GAUTENG DEPARTMENT OF HEALTH

QUARTER ONE (2025/26): GAUTENG PROVINCIAL LEGISLATURE

AUGUST 2025

GAUTENG
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

GGT2030
GROWING GAUTENG TOGETHER

CONTENTS

PURPOSE

- To present the non-financial and financial performance of the Gauteng Department of Health for Quarter One, April 2025 to June 2025 of the 2025/26 Financial Year

CONTEXT

- The reporting focusses on the First Quarter of the 2025/26 financial year.
- The overall performance in Quarter 1 was (61%) with 43 out of 71 targets achieved and 28 targets (39%) not achieved; representing an 11 percentage points increase compared to quarter 1 of 2024/25.
- Underperformance was predominantly in Budget programme 1 Administration & Budget programme 2 (District Hospitals).

KEY INITIATIVES DURING THIS QUARTER

Infrastructure, Health Technology and I serve with a smile

- Infrastructure and Health Technology Enhancements
- Launch of "I Serve with a Smile" and unveiling of Health Technology – Tshwane District Hospital
- Unveiling of renovated wards and medical equipment – Dr George Mukhari Academic Hospital
- Unveiling of specialised rescue equipment – Zoo Lake
- Launch of "I Serve with a Smile" – Tambo Memorial Hospital

Outreach Support and Logistics Handover

- Youth Plug Career Expo – conducted across five districts
- Hand over of vehicles to Integrated School Health Programme teams – Tembisa
- Launch of Mpathy Clinic – Orange Farm
- Phelophepha Train Health Services activation – Heidelberg

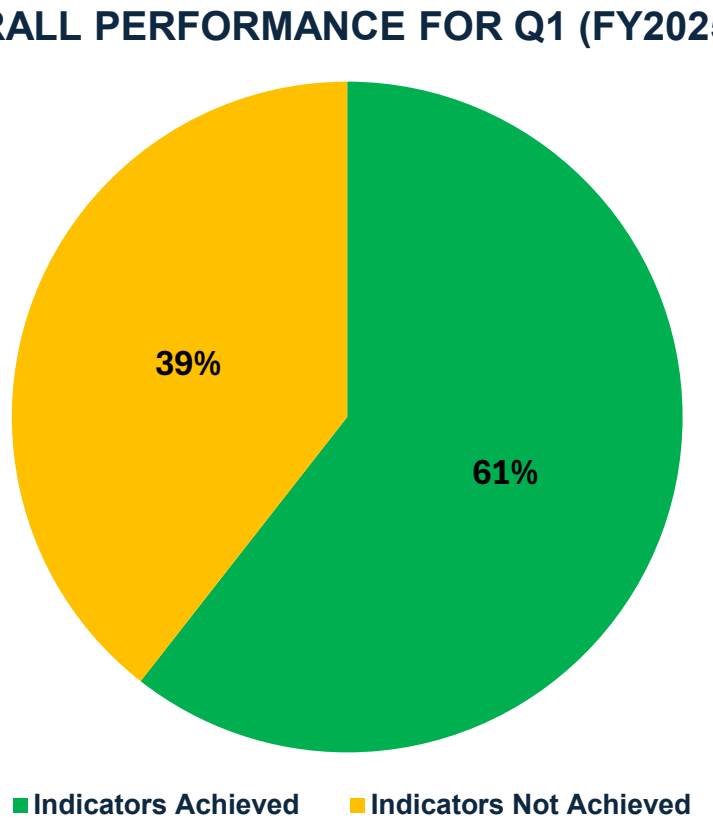
OVERVIEW OF PERFORMANCE

COMPARISON OF Q1 (2024/25) AND Q1 (2025/26)

Q1 24/25	Programmes	Achieved	%	Not achieved	%	Not reported	TOTAL
Prog. 1	Admin	0	0%	2	100%	0	2
Prog. 2	DHS	1	33%	2	67%	0	3
Prog. 2.1	DIST HOSP	8	80%	2	20%	0	10
Prog. 2.2	HAST	6	43%	8	57%	0	14
Prog. 2.3	MCWHN	11	65%	6	35%	0	17
Prog. 2.4	PH	1	17%	5	83%	0	6
Prog. 3	EMS	4	80%	1	20%	0	5
Prog. 4	REGHOSP	4	50%	4	50%	0	8
	SPLHOSP	1	25%	3	75%	0	4
Prog 5	TERHOSP	2	22%	7	78%	0	9
	CENHOSP	3	33%	6	67%	0	9
	SBAH	5	56%	4	44%	0	9
	DGMAH	9	100%	0	0%	0	9
	CMJAH	2	22%	7	78%	0	9
	CHBAH	3	33%	6	67%	0	9
Prog 6	HS&T	Annual	0%	0	0%	0	0
Prog 7	HCSS	3	100%	0	0%	0	3
Prog 8	HFM	Annual	0%	Annual	0%	0	0
	Total	**63**	**50%**	**63**	**50%**	**0**	**126**

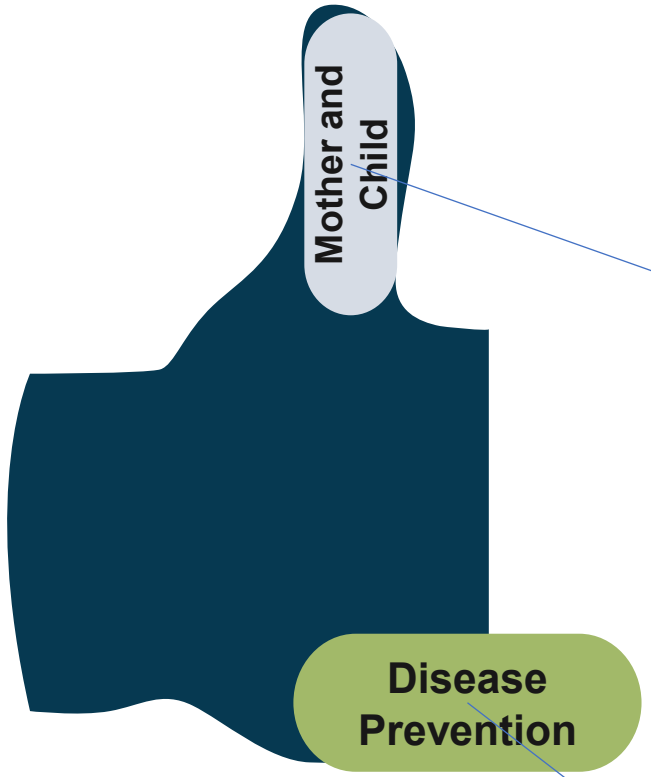
Q1 25/26	Programmes	Achieved	%	Not achieved	%	Not reported	TOTAL
Prog. 1	Admin	0	0%	1	100%		1
Prog. 2	DHS	2	50%	2	50%		4
Prog. 2.1	DIST HOSP	1	25%	3	75%		4
Prog. 2.2	HAST	8	73%	3	27%		11
Prog. 2.3	MCWHN	7	64%	4	36%		11
Prog. 2.4	PH	2	67%	1	33%		3
Prog. 3	EMS	1	50%	1	50%		2
Prog. 4	REGHOSP	3	75%	1	25%		4
	SPLHOSP	3	75%	1	25%		4
Prog 5	TERHOSP	2	50%	2	50%		4
	CENHOSP	2	50%	2	50%		4
	SBAH	2	50%	2	50%		4
	DGMAH	3	75%	1	25%		4
	CMJAH	2	50%	2	50%		4
	CHBAH	3	75%	1	25%		4
Prog 6	HS&T	Annual	N/A	Annual	N/A		0
Prog 7	HCSS	2	67%	1	33%		3
Prog 8	HFM	Annual	N/A	Annual	5		0
	Total	**43**	**61%**	**28**	**39%**		**71**

Overall Performance For Q1 (Apr-25 to Jun-25)



- 61% of indicators achieved in Q1 2025/26, an increase of 11 percentage point compared to Q1 2024/25

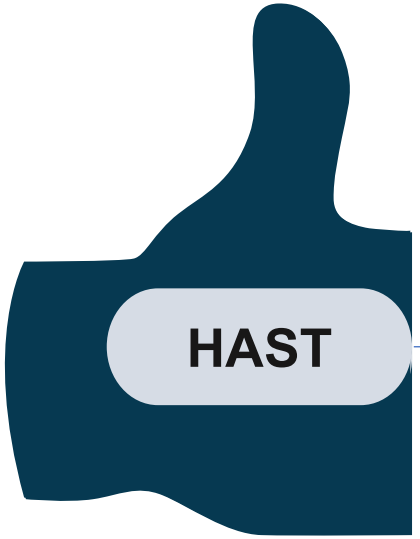
DETAILED PERFORMANCE STATUS – TARGETS ACHIEVED WITH SIGNIFICANT IMPROVEMENTS



- Number of Deliveries in 10-14 years in facility as a measure of managing teenage pregnancies were 89 for Q1 2025/26 which outperformed the targeted 124 deliveries. **This was due to improved access to contraceptives and strengthened youth-focused outreach.**
- The antenatal 1st visit rate before 20 weeks increased from 71.1% Q1 2024/25 to 73.0% in Q1 2025/26**, driven by ongoing routine pregnancy testing at both facility and household levels.**
- In Q1 2025/26, the postnatal visit rate within 6 days was 82%, slightly above the 81% target, **due to ANC health education and effective hospital-to-community WBOT linkages.**
- Infant 1st PCR positive rate at birth for Q1 2025/26 was 0.4%, **reflecting effective mother-to-child HIV prevention through adherence to VTP guidelines, including early ART initiation, viral load monitoring, and provision of PrEP during pregnancy.**
- **Improved triaging and emergency management at PHC facilities, along with the placement of IMCI-trained clinicians in Child Health rooms, contributed to the achievement of** Q1 2025/26 targets for under-5 diarrhoea and pneumonia, which were recorded at 1.7% and 1.0% respectively.
- **The implementation of the Severe Acute Malnutrition (SAM) protocol led to a reduction in under-5 SAM deaths**, improving from 7.0% in Q1 2024/25 to 6.3% in Q1 2025/26.

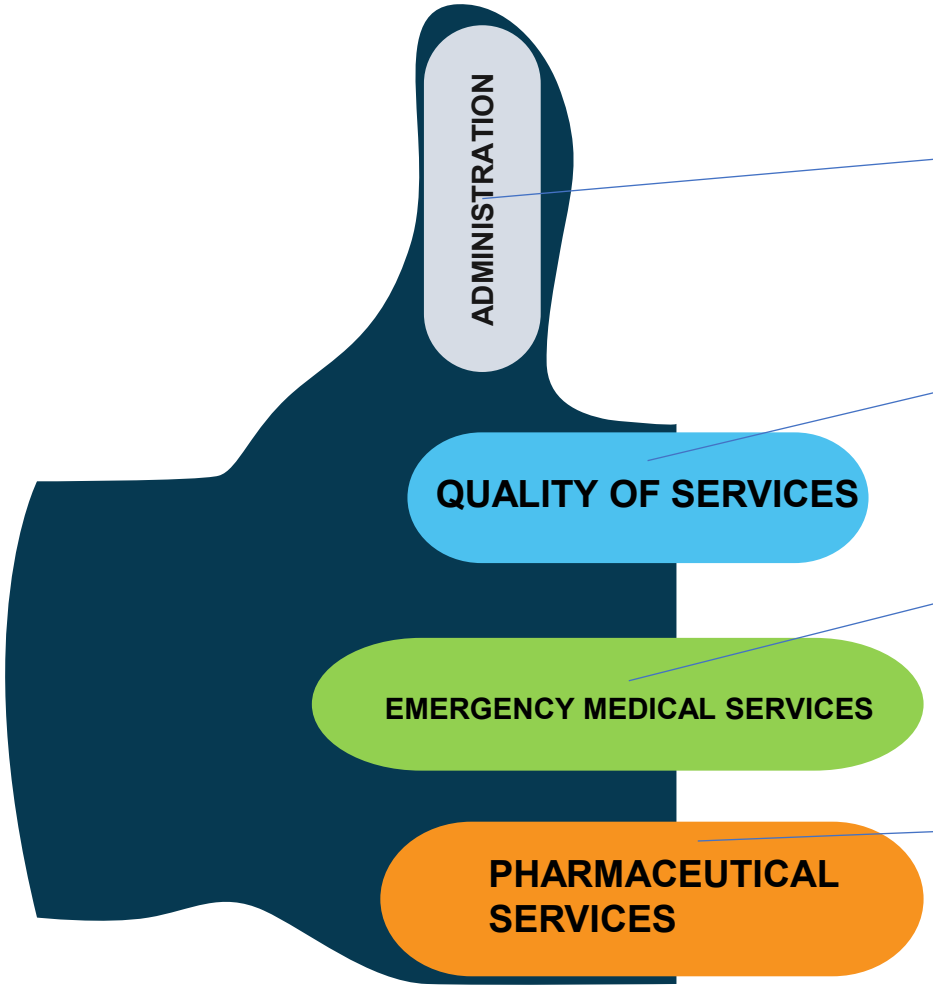
- **Ongoing malaria case management training for clinicians in Gauteng has contributed** to a reduction in the malaria case fatality rate, which declined from 1.5% in Q1 2024/25 to 0.9% in Q1 2025/26
- To better manage diabetes prevalence, the rate of patients achieving a normal Haemoglobin A1c (HbA1c) result of ≤ 8% has increased significantly by 28.4 percentage points, rising from 36.6% in Q1 2024/25 to 65% in Q1 2025/26. **This improvement is attributed to the enforced regular monitoring of diabetes patients through HbA1c testing every 3 to 6 months**.
- The PHC mental disorders treatment rate, as part of the community-based mental health programme rollout, was 0.1% in Q1 2024/25. This reflects ongoing efforts to screen and treat first-time mental health patients.

DETAILED PERFORMANCE STATUS – TARGETS ACHIEVED WITH SIGNIFICANT IMPROVEMENTS



- In Q1 2025/26, the HIV-positive rate among 5–14-year-olds (excluding ANC) was 0.25%, **due to effective implementation of the Vertical Transmission Prevention programme. This success was driven by PrEP for pregnant women and adolescents, alongside Voluntary Medical Male Circumcision to reduce transmission.**
- In Q1 2025/26, the HIV-positive rate among 15–24-year-olds (excluding ANC) decreased by 0.21 percentage points to 0.775%, down from 0.98% in Q1 2024/25**. This improvement is attributed to the expanded HIV prevention strategies, including PrEP, condom distribution, and Medical Male Circumcision.**
- The ART child remain in care rate (12 months) increased by 6.5 percentage points, rising from 69.2% in Q1 2024/25 to 75.75% in Q1 2025/26. **This improvement is due to better adherence to appointment schedules by caregivers.**
- ART adult viral load suppressed rate - below 50 (12 months) increased by 7.4 percentage points, from 70% in Q1 2024/25 to 77.4% in Q1 2025/26. **This improvement is attributed to enhanced case management and adherence support, leading to better treatment adherence**.
- ART child viral load suppressed rate - below 50 (12 months) increased by 4.4 percentage points, rising from 47.5% in Q1 2024/25 to 51.9% in Q1 2025/26. **This improvement is attributed to better adherence to treatment**.
- The TB RR/MDR Treatment Success Rate reached 63% in Q1 2025/26, surpassing the target of 60%. **This was achieved through early tracing and tracking of patients who missed appointments, along with proper implementation of drug-resistant TB clinical guidelines.**
- In Q1 2025/26, a total of 6,220 DS-TB treatment starts were recorded for individuals aged 5 years and older. **This was driven by strengthened community TB social mobilization to enhance case detection, as well as daily TB screening across all healthcare facilities to ensure prompt treatment initiation.**
- In Q1 2025/26, 278 DS-TB treatment starts were recorded for children under 5 years. **This was the result of strengthened community TB social mobilization to improve case detection, along with daily TB screening at all healthcare facilities to ensure timely treatment initiation.**

DETAILED PERFORMANCE STATUS – TARGETS ACHIEVED WITH SIGNIFICANT IMPROVEMENTS



- Rand value of medico-legal claims decreased by 35% from R11.4 in Q1 2024/25 billion to R7.4 billion during Q1 2025/26 **due to continued strengthened implementation of the medico-legal strategy.**

- **Severity assessment code (SAC) 1 incident reported within 24-hours rate were at 98%, 98.6%, 97.4%,100%, 95.7% and 99.5% for DHS, District Hospitals, Regional Hospitals, Specialised Hospitals, Tertiary and Central hospitals, respectively. This was due to the recent implementation of completion of notification forms at the end of staff shifts.**

- **Improvements in addressing internal challenges at hospitals related to ambulance turnaround times led to an 11-percentage point increase** in the EMS P1 rural inter-facility transfer (IFT) under-60-minutes rate, rising from 72% in Q1 2024/25 to 83% in Q1 2025/26.

- The availability of essential medicines at health facilities reached 97% in Q1 2025/26, marking a 0.7 percentage point increase from 96.3% in Q1 2024/25. This improvement is attributed to the adequate procurement of essential medicines through contracted suppliers.
- A total of 1,542,067 patients were enrolled in the Centralised Chronic Medicine Dispensing and Distribution (CCMDD) programme in Q1 2025/26. This initiative aims to reduce waiting times at health facilities by allowing chronic patients to voluntarily collect their medication from designated pickup points.

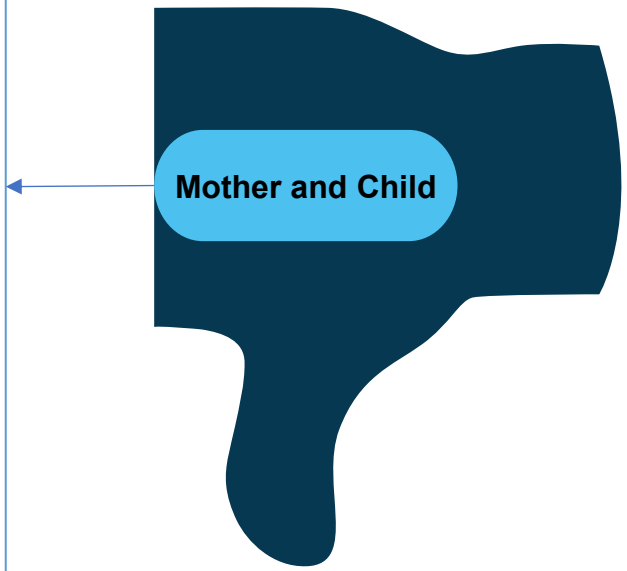
DETAILED PERFORMANCE STATUS CONT'D: AREAS OF CONSISTENT UNDERPERFORMANCE

- The couple year protection rate decreased by 20.5 percentage points from 49.7% during Q1 2024/25 to 29.2% during Q1 2025/26 due to a decline in the number of incetrted IUCDs and unavailability of private services provider data. **Mitigating Measure: Continue promotion of IUCDs will be prioritised during outreach campaigns, along with on-site insertions at health facilities. Additionally, the registration of data from Private Service Providers (PSPs) will be expedited for completion by the end of September, supported by thorough data verification processes to ensure accuracy and completeness**.

- Immunisation coverage for children under 1 year decreased by 2.4 percentage points, from 81.2% in Q1 2024/25 to 78.8% in Q1 2025/26, largely due to caregivers defaulting on scheduled immunisation visits. **Mitigating Measure: To address this, key mitigation measures include intensified advocacy and social mobilisation, reinforcing the booking system and defaulter tracing, conducting integrated outreach campaigns to reach zero-dose children, and strengthening collaboration with both public and private service providers.**

- Measles 2nd dose coverage at 1 year decreased by 3 percentage points, from 79.2% in Q1 2024/25 to 76.2% in Q1 2025/26, largely due to caregivers defaulting on scheduled immunisation visits. **Mitigating Measure: To address this, key mitigation measures include intensified advocacy and social mobilisation, reinforcing the booking system and defaulter tracing, conducting integrated outreach campaigns to reach zero-dose children, and strengthening collaboration with both public and private service providers.**

- Cervical cancer screening coverage increased by 2 percentage points, from 24.1% in Q1 2024/25 to 26.1% in Q1 2025/26. However, the target was not achieved due to inadequate marketing of the service and unavailability of vaginal speculums required for screening. **Mitigating Measure: key mitigation measures include finalising and procuring data reporting tools, intensifying marketing efforts in all health facilities and outreach events, and implementing provider-initiated HPV testing from 1 July 2025 in three additional Metro Health Districts. Furthermore, in-service training will be conducted for clinicians on the 90-70-90 cancer elimination strategy and proper LBC specimen collection during supervisory support visits, including other service delivery streams.**



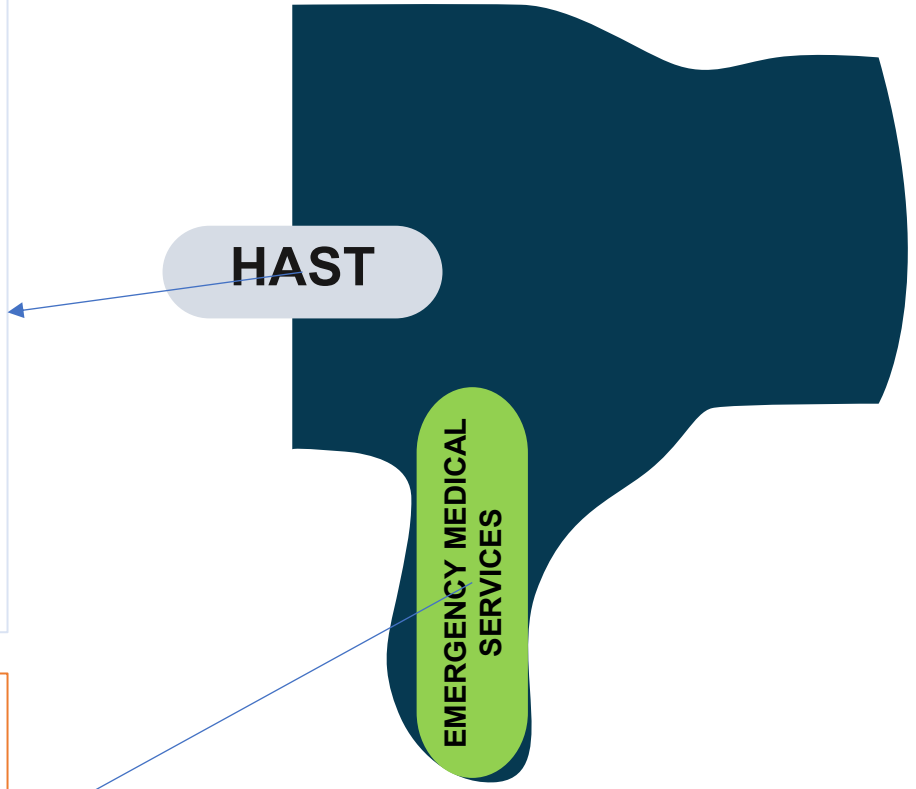
DETAILED PERFORMANCE STATUS CONT'D: AREAS OF CONSISTENT UNDERPERFORMANCE

- ART adult remained in care rate (12 months) was 64.8% and did not meet the 705 Q1 2025/26 target due to a higher number of missed appointments by the adult patients. **Mitigating Measure: Intensify daily tracing and tacking of missed appointments monthly.**

- All DS-TB Client Treatment Success Rate was at 73.2% below the target of 75% in Q1 2025/26 due to ineffective referral system from the hospital to PHC facilities. **Mitigating Measure: Implement TB clinical governance to address the root causes of TB-related deaths, conduct monthly TB review meetings, and carry out facility-based folder reviews to monitor and improve patient outcomes.**

- The number of TB Rifampicin resistant/multidrug-resistant patients that started treatment was 151 below the 221 Q1 2025/26 target. This was due to low DR-TB case finding. **Mitigating Measure: Testing of all eligible patients using TB NAAT and follow up culture sputum for those with negative TB NAAT test by September 2025.**

- The EMS P1 urban interfacility transfer (IFT) under-30-minutes rate was 38% in Q1 2025/26, falling short of the targeted 55%. This underperformance was primarily due to service delivery protests that delayed response times, as well as infrastructure, human resource, and service footprint limitations across districts. **Mitigating Measure: Engagement with Community Leaders, Ward Councillors, SAPS, Community Policing Forums (CPF's) on impact of service delivery protests. Expand footprint of EMS services. Engagement with respective Clinical Management and CEO's on ambulance turnaround times**



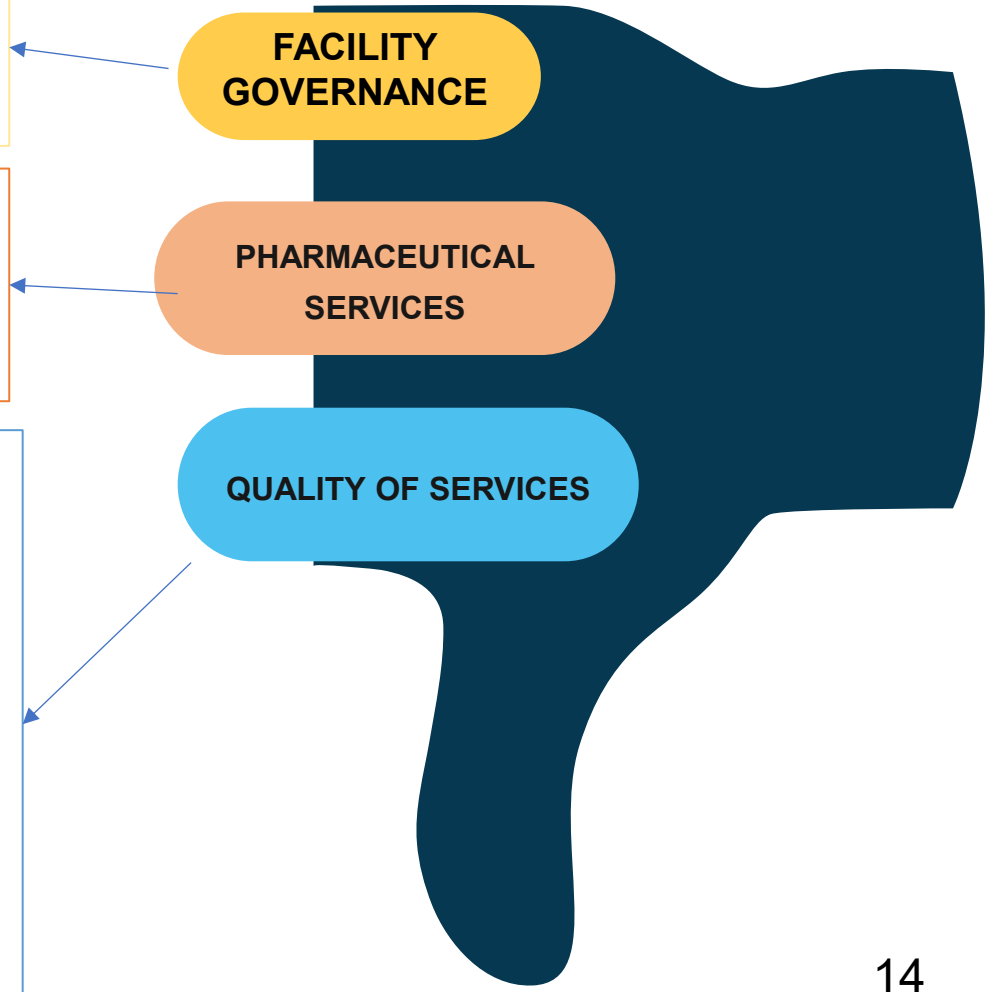
DETAILED PERFORMANCE STATUS CONT'D: AREAS OF CONSISTENT UNDERPERFORMANCE

- None of the hospital levels had 100% functional hospital board due to various reasons including board not meeting quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend. **Mitigating Measure: Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid.**

- The availability of vital medicines at health facilities was 95% in Q1 2025/26, below the targeted 96%. This was mainly due to regional pharmacies reporting below the threshold, as their formularies still included items that have been phased out following updates to the ARV regimens. **Mitigating Measure: the formularies for regional pharmacies will be reviewed and updated ("cleaned out") in Quarter 2 of 2025 to align with the latest treatment guidelines and ensure more accurate reporting.**

- In Q1 2025/26, the complaint resolution rate within 25 working days was 98.5% at district hospitals and 92% at Charlotte Maxeke Academic Hospital which were below the target for this quarter. The primary reason for this shortfall was the unavailability of complainants to attend scheduled redress meetings. **Mitigating Measure: Complainants will be regularly reminded of the complaint resolution timeframes and encouraged to notify facilities in advance if they are unable to attend. Additionally, the option of virtual redress meetings will be offered to improve accessibility and ensure timely resolution.**

- The Patient Safety Incident (PSI) case closure rate in Q1 2025/26 fell below targets across several levels of care: 76.9% for the District Health Services (DHS), 71.4% for District Hospitals, 66.5% for Tertiary Hospitals, and 89.9% for Central Hospitals. The lower closure rates were mainly due to the complexity of outstanding cases, which require thorough investigation and presentation at PSI committee meetings, while still adhering to the 60-day closure timeframe. **Mitigating Measure: Enforce managers to start investigation immediately after PSIs are reported. Instruct PSI committee to convene meetings as scheduled and adding Adhoc meeting to close all PSIs within the reporting quarter.**



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FINANCIAL PERFORMANCE

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FINANCIAL PERFORMANCE OVERVIEW

3.1 DEPARTMENT BUDGET EXPENDITURE FIGURES

Programme	Main Appropriation	Adjusted Appropriation	Projected Budged for the Quarter 1 under review Section 40	Actual Expenditure for the Q1 2025 Under review R'000	Percentage Expenditure for the Q1 Under review	Actual Expenditure (Year to Date) June 2025	Percentage Expenditure (Year to Date) June 2025
	R'000	R'000	R'000	R'000	%	R'000	%
1. ADMINISTRATION	1,915,488	1,915,488	663,568	736,867	111.0%	736,867	38.5%
2. DISTRICT HEALTH SERVICES	22,756,387	22,756,387	6,655,345	6,052,899	90.9%	6,052,899	26.6%
3. EMERGENCY MEDICAL SERVICES	2,244,019	2,244,019	932,597	524,811	56.3%	524,811	23.4%
4. PROVINCIAL HOSPITAL SERVICES	13,370,085	13,370,085	3,737,474	3,213,604	86.0%	3,213,604	24.0%
5. CENTRAL HOSPITAL SERVICES	23,426,595	23,426,595	6,961,992	5,653,776	81.2%	5,653,776	24.1%
6. HEALTH SCIENCES & TRAINING	935,254	935,254	214,371	158,129	73.8%	158,129	16.9%
7. HEALTH CARE SUPPORT SERVICES	497,023	497,023	155,541	123,024	79.1%	123,024	24.8%
8. HEALTH FACILITIES MANAGEMENT	1,897,646	1,897,646	892,323	620,465	69.5%	620,465	32.7%
	67,042,497	**67,042,497**	**20,213,211**	**17,083,575**	**84.5%**	**17,083,575**	**25.5%**

FINANCIAL PERFORMANCE (REASONS AND MITIGATION FOR UNDER/OVER EXPENDITURE)

Programme 1: Administration: The over-expenditure in this programme is mainly due to the payment of legal fees and claims against the state and payment of GG vehicle.

Programme 2: District Health Services: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 3: Emergency Medical Services: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 4: Provincial Hospital Services: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 5: Central Hospital Services: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 6: Health Sciences and Training: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 7: Health Care Support Services: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

Programme 8: Health Facilities Management: Underspending is due to delays in finalisation of budget, changes in the SCOA from V5 to V6 which resulted in delays of creation of purchase orders and change in processing systems from SAP to Invoice Management System (IMS).

ANNEXURES: NON-FINANCIAL PERFORMANCE

Programme 1: ADMINISTRATION

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Percentage of hospitals compliant with occupational health and safety regulations	68% (25/37)	Annual target	56.8% (21/37)	Sixteen hospitals scored 70%, primarily due to consistent non-compliance with fire detection and suppression equipment standards. Additional areas of concern include non-compliance with electrical installations, General Machinery Regulations, wayfinding and information signage, servicing of lifts, escalators and passenger conveyors, as well as poor housekeeping in storage areas.	Hospitals continue to receive support to conduct monthly First Party Audits and quarterly Second Party Audits, alongside monthly infrastructure maintenance by the Chief Directorate: Infrastructure Maintenance. Training is underway for GDOH officials including Facility Managers, OHS Practitioners, and Environmental Managers in Construction Health and Safety and Project Management to strengthen contractor supervision. The first group of 30 officials began training in May 2025, with additional cohorts scheduled for the third and fourth quarters.
Rand value of medico-legal claims	R10.8bn	Annual target	R7.4bn	This contingent liability comprises Medico-legal, EMS, and Civil-related matters. The department currently has 707 active medico-legal claims, with a corresponding claim value of R 6,9 billion.	The department has implemented a comprehensive medico-legal risk mitigation plan that includes legal, administrative, and ICT-focused interventions. Legal measures involve mediation, administrative archiving, defending public healthcare cases, and offering alternative payment models like staggered settlements. Administratively, efforts focus on improving record-keeping and strengthening communication with patients and the public. Ongoing human resources development includes training legal staff on file management, confidentiality, and ethical practices. To support these efforts, ICT is facilitating the centralization of electronic document storage and is working with legal services to develop a robust disaster recovery plan for both digital and physical medico-legal files.

Programme 1: ADMINISTRATION

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Number of hospitals implementing the Queue Management System	11 (Annual target)	Annual target	0	Implementation at CMJAH had initially followed a phased approach process. Implementation of Integrated Patient Queue Management System (IPQMS) was planned to be concluded in May 2025, however there were technical glitches on the system that led a project to be halted. A meeting was held with the CEO and the team at CMJAH.	A new project plan to finalise the implementation at CMJAH is underway. A plan for province-wide implementation has been developed. SCM processes are completed with the preferred supplier to support the implementation of the IPQMS.
Percentage of CHCs with integrated health information systems	100% (38/38)	Annual target	31.6% (12/38)	Network instability (LAN and WAN) in the facilities that are implementing the clinical module to achieve a complete systems integration. Weak wireless networks signal strength in the consulting rooms.	Procurement of a Corporate APN solution to augment existing GBN infrastructure, offering a dedicated, secure, and performance-optimized mobile connectivity layer that addresses key reliability and reach challenges. The solution will also support the deployment of clinical module, a mobile-based clinical system.
Percentage of hospitals with Integrated Health Information systems	100% (37/37)	Target for Q2	2.7% (1/37)	The clinical documents (PMDs) were not fully developed in some specialty areas in the hospitals. The delays on finalization of the clinical documents contributed to under achievement of the target. Shortage of mobile devices, such as tablets. Network instability (LAN and WAN) in the facilities that are implementing the clinical module to achieve a complete systems integration. Weak wireless networks signal strength in the consulting rooms.	The finalization of the clinical documents shall be completed by end of August 2025. Procurement of a Corporate APN solution to augment existing GBN infrastructure, offering a dedicated, secure, and performance-optimized mobile connectivity layer that addresses key reliability and reach challenges. The solution will also support the deployment of clinical module, a mobile-based clinical documentation system.

Programme 1: ADMINISTRATION

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Percentage of service providers invoices without dispute paid within 30 days	100% (399 197/399 197)	100% (99 799/99 799)	20% (4 954/24 514)	Target not achieved due to cash flow constraints caused by payment of high accrual balances from previous periods, unbudgeted litigation costs (including medico-legal claims), and over-commitment of budgets by some institutions. Additional delays were experienced in clearing work cycle exceptions, confirming receipt of goods or services, creating purchase orders, and capturing GRVs on the financial system.	The new Invoice Management System (IMS) ensures that no invoice can be submitted without a valid Purchase Order (PO) number (425… sequence). Priority is given to paying all invoices processed within 30 days to comply with Treasury Regulation 8.2.3. Invoices dated 2022 and earlier have been removed from the payment run to enforce accountability at the institutional level. CEOs and their teams are required to provide written motivation and reasons for the delay before any aged invoice can be released, subject to approval by GDoH Executive Management.
Percentage of budget spent on Township enterprises against discretionary spent	60% (66 000 000/110 000 000)	Annual target	14% (340 368 026.44/236 709 8890.93)	Target not achieved. The bulk of GDoH procurement is geared towards Original Equipment Manufacturers (OEM'S) for example, medical equipment, medical consumables and pharmaceuticals, procured from non-township enterprises	Contracts for identified commodities >1 000 000 awarded to historically disadvantaged individual owned enterprises. Support from institutions in meeting PP spend targets. Utilization of P Card for purchases <R30 000.
Percentage of women in senior management posts	50% (59/117)	Annual target	46% (49/107)	Natural Attrition, during this quarter one female left the Department due to retirement.	The Department will continue to target women for filling of posts at SMS to achieve the set annual target by the end of March 2026

Programme 2: DISTRICT HEALTH SERVICES

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patient Experience of Care survey rate	100% (372/372)	Conducted in Q2-annual	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Severity assessment code (SAC) 1 incident reported within 24 hours rate	85.7% (120/140)	85.7% (30/35)	98% (49/50)	Target achieved because SAC 1 cases were reported on time, due to prompt completion and submission of section A notification forms to the immediate manager before the end of shift/working day.	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms to the supervisor/manager before the end of shift/ working day. Emphasise effective communication between wards and QA office monthly.
Patient Safety Incident (PSI) case closure rate	95% (300/316)	95% (75/79)	76.9% (50/65)	Target not achieved due to PSI not closed in the following district: **Ekurhuleni-** 2 PSI were reported 28 May and 27 June, are complex and still under investigation **JHB-** 5 PSIs reported last month of Q1, 7/18/22/26/27 June, are still under investigation and to be discussed in the next meeting for closure, while observing 60 days of closure. **Sedibeng** - 1 PSI reported last month of Q1 6/6 is still under investigation **Tshwane** - 7 cases still open, reported on the last month of the quarter 1/1/2/7/9/12/30 June, complex and investigation still underway	Enforce managers to start investigation as soon as the PSI is reported. Instruct PSI committee to convene meetings as scheduled and add Adhoc meeting to facilitate closure of all PSIs within the reporting quarter. Encourage managing PSI according to PSI National guideline.

Programme 2: DISTRICT HEALTH SERVICES

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Complaints resolution within 25 working days rate	97% (1 232/1 264)	97% (308/316)	98.4% (444/451)	Target achieved due to There was timeous investigation of complaints and redress meetings.	Continued to monitor complaints management process (monthly)
Ideal Clinic status obtained rate	92% (342/372)	Annual target	No Ideal Clinic assessment conducted	ICRM System upgrade and framework update.	The first phase of Ideal Clinic Assessment for Q1 was not conducted due to upgrade in the system which was not yet finalised. Baseline Status determination by facilities will be conducted from the 14th – 31st July 2025.
Number of facilities providing 24-hour emergency services	40	Annual target	40	Within target. Two facilities namely Florida and Westbury Clinics were activated to offer 24-hour MoU services, increasing the number of CHCs providing 24-hour service to 40.	Awaiting upliftment of halt in recruitment processes.
Percentage of PHC facilities with functional clinic committees	100% (373/373)	100% (373/373)	85.2% (316/371)	Target not achieved, as only 316 Clinics had fully functional Clinic Committees, while 55 Clinics fell short due to having fewer than the required three members to be considered functional.	The Department continuously engages with all Primary Health Care Facilities for new nominations

Programme 2: DISTRICT HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patient Experience of Care survey rate	100% (12/12)	Conducted in Q2-annual	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal hospital status obtained rate	100% (12/12)	Annual target	0% (0/12)	Ideal Health Facility system under review-process currently being finalised. Expected completion and resumption of operation by the 14th of July 2025	Facilities to comply with timelines as communicated by NDoH while the province negotiates for flexibility.
Severity assessment code (SAC) 1 incident reported within 24-hours rate	93% (320/344)	93% (80/86)	98.6% (72/73)	Target achieved SAC 1 cases were reported on time, due to prompt completion and submission of section A notification forms to the immediate manager before the end of shift/working day.	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms to the supervisor/manager before the end of shift/ working day. Emphasise effective communication between wards and QA office monthly.
Patient Safety Incident (PSI) case closure rate	95% (760/800)	95% (190/200)	71.4% (125/175)	Target not achieved due to the PSI cases not closed on time in **Bertha Gxowa has 41 PSIs still open,** they prioritised closing the overlapping cases from previous quarter, open cases are of current quarter, still under investigation, to be discussed, redressed, and closed while observing the 60 days of closure. All other facilities have 1 or 2 PSI open that were reported last month of the quarter/ in June, that are still under investigations while observing 60 days of closure.	Enforce managers to start investigation as soon as the PSI is reported. Conduct supervisory support visit to the facility. Instruct PSI committee to convene meetings as scheduled, adding Adhoc meeting to facilitate closure of all PSIs within the reporting quarter. Encourage managing PSI according to PSI National guideline.

Programme 2: DISTRICT HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Complaint resolution within 25 working days rate	98.8% (340/344)	98.8% (85/86)	98.5% (67/68)	Target not achieved. One complaint resolved after 25 working days due to the complainant due to the complainant postponing the meeting several times. The complainant withdrew the after she requested the meeting to be held on teams as she could not attend the meeting.	Complainants to be continuously reminded regarding time frames to resolve complaints so that they can indicate on time if they are/ will not be able to present themselves for redress meeting. (monthly)
Percentage of beds in district hospitals offering acute ill mental health care users (72hrs assessment)	10% (300/3 000)	Annual target	9.69% (290/2 993)	Target not achieved due to Bronkhorstspruit hospital rendering outpatient mental health services due to infrastructure and human resource limitations.	Space identified for construction of mental health unit. Meeting held with the Provincial mental health and infrastructure directorate on 01 and 02 July 2025 to conceptualise the proposed unit
Percentage of hospitals with functional hospital boards	100% (12/12)	100% (12/12)	33.3% (4/12)	Target not achieved due to the board not meeting quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid.

Programme 2: HIV/AIDS, STI and TB Control (HAST)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
HIV positive 5-14 years (excl. ANC) rate	0.75% (1 595/2 211 004)	0.75% (398/52 751)	0.25% (143/57 805)	Target was achieved due to successful implementation of Vertical Transmission Prevention of (VTP) programme including PrEP initiation to pregnant women and tanner 3 adolescents and VMMC to reduce transmission of HIV	Continue implementing and monitoring the prevention strategies.
HIV positive 15-24 years (excl. ANC) rate	2.8% (63 360/2 226 034)	2.8% (15 840/556 508)	0.77% (2 443/317 992)	Target achieved through implementation of HIV prevention strategies including PrEP, condom distribution, and Medical Male Circumcision	Continue with the prevention strategies implementation and monitoring.
ART adults remain in care rate (12 months)	70% (54 804/78 292)	70% (13 701/19 573)	64.8% (15 370/23 719)	Target not achieved due to high missed appointment	Intensify daily tracing and tacking of missed appointments monthly.
ART child remain in care rate (12 months)	70% (381/544)	70% (95/136)	75.7% (281/371)	Target achieved due to improved honouring of appointment dates	Continue enhancing appointment honouring monthly.
ART adult viral load suppressed rate - below 50 (12 months)	70% (45 199/64 570)	70% (11 299/16 143)	77.4% (8 348/10 779)	Target achieved due to improved adherence to treatment	Continue implementing enhanced adherence monthly.
ART child viral load suppressed rate - below 50 (12 months)	50% (2 772/5 544)	50% (693/1 386)	51.9% (110/212)	Target achieved due to improved adherence to treatment	Continue implementing enhanced adherence to treatment.

Programme 2: HIV/AIDS, STI and TB Control (HAST)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
TB - RR/MDR -Treatment Success Rate * (* All RR/MDR-TB outcome data is reported 12 months later)	60% (600/1 000)	60% (150/250)	63% (135/215)	Target achieved this has been achieved by means of early tracing and tracking of patients who missed their appointments. Proper implementation of DR-TB clinical guidelines	Continuous support, mentoring and supervision of TB clinicians when it comes to DR-TB clinical management.
All DS-TB Client Treatment Success Rate	75% (28 710/38 280)	75% (7 177/9 570)	73.2% (5 898/8 060)	Target not achieved due to ineffective referrals system from the hospital to PHC facilities.	Implement TB clinical governance to address the root causes of TB-related deaths, conduct monthly TB review meetings, and carry out facility-based folder reviews to monitor and improve patient outcomes.
Number of DS-TB treatment start 5 years and older	22 464	5 616	6 220	Target achieved due to strengthening of community TB social mobilization for increased TB case detection and prompt treatment initiation Daily facility TB screening in all the Healthcare facilities	Continue with TB community mobilization and TB screening in the facilities.
Number of DS-TB treatment start under 5 years	769	192	278	Target achieved due to strengthening of community TB social mobilization for increased TB case detection and initiation on treatment Daily facility TB screening in all the Healthcare facilities	Continue with TB community mobilization and TB screening in the facilities
TB Rifampicin resistant/multidrug-resistant treatment start	882	221	151	Target not achieved due to low DR-TB case finding.	Testing of all eligible patients using TB NAAT and follow up culture sputum for those with negative TB NAAT test by September 2025.

Programme 2: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Couple year protection rate	43% (2 056 530/4 782 629)	43% (514 124/1 195 657)	29.2% (374 838/ (1506 807,57/5 156 693)	Target not achieved due to decline in the number of IUCDs inserted. Inadequate capturing of Private Service Providers data on DHIS	Continue marketing of IUCDs during outreach campaigns and insertion in facilities. Expedite registration of data for Private Service Providers (PSPs) by end of September Do data verification
Number of Deliveries in 10-14 years in facility	494	124	89	Target achieved due to teenagers having access to contraceptive methods including Long Acting Reversable Contraceptives (LARC) in health facilities, during Intersectoral youth events, AYFS awareness campaigns in schools, institutions of higher learning and at community level.	Continue to encourage insertion of LARC methods during youth engagement, daily AYFS implementation and events at all levels of care.
Antenatal 1st visits before 20 weeks rate	71% (162 764/229 244)	71% (40 691/57 311)	73% (33 693/46 170)	Target achieved due to routine pregnancy testing for women of childbearing potential at facility and household level ongoing	Continue timeous procurement of adequate pregnancy test strips
Mother postnatal visit within 6 days rate	81% (174 240/215 111)	81% (43 560/53 778)	82% (38 153/46 505)	Target achieved. Health education given at ANC on the importance of Post natal care. Hospital deliveries linkage to Community WBOT where patients are encouraged to visit the clinics within 3-6 days post discharge	Sustain the performance monthly

Programme 2: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Infant 1st PCR test positive at birth rate	0.5% (208/41 164)	0.5% (52/10 291)	0.4% (37/9 307)	Target achieved due to adherence to VTP Guidelines - Early ART initiation on HIV positive women, Viral Load Monitoring in Pregnant women offering PrEP in pregnancy	Continue adherence to VTP Guidelines - Early ART initiation on HIV positive women, Viral Load Monitoring in Pregnant women offering PrEP in pregnancy
Immunisation under 1 year coverage	90% (236 010/262 234)	90% (59 003/65 559)	78.8% (50 886/((204 103,187/258 879)	Target not achieved due to mothers defaulting to bring children for immunization	Advocacy and social mobilisation Reinforce booking system and defaulter tracing Conduct integrated outreach campaigns to reach zero dosed children Strengthen Public and Private Service Providers partnership (Signed SLA) and data verification.
Measles 2nd dose 1 year coverage	92% (241 255/262 234)	92% (60 314/65 559)	76.2% (49 775/((199 646,978 /262 158)	Target not achieved Mothers defaulting to bring children for immunization	Advocacy and social mobilisation Reinforce booking system and defaulter tracing Conduct integrated outreach campaigns to reach zero dosed children Strengthen Public and Private Service Providers partnership (Signed SLA) and data verification.
Child under 5 years diarrhoea case fatality rate	1.7% (119/7 023)	1.7% (30/1 756)	1.7% (22/1 319)	Target achieved due to improved triaging and management of emergencies at PHC. Allocation of IMCI trained clinicians in the Child Health rooms	Quarterly training and mentoring on IMCI Community Component.

Programme 2: MATERNAL, CHILD AND WOMEN'S HEALTH AND NUTRITION (MCWH&N)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Child under 5 years pneumonia case fatality rate	1.4% (162/11 006)	1.4% (41/2 752)	1.02% (49/4 818)	Target achieved due to Improved triaging and management of emergencies at PHC Allocation of IMCI trained clinicians in the Child Health rooms	Quarterly training and mentoring on IMCI Community Component.
Child under 5 years Severe acute malnutrition case fatality rate	6.4% (129/1 985)	6.4% (32/496)	6.3% (24/379)	SAM treatment protocol implemented	Daily nutritional classification of all new children in hospital and presenting at PHC facilities
Cervical cancer screening coverage	40% (244 070/610 175)	40% (61 018/152 544)	26.1% (40 022/613 945)	Target not achieved. Underreporting at hospital level due to lack of data collection tools. Inadequate marketing of the service and Unavailability of vaginal speculum for screening.	Finalise and procure data reporting tools. Support hospitals in reporting and ensure that Pinkdrive stats are reported on DHIS. Continue marketing of the service in all health facilities and outreach events. Provider initiated HPV testing implemented from 1 July 2025 in additional 3 Metro Health Districts. Inservice training on the 90-70-90 Cancer elimination strategy and proper LBC specimen collection to be conducted for clinicians working in health facilities including other streams during supervisory support visits
School Grade 1 learners screened	73 000	Annual target	34 522	Dedicated ISHP teams focused on daily health screening of targeted grades	ISHP Teams to continue focusing on targeted grades
School Grade 8 learners screened	48 000	Annual target	27 355	Dedicated ISHP teams focused on daily health screening of targeted grades	ISHP Teams to continue focusing on targeted grades

Programme 2: DISEASE PREVENTION AND CONTROL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Malaria case fatality rate	1% (12/1 281)	1% (3/320)	0.9% (2/220)	Target achieved due to the ongoing malaria case management training conducted among clinicians.	Continue with regular Monthly Quality assurance & In-service Trainings for clinicians during support visits. Community Engagement awareness through TISH & Corner to Corner campaigns
Normal Haemoglobin A1c (HbA1c) test with result ≤ 8% rate	65% (246 780/376 928)	65% (61 695/94 232)	65% (73 306/112 170)	Target achieved due to Implementation of the Adult Primary Care (APC) 2023 Guidelines which advocates for regular monitoring of Diabetic patients using the HBA1C Test every 3 to 6 months.	Implement the NDoH Point of Care contract and advocate to HBA1C Point of care to boos uptake of the HBA1C tests by clinicians by Quarter 2 Continue monthly in-service training and education sessions for clinicians and patients. Conduct monthly facility support visits to oversee data management, optimize resources, engage with the community/clinicians, integrate technology, and ensure patient-centred care.
PHC mental disorders treatment rate new	0.1% (144 138/14 413 803)	0.1% (36 034/3 603 450)	0.1% (6 857/4 666 973)	Target achieved due to ongoing screening and treatment of first-time mental health patients.	Ongoing communication efforts will continue to focus on strengthening knowledge on identification and treatment of mental health patients.

Programme 3: EMERGENCY MEDICAL SERVICES

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
EMS P1 urban interfacility transfer (IFT) under 30 minutes rate	55% (1 000/1 812)	55% (250/453)	38% (397/1049)	Target not achieved due to service delivery protests which delayed response times. Infrastructure, Human Resource and footprint limitations in Districts to optimize service delivery.	Engagement with Community Leaders, Ward Councillors, SAPS, Community Policing Forums (CPF's) on impact of service delivery protests. Expand footprint of EMS services. Engagement with respective Clinical Management and CEO's on ambulance turnaround times.
EMS P1 urban inter-facility transfer (IFT) under 60 minutes rate	65% (196/300)	65% (49/75)	83% (5/6)	Target achieved due to Improvement on Internal challenges at Hospitals on turnaround times for ambulances.	Expand footprint of GSET in high call volume areas. Engagement with respective Clinical Management and CEO's on ambulance turnaround times. Recruitment of additional clinical human resource.

Programme 4: REGIONAL HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (9/9)	Conducted in Q2-annual	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal Hospital status obtained rate	88.9% (8/9)	Annual target	0% (0/9)	No facility was scheduled for Q1 self-assessment due to system review.	Annual facility self-assessment schedule will be finalised and implemented as informed by the expected system resumption on 14 July 2025.
Severity assessment code (SAC) 1 incident reported within 24 hours rate	94% (880/936)	94% (220/234)	97.4% (229/235)	Target achieved. SAC 1 cases were reported on time, due to prompt completion and submission of section A notification forms to the managers on call before the end of the shift/working day.	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms to the supervisor/manager immediately when PSI occurs before the end of shift/ working day.
Patient Safety Incident (PSI) case closure rate	87% (1 712/1 968)	87% (428/492)	91.8% (546/595)	Target achieved due to facilities conducting scheduled PSI meetings to discuss PSIs for redress and closure.	Encourage and motivate managers to resume investigations as soon as the PSIs are reported. Encourage PSI committee to convene meetings as scheduled, adding Adhoc meeting to facilitate closure of all PSIs within the reporting quarter.
Complaint resolution within 25 working days rate	97% (636/656)	96.9% (159/164)	97.3% (143/147)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of beds in regional hospitals offering acute ill mental health care users (72hrs assessment)	6% (256/ 4 566)	Annual target	6.2 (275/4 451)	Most hospitals have adequate acute ill mental health beds except for Tambo Memorial and Thelle Mogoerane hospital.	Request for additional resources to extend the number of mental health beds is in progress.
Percentage of hospitals with functional hospital boards	100% (9/9)	100% (9/9)	33.3% (3/9)	Target not achieved due to the board not meeting quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid

Programme 4: SPECIALIZED HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (6/6)	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal Hospital status obtained rate	56% (5/9)	Annual target	0% (0/90	No facility was scheduled for Q1 self-assessment due to system review.	Annual facility self-assessment schedule will be finalised and implemented as informed by the expected system resumption on 14 July 2025.
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	85% (68/80)	85% (17/20)	100% (15/15)	Target achieved. All Specialised Facilities ensured prompt reporting by competing and submitting section A Notification forms to the immediate supervisor immediately before the end of working day/ shift.	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms to the supervisor/manager immediately when PSI occurs before the end of shift/ working day.
Patient Safety Incident (PSI) case closure rate	95% (380/400)	95% (95/100)	96.2% (150/156)	Target achieved. PSIs were discussed in the scheduled and/or Adhoc meetings to facilitate closure within the reporting quarter.	Encourage and motivate managers to resume investigations immediately after the PSIs are reported. Encourage PSI committee to convene meetings as scheduled, adding Adhoc meeting to facilitate closure of all PSIs within the reporting quarter.

Programme 4: SPECIALIZED HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Complaint resolution within 25 working days rate	96% (88/92)	96% (22/23)	100% (17/17)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (6/6)	100% (6/6)	66.7% (4/6)	Target not achieved due to the board not meeting quorum or not honour invitation as a result the meeting was not held. Board members were despondent due to non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEOs must ensure that the board stipend is duly paid.

Programme 5: CENTRAL HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (4/4)	Conducted in Q2-annual	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal Hospital status obtained rate	75% (3/4)	Annual target	0% (0/4)	No facility was scheduled for Q1 self-assessment due to system review.	Annual facility self-assessment schedule will be finalised and implemented as informed by the expected system resumption on 14 July 2025.
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	98% (392/400)	98% (98/100)	99.5% (205/206)	Target achieved due to continuous monitoring and meetings conducted to discuss SAC 1 PSIs and prompt completion and submission of section A notification forms to the manager.	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms, email or WhatsApp reporting to the supervisor/manager immediately before the end of shift/ working day.

Programme 5: CENTRAL HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patient Safety Incident (PSI) case closure rate	95% (628/660)	95% (157/165)	89.9% (657/731)	Target not achieved due to CMJAH and SBAH cases still awaiting PSI investigation still to be discussed in PSI meetings and to conduct redress to close while observing the 60 days of closure.	Enforce managers to start investigation immediately after PSIs are reported. Instruct PSI committee to convene meetings as scheduled, adding Adhoc meeting to facilitate closure of all PSIs within the reporting quarter.
Complaints resolution within 25 working days rate	95% (220/232)	95% (55/58)	97% (212/219)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (4/4)	100% (4/4)	0% (0/4)	Target not achieved due to the board not meeting quorum or not honouring the invitation as a result the meeting was not held. Board members were despondent due to non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEOs must ensure that the board stipend is duly paid.

Programme 5: CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (1/1)	Conducted annually in Q2	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal Hospital status obtained rate	100% (1/1)	Annual target	0% (0/1)	Facility was not scheduled for Q1 self-assessment.	Annual facility self-assessment schedule will be finalised and adhered to by the facility.
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	98% (1 144/1 168)	98% (286/292)	100% (149/149)	Target achieved due to continuous monitoring and meetings conducted to discuss SAC 1 PSIs and prompt completion and submission of section A notification forms to the manager	Encourage and support continuous monitoring of reporting and capturing of SAC 1 PSIs.
Patient Safety Incident (PSI) case closure rate	95% (208/220)	95% (52/55)	97.5% (312/320)	Target achieved due to continuous monitoring and meetings conducted to discuss SAC 1 PSIs and prompt completion and submission of section A notification forms to the manager	Encourage starting of investigation as soon as PSIs are reported. Encourage PSI committee to convene meetings as scheduled and additional Adhoc meeting to close all PSIs within the reporting quarter. Encourage managing PSI according to PSI National guideline.
Complaints resolution within 25 working days rate	95% (220/232)	95% (55/58)	96% (76/79)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (1/1)	100% (1/1)	0% (0/1)	Target not achieved due to the board not meeting quorum or not honour the invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEOs must ensure that the board stipend is duly paid.

Programme 5: CHARLOTTE MAXEKE ACADEMIC HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care satisfaction rate	100% (1/1)	Conducted annually in Q2	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal hospital status obtained rate	100% (1/1)	Annual target	0% (0/1)	Facility was not scheduled for Q1 self-assessment.	Annual facility self-assessment schedule will be finalised and adhered to by the facility.
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	95% (76/80)	95% (19/20)	100% (12/12)	Target achieved. All SAC 1 incident reported on time due to sending WhatsApp message and completing SAC1 Notification forms for submission to the immediate managers before the end of shift/working day.	Encourage and support continuous monitoring of reporting and capturing of SAC 1 PSIs monthly.
Patient Safety Incident (PSI) case closure rate	93% (396/416)	93% (99/104)	67.2% (78/116)	Target not achieved due to PSIs that are still open are complex, to be investigated and presented in PSI committee meeting while observing the 60 days closure rate.	Enforce managers to start investigation immediately after PSIs are reported. Instruct PSI committee to convene meetings as scheduled and adding Adhoc meeting to close all PSIs within the reporting quarter.
Complaints resolution within 25 working days rate	95.4% (84/88)	95.4% (21/22)	92% (33/36)	Target not achieved due to unavailability of complainant for redress meeting.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (1/1)	100% (1/1)	0% (0/1)	Target not achieved due to the board not meeting quorum or not honouring the invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that the board stipend is duly paid

Programme 5: STEVE BIKO ACADEMIC HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (1/1)	Conducted annually in Q2	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	95% (76/80)	95% (19/20)	96.5% (28/29)	Target achieved, due to sending of emails immediately to immediate managers before the end of shift.	Encourage and support continuous monitoring of reporting and capturing of SAC 1 PSIs.
Patient Safety Incident (PSI) case closure rate	85% (204/240)	85% (51/60)	80.8% (110/136)	Target not achieved. Due to PSIs that are still open are complex, to be investigated and presented in PSI committee meeting while observing the 60 days closure rate.	Enforce managers to start investigation immediately after PSIs are reported. Instruct PSI committee to convene meetings as scheduled and adding Adhoc meeting to close all PSIs within the reporting quarter.
Complaints resolution within 25 working days rate	95% (84/88)	95% (21/22)	96% (25/26)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (1/1)	100% (1/1)	0% (0/1)	Target not achieved due to the board did not meet quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid

PROGRAMME 5: DR GEORGE MUKHARI ACADEMIC HOSPITAL

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (1/1)	Conducted annually in Q2	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	96.4% (108/112)	96.4% (27/28)	100% (16/16)	Target achieved by ensuring SAC1 PSI reporting on Section A notification form to the immediate supervisor/manager before the end of shift/working day.	Encourage and support continuous monitoring of reporting and capturing of SAC 1 PSIs.
Patient Safety Incident (PSI) case closure rate	99.3% (604/608)	99.3% (151/152)	98.7% (157/159)	Target not achieved due to delays in initiating investigations once PSIs were reported, inconsistent scheduling of PSI committee meetings.	Encourage starting of investigation as soon as PSIs are reported. Encourage PSI committee to convene meetings as scheduled and additional Adhoc meeting to close all PSIs within the reporting quarter. Encourage managing PSI according to PSI National guideline.
Complaints resolution within 25 working days rate	98% (164/168)	98% (41/42)	100% (78/78)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days.	Investigative reports submitted timeously, and redress meetings held. Continue in service training of managers and maintain good practice.
Percentage of hospitals with functional hospital boards	100% (1/1)	100% (1/1)	0% (0/1)	Target not achieved due to the board did not meet quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid

PROGRAMME 5: TERTIARY HOSPITALS

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Patients experience of care survey rate	100% (3/3)	Conducted annually in Q2	Conducted in Q2- annual	Conducted in Q2- annual	Conducted in Q2- annual
Ideal Hospital status obtained rate	66.7% (2/3)	Annual target	0% (0/3)	No facility was scheduled for Q1 self-assessment due to system review.	Annual facility self-assessment schedule will be finalised and implemented as informed by the expected system resumption on 14 July 2025.
Severity assessment code (SAC) 1 incident reported within 24 hours' rate	80% (800/1 000)	80% (200/250)	95.7% (67/70)	Target achieved due to Section A Notification forms are completed and submitted to the immediate manager/supervisor before the end of day/shift and utilising WhatsApp reporting to reach all managers all at once followed by submission of section A notification forms	Encourage prompt completion and submission of SAC 1 PSI on Section A notification forms to the supervisor/manager immediately when PSI occurs before the end of shift/ working day.
Patient Safety Incident (PSI) case closure rate	85% (980/1 148)	85% (245/287)	66.5% (155/233)	Target not achieved due to Ward managers not submitting investigation reports to QA on time for discussion in PSI meetings to facilitate closure of PSIs. In Tembisa, the fire damaged the complained office, and there were delays in commencement of investigating of complaint by the units.	Enforce managers to start investigations immediately after PSIs are reported. Conduct supervisory support visits for less performing facilities. Instruct PSI committee to convene meetings as scheduled, adding Adhoc meeting to facilitate closure of all PSIs within the reporting quarter. Encourage managing PSI according to PSI National guideline.
Complaints resolution within 25 working days rate	95% (380/400)	95% (95/100)	97% (37/38)	Target achieved. Complaints were investigated and resolved. The complainants were called and redressed within 25 working days	To continue with trend of investigation and redressing within the said time (kept to time frame)
Percentage of hospitals with functional hospital boards	100% (3/3)	100% (3/3)	0% (0/1)	Target not achieved due to the board did not meet quorum or did not honour invitation as a result the meeting was not held. Board members were despondent due non-payment of their stipend.	Board members to be encouraged to claim stipend on monthly basis. The CEO's must ensure that board stipend is duly paid

PROGRAMME 6: HEALTH SCIENCES AND TRAINING (HST)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Employee satisfaction rate	63% (5 909/9 380)	Annual target	N/A	Revision of the tool.	Commence survey by 15 September 2025
Number of nursing students enrolled	800	Annual target	1 917	The target is exceeded due to the following reasons: • The college had two classes of level 3 until 31 May 2025, which was the last intake of June 2022. This occurred due to the regulatory body's decision to institution to have an intake in January only, while there was already a June intake which resulted in two groups running concurrently since 2022, resulting in additional R171 students, including repeats. • The approved number of diploma in nursing (R171) students is 550 per intake, which equals to 1650 students in all three levels and 200 advanced diploma in midwifery students resulting in 1850 enrolment.	• One of the level 3 classes that commenced in June 2022 completed in May 2025, however, the repeat students will continue to increase the number until teach out period in 2027, depending on the number of students that will complete the programme on record time. • The 800 reflecting on the annual target refers to an intake and not enrolment. • The target to be corrected in the next 2025/26 – 2028/29 strategic plan to reflect 1850 as a target.
Number of emergency medical care students enrolled	90	Annual target	117	Target achieved. The number of students enrolled in the EMC programs increased due to the inclusion of students who were academically excluded but applied for academic appeal through SMU, a partner institution in offering EMC programs.	The target has met as the number of students enrolled has surpassed the annual target.
Number of bursaries awarded to internal employees	460	Annual target	251	The 251 bursaries awarded to officials continuing with their studies (maintenance).	None

PROGRAMME 7: HEALTH CARE SUPPORT SERVICES (HCSS)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Percentage vital medicine availability at health facilities	96%	96%	95%	Target not achieved District (Regional) Pharmacies have mostly been reporting well below 95%, due to items appearing on their formularies still, but actually phased out with the latest ARV regimen changes.	The formularies for regional pharmacies will be “cleaned out” in Quarter 2 of 2025.
Percentage essential medicine availability at health facilities	96%	96%	97%	Target achieved. Sufficient essential medicines were procured during the first quarter.	N/A
Number of patients enrolled on centralised chronic medicine dispensing and distribution programme (Cumulative)	1 700 000	425 000	1 542 067	Target achieved as 1 542 067 clients were enrolled on CCMDD.	N/A

PROGRAMME 8 :HEALTH FACILITIES MANAGEMENT (HFM)

Output Indicator	Annual Target	Q1 Target	Q1 Actual Achievement	Reason for Deviation	Mitigating measure (with timeframe)
Number of capital infrastructure projects completed in health facilities	7	Annual target	0	Still on track. The first quarter was used to finalised contractor appointments and commencement of work in various facilities. These projects will be completed in the second quarter of 2025/26 F/Y.	None
Number of new Primary Health Care Centres completed	1	Annual target	0	Still on track. The current contractor appointed to complete the Randfontein CHC struggled with cash flows and this led to numerous delays on the project. We have been engaging the GDID to submit a turnaround strategy including terminating the current contractor.	None

THANK YOU