OFFICE OF HEALTH STANDARDS COMPLIANCE

ANNUAL PERFORMANCE PLAN

2022/2023

Date of Tabling: March 2022

Contents

1. Executive Authority Statement

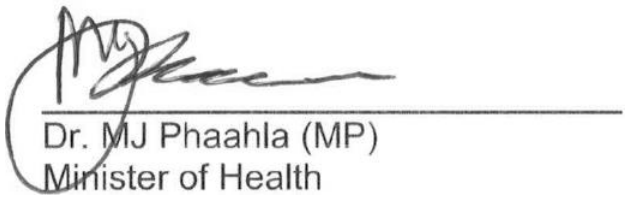
The Office of Health Standards Compliance (OHSC) has submitted its 2022/23 Annual Performance Plan (APP), which is aligned to the organisation's Strategic Plan 2020 – 2025 and to the guidelines developed by the Department of Planning, Monitoring and Evaluation which aim to provide overarching framework for monitoring service delivery by public sector structures. The plan considered the health sector constraints experienced through the COVID-19 pandemic

The COVID-19 pandemic has demonstrated the significance of collective partnerships from both the public and private health sector for coordinated responses to manage and eventually eliminate the pandemic. The Constitution requires the government to take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of access to healthcare services. Although the COVID-19 pandemic posed challenges for the health sector, the quality of the services provided remains a priority for the South African government and fundamental to the transformation of the health system.

The OHSC as an oversight regulatory body created by the National Health Amendment Act No. 12 of 2013, plays a key role to promote and protect the health and safety of users of health services. The OHSC is fulfilling its mandate by conducting routine inspections of health establishments to measure them against prescribed norms and standards regulations as part of ensuring consistent safe and quality healthcare for all.

The National Health Insurance Bill (NHI Bill), which aims to distribute health resources more equitably and ensure all citizens have access to quality, essential health services regardless of their socio-economic status and ability to pay for healthcare. The NHI Bill provides that certification by the OHSC will be a precondition for health service providers seeking to obtain accreditation and ultimately be able to contract with the National Health Insurance Fund.

The OHSC's role is to accelerate monitoring of quality and safety of healthcare services to eliminate challenges related to the quality and safety experienced by public and private health sector. The OHSC is guided by several national health and development policies to execute its role of improving the quality of public and private health sector.



Dr. MJ Phaahla (MP)
Minister of Health

2. Accounting Authority Statement

The Office of Health Standards Compliance (OHSC) is grateful to submit its Annual Performance Plan (APP) for the period 2022/23. The APP was influenced by the Constitution, legislative mandates, and other related policy mandates that impact on the functions of the OHSC. This APP describes the activities of the office in terms of its Strategic Plan 2020 – 2025 and interventions identified to mitigate applicable risks, while the office deliver services to health service users.

The Portfolio Committee on Health plays an oversight role in respect of activities of the OHSC and the health establishments the office regulates. The Presidential Health Summit Compact, 2018, states that the Office of the Health Ombud must be separated from the OHSC to ensure independence, transparency, and good governance and similarly the independence of the OHSC as a regulatory entity. The process of drafting the Health Ombud Bill and the OHSC bill to separate the Office of the Health Ombud from the OHSC has commenced. The drafting of a separate OHSC Bill which would remove the functions of the OHSC from chapter 10 of the National Health Act, 2003 is also in progress.

The OHSC needs to expand inspections both in the public and private health sector through decentralisation of the OHSC functions to all provinces. The OHSC is exploring options to generate funds for its service offerings such as a service fees for inspections. The additional income will fund for decentralisation project of the OHSC.

Unsurprisingly, the burden of demand related to the quality of services on public and private health services remains to be extreme, especially in densely populated areas where a steady stream of rural-urban migration swells the numbers. The OHSC remains resolute in working towards increasing inspections despite the constraints on its operations and the health establishments which office regulates. The organisation continues to fulfil its mandate by ensuring health establishments deliver the quality health services through quality assurance so that safety of health users is not compromised, including the well-being of its staff.

The OHSC continues to conduct inspections in health establishments in order to certify whether or not they are compliant with the prescribed norms and standards regulations and investigate complaints from the public and users of healthcare services.

The OHSC believes that the quality of healthcare can never be ignored, and it is more difficult to sustain in these circumstances, where human and other resources, as well as physical infrastructure, are often inadequate for service needs. It is a common cause that quality of care is a serious challenge in many public health establishments.

Change remains significant for the OHSC, particularly as the organisation experiences successive cycles. The OHSC is on course to support strategic initiatives by continuously interrogating universal factors, and applicable risks to deliver on its vision for consistent safe and quality healthcare for all.

Dr. Ernest Kenoshi
Chairperson of the Board

3. Official Sign-Off

It is hereby certified that this Annual Performance Plan:

- Was developed by the Accounting Authority and Management of the Office of Health Standards Compliance under the guidance of the National Department of Health
- Takes into account all the relevant policies, legislation and other mandates for which the Office of Health Standards Compliance is responsible
- Accurately reflects the outcomes and outputs which the Office of Health Standards Compliance will endeavour to achieve over the period 2022/23

Ms. Kantha Padayachee

Director: Governance, Board Secretariat and Legal Services

Ms Dikeledi Tsukudu

Executive Manager: Compliance Inspectorate

Mr. Philip Mohololа

Director: Human Resources

Dr. Donna Jacobs

Executive Manager: Complaints Management and Ombud

Mr. Jay Tulsee

Director: Information Technology

Ms. Winnie Moleko

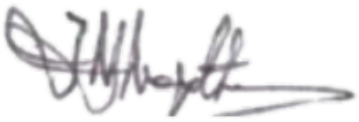
Executive Manager: Health Standards Design, Analysis and Support

Mr. Ricardo Mahlakanya

Director: Communication and Stakeholder Relations

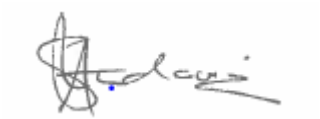
Adv. Makhwedi Makgopa-Madisa

Director: Certification and Enforcement



Mr. Julius Mapatha
Chief Financial Officer

Mr. Mondi Govuzela
Director: Planning, Monitoring and Evaluation



Dr. Siphiwe Mndaweni
Chief Executive Officer

Dr. Ernest Kenoshi
Chairperson of the Board

APPROVED BY:

Dr. MJ Phaahla (MP)
Minister of Health

4. List of Abbreviations

APP	Annual Performance Plan
ARFC	Audit Risk and Finance Committee
AU	African Union
BCP	Business Continuity Plan
CAU	Complaints Assessment Unit
CCC	Complaints Call Centre
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CIU	Complaints Investigation Unit
CMS	Centres for Medicare & Medicaid Services
CQC	Centre Quality Commission
HE(s)	Health Establishment(s)
HHS	Health and Human Services
HR	Human Resource
HSDAS	Health Standards Design, Analysis and Support
ICT	Information and Communication Technology
IOI	International Ombudsman Institutes
IRP	Integrated Resource Plan
MECs	Members of the Executive Councils
MTEF	Medium Term Expenditure Fund
MTSF	Medium Term Strategic Framework
NDoH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHAA	National Health Amendment Act
NHI	National Health Insurance
NHS	National Health Service
NPQ	National Policy on Quality in Healthcare
OHSC	Office of Health Standards Compliance
PESTLE	Political, Economic, Social, Technological, Legal, Environmental
PFMA	Public Finance Management Act
PHSC	Presidential Health Summit Compact
PHSO	Parliamentary Health Services Ombud
PME	Planning, Monitoring and Evaluation
PoPI	Protection of Personal Information
QIOs	Quality Improvements Organisations
QMS	Quality Management System
SADC	South African Development Community
SCM	Supply Chain Management
SDGs	Sustainable Development Goals
SFDRR	Sendai Framework for Disaster Risk Reduction
SHEQ	Safety, Health, Environment and Quality
SWOT	Strengths, Weaknesses, Opportunities and Threats

Part A: Our Mandate

1. Updates to the relevant legislative and policy mandates

The OHSC is established in terms of the National Health Amendment Act (NHA) of 2013, to promote and protect the health and safety of the users of health services. The OHSC is listed as a Schedule 3A public entity in terms of the PFMA.

The legislative mandate of the OHSC is derived from the Constitution, the National Health Amendment Act No. 12 of 2013, several pieces of legislation passed by Parliament guided by sections 9, 12 and 27 of the Constitution, regulations, and national policies.

LEGISLATIVE MANDATES

Constitution of the Republic of South Africa

The Bill of Rights, which forms part of the Constitution, underpins the entire health system.

Section 27 establishes a universal right to have access to healthcare services, including reproductive health services and emergency medical treatment. It states categorically that nobody may be refused emergency medical treatment. The Constitution requires the state to take reasonable legislative and other measures, within available resources, to achieve the progressive realisation of access to healthcare. Section 28 of the South African Constitution provides an important benchmark in the protection of children in South Africa as principles derived from international law on children's rights are now enshrined as the highest law of the land. It states that every child has a right to basic health care services.

The regulation of the quality of health services requires all health establishments to comply with policy priorities and minimum standards of care. In this manner, the regulation of quality contributes directly to the government’s progressive realisation of its constitutional obligations. The OHSC carries out its work having due regard to the fundamental rights as contained in the Constitution and other related legislation.

The National Health Act, 2003 (Act No. 61 of 2003)

The National Health Act, 2003 (Act No. 61 of 2003) (NHA) reaffirms the constitutional rights of users to access health services and unjust administrative action. As a result, Section 18 allows any user of health services to lay a complaint about the way he or she was treated at a health establishment. The NHA further obliges Members of the Executive Councils (MECs) to establish procedures for dealing with complaints within their areas of jurisdiction. Complaints provide useful feedback on the areas within

health establishments that do not comply with prescribed standards or pose a threat to the health and safety of users and healthcare staff alike.

The NHA provides the overarching legislative framework for a structured and uniform national healthcare system. The Act highlights the rights and responsibilities of healthcare providers and healthcare users and ensures broader community participation in healthcare delivery from a health facility level up to national level. Chapter 10 of the NHA, as it relates to the OHSC, was repealed in its entirety (and other minor changes were enacted) through the promulgation of the National Health Amendment Act, 2013 (Act No. 12 of 2013) (NHAA). This replaced the previous provisions that had never been brought into effect with a new independent entity, the OHSC.

The object of the OHSC in Section 78 of the NHAA is to protect and promote the health and safety of users of health services by:

- Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister concerning the national health system; and
- Ensuring that complaints about non-compliance with prescribed norms and standards are considered, investigated, and disposed of in a procedurally fair, economical, and expeditious manner.

In terms of Section 79 of the NHAA, the OHSC must:

- **Advise the Minister** on matters relating to norms and standards for the national health system and the review of such norms and standards, or any other matter referred to it by the Minister:
- **Inspect and certify** compliance by health establishments with prescribed norms and standards, or where appropriate and necessary, withdraw such certification:
- **Investigate complaints** about the national health system:
- **Monitor indicators of risk** as an early-warning system about serious breaches of norms and standards and report any breaches to the Minister without delay:
- **Identify areas and make recommendations for intervention** by a national or provincial department of health or municipal health department, where necessary, to ensure compliance with prescribed norms and standards.
- **Recommend quality assurance and management systems** for the national health system to the Minister for approval: and
- **Keep records** of all OHSC activities.

In addition, the OHSC may:

- **Issue guidelines** for the benefit of health establishments to implement prescribed norms and standards:
- **Publish any information relating to prescribed norms and standards** through the media and, where appropriate, within specific communities:
- **Collect or request any information relating to prescribed norms and standards** from health establishments and users:
- **Liaise with any other regulatory authority** and, without limiting the generality of this power, request information from, exchange information with and receive information from any such authority about matters of common interest or a specific complaint or investigation: and
- **Negotiate cooperative agreements with any regulatory authority** to coordinate and harmonise the exercise of jurisdiction over health norms and standards and ensure the consistent application of the principles of this Act.

Norms and standards applicable to different categories of health establishments

The Minister of Health promulgated the norms and standards regulations on 2 February 2018. The norms and standards regulations came into operation on 2 February 2019 and apply to the following categories of health establishments:

- Public sector hospitals, as set out Government Gazette, No 35101:
- Public sector clinics:
- Public sector community health centres:
- Private sector acute hospitals:
- Private sector Primary Health Care clinics and centres: and
- General Practitioners.

Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud

These regulations will guide the exercise of powers conferred on the OHSC and its Board, the Chief Executive Officer, the Ombud, Inspectors and Investigators, which they will elaborate on in the form of details, procedures, and processes.

The regulations cover the following areas:

- Collection of information from health establishments and designation and duties of the person in charge:
- Appointment of Inspectors, training and expertise:

- The inspection process and timelines:
- Additional inspections:
- Entry and search of premises including prior-consent procedures or the application for a warrant if required:
- Processes of certification, renewal and suspension:
- Compliance notice and enforcement process, including formal hearing, revocation of a certificate, fines or referral to prosecuting authority, appeals and reporting:
- Complaints handling, investigation and resolution procedures, lodging of complaints, screening, investigation and reporting and turnaround times: and
- General provisions about using prescribed forms (listed in Schedule 1).

Public Finance Management Act, 1999 (Act No. 1 of 1999)

Section 50 of the Public Finance Management Act, 1999 (Act 1 of 1999) (PFMA) sets out the fiduciary duties of accounting authorities. Section 51 sets out the responsibilities of accounting authorities. The PFMA regulates public sector managers to manage and improve accountability in by eliminating waste and corruption in the use of public funds.

The act enables public sector managers to manage and improve accountability in terms of eliminating waste and corruption in the use of public funds. OHSC is listed as a *Schedule 3A* public entity.

The Protection of Personal Information Act, 2013 (Act No. 4 of 2013)

The purpose of the Protection of Personal Information Act, 2013 (Act No. 4 of 2013) (PoPI Act) is to ensure that all South African institutions, including the OHSC, conduct themselves in a responsible manner when collecting, processing, storing and sharing personal information by holding them accountable should they abuse or compromise such information in any way. The PoPI Act regards personal information as “precious goods” and gives owners of personal information certain rights of protection and the ability to exercise control over:

When and how the information is shared (requires individual consent):

- The type and extent of information that is shared (must be collected for valid reasons):

- The transparent and accountable use of the data (limited to the purpose) and notification if/when the data are compromised:
- Who accesses personal information and the right to have personal data removed and/or destroyed:
- Adequate measures and controls to access personal information and tracking access to prevent unauthorised access:
- The storage of personal information (requires adequate measures and controls to safeguard personal information and protect it from theft or being compromised): and
- The integrity and continued accuracy of personal information (must be captured correctly and maintained by the institution that/ person who accessed it).

Promotion of Access to Information Act, 2000 (Act No. 2 of 2000)

Section 32 (1) (a) of the Constitution states that everyone has a right to access any information held by the state or another person to protect any rights. The Promotion of Access to Information Act, 2000 (Act No. 2 of 2000) (PAIA) gives all South Africans the right to access records held by the State, government institutions and private bodies.

The objectives of the PAIA are to:

- Ensure that the State promotes a human rights culture and social justice:
- Encourage openness and establish voluntary and mandatory mechanisms:
- Establish procedures for the right to access information quickly, effortlessly, cost-effectively and as reasonably as possible:
- Promote transparency, accountability and effective governance of all public and private bodies by empowering and educating everyone to understand their rights in terms of the PAIA and to public and private bodies:
- Create and understanding of the functions and operation of public bodies: and
- Encourage the scrutiny of and participation in decision-making by public bodies that affect individual/public rights.

Promotion of Administrative Justice Act, 2000 (Act No. 3 of 2000)

Section 33 (1) and (2) of the Constitution guarantees that administrative action will be reasonable, lawful and procedurally fair, and it makes sure that people have the right to ask for written reasons when administrative action has a negative impact on them. Promotion of Administrative Justice Act, 2000 (Act No. 3 of 2000) (PAJA) aims to make

the administration effective and accountable to people for its actions. The objectives of the PAJA are to:

- Promote an efficient administration and good governance; and
- Create a culture of accountability, openness and transparency in the public administration.

Disaster Management Act, 2002 (Act 57 of 2002)

The Disaster Management Act, 2002 (Act No. 57 of 2002) (DMA) provides for an integrated and coordinated disaster management policy in South Africa that focuses on preventing and reducing the risk of disasters, mitigating the severity of disasters, emergency preparedness, rapid and effective response to disasters and post-disaster recovery. It regulates the establishment of national, provincial, and municipal disaster management centres.

Preferential Procurement Policy Framework Act, 2000 (Act No. 05 of 2000)

The Preferential Procurement Policy Framework Act, 2000 (Act No. 05 of 2000) (PPPFA) gives effect to Section 217 (3) and provides a framework for the implementation of the procurement policy contemplated in Section 217 (2) of the Constitution.

Skills Development Act, 1998 (Act No. 97 of 1998)

The Skills Development Act, 1998 (Act No. 97 of 1998) (SDA) provides an institutional framework to devise and implement national, sector and workplace strategies to develop and improve the skills of the South African workforce.

Employment Equity Act, 1998 (Act No. 55 of 1998)

The Employment Equity Act, 1998 (Act No. 55 of 1998) serves as a mechanism to redress the effects of unfair discrimination and to assist in the transformation of workplaces, so as to reflect a diverse and broadly representative workforce.

Intergovernmental Relations Framework Act, 2005 (Act No.13 of 2005) (IRFA)

Establishes a framework for national, provincial and local government to promote and facilitate intergovernmental relations and to provide a mechanism and procedure to facilitate the settlement of intergovernmental disputes.

POLICY MANDATES

In addition to the Constitution and Legislative mandates, the following related policy mandates have an impact and influence on the functioning of the OHSC:

National Health Insurance ("NHI")

South Africa, in pursuance of fundamental transformation of the health system and implementation of universal health coverage, has embarked upon the National Health Insurance (NHI) program in order to grant all citizens access to good quality health services irrespective of their socio-economic status. NHI, as proposed and envisaged by the National Department of Health (NDOH) of South Africa, is not just a new financing mechanism for the health system but a significant paradigm shift in the system that is based on the principles of universal coverage, right of access to basic and quality health care, social solidarity and equity.

The National Health Insurance Bill (NHI Bill) provides for mandatory prepayment of healthcare services in the Republic in pursuance of Section 27 of the Constitution. It further establishes a National Health Insurance Fund and provides for its powers, functions and governance structures. The NHI Bill recognises the socio-economic injustices, imbalances and inequalities of the past, the need to heal the divisions of the past and the need to establish a society based on democratic values, social justice and fundamental human rights and to improve the life expectancy and the quality of life for all citizens.

In relation to the OHSC, the NHI Bill provides that "the process of accreditation of health care providers will require that health establishments are inspected and certified by the OHSC". This provision in the Bill therefore outlines and underscores the crucial role to be played by the OHSC in relation to the implementation of NHI in the country. It is also key to note, however, that the importance of the OHSC lies not only in its role under the NHI but that it must also play a role in the improvement of healthcare quality in South Africa as it relates to both private and public healthcare establishments.

National Development Plan (NDP)

The NDP Vision 2030 states that a health system with positive health outcomes for the country is possible and will:

- Raise the life expectancy of South Africans to at least 70 years:
- Ensure that the under-20s generation is largely free of HIV:
- Significantly reduce the burden of disease: and
- Achieve an infant mortality rate of fewer than 20 deaths per thousand live births and under-5 mortality rate of fewer than 30 per thousand.

Priority 2 as contained in chapter 10 of the NDP focuses on strengthening the healthcare system and includes the role of the OHSC as the independent entity mandated to promote quality by measuring, benchmarking, and accrediting actual performance against quality standards. A specific OHSC focus is on achieving common basic standards in the public and private sectors.

Medium Term Strategic Framework 2019-2024 (MTSF)

The purpose of the Medium-Term Strategic Framework (MTSF) is to outline the Government strategic intent in implementing the electoral mandate and National Development Plan (NDP) Vision 2030. The structure of the MTSF document provides a situational analysis outlining the developmental challenges we are facing as a country, particularly in addressing the triple challenges of poverty, inequality, and unemployment.

The MTSF 2019-2024 aims to address the challenges of unemployment, inequality, and poverty through three pillars of the NDP. The three pillars are: achieving a more capable state, driving a strong and inclusive economy, and building and strengthening the capabilities of South Africans. The seven priorities of Government are embedded into the 3 pillars. Priority 3: Education, skills and health are of specific importance to the OHSC. The OHSC will take into account the Medium-Terms Strategic Framework (MTSF) in the execution of its mandate. The OHSC responses are structured into five outcomes which are well aligned to the NDoH MTSF goals.

National Policy on Quality in Healthcare, 2007 (NPQ)

A focus on quality assurance and improvement is not a new concept. The 2001 NPQ was revised in 2007. The policy identifies mechanisms to improve the quality of healthcare in the public and private sectors and highlights the need to involve health professionals, communities, patients and the broader healthcare delivery system (National Department of Health, referred to as the NDoH) in capacity-building efforts and quality initiatives.

The objectives of the NPQ are to:

- Improve access to quality healthcare:
- Increase patients' participation and the dignity afforded to them:
- Reduce underlying causes of illness, injury and disability:
- Expand research on treatments specific to South African needs and the evidence of effectiveness:
- Ensure the appropriate use of services: and
- Reduce errors in healthcare.

Batho Pele and the Patient's Rights Charter

Alongside health-specific policies and legislation, the Batho Pele principles govern all public services, including healthcare delivery. The Batho Pele ("People First") initiative encourages service-orientation, excellence, and improved delivery among public servants. The eight Batho Pele principles, aimed at enhancing public service delivery (Republic of South Africa, 2007) are:

- Regularly consult with customers:
- Set service standards:
- Increase access to services:
- Ensure higher levels of courtesy:
- Provide more and better information about services:
- Increase openness and transparency about services:
- Remedy failures and mistakes: and
- Give the best possible value for money.

In response, the health sector promulgated the "Patient's Rights Charter", which specifies – as reiterated in the Norms and Standards Regulations applicable to different categories of Health Establishments– that the rights of patients must be respected and upheld, including the right to access to basic care and receive a respectful, informed, and dignified attention in an acceptable and hygienic environment.

Patients should be empowered to make informed decisions about their health and complain if they do not receive decent care.

Presidential Health Summit Compact, 2018 (PHSC)

The Presidential Health Summit Compact, 2018 states "Regulation plays a crucial role in establishing the rules within which professionals and organisations must operate within a more people-centred and integrated health system". One of the interventions recommended at the Presidential Health Summit is a full organisational review of the legislation on health and new governance and administrative structures to improve quality, transparency, accountability, and efficiency in the health sector (public and private). Furthermore, the Office of the Health Ombud must be separated from the OHSC to ensure independence, transparency, and good governance. To that extent the Ombud and the Minister are in a process of drafting the Health Ombud Bill. There is also a process of drafting a separate OHSC Bill which would remove the functions of the OHSC from chapter 10 of the National Health Act, 2003.

United Nations Sustainable Development Goals (SDGs)

The Sustainable Development Goals (SDGs) are part of the United Nation's global agenda, made up of 17 interlinked goals, with a vision of ending poverty, protecting the planet, and ensuring that humanity enjoys peace, prosperity and sustainable future. The agenda appreciates that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development.

African Union 2063 Agenda (AU)

The Africa 2063 Agenda envisages an integrated, prosperous and peaceful Africa through inclusive growth and sustainable development.

Sendai Framework for Disaster Risk Reduction 2015-2030 (SFDRR)

The Sendai Framework is a non-binding voluntary framework; whose main focus is on the reduction of disaster risk.

2. Updates to institutional policies and strategies

There are no changes to the Office of Health Standards Compliance institutional policies and strategies.

3. Updates to relevant court rulings

There are no current court actions or rulings regarding the OHSC, its establishment and/or functions.

Part B: Our Strategic Focus

1. Strategic Overview

OFFICE OF HEALTH STANDRADS COMPLIANCE

NATIONAL DEVELOPMENT PLAN 2030

NHA-61 of 2003 [NHAA-12 of 2013] | **MTSF 2019-2024**

MANDATE

The OHSC has been created by the National Health Amendment Act of 2013 and, in terms of section 78 of the Act, the objects of the Office are to protect and promote the health and safety of users of health services by:

i) Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system.

ii) Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards for health establishments in a procedurally fair, economical and expeditious manner.

1.1 Vision

Consistent safe and quality healthcare for all

1.3 Mission

We monitor and enforce healthcare safety and quality standards in health establishments independently, impartially, fairly, and fearlessly on behalf of health care users

1.4 Impact

Safe and quality health care services

1.2 Values

Human Dignity	We will have respect for human individuality and treat each individual as a unique human being.
Accountability	We will take responsibility for our results and outcomes.
Transparency	We will operate in a way that creates openness between managers and employees.
Quality healthcare	Quality health care means doing the right thing, at the right time, in the right way, for the right person – and having the best possible results
Safety	Maintain a safe and healthy workplace for all employees in compliance with all applicable laws and regulations
Integrity	We will conduct ourselves with openness, honesty, and respect for all stakeholders

OUTCOMES

Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**	**Outcome 5**
A fully functional OHSC	Compliance with norms and standards is effectively monitored	Improved quality of health care services rendered to the users in the health establishments	Facilitate achievement of compliance with the norms and standards regulations for different categories of health establishments	Compliance with norms and standards increased

OHSC has adopted corporate values, which serve as guiding principles around which its corporate culture and actions are governed and shaped. The OHSC's values are grounded in strong ethical considerations. As a result, OHSC staff members are required to maintain a highest standard of proper conduct and integrity at all times and to ensure that there is no doubt as to what is required.

The OHSC will strive to be a learning organisation, continuously evolving and developing to ensure safe and quality healthcare for all. All OHSC employees are consistently encouraged to live the OHSC's values in all that they do. The OHSC will continue to encourage staff to do so until such time as the values form an integral part of the work life of all staff at the OHSC. Regular communication sessions will continue to be held detailing the OHSC's purpose, mandate, role, functions and ways of working. This will ensure that the OHSC's strategy and values remain relevant and become firmly institutionalised.

2. Updated Situational Analysis

Global Health Care Environment

The COVID-19 Pandemic is placing enormous strain on the global health care sector's workforce, infrastructure, and supply chain, and exposing social inequities in health and care. COVID-19 is also accelerating change across the ecosystem and forcing public and private health systems to adapt and innovate in a short period.

A number of foundational shifts are arising from and being exacerbated by COVID-19's spread. Examples include consumers' increasing involvement in health care decision-making; the rapid adoption of virtual health and other digital innovations; the push for interoperable data and data analytics usage; unprecedented public-private collaborations in vaccine and therapeutics development. Amid these dynamics, governments, health care providers, payers, and other stakeholders around the globe are being challenged to quickly pivot, adapt, and innovate. Industry leaders are being challenged to use the momentum ignited by organisational and ecosystem responses to COVID-19 to address six pressing sector issues in 2021. How health care stakeholders analyse, understand and respond to these issues will shape their ability to navigate from recovering to thriving in the post-pandemic "new normal" and advance their journey along the path to the Future of Health.

2021 Global Health Care Sector Issues[1]

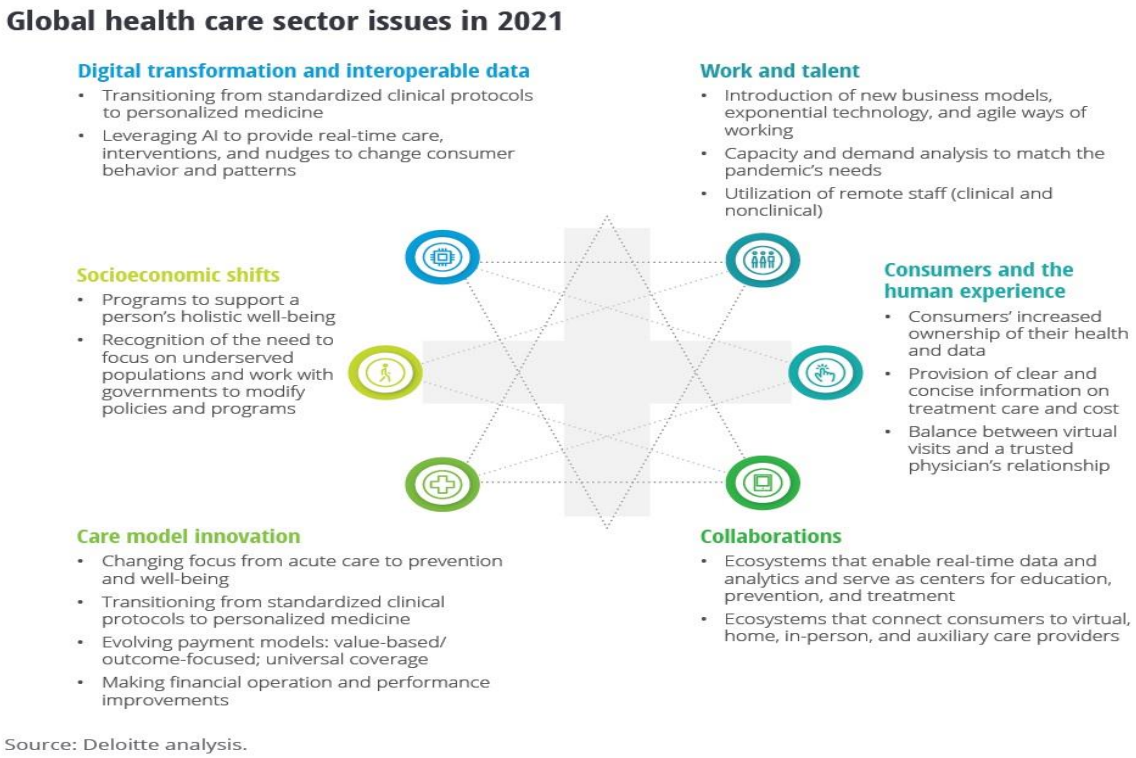


Diagram 1: Highlights the 6 Health Care Sectoral Issues in 2021

COVID-19 Global Impact on Public Health Care Facilities & Practitioner's

The long-term health impacts of COVID-19 remain unknown. A survey found that 90% of recovered COVID-19 patients were still suffering from physical and psychological side effects such as ageusia (loss of taste), anosmia (loss of smell), attention disorder and fatigue. Collateral health impacts — physical and mental will continue to have devastating consequences worldwide.

In the United States, delayed treatment of emergencies, chronic diseases and psychological distress have already caused a death rate of 6% over what would normally be expected. The pandemic has strained healthcare systems, exposing their lack of capacity.

Hospitals worldwide were quickly overwhelmed, and many were again at risk in several countries from Europe to India, Mexico, South Africa and the United States. Some countries have reported new shortages of medical supplies.

[1] Deloitte Insights: 2021 Global Health Care Outlook, pg2-3.

Healthcare professionals have struggled with anxiety, depression, fear, isolation and even social stigma. In countries such as Australia, Colombia, Ecuador, India, the United Kingdom, and the United States, financial, physical and mental stress have caused many to plan to stop working or leave the health profession.

Health Care Environment in the South African Context

The COVID-19 pandemic has revealed pre-existing weaknesses in our healthcare system that have been exacerbated. Efficient and equitable allocation of resources are thus critical now more than ever. Unless we prioritise interventions that are cost-effective and address the major challenges from both the demand side and the supply side, South Africa will experience increased mortality and morbidity from diseases that have been side-lined in favour of COVID-19. This outcome will obliterate hard-won improvements in life expectancy over the past decade, thwarting any chance of South Africa reaching its SDG 2030 targets.

Healthcare systems are unable to track trends in infection and mortality in real time. The sero-survey (testing for antibody to determine past infection), reported that 32% to 63% of blood donors across four provinces in South Africa had been infected by COVID-19 prior to the current resurgence of the 3rd wave. This indicates that COVID-19 infection rates have been under-estimated in South Africa. Consequently, further extrapolating from the 2,39 million recorded COVID-19 cases (4% of the population) probably represents $^{1}/_{10^{th}}$ of the COVID-19 infections that have occurred in South Africa.

COVID-19 South African Numbers & Timeline

The green line on the graph below displays confirmed COVID-19 cases in South Africa from March 2020 to April 2021, reflecting the peaks of 1st and 2nd waves respectively. The various info blocks highlight the lockdown levels and key milestones.

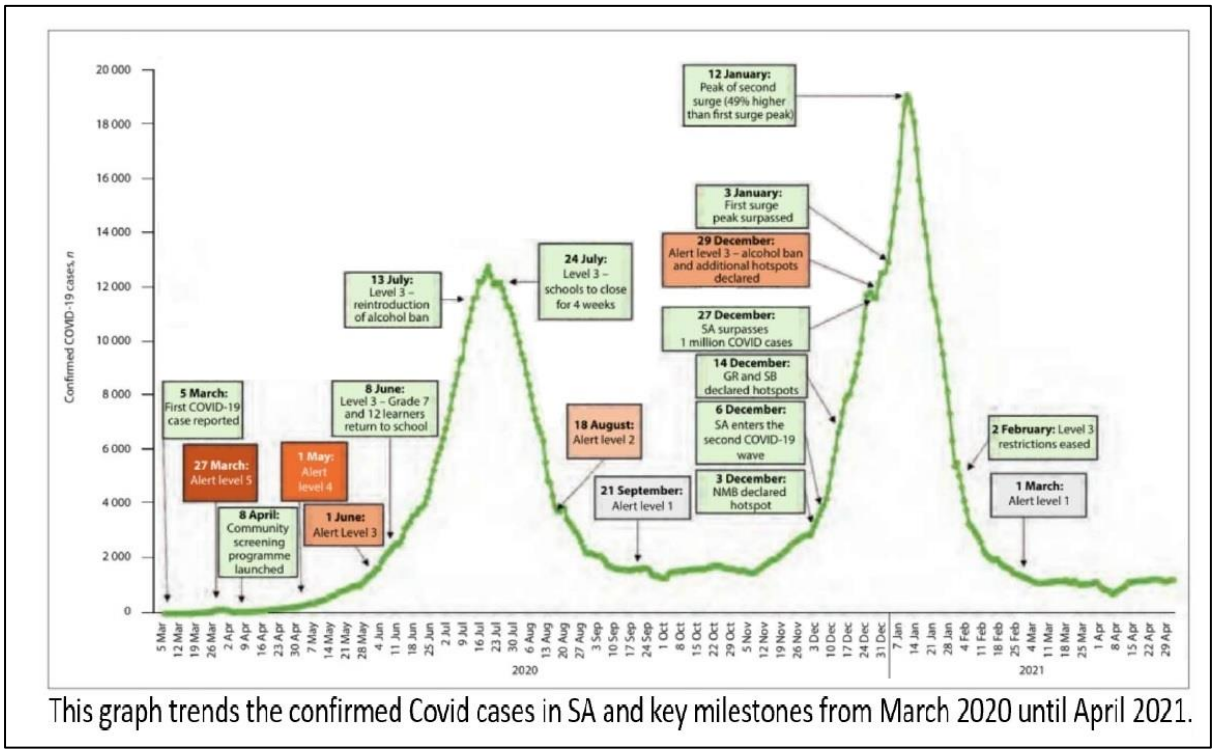


Diagram 2: Trends the South African COVID-19 timeline

Inequality: A Wicked Problem in the Health Environment

The damage from COVID-19 has been worsened by long-standing gender, race, age and income inequalities. Disadvantaged groups went into the crisis with lower resilience as a result of disparities in well-being; financial stability and security; and access to healthcare, education and technology. Income inequality, despite declining on a global scale, had reached historical highs in many countries.

Health systems globally were already under strain from gathering pressures and emerging public health threats. Half of the world's population lacks access to essential health services, and shortfalls in public health push 100 million people into extreme poverty every year. This has amplified the pandemic's impact on the physical well-being of people in low-income households, women, children and the elderly.

Globally 60% of adults lacked basic digital knowledge and skills when workplaces and schools across the world suddenly closed to curb the spread of COVID-19, forcing a rapid leap to online operations. Many students lacked access to a computer for schoolwork: percentages of students affected ranged from 25% in China to 45% in Mexico and 65% in Indonesia.

Digital divides were already worrisome before the pandemic. In 2018 World Economic Forum (WEF) reported that half the world's population were connected to the internet and the International Telecommunication Union called to "*redouble our collective efforts to leave no one offline*".

The development of multiple vaccines may herald the beginning of recovery from the COVID-19 crisis, but the structural fissures that the crisis exacerbated, from individual well-being to societal resilience and global stability, threaten to make that recovery deeply uneven.

"Livelihood crises", "digital inequality", "youth disillusionment" and "social cohesion erosion" all show up in the Global Risks Perception Survey as critical global threats for the next two years. Across developed and developing economies alike, the number of people without access to quality and affordable healthcare, education or digital tools is at risk of increasing. Billions of people face narrowing pathways to future well-being.

In the short term, equitable and effective vaccine distribution is at risk from protectionist tendencies and geopolitical tensions, just as these tendencies and tensions put essential medical supplies at risk when the pandemic started.

In the longer term, inequitable access to quality healthcare will persist as a result of continued stress on healthcare systems globally. Health capacity in some European countries has already suffered from prolonged austerity measures. In Sub-Saharan Africa, 20% of people over 60 (the highest-risk age group) are at least three hours away from the nearest health facility.

Such obstacles have complicated the response to the pandemic. Looking ahead, failing to close public health gaps will exacerbate existing vulnerabilities and risk further humanitarian and economic damage. As we have recently noted, public health gaps, digital inequality, educational disparities and unemployment may fray social cohesion.

Universal Access to Effective Healthcare: UNDP SDG3

Diagram 3: Universal Access to Effective Healthcare: UNDP SDG3

Universal Access to Effective Healthcare: NDP2030 CH10

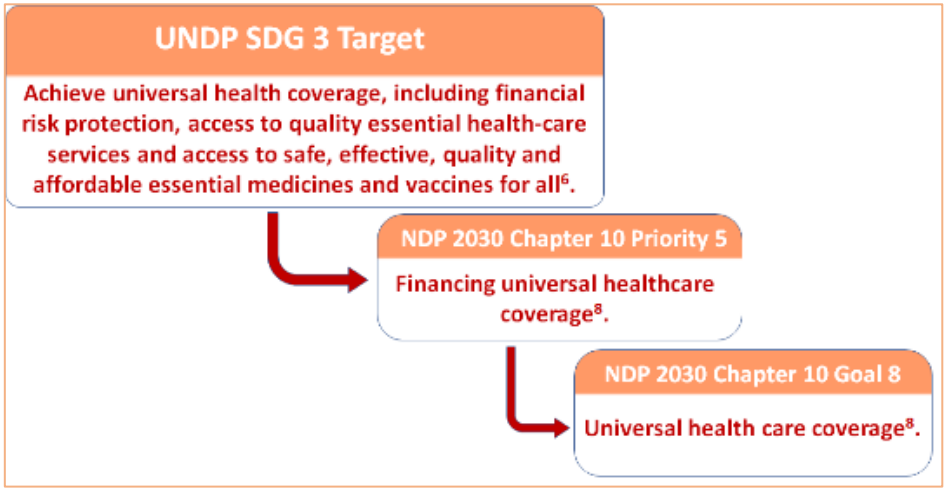


Diagram 3: Universal Access to Effective Healthcare: NDP2030 Chapter 103

Health is not just a medical issue. The social determinants of health need to be addressed, including promoting healthy behaviours and lifestyles. A major goal is to reduce the disease burden to manageable levels. Human capacity is key. Managers, doctors, nurses and community health workers need to be appropriately trained and managed, produced in adequate numbers, and deployed where they are most needed[8]. The national health system as a whole needs to be strengthened by improving governance and eliminating infrastructure backlogs. A national health insurance system needs to be implemented in phases, complemented by a reduction

in the relative cost of private medical care and supported by better human capacity and systems in the public health sector.

Health Reform

The NDoH focused on accelerating the path towards Universal Health Coverage and implementing the resolutions of the Presidential Health Compact and Quality Improvement Plan with a view to introduce the necessary health reformations for successful implementation and rollout of the National Health Insurance. The Presidential Health Compact seeks to address the crisis facing the health system through nine pillars with key activities, interventions, indicators, and time-bound targets. In line with the WHO call for Member States to develop digital health strategies to harness the digital health benefits, the NDoH has developed the National Digital Health Strategy for South Africa 2019 – 2024. It presents a vision of "Better health for all South Africans enabled by person-centred digital health".

Benchmarking with the UK: What can we learn?

Benchmarking with health care regulators in other countries provides valuable insight and methodologies to understand how these regulators adapted and faced the challenges presented by the coronavirus pandemic within their functional mandates. In the United Kingdom the Care Quality Commission (CQC) has adopted the following measures; they put an immediate stop to all routine inspections from the 16th March 2020, and this currently remains unchanged. The CQC however noted that during the pandemic they would still conduct some physical/onsite inspection activities in a small number of special circumstances, such as instances where there are allegations of abuse for example.

The CQC indicated moving towards other remote methods to ensure that they are able to still give assurance of safety and quality of healthcare. They are working on measures to reduce the administrative demands on healthcare providers in this critical period in which their resources are being stressed beyond their capacity.

These measures, include reducing requirements for preparation of inspections and looking at how to limit the need to be on site, amongst others. Another intervention by the CQC was the secondment of clinically qualified Care Quality Commission special advisors who have the relevant skills to assist the Department of Health and Social Care, Public Health England and the National Health Service (NHS) on the "frontline" in their efforts to fight the pandemic. The CQC indicated that their goal is to prioritise activities to ensure people continue to receive safe and quality care by concentrating on those areas where the risk to the quality of care is the highest.

On a cautionary note, it should be noted that the suspension of onsite inspections has evoked a huge backlash from the general public and watchdog organisations alike, citing among other concerns, neglect, lack of accountability, transparency and "blatant lies" exposing shortcomings at the cost of lives, due to which a public inquiry seems inevitable.

Benchmarking with the United States of America: What can we learn?

When we look at the USA, we see some similarities. It must be noted that large budgets were allocated to deal with concerns in nursing homes. Consequently, all inspections were resumed in August 2020, which was just five months after suspending routine inspections. Also worth noting, is that this transpired in the climate of the looming 2020 US presidential elections.

In the USA, the Human Rights Watch expressed "Concerns of Neglect in Nursing Homes", citing the need for improvements in staffing, oversight and accountability as key areas of concern. The Centers for Medicare & Medicaid Services (CMS), which is part of the Department of Health and Human Services (HHS), performs similar tasks to that of a regulator. Some of the measures they undertook are listed: On 23rd March 2020 the CMS announced a suspension of routine inspections. CMS has worked closely with states to complete focussed infection control surveys. These surveys fortified healthcare facilities around the country to prepare for and implement actions to prevent transmission of the virus and provided indispensable insight into the situation on the ground.

CMS setup an independent commission that will conduct a comprehensive assessment of nursing home responses to COVID-19.

CMS announced they will nearly double payment for certain lab tests that use high-throughput technologies. CMS published a new informational toolkit comprising recommendations and best practices from a variety of front-line health care providers, governors' COVID-19 task forces, associations and other organisations and experts. Deployed Quality Improvement Organisations (QIOs) across the country to provide immediate assistance to nursing homes in hotspot areas.

HHS and CMS announced an initiative for rapid point-of-care diagnostic devices and tests in nursing homes. HHS announced the distribution of $5 billion in Provider Relief Funds, to be used to protect residents of nursing homes and long-term care facilities from the impact of COVID-19. On 17 August 2020, CMS announced resumption of all routine inspections of all care providers and suppliers.

Benchmarking with Australia: What can we learn?

In the Australian context, the Australian Commission on Safety and Quality in Health Care, defines the standards for health care. Inspections are carried out by approved accrediting agencies who assess health service organisations on the National Safety and Quality Health Service Standards. Thus far, seven agencies have been accredited to carry out inspections. Since these are private commercial organisations, information pertaining to their operations and adaptation of inspection methodologies to the COVID-19 pandemic is not readily available as would be the case with state owned enterprises.

Safe Work South Australia (SafeWorkSA) is a state-owned agency within the provincial government of South Australia. They are tasked with a similar role inasmuch as they are South Australia's workplace health and safety (WHS) regulator. They offer advice and education on work health and safety, provide licences and registration for workers and plant(equipment), investigate workplace incidents and enforce the work health and safety laws in South Australia.

SafeWorkSA has undertaken the following steps in adapting their operations as a result of COVID-19 i.e., closed its Customer Service Centre, on 19 March 2020. SafeWorkSA also postponed all non-essential site visits to minimise face-to-face interactions. Inspectors continued to physically/onsite respond to matters involving serious incidents and fatalities. Increased productivity to conduct a number of their activities online or via telephone. Inspectors undertook a telephone-based campaign. Implemented a rotational 50/50 split work from home arrangement.

An intranet portal was established for staff to interact with each other. SafeWorkSA staff were seconded to assist the Department of Health. They developed interim procedures, including a new risk assessment, to ensure that inspectors could respond to incidents without placing their health and wellbeing at risk. Interim procedures included not issuing any statutory notices, licence exemptions and fee waivers for those suffering financial hardship due to COVID-19.

2.1 External Environmental Analysis

The OHSC’s macro-environment was assessed, taking into consideration the: Political, Economic, Social, Technological, Legal/Ethics, Environmental (PESTLE) aspects. These trends have informed the development of the impact statement, outcomes, and outcome indicators to steer the organisation on its path to deliver on its mandate.

The OHSC’s macro-environment was assessed, taking into consideration the: Political, Economic, Social, Technological, Legal/Ethics, Environmental (PESTLE) aspects. These trends have informed the development of the impact statement,

outcomes, and outcome indicators to steer the organisation on its path to deliver on its mandate.

Table 1: Political, Economic, Social, Technological, Legal/Ethics, Environmental (PESTLE) Analysis

Political Environment
• Generally good political support for OHSC. • There is strong political will to embrace NHI and the role of the OHSC in this landscape. • Increased activism regarding public service delivery. • Potential for reports issued to be used for political purposes. • Rise in populism with a more militant approach to social change. • More conflictual collective bargaining environment.

Economic
• COVID-19, unrest within the country and other austerity measures have resulted in government funding being under pressure. • The levels of investor confidence are extremely low. • Unemployment rate in the country is at an all-time high. • South Africa has competing social, education, infrastructure, and health budget priorities. • OHSC currently has financial challenges with regards to conducting of inspections in all provinces. OHSC needs to diversify its income streams. • Additional sources of funding for the OHSC under consideration. • The weakening of the Rand, rising inflation levels and possible interest rate increases are soon to become a reality. • Potential for economic opportunities and employment on the decline. • Possibility of further consolidation of public sector entities.

Social

• OHSC has received generally good public support.
• There needs to be greater social education and awareness of the OHSC and its functions.
• Impact of COVID-19:
  • Social impact of COVID-19 on the workforce.
  • Workplaces migrated to working from home (hybrid model).
  • There is an increased awareness of social media and digital connectedness. Social media like (Facebook, Twitter, Snapchat, blogs) can be used as an effective tool for communication with stakeholders to keep them informed of the work of OHSC.
• Degradation of social fibre.
• The organisation has cultivated a good working relationship with other health agencies/regulators.
• The OHSC receives good support from the Auditor-General.
• Co-operation with key external stakeholders i.e., (private healthcare facilities, medical aid schemes, etc is required.
• Form loose affiliations with organised labour.

Technological
• Investigate new trends and technology in safe and quality healthcare – embrace the most recent technology. • There is a need to keep abreast of advances in technology (4IR) as well as new trends and methodologies in respect of safe and quality healthcare facilities. • Information security challenges. • Open-source platforms and optimising operations and access to technology. • Rise of flexible working and tele-commuting. • Real potential of a paperless environment. • The rise of 'big data', predictive analytics and intelligent forecasting and reporting tools. • Availability of "off-the-shelf" software to impact ICT process, e.g., recording, tracking, and reporting. • Increasing sophistication of threats on IT security and HRM processes. • Increasing cost effective technology for effective knowledge management. • Prioritise electronic communication.

Legal/Ethics
• Delays in the implementation of the NHI. • Current changes in the legislative environment - the NHI Bill will potentially influence operations. • Look at steps and procedures to be followed on litigations - there will always be legal challenges from health facilities.

Environmental
• Geographical distance makes work challenging - nature of where we work. • Climate change and global warming has led to the environment becoming a global agenda item. The public is becoming more and more aware of the environment as they would like to preserve the environment for future generations. OHSC plays a key role in protecting the environment for the current and future generations through its regulatory functions on the safe management and disposal of waste from health establishments. • OHSC environmental responsibilities in respect of sustainable consumption. • Increasing resource scarcity - water & electricity. • Need to minimise its Carbon Footprint. Reduced consumption - printing, water, and electricity. Rise in environmentally friendly practices. • Need to innovatively share and package information.

2.2 Internal Environmental Analysis

A SWOT analysis is a powerful tool for sizing up an organisation's resource capabilities and deficiencies. The OHSC's internal strengths and weaknesses,

together with the external opportunities and threats referenced earlier, were evaluated to provide a basis for re-aligning, re-prioritising and refining the OHSC's impact statement, outcomes and outcome indicators. The purpose is for the OHSC to optimise identified strengths, harness opportunities, offset identified weaknesses and mitigate threats.

Strengths are factors that give the OHSC a distinctive advantage or competitive edge within the environment within which it operates. The organisation can use such factors to accomplish its strategic objectives. The weaknesses refer to a limitation, fault, or defect within the organisation that prevent it from achieving its objectives; it is what an organisation does poorly or where it has inferior capabilities or limited resources as compared to other organisations within which it operates. Opportunities include any favourable current or prospective situation which could be facilitated to allow the organisation to enhance its competitive edge. Threats may be a barrier, constraint, or anything which may inflict challenges, damages, harm, or injury to the organisation.

Table 2: (Strengths, Weaknesses, Opportunities, and Threats) SWOT Analysis

Strengths	**Weaknesses**
• OHSC's mandate is legislated and unambiguous. • Core staff is qualified and experienced. • Technical expertise in inspections and complaints investigations. • Board and management are committed to the open, transparent, and accountable management of OHSC – approachable leadership. • Political support for the OHSC. • International and local connectedness and Memoranda of Understanding (MoUs) in place. • Clean audits as part of good reputation. • Young staff contingent, who are dedicated, innovative and open to change. • Strong, ethical ethos of management and staff.	• Unsustainability of funding – this negatively influences acting on the mandate. • Lack of resources (human and financial) and equipment (tools of trade). • Lack of project management capability. • Unconducive organisational culture. • Lack of adequate funding to fulfil mandate. • Lack of advanced ICT and analysis systems. • Centralised at the moment but diversified service delivery model to be implemented when funding is made available. • Lack of a clear cohesive focus – interpretation of mandate varied. • Conduct and style - tick-box compliance mode. • Sustainable leadership – high rate of turnover.

	• Internal communication structures not adequate and needs improvement. • Lack of brand identity and image. • Internal processes and systems not completely in place. • Change management processes need to be strengthened. • Lack of critical mass of skilled and suitable qualified individuals to conduct inspections - critical skills shortage.
Opportunities	**Threats**
• Establish own legislation as a Regulator. • Embrace technology (4IR) to drive all processes in the organisation. • Self-funding activities: offer other services, training opportunities etc. • Alternative sources of funding – co-joining other institutions. • Room for physical and resource growth. • Contributing to quality care for patients. • Look at ways to support health care for women (7 domains of health). • Catalyst to fast track the NHI – being adequately prepared. • Opportunity to pursue and implement the Health Market Inquiry recommendations. • Charging for inspections. • Evolving culture. • Meaningful contribution to South Africa's socio-economic transformation, NDP and MTSF imperatives.	• Partial funding of mandate. • Massive mandate – the task will take time to fulfil. • Other bodies and institutions creeping on OHSC mandate. • Litigation. • High staff turnover – loss of critical skills. • Communication with stakeholders not adequate. • Negative public perception and sentiment regarding the inspections of health facilities. • Delays in finalisation of NHI Bill will compromise sustainability and mandate of the OHSC. • Change in regulatory requirements. • Loss of mandate due to non-delivery.

• Centre of excellence in regulation. • Render advisory services to the AU and SADC countries. • Build strong co-operative partnerships with research organisations and higher education institutions to enhance and complement OHSC's competencies. • Public participation. • Harness innovation by staff. • Become the employer of choice in the sector. • Nurture and cultivate a productive workforce.	

2.3 Stakeholder Analysis

OHSC's stakeholder management strategy ensures that the advancement of enhanced stakeholder participation and corporate transparency go hand in glove. Stakeholder confidence building strategies and policies are specific and take into account various diversities.

Table 3: Stakeholder Analysis Matrix depicts the variety of stakeholders who assume substantial influence over the operation of the organisation. These stakeholders have respective expectations that must be fulfilled as tabulated below:

Table 3: Stakeholder Analysis Matrix

Stakeholder	Influence	Expectation
Minister (Executive Authority)	• Identifying, monitoring, and reporting on impact of strategy	• Policy development • Enhancing reputation • Risk Management
National & Provincial Depts of Health	• Consultation	• Accountability • Contribution to National Priorities
Recipients of Healthcare	• Report complaints to various stakeholders	• Deal with complaints
Public & Private Health Establishments	• Implement healthcare standards / Compliance	• Fair process
Health Ombud	• Deal with appeals	• OHSC will respond in compliance with legislation
The Board & Governance Committees	• Strategic direction	• Transparency • Accountability • Governance, Integrity, Ethics
Parliamentary Portfolio Committees	• Sanction • Legislation • Oversight budget and reporting	• Accountability • Governance, Integrity, Ethics • Contribution to National Priorities
Staff	• Productivity • Morale • Public perception • Performance effectiveness	• Fairness • Respect of worker rights • Equity • Involvement • Best practice HRM policies/practices • Conducive work environment • Adequate resourcing • Transparency

Stakeholder	Influence	Expectation
		• Ethical behaviour
Media	• Public perception	• Regular communication • Transparency • Access to information
Organised Labour	• Policies • Productivity	• Framework for engagement • Willingness to work • Transparency • Communication • Fairness • Enabling environment for association
The Public/ Public Interest Groups	• Operations • Strategy • Culture	• Transparency • Fairness • Consistent delivery • Integrity • Values orientation • Information sharing
Suppliers	• Risk • Effectiveness • Turnaround	• Transparency • Fairness • Consistency • Ethical behaviour
National Treasury (NT)	• Regulatory environment • Remuneration • Budgeting	• Reporting • Governance • Revenue collection
Auditor General (AG)	• Regulatory environment • Remuneration	• Reporting • Governance • Audit outcomes • Performance
International Partners, Agencies and other international bodies etc	• Policy • Guidance • Safety standards • Direction	• Compliance • Implement international best practice-benchmarking • Capacity building • Research and Development • Collaboration
Regulators	• Source of regulation	• Service delivery • Efficiency • Fairness • Regulate

Stakeholder	Influence	Expectation
		• Transparency • Due process • Cooperation
Scientific & Academic Institutions	• Research agenda	• Partnerships • Collaboration • Compliment the research and development mandate

2.4 Status of compliance with the Broad-Based Black Economic Empowerment (BBBEE) Act

A BBBEE compliance status was prepared by an independent service provider. This report indicated a non-compliance status. The OHSC will engage with the Broad-Based Black Economic Empowerment Commission to seek advice on how to enhance compliance with the Broad-Based Economic Empowerment Act. These activities will be completed during the 2022/23 financial year.

2.5 Organisational Structure

2.5.1 Governance Structure

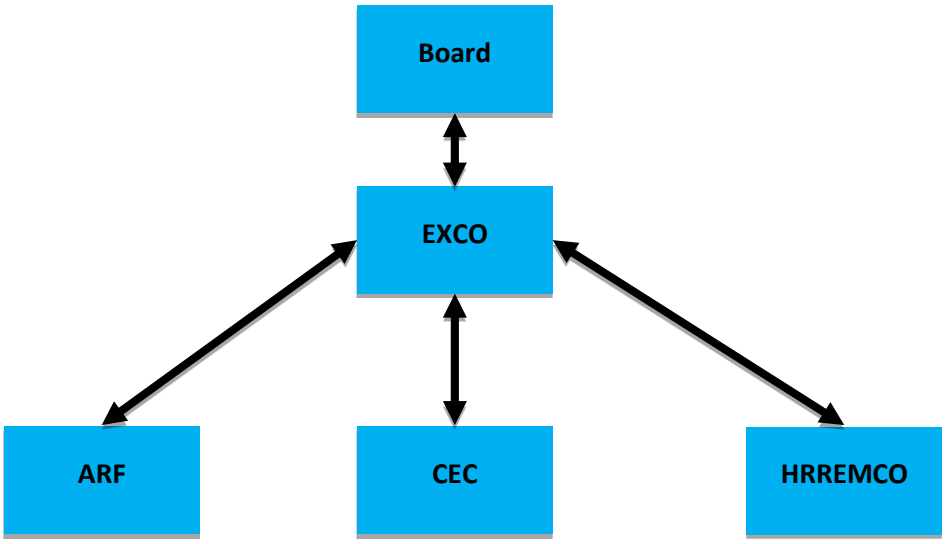
The OHSC is a Schedule 3A public entity that reports to the Executive Authority i.e., the Minister of Health. The OHSC's activities are funded by the provision of a budget from funds voted annually to the NDoH. The governance of the OHSC is entrusted to a Board appointed in accordance with Section 79 of the National Health Amendment Act, 2013 (Act No 12 of 2013). Section 79 B (1) provides that the Board consists of no less than 7 and no more than 12 members appointed by the Minister. In terms of Section 79B, the Minister has appointed 11 members.

Currently the Board has the following committees:

1) EXCO- Board Chairperson and Chairpersons of the Board sub-committees
2) Certification and Enforcement Committee
3) Audit, Risk and Finance Committee
4) Human Resource and Remuneration Committee

The OHSC's Accounting Authority (OHSC Board) is accountable for the OHSC governance and oversight. Good governance is crucial to business sustainability and growth of the organisation. The OHSC Board sub-committees advise the Accounting Authority on matters pertaining to the OHSC programmes and governance.

The Chief Executive Officer, assisted by a senior management team which comprises of the Chief Financial Officer, Executive Managers and Programme Managers, are responsible for the day-to-day running of the OHSC.



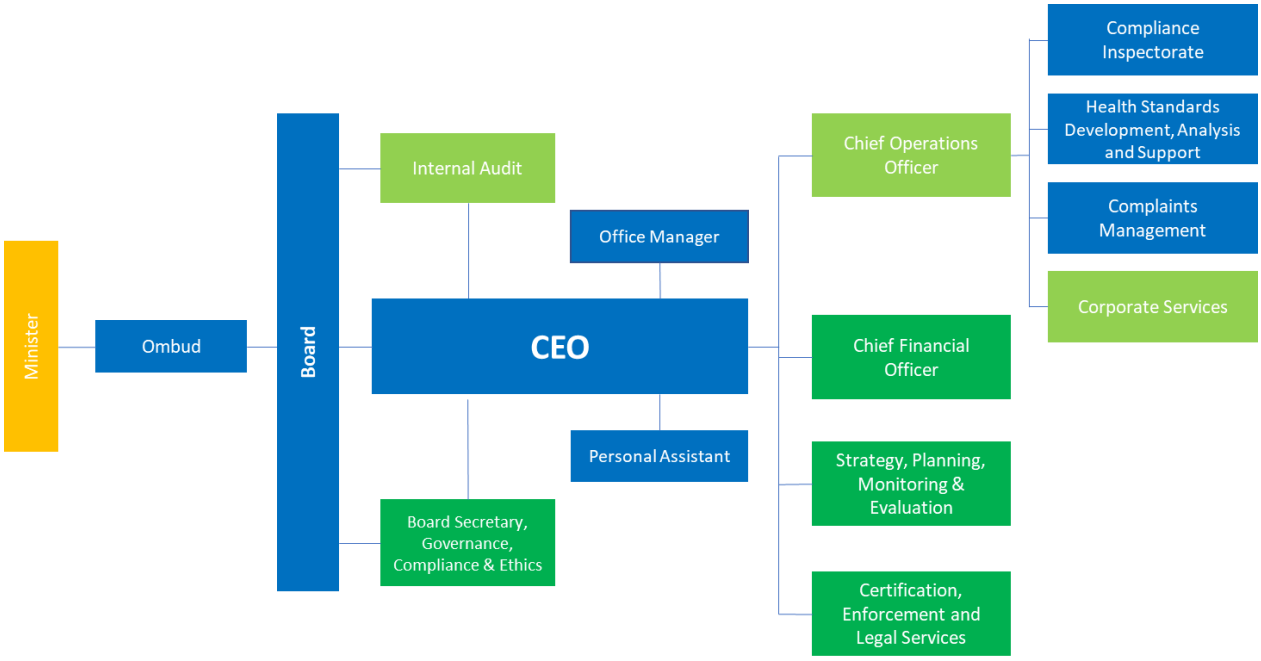
2.5.2 Operational Structure

The current operational structure of the OHSC was approved by the Board. The OHSC underwent an organisational development and design process where the structure has been adjusted to ensure that it remains relevant and appropriate to organisational requirements. The organisational structure of the OHSC has therefore been designed according to the design principles of consistency, continuity, accountability, flexibility and efficiency. The OHSC strives to ensure that it has the right people, with the right skills and competencies available at the right time, at the appropriate level to deliver on its mandate.

In order to ensure consistency and continuity, the OHSC will embark on a full Workforce Planning exercise or scenario forecasting (quantitative and qualitative)

exercise that will determine its specific resourcing requirements (as contained within a Workforce and Strategic Sourcing Plan) for coming years.

The organogram that follows represents the organisational structure for 2022/23 of the OHSC. It sets out the operational structures, based on the OHSC's Strategy 2020-2025 and Annual Performance Plan 2022/23, which will best enable it to deliver on its mandate.



Part C: Measuring Our Performance

1. Institutional Programme Performance Information

1.1 Programme 1: Administration

Programme Purpose

The purpose of the programme is to provide the leadership and administrative support necessary for the OHSC to deliver on its mandate and comply with all relevant legislative requirements.

1.1.1 Sub-programme: Human Resource Management

Sub-programme Purpose

The purpose of the sub-programme is to create an enabling environment for employees to contribute towards the achievements of the organisation objectives and mandate. The Human Resource Management Unit (HR) enables the Office to attract, develop and retain skilled people and to meet transformation targets.

1.1.1.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 1: A fully functional OHSC								
Output 1.1: Vacancies filled within four months of the vacancy existing								
Output Indicator 1.1.1	Percentage of vacancies filled within four months of the vacancy existing[1]	-	-	41.7% (10/24)	90%	90%	91%	92%
Output Indicator 1.1.2	Percentage vacancy rate per year[2]	-	-	-	New Indicator	7%	6%	5%
Output 1.2: Inspectors certified after completion of training								
Output Indicator 1.2.1	Percentage of certified inspectors after completion of training[3]	-	-	80% (49/61)	95%	95%	95%	95%

1.1.1.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 1.1: Vacancies filled within four months of the vacancy existing							
Output Indicator 1.1.1	Percentage of vacancies filled within four months of the vacancy existing	Quarterly	90%	75%	76%	85%	90%
Output Indicator 1.1.2	Percentage vacancy rate per year	Annually	7%	-	-	-	7%
Output 1.2: Inspectors certified after completion of training							
Output Indicator 1.2.1	Percentage of certified inspectors after completion of training	Annually	95%	-	-	-	95%

1.1.1.3 Explanation of Planned Performance Over the Medium-Term Period

A fully functional OHSC, staffed with people with right skills and knowledge to perform their work in order to enable the OHSC to achieve its mandate.

Certified Inspections will assist the OHSC in ensuring that the quality of inspection reports is greatly improved. The outcomes contribute to ensuring that OHSC fulfil its mandate through the use of certified inspectors, and it is also fully functional as an organisation in which posts are filled within a specific time period.

1.1.1.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	Quality improvement in the provision of care	Augment Human resources for Health operation plan	A fully functional OHSC

1.1.2 Sub-programme: Information and Communication Technology (ICT)

Sub-programme Purpose

The purpose of the Information and Communication Technology (ICT) sub-programme is to provide and ensure infrastructure and systems are fully available for business to utilise effectively in achieving its operational objectives. The ICT programme undertakes long-term planning and provides day-to-day support across the OHSC in respect of ICT needs, services and systems. The main purpose of this ICT strategic plan is to guide the development and management of the ICT environment within the OHSC to contribute to effective service delivery and to meet a broad set of evolving organisational needs.

1.1.2.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 1: A fully functional OHSC								
Output 1.4: IT Service Availability								
Output Indicator 1.4.1	Percentage of ICT availability for core OHSC services	-	-	99.84%	95%	95%	95%	95%
Output Indicator 1.4.2	Percentage of ICT availability for OHSC support services	-	-	98.22%	95%	95%	95%	95%

1.1.2.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 1.4: IT Service Availability							
Output Indicator 1.4.1	Percentage of ICT availability for core OHSC services	Quarterly	95%	95%	95%	95%	95%
Output Indicator 1.4.2	Percentage of ICT availability for OHSC support services	Quarterly	95%	95%	95%	95%	95%

1.1.2.3 Explanation of Planned Performance Over the Medium-Term Period

The OHSC aims to expand its ICT efforts by**:**

- Strengthen the use of technology to improve service delivery.
- Ensure that OHSC as proper functional equipment for staff to achieve operational objectives.
- Monitoring and evaluation of IT systems on monthly basis.
- Scheduled maintenance on IT infrastructure to ensure technology is healthy.
- Upgrade of system software.
- Future enhancement to system to optimise performance (upgrade of technology and systems)

1.1.2.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
Goal 8: Universal health care coverage	**Goal 4** – Build Health infrastructure for effective service delivery.	Efficient health management information system for improved decision making.	Fully functional OHSC Ensure that OHSC systems are functional this allows for OHSC to contribute toward NDOH/MTSF and Presidential Health Summit objectives

1.1.3 Sub-programme: Communication and Stakeholder Relations

Sub-programme Purpose

To raise awareness on the role and powers of the OHSC and Health Ombud. The Communication and Stakeholder Relations sub-programme aims to facilitate delivery of the OHSC and Health Ombud's mandate through effective stakeholder engagement and developing partnerships that are mutually beneficial.

1.1.3.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 1: A fully functional OHSC								
Output 1.5: Awareness about the role and powers of the OHSC is raised								
Output Indicator 1.5.1	Number of community stakeholder engagements to raise public awareness on the role and powers of the OHSC and Health Ombud[4]	-	-	12	12	12	12	12
Output Indicator 1.5.2	Number of private sector engagements to raise awareness on the role and powers of the OHSC and Health Ombud[5]	-	-	8	8	8	8	8

1.1.3.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 1.5: Awareness about the role and powers of the OHSC is raised							
Output Indicator 1.5.1	Number of community stakeholder engagements to raise public awareness on the role and powers of the OHSC and Health Ombud	Quarterly	12	3	3	3	3
Output Indicator 1.5.2	Number of private sector engagements to raise awareness on the role and powers of the OHSC and Health Ombud	Quarterly	8	2	2	2	2

1.1.3.3 Explanation of Planned Performance Over the Medium-Term Period

The OHSC aims to expand its communication efforts to the public and stakeholders – especially health establishments – by:

- Utilising community radio to reach greater numbers of stakeholders including women more efficiently than is possible by face-to-face communication – and overcoming potential barriers posed by the COVID-19 pandemic.
- Building its programme of webinars to reach more stakeholders across all provinces.
- Collaborating with other regulators and organisations representing health establishments and health service users to share information across the country.
- Strengthening the use of digital media platforms to update stakeholders timeously of decisions taken by the OHSC.
- In addition, now that the inspection of health establishments is based on promulgated regulations, priority will be given to working with relevant programmes to publish reports on the process and outcomes of inspection, as required by legislation.

1.1.3.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	**Goal 1:** Increase Life Expectancy, improve health and Prevent Disease	**Pillar 4:** Engage the private sector in improving the access, coverage, and quality of health services.	**A fully functional OHSC:** Community and private sector engagements to raise awareness of the role and powers of the OHSC and Ombud.

1.1.4 Sub-programme: Finance and Supply Chain Management

Sub-programme Purpose

The OHSC is a public entity with a regulatory mandate in the health sector, where accountability and transparency are of paramount importance. It is crucial for the OHSC to demonstrate accountability by obtaining an unqualified audit in order to promote public trust in the OHSC and the way the OHSC conducts its affairs, both in financial governance and performance reporting

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1.1.4.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 1: A fully functional OHSC								
Output 1.6: Unqualified audit opinion achieved								
Output Indicator 1.6.1	Unqualified audit opinion achieved	-	-	Unqualified audit	Unqualified audit	Unqualified audit	Unqualified audit	Unqualified audit

1.1.4.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 1.6: Unqualified audit opinion achieved							
Output Indicator 1.6.1	Unqualified audit opinion achieved	Annual	Unqualified audit	N/A	N/A	N/A	Unqualified audit

1.1.4.3 Explanation of Planned Performance Over the Medium-Term Period

The Finance and Supply Chain Management sub-programme ensures compliance with all relevant financial statutes and regulations. In order to ensure the achievement of an unqualified audit, the following will be implemented:

- Ensuring compliance with the relevant legislative prescripts
- Monitoring of implementation of audit recommendations
- Regular risk and fraud risk assessments

- Policies and procedures are reviewed from time to time to ensure relevance and responsiveness to changing circumstances

1.1.4.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	**Goal 2:** Achieve UHC by implementing NHI Policy	**Pillar 6:** Improve the efficiency of public sector financial management systems and processes	**A fully functional OHSC** Unqualified Audit Opinion Achieved by the OHSC

1.1.5 Programme Resource Considerations

Overall Budget Allocation

OHSC

Economic classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	**133,081,000**	**149,449,624**	**150,382,076**	**146,581,642**	**153,708,208**
Compensation of employees	89,781,489	105,444,163	98,788,864	99,108,297	102,456,207
Goods and services of which:	43,299,511	44,005,462	51,593,212	47,473,345	51,252,001
Board fees and related costs	959,202	1,491,339	1,344,579	1,344,579	1,344,579
Travel,subsistence and accommodation	4,533,873	11,764,146	19,344,331	13,611,460	14,346,321
Training and development	393,210	1,054,442	987,889	991,083	1,024,562
Venues and facilities	-	1,055,987	391,488	503,156	525,747
Catering services	35,775	50,000	47,968	39,574	41,351
Consulting and professional services	1,438,675	1,370,188	1,858,861	1,972,898	2,094,196
Inventory and consumables	941,828	355,615	857,667	895,670	935,714
Advertising	365,307	249,698	260,261	196,842	284,048
Relocation expenses	60,301	57,650	62,851	62,984	63,008
Printing and stationery	352,118	300,000	300,000	300,000	300,000
Bank charges	63,482	78,867	82,203	85,861	89,716
Insurance	268,914	280,000	350,000	385,000	423,500
Water, electricity, rates and taxes	3,927,463	3,600,066	3,600,066	3,589,755	3,749,499
Cleaning services	1,845,280	1,971,914	648,407	675,926	704,928
Communication costs (telephone and data)	1,741,249	1,300,000	932,754	974,262	1,018,006
Lease payments	10,259,103	12,448,689	13,411,243	14,475,685	15,625,007
Depreciation and amortisation	7,068,643	-	-	-	-
Audit costs	1,217,844	1,447,542	1,421,240	1,487,567	1,557,358
IT maintenance and support	4,819,342	2,230,997	1,236,000	1,346,000	2,489,883
Legal fees	467,528	1,000,000	1,374,136	1,395,235	1,417,471
Motor Vehicle expenses	80,870	100,000	112,568	117,578	122,857
Loss on asset theft	20,637	-	-	-	-
Postage and couriers	8,497	8,967	9,000	9,000	9,000
Subscription	278,942	-	188,512	196,456	204,827
Repairs and maintenance	204,071	149,630	586,481	588,248	605,714
Security services	682,882	839,724	984,708	1,028,528	1,074,708
Publications and marketing	1,264,478	800,000	1,200,000	1,200,000	1,200,000
PAYMENTS FOR CAPITAL ASSETS	**2,632,826**	**2,439,376**	**7,126,924**	**6,144,358**	**5,890,792**
Other machinery and equipments	163,125	328,126	300,000	150,000	-
Office furniture	10,447	-	50,000	-	50,000
Software and intangible assets	2,005,195	1,591,250	6,276,924	5,444,358	5,240,792
Computer equipment	454,059	520,000	500,000	550,000	600,000
TOTAL	**135,713,826**	**151,889,000**	**157,509,000**	**152,726,000**	**159,599,000**

Programme 1: Administration

Economic Classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	**61,819,046**	**58,983,712**	**57,553,081**	**59,083,622**	**62,782,965**
Compensation of employees	24,214,238	28,260,074	27,189,350	27,265,599	28,007,715
Goods and services of which:	37,604,808	30,723,638	30,363,731	31,818,023	34,775,250
Board fees and related costs	959,202	1,491,339	1,344,579	1,344,579	1,344,579
Travel,subsistence and accommodation	29,463	454,123	690,865	721,608	754,008
Training and development	393,210	1,054,442	987,889	991,083	1,024,562
Venues and facilities	-	194,631	191,488	200,010	208,990
Catering services	21,869	15,891	16,563	17,300	18,077
Consulting and professional services	403,512	748,277	538,075	562,019	584,588
Inventory and consumables	938,142	301,190	848,258	886,006	925,787
Advertising	350,175	249,698	260,261	196,842	284,048
Relocation expenses	60,301	57,650	62,851	62,984	63,008
Printing and stationery	352,118	300,000	300,000	300,000	300,000
Bank charges	63,482	78,867	82,203	85,861	89,716
Insurance	268,914	280,000	350,000	385,000	423,500
Water, electricity, rates and taxes	3,927,463	3,600,066	3,600,066	3,589,755	3,749,499
Cleaning services	1,845,280	1,971,914	648,407	675,926	704,928
Communication costs (telephone and data)	1,741,249	1,300,000	932,754	974,262	1,018,006
Lease payments	10,259,103	12,448,689	13,411,243	14,475,685	15,625,007
Depreciation and amortisation	7,068,643	-	-	-	-
Audit costs	1,217,844	1,447,542	1,421,240	1,487,567	1,557,358
IT maintenance and support	4,819,342	2,230,997	1,236,000	1,346,000	2,489,883
Legal fees	345,122	600,000	359,721	375,728	392,598
Motor Vehicle expenses	80,870	100,000	112,568	117,578	122,857
Loss on asset theft	20,637	-	-	-	-
Postage and couriers	8,497	8,967	9,000	9,000	9,000
Subscription	278,942	-	188,512	196,456	204,827
Repairs and maintenance	204,071	149,630	586,481	588,248	605,714
Security services	682,882	839,724	984,708	1,028,528	1,074,708
Publications and marketing	1,264,478	800,000	1,200,000	1,200,000	1,200,000
PAYMENTS FOR CAPITAL ASSETS	**2,632,826**	**2,439,376**	**7,126,924**	**6,144,358**	**5,890,792**
Other machinery and equipments	163,125	328,126	300,000	150,000	-
Office furniture	10,447	-	50,000	-	50,000
Software and intangible assets	2,005,195	1,591,250	6,276,924	5,444,358	5,240,792
Computer equipment	454,059	520,000	500,000	550,000	600,000
TOTAL	**64,451,872**	**61,423,088**	**64,680,005**	**65,227,980**	**68,673,757**

The Administration Programme comprises the Office of the CEO, Corporate Services, Governance, Monitoring and Evaluation, Board Secretariat, as well as Communication and Stakeholder Relations. The programme provides the critical strategic support services and systems necessary for the OHSC to deliver on its mandate and comply with relevant legislative requirements.

The budget in this Programme will fund the requisite information systems which will support all functions of the OHSC, including the lease of office space, as well as Board and related costs to enable adequate corporate governance and oversight.

Other support functions include audit costs, training and development, telephone, and data costs, as well as information technology maintenance and support.

Provision has also been made for the development of a business continuity plan to ensure sustainability of the OHSC operations.

1.2 Programme 2: Compliance Inspectorate

Programme Purpose

To manage the inspection of health establishments in order to assess compliance with the national health system norms and standards regulations, as prescribed by the Minister.

1.2.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 2: Compliance with norms and standards is effectively monitored								
Output 2.1: Health establishments are inspected for compliance with the norms and standards								
Output Indicator 2.1.1	Percentage of public health establishments inspected for compliance with the norms and standards	19,13% (730/ 3 816)	16,95% (647/ 3 816)	10,14% (387/ 3 816)	8% (299/ 3 741)	21% (788/ 3 741)	22% (823/ 3 741)	22% (823/ 3 741)
Output Indicator 2.1.2	Percentage of private health establishments inspected for compliance with the norms and standards	-	-	0% (0/431)	6% (26/431)	12% (52/431)	15% (65/431)	20% (87/431)
Output 2.2: Additional inspection is conducted in health establishments where non-compliance was identified								
Output Indicator 2.2.1	Percentage of additional inspection (re-inspection) conducted in public and private health establishments that have completed the regulated reporting period where non-compliance was identified	-	-	100%	100%	100%	100%	100%
Output 2.3: Regulated inspection reports are published								
Output Indicator 2.3.1	Number of reports of inspections conducted with the names and location of the health establishments every six months published[6]	-	-	-	-	2	2	2
Output Indicator 2.3.2	Number of annual reports that set out the compliance status of all health establishments and summarises the number and nature of the compliance notices issued published[7]	-	-	1	1	1	1	1

1.2.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 2.1: Health establishments are inspected for compliance with the norms and standards							
Output Indicator 2.1.1	Percentage of public health establishments inspected for compliance with the norms and standards	Quarterly	21% (788/ 3 741)	5,27% (197/ 3 741)	5,27% (197/ 3 741)	5,27% (197/ 3 741)	5,27% (197/ 3 741)
Output Indicator 2.1.2	Percentage of private health establishments inspected for compliance with the norms and standards	Quarterly	12% (52/431)	3,02% (13/431)	3,02% (13/431)	3,02% (13/431)	3,02% (13/431)
Output 2.2: Additional inspection is conducted in health establishments where non-compliance was identified							
Output Indicator 2.2.1	Percentage of additional inspection (re-inspection) conducted in public and private health establishments that have completed the regulated reporting period where non-compliance was identified	Quarterly	100%	-	80%	90%	100%
Output 2.3: Regulated inspection reports are published							
Output Indicator 2.3.1	Number of reports of inspections conducted with the names and location of the health establishments every six months published	Bi-Annual	2	-	1	-	1
Output Indicator 2.3.2	Number of annual reports that set out the compliance status of all health establishments and summarises the number and nature of the compliance notices issued published	Annual	1	-	-	-	1

1.2.3 Explanation of Planned Performance Over the Medium-Term Period

The most critical input is the appointment of additional inspection teams to increase coverage of all types of institutions over time. In order to ensure effective functioning of the inspection teams during onsite inspections, there is a critical need for tools of trade, travel costs, as well as accommodation. Inspection coverage should reach 100% in remaining 3 years. There will also be a need to conduct additional inspections in cases where the health facilities are not compliant. In addition, the early warning system may trigger that a risk-based inspection be conducted.

Assumptions for planned performance over the medium-term period:

- Quality Learning Centre (QLC) project with NDOH to augment the budget of the inspectorate
- Reconsideration of budget priorities to increase the budget of the inspectorate
- No major disruptions (COVID-19, unrests, staff turnover, etc.)
- Alternative staffing solutions to allow for temporary and other forms of employment

1.2.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	Quality improvement in the provision of care	Augment Human resources for health operational plan	Compliance with norms and standards is effectively monitored

1.2.5 Programme Resource Considerations

Economic classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	40,988,501	53,988,829	58,469,205	52,854,270	55,233,203
Compensation of employees	36,166,234	44,129,113	40,804,570	40,994,949	42,715,369
Goods and services of which:	4,822,267	9,859,716	17,664,635	11,859,321	12,517,834
Travel,subsistence and accommodation	4,457,560	9,848,308	17,652,744	11,846,901	12,504,856
Catering services	707	6,068	6,325	6,606	6,903
Consulting and professional services	364,000	-	-	-	
Inventory and consumables	-	5,341	5,566	5,814	6,075
TOTAL	**40,988,501**	**53,988,829**	**58,469,205**	**52,854,270**	**55,233,203**

The Compliance Inspectorate is the largest programme of the OHSC and requires adequate funding to achieve its performance targets for the inspection of health establishments.

The mandate of the OHSC, coupled with the critical role in the implementation of the NHI requires that the current number of inspectors be increased.

The biggest proportion of the unit's budget is allocated towards salaries to ensure that there are enough inspectors and support staff to enable the OHSC to conduct the legislated inspections required to enhance and enforce compliance with the

promulgated norms and standards. The remainder of the budget goes towards the actual cost of inspections, including travel, subsistence, and accommodation.

Inspections come with all the requirements for the inspection teams to function in terms of travel costs, subsistence, and accommodation.

1.3 Programme 3: Complaints Management

Programme Purpose:

The purpose of this programme is to consider, investigate and dispose of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical, and expeditious manner

Sub-programme:

Sub-programmes: The Complaints Management Programme comprises three distinct but inter-related programmes:

i. Complaints Call Centre (CCC) – call centre operators are employed by OHSC to receive complaints from the public through calls, email and written letters. They register, record and screen all complaints received and refer to the next level as appropriate. All low-risk complaints are addressed at the level of the call centre.

ii. Complaints Assessment Unit (CAU) – All complaints that receive a medium and high-risk rating are referred to the Complaints Assessment Unit (CAU). Assessors are employed by OHSC to analyse and assess medium and high-risk rated complaints. Cases that are assessed as high are further escalated to the Investigation Unit to be investigated.

iii. Complaints Investigation Unit (CIU) – All complaints that receive a high and extreme risk rating are referred to the Complaints Investigation Unit. Investigators are employed to investigate high and extreme risk rated complaints.

1.3.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018/19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 3: Improved quality of health care services rendered to the users in the Health Establishments								
Output 3.1: Low risk complaints resolved within twenty-five working days of lodgement in the call centre								
Output Indicator 3.1.1	Percentage of low-risk complaints resolved within twenty-five working days of lodgement in the call centre	-	-	91,81%	74,59%	80%	85%	90%
Output 3.2: User complaints resolved within 30 working days through assessment after receipt of a response from the complainant and/or the health establishment								
Output Indicator 3.2.1	Percentage of user complaints resolved through assessment within 30 working days of receipt of a response from the complainant and/or the health establishment	49,42%	7.3%	2.46%	11.8%	65%	70%	75%
Output 3.3: Complaints resolved within 6 months through investigation								
Output Indicator 3.3.1	Percentage of complaints resolved within 6 months through investigation	6.5%	10%	11,11%	12%	15%	20%	40%
Output 3.4: Complaints resolved within 12 months through investigation								
Output Indicator 3.4.1	Percentage of complaints resolved within 12 months through investigation[8]	-	-	0%	0%	5%	5%	5%

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018/19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Output 3.5: Complaints resolved within 18 months through investigation								
Output Indicator 3.5.1	Percentage of complaints resolved within 18 months through investigation[9]	-	-	New Indicator	0%	2%	2%	2%

1.3.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting period	Annual targets	Q1	Q2	Q3	Q4
Output 3.1: Low risk complaints resolved within twenty-five working days of lodgement in the call centre							
Output Indicator 3.1.1	Percentage of low-risk complaints resolved within twenty-five working days of lodgement in the call centre	Quarterly	80%	60%	70%	75%	80%
Output 3.2: User complaints resolved within 30 working days through assessment after receipt of a response from the complainant and/or the health establishment							
Output Indicator 3.2.1	Percentage of user complaints resolved through assessment within 30 working days of receipt of a response from the complainant and/or the health establishment	Quarterly	65%	40%	45%	55%	65%
Output 3.3: Complaints resolved within 6 months through investigation							
Output Indicator 3.3.1	Percentage of complaints resolved within 6 months through investigation	Quarterly	15%	5%	10%	10%	15%
Output 3.4: Complaints resolved within 12 months through investigation							
Output Indicator 3.4.1	Percentage of complaints resolved within 12 months through investigation	Quarterly	5%	5%	5%	5%	5%
Output 3.5: Complaints resolved within 18 months through investigation							
Output Indicator 3.5.1	Percentage of complaints resolved within 18 months through investigation	Quarterly	2%	2%	2%	2%	2%

1.3.3 Explanation of Planned Performance Over the Medium-Term Period

The effective and efficient consideration of complaints by the Complaints Management Programme and Office of the Ombud will support strengthening of the health system, improve safe and quality healthcare as well as reduce the high burden of medico-legal claims against the national health system.

There will be effective health services for users as the basis for an equitable healthcare delivery platform, who will receive timely responses to their complaints.

Quality of healthcare services will be improved for the users of health services

Secondment of staff to the Health Ombud by the OHSC will limit dual reporting and handling of complaints by the relevant authority as guided by NHA and related regulations.

The capacitation of the Complaints Management programme, in terms of staff and / training will add value towards the achievement of the programme outputs and other related projects.

The resolution of user complaints and the impact of the Health Ombud's recommendations on the national health system will be monitored.

Capacity building and peer review mechanisms with similar organisations are envisaged to streamline the management of complaints, especially with regards to production of complaints reports that will add impact. There is current engagement with the UK Parliamentary Health Services Ombud (PHSO) and ongoing engagement with the International Ombudsman Institute (IOI).

1.3.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	**Goal 2:** Achieve UHC by implementing NHI	**Pillar 4:** Engage the private sector in improving the access, coverage, and quality of health service; and **Pillar 6:** Improve the efficiency of public section financial management systems and processes.	Improved quality of health care services rendered to the users in the Health Establishments
	Goal 3: Quality improvement in the Provision of care	**Pillar 1:** Augment Human Resources Health Operational Plan **Pillar 2:** Ensure improved access to essential medicines, vaccines, and medical products through better management of supply chain equipment and machinery.	

1.3.5 Programme Resource Considerations

Economic classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	18,839,509	20,388,822	20,890,411	20,940,427	21,485,372
Compensation of employees	18,492,760	19,208,338	18,953,578	18,979,017	19,498,068
Goods and services of which:	346,749	1,180,484	1,936,833	1,961,410	1,987,304
Travel,subsistence and accommodation	(39,799)	328,389	552,110	576,679	602,572
Venues and facilities	-	61,356	-	-	-
Catering services	488	4,348	-	-	-
Agency and support outsourced	259,968	287,307	330,880	330,880	330,880
Legal fees	122,406	300,000	900,000	900,000	900,000
Consulting and professional services	-	150,000	150,000	150,000	150,000
Inventory and consumables	3,686	49,084	3,842	3,850	3,852
TOTAL	**18,839,509**	**20,388,822**	**20,890,411**	**20,940,427**	**21,485,372**

Over the past few years, there has been steady increase in the number of complaints received by the OHSC. The increase in the volume of complaints requires an addition of human resource capacity to enable timeous investigation, resolution, and disposal of complaints. Currently, the programme is inadequately resourced in terms of human resources, which, in some instances, contributes to delayed resolution of complex complaints.

The total budget in the programme has stayed virtually the same as in the prior year due to financial resource constraints and caters for the investigation of an increasing number of complaints received from the users of health care services.

Provision has also been made for expert panels to assist in investigations where appropriate, functioning of the complaints call centre, as well .as legal fees to cater for potential challenges related to the findings on investigations

1.4 Programme 4: Health Standards Design, Analysis and Support (HSDAS)

Programme Purpose

To provide high level technical analytical support to the functions of the Office through research and health system analysis; development of data collection tools, provide training in the use of the tools and in-depth analysis and interpretation of data collected, and the establishment of stakeholder networks for capacity building and co-creation of information management systems.

- Design and develop health norms and standards.
- Monitor and analyse health establishment data
- Manage research,

- Provide guidance to the relevant authorities on the implementation of the health norms and standards
- Provide ongoing training to inspectors
- Establish communication networks with stakeholders.

1.4.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018/19	2019/20	2020/21	2021/22	2022/23	2023/24	2024/25
Outcome 4: Facilitate achievement of compliance with the norms and standards regulations for different categories of health establishments								
Output 4.1: Implementation of recommended improvements by relevant authorities in the healthcare authorities								
Output Indicator 4.1.1	Number of recommendations reports for improvement in the healthcare sector made to relevant authorities	-	-	3	3	3	3	3
Output 4.2: Improved implementation of the norms and standards								
Output Indicator 4.2.1	Number of guidance workshops conducted to facilitate implementation of the norms and standards regulations	-	15	18	24	24	24	24

1.4.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 4.1: Implementation of recommended improvements by relevant authorities in the healthcare authorities							
Output Indicator 4.1.1	Number of recommendations reports for improvement in the healthcare sector made to relevant authorities	Annual	3	-	-	-	3
Output 4.2: Improved implementation of the norms and standards							
Output Indicator 4.2.1	Number of guidance workshops conducted to facilitate implementation of the norms and standards regulations	Quarterly	24	4	6	8	6

1.4.3 Explanation of Planned Performance Over the Medium-Term Period

The OHSC is required by law to inspect and certify health establishments as compliant with the norms and standards regulations. The inspection and certification processes are directly aligned to three (3) of the five (5) OHSC outcomes.

In view of the above outcomes, it is worth emphasising that the compliance inspection process for different categories of health establishments is dependent on:

(1) The development and availability of approved inspection tools
(2) Training of inspectors on the use of the inspection tools
(3) The guidance and support training provided to the relevant health authority on the intention of the norms and standards regulations, methods of collecting data and tools to be used.

In this regard, development of primary health care clinics (PHCs), community health centres (CHCs), the district and regional hospital tools have been finalised. We also envisage that inspection tools for private sector hospitals, tertiary and central hospitals would be finalised. Guidance and training workshops will continue for the different categories of health establishments. The General Practitioners (GP) consultative workshops will resume once the draft of the General Practice inspection tool is available. Recommendations reports for improvement of health establishments in relation to compliance with norms and standards regulations, Annual returns, Early Warning System, and norms and standards to be considered for promulgation by the Minister of health is ongoing.

The programme outputs in terms of development of inspection tools is an ongoing process and significant ground is being covered to finalise these to allow for

compliance inspections. The guidance and support workshops are being rolled to all relevant health authority to provide the requisite guidance on compliance with norms and standards regulations. In-depth analysis of data from the annual returns, the early warning system, complaints management system, and compliance inspection would enable production of recommendation reports for norms and standards to be promulgated as well as for improvement on compliance with norms and standards regulations.

1.4.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	Goal 2: Achieve UHC by Implement NHI	Pillar 5: Improve the quality, safety, and quantity of health services provided with a focus on primary health care	Facilitate achievement of compliance with the norms and standards regulations for different categories of health establishments.
	Goal 3: Quality Improvement in the Provision of care	Pillar 5: Improve the quality, safety, and quantity of health services provided with a focus on primary health care	Facilitate achievement of compliance with the norms and standards regulations for different categories of health establishments.

1.4.5 Programme Resource Considerations

Economic classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	**9,189,268**	**13,395,909**	**10,971,686**	**11,179,855**	**11,619,392**
Compensation of employees	8,683,889	11,530,058	9,743,721	9,760,812	10,079,662
Goods and services of which:	505,379	1,865,852	1,227,965	1,419,043	1,539,730
Travel,subsistence and accommodation	81,473	976,576	287,420	300,210	313,690
Venues and facilities	-	800,000	200,000	303,146	316,757
Catering services	12,711	9,671	10,080	-	-
Consulting and professional services	411,195	79,605	730,465	815,687	909,283
TOTAL	**9,189,268**	**13,395,909**	**10,971,686**	**11,179,855**	**11,619,392**

The OHSC's founding legislation mandates the OHSC to advise the Minister of Health on matters relating to the determination of norms and standards to be prescribed for the national health system and the review of such norms and standards. The

programme is responsible for the development of standards and tools, tracking and analysis of health establishment data, provision of guidance, support to health establishments and making recommendations to relevant authorities for implementation in the health system.

The budget caters for:

- the remuneration of employees in the programme;
- additional work in terms of guidance, support and research at both national and provincial levels;
- additional external technical expertise and input in the development of inspection tools for the norms and standards.

1.5 Programme 5: Certification and Enforcement

Programme Purpose

The purpose of Certification and Enforcement is to certify compliant health establishments and take enforcement action against non-compliant health establishments. The programme is also responsible to publish information relating to certificates of compliance issued and enforcement actions taken against health establishments, this includes convening of *ad hoc* hearing tribunals for the purposes of enforcing compliance.

1.5.1 Outcomes, Outputs, Outcome Indicators and Targets

Output Indicators		Audited Performance			Estimated Performance	MTEF Targets		
		2018 /19	2019 /20	2020 /21	2021 /22	2022 /23	2023 /24	2024 /25
Outcome 5: Compliance with norms and standards increased								
Output 5.1: Compliant heath establishments are issued with a certificate of compliance								
Output Indicator 5.1.1	Percentage of health establishments issued with a certificate of compliance within 15 days from the date of the final inspection report and a recommendation by an Inspector[10]	-	-	100%	100%	100%	100%	100%
Output 5.2: Enforcement action is taken against non-compliant health establishments								
Output Indicator 5.2.1	Percentage of health establishments against which enforcement action has been initiated within 10 days from the date of the final inspection report and a recommendation by an Inspector[11]	-	-	0%	100%	100%	100%	100%
Output 5.3: Health establishment compliance status reports are published								
Output Indicator 5.3.1	Number of bi-annual reports developed for publication on the OHSC website[12]	-	-	1	2	2	2	2

1.5.2 Output Indicators: Annual and Quarterly Targets

Performance indicators		Reporting Period	Annual targets	Q1	Q2	Q3	Q4
Output 5.1: Compliant heath establishments are issued with a certificate of compliance							
Output Indicator 5.1.1.	Percentage of health establishments issued with a certificate of compliance within 15 days from the date of the final inspection report and a recommendation by an Inspector	Bi-Annual	100%	-	100%	-	100%
Output 5.2: Enforcement action is taken against non-compliant health establishments							
Output Indicator 5.2.1.	Percentage of health establishments against which enforcement action has been initiated within 10 days from the date of the final inspection report and a recommendation by an Inspector	Bi-Annual	100%	-	100%		100%
Output 5.3: Health establishment compliance status reports are published							
Output Indicator 5.3.1	Number of bi-annual reports developed for publication on the OHSC website	Bi-Annual	2	-	1	-	1

1.5.3 Explanation of Planned Performance Over the Medium-Term Period

The OHSC is required by law to inspect and certify health establishments as compliant with the norms and standards. Furthermore, the certificate of compliance issued by the OHSC is a pre-requisite for health establishments to apply for accreditation to participate in the NHI fund. Certification is also a way of encouraging health establishments to work hard to achieve compliance.

1.5.4 Programme Alignment to Imperatives

NDP 2030	NDOH/MTSF Outcomes	Presidential Health Summit Compact Pillars	OHSC Strategic Outcomes
GOAL 8: Universal health care coverage	**Goal 2:** Achieve Universal Health Coverage by implementing NHI Policy	**Pillar 5:** Improve the quality and safety	Compliance with norms and standards increased – health establishments certified for compliance with the norms and standards
	Goal 3: Quality Improvement in the provision of care	**Pillar 5:** Improve the quality and safety	

1.5.5 Programme Resource Considerations

Economic classification			Medium-term estimates		
	Audited outcomes 2020/21	2021/22	2022/23	2023/24	2024/25
CURRENT PAYMENTS	2,244,676	2,692,353	2,497,693	2,523,468	2,587,275
Compensation of employees	2,224,368	2,316,581	2,097,645	2,107,921	2,155,393
Goods and services of which:	20,307	375,772	400,048	415,547	431,882
Travel,subsistence and accommodation	5,175	156,750	161,192	166,062	171,194
Advertising	15,132	-	-	-	-
Catering services	-	14,022	15,000	15,668	16,371
Consulting and professional services	-	105,000	109,442	114,312	119,444
Legal Fees	-	100,000	114,415	119,506	124,872
TOTAL	**2,244,676**	**2,692,353**	**2,497,693**	**2,523,468**	**2,587,275**

The Certification and Enforcement Programme is responsible for the certification of health establishments found to be compliant with the norms and standards, as well as to effect enforcement action against those found to be non-compliant. The certification function is anticipated to have a direct impact on the implementation of the National Health Insurance (NHI).

There is minimal budget and human resource allocation which may negatively impact on the OHSC's achievement of its certification and enforcement mandate. The function of this Programme is largely dependent on the work of inspections and/or the inspection outcomes. The volume of inspection coverage and the anticipated additional norms and standards to be developed and monitored automatically impact on the workload within this Programme

2. Updated Key Risks and Mitigation from the SP/APP

Risk No	Outcome	Key Risk	Risk Mitigation
1	Outcome 3	Delays in the resolution of complaints	1. Motivate for additional funding. 2. Review and amendment of the relevant legislation. 3. Implement the revised organisational structure 4. Continue engagements with relevant stakeholders 5. Implement joint investigation with other stakeholders.
2	Outcome 2 & 4	Limited set of norms and standards for different types of HEs	1. Continued engagements with the Minister. 2. Ongoing communication to the NDoH by means of recommendation reports.
3	All Outcomes	Weaknesses in organisational culture	1. Develop and implement a change strategy for the organisation. 2. Encourage inter-unit collaborations. 3. Design feedback mechanism (i.e. suggestion box) from OHSC employees on a quarterly basis. 4. Develop action plan for implementing outputs of employee perception and/or satisfaction surveys conducted. 5. Conduct virtual team building initiatives. 6. Implement consequence management.
4	Outcomes 2, 3, 4 & 5	Litigation against the OHSC	1. Ensure compliance with the relevant inspection and certification frameworks. 2. Continuous training of inspectors. 3. Regular review of OHSC regulatory framework. 4. Conduct internal audits and implementing recommendations thereof. 5. Advocate for the resourcing of the compliance function.
5	All Outcomes	Business Continuity risk	1. Obtain additional funding. 2. Conduct a Business Impact analysis 3. Develop a Business Continuity Plan (BCP)
6	All Outcomes	Insufficient human resource capacity and skills-mix	1. Review the remuneration strategy. 2. Source donor assistance. 3. Reprioritisation of existing funds. 4. Implementation of the revised organisational structure.
7	All Outcomes	Inadequate funding for OHSC operations	1. Develop and obtain approval for a revenue generation model. (To include charging for services rendered). 2. Source for donor funding. 3. Motivate for additional funding from the National Treasury.
8	All Outcomes	Limited understanding and clarity on independence and mandate of OHSC by key stakeholders	1. Enter into new MoUs with other relevant entities and regulators. 2. Continuous implementation and monitoring of the Communication and Stakeholder Relations Strategy, stakeholder map and protocol of engagement.

Risk No	Outcome	Key Risk	Risk Mitigation
			3. Conduct a perception survey to test the effectiveness of the communication strategy. 4. Publish OHSC work in relevant publications.
9	All Outcomes	Non-compliance with applicable regulatory requirements (core business and administrative processes)	1. Implement consequence management for instances of non-compliance. 2. Establishing and resourcing of an independent compliance function. 3. Induction and re-orientation of existing policies, procedures and frameworks.
10	All Outcomes	Fraud and Corruption	1. Induction and re-orientation of existing policies, procedures and frameworks. 2. Conduct Ethics awareness workshop for OHSC employees. (To include training on the code of conduct) 3. Establish a social and ethics committee.

Outcome 01: A fully functional OHSC
Outcome 02: Compliance with norms and standards is effectively monitored.
Outcome 03: Improved quality of health care services rendered to the users in the Health Establishments.
Outcome 04: Facilitate achievement of compliance with the norms and standards regulations for different categories of health establishments.
Outcome 05: Compliance with norms and standards increased.

12. MATERIALITY AND SIGNIFICANCE FRAMEWORK FOR THE FINANCIAL YEAR 2021/22

12.1 BACKGROUND

a) The OHSC was established by the National Health, 2003 (Act No. 61 of 2003), and also listed as Schedule 3A public entity in terms of the Public Finance Management Act (PFMA) No 1 of 1999.
b) The OHSC's materiality and significance framework is developed in terms of the following sections of the PFMA:

    i) Section 50 - Fiduciary duties of the Accounting Authority;
    ii) Section 54 - Information to be submitted by the Accounting Authorities; and
    iii) Section 55 - Annual report and financial statements.

c) In terms of Treasury Regulation 28.3, the Accounting Authority must develop and agree a framework of acceptable levels of materiality and significance with the relevant Executive Authority.
d) In terms of the South African Auditing Standards, SAAS 320, "information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements. Materiality depends on the size of the item or error judged in particular circumstances of its omission or misstatement. Thus, materiality provides a threshold or cut-off point, rather than being a primary qualitative characteristic which information must have if it is to be useful."
e) In line with the legislative requirements stipulated above, the OHSC's materiality and significance framework is herein developed and is based on both qualitative and quantitative aspects.
f) In arriving at the materiality levels, the OHSC took into account the nature of its mandate and the statutory requirements prescribed under its founding legislation.

12.2 QUALITATIVE ASPECTS

a) Irrespective of the amount involved, the following significant events will be disclosed to the Executive Authority in the event that they occur within the OHSC, and further that approval will be sought from the Executive Authority before the OHSC can conclude on them:
    i) establishment or participation in the establishment of a company or public entity;
    ii) participation in a significant partnership, trust, unincorporated joint venture, public private partnerships or similar arrangement;
    iii) acquisition or disposal of a significant shareholding in a company;
    iv) acquisition or disposal of a significant asset that would significantly affect the operations of the OHSC;
    v) commencement or cessation of a significant business activity; and

vi) a significant change in the nature or extent of its interest in a significant partnership, trust, unincorporated joint venture or similar arrangement.

b) The following significant events will be disclosed to the Executive Authority if they occur within the OHSC:
   i) material infringement of legislation that governs the OHSC;
   ii) material losses resulting from criminal or fraudulent conduct in excess of the parameters significance parameters below; and
   iii) all material facts and/or events, including those reasonably discoverable, which in any way may influence the decisions or actions of the executive authority.

12.3 QUANTITATIVE ASPECTS

a) The National Treasury issued a Practice Note - "Practice Note on Applications Under Section 54 of the Public Management Act No. 1 of 1999 by Public Entities" - setting the parameters for the rand value determinations of significance. The Practice Note further stipulates that the parameters should be derived from the rand values of certain elements of the audited annual financial statements as follows:

Element	% Range to be applied against the rand value
Total assets	1% - 2%
Total revenue	0,5% - 1%
Profit after tax [Surplus]	2% - 5%

b) The OHSC takes cognizance of the fact that financial transactions are not of the same nature. Thus, the determination of the materiality parameters takes into account that some of the transactions may not arise out of the normal activities of the OHSC.

c) When determining materiality, it is generally accepted that the lower the risk, the higher the percentage to be used, and the higher the risk, the lower the percentage to be used.

d) For purposes of determining the rand values of the identified elements, the audited annual financial statements of OHSC for the year ended 31 March 2021 were applied as follows:

Element	% range to be applied against the rand value	Amount per audited financial statements (2020/21)	Significance amount
Total revenue	1%	R139 193 588	R 1 391 935

12.4 REVIEW

a) The OHSC is fully aware that the environment in which it operates is a dynamic one, wherein key developments may affect the way it conducts its business.
b) On an annual basis, the OHSC will conduct a strategic risk assessment to determine any new risks that may have emerged since the conclusion of the prevailing risk management framework.
c) In line with the afore-mentioned process, the OHSC will revisit the materiality and significance framework and align it accordingly to deal with any new and emerging risks in its portfolio.
d) The review of the materiality and significance framework will, among others, take into account the previous year's audited financial statements, management letter by the Auditor General, the internal auditor's report, any new and relevant legislation, and the expectations of the OHSC's stakeholders.
e) However, more frequent review of the framework may be necessary if major changes in the operating environment occur during the year.

3. Public Entities

Name of public entity	Mandate	Key Outputs	Current annual budget (R thousands)
Not Applicable			

4. Infrastructure Projects

No.	Project name	Programme	Description	Outputs	Start date	Completion date	Total estimated cost	Current year expenditure
Not Applicable								

5. Public-Private Partnerships (PPPs)

PPP name	Purpose	Outputs	Current value of agreement	End-date of agreement
Not Applicable				

Part D: Technical Indicator Descriptions (TIDs)

1.1.1. Sub-programme: Human Resources

1.1.1 Indicator title	Percentage of vacancies filled within four months of the vacancy existing
Definition	Vacancies should be filled within four months of existence.
Source of data	List of vacant and funded posts including appointment letters. The list to include the date of post existing and the date post was filled.
Method of calculation	$\left(\frac{Number\ of\ vacancies\ filled\ within\ four\ months\ of\ the\ existence}{Total\ number\ of\ funded\ vacant\ posts}\right) \times 100$
Means of verification	Copy of a list of vacant and funded posts including appointment letters. The list to include the date of post existing and the date post was filled.
Assumptions	• Line managers and HR unit available and co-operating with each during the recruitment process • Suitable candidates found in first round of recruitment and no readvertisement of posts will be desired • Post to be filled already evaluated • Line managers will always be available for shortlisting and interviews • There won't be a need for headhunting process desired for any posts and that all first round of recruitment process will always be successful • There will always be vacancies. • Successful candidates will always accept our offer of employer • Post of the Chief Executive Officer is excluded. The position of CEO is outside the control of the OHSC as the appointment of this position is carried out with the concurrence of the Executive Authority
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-date
Reporting cycle	Quarterly
Desired performance	93%- of vacant and funded posts filled within four months of vacancy existing.
Indicator responsibility	Director: Human Resources

1.1.2 Indicator title	**Percentage vacancy rate per year**
Definition	This is the level at which the Human Resources Unit aims to maintain vacancy rate at all times.
Source of data	Register of approved funded posts (1 April to 31 March)
Method of calculation	$\left(\frac{Total\ number\ of\ funded\ vacant\ posts}{Total\ number\ of\ approved\ funded\ posts}\right) \times 100$
Means of verification	Register of approved funded posts (1 April to 31 March)
Assumptions	• The OHSC can retain scarce, critical, professional and technical skills and maintain a low staff turnover. • Post of the Chief Executive Officer is excluded as it is dependent on external party decision making process
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Non-Cumulative
Reporting cycle	Annual
Desired performance	A low vacancy rate
Indicator responsibility	Director: Human Resources

1.2.1 Indicator title	**Percentage of certified inspectors after completion of training**
Definition	Inspectors certified as Inspectors upon completion of Inspector Training Course approved by the OHSC
Source of data	Certificate of appointment as an inspector.
Method of calculation	$\left(\frac{Number\ of\ certified\ inspectors}{Total\ number\ of\ inspectors\ in\ the\ employ\ of\ the\ OHSC}\right) \times 100$
Means of verification	Register of certified inspectors and/ or a copy of the certificate
Assumptions	Staff to be trained are made available for training by line managers There will be new inspectors to be trained
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Non-cumulative
Reporting cycle	Annual
Desired performance	95%- of inspectors trained and certified upon completion of the course.
Indicator responsibility	Director: Human Resources

1.1.2. Sub-programme: Information and Communications Technology

Indicator title 1.4.1	**Percentage of ICT availability for core OHSC services**
Definition	This indicator refers to the average percentage core systems up-time and availability maintained over the year or a period of time. The systems include Electronic Inspection System, Call Centre System and Annual Returns Systems.
Source of data	Reports generated from server and network infrastructure
Method of calculation	• **Percentage uptime information is obtainable from the reports generated from server and network infrastructure** $$\boldsymbol{Uptime\ for\ all\ tracked\ core\ service\ per\ month} = \left(\frac{\%\ Uptime\ core\ service_1\ +\ \%\ Uptime\ core\ service_2 + \cdots + \%Uptime\ core\ service_n}{n}\right)$$ *where n = number of tracked core services* $$\boldsymbol{Average\ uptime\ for\ all\ tracked\ core\ services\ per\ quarter} = \left(\frac{Month_1\ +\ Month_2 +\ Month_3}{3}\right)$$
Means of verification	Copy of reports generated from server and network infrastructure
Assumptions	Fully serviced and operational: • OHSC power generator • Uninterrupted Power Supply (UPS) Reports are system generated – no absolute numbers relating to system performance are available for some services
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	An achievement of 95% of core OHSC ICT availability services
Indicator responsibility	Director: Information Technology

1.4.2 Indicator title	**Percentage of ICT availability for OHSC support services**
Definition	This indicator measures availability of Wide Area Network, Local Area Network, Active Directories, File server and Websites to ensure that the level of service availability meets the current business needs.
Source of data	Reports generated from server and network infrastructure
Method of calculation	• **Percentage uptime information is obtainable from the reports generated from server and network infrastructure** $$\boldsymbol{Uptime\ for\ all\ tracked\ support\ service\ per\ month} = \left(\frac{\%\ Uptime\ support\ service_1 + \%\ Uptime\ support\ service_2 + \cdots + \%\ Uptime\ support\ service_n}{n}\right)$$ *where n = number of tracked support services* $$\boldsymbol{Average\ uptime\ for\ all\ tracked\ core\ services\ per\ quarter} = \left(\frac{Month_1 + Month_2 + Month_3}{3}\right)$$
Means of verification	Copy of reports generated from server and network infrastructure
Assumptions	Fully serviced and operational: • OHSC power generator, and • Uninterrupted Power Supply (UPS) Reports are system generated – no absolute numbers relating to system performance are available for some services
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	An achievement of 95% of support OHSC ICT availability services
Indicator responsibility	Director: Information Technology

1.1.3. Sub-programme: Communication and Stakeholder Relations

1.5.1 Indicator title	**Number of community stakeholder engagements to raise public awareness on the role and powers of the OHSC and Health Ombud**
Definition	This indicator measures awareness campaigns, roadshows, events and other engagements conducted to promote the role and powers of the OHSC and Health Ombud in the communities or to the public
Source of data	Reports and/ or attendance registers and/ or recordings for the awareness activities/events conducted with the public
Method of calculation	A simple count of awareness activities and events conducted
Means of verification	Attendance registers and/or reports/media clips and/ or recordings for awareness/events activities conducted
Assumptions	Stakeholder engagements on the role and powers of the OHSC and Health Ombud conducted
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	An achievement of 12 and above
Indicator responsibility	Director: Communication and Stakeholder Relations

1.5.2 Indicator title	**Number of private sector engagements to raise awareness on the role and powers of the OHSC and Health Ombud**
Definition	This indicator measures awareness campaigns, workshops, seminars, training sessions, lectures, conferences and other engagements conducted to promote the role and powers of the OHSC and Health Ombud to the private sector.
Source of data	Reports and/ or attendance registers and/ or recordings for the awareness activities/event conducted with the private sector
Method of calculation	A simple count of awareness activities and events conducted
Means of verification	Attendance registers and/or reports/media clips and/ or recordings for awareness/events activities conducted
Assumptions	Stakeholder engagements on the role and powers of the OHSC and Health Ombud conducted
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	An achievement of 12 and above
Indicator responsibility	Director: Communication and Stakeholder Relations

1.1.4. Sub-programme: Finance and Supply Chain Management

1.6.1 Indicator title	Unqualified Audit opinion achieved
Definition	This indicator measures the Annual Unqualified Audit Opinion on the annual financial statements achieved by the OHSC as determined by Auditor General. Normally the audit report is contained in the Annual Report preceding financial year period.
Source of data	Auditor General Report
Method of calculation	A simple capturing of the audit opinion obtained
Means of verification	Copy of Auditor General Report with Audit Status
Assumptions	Management and staff follow all prescripts, policies and procedures as expected
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Non-Cumulative
Reporting cycle	Annual
Desired performance	An achievement of an unqualified audit opinion by the Auditor-General
Indicator responsibility	Chief Financial Officer

Programme 2: Compliance Inspectorate

2.1.1 Indicator title	**Percentage of public health establishments inspected for compliance with the norms and standards**
Definition	Public health establishments are inspected for compliance with norms and standards
Source of data	Inspection register and inspection reports
Method of calculation	$\left(\frac{\text{Number of inspections conducted in the public health establishments}}{\text{Total number of public health establishments}}\right) x\ 100$
Means of verification	Inspection register and inspection reports
Assumptions	All public health establishments will be inspected, human and financial resources will be provided accordingly Inspections tools are in place
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	21% (786 of 3741) of public health establishments are inspected
Indicator responsibility	Executive Manager: Compliance Inspectorate

2.1.2 Indicator title	**Percentage of private sector health establishments inspected for compliance with the norms and standards**
Definition	Private health establishments are inspected for compliance with norms and standards
Source of data	Inspection register and inspection reports
Method of calculation	$\left(\frac{\text{Number of inspections conducted in the private health establishments}}{\text{Total number of private health establishments}}\right) x\ 100$
Means of verification	Inspection register and inspection reports
Assumptions	All private health establishments will be inspected, human and financial resources will be provided accordingly; The denominator will change to include all categories of private health establishments which will require a review of the denominator for this indicator. The private hospitals will be inspected, assuming that inspection tools will be available
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	12% (52 of 431) of private health establishments are inspected
Indicator responsibility	Executive Manager: Compliance Inspectorate

2.2.1 Indicator title	**Percentage of additional inspection (re-inspection) conducted in public and private health establishments that have completed the regulated reporting period where non-compliance was identified**
Definition	Additional inspections conducted (re-inspection) at public and private health establishments that did not comply with the non-negotiable vital measures but were graded either excellent, good or satisfactory.
Source of data	Re-inspection register and inspection reports
Method of calculation	$\left(\frac{\begin{array}{c}Total\ number\ of\ health\ establishment\ (public\ and\ private) \\ which\ are\ graded\ excellent, good \\ or\ satisfactory\ but\ not\ certified\ that\ were\ re-inspected\end{array}}{\begin{array}{c}Total\ number\ of\ health\ establishments (public\ and\ private) \\ \text{that did not comply with the non-negotiable vital measures} \\ \text{but were graded either excellent, good or satisfactory}\end{array}} \right) x\ 100$
Means of verification	Re-inspection register and inspection reports
Assumptions	All Public and private health establishments which are graded Excellent, Good, Satisfactory or Unsatisfactory and not certified will be re-inspected
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative (Year-To-Date)
Reporting cycle	Quarterly
Desired performance	100% additional inspections be conducted at eligible HE
Indicator responsibility	Executive Manager: Compliance Inspectorate

2.3.1 Indicator title	**Number of reports of inspections conducted with the names and location of the health establishments every six months published**
Definition	A report on inspections conducted every six months, with the names and location of the health establishments
Source of data	A consolidated report of individual health establishment inspection report and provincial reports including inspection register and inspection system.
Method of calculation	Simple count of a consolidated report of individual health establishment inspection report and provincial reports.
Means of verification	A consolidated report of individual health establishment inspection report and provincial reports
Assumptions	Inspection reports will be published as required by the regulations.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Bi-annual
Desired performance	One (1) report with the names and location of the health establishments inspected every six months.
Indicator responsibility	Executive Manager: Compliance Inspectorate

2.3.2 Indicator title	**Number of annual reports that set out the compliance status of all health establishments and summarises the number and nature of the compliance notices issued published**
Definition	Publish an annual report that sets out the compliance status of all HEs and summarises the number and nature of the compliance notices issued.
Source of data	A consolidated single annual report containing information from individual health establishment inspection report and provincial reports including inspection register and inspection system.
Method of calculation	Simple count of a consolidated report of individual health establishment inspection report and provincial reports converted into a single annual report
Means of verification	A consolidated report converted into s single annual report from the Individual health establishment inspection report and provincial reports
Assumptions	Inspection reports will be published as required by the regulations.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Non-cumulative
Reporting cycle	Annually
Desired performance	1 (one) report sets out the compliance status of all health establishments inspected and summarises the number and nature of the compliance notices published.
Indicator responsibility	Executive Manager: Compliance Inspectorate

Programme 3: Complaints Management and Office of Ombud

3.1.1 Indicator title	**Percentage of low-risk complaints resolved within twenty-five working days of lodgement in the call centre**
Definition	Low risk complaints received through the Call Centre, logged on the OHSC Complaint Management System and responded to within 25 working days from date of logging. A complaint is resolved when it was signposted to the health establishment for action, an acknowledgement received from the health establishment and complainant informed OHSC of his/her satisfaction to the signposting.
Source of data	Request Details input form, Complaints register and or report
Method of calculation	$\left(\frac{Number\ of\ low-risk\ complaints\ resolved\ within\ 25\ working\ days\ of\ logging}{Total\ number\ of\ low-risk\ complaints\ logged\ during\ the\ current\ reporting\ period\ plus\ the\ total\ number\ of\ unresolved\ low\ risk\ complaints\ logged\ in\ the\ previous\ reporting\ period\ minus\ complaints\ assigned\ for\ assessment} \right) x\ 100$
Means of verification	Call Centre Complaints Report
Assumptions	Full human resource capacity within the Call Centre. Performance is predicated on the continued employment of the contract workers. The unresolved complaints carried over from the previous reporting period are included in the complaints register. Tickets assigned to Assessors excluded from the calculation method to avoid double reporting
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-Date
Reporting cycle	Quarterly
Desired performance	Achievement of the target of 90% desirable
Indicator responsibility	Executive Manager: Complaints Management and Ombud

3.2.1 Indicator title	**Percentage of user complaints resolved through assessment within 30 working days of receipt of a response from the complainant and/or the health establishment**
Definition	Complaints assigned to assessors for screening and a final report tabled with appropriate decision within 30 working days from date of receipt of response to complaint request from the complainant and/or health establishment. The decision may be either to dispose, investigate or refer to external stakeholders in accordance with regulation 38 of the Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud.
Source of data	Request Details input form, Complaints register and or report
Method of calculation	$\left(\frac{Number\ of\ complaints\ resolved\ through\ assessment\ within\ 30\ working\ days\ of\ receipt\ of\ responses\ to\ complaint\ request\ from\ complainants\ and\ /\ or\ health\ establishments}{Total\ number\ of\ complaints\ assigned\ to\ assessment\ during\ the\ period\ under\ review\ plus\ complaints\ that\ remain\ unresolved\ from\ the\ previous\ period} \right) x\ 100$
Means of verification	Complaints register and or report, Service Level Agreement (SLA)
Assumptions	Full human resource capacity of Assessors. Performance is predicated on the continued employment of the contract workers. The unresolved complaints carried over from the previous reporting period are included in the complaints register. Assigned cases to investigation regarded as resolved through screening.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-Date
Reporting cycle	Quarterly
Desired performance	Achievement of the target of 75% desirable
Indicator responsibility	Executive Manager: Complaints Management and Ombud

3.3.1 Indicator title	**Percentage of complaints resolved within 6 months through investigation**
Definition	Complaints that are investigated within 6 months from date of assignment from Complaints Assessment Centre to the Complaints Investigations Unit. A final report, referral report to other entities and close out reports are produced.
Source of data	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Method of calculation	$\left(\frac{Number\ of\ complaints\ resolved\ within\ 6\ months\ of\ assignment\ from\ Complaints\ Assessment\ Centre\ to\ the\ Complaints\ Investigation\ Unit}{Total\ number\ of\ cases\ referred\ for\ investigation\ during\ the\ current\ reporing\ period\ plus\ number\ of\ unresolved\ complaints\ referred\ for\ investigation\ in\ the\ previous\ reporting\ period}\right) x\ 100$
Means of verification	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Assumptions	A final report, referral report to other entities and close out report. A register of assigned complaints including the status of each complaint.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-Date
Reporting cycle	Quarterly
Desired performance	Achievement of the target of 10% desirable
Indicator responsibility	Executive Manager: Complaints Management and Ombud

3.4.1 Indicator title	**Percentage of complaints resolved within 12 months through investigation**
Definition	Complaints that are investigated within 12 months from date of assignment from Complaints Assessment Centre to the Complaints Investigations Unit. A final report, referral report to other entities and close out reports are produced
Source of data	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Method of calculation	$\left(\frac{Number\ of\ complaints\ resolved\ within\ 12\ months\ of\ assignment\ from\ Complaints\ Assessment\ Centre\ to\ the\ Complaits\ Investigation\ Unit}{Total\ number\ of\ cases\ referred\ for\ investigation\ during\ the\ current\ reporing\ period\ plus\ number\ of\ unresolved\ complaints\ referred\ for\ investigation\ in\ the\ previous\ reporting\ period} \right) x\ 100$ The total number of cases resolved within 6 months through investigation do not form part of the population.
Means of verification	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Assumptions	A final report, referral report to other entities and close out report. A register of assigned complaints including the status of each complaint.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-Date
Reporting cycle	Quarterly
Desired performance	Achievement of the target of 5% desirable
Indicator responsibility	Executive Manager: Complaints Management and Ombud

3.5.1 Indicator title	**Percentage of complaints resolved within 18 months through investigation**
Definition	Complaints that are investigated within 18 months from date of assignment from Complaints Assessment Centre to the Complaints Investigations Unit. A final report, referral report to other entities and close out reports are produced
Source of data	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Method of calculation	$\left(\frac{Number\ of\ complaints\ resolved\ within\ 18\ months\ of\ assignment\ from\ Complaints\ Assessment\ Centre\ to\ the\ Complaits\ Investigation\ Unit}{Total\ number\ of\ cases\ referred\ for\ investigation\ during\ the\ current\ reporing\ period\ plus\ number\ of\ unresolved\ complaints\ referred\ for\ investigation\ in\ the\ previous\ reporting\ period} \right) x\ 100$ The total number of cases resolved within 6 and 12 months through investigation do not form part of the population.
Means of verification	Investigation register, Investigation Service Level Agreement (SLA) and final Investigation Report, Close out report and Referral to other entities report
Assumptions	A final report, referral report to other entities and close out report. A register of assigned complaints including the status of each complaint.
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-to-Date
Reporting cycle	Quarterly
Desired performance	Achievement of the target of 2% desirable
Indicator responsibility	Executive Manager: Complaints Management and Ombud

Programme 4: HEALTH STANDARDS DESIGN, ANALYSIS AND SUPPORT

4.1.1 Indicator title	**Number of recommendations reports for improvement in the healthcare sector made to relevant authorities**
Definition	The indicator will track the number of reports submitted to relevant authorities on an annual basis
Source of data	EWS, Annual returns and Inspection findings analysis reports
Method of calculation	A simple count of reports produced containing recommendations made
Means of verification	A copy of actual report with recommendations
Assumptions	Relevant authorities will cooperate and provide data for annual returns and EWS from health establishment. Compliance inspection reports are finalised and available Relevant stakeholders will implement the recommendations
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Non-Cumulative
Reporting cycle	Annual
Desired performance	3 recommendations report
Indicator responsibility	Executive Manager: Health Standards Design, Analysis and Support

4.2.1 Indicator title	**Number of guidance workshops conducted to facilitate implementation of the norms and standards regulations**
Definition	Makes reference to the number of guidance workshops conducted with the aim of facilitating implementation of norms and standards regulations At least two guidance workshop sessions to be provided to each province and each private health care organisation on an annual basis
Source of data	Agenda, Attendance Registers, Presentations and Reports for each training session provided
Method of calculation	A simple count of the number of workshop sessions delivered
Means of verification	Agenda and Attendance Registers and Presentations and/ or Reports for each guidance workshop session provided
Assumptions	Health care personnel to be workshopped are made available for the workshop
Disaggregation of beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial transformation (where applicable)	N/A
Calculation type	Cumulative Year-End
Reporting cycle	Quarterly
Desired performance	24 recommendations reports
Indicator responsibility	Executive Manager: Health Standards Design, Analysis and Support

Programme 5: Certification and Enforcement

5.1.1 Indicator Title	**Percentage of health establishments issued with a certificate of compliance within 15 days from the date of the final inspection report and a recommendation by an Inspector**
Definition	Certified health establishments are health establishment found to be compliant with the norms and standards and are recommended for certification in the final inspection report. A final inspection report is an inspection report which would have been processed through preliminary, review and final stages. The report will also state the compliance status of a health establishment, grading level and will be accompanied by an Inspector's recommendation for certification.
Source of Data	Final Inspection report
Method of Calculation/Assessment	$\left(\frac{\text{Total number of compliant health establishments and issued with a certificate of compliance within 15 days from the date of the recommendation by an Inspector}}{\text{Total number of health establishment found to be compliant with the norms and standards and are recommended for certification}} \right) \text{X } 100$
Means of Verification	Inspector's Recommendations for certification and or a copy of Certificate of Health Establishment
Assumptions	HEs will comply with the norms and standards There will be recommendations for certification of Health Establishment (HEs)
Disaggregation of Beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial Transformation (where applicable)	N/A
Calculation Type	Cumulative Year-End
Reporting Cycle	Bi-Annually
Desired Performance	The desired performance is that 100% of compliant health establishment must be issued with a certificate of compliance within 15 days from the date of the recommendation by an Inspector
Indicator Responsibility	Director: Certification and Enforcement

5.2.1 Indicator Title	**Percentage of health establishments against which enforcement action has been initiated within 10 days from the date of the final inspection report and a recommendation by an Inspector**
Definition	Non-compliant health establishments referred for enforcement in the final additional inspection report. The final additional inspection report is report emanating from an additional inspection conducted in a health establishment which was found to be non-compliant with norms and standards during a routine inspection. The report will also state the compliance status of a health establishment, grading level and will be accompanied by an Inspector's recommendation for compliance enforcement.
Source of Data	Final Additional Inspection report
Method of Calculation/Assessment	$\left(\frac{\text{Total number of non} - \text{compliant health establishments against which enforcement action has been initiated within 10 days from the date of the referral fo enforcement}}{\text{Total number of non} - \text{compliant health establishments referred for enforcement}} \right) X\ 100$
Means of Verification	Inspector's recommendation / referral for enforcement and or enforcement verdict
Assumptions	Health Establishment (HEs) will not comply with the norms and standards There will be referrals for compliance enforcement
Disaggregation of Beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial Transformation (where applicable)	None
Calculation Type	Cumulative Year-End
Reporting Cycle	Bi-Annually
Desired Performance	The desired performance is that compliance enforcement be effected against all persistently non-compliance health establishments.
Indicator Responsibility	Director: Certification and Enforcement

5.3.1 Indicator Title	**Number of bi-annual reports developed for publication on the OHSC website**
Definition	Compliance status report prescribed by Regulation 31 (1) (b) (ii) and (iii) is published every six months. The compliance status report will include the compliance certificates issued and enforcement hearings conducted, outcome of the hearing as well as the names and location of the health establishments.
Source of Data	*Ad hoc* enforcement hearing tribunal reports List of Certified health establishments List of health establishments referred for enforcement
Method of Calculation/Assessment	A simple count of reports on certification and enforcement published every six months
Means of Verification	Inspection Register and or copy of bi-annual report/s
Assumptions	Inspections will be conducted Certificates of compliance will be issued to health establishments *Ad hoc* enforcement hearings will be convened
Disaggregation of Beneficiaries (where applicable)	Women: N/A Youth: N/A People with disabilities: N/A
Spatial Transformation (where applicable)	N/A
Calculation Type	Cumulative Year-End
Reporting Cycle	Bi-Annually
Desired Performance	The desired performance is that health establishments compliance status is published for public information.
Indicator Responsibility	Director: Certification and Enforcement

Annexures:

Annexure A: Amendments to the Strategic Plan

No revisions have been made to the 2020 – 2025 Strategic Plan.

Annexure B: Conditional grants

Not applicable

Annexure C: Consolidated indicators

Office of Health Standards Compliance does not have consolidated indicators.

Annexure D: District Development Model

Not Applicable

Endnotes

The OHSC revised several output indicators in the 2022-2023 Annual Performance Plan in terms of the Revised Framework for Strategic Plans and Annual Performance Plans, to align with outcomes performance reporting and/or to address findings by the auditors. Please refer to these end notes for information on actual amendments made and published.

-: No target for the period.

[1] Output Indicator 1.1.1 "Percentage vacancies filled within four months of the vacancy existing". The indicator Technical Indicator Description is revised to explicitly exclude the position of the Chief Executive Officer (CEO). The appointment of the CEO is the responsibility of the Executive Authority and therefore is outside the control of the OHSC.

[2] Output Indicator 1.1.2 "Percentage vacancy rate per year". New indicator added to the 2022-2023 Annual Performance Plan

[3] Output Indicator 1.2.1 "Percentage of certified inspectors after completion of training". Denominator in the Method of Calculation changed from "Total number of inspectors trained in a curriculum and training course approved by the board" to "Total number of inspectors in the employ of the OHSC".

[4] Output Indicator 1.5.1 "Number of community stakeholder engagements to raise public awareness on the role and powers of the OHSC and Health". Means of Verification revised to include: "Attendance registers and/or reports/media clips and/ or recordings for awareness/events activities conducted"

[5] Output Indicator 1.5.2 "Number of private sector engagements to raise awareness on the role and powers of the OHSC and Health Ombud". Means of Verification revised to include "Attendance registers and/or reports/media clips and/ or recordings for awareness/events activities conducted"

[6] Output indicator 2.3.1 "Number of reports of inspections conducted with the names and location of the health establishments every six months published" revised. Previously "Publish reports of inspections conducted with the names and location of the health establishments every six months"

[7] Output Indicator 2.3.2 "Number of annual reports that sets out the compliance status of all health establishments and summarises the number and nature of the compliance notices issued published" revised. Previously "Publish an annual report that sets out the compliance status of all health establishments and summarises the number and nature of the compliance notices issued"

[8] Output Indicator 3.4.1 "Percentage of complaints resolved within 12 months through investigation". Method of Calculation revised to include: "The total number of cases resolved within 6 months through investigation do not form part of the population".

[9] Output Indicator 3.5.1 "Percentage of complaints resolved within 18 months through investigation". Method of Calculation revised to include: "The total number of cases resolved within 6 and 12 months through investigation do not form part of the population".

[10] Output Indicator 5.1.1 "Percentage of health establishment issued with a certificate of compliance within 15 days from the date of the final inspection report and a recommendation by an inspector" Method of Calculation expanded to include "recommendation by an inspector", Means of Verification expanded to include" a copy of certificate of Health Establishment", Desired Performance revised to:

"The desired performance is that 100% of compliant health establishment must be issued with a certificate of compliance within 15 days from the date of the recommendation by an Inspector".

[11] Output Indicator 5.2.1 "Percentage of health establishment against which enforcement action has been initiated within 10 days from the date of the final inspection report and recommendation by an inspector". Method of Calculation revised to include of the "referral for enforcement". Means of Verification revised to include "enforcement verdict".

[12] Output Indicator 5.3.1 "Number of bi-annual reports developed for publication on the OHSC website" Method of Calculation expanded reports on certification and enforcement published every six months, Means of Verification expanded to include a copy of bi-annual report/s.

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