From development to implementation:
A better healthcare system for all

# ANNUAL REPORT
# 2016/17

OHSC
Office of Health Standards Compliance
Ensuring quality and safety in health care

## The OHSC: A brief overview

The Office of Health Standards Compliance (OHSC), as a Schedule 3A public entity, came into effect in January 2014 when the Minister of Heath, Dr. Aaron Motsoaledi, appointed the first OHSC Board for a three year term of office.

The overall purpose of establishing the OHSC as an independent entity is:

1. To protect and promote the health and safety of all people who use health services in South Africa – both in the public and the private healthcare sector;
2. To reduce avoidable mortality, morbidity and harm within health establishments through reliable and safe health services; and
3. To improve the availability, responsiveness and acceptability of health services for users.

In brief, the OHSC is mandated to:

- Facilitate compliance with the norms and standards of the National Core Standards (NCS) by healthcare providers and health establishments, facilities and workers;
- Inspect health establishments to ensure they comply with essential quality and safety standards;
- Investigate complaints of non-compliance;
- Provide an independent system to hold healthcare providers accountable for poor quality of care;
- Advise the Minister (of Health) on the setting of different standards suited to different types of health care establishments; and
- Ensure norms, standards and regulations are clear, specific, applied in a transparent manner, consistent, objective and measurable.

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# PART A

# GENERAL INFORMATION

# GENERAL INFORMATION

| | |
|---|---|
| REGISTERED NAME: | OFFICE OF HEALTH STANDARDS COMPLIANCE |
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| POSTAL ADDRESS: | Private Bag X21<br>Arcadia<br>0007 |
| TELEPHONE NUMBER/S: | +27 12 339 8693 |
| EMAIL ADDRESS: | mmakgopa-madisa@ohsc.org.za |
| WEBSITE ADDRESS: | www.ohsc.org.za |
| EXTERNAL AUDITOR: | Auditor-General of South Africa |
| BANKERS: | Standard Bank |
| ACTING BOARD SECRETARY: | Makhwedi Makgopa-Madisa |

# LIST OF ABBREVIATIONS/ ACRONYMS

| | |
|---|---|
| AGSA | Auditor-General of South Africa |
| ARFC | Audit, Risk and Finance Committee |
| B-BBEE | Broad-Based Black Economic Empowerment |
| CEC | Certification and Enforcement Committee |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CHC | Community Health Centre |
| DoH | Department of Health |
| DHIS | District Health Information System |
| HE | Health Establishment |
| HPCSA | Health Professions Council of South Africa |
| HRREMCO | Human Resources and Remuneration Committee |
| LOBS | Line-of-Business Solutions |
| MEC | Member of Executive Council |
| MoA | Memorandum of Agreement |
| MTEF | Medium-Term Expenditure Framework |
| NCS | National Core Standards |
| NHA | National Health Act, 2003 (Act No. 61 of 2003) |
| NHC | National Health Council |
| NHI | National Health Insurance |
| NDP | National Development Plan |
| NPQ | National Policy on Quality in Healthcare |
| OHSC | Office of Health Standards Compliance |
| OSC | Office of Standards Compliance |
| PAIA | Promotion of Access to Information Act, 2000 (Act No. 2 of 2000) |
| PFMA | Public Finance Management Act, 1999 (Act No.1 of 1999) |
| PoPI | Protection of Personal Information Act, 2013 (Act No. 4 of 2013) |
| SANC | South African Nursing Council |
| SCM | Supply Chain Management |
| SMME | Small Medium and Micro Enterprises |
| SOP | Standard Operating Procedures |
| TR | Treasury Regulations |

# FOREWORD BY THE CHAIRPERSON

Three years after the formation of the OHSC which was created to promote and protect the health and safety of the users of health establishments and thus contribute to improved outcomes, the Office continues strengthening its capacity. This report details the work undertaken by the OHSC over the 2016/17 financial year and its performance in terms of strategic objectives under the auspices of its mandate as set by the National Health Act, 2003, (Act No. 61 of 2003).

## Strategy and performance overview

In the current health environment of South Africa, there is an increasing public clamour for access to a safe and efficient health system and better quality health for all.

The events of Life Esidimeni and subsequent reports have caught the attention of both national and international organisations. This has put the spotlight on OHSC to perform even better and act faster to deliver on its mandate of inspection of health establishments.

It is against this backdrop that the OHSC operates to develop and sustain responsiveness at all health establishments, both public and private, through effective monitoring, certification and enforcement of legislated norms and standards.

The OHSC has continued to achieve notable results in achieving its strategic deliverables.

**A snapshot of operational achievements**

- Appointment of the Health Ombud.
- Launch of the Complaints Call Centre.
- Development of ICT systems including electronic inspection system and early warning surveillance.
- Comprehensive awareness and communication campaigns.

## Board oversight

The Board continues to exercise efficient oversight at all levels of operations with regular Board and Committee meetings. Financial and corporate controls are managed with guidance of both internal and external auditors and National Treasury. While

the OHSC has met most of the expectations over the year, the organisation still has a long road ahead in promoting quality and safe healthcare for everyone across the entire health system of the country, from public and private health establishments.

Strengthening of the leadership at Executive Management level, and additional space are challenges which have to be overcome. Communication with internal and external role players regarding their engagement and participation is essential and the OHSC is in the process of creating platforms to further engage staff and build strong, competent and dynamic teams.

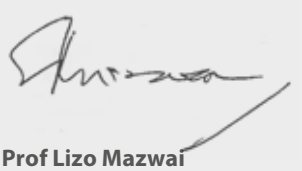
## Acknowledgements

I would like to thank the OHSC management and staff for their cooperation, hard work, dedication and support in maintaining the work of the OHSC.

I would especially like to express my appreciation for the support from the Office of the Minister of Health, Dr Aaron Motsoaledi; the Director-General, Ms Malebona Matsoso and the National Department of Health (NDoH) officials. I also wish to acknowledge the previous Board who did all the ground work in order to establish a new Office of Health Standards Compliance in South Africa. My final acknowledgement is to the current Board members who will be serving on this Board until December 2019 and are part of this important journey.

## Conclusion

We live in very challenging times in South Africa and access to quality healthcare for all South African citizens is in the forefront of discussion amongst all stakeholders. Collaborating and cooperation is essential if we are to collectively meet the Sustainable Development Goals. Finally in recognition of the task ahead, the OHSC has adopted a developmental approach wherein Quality Improvement becomes part of the Quality Assurance for all health establishments.



**Prof Lizo Mazwai**
**Chairperson**
**31 July 2017**

# CHIEF EXECUTIVE OFFICER'S OVERVIEW

It is my pleasure to present the second annual report of the OHSC for the financial year 1 April 2016 to 31 March 2017. The purpose is to report on the organisation's performance in support of our key regulatory roles to firstly inspect health establishments (HEs) and ensure compliance with the essential NCS, quality and safety standards, and secondly investigate complaints of non-compliance.

During the past year, four matters had a significant impact on the execution of the OHSC's legal and operational mandates, namely the delay in the promulgation of norms and standards; appointment of the first Health Ombud; launch of a Complaints Call Centre; and the development and implementation of strategic ICT systems aimed at simplifying and streamlining OHSC process for both internal and external stakeholders.

## Inspections and compliance enforcement

While the OHSC has the mandate to advice on the norms and standards to be regulated, we have limited powers to enforce compliance, especially in the absence of regulations. The anticipated promulgation of the prescribed norms and standards and procedural regulations is aimed to pave the way for the inclusion of private sector hospitals and clinics in the key performance indicators of the Compliance Inspectorate. Unfortunately the delay of this promulgation impacted negatively on almost each of the OHSC Programmes during the period under review. Most importantly our ability to meet all the Certification and Enforcement strategic objectives under Programme 1 and Compliance Inspectorate strategic objectives under Programme 3 were negatively affected.

## Health Ombud

The appointment of South Africa's first independent Health Ombud, effective 1 June 2016, was highly publicised and followed by engagement visits to establish working relationships in Gauteng, Limpopo, KwaZulu-Natal, Free State, some of the Chapter 9 institutions (including the Public Protector and South African Human Rights Commission) and the Public Service Commission.

On 1 February 2017, the Health Ombud's report on the deaths of mentally-ill patients after their relocation from Life Esidimeni was released. All the recommendations made by the Ombud in terms of this report were accepted by the Gauteng Department of Health and good progress was made on the implementation of those recommendations. The release of the report generated wide media and public interest, with just over 1046 media reports, nationally and internationally, generated over a period of five weeks. The professional management of complaints by the Ombud in October 2016 ensured the cooperation of private health establishments in terms of the OHSC's investigation of complaints.

## National Call Centre

The OHSC launched a National Toll-Free Complaints Call Centre on 28 November 2016 to ensure access to the OHSC and Ombud's complaints process. Following a nationwide awareness campaign, the Complains Management (and Ombud) unit received a total of 730 complaints with 331 resolved by means of the Call Centre. This is compared to only 73 complaints received during the same period in the previous year, which we believe testifies to the success of the Call Centre in escalating the number of complaints lodged and managed during the year.

## ITC systems development and implementation

Over the period, the OHSC made great strides in terms of the development of systems and processes to ensure delivery on the core business and support functions of the entity. These included development and implementation of the following:

- An Electronic Inspection System which will significantly enhance the inspection process during inspections of health establishments, both in areas with connectivity and in rural areas where the system is used offline;
- An Early Warning System to help inspectors detect the probability of negative conditions in advance, which could result in the timeous inspection of health establishments or the initiation of an investigation;
- An Annual Returns System to simplify and streamline the submission and monitoring of annual returns process.

## Stakeholder outreach and awareness

The Office of the CEO exceeded its planned target of creating public awareness about the OHSC, with specific focus on education about the role and functions of the OHSC; the launch of the Call Centre; and the processes and procedures stakeholders need to follow when engaging with the Office.

## Governance and accountability

Internal control systems were developed to create management and Board confidence in the financial position of the OHSC and ensure the safeguarding of assets (including the security of information) and compliance with applicable laws, regulations and government policy prescripts. The Board adopted a risk management policy and strategy which are aimed at optimal management of risk for the entity to achieve its vision and mission, principal tasks, key strategic objectives and protect the core values of the organisation.

Under the risk management policy, management conducts regular risk assessments to determine the effectiveness of the risk management strategy and identify new and emerging risks. A strategic risk register was developed and identifies the top risks facing the entity. Mitigating controls are continuously being monitored for effectiveness in addressing the risks. Where these are found to be ineffective, new control measures are developed to mitigate risks to acceptable levels.

## Human resource management and development

To function optimally and fulfil our mandate to provide quality service, the OHSC needs to balance its human resources with adequate representation from all healthcare disciplines and expertise, including specialists in their field. During 2016/17 the OHSC appointed inspectors and senior inspectors with a depth of experience and specialist knowledge in medical, pharmaceutical and health systems in both the public and private sectors. At the same time the Complaints Management unit operated with minimum staff members. As at 31 March 2017, 104 of the 108 funded posts were filled, which represented a 96% success, 16% higher than the target of 80%. In addition to this, a number

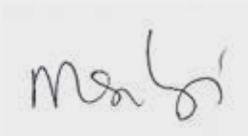
of human resource policies and procedures were developed, approved and implemented to derive value from the human capital within the OHSC.

## Future plans

While the Office is still new, it is actively developing by leaps and bounds. This in turn has created an urgent need for larger premises to accommodate our growing infrastructure and increase our human resource capacity. In view of the requirement for additional office space and related furniture, fixtures and equipment (FF&E), the office has requested approval from the National Treasury to retain the surplus for this purpose. In addition, we will continue to focus on improving administrative and management systems to enhance internal control deficiencies and developing the requisite policies and procedures for effective supply chain management.

## Appreciation and conclusion

The milestones we achieved were only possible with the counsel, guidance, commitment and support of the Board and the hard work, perseverance and dedication of our staff. As we move forward, we would like to ask for the continued support of our stakeholders. I would also like to express my gratitude to the following institutions and people: The NDoH and the Director-General, Ms Malebona Matsoso, who supported the OHSC through our period of transition; and National Treasury for the guidance and support throughout the financial year; as well as the Centre for Disease Control and Prevention for financially supporting the development of the electronic inspection system. Finally, thank you to our Board Chairperson, Prof Lizo Mazwai, for the exemplary manner in which he observed the distinction between oversight and management, which is critical for the efficient and effective functioning of any organisation.



**Mr Bafana Msibi**
**Acting Chief Executive Officer**
**31 July 2017**

# STATEMENT OF RESPONSIBILITY FOR AND CONFIRMATION OF ACCURACY OF THE ANNUAL REPORT

To the best of our knowledge and belief, we confirm that:

All information and amounts disclosed in this annual report are consistent with the annual financial statements audited by the Auditor-General.

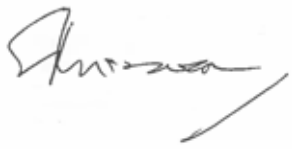
The annual report is complete, accurate and free from any omissions and the annual financial statements have been prepared in accordance the South African Standards of Generally Recognised Accounting Practice (SA Standards of GRAP) that apply to a public entity.

The accounting authority is responsible for the preparation of the annual financial statements and judgements made in this information. The accounting authority is also responsible for establishing and implementing a system of internal controls designed to provide reasonable assurance about the integrity and reliability of the performance and human resources information and the annual financial statements.

The external auditors (Auditor-General of South Africa) were engaged to express an independent opinion on the annual financial statements.

In our opinion, the annual report fairly reflects the operations, performance information and human resources information and financial affairs of the OHSC for the financial year ended 31 March 2017.

**Bafana Msibi**
**Acting Chief Executive Officer**
**31 July 2017**



**Prof Lizo Mazwai**
**Chairperson**
**31 July 2017**

# STRATEGIC OVERVIEW

## Vision

*Safe and quality healthcare for all South Africans.*

## Mission

*We 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.*

## Values

*Our values are informed by the South African Constitution and Batho Pele principles:*

*"Human dignity; freedom and the achievement of equality; and that people must come first."*

## Strategic imperatives


In adherence to our legislative mandate in terms of the National Health Act, 2013 (Act No. 61 of 2003), (NHA) as amended, and the Strategic Goals set by the Board, the OHSC compiled a strategic plan for the five years from 2015 until 2020. The key imperatives of our strategy are based on upholding the following objectives of the OHSC to:

- Prioritise those establishments that are the weakest and serve the most disadvantaged users in order to shift the system towards safer care, while still recognising 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 users, 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.

## Target setting

Every year, the OHSC performs a formal annual review of its strategy – monitoring and measuring performance against key performance indicators. The formal review is supplementary to the ongoing Board and management review of strategy and related performance measures. This Annual Report presents the OHSC's deliverables in terms of the objectives, performance indicators, and targets for the 2016/17 financial year in terms of the strategic outcomes-orientated goals.

## Strategic outcome-orientated goals

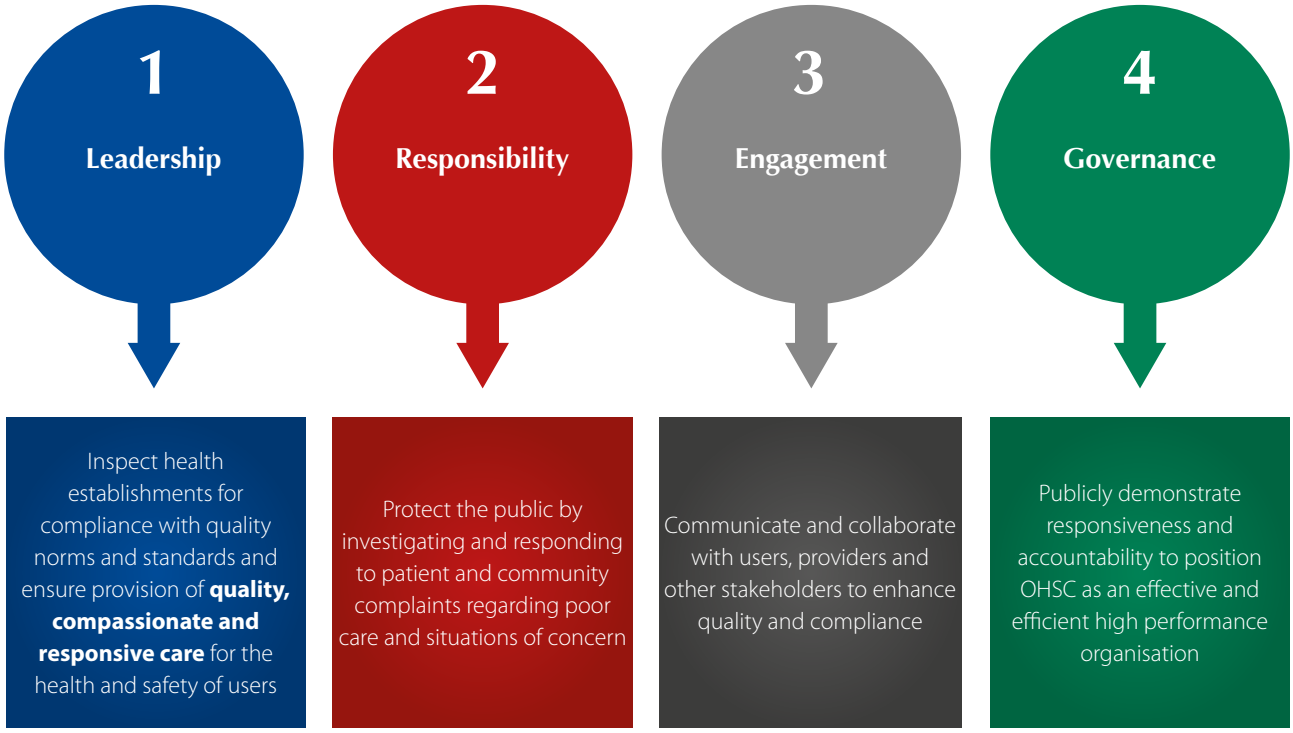



**Figure 1: Strategic outcome-orientated goals**

# LEGISLATIVE AND OTHER MANDATES

The OHSC is established under the National Health Act, 2003, 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, 1999.

As a public entity monitoring quality in the health sector, the role of the OHSC is influenced by the following governing legislation, regulations and national policies:

## Constitution of the Republic of South Africa

The Bill of Rights underpin the entire health system, specifically Section 27 of the Constitution, which guarantees everyone the right of access to healthcare services, including reproductive health services and emergency medical treatment. The Constitution further requires the State to take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

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 government's progressive realisation of its constitutional obligations.

## The National Health Act, 2003, (NHA)

The NHA, reaffirms the constitutional rights of users to access health services and just administrative action. As a result, Section 18 allows any user of health services to lay a complaint about the manner in which 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). This replaced the previous provisions that had never been brought into effect with a new independent entity, the OHSC.

The purpose of the Office is reflected in the NHA as that of protecting and promoting 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 in relation to 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 the NHA, 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.

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

The purpose of the 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 legislation 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 is 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) (PAIA)

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 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 in relation to public and private bodies;
- create an 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) (PAJA)

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. 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.

## 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 (Department of Health) 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 appropriate use of services; and
- reduce errors in healthcare.

## National Core Standards for Health Establishments in South Africa (NCS)

The NCS is based on input from numerous stakeholders and extensive field use and forms the basis for the proposed norms and standards that the Minister will prescribe into law through regulations. The standards are aligned with South Africa's existing policy and healthcare context and reflect international best practice and a strong evidence base.

The purpose of the NCS is to:

- Develop a common quality care definition for all Health establishments in South Africa to guide the public, managers and staff at all levels;
- Establish a benchmark to assess Health establishments, identify gaps and appraise strengths; and
- Certify Health establishments that comply with mandatory standards.

The public health system prioritises the following six critical standards as of most concern to patients:

- Values and attitudes;
- Waiting times;
- Cleanliness;
- Patient and staff safety and security;
- Infection prevention and control; and
- Availability of medicines and supplies.

The Minister of Health published the proposed norms and standards regulations for comment in February 2015 under Sections 90(b) and 90(c) of the NHA, as amended. Constructive comments were incorporated in the draft regulations and submitted to the Minister for final promulgation in the Government Gazette. The prescribed norms and standards will to 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; and
- Private sector primary healthcare clinics and centres.

The regulations for norms and standards will also apply to other health establishment categories in the NHA when the Minister, advised by the OHSC, has issued the related norms and standards. The proposed norms and standards are informed mainly by the NCS, published in 2011, with approval from the NHC. The OHSC has consulted extensively since 2013 to correct errors, clarify ambiguities, ensure measurability and align the framework of domains and sub-domains as areas of risk.

## 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;
- Inspectors and inspections including appointment, training, experience and conduct and the inspection approach and process including notice and 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 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).

## National Health Insurance (NHI)

The NHI is based on the principles of universal coverage, equity, right of access to basic healthcare and social solidarity, irrespective of a person's socio-economic status. An effective and well-functioning health quality system with set standards and norms that are implemented effectively is essential for the successful execution of the NHI. The OHSC's certification of Health establishments will in future be a prerequisite for accessing NHI funding.

## *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 (8) *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 re-iterated in the NCS – that the rights of patients must be respected and upheld, including the right to access basic care and receive 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.

## 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 less than 20 deaths per thousand live births and under-5 mortality rate of less than 30 per thousand.

Priority 2 in the NDP focuses on strengthening the health 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.

## Other legislation relevant to the delivery of health services

The legislation referred to in the NHA that influences the execution of the OHSC mandate and functions are reflected in Table 1.

**Table 1: Legislation that influences the OHSC in the fulfilment of its mandate**

| | |
|---|---|
| **Medical Schemes Act, 1998 (Act No. 131 of 1998)** | Regulates the medical schemes industry to ensure alignment with national health objectives |
| **Medicines and Related Substances Act, 1965 (Act No. 101 of 1965)** | Registers medicines and other medicinal products for safety, quality and efficacy and provides pricing transparency |
| **National Health Laboratory Service Act, 2000 (Act No. 37 of 2000)** | Acts as a statutory body for laboratory services to the public health sector |
| **Health Professions Act, 1974 (Act No. 56 of 1974)** | Regulates the health professions, specifically medical practitioners, dentists, psychologists and other health-related professions, including their community services |
| **Pharmacy Act, 1974 (Act No. 53 of 1974)** | Regulates the pharmacy profession, including community service by pharmacists |
| **Nursing Act, 2005 (Act No. 33 of 2005)** | Regulates the nursing profession |
| **Allied Health Professions Act, 1982 (Act No. 63 of 1982)** | Regulates health practitioners such as chiropractors, homeopaths and others, and for the establishment of a council to regulate these professions. |
| **Dental Technicians Act, 1979 (Act No. 19 of 1979)** | Regulates dental technicians and the establishment of a council to regulate the profession |
| **Hazardous Substances Act, 1973 (Act No. 15 of 1973)** | Controls hazardous substances, particularly those that emit radiation |
| **Foodstuffs, Cosmetics and Disinfectants Act, 1972 (Act No. 54 of 1972)** | Regulates foodstuffs, cosmetics and disinfectants and sets quality and safety standards for their sale, manufacturing and importation |
| **Occupational Diseases in Mines and Works Act, 1973 (Act No. 78 of 1973)** | Provides for medical examinations of persons suspected of having contracted occupational diseases, especially in mines, and for compensation in respect of those diseases |
| **Human Tissue Act, 1983 (Act No. 65 of 1983)** | Administers matters that relate to human tissue |

# ORGANISATIONAL STRUCTURE

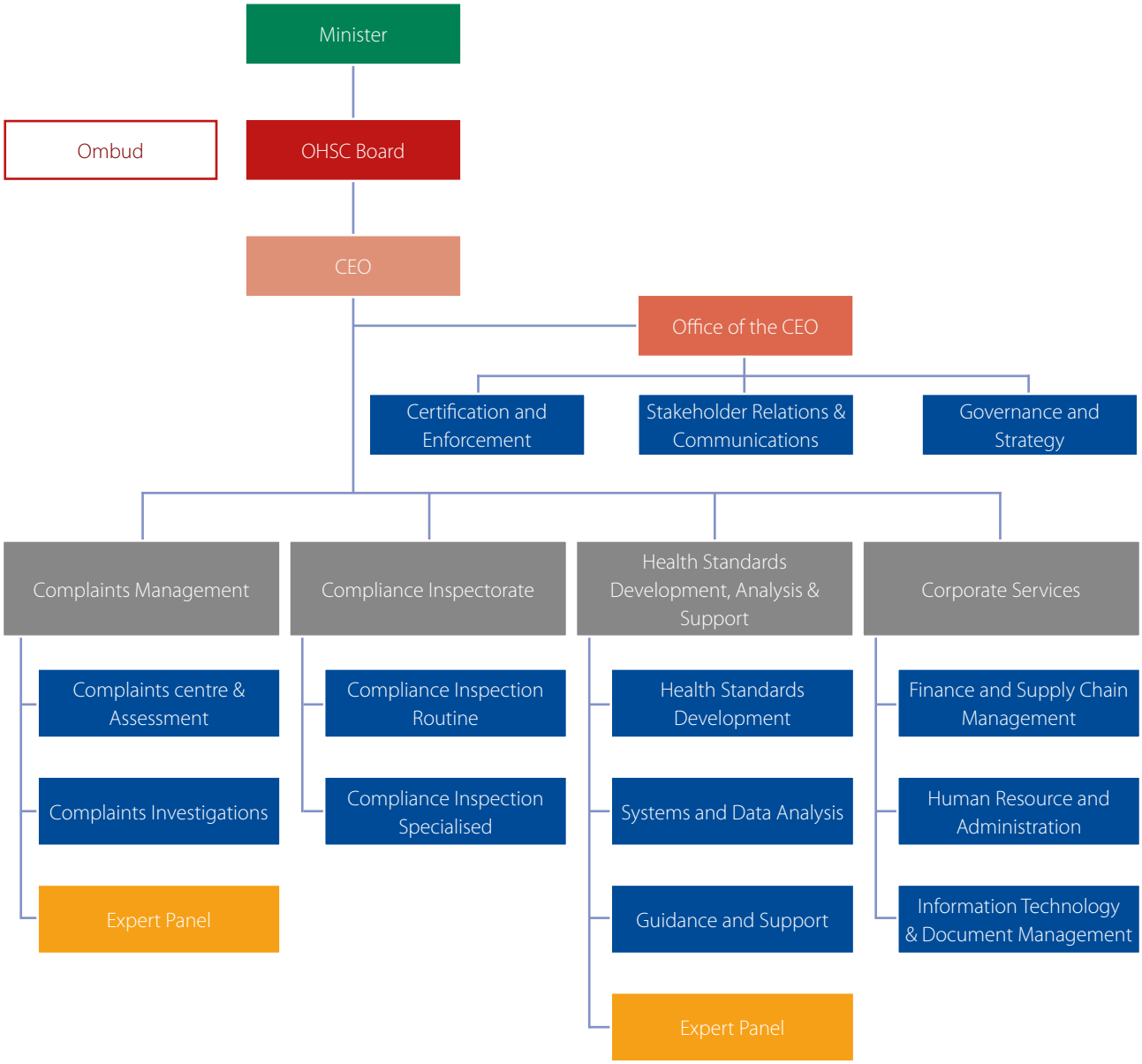



**Figure 2: OHSC organisational structure**

# PART B

# PERFORMANCE INFORMATION

# AUDITOR'S REPORT: PREDETERMINED OBJECTIVES

The Auditor-General of South Africa currently performs the necessary audit process on the OHSC performance information to provide reasonable assurance in the form of an audit conclusion.

The audit conclusion on performance against predetermined objectives is included in the report to management, with material findings reported under *Report on the audit of the annual performance* report.

**Refer to page 89 of the Report of the Auditors under Part E: Financial Information.**

# SITUATIONAL ANALYSIS

## Service delivery environment

Healthcare today occupies a fragmented environment that needs to adapt to rapid change in order to provide continuous and coordinated people-centred care. Health service delivery faces increasing public demands for access to and use of new technologies, new medications and new models of care, as well as higher expectations of quality and safe care.

Quality standards are more difficult to establish in service operations. Healthcare service quality is even more difficult to define and measure than in other sectors, with healthcare service quality depending on technical quality or service processes, interpersonal quality between the patient and carer facility in terms of accommodating patient needs and preferences, as well as the amenities or physical attributes of the organisation of service provision.

### *The quality challenge*

Quality healthcare is a subjective, complex, and multi-dimensional concept. In healthcare, as in many other sectors, it has been recognised that while major strides had been made in improving access to services over the previous 15 years, the quality of that access was widely perceived to be inadequate. Improving the quality of healthcare thus became a key objective, reflecting in large part the widespread dissatisfaction with the acceptability or patient experience of health care especially in the public sector, the perceived levels of harm to patients, and the unaffordable costs and persisting inequities apparent in previously disadvantaged areas and between public and private sectors.

These concerns were confirmed by the results of a national audit of all public sector healthcare facilities conducted in 2011 and 2012, showing very low levels of compliance with standards in the six identified priority areas or basic critical requirements. Other identified health sector organisational problems include:

- Unacceptable poor quality and unsafe health services;
- High levels of inequality in per capita health expenditure between public and private sectors;
- Public health system with poor outcomes or return on investment in the context of:
    - Under resourced/overburdened public health sector;
    - A fragmented health system; and
    - Poor leadership and management at different levels of care.
- Fragmented health information management system characterised by lack of standardisation and poor measurement of outcomes; and
- Increasing public discontent and frustrations with the health system based on their experiences.

Some of the critical underlying causes for this situation were seen to lie in a mismatch between resources and workload or frankly inadequate resources; and the inadequate knowledge, experience and skills of many managers and staff. A further important underlying reason for this situation was the weak accountability mechanisms with few consequences for poor (or good) care, exacerbated by the semi-federal public system with a multitude of different standards being practiced across the country, and the largely unregulated situation in the private sector.

### *Health reform efforts and quality implications*

The NDoH has been implementing a large number of initiatives for reform of the healthcare sector as preparation for the implementation of NHI. The focus of these initiatives are to ensure the public health sector can deliver on key expectations and requirements, including those for quality. This also reflects that the role of the OHSC as the regulator of quality is to remain an objective guide and assessor of performance.

Initiatives of relevance to the work of the Office range from the:

- development of staffing norms for hospitals and clinics;
- processes to rehabilitate health infrastructure and improve its maintenance;

- the review of structures and systems to strengthen governance, oversight and management and the recruitment of managers of hospitals (and later clinics);
- the introduction of better controls on the acquisition and use or over-use of resources; and
- major focus on clinic management and service delivery.

All of these aspects are already directly reflected in the NCS and the regulations published for comment. This focus on improved delivery is essential for improving levels of compliance and the health and safety of users.

A key area of relevance in ensuring improved quality and safety are the many initiatives directed towards improving the knowledge and skills base of managers, whether through appropriate formal training, seminars, mentoring and collaborative efforts, health worker motivation and e-learning, as well as operational research and documentation of best practice.

These efforts tie in directly with the function of the Office in proving guidance on norms and standards. The socio-political and economic situation and its relationship with healthcare resourcing is of critical importance in the work of the Office, as without improvements in efficiencies, reductions in budgets allocated to health and an escalation in costs can lead to reduced levels of quality and safety.

This is a further reason for the urgent establishment of external monitoring and regulation as envisaged in the NHAA, as a critical mechanism to offer some protection to patients and users in such a situation. The overall economic situation and the funding of public services will also influence the timing and level of introduction of revenue to be raised by the OHSC for services rendered in terms of the legislative provisions to this effect.

## *Mock inspections and findings*

The OSC, set up within the NDoH as a precursor to the OHSC, has since late 2011 been doing "mock" or training inspections of public sector institutions. The total number of validated inspection results for health establishments by March 2017 was 1386 or over 35% of all public healthcare establishments – sufficient for an analysis of the challenges being faced and the rationale for the existence of the regulator. This analysis shows large deficits as well as variations in the quality of health services between health establishments and types of health establishments, in particular showing problems in the following areas:

- With clinics, which are a cornerstone for NHI;
- Between provinces, where persistent inequities are still apparent;
- In the functionality of supply and support systems at all levels; and
- In the degree of individual responsibility and accountability (managerial, clinical) for delivering basic quality care and ensuring respect for users of health services.

## *Envisaged impact*

The two core health sector aims (in which quality is seen as playing a major role) are those of improving outcomes and thus impacting on life expectancy as well as on the achievement of the millennium development goals (MDGs); and the move towards universal quality healthcare coverage (UHC), widely known by its local name of National Health Insurance or NHI.

The contribution of improved quality in achieving better outcomes would be seen through an improvement in the implementation of defined best practice guidelines, resulting from availability of needed inputs and the reliable implementation (at all times, in all places, for all patients) of identified processes and practices, especially those designed to reduce unintended harm to patients and thus reduce avoidable mortality and morbidity.

The contribution of improved quality to universal healthcare coverage would firstly be through improving the acceptability or patient experience of care and thus impacting on the critical element of utilisation, patient choice and the acceptance of the needed social solidarity for cross-subsidisation between richer and poorer segments of the user population. Secondly, improved quality will be necessary to assure the public in general that the improved level of resources to flow into healthcare will be effectively and efficiently used.

## Organisational environment

The organisational environment of the Office itself is critical if it is to effectively use its powers to influence the desired changes in healthcare delivery but over which it has no direct control. The evolution of the OHSC, up to the point of the formal appointment of the Board in early 2014, has extended over seven years and has created a foundation both internally in terms of inspectors and the work they do, and externally in terms of knowledge and awareness across the health system itself. The establishment of a new independent organisation brings with it both a key strength in that its work will become institutionalised and more objective and focused, as well as the challenge of setting up of completely new structures and systems and attempting to meet public expectations for immediate impact while still in the growth and development phase itself.

# THE HEALTH OMBUD: AN OVERVIEW

| | |
|---|---|
| **Description** | The Health Ombud is an independent Office established in accordance with National Health Amendment Act No. 61 of 2003 the key purpose of ensuring that the complaints of all healthcare users are heard and resolved.<br>• Its main purpose is to be the voice of the people in instances where health establishments have breached prescribed norms and standards (in contrast to individual healthcare workers' professional misconduct).<br>• The Ombud must perform his or her functions *"in good faith and without fear, favour, bias or prejudice".* |
| **Purpose** | To receive, investigate and dispose of complaints from the public related to breaches of norms and standards of health care, the Ombud has to make sure that the healthcare user's complaint is heard, investigated and redressed, as well as:<br>• Referring any complaints received from the public that warrants investigation and managed by a specific regulatory body e.g. SANC, HPCSA;<br>• Publishing the reports of complaints annually on the website for public consumption;<br>• Providing the Minister with an annual report of all complaints received and the status thereof.<br><br>Any person, guardian or representative of a person to whom health care service was provided in South Africa is welcome to lodge a complaint regarding sub-standard services by any health establishment in South Africa:<br>• One can lodge a complaint on behalf of a relative, a minor or any other person.<br>• Any other person can lodge a complaint as a whistle blower. |
| **Authority** | • The Office of the Ombud operates within the OHSC in accordance with section 78(b) of the National Health Act, 2003.<br>• The office of the Ombud is responsible for investigating all complaints related to breaches of norms and standards related to health care services, both public and private, as well as to:<br>• Make recommendations to healthcare establishments regarding breaches identified; and<br>• Refer any complaint that the Ombud feels needs to be investigated and managed by a regulatory body. |

## Process to lodge a complaint

A complaint has to be lodged within two (2) years of its occurrence for the office to investigate it.

- Complaints may be lodged verbally by visiting our offices or telephonically through the toll-free number or office telephone line.
- The toll-free line is made more user-friendly through the provision of multilingual options.
- Complaints may also be lodged in writing, which is through e-mail, hand delivery or post.
- The public is encouraged to lodge complaints with the relevant health establishment, which can be done verbally or in writing, before approaching the Office.
- Health establishments are expected to follow their established complaints management protocol in addressing user complaints.
- When lodging a complaint with the office the following information should be provided:
    - Name of Complainant;
    - Contact number;
    - Name of patient;
    - Contact number;
    - Patient Registration Number;
    - Name of Health Establishment;
    - Location of Health Establishment (province or district);
    - Date and time of incident;
    - Details of incident;
    - Unit where incident occurred;
    - Names of personnel involved;
    - Date incident reported to Health Establishment;
    - Person reported to;
    - Feedback from facility if any; and
    - If the complaint is made on behalf of a competent adult, the complainant should have received permission.
- The investigation process and the resolution of the complaint will take approximately six (6) months but may be extended to two (2) years depending on the complexity of the matter.

# STRATEGIC OUTCOME-ORIENTATED GOALS

OHSC's strategic outcomes-orientated goals underpin the organisation's strategic imperatives as demonstrated in Figure 3 below.


**Figure 3: Strategic outcomes-orientated goals**

# PERFORMANCE MANAGEMENT BY PROGRAMME

It is important to mention that the OHSC consists of different divisions which are responsible for achieving different strategic objectives per programme. Yet ultimately every division is working towards a common goal – complying with the OHSC's mandate to ensure safe and quality healthcare for everyone. As a result, divisions with different functional expertise work closely together in developing and implementing cross-functional projects towards the organisation's shared purpose.

The content that follows will provide a clear description of each programme, its objectives, deliverables and achievements, as well as demonstrating how the various programmes are integrated.

**1. OFFICE OF THE CEO:**
(Certification and Enforcement; Governance, Strategy and Board Secretariat and Communication and Stakeholder Relations)

**5. HEALTH STANDARDS DEVELOPMENT AND DESIGN**

**2. CORPORATE SEVICES**
(Human Resources, Finance and Information Technology)

**4. COMPLAINTS MANAGEMENT**
(Ombud)

**3. COMPLIANCE INSPECTORATE**

**Figure 4: Illustrates the Programmes within the OHSC**

# PROGRAMME 1: OFFICE OF THE CEO

## Programme purpose

To provide the leadership, communication and regulatory functions required to carry out the mandate and functions of the OHSC as per the legislative requirements.

### Description of strategic objectives

**Table 2: Strategic objectives for the Office of the CEO**

| | |
|---|---|
| **Strategic objective 1.5** | **Health establishments found to be compliant with prescribed norms and standards are certified** |
| **Statement** | Health establishments found on inspection to be compliant with prescribed norms and standards are issued with certificates of compliance within 60 days of inspection |
| **Indicator** | % compliant establishments certified by the OHSC within 2 months of inspection |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 100% |

| | |
|---|---|
| **Strategic objective 1.6** | **Enforcement action is effected with respect to persistently non-compliant health establishments** |
| **Statement** | Enforcement action as regulated is taken with respect to persistently non-compliant health establishments |
| **Indicator** | % persistently non-compliant health establishments for which regulated action is initiated within 6 months of the inspection |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 100% |

| | |
|---|---|
| **Strategic objective 3.1** | **Public, provider and stakeholder awareness on the roles and powers of OHSC is created** |
| **Statement** | Activities are carried out to create public awareness on roles and powers of OHSC |
| **Indicator** | Number of media and communication events and campaigns to increase awareness of the OHSC among public, providers and stakeholders carried annually |
| **Baseline (2015/16)** | 4 |
| **Target (2015-20)** | 12 |

| | |
|---|---|
| **Strategic objective 3.3** | **Memoranda of Agreement (MoAs) to further the mandate and objectives of the OHSC are in place with relevant regulators or other organisations** |
| **Statement** | MoAs to further mandate and objectives of OHSC relating to improved quality and safety are signed with relevant regulators or other organisations and their implementation is monitored prior to annual ratification |
| **Indicator** | Number of signed MoAs with regulators to protect and promote quality and safety of care in place each year |
| **Baseline (2015/16)** | 2 |
| **Target (2015-20)** | 10 |

| | |
|---|---|
| **Strategic objective 3.6** | **Information relating to compliance with norms and standards is published** |
| **Statement** | Information relating to compliance with norms and standards is published |
| **Indicator** | Number of published reports on compliance status of health establishments |
| **Baseline (2015/16)** | 2 |
| **Target (2015-20)** | 5 |

**Table 3: Performance against strategic objectives for the 2016/17 financial year**

| **Programme 1: Office of the CEO** | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic objective** | **Performance indicator** | **Actual achievement 2015/16** | **Planned target 2016/17** | **Actual achievement 2016/17** | **Deviation from planned target to actual achievement for 2016/17** | **Comment on deviations** |
| **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 | New indicator | 100% | Target not achieved | Certification and Enforcement Framework approved. Implementation is awaiting promulgation of norms and standards regulations | Awaiting promulgation of the norms and standards and regulations |
| **1.6. Enforcement action is effected with respect to persistently non-compliant health establishments** | % persistently non-compliant establishments for which regulated actions initiated within 6 months of inspection | New indicator | 100% | Target not achieved | Enforcement Policy approved. Implementation is awaiting promulgation of norms and standards regulations | Awaiting promulgation of the norms and standards regulations |

| Strategic objective | Performance indicator | Actual achievement 2015/16 | Planned target 2016/17 | Actual achievement 2016/17 | Deviation from planned target to actual achievement for 2016/17 | Comment on deviations |
|---|---|---|---|---|---|---|
| **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 the OHSC among public, providers and stakeholders carried out annually | Conducted 8 media communication events and campaigns | 4 | Conducted 14 media and communication events and campaigns | Target exceeded | Media briefing was held during release of the Report on the Circumstances Surrounding the death of mentally-ill patients in Gauteng Province in February 2017.<br><br>Media advisory was issued and interviews were solicited for the Health Ombud to talk about the Report on the Circumstances Surrounding the death of mentally-ill patients in Gauteng Province.<br><br>Roadshow campaigns were held to promote the OHSC Complaints Management Call Centre and services offered by the OHSC in the following provinces:<br>- Limpopo in February 2017<br>- KwaZulu-Natal and Northern Cape from 13-17 March 2017<br>- Eastern Cape from 27 – 31 March 2017. |

| Strategic objective | Performance indicator | Actual achievement 2015/16 | Planned target 2016/17 | Actual achievement 2016/17 | Deviation from planned target to actual achievement for 2016/17 | Comment on deviations |
|---|---|---|---|---|---|---|
| **3.3. Memoranda of Agreement (MoAs) to further the mandate and objectives of the OHSC are in place with relevant regulators or other organisations** | Number of MoAs with regulators to protect and promote quality and safety of care in place each year | Signed 2 MOAs to second staff to assist the OHSC during its development stage | 2 | Signed 2 MoAs with the HPCSA and Trade Unions | Target achieved | No deviation |
| **3.6. Information relating to compliance with norms and standards is published** | Number of reports on inspections conducted, recommendations issued, and compliance status of HEs | Issued 2 Inspection Reports | 1 | Issued 1 Inspection Report | Target achieved | No deviation |

**Key for Actual Achievement column**

Not achieved

Achieved

## Achievements

In terms of its legislative mandate, the OHSC has, among others, the following responsibilities:

- Certifying health establishments that are compliant to the norms and standards as indicated by the Department of Health; and
- Enforcing compliance measures against health establishments that are found to be non-compliant with the aforementioned norms and standards.

Despite the fact that the OHSC was not able to achieve its objectives in this regard due to challenges beyond its control, the Office of the CEO developed both the Enforcement Policy and the Certification and Enforcement Framework during the reporting period.

### Enforcement Policy

The Office developed an Enforcement Policy that outlines the approach followed by the OHSC in terms of compliance enforcement actions, as well as the criteria that will be used. The Policy was approved by the Board in April 2016.

### Certification and Enforcement Framework

The Office drafted a Certification and Enforcement Framework detailing the process of certifying a compliant establishment as well as describing the risks and criteria in terms of certification. The Framework was approved by the Board in April 2016.

## Challenges

The OHSC is mandated to certify and enforce compliance of health establishments according to regulated norms and standards; however, the norms and standards have not been promulgated yet, limiting the OHSC in the objectives it was meant to achieve. Not only is the OHSC unable to certify health establishments and enforce measures against non-compliant health establishments until promulgation of the norms and standards, but it is also unable to implement an enforcement policy.

The lack of promulgated norms and standards is also the biggest overall challenge the OHSC experienced during the financial year, as it impacted on each of the OHSC's functions, with specific emphasis on the Compliance Inspectorate division.

## Moving forward

Systems to certify compliant health establishments will be finalised in the next financial year and the Board's Certification and Enforcement Committee agreed to the compliance thresholds on the IT system that require timeous reporting for decisions on the certification of compliant health establishments.

Additionally, the NDoH will facilitate the engagement between OHSC and relevant health regulators which will result in finalisation of the MoAs to further the mandate and objectives of the OHSC.

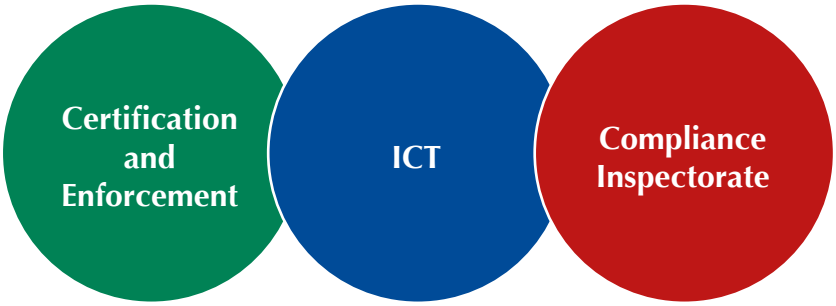



**Figure 5: Illustrates the relationship between Certification and Enforcement, ICT and Compliance Inspectorate Units within the OHSC.**

# COMMUNICATION AND STAKEHOLDER AWARENESS

## Achievements

The Office of the CEO exceeded its planned target of creating public awareness about the OHSC, with specific focus on the following:

- The role and functions of the OHSC;
- Launch of the Call Centre; and
- Processes and procedures of the OHSC.

Our multi-pronged communications strategy included reach-out and stakeholder engagement programmes to specific communities, the media, staff and general public. This was achieved by means of public awareness roadshows, media engagement, brand development, promotional material, social and digital media and internal communication initiatives.

### Roadshows

**Table 4: Illustrates the complete details relating to the roadshows conducted by the OHSC**

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | November 2016 | Gauteng | • Bloed Street Taxi Rank<br>• Mpumalanga Taxi Rank<br>• George Mukhari Hospital<br>• Steve Biko Academic Hospital<br>• Bloed Mall |

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | December 2016 | North West / Mpumalanga | North West:<br><br>7 x Hospitals:<br>• Job Shimankana Tabane Hospital<br>• Koster Hospital<br>• Thusong Hospital<br>• Pochefstroom Hospital<br>• Klerksdorp Hospital<br>• Tshepong Hospital<br>• Vendersdorp Hospital<br><br>9 x Clinics:<br>• Bethanie Clinic<br>• Boitekong Clinic<br>• Maboloka Clinic<br>• Segwaelana Clinic<br>• Sunrise Park Clinic<br>• Wonderkop Clinic<br>• Welgervonden Clinic<br>• Tsholofelo Clinic<br>• Potchefstroom Clinic<br><br>8 x Community Healthcare Centres (CHC):<br>• Bapong CHC<br>• Phokeng CHC<br>• Tlhabane CHC<br>• JB Marks CHC<br>• Joubeton CHC<br>• Boiki Thlapi CHC<br>• Steve Tshwete CHC<br>• Primosa CHC<br><br>1 x Shopping Centre:<br>• Letlhabile Shopping Complex<br><br>Mpumalanga:<br><br>7 x Hospitals:<br>• Carolina Hospital<br>• Ermelo Hospital<br>• Witbank Hospital<br>• Tintswalo Hospital<br>• Mapulaneng Hospital<br>• Matikwane Hospital<br>• Rob Ferreira Hospital |

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | December 2016 | North West / Mpumalanga | 9 x Clinics:<br>• Carolina Clinic<br>• Silobela Clinic<br>• Ermelo Clinic<br>• Emthonjeni (Msukaligwa) Clinic<br>• Middleburg Civic Centre Clinic<br>• Eastdene Clinic<br>• Madras Clinic<br>• Maviljan Clinic<br>• Mariti Clinic<br><br>2 x Community Healthcare Centres:<br>• Thulamahashe Community Health Centre.<br>• Engincourt Community Health Centre<br><br>7 x Shopping Centres:<br>• Carolina Shopping Centre<br>• Hendrina Shopping Centre<br>• Ermelo Mall<br>• Middleburg Shopping Centre<br>• Witbank Downtown Mall<br>• Acornhoek Plaza<br>• Hazyview Shopping Centre<br><br>7 x Taxi ranks:<br>• Carolina Taxi rank<br>• Ermelo Taxi rank<br>• Middleburg Van Calder Paypoint Taxi rank<br>• Witbank Downtown Taxi rank<br>• Acornhoek taxi rank<br>• Bushbuckridge Taxi Rank<br>• Nelspruit Taxi Rank<br><br>3 x Others:<br>• Magistrate Court:<br>• Carolina Magistrate Court<br>• Bushbuckridge Local Municipality Offices |
| • Encouraging public participation<br>• Presentation<br>• Exhibition | February 2017 | Limpopo | Ngoako Ramathlodi Sport Complex (Seshego ) |

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | March 2017 | Eastern Cape / KwaZulu Natal & Northern Cape | • Eastern Cape<br><br>8 x Hospitals:<br>• Tayler Bequest Hospital<br>• Mount Ayliff Hospital<br>• Holy Cross Hospital<br>• St Elizabeth Hospital<br>• Frontier Hospital<br>• Victoria Hospital<br>• Nompumelelo Hospital<br>• SS Gida Hospital<br><br>22 x Clinics:<br>• Matatiele Community Clinic<br>• Mount Ayliff Gateway Clinic<br>• Holy Cross Gateway Clinic<br>• Magadla Clinic<br>• Ntsizwa Clinic<br>• Mapheleni Clinic<br>• Flagstaf Clinic<br>• Mbadango Clinic<br>• Lusikisiki Clinic<br>• Bodweni Clinic<br>• Tatya Clinic<br>• Philani NU1 Clinic<br>• Zingisa NU1 Clini<br>• War Memorial Clinic<br>• Mxelo Clinic<br>• Bhele Clinic<br>• Nompumelelo Gateway Clinic<br>• Openshaw Clinic<br>• Lenye Clinic<br>• Masincedane Clinic<br>• New Rest Clinic<br>• Phulani Clinic<br><br>2 x Community Healthcare Centres:<br>• Maluti Community Clinic<br>• Port Saint John CHC |

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | March 2017 | Eastern Cape / KwaZulu Natal & Northern Cape | KwaZulu-Natal:<br><br>6 x Hospitals:<br>• Madadeni Hospital<br>• NieMeyer Hospital<br>• Vryheid Hospital<br>• Benedictine hospital<br>• St Francis Hospital<br>• Enkonjeni Hospital<br><br>14 x Clinics:<br>• Umdumezulu Clinic<br>• Mashoba Clinic<br>• Kwa Mame Clinic<br>• Queen Nolonolo Clinic<br>• Usuthu Clinic<br>• Bhekuzulu Clinic<br>• Hlobane Clinic<br>• Kwa Fuduka Clinic<br>• Khambi Clinic<br>• Mason Street Clinic<br>• Groenvlei Clinic<br>• NieMeyer Gateway Clinic<br>• Madadeni 1 Cllinic.<br>• Madadeni 7 Clinic<br><br>1 x Shopping Centre:<br>• Newcastle shopping Centre<br><br>1 x Taxi Rank:<br>• Newcastle Taxi Rank<br><br>1 x Other:<br>• Nqoqo Community<br><br>Northern Cape:<br>7 x Hospitals:<br>• Kakamas Hospital<br>• Dr Harry Surtie Hospital<br>• Kuruman Hospital<br>• Tshwaraganang Hospital<br>• Prof ZK Matthews Hospital<br>• Galeshewe Day Hospital<br>• Kimberley Hospital Complex |

| Activities | Period | Province | Location |
|---|---|---|---|
| • Stakeholder engagement roadshow at healthcare establishments, shopping malls, and taxi ranks to create awareness of OHSC's role and functions<br>• Taxi Rank Activation Roadshow to launch and create public awareness of the Call Centre<br>• Handing out promotional material<br>• Creating Word of Mouth awareness among commuters<br>• Handing out promotional material including flyers, posters, pamphlets – printed in all 11 official languages<br>• Patients, visitors, staff and management engagement in health establishments | March 2017 | Eastern Cape / KwaZulu Natal & Northern Cape | 22 x Clinics:<br>• Kakamus Clinic<br>• Keimoes Clinic<br>• Kenhardt Clinic<br>• Lennertsville Clinic<br>• Raaswater Clinic<br>• Louisvale weg Clinic<br>• Kalksloot Clinic<br>• Upington Clinic<br>• Lingelethu Clinic<br>• Sarah Strauss Clinic<br>• Kuruman Clinic<br>• Wrenchville Clinic<br>• Warrenvale Clinic -<br>• Pholong Clinic -<br>• Ikhutseng Clinic<br>• Mataleng Clinic<br>• De Beershoogte Clinic<br>• Betty Gaetsewe Clinic<br>• Mapule Matsepana<br>• Masakhane Clinic<br>• Beaconsfield Clinic<br>• Roodepan Clinic<br><br>3 x Community Healthcare Centres:<br>• Keimoes CHC<br>• Kenhardt CHC<br>• Warrenton CHC<br><br>1 x Shopping Centres:<br>• Upington Town<br><br>2 x Taxi Ranks:<br>• Kakamus taxi rank<br>• Upington taxi rank<br><br>1 x Other:<br>• Upington Department of Home Affairs |

## Media engagement

**Table 4: Illustrates the complete details relating to the media engagements conducted by the OHSC**

| Period | Activity | Purpose | Results |
|---|---|---|---|
| **Q1** | Seminar on OHSC functions, processes, inspections findings and universal health coverage was convened | To inform the public of the functions, processes, inspections findings and universal health coverage | **Media coverage:**<br>• Radio 702<br>• SAFM<br>• The Times<br>• SABC radio stations<br>• Business Day<br>• Sunday Times<br>• City Press<br>• Sowetan<br>• Healthi E-News |
| **Q2** | CEO interview: Business Day<br>Chairperson interview: Checkpoint<br><br>Press release to general media: (Investigations into the circumstances surrounding the death of mentally-ill patients in Gauteng Province) | To inform the general public of the Role of the OHSC<br>To inform the general public of the Role of the OHSC | **Media coverage:**<br>• Business Day<br>• eNCA Checkpoint<br>• EWN (Radio 702)<br>• Sowetan<br>• Sunday Independent<br>• Sunday Times<br>• City Press<br>• Drum Magazine<br>• Power FM<br>• Radio 702<br>• Citizen<br>• Business Day<br>• The Times Live<br>• Weekend Argus<br>• ANN7<br>• SABC Radio stations<br>• Metrotell<br>• SA Breaking News<br>A total of 16 print and broadcast publicity tracked |

| Period | Activity | Purpose | Results |
|---|---|---|---|
| **Q3** | Launch of the Call Centre on 28 November 2016 | To promote and publicise the Call Centre | **Media coverage:**<br>• Morning Live<br>• Lesedi FM<br>• Pretoria News<br>• SABC 2 (Yilungelo Lakho)<br>• EWN Radio 702<br>• eNCA Checkpoint<br>• Jacaranda fm<br>• Sowetan<br>• Star<br>• Health-e News Service<br><br>A total of 12 print and broadcast publicity tracked |
| **Q4** | Ombud Report Released | To inform stakeholders and general public about the outcome of the investigations | **Media coverage:**<br>Massive local and internal coverage<br><br>A total of 1207 print and broadcast publicity tracked |

## Promotional material

The OHSC developed a variety of promotional materials to assist in the promotion and awareness of the role and function of the OHSC, as well as assisting all stakeholders with easy understanding, access and use. Promotional material was developed and translated into all eleven (11) official languages.

## Corporate Publications

The OHSC produced various corporate publications designed, layout and printed in accordance with its branding manual, including:

- Strategic Plan for Fiscal Year 2015/16 to 2019/20;
- Annual Performance Plan for the Fiscal Year 2016/2017;
- Annual Inspection Report 2015/2016;
- OHSC Annual Report 2015/16 financial year;
- Report into circumstances surrounding the death of mentally-ill patients in Gauteng.

### Social and digital media

**Table 6: Provides a list of social and digital media channels utilised by the OHSC**

| Channel | Activity | Purpose |
|---|---|---|
| **Facebook** | Created a Facebook profile for the OHSC<br>Created regular Facebook posts | Information, Education, Awareness |
| **Twitter** | Created a Twitter profile for the OHSC<br>Regular Tweets | Information, Education, Awareness |
| **YouTube** | Created a YouTube profile for the OHSC | Information, Education, Awareness |
| **Website** | Web content uploaded | Information, Education, Awareness |

### Internal communication

Over the reporting period, the OHSC has established two critical internal communications tools to ensure staff is kept up to date with internal news and operational matters. These include:

- *Ad hoc* email circulars;
- Quarterly newsletter (first issue published in February 2017).

## Challenges

The Communication and Stakeholder function did not experience any challenges during the financial year that unduly limited its capacity to achieve its objectives.

## Moving forward

The OHSC has signed a Memorandum of Understanding with the Government Communication and Information System (GCIS) in which the GCIS agreed to assist the Office with the placement of advertising on a variety of radio and television channels. This collaboration will ensure greater visibility for the OHSC and promote the services of the organisation at community and district level through a targeted radio campaign due to kick off in 2017/18 financial year.

The branding of the OHSC compliance inspectorate unit (i.e. uniforms and magnetic stickers) is ongoing and will continue to form part of the OHSC's branding strategy.

In collaboration with the ICT unit, an Intranet system will be developed for the OHSC, which will be used by Communication and Stakeholders unit in the execution of its internal communication strategy.

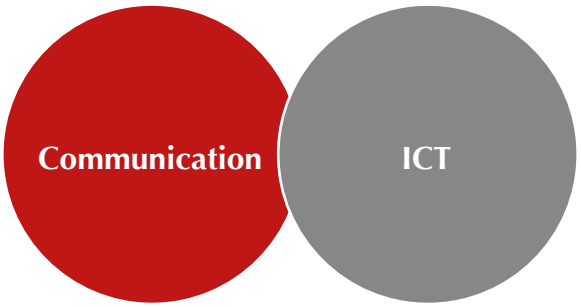



**Figure 6: Illustrates the linkage between communications and ICT Unit within the OHSC**

**Table 7: Performance against allocated budget: Office of the CEO**

| Programme | Budget | Actual expenditure | (Over)/Under expenditure |
|---|---|---|---|
| Office of the CEO | 12 402 743 | 9 153 057 | 3 249 686 |
| **TOTAL** | **12 402 743** | **9 153 057** | **3 249 686** |

# PROGRAMME 2: CORPORATE SERVICES

## Programme purpose

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

### Description of strategic objectives

**Table 8: Strategic Objectives for corporate services**

| | |
|---|---|
| **Strategic objective 4.1** | A fully functional Office is set-up and suitably staffed in accordance with the mandate and goals of the OHSC |
| **Statement** | A functional OHSC is established with a budget and personnel in place to effectively implement the mandate of the Office. |
| **Indicator** | % funded staff appointed |
| **Baseline (2015/16)** | 92% |
| **Target (2015-20)** | 90% |
| **Indicator** | # of interns appointed |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 15 |

| | |
|---|---|
| **Strategic objective 4.4** | Financial management and PFMA requirements complied with |
| **Statement** | The PFMA Procedures for management controls and accountability as per the PFMA are in place. |
| **Indicator** | Unqualified audit report |
| **Baseline (2015/16)** | Unqualified audit report |
| **Target (2015-20)** | Unqualified report |

| | |
|---|---|
| **Strategic objective 4.5** | The IT system leverages technology to meet the needs of the OHSC |
| **Statement** | Specialised IT system for the OHSC is implemented |
| **Indicator** | IT system in place and fully functional |
| **Baseline (2015/16)** | System in place |
| **Target (2015-20)** | System in place and fully functional |
| **Indicator** | Percentage systems uptime and availability maintained |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | System in place and fully functional |

**Table 9: Performance against strategic objectives for the 2016/17 financial year**

| Programme 2: Corporate Services | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic objective** | **Performance indicator** | **Actual achievement 2015/16** | **Planned target 2016/17** | **Actual achievement 2016/17** | **Deviation from planned target to actual achievement for 2016/17** | **Comment on deviations** |
| **4.1 A fully functional Office is set-up and suitably staffed in accordance with the mandate and goals of the OHSC** | % funded staff appointed | 92% | 80% | 96% | Target exceeded by 16% | Target exceeded as the recruitment process accelerated to fill more posts |
| | # of interns appointed | New Indicator | 3 | 4 | Target exceeded | Target was exceeded as extra intern was appointed to improve operational capacity |
| **4.4. Financial management and PFMA requirements are complied with** | Unqualified audit report | Unqualified audit report | Unqualified audit report | Unqualified audit report | None | N/A |
| **4.5 Leveraging technologies to deliver OHSC services more effectively** | IT system in place and fully functional | Partially achieved | System in place | Target partially achieved | Target partially achieved | Inspection tool undergoing pilot phase.<br><br>Call Centre fully commissioned.<br><br>Development of the OHSC Intranet and OHO website was in progress.<br><br>Server infrastructure was in procurement. |
| | Percentage systems uptime and availability maintained | New Indicator | 80% | 95% | System uptime exceeded by 15% | Stabilisation and maturity of ICT infrastructure. |

**Key for Actual Achievement column**

Partially achieved

Achieved

# HUMAN RESOURCES

## Achievements

During the financial year under review, 104 of the 108 (96%) funded posts were filled as at 31 March 2017. This is 16% higher than the set target of 80%. A recruitment process was accelerated to fill more funded posts using a combination of recruitment methods which included advertising, re-advertising and headhunting where necessary.

Furthermore, in order to ensure that a fully functional Office is set up and suitably staffed as envisaged in the strategic plan to fulfil the mandate of the organisation, the OHSC developed and implemented the necessary human resource policies, programmes and systems to ensure a productive and conducive work environment.

## Challenges

Inadequate office space for the OHSC, as a fast-expanding organisation, was a major challenge during the past year and became more critical as the number of staff increased. In addition, the scarcity of health professionals with specialised skills led to the re-advertising of some posts but met with no success.

## Action plans

In the year ahead, the OHSC will procure sufficient office space to cater for a growing organisation and head-hunt specialised health professionals where the traditional recruitment methods are unsuccessful.

## Moving forward

In the year ahead, the OHSC will initiate the necessary arrangements to procure office space that will cater for a growing organisation. The challenges of recruiting health professionals with specialised skills will be addressed by using alternative recruitment processes, such as head hunting, where traditional recruitment methods do not yield the desired results.

# FINANCE

## Achievements

In its second year of operation, the OHSC has once again achieved an unqualified audit report from the Auditor-General. The OHSC is committed to ensuring that it has procedures in place to help expose malpractice, misconduct, fraud, corruption, mal-administration or other impropriety. To this end, the OHSC has launched an anonymous fraud hotline number 0800 003 321 for anyone to report issues of concern that might otherwise be difficult to deal with through normal channels.

All allegations are thoroughly investigated and, where warranted, followed up with the full force of the law. All calls are treated in the strictest confidence and callers can remain anonymous.

Furthermore, the outsourced internal audit function conducted audits in the following areas:

- Supply chain management;
- Compliance inspectorate;
- Complaints management;
- Communications; and
- HSDAS.

## Risk Management

The Audit, Risk and Finance Committee provides oversight on the overall system of risk management, especially the mitigation of unacceptable levels of risk. The Committee further advises the Board on risk management and independently monitors the effectiveness of the system of risk management.

A strategic risk register was developed and identifies the top risks facing the entity. Mitigating controls are continuously being monitored for effectiveness in addressing the risks. Where these are found to be ineffective, new control measures are developed to mitigate risks to acceptable levels.

Internal controls have also been designed for the effective management of assets, as well as supply chain management functions. Periodic and regular financial reports are prepared and presented to the relevant internal and external stakeholders.

## Moving forward

The OHSC continues to be largely dependent on the national fiscus for the funding of its activities. It is envisaged that the work of the OHSC will continue to increase on an annual basis, and this will require corresponding financial resources to keep pace with the increase in the volume of activities. In this regard, the OHSC will continue to have engagements with the national government for additional funding.

# INFORMATION COMMUNICATION TECHNOLOGY (ICT)

## Achievements

### ICT strategy

During the year under review, the OHSC developed an ICT strategy which covered critical aspects such as infrastructure, digitisation, automation, business intelligence, security and risk management. The implementation of the strategy takes into account the availability of resources, and will be done in phases over the MTEF period.

### Call Centre

One of the key mandates of the OHSC is the consideration, investigation and disposal of complaints relating to non-compliance with prescribed norms and standards. In order to realise this mandate, the OHSC successfully commissioned a Call Center which serves as the complaints management system. The Call Center was launched on the 28th November 2016.

### Electronic Inspection System

In support of the mandate of monitoring and enforcing compliance by health establishments with norms and standards, the OHSC commissioned the development of an Electronic Inspection System to enhance the processes during inspections of health establishments. During the reporting period the system was developed and is currently being piloted by the inspection unit.

The Electronic Inspection System provides inspectors in the field with the ability to capture data with auto-calculations, and in areas with sufficient connectivity, in real-time mode. It significantly simplifies the inspection process, both in areas with connectivity and in rural areas where the system is used in offline mode.

As a result, the electronic system will enable a drastic change in the level of efficiency and effectiveness of the service offering, as well as increase the turnaround times of inspection processing.

### Annual Returns System

All health establishments are required by law to lodge their Annual Returns with the OHSC within a certain period of time every year. To simplify and streamline the submission and monitoring Annual Returns process for both the submitting establishment and the OHSC, an interactive online system for the submission of Annual Returns by health establishments was developed internally. It is foreseen that this digital system will play a significant role in improving the expediency and accuracy of submissions and the monitoring and control thereof.

## Challenges

The OHSC, as a fast-expanding organisation that provides an essential service to all South African citizens, is faced with inadequate office space, specifically in relation to the implementation of ICT infrastructure. The lack of suitable premises was a major challenge during the year and became more critical as the number of staff increased.

## Moving forward

### ICT infrastructure

In addressing the office space challenge, plans are at an advanced stage for the OHSC to procure its own office space over the MTEF period. This will enable the OHSC to implement its own ICT infrastructure and related systems which will enhance the sharing and dissemination of information both internally and externally with stakeholders. The OHSC also plans to build the requisite internal ICT capacity to render continuous support to a fast-growing organisation.

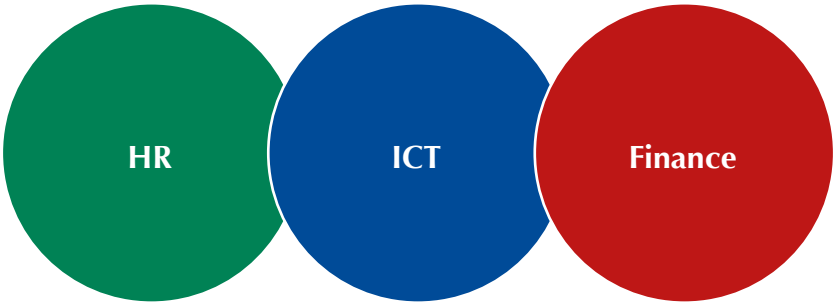



**Figure 7: The linkage between HR, ICT and Finance Unit within the OHSC**

From the information detailed above, it is clear that ICT is central to the improvement of efficiency and effectiveness of all the OHSC's functions, as demonstrated in **Figure 8** below:

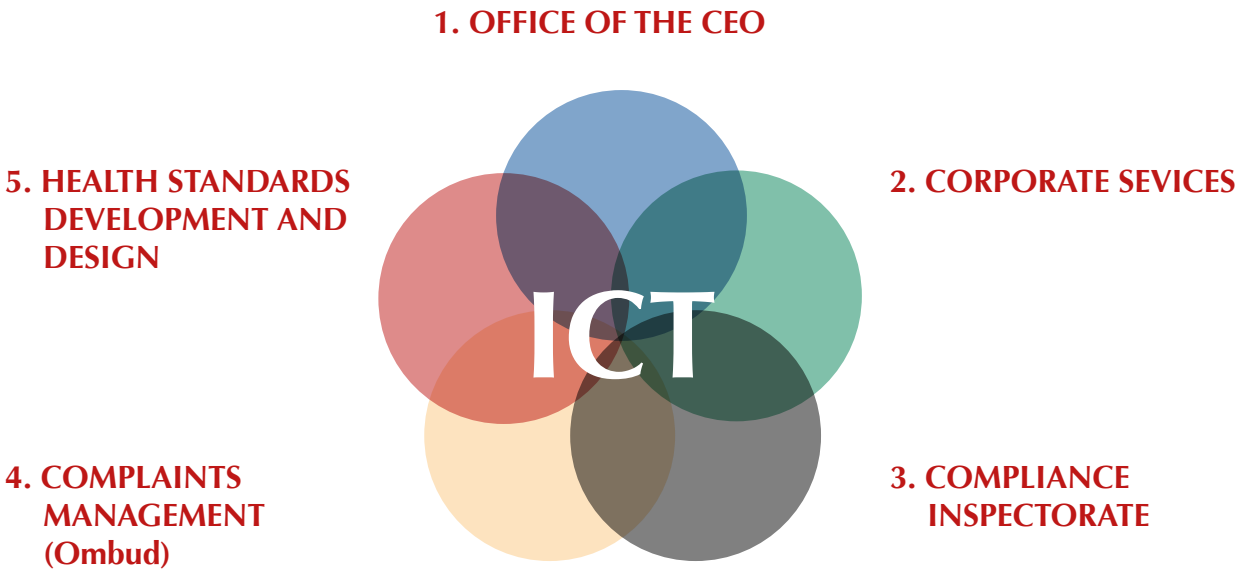



**Figure 8: ICT's role in the functionality of the OHSC**

**Table 10: Performance against allocated budget: Corporate Services**

| Programme | Budget | Actual expenditure | (Over)/Under expenditure |
|---|---|---|---|
| Corporate Services | 26 839 310 | 24 854 243 | 1 985 067 |
| **TOTAL** | **26 839 310** | **24 854 243** | **1 985 067** |

# 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. The Compliance Inspectorate is the core function within the OHSC. The division inspects all health establishments for compliance with the prescribed norms and standards in the NHA, as amended, to ensure that the people of South Africa receive safe and quality healthcare services. The nature, extent and gravity of HE non-compliance inform the need for re-inspection.

### Description of strategic objectives

**Table 11: Strategic objectives for the Compliance Inspectorate**

| | |
|---|---|
| **Strategic objective 1.3** | Compliance with quality standards in regulated health establishments is monitored and inspected at least every 4 years and relevant action is taken |
| **Statement** | To ensure acceptable standards of quality and safe healthcare delivery through compliance inspections in public health establishments and health establishments inspected at least every 4 years and relevant action is taken |
| **Indicator** | % of public sector health establishments inspected annually by the OHSC |
| **Baseline (2015/16)** | 13% |
| **Target (2015-20)** | 20% |
| **Indicator** | % of private sector health establishments inspected annually by the OHSC |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 30% |

| | |
|---|---|
| **Strategic objective 1.4** | Non-compliant HE are subjected to re-inspection or review within 6 months |
| **Statement** | Non-compliant health establishments are subjected to re-inspection or review within six months |
| **Indicator** | % of provisionally non-compliant health establishments subjected to re-inspection or review within 6 months |
| **Baseline (2015/16)** | 36% |
| **Target (2015-20)** | 80% |

| | |
|---|---|
| **Strategic objective 4.3** | Inspectors accredited after successfully completing approved training course |
| **Statement** | To formally accredit inspectors through staff training and development within the OHSC as part of overall training an staff development function |
| **Indicator** | # compliance inspectors accredited as competent |
| **Baseline (2015/16)** | New indicator |
| **Target (2015/20)** | 60 |

## Overview of deliverables vs. achievements

**Table 12: Performance against strategic objectives for the 2016/17 financial year**

| Programme 3: Compliance Inspectorate | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic objective** | **Performance indicator** | **Actual achievement 2015/16** | **Planned target 2016/17** | **Actual achievement 2016/17** | **Deviation from planned target to actual achievement for 2016/17** | **Comment on deviations** |
| **1.3. Compliance with quality standards in regulated health establishments is monitored and inspected at least every 4 years and relevant action is taken** | % of public sector health establishments inspected annually by the OHSC | 13% | 17% | 18,2% (697 of 3816) | Target Exceeded by 1,2% (48 of 3816) | Target exceeded. Used resources that was allocated to inspect private hospitals. |
| | # and % of private sector health establishment inspected annually by the OHSC | New indicator | 20% | 0% | (20%) | Norms and standards not promulgated yet. |
| **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 | 36% | 35% | 38,9% | Target exceeded by 3.9% | Target exceeded. Used resources that was allocated for private hospitals. |
| **4.3. Inspectors accredited after successfully completing approved training course** | # compliance inspectors accredited as competent | New indicator | 20 | 0 | (20) | Training started from 13/03/2017 to 11/04/2017. 97.5% is on training. Only one on maternity leave. |

**Key for Actual Achievement column**

Achieved

Not Achieved

## Achievements

### Inspection and re-inspection

The OHSC is tasked with inspecting health establishments every four years and also re-inspecting high risk health establishments based on the OHSC's inspection strategy to ensure acceptable standards of quality and safe healthcare delivery through compliance inspections. In 2016/17, the OHSC exceeded its inspection and re-inspection target for public health establishments by 1.2% and 3.9% respectively.

Due to the non-promulgation of norms and standards during the year under review, the private sector health establishments could not be inspected for compliance. As soon as the regulations are promulgated the OHSC will have the authority to inspect and monitor compliance at all public and private health establishments and as a result enforce compliance.

The implementation of Standard Operating Procedures (SOPs) supported the well-planned and rigorous inspections. The integrity, reliability and credibility of inspection reports were critical in determining the criteria for re-inspection and the application of quality control processes/measures, such as intra-team validation and peer review, strengthened these outcomes.

The major steps in the inspection process (pre, during, and post inspections), follow a logical cycle which results in continuous improvement in the tools and methods used.

Each major step (Plan, Do, Check and Act) has a series of sub-steps which can be defined and placed within a Standard Operating Procedures type document or Inspectors Manual.

**Figure 9** below illustrates the inspection process flow in line with ISO 90011:2002

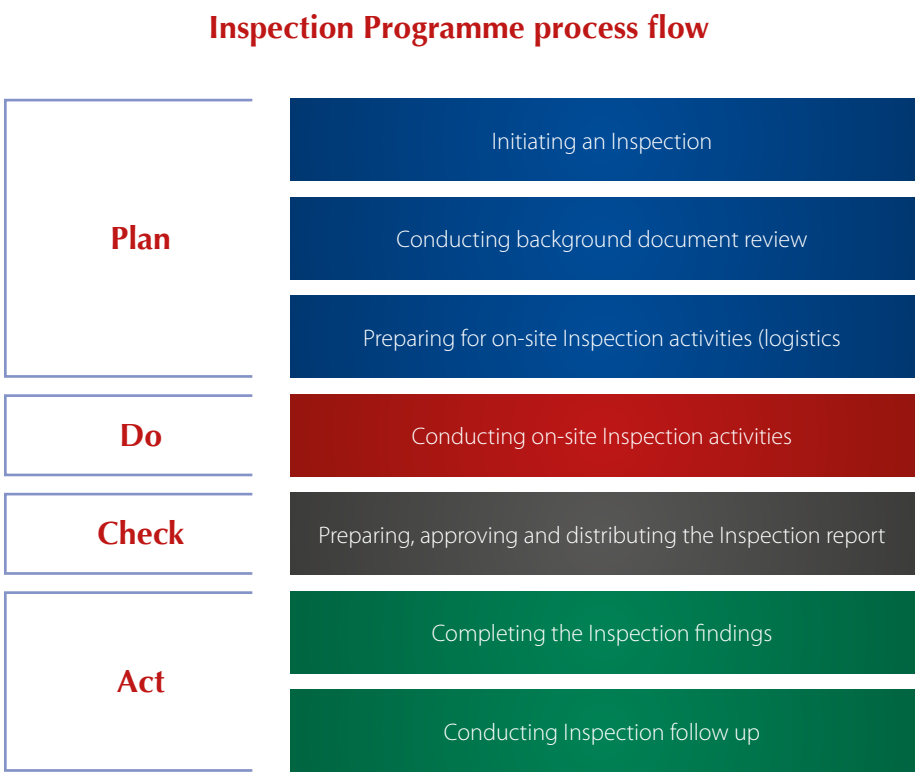



**Figure 9: Inspection process flow in line with ISO 90011:2002**

**Table 13 below illustrates the overall coverage routine and re inspections**

| | EC | FS | GP | KZN | LP | MP | NW | NC | WC | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|
| **Clinics** | 187 | 67 | 95 | 96 | 144 | 41 | 56 | 31 | 51 | 768 |
| **CHC** | 5 | 3 | 1 | 1 | 4 | 4 | 5 | 8 | 3 | 34 |
| **District Hospital** | 9 | 4 | 1 | 4 | 4 | 4 | 3 | 2 | 4 | 35 |
| **Regional Hospital** | 1 | 1 | 4 | 3 | 1 | 0 | 1 | 0 | 1 | 12 |
| **Provincial Tertiary** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 2 |
| **Central Hospital** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Total** | 202 | 75 | 102 | 104 | 153 | 50 | 65 | 42 | 59 | 852 |

**Table 14 below illustrates the coverage for routine inspections conducted**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Clinics** | 150 | 43 | 74 | 88 | 102 | 37 | 56 | 26 | 44 | 620 |
| **CHC** | 3 | 3 | 1 | 1 | 3 | 4 | 5 | 8 | 3 | 31 |
| **District Hospital** | 7 | 3 | 1 | 4 | 4 | 4 | 3 | 2 | 4 | 32 |
| **Regional Hospital** | 1 | 1 | 4 | 3 | 1 | 0 | 1 | 0 | 1 | 12 |
| **Provincial Tertiary** | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 |
| **Central Hospital** | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| **Total** | 161 | 50 | 81 | 96 | 110 | 46 | 65 | 36 | 52 | 697 |

697/3816*100=18.2%

Denominator Total number of HE

**Table 15 below illustrates Re inspections conducted**

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Clinics** | 37 | 24 | 21 | 8 | 42 | 4 | | 5 | 7 | 148 |
| **CHC** | 2 | 0 | 0 | 0 | 1 | 0 | | 0 | 0 | 3 |
| **District Hospital** | 2 | 1 | 0 | 0 | 0 | 0 | | 0 | 0 | 3 |
| **Regional Hospital** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| **Provincial Tertiary** | 0 | 0 | 0 | 0 | 0 | 0 | | 1 | 0 | 1 |
| **Central Hospital** | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 | 0 |
| **Total** | 41 | 25 | 21 | 8 | 43 | 4 | Re-inspection cancelled due to Floods | 6 | 7 | 155 |

155/412 *100 =38% Denominator total number of facilities scored below 50%

### Training and accreditation

The formal training of the inspectors started toward the end of the financial year which resulted in the delayed accreditation of inspectors. However, in-house training was continuously given to inspectors throughout the financial year.

## Challenges

During the year the inspection teams encountered several challenges in achieving the OHSC Compliance Inspectorate's deliverables.

The non-promulgation of regulations and inadequate resources made it difficult to exercise powers of enforcement and inspect at least 25% of health establishments as mandated by the NHA to achieve 100% coverage by the fourth year. Additional funding is required for additional resources to meet the set targets.

Most of the public health establishments (Primary Health Care and District Hospitals) struggle to achieve the acceptable performance rating of 70% for compliance. This increased the number of re-inspections significantly and impacted on resources which could have been directed towards routine inspections.

Aside from challenges in respect of enforcing the inspection and monitoring of compliance at Private health establishments, the Inspectorate also had to re-route inspections due to floods and riots. The provinces and districts affected were:

- KZN in Jozini district due to protests;
- Limpopo in Mopani District due to protests;
- Limpopo in Vhembe district due to protests; and
- Northwest Dr Ruth Segomotsi District due to floods.

The inspection coverage was not affected because the inspections were re-routed to other areas.

## Moving forward

The OHSC will appoint inspectors and senior inspectors to increase the capacity within and increase the number of inspection teams from five to eight to deal with the inclusion of private health establishments under the awaited promulgated regulations. The development of an Early Warning System will play a significant role in enabling the Inspectorate to detect, monitor and pre-empt compliance issues before or as they occur, in turn playing a role in lightening the burden on the Complaints Management unit.

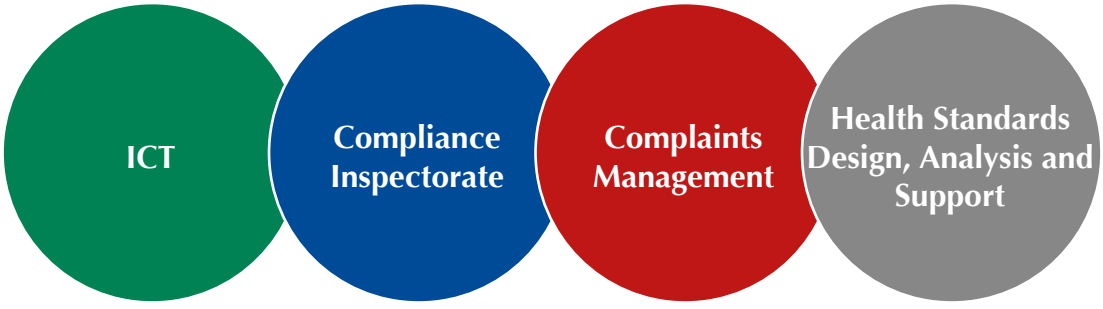



**Figure 10: Illustrates the linkage between ICT, Compliance Inspectorate, Complaints Management and HSDAS Units within the OHSC**

**Table 16: Performance against allocated budget: Compliance Inspectorate**

| Programme | Budget | Actual expenditure | (Over)/Under expenditure |
|---|---|---|---|
| Compliance Inspectorate | 39 429 532 | 42 078 632 | (2 649 100) |
| **TOTAL** | **39 429 532** | **42 078 632** | **(2 649 100)** |

# PROGRAMME 4: COMPLAINTS MANAGEMENT AND OMBUD

## Programme purpose

To consider, investigate and dispose of complaints relating to the non-compliance with prescribed norms and standards in a procedurally fair, economical and expeditious manner.

This division provides independent and objective consideration and investigation to overcome complaints with the intention to add value to and improve the OHSC's operations, as well as achieve the set objectives.

For the purpose of this report the Ombud functions have been integrated into the programme's strategic objectives and indicators as the Ombud is functionally located within the OHSC and uses OHSC staff and resources (Section 81 (3)(b) and (c) of the National Health Act, 2003, as amended).

### Description of strategic objectives

**Table 17: Strategic objectives for Complaints Management and Ombud**

| | |
|---|---|
| **Strategic objective 2.1** | An accessible mechanism by which Complaints can be lodged with the OHSC is in place |
| **Statement** | An accessible mechanism by which Complaints can be lodged with the OHSC is in place |
| **Indicator** | Functional Call Centre maintained with supporting processes and technology platform aligned to OHSC mandate |
| **Baseline (2015/16)** | Call Centre Functional |
| **Target (2015-20)** | Call Centre Functional |

| | |
|---|---|
| **Strategic objective 2.2** | Complaints or concerns regarding non-compliance with norms and standards are effectively managed and resolved |
| **Statement** | Complaints regarding non-compliance with norms and standards are effectively managed and disposed of |
| **Indicator** | Procedures for receiving and managing complaints developed |
| **Baseline (2015/16)** | Procedures in place |
| **Target (2015/20)** | Procedures in place |
| **Indicator** | % of complaints successfully resolved within 6 months |
| **Baseline (2015/16)** | 50% |
| **Target (2015-20)** | 80% |

| | |
|---|---|
| **Strategic objective 2.3** | Findings and recommendations relating to complaints of non-compliance with prescribed norms and standards are issued within agreed time frames |
| **Statement** | Findings and recommendations relating to complaints of non-compliance with prescribed norms and standards are issued within six months |
| **Indicator** | System and procedures for investigation of complaints set up |
| **Baseline (2015/16)** | System set up and functional |
| **Target (2015/20)** | System set up and functional |
| **Indicator** | % investigations closed within 6 months by the Ombud |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 80% |

| | |
|---|---|
| **Strategic objective 2.4** | Recommendation made by the Ombud are monitored |
| **Statement** | Recommendations relating to complaints of non-compliance with prescribed norms and standards are monitored and follow-up by the OHSC |
| **Indicator** | Procedures for communication and monitoring of Ombud recommendations set up and functional |
| **Baseline (2015/16)** | Procedures developed |
| **Target (2015/20)** | System set up and functional |
| **Indicator** | % of Ombud recommendations monitored for implementation by health establishment within six months of tabling to OHSC |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 80% |

## Overview of deliverables vs. achievements

**Table 18: Performance against strategic objectives for the 2016/17 financial year**

| **Programme 4: Complaints Management (and Ombud*)** | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic objective** | **Performance indicator** | **Actual achievement 2015/16** | **Planned target 2016/17** | **Actual achievement 2016/17** | **Deviation from planned target to actual achievement for 2016/17** | **Comment on deviations** |
| **2.1. An accessible mechanism by which complaints can be lodged with the OHSC is in place** | Functional Call Centre maintained with supporting processes and technology platform aligned to OHSC mandate | Target not achieved | Call Centre functional | Call Centre functional | None | N/A |

| Strategic objective | Performance indicator | Actual achievement 2015/16 | Planned target 2016/17 | Actual achievement 2016/17 | Deviation from planned target to actual achievement for 2016/17 | Comment on deviations |
|---|---|---|---|---|---|---|
| **2.2. Complaints or concerns regarding non-compliance with norms and standards are effectively managed and resolved** | Procedures for receiving and managing complaints developed | Target partially achieved | Procedures in place | Procedures in development phase | Procedures not yet in place | Developed policy and procedures send for professional editing. Once professional editing is completed approval will be sought. |
| | % of complaints successfully resolved within 6 months | 45% | 60% | 38.2% | (21.8%) | Late promulgation of procedural Regulations, objection by private health facilities and lack of investigators. |
| **2.3. Findings and recommen-dations relating to complaints of non-compliance with prescribed norms and standards are issued within agreed time frames** | % of investigation closed within 6 months by the Ombud | New Indicator | 60% | 15% | (45%) | Of the four (4) cases for Ombud investigation only one (1) resolved within 6 months. The remaining three cases are still under investigation. |
| **2.4 Recommen-dation made by the Ombud are monitored** | Procedures for communication and monitoring of Ombud recommendations set up and functional | Procedures developed | Procedures developed | Procedures in development phase | Procedures not yet developed. | Developed procedures sent for professional editing. Once professional editing is completed approval will be sought. |
| | % of Ombud recommendations monitored for implementation by health establishment within six months of tabling to OHSC | New Indicator | 60% | 100% | 40% | Over achieved; all 18 recommendations made on the circumstances surrounding death of mentally ill patients implemented. |

**Key for Actual Achievement column**

- Achieved
- Partially achieved
- Not achieved

## Achievements

During the year under review the OHSC achieved two of the six performance indicators in Programme 4 – Complains Management (and Ombud).

A total of 730 complaints have been received thus far and 331 were resolved. These complaints comprised the following risk factors: Extreme 57, High 161, Medium 302 and Low 210. Most complaints are from Gauteng (317), followed by KwaZulu-Natal (116), North West (61), Eastern Cape (53), Mpumalanga (45), Western Cape (43), Limpopo (35), Free State (34) and Northern Cape (26). A total of 119 complaints were related to the private sector and 611 to the public sector.

### Launch of Complaints Call Centre

A National Toll-Free Complaints Call Centre was set up and fully operationalised to ensure access to the OHSC complaints process. The official launch of the Call Centre took place on the 28th November 2016 and awareness campaigns were undertaken in six provinces, namely North West, Mpumalanga, Eastern Cape, Northern Cape, KwaZulu-Natal, and Limpopo as a joint engagement with Health Professions Council of South Africa (HPCSA).

Callers are encouraged to report the following types of complaints to the Call Centre:

- Inappropriate treatment or care;
- Inappropriate behaviour by a healthcare facility;
- Poor quality healthcare service provided by a healthcare establishment; and
- Unsatisfactory management of a complaint by a healthcare establishment.

The OHSC believes that the launch of the Call Centre played a significant role in the escalation of complaints lodged and managed during the year.

### Appointment of Health Ombud

The Health Ombud was appointed on 1 June 2016. This appointment was followed by engagement visits to establish working relationships in Gauteng, Limpopo, KwaZulu-Natal, Free State, Chapter 9 institutions (including the Public Protector and SAHRC) and the Public Service Commission.

On 1 February 2017 the Health Ombud's report on the deaths of mental healthcare patients after their relocation from Life Esidimeni was released. All the recommendations made by the Ombud in terms of this report were accepted by the Gauteng Department of Health and good progress was made on the implementation of those recommendations. The release of the report generated wide media and public interest, with just over 1046 media reports, nationally and internationally, generated over a period of 5 weeks.

The achievements were made possible by the Promulgation of the Procedural Regulations pertaining to the functioning of the Office of Health Standards Compliance. The professional management of complaints by the Ombud in October 2016 ensured the co-operation of private health establishments in terms of OHSC's investigation of complaints.

## Challenges

Over the period only 38.2 % of complaints received were resolved. The 21.8 % underachievement of targets was mainly due to the following factors:

- Late promulgation of procedural regulations;
- Objections by Private Hospital Groups due to unavailability of regulated norms and standards;
- Human resource capacity;
- Lack of co-operation by Provincial Health Departments and the Private Health sector with regard to complaints reports of cases escalated for their action.

The OHSC acknowledges that the promulgation of the norms and standards regulations is an intensive process that involves public participation. However, the delayed promulgation of the norms and standards regulations in turn impacted negatively on the OHSC's outputs.

The Complaints Management unit operated with limited staff members due to budgetary constraints. This left the unit without enough operational investigators, which in turn had a negative impact on the investigation of complaints within the set benchmark of six months.

## Moving forward

The unit's plans for the 2017/2018 year include the following:

1. Development of the OHSC's Complaints Policy and Procedures;
2. Activation of Phase 2 of the Call Centre – the short messaging system (sms);
3. Implementation of the Quality Control Module for CallCabinet;
4. Increase in human resource capacity subject to availability of additional funds.

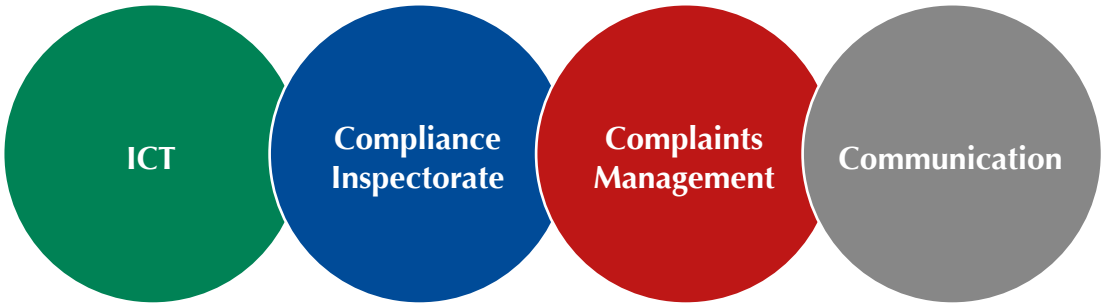



**Figure 11: Illustrates the linkage between ICT, Compliance Inspectorate, Complaints Management and Communication Units within the OHSC**

**Table 19: Performance against allocated budget: Complaints Management (and Ombud)**

| Programme | Budget | Actual expenditure | (Over)/Under expenditure |
|---|---|---|---|
| Complaints Management and Ombud | 12 999 833 | 8 791 504 | 4 208 329 |
| **TOTAL** | **12 999 833** | **8 791 504** | **4 208 329** |

# PROGRAMME 5: HEALTH STANDARDS DESIGN, ANALYSIS AND SUPPORT

## Programme purpose

To provide high-level technical, analytical and educational support to the work of the OHSC in relation to research of norms and standards; guidance on compliance with norms and standards, analysis of data collected and establishment of communication networks with other stakeholders.

### Description of strategic objectives

**Table 20: Strategic objectives for Health Standards Design, Analysis and Support**

| | |
|---|---|
| **Strategic objective 4.1** | All health establishments obligated or regulated by prescribed norms and standards are registered annually for purposes of monitoring and inspections |
| **Statement** | All health establishments obligated by prescribed norms and standards / regulated health establishments submit required data for registration annually |
| **Indicator** | System for submission of annual returns by health establishments set up |
| **Baseline (2015/16)** | System set up |
| **Target (2015-20)** | System set up and functional |
| **Indicator** | % regulated health establishment which has submitted their annual returns |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 80% |

| | |
|---|---|
| **Strategic objective 4.2** | Norms and standards for different types of health establishments are consulted, developed and/or revised for submission to the Minister for promulgation |
| **Statement** | Norms and standards for different types of health establishments are consulted, developed and/or revised for submission to the Minister for promulgation |
| **Indicators** | Norms and standards developed or reviewed annually |
| **Baseline (2015/16)** | New indicator |
| **Target (2015-20)** | 3 |

| | |
|---|---|
| **Strategic objective 1.2** | Guidance is provided on compliance with norms and standards for regulated health establishments |
| **Statement** | National, provincial, district and municipal authorities and hospital groups that have completed the OHSC training of trainers programme |
| **Indicators** | % of relevant authorities responsible for support to health establishments that have received guidance to comply with norms and standards |
| **Baseline (2015/16)** | 40% |
| **Target (2015-20)** | 90% |

| | |
|---|---|
| **Strategic objective 1.6** | Early warning reports of potential situations of risk from health establishments or users are monitored to prioritise inspections |
| **Objective statement** | Health establishments identified as high risk by early warning reports for which appropriate action (reporting, inspection, investigation) was taken within 2 months |
| **Indicator** | % of high risk health establishments with action taken within 2 months |
| **Baseline (2015/16)** | New Indicator |
| **Target (2015-20)** | 70% |

## Overview of deliverables vs. achievements

**Table 21: Performance against strategic objectives for the 2016/17 financial year**

| Programme 5: Health Standards Design, Analysis and Support | | | | | | |
|---|---|---|---|---|---|---|
| **Strategic objectives** | **Performance indicator** | **Actual achievement 2015/16** | **Planned target 2016/17** | **Actual achievement 2016/17** | **Deviation from planned target to actual achievement for 2016/17** | **Comment on deviations** |
| **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 | Target not achieved | System set up | System set up | None | N/A |

| Strategic objectives | Performance indicator | Actual achievement 2015/16 | Planned target 2016/17 | Actual achievement 2016/17 | Deviation from planned target to actual achievement for 2016/17 | Comment on deviations |
|---|---|---|---|---|---|---|
| **4.1. All health establishments obligated or regulated by prescribed norms and standards are registered annually for purposes of monitoring and inspections** | % regulation health establishment which has submitted their annual returns | New Indicator | 80% | 93% | Target exceeded by 13% | These returns have been received. Returns were submitted during the pilot phase. The health establishments received training and immediately thereafter were requested to submit the annual returns. |
| **4.2. Norms and standards for different types of health establishments are consulted, developed and/ or revised for submission to the Minister for promulgation** | Norms and standards developed or reviewed annually | New indicator | 1 | 1 | 0 | N/A |
| **1.2. Guidance is provided on compliance with norms and standards for regulated health establishments** | % of relevant authorities responsible for support to health establishments that have received guidance on compliance with norms and standards | 89% | 50% | 50% | 0% | Target was achieved because the team had to ensure that guidance was provided in the understanding and interpretation of the standards and measurement tools in the four provinces (Free State; Gauteng; Mpumalanga and Western Cape) as part of guidance and support and the process of communicating changes in the tools based in the norms and standards to be prescribed. |

| Strategic objectives | Performance indicator | Actual achievement 2015/16 | Planned target 2016/17 | Actual achievement 2016/17 | Deviation from planned target to actual achievement for 2016/17 | Comment on deviations |
|---|---|---|---|---|---|---|
| **1.6. Early warning reports of potential situations of risk from health establishments or users are monitored to prioritise inspections** | % of high risk health establishments with action taken within 2 months | New indicator | 50% | 52% | Target was exceeded by 2% | Target was exceeded because this was a new indicator in 2016/17, the response to the EWS report was set at 50% as there was no baseline to this indicator. |

**Key for Actual Achievement column**

Partially achieved

Achieved

## Achievements

Norms and Standards for General Practice are at an advanced stage of development and will be submitted to the Minister for consideration early in the second quarter of 2017/18.

A key milestone during the period under review was the promulgation of the procedural regulations addressing both the Annual Returns and the Early Warning System processes. The system for submission of annual returns was established and a pilot was conducted in four provinces in order to test the system.

The OHSC has conducted guidance and support visits to the relevant authorities in relation to:

- Annual Returns (eight out of nine provinces visited); and
- Interpretation of inspection reports and development of Quality Improvement Plans using quality improvement methodologies, implementation and monitoring thereof in order to close the gaps (five out of nine provinces visited).

### Early Warning System

The National Health Act mandates the OHSC to 'monitor indicators of risk as an early warning system and report breaches to the Minister without delays'. This mandate gives the OHSC the powers to require health establishments to report on specific indicators and events that pose a risk to patient safety.

The primary purpose of the EWS is to monitor a set of indicators that poses a risk to patient safety. These indicators then have to be reported by health establishments to the OHSC as prescribed. Furthermore, EWS plays an important role in monitoring compliance with norms and standards. This additional monitoring through the EWS enables the OHSC to categorise all health establishment based on the level of risk by following a simple process:

- Assign a risk profile for each health establishment, which indicate the level of risk to patient safety for the individual health establishments;

- Prioritise high risk health establishments and schedule inspections to take place as soon as possible;
- Contribute to ongoing research on areas of risk where there are gaps in the quality of care, particularly around patient safety; and
- Proactively predict risk to prompt corrective action.

Due to ongoing monitoring, the OHSC will be able to study trends over time in all the health establishments. Analysis of these trends, in conjunction with data from the annual returns, inspections and complaints, will inform the risk identification framework used by the OHSC to identify health establishments where serious patient safety incidents are highly likely to occur. Early intervention at such health establishments may assist in averting the occurrence of such incidents. The risk identification framework will be refined in response to monitoring and analysis of its performance over time.

## Challenges

The delay in promulgation of the norms and standards regulations has resulted in delays within HSDAS, such as the finalisation of the Inspection Tools, formalising the system for submission of annual returns and engagement with private health establishments.

## Moving forward

In the forthcoming financial year, the OHSC will hold workshops with Private Practitioners as part of consultations on the proposed norms and standards for General Practice, pending the incorporation of public comments received following publication of the proposed Norms and Standards for public comment by the NDoH.

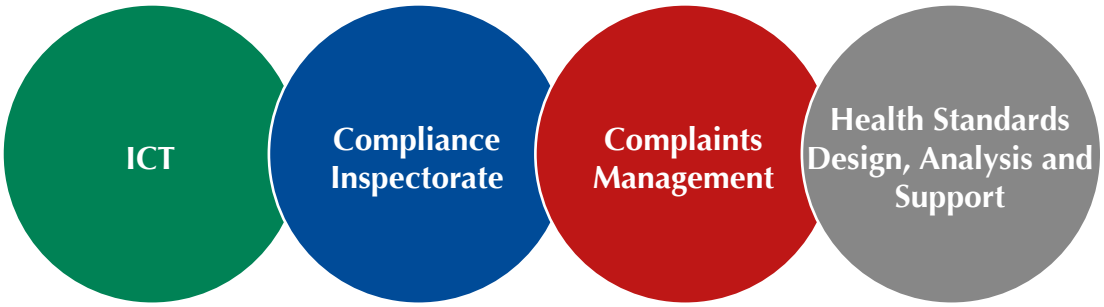



**Figure 12: Linkage between ICT, Compliance Inspectorate, Complaints Management and HSDAS Units within the OHSC**

**Table 22: Performance against allocated budget: Health Standards Design, Analysis and Support**

| Programme | Budget | Actual expenditure | (Over)/Under expenditure |
|---|---|---|---|
| Health Standards Design, Analysis and Support | 8 863 582 | 6 025 122 | 2 838 460 |
| **TOTAL** | **8 863 582** | **6 025 122** | **2 838 460** |

# REVENUE COLLECTION

**Table 23: Revenue Collection**

| Source of revenue | Estimate | Actual amount collected | (Over)/Under collection |
|---|---|---|---|
| Government grant | 100 535 000 | 100 195 453 | 339 547 |
| Interest received | - | 1 486 402 | (1 486 402) |
| Other income | - | 18 226 | (18 226) |
| **TOTAL** | **100 535 000** | **101 700 081** | **(1 165 081)** |

The OHSC received R100 195 453 from the NDoH which was R339 547 short of the full transfer for the 2016/17 financial year. An additional amount of R1 486 402 was received as interest on investment together with, R18 226 as fees charged in terms of the Promotion of Access to Information Act, 2000.

# PART C
# GOVERNANCE

# INTRODUCTION

The OHSC is a schedule 3A public entity under the PFMA, 1999, with a Board appointed by the Minister of Health under the NHA, 2003, as amended, and accountable to the Minister in terms of reporting on the operational activities of the entity. In executing its responsibility for corporate governance within the OHSC, the Board has put in place governance processes, systems and structures to assist in the control, direction and accountability of the entity.

# PORTFOLIO COMMITTEE

During the year under review, the OHSC had various meetings with the Portfolio Committee on Health where presentations were made on the strategic plan, annual performance plan, annual reports (2015/16), and compliance inspection results. The Portfolio Committee supported the mandate of the entity to protect and promote the safety and quality of healthcare for patients and users through regulating the compliance of health establishments with prescribed norms and standards. The Committee, however, emphasised the need for the OHSC to increase its visibility and reach, which include the deep rural areas of South Africa, as well as ensuring that the service of the OHSC are accessible to ordinary citizens. In line with this, a Call Centre was launched, supported by various outreach programs to communicate the mandate and services of the OSHC. This was further supported by increasing coverage on compliance inspections, together with consultation workshops on norms and standards.

# EXECUTIVE AUTHORITY

During the year under review, the OHSC submitted the following reports/returns to the executive authority as required by the PFMA, 1999:

- Quarterly performance information reports and management accounts for the year 2016/17.
- 2017/18 Annual Performance Plan and Budget, including the Materiality and Significance Framework.
- Results on compliance inspections conducted on health establishments in the public sector.

The procedural regulations were promulgated during the year under review. Furthermore, it is expected that the promulgation of the norms and standards and procedural regulations by the Minister will enable the OHSC to inspect all health establishments, both private and public, as well as ensuring the certification and enforcement thereof. All these interventions will be in support of the broader program on the NHI.

These HE interventions and interaction will also help to determine their readiness for the introduction of the NHI.

# THE ACCOUNTING AUTHORITY/ BOARD

**Prof. Lizo Mazwai**
*Chairperson*

**Ms. Audrey Montshiwa**
*Deputy Chairperson*

**Prof. Stuart Whittaker**
*Board Member*

**Mr. Bada Pharasi**
*Board Member*

**Dr. Bandile Masuku**
*Board Member*

**Prof. Ethelwym Stellenberg**
*Board Member*

**Mr. Abdul Kariem Hoosain**
*Board Member*

## Introduction

As the focal point of corporate governance within the OHSC, the Board is responsible for ensuring that the entity's strategic direction is aligned with its mandate and that the entity complies with legislative prescripts, including the PFMA, 1999 and National Treasury Regulations. The Board exercises leadership, enterprise and judgement in directing the OHSC in fulfilling its constitutional mandate and acts in the best interests of the OHSC at all times in a manner imbued with integrity, transparency, accountability and responsibility.

The Board's primary responsibilities include:

- Determining the purpose and values of the OHSC and giving it strategic direction;
- Identifying the key risk areas and key performance indicators of the business;
- Monitoring the performance of the OHSC against agreed objectives; and
- Advising the OHSC on significant financial matters and reviewing the performance of the executive management against defined objectives and, where applicable, industry standards.

During the review period, the Board continued to provide management with strategic direction to execute the OHSC strategy and implement the operational plans for the strategic programmes. The Board monitored and reviewed the quarterly performance reports in terms of strategic goal achievement and was satisfied with management's progress in executing the entity's strategic plan.

The role of the Board, specifically, is to:

- retain full and effective control over the OHSC and monitor the implementation of the strategic plans and Board-approved financial, environmental and social objectives;
- define levels of authority, reserving specific powers to itself and delegating other matters, with the necessary written authority, to the CEO;
- regularly monitoring the delegation of authority;
- ensure that an appropriate system of policies and procedures is in place and maintained and that suitable governance structures exist for the smooth, efficient and prudent stewardship of the OHSC;
- ensure OHSC compliance with all relevant laws and regulations, audit and accounting standards, codes of conduct and best business practice and any other such principles and codes as may be established by the Board from time to time;
- regularly review and evaluate business risks to the OHSC and ensure that comprehensive, appropriate internal controls exist to mitigate such risks;
- exercise objective judgement about the business affairs of the OHSC, independent from management but with sufficient management information to enable a proper and informed assessment; and
- identify and monitor all aspects relevant to the business of the OHSC and ensure its responsible conduct towards all relevant stakeholders with a legitimate interest in its affairs.

In giving effect to its role, the Board defined the following key issues to consider in its control and direction of the OHSC:

- The Board assumes ultimate accountability and responsibility for the performance and affairs of the OHSC and therefore effectively represents and promotes the mandate and legitimate interests of the organisation and its stakeholders;
- The Board has a responsibility to the broader stakeholders who include, inter alia, the present and potential beneficiaries of OHSC services, clients, suppliers, employees and the wider community, to ensure their continuing benefits from the services of the OHSC;
- The Board develops clear definitions of the levels of appropriate materiality or sensitivity to determine the scope and delegation of its authority and ensure that it reserves specific powers and authority for itself as outlined in the enabling Act;
- All delegated authority is in writing and evaluated on a regular basis to ensure relevance and effectiveness and alignment with the relevant changes in the OHSC;
- The Board manages the potential conflicts of interest of Board members, management and the wider stakeholders

and ensures clean, transparent and accountable governance throughout the OHSC at all times;

- The Board oversees the values and ethics of the OHSC and ensures that an appropriate corporate code of conduct is in place;
- The Board is responsible for ensuring that succession plans are in place for the CEO, executive management and key posts in the OHSC;
- The Board ensures that the technology and systems in the OHSC are appropriate for it to run the organisation effectively and competitively through the efficient use of its resources;
- The Board manages and protects the financial position of the OHSC with assistance from the Internal Audit function to ensure that:
  - there is strict adherence to the PFMA and National Treasury Regulations;
  - the annual financial statements fairly present the business of the entity, contain proper disclosures and conform to the requirements of the National Treasury Regulations;
  - appropriate internal controls and regulatory compliance, policies, procedures and processes are in place, and
  - that non-financial aspects relevant to the OHSC are identified and monitored.
- The Board implements and maintains an effective organisational risk management framework and ensure that the key risk areas and key performance indicators of the OHSC are identified and monitored;
- The Board is satisfied that the OHSC has a sound communication policy and an effective stakeholder management framework and that it communicates regularly, openly and promptly with its staff and all relevant stakeholders, with substance prevailing over form;
- The Board reviews the strategic direction of the OHSC and adopts business plans proposed for the achievement of objectives;
- The Board reviews processes to ensure that the OHSC complies with key legal obligations;
- The Board delegates appropriate authority to the CEO for capital expenditure and reviews investment, capital and funding proposals;
- The Board oversees performance against agreed targets and objectives; and
- The Board provides leadership and vision to enhance value and ensure the long-term sustainability of the OHSC.

## Board Charter

Board activities are undertaken in line with the Board Charter developed in consultation with the executive authority. The Charter identifies the roles and responsibilities of the Board in relation to the interactions with management and sets out the fiduciary duties of the individual Board members and role of the Chairperson of the Board. The Board Charter further deals with the management of conflicts of interests to ensure that the interests of the OHSC remain paramount in its decision-making process. The Board monitors compliance with the Charter by Board members and deal with issues of conflict in the manner provided for in the Charter.

## Composition of the Board

The previous Board was appointed in January 2014 for a three year term which ended on 31 December 2016. Subsequently, a new Board consisting of 7 non-executive Board members was appointed in January 2017 by the Minister of Health in terms of Section 79B of the NHA, as amended, for a three year term ending in December 2019. There is diversity in the Board in terms of skills and competencies as prescribed under the NHA.

**Table 23: Board members' information and meetings attended during the 2016/17 financial year**

| Name and designation | Date appointed | Date resigned | Qualification | Area/s of expertise | Board Directorships | Other Committees | Meetings attended |
|---|---|---|---|---|---|---|---|
| Prof LE Mazwai Chairperson | 01/01/2017 | n/a | MBChB, FRCS FICA | Medicine Higher Education | St Mary's Private Hospital Board Modern Business Holdings & Sales Affiliate (Pty) Ltd | None | 5 |
| *Prof LC Rispel Deputy Chairperson | 01/01/2014 | n/a | BSc (Nursing) BSc Hons (Medical Sciences) Masters (Medicine) PhD | Nursing Medical Sciences Public Sector Management and Higher Education | Telkom Foundation World Federation of Public Health Associations | CEC | 5 |
| *Mr MJ Kuscus Member | 01/01/2014 | n/a | BA Cur Exec Programme for Leaders in Development | Finance Governance and Compliance | None | ARF Committee | 5 |
| *Prof SY Essack Member | 01/01/2014 | n/a | BPharm MPharm PhD | Pharmacy Antibiotic Resistance and Stewardship | None | HRREMCO | 5 |
| *Ms KJ Mabotja Member | 01/01/2014 | n/a | Certified Ethics Officer MA (Econ) BCom (Hons) (Econ) Bcom Diploma (General Nursing and Midwifery) | Regulatory Governance Economics Finance | None | ARF Committee | 6 |

| Name and designation | Date appointed | Date resigned | Qualification | Area/s of expertise | Board Directorships | Other Committees | Meetings attended |
|---|---|---|---|---|---|---|---|
| *Prof GJ van Zyl Member | 01/01/2014 | n/a | MBChB Magister (Family Medicine) Postgraduate Diplomas in Community Health and Health Administration MBA; PhD | Medicine Community Health Health Professions Education | COHSASA | HRREMCO | 4 |
| *Ms TT Gwagwa Member | 01/01/2014 | n/a | BCur Programme on Leadership for Change | Nursing Labour Relations & Leadership | None | HRREMCO | 6 |
| *Adv MS Lebala Member | 01/01/2014 | n/a | Bluris LLB (Hons) LLM | Legal | | HRREMCO | 1 |
| *Dr Z Brey Member | 01/01/2014 | n/a | MBChB MBA PhD | Health Systems Quality Improvement | SKZM Investments Groote Schuur Hospital Facility Board | ARF Committee | 4 |
| Prof S Whittaker Member | 01/01/2017 | n/a | BSc UED MBChB, FFCH (CM) SA MMed MD | Medicine | None | CEC | 4 |
| Prof EL Stellenberg Member | 01/01/2017 | n/a | BCur (Gen Nursing, Midwifery and Psychology), B Hons (Nursing Education and Community Health Nursing) MCur, DCur. PGD in Nursing Admin, ICU and Psychiatry | Nursing/ Health Services Higher Education Quality Assurance in Health Services | None | CEC | 6 |

| Name and designation | Date appointed | Date resigned | Qualification | Area/s of expertise | Board Directorships | Other Committees | Meetings attended |
|---|---|---|---|---|---|---|---|
| *Ms V Dubula-Majola Member | 01/01/2014 | 01/10/15 | BA (Health Sciences and Social Services) MPhil (HIV/AIDS) | Social Services NGOs | None | CEC | 1 |
| ** Ms OA Montshiwa | 01/01/2017 | | B Hons (Community Health), B Nursing, N Dip (Midwifery), N Dip (General Nursing) | Social Services NGOs | None | CEC, HR | 2 |
| ** MR OMB Pharasi | 01/01/2017 | n/a | Master of Pharmacy | Pharmacy Antibiotic Resistance and Stewardship | None | AR&F | 2 |
| ** Mr AK Hoosain | 01/01/2017 | n/a | MBA, Bcom Honours, Certificate in Forensic Accounting, Registered CA | Finance Governance and Compliance | None | AR&F, HR | 2 |
| ** Dr BEW Masuku | 01/01/2017 | n/a | MBcHB, M Med, BSc, registered with FCOG | Medicine | None | HR | 2 |

* Term ended on 31 December 2016

** Appointed from 01 January 2017

## Board Committees

The Board established three sub-committees to assist it in discharging its duties. The sub-committees operate according to the function set out in Board-approved Terms of Reference for each sub-committee.

The table below lists the sub-committees, their members and the number of meetings held during the year under review.

**Table 24: Board Sub-Committees, members and meetings for the 2016/17 financial year**

| Committee | Members | Number of members |
|---|---|---|
| Audit, Risk and Finance Committee (ARF) | *M Kuscus (Chairperson)<br>*KJ Mabotja<br>*Z Brey | 3 |
| Certification and Enforcement Committee (CEC) | *L Rispel (Chairperson)<br>*EL Stellenberg;<br>*S Whittaker<br>*V Dubula-Majola (resigned 01/10/2015) | 3 (4) |
| Human Resource and Remuneration Committee (HRREMCO) | *S Essack (Chairperson)<br>*T Gwagwa<br>*S Lebala<br>*G Van Zyl | 4 |

* Term ended on 31 December 2016

# REMUNERATION OF BOARD MEMBERS

Board members are remunerated in terms of National Treasury tariffs for office-bearers of certain statutory and other institutions. The OHSC Board is classified under Category A, Sub-category A2 of the National Treasury tariffs. In terms of the Board Remuneration policy, remuneration is approved for meeting preparation of four hours in line with National Treasury hourly tariffs for sub-category A2 entities. The remuneration paid to each Board member for the year under review are included in the Annual Financial Statements under "Related Parties Transactions" (Note 23).

# RISK MANAGEMENT

The Board adopted a risk management policy and strategy which are aimed at optimal management of risk for the entity to achieve its vision and mission, principal tasks, key strategic objectives and protect the core values of the organisation.

Under the risk management policy, management conducts regular risk assessments to determine the effectiveness of the risk management strategy and identify new and emerging risks. A strategic risk register was developed and identifies the top ten risks facing the entity. Mitigating controls are continuously being monitored for effectiveness in addressing the risks. Where these are found to be ineffective, new control measures are developed to mitigate risks to acceptable levels.

The Internal Audit function plays an important role when conducting risk based audits to evaluate the effectiveness of management controls in mitigating risks and where gaps are identified, management implements recommended action plans to address the identified gaps.

The Board is ultimately responsible for and assumes ownership of risk management as the accounting authority in line with Section 51 of the PFMA, 1999. In this regard the Board has undertaken the following:

- setting an appetite for risk for the OHSC;
- determining the risk-bearing capacity and tolerance level for key risks, which should not exceed the risk appetite;
- monitoring and reviewing the extent to which management has established effective risk management in their respective units;
- ensuring that management has implemented an ongoing process to identify, assess and manage risks;
- forming its own opinion about the effectiveness of the risk management process;
- ensuring that the risk management process is formally evaluated on an annual basis, and
- providing guidance and direction to management in respect of risk management.

The ARF Committee was established to advise management on the overall system of risk management, especially the mitigation of unacceptable levels of risk. The Committee further advises the Board on risk management and independently monitors the effectiveness of the system of risk management.

The effective risk management process has resulted in improved performance and where controls were found to be ineffective, other controls were developed to address risks at tolerable levels.

# INTERNAL CONTROL UNIT

Internal control systems were developed to create management and Board confidence in the financial position of the OHSC and ensure the safeguarding of assets (including the security of information) and compliance with applicable laws, regulations and government policy prescripts. Our internal auditors monitor the functioning and effectiveness of the internal control systems and make recommendations to management and the ARF Committee. The ARF Committee reports to the Board regarding the internal control environment within OHSC and, where necessary, the Board adopts recommendations from the Committee to improve the internal control environment.

The internal control systems were designed to provide reasonable, but not absolute, assurance about the integrity and reliability of the financial statements; safeguard, verify and maintain accountability of assets and detect fraud, potential liability, and loss and material misstatement; and comply with applicable laws and regulations.

The Auditor-General and Internal Audit have considered the internal control systems as part of the annual audit and planned audits, respectively, and identified some deficiencies for which management had to implement an agreed action plans that address the deficiencies and report progress with implementation to the ARF Committee to ensure an acceptable audit outcome in the next financial year.

# INTERNAL AUDIT AND AUDIT, RISK AND FINANCE COMMITTEE

Internal Audit is an outsourced function for a three-year period during which the entity will review its status to determine if the function could be insourced. Internal Audit is important as it provides an independent assurance to the Board about the internal control environment in relation to business operations.

The Internal Audit function operates in terms of the Internal Audit Charter adopted by the Board on the recommendation of the ARF Committee. The Charter set outs the nature, role, responsibility, status and authority of internal auditing within the OHSC and outlines the broad scope of the Internal Audit function. The OHSC recognises that internal auditing is an independent, objective assurance and consulting activity designed to add value and improve operations through a systematic and disciplined approach to evaluating and improving the effectiveness of risk management, control and governance processes that assist the entity to accomplish its objectives.

The Internal Audit function operates under the guidance and support of the ARF Committee. The Committee was established by the Board under the Terms of Reference (Charter) that outline the functions, role and responsibilities of the Committee.

An internal audit plan, as agreed between the Board and the internal auditors, was implemented during the year under review. The internal audit was conducted in the following areas:

- Supply Chain Management;
- Compliance Inspectorate;
- Complaints Management;
- Communications; and
- Health Standards Design, Analysis and Support.

Management has developed a plan to address the shortcomings identified by the internal auditors.

The ARF Committee provides assurance to the Board about the internal control environment in the OHSC, governance, risk management and financials, including budgeting, and is responsible for:

- Reviewing the Internal Audit Charter, including the scope of work undertaken by Internal Audit and the Internal Audit structure and budget;
- Ensuring effective coordination between Internal Audit and management, including the implementation, monitoring, evaluation and review of significant findings and recommendations by Internal Audit and management's responses and implementation of action plans;
- Reviewing the external auditors' proposed annual audit scope, approach and fees and ensuring proper coordination between external and internal auditors;
- Reviewing management requests for the provision of non-audit services to ensure that such services do not impair the independence of the auditors;
- Reviewing the adequacy of the internal control environment, including information and communications technology, security and control;
- Monitoring the implementation of the risk management framework and reviewing significant changes to the risk profiles of the OHSC;
- Providing regular feedback to the Board about the adequacy and effectiveness of risk mitigation and management in the OHSC, including recommendations for improvement;
- Appropriately addressing:
  - financial reporting risks, including the risk of fraud;
  - internal financial controls, and
  - IT risks as they relate to financial reporting.
- Reviewing whether management has considered legal and compliance risks as part of the OHSC risk assessments and effectiveness of the system for monitoring compliance, including management's investigation and subsequent follow-up;
- Obtaining reports from management and the internal auditors and external auditors regarding compliance with all applicable legal and regulatory requirements and acting on them as appropriate;
- Reviewing the entity's compliance with the National Treasury Framework for managing programme performance information and reporting systems and acting on them as appropriate;
- Evaluating the appropriateness of accounting policies and practices and changes to these, as well as compliance with applicable accounting standards and legal requirements;
- Assessing whether the financial statements present a balanced and understandable assessment of the entity's financial position and performance, and whether they are complete and consistent with prescribed accounting and information known to Committee members and stated by management to be accurate;
- Reviewing with management and the external auditors the results of the external audit on financial statements, including any significant issues identified and acting on them as appropriate;
- Reviewing the annual report and related regulatory reports before release and considering the accuracy and completeness of the information; and
- Reviewing the "going concern" assumptions.

**Table 25: Audit, Risk and Finance Committee members and meetings attended for the 2016/17 financial year**

| Name | Qualifications | Internal or external | If internal, position in the public entity | Date appointed | Date resigned | Number of meetings attended |
|---|---|---|---|---|---|---|
| * Mr MJ Kuscus | BA Cur<br>Executive Programme for Leaders in Development | External | N/A | 04/04/2014 | N/A | 4 |
| * Ms KJ Mabotja | BCom (Hons) (Economics)<br>Masters (Economics) | External | N/A | 04/04/2014 | N/A | 4 |
| * Dr Z Brey | MBChB<br>MBA; PhD | External | N/A | 04/04/2014 | N/A | 2 |
| ** Mr AK Hoosain | MBA, Bcom Honours, Certificate in Forensic Accounting, CA (SA) | External | N/A | 08/03/2017 | N/A | 0 |
| ** Mr OBM Pharasi | Master of Pharmacy | External | N/A | 08/03/2017 | N/A | 0 |

* Term ended on 31 December 2016

** Appointed to OHSC Board from 01 January 2017

# COMPLIANCE WITH LAWS AND REGULATIONS

The OHSC is also governed by legislation other than its founding legislation, the NHA, 2003, as amended. As a Schedule 3A public entity, the OHSC is governed by the PFMA, 1999 and National Treasury Regulations published under the PFMA. Legislative compliance is an ongoing activity within OHSC and monitoring of any non-compliance with legislative prescripts and reporting thereof for corrective action is the responsibility of every manager in the OHSC. A PFMA compliance checklist, developed by National Treasury, is used to monitor compliance with the PFMA. The checklist is part of management's reporting responsibilities to the Board through its sub-committees, especially the ARF Committee.

# FRAUD AND CORRUPTION

The Board has committed itself to combating all forms of fraud and corruption and remaining proactive in the fight against fraud and other "white collar" crimes. During the year under review, the first OHSC Fraud Prevention Plan was developed and workshopped with staff to create awareness and teach employees how to report suspected cases of fraud and corruption. The plan was well received by employees and the Board is confident that they will use the reporting channels, including a fraud hotline in the forthcoming financial year, to report any suspected case of fraud and corruption.

The Fraud Prevention Plan consists of a system of internal controls to prevent and detect fraud and corruption. The system of internal controls includes, among others, creating a fraud awareness culture, developing policies and procedures, implementing a system for segregation of duties in business transactions, internal auditing, on-going risk assessment and a process for reporting and monitoring allegations of fraud and corruption. The Board, through the ARF Committee, regularly monitors and reviews business risk relating to fraud and corruption.

# MINIMISING CONFLICT OF INTEREST

The Board has developed a Board Charter and procedures to manage issues of conflicts of interest (perceived, potential or actual) to minimise if not prevent them. On an annual basis, Board members and OHSC senior employees are required to disclose financial interests. The disclosures are meant to ensure that there is no conflicts of interest when decisions are made by anyone within the OHSC governance structures.

Furthermore, at every OHSC meeting employees and Board members sign a register of declaration of interests in any of the agenda items for discussion to identify any conflict and recuse themselves from the meeting during the discussion of the item of conflict.

# CODE OF CONDUCT

The Board Charter includes a Code of Conduct for Board members. The Charter sets out, among others, the roles of the Board, Board Chairperson and individual Board members, governance of Board meetings, reporting responsibilities of the Board, communication of Board decisions and a Code of Ethics. The Board Code of Conduct and Ethics is based on the principles of honesty, integrity and ethical leadership and serves as a guide to Board members about protecting OHSC assets and information, as well as managing conflicts of interest.

The OHSC Code of Conduct for employees is premised on the same principles as that of the Board and guides employees in their interaction with one another and the public to ensure that the reputation of the OHSC is protected.

During the year under review, there were no reported cases of breach by Board members or employees of the respective Codes of Conduct and Ethics. Disciplinary steps are taken by the OHSC against any employee who breaches the Code. The Board decides whether a Board member in breach of the Code should be referred to the Minister for appropriate action in terms of the NHA, 2003, as amended.

# AUDIT, RISK AND FINANCE COMMITTEE REPORT

The ARF Committee is pleased to present its report for the financial year ended 31 March 2017.

## AUDIT, RISK AND FINANCE COMMITTEE RESPONSIBILITY

During the review period, the ARF Committee complied with its responsibilities in Section 51(1)(a) (ii) of the PFMA and Treasury Regulation 27.1, adopted appropriate formal Terms of Reference as its Charter, regulated its affairs in compliance with the Charter and discharged its responsibilities therein.

## THE EFFECTIVENESS OF INTERNAL CONTROL

Our review of the findings of the internal audit function, which was based on the risk assessments conducted in the OHSC, revealed certain weaknesses that were raised with the public entity. Audits were conducted in the following areas: supply chain management; compliance inspectorate; complaints management; communications; and standards design. Control measures are being implemented to address the areas of concern raised by the internal auditors.

## IN-YEAR MONITORING AND QUARTERLY REPORTS

The OHSC submitted quarterly reports to the Executive Authority and the National Treasury as required. The Committee reviewed the reports and recommended them to the Board for approval. The Committee is satisfied with the reported progress by management in implementing the plans for the year and the achievements as at end of the 2016/17 financial year. The Committee will continue to monitor and review implementation of action plans to ensure that there is improvement from the baseline set second year of operations.

## EVALUATION OF ANNUAL FINANCIAL STATEMENTS

The ARF Committee reviewed the Annual Financial Statements prepared by the public entity before submission to the external auditors and was satisfied that the statements reflected all the disclosures required in terms of accounting policies and standards. The audit of the financial statements also confirmed that the statements submitted were prepared in accordance with the prescribed financial reporting framework as required by section 55(1) (a) and (b) of the PFMA.

The audit of the financial statements indicated that there was a significant improvement from the prior year, building on the foundation that has been laid. Moving forward, emphasis will be placed on continuous improvement on an on-going basis.

**AK Hoosain**
**Chairperson: Audit, Risk and Finance Committee**
**31 July 2017**

# PART D

# HUMAN RESOURCE MANAGEMENT

## Introduction

The Human Resources Management Unit provides an integrated and comprehensive human resource services (HR) to enable the organisation to achieve its strategic goals and objectives by creating a productive and conducive work environment.

Accordingly, in order to ensure that a fully functional Office is set up and suitably staffed as envisaged in the strategic plan to fulfil the mandate of the organisation, a number of HR programmes were prioritised and successfully executed for the financial year under review. These programmes included amongst others:

- recruitment of staff and internship programme;
- performance management;
- training and development of staff;
- development and review of policies;
- labour relations;
- employee wellness and induction programmes; and
- organisational development and conditions of service.

The achievements in respect of each of these programmes are set out below.

## Achievements

### Recruitment of staff

As the office is still new, much emphasis was placed on the recruitment of staff to ensure that the office is fully set up and suitably staffed to fulfil the mandate of the organisation. To achieve this, a rigorous recruitment drive was embarked upon and as a result of this, of the 108 funded posts for the year under review, 104 posts were filled as at 31 March 2017 – representing a 96% success (16% higher than the target of 80%).

### Internship Programme

In order to contribute towards the skills development in the country and to give effect to the organisation's strategic goal regarding internship, four interns have been appointed into the internship programme. The essence of the internship programme is to assist the interns to acquire the necessary work experience, thereby increasing the skills pool in the organisation and the country. All the interns were appointed on a 12-month contract.

### Performance Management

In order to monitor and improve the performance of both the organisation and the employees, a performance management system was implemented within the organisation for the year under review. Workshops on performance management were conducted to enhance the proper application or use of the performance management system. Furthermore, as part of implementation, performance recognition rewards during the current financial year aimed to recognise and encourage the staff members that demonstrated exceptional performance in 2015/2016. As a result of this process, performance bonuses and notch progressions were paid to staff members who qualified for such benefits in terms of the OHSC policy.

### Training and development

In order to enhance the skills of employees for the benefit of both the organisation and employees themselves, a Workplace Skills Plan (WSP) was developed and implemented. As part of implementation staff members attended skills development programmes in the form of training, workshops, seminar, conferences, etc.

### Development of policies and procedures

An HR policy manual was developed based on all approved policies and this manual forms part of the induction programme to new employees as and when such programmes are rolled out. The manual comprises of 17 approved human resources policies and such policies included amongst others: employee leave policy; performance management policy; remuneration policy; conditions of service policy; recruitment and selection policy; education, training and development policy; employment equity policy; disciplinary policy and procedure; job evaluation policy; grievance handling and dispute resolution policy; acting allowance policy; occupational health and safety policy; internship policy, post retirement policy, sexual harassment policy, employee code of conduct policy; and relocation policy.

For the year under review, the following policies or frameworks were developed and approved:

- Sexual Harassment Policy;
- Code of Conduct Policy;
- Relocation Policy; and
- HR Plan.

### Employee wellness programme

The employee wellness programme was developed and implemented to improve health and wellbeing of employees through health education and activities that will support positive lifestyle changes. To ensure that the confidentiality of the staff on this programme is protected, a service provider was procured and the programme is currently run through Careways as a procured service provider.

### Labour Relations

In order to create a harmonious work relationship between the organisation and its employees, a process of establishing a bargaining forum was initiated and completed. As a result of this, to establish the bargaining forum an organisational rights agreement was reached with five (5) Trade Unions, namely NEHAWU, PSA, DENOSA, NUPSAW and HOSPERSA.

## Challenges

Although progress has been made in terms of achievement of activities as highlighted above, the following challenges were also encountered during the process:

### Recruitment of staff with specific skills

Recruitment of staff with specialised skills, especially in core business units, has proved to be a challenge for a number of positions that were part of the recruitment drive of the organisation during the year under review. These challenges were and are still more evident in the recruitment process of the following key senior positions:

- CEO; and
- Senior Inspector (Medical Specialist)

To overcome the challenges, a headhunting process was initiated which in some instances ran parallel with the normal recruitment method of advertising. These processes are still ongoing.

### Employee conditions of service

The collective agreement for employees, who were transferred from the National Department of Health in terms of section 197 of the Labour Relations Act, obliged OHSC to ensure that the conditions of service for this category of employees should remain unchanged until 31 March 2017. As a result of this, the OHSC had to operate with two parallel systems relating to conditions of service, particularly regarding new employees who were appointed in terms of OHSC policy dispensation which terms differed from those of the transfer agreement. The situation has presented operational challenges due to conflicting policy dispensation and for this reason a review of policies and conditions of service has been identified as one of the key priorities for the new financial year.

## Action plans

In the next financial year, in an effort to further enhance the productive and work environment, the HR unit will prioritise the review of employees' conditions of service and relevant policies to ensure they are aligned to the goals of the organisation.

Furthermore, a review of the organisational structure will also be one of the priorities to be executed to ensure that the structure effectively support the organisational strategy.

## Human Resource Oversight Statistics

**Table 26: Personnel costs by Programme**

| Programme | Total expenditure | Personnel expenditure | Personnel expenditure as % of total expenditure | No of employees | Average personnel cost per employee |
|---|---|---|---|---|---|
| Office of the CEO | 9 153 057 | 4 886 737 | 5% | 5 | 977 347 |
| Corporate Services | 24 854 243 | 10 472 579 | 12% | 17 | 616 034 |
| Compliance Inspectorate | 42 078 632 | 29 200 061 | 32% | 57 | 512 282 |
| Complaints Management and Ombud | 8 791 504 | 5 990 669 | 7% | 16 | 374 417 |
| Health Standards Design, Analysis and Support | 6 025 122 | 4 626 177 | 5% | 9 | 514 020 |
| **TOTAL** | **90 902 558** | **55 176 223** | **61%** | **104** | **530 541** |

**Table 27: Personnel costs by salary band***

| Level | Personnel expenditure | % of personnel expenditure to the total personnel cost | No of employees | Average personnel cost per employee |
|---|---|---|---|---|
| Executive management | 5 003 630 | 9% | 4 | 1 250 908 |
| Senior management | 8 696 328 | 16% | 11 | 790 575 |
| Professionally qualified and experienced specialists and mid-management | 16 027 202 | 29% | 23 | 696 835 |
| Skilled technical and academically qualified workers, junior management and supervisors | 17 830 040 | 32% | 38 | 469 212 |
| Semi-skilled and descretionary decision-making | 7 619 023 | 14% | 28 | 272 108 |
| Unskilled and defined decision-making | | | - | - |
| **TOTAL** | **55 176 223** | **100%** | **104** | **530 541** |

**Table 28: Performance rewards in 2016/17 financial year**

| Level | Performance awards | Personnel expenditure | % of performance rewards to the total personnel cost |
|---|---|---|---|
| Executive management | 151 380 | 5 003 630 | 0 |
| Senior management | 113 870 | 8 696 328 | 0 |
| Professionally qualified and experienced specialists and mid-management | 149 719 | 16 027 202 | 0 |
| Skilled technical and academically qualified workers, Junior management and supervisors | 145 292 | 17 830 040 | 0 |
| Semi-skilled and descretionary decision-making | 45 680 | 7 619 023 | 0 |
| Unskilled and defined decision-making | - | - | - |
| **TOTAL** | **605 941** | **55 176 223** | **0** |

The performance bonus paid for the assessment period 2015/16 which were paid in the financial year under review.

**Table 29: Training costs for the 2016/17 financial year**

| Programme | Personnel expenditure | Training expenditure | Training expenditure as a % of personnel cost | No. of employees trained | Average training cost per employee |
|---|---|---|---|---|---|
| Training expenditure | 55 176 223 | 775 331 | 1% | 89 | 8 712 |
| **TOTAL** | **55 176 223** | **775 331** | **1%** | **89** | **8 712** |

**Table 30: Employment and vacancies by division**

| Programme | No. of employees 2015/16 | No. of employees 2016/17 | Approved posts 2016/17 | Employee vacancies 2016/17 | % of vacancies |
|---|---|---|---|---|---|
| Office of the CEO | 6 | 5 | 7 | 2 | 29% |
| Corporate Services | 15 | 17 | 19 | 2 | 11% |
| Compliance Inspectorate | 55 | 57 | 58 | 1 | 2% |
| Complaints Management and Ombud | 6 | 16 | 13 | 0 | 0% |
| Health Standards Design, Analysis and Support | 6 | 9 | 11 | 1 | 9% |
| **TOTAL** | **88** | **104** | **108** | **6** | **6%** |

*The 16 posts under the complaints management division include an extra two posts of Compliance Officer/call takers appointed on contract within the Call Centre unit that are not funded but had to be filled to establish the unit. In addition one extra post of Assistant Director: Assessment was filled by employee transferred to the division due to ill health.

**Table 31: Employment and vacancies by level**

| | No. of employees 2015/16 | No. of employees 2016/17 | Approved posts 2016/17 | Employee vacancies 2016/17 | % of vacancies |
|---|---|---|---|---|---|
| Executive management | 2 | 4 | 5 | 1 | 20% |
| Senior management | 8 | 11 | 13 | 3 | 23% |
| Professionally qualified and experienced specialists and mid management | 20 | 23 | 23 | - | 0% |
| Skilled technical and academically qualified workers, junior management and supervisors | 37 | 44 | 45 | 3 | 7% |
| Semi-skilled and discretionary decision making | 21 | 22 | 22 | - | 0% |
| Unskilled and defined decision making | - | - | - | - | |
| **TOTAL** | **88** | **104** | **108** | **7** | **6%** |

The post of the CEO was advertised during 2016 but as at 31 March 2017 no suitable candidate had been found. The post is being re-advertised and the Board is handling the matter, including a head hunting process, to ensure a speedy conclusion to the process.

The bulk of the vacancies have been advertised and it is expected that the process of filling them will be finalised in the new financial year. The key positions in this category include, Senior Inspector (Medical Specialist), Director: Governance, Strategy and Board Secretariat.

**Table 32: Employment changes and staff turnover during the 2016/17 financial year**

| Salary Band | Employment at beginning of period 1 April 2016 | Appointments | Terminations | Employment at the end of period 31 March 2017 |
|---|---|---|---|---|
| Executive management | 2 | 2 | - | 4 |
| Senior management | 8 | 4 | 3 | 9 |
| Professionally qualified and experienced specialists and mid management | 20 | 4 | - | 24 |
| Skilled technical and academically qualified workers, junior management and supervisors | 37 | 11 | 4 | 44 |
| Semi-skilled and discretionary decision making | 21 | 2 | - | 23 |
| Unskilled and defined decision making | - | - | - | - |
| **TOTAL** | **88** | **23** | **7** | **104** |

**Table 33: Reasons for staff leaving**

| Reason | Number | % of total no. of staff leaving |
|---|---|---|
| Death | - | 0% |
| Resignation | 3 | 43% |
| Dismissal | - | 0% |
| Retirement | - | 0% |
| Poor health | - | 0% |
| Expiry of contract | - | 0% |
| Transfers | 4 | 57% |
| **TOTAL** | **7** | **100%** |

Most of the staff left the organisation to pursue careers in other organisations; placing greater emphasis on the OHSC's drive to create a productive and conducive work environment to retain staff.

## Labour relations: misconduct and disciplinary action during the review period

During the year under review, no disciplinary proceeding was taken as no incident of misconduct occurred or was reported.

However, to further enhance the labour relations management system, an organisational rights agreement was negotiated and signed with trade unions to establish a formal bargaining forum structure for the OHSC.

**Table 34: Equity target and employment equity status: Males, Females and Disabled**

| Levels | MALE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | African | | Coloured | | Indian | | White | |
| | Current | Target | Current | Target | Current | Target | Current | Target |
| Executive management | 3 | 3 | - | - | - | - | - | - |
| Senior management | 6 | 4 | - | - | 1 | 1 | - | - |
| Professionally qualified and experienced specialists and mid management | 6 | 8 | 1 | 1 | - | - | - | - |
| Skilled technical and academically qualified workers, junior management and supervisors | 9 | 15 | - | 1 | - | 1 | 1 | 1 |
| Semi-skilled and discretionary decision making | 8 | 9 | - | - | - | - | - | - |
| Unskilled and defined decision making | - | - | - | - | - | - | - | - |
| **TOTAL** | **32** | **39** | **1** | **2** | **1** | **2** | **1** | **1** |

| Levels | FEMALE | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | African | | Coloured | | Indian | | White | |
| | Current | Target | Current | Target | Current | Target | Current | Target |
| Executive management | 1 | 2 | - | - | - | | - | - |
| Senior management | 3 | 5 | - | | - | - | 1 | 1 |
| Professionally qualified and experienced specialists and mid management | 15 | 12 | - | - | - | 1 | 1 | 2 |
| Skilled technical and academically qualified workers, junior management and supervisors | 34 | 28 | - | 1 | - | 1 | - | - |
| Semi-skilled and discretionary decision making | 13 | 12 | - | - | - | - | 1 | - |
| Unskilled and defined decision making | - | - | - | - | - | - | - | - |
| **TOTAL** | **66** | **59** | **-** | **1** | **-** | **2** | **3** | **3** |

| Levels | DISABLED STAFF | | | |
|---|---|---|---|---|
| | MALE | | FEMALE | |
| | Current | Target | Current | Target |
| Executive management | - | - | - | - |
| Senior management | - | - | - | - |
| Professionally qualified and experienced specialists and mid management | - | - | - | - |
| Skilled technical and academically qualified workers, junior management and supervisors | - | 1 | - | - |
| Semi-skilled and discretionary decision making | - | - | - | 1 |
| Unskilled and defined decision making | - | - | - | - |
| **TOTAL** | **-** | **1** | **-** | **1** |

During the year under review, whilst recruitment drives focused on acquiring the required skills to support the organisation to achieve its goals, gender parity was taken into account in ensuring that the staff complement was demographically representative. Accordingly, significant progress has been made in most areas to ensure representation of previously disadvantaged groups across occupational categories. The table above illustrates that the organisation employed more women (66%) and further shows good representation of this category in the middle management level which is represented as professionally qualified occupational category.

# PART E

# FINANCIAL INFORMATION

# REPORT OF THE EXTERNAL AUDITOR

## Report of the Auditor-General to Parliament on Office of Health Standards Compliance

### *Report on the audit of the financial statements*

#### Opinion

1. I have audited the financial statements of the Office of Health Standard Compliance set out on pages 4 to 30, which comprise the statement of financial position as at 31 March 2017, the statement of financial performance, statement of changes in net assets, cash flow statement and statement of comparison of budget information with actual information for the year then ended, as well as the notes to the financial statements, including a summary of significant accounting policies.

2. In my opinion, the financial statements present fairly, in all material respects, the financial position of the Office of Health Standards Compliance as at 31 March 2017, and its financial performance and cash flows for the year then ended in accordance with Generally Recognised Accounting Practice and the requirements of the Public Finance Management Act.

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the auditor-general's responsibilities for the audit of the financial statements section of my report.

4. I am independent of the Office of Health Standards Compliance in accordance with the International Ethics Standards Board for Accountants' *Code of ethics for professional accountants* (IESBA code) together with the ethical requirements that are relevant to my audit in South Africa. I have fulfilled my other ethical responsibilities in accordance with these requirements and the IESBA code.

5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

#### Other matters

6. I draw attention to the matter below. My opinion is not modified in respect of this matter.

#### Unaudited supplementary schedules

7. The supplementary information set out on pages xx to xx does not form part of the financial statements and is presented as additional information. I have not audited these schedules and, accordingly, I do not express an opinion thereon.

#### Responsibilities of the accounting authority responsible for the financial statements

8. The accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework and the requirements of the PFMA and for such internal control as the accounting authority determines is necessary to enable the preparation of the financial statements that are free from material misstatement, whether due to fraud or error.

9. In preparing the financial statements, the accounting authority is responsible for assessing the Office of Health Standards Compliance's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless the accounting officer either intends to liquidate the

entity or to cease operations, or has no realistic alternative but to do so.

### Auditor-General's responsibilities for the audit of the financial statements

10. My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

11. A further description of my responsibilities for the audit of the financial statements is included in the annexure to the auditor's report.

## *Report on the audit of the annual performance report*

### Introduction and scope

12. In accordance with the Public Audit Act of South Africa, 2004 (Act No. 25 of 2004) (PAA) and the general notice issued in terms thereof, I have a responsibility to report material findings on the reported performance information against predetermined objectives for selected programmes presented in the annual performance report. I performed procedures to identify findings but not to gather evidence to express assurance.

13. My procedures address the reported performance information, which must be based on the approved performance planning documents of the department. I have not evaluated the completeness and appropriateness of the performance indicators included in the planning documents. My procedures also did not extend to any disclosures or assertions relating to planned performance strategies and information in respect of future periods that may be included as part of the reported performance information. Accordingly, my findings do not extend to these matters.

14. I evaluated the usefulness and reliability of the reported performance information in accordance with the criteria developed from the performance management and reporting framework, as defined in the general notice, for the following selected programmes presented in the annual performance report of the department for the year ended 31 March 2017:

| Programme | Pages in the annual performance report |
|---|---|
| Programme 3 – Compliance Inspectorate | 55 – 61 |
| Programme 4 – Complaints Management and Ombud | 62 – 67 |
| Programme 5 – Health Standards Design Analysis and Support | 68 – 73 |

15. I performed procedures to determine whether the reported performance information was properly presented and whether performance was consistent with the approved performance planning documents. I performed further procedures to determine whether the indicators and related targets were measurable and relevant, and assessed the reliability of the reported performance information to determine whether it was valid, accurate and complete.

16. The material findings in respect of the usefulness and reliability of the selected programmes are as follows:

### Programme 3 – Compliance Inspectorate

**Indicator: percentage of public sector establishments inspected annually by the OHSC**

17. The reported achievement for target 17% was misstated as the evidence provided indicated 13.7% and not 18.2% as reported.

### Programme 4 – Complaints Management and Ombud

**Indicator: percentage of complaints successfully resolved within six months**

18. The reported achievement for target 60% was misstated as the evidence provided indicated 38.2% and not 45.3% as reported

### Programme 5 – Health Standards Design Analysis and Support

**Indicator: percentage of relevant authorities responsible for support to health establishments that have received guidance on compliance with norms and standards**

19. The reported achievement for target of 50% was misstated as the evidence provided indicated 50% and not 60% as reported.

**Indicator: percentage of high-risk health establishments with action taken within two months**

20. The reported achievement for target 50% was misstated as the evidence provided indicated 52% and not 89% as reported.

### Other matters

21. I draw attention to the matters below.

### Achievement of planned targets

22. Refer to the annual performance report on pages 19 to 63 for information on the achievement of planned targets for the year and explanations provided for the under/overachievement of a significant number of targets. This information should be considered in the context of the qualified conclusions expressed on the usefulness and reliability of the reported performance information in paragraphs 17 to 20 of this report.

### Adjustment of material misstatements

23. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were on the reported performance information of Programme 3 – Compliance Inspectorate, Programme 4 – Complaints Management and Ombud and Programme 5 - Health Atandards Design Analysis and Support. As management subsequently corrected only some of the misstatements, I reported material findings on the usefulness and reliability of the reported performance information. Those that were not corrected are included as material findings in paragraphs 17 to 20 of this report.

## *Report on audit of compliance with legislation*

### Introduction and scope

24. In accordance with the PAA and the general notice issued in terms thereof I have a responsibility to report material findings on the compliance of the entity with specific matters in key legislation. I performed procedures to identify findings but not to gather evidence to express assurance.

25. Effective steps were not taken to prevent fruitless and wasteful expenditure amounting to R53 110, as disclosed in note 29 to the annual financial statements, in contravention of section 38(1)(c)(ii) of the PFMA, treasury regulation 9.1.1 and section 51(1)(b)(ii) of the PFMA. The majority of the fruitless and wasteful expenditure incurred was due to late payments made to SARS.

## *Other information*

26. The OHSC accounting authority is responsible for the other information. The other information comprises the information included in the annual report. The other information does not include the financial statements, the

auditor's report thereon and those selected programmes presented in the annual performance report that have been specifically reported on in the auditor's report.

27. My opinion on the financial statements and findings on the reported performance information and compliance with legislation do not cover the other information and I do not express an audit opinion or any form of assurance conclusion thereon.

28. In connection with my audit, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements and the selected programmes presented in the annual performance report, or my knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work I have performed, I conclude that there is a material misstatement of this other information; I am required to report that fact.

29. I did not identify any material inconsistencies between other information and the financial statements and the selected programmes presented in the annual performance report.

## *Internal control deficiencies*

30. I considered internal control relevant to my audit of the financial statements, reported performance information and compliance with applicable legislation; however, my objective was not to express any form of assurance thereon. The matters reported below are limited to the significant internal control deficiencies that resulted in the findings on the annual performance report included in this report.

### Financial and performance management

- The incurrence of fruitless and wasteful expenditure was due to unforeseen circumstances beyond management's control, this was a one-off incident that resulted in the non-compliance. There are controls in place to prevent the incurrence of fruitless and wasteful expenditure.

- Management did not adequately review the annual performance report for accuracy and completeness prior to submission for audit.

Auditor - General

**Pretoria**
**31 July 2017**

AUDITOR-GENERAL
SOUTH AFRICA

*Auditing to build public confidence*

# Annexure: Auditor-General's responsibility for the audit

1. As part of an audit in accordance with the ISAs, I exercise professional judgement and maintain professional scepticism throughout my audit of the financial statements, and the procedures performed on reported performance information for selected programmes and on the entity's compliance with respect to the selected subject matters.

## Financial statements

2. In addition to my responsibility for the audit of the financial statements as described in the auditor's report, I also:

- identify and assess the risks of material misstatement of the financial statements whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control.

- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the accounting authority.

- conclude on the appropriateness of the board of directors, which constitutes the accounting authority's use of the going concern basis of accounting in the preparation of the financial statements. I also conclude, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the OHSC ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements about the material uncertainty or, if such disclosures are inadequate, to modify the opinion on the financial statements. My conclusions are based on the information available to me at the date of the auditor's report. However, future events or conditions may cause an entity to cease to continue as a going concern.

- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

- obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the group to express an opinion on the consolidated financial statements. I am responsible for the direction, supervision and performance of the group audit. I remain solely responsible for my audit opinion.

## Communication with those charged with governance

3. I communicate with the accounting authority regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

4. I also confirm to the accounting authority that I have complied with relevant ethical requirements regarding independence, and communicate all relationships and other matters that may reasonably be thought to have a bearing on my independence and here applicable, related safeguards.

# ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2017

# Index

The reports and statements set out below comprise the annual financial statements presented to the Parliament:

# ACCOUNTING AUTHORITY'S RESPONSIBILITIES AND APPROVAL

The Accounting Authority is required by the Public Finance Management Act (Act 1 of 1999), to maintain adequate accounting records and is responsible for the content and integrity of the annual financial statements and related financial information included in this report. It is the responsibility of the Accounting Authority to ensure that the annual financial statements fairly present the state of affairs of the entity as at the end of the financial year and the results of its operations and cash flows for the period then ended. The external auditors are engaged to express an independent opinion on the annual financial statements and was given unrestricted access to all financial records and related data.

The annual financial statements have been prepared in accordance with Standards of Generally Recognised Accounting Practice (GRAP) including any interpretations, guidelines and directives issued by the Accounting Standards Board.

The annual financial statements are based upon appropriate accounting policies consistently applied and supported by reasonable and prudent judgements and estimates.

The Accounting Authority acknowledges that it is ultimately responsible for the system of internal financial control established by the entity and place considerable importance on maintaining a strong control environment. To enable the Accounting Authority to meet these responsibilities, it sets standards for internal control aimed at reducing the risk of error or deficit in a cost effective manner. The standards include the proper delegation of responsibilities within a clearly defined framework, effective accounting procedures and adequate segregation of duties to ensure an acceptable level of risk. These controls are monitored throughout the entity and all employees are required to maintain the highest ethical standards in ensuring the entity's business is conducted in a manner that in all reasonable circumstances is above reproach. The focus of risk management in the entity is on identifying, assessing, managing and monitoring all known forms of risk across the entity. While operating risk cannot be fully eliminated, the entity endeavors to minimise it by ensuring that appropriate infrastructure, controls, systems and ethical behaviour are applied and managed within predetermined procedures and constraints.

The Accounting Authority is of the opinion, based on the information and explanations given by management, that the system of internal control provides reasonable assurance that the financial records may be relied on for the preparation of the annual financial statements.

The Accounting Authority has reviewed the entity's cash flow forecast for the year to 31 March 2017 and, in the light of this review and the current financial position, they are satisfied that the entity has or has access to adequate resources to continue in operational existence for the foreseeable future.

The annual financial statements set out on pages 98 to 132, which have been prepared on the going concern basis, were approved by the Accounting Authority on 28 July 2017 and were signed on its behalf by:

**Mr. B Msibi**
**Acting Chief Executive Officer**

**Prof. L Mazwai**
**Chairperson of Board**

# ACCOUNTING AUTHORITY'S REPORT

The Accounting Authority submit their report for the year ended 31 March 2017.

## 1. Incorporation

The OHSC is a Schedule 3A Public Finance Management Act (Act 1 of 1999) public entity established in terms of the National Health Amendment Act, 12 of 2013. It commenced its operation on the 1st of April 2015 and its Executive Authority is the Minister of Health.

## 2. Review of activities

### Main business and operations

The OHSC's mandate 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 of Health in relation to the national health systems; and
- Ensuring consideration, investigation and disposal of complaints relating to non-compliance with the prescribed norms and standards in a procedurally fair, economical and expeditious manner.

The operating results and state of affairs of the entity are fully set out in the attached annual financial statements. The OHSC recorded a surplus of R16 193 972 and R26 487 862 in the prior year.

## 3. Going concern

We draw attention to the fact that at 31 March 2017, the entity had accumulated surplus of R 42 681 834 and that the entity's total assets exceed its liabilities by R 42 681 834.

The annual financial statements have been prepared on the basis of accounting policies applicable to a going concern. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business.

## 4. Subsequent events

The members are not aware of any matter or circumstance arising since the end of the financial year that needs to be disclosed in the annual financial statements.

## 5. Accounting policies

The annual financial statements have been prepared in accordance with the South African Statements of Generally Recognised Accounting Practice (GRAP), including any interpretations of such statements issued by the Accounting Standard Board, as the prescribed framework by National Treasury.

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2017

# STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2017

| Figures in Rand | Note(s) | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|---|
| **Assets** | | | |
| Current assets | | | |
| Receivables from exchange transactions | 6 | 3 296 132 | 63 858 |
| Receivables from non-exchange transactions | 7 | 74 452 | 24 600 |
| Cash and cash equivalents | 8 | 43 534 859 | 32 149 886 |
| | | **46 905 443** | **32 238 344** |
| Non-current assets | | | |
| Property, plant and equipment | 3 | 5 279 320 | 3 693 955 |
| Intangible assets | 4 | 2 519 926 | 438 934 |
| | | **7 799 246** | **4 132 889** |
| **Total assets** | | **54 704 689** | **36 371 233** |
| Liabilities | | | |
| Current liabilities | | | |
| Operating lease liability | 5 | 67 441 | 293 771 |
| Payables from exchange transactions | 11 | 8 115 318 | 6 100 742 |
| Provisions | 9 | 3 639 456 | 3 488 858 |
| | | **11 822 215** | **9 883 371** |
| Non-current liabilities | | | |
| Other liability | 10 | 200 640 | |
| **Total liabilities** | | **12 022 855** | **9 883 371** |
| **Net assets** | | **42 681 834** | **26 487 862** |
| Accumulated surplus | | 42 681 834 | 26 487 862 |

ANNUAL FINANCIAL STATEMENTS FOR THE YEAR ENDED 31 MARCH 2017

# STATEMENT OF FINANCIAL PERFORMANCE

| Figures in Rand | Note(s) | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|---|
| **Revenue** | | | |
| **Revenue from exchange transactions** | | | |
| Interest received - investment | 13 | 1 486 402 | 194 489 |
| Other income | | 18 226 | - |
| **Total revenue from exchange transactions** | | **1 504 628** | **194 489** |
| **Revenue from non-exchange transactions** | | | |
| **Transfer revenue** | | | |
| Government grants | 14 | 100 195 453 | 88 906 000 |
| **Total revenue** | 12 | **101 700 081** | **89 100 489** |
| **Expenditure** | | | |
| Compensation of employees | 15 | (55 176 223) | (39 478 925) |
| Board fees and related costs | 32 | (1 577 014) | (1 429 668) |
| Depreciation and amortisation | | (1 751 834) | (655 203) |
| General expenses | 16 | (27 001 038) | (21 048 831) |
| **Total expenditure** | | **(85 506 109)** | **(62 612 627)** |
| **Surplus for the year** | | **16 193 972** | **26 487 862** |

# STATEMENT OF CHANGES IN NET ASSETS

| Figures in Rand | Accumulated surplus | Total net assets |
|---|---|---|
| **Balance at 01 April 2015** | **-** | **-** |
| Changes in net assets | | |
| Surplus for the year | 26 487 862 | 26 487 862 |
| Total changes | 26 487 862 | 26 487 862 |
| **Balance at 01 April 2016** | **26 487 862** | **26 487 862** |
| Changes in net assets | | |
| Surplus for the year | 16 193 972 | 16 193 972 |
| Total changes | 16 193 972 | 16 193 972 |
| **Balance at 31 March 2017** | **42 681 834** | **42 681 834** |

# CASH FLOW STATEMENT

| Figures in Rand | Note(s) | 31 March 2017 | 31 March 2016 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| **Receipts** | | | |
| Grants | | 100 195 453 | 88 906 000 |
| Interest income | | 1 486 402 | 194 489 |
| Other income | | 18 226 | - |
| | | 101 700 081 | 89 100 489 |
| **Payments** | | | |
| Compensation of employees | | (55 025 626) | (37 030 288) |
| Suppliers | | (28 516 658) | (14 885 774) |
| Other payments | | (1 577 014) | (1 397 970) |
| | | (85 119 298) | (53 314 032) |
| **Net cash flows from operating activities** | 19 | **16 580 783** | **35 786 457** |
| **Cash flows from investing activities** | | | |
| Purchase of property, plant and equipment | 3 | (3 066 063) | (3 174 212) |
| Purchase of intangible assets | 4 | (2 330 387) | (462 359) |
| **Net cash flows from investing activities** | | **(5 396 450)** | **(3 636 571)** |
| **Cash flows from financing activities** | | | |
| Movement in non-current liability | | 200 640 | - |
| **Net increase/(decrease) in cash and cash equivalents** | | **11 384 973** | **32 149 886** |
| Cash and cash equivalents at the beginning of the year | | 32 149 886 | - |
| **Cash and cash equivalents at the end of the year** | 8 | **43 534 859** | **32 149 886** |

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| **Figures in Rand** | **Approved budget** | **Adjustments** | **Final Budget** | **Actual amounts on comparable basis** | **Difference between final budget and actual** | **Reference: Notes 31 & 33** |
| **Statement of Financial Performance** | | | | | | |
| **Revenue** | | | | | | |
| **Revenue from exchange transactions** | | | | | | |
| Other income | - | - | - | 18 226 | **18 226** | |
| Interest received - investment | - | - | - | 1 486 402 | **1 486 402** | |
| **Total revenue from exchange transactions** | **-** | **-** | **-** | **1 504 628** | **1 504 628** | |
| **Revenue from non-exchange transactions** | | | | | | |
| **Transfer revenue** | | | | | | |
| Government grants & subsidies | 100 535 000 | - | **100 535 000** | 100 195 453 | **(339 547)** | |
| **Total revenue** | **100 535 000** | **-** | **100 535 000** | **101 700 081** | **1 165 081** | |
| **Expenditure** | | | | | | |
| Compensation of employees | (64 645 158) | - | **(64 645 158)** | (55 176 223) | **9 468 935** | |
| Board fees and related costs | (1 823 643) | - | **(1 823 643)** | (1 577 014) | **246 629** | |
| Depreciation and amortisation | - | - | **-** | (1 751 834) | **(1 751 834)** | |
| General Expenses | (25 137 482) | - | **(25 137 482)** | (27 001 038) | **(1 863 556)** | |
| **Total expenditure** | **(91 606 283)** | **-** | **(91 606 283)** | **(85 506 109)** | **6 100 174** | |
| **Operating surplus** | **8 928 717** | **-** | **8 928 717** | **16 193 972** | **7 265 255** | |

# STATEMENT OF COMPARISON OF BUDGET AND ACTUAL AMOUNTS

| Budget on Cash Basis | | | | | | |
|---|---|---|---|---|---|---|
| **Figures in Rand** | **Approved budget** | **Adjustments** | **Final budget** | **Actual amounts on comparable basis** | **Difference between final budget and actual** | **Reference - note 31 & 33** |
| **Statement of Financial Position** | | | | | | |
| **Assets** | | | | | | |
| **Current assets** | | | | | | |
| Receivables from exchange transactions | - | - | - | 3 296 132 | **3 296 132** | |
| Receivables from non-exchange transactions | - | - | - | 74 452 | **74 452** | |
| Cash and cash equivalents | - | - | - | 43 534 859 | **43 534 859** | |
| | **-** | **-** | **-** | **46 905 443** | **46 905 443** | |
| **Non-current assets** | | | | | | |
| Property, plant and equipment | 4 680 000 | - | **4 680 000** | 5 279 320 | **599 320** | |
| Intangible assets | 4 248 717 | - | **4 248 717** | 2 519 926 | **(1 728 791)** | |
| | **8 928 717** | **-** | **8 928 717** | **7 799 246** | **(1 129 471)** | |
| **Total assets** | **8 928 717** | **-** | **8 928 717** | **54 704 689** | **45 775 972** | |
| **Liabilities** | | | | | | |
| **Current liabilities** | | | | | | |
| Operating lease liability | - | - | - | 67 441 | **67 441** | |
| Payables from exchange transactions | - | - | - | 8 115 318 | **8 115 318** | |
| Provisions | - | - | - | 3 639 456 | **3 639 456** | |
| | **-** | **-** | **-** | **11 822 215** | **11 822 215** | |
| **Non-current liabilities** | | | | | | |
| Non current liability | - | - | - | 200 640 | **200 640** | |
| **Total liabilities** | **-** | **-** | | **12 022 855** | **12 022 855** | |
| **Net assets** | **8 928 717** | **-** | **8 928 717** | **42 681 834** | **33 753 117** | |

# ACCOUNTING POLICIES

## 1. Presentation of Annual Financial Statements

The annual financial statements have been prepared in accordance with the Standards of Generally Recognised Accounting Practice (GRAP), issued by the Accounting Standards Board in accordance with Section 55 (1) (b) of the Public Finance Management Act (Act 1 of 1999).

These annual financial statements have been prepared on an accrual basis of accounting and are in accordance with historical cost convention as the basis of measurement, unless specified otherwise.

In the absence of an issued and effective Standard of GRAP, accounting policies for material transactions, events or conditions were developed in accordance with paragraphs 8, 10 and 11 of GRAP 3 as read with Directive 5.

Assets, liabilities, revenues and expenses were not offset, except where offsetting is either required or permitted by a Standard of GRAP.

The principal accounting policies, which have been applied in the preparation of these annual financial statements, is disclosed below.

These accounting policies are consistent with the previous year.

### 1.1 Presentation currency

These annual financial statements are presented in South African Rand, which is the functional currency of the OHSC.

### 1.2 Going concern assumption

The annual financial statements have been prepared based on a going concern basis and the Accounting Authority has no reason to believe that the entity will not be a going concern in the foreseeable future. This basis presumes that funds will be available to finance future operations and that the realisation of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business.

### 1.3 Transfer of functions between entities under common control

**Accounting by the entity as acquirer**

**Initial recognition and measurement**

As of the transfer date, the entity recognises the assets transferred and liabilities assumed in a transfer of functions. The assets acquired and liabilities assumed are measured at their carrying values.

The difference between the carrying amounts of the assets acquired, the liabilities assumed and the consideration paid to the transferor, is recognised in accumulated surplus.

# ACCOUNTING POLICIES

## 1.4 Significant judgements and sources of estimation uncertainty

In preparing the annual financial statements, management is required to make estimates and assumptions that affect the amounts represented in the annual financial statements and related disclosures. Use of available information and the application of judgement is inherent in the formation of estimates. Actual results in the future could differ from these estimates which may be material to the annual financial statements. However, no material differences are envisaged.

**Impairment testing**

The recoverable amounts of cash-generating units and individual assets have been determined based on the higher of value-in- use calculations and fair values less costs to sell. These calculations require the use of estimates and assumptions. It is reasonably possible that the assumptions may change which may then impact our estimations and may then require a material adjustment to the carrying value of property, plant and equipment and intangible assets.

**Effective interest rate**

The entity uses an appropriate interest rate taking into account guidance provided in the standard, and applying professional judgement to the specific circumstances to discount future cash flows. The entity uses the prime interest rate to discount future cash flows.

Areas where estimates were made are:

Provisions

Provisions were measured based on the probable estimated future cash outflows that may be needed to settle the obligation that may arise. Additional disclosures of these provisions are made in Note 9.

Depreciation and amortization

Depreciation and amortization amounts on property, plant and equipment, as well as intangible assets, were calculated based on the expected useful lives of the underlying assets. The estimation of the assets' useful lives is based on the management's judgement related to the expected assets condition at the end of the period of use. The estimates took into account the nature of the OHSC's business and how the assets will be utilised in the normal operations of the OHSC, including the impact of advancing technology.

## 1.5 Property, plant and equipment

Property, plant and equipment are tangible non-current assets (including infrastructure assets) that are held for use in the production or supply of goods or services, rental to others, or for administrative purposes, and are expected to be used during more than one period.

# ACCOUNTING POLICIES

### 1.5 Property, plant and equipment (continued)

The cost of an item of property, plant and equipment is recognised as an asset when:

- it is probable that future economic benefits or service potential associated with the item will flow to the entity; and
- the cost of the item can be measured reliably.

Property, plant and equipment is initially measured at cost.

The cost of an item of property, plant and equipment is the purchase price and other costs attributable to bring the asset to the location and condition necessary for it to be capable of operating in the manner intended by management. Trade discounts and rebates are deducted in arriving at the cost.

Where an asset is acquired through a non-exchange transaction, its cost is its fair value as at date of acquisition.

Where an item of property, plant and equipment is acquired in exchange for a non-monetary asset or monetary assets, or a combination of monetary and non-monetary assets, the asset acquired is initially measured at fair value (the cost). If the acquired item's fair value was not determinable, it's deemed cost is the carrying amount of the asset(s) given up.

When significant components of an item of property, plant and equipment have different useful lives, they are accounted for as separate items (major components) of property, plant and equipment.

Costs include costs incurred initially to acquire or construct an item of property, plant and equipment and costs incurred subsequently to add to, replace part of, or service it. If a replacement cost is recognised in the carrying amount of an item of property, plant and equipment, the carrying amount of the replaced part is derecognised.

Recognition of costs in the carrying amount of an item of property, plant and equipment ceases when the item is in the location and condition necessary for it to be capable of operating in the manner intended by management.

Property, plant and equipment is carried at cost less accumulated depreciation and any impairment losses. The residual value, useful life and depreciation method of each asset are reviewed at the end of each reporting date.

Property, plant and equipment are depreciated on the straight-line basis over their expected useful lives to their estimated residual value.

Items of property, plant and equipment are derecognised when an asset is disposed of or when there are no further economic benefits or service potential expected from use of the asset. The gain or loss arising on the disposal of an asset is determined as the difference between the proceeds from the disposal and the carrying value of the assets, and is recognised in the statement of financial performance.

# ACCOUNTING POLICIES

### 1.5 Property, plant and equipment (continued)

The useful lives of items of property, plant and equipment have been assessed as follows:

| Item | Depreciation method | Average useful life |
|---|---|---|
| Buildings | Straight line | 20 years |
| Furniture and fixtures | Straight line | 10 years |
| Motor vehicles | Straight line | 5 years |
| Office equipment | Straight line | 5 years |
| Computer equipment | Straight line | 5 years |
| Leasehold improvements | Straight line | Lease period |

### 1.6 Intangible assets

An asset is identifiable if it either:

- is separable, i.e. is capable of being separated or divided from an entity and sold, transferred, licensed, rented or exchanged, either individually or together with a related contract, identifiable assets or liability, regardless of whether the entity intends to do so; or
- arises from binding arrangements (including rights from contracts), regardless of whether those rights are transferable or separable from the entity or from other rights and obligations.

A binding arrangement describes an arrangement that confers similar rights and obligations on the parties to it as if it were in the form of a contract.

An intangible asset is recognised when:

- it is probable that the expected future economic benefits or service potential that are attributable to the asset will flow to the entity; and
- the cost or fair value of the asset can be measured reliably.

The entity assesses the probability of expected future economic benefits or service potential using reasonable and supportable assumptions that represent management's best estimate of the set of economic conditions that will exist over the useful life of the asset.

Where an intangible asset is acquired through a non-exchange transaction, its initial cost at the date of acquisition is measured at its fair value as at that date.

Expenditure on research (or on the research phase of an internal project) is recognised as an expense when it is incurred. Intangible assets are carried at cost less any accumulated amortisation and any impairment losses.

The amortisation period and the amortisation method for intangible assets are reviewed at each reporting date.

Reassessing the useful life of an intangible asset with a finite useful life after it was classified as indefinite is an indicator that the asset may be impaired. As a result the asset is tested for impairment and the remaining carrying amount is amortised over its useful life.

# ACCOUNTING POLICIES

## 1.6 Intangible assets (continued)

Where the carrying amount of an item of intangible assets is greater than the estimated recoverable amount, it is written down immediately to its recoverable amount and an impairment loss is charged to the statement of financial performance.

Item of intangible assets are derecognised when the asset is disposed of or when there are no further economic benefit or service potential expected from the use of the asset. The gain or loss arising on the disposal of an asset is determined as the difference between the proceeds from the disposal and the carrying value of the assets, and is recognised in the statement of financial performance.

Amortisation is provided to write down the intangible assets, on a straight-line basis, to their residual values as follows:

| Item | Depreciation method | Average useful life |
|---|---|---|
| Computer software | Straight line | 5 years or license period |

Intangible assets are derecognised:

- on disposal; or
- when no future economic benefits or service potential are expected from its use or disposal.

## 1.7 Financial instruments

In the course of the OHSC operations it is exposed to interest rate, credit, liquidity and market risk. The risk management process relating to each of these risks is discussed the headings below.

**Credit risk**

Financial assets which potentially subject the OHSC to the risk of non-performance by the counter-parties and hereby subject to credit concentrations of credit risk, consist mainly cash and cash equivalents and receivable from exchange transactions.

The OHSC manages/limits its treasury counter-party exposure by only dealing with well-established financial institutions approved by the National Treasury through the approval of the investment policy in terms of Treasury Regulations.

**Market risk**

The OHSC is exposed to fluctuations in the employment market, for example, sudden increases in events, unemployment and changes in the wage rates. No significant event occurred during the year that the OHSC is aware of.

**Liquidity risk**

The OHSC manages liquidity risk through proper management of working capital, capital expenditure and actual expenditure vs. forecasted cash flows and its cash management policy. Adequate reserves and liquid resources are also maintained.

# ACCOUNTING POLICIES

## 1.7 Financial instruments (continued)

**Fair values**

The OHSC's financial instruments consists mainly of cash and cash equivalents. No financial instruments was carried at an amount in excess of its fair value and fair values could be measured for all financial instruments. The following methods and assumptions are used to determine the fair value of each class of financial instrument.

- Investments

Investments consists of short-term deposits invested in registered commercial banks, and are measured at fair value. Interest on investment is calculated using the effective interest method and is recognised in the statement of financial performance as revenue from exchange transactions.

Investments are derecognised when the rights to receive cash flows from the investments have expired or have been transferred or when substantially all risk and reward of ownership have been transferred.

- Cash and cash equivalents

Cash and cash equivalents is made of cash on hand, cash held at banks and deposits with banks. The carrying amount of cash and cash equivalents approximates fair value.

- Other receivables from exchange transactions

The carrying amount of other receivables from exchange transactions approximates fair values due to the relatively short-term maturity of these assets.

- Trade and other receivables

Trade and other receivables are recognised as financial assets; loans and receivables are initially recognised at fair value and subsequently measured at amortised cost using the interest rate method. Appropriate allowances for estimated irrecoverable amounts are recognised in surplus/deficit when there is an objective believe that the asset is impaired. Significant financial difficulties of the debtor, and default or delinquency in payments are considered indicators that the trade receivable is impaired. The allowance recognised is measured for all the debtors with an indication of impairment. Impairments are determined based on the risk profile of each debtor. Amounts that are receivable within 12 months from the reporting date are classified as current. The carrying amount of an asset is reduced through the use of an allowance account, and the amount of the loss is recognised in the statement of financial performance. within the operating expenses. When a trade receivable is uncollectable, it is written off against the allowance account for trade receivables. Subsequent recoveries of amounts previously written off are recognised as recoveries in the statement of financial performance.

- Trade and other payables

Financial liabilities consist of payables and borrowings. They are initially measured at fair value and are subsequently measured at amortised cost using the effective interest rate method, which is the initial carrying amount, less repayments, plus interest.

# ACCOUNTING POLICIES

## 1.7 Financial instruments (continued)

### Derecognition

### Financial assets

The entity derecognises financial assets using trade date accounting.

The entity derecognises a financial asset only when:

- the contractual rights to the cash flows from the financial asset expire, are settled or waived;
- the entity transfers to another party substantially all of the risks and rewards of ownership of the financial asset; or
- the entity, despite having retained some significant risks and rewards of ownership of the financial asset, has transferred control of the asset to another party and the other party has the practical ability to sell the asset in its entirety to an unrelated third party, and is able to exercise that ability unilaterally and without needing to impose additional restrictions on the transfer. In this case, the entity:
  - derecognise the asset; and
  - recognise separately any rights and obligations created or retained in the transfer.

If, as a result of a transfer, a financial asset is derecognised in its entirety but the transfer results in the entity obtaining a new financial asset or assuming a new financial liability, or a servicing liability, the entity recognise the new financial asset, financial liability or servicing liability at fair value.

On derecognition of a financial asset in its entirety, the difference between the carrying amount and the sum of the consideration received is recognised in surplus or deficit.

If the transferred asset is part of a larger financial asset and the part transferred qualifies for derecognition in its entirety, the previous carrying amount of the larger financial asset is allocated between the part that continues to be recognised and the part that is derecognised, based on the relative fair values of those parts, on the date of the transfer. For this purpose, a retained servicing asset is treated as a part that continues to be recognised. The difference between the carrying amount allocated to the part derecognised and the sum of the consideration received for the part derecognised is recognised in surplus or deficit.

If a transfer does not result in derecognition because the entity has retained substantially all the risks and rewards of ownership of the transferred asset, the entity continues to recognise the transferred asset in its entirety and recognise a financial liability for the consideration received. In subsequent periods, the entity recognises any revenue on the transferred asset and any expense incurred on the financial liability. Neither the asset, and the associated liability nor the revenue, and the associated expenses are offset.

### Financial liabilities

The entity removes a financial liability (or a part of a financial liability) from its statement of financial position when it is extinguished — i.e. when the obligation specified in the contract is discharged, cancelled, expires or waived.

# ACCOUNTING POLICIES

### 1.7 Financial instruments (continued)

An exchange between an existing borrower and lender of debt instruments with substantially different terms is accounted for as having extinguished the original financial liability and a new financial liability is recognised. Similarly, a substantial modification of the terms of an existing financial liability or a part of it is accounted for as having extinguished the original financial liability and having recognised a new financial liability.

The difference between the carrying amount of a financial liability (or part of a financial liability) extinguished or transferred to another party and the consideration paid, including any non-cash assets transferred or liabilities assumed, is recognised in surplus or deficit. Any liabilities that are waived, forgiven or assumed by another entity by way of a non-exchange transaction are accounted for in accordance with the Standard of GRAP on Revenue from Non-Exchange Transactions (Taxes and Transfers).

### 1.8 Taxation

The OHSC is exempt from income tax in terms of section 10 (1) of the Income Tax Act No 58 of 1962.

### 1.9 Leases

A lease is classified as a finance lease if it transfers substantially all the risks and rewards incidental to ownership. A lease is classified as an operating lease if it does not transfer substantially all the risks and rewards incidental to ownership.

**Operating leases - lessor**

Operating lease revenue is recognised as revenue on a straight-line basis over the lease term.

Initial direct costs incurred in negotiating and arranging operating leases are added to the carrying amount of the leased asset and recognised as an expense over the lease term on the same basis as the lease revenue.

The aggregate cost of incentives is recognised as a reduction of rental revenue over the lease term on a straight-line basis. The aggregate benefit of incentives is recognised as a reduction of rental expense over the lease term on a straight-line basis. Income for leases is disclosed under revenue in statement of financial performance.

**Operating leases - lessee**

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. The difference between the amounts recognised as an expense and the contractual payments are recognised as an operating lease asset or liability.

### 1.10 Employee benefits

**Short-term employee benefits**

The cost of short-term employee benefits, (those payable within 12 months after the service is rendered, such as paid vacation leave and sick leave, bonuses, and non-monetary benefits such as medical care), are recognised in the period in which the service is rendered and are not discounted.

# ACCOUNTING POLICIES

## 1.10 Employee benefits (continued)

**Defined contribution plans**

Payments to defined contribution retirement benefit plans are charged as an expense as they become due. Payments made to industry-managed (or state plans) retirement benefit schemes are dealt with as defined contribution plans where the entity's obligation under the schemes is equivalent to those arising in a defined contribution retirement benefit plan.

## 1.11 Provisions and contingencies

Provisions are recognised when:

- the OHSC has a present obligation as a result of a past event;
- it is probable that an outflow of resources embodying economic benefits or service potential will be required to settle the obligation; and
- a reliable estimate can be made of the obligation.

The amount of a provision is the best estimate of the expenditure expected to be required to settle the present obligation at the reporting date.

Where some or all of the expenditure required to settle a provision is expected to be reimbursed by another party, the reimbursement is recognised when, and only when, it is virtually certain that reimbursement will be received if the OHSC settles the obligation. The reimbursement is treated as a separate asset. The amount recognised for the reimbursement does not exceed the amount of the provision.

Provisions are reviewed at each reporting date and adjusted to reflect the current best estimate. Provisions are reversed if it is no longer probable that an outflow of resources embodying economic benefits or service potential will be required, to settle the obligation.

A provision is used only for expenditures for which the provision was originally recognised. Provisions are not recognised for future operating deficits.

If an entity has a contract that is onerous, the present obligation (net of recoveries) under the contract is recognised and measured as a provision.

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note 22.

## 1.12 Commitments

Items are classified as commitments when an entity has committed itself to future transactions that will normally result in the outflow of cash.

# ACCOUNTING POLICIES

## 1.13 Revenue from exchange transactions

Revenue from exchange transactions refers to revenue that accrued to the entity directly in return for services rendered or goods sold, the value of which approximates the consideration received or receivable. Revenue is recognised to the extent that is probable that the economic benefits will flow to the OHSC and revenue can be reliably measured. Revenue is measured at fair value of the consideration receivable on an accrual basis. Revenue includes investments and non-operating income exclusive of value added taxation, rebates and discounts.

**Interest received**

Revenue arising from the use by others of entity assets yielding interest is recognised when:

- It is probable that the economic benefits or service potential associated with the transaction will flow to the entity, and
- The amount of the revenue can be measured reliably.

Interest is recognised, in surplus or deficit, using the effective interest rate method.

## 1.14 Revenue from non-exchange transactions

Revenue from non-exchange transactions refers to transactions where the entity received revenue from another entity without giving approximately equal value in exchange. Revenue from non-exchange transaction is generally recognised to the extent that the related receipt or receivable qualifies for recognision as an asset and there is no liability to repay the amount.

**Government grants**

Government grant are recognised as revenue when:

- it is probable that the economic benefit or service potential associated with the transaction will flow to the entity,
- the amount of the revenue can be measured reliably, and
- to the extent that there has been compliance with any restrictions associated with the grant

## 1.15 Borrowing costs

Borrowing costs are interest and other expenses incurred by an entity in connection with the borrowing of funds. Borrowing costs are recognised as an expense in the period in which they are incurred.

## 1.16 Unauthorised expenditure

Unauthorised expenditure means:

- overspending of a program or a main division within a program; and
- expenditure not in accordance with the purpose of a program or, in the case of a main division, not in accordance with the purpose of the main division.

All expenditure relating to unauthorised expenditure is recognised as an expense in the statement of financial performance in the year that the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

# ACCOUNTING POLICIES

## 1.17 Fruitless and wasteful expenditure

Fruitless expenditure means expenditure which was made in vain and would have been avoided had reasonable care been exercised.

All expenditure relating to fruitless and wasteful expenditure is recognised as an expense in the statement of financial performance in the year that the expenditure was incurred. The expenditure is classified in accordance with the nature of the expense, and where recovered, it is subsequently accounted for as revenue in the statement of financial performance.

## 1.18 Irregular expenditure

Irregular expenditure as defined in section 1 of the PFMA is expenditure other than unauthorised expenditure, incurred in contravention of or that is not in accordance with a requirement of any applicable legislation, including

(a) this Act; or
(b) the State Tender Board Act, 1968 (Act No. 86 of 1968), or any regulations made in terms of the Act; or
(c) any provincial legislation providing for procurement procedures in that provincial government.

National Treasury practice note no. 4 of 2008/2009 which was issued in terms of sections 76(1) to 76(4) of the PFMA requires the following (effective from 1 April 2008):

Irregular expenditure that was incurred and identified during the current financial and which was condoned before year end and/or before finalisation of the financial statements must also be recorded appropriately in the irregular expenditure register. In such an instance, no further action is also required with the exception of updating the note to the financial statements.

Irregular expenditure that was incurred and identified during the current financial year and for which condonement is being awaited at year end must be recorded in the irregular expenditure register. No further action is required with the exception of updating the note to the financial statements.

Where irregular expenditure was incurred in the previous financial year and is only condoned in the following financial year, the register and the disclosure note to the financial statements must be updated with the amount condoned.

## 1.19 Budget information

Entities are typically subject to budgetary limits in the form of appropriations or budget authorisations (or equivalent), which is given effect through authorising legislation, appropriation or similar.

General purpose financial reporting by entity shall provide information on whether resources were obtained and used in accordance with the legally adopted budget.

The approved budget is prepared on a accrual basis and presented by economic classification linked to performance outcome objectives.

The approved budget covers the fiscal period from 2016-04-01 to 2017-03-31.

# ACCOUNTING POLICIES

### 1.19 Budget information (continued)

The Statement of comparative and actual information has been included in the annual financial statements as the recommended disclosure when the annual financial statements and the budget are on the same basis of accounting as determined by National Treasury.

The annual financial statements and the budget are not on the same basis of accounting therefore a reconciliation between the statement of financial performance and the budget have been included in the annual financial statements. Refer to note 31 and 33.

### 1.20 Related parties

The entity operates in an economic sector currently dominated by entities directly or indirectly owned by the South African Government. As a consequence of the constitutional independence of the three spheres of government in South Africa, only entities within the national sphere of government are considered to be related parties.

Management are those persons responsible for planning, directing and controlling the activities of the entity, including those charged with the governance of the entity in accordance with legislation, in instances where they are required to perform such functions.

The following parties deemed to be related parties of the OHSC.

- Controlling party - this refers to the NDoH which the OHSC reports to, and from where the OHSC receives its funding. This includes the Executive Authority of the NDoH.
- The Board of the OHSC - this refers to persons appointed by the Minister of Health in terms of sections 79A. 79B and 79 C of the National Health Amendment Act 2013. Included in this category are all the Committees of the Board as constituted by the Board from time to time.
- Key management personnel - this includes all persons having the authority and responsibility for planning, directing and controlling the operational activities of the entity. Such personnel include the Chief Executive Officer, Chief Financial Officer and other members of the Executive Management Committee.
- Close family members of key management personnel and Board members of the OHSC. In accordance with GRAP 20, as a minimum, the following shall be considered to be close family members:
  - that person's children and spouse or domestic partner;
  - children of that person or that person's spouse or domestic partner;
  - Dependants of that person or that person's spouse or domestic partner;
  - a grandparent, grandchild, parent, brother, or sister; and
  - a parent -in - law, brother-in-law or sister- in - law.
- Entities under common control - this refers to public entities that are under the control of the NDoH, under which the OHSC reports.

# ACCOUNTING POLICIES

### 1.21 Events after reporting date

Events after reporting date are those events, both favourable and unfavourable, that occur between the reporting date and the date when the financial statements are authorised for issue.

Two types of events can be identified:

- those that provide evidence of conditions that existed at the reporting date (adjusting events after the reporting date); and
- those that are indicative of conditions that arose after the reporting date (non-adjusting events after the reporting date).

The entity will adjust the amount recognised in the financial statements to reflect adjusting events after the reporting date once the event occurred.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## 2. New standards and interpretations

### 2.1 Standards and interpretations effective and adopted in the current year

In the current year, the entity has adopted the following standards and interpretations that are effective for the current financial year and that are relevant to its operations:

| Standards/ Interpretation: | Effective Date: Years beginning on or after | Expected Impact: |
|---|---|---|
| GRAP 17 (as amended 2015): Property, Plant and Equipment | 1 April 2016 | The impact of the standard is not material. |
| GRAP 16 (as amended 2015): Investment Property | 1 April 2016 | The impact of the standard is not material. |

### 2.2 Standards and interpretations issued, but not yet effective

| Standards/ Interpretation: | Effective Date: Years beginning on or after | Expected Impact: |
|---|---|---|
| Directive 12: The Selection of an Appropriate Reporting Framework by Public Entities | 1 April 2018 | Unlikely there will be a material impact |
| GRAP 109: Accounting by Principals and Agents | 1 April 2017 | Unlikely there will be a material impact |
| GRAP 20: Related Party Disclosures | Not yet effective | The OHSC has disclosed the related party transactions |
| GRAP 32: Service Concessions Arrangements: Grantor | Not yet effective | Statement is not relevant to the OHSC |
| GRAP 108: Statutory Receivables | Not yet effective | No statutory receivables were received |
| GRAP 109: Accounting for Principals and Agents | Not yet effective | Statement is not relevant to the OHSC |
| GRAP 12 Inventory: | 1 April 2017 | Unlikely there will be a material impact |
| GRAP 12 Inventory: | 1 April 2017 | Unlikely there will be a material impact |
| GRAP 27 Agriculture | 1 April 2017 | Standard is not relevant to OHSC. |
| GRAP 31 Intangible assets | 1 April 2017 | Unlikely there will be a material impact |
| GRAP 34 Seperate financial Statements | 1 April 2017 | Standard is not relevant |
| GRAP 35 Consolidate financial statement | 1 April 2017 | Standard is not relevant to OHSC |
| GRAP 36 Investment in associates and joint arrangements | 1 April 2017 | Standard is not relevant to OHSC |
| GRAP 37 Joint arrangements | 1 April 2017 | Standard is not relevant to OHSC |
| GRAP 38 Disclosure of interest in other entities | 1 April 2017 | Standard is not relevant to OHSC |
| GRAP 103 Heritage assets | 1 April 2017 | Standard is not relevant to OHSC |
| GRAP 110 Living & non-living resources | 1 April 2017 | Standard is not relevant OHSC |
| IGRAP 18 - Interpretation of the standard of GRAP on the recognition and derecognition of land | 1 April 2017 | Standard is not relevant to OHSC |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

**Figures in Rand**

## 3. Property, plant and equipment

| | 2017 | | | 2016 | | |
|---|---|---|---|---|---|---|
| | Cost / Valuation | Accumulated depreciation and accumulated impairment | Carrying value | Cost / Valuation | Accumulated depreciation and accumulated impairment | Carrying value |
| Office equipment | 1 744 257 | (373 033) | 1 371 224 | 775 933 | (151 915) | 624 018 |
| Furniture and fixtures | 1 901 117 | (246 262) | 1 654 855 | 1 207 898 | (76 529) | 1 131 369 |
| Motor Vehicles | 481 059 | (8 018) | 473 041 | - | - | - |
| Computer equipment | 2 378 970 | (598 770) | 1 780 200 | 1 498 125 | (281 969) | 1 216 156 |
| Leasehold improvements | 843 777 | (843 777) | - | 843 777 | (121 365) | 722 412 |
| **Total** | **7 349 180** | **(2 069 860)** | **5 279 320** | **4 325 733** | **(631 778)** | **3 693 955** |

**Reconciliation of property, plant and equipment - 2017**

| | Opening balance | Additions | Additions through transfer of functions/ mergers | Disposals | Depreciation | Total |
|---|---|---|---|---|---|---|
| Office equipment | 624 018 | 968 325 | - | - | (221 119) | 1 371 224 |
| Furniture and fixtures | 1 131 369 | 680 777 | 12 442 | - | (169 733) | 1 654 855 |
| Motor Vehicles | - | 481 059 | - | - | (8 018) | 473 041 |
| Computer equipment | 1 216 157 | 935 904 | - | (46 238) | (325 623) | 1 780 200 |
| Leasehold improvements | 722 411 | - | - | - | (722 411) | - |
| **Total** | **3 693 955** | **3 066 065** | **12 442** | **(46 238)** | **(1 446 904)** | **5 279 320** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

**Figures in Rand**

## 3. Property, plant and equipment (continued)

### Reconciliation of property, plant and equipment - 2016

| | Opening balance | Additions | Additions through transfer of functions/ mergers | Depreciation | Total |
|---|---|---|---|---|---|
| Office equipment | - | 590 421 | 185 511 | (151 914) | 624 018 |
| Furniture and fixtures | - | 656 263 | 551 635 | (76 529) | 1 131 369 |
| Computer equipment | - | 1 083 752 | 414 374 | (281 969) | 1 216 157 |
| Leasehold improvements | - | 843 776 | - | (121 365) | 722 411 |
| **Total** | **-** | **3 174 212** | **1 151 520** | **(631 777)** | **3 693 955** |

## 4. Intangible assets

| | 2017 | | | 2016 | | |
|---|---|---|---|---|---|---|
| | Cost / Valuation | Accumulated amortisation and accumulated impairment | Carrying value | Cost / Valuation | Accumulated amortisation and accumulated impairment | Carrying value |
| Computer software | 2 848 282 | (328 356) | 2 519 926 | 462 359 | (23 425) | 438 934 |

### Reconciliation of intangible assets - 2017

| | Opening balance | Additions | Additions through transfer of functions/ mergers | Amortisation | Total |
|---|---|---|---|---|---|
| Computer software | 438 934 | 2 330 387 | 55 535 | (304 931) | 2 519 925 |

### Reconciliation of intangible assets - 2016

| | Opening balance | Additions | Amortisation | Total |
|---|---|---|---|---|
| Computer software | - | 462 359 | (23 425) | 438 934 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 5. Operating lease liability

| | | |
|---|---|---|
| Current liabilities | (67 441) | (293 771) |

## 6. Receivables from exchange transactions

| | | |
|---|---|---|
| Deposits | 62 050 | 62 050 |
| Prepaid expenses | 3 234 082 | 1 808 |
| | **3 296 132** | **63 858** |

## 7. Receivables from non-exchange transactions

| | | |
|---|---|---|
| Other receivables from non-exchange transactions | 74 452 | 24 600 |

## 8. Cash and cash equivalents

Cash and cash equivalents consist of:

| | | |
|---|---|---|
| Bank balances | 967 | 1 632 |
| Cash on hand | 19 853 001 | 9 953 765 |
| Short-term investment | 23 680 891 | 22 194 489 |
| | **43 534 859** | **32 149 886** |

## 9. Provisions

**Reconciliation of provisions - 2017**

| | Opening Balance | Additions | Utilised during the year | Reversed during the year | Total |
|---|---|---|---|---|---|
| Provision for performance bonuses | 796 506 | 969 677 | (605 941) | (190 565) | 969 677 |
| Provision for leave | 1 577 231 | 1 540 690 | - | (1 577 231) | 1 540 690 |
| Provision for 13th cheque | 1 115 121 | 1 129 089 | (1 107 558) | (7 563) | 1 129 089 |
| | **3 488 858** | **3 639 456** | **(1 713 499)** | **(1 775 359)** | **3 639 456** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 9. Provisions (continued)

| | Opening Balance | Additions | Total |
|---|---|---|---|
| Provision for performance bonuses | - | 796 506 | 796 506 |
| Provision for leave | 1 178 655 | 398 576 | 1 577 231 |
| Provision for 13th cheque | - | 1 115 121 | 1 115 121 |
| | **1 178 655** | **2 310 203** | **3 488 858** |

## 10. Non-currnet liabilities

| | | |
|---|---|---|
| Other accrued expenses | 200 640 | - |

## 11. Payables from exchange transactions

| | | |
|---|---|---|
| Trade payables | 7 618 393 | 5 346 528 |
| Other accrued expenses | 496 925 | 754 214 |
| | **8 115 318** | **6 100 742** |

## 12. Revenue

| | | |
|---|---|---|
| Other revenue | 18 226 | - |
| Interest received - investment | 1 486 402 | 194 489 |
| Government grants & subsidies | 100 195 453 | 88 906 000 |
| | **101 700 081** | **89 100 489** |

**Other revenue consists of:**

| | | |
|---|---|---|
| Proceeds from insurance claim | 17 099 | - |
| Fees charged in terms of PAIA | 1 127 | - |
| | **18 226** | **-** |

**The amount included in revenue arising from non-exchange transactions is as follows:**

**Transfer revenue**

| | | |
|---|---|---|
| Government grants & subsidies | 100 195 453 | 88 906 000 |

## 13. Investment revenue

**Interest revenue**

| | | |
|---|---|---|
| Bank | 1 486 402 | 194 489 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|
| Interest from Standard Bank investment account. | | |

## 14. Government grants and subsidies

| | | |
|---|---|---|
| **Operating grants** | | |
| Government grant | 100 195 453 | 88 906 000 |

## 15. Compensation of employees

| | | |
|---|---|---|
| Basic salary | 40 039 618 | 27 385 147 |
| Service and performance bonuses paid | 2 421 566 | 2 987 940 |
| Medical aid - employer contributions | 1 339 402 | 1 203 571 |
| UIF- employer contribution | 95 232 | 38 944 |
| Workmen compensation fund | 75 819 | - |
| Leave paid and provided for | 45 715 | 534 780 |
| Pension-employer contribution | 5 002 365 | 3 481 124 |
| Long-service awards | 9 291 | - |
| Other non-pensionable allowances | 5 365 199 | 2 923 030 |
| Bargaining council | 2 905 | 3 372 |
| Salary accrual | - | 124 511 |
| Provision for performance bonuses | 779 112 | 796 506 |
| | **55 176 224** | **39 478 925** |

## 16. General expenses

| | | |
|---|---|---|
| Advertising | 412 337 | 1 194 149 |
| Audit costs (refer to note 17) | 1 101 065 | 814 872 |
| Bank charges | 54 183 | 57 331 |
| Cleaning services | 130 064 | 65 411 |
| Consulting and professional fees | 1 204 160 | 6 283 119 |
| Inventory and other consumables | 545 416 | 178 469 |
| Legal fees | 128 103 | - |
| Insurance | 118 088 | - |
| IT maintenance and support | 294 885 | 79 308 |
| Marketing and publication costs | 1 649 414 | 236 392 |
| Motor vehicle expenses | 2 236 | - |
| Staff relocation | 172 414 | 49 412 |
| Postage and courier | 28 275 | - |
| Printing and stationery | 586 947 | 467 749 |
| Telephone communication costs | 1 265 122 | 623 211 |
| Training and skills development | 775 331 | 834 619 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 16. General expenses (continued)

| | | |
|---|---|---|
| Travel, subsistence and accommodation (refer to note 34) | 14 649 461 | 7 861 008 |
| Office utensils | 40 271 | 167 814 |
| Water and electricity | 337 449 | 184 648 |
| Penalty and interest | 28 545 | 5 884 |
| Catering services | 121 029 | 289 810 |
| Operating lease costs | 1 788 555 | 1 416 204 |
| Gain/(loss) from transfer of function (refer to note 20) | (67 978) | 27 134 |
| Loss or theft of assets | 46 238 | - |
| Venues and facilities | 1 589 428 | 212 287 |
| | **27 001 038** | **21 048 831** |

## 17. Audit costs

| | | |
|---|---|---|
| Internal audit | 483 552 | 459 905 |
| External audit | 617 513 | 354 967 |
| | **1 101 065** | **814 872** |

## 18. Operating lease commitments

### 18.1 Operating lease liability - Office space

| | | |
|---|---|---|
| Escalation rate | 10% | |

**Future minimum lease payments**

| | | |
|---|---|---|
| Up to one year | 855 825 | 1 123 274 |
| Within two years to five years | - | - |
| | **855 825** | **1 123 274** |

The OHSC had an outstanding commitment in respect of lease of office space with the South African Medical Research Council. The lease agreement was entered into for a period of two (2) years effective from 01 March 2015 to 28 February 2017.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 18. Operating lease commitments (continued)

### 18.2 Operating lease liability - Photocopying machines

| | | |
|---|---|---|
| Escalation rate | 8% | |
| **Future minimum lease payments** | | |
| Up to 1 year | 215 986 | 76 695 |
| 2 - 5 years | 231 661 | 122 633 |
| | **447 647** | **199 328** |

## 19. Cash generated from operations

| | | |
|---|---|---|
| Surplus | 16 193 972 | 26 487 862 |
| **Adjusted for:** | | |
| Depreciation and amortization | 1 751 834 | 655 203 |
| Movements in operating lease assets and accruals | (226 330) | 293 771 |
| Movements in provisions | 150 598 | 2 310 203 |
| Adjustment for gain (loss) from transfer of functions included in the surplus | (67 979) | 27 134 |
| Adjust for depreciation on assets lost | (8 821) | - |
| **Changes in working capital:** | | |
| Receivables from exchange transactions | (3 232 274) | (62 050) |
| Other receivables from non-exchange transactions | (49 852) | (26 410) |
| Payables from exchange transactions | 2 014 577 | 6 100 743 |
| Adjustment for cost of lost assets | 55 058 | - |
| | **16 580 783** | **35 786 457** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 20. Financial instruments disclosure

### Categories of financial instruments

**2017**

**Financial assets**

| | At amortised cost | Total |
|---|---|---|
| Trade and other receivables from exchange transactions | 3 296 132 | 3 296 132 |
| Other receivables from non-exchange transactions | 74 452 | 74 452 |
| Cash and cash equivalents | 43 534 859 | 43 534 859 |
| | **46 905 443** | **46 905 443** |

**Financial liabilities**

| | At amortised cost | Total |
|---|---|---|
| Trade and other payables from exchange transactions | 8 182 759 | 8 182 759 |

**2016**

**Financial assets**

| | At amortised cost | Total |
|---|---|---|
| Trade and other receivables from exchange transactions | 63 858 | 63 858 |
| Other receivables from non-exchange transactions | 24 600 | 24 600 |
| Cash and cash equivalents | 32 149 886 | 32 149 886 |
| | **32 238 344** | **32 238 344** |

**Financial liabilities**

| | At amortised cost | Total |
|---|---|---|
| Trade and other payables from exchange transactions | 6 394 513 | 6 394 513 |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 21. Transfer of functions between entities under common control

### Value of the assets acquired and liabilities assumed

### Nature of transfer

Entities involved in the transfer of functions were the NDoH (transferor) and the OHSC (acquirer). The functions relating to the monitoring and enforcing compliance by the health establishments with the health norms and standards were transferred to the OHSC. The transfer was in terms of the National Health Amendment Act 12 of 2013. The transfer became effective from 01 April 2015.

### Value of the assets acquired and liabilities assumed

| | | |
|---|---|---|
| Assets acquired | | |
| Property plant and equipment | 67 978 | 1 151 521 |
| **Liabilities assumed** | | |
| Provision for leave | - | 1 178 655 |
| **Difference between the assets and liabilities transferred** | **67 978** | **27 134** |

## 22. Commitments

### Authorised capital expenditure

The following capital commitments were made by year-end, but the services would be rendered after the end of the financial year

### Approved expenditure

| | | |
|---|---|---|
| **Capital expenditure** | **647 130** | **267 430** |

## 23. Contingencies

No provision for contingencies has been made as at 31 March 2017.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 24. Related parties

The OHSC has a related party relationship with the NDoH as the Executive Authority of the entity. It further has a related party transaction with Medical Research Council of South African through the lease of office space. The OHSC and the Medical Research Council of South Africa report under the same Executive Authority.

**Related party transactions**

| | | |
|---|---|---|
| **Grant received** | | |
| National Department of Heath | 100 195 543 | 88 906 000 |
| **Reimbursement** | | |
| National Department of Health | 29 090 662 | 31 072 341 |
| **Outstanding balance owed to:** | | |
| National Department of Health | 2 120 549 | 3 296 271 |
| **Amount owed from:** | | |
| National Department of Health | 71 917 | - |
| **Medical Research Council** | | |
| Rental of office space | 2 871 119 | 1 671 734 |
| Leasehold improvements | - | 843 777 |
| Computer equipment (switches for the server) | - | 315 194 |

| Non-executive members | Board fees | Reimbursement | Total |
|---|---|---|---|
| Prof. L Mazwai (Chairperson of the board) | 162 623 | 77 916 | 240 539 |
| Prof. S Essack * | 43 845 | 5 083 | 48 928 |
| Dr. Z Brey | - | - | - |
| Prof. L Rispel | 70 120 | 6 913 | 77 033 |
| Mr. M Kuscus * | 61 632 | 6 497 | 68 129 |
| Ms. J Mabotja * | 62 562 | 2 121 | 64 683 |
| Prof. S Whittaker | 40 918 | - | 40 918 |
| Dr. E Stellenberg | 118 108 | 7 247 | 125 355 |
| Adv. S Lebala SC * | - | - | - |
| Ms. T Gwagwa * | 80 577 | 31 575 | 112 152 |
| Prof. G van Zyl * | 23 898 | - | 23 898 |
| Mr. A Hoosain ** | 4 422 | 231 | 4 653 |
| Dr. B Masuku | 9 246 | 1 370 | 10 616 |
| Ms. O.A Montshiwa (Deputy Chairperson of the Board) ** | 18 246 | 536 | 18 782 |
| Mr. B Pharisa ** | 10 854 | 660 | 11 514 |
| | **707 051** | **140 149** | **847 200** |

* Appointed till 31 December 2016
** Appointed from January 2017

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 24. Related parties (continued)

| Executive managers | Basic salary | Pension fund | Non-pensionable allowances and other payments | Service & perfor-mance bonuses | Reimbursements | Total |
|---|---|---|---|---|---|---|
| Mr. B Msibi (Acting Chief Executive Officer) | 754 441 | 98 077 | 482 605 | 169 189 | 42 009 | 1 546 321 |
| Prof. M Makgoba (Ombud) * | 1 106 024 | - | 504 271 | - | 12 318 | 1 622 613 |
| Mr. J Mapatha (Chief Financial Officer) | 744 719 | 99 641 | 204 926 | 107 792 | 13 701 | 1 170 779 |
| Ms. W Moleko (Executive Manager: HSDAS) ** | 498 663 | 64 826 | 126 901 | 41 555 | 5 203 | 737 148 |
| | **3 103 847** | **262 544** | **1 318 703** | **318 536** | **73 231** | **5 076 861** |

* Appointed From 1 June 2016

** Appointed from 1 August 2016

## 25. Risk management

### Financial risk management

The OHSC's activities expose it to a variety of financial risks: market risk (interest rate risk, cash flow interest rate, credit risk and liquidity risk).

### Liquidity risk

The entity's risk to liquidity is a result of the funds available to cover future commitments. The entity manages liquidity risk through an ongoing review of future commitments and credit facilities.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

## 25. Risk management (continued)

| At 31 March 2017 | Less than 1 year | Between 1 and 2 years | Between 2 and 5 years | Over 5 years |
|---|---|---|---|---|
| Current liabilities | 11 822 215 | - | - | - |

### Credit risk

Credit risk consists mainly of cash deposits and cash equivalents. The OHSC only deposits cash with major banks with high quality credit standing and limits exposure to any one counter-party.

### Market risk

### Interest rate risk

By the end of the financial, the OHSC had significant cash invested in a short-term investment account. The OHSC generally adopts an approach ensuring that its exposure to changes in interest rate is on a floating rate basis. The OHSC does not have any interest-bearing borrowings and as a result there is no adverse exposure relating to interest rate movements in borrowings.

## 26. Going concern

The annual financial statements have been prepared on a going concern basis and the Accounting Authority has no reason to believe that the entity will not be a going concern in the foreseeable future.

This basis presumes that funds will be available to finance future operations and that the realization of assets and settlement of liabilities, contingent obligations and commitments will occur in the ordinary course of business.

## 27. Events after the reporting date

The Accounting Authority is not aware of any matter or circumstance arising since the end of the financial year that needs to be disclosed in the annual financial statements.

## 28. Unauthorised expenditure

No unauthorised expenditure was incurred during the financial year.

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 29. Fruitless and wasteful expenditure

| | | |
|---|---|---|
| Opening balance | 5 884 | - |
| For the year | 53 110 | 5 884 |
| Condoned by the Board during the year | (5 884) | - |
| | **53 110** | **5 884** |

The penalty and interest of R 28 545 was incurred as a result of a partial late payment made to SARS by cheque. An investigation is underway.

An amount R 24 565 was as result of leave pay and acting allowance which were incorrectly calculated. Measures are being taken to recover the amounts.

## 30. Irregular expenditure

| | | |
|---|---|---|
| Opening balance | 1 963 263 | - |
| Add: Irregular Expenditure - current year | 2 871 119 | 1 963 263 |
| | **4 834 382** | **1 963 263** |

The OHSC was listed in accordance with the PFMA as a Schedule 3A public entity in May 2014. The NDoH requested the OHSC to move out of their office space as soon as possible, and this required the OHSC to find alternative office space on a temporary basis until a long-term arrangement is made. The office that was immediately available was found at the South African Medical Research Council, and the OHSC entered into a lease for this office space for a period of one year, which was subsequently extended by another year. The decision was taken and approved by the accounting authority of the OHSC. The irregular expenditure is awaiting condonement from the National Treasury which was applied for in September 2016.

## 31. Reconciliation between budget and statement of financial performance

Reconciliation of budget surplus/deficit with the surplus/deficit in the statement of financial performance:

| | | |
|---|---|---|
| Net surplus per the statement of financial performance | 16 193 971 | 26 487 862 |
| **Adjusted for:** | | |
| (Over)/ under collection | (1 504 628) | (194 489) |
| Over/ (under) budget expenditure | (6 100 174) | (21 929 550) |
| (Over)/ under collection of Government grant and subsidies | 339 547 | - |
| **Net surplus per approved budget** | **8 928 717** | **4 363 823** |

# NOTES TO THE ANNUAL FINANCIAL STATEMENTS

| Figures in Rand | 3 1 March 2017 | 3 1 March 2016 |
|---|---|---|

## 32. Board fees and related expenses

| | | |
|---|---|---|
| Board fees and reimbursements | 847 200 | 832 107 |
| Other expenses | 729 814 | 597 562 |
| | **1 577 014** | **1 429 669** |

## 33. Budget differences Material differences between

### Material differences between budget and actual amounts

### Compensation of employees

- The process for the recruitment of the Chief Executive Officer was underway by the end of the financial year.
- The recruitment for the positions of Ombud and Executive Manager: HSDAS was finalised during the course of the year, thus savings were incurred for the period they were vacant. This also applies to several other positions which were finalised mid-year.
- There were six (6) vacant positions by year end.

### Goods and services

- The major contributor for the over-expenditure was the Compliance Inspectorate division due to the inspection and re-inspection targets being exceeded. However, this expenditure was defrayed from the prior year's surplus.

### Capital expenditure

- Budgetary provision was made for the procurement of the server infrastructure, which by year end was undergoing the procurement process, and would be finalised in the new financial year.

### Travel, Subsistence and Accommodation

| | | |
|---|---|---|
| Travel | 6 819 186 | 3 500 929 |
| Accommodation | 5 674 972 | 3 168 872 |
| Subsistence | 2 155 303 | 1 191 207 |
| | **14 649 461** | **7 861 008** |

# Notes

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# ANNUAL REPORT
# 2016/17

OHSC

Office of Health Standards Compliance

Ensuring quality and safety in health care