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Office of Health Standards Compliance (OHSC)

Improving the quality of healthcare in South Africa

FINAL draft annual performance PLAN

For the Fiscal Year 2016/17

[Beginning with 2015/16]

Date of Tabling:Feb/March, 2016

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# **FOREWORD**

The development of the OHSC Annual Performance Plan for 2016/17 was informed largely by the expectations of the Portfolio Committee as raised during the presentation of the first APP for the newly established entity in April 2015. The priorities which guided the development of this APP included increased compliance inspectioncoverage of public sector health establishments, inspection coverage of private and mental health establishments and improved investment on the communication programme in the second year of the existence of the entity.This is another step in ensuring the full execution of the entity’s mandate as per the National Health Act, 2003as amended and in support of government national policy priorities.

This APP introduces increased coverage in the compliance inspections for the public sectorhealth establishments and a new indicator for the coverage of private sector health establishments which flows from the anticipated promulgation of the regulations in the last quarter of 2015/16. The communications programme will also remain the priority area to ensure increased awareness by users of health care services regarding the functions of the Office.

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**Dr P.A Motsoaledi, MP**

**Executive Authority, Minister of Health**

# **OFFICIAL SIGN-OFF**

It is hereby certified that this OHSC Annual Performance Plan:

* Was developed by the management of the OHSC under the guidance of the OHSC Board;
* Takes into account all the relevant policies, legislation and other mandates relevant to the Office; and
* Reflects the strategic outcome-oriented goals and objectives which the OHSC willendeavour to achieve over the period 2015to 2019.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mr. J. Mapatha**

**Chief Financial Officer**

**Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mr. J. Makgolane**

**Director: Governance, Strategy and Board Secretariat**

**Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mr. B. Msibi**

**Acting Chief Executive Officer**

**Date:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Prof L.EMazwai:**

**OHSC Chairperson (Accounting Authority)**

**Date:**

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**Dr P.A Motsoaledi, MP**

**Executive Authority, Minister of Health**

**INTRODUCTION**

The Office of Health Standards Compliance (OHSC) has been established in terms of the National Health Amendment Act, 2013 (Act No. 12 of 2013) as a juristic person under the oversight control and leadership of a Board appointed by the Minister of Health under the Act. The entity is further governed through the Public Finance Management Act, 1999 (PFMA) and has been listed by the Minister of Finance under Schedule 3A of the PFMA as a public entity.

1. **Our Mandate**

The main objects of the OHSC as outlined in the Act are to protect and promote the health and safety of users of health services by;

1. Monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister in relation to the national health system; and
2. Ensuring consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.

The mandate contributes to two distinct but interdependent regulatory outcomes, which are

* Reduction in avoidable mortality, morbidity and harm within health establishments through reliable and safe health services; and
* Improvements in the availability, responsiveness and acceptability of health services for users.

1. **Our Vision**

Our vision is “*Safe and Quality Healthcare for all South Africans*”

1. **Our Mission**

Our Mission is to “*Act independently, impartially, fairly and fearlessly on behalf of the people of South Africa in guiding, monitoring, and enforcing healthcare safety and quality standards in health establishments*”

1. **Our Values and Principles**

Our Values are informed by the South African Constitution and Batho Pele Principles, i.e “*Human Dignity; Freedom; Achievement of Equality; and that people must come first”.*

Our Mandate implies that we shall:

1. *Act as the champion of the public and of healthcare users so as to restore credibility and trust;*
2. *Respect healthcare users and their families as well as healthcare personnel;*
3. *Push for effectiveness in achieving health system change and social impact;*
4. *Strive for excellence, innovation and efficiency in our operations;*
5. *Be truthful, fair and committed to intellectual honesty;*
6. *Practice transparency, but respect confidentiality;*
7. *Achieve the highest standards of ethical behaviour, teamwork and collaboration; and*
8. *Promote professionalism, compassion, diversity and social responsibility.*
9. **Our Strategic Outcome Oriented Goals**

The broad strategies adopted by the Board during the first year of the entity’s operation were designed to achieve the legislative mandate and the Strategic Goals the Board has set for the entity. These are summarised as follows:

* Prioritize those establishments that are the weakest and serve the most disadvantaged users in order to shift the system towards safer care, while still recognizing excellence wherever it is found;
* Use a progressive and developmental approach to enforcement in order to enhance change at different levels of the system;
* Use the power of information and communication, ranging from awareness and guidance through monitoring, analysis, reporting and publication, as a strategic tool to influence decisions and behaviour;
* Create and effectively use platforms for interaction with key user, providers and leadership groups to foster collaborative efforts towards improved outcomes; and
* Develop the capacity of staff and those who work directly with the Office as agents of change through training, rigorous control of the quality of outputs and ongoing learning.

These broad strategies were further broken down into the following four (4) strategic outcome oriented goals of the entity:

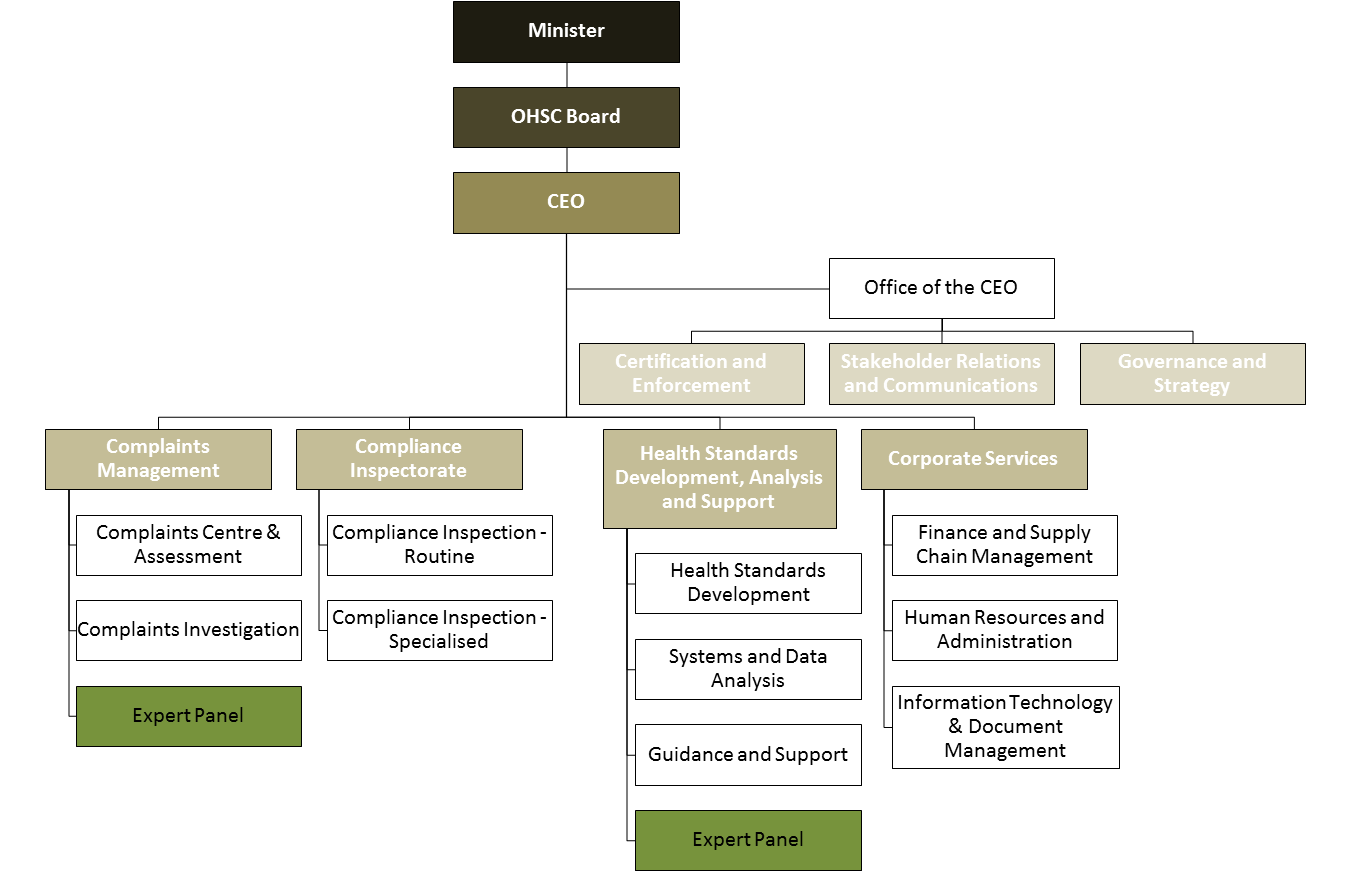
|  |  |
| --- | --- |
| **Goal 1** | Health establishments (HEs) comply with quality norms and standards. |
| **Goal statement** | Health establishments comply with norms and standards for health and safety of users and provision of quality, compassionate and responsive care. |
| **Indicator** | Number and % of HEs certified as complying with quality standards. |

|  |  |
| --- | --- |
| **Goal 2** | Patient and community complaints regarding poor care and situations of concern are heard and responded to. |
| **Goal statement** | The public is protected through ensuring that poor care and situations of concern are heard and responded to. |
| **Indicator** | Number and % of complaints from users and communities that are responded to within 6 months. |

|  |  |
| --- | --- |
| **Goal 3** | The quality and safety of healthcare is progressively improved through effective communication and collaboration between the OHSC and users, providers and other entities. |
| **Goal statement** | The OHSC communicates and works with users, providers and other entities through written agreements for collaboration and information sharing to enhance quality and compliance. |
| **Indicator** | Number of public awareness initiatives executed. |

|  |  |
| --- | --- |
| **Goal 4** | The OHSC is an efficient and effective high performing organisation that is responsive and publicly accountable. |
| **Goal statement** | The OHSC is efficient and effective high performing organisation that is responsive and publicly accountable. |
| **Indicator** | Auditor-General annual findings rating. |

# HIGH LEVEL ORGANISATIONAL STRUCTURE



# Part A

# STRATEGIC OVERVIEW

# **UPDATED Situational Analysis**

In presenting this Annual Performance Plan of the Office of Health Standards Compliance, it must be borne in mind that this is a new organisation, which started its operations independently from the National Department of Health on 1 April 2015. The first year of operations was mainly focused on putting systems and processes in place which will enable the execution of the mandate as per the Act. The promulgation of regulations published for comment just before the start of the 2015/16 financial year is anticipated to be finalised by the end of the third quarter of that year, which will pave the way for the refinement and finalisation of the systems and processes for alignment with the regulations.

Given this, the entity had to develop an Annual Performance Plan for 2016/17 which introduces some new key indicators which are informed by the developmental phase at which the entity finds itself as at end of the first year of operations. The new indicators are in the areas of corporate services, compliance inspectorate and complaints process and management. The new indicators are aligned to the approved strategic objectives of the entity for the Medium Term Strategic Framework (MTSF) period and have been added under the relevant objectives as per Strategic Corporate Plan.Developments in these areas have seen achievements in terms of systems and process development in the first year of operations which have now paved the way for the actual core operations in these areas to be implemented.

These changes will contribute towards the OHSC’s continued support to government to achieve its goals and objectives in terms of reducing avoidable mortality, morbidity and harm within health establishments and improving availability, responsiveness and acceptability of health care services for users. The Office will continue to monitor and enforce compliance by health establishments with regulated norms and standards in relation to the national health system as a way of protecting and promoting the health and safety of users of health care services.

Improving the quality of health care is one of the critical components of the National Development Plan outcome to "strengthen health system effectiveness" through enabling external assessments of compliance with prescribed standards. Improving the quality of health care through the implementation of the National Core Standards is one of the sub-outputs of "improving health system effectiveness" and will contribute not only to improved patient care and satisfaction but will also enable the system to better meet the specified outcomes for National Core Standards.

# **Performance Delivery Environment**

The changes in the performance delivery environment that gave rise to the need to introduce new performance indicators were:

* The anticipated promulgation of the prescribed norms and standards and procedural regulations which will pave the way for the inclusion of private sector hospitals and clinics in the key performance indicators of the compliance inspectorate;
* The existence of systems and processes in the other areas which will ensure delivery on the core business and support functions of the entity; and
* Availability of personnel appointed through the recruitment drive which saw the target for the filling of vacancies in the first year of operations achieved in the first quarter of 2015/16.

These improvements informed the need for the review of the performance indicators initially intended for the 2016/17 financial year to introduce new ones which are aimed at the actual execution of the mandate as per the Act.

# **Organisational environment**

The anticipated promulgation of the norms and standards and the procedural regulations in the third quarter of 2015/16 would make much clearer the obligations on the OHSC to ensure that there is a much more focussed understanding of the entity’s mandate, which resulted in changes to some of the indicators of performance as contained in this Annual Performance Plan for 2016/17.

The need for the budget increase over the baseline, in the context of the finalisation of the organisational design including of the administrative functions of this new entity, and the oversight and direction provided by the Board, were other critical changes in the organisational environment.

The main changes to the strategic direction that are reflected in this APP are:

* The inspector skills and accreditation for assessing HEs as required by the Act and of the guidance provided to them, which were incorporated into refined indicators;
* The inclusion of private health establishments in the indicators for compliance inspections and the critical importance of follow-up and re-inspection, and of progressive enforcement in the exercise of regulatory power, which has led to establishment of an additional team of inspectors;
* The expansion in capacity during the first financial year of operations which has been reflected in an expanded staff establishment that has enabled the critical management and administrative systems to be set up;
* The progress towards independent functioning during the transition which has led to the specification of staffing, budgets and outputs for each budget programme, including that of administration through the corporate services division;and
* A clearer understating of the role of the Office with respect to other regulators and stakeholders and activities to concretise this.

# **Revisions to legislative and other mandates**

There have been no significant changes to the OHSC’s legislative and other mandates apart from the publication and anticipated promulgation of the regulations governing its work.The majority of comments received in relation to the published draft regulations were found to be constructive, which is an indication of the acceptance of the entity into the health sector by the public to bring about quality standards for health establishments. The review of the comments and the draft regulations would ensure that the final regulations take into consideration all the regulatory elements which may have been missed during the initial drafting stage.

# **Overview of 2016 budget and MTEF estimates**

# **Expenditure Estimates**

# **OHSC Budget Programme Summary and Detailed Costing**

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# **Personnel Information**



# **Relating expenditure trends to strategic outcome-oriented goals**

**Overall**

* Over the five year period covered by the OHSC’s strategic plan, the OHSC has set itself the inspection targets of 20% of health establishments in the public sector, as well as 30% of health establishments in the private sector. These objectives serve to promote one of the OHSC’s principles, which is to act as the champion of the public and of healthcare users so as to restore credibility and trust. To this end, the OHSC’s financial and human resource allocation is geared towards the core functions of inspections, and design of complaint management systems which serve as the interface with the stakeholders, thus making the OHSC accessible to the public which is the core customer base of the OHSC.
* The total budget allocation for the 2016/17 is expected to be R100,5 million with 61% geared towards the core business activities, and increasing to R133 million in the 2018/19 financial year, of which 63% is earmarked for the core operations. In the same manner, the total staff complement is projected to grow from 108 in 2016/17 to 151 in 2018/19 of which more than 70% will be staff in the core operations over the same period.
* As part of the initial stages of the development of the OHSC, resources have been allocated for the development and implementation of the necessary and critical support systems, which will enhance communication and collaboration between the OHSC and users of health services. These costs have been included under the Administration Programme. Furthermore, the OHSC is likely to change office premises in the 2017/18 financial year, and this has an impact on the projections for the MTEF period.

**Specific budget programmes**:

* The *Compliance Inspectorate*, which is the largest programme of the entity, grows over the medium term by increasing the number of inspectors to improve the coverage of inspections in the public and private sectors and progressive enforcement of compliance as dictated by the National Health Amendment Act.
* Once the *Ombud* office is fully established, it will investigate complaints received through the call centre and issue findings and recommendations. Investigative staff will be appointed over the period covered by the Strategic Plan. The Ombud will function with the staff in the *Complaints Management* program who will be able to handle complaints through the call centre. This will result in increased performance in terms of the number of complaints managed and resolved.
* Critical strategic support services are placed in the office of the CEO, namely the Board secretariat, Communication and stakeholder relations and Certification and enforcement, in addition to the essential *Corporate Services*, which together constitute the Administration programme. In addition to the hiring of key staff and attendant costs, the budget will also fund the IT infrastructure and systems which will support all functions of the OHSC; and
* The *Health Standards Design, Analysis and Support* programme will assist in the design of standards and tools, tracking and analysis of health establishment data, and provision of guidance and support material for establishments.

# PART B

# STRATEGIC OBJECTIVES

# 

# **Programme 1: Office of the CEO**

# **Programme Purpose**

To provide theleadership, communication and regulatory functionsrequired to carry out the mandate of the OHSC as per legislative requirements

# **Strategic objective annual targets for 2016/17**

The following tables outline the output targets for the budget year and over the MTEF period for each strategic objective specified for this programme in the Strategic Plan.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Strategic Objective** | **Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| 1.5 Health Establishments found to be compliant with prescribed norms and standards are certified | % compliant health establishments certified by the OHSC within 2 months of the inspection | 100% |  |  |  | New indicator | 100% | 100% | 100% |
| 1.6 Enforcement action is effected with respect to persistently non-compliant health establishments | % of persistently non-compliant health establishment for which regulated action is initiated within 6 months of the inspection. | 100% |  |  |  | New indicator | 100% | 100% | 100% |
| 3.1. Public, provider and stakeholder awareness on the roles and powers of OHSC is created | Number of media and communication events and campaigns to increase awareness of OHSC among public, providers and stakeholders carried out annually | 12 |  |  | New indicator | 4 | 4 | 4 | 4 |
| 3.3. Memoranda of Agreement (MOAs) to further the mandate and objectives of the OHSC are signed with relevant regulators or other organisations | Number of signed MOAs with regulators to protect and promote quality and safety of care in place each year | 10 |  |  | New indicator | 2 | 2 | 4 | 4 |
| 3.6. Information relating to compliance with norms and standards is published | Number of published reports on compliance status of health establishments | 5 |  |  | New indicator | 2 | 1 | 1 | 1 |

# **Programme performance indicators and annual targets for 2016/17**

The following table sets out the annual performance targets for the programme using indicators as identified

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Strategic Plan Target** | **Estimated performance** | | | **Medium-term targets** | | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| % compliant health establishments certified by the OHSC within 2 months of the inspection | 100% |  |  |  | New indicator | 100% | 100% | 100% |
| % of persistently non-compliant health establishment for which regulated action is initiated within 6 months of the inspection. | 100% |  |  |  | New indicator | 100% | 100% | 100% |
| Number of media and communication events and campaigns to increase awareness of OHSC among public, providers and stakeholders carried out annually | 12 | - | - | New indicator | 4 | 4 | 4 | 4 |
| Number of signed MOAs with regulators to protect and promote quality and safety of care in place each year | 10 | - | - | New indicator | 2 | 2 | 4 | 4 |
| Number of published reports on compliance status of health establishments | 5 | - | - | New indicator | 2 | 1 | 1 | 1 |

# **Quarterly targets for 2016/17**

The following table sets out the quarterly targets for the unit performance indicators identified above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Reporting period** | **Annual target** | **Quarterly targets** | | | |
| **1st** | **2nd** | **3rd** | **4th** |
| % compliant health establishments certified by the OHSC within 2 months of the inspection | Quarterly | 100% | 100% | 100% | 100% | 100% |
| % of persistently non-compliant health establishment for which regulated action is initiated within 6 months of the inspection. | Quarterly | 100% | 25% | 25% | 25% | 25% |
| Number of media and communication events and campaigns to increase awareness of OHSC among public, providers and stakeholders carried out annually | Annual | 4 | 1 | 1 | 1 | 1 |
| Number of signed MOAs with regulators to protect and promote quality and safety of care in place each year | Annual | 2 |  | 1 |  | 1 |
| Number of published reports on compliance status of health establishments | Annual | 1 |  |  |  | 1 |

# **Reconciling performance targets with the Budget and MTEF**

**Expenditure Estimates: Programme 1- Office of the CEO**



**Performance and expenditure trends**

* The CEO’s budget estimates increase from R11 million in 2015/16 to R15.9 Million in 2018/19 to enable the Office to meet its strategic objectives.
* The large budget items within the Office of the CEO are:

1. The employment of additional staff members to assist with certification and enforcement.
2. Publications and marketing to enhance the OHSC’s visibility and accessibility, as well as foster collaboration with the stakeholders.
3. The Board and related costs to enable the board to exercise corporate governance and obtainthe necessary professional expertise as deemed appropriate; and
4. Travel and subsistence to enable the staff within the unit to carry out the strategic objectives.

# **Programme 2: Corporate services**

# **Programme purpose**

To provide the financial, human resources, IT and administrative support necessary for the OHSC to deliver on its mandate and comply with all relevant legislative requirements

# **Strategic objective annual targets for 2016/17**

The following tables outlines the output targets for the budget year and over the MTEF period for each strategic objective specified for this programme in the Strategic Plan.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Strategic Objective** | **Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| 4.1A fully functional Office is set-up and suitably staffed in accordance with the mandate and goals of the OHSC | % of funded staff appointed | 90% | - | - | - | 60% | 80% | 90% | 90% |
| # of Interns appointed | 15 | - | - | - | New indicator | 3 | 3 | 3 |
| 4.4. Financial management and PFMA requirements are complied with | Unqualified audit report | Unqualified report | - | - | - | Unqualified report | Unqualified report | Unqualified report | Unqualified report |
| 4.5 Leveraging technologies to deliver OHSC services more effectively | IT System in place and fully functional | System in place & fully functional | - | - | - | System in place | System in place | - | - |
| Percentage systems uptime and availability maintained. | 95% |  |  |  | New indicator | 80% | 90% | 95% |

# **Programme performance indicators and annual targets for 2016/17**

The following table sets out the annual performance targets for the programme using indicators as identified

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Strategic Plan Target** | **Estimated performance** | | | **Medium-term targets** | | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| % of funded staff appointed | 90% | - | - | - | 60% | 80% | 90% | 90% |
| Interns appointed | 15- Interns | - | - | - | New indicator | 3 | 3 | 3 |
| Unqualified audit report | Unqualified report | - | - | - | unqualified report | Unqualified report | Unqualified report | Unqualified report |
| IT system in place and functional | System in place & fully functional | - | - | - | System in place | System in place | - | - |
| % of uptime of the integrated IT system | 95% |  |  |  | New indicator | 80% | 90% | 95% |

# **Quarterly targets for 2016/17**

The following table sets out the quarterly targets for the unit performance indicators identified above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Reporting period** | **Annual target** | **Quarterly targets** | | | |
| **1st** | **2nd** | **3rd** | **4th** |
| % of funded staff appointed | Annual | 80% |  |  |  | 80% |
| # of Interns appointed | Annual | 3 | 1 | 1 | 1 |  |
| Unqualified audit report | Annual | Unqualified report |  |  |  | Unqualified report |
| IT system in place and functional | Annual | System in place |  |  |  | System in place |
| % of uptime of the integrated IT system | Quarterly | 80% | 80% | 80% | 80% | 80% |

# **Reconciling performance targets with the Budget and MTEF**

**Expenditure Estimates: Programme 2: Corporate Services**



**Performance and expenditure trends**

* The budget estimates increase from a total of R25,6million in 2015/16 to R33,6 million in 2017/18, before decreasing to R29,6 million in 2018/19.
* The main budget items are:
  1. The office move and the resultant operational and infrastructure requirements for the new offices in the 2017/18 financial year
  2. The training and development budget is allocated for the internship program, as well as the training of all employees.
  3. Audit costs are meant for internal and external audits
  4. Communication (Telephone) budget increases from R1.3 million in 2016/17 to R1.6 to cater for a growing organisation

# **Programme 3: Compliance inspectorate**

# **Programme Purpose**

To manage the inspections of health establishments in order to assess and encourage compliance with national health system norms and standards as prescribed by the Minister and take measures to ensure such compliance.

# **Strategic objective annual targets for 2016/17**

The following tables outlines the output targets for the budget year and over the MTEF period for each strategic objective specified for this programme in the Strategic Plan.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Strategic Objective** | **Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| 1.3.Compliance with quality standards in regulated health establishments is monitored and inspected at least every 4 years and relevant action is taken | # and % of public sector health establishment inspected annually by the OHSC | 20% | - | - | (10) | 10%  (382 of 3816) | 17%  (649 of 3816) | 18%  (689 of 3816) | 19%  (725 of 3816) |
| # and % of private sector health establishment inspected annually by the OHSC | 30% |  |  | - | New indicator | 20%  (74 of 369) | 25%  (92 of 369) | 30%  (111 of 369) |
| 1.4. Non-compliant HE are subjected to re-inspection or review within 6 months | % of provisionally non-compliant health establishments subjected to re-inspection or review within 6 months | 80% | - | - | - | 30% | 35% | 40% | 45% |
| 4.3. Inspectors accredited after successfully completing approved training course | # compliance inspectors accredited as competent | 60 |  |  |  | New indicator | 20 | 20 | 20 |

# **Programme performance indicators and annual targets for 2016/17**

The following table sets out the annual performance targets for the programme using indicators as identified

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| # and % of public sector health establishment inspected annually by the OHSC | 20% | - | - |  | 10% | 10%  (382 of 3816) | 17%  (649 of 3816) | 18%  (689 of 3816) |
| # and % of private sector health establishment inspected annually by the OHSC | 30% | - | - | - | New indicator | 20%  (74 of 369) | 25%  (92 of 369) | 30%  (111 of 369) |
| % of provisionally non-compliant health establishments subjected to re-inspection or review within 6 months | 80% | - | - | - | 30% | 35% | 40% | 45% |
| # compliance inspectors accredited as competent | 60 |  |  |  | New indicator | 20 | 20 | 20 |

# **Quarterly targets for 2016/17**

The following table sets out the quarterly targets for the unit performance indicators identified above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Reporting period** | **Annual target** | **Quarterly targets** | | | |
| **1st** | **2nd** | **3rd** | **4th** |
| # and % of public sector health establishment inspected annually by the OHSC | Quarterly | 17% | 4.5% | 4.5% | 3.5% | 4.5% |
| # and % of private sector health establishment inspected annually by the OHSC | Quarterly | 20% | 5% | 5% | 5% | 5% |
| % of provisionally non-compliant health establishments subjected to re-inspection or review within 6 months | Bi-Annual | 35% | - | 11.6% | 11.6% | 11.6% |
| # compliance inspectors accredited as competent | Annual | 20 |  |  |  | 20 |

# **Reconciling performance targets with the Budget and MTEF**

**Expenditure Estimates: Programme 3: Complaints Inspectorate**



**Performance and expenditure trends**

* This is the biggest division driven by the staff numbers required to ensure on-the-ground inspection coverage of all health establishments across the country.
* The increased budget allocation has gone in large part into increasing the number of inspectors to initiate inspections of both public and private health establishments, which are needed in order to contribute to the objective of enhancing and enforcing compliance.
* The increased inspection coverage will come with all the requirements for the inspection teams to function - travel costs, subsistence and accommodation.

# **Programme 4: Complaints Management (and Ombud)\***

# **Programme Purpose**

To consider, investigate and dispose of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.*\*Ombud functions integrated into Strategic objectives and indicators as functionally Ombud is located with the Office [NHAA S 81 (3) (b) and uses staff of the Office NHAA S 81 (3) (c)]*

# **Strategic objective annual targets for 2016/17**

The following tables outlines the output targets for the budget year and over the MTEF period for each strategic objective specified for this programme in the Strategic Plan.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Strategic Objective** | **Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| 2.1. An accessible mechanism by which Complaints can be lodged with the OHSC is in place | Functional Call Centre maintainedwith supporting processes and technology platform aligned to OHSC mandate | Call centre functional | - | - | New indicator | Call centre functional | Call centre functional | -l | - |
| 2.2. Complaints or concerns regarding non-compliance with norms and standards are effectively managed and resolved | Procedures for receiving and managing complaints developed | Procedures in place | - | - | - | Procedures in place | -Procedures in place | - | - |
| (%) of complaints successfullyresolved within 6 months. | 80% |  |  | - | 50% | 60% | 70% | 80% |
| 2.3. Findings and recommendations relating to complaints of non-compliance with prescribed norms and standards are issued within agreed time frames | System and procedures for investigation of complaints set up | System set up and functional |  |  |  | System set up and functional | - | - | - |
| % of investigation closed within 6 months by the Ombud | 80% |  |  |  | New indicator | 60% | 70% | 80% |
| 2.4 Recommendation made by the Ombud are monitored | Procedures for communication and monitoring of Ombud recommendations set up and functional | System set up and functional |  |  | New indicator | Procedures developed | Procedures developed | - | - |
| % of Ombud recommendations monitored for implementation by health establishment within six months of tabling to OHSC | 80% |  |  |  | New indicator | 60% | 70% | 80% |

# **Programme performance indicators and annual targets for 2016/17**

The following table sets out the annual performance targets for the programme using indicators as identified

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| Functional Call Centre maintainedwith supporting processes and technology platform aligned to OHSC mandate | Call centre functional | - | - |  | Call centre functional | Call centre functional | - | - |
| Procedures for receiving and managing complaints developed | Procedures in place |  |  |  | New  indicator | Procedures in place |  |  |
| (%) of complaints successfully resolved within 6 months. | 80% |  |  |  | 50% | 60% | 70% | 80% |
| System and procedures for investigation of complaints set up | System set up and functional |  |  |  | New indicator | System set up and functional |  |  |
| % of investigation closed within 6 months by the Ombud | 80% |  |  |  | New indicator | 60% | 70% | 80% |
| Procedures for communication and monitoring of Ombud recommendations set up and functional | System set up and functional |  |  |  | New indicator | Procedures developed |  |  |
| % of Ombud recommendations monitored for implementation by health establishment within six months of tabling to OHSC | 80% |  |  |  | New indicator | 60% | 70% | 80% |

# **Quarterly targets for 2016/17**

The following table sets out the quarterly targets for the unit performance indicators identified above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Reporting period** | **Annual target** | **Quarterly targets** | | | |
| **1st** | **2nd** | **3rd** | **4th** |
| Functional Call Centre maintainedwith supporting processes and technology platform aligned to OHSC mandate | Annual | Call centre functional | - | - | - | Call centre functional |
| Procedures for receiving and managing complaints developed | Annual | Procedures developed | - | - | - | Procedures developed |
| (%) of complaints successfully resolved within 6 months. | Quarterly | 60% | - | 30% | - | 30% |
| System and procedures for investigation of complaints set up | Annual | System set up and functional | - | - | - | System set up and functional |
| % of investigation closed within 6 months by the Ombud | Quarterly | 60% | 60% | 60% | 60% | 60% |
| Procedures for communication and monitoring of Ombud recommendations set up and functional | Annual | Procedures developed |  |  |  | Procedures developed |
| % of Ombud recommendations monitored for implementation by health establishment within six months of tabling to OHSC | Quarterly | 60% | 60% | 60% | 60% | 60% |

# **Reconciling performance targets with the Budget and MTEF**

**Expenditure Estimates: Programme 4: Complaints Management (and Ombud) Budget**



***Ombud Budget***



# **Performance and expenditure trends**

* The budget of the Complaints Management division is expected to increase from R7 million in 2015/16 to R18,2 million. This is largely due to the costs required to run the complaints call centre, as well as additional staff who will operate from the call centre.
* The budget of the Ombud is carried by the OHSC as required by the National Health Amendment Act. TheOHSC will put in place mechanisms for the proper channels for the complaints system, including assessment and referral and communication with the Ombud regarding monitoring of the implementation of recommendations.

# **Programme 5: Health Standards design Analysis and support**

# **Programme Purpose**

To provide high-level technical, analytical and educational support to the work of the Office in relation to the development and analysis of norms and standards and support for their dissemination

# **Strategic objective annual targets for 2016/17**

The following tables outlines the output targets for the budget year and over the MTEF period for each strategic objective specified for this programme in the Strategic Plan.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Strategic Objective** | **Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| 4.1. All health establishments obligated or regulated by prescribed norms and standards are registered\* annually for purposes of monitoring and inspections | System for submission of annual returns by health establishments set up | System set up & functional | - | - |  | System set up | System set up | - | - |
| % regulated health establishment which has submitted their annual returns | 80% |  |  |  | New indicator | 80% | 80% | 80% |
| 4.2. Norms and standards for different types of HEs are consulted, developed and/or revised for submission to the Minister for promulgation | Norms and standards developed or reviewed annually | 3 |  |  | - | New indicator | 1 | 1 | 1 |
| 1.2. Guidance is provided on compliance with norms and standards for regulated HEs | % of relevant authorities responsible for support to health establishments that have received guidance on compliance with norms and standards | 90% | - | - |  | 40% | 50% | 60% | 80% |
| 1.6. Early warning reports of potential situations of risk from HEs or users are monitored to prioritise inspections | % of high risk health establishments with action taken within 2 months | 70% |  |  |  | New indicator | 50% | 60% | 70% |

\*Registration of health establishment is not within the mandate of OHSC as per NHAA, and therefore, the objective under 4.1 needs review in the future. Submission of annual returns by HE would be most appropriate under section 79 (2)(b) of the Act.

# **Programme performance indicators and annual targets for 2016/17**

The following table sets out the annual performance targets for the programme using indicators as identified

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Strategic Plan Target** | **Estimated performance** | | | | **Medium-term targets** | | |
| **2012/13** | **2013/14** | **2014/15** | **2015/16** | **2016/17** | **2017/18** | **2018/19** |
| System for submission of annual returnsby regulated health establishments set up | System set up & functional | - | - |  | System set up | System set up | - | - |
| % regulated health establishment which has submitted their annual returns | 80% |  |  |  |  | 100% | 100% | 100% |
| Norms and standards developed or reviewed annually | 3 |  |  |  | New indicator | 1 | 1 | 1 |
| % of relevant authorities responsible for support to public health establishments that have received guidance on compliance with norms and standards | 90% | - | - |  | 40% | 50% | 60% | 80% |
| % of high risk health establishments with action taken within 2 months | 70% |  |  |  | New indicator | 50% | 60% | 70% |

# **Quarterly targets for 2016/17**

The following table sets out the quarterly targets for the unit performance indicators identified above.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Programme Performance Indicator** | **Reporting period** | **Annual target** | **Quarterly targets** | | | |
| **1st** | **2nd** | **3rd** | **4th** |
| System for submission of annual returns by regulated health establishments set up | Annual | System set up & functional |  |  |  | System set up & functional |
| % regulated health establishment which has submitted their annual returns | Annual | 80% |  |  |  | 80% |
| Norms and standards developed or reviewed annually | Annual | 1 |  |  |  | 1 |
| % of relevant authorities responsible for support to public health establishments that have received guidance on compliance with norms and standards | Quarterly | 50% | 10% | 10% | 15% | 15% |
| % of high risk health establishments with action taken within 2 months | Quarterly | 70% | 15% | 15% | 20% | 20% |

# **Reconciling performance targets with the Budget and MTEF**

**Expenditure Estimates - Programme 5: Health Standards Design, Analysis and Support Budget**



# **Performance and expenditure trends**

* Fees for consultants are relatively high for this programme reflecting the need to source additional expertise from consultancies, partnerships and expert advisors.
* Furthermore, additional staff members will be recruited to boost the capacity of this division.

# PART C

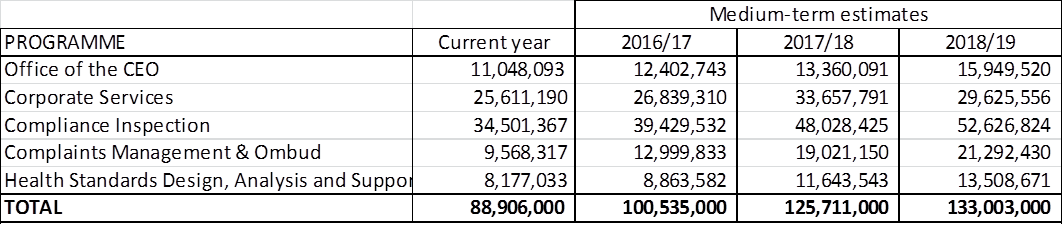
# LINKS TO OTHER PLANS

# There are no links to other plans or envisaged capital investments at this stage.

# PART D

# ANNEXURES

# **Annexure 1: Budget programme summary:Costing For ENE 2016**



## **ANNEXURE 2: Technical indicator description sheet**

| **Indicator Name** | **Short Definition** | **Purpose /Importance** | **Source** | **Calculation Method** | **Data Limitations** | **Type of Indicator** | **Calculation Type** | **Reporting Cycle** | **New Indicator** | **Desired Performance** | **Responsibility** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| System for certification of compliant establishments set up and functional | System for issuing certificate of compliance within stipulated time frame, based on criteria, procedures, security provisions and quality control | System must be efficient, fair, credible and transparent and meet regulatory provisions | OHSC documents of system and procedures | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | Director Certification and enforcement (once appointed) |
| % compliant health establishments certified by the OHSC within 2 months of the inspection | Health establishments that are found complaint with regulated norms and standards are certified | Certification of complaint health establishments | Final inspection report | Numerator: # health establishment found compliant  Denominat0r: total # of health establishment inspected | Requires regulations to be promulgated | Activity | % | Quarterly | Yes | Compliant health establishments certified | CEO |
| System and procedures for timely enforcement action set up | Enforcement action as defined in the legislation implemented through set criteria and procedures | Regulatory enforcement action requires standardized, fair and transparent procedures | Documented systems including criteria and procedures | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | Director Certification and enforcement (once appointed) |
| % of persistently non-compliant health establishment for which regulated action is initiated within 6 months of the inspection. | Action is taken against health establishments that are found to be persistently non-compliant | Action taken to ensure quality improvement is set up towards compliance with norms and standards | Inspection register | Numerator:  # ofhealth establishments found to be persistently non complaint  Denominator: Total # of health establishments re-inspected | Seriously non-compliant establishment may be counted twice in a 6-month period | Output | % | Quarterly | New | Performance above the target might be desirable once full capacity exists | CEO |
| System and procedures for communication of Ombud recommendations and action to ensure implementation set up and functional | Legislated obligation on Ombud to communicate report and recommendations and on CEO to monitor their implementation and take regulatory action of necessary must be set out in system and procedures | Fair and reliable system to assure complainants and respondents that Ombud recommendations will be monitored and regulatory action taken if non-compliance | Documented systems for referral of recommendations and appropriate monitoring of affected establishments with action taken | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | Ombud (once appointed)  EM Compliance inspectorate (once appointed) |
| Number of media and communication events and campaigns to increase awareness of OHSC among public, providers or stakeholders carried out annually | Seminars, workshops, conferences and use of radio, publications or television designed to increase awareness of work of OHSC among providers and users of health services or stakeholders concerned with this. | As a new regulator with a mandate to promote the health and safety of users the OHSC must ensure all relevant parties are aware of its work and assist in enhancing its effectiveness | OHSC record of events, copies of publications distributed, media awareness programme reports | Total number of events and campaigns | Nil | Activity | Number | Annual | Yes | Performance above the target might be desirable once full capacity exists | Director Communications (once appointed) |
| Number of signed MOAs with regulators to protect and promote quality and safety of care in place each year | MOAs setting out respective actions of the signatories towards enhancing quality and safety are signed and current in that year. | The OHSC has a legislated and operational need to formalize its working relationships with regulators who can contribute to its mandate | Signed MOUs | Total number of signed MOUs | Will require evidence of annual review and agreement | Output | Number | Annual | Yes | Performance above the target might be desirable once full capacity exists | Director Communications |
| No. of published reports on compliance status of health establishments | No. of reports produced on inspections conducted, recommendations issued,and compliance status of health establishments as assessed | The OHSC as a regulator must ensure that stakeholders, users and providers are aware of its of its findings | Reports covering either inspections conducted, recommendations issued or compliance status | Total number of reports issued on inspections conducted, recommendations issued or compliance status | N/A | Output | Number | Annual | Yes | Performance above the target might be desirable once full capacity exists | Director Communications  Director Guidance and support |
| % of funded staff appointed | Staff for which funding exits in the annual budget who are appointed by the end of that year | Where funding is available the OHSC must ensure it is fully utilized | Register of appointed staff  Annual staffing plan | Numerator:  # of appointed staff in March of each year  Denominator:  Total # of funded posts for that year | Picture in a single month may not reflect the situation during the remainder of the year | Output | % | Annual | New | Performance above target desirable if suitable candidates found | Director HR |
| Number of Interns appointed | Interns for which funding exist in the annual budget who are appointed by the end of the year | Contribute in skills development of the country | Register of Interns appointed | Number of Interns appointed | N/A | Output | number | Annual | New | Performance above target desirable if suitable candidates found | Director: HR |
| Unqualified audit report | Annual audit by Auditor General is unqualified without findings | As a regulator, it is critical that the OHSC should set an example | Auditor general report | N/A | N/A | Output | N/A | Annual | New | N/A | CFO |
| IT system in place and functional | OHSC IT system as detailed in the ICT strategy aligns to the core business functions of the Office. | IT system is a critical enabler for OHSC to functions effectively and must be delivered according to plan | OHSC documentation on IT system implementation. Project plan for roll-out. | N/A | Absence of integrated IT system | Activity | N/A | Annual | New | N/A | Director IT |
| Percentage systems uptime and availability maintained. | Uptime usually means the percentage of the time while the service was up, calculated by minutes. | The availability of the integrated IT solution is crucial to running of OHSC daily operations. | Server infrastructure | Numerator:  Minutes of uptime / Denominator: Total number of minutes for the specified period | availability of server management | output | Percentage | Quarterly | New | 99% | Director IT |
| # and % of public health establishments inspected annually by the OHSC | # and % of public sector clinics, CHCs and hospitals for which an OHSC inspection team has carried out an assessment and issued a report to the HE in each year | The coverage of inspections is fundamental to the regulatory mandate of the OHSC | Inspection register  Register of reports issued | Numerator:  # of each type of public HE for which assessment report issued following inspection visit  Denominator: total # of public sector clinics, CHCs and hospitals | Incomplete-ness or variations in the denominator numbers as supplied by the NDOH | Output | % | Quarterly | No | Performance above the target might be desirable once full capacity exists | EM Compliance inspections |
| # and % of privatehealth establishments inspected annually by the OHSC | # (37)and 10 % of private sector clinics, CHCs and hospitals for which an OHSC inspection team has carried out an assessment and issued a report to the HE in each year | The coverage of inspections is fundamental to the regulatory mandate of the OHSC | Inspection register  Register of reports issued | Numerator:  #(37) of each type of private HE for which assessment report issued following inspection visit  Denominator: total #(369) of private sector clinics, CHCs and hospitals | Incomplete-ness or variations in the denominator numbers as supplied by the NDOH | Output | % | Quarterly | No | Performance above the target might be desirable once full capacity exists | EM Compliance inspections |
| % of provisionally non-compliant health establishments subjected to re-inspection or review within 6 months | Inspected health establishments not meeting current provisional threshold of 50% on inspection who are either re-inspected fully or partially, or required to submit a signed QI plan for verification, within 6 months of the initial inspection visit | Only through follow up of non-compliant establishments will changes be made towards improvement | Inspection register including  re-inspections  Register of submitted and signed QI plans  Register of random verification visits. | Numerator:  # of provisionally non-compliant health establishments re-inspected or reviewed within 6 months  Denominator: total # of provisionally non-compliant HEs | Seriously non-compliant establishment may be counted twice in a 6-month period | Output | % | Annual | New | Performance above the target might be desirable once full capacity exists | EM Compliance inspections |
| Requirements and procedures for accreditation of inspectors approved by the Board | Requirements as set out in a curriculum and training course and procedures relating to evaluation for accreditation of inspectors set up, functional and approved by the Board | Credibility and competence of inspectors is a legislated and operational requirements | Approved requirements and procedures for accreditation of inspectors | N/A | Progress will depend on promulgation of regulations | Activity | N/A | Annual | New |  | Director Guidance and Support  Director HR |
| # compliance inspectors accredited as competent | Inspectors trained in a curriculum and training course and procedures relating to evaluation for accreditation of inspectors set up, functional and approved by the Board | The credibility and competence of inspectors is a legislated and operational pre-requisite. | Approved requirements and procedures for accreditation of inspectors | Numerator: # of inspectors trained  Denominator: total # of inspectors in the OHSC database | Progress will depend on promulgation of regulations | Output | % | Quarterly | New | The credibility and competence of inspectors meets legislated and operational pre-requisite. | Director Guidance and support  Director HR |
| Functional Call Centre maintained with supporting processes and technology platform aligned to OHSC mandate | Call centre for public to lodge complaints relating to non-compliance with prescribed norms and standards set up with toll free line and trained complaints officers | Access for the public to the complaints unit and Ombud is a fundamental responsibility of the OHSC | OHSC documents on toll free line and training of call-takers | N/A | N/A | Activity | N/A | Annual | New |  | Director Complaints management |
| Procedures for receiving and managing complaints are developed | Receiving, logging and  managing of complaints  is monitored using a set  of standard procedures  and criteria and captured  in an electronic register | The public needs to know that their complaints will be effectively and efficiently and heard and addressed | OHSC Complaints procedure manual | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | Yes | Compliance with developed procedures | Director Complaints management |
| % of Complaints successfully resolved within 6 months | Complaints that the OHSC receives through its call centre or registry and logs on its system that it assesses or investigates with production of a final report resolving the matter within 6 months | The efficiency with which the OHSC assesses and investigates complaints and can produce a report is important for users | OHSC complaints register showing calls logged, progress and final report with dates | Numerator: # of calls logged by OHSC that are resolved and reported within 6 months of being logged  Denominator: # of calls logged by OHSC within the 6 month period | The time period covered by the numerator and denominator may differ | Output | % | Bi - annual | Yes | Performance above the target might be desirable once full capacity exists | Director Complaints management |
| % of investigation closed within 6 months by the Ombud | Complaints that the OHSC refers to the Ombud for further investigation with production of a final report resolving the matter within 6 months | The efficiency with which the Ombud assesses and investigates complaints and can produce a report is important for users | Investigation register | Numerator: # of investigations closed within 6 months  Denominator: # of investigations referred to the Ombud. | Ombud appointment | Output | % | Quarterly | Yes | 100% | Ombud |
| Procedures for communication and monitoring of Ombud recommendations set up and functional | Ombud investigation recommendations for implementation by health establishments are monitored by the OHSC through follow up inspections | To ensure Ombud recommendations are implemented by health establishments | Follow up register | N/A | Appointment of Ombud and promulgation of the regulations | Activity | N/A | Quarterly | Yes | Procedures in place and implemented | Director Complaints |
| % of Ombud recommendations monitored within six months of tabling to OHSC | Recommendation by the Ombud on complaints lodged are monitored by OHSC for implementation by Health establishments | To ensure that recommendations are implemented by health establishments for quality improvement | Follow up register | Numerator: # of followed up recommendation  Denominator: Total # of recommendations by the Ombud | Appointment of Ombud and promulgation of the regulations | Activity | % | Quarterly | Yes | the Ombud’s recommendation implemented by the health establishment | Director complaint |
| System for submission of annual returns by regulated health establishments set up | Procedures and register set up for all establishments covered by the promulgated norms and standards to report on standardized information according to regulations | Without a listing of which establishments are subject to regulation the Office cannot plan or discharge its regulatory function | OHSC records | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | Director Health standards analysis |
| Norms and standards developed or reviewed annually | Norms and standards promulgated, implemented and reviewed | To ensure the norms and standards remain current and relevant | Regulations | N/A | Requires regulations to be promulgated | Output | N/A | Annual | Yes | Once per annum | Director: Health Standards and analysis |
| % regulated health establishment submitting their annual returns | Health establishment regulated submit standardized information according to the requirements in terms of the regulations | Maintain and update a database of all regulated health establishments | OHSC database | Numerator: # of regulated health establishments that have submitted annual returns  Denominator: total # of regulated health establishment in the OHSC database | Requires regulations to be promulgated | Activity | % | Annual | New | Performance above the target might be desirable once full capacity exists | Director: Health Standards and analysis |
| Procedures for selection, development or periodic review of norms and standards for different types of health establishments set up | Procedures and criteria for selection, development or periodic review of norms and standards for different types of health establishments set up | Development or review of norms and standards will follow stipulated criteria in order to address priorities and ensure relevance | OHSC records | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | EM Health Standards design |
| % of relevant authorities responsible for support to health establishments that have received guidance on compliance with norms and standards | Percentage of those authorities defined in the NHAA (national, provincial, municipal and private hospital groups) for whom documentation and a guidance workshop on the norms and standards, the assessment methods, and the obligations of health establishments have been provided in the financial year | In order for norms and standards to be implemented and regulatory action to be taken, regulated entities must be aware of the obligations placed on them, as conveyed through their relevant authorities | Register of guidance events including agenda  Register of materials distributed | Numerator:  # of relevant authorities provided with guidance workshop and materials in that financial year  Denominator:  # of relevant authorities | N/A | Activity | % | Annual | New | Performance above the target might be desirable once full capacity exists | Director Guidance and support |
| Surveillance system set up for reporting on indicators of risks to compliance | A surveillance system to receive standardized or ad-hoc reports indicating potential situations of risk from health establishments or communities is set up with needed procedures and forms | The legislation and regulations make provision for and early warning system to enable the OHSC top prioritize its inspections by focusing on highest risk | OHSC records | N/A | Requires regulations to be promulgated | Activity | N/A | Annual | yes | System functional | Director Health standards analysis |
| % of high risk health establishments with action taken within 2 months | High risk health establishments are inspected/investigated and action taken on findings for the breach of norms and standards | Action taken to ensure quality improvement is set up towards compliance with norms and standards | Inspection and complaints register | Numerator:  # of high risk health establishments inspected/investigated  Denominator: Total # of high risk health establishments reported | Seriously non-compliant establishment may be counted twice in a 6-month period | Activity | % | Quarterly | New | Performance above the target might be desirable once full capacity exists | EM Compliance inspections |

## **ANNEXURE 3: MATERIALITY AND SIGNIFICANCE FRAMEWORK FOR THE FINANCIAL YEAR 2016/17**

1. BACKGROUND
2. The OHSC was established by the National Health Amendment Act No 12 of 2013, and also listed as Schedule 3A public entity in terms of the Public Finance Management Act (PFMA) No 1 of 1999.
3. The OHSC’s materiality and significance framework is developed in terms of the following sections of the PFMA:
4. Section 50 - Fiduciary duties of the Accounting Authority;
5. Section 54 - Information to be submitted by the Accounting Authorities; and
6. Section 55 - Annual report and financial statements
7. 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
8. In terms of the South African Auditing Standard, 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 the 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.”
9. 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. This takes into account the fact that different transactions and events may require different levels of materiality and significance.
10. 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.
11. QUALITATIVE ASPECTS
12. 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:
13. establishment or participation in the establishment of a company or public entity;
14. participation in a significant partnership, trust, unincorporated joint venture, public private partnerships or similar arrangement;
15. acquisition or disposal of a significant shareholding in a company;
16. acquisition or disposal of a significant asset that would significantly affect the operations of the OHSC;
17. commencement or cessation of a significant business activity;
18. a significant change in the nature or extent of its interest in a significant partnership, trust, unincorporated joint venture or similar arrangement; and
19. The following significant events will be disclosed to the executive authority in the event that they occur within the OHSC:
20. material infringement of legislation that governs the OHSC;
21. material losses resulting from criminal or fraudulent conduct in excess of the significance parameters below.
22. all material facts and/or events, including those reasonably discoverable, which in any way may influence the decisions or actions of the executive authority.
23. QUANTITATIVE ASPECTS
24. The National Treasury issued a Practice Note - “Practice Note on Applications Under Section 54 of the Public Management Act No. 1 of 1999 (as amended) 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% |

1. The OHSC is a new public entity having commenced functioning independently on the 01st April 2015, thus it has no audited financial statements as the external audit will be conducted after the end of the current financial year 2015/16.
2. The OHSC takes cognisance 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.
3. 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.
4. For purposes of determining the rand values of the identified elements, the current OHSC’s 2015/16 budget was applied as follows:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Element | % Range to be applied against the rand value | Budget Amount (2015/16) | Significance Amount | Rationale for the % used |
| Total assets[[1]](#footnote-2) | 2% | R 14 363 823 | R287 276 | Upper limit of the National Treasury’s parameters |
| Total revenue | 0,75% | R88 906 000 | R666 795 | Mid-point of the National Treasury’s parameters |
| Estimated Surplus | 5% | R11 000 0000 | R666 795 | Upper limit of the National Treasury’s parameters |

1. REVIEW
2. 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.
3. On an annual basis, the OHSC will conduct a thorough risk identification and assessment process to determine any new risks that may have emerged since the conclusion of the prevailing risk management framework.
4. 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.
5. 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.
6. However, more frequent review of the framework may be necessary if major changes in the operating environment occur during the year.

1. Based on the 2015/26 budgeted capital expenditure of R4 363 823 and an estimated cash balance of R10 million by year end [↑](#footnote-ref-2)