QUARTER 1 ACTUAL PERFFORMANCE OF FY 2019/2020							
Department of Health	Progress						
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**
Administration	2	2	0	0	100	0	0
2. District Health Services	**32**	**25**	**7**	**0**	**78**	**22**	**0**
District Health Services	2	2	0	0	100	0	0
District Hospitals Services	4	4	0	0	100	0	0
HIV, AIDS, STI and TB Control	10	6	4	0	60	40	0
Maternal, Child and Women's	14	11	3	0	79	21	0
Disease Prevention and Control	2	2	0	0	100	0	0
3. Emergency Medical Services	**4**	**1**	**3**	**0**	**25**	**75**	**0**
Emergency Medical Services	4	1	3	0	25	75	0
4. Provincial Hospital Services	**11**	**10**	**1**	**0**	**91**	**9**	**0**
4.1 General (Regional) Hospitals	5	5	0	0	100	0	0
4.2 Tuberculosis Hospitals	1	1	0	0	100	0	0
4.3 Psychiatric Hospitals	1	1	0	0	100	0	0
4.4 Rehabilitation Hospitals	1	1	0	0	100	0	0
Specialised Hospitals	1	1	0	0	100	0	0
4.5 Dental Training Hospitals	2	1	1	0	50	50	0
5. Central Hospital Services	**10**	**10**	**0**	**0**	**100**	**0**	**0**
Central Hospital Services	5	5	0	0	100	0	0
RCWMCH	5	5	0	0	100	0	0
6. Health Sciences and Training	**0**	**0**	**0**	**0**			
Health Sciences and Training	0	0	0	0	-	-	-
7. Health Care Support Services	**6**	**3**	**2**	**1**	**50**	**33**	**17**
7.1 Laundry Services	2	2	0	0	100	0	0
7.2 Engineering Services	2	1	0	1	50	0	50
7.3 Forensic Pathology Services	1	0	1	0	0	100	0
7.4 Cape Medical Depot	1	0	1	0	0	100	0
8. Health Facilities Management	**3**	**0**	**2**	**1**	**0**	**67**	**33**
Health Facilities Management	3	0	2	1	0	67	33
Total	**68**	**51**	**15**	**2**	**75**	**22**	**3**

QUARTER 2 ACTUAL PERFFORMANCE OF FY 2019/2020								
Department of Health		Progress						
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**
	Administration	2	2	0	0	100	0	0
2.	**District Health Services**	**32**	**25**	**7**	**0**	**78**	**22**	**0**
	District Health Services	2	2	0	0	100	0	0
	District Hospitals Services	4	4	0	0	100	0	0
	HIV, AIDS, STI and TB Control	10	5	5	0	50	50	0
	Maternal, Child and Women's	14	12	2	0	86	14	0
	Disease Prevention and Control	2	2	0	0	100	0	0
3.	**Emergency Medical Services**	**4**	**1**	**3**	**0**	**25**	**75**	**0**
	Emergency Medical Services	4	1	3	0	25	75	0
4.	**Provincial Hospital Services**	**11**	**11**	**0**	**0**	**100**	**0**	**0**
4.1	General (Regional) Hospitals	5	5	0	0	100	0	0
4.2	Tuberculosis Hospitals	1	1	0	0	100	0	0
4.3	Psychiatric Hospitals	1	1	0	0	100	0	0
4.4	Rehabilitation Hospitals	1	1	0	0	100	0	0
	Specialised Hospitals	1	1	0	0	100	0	0
4.5	Dental Training Hospitals	2	2	0	0	100	0	0
5.	**Central Hospital Services**	**10**	**8**	**2**	**0**	**80**	**20**	**0**
	Central Hospital Services	5	5	0	0	100	0	0
	RCWMCH	5	3	2	0	60	40	0
6.	**Health Sciences and Training**	**0**	**0**	**0**	**0**			
	Health Sciences and Training	0	0	0	0	-	-	-
7.	**Health Care Support Services**	**6**	**4**	**2**	**0**	**67**	**33**	**0**
7.1	Laundry Services	2	2	0	0	100	0	0
7.2	Engineering Services	2	2	0	0	100	0	0
7.3	Forensic Pathology Services	1	0	1	0	0	100	0
7.4	Cape Medical Depot	1	0	1	0	0	100	0
8.	**Health Facilities Management**	**3**	**0**	**2**	**1**	**0**	**67**	**33**
	Health Facilities Management	3	0	2	1	0	67	33
Total		**68**	**51**	**16**	**1**	**75**	**24**	**1**

QUARTER 3 ACTUAL PERFFORMANCE OF FY 2019/2020								
Department of Health		Progress						
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**
	Administration	2	2	0	0	100	0	0
2.	**District Health Services**	**32**	**23**	**9**	**0**	**72**	**28**	**0**
	District Health Services	2	2	0	0	100	0	0
	District Hospitals Services	4	3	1	0	75	25	0
	HIV, AIDS, STI and TB Control	10	4	6	0	40	60	0
	Maternal, Child and Women's	14	12	2	0	86	14	0
	Disease Prevention and Control	2	2	0	0	100	0	0
3.	**Emergency Medical Services**	**4**	**2**	**2**	**0**	**50**	**50**	**0**
	Emergency Medical Services	4	2	2	0	50	50	0
4.	**Provincial Hospital Services**	**11**	**11**	**0**	**0**	**100**	**0**	**0**
4.1	General (Regional) Hospitals	5	5	0	0	100	0	0
4.2	Tuberculosis Hospitals	1	1	0	0	100	0	0
4.3	Psychiatric Hospitals	1	1	0	0	100	0	0
4.4	Rehabilitation Hospitals	1	1	0	0	100	0	0
	Specialised Hospitals	1	1	0	0	100	0	0
4.5	Dental Training Hospitals	2	2	0	0	100	0	0
5.	**Central Hospital Services**	**10**	**10**	**0**	**0**	**100**	**0**	**0**
	Central Hospital Services	5	5	0	0	100	0	0
	RCWMCH	5	5	0	0	100	0	0
6.	**Health Sciences and Training**	**0**	**0**	**0**	**0**			
	Health Sciences and Training	0	0	0	0	-	-	-
7.	**Health Care Support Services**	**6**	**2**	**2**	**2**	**33**	**33**	**33**
7.1	Laundry Services	2	2	0	0	100	0	0
7.2	Engineering Services	2	0	0	2	0	0	100
7.3	Forensic Pathology Services	1	0	1	0	0	100	0
7.4	Cape Medical Depot	1	0	1	0	0	100	0
8.	**Health Facilities Management**	**3**	**0**	**3**	**0**	**0**	**100**	**0**
	Health Facilities Management	3	0	3	0	0	100	0
Total		**68**	**50**	**16**	**2**	**74**	**24**	**3**

QUARTER 4 PRELIMINARY PERFFORMANCE OF FY 2019/2020								
Department of Health		Progress						
	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**
	Administration	7	7	0	0	100	0	0
2.	**District Health Services**	**40**	**28**	**12**	**0**	**70**	**30**	**0**
	District Health Services	3	1	2	0	33	67	0
	District Hospitals Services	4	3	1	0	75	25	0
	HIV, AIDS, STI and TB Control	12	6	6	0	50	50	0
	Maternal, Child and Women's	19	17	2	0	89	11	0
	Disease Prevention and Control	2	1	1	0	50	50	0
3.	**Emergency Medical Services**	**5**	**3**	**2**	**0**	**60**	**40**	**0**
	Emergency Medical Services	5	3	2	0	60	40	0
4.	**Provincial Hospital Services**	**16**	**15**	**1**	**0**	**94**	**6**	**0**
4.1	General (Regional) Hospitals	6	5	1	0	83	17	0
4.2	Tuberculosis Hospitals	2	2	0	0	100	0	0
4.3	Psychiatric Hospitals	2	2	0	0	100	0	0
4.4	Rehabilitation Hospitals	2	2	0	0	100	0	0
	Specialised Hospitals	2	2	0	0	100	0	0
4.5	Dental Training Hospitals	2	2	0	0	100	0	0
5.	**Central Hospital Services**	**12**	**10**	**2**	**0**	**83**	**17**	**0**
	Central Hospital Services	6	6	0	0	100	0	0
	RCWMCH	6	4	2	0	67	33	0
6.	**Health Sciences and Training**	**11**	**10**	**1**	**0**	**91**	**9**	**0**
	Health Sciences and Training	11	10	1	0	91	9	0
7.	**Health Care Support Services**	**8**	**4**	**2**	**2**	**50**	**25**	**25**
7.1	Laundry Services	2	2	0	0	100	0	0
7.2	Engineering Services	4	2	0	2	50	0	50
7.3	Forensic Pathology Services	1	0	1	0	0	100	0
7.4	Cape Medical Depot	1	0	1	0	0	100	0
8.	**Health Facilities Management**	**5**	**2**	**2**	**1**	**40**	**40**	**20**
	Health Facilities Management	5	2	2	1	40	40	20
Total		**104**	**79**	**22**	**3**	**76**	**21**	**3**

Monitoring and Evaluation Report
PROGRAMME 1: Administration

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
	Administration															
1.1.1	**Percentage of the annual equitable share budget allocation spent**	Annual target	-	-	Annual target	-	-	Annual target	-	-	100.0%	99.4%	99.4%	100.0%	99.4%	99.4%
Num	Annual expenditure on equitable share budget	Annual target	-	-	Annual target	-	-	Annual target	-	-	17 413 820 000	18 197 294	0.1%	17 413 820 000	18 197 294	0.1%
Den	Total BAS annual equitable share budget allocation	Annual target	-	-	Annual target	-	-	Annual target	-	-	17 413 820 000	18 314 005	0.1%	17 413 820 000	18 314 005	0.1%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target.					
	ACTION PLAN															
1.2.1	**Timeous submission of a Human Resource Plan for 2015 - 2019 to DPSA**	Annual target	-	-	Annual target	-	-	Annual target	-	-	Yes	Yes	100.0%	Yes	Yes	100.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Target achieved.					
	ACTION PLAN															
1.3.1	**Cultural entropy level for WCG:Health**	Annual target	21.0%	-	Annual target	-	-	Annual target	-	-	16.0%	15.5%	103.5%	16.0%	-	-
Num	Votes for potentially limiting values (PL) in current culture	Annual target	5200.0%	-	Annual target	-	-	Annual target	-	-	12 000	11 903		12000	-	-
Den	Participants in the survey X 10 possible values	Annual target	24800.0%	-	Annual target	-	-	Annual target	-	-	75 000	76 990		75000	-	-
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target.					
	ACTION PLAN															
1.3.2	**Number of value matches in the Barrett survey**	Annual target	-	-	Annual target	-	-	Annual target	-	-	6	7	116.7%	6	-	-
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Over performance (1 more value match) is considered as acceptable and as an advantage to the Department.					
	ACTION PLAN															
1.1	**Audit opinion from Auditor-General of South Africa**	Annual target	-	-	Annual target	-	-	Annual target	-	-	Unqualified	Unqualified	100.0%	Unqualified	Unqualified	100.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Clean audit/target achieved.					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
1.2	**Percentage of hospitals with broadband access**	100.0%	98.1%	98.1%	100.0%	98.1%	98.1%	100.0%	98.1%	98.1%	100.0%	98.1%	98.1%	100.0%	98.1%	98.1%
Num	Hospitals with minimum 2 Mbps connectivity	52	51	98.1%	52	51	98.1%	52	51	98.1%	52	51	98.1%	52	51	98.1%
Den	Number of hospitals	52	52	100.0%	52	52	100.0%	52	52	100.0%	52	52	100.0%	52	52	100.0%
Notes:	COMMENT	The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target. (Additional Note: Murraysburg Hospital is the only hospital that does not currently meet the minimum broadband requirement of 2 Mbps, but it has access to 1 Mbps broadband connectivity.)			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target. (Additional Note: Murraysburg Hospital is the only hospital that does not currently meet the minimum broadband requirement of 2 Mbps, but it has access to 1 Mbps broadband connectivity.)			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target. (Additional Note: Murraysburg Hospital is the only hospital that does not currently meet the minimum broadband requirement of 2 Mbps, but it has access to 1 Mbps broadband connectivity.)			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target. (Additional Note: Murraysburg Hospital is the only hospital that does not currently meet the minimum broadband requirement of 2 Mbps, but it has access to 1 Mbps broadband connectivity.)					
	ACTION PLAN				Further engagement with Cel to take place in terms of feasibility of broadband roll out/connectivity at Murraysburg Hospital to meet minimum 2 Mbps connectivity, as the remote/rural locality is a limiting factor that affects optimal broadband versus the cost factor. Cost-benefit analysis to be conducted and feedback to be provided in the next quarter.			Due to ICT infrasructure, cost and service provider limitations, broadband roll out is not feasible at Murraysburg hospital for 2 Mbps yet. The hospital does however have 1 Mbps broadband access. Cel is aware of the challenges and are prioritising broadband access accordingly, within allocated resources.								
1.3	**Percentage of fixed PHC facilities with broadband access**	94.3%	94.3%	100.0%	94.7%	94.3%	99.6%	95.1%	94.3%	99.2%	95.5%	94.3%	98.8%	95.5%	94.3%	98.8%
Num	Fixed PHC facilities with minimum 1 Mps connectivity	250	248	99.2%	251	249	99.2%	252	250	99.2%	253	250	98.8%	253	250	98.8%
Den	Number of fixed PHC facilities	265	263	99.2%	265	264	99.6%	265	265	100.0%	265	265	100.0%	265	265	100.0%
Notes:	COMMENT	Based on preliminary data, the target has been achieved for the quarter.			Based on preliminary data, the target has been achieved for the quarter. (Note: Asla Clinic opened during quarter 2 and also prescribes to the minimum broadband access)			Based on preliminary data, the target has been achieved for the quarter. (Note: Pelican Park CDC opened during quarter 3 and also prescribes to the minimum broadband access)			The marginal deviation from the planned performance target is considered by the Department as acceptable and is therefore considered as having achieved the target.					
	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 2: District Health Services

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
District Health Services																
2.1	**Ideal clinic status rate**	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	90.5%	65.7%	72.6%	90.5%	65.7%	72.6%
Num	Ideal clinic status	Annual target	–	Annual target	Annual target	–	Annual target	Annual target	–	Annual target	239	174	72.8%	239	174	72.8%
Den	Fixed PHC facilities	Annual target	263	Annual target	Annual target	264	Annual target	Annual target	265	Annual target	264	265	100.4%	264	265	100.4%
Notes:	COMMENT				New facility - Pelican Park CDC						*not forecast* *Due to the impact of the COVID-19 pandemic, capture of assessments is still in progress.*			New facility opened, Pelican Park CDC		
	ACTION PLAN															
2.2	**PHC utilisation rate - total**	2.2	2.2	98.4%	2.3	2.2	96.6%	2.1	2.1	101.8%	2.2	2.1	97.6%	2.2	2.2	98.5%
Num	PHC total Headcount	3560004	3570812	100.3%	3740159	3670581	98.1%	3501442	3 524 414	100.7%	3 638 393	3 541 533	97.3%	14439998	14307340	99.1%
Den	Total Population	1652737	1649137	99.8%	1652737	1652737	100.0%	1652737	1 649 137	99.8%	1 652 734	1 649 135	99.8%	6610945	6600145	99.8%
Notes:	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. The marginal deviation is considered by the Department as having achieved the planned target.			Target achieved			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 higher utilisation rate is reflective of service pressures on primary healthcare. **DO WE KNOW WHAT CAUSED THIS SPIKE?**			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
2.3	**Complaints resolution within 25 working days rate (PHC)**	94.6%	97.6%	103.1%	94.5%	96.6%	102.2%	94.7%	93.9%	99.2%	95.2%	74.3%	78.0%	94.8%	91.1%	96.1%
Num	Complaints resolved within 25 working days	455	682	149.9%	427	672	157.4%	432	512	118.5%	477	434	90.9%	1 791	2 300	128.4%
Den	Complaints resolved	481	699	145.3%	452	696	154.0%	456	545	119.5%	501	584	116.5%	1 890	2524	133.5%
Notes:	COMMENT	This is a positive performance as the percentage of complaints resolved within 25 working days is higher than targetted.			This is a positive performance as the percentage of complaints resolved within 25 working days is higher than targetted.						As a result of COVID-19 pandemic, availability of staff to capture complaints and outcomes is impacted this quarter.					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
	District Hospitals															
2.4	**Average length of stay (district hospitals)**	3.4	3.5	98.5%	3.3	3.4	96.9%	3.3	3.4	97.6%	3.4	3.4	99.6%	3.4	3.4	99.6%
Num	Calculated field: Patient days (sum of inpatient days and ½ day patients)	238712	248096	96.2%	242839	249831	97.2%	239120	245 027	97.6%	239 423	240 849	99.4%	960094	983803	97.6%
Den	Calculated field: Inpatient Separations in district hospitals	70975	71894	101.3%	72617	73367	101.0%	71627	72 483	101.2%	71 295	70 580	99.0%	286514	288324	100.6%
Notes:	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. The marginal deviation is considered by the Department as having achieved the planned target. The high averagel length of stay indicates the service pressures on district hospitals.			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 marginal deviation is considered by the Department as having achieved the planned target. The high averagel length of stay indicates the service pressures on district hospitals.						Target achieved					
	ACTION PLAN															
2.5	**Inpatient bed utilisation rate (district hospitals)**	89.8%	91.5%	101.9%	91.3%	92.2%	101.0%	89.9%	90.3%	100.5%	90.0%	88.7%	98.6%	90.3%	90.7%	100.5%
Num	Calculated field: Patient days in district hospitals	238712	248096	96.2%	242839	249831	97.2%	239120	245 027	97.6%	239 423	240 849	99.4%	960094	983803	97.6%
Den	"Inpatient bed days available (district hospitals) Usable beds total x 30.42"	265932	271012	101.9%	265933	271042	101.9%	265933	271 286	102.0%	265 928	271 407	102.1%	1063726	1084747	102.0%
Notes:	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. The marginal deviation is considered by the Department as having achieved the planned target. The high bed utilisation rate indicates the service pressures on district hospitals.			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 marginal deviation is considered by the Department as having achieved the planned target. The high bed utilisation rate indicates the service pressures on district hospitals.						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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
2.6	**Expenditure per (PDE) (district hospitals)**	R 2 600.22	R 2 396.38	108.5%	R 2 552.97	R 2 595.34	98.4%	R 2 589.36	R 2 657.20	97.4%	R 2 578.40	R 2 701.04	95.5%	R 2 580.12	R 2 586.57	99.8%
Num	Expenditure in district hospitals	R 913 122 250	879 899 450	103.8%	R 913 122 250	958 824 986	95.2%	R 913 122 250	965 717 433	94.6%	R 913 122 250	R 965 946 191	94.5%	3 652 489 000	3 770 388 059	96.9%
Den	Calculated field: Patient day equivalent (PDE) (district hospitals)	351 171	367 179	95.6%	357 670	369 442	96.8%	352 644	363 435	97.0%	354 143	357 621	99.0%	1 415 628	1 457 676	97.1%
Notes:	COMMENT	Underspending in the first quarter is anticipated and aligns with historical trends, this is expected to reconcile through the year. As this is based on the service demand the Department cannot target with 100% accuracy.			Higher than planned expenditure this quarter however on track for the year.						*overexpenditure*					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.7	**Complaint resolution within 25 working days rate (district hospitals)**	91.3%	95.8%	105.0%	91.4%	91.7%	100.4%	91.7%	84.9%	92.6%	90.9%	83.1%	91.4%	91.3%	89.2%	97.7%
Num	Complaints resolved within 25 working days (district hospitals)	199	298	149.7%	201	278	138.3%	199	258	129.6%	200	200	99.8%	799	1 034	129.3%
Den	Complaints resolved (district hospitals)	218	311	142.7%	220	303	137.7%	217	304	140.1%	220	240	109.1%	875	1 158	132.3%
Notes:	COMMENT	This is a positive performance as the percentage of complaints resolved within 25 working days is higher than targetted.			Target achieved						As a result of COVID-19 pandemic, availability of staff to capture complaints and outcomes is impacted this quarter.					
	ACTION PLAN															
	HIV and AIDS, STIs and TB															
2.8	**ART client remain on ART end of month - total**	282050	282277	100.1%	288540	288319	99.9%	294981	289834	98.3%	300369	290205	96.6%	300369	290205	96.6%
Notes:	COMMENT	A positive performance with less than 1% deviation from target. This indicator is reliant on clients self managing their care and the minor deviation is considered by the Department as having achieved target.			A positive performance with minor deviation from target. This indicator is reliant on clients self managing their care and the minor deviation is considered by the Department as having achieved target.			A positive performance with minor deviation from target. This indicator is reliant on clients self managing their care and the minor deviation is considered by the Department as having achieved target.			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 marginal deviation is considered as having achieved the planned target.					
	ACTION PLAN															
2.9	**TB/HIV co-infected client on ART rate**	88.0%	92.0%	104.6%	88.0%	90.5%	102.9%	88.0%	91.0%	103.4%	88.0%	89.0%	101.2%	88.0%	90.6%	103.0%
Num	Total number of registered HIV and TB co-infected patients on ART	3478	3637	104.6%	3564	3 467	97.3%	3 517	3 690	104.9%	3 552	3 569	100.5%	14111	14363	101.8%
Den	Total number of registered HIV and TB co-infected patients	3951	3952	100.0%	4049	3 829	105.7%	3 995	4 056	98.5%	4 038	4 009	100.7%	16033	15846	101.2%
Notes:	COMMENT	A positive performance as more co-infected clients are on ART than planned.			A positive performance as more co-infected clients are on ART than planned.						*Target achieved*					
	ACTION PLAN															
2.10	**HIV test done - Total**	382635	436145	114.0%	410659	452496	110.2%	405739	414 390	102.1%	425420	426 939	100.4%	1624453	1729970	106.5%
Notes:	COMMENT	Positive performance as more clients tested than planned			Positive performance as more clients tested than planned			Positive performance as more clients tested than planned			target achieved					
	ACTION PLAN															
2.11	**Male condom distributed**	28025882	22055200	78.7%	28798262	16897960	58.7%	28347993	22537800	79.5%	28724518	20494500	71.3%	113896655	81985460	72.0%
Notes:	COMMENT	Targets not adjusted sufficiently for seasonal influences, performance aligns with same period last year. Expected to improve through the year.			Lower than expected number of condoms distributed due to a combination of delayed deliveries and reduced orders whilst facilities reconcile existing stock. This will be monitored through the year.						Changes in the ordering process (from push to pull) has facilitiated a better managed stock flow at facilities. Health Services management are maintaining oversight mechanisms.					
	ACTION PLAN	Due to the change in ordering process (from push to pull) sub districts are going to need to "pull" harder in order to achieve targets. Health Services management to discuss oversight mechanisms for this.			Districts to verify whether they have made any adjustments to their orders						*Note: this is not an indicator for FY20/21*					

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.12	**Medical male circumcision - total**	4104	5065	123.4%	6514	5038	77.3%	4617	4320	93.6%	5295	3888	73.4%	20530	18311	89.2%
Notes:	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. The marginal deviation is considered as having achieved the			Performance lower than expected this quarter. Districts continue to maintain engagements with NPO service partners to address challenges.			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 marginal deviation is considered as having achieved the planned target.			*performance is consistent for the year and even an increase on January.*					
	ACTION PLAN										*Note: this is not an indicator for FY20/21*					
2.13	**TB client 5 yrs and older start on treatment rate**	92.4%	90.3%	97.8%	92.6%	90.9%	98.2%	93.1%	90.1%	96.8%	92.5%	89.7%	97.0%	92.7%	90.3%	97.4%
Num	Sum (TB client 5 years and older start on treatment)	5 007	5 237	104.6%	6 157	5 805	94.3%	5 885	5 341	90.8%	5 949	5 883	98.9%	22 998	22 266	96.8%
Den	Sum (TB symptomatic client 5 years and older tested positive)	5 418	5 798	93.4%	6 646	6 384	104.1%	6 321	5 929	106.6%	6 433	6 557	98.1%	24 818	24 668	100.6%
Notes:	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. The marginal deviation is considered as having achieved the planned target.			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 marginal deviation is considered as having achieved the planned target.			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 marginal deviation is considered as having achieved the planned target.			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 marginal deviation is considered as having achieved the planned target.					
	ACTION PLAN															
2.14	**TB client treatment success rate**	81.8%	80.8%	98.8%	81.8%	77.9%	95.2%	81.8%	76.7%	93.8%	81.8%	72.6%	88.8%	81.8%	76.9%	94.0%
Num	TB client successfully completed treatment	8 211	8 548	104.1%	8 458	7 783	92.0%	8 329	8 341	100.1%	8 437	8 105	96.1%	33 435	32 777	98.0%
Den	All TB clients started on treatment	10 038	10 579	105.4%	10 339	9 993	96.7%	10 179	10 871	106.8%	10 312	11 157	108.2%	40 868	42 600	104.2%
Notes:	COMMENT										*Reporting incomplete, next cohort import due April 2020*					
	ACTION PLAN	The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.					

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.15	**TB client lost to follow up rate**	9.6%	11.2%	85.6%	9.7%	12.3%	78.8%	9.6%	11.3%	85.1%	9.6%	11.4%	83.9%	9.6%	11.5%	83.6%
Num	Sum (TB client lost to follow-up)	968	1 187	81.6%	999	1 230	81.2%	982	1 226	80.1%	994	1 276	77.9%	3 943	4 919	80.2%
Den	All TB clients started on treatment	10 038	10 579	94.9%	10 339	9 993	103.5%	10 179	10 871	93.6%	10 312	11 157	92.4%	40 868	42 600	95.9%
Notes:	COMMENT	Underperformance for TB success rate, loss to follow up for TB and Retention in Care for HIV is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone			Underperformance for TB success rate is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.			Underperformance for TB success rate is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.			*Next cohort import end April* *Underperformance for TB success rate is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.*					
	ACTION PLAN	The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.					
2.16	**TB client death rate**	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	3.7%	3.8%	97.2%	3.7%	3.8%	97.2%
Num	Sum (TB client died during treatment)	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	1 515	1 624	93.3%	1 515	1 624	93.3%
Den	All TB clients started on treatment	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	40 868	42 600	95.9%	40 868	42 600	95.9%
Notes:	COMMENT															
	ACTION PLAN															
2.17	**TB MDR treatment success rate**	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	50.5%	55.8%	110.4%	50.5%	55.8%	110.5%
Num	TB MDR client successfully completed treatment	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	755	790	104.6%	755	790	104.6%
Den	TB MDR confirmed client start on treatment	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	1 496	1 417	94.7%	1 496	1 417	94.7%
Notes:	COMMENT															
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.18.1	**ART Retention in care after 12 months**	63.1%	58.9%	93.3%	63.1%	58.4%	92.5%	63.1%	56.7%	89.9%	63.1%	58.0%	91.9%	63.1%	58.0%	92.0%
Num	ART clients retained in care after 12 months	7 326	6 569	89.7%	7 270	7 221	99.3%	7 394	6 155	83.2%	7 668	6 303	82.2%	29 658	26 248	88.5%
Den	ART clients initiated on treatment (12 month Cohort)	11 614	11 153	96.0%	11 526	12 367	107.3%	11 723	10 851	92.6%	12 151	10 875	89.5%	47 014	45 246	96.2%
Notes:	COMMENT	Underperformance for TB success rate, loss to follow up for TB and Retention in Care for HIV is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.			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 marginal deviation is considered as having achieved the planned target.			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 marginal deviation is considered as having achieved the planned target.			Next cohort import end April 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 marginal deviation is considered as having achieved the planned target.					
	ACTION PLAN	The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.					
2.18.2	**ART Retention in care after 48 months**	54.2%	44.9%	82.8%	54.6%	47.7%	87.3%	54.3%	50.0%	92.1%	54.2%	48.7%	89.8%	54.3%	48.0%	88.3%
Num	ART clients retained in care after 48 months	5 331	4 043	75.8%	5 385	5 776	107.3%	5 379	5 803	107.9%	5 580	5 490	98.4%	21 675	21 112	97.4%
Den	ART clients initiated on treatment (48 months Cohort)	9 829	9 006	91.6%	9 869	12 114	122.7%	9 915	11 606	117.1%	10 286	11 274	109.6%	39 899	44 000	110.3%
Notes:	COMMENT	Underperformance for TB success rate, loss to follow up for TB and Retention in Care for HIV is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.			Underperformance for Retention in Care for HIV is acknowledged. Challenges include data capture difficulties, inconsistent use of loss to follow up lists, incorrect addresses and telephone numbers and staff turnover.			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 marginal deviation is considered as having achieved the planned target.			Next cohort import end April 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 marginal deviation is considered as having achieved the planned target.					
	ACTION PLAN	The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.			The Province has in principle adopted the 10 point plan of the National Department of Health to address HIV and TB performance and will be working with City of Cape and NPO partners to implement these strategies appropriately in our context to improve performance.					

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
	Maternal, Child and Women's Health (MCWH)															
2.19	**Antenatal 1st visit before 20 weeks rate**	71.0%	71.8%	101.1%	71.0%	72.5%	102.1%	71.1%	72.6%	102.1%	71.1%	70.3%	98.8%	71.1%	71.7%	100.9%
Num	Antenatal 1st visit before 20 weeks	16 954	18 635	109.9%	18 818	21 015	111.7%	17 877	19 930	111.5%	19 012	22 040	115.9%	72 661	81 620	112.3%
Den	"Antenatal 1st visit Sum of: Antenatal 1st visit before 20weeks Antenatal 1st visit 20 weeks or later"	23 870	25 951	108.7%	26 493	29 003	109.5%	25 146	27 457	109.2%	26 734	31 370	117.3%	102 243	113 781	111.3%
Notes:	COMMENT	Target achieved			A positive performance, target exceeded with more visits conducted than planned.			A positive performance, target exceeded with more visits conducted than planned.			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 marginal deviation is considered as having achieved the planned target.					
	ACTION PLAN															
2.20	**Mother postnatal visit within 6 days rate**	60.1%	59.3%	98.6%	61.8%	61.9%	100.2%	63.4%	63.0%	99.4%	61.9%	65.5%	105.9%	61.8%	62.4%	101.0%
Num	Mother postnatal visit within 6 days after delivery	13 950	14 543	104.3%	14 794	15 515	104.9%	15 436	15 755	102.1%	14 910	16 076	107.8%	59 090	61 889	104.7%
Den	Delivery in facility total	23 227	24 535	105.6%	23 946	25 062	104.7%	24 346	25 008	102.7%	24 094	24 525	101.8%	95 613	99 130	103.7%
Notes:	COMMENT	Target achieved			A positive performance, target exceeded with more visits conducted than planned.			Target achieved			A positive performance, target exceeded with more visits conducted than planned.					
	ACTION PLAN															
2.21	**Antenatal client start on ART rate**	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	Annual target	0.0%	Annual target	86.9%	78.8%	90.7%	86.9%	78.8%	90.8%
Num	Antenatal client start on ART	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	6 183	4 859	78.6%	6 183	4 859	78.6%
Den	Antenatal client known HIV positive + Antenatal client first test positive + Antenatal client HIV retest positive	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	7 119	6 164	86.6%	7 119	6 164	86.6%
Notes:	COMMENT										*Appears to be an underperformance in Metro*					
	ACTION PLAN															

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.22	**Infant 1st PCR test positive around 10 weeks rate**	0.6%	0.2%	267.5%	0.5%	0.3%	196.8%	0.5%	0.3%	183.2%	0.5%	0.3%	149.8%	0.5%	0.3%	185.8%
Num	Infant PCR test positive around 10 weeks	19	8	237.5%	19	9	211.1%	18	10	180.0%	17	12	147.8%	73	39	189.6%
Den	Infant PCR test around 10 weeks	3 450	3 567	96.7%	3 750	3 542	105.9%	3 730	3 664	101.8%	3 583	3 446	104.0%	14 513	14 219	102.1%
Notes:	COMMENT	*Birth PCR positive rate is 0.8% (31/4104 forecast)* Due to the success of the "test and treat programme" the majority of babies are tested and, if positive, initiated on treatment at birth.			Birth PCR positive rate is 0.6% (26/4374) Due to the success of the "test and treat programme" the majority of babies are tested and, if positive, initiated on treatment at birth.			Birth PCR positive rate is 1.0% (40/4248 forecast) Due to the success of the "test and treat programme" the majority of babies are tested and, if positive, initiated on treatment at birth.			Birth PCR positive rate is 0.8% (11/1393 forecast) Due to the success of the "test and treat programme" the majority of babies are tested and, if positive, initiated on treatment at birth.			Due to the success of the "test and treat programme" the majority of babies are tested and, if positive, initiated on treatment at birth.		
	ACTION PLAN															
2.23	**Immunisation under 1 year coverage**	82.7%	83.6%	101.1%	86.4%	83.2%	96.3%	84.1%	84.8%	100.8%	83.1%	88.7%	106.7%	84.1%	85.1%	101.2%
Num	Immunised fully under 1 year new	22 186	22 430	101.1%	23 184	22 321	96.3%	22 557	22 746	100.8%	22 290	23 784	106.7%	90 217	91 281	101.2%
Den	Population under 1 year	26 826	26 826	100.0%	26 826	26 826	100.0%	26 826	26 826	100.0%	26 818	26 818	100.0%	107 296	107 296	100.0%
Notes:	COMMENT	Target achieved			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 marginal deviation is considered as having achieved the planned target.			Target achieved			A positive performance as more children immunised than planned.					
	ACTION PLAN															
2.24	**Measles 2nd dose coverage**	78.4%	79.7%	101.6%	82.0%	80.9%	98.6%	79.8%	77.7%	97.4%	78.8%	85.0%	107.8%	79.7%	80.8%	101.3%
Num	Measles 2nd dose	21 210	21 544	101.6%	22 175	21 877	98.7%	21 576	21 025	97.4%	21 300	22 979	107.9%	86 261	87 425	101.3%
Den	Population aged 1 year	27 045	27 045	100.0%	27 045	27 045	100.0%	27 046	27 046	100.0%	27 042	27 042	100.0%	108 178	108 178	100.0%
Notes:	COMMENT	Target achieved			Target achieved			A positive performance as more children immunised than planned.			A positive performance as more children immunised than planned.					
	ACTION PLAN															
2.25	**Diarrhoea case fatality under 5 years rate**	0.3%	0.3%	102.4%	0.3%	0.2%	158.9%	0.3%	0.0%	100.0%	0.4%	0.3%	114.8%	0.3%	0.2%	140.3%
Num	Child under 5 years diarrhoea death	5	5	100.0%	5	2	250.0%	5	0	100.0%	8	6	133.3%	23	13	176.9%
Den	Diarrhoea separation under 5 years	1 800	1 706	105.5%	1 782	1 059	168.3%	1 876	1 326	141.5%	1 873	1 722	108.8%	7 331	5 813	126.1%
Notes:	COMMENT	A positive performance as the fatality rate is lower than targetted.			Target achieved			No deaths reported, therefore performance is better than target.			A positive performance as the fatality rate is lower than targetted.					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.26	**Pneumonia case fatality under 5 years rate**	0.3%	0.2%	137.8%	0.2%	0.2%	116.4%	0.4%	0.2%	164.4%	0.4%	0.3%	117.2%	0.3%	0.2%	140.9%
Num	Pneumonia death under 5 years	8	11	72.7%	7	6	116.7%	11	5	220.0%	12	6	200.0%	38	28	135.7%
Den	Pneumonia separation under 5 years	2 988	5 052	59.1%	2 970	3 493	85.0%	3 112	2 325	133.8%	3 095	1 758	176.1%	12 165	12 628	96.3%
Notes:	COMMENT	A positive performance as the fatality rate is lower than targetted.			A positive performance as the fatality rate is lower than targetted.			A positive performance as the fatality rate is lower than targetted.			A positive performance as the fatality rate is lower than targetted.					
	ACTION PLAN															
2.27	**Severe acute malnutrition case fatality rate**	1.5%	2.1%	70.0%	2.2%	0.0%	100.0%	2.1%	0.0%	100.0%	3.5%	3.3%	105.0%	2.4%	1.5%	156.1%
Num	Severe acute malnutrition (SAM) death in facility under 5 years	2	3	66.7%	3	0	100.0%	3	0	100.0%	5	5	111.1%	13	8	173.3%
Den	Severe acute malnutrition (SAM) separation under 5 years	134	140	95.7%	135	114	118.4%	142	108	131.5%	141	135	104.4%	552	497	111.1%
Notes:	COMMENT	1 death more than planned, however due to the small numbers the deviation appears greater.			A positive performance as the fatality rate is lower than targetted.			No deaths reported and fewer cases admitted, therefore performance is better than target.			A positive performance as the fatality rate is lower than targetted.					
	ACTION PLAN	Monitor through the year.														
2.28	**School Grade 1 learners screened**	8928	22116	247.7%	4383	8539	194.8%	6243	12719	203.7%	4181	5421	129.7%	23735	48795	205.6%
Notes:	COMMENT	Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report					
	ACTION PLAN															
2.29	**School Grade 8 learners screened**	2474	3887	157.1%	1055	2890	273.9%	1755	3149	179.4%	1126	4043	359.0%	6410	13969	217.9%
Notes:	COMMENT	Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report			Metro has set zero targets for the year due to indicator definition requirements at the time of target setting. Definition was subsequently clarified and Metro is now able to report					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.30	**Delivery in 10 to 19 years in facility rate**	10.2%	10.6%	95.8%	11.4%	12.0%	95.2%	10.7%	12.5%	85.9%	11.1%	11.5%	96.2%	10.9%	11.7%	93.3%
Num	Delivery 10 - 19 years in facility	2 378	2 611	91.1%	2 728	3 000	90.9%	2 603	3 114	83.6%	2 683	2 829	94.8%	10 392	11 554	89.9%
Den	Delivery in facility total	23 227	24 535	94.7%	23 946	25 062	95.5%	24 346	25 008	97.4%	24 094	24 525	98.2%	95 613	99 130	96.5%
Notes:	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. The marginal deviation is considered as having achieved the planned target.						Target achieved					
	ACTION PLAN															
2.31	**Couple year protection rate (Int)**	79.7%	67.9%	85.2%	80.4%	58.6%	72.8%	81.5%	68.7%	84.3%	81.9%	65.6%	80.0%	80.9%	65.2%	80.6%
Num	"Sum of: Male sterilisation x10 Female sterilisation x10 Medroxyprogesterone ÷4 Norethisterone enathate ÷6 Oral pill cycles ÷15 IUCD inserted x4.5 Subdermal implant x2.5 Male condoms ÷120 Female condoms ÷120"	360 267	306 745	85.1%	363 172	264 518	72.8%	368 226	310 356	84.3%	369 801	296 127	80.1%	1 461 466	1 177 745	80.6%
Den	Female population 15-49 years	451 749	451 749	100.0%	451 748	451 748	100.0%	451 748	451 748	100.0%	451 745	451 745	100.0%	1 806 990	1 806 990	100.0%
Notes:	COMMENT	The lower than expected male condoms performance has influenced the outcome of this indicator.			Lower than expected number of condoms distributed (see related indicator). This has impacted the overall couple year protection rate performance.			IUCD and Medroxy lower than usual in November. Condom distribution remains low			Condom distribution performance remains low this quarter, impacting this indicator					
	ACTION PLAN															
2.32	**Cervical cancer screening coverage (annualised)**	57.7%	56.5%	97.8%	61.2%	61.9%	101.1%	59.2%	56.7%	95.7%	59.2%	55.9%	94.5%	59.4%	57.8%	97.4%
Num	Cervical cancer screening in women 30 years and older	24 473	23 942	97.8%	28 026	28 342	101.1%	24 448	23 393	95.7%	26 436	24 983	94.5%	103 383	100 660	97.4%
Den	Female population 30 years and older ÷ 10	42 413	42 413	100.0%	45 798	45 798	100.0%	41 284	41 284	100.0%	44 666	44 666	100.0%	174 161	174 161	100.0%
Notes:	COMMENT	This is a demand driven service which the Department cannot predict with 100% accuracy. The marginal deviation is considered as having achieved target.			A positive performance as more women screened than targetted.						This is a demand driven service which the Department cannot predict with 100% accuracy. Performance may improve to with finalised data.					
	ACTION PLAN															
2.33	**HPV 1st dose**	Annual target	-	Annual target	Annual target	0	Annual target	Annual target	-	Annual target	35279	41604	117.9%	35279	41604	117.9%
Notes:	COMMENT										Positive performance exceeded target, more learners vaccinated than planned.			Positive performance exceeded target, more learners vaccinated than planned.		
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2.34	**HPV 2nd dose**	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	40864	42413	103.8%	40864	42413	103.8%
Notes:	COMMENT										Positive performance exceeded target, more learners vaccinated than planned.			Positive performance exceeded target, more learners vaccinated than planned.		
	ACTION PLAN															
2.35	**Vitamin A 12 – 59 months coverage**	50.8%	52.4%	103.2%	53.0%	53.7%	101.2%	52.8%	54.3%	102.8%	54.8%	56.1%	102.5%	38.3%	54.1%	141.4%
Num	Vitamin A 12 – 59 months	110 844	114 403	103.2%	115 658	117 037	101.2%	115 170	118 380	102.8%	119 605	122 478	102.4%	461 277	472 298	102.4%
Den	Population 12-59 months x2	218 138	218 138	100.0%	218 139	218 139	100.0%	218 139	218 139	100.0%	218 141	218 141	100.0%	1 204 672	872 557	72.4%
Notes:	COMMENT	Performance better than expected as more children provided with Vitamin A than planned.			Target achieved			Performance better than expected as more children provided with Vitamin A than planned.			Performance better than expected as more children provided with Vitamin A than planned.			Errata in APP 2019/20 and performance target should be 53%. Therefore performance still exceeded target.		
	ACTION PLAN															
2.36	**Maternal Mortality in facility ratio**	Annual target	0.00	Annual target	Annual target	0.00	Annual target	Annual target	0.00	Annual target	60.8	45.6	133.2%	60.8	45.6	133.2%
Num	Maternal death in facility	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	60	47	127.7%	60	47	127.7%
Den	Live birth in facility + baby born alive before arrival at facility	Annual target	0.00	Annual target	Annual target	0.00	Annual target	Annual target	0.00	Annual target	0.986	1.03	95.8%	0.986	1.03	95.8%
Notes: Ratio per 100 000 live births	COMMENT										Positive performance as fewer deaths reported than targetted.					
	ACTION PLAN										*verified with Provincial Programme*					
2.37	**Neonatal death in facility rate**	Annual target	0.0	Annual target	Annual target	0.00	Annual target	Annual target	0.00	Annual target	8.1	8.4	96.8%	8.1	8.4	97.1%
Num	Inpatient death 0-7 days + Inpatient death 8-28 days	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	775	828	93.6%	775	828	93.6%
Den	Live birth in facility	Annual target	0	Annual target	Annual target	0	Annual target	Annual target	0	Annual target	95.4	98.9	96.4%	95.4	98.9	96.4%
Notes: Ratio per 1 000 live births	COMMENT										The Department cannot predict mortality rates with 100% accuracy. The marginal deviation is considered as having achieved target.					
	ACTION PLAN															

Performance measure/ Indicator			Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019_20		
			Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Disease Prevention and Control																	
2.38	**Cataract surgery performed**		1948	1870	96.0%	1973	2170	110.0%	1902	1843	96.9%	1908	1640	85.9%	7731	7523	97.3%
Notes:		COMMENT				A positive performance as target was exceeded, more surgeries performed than planned.			A positive performance as target was exceeded, more surgeries performed than planned.			Due to the impact of the COVID-19 pandemic, roaming outreach teams were restricted from services.					
		ACTION PLAN															
2.39	**Malaria case fatality rate**		0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	0.0%	0.0%	100.0%	2.5%	0.0%	100.0%	0.6%	0.0%	100.0%
Num	Deaths from Malaria		0	0	100.0%	0	0	100.0%	0	0	100.0%	1	0	100.0%	1	0	100.0%
Den	Total number of Malaria cases reported		41	21	195.2%	43	22	195.5%	40	16	250.0%	40	54	74.1%	164	113	145.1%
Notes:		COMMENT	Target achieved			Target achieved			Target achieved			Positive performance as no deaths due to Malaria reported.					
		ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 3: Emergency Medical Services

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
EMS																
1.1.1	**Number of WCG: Health Operational ambulances registered and licenced**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	249	249	100.0%	249		0.0%
Den	Number of WCG: Health Operational ambulances registered and licenced	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	249	249	100.0%	249		0.0%
Notes:	COMMENT	annual target			Annual target						Target Achieved					
	ACTION PLAN	no action at present.			No actions required											
1	**EMS P1 urban response under 15 minutes rate**	50.0%	38.2%	76.4%	50.0%	38.0%	76.0%	50.0%	35.5%	71.1%	50.0%	38.4%	76.9%	50.0%	37.5%	75.1%
Num	EMS P1 urban response under 15 minutes	16 874	10 921	64.7%	16 874	11 243	66.6%	16 874	10 212	60.5%	16 873	10 256	60.8%	67 495	42 632	63.2%
Den	EMS P1 urban calls	33 748	28 587	84.7%	33 748	29 588	87.7%	33 748	28 745	85.2%	33 747	26 688	79.1%	134 991	113 608	84.2%
Notes:	COMMENT	Respose times remains a problem within the City of Cape Town (CoCT). Availibiity of vehicles plays a very big part in completing the missions. Waiting time of clients are affected by the control centres(ECC Time). The measure of 15 minutes to be relooked. This is evident when looking the average response time of 36min. Overall performance increases with increments of 3% per minute in the range between response under 16 - 30 minutes.			Vehicle mandate within the CoCT remains around 62 rostered Ambulances of the 135 operational Ambulances per 12 hour shift. Acting Tygerberg Communication Centre MAnager (TCC Manager)has been appointed and measures have been put in place to improve on service delivery within the Communication Centre (ECC) . Between Q1 and Q2, the mission time has come down with 20min on average per mission. As displayed below, the 20min drop is due to the improved management of incidents within the Control Centre. The ECC time has gone from 129min to dispatch a vehicle, to 108min on average. On-going efforts to improve the ECC time within the control room are on-going. The number of staff on leave is 185(Pillar -40,Training - 102, Maternity – 9, Temp Placement – 35).			The response time within the CoCT remains a challenge due to the limited number of rostered ambulances. On average the number of ambulances in the City ranges between 50 and 60 vehicles. With the staff attacks during this period resulting in people being booked off on PTSD and the unavailibility of overtime, TCC has not been able to ensure a strong vehicle mandate for Q3. Increments of 3% per minute, still remains between minutes 15 and 20. Crew response time has remained consistant bu the dealy in the control room remains a challenge.			The number of resources in the City of Cape Town remains to affect the performance of the organization. With the limited resources, we have been able to maintain performance of the previous reporting cycle. We have managed to improve on our overall mission time. Specifically in areas such as our scene and hospital turn-around times. We have managed to successfully drive down scene times from an average of 26min down to 19min on average. The ECC time remains high due to vehicle availability.					
	ACTION PLAN	on-going monitoring of response time in the CoCT. Draft motivation for amendment of response time targets for the service to be lobied afor at a national level with the HOD.			On-going monitoring of TCC time.											

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
2	**EMS P1 rural response under 40 minutes rate**	81.0%	72.2%	89.1%	81.0%	73.0%	90.1%	81.0%	70.7%	87.3%	81.0%	72.8%	89.9%	81.0%	72.2%	89.1%
Num	EMS P1 rural response under 40 minutes	2 481	1 984	80.0%	2 481	1 921	77.4%	2 481	1 887	76.1%	2 482	1 859	74.9%	9 925	7 651	129.7%
Den	EMS P1 rural calls (responses)	3 063	2 748	89.7%	3 063	2 631	85.9%	3 063	2 670	87.2%	3 064	2 552	83.3%	12 253	10 601	115.6%
Notes:	COMMENT	Recruitement and retention of qualified staff and the distances staff have to cover in order to service P1 cases remain a challenge in the rural areas.			Slight increase in performance in rural areas. Operational time, Scene Time and Hospital time in rural areas remain constant. Due to the shortage of vehicles, travel times still contributes to an increased mission time. Continue monitoring performance and crew mandate at rural stations.			Mission times in rural areas are still increasing. Continue monitoring the crew mandate at rural stations.			Slight improvement in Rural areas with the appointment of critical posts in an attempt to increase daily mandate. Some smaller sized stations has been temporarily closed(Unable to roster an affective crew mandate) and is being serviced from the nearest bigger station. This allows for better staff management but in turn affects the response times to far out communities.					
	ACTION PLAN	Continue close monitoring of performance at facilities.			Continue close monitoring of performance at facilities.											
3	**EMS inter-facility transfer rate**	32.5%	32.6%	99.6%	32.5%	33.0%	98.4%	32.5%	31.9%	101.9%	32.5%	30.9%	105.1%	32.5%	32.1%	101.2%
Num	EMS inter-facility transfer	39 646	37 568	105.5%	39 646	37 786	95.3%	39 646	37 301	94.1%	39 647	36 395	91.8%	158 585	149 050	106.4%
Den	EMS clients total	122 070	115 257	94.4%	122 070	114 449	93.8%	122 070	117 008	95.9%	122 069	117 788	96.5%	488 279	464 502	105.1%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Increase in the total number of Inter Facility transfer (IFT) requests received by the department. Tygerberg Hospital (TBH)(2%), Paarl Hospital (PDH)(9%) and Bishop Lavis(4%) % increase to Q1 respectively. Improvement Projects are on-going and is being monitored closely. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Continued Inter- facility transfer (IFT) Projects still contributes to a positive performance. Relationships with facilities has improved and facility based reports provided to facilities to monitor performance on this indicator.			Inter-Facility projects are being maintained and monitored to ensure that the processes that were put in place is adhered to. Continue building stronger relationships with facilities in order to ensure optimal management of transfer requests.					
	ACTION PLAN	Continued Inter- facility transfer (IFT) Projects still contributes to a positive performance. Relationships with facilities has improved and facility based reports provided to facilities to monitor performance on this indicator.			Continued Inter- facility transfer (IFT) Projects still contributes to a positive performance. Relationships with facilities has improved and facility based reports provided to facilities to monitor performance on this indicator.											
4	**Total number of EMS emergency cases**	122 070	115 257	94.4%	122 070	114 449	93.8%	122 070	117 008	95.9%	122 069	117 788	96.5%	488 279	464 502	105.1%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Projected drop in the number of patients services. This could be seasonal as a more accurate reflection will be seen after the close of the September holiday season.			Projected drop in the number of patients services. This could be seasonal.			Slight increase in the number of projected clients. Will review actual data to determin the areas where signaficant increases were experienced.					
	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 4: Provincial Hospital Services

Performance measure/ Indicator			Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
			Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
				Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
REGIONAL HOSPITALS (COMBINED)																	
1.1.1	**Number of usable regional hospital beds**		Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1427	1438	100.8%	1427	1430	100.2%
Den	Number of usable regional hospital beds		Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1427	1 438	100.8%	1 427	1 430	100.2%
Notes:		COMMENT										George Hospital: 8 EC beds closed due to renovations and 11 medicine beds opened - change done after APP target was set because additional staff that can be appointed using the Human Resource Capacitation Grant only became available in February 2019. New Somerset Hospital: 8 psychiatry beds opened in October 2019 to reflect additional beds already in use, and to correctly reflect service pressures.					
		ACTION PLAN															
2	**Average Length of stay (Regional Hospitals)**		4.0	4.1	104.1%	4.0	4.0	100.0%	4.1	3.9	105.0%	3.9	3.9	101.7%	4.0	4.0	100.8%
Num	Patient days (inpatient days +1/2 day patients) (regional hospitals)		116 878	119 371	102.1%	116 596	117 812	101.0%	117 239	116 452	99.3%	115 667	115 088	99.5%	466 380	468 722	99.5%
Den	Inpatient separations (regional hospitals)		29 485	28 930	98.1%	29 194	29 575	101.3%	28 453	29 835	104.9%	29 434	29 780	101.2%	116 566	118 120	101.3%
Notes:		COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target Achieved			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 marginal deviation is considered by the Department as having achieved the planned target.			Target Achieved					
		ACTION PLAN															
3	**Inpatient bed utilisiation rate (Regional Hospitals)**		89.7%	91.2%	101.6%	89.5%	90.3%	100.8%	90.0%	88.7%	98.6%	88.8%	87.7%	98.7%	89.5%	89.5%	99.9%
Num	Patient days (inpatient days +1/2 day patients) (regional hospitals)		116 878	119 371	102.1%	116 596	117 812	101.0%	117 239	116 452	99.3%	115 667	115 088	99.5%	466 380	468 722	99.5%
Den	Inpatient bed days available (Usuable beds total X30.42)(Regional Hospital)		130 228	130 866	100.5%	130 228	130 502	100.2%	130 228	131 232	100.8%	130 228	131 232	100.8%	520 912	523 832	100.6%
Notes:		COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.					
		ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
4	**Expenditure per PDE (Regional Hospitals)**	R 3 345	R 3 218	104.0%	R 3 608	R 3 525	97.7%	R 3 622	R 3 618	100.1%	R 3 674	R 3 599	102.1%	R 3 562	R 3 489	102.1%
Num	Expenditure in regional hospitals	512 062 777	499 577 538	97.6%	556 037 584	543 929 555	97.8%	557 783 765	551 198 913	98.8%	540 855 874	546 263 526	101.0%	########	2 140 969 532	101.2%
Den	Patient Day Equivalent (PDE) (regional Hospitals)	153 062	155 234	101.4%	154 116	154 290	100.1%	153 984	152 342	98.9%	147 207	151 770	103.1%	608 369	613 635	99.1%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
5	**Complaints Resolution within 25 working days rate (Regional Hospitals)**	98.6%	95.1%	96.5%	100.0%	98.9%	98.9%	98.6%	95.3%	96.7%	98.3%	98.0%	99.7%	98.9%	96.8%	97.9%
Num	Complaints resolved within 25 working days (regional hospitals)	69	78	113.0%	67	91	135.8%	70	81	115.7%	57	72	126.3%	263	322	122.4%
Den	Complaints resolved (Regional Hospitals)	70	82	117.1%	67	92	137.3%	71	85	119.7%	58	74	126.7%	266	333	125.0%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
6	**Mortality and morbidity review rate (regional hospitals)**	84.3%	100.0%	118.6%	86.3%	92.2%	106.8%	78.4%	76.5%	97.5%	84.3%	73.5%	87.2%	83.3%	85.5%	102.6%
Num	Mortality and morbidity review rate (regional hospitals)	43	51	118.6%	44	47	106.8%	40	39	97.5%	43	38	87.2%	170	175	102.6%
Den	Possible mortality and morbidity reviews (regional hospitals) x number of disciplines within regional hospitals	51	51	100.0%	51	51	100.0%	51	51	100.0%	51	51	100.0%	204	204	100.0%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Overperformance due to improved clincial governance and M&M's conducted per clinical unit.			Overperformance due to improved clincial governance and M&M's conducted per clinical unit.			Underperformance due to March projected figures - fewer mortality and morbidity meetings held at New Somerset and Worcester Hospitals.					
	ACTION PLAN															
TUBERCULOSIS HOSPITALS																
1.1.1	**Number of usable tuberculosis hospital beds**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1026	1026	100.0%	1026	1026	100.0%
Den	Number of usabletuberculosis hospital beds	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1026	1 026	100.0%	1 026	1 026	100.0%
Notes:	COMMENT										Target Achieved					
	ACTION PLAN															
1	**Mortality and morbidity review rate (tuberculosis hospitals)**	94.4%	100.0%	105.9%	88.9%	100.0%	112.5%	94.4%	77.8%	82.4%	88.9%	88.9%	100.0%	91.7%	91.7%	100.0%
Num	Mortality and morbidity review rate (tuberculosis hospital	17	18	105.9%	16	18	112.5%	17	14	82.4%	16	16	100.0%	66	66	100.0%
Den	Possible mortality and morbidity reviews (tuberculosis hospitals) x number of disciplines within tuberculosis hospital	18	18	100.0%	18	18	100.0%	18	18	100.0%	18	18	100.0%	72	72	100.0%
Notes:	COMMENT	Target Achieved			Overperformance due to improved clincial governance.			Target Achieved			Target Achieved					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
PSYCHIATRIC HOSPITALS																
1.1.1	**Number of usable psychiatric hospital beds**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1799	1799	100.0%	1799	1 799	100.0%
Den	Number of usable psychiatric hospital beds	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	1799	1 799	100.0%	1 799	1 799	100.0%
Notes:	COMMENT										Target achieved					
	ACTION PLAN															
1	**Mortality and morbidity review rate (psychiatric hospitals)**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	75.0%	100.0%	91.7%	91.7%	100.0%	91.7%	91.7%	100.0%
Num	Mortality and morbidity review rate (psychiatric hospital)	12	12	100.0%	12	12	100.0%	9	9	100.0%	11	11	100.0%	44	44	100.0%
Den	Possible mortality and morbidity reviews (psychiatric hospital) x number of disciplines within psychiatric hospitals	12	12	100.0%	12	12	100.0%	12	12	100.0%	12	12	100.0%	48	48	100.0%
Notes:	COMMENT	Target Achieved			Lentegeur Hospital did not conduct a mortality & morbidity review meeting in August 2019.			Target Achieved			Target Achieved					
	ACTION PLAN															
REHABILITATION HOSPITALS																
1.1.1	**Number of usable rehabilitation hospital beds**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	156	156	100.0%	156	156	100.0%
Den	Number of usable rehabilitation hospital beds	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	156	156	100.0%	156	156	100.0%
Notes:	COMMENT															
	ACTION PLAN															
1	**Mortality and morbidity review rate (rehabilitation hospitals)**	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%	91.7%
Num	Mortality and morbidity review rate (rehabilitation hospital)	3	3	100.0%	3	3	100.0%	2	3	150.0%	3	3	100.0%	11	12	109.1%
Den	Possible mortality and morbidity reviews (rehabilitationl hospitals) x number of disciplines within rehabilitation hospital	3	3	100.0%	3	3	100.0%	3	3	100.0%	3	3	100.0%	12	12	100.0%
Notes:	COMMENT	Target Achieved			Target Achieved			Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target Achieved					
	ACTION PLAN															
SPECIALISED HOSPITALS																
2	**Complaints Resolution within 25 working days rate (Specialised Hospitals)**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.9%	100.0%	103.2%	96.2%	100.0%	103.9%	98.1%	100.0%	102.0%
Num	Complaints resolved within 25 working days (specialised hospitals)	41	36	87.8%	50	48	96.0%	63	40	63.5%	51	48	94.1%	205	172	83.9%
Den	Complaints resolved (Specialised Hospitals)	41	36	87.8%	50	48	96.0%	65	40	61.5%	53	48	90.6%	209	172	82.3%
Notes:	COMMENT	Target Achieved			Target Achieved			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 marginal deviation is considered by the Department as having achieved the planned			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 marginal deviation is considered by the Department as having achieved the planned					
	ACTION PLAN															

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
DENTAL HOSPITALS																
1.1.1	**Oral health patient visits at dental training hospitals**	34 406	35 096	102.0%	34 945	35 263	100.9%	24 758	26 265	106.1%	32 692	22 628	69.2%	126 801	119 252	94.0%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Over-performance due to December data (which is a low-yield month) projected from October and November data. More correct performance figures should reflect in actual figures for December. Q3, 2018/19 performance was 26,522.			Underperformance due to January and February being low yield months due to academic term only starting in February.					
	ACTION PLAN															
1	**Number of removable oral health prosthetic devices manufactured (dentures)**	1 169	1 079	92.3%	1 532	1 490	97.3%	1 449	1 463	101.0%	409	296	72.2%	4 559	4 328	94.9%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Performance projected from July & August, which are low-yield months due to school holidays. Performance expected to increase with actual figures for September (high-yield month). Q2, 2018/19 performance was 1,562.			Over-performance due to December data (which is a low-yield month) projected from October and November data. More correct performance figures should reflect in actual figures for December. Q3, 2018/19 performance was 1,145.			Underperformance due to January and February being low yield months due to academic term only starting in February.					
	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 5: CENTRAL HOSPITAL SERVICES

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
CENTRAL HOSPITALS																
1.1.1	**Number of usable central hospital beds**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	2359	2359	100.0%	2359	2359	100.0%
Den	Number of usable central hospital beds	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	2359	2 359	100.0%	2 359	2 359	100.0%
Notes:	COMMENT										Target Achieved					
	ACTION PLAN															
2	**Average Length of stay (central Hospitals)**	6.5	6.5	100.0%	6.7	6.3	106.0%	6.5	6.3	102.2%	6.6	6.4	101.9%	6.6	6.4	103.2%
Num	Patient days (inpatient days +1/2 day patients) (central hospitals)	188 848	195 646	103.6%	192 618	195 293	101.4%	184 148	191 147	103.8%	188 538	188 525	100.0%	754 152	582 086	129.6%
Den	Inpatient separations (central hospitals)	28 977	29 921	103.3%	28 747	30 887	107.4%	28 517	30 253	106.1%	28 747	29 304	101.9%	114 988	91 061	79.2%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			The ALOS has decreased due to an increase in day cases. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			The ALOS has decreased due to an increase in day cases. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned					
	ACTION PLAN															
3	**Inpatient bed utilisiation rate (central Hospitals)**	88.0%	90.9%	103.3%	88.7%	90.7%	102.2%	85.8%	88.8%	103.5%	87.8%	87.6%	99.7%	87.6%	89.5%	97.9%
Num	Patient days (inpatient days +1/2 day patients) (central hospitals)	188 848	195 646	103.6%	192 618	195 293	101.4%	184 148	191 147	103.8%	188 538	188 525	100.0%	754 152	770 611	102.2%
Den	Inpatient bed days available (Useable beds total X30.42)(central Hospital)	214 692	215 282	100.3%	217 052	215 282	99.2%	214 693	215 282	100.3%	214 692	215 282	100.3%	861 129	861 129	100.0%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned target			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 marginal deviation is considered by the Department as having achieved the planned target			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 marginal deviation is considered by the Department as having achieved the planned target					
	ACTION PLAN															
4	**Expenditure per PDE**	R 5 979	R 5 602	106.7%	R 5 798	R 5 949	97.5%	R 5 979	R 6 010	99.5%	R 6 171	R 6 151	100.3%	R 5 979	R 5 852	102.2%
Num	Expenditure in central hospitals	1 506 973 250	1 445 137 114	95.9%	1 506 973 250	1 546 344 695	102.6%	1 506 973 250	1 509 204 572	100.1%	1 506 973 250	1 521 717 940	101.0%	6 027 893 000	4 500 686 381	133.9%
Den	Patient Day Equivalent (PDE) (central Hospitals)	252 062	257 969	102.3%	259 915	259 936	100.0%	252 063	251 132	99.6%	244 208	247 403	101.3%	1 008 248	769 037	131.1%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department. Q1 Expenditure is lower as a result of pre-payments made in Q4 of the previous FY			Expenditure is increased due to expnditure on accruals from Quarter 1 and due to increased expenditure on consumables for the increased PDE.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
5	**Complaints Resolution within 25 working days rate (central Hospitals)**	89.7%	97.3%	108.4%	88.8%	95.9%	108.1%	89.3%	96.6%	108.2%	87.7%	88.4%	100.8%	88.9%	94.7%	93.8%
Num	Complaints resolved within 25 working days (central hospitals)	175	142	81.1%	174	142	81.6%	175	142	81.1%	171	114	66.7%	695	540	77.7%
Den	Complaints resolved (central Hospitals)	195	146	74.9%	196	148	75.5%	196	147	75.0%	195	129	66.2%	782	570	72.9%
Notes:	COMMENT	The drop in the number of complaints received is as a result of a change in processes by stopping the walk in complaints at the QA office. Verbal complaints are dealt with directly at point of dissatisfaction by front line managers, which now enables immediate resolution and do not need to be recorded. Its only if they are not able to resolve it at front line level that it recorded and channelled through to QA for capturing .This is in line with the updated National Policy.			The drop in the number of complaints received is as a result of a change in processes by stopping the walk in complaints at the QA office. Verbal complaints are dealt with directly at point of dissatisfaction by front line managers, which now enables immediate resolution and do not need to be recorded. Its only if they are not able to resolve it at front line level that it recorded and channelled through to QA for capturing .This is in line with the updated National Policy.			Noted that the number of comlaints has dropped. Target achieved. The marginal deviation is deemed as an advantage to the Department.			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
6	**Mortality and morbidity review rate (central hospitals)**	100.0%	95.2%	95.2%	100.0%	100.0%	100.0%	100.0%	104.8%	104.8%	100.0%	100%	100.0%	100.0%	100.0%	100.0%
Num	Mortality and morbidity review rate (central hospitals)	21	20	95.2%	21	21	100.0%	21	22	104.8%	21	21	100.0%	84	84	100.0%
Den	Possible mortality and morbidity reviews (central hospitals) x number of disciplines within central	21	21	100.0%	21	21	100.0%	21	21	100.0%	21	21	100.0%	84	84	100.0%
Notes:	COMMENT	Target Achieved			Target Achieved			Overperformance due to improved clincial governance and M&M's conducted per clinical unit.			Target Achieved					
	ACTION PLAN															
TERTIARY HOSPITAL																
1.1.1	**Number of usable tertiary hospital beds**	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	272	272	100.0%	272	272	100.0%
Den	Number of usable tertiary hospital beds	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	Annual target	272	272	100.0%	272	272	100.0%
Notes:	COMMENT										Target Achieved					
	ACTION PLAN															
2	**Average Length of stay (tertiary Hospitals)**	3.9	3.8	97.3%	4.0	3.9	101.6%	3.8	3.8	98.8%	3.9	4.0	97.1%	3.9	3.9	100.2%
Num	Patient days (inpatient days +1/2 day patients) (tertiary hospitals)	20 185	20 005	99.1%	20 667	19 385	93.8%	19 461	18 520	95.2%	20 104	17 876	88.9%	80 417	75 784	106.1%
Den	Inpatient separations (tertiary hospitals)	5 196	5 294	101.9%	5 155	4 914	95.3%	5 114	4 813	94.1%	5 155	4 451	86.3%	20 620	19 472	94.4%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Qtr 1 was busier due to the Respiratory season surge in Medical Patients. Qtr2 is more reflective of the usual patient load.			Target Achieved			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
3	**Inpatient bed utilisiation rate (tertiary Hospitals)**	81.5%	80.6%	98.8%	82.6%	78.1%	94.6%	78.6%	74.6%	94.9%	81.2%	72.0%	88.7%	81.0%	76.3%	106.1%
Num	Patient days (inpatient days +1/2 day patients) (tertiary hospitals)	20 185	20 005	99.1%	20 667	19 385	93.8%	19 461	18 520	95.2%	20 104	17 876	88.9%	80 417	75 784	106.1%
Den	Inpatient bed days available (Useable beds total X30.42)(tertiary Hospital)	24 755	24 823	100.3%	25 027	24 823	99.2%	24 754	24 823	100.3%	24 755	24 823	100.3%	99 291	99 291	100.0%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Bed Occupancy is lower due to a decrease in Medical admissions.			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 marginal deviation is considered by the Department as having achieved the planned target.			Bed Occupancy is lower due to a decrease in Medical admissions.					
	ACTION PLAN															
4	**Expenditure per PDE**	R 7 044	R 6 310	111.6%	R 6 774	R 6 952	102.6%	R 7 045	R 7 601	92.7%	R 7 338	R 8 401	87.3%	R 7 044	R 7 286	96.7%
Num	Expenditure in tertiary hospitals	222 495 750	197 532 020	88.8%	222 495 750	213 836 306	96.1%	222 495 750	221 741 200	99.7%	222 495 750	238 488 043	107.2%	889 983 000	871 597 569	102.1%
Den	Patient Day Equivalent (PDE) (tertiary Hospitals)	31 585	31 306	99.1%	32 848	30 759	93.6%	31 584	29 173	92.4%	30 321	28 389	93.6%	126 338	119 626	105.6%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department. Q1 Expenditure is lower as a result of pre-payments made in Q4 of the previous FY			Reduced (April) Qtr1 expenditure resulting from increased payments in closing months of last financial year. Qtr2 projection based on reduced spend pattern of Qtr1.			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 marginal deviation is considered by the Department as having achieved the planned target								
	ACTION PLAN															
5	**Complaints Resolution within 25 working days rate (tertiary Hospitals)**	90.5%	100.0%	110.5%	95.2%	87.8%	92.1%	95.2%	97.2%	102.1%	93.0%	92.9%	99.8%	94.0%	93.6%	99.5%
Num	Complaints resolved within 25 working days (tertiary hospitals)	38	26	68.4%	40	43	107.5%	40	35	87.5%	40	20	48.8%	158	124	78.2%
Den	Complaints resolved (tertiary Hospitals)	42	26	61.9%	42	49	116.7%	42	36	85.7%	43	21	48.8%	169	132	78.1%
Notes:	COMMENT	Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Due to the complexity of the complaints, varous units were involved and therefore took a bit longer than anticipated to resolve.			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 marginal deviation is considered by the Department as having achieved the planned target.			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 marginal deviation is considered by the Department as having achieved the planned target.					
	ACTION PLAN															
6	**Mortality and morbidity review rate (tertiary hospitals)**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	150.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Num	Mortality and morbidity review rate (tertiary hospitals)	3	3	100.0%	3	3	100.0%	2	3	150.0%	3	3	100.0%	12	12	100.0%
Den	Possible mortality and morbidity reviews (tertiary hospitals) x number of disciplines within tertiary hospitals	3	3	100.0%	3	3	100.0%	3	3	100.0%	3	3	100.0%	12	12	100.0%
Den	Hospital that conducted a national core standard self-assessment during the financial year (regional hospital) COMMENT	Target Achieved			Target Achieved			Target achieved. The marginal deviation is considered acceptable and deemed as an advantage to the Department.			Target achieved.					
Notes:	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 6: Health Science & Training

<table>
<tr><th rowspan="3" colspan="3">Performance measure/ Indicator</th><th colspan="3">Quarter 1</th><th colspan="3">Quarter 2</th><th colspan="3">Quarter 3</th><th colspan="3">Quarter 4</th><th colspan="3">Annual 2019/20</th></tr>
<tr><th rowspan="2">Target</th><th colspan="2">Actual</th><th rowspan="2">Target</th><th colspan="2">Actual</th><th rowspan="2">Target</th><th colspan="2">Actual</th><th rowspan="2">Target</th><th colspan="2">Preliminary</th><th rowspan="2">Target</th><th colspan="2">Q4 Year to date</th></tr>
<tr><th>Performance</th><th>% Achieved</th><th>Performance</th><th>% Achieved</th><th>Performance</th><th>% Achieved</th><th>Performance</th><th>% Achieved</th><th>Performance</th><th>% Achieved</th></tr>
<tr><th colspan="18">Sub-Programme 6: Health Science & Training</th></tr>
<tr><td>6.1.1</td><td colspan="2">Number of bursaries awarded for scarce and critical skills categories</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>1900</td><td>2090</td><td>110.0%</td><td>1900</td><td>2 090</td><td>110.0%</td></tr>
<tr><td rowspan="2" colspan="2">Notes:</td><td>COMMENT</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Additional bursaries awarded to Study by Assignment Nurse Specialties based on scarce skills need</td><td colspan="3"></td></tr>
<tr><td>ACTION PLAN</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>6.1</td><td colspan="2">Number of bursaries awarded to first year medicine students</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>50</td><td>51</td><td>102.0%</td><td>50</td><td>51</td><td>102.0%</td></tr>
<tr><td rowspan="2" colspan="2">Notes:</td><td>COMMENT</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Marginal deviation considered as acceptable by the Department and as having achieved the target.</td><td colspan="3"></td></tr>
<tr><td>ACTION PLAN</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>6.2</td><td colspan="2">Number of bursaries awarded to first year nursing students</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>130</td><td>138</td><td>106.2%</td><td>130</td><td>138</td><td>106.2%</td></tr>
<tr><td rowspan="2" colspan="2">Notes:</td><td>COMMENT</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Additional bursaries awarded to Study by Assignment Nurse Specialties based on scarce skills need</td><td colspan="3"></td></tr>
<tr><td>ACTION PLAN</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>6.3</td><td colspan="2">EMC intake on accredited HPCSA courses</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>60</td><td>90</td><td>150.0%</td><td>60</td><td>90</td><td>150.0%</td></tr>
<tr><td rowspan="2" colspan="2">Notes:</td><td>COMMENT</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Additional intake for the AEA course. As of January 2020 HPCSA closed register for AEA.</td><td colspan="3"></td></tr>
<tr><td>ACTION PLAN</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td></tr>
<tr><td>6.4</td><td colspan="2">Intake of home community based carers (HCBCs)</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>Annual target</td><td>-</td><td>Annual target</td><td>800</td><td>800</td><td>100.0%</td><td>800</td><td>800</td><td>100.0%</td></tr>
<tr><td rowspan="2" colspan="2">Notes:</td><td>COMMENT</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Annual indicator. Only required to report in Quarter 4.</td><td colspan="3">Target achieved.</td><td colspan="3"></td></tr>
<tr><td>ACTION PLAN</td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td><td colspan="3"></td></tr>
</table>

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
6.5 Intake of admin interns		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	300	322	107.3%	300	322	107.3%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Target exceeded due to the number of contract extensions for an additional year funded by P6.5 (to meet service demands)					
	ACTION PLAN															
6.6 Intake of learner basic/post basic pharmacist assistants		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	130	130	100.0%	130	130	100.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Target achieved.					
	ACTION PLAN															
6.7 Intake of assistant to artisan (ATA) interns		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	120	234	195.0%	120	234	195.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Funded by Programme 7. Additional service needs and funding availability. Interns absorbed into permanent posts					
	ACTION PLAN															
6.8 Intake of PAY interns		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	300	285	95.0%	300	285	95.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Marginal deviation considered as acceptable by the Department and as having achieved the target.					
	ACTION PLAN															
6.9 Intake of emergency medical care (EMC) assistant interns		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	100	100	100.0%	100	100	100.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Target achieved.					
	ACTION PLAN															
6.10 Intake of forensic pathology service (FPS) assistant interns		Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	50	30	60.0%	50	30	60.0%
Notes:	COMMENT	Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Annual indicator. Only required to report in Quarter 4.			Not sufficient amount of candidates met the minimum educational entrance criteria. Interns also					
	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 7: Health Care Support

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
Sub-Programme 7.1: Laundry Services																
7.1.1	**Average cost per item laundered in-house**	R 5.80	R 5.07	114.5%	R 5.83	R 5.35	109.0%	R 5.84	R 4.80	121.7%	R 5.86	R 5.59	104.8%	R 5.83	R 5.20	112.1%
Num	Expenditure on in-house laundries excluding capital	19 412 178	16 144 138	120.2%	19 447 384	18 687 531	104.1%	19 495 688	16 979 633	114.8%	19 760 845	18 948 716	104.3%	78 116 095	70 760 018	110.4%
Den	Items laundered in-house	3 349 747	3 186 812	95.1%	3 337 727	3 494 244	104.7%	3 340 522	3 537 966	105.9%	3 370 991	3 389 172	100.5%	13 398 987	13 608 194	101.6%
Notes:		Preliminary results reflect that the average cost per item laundered is below target. Cost breakdown: Lentegeur Tygerberg Total Personnel 71.8% 71.3% 71.6% Steam 12.5% 10.1% 11.4% Electricity 6.3% 6.9% 6.6% Water & Drainage 6.0% 0.6% 3.5% Detergent 2.6% 3.4% 3.0% Transport 0.4% 0.0% 0.2% Equipment Maintenance 0.3% 7.6% 3.6% Leases 0.0% 0.0% 0.0%			**QUARTER 1 ACTUAL VS PRELIMINARY PERFORMANCE** Both preliminary and actual performance was below target. Difference between preliminary and actual performance is mainly due to intermittent billing for utilities and GG vehicles. **QUARTER 2 PRELIMINARY PERFORMANCE** Preliminary results reflect that the average cost per item laundered is below target. It is, however, important to note that billing for utilities and GG vehicles continues to be intermittent. Cost breakdown: Lentegeur Tygerberg Total Personnel 48.5% 67.3% 57.4% Steam 17.6% 12.2% 15.0% Electricity 8.9% 7.0% 8.0% Water & Drainage 9.1% 0.5% 5.0% Detergent 3.5% 2.7% 3.1% Transport 4.1% 3.2% 3.7% Equipment Maintenance 6.6% 5.7% 6.2% Leases 1.7% 1.5% 1.6%			**QUARTER 2 ACTUAL VS PRELIMINARY PERFORMANCE** Both preliminary and actual performance was below target. **QUARTER 3 PRELIMINARY PERFORMANCE** Preliminary results reflect performance as below target. Cost breakdown: Lentegeur Tygerberg Total Personnel 67.9% 57.7% 62.6% Steam 6.8% 20.5% 13.9% Electricity 3.9% 4.4% 4.2% Water & Drainage 3.1% 1.2% 2.1% Detergent 5.2% 5.2% 5.2% Transport 6.7% 3.6% 5.1% Equipment Maintenance 3.6% 4.9% 4.3% Leases 2.8% 2.5%			**QUARTER 3 ACTUAL VS PRELIMINARY PERFORMANCE** Both preliminary and actual performance was below target. **QUARTER 4 PRELIMINARY PERFORMANCE** Preliminary results reflect performance is still below target. Cost breakdown: Lentegeur Tygerberg Total Personnel 58.1% 63.8% 60.6% Steam 18.9% 16.3% 17.8% Electricity 4.9% 6.8% 5.7% Water & Drainage 6.2% 0.9% 3.9% Detergent 3.2% 2.8% 3.0% Transport 4.5% 4.6% 4.6% Equipment Maintenance 2.1% 2.2% 2.1% Leases 2.1% 2.6%					
		Continuous focus on maintenance of equipment to improve efficiency, especially at Tygerberg Laundry. The water bill for Lentegeur Laundry is under review with relevant stakeholders.			Continuous focus on maintenance of equipment to improve efficiency, especially at Tygerberg Laundry. Memorandum of Understanding regarding utility bills / allocation of cost, between Directorate: Facilities Management and Lentegeur Hospital, is being prepared - aim is to have this finalised in Quarter 3. Regularise billing from GMT. Activation of the grey water recycling plant at Lentegeur Laundry.			Analysis of November 2019 cost of steam, especially at Tygerberg Regional Laundry.								

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
7.1(a)	**Average cost per item laundered outsourced**	R 4.40	R 4.18	105.3%	R 4.43	R 4.25	104.3%	R 4.44	R 4.39	101.1%	R 4.45	R 4.50	98.9%	R 4.43	R 4.33	102.4%
Num	Expenditure on outsourced laundry services	9 457 794	8 016 714	118.0%	8 962 922	8 449 349	106.1%	9 647 576	8 564 626	112.6%	10 004 386	8 143 569	122.9%	38 072 678	33 174 257	114.8%
Den	Items laundered outsourced	2 148 571	1 919 008	89.3%	2 023 558	1 989 293	98.3%	2 173 584	1 949 830	89.7%	2 248 571	1 809 722	80.5%	8 594 284	7 667 853	89.2%
Notes:		Cost per piece is below target.			QUARTER 1 ACTUAL VS PRELIMINARY PERFORMANCE Both preliminary and actual performance was below target. Actual cost per piece higher than preliminary results due to annual inflation increase as per the contractual agreement. QUARTER 2 PRELIMINARY PERFORMANCE Preliminary results reflect performance as below target.			QUARTER 2 ACTUAL VS PRELIMINARY PERFORMANCE No significant difference between preliminary and actual performance. QUARTER 3 PRELIMINARY PERFORMANCE Preliminary results reflect performance as slightly below target.			QUARTER 3 ACTUAL VS PRELIMINARY PERFORMANCE No significant difference between preliminary and actual performance. QUARTER 4 PRELIMINARY PERFORMANCE Preliminary results reflect performance as slightly above target. The decision to insource Wesfleur Hospital on the 01 March 2020 has led to an increase in cost per item in the fourth quarter.					
		Continued focus on resolving challenges experienced with service providers, in line with respective Service Level Agreements, to improve the quality of the outsourced linen service.			Continued focus on resolving challenges experienced with service providers, in line with respective Service Level Agreements, to improve the quality of the outsourced linen service.						To review the target.					
Sub-Programme 7.2: Engineering Services																
7.1.2	**Percentage reduction in energy consumption at provincial hospitals (compared to 2014/15 baseline)**	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	10.0%	10.9%	109.3%	10.0%	10.9%	109.3%
Num	Baseline (2014/15 kwh/year) energy utilisation for all provincial hospitals minus utilisation for all provincial hospitals for current financial year	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	15 327 925	16 758 372	109.3%	15 327 925	16 758 372	109.3%
Den	Baseline (2014/15 kwh/year) energy utilisation for all provincial hospitals	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	153 279 246	153 279 246	100.0%	153 279 246	153 279 246	100.0%
Notes:		Annual indicator - not required to report. Interim results indicate that performance is at 1%, which is significantly below the benchmark. Inclement weather negatively impacts on consumption. Performance is therefore expected to improve in Quarters 3 and 4.			Annual indicator - not required to report. Interim results indicate that performance is 8% above the benchmark or 2014/15 baseline (target is to achieve a 10% saving compared to the benchmark). Interim performance is thus significantly below the benchmark. Inclement weather negatively impacts on consumption. Performance is expected to improve in Quarters 3 and 4.			Annual indicator - not required to report. Interim results indicate that performance is on track with current projections reflecting an over achievement (11% saving on energy consumption; target is 10%). The change is due to smart metering being used and the previous projections were based on actuals (and, due to billing cycles, based on historical /estimated information) which included winter usage.			Preliminary performance indicates that reduction in energy exceeds the target, which means that more hospitals have managed to reduce their energy consumption. This is to the benefit of both the Department and the Province.					
		Encouraging management teams to continuously remind staff and visitors of the need to conserve energy. Instruction to all facilities re the use of private heaters, kettles etc. to be issued. Continue with roll-out to implement energy saving measures and devices at health facilities.			Encouraging management teams to continuously remind staff and visitors of the need to conserve energy. Instruction to all facilities re the use of private heaters, kettles etc. to be issued. Continue with roll-out to implement energy saving measures and devices at health facilities.			Encouraging management teams to continuously remind staff and visitors of the need to conserve energy. Instruction to all facilities re the use of private heaters, kettles etc. to be issued. Continue with roll-out to implement energy saving measures and devices at health facilities.			Encouraging management teams to continuously remind staff and visitors of the need to conserve energy. Continue with roll-out to implement energy saving measures and devices at health facilities.					

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
7.1(b)	**Threshold (provincial benchmark) achieved for clincial engineering maintenance jobs completed**	Yes	No	0.0%	Yes	Yes	100.0%	Yes	No	0.0%	Yes	No	0.0%	Yes	No	0.0%
Notes:		Threshold per Quarter: 70% (Q1); 100% (Q2); 110% (Q3); 95% (Q4) Q1 actual performance: 54.1% Under performance due to: * Reporting excludes jobs carried forward from 2018/19 to 2019/20. However, jobs are undertaken in the order received and there is therefore always a backlog at the beginning of the financial year, hence the lower threshold for Q1. * Primary contributor is the backlog in the Electronics Unit.			Threshold per Quarter: 70% (Q1); 100% (Q2); 110% (Q3); 95% (Q4) Q2 estimated performance: 103% Inroads have been made with reducing backlog through overtime. Estimated over performance is to the benefit of the department.			Threshold per Quarter: 70% (Q1); 100% (Q2); 110% (Q3); 95% (Q4) Q2 actual performance: 104% Q3 preliminary performance: 86.4% Backlog in Electronics Unit is still negatively impacting on performance. In addition, annual preventative maintenance trips were undertaken during this Quarter, negatively impacting on completion of jobs at the Unit. Two vacant posts were filled from 1 November (entry-level posts,it will thus require some time to achieve acceptable efficiency levels). One Level 8 post incumbent has been on extended sick leave; ill-health retirement is pending.			Threshold per Quarter: 70% (Q1); 100% (Q2); 110% (Q3); 95% (Q4) Q3 actual performance: 79% Q4 actual performance: 63.5% Performance remains below the threshold due to the backlog in the Electronics Unit. Although the two vacant posts in this Unit were filled in November, these are entry-level posts and it will take some time to achieve acceptable efficiency levels. Technical Assistant undertaking triage of electronic equipment is in place and this is reported to be working well. Ill-health retirement of the one Level 8 post incumbent became effective 1 February 2020. This has been mitigated by transferring a technician from the Dental Unit to the Electronics Unit. This results in three inexperienced Level 7 posts. The Dental Unit is better able to prioritise work (more experienced staff) to lessen the impact of their vacancy. Vacancy advertised but shortlisting etc. postponed due to COVID-19. Delays in replenishment of spares and some repairs started to impact on outputs from mid January (delays to eventually non					
		Electronics Unit staff continues to work overtime to reduce the backlog; recruitment process under way to fill vacancies in the unit. Technical assistance for triage of electronic equipment in process of being put in place. Establishment of a clinical engineering hub in Paarl to be discussed with the Chief Director: Rural District Health Services.						Electronics Unit staff continues to work overtime to reduce the backlog. Technical assistance for triage of electronic equipment in process of being put in place. Implementation of Hub and Spoke approved, funding pending.			Reducing backlog. Prioritising training and increasing productivity of new technicians. Implementation of Hub and Spoke approved, funding pending.					
7.2(b)	**Threshold (provincial benchmark) achieved for engineering maintenance jobs completed**	Yes	Yes	100.0%	Yes	Yes	100.0%	Yes	No	0.0%	Yes	No	0.0%	Yes	No	0.0%
Notes:		Threshold per Quarter: 88% (Q1); 87% (Q2); 93% (Q3); 91% (Q4) Q1 preliminary performance = 111% Preliminary results reflect that threshold exceeded. A number of new posts have been created at engineering workshops and vacancies filled, which is reflecting in the preliminary performance. It should however be noted that, due to vacancies (of some 12%) at Bellville Engineering Workshop, performance is expected to decline.			Threshold per Quarter: 88% (Q1); 87% (Q2); 93% (Q3); 91% (Q4) Q2 estimated performance: 109%			Threshold per Quarter: 88% (Q1); 87% (Q2); 93% (Q3); 91% (Q4) Q2 actual performance: 113% Q3 estimated performance: 89% Under performance mainly due to the fire at Worcester Hospital, which necessitated staff to work focused at this facility for more than a week.			Threshold per Quarter: 88% (Q1); 87% (Q2); 93% (Q3); 91% (Q4) Q3 actual performance: 92.7% Q4 estimated performance: 85% Under performance due to issues with WC supplier database and some vacancies in the Unit.					
		Recruitment processes are currently underway to fill vacancies.									Continue liaison with People Management to expedite filling of both vacant and additional posts.					

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
7.3(b)	**Percentage of hospitals achieving the provincial benchmark for water utilisation**	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	69.2%	76.9%	111.2%	75.0%	76.9%	102.6%
Num	Hospitals achieving the provinical benchmark for average water consumption per hospital bed per day	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	36	40	111.1%	39	40	0.0%
Den	All provincial hospitals	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	52	52	100.0%	52	52	0.0%
Notes:		Annual indicator - not required to report. Due to incomplete data, it is not possible to report on interim performance.			Annual indicator - not required to report. Interim results indicate that performance is on track with 41 of the 52 hospitals achieving the benchmark.			Annual indicator - not required to report. Interim results unfortunately not available yet.			More hospitals achieved the provincial benchmark for average water consumpiton per hospital bed per day, which is to the advantage of the Department and the Province.					
		Send official communication to all facilities to again request that monthly data is provided to Directorate: Engineering and Technical Support. Monitoring of water consumption at facilities is ongoing.			Send official communication to all facilities to again request that monthly data is provided to Directorate: Engineering and Technical Support. Monitoring of water consumption at facilities is ongoing.			Monitoring of water consumption at facilities remains ongoing.			Monitoring of water consumption at facilities remains ongoing.					

PROGRAMME 7.3: FORENSIC PATHOLOGY

Performance measure/ Indicator		Quarter 1		Quarter 2			Quarter 3		Quarter 4			Annual 2019/20		
		Actual		Target	Actual		Actual		Target	Preliminary		Target	Year to date	
		Performance	% Achieved		Performance	% Achieved	Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
FORENSIC PATHOLOGY SERVICES														
1.1.1	**Percentage of child Death cases reviewed by the Child Death Review Boards**	67.3%	67.3%	100.0%	79.6%	79.6%	75.1%	75.1%	100.0%	57.9%	57.9%	100.0%	70.4%	70.4%
Num	No of Child death cases reviewed	325	62.0%	535	296	55.3%	269	51.8%	505	170	33.6%	2 083	1 060	50.9%
Den	No of child death cases	483	92.2%	535	372	69.5%	358	69.0%	505	293	57.9%	2 083	1 506	72.3%

Notes:		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual 2019/20
	COMMENT	CDR Meetings have only been held for cases received in April and May 2019. Metro East has not held any meeting for cases received in May 2019.	Metro East has not held a CDR meeting in September to discuss August 2019 cases due to a mass disaster which was declared as a result of a huge caseload and backlog in post-mortem examinations. Cases for September 2019 to be discussed in October 2019 Child Death Review Boards.	Metro West held a review board for November cases in December. All other review boards will review November and December cases in January 2020	No meeting held in Metro West. All February cases will be discussed in March.	
	ACTION PLAN		Monitoring caseload closely.			

Monitoring and Evaluation Report
PROGRAMME 7: Health Care Support Services

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			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**	95.1%	88.6%	93.2%	95.1%	87.8%	92.3%	95.1%	89.0%	93.6%	95.1%	84.2%	88.6%	95.1%	84.2%	89.1%
Num	Pharmaceutical items that are in stock at the CMD	694	637	91.8%	694	640	92.2%	694	614	88.5%	694	583	84.0%	694	583	84.0%
Den	Pharmaceutical items on the stock register	730	719	98.5%	730	729	99.9%	730	690	94.5%	730	692	94.8%	730	692	94.8%
Notes:	COMMENT	The partial achievement is mainly attributed due to the late award of tenders by National Treasury, together with the reduced number of pharmaceutical items included within these tenders, and poor supplier performance has directly affected medicine availability in the reporting period. As of 01 April 2019, National DOH manages the pharmaceutical tenders processes, and it is cautiously anticipated supply to improve.			The partial achievement is mainly attributed due to the late award of tenders by National Treasury, together with the reduced number of pharmaceutical items within these tenders for which bids were received. Continued poor supplier performance has directly affected medicine availability in the reporting period. As of 01 April 2019, National DOH has managed the pharmaceutical tender processes, as well as the re-tender process for items no bids were previously received. It is cautiously anticipated that medicine availability will improve. Delegates of pharmacy services in the Western Cape are assisting NDoH where possible.			The partial achievement is mainly attributed due to the late award of tenders by National Treasury, together with the reduced number of pharmaceutical items within these tenders for which bids were received. Continued poor supplier performance has directly affected medicine availability in the reporting period. As of 01 April 2019, National DOH has managed the pharmaceutical tender processes, as well as the re-tender process for items no bids were previously received. It is cautiously anticipated that medicine availability will improve. Delegates of pharmacy services in the Western Cape are assisting NDoH where possible.			The partial achievement is mainly attributed due to the late award of tenders by National Treasury, together with the reduced number of pharmaceutical items within these tenders for which bids were received. Continued poor supplier performance has directly affected medicine availability in the reporting period. As of 01 April 2019, National DOH has managed the pharmaceutical tender processes, as well as the re-tender process for items no bids were previously received. Delegates of pharmacy services in the Western Cape are assisting NDoH where possible. The added constraint that became apparent was the effect of the Corona vuris in China and India, with its concomittant lockdown where signficant amount of the active pharmaceutical ingredients (API) is sourced, thus delivery sparse resulting in decreased medicine avialibility.			The partial achievement is mainly attributed due to the late award of tenders by National Treasury, together with the reduced number of pharmaceutical items within these tenders for which bids were received. Continued poor supplier performance has directly affected medicine availability in the reporting period. As of 01 April 2019, National DOH has managed the pharmaceutical tender processes, as well as the re-tender process for items no bids were previously received. Delegates of pharmacy services in the Western Cape are assisting NDoH where possible. The added constraint that became apparent was the effect of the Corona vuris in China and India, with its concomittant lockdown where signficant amount of the active pharmaceutical ingredients (API) is sourced, thus delivery sparse resulting in decreased medicine avialibility.		
	ACTION PLAN															

Monitoring and Evaluation Report
PROGRAMME 8: Health Facilities

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
	Programme 8: Health Facilities Management															
8.1.1	**Percentage of Programme 8 Capital infrastructure budget spent (excluding Maintenance)**	19.9%	9.3%	46.6%	45.1%	23.9%	53.1%	75.8%	65.7%	86.7%	100.0%	97.3%	97.3%	100.0%	97.3%	97.3%
Num	Programme 8 Capital infrastructure expenditure (excluding Maintenance)	106 252 400	49 592 470	46.7%	241 554 639	128 064 991	53.0%	405 665 156	263 385 552	64.9%	535 214 000	390 042 651	72.9%	535 214 000	390 042 651	72.9%
Den	Programme 8 Capital infrastructure budget (excluding Maintenance)	535 214 000	535 214 000	100.0%	535 214 000	535 214 000	100.0%	535 214 000	400 962 000	74.9%	535 214 000	400 962 000	74.9%	535 214 000	400 962 000	74.9%

Notes:		Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual 2019/20
	COMMENT	Under performance is due to: * Slow progress on design stages. * Delay in projects progressing to tender. * Slow progress in construction stage. * Delays in conclusion of Final Accounts.	QUARTER 1 ACTUAL VS PRELIMINARY PERFORMANCE Preliminary performance included projection for June, based on cash flow. Difference between preliminary and actual performance indicates that cash flow is not reliable. QUARTER 2 PRELIMINARY PERFORMANCE Under performance is due to: * Slow progress on design stages. * Delay in projects progressing to tender. * Slow progress in construction stage. * Delays in conclusion of Final Accounts.	QUARTER 2 ACTUAL VS PRELIMINARY PERFORMANCE Preliminary performance included projection for September, based on cash flow. Difference between preliminary and actual performance reflects unpredictable cash flows. QUARTER 3 PRELIMINARY PERFORMANCE Under performance is due to: * Slow progress on design stages. * Delays or extensions of time for projects in construction.	QUARTER 3 ACTUAL VS PRELIMINARY PERFORMANCE There is no significant difference between the preliminary and actual performance. QUARTER 4 PRELIMINARY PERFORMANCE Based on the cashflow, a minimal under expenditure is estimated.	
	ACTION PLAN	* Chief Directorate is looking at efficiency gains wrt stage comments and approvals. * 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 and subsequent reprioritisation of projects. * Continue to over-commit capital infrastructure projects.	* Chief Directorate is looking at efficiency gains wrt stage comments and approvals. * 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 and subsequent reprioritisation of projects. * Continue to over-commit capital infrastructure projects.	* Continuous improvement of IDMS processes. * Continuous rigorous programme management and oversight of Implementing Agent. * Ongoing implementation of the Framework for Infrastructure Delivery and Procurement Management, effective from 1 October 2019. * Rigorous review of project cash flows.	* Continuous improvement of IDMS processes. * Continuous rigorous programme management and oversight of Implementing Agent. * Ongoing implementation of the Framework for Infrastructure Delivery and Procurement Management, effective from 1 October 2019. * Rigorous review of project cash flows.	

	Performance measure/ Indicator	Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
8.1	**Number of health facilities that have undergone major and minor refurbishment in NHI Pilot District (Garden Route District)**	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	1	1	100.0%	1	1	100.0%
Notes:	COMMENT	Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Interim results - work at the health facility planned to undergo major and / or minor refurbishment, has not been completed.			Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Interim results - work at the health facility planned to undergo major and / or minor refurbishment, has not been completed.			Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Furthermore, this indicator is not included in the 2019/20 NDoH APP, which was not formally communicated to WCGH. Interim results - work completed at the health facility planned to undergo major and / or minor refurbishment.			This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Furthermore, this indicator is not included in the 2019/20 NDoH APP, which was not formally communicated to WCGH. Work has been completed at the health facility planned to undergo major and / or minor refurbishment.					
	ACTION PLAN															
8.2	**Number of health facilities that have undergone major and minor refurbishment outside NHI Pilot District**	Annual target	-	Annual target	Annual target	-	Annual target	Annual target	-	Annual target	26	12	46.2%	26	12	46.2%
Notes:	COMMENT	Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Interim results - work at four of the health facilities planned to undergo major and / or minor refurbishment has been completed.			Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Interim results - work at four of the health facilities planned to undergo major and / or minor refurbishment has been completed.			Annual indicator - not required to report. This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Furthermore, this indicator is not included in the 2019/20 NDoH APP. This was not formally communicated to WCGH. Interim results - work at seven of the health facilities planned to undergo major and / or minor refurbishment has been completed.			This indicator (National indicator) is not relevant as NHI is now focusing on all districts. Furthermore, this indicator is not included in the 2019/20 NDoH APP. This was not formally communicated to WCGH. Work at twelve of the health facilities planned to undergo major and / or minor refurbishment has been completed. Under performance is due to: * Slow progress on design stages. * Delays or extensions of time for projects in construction. * Delay in tender processes for Scheduled Maintenance projects. * Significant delays on Scheduled Maintenance projects in construction					
	ACTION PLAN										* Continuous rigorous programme management and oversight of Implementing Agent. * Over-committing of maintenance undertaken by WCGH. * Expedite awarding of tenders using Framework Agreement. * Mitigation processes underway to address decanting challenges with respect to Scheduled Maintenance projects. * Ongoing implementation of the Framework for Infrastructure Delivery and Procurement Management, effective from 1 October 2019. * Rigorous review of project cash flows					

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
8.3	**Percentage of Programme 8 Maintenance budget spent**	18.1%	11.9%	65.6%	43.7%	25.2%	57.6%	69.7%	57.1%	81.9%	100.0%	87.5%	87.5%	100.0%	87.5%	87.5%
Num	Programme 8 Maintenance expenditure	74 372 104	48 870 075	65.7%	179 757 483	103 736 590	57.7%	287 107 733	198 733 618	69.2%	411 771 000	304 596 272	74.0%	411 771 000	304 596 272	135.2%
Den	Programme 8 Maintenance budget	411 771 000	411 771 000	100.0%	411 771 000	411 771 000	100.0%	411 771 000	347 942 000	84.5%	411 771 000	347 942 000	84.5%	411 771 000	347 942 000	84.5%
Notes:	COMMENT	Under performance is due to: * Slow progress on design stages. * Delays in projects progressing to tender. * Slow progress in construction stage. * Delays in conclusion of Final Accounts. * Capacity of service providers. * Various challenges with suppliers / contractors in rural areas: Limited registered service providers in rural areas (WC supplier database, CIDB etc.); Service providers prefer to work in big centres; Service providers comply with all requirements at time of tendering but some of these have expired by the time of tender award, causing long delays.			QUARTER 1 ACTUAL VS PRELIMINARY PERFORMANCE Preliminary performance included projection for June, based on cash flow. Difference between preliminary and actual performance indicates that cash flow is not reliable. QUARTER 2 PRELIMINARY PERFORMANCE Under performance is due to: * Slow progress on design stages. * Delays in projects progressing to tender. * Slow progress in construction stage. * Delays in conclusion of Final Accounts. * Capacity of service providers. * Various challenges with suppliers / contractors in rural areas: Limited registered service providers in rural areas (WC supplier database, CIDB etc.); Service providers prefer to work in big centres; Service providers comply with all requirements at time of tendering but some of these have expired by the time of tender award, causing long			QUARTER 2 ACTUAL VS PRELIMINARY PERFORMANCE Preliminary performance included projection for September, based on cash flow. Difference between preliminary and actual performance reflects unpredictable cash flows. QUARTER 3 PRELIMINARY PERFORMANCE Under performance is due to: * Slow progress on design stages. * Delay in tender processes for Scheduled Maintenance projects. * Significant delays on Scheduled Maintenance projects in construction. * Various challenges with suppliers / contractors in rural areas: Limited registered service providers in rural areas (WC supplier database, CIDB etc.).			QUARTER 3 ACTUAL VS PRELIMINARY PERFORMANCE Preliminary performance included projection for December, based on cash flow. Difference between preliminary and actual performance reflects unpredictable cash flows. QUARTER 4 PRELIMINARY PERFORMANCE Under performance is due to: * Slow progress on design stages. * Delay in tender processes for Scheduled Maintenance projects. * Significant delays on Scheduled Maintenance projects in construction. * Various challenges with suppliers / contractors in rural areas: Limited registered service providers in rural areas (WC supplier database, CIDB etc.).					
	ACTION PLAN	* 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 to over-commit maintenance projects. * Recruitment of additional staff for Directorate: Engineering and Technical Support.			* 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 to over-commit maintenance projects. * Recruitment of additional staff for Directorate: Engineering and Technical Support.			* Continuous rigorous programme management and oversight of Implementing Agent. * Over-committing of maintenance undertaken by WCGH. * Expedite awarding of tenders using Framework Agreement. * Mitigation processes underway to address decanting challenges with respect to Scheduled Maintenance projects. * Ongoing implementation of the Framework for Infrastructure Delivery and Procurement Management, effective from 1 October 2019. * Rigorous review of project cash flows based on project information supplied. * Recruitment of additional technical staff for Directorate: Engineering and Technical Support.			* Continuous rigorous programme management and oversight of Implementing Agent. * Over-committing of maintenance undertaken by WCGH. * Expedite awarding of tenders using Framework Agreement. * Continue with mitigation processes to address decanting challenges with respect to Scheduled Maintenance projects. * Ongoing implementation of the Framework for Infrastructure Delivery and Procurement Management, effective from 1 October 2019. * Rigorous review of project cash flows based on project information supplied. * Recruitment of additional technical staff for Directorate: Engineering and Technical Support.					

Performance measure/ Indicator		Quarter 1			Quarter 2			Quarter 3			Quarter 4			Annual 2019/20		
		Target	Actual		Target	Actual		Target	Actual		Target	Preliminary		Target	Q4 Year to date	
			Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved		Performance	% Achieved
8.4	**Percentage of Programme 8 Health Technology budget spent**	5.0%	3.1%	62.4%	15.0%	29.5%	196.4%	30.0%	23.2%	77.2%	100.0%	108.8%	108.8%	100.0%	108.8%	108.8%
Num	Programme 8 Health Technology expenditure	6 316 750	3 940 875	62.4%	18 950 250	37 209 675	196.4%	37 900 500	62 611 699	165.2%	126 335 000	293 878 426	232.6%	126 335 000	293 878 426	43.0%
Den	Programme 8 Health Technology budget	126 335 000	126 335 000	100.0%	126 335 000	126 335 000	100.0%	126 335 000	270 191 000	213.9%	126 335 000	270 191 000	213.9%	126 335 000	270 191 000	213.9%
Notes:	COMMENT	Procurement is aligned to estimated Practical Completion dates of related infrastructure projects to avoid risks associated with storage and, potentially, reduced warranty periods(e.g. delay in completion of Swartland Hospital - Prefab wards). Many procurement transactions commenced in Quarter 1 but not concluded, and expenditure will reflect in Quarter 2.			QUARTER 1 ACTUAL VS PRELIMINARY PERFORMANCE Actual performance was higher as lead time for delivery of some items was shorter than planned. QUARTER 2 PRELIMINARY PERFORMANCE Improved Quarter 2 performance reflects delayed expenditure carried over from Quarter 1.			QUARTER 2 ACTUAL VS PRELIMINARY PERFORMANCE Advanced procurement of non-electro medical items to 'speed up' expenditure. QUARTER 3 PRELIMINARY PERFORMANCE Budget allocation doubled due to budget shifts to mitigate under expenditure in infrastructure. In view of the additional allocation, performance of 77% is considered as good progress.			QUARTER 3 ACTUAL VS PRELIMINARY PERFORMANCE No significant difference between preliminary and actual performance. QUARTER 4 PRELIMINARY PERFORMANCE In spite of increased budget allocation, planned over expenditure is forecasted as a mitigating strategy to address under expenditure in other Programme 8 components					
	ACTION PLAN	Continued collaboration and communication with Directorate: Infrastructure Programme Delivery in terms of infrastructure project progress - introduce 'check point' process between Directorates: Health Technology and Infrastructure Programme Delivery. Introduce collateral damage penalties for HT.			The rate and level of expenditure are both increasing and therefore no intervention is currently required.			The rate and level of expenditure are both increasing and therefore no intervention is currently required.			The rate and level of expenditure have both increased, No intervention is therefore currently required.					