%	R 1,590	R 1,591	100%
	Numerator	Expenditure in Psychiatric Hospital	855,139,200	229,814,200	215,300,051	106.7%	229,814,200	225,659,592	102%	229,814,200	229,352,076	100%	229,814,200	233,229,993	99%	919,256,800	903,541,712	98%
	Denominator	Patient Day Equivalent (PDE) (Psychiatric Hospital)	578,206	143,569	141,189	101.7%	144,028	144,263	100%	145,160	141,482	103%	145,452	141,060	103%	578,208	567,993	98%
	COMMENT			(2016/17 Q1 performance = R 1 465). Performance in line with last year's performance. Low level of payment activity resulting in a lower expenditure figure for this quarter. June expenditure projected from lower April figures. Expenditure figure expected to rise with actual expenditure figures for June			(2016/17 Q2 performance = R 1 416). Performance in line with last year's performance. Effective budget management and expenditure control.			(2016/17 Q3 performance = R 1,467). Expenditure higher than target. December data impacts on the current performance and this figure will be adjusted once the final data has been submitted.			(2016/17 Q4 performance = R 1,663).Expenditure higher than target. March data impacts on the current performance and this figure will be adjusted once the final data has been submitted.			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.					

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
5	**Complaint Resolution rate (Psychiatric Hospital)**		99.0%	96.2%	100.0%	104.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	99.0%	100.0%	101%
	Numerator	Complaints resolved (Psychiatric Hospital)	102	25	32	128.0%	26	39	150.0%	26	34	130.77%	26	39	150%	103	144	140%
	Denominator	Complaints Received (Psychiatric Hospital)	103	26	32	123.1%	26	39	150.0%	26	34	130.77%	26	39	150%	104	144	138%
	COMMENT			(Q1 2016/17 performance = 35 complaints received, 100% resolved) All hospitals compliant with a more active complaints management approach.			(Q2 2016/17 performance = 30 complaints received, 100% resolved) All hospitals compliant with a more active complaints management approach.			(Q3 2016/17 performance = 25 complaints received, 100% resolved) All hospitals compliant with a more active complaints management approach. Performance for Q3=24 complaints lodged and 36 complaints projected, **ALX=4 (100%), LGH=7 (100%), SLH=4 (100%), VBH=9 (100%).** All hospitals compliant.			Target Achieved			Target Achieved		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
6	**Complaint resolution within 25 working days rate (Psychiatric Hospital)**		98.1%	92.3%	100%	108%	100.0%	100%	100%	100.0%	97%	97%	100.0%	1.0	97%	99.0%	98.6%	100%
	Numerator	Complaints resolved within 25 working days (Psychiatric Hospital)	101	24	32	133%	26	39	150%	26	33	127%	26	38	146%	102	142	139%
	Denominator	Complaints resolved (Psychiatric Hospital)	103	26	32	123%	26	39	150%	26	34	131%	26	39	150%	103	144	140%
	COMMENT			(Q1 2016/17 performance = 35 complaints resolved, 100% resolved within 25 days) All hospitals compliant with a more active complaints management approach.			(Q2 2016/17 performance = 30 complaints resolved, 100% resolved within 25 days) All hospitals compliant with a more active complaints management approach.			(Q3 2016/17 performance = 25 complaints received, 92% resolved). Performance for Q3=24 complaints lodged, **ALX=4 and 3 resloved within 25 days(75%), LGH=7 (100%), SLH=4 (100%), VBH=9 (100%).**			Target Achieved			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
7	**Mortality and morbidity review rate (Psychiatric Hospital)**		91.7%	100.0%	100.0%	100.00%	100.0%	91.7%	91.7%	83.3%	91.7%	110.04%	83.3%	83.3%	100.04%	91.7%	91.7%	100%
	Numerator	Mortality and morbidity review conducted per discipline (Psychiatric Hospital)	44	12	12	100.00%	12	11	91.7%	10	11	110.00%	10	10	100%	44	44	100%
	Denominator	Possible mortality and morbidity reviews(Psychiatric Hospitals) x number of disciplines within Psychiatric Hospital	48	12	12	100.00%	12	12	100.0%	12	12	100.00%	12	12	100%	48	48	100%
	COMMENT			(Q1 2016/17 performance = 12) All hospitals conducting their monthly M&M reviews as planned.			(Q2 2016/17 performance = 12) All hospitals conducting their monthly M&M reviews as planned.			(Q3 2016/17 performance = 12) All hospitals conducting their monthly M&M reviews as planned.			(2016/17 Q4 performance = 11) All hospitals conducting their monthly Morbidity & Mortality reviews as planned.			Target achieved, zero deviation.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
8	**Inpatient bed utilisation rate (step down facilities)**		83.5%	84.7%	80.27%	94.8%	85.7%	80.49%	93.9%	80.1%	80.09%	100.0%	83.5%	80.64%	96.6%	83.5%	80.37%	96%
	Numerator	Patient days (step down Facilities)	45,701	11,591	10,988	94.8%	11,733	11,018	94%	10,959	10,963	100.0%	11,427	11,039	97%	45,710	44,008	96%
	Denominator	Usable beds total x 30.42 (step-down facilities)	54,756	13,689	13,689	100.0%	13,689	13,689	100%	13,689	13,689	100.0%	13,689	13,689	100%	54,756	54,756	100%
	COMMENT			(Q1 2016/17 performance = 84.1%) Slight drop in performance due to loss in Patient days (weekend/holiday leave). Easter fell in March 2016 (not affecting 2016/17 Q1) and fell in April 2017 this year (affecting 2017/18 Q1 data).			(Q2 2016/17 performance = 82.1%) Clinicom implementation on 1 July 2017 at Lentegeur Intermediate and William Slater step-down facilities. Drop in patient-days due to Clinicom system excluding week-end and other leave days that may have been erroneously counted when using data collected manually - normal experience with Clinicom implementation as electronic systems are more efficient.			(Q3 2016/17 performance = 72.1%) Clinicom implementation on 1 July 2017 at Lentegeur Intermediate and William Slater step-down facilities. December data impacts on the current performance and this figure will be adjusted once the final data has been submitted. More patient tends to be discharged for the festive season.			(2016/17 Q4 performance = 88.3%) Usable bed-days = 13 689 (not 13233). Clinicom implementation on 1 July 2017 at Lentegeur Intermediate and William Slater step-down facilities. March data impacts on the current performance and this figure will be adjusted once the final data has been submitted.			The bed utilisation rate in step down facilities was marginally lower than anticipated. The marginal deviation from the performance target is considered by the department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					

Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Rehabilitation hospitals																	
1.1.1	**Number of usable rehabilitation hospital beds** **Actual (usable) beds (rehabilitation hospitals)**	156	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	156	156	100%	156	156	100%
	COMMENT		No change in the number of usable Rehabilitation hospital beds.			No change in the number of usable Rehabilitation hospital beds.			No change in the number of usable Rehabilitation hospital beds.			No change in the number of usable Rehabilitation hospital beds.			Target achieved, zero deviation.		
	ACTION PLAN		Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.			Continue to monitor effective bed management.					
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (rehabilitation hospitals)**	Not Required to report	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	100.0%	100%	0.0%	100.0%	100%
	Numerator Hospitals that achieved at least 75% compliance with the national core standard (rehabilitation hospitals)	0	0	0	100%	0	0	100%	0	0	100%	0	1	100%	0	1	100%
	Denominator hospital that conducted a national core standard self-assessment during the financial year (rehabilitation hospitals)	1	1	0	0%	1	0	0%	1	0	0%	1	1	100%	1	1	100%
	COMMENT		No hospitals conducted NCS assessments yet.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.								
	ACTION PLAN		Planned to start in Q2, reporting in Q3 and Q4.			Planned to start in Q2, reporting in Q3 and Q4.			Planned to conduct in Q4 when the National Core Standard (NCS) system enhancements are done, then hospitals will report in Q4.								
2	**Average length of stay (rehabilitation hospitals)**	53.7	53.5	54.3	98.5%	56.6	56.5	100.2%	62.6	55.8	112.2%	52.3	51.5	101.6%	56.0	54.5	102.8%
	Numerator Patient days (inpatient days +1/2 day patients) (rehabilitation hospitals)	43,195	10,923	10,425	104.8%	11,661	11,077	105.3%	10,825	10,544	103%	10,888	10,606	103%	44,297	42,652	96%
	Denominator Inpatient separations (rehabilitation hospitals)	805	204	192	106.3%	206	196	105.1%	173	189	92%	208	206	101%	791	783	101%
	COMMENT		(2016/17 Q1 performance = 54.8) Average length of stay in rehabilitation hospitals is best monitored three-monthly as this more accurately reflects the turn-around time for rehab of 50% plus of our patients (spinal cord afflicted). Strokes/traumatic brain injuries have shorter lengths of stay. With the Easter holidays in April, many patients took long weekend/holiday leave, which increases the turn-around time for rehab and therefore length of stay. A higher number of patients to be discharged in June, which will reflect in the actual June figures.			(2016/17 Q2 performance = 57.4) Higher ALOS mainly due to long staying patients. In the past, high ALOS for Western Cape Rehabilitation Centre was due to a number of medical problems, but now the main issues affecting ALOS are placement of discharged patients and treatment of pressure sores. 5 Long-stayers were discharged or placed from June 2017, and 4 patients awaiting placement at Cheshire Homes, 1 is a foreign national.			This is a demand driven indicator.(2016/17 Q3 performance = 64.2) The Top Management Team reviews monthly reports on all "long-stayers i.e patients that have exceeded their original date of discharge. Each case is reviewed with the Team, and different Solutions to expedite discharge are discussed, and where possible implemented. These monthly reviews have increased the accountability of the Teams, to be both effective and efficient. The 3 x In-patient Interprofessional Teams continue to work towards Discharge Planning from day 1 of admission, and achieving an optimal outcome level for each patient, keeping in mind the AOP/APP Target for ALOS. There remain a number of patients who exceed by far the target LOS for their diagnostic group (e.g. "long-stayers" , patients with pressure sores, no discharge destination, long-term ventilated patients, illegal/foreign nationals requiring repatriation). The number of admissions for Stroke Rehabilitation has increased to ≥ 50% of all admissions. Their rehabilitation period is shorter than that of Spinal Cord Afflicted patients (quadriplegia and paraplegia), approx40-50 days vs 2-3 months. This probably off-sets the excessive long stay of some of our patients.			(2016/17 Q4 performance = 56.3) Average Length of Stay in line with target mainly due to high number of separations in February compared to last year, as well as February being a shorter month and March projected. Average Length of Stay will be higher with actual March numbers due to long-stay (placement issues, patients with pressure sores and ventilated patients).			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN		Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Interim plan will be communicated to top management, which can only be finalised once we have a new provider. That process will be concluded during October. The contract with Life Esidimeni extended until end of December 2017. It is envisaged that the new organisation will take over from January 2018 but new admissions for the new provider may only take place in the new financial year. Realistically, we are aiming for 1 April 2018. The programme will closely monitor the progress and overall performance.			Continue to review on a monthly basis, every case where the patient has exceeded the predicted Lengtg of stay (LOS), and has passed their originally identified Discharge date. Continue with Ward Rounds and discussion with the respetive Inter-professional Teams (Team 1, 2 or 3).			Continue to review on a monthly basis, every case where the patient has exceeded the predicted Length of stay (LOS), and has passed their projected discharge date.					

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
3	**Inpatient bed utilisation rate (rehabilitation hospitals)**		75.9%	76.7%	73.2%	95.5%	81.9%	77.8%	95%	76.0%	74.1%	97%	76.5%	74.5%	97.4%	77.8%	74.9%	96%
	Numerator	Patient days (inpatient days +1/2 day patients) (rehabilitation hospitals)	43,195	10,923	10,425	95.4%	11,661	11,077	95.0%	10,825	10,544	97%	10,888	10,606	97%	44,297	42,652	96%
	Denominator	Inpatient bed days available (Usuable beds total X30.42)(rehabilitation hospitals)	56,946	14,237	14,237	100.0%	14,237	14,237	100.0%	14,237	14,237	100%	14,235	14,237	100%	56,946	56,946	100%
	COMMENT			(Q1 2016/17 performance = 76.7%) Slight drop in performance due to loss in Patient days (weekend/holiday leave). Easter fell in March 2016 (not affecting 2016/17 Q1) and fell in April 2017 this year (affecting 2017/18 Q1 data).			(Q2 2016/17 performance = 78.6%) Minimal patient fluctuation.			(Q3 2016/17 performance = 79.1%) Minimal patient fluctuation. BUR Is sligtly above the target. Bed Occupancy Monday to Friday remains in excess of 80%. (Q 2= 86% & YTD = 82%). However, patients going on week-end "leave" as part of the rehabilitation process and identifying home reintegration challenges then reduces the BUR to in the region of 75%.			(Q3 2016/17 performance = 78.3%). Minimal patient fluctuation. Bed utilisation sligtly below target due to March projected from January and February (shorter month). Performance will be in line with target with actual figures for March.			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Clinical Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.			Performance discussed at Corporate Governance meetings. The programme will closely monitor the overall performance.					
4	**Expediture PDE (rehabilitation hospitals)**		R 2,693	R 2,933	R 2,766	106.0%	R 2,933	R 2,890	101.5%	R 2,933	R 3,004	98%	R 2,931	R 2,901	101%	R 2,933	R 2,891	101.5%
	Numerator	Expenditure in rehabilitation hospitals	120,067,800	32,696,050	29,643,759	110.3%	32,696,050	32,842,454	99.6%	32,696,050	32,576,549	100%	32,696,050	31,500,602	104%	130,784,200	126,563,364	97%
	Denominator	Patient Day Equivalent (PDE) (rehabilitation hospitals)	44,587	11,146	10,715.67	104.0%	11,147	11,363.83	98.1%	11,147	10,843.00	103%	11,157	10,859.33	103%	44,597	43,782	98%
	COMMENT			(2016/17 Q1 performance = R2 604). In line with last year's performance. Low level of payment activity resulting in a lower expenditure figure for this quarter. June expenditure projected from lower April figures. Expenditure figure expected to rise with actual expenditure figures for June.			(2016/17 Q2 performance = R2 503). In line with last year's performance.			(2016/17 Q3 performance = R2 549). Inline with target set for Q3.			(2016/17 Q4 performance = R2 631). In line with target set for Q4. Expenditure is lower than target due to March projected figures. Increased payments will be made in March due to late deliveries on equipment and increased efforts made to follow up on invoices before financial year-end. Very expensive post also not filled in Approved Post List, therefore hospitals will underspend.			Patient day equivalents (PDE) is a demand-driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. The expenditure per PDE was slightly less than anticipated.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.			Performance is discussed at monthly Focus FMC meetings. The programme will closely monitor the overall performance.					
5	**Complaint Resolution rate (rehabilitation hospitals)**		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.00%	100.0%	100.0%	100.0%	100.0%	100.0%	100%	100.0%	100.0%	100%
	Numerator	Complaints resolved (rehabilitation hospitals)	42	10	12	120.0%	11	6	54.55%	11	11	100.0%	10	9	90%	42	38	90%
	Denominator	Complaints Received (rehabilitation hospitals)	42	10	12	120.0%	11	6	54.55%	11	11	100.0%	10	9	90%	42	38	90%
	COMMENT			(Q1 2016/17 performance = 5 complaints received, 100% resolved) Hospital compliant with a more active complaints management approach.			(Q2 2016/17 performance = 7 complaints resolved, 100% resolved). Rehab hospital compliant with a more active complaints management approach.			(Q3 2016/17 performance = 8 complaints resolved, 100% resolved). Rehabilitation hospital compliant with a more active complaints management approach. **WCRC=6 (100%)**complaints lodged and 9 projected.			(2016/17 Q4 performance = 12 complaints resolved, 100% resolved). Rehabilitation hospital compliant.			Target Achieved		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
6	**Complaint resolution within 25 working days rate (rehabilitation hospitals)**		95.2%	100.0%	100%	100%	90.9%	100%	110%	90.9%	100%	110%	100.0%	100%	100%	95.2%	100%	105%
	Numerator	Complaints resolved within 25 working days (rehabilitation hospitals)	40	10	12	120%	10	6	60%	10	11	110%	10	9	90%	40	38	95%
	Denominator	Complaints resolved (rehabilitation hospitals)	42	10	12	120%	11	6	55%	11	11	100%	10	9	90%	42	38	90%
	COMMENT			(Q1 2016/17 performance = 5 complaints resolved, 100% resolved within 25 days) All hospitals compliant with a more active complaints management approach.			(Q2 2016/17 performance = 7 complaints resolved, 100% resolved within 25 days) Rehab hospital compliant with a more active complaints management approach.			(Q3 2016/17 performance = 8 complaints resolved, 100% resolved). Rehabilitation hospital compliant with a more active complaints management approach. **WCRC=6 (100%)**complaints lodged and 9 projected.			(2016/17 Q3 performance = 12 complaints resolved, 83.3% resolved within 25 days). Rehabilitation hospital 100% compliant.			A marginal deviation from the performance target is considered by the Department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					
7	**Mortality and morbidity review rate (rehabilitation hospitals)**		100.0%	100.0%	100.0%	100%	100.0%	100.0%	100%	100.0%	66.7%	66.67%	100.0%	100.0%	100.00%	100.0%	91.7%	92%
	Numerator	Mortality and morbidity review conducted per discipline (rehabilitation hospitals)	12	3	3	100%	3	3	100%	3	2	66.67%	3	3	100%	12	11	92%
	Denominator	Possible mortality and morbidity reviews (rehabilitation hospitals) x number of disciplines within rehabilitation hospitals	12	3	3	100%	3	3	100%	3	3	100.00%	3	3	100%	12	12	100%
	COMMENT			(Q1 2016/17 performance = 3) Hospital conducting its monthly M&M reviews as planned.			(Q2 2016/17 performance = 3) Rehab hospital conducting their monthly M&M reviews as planned.			(Q3 2016/17 performance = 3) Rehabilitation hospital conducting their monthly M&M reviews as planned. Compliant.			(2016/17 Q4 performance = 3) Rehabilitation hospital 100% compliant.			Fewer meetings were conducted than planned. No mortality and morbidity review was conducted in December 2017. The marginal deviation from the performance target is considered by the department as having achieved the target.		
	ACTION PLAN			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.					

Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
			Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target Total	YTD	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Dental training hospitals																	
1.1	Oral health patient visits at dental training	Oral Health visits at dental training hospitals	122,250	37,000	33,974	92%	38,904	34,505	89%	23,976	28,378	118%	22,380	30,081	134%	122,260	126,938	104%
	COMMENT			(2016/17 Q1 performance = 35,840) Students stopped academic programme for mid-term exam preparations.			(2016/17 Q2 performance = 34,953) These are closely linked to student attendance. The mid-year examination and vacation periods in July impacted on the patient visits and resultant drop in patient visits. Students are also reluctant to start new patients whom the laboratory work will not be completed within the academic time available for them. September projected from low figures - increase expected with actual figures.			(2016/17 Q3 performance = 22,967) This quarter shows an increase above target projection but balances out the overall projected figure for patient visits. This quarter saw the students completing their clinical work before the final examinations and year end. Over-performance due to projected figures for December (low-yield month as students on vacation). More realistic performance will show in actual figures for December.			(2016/17 Q4 performance = 30,343) This quarter shows an increase above target but balances out the annual projected figure for patient visits. The positive for the quarter are New and Follow up patient visits of students. The projection does not take into account the Easter break, which starts end March.			The number of oral health patient visits is a demand-driven indicator, which means it is not possible for the Department to predict with 100% accuracy the number of people that will require a health service. This is mainly a student driven service, supported by service rendering staff. This indicator will stay more or less the same due to the number of student intake being controlled. Over-performance mainly due to fewer disruptions in student curriculum compared to last year and patient visits from last year being carried over to the new year.		
	ACTION PLAN			Students working throughout the first semester with no mid-term vacation period. Uninterrupted clinical period up to June, which will result in more patients receiving oral health services. The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance. More patients to be seen in September (as experienced in previous years), which will show in actual Q2 figures.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance. Re-distribute performance targets to take student carriculum into account.					
1	Number of removable oral health	Prosthetic units (dentures) issued	3,890	1,010	1,123	111%	1,350	1,580	117%	1,080	1,742	161%	455	408	90%	3,895	4,853	125%
	COMMENT			(2016/17 Q1 performance =1,224) Students stopped academic programme for mid-term exam preparations. Prosthetic device takes 4 to 5 weeks to complete and therefore the examination break means some devices are in "mid-stream".			(2016/17 Q2 performance =1,224) The performance is linked to completion time of devices rolling over into the new quarter. Dental lab technicians take up to 6 - 7 weeks to construct the dental devices. A number of dental devices issued in this quarter were still in process from previous quarter.			(2016/17 Q3 performance =1,399) It is not clinically sound practice to leave prosthetic work incomplete for an extended time period (end of year vacation). Therefore all work in progress was completed in this quarter with an additional load on the outsourcing laboratory work. Completion of prosthetic work before examinations and fulfilling of clinical requirements resulted in an increase in the number of prosthetic devices issued. Over-performance due to projected figures for December (low-yield month as students on vacation). More realistic performance will show in actual figures for December.			(2016/17 Q4 performance =410) Prosthetic devices take 6 weeks to complete - recorded only once issued. Jobs done by students only start after patient visits for fitting, re-fitting, adjustments, etc. - student curriculum only starts in February. Performance expected to spike in following quarters as devices will be completed and issued.			The overall prosthetic devices were higher than the target total for the year. Over-performance mainly due to fewer disruptions in student curriculum compared to last year and outstanding prosthetic work from last year being carried over to the new year. Prosthetic work in progress was completed with an additional load on the outsourcing laboratory. The service also had students completing their work before examinations and fulfilling of clinical requirements resulted in an increase in the number of prosthetic devices manufactured.		
	ACTION PLAN			Students working throughout the first semester with no mid-term vacation period. Uninterrupted clinical period up to June, which result in more prosthetic devices completed and issued to patients. The programme will closely monitor the overall performance to ensure that completed units are delivered when students are back in the clinics.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance.			The programme will closely monitor the overall performance. Re-distribute performance targets to take student carriculum into account.					

PROGRAMME 5: Central and Tertiary Hospitals

	Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Central Hospitals																		
1.1.1	**Actual (usable) beds in central hospitals**		2359	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	2,359	2359	100%	2,359	2,359	100%
	COMMENT															Target achieved		
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (central hospitals**		New Indicator	0.0%	0.0%	100%	0.0%	0.0%	100%	0.0%	0.0%	100%	100.0%	100.0%	100%	100.0%	100.0%	100.0%
	Numerator	Hospitals that achieved at least 75% compliance with the national core standard (Central hospitals)	0	0	0	100%	0	0	100%	0	0	100%	2	2	100%	2	2	100%
	Denominator	hospital that conducted a national core standard self-assessment during the financial year (Central hospitals)	2	2	0	0%	2	0	0%	2	0	0%	2	2	100%	2	2	100%
	COMMENT						We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment						Target achieved		
	ACTION PLAN									Prioritise finalisation of National Core Standard system enhancements								
2	**Average length of stay (central hospitals)**		6.3	6.1	6.5	94.3%	6.3	6.5	97.4%	6.1	6.4	95.7%	6.2	6.6	94.6%	6.2	6.5	95.4%
	Numerator	Patient days (inpatient days +1/2 day patients) (Central hospitals)	743,525	185,798	187,582	99%	189,508	192,482	98%	181,181	185,314	98%	185,496	185,577	100%	741,983	750,954	99%
	Denominator	Inpatient separations (central hospitals)	118,272	30,284	29,011	104%	30,044	29,748	101%	29,804	29,079	102%	30,044	28,314	106%	120,176	116,152	103%
	COMMENT									This is a demand driven indicator. Although the average length of stay has decreased slightly from Q2 it is still above the target due to longer stays of spinal cases , psychiatric inpatients and waiting for patient transport for discharged rural cases .			Increase due to longer stays of ICU, High Care, Psychiatric inpatients and waiting times for patient transport for discharged rural cases			Average length of stay is slightly higher than the target. The small increase was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units.		
	ACTION PLAN									Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Health net transport services.			Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Healthnet Transport services.			Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Healthnet Transport services.		
3	**Inpatient bed utilisation rate (central hospitals)**		86.3%	86.5%	87.1%	100.73%	87.3%	89%	102.4%	84.4%	86.1%	102.0%	86.4%	86.2%	99.8%	86.2%	87.2%	101.2%
	Numerator	Patient days (inpatient days +1/2 day patients) (central hospitals)	743,525	185,798	187,582	100.96%	189,508	192,482	102%	181,181	185,314	102%	185,496	185,577	100%	741,983	750,954	101%
	Denominator	Inpatient bed days available (Usable beds total x 30.42) (central hospitals)	861,129	214,692	215,282	100.27%	217,052	215,282	99%	214,692	215,282	100%	214,692	215,282	100%	861,129	861,129	100%
	COMMENT									Higher bed utilisation is due to an increased burden of disease as reflected in the increase in patient days and an increase in the average length of stay.			Lower Bed Utilization Rate in Quarter 4 due to the de-escalation in Dec-January period.			Positive deviation with a small increase in bed utilisation indicates efficient use of available beds.		
	ACTION PLAN									Efforts to decrease the average length of stay are as detailed above and monitoring of disease burden will continue.			Bed utilisation is demand driven with quarter to quarter variation but the annual average will align to the target.					
4	**Expenditure per patient day equivalent [PDE] (in central hospitals)**		R 4,863	R 5,170	R 4,967	104.1%	R 5,013	R 5,081	99%	R 5,170	R 5,371	96%	R 5,337	R 5,869	91%	R 5,170	R 5,319	97.2%
	Numerator	expenditure (central hospitals)	R 4,957,910,000	1,319,009,500	1,238,100,183	107%	1,319,009,500	1,308,502,266	101%	1,319,009,500	1,329,508,162	99%	1,319,009,500	1,451,958,546	91%	5,276,038,000	5,328,069,157	99%
	Denominator	Patient day equivalent (central hospitals)	1,019,427	255,125	249,256	102%	263,120	257,523	102%	255,125	247,526	103%	247,128	247,382	100%	1,020,498	1,001,686	102%
	COMMENT			Expenditure was low due to BAS not being available for a part of April to process payments, as well as partial payment of services rendered in March and paid in March.						An increase in expenditure occurred due to the increase in consumables used as a result of increased patient days and the increased length of stay.			Due to the increase due to longer stays of ICU, High Care, Spinal cases and Psychiatric inpatients and waiting times for patient transport for discharged rural cases, there was an increase in expenditure occurred due to the increase in consumables used.			The small increase in expenditure was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units.		
	ACTION PLAN			Expenditure will accelerate to ensure the full budget is spent.						Efforts to decrease the average length of stay as detailed above are being put in place.								

	Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
5	**Complaint resolution rate (central hospitals)**		92.1%	92.5%	99.4%	107.5%	92.5%	100.0%	108.1%	92.5%	99.4%	107.4%	92.5%	98.5%	106.5%	92.6%	99.4%	107.4%
	Numerator	Complaints resolved (central hospitals)	778	195	176	90%	196	188	96%	196	157	80%	194	130	67%	782	651	83%
	Denominator	Complaints received (central hospitals)	845	211	177	84%	212	188	89%	212	158	75%	210	132	63%	845	655	78%
	COMMENT						Good complaints management in place and the performance exceeded the target.			Are within target for resolving complaints and received fewer complaints			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN						If performance is sustained the targets will be reviewed based on the annual performance.			Ongoing monitoring of resolution of complaints by sending out reminders			Targets will be reviewed and adjusted in subsequent years					
6	**Complaint resolution within 25 working days rate (central hospitals)**		83.0%	89.7%	92.0%	102.6%	89.3%	91.0%	101.9%	89.3%	94.9%	106.3%	90.7%	90.0%	99.2%	89.6%	92.0%	102.6%
	Numerator	Complaints resolved within 25 working days (central hospitals)	701	175	162	93%	175	171	98%	175	149	85%	176	117	66%	701	599	85%
	Denominator	Complaints resolved (central hospitals)	845	195	176	90%	196	188	96%	196	157	80%	194	130	67%	782	651	83%
	COMMENT						Good complaints management in place and the performance exceeded the target.			Good complaints management in place and the performance exceeded the target.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN						If performance is sustained the targets will be reviewed based on the annual performance.			If performance is sustained the targets will be reviewed based on the annual performance.			Targets will be reviewed and adjusted in subsequent years			Targets will be reviewed and adjusted in subsequent years		
7	**Mortality and morbidity review rate (in central hospitals)**		100.0%	90.5%	100.0%	110.5%	95.2%	100.0%	105.0%	90.5%	100.0%	110.5%	100.0%	95.2%	95.2%	94.0%	98.8%	105.1%
	Numerator	Mortality and morbidity reviews conducted per discipline (central	84	19	21	111%	20	21	105%	19	21	111%	21	20	95%	79	83	105%
	Denominator	Possible mortality and morbidity reviews (central hospitals) x	84	21	21	100%	21	21	100%	21	21	100%	21	21	100%	84	84	100%
	COMMENT						The performance exceeded the target as one more meeting was held than anticipated,			This figure is a projected result, only two meetings were held in the last month, thus the target will be achieved.			The programme has over performed consistently throughout the year and the slight underperformance this quarter will not effect the overall annual performance, which is on track.			This is a positive deviation as a result of ongoing improvements in the review system.		
	ACTION PLAN						Targets will be adjusted based on the annual outcome.			Will achieve target when actual results are recorded.			Will achieve target when actual results are recorded.					
Groote Schuur Hospital																		
1.1.1	**Actual (usable) beds in Groote Schuur Hospital**		975	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	975	975	100%	975	975	100%
	COMMENT															Target achieved		
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (Groote Schuur Hospital)**		New Indicator	No	No	100%	No	No	100%	No	No	100%	Yes	Yes	100%	Yes	Yes	100%
	COMMENT						We are unfortunately not able to provide data on this			We are unfortunately not able to provide data on this						Target achieved		
	ACTION PLAN									Prioritise finalisation of National Core Standard system enhancements			Prioritise finalisation of National Core Standard system enhancements					
2	**Average length of stay (Groote Schuur Hospital)**		6.1	6.0	6.1	97.8%	6.1	6.1	99.5%	5.9	6.0	98.1%	6.0	6.4	94.3%	6.0	6.2	97.4%
	Numerator	Patient days (inpatient days +1/2 day patients) (Groote Schuur	303,232	75,926	76,892	99%	77,438	78,055	99%	73,506	75,706	97%	75,624	77,028	98%	302,494	307,680	98%
	Denominator	Inpatient separations (Groote Schuur Hospital)	49,732	12,705	12,527	101%	12,604	12,735	99%	12,503	12,588	99%	12,604	12,102	104%	50,416	49,952	101%
	COMMENT												Increase due to longer stays of ICU, High Care, Psychiatric inpatients and waiting times for patient transport for discharged rural cases. Increased waiting time for transfer of patients to stepdown facilities.			Average length of stay is slightly higher than the target. The small increase was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units.		
	ACTION PLAN												Further steps have been undertaken to improve both the efficiency and optimize the utilisation of EMS and Healthnet Transport services.			Further steps have been undertaken to improve both the efficiency and optimize the utilisation of EMS and Healthnet Transport services.		

	Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
3	**Inpatient bed utilisation rate (Groote Schuur Hospital)**		85.2%	85.6%	86.4%	101.0%	86.3%	87.7%	101.6%	82.8%	85%	102.8%	85.2%	86.6%	101.6%	85.0%	86.4%	101.7%
	Numerator	Patient days (inpatient days +1/2 day patients) (Groote Schuur hospital)	303,232	75,926	76,892	101%	77,438	78,055	101%	73,506	75,706	103%	75,624	77,028	102%	302,494	307,680	102%
	Denominator	Inpatient bed days available (Useable beds total X30.42)(Groote Schuur hospital)	355,914	88,735	88,979	100%	89,710	88,979	99%	88,735	88,979	100%	88,735	88,979	100%	355,914	355,914	100%
	COMMENT									Higher bed utilisation is due to an increased burden of disease as reflected in the increase in patient days despite a decrease in average length of stay.						Positive deviation with a small increase in bed utilisation indicates efficient use of available beds.		
	ACTION PLAN									Bed utilisation levels are within manageable levels but tracking of disease burden will continue allowing forecasting of potential bed pressures						Bed utilisation is demand driven with quarter to quarter variation and will be monitored accordingly.		
4	**Expenditure per patient day equivalent [PDE] (Groote Schuur Hospital)**		R 5,319	R 5,642	R 5,172	109.1%	R 5,532	R 5,497	100.6%	R 5,642	R 5,779	97.6%	R 5,757	R 6,324	91.0%	R 5,642	R 5,692	99.1%
	Numerator	expenditure (Groote Schuur Hospital)	2,337,807,000	623,088,500	566,633,093	110.0%	623,088,500	620,437,418	100%	623,088,500	630,007,708	99%	623,088,500	697,579,425	89%	2,492,354,000	2,514,657,644	99%
	Denominator	Patient day equivalent (PDE) (Groote Schuur Hospital)	439,509	110,432	109,552	100.8%	112,641	112,876	100%	110,432	109,022	101%	108,224	110,306	98%	441,729	441,755	100%
	COMMENT			Expenditure was low due to BAS not being available for a part of April to process payments, as well as partial payment of services rendered in March and paid in March												The small increase in expenditure was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units.		
	ACTION PLAN			Expenditure will accelerate to ensure the full budget is spent.														
5	**Complaint resolution rate (Groote Schuur Hospital)**		94.0%	96.0%	99.0%	103.1%	96.0%	100.0%	104.2%	96.0%	100.0%	104.2%	96.0%	100.0%	104.2%	96.0%	99.7%	103.9%
	Numerator	Complaints resolved (Groote Schuur Hospital)	453	115	99	86.1%	116	95	82%	116	78	67%	115	64	56%	463	336	73%
	Denominator	Complaints received (Groote Schuur Hospital)	482	120	100	83.3%	121	95	79%	121	78	64%	120	64	53%	482	337	70%
	COMMENT			Are within target for resolving complaints and received fewer complaints			Good complaints management processes in place.			Are within target for resolving complaints and received fewer complaints			Are within target for resolving complaints and received fewer complaints			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN			Ongoing monitoring of resolution of complaints by sending out reminders						Ongoing monitoring of resolution of complaints by sending out reminders			Ongoing monitoring of resolution of complaints by sending out reminders			Ongoing monitoring of resolution of complaints by sending out reminders		
6	**Complaint resolution within 25 working days rate (in Groote Schuur Hospital)**		89.8%	93.9%	96.0%	102.2%	93.1%	97.9%	105.1%	93.1%	96.2%	103.3%	94.8%	96.9%	102.2%	93.5%	96.7%	103.5%
	Numerator	Complaints resolved within 25 working days (Groote Schuur Hospital)	433	108	95	88%	108	93	86%	108	75	69%	109	62	57%	433	325	75%
	Denominator	Complaints resolved (Groote Schuur Hospital)	482	115	99	86%	116	95	82%	116	78	67%	115	64	56%	463	336	73%
	COMMENT			A number of complex complaints were received that require inputs from multiple role-players.			Good complaints management in place and the performance exceeded the target.			Good complaints management in place and the performance exceeded the target.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN			Ongoing monitoring of resolution of complaints by sending out reminders			If performance is sustained the targets will be reviewed based on the annual performance.			If performance is sustained the targets will be reviewed based on the annual performance.			Targets will be reviewed and adjusted in subsequent years			Targets will be reviewed based on the annual performance.		
7	**Mortality and morbidity review rate (Groote Schuur Hospital)**		100.0%	88.9%	100.0%	112.5%	88.9%	100.0%	112.5%	88.9%	100.0%	112.5%	100.0%	88.9%	88.9%	91.7%	97.2%	106.1%
	Numerator	Mortality and morbidity reviews conducted per discipline (Groote Schuur Hospital)	36	8	9	113%	8	9	113%	8	9	113%	9	8	89%	33	35	106%
	Denominator	Possible mortality and morbidity reviews (Groote Schuur hospital)	36	9	9	100%	9	9	100%	9	9	100%	9	9	100%	36	36	100%
	COMMENT			This figure is a projected result, only two meetings were held in the last month, thus the target will be achieved.			The performance exceeded the target as one more meeting was held than anticipated,			This figure is a projected result, only two meetings were held in the last month, thus the target will be achieved.			The programme has over performed consistently throughout the year and the slight underperformance this quarter will not effect the overall annual performance, which is on track.			This is a positive deviation as a result of ongoing improvements in the review system.		
	ACTION PLAN			Will achieve target when actual results are recorded.			Targets will be adjusted based on the annual outcome.			Will achieve target when actual results are recorded.			Will achieve target when actual results are recorded.					

	Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Tygerberg Hospital																		
1.1.1	**Actual (usable) beds in Tygerberg hospital**		1,384	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	1,384	1,384	100%	1,384	1,384	100%
	COMMENT															Target achieved.		
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (Tygerberg hospitals)**		New Indicator	No	No	100%	No	No	100%	No	No	100%	Yes	Yes	100%	Yes	Yes	100%
	COMMENT						We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.					Target Achieved		
	ACTION PLAN									Prioritise finalisation of National Core Standard system enhancements								
2	**Average length of stay (Tygerberg Hospital)**		6.4	6.3	6.7	93.8%	6.4	6.7	95.2%	6.2	6.6	93.3%	6.3	6.70	94.1%	6.3	6.7	94.1%
	Numerator	Patient days (inpatient days +1/2 day patients) (Tygerberg	440,293	109,872	110,690	99%	112,070	114,428	98%	107,675	109,608	98%	109,872	108,549	101%	439,489	443,274	99%
	Denominator	Inpatient separations (Tygerberg Hospital)	68,540	17,580	16,484	107%	17,440	17,013	103%	17,300	16,491	105%	17,440	16,212	108%	69,760	66,200	105%
	COMMENT			Average length of stay was increased due to longer stays of spinal cases , psychiatric inpatients and waiting for patient transport for discharged rural cases .			Average length of stay was increased due to longer stays of spinal cases , psychiatric inpatients and waiting for patient transport for discharged rural cases .			This is a demand driven indicator.Although the average length of stay has decreased slightly from Q2 it is still above the target due to longer stays of spinal cases, psychiatric inpatients and waiting for patient transport for discharged rural cases .			Increase due to longer stays of ICU, High Care, Spinal cases and Psychiatric inpatients and waiting times for patient transport for discharged rural cases.			Average length of stay is slightly higher than the target. The small increase was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units.		
	ACTION PLAN			Discharge lounge will be utilized and transport arrangements will be arranged more timeously.			Discharge lounge has been recommissioned and transport arrangements will be arranged timeously.			Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Healthnet Transport services.			Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Healthnet Transport services.			Further steps have been undertaken to improve both the efficiency and utilisation of the discharge lounge and optimize the utilisation of EMS and Healthnet Transport services.		
3	**Inpatient bed utilisation rate (Tygerberg Hospital)**		87.1%	87.2%	87.6%	100.5%	88.0%	90.6%	103.0%	85.5%	86.8%	101.5%	87.2%	85.9%	98.6%	87.0%	87.7%	100.9%
	Numerator	Patient days (inpatient days +1/2 day patients) (Tygerberg	440,293	109,872	110,690	101%	112,070	114,428	102%	107,675	109,608	102%	109,872	108,549	99%	439,489	443,274	101%
	Denominator	Inpatient bed days available (Useable beds total X30.42)(Tygerberg hospital)	505,215	125,958	126,304	100%	127,342	126,304	99%	125,958	126,304	100%	125,958	126,304	100%	505,215	505,215	100%
	COMMENT									Higher bed utilisation is due to an increased burden of disease as reflected in the increase in patient days and an increase in the average length of stay.			Lower Inpatient Bed utilisation rate in Quarter 4 due to the de-escalation in Dec-January period.			Positive deviation with a small increase in bed utilisation indicates efficient use of available beds.		
	ACTION PLAN									Efforts to decrease the average length of stay are as detailed above and monitoring of disease burden will continue.			This is expected seasonal variation					
4	**Expenditure per [PDE] (Tygerberg Hospital)**		R 4,518	R 4,810	R 4,806	100.1%	R 4,625	R 4,757	97.2%	R 4,810	R 5,050	95.2%	R 5,010	R 5,503	91.0%	R 4,810	R 5,025	95.7%
	Numerator	expenditure (Tygerberg Hospital)	2,620,103,000	695,921,000	671,467,090	104%	695,921,000	688,064,848	101%	695,921,000	699,500,454	99%	695,921,000	754,379,121	92%	2,783,684,000	2,813,411,513	99%
	Denominator	Patient day equivalent (PDE) (Tygerberg Hospital)	579,917	144,692.35	139,704	104%	150,480.04	144,647	104%	144,692.35	138,504	104%	138,904.66	137,076	101%	578,769	559,931	103%
	COMMENT			Expenditure was low due to BAS not being available for a part of April to process payments, as well as partial payment of services rendered in March and paid in March.						An increase in expenditure occurred due to the increase in consumables used as a result of increased patient days and the increased length of stay.			Due to the increase due to longer stays of ICU, High Care, Spinal cases and Psychiatric inpatients and waiting times for patient transport for discharged rural cases, there was an increase in expenditure occurred due to the increase in consumables used.			The small increase in expenditure was due to longer stays of patients in ICU, High Care, Psychiatric and Spinal units, coupled with lower outpatient attendances.		
	ACTION PLAN			Expenditure will accelerate to ensure the full budget is spent.						Efforts to decrease the average length of stay as detailed above are being put in place.			The de-escalation period in December 2018 and January 2019 is envisage to be shorter and this will impact positively on the Patient day equivalent			The de-escalation period in December 2018 and January 2019 is envisage to be shorter and this will impact positively on the Patient day equivalent		

No.	Indicator	Element	2016/17 Annual Report	Quarter 1 Target	Quarter 1 Actual Performance	Quarter 1 Actual % Achieved	Quarter 2 Target	Quarter 2 Actual Performance	Quarter 2 Actual % Achieved	Quarter 3 Target	Quarter 3 Actual Performance	Quarter 3 Actual % Achieved	Quarter 4 Target	Quarter 4 Actual Performance	Quarter 4 Actual % Achieved	Annual Target	Annual YTD Performance	Annual YTD % Achieved
5	**Complaint resolution rate (Tygerberg Hospital)**		89.5%	87.9%	100.0%	113.8%	87.9%	100.0%	113.8%	87.9%	98.8%	112.3%	87.8%	97.1%	110.5%	87.9%	99.1%	112.7%
	Numerator	Complaints resolved (Tygerberg Hospital)	325	80	77	96%	80	93	116%	80	79	99%	79	66	84%	319	315	99%
	Denominator	Complaints received (Tygerberg Hospital)	363	91	77	85%	91	93	102%	91	80	88%	90	68	76%	363	318	88%
	COMMENT			Positive deviation - better complaints management processes , also less complaints received than anticipated			Positive deviation -good complaints management processes in place.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN			Positive deviation - better complaints management processes , also less complaints received than anticipated			Target to be revisited based on annual performance.			Target to be revised upwards in next M&E cycle , based on annual performance.			Targets will be reviewed and adjusted in subsequent years					
6	**Complaint resolution within 25 working days rate (in Tygerberg Hospital)**		73.8%	83.8%	87.0%	103.9%	83.8%	83.9%	100.1%	83.8%	93.7%	111.8%	84.8%	83.3%	98.3%	84.0%	87.0%	103.5%
	Numerator	Complaints resolved within 25 working days (Tygerberg	268	67	67	100%	67	78	116%	67	74	110%	67	55	82%	268	274	102%
	Denominator	Complaints resolved (Tygerberg Hospital)	363	80	77	96%	80	93	116%	80	79	99%	79	66	84%	319	315	99%
	COMMENT			Positive deviation - better complaints management processes also received less complaints than anticipated.			Positive deviation -good complaints management processes in place.			Positive deviation -good complaints management processes in place.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN			Target will be adjusted for next year pending the annual result			Target to be revisited based on annual performance.			Target to be revised upwards in next M&E cycle , based on annual performance.			Targets will be reviewed and adjusted in subsequent years					
7	**Mortality and morbidity review rate (Tygerberg Hospital)**		100.0%	91.7%	100.0%	109.09%	100.0%	100.0%	100.0%	91.7%	100.0%	109.1%	100.0%	100.0%	100.0%	95.8%	100.0%	104.3%
	Numerator	Mortality and morbidity reviews conducted (Tygerberg Hospital)	48	11	12	109%	12	12	100%	11	12	109%	12	12	100%	46	48	104%
	Denominator	Possible mortality and morbidity reviews (Tygerberg hospital) x	48	12	12	100%	12	12	100%	12	12	100%	12	12	100%	48	48	100%
	COMMENT			This figure is a projected result, only two meetings were held in the last month, thus the target will be achieved.						This figure is a projected result, only two meetings were held in the last month, thus the target will be achieved.						Target achieved		
	ACTION PLAN			Will achieve target when actual results are recorded.						Will achieve target when actual results are recorded.						Target achieved		
Red Cross War Memorial Children's Hospital																		
1.1.1	**Actual (usable) beds in RCWMCH**		272	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	Annual Target	272	272	100%	272	272	100%
	COMMENT															Target achieved.		
	ACTION PLAN																	
1	**Hospitals that achieved an overall performance ≥75% compliance with the national core standard (RCWMCH)**		New Indicator	No	No	100%	No	No	100%	No	No	100%	Yes	Yes	100%	Yes	Yes	100%
	COMMENT						We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			We are unfortunately not able to provide data on this indicator as the development work on NCS DHIS 2 system is still not complete. The reports that the system currently generates are inaccurate and we await the deployment of the bug fixes to the system. Subsequently hospitals have not captured the results of their assessments and/or been able to run accurate reports.			As a consequence of being a children's hospital several of the national core stanadarsd do not apply, however the template requires that we measure and assess the hospital on them, giving a skewed low assessment .		
	ACTION PLAN									Prioritise finalisation of National Core Standard system enhancements			Prioritise finalisation of National Core Standard system enhancements					

	Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2	**Average length of stay (RCWMCH)**		4.0	4.0	3.9	102.4%	4.1	3.9	105.1%	3.9	3.8	103.4%	4.0	3.74	106.9%	4.0	3.8	104.4%
	Numerator	Patient days (inpatient days +1/2 day patients) (RCWMCH)	82,596	20,434	20,523	100%	20,922	19,960	105%	19,701	19,109	103%	20,353	18,812	108%	81,410	78,402	104%
	Denominator	Inpatient separations (RCWMCH)	20,788	5,129	5,254	98%	5,088	5,117	99%	5,047	5,067	100%	5,088	5,027	101%	20,352	20,465	99%
	COMMENT						The impact of the respiratory season has been less pronounced in in Quarter 2 than anticipated partly as a result of an early onset.			This is a demand driven indicator.The impact of the respiratory season has been less pronounced in Quarter 3 than anticipated partly as a result of an early onset.			Inpatient days have decreased due to deescalation in January, the short February month which formed the basis for the March projection. The final actual data is expected to be higher. As this is a demand driven indicator it is difficult to predict performance accurately.			Positive deviation as a low average length of stay reflects high levels of efficiency.		
	ACTION PLAN						Target will be reviewed based on the variation in the seasonal trends			Target will be reviewed based on the variation in the seasonal trends			This is a demand driven indicator with Quarter to quarter variation and will be monitored.			This is a demand driven indicator with Quarter to quarter variation and will be monitored.		
3	**Inpatient bed utilisation rate (RCWMCH)**		83.2%	82.5%	82.7%	100.2%	83.6%	80.4%	96.2%	79.6%	77.0%	96.7%	82.2%	75.8%	92.2%	82.0%	79.0%	96.3%
	Numerator	Patient days (inpatient days +1/2 day patients) (RCWMCH)	82,596	20,434	20,523	100%	20,922	19,960	95%	19,701	19,109	97%	20,353	18,812	92%	81,410	78,402	96%
	Denominator	Inpatient bed days available (Useable beds total X30.42) (RCWMCH)	99,291	24,755	24,823	100%	25,027	24,823	99%	24,755	24,823	100%	24,755	24,823	100%	99,291	99,291	100%
	COMMENT									A higher burden of non-respiratory disease resulted in an overall increase in patient Days.			Lower Bed Utilisation Rate in Quarter 4 due to the de-escalation in Dec-January period.			This is a demand driven indicator and suggests that the lower demand is due to improved effectiveness of the referring district hospitals.		
	ACTION PLAN									Bed utilisation levels are within manageable levels but tracking of disease burden will continue allowing forecasting of potential bed pressures.			This is a demand driven indicator with Quarter to quarter variation and will be monitored.			This is a demand driven indicator with Quarter to quarter variation and will be monitored.		
4	**Expenditure per[PDE] (RCWMCH)**		R 5,491	R 5,885	R 5,462	107.7%	R 5,659	R 5,961	94.9%	R 5,885	R 6,465	91.0%	R 6,130	R 8,026	76.4%	R 5,885	R 6,453	91.2%
	Numerator	expenditure in RCWMCH	732,622,000	197,441,250	173,683,113	114%	197,441,250	186,731,850	106%	197,441,250	192,103,554	103%	197,441,250	237,563,187	83%	789,765,000	790,081,704	100%
	Denominator	Patient day equivalent (PDE) (RCWMCH)	133,420	33,551	31,800	106%	34,893	31,328	111%	33,551	29,714	113%	32,209	29,598	109%	134,203	122,439	110%
	COMMENT			Expenditure was low due to BAS not being available for a part of April to process payments, as well as partial payment of services rendered in March and paid in March.			Back pay on grade progression resulted in high expenditure in Q3.			Complexity of procedures have increased . Impacts on patient recovery time.			:The hospital had significant increase in the number of complex and high cost procedures especially transplant cases.			The expenditure per PDE is higher due to an increasing complexity and cost of procedures especially transplants undertaken and due to inflexibility of fixed costs.		
	ACTION PLAN			Expenditure will accelerate to ensure the full budget is spent.						Expected to even out in final Qtr.			Hospital will review the high cost of the procedures to reduce the expenditure.			Hospital will review the high cost of the procedures to reduce the expenditure.		
5	**Complaint resolution rate (RCWMCH)**		96.0%	95.3%	100.0%	104.9%	95.3%	100.0%	104.9%	95.3%	100.0%	104.9%	97.7%	96.3%	98.6%	95.9%	99.3%	103.5%
	Numerator	Complaints resolved (RCWMCH)	238	41	55	134%	41	26	63%	41	26	63%	42	26	62%	165	133	81%
	Denominator	Complaints received (RCWMCH)	248	43	55	128%	43	26	60%	43	26	60%	43	27	63%	172	134	78%
	COMMENT									This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning complaints management system.		
	ACTION PLAN									Target to be revised upwards in next M&E cycle, based on annual performance.			Target to be revised upwards in next M&E cycle, based on annual performance.					
6	**Complaint resolution within 25 working days rate (RCWMCH)**		93.5%	92.7%	92.7%	100.0%	95.1%	92.3%	97.0%	95.1%	88.5%	93.0%	90.5%	96.2%	106.3%	93.3%	92.5%	99.1%
	Numerator	Complaints resolved within 25 working days (RCWMCH)	232	38	51	134%	39	24	62%	39	23	59%	38	25	66%	154	123	80%
	Denominator	Complaints resolved (RCWMCH)	248	41	55	134%	41	26	63%	41	26	63%	42	26	62%	165	133	81%
	COMMENT									Despite improvements in the complaint resolution system having being effected the speed with which complaints are attended to requires further attention.			This is a positive deviation as a result of well functioning complaints management system.			This is a positive deviation as a result of well functioning and more rapid complaints management system.		
	ACTION PLAN									Attention will be given to increasing the speed of complaint resolution by addressing the delay points in the			Targets will be reviewed and adjusted in subsequent years			Continue with actions taken.		
7	**Mortality and morbidity review rate (RCWMCH)**		91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	150.0%	100.0%	100.0%	100.0%	91.7%	100.0%	109.1%
	Numerator	Mortality and morbidity reviews conducted (RCWMCH)	11	3	3	100%	3	3	100%	2	3	150%	3	3	100%	11	12	109%
	Denominator	Possible mortality and morbidity reviews (RCWMCH) x number of [illegible] (RCWMCH)	12	3	3	100%	3	3	100%	3	3	100%	3	3	100%	12	12	100%
	COMMENT			Average of two months was projected so target will be achieved.						The performance exceeded the target as one more meeting was held than anticipated,			The performance exceeded the target as one more meeting was held than anticipated,			This is a positive deviation as a result of ongoing improvements in the review system.		
	ACTION PLAN									Targets will be adjusted based on the annual outcome.			Targets will be adjusted based on the annual outcome.			Targets will be adjusted based on the annual outcome.		

PROGRAMME 6: Health Science and Traini

	Performance Measure/Indicator	Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target	Actual		Q2 Target	Actual		Q3 Target	Actual		Q4 Target	Actual		Annual	ESTIMATED YTD	
				Target	Performance	% Achieved	Target	Performance	% Achieved	Target	Performance	% Achieved	Target	Performance	% Achieved	Annual Target	Performance	% Achieved
Health Science and Training																		
1.1.1	**Number of bursaries awarded for scarce and critical skills categories**	2,447	2,358	2,358	2,052	87.0%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	2358	2052	87.0%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of bursaries awarded, as the number of bursaries are dependent on applications received and available funding.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 2052 reflected in quarter 1.			The Department cannot predict with 100% accuracy the number of bursary applications for the selected priority areas. Bursaries are awarded to students studying in the health and related professions at Higher Education Institutions (HEIs) to address scarce skills and to ensure a pipeline of talent in the Department. The shortfall in the number of bursaries awarded was mainly due to students applying for bursaries but who did not necessarily meet the minimum entry requirements at the HEIs. In addition, there was attrition of existing student bursars who failed and had to repeat the year of study at own cost. Bursaries are also awarded to current staff for part-time study to address critical skills. Speciality nursing is an identified area which requires Study by Assignment, and requires the release of nursing staff from the services to fulfil full-time study and completion of their speciality nursing programmes. In order to ensure that the services are maintained while the nurses are on Study by Assignment, the remaining budget is utilised to ensure that relief staff are appointed.
	ACTION PLAN			None required, as bursaries are dependent on availability of funds.			No action required.									None required.		
1	**Number of bursaries awarded for first year medicine students**	49	53	53	58	109.4%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	53	58	109.4%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of bursaries awarded. Additional MBCHB bursaries was awarded to the increasing service needs in rural areas.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 58 reflected in quarter 1.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of bursaries awarded. Additional MBCHB bursaries were awarded to meet the increasing service needs in rural areas. The slight over-performance is deemed as a benefit to the Department.		
	ACTION PLAN			No action required.			No action required.									None required.		
2	**Number of bursaries awarded for first year nursing students**	195	150	150	153	102.0%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	150	153	102.0%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of bursaries awarded. Additional nursing bursaries was awarded due to re-instatement of nursing students. The marginal deviation from the performance target is considered by the Department as acceptable and is therefor considered as having achieved the target.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 153 reflected in quarter 1.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of bursaries awarded. Additional nursing bursaries were awarded due to re-instatement of nursing students. The slight over-performance is deemed as a benefit to the Department.		
	ACTION PLAN			No action required.			No action required.									None required.		
3	**EMC intake on accredited HPCSA courses**	90	90	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	90	90	100.0%	90	90	100.0%
	COMMENT			Annual indicator. The first intake of 30 students for Q1 took place for the annum. The second intake of 30 students is scheduled for Q2 and the 3rd intake of 30 students in Q4. It is anticipated that the target of 90 EMC students for the year (3 course intakes of 30 students) will most likely be achieved by Quarter 4 as planned.			Annual indicator. The second intake of 30 students took place in Quarter 2 for the annum. The third intake of 30 students is scheduled for Quarter 4, to make up the total of 90 students for the year.			Annual Indicator. Not required to report in Quarter 3.			Target achieved.			Target achieved.		
	ACTION PLAN			No action required.			No action required.									None required.		
4	**Intake of home community based carers (HCBCs)**	882	800	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	800	1154	144.3%	800	1,154	144.3%
	COMMENT			Annual indicator. Performance reporting only to take place in Quarter 4.			Annual indicator. Performance reporting only to take place in Quarter 4.			Annual Indicator. Not required to report in Quarter 3. Performance reporting only to take place in Quarter 4.			Target achieved.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of HCBCs. In order to alleviate service pressures, and within resources available, the Department could appoint more HCBCs than anticipated. The over-performance is deemed as a benefit to the Department.		
	ACTION PLAN			No action required.			No action required.									None required.		

	Performance Measure/Indicator	Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target	Q1 Actual		Q2 Target	Q2 Actual		Q3 Target	Q3 Actual		Q4 Target	Q4 Actual		Annual	ESTIMATED YTD	
				Target	Performance	% Achieved	Target	Performance	% Achieved	Target	Performance	% Achieved	Target	Performance	% Achieved	Annual Target	Performance	% Achieved
5	**Intake of data capturer interns**	220	160	160	219	136.9%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	160	219	136.9%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of interns required and appointed. There was however an increased need due to the amount of permanent posts that were not filled due to budgetary constraints. In order to alleviate service pressures, and within resources available, the Department could appoint more interns than anticipated. The Department deems the over-performance as acceptable.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 219 reflected in quarter 1.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of data capturer interns. There was however an increased need due to the amount of permanent posts that were not filled due to budgetary constraints. In order to alleviate service pressures, and within resources available, the Department could appoint more interns than anticipated. The challenge of meeting service needs expanded to work opportunities via internships for the youth and unemployed, leading to a pool of talent to recruit from as posts become vacant in the near future, which resulted in a win-win scenario. The over-performance is deemed as a benefit to		
	ACTION PLAN			No action required.			No action required.									None required.		
6	**Intake of learner basic/ post basic pharmacist assistants**	123	120	120	125	104.2%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	120	125	104.2%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmacy assistants (PAs) required and appointed. Additional PA's were recruited to allow for a seamless handover between the previous and new intakes, without impacting too much on the service delivery at facilities. It is also important to note that recruitment of PAs took place in a staggered approach. In order to alleviate service pressures, and within resources available, the Department could appoint more PAs than anticipated. The Department deems the slight			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 125 reflected in quarter 1.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of learner basic/post basic pharmacy assistants (PAs). Additional PA's were recruited to allow for a seamless handover between the previous and new intakes, without impacting too much on the service delivery at facilities. It is also important to note that recruitment of PAs took place in a staggered approach. In order to alleviate service pressures, and stay within resources available, the Department could appoint more PAs than anticipated. The over-performance is deemed		
	ACTION PLAN			No action required.			No action required.									None required.		
7	**Intake of assistant to artisan (ATA) interns**	119	120	120	116	96.7%	Annual Target	-	Annual Target	Annual Target	30	Annual Target	Annual Target	-	Annual Target	120	146	121.7%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of assistant to artisan (ATAs) required and appointed. In order to alleviate service pressures (especially from facilities that had a significant need for handymen, due to attrition), and within resources available, the Department was requested to appoint more ATAs than anticipated. However, only 116 of the 135 interns were appointed so far, as the remaining 19 interns' MIE verification is still awaited. Actual performance on the intake of ATA interns might still improve upon finalisation of the verification process.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 146 reflected in previous quarters (quarter 1 = 116 + quarter 3 = 30).			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of assistant to artisan (ATAs) required and appointed. In order to alleviate service pressures (especially from facilities that had a significant need for handymen, due to attrition), and stay within resources available, the Department was requested to appoint more ATAs than anticipated. The challenge of meeting service needs expanded to work opportunities via internships, leading to a pool of talent to recruit from as posts become vacant in the near future, which resulted in a win-win scenario. The over-performance is deemed as a benefit to the		
	ACTION PLAN			None.			None.									None required.		
8	**Intake of HR and finance interns**	153	170	170	185	108.8%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	170	185	108.8%
	COMMENT			Annual indicator. Reported in Quarter 1. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of HR and finance interns required and appointed. There was however an increased need due to the amount of permanent posts that were not filled due to budgetary constraints. In order to alleviate service pressures, and within resources available, the Department could appoint more HR and finance interns than anticipated. The Department deems the over-performance as acceptable.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 185 reflected in quarter 1.			Target exceeded. This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of HR and finance interns. There was however an increased need due to the amount of permanent posts that were not filled due to budgetary constraints. In order to alleviate service pressures, and stay within resources available, the Department could appoint more interns than anticipated. The challenge of meeting service needs expanded to work opportunities via internships for the youth and unemployed, leading to a pool of talent to recruit from as posts become vacant in the near future, which resulted into a win-win scenario. The over-performance is deemed as		
	ACTION PLAN			No action required.			No action required.									None required.		
9	**Intake of emergency medical care (EMC) assistant interns**	162	140	140	137	97.9%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	140	137	97.9%
	COMMENT			Target achieved.			Annual Indicator. Not required to report in Quarter 2.			Annual Indicator. Not required to report in Quarter 3.			Performance of 140 reflected in quarter 1.			This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of Emergency Medical Care (EMC) assistant interns. The slight under performance is however deemed acceptable by the Department as having achieved the target		
	ACTION PLAN			No action required.			No action required.									None required.		

	Performance Measure/Indicator	Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target			Q2 Target			Q3 Target			Q4 Target			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Annual Target	ESTIMATED YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
10	**Intake of forensic pathology services (FPS) assistant interns**	10	10	10	8	80.0%	Annual Target	-	Annual Target	Annual Target	1	Annual Target	Annual Target	-	Annual Target	10	9	90.0%
	COMMENT			Difficulty in recruitment of appropriate FPS interns due to entrance requirements and nature of the work.			Annual Indicator. Not required to report in Quarter 2.						Performance of 8 reflected in quarter 1 and performance of 1 reflected in quarter 3. Total of 9 for the year.			This is a demand/service driven indicator which means it is not possible for the Department to predict with 100% accuracy the intake of Forensic Pathology Services (FPS) assistant interns. The main reason for the under-performance is the difficulty in recruitment of appropriate FPS interns due to entrance requirements and nature of the work.		
	ACTION PLAN			Recruitment drive to market Forensic Pathology Services. FPS are using Admin assistants to fill the												None required.		

PROGRAMME 7: Health Care Support Services

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target	Quarter 1 Actual Performance	Quarter 1 Actual % Achieved	Q2 Target	Quarter 2 Actual Performance	Quarter 2 Actual % Achieved	Q3 Target	Quarter 3 Actual Performance	Quarter 3 Actual % Achieved	Q4 Target	Quarter 4 Actual Performance	Quarter 4 Actual % Achieved	Annual Annual Target	Annual ACTUAL YTD Performance	Annual ACTUAL YTD % Achieved
Sub-Programme 7.1: Laundry Services																			
1.1.1	**Average cost per item laundered in-house**	R 4.67	R 5.18	R 5.16	R 4.77	108.0%	R 5.24	R 5.28	99.3%	R 5.18	R 4.49	115.3%	R 5.14	R 5.58	92.2%	R 5.18	R 5.03	102.9%
	Numerator: Expenditure on in-house laundries excluding capital	58,696,958	68,544,536	17,536,134	15,439,529	-	17,336,134	17,372,879	-	17,136,134	14,559,466	-	16,536,134	18,511,044	-	68,544,536	65,882,918	-
	Denominator: Items laundered in-house	12,562,691	13,232,536	3,400,134	3,233,990	-	3,307,134	3,292,992	-	3,306,134	3,241,594	-	3,219,134	3,319,253	-	13,232,536	13,087,829	-
	COMMENT			Cost per piece is below target due to some outstanding invoices. Cost breakdown: Lentegeur Tygerberg Total Personnel 66.4% 59.0% 62.6% Steam 11.5% 10.6% 11.0% Electricity 3.8% 5.8% 4.9% Water & Drainage 8.9% 7.1% 8.0% Detergent 1.8% 4.1% 3.0% Transport 4.1% 4.6% 4.4% Maintenance 1.6% 7.1% 4.4%			Cost per piece is below target due to ten posts (at Tygerberg Laundry) currently not filled - aim is not to fill these posts in the near future - efficiency is however maintained within the same number of working hours (utilisation of EPWP staff). Cost breakdown: Lentegeur Tygerberg Total Personnel 57.1% 28.0% 46.1% Steam 10.1% 20.6% 14.1% Electricity 5.7% 9.3% 7.1% Water & Drainage 5.9% 8.1% 6.8% Detergent 3.3% 5.6% 4.2% Transport 4.6% 4.1% 4.4% Maintenance 11.6% 21.6%			As reported in Q2, cost per piece is below target due to ten posts (at Tygerberg Laundry) currently not filled - aim is not to fill these posts in the near future - efficiency is however maintained within the same number of working hours (utilisation of EPWP staff). Additional maintenance work undertaken. Cost breakdown: Lentegeur Tygerberg Total Personnel 66.2% 42.6% 58.4% Steam 10.0% 17.7% 12.5% Electricity 3.9% 8.3% 5.4% Water & Drainage 4.2% 4.4% 4.3% Detergent 3.2% 7.5% 4.6% Transport 4.8% 5.8% 5.1% Maintenance 5.6% 10.0% 7.0%			As previously reported, the cost per piece is below target due to ten posts (at Tygerberg Laundry) currently not filled - aim is not to fill these posts in the near future - efficiency is however maintained within the same number of working hours (utilisation of EPWP staff). Additional maintenance work undertaken. Cost breakdown: Lentegeur Tygerberg Total Personnel 65.2% 31.9% 52.9% Steam 10.4% 29.9% 17.6% Electricity 5.0% 14.7% 8.6% Water & Drainage 5.6% 8.9% 6.8% Detergent 4.1% 4.5% 4.2% Transport 4.2% 4.2% 4.2% Maintenance 3.5% 3.0% 3.3%			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of items to be laundered (in-house). Due to improved efficiencies, performance surpassed the planned target. The Department therefore considers the marginal deviation of performance as having achieved the target.	
	ACTION PLAN			Tygerberg Laundry feasibility study to be undertaken. Continuous focus on maintenance of infrastructure and equipment to improve efficiency. Improving productivity - introduction of lean management principles and process improvement investigated.			Tygerberg Laundry feasibility study is work in progress - to be finalised by the end of March 2018. Continuous focus on maintenance of infrastructure and equipment to improve efficiency.			Tygerberg Laundry feasibility study is work in progress - to be finalised by the end of March 2018. Continuous focus on maintenance of infrastructure and equipment to improve efficiency.			Tygerberg Laundry draft feasibility study was submitted; some revision is required and is expected by 30 April 2018. Continuous focus on maintenance of infrastructure and equipment to improve efficiency. Steam reticulation and infrastructure is monitored with the aim to reduce utilisation.				
1	**Average cost per item laundered outsourced**	R 3.56	R 3.93	R 3.79	R 3.69	102.8%	R 3.79	R 3.75	101.1%	R 4.02	R 3.83	104.9%	R 4.12	R 3.92	105.0%	R 3.93	R 3.80	103.5%
	Numerator: Expenditure on outsourced laundry services	28,471,463	33,643,884	7,829,083	6,909,383	-	8,492,333	7,532,308	-	8,605,698	7,650,865	-	8,716,771	7,306,947	-	33,643,884	29,399,503	-
	Denominator: Items laundered outsourced	7,991,134	8,562,884	2,065,721	1,873,269	-	2,240,721	2,009,987	-	2,140,721	1,996,933	-	2,115,721	1,862,380	-	8,562,884	7,742,569	-
	COMMENT			Cost per piece is below target. Procurement process for Worcester Hospital is still delayed. The current contract is below market price. It is expected that the new contract, which should have been in place already, will be at a more market-related price.			Cost per piece is below target. Procurement process for Winelands contract (including Worcester Hospital) is still underway. Site meeting was held on 07 September; contract is expected to be finalised in October 2017. The current contract is below market price. It is expected that the new contract will be at a more market-related price.			Cost per piece is below target. Cape Winelands contract currently with Bid Evaluation Committee for submission to Departmental Bid Adjudication Committee for consideration later in December.			Cost per piece remains below target. Cape Winelands contract (for services to be rendered to five hospitals) has been approved by delegated official; contract award still pending.			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of items to be laundered (outsourced). Due to improved efficiencies, performance exceeded the planned target. The Department therefore considers the marginal deviation of performance as having achieved the target.	
	ACTION PLAN			Bid for Worcester Hospital to be implemented.			Contract for Winelands to be finalised in October 2017.			Awaiting conclusion of procurement process.			Continuous contract management in association with the hospital.					
Sub-Programme 7.2: Engineering Services																			
1.1.1	**Percentage reduction in energy consumption at provincial hospitals (compared to 2014/15 baseline)**	**Not required to report**	7.2%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	7.2%	4.0%	56.2%	7.2%	4.0%	56.2%
	Numerator: Baseline (2014/15 kw h/year) energy utilisation for all provincial hospitals minus utilisation for all provincial hospitals for current financial year		10,969,864	Annual Target	-	-	Annual Target	-	-	Annual Target	-	-	10,969,864	6,197,229	-	10,969,864	6,197,229	
	Denominator: Baseline (2014/15 kw h/year) energy utilisation for all provincial hospitals		153,279,246	Annual Target	-	-	Annual Target	-	-	Annual Target	-	-	153,279,246	153,279,246	-	153,279,246	153,279,246	
	COMMENT			Annual indicator - not required to report. Utilities Report will be submitted in Quarters 2 and 4.			Annual indicator - not required to report. Utilities Report will be submitted in Quarters 2 and 4.			Annual indicator - not required to report. Utilities Report will be submitted in Quarter 4.			Target achieved. WCGH received the 2020 Healthcare Climate Challenge's 2017 Gold Climate Leadership Award.			In spite of various initiatives implemented during 2017/18, utilisation at facilities exceeded the benchmark. The 2017/18 financial year was free from the electrical supply problems witnessed in the previous few years, and, with an increasing focus on water shortages in the province, the focus on saving electricity at WCGH facilities appears to have reduced, resulting in both staff and the public beginning to return to poor electricity-usage habits.	
	ACTION PLAN			Not required to report. Draft Energy Policy to be endorsed by TEXCO. Circular must be finalised and issued.			Energy Policy finalised and approved.						* Awaiting approval of ESCO contract by WCGPT. * Four hospitals (Tygerberg, Eerste River, Paarl and Red Cross Hospitals) will form part of pilot. * Implementation of LED site lighting at Tygerberg Hospital.					
1	**Threshold (provincial benchmark) achieved for clinical engineering maintenance jobs completed**	**Not required to report**	Yes	Yes	No	0.0%	Yes	Yes	100%	Yes	Yes	100%	Yes	Yes	100%	Yes	Yes	100%
	COMMENT			Threshold per Quarter: 75% (Q1); 95% (Q2) ; 105% (Q3); 88% (Q4) Q1 Performance: 51% Under performance due to: * Finalisation of SCOA codes during April resulted in delays with procurement processes. * NT SCM Instruction No 4 of 2016/17 re utilisation of the Central Supplier Database - registration of suppliers negatively impacted on procurement processes.			Threshold per Quarter: 75% (Q1); 95% (Q2) ; 105% (Q3); 88% (Q4) Q2 Performance: 99% (actual performance) Slight over performance, which is to the benefit of the Department: • Majority of Life Support and Electronic equipment is serviced (preventative) every six months. Requisitions for servicing were issued in August and servicing was undertaken in September. • Two posts are currently vacant (one each in Electronics and Dental Units). Processes with respect to filling the post in the Electronics Unit have been completed, the motivation for which was submitted to HR approximately a month ago. The competency test for the position in the Dental Unit is scheduled for the last week in September 2017. • Currently experiencing a huge demand for maintenance, which especially has an impact on the Electronics and Dental Units.			Threshold per Quarter: Q1 = 75%; Q2 = 95%; Q3 = 105%; Q4 = 88% Q3 Performance: 96% (actual performance), which is below the Q3 threshold of 105%. • Requisitions for outsourced servicing of life-support and selected electronics equipment have been issued but not completed as service providers perform servicing sequentially and have limited capacity (done by the same team/s). • The posts in Electronics and Dental Units (one each) are still vacant. • Dental Unit: Increased number of site inspections and installations of new facilities impact on maintenance productivity.			Threshold per Quarter: Q1 = 75%; Q2 = 95%; Q3 = 105%; Q4 = 88% Q4 preliminary performance = 103% Exceedubg threshold, which is to the benefit of the Department.			Target achieved.		
	ACTION PLAN			Challenges at the beginning of the financial year to be taken into consideration when setting targets for 2018/19.			* The Eectronics Unit has implemented Saturday catch-ups to reduce the backlog. • One post from Life Support has been moved to X-Rays, where demand is currently greater. * Additional post, prevously approved, is in process of being created on the system. Once processes are in place, recruitment will commence for post to be filled in the Dental Unit.			• The Electronics Unit has implemented Saturday catch-ups to reduce the backlog. • Interviews for the two vacancies have been conducted and recommendations forwarded to People Management for further action.			None required.		

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target	Quarter 1 Actual		Q2 Target	Quarter 2 Actual		Q3 Target	Quarter 3 Actual		Q4 Target	Quarter 4 Actual		Annual	Annual ACTUAL YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved	Annual Target	Performance	% Achieved
2	**Threshold (provincial benchmark) achieved for engineering maintenance jobs completed**	**Not required to report**	Yes	Yes	No	0.0%	Yes	Yes	100%	Yes	0	0.0%	Yes	Yes	100%	Yes	Yes	100%
	COMMENT			Threshold per Quarter: 87% (Q1) 85% (Q2) 92% (Q3) 88% (Q4) Q1 Performance = 78% Under performance due to: * Finalisation of SCOA codes during April, resulted in delays with procurement processes. * NT SCM Instruction No 4 of 2016/17 re utilisation of the Central Supplier Database - registration of suppliers negatively impacted on procurement processes. * More staff taking leave during first quarter of financial year (before leave expires at the end of June). * A number of bigger jobs were undertaken (e.g. two 2-week projects at Swartland Hospital occupying teams of 5 and 8-10 respectively = total of 4 job cards; 10-day project in Bredasdorp; Stikland Nurses Home - number of teams occupied for a few days; project in Mfuleni which occupied teams for 6 weeks).			Threshold per Quarter: 87% (Q1); 85% (Q2); 92% (Q3); 88% (Q4) Q2 Performance = 73% Under performance due to: * Some job cards closed (Mechanical and Medical Gas Workshops) are still in the system and will only reflect in September. * A number of bigger jobs were undertaken which required more resources (Bredasdorp Hospital Laundry; Stikland Nurses Home (Admin); Mfuleni (old premises)).			Threshold per Quarter: Q1 = 87%; Q2 = 85%; Q3 = 92%; Q4 = 88% Q3 performance = 94% Over performance which is to the benefit of the Department.			Threshold per Quarter: Q1 = 87%; Q2 = 85%; Q3 = 92%; Q4 = 88% Q4 preliminary performance - 110% Exceeding threshold, which is to the benefit of the Department.			Target achieved.		
	ACTION PLAN			Investigate possibility to issue a separate job card(s) for each job category for bigger projects.			Limit larger projects as far as possible (in some cases not possible due to inability to find contractors to undertake work in remote areas, resulting in work to be undertaken in-house).									None required.		
3	**Percentage of selected hospitals achieving the provincial benchmark for maximum water utilisation**	**Not required to report**	54.0%	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	54.0%	70.0%	129.6%	54.0%	70.0%	129.6%
	Numerator: Selected hospitals achieving the provincial benchmark for average water consumption per hospital bed per day		27	Annual Target	-	-	Annual Target	-	-	Annual Target	-	-	27	35	-	27	35	
	Denominator: Hospitals selected to monitor average water consumption per hospital bed per day		50	Annual Target	-	-	Annual Target	-	-	Annual Target	-	-	50	50	-	50	50	
	COMMENT			Annual indicator - not required to report.			Annual indicator - not required to report.			Annual indicator - not required to report.			Target exceeded.			Target exceeded. The 2017/18 financial year witnessed one of the worst droughts that the province has seen to date – this has resulted in an extensive and widespread campaign to conserve water, throughout both government and the private sector. WCGH has itself been an active partner in this campaign and utilising varying means of communication, has spread the water-saving message to both staff and the public alike. In addition, it has installed multiple infrastructure solutions, including boreholes, rainwater harvesting, water treatment plants, water saving devices, as well as devices for monitoring water usage. The result has been a notable decrease in water usage across all WCGH facilities throughout the province.		
	ACTION PLAN			Not required to report. Utilities Report will be submitted in Quarters 2 and 4.			Not required to report. Utilities Report submitted for Quarter 2.			Not required to report. Interim (summary) report on water consumption will be submitted. Utilities Report will be submitted in Quarter 4. Benchmarks will be reviewed early in Quarter 4.			* Collaboration with Microsoft International for installation of smart metering * Directorate: Policy, DotP - assistance to provide smart metering (in assocation with Universities of Stellenbosch and Cape Town) * ESCO contract - awaiting WCGPT approval * Programme for alternative water supply being implemented in association with WCGTPW * Planning underway for Treated Effluent project for seven facilities			None required.		

PROGRAMME 7: Health Care Support Services

	Performance measure/ Indicator	Element	2016/17 Annual Report	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Target	Actual		Target	Actual		Target	Actual		Target	Actual		Annual Target	YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Forensic Pathology Services																		
1.1.1	**Number of Child Death Review Boards established**		New Indicator	0	4	0%	0	4	100.00%	0	5	100.00%	5	5	100.00%	5	5	100.00%
	COMMENT			Child Death Review Boards have been established at the following locations: Metro West Metro East West Coast/Winelands Eden/Central Karoo A fifth board to be established at Worcester for Winelands/Overberg			Child Death Review Boards have been established at the following locations: Metro West Metro East West Coast/Winelands Eden/Central Karoo A fifth board to be established at Worcester for Winelands/Overberg			Child Death Review Boards have been established at the following locations: Metro West Metro East West Coast/Winelands Eden/Central Karoo Winelands/Overberg			Child Death Review Boards have been established at the following locations: Metro West Metro East West Coast/Winelands Eden/Central Karoo Winelands/Overberg					
	ACTION PLAN																	
1	**Number of Post - Mortem Examinations per FTE Pathologist**		New Indicator	89	201.66	226.6%	89	220.41	247.6%	88	215.09	244.4%	84	198.16	235.9%	350	835.05	238.6%
	Numerator	Number of Post - Mortem Examination Performed		2,870	2,680	93%	2,859	3,024	105.77%	2,851	2,951	103.51%	2,718	2,802	103.09%	11,298	11,457	101%
	Denominator	Full time Equivalent (medical Personnel)		32	13.29	42%	32	13.72	42.88%	32	13.72	42.88%	32	14.14	44.19%	32	13.72	43%
	COMMENT			Healthcare 2030 standard for Cases/Full-Time Equivelant Pathologist set at 350 per annum. Workload increase without commenserate increase in staff results in Case Load/Full time Equivalent far exceeding the agreed norm.			Healthcare 2030 standard for Cases/Full-Time Equivelant Pathologist set at 350 per annum. Workload increase without commenserate increase in staff results in Case Load/Full time Equivalentfar exceeding the agreed norm.			Healthcare 2030 standard for Cases/Full-Time Equivelant Pathologist set at 350 per annum. Workload increase without commenserate increase in staff results in Case Load/Full time Equivalent far exceeding the agreed norm.			In an effort to plan for adequate human resourcing, the Departments as part of the modelling in term Healthcare 2030 vision modelled the norm of 350 cases per /Full-Time Equivalent Medical Personnel. The internationally acceptable norm as set by the 'NAME' international body is 250 Post Mortem/Pathologist excluding Medical Officer and Registrar). It is acknowledged that the current staffing reality is far removed from the agreed WCGH norm of 350 cases per Full time Equivalent medical personnel and that the workload increase without commensurate increase in staff results in Case Load/Full time Equivalent far exceeding the agreed norm.					
	ACTION PLAN																	
2	**Toxicology service commissioned**		No	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	No	No	100%	No	No	100%
	COMMENT			Equipment has been procured (LC/MSMS) and commissioned. Infrastructure changes required to install GC/MS. Practice Standards are in the process of being developed. Post of Toxicologist Assistant in the process of being filled, funded via the Alcohol Game Changer project			Equipment has been procured Liquid Chromatography/Mass Spectrometry (LC/MSMS) and commissioned. Infrastructure changes required to install Gas Chromatography/Mass Spectrometry (GC/MS). Practice Standards are in the process of being developed. Post of Toxicologist Assistant has been filled, funded via the Alcohol Game Changer project			Equipment has been procured Liquid Chromatography/Mass Spectrometry (LC/MSMS) and commissioned. Infrastructure changes required to install Gas Chromatography/Mass Spectrometry GC/MS. Practice Standards are in the process of being developed. Post of Toxicologist Assistant has been filled, funded via the Alcohol Game Changer project			Equipment has been procured Liquid Chromatography/Mass Spectrometry (LC/MSMS) and commissioned. Infrastructure changes required to install Gas Chromatography/Mass Spectrometry (GC/MS). Practice Standards are in the process of being developed. Post of Toxicologist Assistant has been filled, funded via the Alcohol Game Changer project					
	ACTION PLAN																	

PROGRAMME 7: Health Care Support Services

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Q1 Target	Quarter 1 Actual		Q2 Target	Quarter 2 Actual		Q3 Target	Quarter 3 Actual		Q4 Target	Quarter 4 Actual		Annual Target	Annual ACTUAL YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Sub-Programme 7.5: Cape Medical Depot																		
1.1.1	**Percentage of pharmaceutical stock available**	93.8%	95.1%	95.1%	91.8%	96.6%	95.1%	92.8%	97.6%	95.1%	94.7%	99.6%	95.1%	91.9%	96.7%	95.1%	91.9%	96.7%
	Numerator: Pharmaceutical items that are in stock at the CMD	676	694	694	661	-	694	673	-	694	681	-	694	657	-	694	657	
	Denominator: Pharmaceutical items on the stock register	721	730	730	720	-	730	725	-	730	719	-	730	715	-	730	715	
	COMMENT			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmaceutical stock. Based on the actual data of Quarter 1, the slight deviation of 3.3% from the Quarter 1 performance target is considered by the Department as acceptable and is therefor considered as having achieved the target.			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmaceutical stock. The deviation of 3.3% from the set target is also based on projected data, of which actual performance may still improve. The slight deviation from the performance target is considered by the Department as acceptable and is therefor considered as having achieved the target.			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmaceutical stock. The marginal deviation of 0.4% from the set performance target is considered by the Department as acceptable and is therefor considered as having achieved the target.			This is a demand driven indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmaceutical stock. The slight deviation of 3.3% from the set target is also based on projected data, of which actual performance may still improve. The slight deviation from the performance target is considered by the Department as acceptable and is therefor considered as having achieved the target. (Note for M&E informational purposes only: The removal and / or the non - award of provincially coded medicines not listed in the National Essential Medicines list, from national tenders / contracts, together with the late award of pharmaceutical tenders by the National Department of Health, resulted in supply challengers which ultimately caused short and / or no supply of pharmaceuticals. Many contracted suppliers are unable to increase production within the prescribed time as per the GCC in order to meet the demands of a national contract. A range of 30-40% of items per pack size not routinely available, are not included in national contracts, making secured continuous availability of these items a challenge.)			This is a demand driven/service delivery indicator which means it is not possible for the Department to predict with 100% accuracy the number of pharmaceutical stock. The slight deviation of from the set performance target is considered by the Department as acceptable and is therefor considered as having achieved the target.		
	ACTION PLAN			No action required.			No action required.			No action required.			None required.			None required.		

PROGRAMME 8: Health Facilities Management

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Q1 Target	Actual Performance	Actual % Achieved	Q2 Target	Actual Performance	Actual % Achieved	Q3 Target	Actual Performance	Actual % Achieved	Q4 Target	Actual Performance	Actual % Achieved	Annual Target	ACTUAL YTD Performance	ACTUAL YTD % Achieved
1.1.1	**Percentage of Programme 8 capital infrastructure budget spent (excluding maintenance)**	105.5%	100.0%	20.2%	21.2%	104.9%	46.5%	37.9%	81.6%	77.8%	63.0%	81.0%	100.0%	93.1%	93.1%	100.0%	93.1%	93.1%
	Numerator: Programme 8 Capital infrastructure expenditure (excluding Maintenance)	344,324,084	327,685,000	66,173,991	69,413,239	-	152,352,694	124,327,584	-	255,091,626	194,704,767	-	327,685,000	287,493,435	-	327,685,000	287,493,435	-
	Denominator: Programme 8 Capital infrastructure budget (excluding Maintenance)	326,399,000	327,685,000	327,685,000	327,685,000	-	327,685,000	327,685,000	-	327,685,000	308,949,000	-	327,685,000	308,949,000	-	327,685,000	308,949,000	-
	COMMENT			* May cash flow (as approved at the Financial Management Committee Meeting held on 15 June 2017) utilised to forecast June expenditure. * Accruals from 2016/17. * Concerted effort from IA to finalise Final Accounts and PSP fees related to final accounts. * Due to delays during construction - expenditure incurred later than planned i.e. 2017/18.			August cash flow, as approved at the Financial Management Committee held on 15 September 2017, utilised to forecast September expenditure.			* PSP appointments not progressing as planned. * Slow progress on design stages. * Saving on Stellenbosch Hospital EC. * Delay in projects progressing to tender.			Indicator is service delivery driven and not within full control of the Department. Under performance is due to: * PSP appointments not progressing as planned. * Slow progress on design stages. * Delay in projects progressing to tender. * Expenditure for March is based on interim results as at 28 March 2018. Taking the above into consideration, the Department still deems the performance within an acceptable range.			Capital projects underspent due to delays in the appointment of Professional Service Providers (PSPs) and Contractors, the poor performance of Contractors, the poor and slow performance of PSPs in general, long lead times for stage deliverables, and delays in the finalisation of Final Accounts.		
	ACTION PLAN			* Rigorous Programme Management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			* Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			None required.		
1	**Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District (Eden District)**	5	4	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	4	4	100.0%	4	4	100.0%
	COMMENT			Annual indicator - not required to report. Interim results - work at none of the health facilities planned to undergo major and / or minor refurbishment has been completed. However, two other facilities have undergone major and / or minor refurbishment.			Annual indicator - not required to report. Interim results: Work at none of the health facilities planned to undergo major and / or minor refurbishment in 2017/18 has been completed. However, two other facilities have undergone major and / or minor refurbishment during this financial year.			Annual indicator - not required to report. Interim results: Work at two of the health facilities planned to undergo major and / or minor refurbishment in 2017/18 has been completed. In addition, three other facilities have undergone major and / or minor refurbishment during this financial year. Further to the above, NDoH undertake some other projects in Eden as NHI Pilot District - these are funded through the In-kind Grant.			Target achieved. The following facilities have undergone minor / major refurbishment: Herold Satellite Clinic and Craggs, Brandwacht and Conville Clinics.			Target achieved.		
	ACTION PLAN			Not required to report.			Not required to report.			* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			* Continue with roll-out of NHI projects as planned.			None required.		
2	**Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District (Eden District)**	58	38	Annual Target	-	Annual Target	Annual Target	-	Annual Target	Annual Target	-	Annual Target	38	38	100.0%	38	38	100.0%
	COMMENT			Annual indicator - not required to report. Interim results - work at three of the health facilities planned to undergo major and / or minor refurbishment has been completed. In addition, three other facilities have undergone major and / or minor refurbishment.			Annual indicator - not required to report. Interim results: Work at three of the health facilities planned to undergo major and / or minor refurbishment in 2017/18 has been completed. In addition, three other facilities have undergone major and / or minor refurbishment during this financial year.			Annual indicator - not required to report. Interim results: Work at 18 of the health facilities planned to undergo major and / or minor refurbishment in 2017/18 has been completed. In addition, 6 other facilities have undergone major and / or minor refurbishment during this financial year.			Target achieved.			Target achieved.		
	ACTION PLAN			Not required to report.			Not required to report.			* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows. * Improve Scope of Works, Strategic Briefs and streamline approvals process before work commences on site. * Proposed decanting plan to be discussed and signed off by End Users before construction on site commences. * Continuous rigorous programme management and monitoring of Implementing Agent.			None required.		
	Percentage of Programme 8 Maintenance budget spent	Not required to report	100.0%	13.4%	23.2%	172.3%	31.2%	39.4%	126.2%	53.7%	57.5%	107.1%	100.0%	88.3%	88.3%	100.0%	88.3%	88.3%
	Numerator: Programme 8 Expenditure on Maintenance		329,583,000	44,294,409	76,325,685	-	102,752,738	129,798,939	-	176,966,198	191,839,617	-	329,583,000	294,424,853	-	329,583,000	294,424,853	-
	Denominator: Programme 8 Maintenance budget		329,583,000	329,583,000	329,583,000	-	329,583,000	329,583,000	-	329,583,000	333,603,000	-	329,583,000	333,603,000	-	329,583,000	333,603,000	-

	Performance Measure/Indicator	Estimated Performance FY 2016/2017 (AR)	APP 2017/18 Annual Target	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual		
				Q1 Target	Actual		Q2 Target	Actual		Q3 Target	Actual		Q4 Target	Actual		Annual Target	ACTUAL YTD	
					Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
3	**COMMENT**			Over-performance due to: * Accruals from 2016/17. Notes: * Unreliable Scheduled Maintenance cash flows per project remains a challenge. * Moderately low target was set.			August cash flow, as approved at the Financial Management Committee held on 15 September 2017, utilised to forecast September expenditure. Management Contractor - over-performance due to: * Projects progressing faster than foreseen at time when targets were set. Routine / Day-to-day Maintenance - over performance due to: * Target based on historical data - contracts were in place in Quarter 4 of 2016/17 that were payable in Quarter 1 of 2017/18.			Performance exceeds target, which is to the benefit of the Department.			Indicator is service delivery driven and not within full control of the Department. Under performance is due to: * PSP appointments not progressing as planned. * Slow progress on design stages. * Delay in projects progressing to tender. * Late access to Framework Agreement. * Claim-backs on alternative water supply projects to be made until 10 April. * Slow progress on alternative water supply projects. * Expenditure for March is based on interim results as at 28 March 2018. Taking the above into consideration, the Department still deems the performance within an acceptable range.			Scheduled maintenance projects underspent as a result of quality of the facility condition assessments, delays in the finalisation of project scope, delays in project procurement and lengthy implementation periods.		
	ACTION PLAN			* Implementing a process of ensuring that reliable per project cash flows are presented on a monthly basis.			* Refining the accuracy of results, rendered by process implemented to ensure that reliable per project cash flows, are presented on a monthly basis.						* WCGTPW utilising "Implementing Support Service" to improve project management and accelerate project delivery. * Continuous rigorous programme management and monitoring of Implementing Agent. * Ongoing implementation of the Standard for Infrastructure Procurement and Delivery Management (SIPDM). * Rigorous review of project cash flows.			None required.		
4	**Percentage of Programme 8 health technology budget spent**	167.5%	100.0%	1.9%	9.9%	517.5%	6.5%	25.2%	388.2%	13.6%	35.3%	259.5%	100.0%	110.6%	110.6%	100.0%	110.6%	110.6%
	Numerator: Programme 8 Health Technology expenditure	113,359,879	76,927,000	1,467,129	7,592,945	-	5,015,487	19,409,823	-	10,476,088	41,081,355	-	76,927,000	128,782,098	-	76,927,000	128,782,098	-
	Denominator: Programme 8 Health Technology budget allocation	67,665,000	76,927,000	76,927,000	76,927,000	-	76,927,000	76,927,000	-	76,927,000	116,394,000	-	76,927,000	116,394,000	-	76,927,000	116,394,000	-
	COMMENT			Expenditure is ahead due to: * Accruals from 2016/17. * Due to late delivery, some outstanding payments planned for 2016/17 are being effected in 2017/18. * Earlier procurement for District Six CDC. Note: Moderately low target was set.			August cash flow, as approved at the Financial Management Committee held on 15 September 2017, utilised to forecast September expenditure. Expenditure is ahead due to: * Expedited procurement for Wolseley, Prince Alfred Hamlet and Napier Clinics and District Six CDC (to facilitate timely operationalisation, lead time is required for procurement and delivery of HT items). Note: Moderately low target was set.			Performance exceeds target, which is to the benefit of the Department.			* Planned over expenditure is being achieved as mitigation for infrastructure-related under expenditure.			Over expenditure can mainly be attributed to Health Technology equipment expenditure, due to: Additional project allocations to mitigate for projected under-expenditure in infrastructure; and occasional changes in expenditure timeframes as a result of either earlier or later Practical Completion of infrastructure projects.		
	ACTION PLAN			Continued collaboration and communication wrt Infrastructure and Health Technology project progress.			Continued collaboration and communication wrt Infrastructure and Health Technology project progress.									None required.		