(Cover Page)

<Name and Address of the Hospital>

Title: **Annual Analytical Report**

<**Year covered by the report**>

<Written by>

(e.g. CEO, Hospital Director etc… but not personal name)

<**Name of Hospital**>

<Date of final writing>

Foreword

This is optional. It may be written by a person other than directly involved in the writing of part or whole of the report e.g. The Chairman of the Board of Governors. In some cases it may be drafted for his / her signature. It gives the personal opinion of that person on the report and issues addressed or raised in the report.

One page is enough.

Table of contents

After marking the headings and subheadings that should appear in the content using the "header function" of the computer, click on this page and run *"Insert / Reference/Index and Tables/Table of contents"* from the computer menu in the word programme. This must be done after already inserting page numbers.

Important Indicators and Definitions

1. **Inpatient Day / Nursing Day / Bed days** = days spent by patients admitted to the health facility wards.
2. **Average Length of stay (ALOS)**
   = Sum of days spent by all patients/number of patients
   = Average length of days each in-patient during each admission. The actual individual days vary.
3. **Bed Occupancy Rate expressed as %**
   = used bed days/available bed days
   = Sum of days spent by all patients/365 x No. of beds
   =ALOS x No. of patients/365 x No. of Beds
4. **Throughput**
   =Average number of patients utilising one bed in a year
   =Number of patients/no. of beds
5. **Turn over interval**
   =Number of days between patients
   = (365 x no. of beds)-Occupied bed days/no. of patients
6. **FSB (Fresh Still Birth)**: This is a baby born with the skin not pealing / not mercerated. The foetal death is thought to have occurred within the 24 hrs before delivery. However it is important for us to know the trend of deaths of foetuses actually occurring in mothers who have arrived already in the hospital (Foetal heart sound heard on arrival). For this purpose we shall monitor FSB in total as well as FSB of fetuses who died in hospital. They have been separated in the table. The hospital should try to provide space to collect this information from the maternity ward / delivery room.
7. ***Post C/S Infection Rate***:
   = (No. mothers with C/S wounds infected / Total No. of mother who had C/S operations in the hospital) x 100.
   = The rate if caesarean section wounds getting infected. It is an indicator of the quality of post-op wound care as well as pre-op preparations.
8. ***Recovery Rate***:
   = % of patients admitted who are discharged while classified as "Recovered" on the discharge form or register.
   = (No. of patients discharged as "Recovered" / Total patients who passed through the hospital) x 100
9. ***Maternal Mortality Rate*** (for the hospital):
   = Rate of mothers admitted for delivery and die due to causes related to the delivery
   = (Total deaths of mothers related to delivery / Total number of live deliveries) x 100
10. ***SUO*** = Standard Unit of Output. This is where all outputs are expressed into a given equivalent so that there is a standard for measurement of the hospital output. It combines Outpatients, Inpatients, Immunisations, deliveries, etc which have different weights in terms of cost to produce each of the individual categories. They are then expressed into one equivalent. As the formula is improved in future it may be possible to include Out-patients equivalence of other activities that may not clearly fall in any of the currently included output categories.
11. SUO_{op} = SUO calculated with inpatients, immunizations, deliveries, antenatal attendance, and outpatients all expressed into their outpatient equivalents. In other words, what would be the equivalent in terms of managing one outpatient when you manage e.g. one inpatient from admission to discharge? Please see the detail formular below or at the foot of table 9.
12. TB case notification rate = total cases of TB notified compared with the expected number for the population in one year =Total cases of TB Notified / Total population x 0.003.
13. OPD Utilisation = Total OPD New attendance in the year / Total population of the area.

1. Executive Summary

The chapter could be structured according to the chapters of the main report.
Summarize in a general way:

- Description of Hospital and its environment
- Achievements or improvements that have been made in the year reported on in the different departments or service areas in comparison to the plan.
- Problems and developments encountered and the
- Factors that have influenced the achievements or problems and developments.
- The extent to which the priorities set the year before have been carried on.
- The year under review can be placed in a wider context by presenting a table that shows development of some important hospital figures over the last 3-5 years.
- Important recommendations/plans for the coming year.

2. Introduction

The section on introduction may include the following:

- The period covered by the report.
- Sources of data and how they have been analyzed;
- Key types of information the report tries to bring out e.g. what the trends mean and prediction of future trends,
- Method of assessment of compliance with faithfulness to the mission in terms of accessibility, equity, quality, efficiency etc;
- Any problems / limitations, if any, that have been experienced in writing the report that may affect the information derivable from the report; etc.
- Request for feedback or comments from readers / reviewers;

3. The Hospital and its environment

Information about the hospital and important aspects within its environment are introduced to the reader. These include:

- History of the hospital:
    - Year of foundation,
    - Current ownership and any Major changes in ownership and management over the past years,
    - Type of hospital (providing specialized services or general hospital or is heading a Health Sub-district),
    - Major changes in facilities over time.

- Geographical location – district, county, Sub-County and Parish.
    - A map is advisable that shows also other health facilities in the area and their distance to the hospital and ownership. (Preferably placed in annex but referred to in the report)
    - The location of the district headquarters, main townships (Also show on the map)

- Communication facilities (roads, public transport, telephone, radio and others. The climate, water and other natural resources).
- Mention and describe if there are important geographic or physical barriers to service provision or utilization, if there have been heavy rains or drought and their effects on food production, transport and other effects.

- Also could include changes in socio-economic environment e.g. conflict within and around the area served, major disasters like floods, land slides, storms (which may have destroyed settlement and property and caused displacement), major immigration or exodus (influx of refugees / IDPs) from other areas of conflict that may have effect on service provision and utilization and budget.
- It can also include other partners (new or old) providing similar or complementary services in the area or close to the area (if this has effect on the hospital). The work or behaviours of some of these partners or stakeholders may have some influence on the performance of the hospital or on utilization positively or negatively e.g. the erecting of a new radio station that was not there in the last FY and this may be promoting or decampaining immunization.

- Recommendations, actions/Plans for the next year for the hospital and environment

4. The community and health status

Here indicate the socio-economic characteristics of the community:
- Ethnic group(s) in the area served by the hospital,
- Social organization,
- Languages and whether these pose any barrier to provision and utilization of services
- Any unique cultural practices that may affect health and health service delivery.
- Economic activity: main food and cash crops, industries, trade, cost of living, income distribution.
- Demographic characteristics: Population total and broken down (could also be put in the Preventive and promotive chapter).

Table 1: Demographic data for the catchment area compared to HSD, District and Uganda

	Catchment Area	**HSD**	**District**	**Uganda**
Total Population *(Projected for the year under report)*				
Total Assisted Deliveries in Health Facilities				
Tot. Assisted Deliveries as % of expected deliveries				
Children <1 year (4.3%)				
Children < 5 years (20.2%)				
Women in Child-bearing age (20.2)				
Children under 15 years (46%)				
Orphans (≈ 10%)				

Comment on what these data portray to you and the hospital

Health status and related indicators (IMR, Under 5 MR, MMR, percentage of supervised deliveries, Total government and NGO OPD utilization per year per person, Fully immunized < 1 year etc.)

Table 2: Health Status indicators for the HSD compared to the District and the National figures

	HSD[1]	District[2]	Country[3]
Total Population			
IMR			
Under 5 MR			
MMR			
Rate of Stunting			
HIV Prevalence (UHSBS result)			
% Supervised deliveries			
Total Govt. & PNFP Utilisation (new cases) per year = *Total New Attendants / Total Population*			
% Children < 1 yr fully immunized			

NB: [1,2], and [3] *Please provide the source of data or information. They may be obtained from District population and statistics offices, District Planners- esp. the District Development Plan, District Health Offices, UBOS, Census reports, Human Development Reports for the Country, Poverty Reports etc*

Comment on what these figures mean or portray to you / the hospital

Mortality and Morbidity

- Major (top 10) causes of morbidity and mortality in the area (draw a table giving the relative %s for the last 3-5 years)
- Situation of notifiable diseases, Epidemics and responses taken.
- Nutritional status and causes of malnutrition and
- Other factors influencing health generally.
- Any changes in the health status overtime.

For the data here compare with the national figures. Use national figures if no local figures available.

HMIS form 109 (Health unit population report) may be placed in the annexes and referenced in this section.

For all data please quote source of the data (these should appear in a list of references).

- This section on community health may also include an analysis of the distribution of some key health conditions in your catchments area or HSD. If possible it may be graphically shown on a map in the annex and referred to.

- It can also reflect issues of reproductive health including where the majority of your caesarean section cases come from and attempt to analyse the reasons and possible solutions needed or already in place.

- Recommendation, actions/Plans for the next year for the community and health status

5. Health Policy and District health services

Health Policy

- Mention of the National Health Policy and Health Sector Strategic plan as a guiding framework for delivery of health services.
- Reference should be made also to other policies, reports, guidelines, studies etc (either disease specific or of other sectors) if they influenced the planning for and provision of services in the period under review / report e.g. the PEAP, the ART Policy, the HCT policy, the OVC policy, the MDG, the Human Development Report for the country, the poverty analysis / mapping report, etc.
- Briefly discuss how your hospital feeds into or what you see as the role of your hospital in the implementation and achievement of the HSSP, the PEAP and the MDGs.

District Health Services

- Indicate the presence of a district health plan (if any) and how your hospital and other partners participated in the development of the plan.
- Mention your membership of important health fora in the district e.g. District Health Management Team, District disaster management committee, District PNFP Coordination Committee etc.,
- The distribution of responsibilities on healthcare in the district and what role your hospital is expected to play according to the district health plan.
- Health infrastructure to carry out district health services, type and number of health facilities and their main characteristics like: staff numbers and qualification, size of catchment area, utilization (Out Patient, Inpatient and deliveries, immunisation), out reaches.
- Factors influencing the running of health units e.g: funds, staff, logistics, supervision, Functional state of a referral system.
- Health care organizations in which the hospital participates / participated on local or district level.

It is useful here to add data table on health infrastructure distribution (if possible attach a map in the annex) and related data like expected deliveries / maternity centre, general population per health facility, % of people living within one hour travel or 5 Km from a health centre providing a minimum health care package (this may not be available for the HSD but for the district and quote that).

- Comment on how this distribution fits or is affected by the current policy and the Health Sector Strategic plan and local government plan.

Table 3:Distribution of Health Service points by Sub-county

	Total Population	No of Hospitals	No of HC IV	No of HC III	No of HC II	Tot. Immunisation Static Stations
S/C or Division 1						
S/C or Division 2						
S/C or Division 3						

Total for HSD						
Total for the District						

Table 4: Ratio of population to health facilities and to immunization points by subcounty in the HSD

	Total Imm. Outreach Stations	Population per HF	Infants (<1yr) Per Imm. Station[1]
S/C or Division 1			
S/C or Division 2			
S/C or Division 3			

Total for HSD			
Total for the District			

[1]*At least each administrative parish is expected to have at least one immunization station. A parish has on average 6,000 people. Infants in a parish of 6000 are 4.3% = 258. Therefore, a number twice or more of 258 infants per station in especially a rural area(rural parishes are large but sparse in population compared to towns) is likely to indicate a need for either another static or mobile station in that parish. But this must also be done in the context of utilization level and other factors.*

NB: This table may be cut and pasted in the annex. The interpretation must be here with clear reference to the table in annex.

Please reflect on what message this table says about equity of distribution and its probable implications. Make comparison between sub-counties or divisions in your HSD and between your HSD and other HSDs and the district as a whole.

- Percent of the population living within 5 Km of HC offering MHCP *(quote source of information).*
- Is there something that is affecting distribution of health infrastructure that may relate to policy, local government decisions etc?
- Recommendation, actions/Plans for the next year for the health policy and district health services

6. Management

Does the hospital have a Charter that spells the composition, roles and method of work of the Board of Governors and its committees, the HMT and Core management team and does it have the modus operandi for the various Congregations working there?

The Board of governors, Diocesan Health Advisory board:

- Existence of the board and members (Profiles of members to be in annex)
- Representation of the local community and local authority in the board of governors.
- The roles of the board.
- How they have been functioning - frequency of meetings, policies and priority problems on the agenda.

(A list of the members and the designation should be placed in the annexes section.)

- Other committees of the Board and their functions should also be mentioned.
- Comment on the existence of a Internal Management process auditor and progress of the auditor's work – any benefits observed already?
- The Hospital Management Team and/or core management team:
    - Roles and functions,
    - Frequency of meetings, main issues on the agenda.
- Other committees or sub-committees of management e.g. workers committees, disciplinary etc and their roles, functions and frequency of meetings.
- Comment on the compliance with statutory commitments (with UCMB, Local Government, Ministry of Health etc)
- Links with district and national bodies like ministry of health, UCMB etc. An Organogramme may be placed in the annexes to summarize relations under this section.
- Is there somebody who handles / facilitates issue of intra and interdepartmental communications and communications between the hospital and other partners etc?
- Presence or absence of manuals / guidelines use to direct management of the hospital (Manual of Employment, Financial Manual) and if available, how useful have they been. Has there been a need to update them?
- Recommendation, actions/Plans for the next year for Management

7. Human Resource (Staff)

- Total number of employees compared to the previous 3-5 years.

Is it the desired number as defined by the hospital establishment/Ministry of Health/UCMB? If establishment has been set please provide this in the annex ***(Level and movement of hospital staff filled in the format designed by UCMB must be placed in the annexes; this form shows the mid- calendar year (end of Financial Year) count of staff. It summarises the staffing against establishment, recruitment/inflow, attrition/outflow for each cadre of staff)***

- Vacancies – comment on Understaffing in the various categories of staff if applicable.
- Turnover of staff – total arrivals in the year and departures of key health personnel.
- Manpower planning in the hospital, the community as a source of staff.
- Actual working hours per week for Nurses, doctors, allied health professionals and support staff.

- Human resource management guidelines utilized (Manual of Employment and other that may be relevant).
- Is there a Human Resource Officer?
- Is there a Human Resource Development Plan?
- Briefly mention what basis or method has been used to fix the hospital establishment
- Facilities and incentives for staff e.g. salaries levels, housing, social activities, bonuses (free water, electricity etc.), mechanism for expression of grievances (staff meetings/workers committee), opportunities for career development (upgrading, training, refresher courses, promotion to a higher salary etc.), the payment of NSSF, any other practices providing incentive that might be new, unique and innovative.
- Temporary exchange of employees with other healthcare institutions, engagement of staff in activities outside the hospital, including private practice, regulations for this engagement.

- Recommendation, actions/Plans for the next year for staff

8. Finances

- Briefly describe the type of accounting procedures and system followed.
- Provide income and expenditure report classified as follows according to the standard provided by UCMB:
  - Income (User fees collection, PHC conditional grant hospital, PHC conditional grant School, PHC Conditional Grant HSD, External donation of goods and services, training school fees, Amount of Credit Line utilized, Other income). Note that goods and services provided in kind must be costed.
  - Expenditure (Employment cost, Hospital Board Costs, Administration Property cost, Transport and plant costs, Supplies and services, Medical goods and services (distinguish "Credit Line" on separate row), Primary Healthcare, Capital Development, Training School).
  - The Income and Expenditures should be compared with the budget and deviations calculated under each item line
  - Provide comments on the deviations for each item line of income and expenditure. Also explain any budgetary adjustments that may have been made.
  - Provide Pie charts to show sources of income and expenditure items for the year under report.
- Compare the years report with the last 3-5 years and comment on the trends. This is to be in the form of table and line graph for both income and expenditure separately.

Table 5: Trend of Income by source over the last 5 years (200… to 200…)

	Income over the Last 5 Years				
	Year 1	Year 2	Year 3	Year 4	Year 5 (year under report)
User Fees					
PHC CG (Hosp)					
PHC CG					
Donations in cash					
Donation of goods in Kind					
Donation of Services					
Others (State)					
(e.g. Credit line procurements)					
Total Income					

- Draw in Excel a line graph of all the income sources and the total over the last five years. Copy and paste it here.
- Calculate Total User fee / SUO and plot a line graph to show trend for the last 5 years.

Table 6: Trend of Expenditure over the last 5 years (200…. to 200….)

	Income over the Last 5 Years				
Expenditure Line	Year 1	Year 2	Year 3	Year 4	Year 5 (year under report)
Human Resource cost					
Drugs					
Medical goods and medical supplies					
Non-medical goods / supplies					
E.g. Credit line procurements					
……					
……					

Total Expenditure					

- Draw in Excel a line graph of all the expenditure lines and the total over the last five years. Copy and paste it here (below the table).
- Calculate the total Expenditure / SUO and plot the trend for the last 5 years.
- Comment on what the income and expenditure trends as well as efficiency trends suggest. Are there indications of areas that need to be addressed either immediately by corrective measures or proactive measures?

- In the annexes include the regular financial report table presented to UCMB.
- Was there any surplus or deficit? If so, what explains the surplus or deficit?
- Have there been any efforts made towards cost containment, internal budgeting and involvement of departmental heads.
- Can resources be shifted to priority activities even after budget approval?

- Have there been any efforts to increase income?
- Which groups are less able to afford hospital charges?
- Give average levels of user fees broken for the following services: It is preferable to use cost-centres if this is possible.

Table 7: Trend of Average user fees by department in the last 5 years (200….to 200…..)

	Average Fees				
	Year 1	Year 2	Year 3	Year 4	Year 5
OPD Adult Male					
OPD Adult Female					
OPD Children < 5yrs					
OPD Children 5-13 yrs					
IP Male					
IPFemale					
IP Maternity					
IP Paediatric < 5 yrs					
IP Paediatric 5-3 yrs					
IP Surgical Ward					
IP Medical Ward					

- From the data in the table above and the earlier trend of user fee / SUO, is there evidence of services becoming more equitable i.e more affordable for the less privileged e.g. children and women? Give reasons for your answer.
- How does this trend of user fees relate to cost recovery from the patients (this will also relate a bit to the sustainability discussion below)? In other words, of the total recurrent expenditures that eventually enabled the hospital to provide services to the patients, how much does the hospital get back from the patients?

Table 8: Cost Recovery Trend in the period 200… to 200…

	Yr1	**Yr2**	**Yr3**	**Yr4**	**Yr5**
Total User fees *(a)*					
Total Recurrent Expenditure *(b)*					
Cost Recovery Rate = *(a/b)x100*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

- If Cost-recovery is low or is dropping and fee/SUO is dropping, how have you been able to meet the costs?
- Do you have a mechanism for regular monitoring of user fees and their effects? If yes, describe it briefly.
- Has there been impact of any new fees structures on utilization – give concrete example(s).
- If you are using cost-centred accounting pleases provide cost indicators for the following: Cost per bed per year, Cost per Inpatient day, Cost Per inpatient contact, and Cost per OPD activity Unit.(provide this in a table for the last 5 years or the years for which you have been able to do this) and comment on the trend .

Table 9: Trend of indicators of efficiency in use of financial resources

	Year 1	Year 2	Year 3	Year 4
Cost per bed				
Cost per inpatient /day				
Cost/SUO_{op}				

(NB: Total SUO_{op} = Total OP + 15*IP + 5*Deliveries + 0.5*Total ANC + 0.2*Total Immunisation) Source: UCMB

- Compare these costs with the costs of the previous 3-5 years**.** Following these cost means hospital has to work towards creating cost centers that will enable them to compute the costs.
- Other financial information: Reserves and investments, can be shown in the balance sheet that needs to be in the section of annexes
- What is the possibility of sustaining the current level of services (i) in the absence of PHC CG and donor funding and (ii) in the absence of donor funds but if PHC CG continues at the current level? *(NB: This is the extent to which the hospital is able to meet recurrent expenditures from locally raised revenues- user fees plus any other local sources of income)*
- Plot a trend of sustainability ratio:

Table 10: Trend of sustainability ratio of the hospital in absence of both donors and PHC CG funding in the last 5 years
(Local Revenue being only user fees and other locally raised funds e.g. IGA, excluding government funds)

	Yr1	Yr2	Yr3	Yr4	Yr5
Total Local Revenues (a)					
Total Recurrent Expenditures (b)					
Sustainability Ratio = (a/b)x100	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Table 11: Trend of sustainability ratio of the hospital in absence of donor funding but with PHC CG in the last 5 years
(Local Revenues refers to "in-country funding" and therefore includes user fees, PHC CG, Local Govt contributions, IGAs, etc)

	Yr1	Yr2	Yr3	Yr4	Yr5
Total Local Revenues (c)					
Total Recurrent Expenditures (d)					
Sustainability Ratio = (c/d)x100	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

- What do you conclude from this trend?
- What factors are influencing the two scenarios of sustainability?

<u>Audit</u>

- Did the hospital have external audit? If so, what were the key observations and recommendations? Were previous audit recommendations complied with?

- Recommendation, actions/Plans for the next year on finance and financial management

9. Activities

This chapter describes the activities of the hospital with regard to care for the patients and health of community. This will be divided in to 3 sections: Curative, Supportive and Preventive services.

Curative:

A. OPD

A brief on the organization and management of OPD services including staffing, working hours. A report on new and re attendances in OPD broken down into Under 5, and above 5 (male and female) in the last 3-5 years. Specialist out-patients services e.g. mental health clinics, ophthalmic clinics, dental clinics are "Out-Patient" services that should be captured as well into the OP data. These are normally also included into the monthly HMIS forms under OP diagnoses. But antenatal clinics are not "specialist clinics". The special clinics will still be described later (see below) only for the purpose of keeping track of their specific outputs.

Table 12: Trend Out-patient Attendance by gender and age group in the period 200.. to 200..

			Yr1	Yr2	Yr3	Yr4	Yr5
FEMALE	New Attendance	0-4 yrs					
		5 yrs and Over					
	Reattendance	0-4 yrs					
		5 yrs and Over					
MALE	New Attendance	0-4 yrs					
		5 yrs and Over					
	Reattendance	0-4 yrs					
		5 yrs and Over					

- From the excel file draw line graphs to show trends over the last 5years or so for:
  - Total OPD attendance
  - OPD attendance by age group
  - OPD attendance by gender disagregation

Definition: A new attendance is an episode of illness in a person and a re-attendance is second, third or more visits due to the same episode of illness. One person may have 2 or more episode of certain diseases e.g. malaria, in a year. Each time the person reports the new episode it is a "new attendance".

- Try to build a record of patients from within your catchment area (*assigned catchment area –HSD*) and of patients from outside your catchment area. Then try to plot the actual catchment area – the area from which most (60%) of the patients come.

- Describe the:
    - Seasonal variations in OPD utilization.
    - Factors influencing utilization.
    - Referrals to and from the hospital.
    - Top ten list of OPD diagnoses,

    For the seasonal variation you are advised to plot monthly OPD attendance data for the 12 months in excel file then draw a line graph. You can do it by gender, by age group and for the total. This can be drawn for the last 5 years or for the years for which you have the disaggregation.
- Draw some conclusions from the OPD morbidity pattern about the morbidity in the catchment area.

Specialist OPD Clinics(e.g mental clinic, TB clinic, Eye clinic, HIV/AIDS etc) services excluding Antenatal/Family Planning/MCH activities that will be reported in the preventive section.

- Describe:
    - The types of services provided in the clinic, who (staffing) operate the clinic,
    - Outputs (attendance – disaggregate as for the general OPD although these have been included there already)
    - Organization and management

Quality assurance processes

- Report on:
    - Medical audit,
    - Prescription practices,
    - Patient satisfaction,
    - Waiting times.

B. INPATIENTS WARDS

- Per ward and for total hospital, report the following:

Table 13: Utilization indicators per ward and for the hospital for 200.. – 200..)

Ward: MALE					
	Yr1	Yr2	Yr3	Yr4	Yr5
No. of beds					
Total Admissions discharged					
Bed days					
Ave. length of stay					
BOR					
Throughput					
Turnover interval					
No. Deaths					
Recovery Rate					
Self discharges					

Ward: FEMALE					
	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
No. of beds					
Total Admissions discharged					
Bed days					
Ave. length of stay					
BOR					
Throughput					
Turnover interval					
No. Deaths					
Recovery Rate					
Self discharges					

Ward: PAEDIATRIC					
	Yr1	Yr2	Yr3	Yr4	Yr5
No. of beds					
Total Admissions discharged					
Bed days					
Ave. length of stay					
BOR					
Throughput					
Turnover interval					
No. Deaths					
Recovery Rate					
Self discharges					

Ward: MATERNITY					
	Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
No. of beds					
Total Admissions discharged					
Bed days					
Ave. length of stay					
BOR					
Throughput					
Turnover interval					
No. Deaths					
Recovery Rate					
Self discharges					

Total for the Hospital (All wards)						**Ward: SURGICAL (**If Separate**)**					
	Yr1	Yr2	Yr3	Yr4	Yr5		Yr 1	Yr 2	Yr 3	Yr 4	Yr 5
No. of beds						No. of beds					
Total Admissions discharged						Total Admissions discharged					
Bed days						Bed days					
Ave. length of stay						Ave. length of stay					
BOR						BOR					
Throughput						Throughput					
Turnover interval						Turnover interval					
No. Deaths						No. Deaths					
Recovery Rate						Recovery Rate					
Self discharges						Self-discharges					

- Indicate the top 10 causes of admission and top 5 top causes of deaths,
- Comment on the trends observable in the top 10 diagnoses and how these relate to the morbidity and mortality patterns in the catchment area.
- Also make a tabular / graphic analysis of trend of disease specific case-mortality-rate for the commonest causes of mortality in the last 3-5 years. e.g.

Table 14: Trends of the Mortality rates of the commonest causes of death in the hospital

	MORTALITY RATES (Disease specific deaths / Total number of cases of the disease admitted) x 100				
	2001/2	2002/3	2003/4	2004/5	2005/6
Malaria					
AIDS					
Diarrhoea					
Trauma					
Etc					

- Describe the organization and management of wards:
    - Procedure for admission and discharge.
    - Frequency of ward rounds,
    - Treatment schedules and standing orders,
    - Working shifts for nurses.
    - Number of nurses per bed in each ward and total for hospital.
    - Health care quality control mechanisms e.g.:
    - Medical audits, recording and follow up of patients improved on discharge,

    - Death rates,
    - Self discharge rate,
    - Appropriate prescription practices,
    - Patient satisfaction),
- Containment of hospital infections.
- Visits of specialists. Self care units (waiting wards),
- Hostel for relatives.
- Pastoral care of patients.

Maternity Ward

- In addition to the other general descriptions, for the maternity ward, the following need to be reported:

Admissions:

- Total number of admissions
- Main reasons for admission (compared to previous years). Compare with observed morbidity for in the catchment area.
- Break down of admission cases according to stages of gestation and after delivery:
    - First half of pregnancy
    - Second half of pregnancy
    - For delivery
    - Puerperium
    - Total admissions

Deliveries and Births

Normal deliveries, Abnormal deliveries, Total admitted for delivery. All these compared with the previous years. Number born alive, still births (fresh and macerated separated). It is important to separate FSB whose mothers arrived in the hospital with already no Foetal Heart Sound from those who arrived with FHS still audible. The latter may (but not always) be related of management of the labour in the hospital. Live births to be differentiated in to normal and abnormal (low birth weight, prematures, Congenital malformation). Hospital perinatal and neonatal mortality rate. Number of deliveries Normal and abnormal in relation to the expected number of deliveries in the catchment area.

Table 15: Deliveries and Births indicators

	Yr1	***Yr2***	***Yr3***	***Yr4***	***Yr5***
Total Admitted for delivery					
Normal delivery					
Abnormal delivery (incl C/S)					
No. born alive					
Total Fresh Still Birth (FSB)					
FSB died in hosp. (FHS Heard before del)					
Mercerated Still Birhts (MSB)					
For Live Births					
Full term Normal wt					
Full term Low birth wt					
Premature					
For Caeserean Sections					
Elective C/S					
Emergency C/S					
Total C/S					
C/S as % of Total deliveries					

Table 16: Other Procedures done in labor

	Yr1	Yr2	Yr3	Yr4	Yr5
Induction					
Episiotomy					
Symphysiotomy					
Forceps					
Vacuum Extraction					

- Give the 10 top reasons for Caesarean Sections
- Make interpretation of the data in the two tables above e.g. what do you make of the trend of FSB (total and the ones who die after arrival in hospital), MSB, C/S as % of total deliveries, trend of elective C/S versus emergency C/S, Trend of full term low birth wt, premature deliveries etc?
- If Caesarean Section as % of total delivery is increasing, decreasing or is constant attempt to explain the trend.

NB: For both General Wards and Maternity make a summary interpretation of the trends of the key indicators like the:
Total Admission, ALOS, BOR, Throughput, Recovery and Mortality Rates, Infection Rates, SUO/Staff, and endeavour to find out what could be responsible for the observed trends. Pay attention to the inter-relationship between these indicators (e.g. A high SUO per staff with a high ALOS and a high Infection Rate may sometimes, but not always, mean the work load is now overstraining for the staff and is beginning to cause inefficiency in performance and more staff is needed in that department; it may also mean facilities e.g. wound dressing equipments are few for the patients etc).

- In the event some patients admitted in the maternity are not true maternity cases this should be reported. **A summary table advised.**

- Attempt to analyse where the majority of your caesarean section cases came from in this past year and compare with the past picture mentioned in the description of community health above. Is there a change or consistency? What could be the reason for either situation?

- In addition to the organizational, management and quality aspects mentioned for the wards generally, the following should be noted for the maternity:
- Maternal deaths following admission,
- Reasons for and maternal death audit procedures – give the reasons found and how they were addressed.
- No. of women who attended ANC in the hospital and delivered in the hospital
- Inferences for the catchments population.,
- Maternity admission and discharge procedures and policies,
- Consequences of the hospital policy on deliveries,
- Labor management procedures and guidelines,
- The use of the partogram,
- Policy on caesarean section,
- Rate of caesarean sections.
- Percentage of admissions referred from lower level units.
- Number of mothers admitted for delivery referred from antenatal clinics.

Premature Deliveries (Gestational age above 28 weeks and below 38 weeks)
Describe the procedures for management of premature babies and measures used to ensure warmth and humidity.

C. THEATRE

Major operations. **A summary table advised** listing types and whether emergency or elective, anesthesia used, minor operations. Definitions of elective and emergency. Death related to operative interventions. Comments on trends in the last 3-5 years. Top 20 types and numbers of major operation done, grouped in to elective and Emergency – Alternatively UCMB may suggest a standard list of operation to report on.

Table 17: Trend of surgical activities in the period 200.. to 200..

Surgery					
	Yr1	Yr2	Yr3	Yr4	Yr5
Major operations (incl C/S)					
Emergencies					
Emergency Op as % of total major operations					
Minor operations					

Comment on the trends and what could be influencing them and what this may imply for the future.
You may put a detail list of each type of operation (especially the major ones) in the annex.

Table of ward utilization indicators (Example)

D. Other clinical services

Tuberculosis and leprosy

- Does the hospital use the national TB/Leprosy control programme guidelines?
- What is the hospital policy on admissions and discharge,
- What treatment schedules are used?
- Expected number of patients in the catchment area.
- Detection rate (may give the trend in the last 5 years)
- The implementation of DOTs, follow up activities, extent of drug resistance.
- TB admissions (smear positive and smear negative PTB and extra pulmonary TB) this should be classified as patients previously untreated, relapses, transfers from elsewhere, cured, died, defaulters.
- It is useful to include OPD, Inpatient and Outreach figures as well, to give a sufficient insight in the dynamics of the disease.
- Leprosy control activities can be added with similar classification.

Dentistry
Nature and quantity of services provided, qualified dental staff, percentage of the population in the catchment area making use of the services, prevalence of carries, outreach activities – school health.

Ophthalmology
Nature and quantity of services provided, qualified ophthalmic staff, discussion of the morbidity pattern and spectacles dispensed.

Orthopaedic Services
Nature and quantity of services provided, qualified physiotherapy staff.

ANTIRETROVIRAL THERAPY (If provided)

- Describe when service was started, how it is supported, staffing and its general organization
- Total number of new clients started on ARV by sex and age group in the year and compared to the previous years (2-5), as applicable
- Cumulative number of clients being treated with ARV – compare with cumulative numbers for previous year(s)
- Total number of defaulters in the year by sex and age and compared to previous years (trend)
- Number of ART clients followed up
- Number man-days of follow-up visits to ART clients (NB: If, for example, on one given day 3 people go out the whole day, that is equal to 3 man-days already)
- Comment on any unexpected positive effect has the ART programme had on the hospital?
- Comment on the supply of ART verses demand e.g. any moments of stock-outs and how the hospital and clients coped with it.
- Comment on any other constraints experienced (human resources, infrastructure, data management and reporting, funding)
- Provide data as in table below:

Table 18: Number of PHAs started on ARV in the last ….. years (200… to 200…)

		Yr1	**Yr2**	**Yr3**	**Yr4**	**Yr5**
Eligible for ART						
Male	<5 yrs					
	5-<18 yrs					
	18 and above					
Female	<5 yrs					
	5-<18 yrs					
	18 and above					
TOTAL ELIGIBLE						
Started on ART						
Male	<5 yrs					
	5-<18 yrs					
	18 and above					
Female	<5 yrs					
	5-<18 yrs					
	18 and above					
TOTAL STARTED ON ART						

- Interpret the data in the table as for the HCT above.
- What are the challenges?
- What are the implications of these for future planning?

(This table may also be placed in the annex but adequately referred to in the interpretation.)

- Comment on the follow-up of the patients receiving ARV and their adherence to treatment.

Table 19: Follow-up of AIDS Patients receiving ARV in the hospital the last …. Years (200… to 200…)

		Yr1			Yr2			Yr3			Yr4			Yr5			Total		
		M	F	To t	M	F	Tot	M	F	Tot	M	F	Tot	M	F	Tot	M	F	Tot
No. of new clients started on ART	1-12 yrs																		
	Over 12 yrs																		
Cummulative No. of clients on ARV																			
Number of ART defaulters																			
No. of ART clients followed up																			

PMCTC

- Total new ANC enrolment
- Total ANC mothers counseled
- Total ANC mothers tested for HIV
- Total ANC mothers tested positive for HIV
- Total ANC mothers tested positive for HIV who have accepted the Nevirapine programme
- Total live babies born to mothers on Nevirapine and tested for HIV after 6 months
- Total babies born to mothers on Nevirapine and tested positive for HIV after 6 months

- If these services (PMTCT and VCT) have been provided for more than a year please draw similar trend tables for them as above.
- Comment on the supply of nevirapine

HIV Counselling and Testing / VCT

- Describe the organization of the service and its staffing
- What types of HCTs are provided by the hospital (Routine, VCT, Diagnostic etc)
- Give data for the year under report as in the table below:

Table 20: HIV Counseling and Testing (by gender and age group) and Relationship to Co-trimozaxol Prophylaxis and TB Detection

	No. < %yrs		No. 5 Yr - < 18 yrs		18 Yrs + above	
	Male	Female	Male	Female	Male	Female
No counseled						
No. Tested for HIV						
No. Received Results						
No. tested +ve for HIV (from lab register						
HIV cases with confirmed TB						
HIV cases started on Cotrimoxazol prophylaxis						

Give the trend of the results for the last 5 years (or less if service has lasted fewer than 5 years). This table may be placed in annex due to its size but its analysis done here in the main text. (See table below)

Table 21: Trend of HCT in the last …. Years (200…. to 200…)

		Yr1	**Yr2**	**Yr3**	**Yr4**	**Yr5**
Number Tested						
Male	<5 yrs					
	5-<18 yrs					
	18 and above					
Female	<5 yrs					
	5-<18 yrs					
	18 and above					
TOTAL(Tested)						
Tested +ve for HIV						
Male	<5 yrs					
	5-<18 yrs					
	18 and above					
Female	<5 yrs					
	5-<18 yrs					
	18 and above					
TOTAL (+ve Tests)						
Posivity Rates of HCT						
Male	<5 yrs					
	5-<18 yrs					
	18 and above					
Female	<5 yrs					
	5-<18 yrs					
	18 and above					

- Draw a line graph of number tested and number testing positive (in %).
- Reflect on the volume of counseling done, the positivity rates of the different age groups and gender perspective.
- Reflect on factors influencing the provision and use of the HIV Counselling and Testing (HCT) services and their implications on the hospital e.g. human and financial resources, etc.
- What are the challenges?
- What are the implications for future planning?

Mental Health

- Does the hospital operate mental clinic or mental health care is provided as part of the routine OPD clinic?
- If there a mental health department or separate mental health clinic, describe its organization, output and possible outcome. (Note that the output here would have also been part of the general outpatient attendance)
- Has there been any training of staffs to provide mental health? If so, give numbers by cadres and where training was carried out and level of training (workshop, certificate, diploma etc). What were the main skills acquired through the trainings.

Palliative care

- Describe its organization and output and possible outcome if observed. What are the challenges?

Others Clinical services as may be provided.

- Recommendation, actions/Plans for the next year for curative activities

Supportive Services

Laboratory and blood transfusion

Types (grouped under Parasitology, hematology, Biochemistry, Bacteriology, Serological) and number of examinations compared to the previous years. Percentage of positive findings per type of examination.

Table 22: Trend of Laboratory testing workload in the period 200.. to 200..

	Type of Tests	**Yr1**	**Yr2**	**Yr3**	**Yr4**	**Yr5**
Parasitology						
Haematology						

Biochemistry						
Bacteriology						
Serology						
	Total tests *(Crude)*					
	Total lab staffs doing tests					
	Average tests per Lab staff (crude)					

NB: The rows in the table can be increased for each category of tests as may be necessary

- Give a number of examinations per 100 OPD patients and per 100 Inpatients.
- What conclusion may be drawn about the workload pattern?
- What are the challenges?
- What are the implications for planning for the future?

Blood transfusions

- Units donated
- No. of patients who received transfusion (<5 yrs and 5 yrs and above),
- Main source of blood (blood bank) and mechanism for delivery.
- Comment on availability of blood donors, the number of blood units ordered compared to actual number of units received from the blood bank, distribution of blood groups and Rh factor. Main reasons for blood transfusion.

Pharmacy

- Staffing level / numbers and levels of qualifications
- Pharmaceutical supplies,

- Ordering system,
- Availability of supplies,
- Amount of credit line orders as compared with amount actually supplied / received and amount used.
- Storekeeping,
- Losses and loss reduction / prevention.
- Frequency of stocktaking,
- Conditions of the store,
    - temperature, humidity,
    - burglar proofing.
- Control of expired drugs.
- The work of the drugs committee if any.
- Information/education on drugs to patients.
- Patients compliance to drug treatment.
- List of essential drugs.
- Treatment Schedules,
- Authority for prescription of certain drugs,
- Problems of drug resistance and availability of alternatives.
- Hospital production:
    - Ointments, IV fluids, etc.
- Twenty most used drugs.
- Total expenditure on drugs and % of the 20 most used drugs by the pharmacy.
- Cost of drugs per outpatient contact and per inpatient day.
- Possibilities of economizing on drug expenditure.
- Stock out monitoring:
    - Which drugs are regularly monitored
    - What monitoring tools are used
    - Who does the monitoring
    - What have been the observations and outcome?

X-ray/Imaging

- Staffing numbers and levels of qualification.
- Number of X-rays taken classified as in the table below.

Table 23: X-ray examinations done over the last 4 years (200.. to 200..) in the hospital

	Yr1	Yr2	Yr3	Yr4	Yr5
Spinal Column					
Skull and Mandible					
Abdominal Contrast					
Screening (chest and other)					
Abdominal – Plain					
Pelvis and hip					
Chest					
Shoulder and clavicle					
Upper extremities					
Lower extremities					
Total examination					

- What are the commonest x-rays examinations done and what are the trends for these categories.
- What could be the reason(s) for this pattern?
- What are the challenges?
- What does the pattern of need for and type of x-ray examinations mean for planning for the future?
- As usual trend is better observed and analysed if a line graph is drawn.

Ultrasound and other imaging investigations done.

- Make similar tabulation and analysis as for x-rays.

NB: Recommendations should be given under each subsection for support services as well after considering what the implications are for future planning.

Administration and Medical records

- Staff in administrative positions, hospital director, administrator and accountants, bursars, cashiers, secretaries, personnel officers, foremen, works supervisor, stores officers, logistics officers etc.
- The reporting lines of these administrative staffs.
- Stores and basic accounting procedures, presence of guidelines/manuals for management processes.
- HMIS:
    - Computerisation
    - Reports compiled and distributed
- Medical records: Staffing and qualification, quality assurance for reliability, system of recording, level of computerization, and mechanisms of utilization of the information generated from record to inform management.
- Dissemination mechanisms for information.

Domestic Services

- Catering, cleaning, laundry services, food prices and expenditure on food per inpatient day, comparison with the previous years.
- Facilities for relatives to cook or avail themselves with ready food.
- Animal husbandry, hospital vegetable garden, hospital firewood supply.
- Sanitary facilities: Toilets, water supply sewage system, waste disposal (pit, incinerator etc.).

Ambulance Service

- Presence of ambulance services,
- state of the ambulance,
- Number of ambulance trips,
- Cost of each trip,
- Patients' contribution,
- Area the ambulance actually serves.
- Challenges of operating ambulance services
- Implications for planning
- Other hospital vehicles and their use / control
- Recommendations

Technical services

- Types of services e.g. Water supply, fuel and electricity supply, solar energy, machinery, transport log book, equipment, buildings maintenance.
- Staffing and Facilities in the technical department, degree of support from external organizations, the role of the technical department for other health units.
- Involvement of the technical department in income generation, fraction of resources and time considered useful for hospital excluding external activities.

Other supporting services

For these describe their staffing and organization, output (also plot trend), challenges and implications for planning.

PASTORAL CARE

- Is this service available in the hospital?
- If not what has made it not possible and is there a plan to start it?
- If the service is available when did it start and who provides it?
- Does the hospital have staffs trained in Clinical Pastoral Care of the sick?
- Describe how the CPC is organized
- Has the hospital realized any benefit from this service? If so, please describe.
- Give statistics of patients who have received CPC at the hospital through this organized system in the last five years or for the period the service has been available if less than 5 years.

SOCIAL CARE

The focus of attention on a patient should not simply be the condition from which he or she may be suffering, but all the needs and anxieties which the condition of illness may generate, including the pressures on family and friends. The mark of the professional is the ability to observe and assess what is happening with a patient at any one time and to select the most effective response. These are diverse depending on the type of illness, age and other background of the patient. The conditions may be handled directed at the patient in the hospital or may involve visiting relatives at home. There may sometimes be need to reassure the employer to avoid loss of employment, something that could be causing anxiety on both sides. These are the social aspects of a patients care. They may have profound effects on the response to medical care. Therefore:

- Does the hospital provide social care to patients?
- If so how is this organized?
- Is / are there qualified Social Medical worker(s)?
- Briefly describe the activities that have been carried out and output.
- What is the impression of the progress over the last five years or the time the service has been there?

PATIENTS' SOCIAL WELFARE

Social comfort refers to the social comfort of a person. After providing hospital care (including social care) to a patient, he / she will return home to a long term social comfort or discomfort depending on the individual situation. This may be influenced by economic position of the person or family, culture etc. The person may have inadequate food, housing, clothing and even subsequent health care. The person may have lost job because of uncertainty developed by the employer. Alternative employment may be needed e.g. helping to cope with less income or helping to start IGA etc or the former employer may need reassurance to get him back. Some of these social welfare factors may affect the continued recuperation of a patient or even cause recurrence of illness.

- Does the hospital provide such welfare services?
- If so, does it have trained social workers to handle it?
- How is it organized?
- Is there, for example, a third party involved to handle that?
- Is there some form of cross-referral with some social welfare organization or community based organization that provides some welfare services etc?

Recommendation, actions/Plans for the next year for supportive activities to be given for each type of these services

Prevention and Health Promotion services

- Describe the PHC / Community Health department
    - Staffing
    - Responsibility for HSD and its implementation,
    - Links with other departments of the hospital and or the district).
    - Short brief about the HSD work plan (its development process and what it contains)

The HC II Function of the hospital

Usually for clinical services the hospital has a wide catchment area (HSD or as assigned). But the hospital functions as a HC II for the people closest to it. For this it carries out preventive services like any other HC II. Therefore, describe or provide:

- Attendance to preventive and promotive services at the hospital and in the outreach areas of the hospital (The area where the hospital has a HC II function):
    - Immunizations,
    - Family Planning,
    - Antenatal care,

Table 24: Contribution of the Hospital as a HC II to the prevention and health promotion services of the HSD and District in the period 200.. to 200..

	In the Hospital and its catchment area	In the HSD	In the District	Hosp attendance / output as % of HSD	Hosp. Attendance / output as % of district
Total Immunisation doses					
Total Family Planning attendances					
Total Antenatal clinic attendance					

- Comment on the output of the hospital as a contribution to the HSD and District preventive services.
- School Health Services
- Presence and function of Village health Teams and Village Health Workers / various Community Resource Persons (COPs).
- What are the challenges faced in providing these services in addition to clinical services?
- Are there recommendations for management as well as for HSD and District management and for the communities?
- National Immunization days results. (Compare hospital catchement area with HSD and District as in the above table). – draw similar table containing the different antigens or accompanying items distributed e.g deworming tablets. ITN etc
- Other preventive activities – Health education, primary eye care, school health, environmental health.
- Special health activities like, campaigns, community development efforts in which the hospital plays a role, diseases surveillance,

- Community eye care, community dental care,
- TB programme etc.
- Training –TBAs, Community health workers, workshops etc.
- Characteristics about the catchment area (Total Population, Infants <1yr, Children <5yrs, Women 15 -49 yrs, Pregnant Women). This description should be limited to the area the hospital considers or is assigned as its catchement area for preventive services only. (*Please use the new rates following the 2002 census i.e. Infants = 4.3% (old = 4.7%), Pregnant mothers = 5% (old = 5.2%), Expected live deliveries = 4.85% (old=5%)*
- Peripheral health units and their staffing, Services to the lower units, Number of supervisions visits done to the lower units. Out reaches for preventive activities.

HSD Function

The hospital may be heading a HSD or may have been assigned part of the HSD to support on behalf of the HSD management. Please describe:

- Participation in DHMT meetings (planning and budgeting, monitoring, evaluation / reviews etc)
- With reference to table 2 (number and distribution of HUs), comment on the staffing and performance of the health facilities in respect to the key indicators of HSSP II in table 24 above.
- Supervision, Training, and Logistical Support etc. provided to the HSD
- Health Promotion and Education and links with communities
- Support in planning
- Drug purchases and distribution to lower level health facilities
- Roles in coordinating, monitoring, supervising community related activities like HBMF, CB-DOTS, HIV/AIDS, Malaria, Sanitation etc programmes.
- Management of PHC CG for lower levels
- How is the relationship or link between the Community Health department and the rest of the hospital departments and hospital management?
- How is the relationship with local and district administrative and political leaders in the implementation of the HSD functions?
- What are the challenges?

Recommendation, actions/Plans for the next year for preventive and promotive activities

10.Training

10.1 Training School (If available):

- Name of the training school(s), short history of the school(s), and the types of courses at the school, enrollment by year in years 1st, 2nd, 3rd year etc. and graduates per year for each of the courses, pass rates.
- Is the training capacity fully utilized?
- Number of tutors and clinical instructors, library facilities, teaching materials, buildings and equipment, transport.
- School management –Governance role of the hospital, Presence and functioning of a School management team, and Disciplinary committee.

- School finances: Income and expenditure. Status of the school as a cost center.
- Support to the school by the hospital and donors.

10.2 Staff Training (Long and short trainings)- All hospitals even those without training schools

Table 25: Training opportunities for the hospital staff in the year 200….

Type of training	Where / School	Sponsored by	Decided by hosp / self	Reason for the training	No. of staff trained / in training

Other training activities:

Courses and workshops organized by the hospital, the role of the hospital in training the lower level staff and the community, Continuing medical education activities.

Recommendation, actions/Plans for the next year for Training

11. CONCLUSION

I. What do you conclude about the following?

1) The roles of the hospital in view of its relationship to its current environment and district health systems
2) The organization and management of the hospital
3) The resource capacity (human, financial, infrastructural etc) of the hospital and their influence on the performance of the hospital and the future based on current policy environment
4) The resource sustainability of the hospital

5) Achievements And Failures

- Did the hospital achieve its objectives and targets set at the end of the previous year / beginning of the year under report?
- What were the main facilitating factors and the main obstacles if any?
- What were the main objectives not achieved that will either need to be dropped (and reasons) or carried forward?

4) Faithfulness To The Mission

Do you think the hospital is demonstrating faithfulness to the Mission for which it is set as a health institution of the Roman Catholic Church? *This should be supported by the analysis / answers to the following questions.*

In each case briefly indicate why you make such a deduction.

- Is the Hospital more accessible especially to the vulnerable groups?
  - *Reflect on the trend of utilization by children, women, pregnant women etc. as evidenced by the report/data*
- Is the Hospital more equitable?
  - *Reflect on the trend of the user fee / SUO over the last 3-5 years as evidenced by the data in the report*
- Is the Hospital more efficient?
  - *Reflect on the SUO/staff (Staff productivity) and the Cost (hospital expenditure)/SUO as evidenced by the data in the report*
- Is the Hospital offering care of better quality?
  - *Reflect on the trend of indicators like FSB rate , Recovery rate, Post C/S infection rate, MMR in the hospital, % of staff who are qualified as evidenced by the data in the report*
  - *Which quality improvement activities were undertaken and what was the effect? What needs to be undertaken next year?*

5) Contribution To HSSP, PEAP And MDG

- How significant do you think the hospital is contributing to the HSSP indicators of the district (e.g. OPD utilization, immunization etc) and Uganda's PEAP and the Millenium Development Goals?
- Is there something affecting the capacity of the hospital to make its due contribution?
- What do you recommend to management, HSD, District, and Central government to do to enable the hospital function optimally and sustainably make more contribution to these indicators?

II. What are the critical issues that need attention in the next financial year and strategically?

1) Requiring local managerial and internal policy decisions
2) Requiring managerial intervention from the HSD and district
3) Requiring lobby and advocacy and partnership at district level
4) Requiring national policy change
5) Requiring attention of / intervention of UCMB

12. Summary of Recommendations

Include here important summary of recommendations based on recommendations already made under different chapters. This should not be a "wish list" only but things that you really think are realistic and feasible. They should focus on the critical issues that need attention mentioned above. They should be grouped according to levels e.g. to the hospital management and departments, to HSD, to District health department, to the general district leadership, to UCMB, to MoH. It is not necessary to line up all these except when considered necessary or relevant depending on the issues raised in the report.

13.Planning for the future

This chapter elaborates on the hospital development/service delivery plan (if it has one – and it should) and how it is going to be implemented.

- Put together a list of the recommendations and actions from the previous chapters. Draw a priority list out of this list.
- The development plan should have: involvement of the hospital in the overall health and healthcare policy at the district, hospital policies involvement of the population and other sectors that have a bearing on health. The capacity and utilization of resources in the hospital, the role of the hospital in the local health care plan etc. Future intentions of the hospital regarding bed capacity, buildings, optimum level of activity.
- *NB: Please look back at the analysis in the report and ensure that the priorities reflect issues brought out in the analysis so that they are justified.*
- What targets does the hospital set for the following indicators to be achieved next year?

Table 26: Hospital Indicator Targets for year 200…..

Indicator	Target last year (200..)	Actual last year (200..)	Target or expected 200…
OPD New case			
Deliveries			
In-patients			
Immunisation doses			
Antenatal Attendance			
Mental Health Clinic attendance			
Clinical Pastoral Care sessions			
Fresh Still Births			
Post C/S infections			
Maternal Mortality Rate (in hosp)			
Hospital Recovery Rate			
No of persons counselled in for HIV testing			
No. of persons tested for HIV			

Table 27: Catchment Area (for the hospital HC II function) Indicators targets for year 200…

Indicator	Target last year (200..)	Actual last year (200..)	Target or expected 200…
OPD New case per capita attendance			
% of Deliveries occuring in HFs			
Pentavalent vaccine 3rd dose covereage i.e.(DPT+HepB+HiB)3			
TB case notification rate			

$$\text{NB: TB case notification rate} = \frac{\text{Total cases of TB Notified}}{\text{Total population} \times 0.003}$$

- How does the hospital plan to increase or decrease the outputs to the new targets mentioned in the above table?

What targets does the hospital, through its community health department, set for the following indicators for the health sub-district or part of the HSD assigned to it for managing on behalf of the HSD? *(Only applicable for those heading HSD or assigned part of the HSD)*

Table 28: Planned targets for the HSD in the year 200…

Indicator	Target last year (200..)	Actual last year (200..)	Target or expected 200…
OPD New case per capita attendance			
% of Deliveries occuring in HFs			
Pentavalent vaccine 3rd dose covereage i.e.(DPT+HepB+HiB)3			
Pentavalent 1 - 3 drop-out rate in under 1			
Measles imm. Coverage in < 1			
% of ANC mothers receiving second IPT doses			
TB case notification rate			
TB Cure rate			

- How have the priority areas been deduced?– to what extent have other staffs or heads of department been involved in this priority setting process? Are there any factors affecting the planning process? What is / has been or will be the role of the Management team and the Board of Governors in the planning process?

Therefore write:

- **Summary Of Key / Priority Issues / Problems To Be Addressed Next Year**
- **Priority Objectives For The Next Year**
- **Priority Actions For The Next Year**
- **Financial Implication For The Next Budget**

14. List of References

These are reports, articles, policy documents etc from which quotations have been made in the text e.g. Census report, past annual reports of the hospital, reports of the district health department, National Health Policy, HSSP, PEAP, Human Development Reports, Poverty mapping reports, MDG documents, Survey reports, MoH Annual Performance Reports, District and MoH BFP, ART Policy, Draft Public-Private Partnership for Health Policy, Malaria Treatment Policy, Mission Statement of UCMB, Hospital Charter, Hospital Audit Reports, etc.

E.g.

1. UNDP; Uganda Human Development Report 2005- *Linking Environment to Human Development: A Delicate Choice*, UNDP, Kampala Office 2005.

15.Annexes

Annex 1. Health Unit Population Report (HMIS 109)
Annex 2. Members of the board of governors and designation
Annex 3. Members of the Management Team and designation
Annex 4. Hospital Staff form by end of financial year (June 30th) = mid calendar year = end of Financial Year. (Format provided by UCMB)
Annex 5. Financial Report
Annex 6. Balance Sheet
Annex 7. Admission and death by diagnosis
Other Annexes.