INVESTIGATION REPORT INTO ALLEGATIONS AGAINST RAHIMA MOOSA MOTHER AND CHILD HOSPITAL (RMMCH)

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OHO
Office of the Health Ombud

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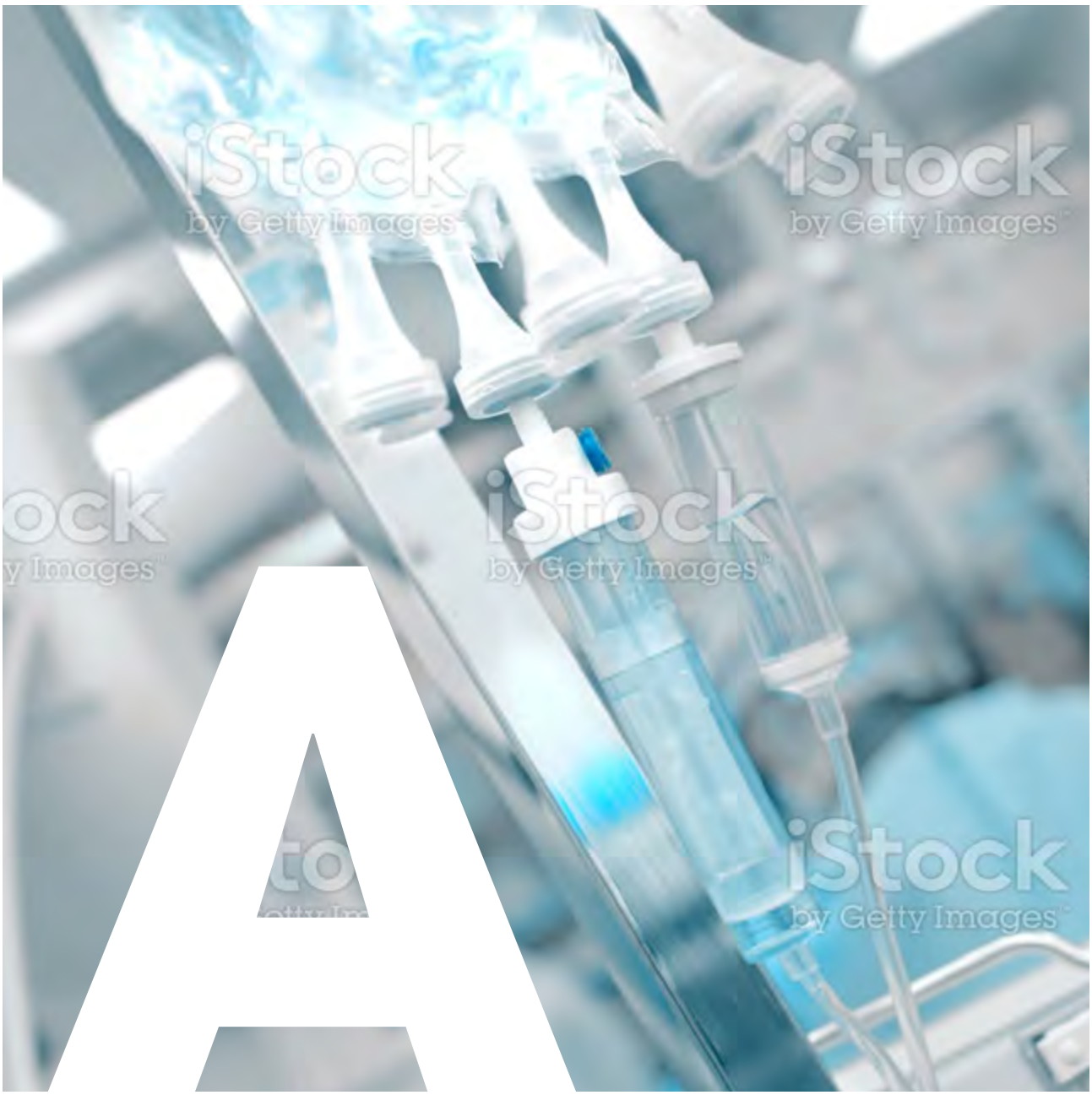

Annexure

From: Haseenabanu Ismail <hismail@parliament.gov.za>
Sent: 05 April 2022 14:17
To: Linda Jiyane <ljiyane@ohsc.org.za>; Prof Malegapuru Makgoba <mmakgoba@ohsc.org.za>
Subject: Rahima Moosa hospital.

Good afternoon

Trust you are well.

There has been various records in the media regarding issues at Rahima Moosa hospital.

Expectant mothers sleep on the floors of the Rahima Moosa Mother and Child Hospital in west Johannesburg, but Hospital CEO Nozuko Mkabayi spends aboul a third of her time working from home.

According to information received , Mokgethi, Mkabayi was appointed as CEO on 1 January last year, and since then she has only spent 182 days at the hospital.

I am astounded that a hospital CEO is not full-time at the hospital to ensure that everything runs smoothly.

No wonder she doesn't know that pregnant women sleep on the floor at the hospital

Doctors and nurses do not have the luxury of working from home, so how can a hospital chief set such a poor example?

I do not know of any other hospital CEO who worked from home even during the worst period of the Covid epidemic.

Not only are the dignity and health of the patients severely affected, but the well-being of the Health care workers at Fatima Rahim must also be addressed.

We understand that Rahima Moosa Mother and Child Hospital have seen an increase in patient load with no increase in infrastructure development and has only two maternity obstetric units.

We also note that the hospital is classified as a specialised hospital, and the majority of patients have been referred from smaller facilities such as clinics.

There are obviously conditions of being chronically understaffed and under- resourced, however , the hospital cannot allow expectant mothers to sleep on the floor.

Please investigate this matter as a matter of priorit. Every life matters.

htt s://www.news24.com/news24/SouthAfrica/News/watch- re nant-women-slee in -on-the-floor-at-obur -hos ital-20220402?s=08

KIND REGARDS

Haseena Ismail

Member of Parliament

Member of Health Portfolio Committee

hismail@parliament.gov.za

0860437915

B

Annexure

Ihovisi Lelulandela Amaqophelo Ezempilo
Office of the Health Ombud
Kantoro ya Mookamedi wa Maphelo

Physical Address: Office of Health Ombud | 79 Steve Biko Road | PRINSHOF
PRETORIA | SOUTH AFRICA
Postal Address: Private Bag X21 | ARCADIA | 0007

Dr. Nomonde Nolutshungu
The Acting Head of Department
Gauteng Department of Health
Private Bag X086
Marshalltown
2107

Our Reference: 32357

Dear Dr. Nolutshungu,

NOTICE OF COMPLAINT: ALLEGATIONS LEVELLED AGAINST RAHIMA MOOSA MOTHER AND CHILD HOSPITAL.

1. The Office of Health Ombud ("OHO") has received a complaint against Rahima Moosa Mother and Child Hospital from the Honourable Ms. Haseena Ismail, Member of Parliament, who alleged that:
   1.1. Expectant mothers sleep on the floors of the Rahima Moosa Mother and Child Hospital. The following is the newspaper article link to the story: https://www.news24.com/news24/SouthAfrica/News/watch-pregnant-women-sleeping-on-the-floor-at-joburg-hospital-20220402?s=08.
   1.2. The Hospital CEO, Dr. Nozuko Mkabayi, is not full-time at the hospital to ensure that everything runs smoothly. Since the CEO was appointed on 01 January 2021, she has only spent 182 days at the hospital.
   1.3. The dignity and health of the patients are severely affected, as well as the well-being of the Health care workers.
   1.4. Rahima Moosa Mother and Child Hospital have seen an increase in patient load with no increase in infrastructure development and have only two maternity obstetric units.
   1.5. The hospital is classified as a specialised hospital, and the majority of patients have been referred from smaller facilities such as clinics.

2. In terms of Section 81A (1) of the National Health Act, 2003 (as amended), the Ombud may, on receipt of a written or verbal complaint relating to norms and standards, or on his or her own initiative, consider, investigate and dispose of the complaint in a fair, economical and expeditious manner.

3. Considering this background, the Ombud kindly requests the health establishment to provide the OHO with a report and the supporting documents relating to this complaint within fourteen (14) working days from receipt of this notice.

We trust that the above is in order

Yours faithfully,

PROF. MALEGAPURU MAKGOBA
HEALTH OMBUD
DATE: 26/09/2022

Annexure

OHO
Ithhovisi Lokulandela Amaqophelo Ezempilo
Office of the Health Ombud
Kantoro ya Moyekateki wa Maphelo

Physical Address: Office of Health Ombud | 79 Steve Biko Road | PRINSHOF
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Dr Nomonde Nolutshungu
The Acting Head of Department
Gauteng Department of Health
Private Bag X 085
Marshalltown
2107

Our reference 32357

Dear Dr. Nolutshungu,

RE: FINAL NOTICE AND REMINDER REGARDING ALLEGATIONS LEVELLED AGAINST RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

1. The Office of the Health Ombud ("OHO") received a complaint from the Honourable Ms Haseena Ismail, Member of Parliament.
against your health establishment; Rahima Moosa Mother and Child Hospital.

2. Subsequently on 16 April 2022, a notice of complaint was transmitted to your office. However, to date, the OHO has not received any response to the complaint and/or allegations.

3. In terms of section 89(1)(h) of the National Health Amendment Act (NHAA), 2013 (Act No. 12 of 2013), any person who interferes with, hinders or obstructs the Ombud or any other person rendering assistance or support to the Ombud when he or she is performing or exercising a function or power under this Act, is guilty of an offence. The OHO views your failure to respond as interference, hindrance or obstruction in the performance or exercise of his function.

4. The OHO urges you to expeditiously deal with the matter and furnish us with the requested information and documentation. You are therefore given a final opportunity to submit the said information within three (3) working days from the date of this notice, failing which the Ombud will invoke the provisions of section 81A (4) NHAA.

5. The OHO is mindful of the COVID-19 pandemic which calls for the repurposing of the health system; however, it is still critical for safe and quality care to be maintained during these challenging times and you are requested to provide the required information within the expected timelines.

We trust that the above is in order.

Yours faithfully,

DR. D. JACOBS
EXECUTIVE MANAGER: COMPLAINTS MANAGEMENT AND OMBUD
DATE: 24/05/2022

D

Annexure

Ihhovisi Lokulandela Amaqophelo Ezempilo
Office of the Health Ombud
Kantoro ya Mosekaseki wa Maphelo

Physical Address: Office of Health Ombud | 79 Steve Biko Road | PRINSHOF
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Postal Address: Private Bag X21 | ARCADIA | 0007

Dr Nomonde Nolutshungu
The Acting Head of Department
Gauteng Department of Health
Private Bag X 085
Marshalltown
2107

Our reference 32357

Dear Dr. Nolutshungu,

NOTICE OF INVESTIGATION IN TERMS OF REGULATION 43 RELATING TO ALLEGATIONS AGAINST RAHIMA MOOSA, MOTHER AND CHILD HOSPITAL, GAUTENG PROVINCE.

1. The Office of the Health Ombud (OHO) has previously issued a Notice of Complaint against Rahima Moosa Mother and Child Hospital dated 26 April 2022. A Final Notice and Reminder were sent on 20 May 2022. The requested report was not received, and we have determined that there is a need to conduct an investigation.

2. In conducting an investigation, the Ombud will be assisted by the Investigator who has been seconded by the Office with the concurrence of the Ombud in terms of section 81(3)(c) of the National Health Amendment Act (NHAA), 12 of 2013. The Investigator will be conducting on-site investigation at your health establishment from 15 June 2022. The Investigator has authority in terms of Section 81A (3) (b) of the NHAA to –
   (i) obtain an affidavit or a declaration from any person.
   (ii) direct any person to appear before him or her.
   (iii) direct any person to give evidence or produce any document in his or her possession or under his or her control which has a bearing on the matter under consideration or investigation.
   (iv) interrogate such person.
   (c) request an explanation from any person who he or she reasonably suspects of having information which has a bearing on the matter under consideration or which is being or to be investigated; and

(d) require any person appearing as a witness to give evidence under oath or after having made an affirmation.

3. The health establishment management, as well as employees, are requested to cooperate and give access to the required information which may be necessary to finalize the investigation.

4. Kindly be informed that in terms of Section 89 (1)(h) of the NHAA, any person who interferes with, hinders, or obstructs the Ombud or any person rendering assistance or support to the Ombud when he or she is performing or exercising the function or power under this Act, is guilty of an offence. In terms of subsection (2) of this Act, any person convicted of an offence in terms of subsection (1)(h) above is liable on conviction to a fine or imprisonment for a period not exceeding 10 years or both the fine and imprisonment.

5. We trust that the above is in order.

Yours faithfully,

DR. D. JACOBS
EXECUTIVE MANAGER: COMPLAINTS MANAGEMENT AND OMBUD
DATE: 10/06/2022

Annexure

SUID-AFRIKAANSE POLISIEDIENS

SWORN AFFIDAVIT

SOUTH AFRICAN POLICE SERVICE

SOPHIATOWN SAPS

NAME: Nicolette Carol Dick ID NUMBER: 711209 0065 083

RESIDENTIAL ADDRESS: C/o Rahima Moosa Mother & Child Hospital

TEL NO: (011) 488-9913

STATE UNDER OATH: In my capacity as HR Officer at Rahima Moosa Mother and Child Hospital, that the facts contained herein are within my own personal knowledge and are to the best of my belief both true and correct unless specifically otherwise indicated. About February of 2022, I received an instruction from my acting HR Manager Mr Qasim Bowes to release a personal file belonging to Dr NP. Mkabayi to the office of the CEO. I confirm further that the file was indeed released to the office of the CEO. It is to the best of my knowledge that the file has not been returned back to HR.

SOUTH AFRICAN POLICE SERVICE
SOPHIATOWN
11 JUL 2022
CSC
SUID-AFRIKAANSE POLISIEDIENS

DATE: 11.07.2022 SIGNATURE:

I CERTIFY THAT BEFORE ADMINISTRATING THE OATH, I ASK THE DEPONENT THE FOLLOWING QUESTIONS AND WRITE HIS/HER ANSWER IN HIS/HER PRESENCE.

1. DO YOU KNOW AND UNDERSTAND THE CONTENTS OF THIS DECLAREATION? YES/NO Yes
2. DO YOU HAVE ANY OBJECTION IN TAKING THE PRESCRIBED OATH? YES/NO No
3. DO YOU CONSIDER THE PRESCRIBED OATH TO BE BINDING ON YOUR CONSCIENCE? YES/NO Yes

COMMISSIONER OF OATH

NAME: Sgt Mokwena

RANK: Sgt

FORCE NO: 611507

SOUTH AFRICAN POLICE SERVICE
SOPHIATOWN
11 JUL 2022
CSC
SUID-AFRIKAANSE POLISIEDIENS

BACK TO BASICS

Annexure

OHO
Ibhovisi Lokulandela Amaqophelo Ezempilo
Office of the Health Ombud
Kantoro ya Mosekaseki wa Maphelo

Physical Address: Office of Health Ombud | 79 Steve Biko Road | PRINSHOF
PRETORIA | SOUTH AFRICA
Postal Address: Private Bag X21 | ARCADIA | 0007

INVESTIGATIONS INTO ALLEGATIONS LODGED AGAINST RMMCH.

LIST OF INTERVIEWEES

NO	Name and Surname	Designation	Date of interview
1.	Hon. Haseena Ismail	Member of the National Assembly (Complainant)	04 August 2022
2.	Mr. Siphelele Zwane	CEO Personal Assistant	10 August 2022
3.	Ms. Lesley Anthea Rose	Deputy Manager Nursing	10 August 2022
4.	Dr. Frew Gerald Benson	Senior Clinical Manager	12 August 2022
5.	Dr. Nozuko Precious Mkabayi	Chief Executive Officer	12 August 2022
6.	M. Thobani Ndlovu	Security Guard - Gate 3	16 August2022
7.	Mr. Themba Mkwanyama	NEHAWU - Chairperson	16 August2022
8.	Mr. Mfuno Khosa	Professional Nurse – Prenatal Ward (High Risk)	17 August 2022
9.	Mr. Mzwaidume Phello Doda	Assistant Director- Labour Relations	17 August 2022
10.	Ms. Dzivhulwani Mukwevho	Professional Nurse – Prenatal Ward (High Risk)	17 August 2022
11.	Ms. Peggy Bella Tserema	Assistant Manager Nursing	18 August 2022
12.	Ms. Makhosazana Tsibu	Risk/Communication Officer	18 August 2022
13.	Ms. Portia Mabengwana	Security Guard – Emergency Department	23 August 2022
14.	Ms. Lizzy Mavhasa	Security Guard – Prenatal Ward (High Risk)	23 August 2022
15.	Mr. Marcus Khensani Ndlovu	DENOSA - Chairperson	23 August 2022
16.	Mr. Gustave Cilliers	Assistant Director – Facility Management	24 August 2022
17.	Mr. Tyrone Wessels	Administration Manager	26 August 2022
18.	Mr. Theo Ernest Van Wyk	Assistant Director - Finance	26 August 2022
19.	Dr. Ammy Wise	Acting HOD- Obstetrics and Gynaecology	29 August 2022
20.	Ms. Lorreta Louw	Assistant Director – Human Resource	31 August 2022
21.	Ms. Mbulaheni Rhona Luphai	Quality Assurance Manager	01 October 2022
22.	Ms. Belinda Minnie Lorraine Williams	Professional Nurse – Infection Prevention Control	04 October 2022

23.	Ms. Thembela Guduka	Operational Nursing Manager – Theatre Department	04 October 2022
24.	Ms. Eveline Hlungwani	Enrolled Nursing Assistant – Labour Ward	05 October 2022
25.	Ms. Naledi Permit Molla	Enrolled Nursing Assistant – Post-Natal Ward	05 October 2022
26.	Ms. Mary Paulsen	Professional Nurse – Labour Admission Ward	05 October 2022
27.	Ms. Lorreta Louw (Re-interview)	Assistant Director – Human Resource	12 October 2022
28.	Dr. Nomonde Nolutshungu	HOD – Gauteng Department of Health	19 October 2022
29.	Dr. Nomathemba Emily Mokgethi	Former MEC- Gauteng Province	19 October 2022
30.	Mr. Ashley Sauls	Former MMC – City of Johannesburg	26 October 2022
31.	Ms. Nazeerah Ismail	Patient at RMMCH	12 November 2022
32.	Ms. Salma Ismail	Relative of Ms. Nazeerah Ismail	12 November 2022
33.	Dr. Tim De Maayer	Paediatrician - RMMCH	15 November 2022
34.	Ms. Basani Baloyi	DDG- Cooperate SERVICES GDoH	29 November 2022
35.	Dr. Nozuko Precious Mkabayi (Re-interview)	Chief Executive Officer	29 November 2022

Annexure

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Mr V.R.P Skosana
Gauteng Legislature
Johannesburg
Private Bag X52
2000

RE: RESPONSE TO LEGISLATURE QUESTION 5. HL022 TABLED BY J B BLOOM OF THE DEMOCRATIC ALLIANCE (DA)

Regarding the Rahima Moosa Mother and Child Hospital:

(i) when did the switchboard break at this hospital;

The switchboard started giving problems in 2020 for incoming calls. It worked on and off for incoming and outgoing calls till June 2021 when it ceased to function for both. Internal lines in the hospital were functional and the switchboard was fixed on 11 March 2022 for both incoming and outgoing calls with the assistance of the Central office ICT team .

(ii) why has it not been fixed or replaced;

We are in the process of replacing the outdated system . The acquisition process is anticipated to be completed between April and May 2022 rafter which the hospital will be prioritized for implementation Central office technicians assisted the hospital and the switchboard was fixed on 11 March 2022 for both incoming and outgoing calls.

(iii) what alternative arrangements are in place for communication with this hospital;

All social media pages of the hospital and the local media were advised of alternative cellphone numbers that are available 24 / 7 for the public. The Management and CEO WhatsApp groups have been advised of the on call Matron number for facilities and EMS to use for referrals / queries . This number operates 24/ 7. Email addresses of the Quality Assurance team and their numbers have also been shared for the public 's use. The cellphone numbers of the Administration manager and Facility manager have also been circulated with the assistance of the Communications Directorate at central office. The hospital is procuring cellphones for all the critical wards and Departments in

the financial year 2022/2023. The CEO is available 24 hours on her cellphone and her details are on the Mpilo app of the Gauteng Department of Health.

(iv) are these regarded as satisfactory;

YES

(v) when was the CEO appointed at the hospital;

01 January 2021

(vi) How many days has she physically attended the hospital since then: 182 days

(vii) has she ever had permission to work from home;

The CEO was appointed in the middle of the second wave of Covid 19 pandemic . Like all SMS members she has permission to work from home as a result of the pandemic.

(viii) why has she been allowed to work from home since she was appointed ?

She was appointed in the middle of the covid 19 pandemic and like all SMS members she is allowed to work from home .

(viii) what monitoring system is there to ensure that she is at the hospital as required;

She has a work mobile phone on which she is accessible 24 hours. She has an email address that she is accessible on 24 / 7 on-site and offsite. All the responsibilities assigned to her have been diligently delivered

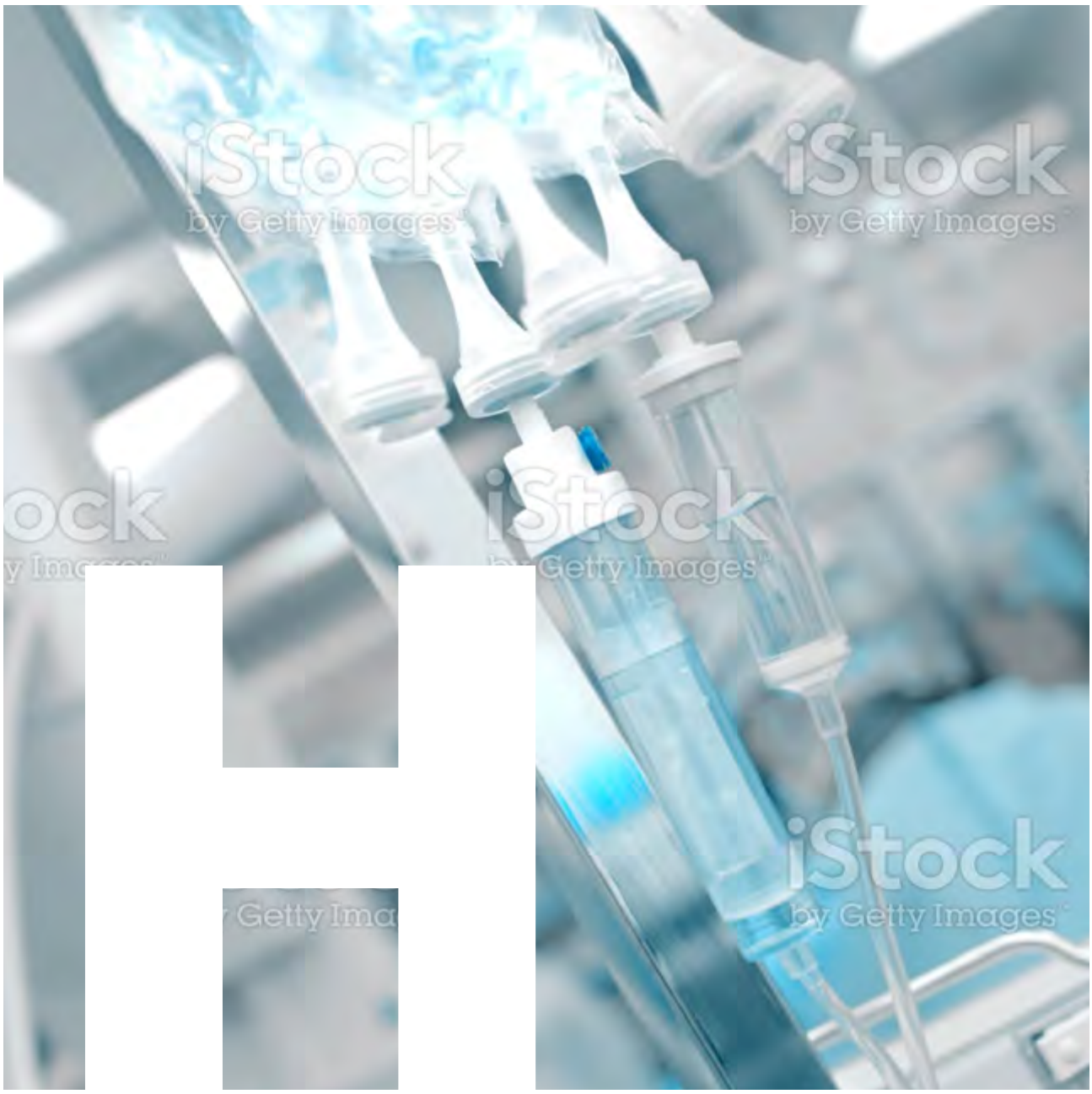
(ix) what steps are being taken to discipline the CEO and ensure she attends the hospital as required?

There has never been any misconduct reported against the CEO of Rahima Moosa Mother and Child hospital

Approved not approved / approved with amendments

Dr. N. E. Mokgethi (MPL)
MEC for Health:
Gauteng Date:
24/03/2022

Gauteng Department of Health
Office of the MEC
S.HL022



Annexure

Dear administrators,

Last week I attended the funeral of a 13-year-old patient of mine who I have looked after for years at Rahima Moosa Mother and Child Hospital.

Today I counselled two mothers, informing them that our resuscitation measures had been in vain.

I wish you could be there to see the pain and grief that these parents and their families go through.

Children are dying and the horrendous conditions in our public hospitals are contributing to their deaths.

I wish you could come to our unit and see doctors trying to intubate children and administer cardiopulmonary resuscitation by their mobile phone's torch, as the power has failed … again… Or the cold neonate whose incubator went off with the loss of power (from load shedding) and did not keep him warm.

How about excluding a mother-and-child hospital from your load shedding schedule? Our generators are unfortunately inadequately sized to supply the hospital.

I wish you could come and explain to parents that their child needs an urgent computerised tomography scan of the brain but he's going to have to wait, since our scanner has been broken for nearly three months, Chris Hani Baragwanath is overflowing, and Charlotte Maxeke has had crucial parts of its scanner stolen.

He ended up waiting for 48 hours, when the Nelson Mandela Children's Hospital managed to assist.

I wish you would come and look at the toilets when the water has been off because the local water reservoir was running low.

Or, even better, come and see how hospital-acquired infections spread like wildfire through the neonatal ward because the taps are dry, and washing your hands while lifting a five-litre water container after examining each child is just not feasible.

No, scrap that. Please come out of your ivory towers and come and use our lidless toilets. (There is one for fathers on the ground floor; the rest are off limits to men.)

Perhaps you could come and try to manage a critically ill little patient without the benefit of blood test results, as the National Health Laboratory Service's turnaround time is frequently more than 24 hours at our hospital.

Or see doctors drive around to different hospitals trying to acquire essential supplies that are not available at our hospital.

I could go on, but want to pose some questions to you:

Would you admit your child to this hospital?

Would you trust the overburdened and burnt-out healthcare staff to look after your little one in their hour of greatest need?

And if you wouldn't, how do you manage to come to work every day, fail at your job of ensuring basic healthcare for the people you serve and still sleep at night?

Having worked in the public sector for 21 years, I can tell you frankly: things are falling apart.

If your healthcare workers are the centre of providing care, we cannot hold. Things are going backwards, fast. The care that is being provided in your less than glittering hospitals is getting worse every day.

Are you worried about the greedy lawyers who are waiting in the wings, suing your department for millions because a premature infant went blind because there was no functional meter (which costs less than R1,000) monitoring her oxygen delivery?

You should be, because money is being wasted on paying negligence lawsuit compensations rather than preventing the problem in the first place.

And before you ask, yes, these issues have been raised with management repeatedly, including two reports on the critical state of the neonatal wards and obstetric services

in 2016 and 2021, and a more recent letter on 11 April 2022 detailing the disastrous state of the hospital.

The "correct procedures" have been followed, with no visible response. Have you read the reports?

I can predict your response: "Illegal foreigners are clogging the system."

Well, if you don't control the borders or have a functional Department of Home Affairs to deal with refugees, you cannot blame desperate and indigent people for trying to improve their lives and seek care when they or their children are ill.

The truth, though, based on Statistics South Africa data, is that at least half of the one million immigrants into Gauteng between 2016 and 2021 were from Limpopo, KwaZulu-Natal, Mpumalanga, and so on. Yes, South Africans.

Despite the ever-expanding demand for health services, the Gauteng Department of Health budget is decreasing in real terms.

And when the Covid-19 budget gets allocated, it goes to hospitals that are struggling to function, such as the Charlotte Maxeke Johannesburg Academic Hospital (CMJAH), and cuts out hospitals managing the redistributed workload such as Rahima Moosa Mother and Child Hospital.

Yes, I know you claim the CMJAH Emergency Department is "open", but since it only accepts patients stabilised at other hospitals, and the Gauteng emergency medical services are unable to provide ambulance transport within a reasonable time, it remains non-functional.

I'm sure district hospitals in Gauteng are feeling the same pain.

I'm fully aware we are not alone or special, and that other hospitals and different disciplines across them are facing equally atrocious conditions.

I do, however, have a calling; a calling to be a paediatrician and to provide the best care I can to our little patients, and a calling to advocate for those without a voice.

I guess your inaction and disregard for the health of children does not matter, since children cannot vote and so why should you bother to meet their needs?

While Nelson Mandela, Chris Hani, Charlotte Maxeke and Rahima Moosa are turning in their graves, disturbed by the dismal conditions at hospitals bearing their names, I want to reassure them that we, the frontline healthcare workers, will keep fighting to maintain the health and wellbeing of our vulnerable children.

But it would be nice if you did something too.

Dr Tim De Maayer is a paediatrician at Rahima Moosa Mother and Child Hospital, where he has worked since 2009. Before that, he worked in other public hospitals in rural Limpopo and trained at the University of the Witwatersrand. He is passionate about children's rights, health and wellbeing.

***This story first appeared on Daily Maverick.**

Note from Mark Heywood, the editor of Maverick Citizen

This article is a cry from the heart.

It arises from moral injury occasioned by silence, from a doctor's Hippocratic oath and after years of unsuccessful efforts by healthcare workers at Rahima Moosa Mother and Child Hospital to have the problems it describes attended to.

Knowing the risk of victimisation for speaking out, careful consideration and discussion with peers accompanied the decision to publish.

The best response of the Gauteng Department of Health and the hospital CEO to the article would be to admit and urgently fix the problems it raises, not shoot the messenger.

Annexure

WEEKLY TEST REPORT FOR POWER GENERATORS

GPW

TION RAHIMA MOOSA	MONTH AUGUST				HOURS		
NO.	MAKE VOLVO				KVA 650		
OF THE MONTH	01/08	08/08	15/08		22/08	29/08	
NG DATES	1st Week	2nd Week	3rd Week		4th week	5th Week	Total
luring week (No test)	3hrs 3mins	1hr 1hr	4hrs 4hrs		9hrs 11hrs		
ded during the week	NO	NO	NO		NO		
during week (liter)	NO	NO	NO		NO		
ded during week (liter)	NO	NO	NO		NO		
vater added	NO	NO	NO		NO		
heater function	YES	YES	YES		YES		
electrolite							
any water leaks? Yes/No	NO	NO	NOT SURE		NO		
fuel-pump switches oiled (Yes/No)	YES	YES	YES		YES		
t takes to start-up (Seconds)	45sec	45sec	45sec		45sec		
tempo at commencement of test (Amps)	N/A	N/A	N/A		N/A		
truments and alarms function (Yes/No)	YES	YES	YES		YES		
(1b/bar/kPa) (Yes/No)							
current consumption after 15 min (Amps):	Red	315A	315A	315A	318A		
	White	295A	295A	295A	295A		
	Blue	228A	228A	228A	228A		
on between phases:	Red	400V	400V	400V	400V		
	White	400V	399V	400V	400V		
	Blue	400V	400V	400V	400V		
ng tempo at conclusion of test (Amps) -Battery							
rature after 20min (°C/°F)							
30 minutes					15min		
aken to switch off					4min		
ency Hertz per second		50Hz	50Hz	50Hz	50Hz		

nician Rinandan Date 08/08/22

ature

MONTHLY REPORT FOR POWER GENERATORS

GPW

...ITUTION RAHIMA MOOSA	MONTH AUGUST	HOURS
...IAL NO.	MAKE VOLVO	KVA 650

	YES	NO
...ere any rust in the radiator?		✓
...he radiator clean?	✓	
...s the oil-pressure circuit funtion properly?	✓	
...ere any water in the fuel?		✓
...e the starting brushes been replaced?		✓
...solenoid been oiled?	✓	
...e the starter connections been checked?	✓	
...e the connections of the battery charger been checked?	✓	
...e exhaust pipe broken or rusty?		✓
...e inlet open?	✓	
...he ...let open?	✓	
...e machine clean?	✓	
...all the alarm indicator system funtion properly	✓	
...e the alternator 's connections been checked?	✓	
...e the alternator 's ball-bearing been lubricated?	✓	
...e the battery poles been cleaned?		✓
...e the battery-cable couplers been checked?	✓	
...e the battery antacid parts been replaced?		✓
...e battery has been replaced?		✓

...te of purchase of defective battery Yes/No Date..........................

...e following filters have been replaced Oil..........................

...el......NO. Air........NO Water......NO........

...e Machine vibration normal Normal..NORMAL Bad..........................

...e ...-vibration pedestals are: Good....GOOD Bad..........................

...e been replaced..

...there any leakage of oil? Yes/No Water..........................

...e starter bearings have been replaced Date..

...bricated Yes.......... No..........................

...e following instruments do not function:

...e following parts have been replaced during the month:

...emarks: NO TEST STILL WAITING FOR CONTRACTOR to come and Fix the generators. Since they fail to come 25JULY22 KVA Generators has been fixed and tested. On to 1/08/22. all working.

...echnician ....RAHMANDSU.......................... Date..01/08/22.........

...ignature ....[signature]..........................

J

Annexure

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Procedure for requesting hospital diversion

Requesting for diversion can only be arranged via Zone Matron to Superintendent on call and granted by MMO on call.

During office hours

- Hospital stats done and numbers checked depending on which department are requesting diversion after patients are mobilized to fill other wards and empty beds.
- Inform the superintendent on duty to request for diversion.
- Diversion may be requested if industrial action leads to interruption of service.

After hours

- Hospital stats done and numbers checked depending on which department are requesting diversion; patients are transferred to fill other wards and beds.
- Theatre being blocked by a patient may also be considered for hospital diversion after hours.
- If there is an unstable electricity supply and water outage.
- Where there is a backlog of emergency theatre cases and we do have beds.

Compiled By: Nursing Management and Clinical Managers

Signed By: _____ Date: 2022/06/20

Dr Frew Benson : Acting CEO

Annexure

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquiries : Mr. AV Mahlangu
Tel (011) 241 5780

Dr. NOZUKO PRECIOUS MKABAYI
(Through the Office of the Acting HOD: Health)

Dear Dr. Mkabayi

APPOINTMENT TO THE POST OF CHIEF EXECUTIVE OFFICER AT RAHIMA MOOSA MOTHER AND CHILD HOSPITAL.

1. It is a pleasure to inform you that approval is granted for your appointment to the position of Chief Executive Officer at Rahima Moosa Mother and Child hospital on a five (5) years performance-based contract.

2. Your appointment conditions of service will be governed by the Public Service Act, 1994 as amended, the Labour Relations Act, 1995 as amended, the Public Finance Management Act, 1999 and the Public Service Regulations, 2001 as amended. SMS handbook, Collective Agreements and any present or future amendments to the aforementioned Acts, Regulations and Instructions, including the attached Code of Conduct of employees in the Public Service.

3. Your appointment particulars are as follows:

Rank	: Chief Executive Officer
Post status	: Contract
Date of effect	: 01 January 2021 to 31 December 2026
Probation	: 12 Calendar months
Salary package	: R1 057 326 per annum (All-inclusive remuneration package)
Centre	: Rahima Moosa Mother & Child hospital
package Conditions	: You will qualify for an annual inflation related salary increase as determined by the Minister for Public Service and Administration. You will also qualify for notch increments and performance bonuses after performance evaluation, if the specific conditions on your performance agreement have been met.

4. The service benefits applicable to your post are as follows:

4.1 Vacation leave of 22 working days per annum (less than ten years in service).

4.2 Vacation Leave of 26 working days per annum (more than ten years in service)

4.3 Sick leave of 36 working days in a three-year cycle, which are non-accumulative.

4.4 Members of the SMS may structure their packages for a 13th cheque, but those who are not admitted to the GEPF may not structure their packages for a 13th cheque.

4.5 The employer contributes 13% of your pensionable emoluments to the Government Pension Fund (GEPF)

4.6 Membership to a medical scheme of your choice is optional. Should you join a medical scheme, the employer's contribution must be structured from the all-inclusive remuneration package.

4.7 Participation in the home-owner scheme is optional.

5. You will be required in terms of Regulation II of Chapter 4 of the Public Service Regulations to enter into a performance agreement with your Supervisor, as soon as you assume your duties in this position.

6. You will be required, on assumption of duty, to restructure your salary package to suit your needs. The software for structuring your package is available from the HR Managers. The services of a Tax Advisor can be obtained in this regard, but the manner in which the package is structured should be compliant to the Government's Personnel and Salary Administration System (PERSAL).

7. Your employment may be terminated under the following circumstances:

7.1 On reaching the end date of your term of contract, if applicable.

7.2 Discharge in terms of Section 17 of the Public Service Act, 1994 as amended.

7.3 Voluntary resignation, giving at least one (1) month's written notice of service termination.

8. The qualifications that have been submitted by you are accepted in good faith and will be verified by the Department. Misrepresentation in terms of qualifications constitutes fraud, which is a disqualifying factor in determining

a candidate's suitability, integrity and security competence and should this be the case, the Department will withdraw its offer of employment with immediate effect.

9. Misrepresentation or omission to mention previous offences cast doubt to an applicant's integrity, honesty and security competence. However, disclosure of previous offences will be

   treated on merit according to the guidelines from the Vetting Norms, Criminal Procedure Act and Departmental Disciplinary procedures.

10. Upon acceptance of the Department's offer and your subsequent appointment, this appointment letter will be regarded as your formal contract of employment.
11. If the salary offered in this letter proves to be erroneous, the Department retains the right to make the necessary adjustment and recover from you any amount that may have been overpaid, irrespective to the cause thereof, underpayment will similarly be paid to you.
12. You shall not without the expressed prior written consent of the Head of Department or delegated employee, perform or undertake to perform any remunerative work outside the Public Service, whether within or outside working hours.
13. You are requested to, within five (5) working days of receipt of this letter; indicate in writing whether you accept the offer.
14. The Department wishes to congratulate you on your appointment and wishes you success in your new work environment.

Yours faithfully

.....

Dr. NE Mokgethi, MPL
MEC: Gauteng Health
Date: 31/12/2020

Annexure

the dpsa

Department:
Public Service and Administration
REPUBLIC OF SOUTH AFRICA

Private Bag X916, PRETORIA, 0001. Tel: (012) 336 1000, Fax: (012) 326 7802
Private Bag X9148, CAPE TOWN, 8000. Tel: (021) 467 5120, Fax: (021) 467 5484

TO ALL HEADS OF DEPARTMENTS AND PROVINCIAL ADMINISTRATIONS

CIRCULAR NO 01 OF 2021

STATE OF DISASTER COVID-19: PUBLIC SERVICE ADJUSTMENTS TO RISK ADJUSTED LEVEL 3 REGULATIONS.

1. INTRODUCTION

1.1 On 11 January 2021, the President announced adjustments to the Cabinet Risk Adjusted Level 3 in response to the discovery of a new variant and an in increase in COVID-19 infections across the Republic.

1.2 A key aspect of the response is that all places of work should continue to have safety protocols in place adhered to in line with the revised Regulations.

1.3 This Circular is a guide to Heads of Department in the Public Service on the decongestion of workspaces through limiting the numbers of employees physically on-site as part of measures to comply with the Regulations to mitigate the effect of the resurgence of COVID-19 during Level 3.

1.4 The circular takes into consideration the service delivery obligations of Departments and the needs of service recipients.

2. KEY PRINCIPLES

Accounting Officers are required to ensure that administrative measures and tools are availed and put in place in each Department, using relevant applicable legal instruments to hold all government officials accountable for service delivery and lawful administrative practices whilst ensuring that they adhere to health protocols:

2.1 REMOTE WORKING ARRANGEMENTS

2.1.1 The Accounting Officer should ensure reduction of the occupancy rate to not more than 50% at any given time for public servants using shift work and remote working arrangements amongst others.

2.1.2 Due to the nature of their role – providing leadership and direction, Members of the Senior Management Service (SMS) are to be in the office at least three days a week. The enforcement of this clause should be applied on a case-by-case basis informed by the Department of Health's Guidelines on the management of risks and comorbidities.

2.1.3 Where employees are approved to work remotely, a Remote Working Contractual Agreement should be in place in order to manage accountability, performance and liabilities. There must be clear deliverables the Manager and employee agree to which can be tracked and accounted for.

2.1.4 Each Accounting Officer is responsible for determining eligible employees for Remote Work based on the nature of service mode and the availability of means/tools to work remotely including for office-based employees.

2.1.5 When determining the eligibility criteria, Accounting Officers should consider the nature of the work scheduling for office-based employees (i.e. security, administrators, cleaners, SCM etc.), as well as the availability of enabled systems. This must be done on a case by case basis after assessment of eligibility and the needs of mission critical functions which support essential services.

2.1.6 Accounting officer may also consider shift work for business continuity and to ensure the Department meets its service delivery commitments, guided by the relevant prescripts.

2.1.7 Where employees are unable to function due to impact or effect of Covid (e.g.quarantine or isolation), the Accounting Officer may consider job rotation to ensure business continuity and availability of services.

2.1.8 Accounting Officers should have a clear outline as to the consequences should employees fail to adhere to the content of the agreement or any other organisational rules while working remotely

2.2 ADMINISTRATIVE CONTROLS

2.2.1 Each Department should ensure that:

2.2.1.1 Both employees and employers benefit optimally from these practical and pragmatic arrangements, based on environmental contextual circumstances.

2.2.1.2 Provide a formal work scheduling arrangement between the employer and employee in order to ensure business continuity, non interruption of products and services and allow an employee to self-manage and perform without focusing narrowly on processes.

2.2.1.3 Provide legal administrative control instruments, to manage accountability of employment obligations during remote working arrangements.

2.2.1.4 Provide protocols where employees are placed in safe bubble workspaces due to vulnerabilities, or who are either infected or affected (either quarantine or isolation) based on assessed risks to others, using occupational health protocols, where they are still able to work remotely.

2.2.1.5 Minimise human contact with the use of digital virtual communication platforms to conduct operational decision making and response planning via conference calls and virtual meetings.

2.2.1.6 Provide digital housekeeping rules and data management protocols that should be made known to all staff in advance.

2.2.1.7 Provide necessary physical distancing ergonomics and Personal Protective Equipment (PPE) protocols according to categories of employee needs, not classified as essential services.

2.2.1.8 Ensure that Occupational Health and Safety compliance and risks to employees are managed.

2.3 LEAVE MANAGEMENT:

2.3.1 The application of the leave policy as previously covered in Circular 7 of 2020 and Circular 11 of 2020, read with the provisions in the Determination and Directive of Leave remain applicable for all categories of employee.

2.4 RESOURCES REQUIRED FOR REMOTE WORKING

2.4.1 Each Accounting Officer has responsibility to determine and ensure availability of identified and appropriate tools of trade for all employees approved for remote work, including measures to keep the team connected and employees informed of new developments regarding their work, Department, and the Public Service in general.

2.5 SECURITY AND CONFIDENTIALITY

2.5.1 For the integrity of the state and government information, security considerations should be kept at the forefront when approving remote working arrangements.

2.5.2 Protocols should be put in place for all employees to understand the requirements of the Minimum Information and Security Standards (MISS) and other relevant legal prescripts especially when working through unsecured Wi-Fi networks to do their work.

2.6 PERFORMANCE MANAGEMENT

2.6.1 Each Accounting Officer has responsibility to determine and ensure the adherence to Performance Management for all employees so as to ensure continued delivery of services and functioning of the Public Service;

2.6.2 All employees must adhere and attend to the necessary time-on-task, and delivery schedules as agreed upon contractually, with their immediate line manager or supervisor.

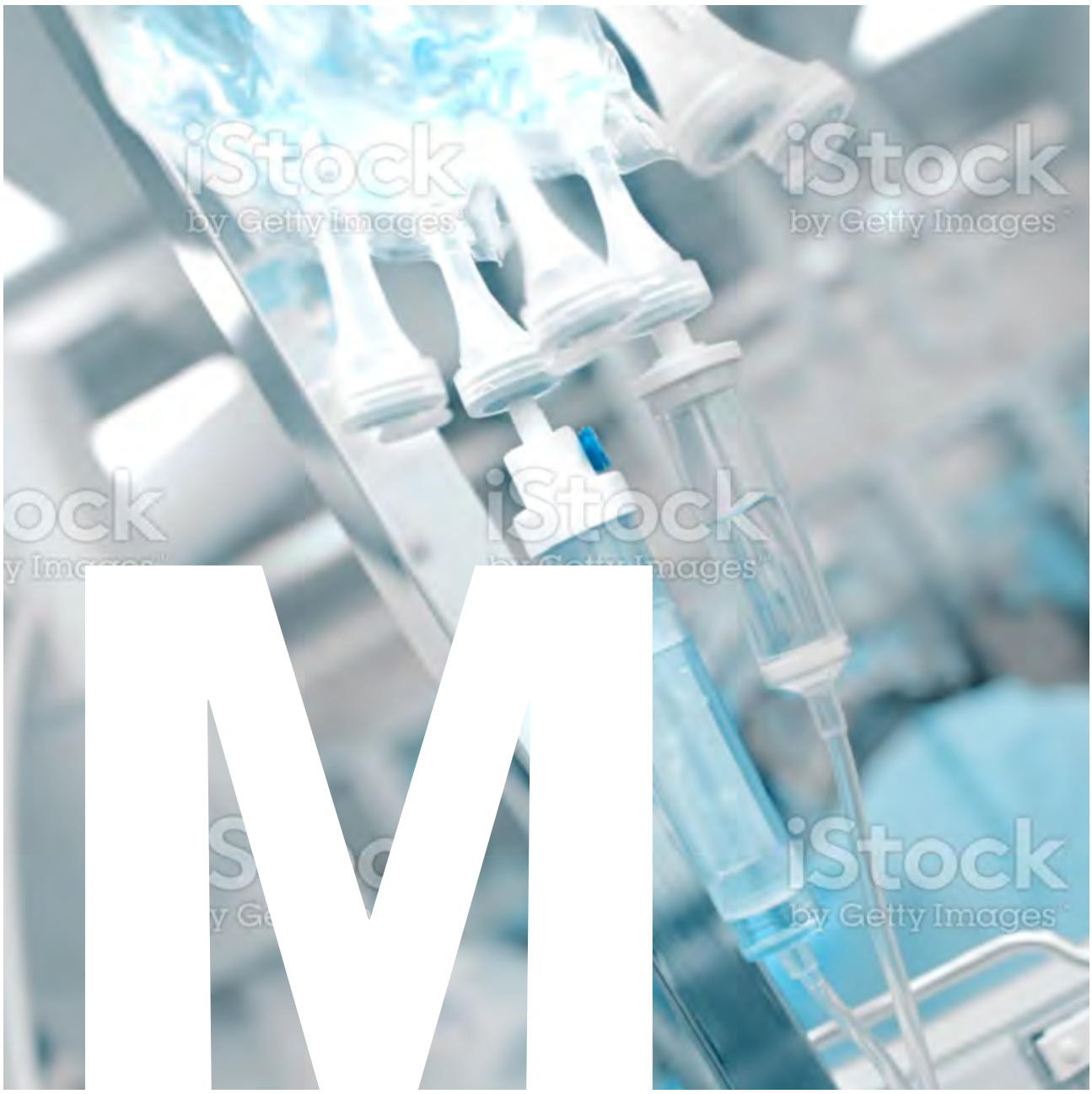
2.6.3 Each employee will have to have a formal Work Schedule based on his or her Key Performance Areas (KPA) and the expected delivery in his or her Key Result Areas (KRA) based on Key Performance Indicators (KPI).

2.6.4 An employee must observe the work hours determined by the relevant Head of Department in terms of Regulation 51 of the Public Service Regulations. The employee and department must agree as to what working hour schedule/arrangement, works productively best for both parties. Contact with employees outside of working hours should be minimised and avoided unless where it is mission critical.

3. All Heads of Departments, in dealing with risk assessment and the categorizing of employee comorbidities and vulnerabilities with respect to work, should use their discretion in dealing with matters which may not be specifically covered in this circular but which may be workplace, occupational or sector specific and in line with the delegated authority.

4. Accounting Officers retain the legal responsibility to determine workplace requirements and for ensuring the delivery of the full public service array. Taking into account the dynamic and fluid contextual circumstances arising from the declared National Disaster, Departments who are unable to implement the above provisions must provide reasons for such failure to the Minister for Public Service and Administration within two weeks of such matter arising.

MS YOLISWA MAKHASI
DIRECTOR-GENERAL
DATE: 13/01/2021



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Annexure

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Mr V.R.P Skosana
Gauteng Legislature
Johannesburg
Private Bag X52
2000

RE: RESPONSE TO LEGISLATURE QUESTION 5. Hl082 TABLED BY J B BLOOM OF THE DEMOCRATIC ALLIANCE (DA)

Regarding the appointment of Dr Nozuko Mkabayi as CEO of the Rahima Moosa;

(i) What process was followed in making this appointment;

Response:

1. The post was advertised in the Sunday Times Newspaper dated 31 June 2020 with the closing date of 05 June 2020. Shortlisting was conducted on 26 June 2020 and the interviews conducted on 13 August 2020.

2. Dr Mkabayi was recommended for the CEO post at Rahima Moosa Mothe & Child hospital based on the outcome of the interview process and competency assessment as well as the requirements.

(ii) what competency tests were carried out in this matter;

Response:

She was subjected to the compulsory DPSA SMS competency assessment

(iii) if not, why not;

Response:

See (ii) above

(iv) how did Dr Mkabayi score in the interview and overall process compared to the other applicants;

Response

We interviewed three candidates to fill three positions in three institutions, each was allocated to the hospitals.

(v) if she was not the highest scorer, why was she appointed;

Response

The appointment processes are not based only on the interview scores but on the technical exercise, competency assessment results and basic requirement. And allocated to the three institutions,

(vi) what positions has she previously held in the Gauteng Health Department;

Response:

a) Principal Medical Officer at Coronation (Rahima Moosa Mother & Child hospital)

b) Principal Medical Officer: Paediatrics and Casualty at Bheki Mlangeni District hospital.

(vii) in the case of each of the positions in (vi) above; what were the dates on which she was appointed;

Response:

a) 01 January 2002 to 31 December 2003

b) 12 May 2014 to 31 July 2014

(viii) in case of each of the positions in (vi) what was the reason for her change in post;

Response:

She resigned from the posts

(ix) at the previous hospital that she was at, what was her performance assessment; and

Response:

There is no evidence of performance assessment that could be found on her files

(x) what is the latest information about how many days she has been at work since she was appointed?

Response:

She has been at work for 346 days since she was appointed.

proved [not approved / approved with amendments

Dr. N. E. Mokgethi (MPL)
MEC for Health: Gauteng
Date: 08/08/2022

Annexure

DETERMINATION AND DIRECTIVE ON LEAVE OF ABSENCE IN THE PUBLIC SERVICE

DATE ISSUED: AUGUST 2021

MADE BY THE MINISTER FOR THE PUBLIC SERVICE AND ADMINISTRATION

TABLE OF CONTENTS

PART 1: TRANSITIONAL ARRANGEMENTS TO FACILITATE IMPLEMENTATION OF CHANGES TO THE LEAVE DISPENSATION

1. INTRODUCTION

1.1. This Part provides transitional arrangements in respect of those changes effected to the leave system that warrant special attention to facilitate proper/smooth implementation.

1.2. This Part must be read in conjunction with Part 4 of this document.

2. TRANSITIONAL ARRANGEMENTS TO FACILITATE IMPLEMENTATION OF PSCBC RESOLUTION 15 OF 2002

2.1 Annual leave for Non-teaching Staff at Schools/Training Institutions

2.1.1. All non-teaching staff at schools and training institutions is, for purposes of annual leave, now categorized in category 3 of Annexure A to this Determination and Directive. Please refer to Part 4 of this document.

2.1.2. In order to allow a fair opportunity for the necessary planning and scheduling of leave for employees concerned, the Minister for Public Service and Administration made a determination that this provision be effected only with effect from the start of the new leave cycle, i.e. 1 January 2004.

2.1.3. It is thus required that the relevant Departments of Education in collaboration with the heads of these institutions and employees concerned do the necessary planning and scheduling of leave, taking into account the principles of fairness and equity stipulated in this Determination and Directive.

2.2 Unpaid Leave (Leave without Pay)

The changed factors for reducing annual and sick leave in the event of leave without pay/unpaid leave as contemplated in paragraphs 5.3 and 14.10 of Part 4 of this document will with due consideration to good administration be effected with effect from the leave cycle which commenced on 1 January 2004.

3. TRANSITIONAL ARRANGEMENTS TO EFFECT PSCBC RESOLUTION 1 OF 2007

3.1 ANNUAL LEAVE

3.1.1 Registered/Enrolled Nurses and Nursing Assistants

a) Registered/enrolled nurses and nursing assistants are, for purposes of annual leave now categorized in category 4(c) of Annexure A to this Determination and Directive. Please refer to Part 4 of this document. Given the fact that this change was introduced in the middle of the current annual leave cycle and that a number of employees concerned already utilised the pre-revised annual leave entitlement, the following transitional arrangements shall apply in the interest of smooth and fair implementation:

(i) Registered and enrolled nurses and nursing assistants, employed on or before 30 June 2007, may retain their entitlement as per contract.

(ii) Registered and enrolled nurses and nursing assistants employed on or after 1 July 2007, qualify for the annual leave entitlement as indicated in category 4(c) of Annexure A to this Determination and Directive.

3.1.2. **Contract Workers**[1]:

A contract worker qualifies with effect from 1 July 2007, for pro rata leave benefits related to his/her term of contract. Please refer to Part 4 of this Determination and Directive. Since these changes were introduced in the middle of the 2007 annual leave cycle and the 2007/09 sick leave cycle the following transitional arrangements shall apply. :

3.1.2.1. **Annual Leave**

(a) A contract worker, who was employed on or before 30 June 2007, shall retain his/her entitlements as per contract.

(b) A contract worker appointed on or after 1 July 2007 qualifies for the pro rata annual leave entitlement as determined in Part 4 of this Determination and Directive.

3.1.2.2. **Sick Leave**

(a) A contract worker, who was employed on or before 30 June 2007, shall retain his/her leave benefits as per contract.

(b) A contract worker appointed on or after 1 July 2007 qualifies for the pro rata sick leave benefits as determined in Part 4 of this Determination and Directive.

3.1.2.3. **Maternity Leave**

(a) A contract worker who was on maternity leave or whose maternity leave commenced on the date of signature of PSCBC Resolution 1 of 2007 shall retain/complete the four months maternity leave.

(b) A contract worker appointed on or after 1 July 2007 qualifies for the pro rata paid maternity leave benefits as stipulated in Part 4 of this Determination and Directive.

[1] Also refer to the Determination on Learners and Interns.

3.1.2.4. Adoption Leave

(a) A contract worker who was on adoption leave or whose adoption leave commenced on the date of signature of PSCBC Resolution 1 of 2007 shall retain/complete the 45 working days paid leave.

(b) A contract worker appointed on or after 1 July 2007 qualifies for the pro rata paid adoption leave benefits as stipulated in Part 4 of this Determination and Directive.

PART 2: EXPLANATORY NOTES ON THE IMPLEMENTATION OF THE INTEGRATED FINANCIAL MANAGEMENT SYSTEM (IFMS) IN RELATION TO PROVISIONS CONTAINED IN THIS DETERMINATION AND DIRECTIVE

1. INTRODUCTION TO THE IFMS

1.1. The HR domain of the Integrated Financial Management System (IFMS) project is an integral part of the overall IFMS initiative that is aimed at modernising the South African Government's current transversal IT systems. The transversal systems to be implemented as part of the IFMS will, amongst others, support the following functional areas:

1.1.1. Human Resource Management;

1.1.2. Financial Management;

1.1.3. Supply Chain Management including Procurement Management; and

1.1.4. Business Intelligence.

1.2. The IFMS covers the full life cycle of an employee within the organisation which includes:

1.2.1. the establishment of a viable organisational structure to support the strategic objectives of the department; and

1.2.2. the effective planning and sourcing of human resources and the management of the employment relationship within the organisation which includes among others Leave Management and Health and Safety Issues.

These processes are underpinned by effective administration and reporting.

1.3. In addition, with the introduction of the IFMS, an employee self service system is established which will allow employees and their supervisors to perform a number of on-line human resource (HR) transactions such as applying for leave, viewing and updating your personal details, etc. It is envisaged that HR management activities, including decision-making, will be streamlined and enhanced by making relevant management information readily available. This will improve efficiency by eliminating duplication and reducing protracted and costly manual processes.

2. PARAGRAPH BY PARAGRAPH IMPLEMENTATION AND APPLICATION NOTES

2.1. LEAVE ENTITLEMENTS

2.1.1. The work schedules of each individual employee must be implemented on the IFMS to ensure that the employee receives the correct leave entitlements and that the utilisation thereof is managed according to the correct rules and circumstances. Work schedules would in this instance constitute employees prescribed working hours and where applicable shift rosters. It is critical that departments maintain the work schedules regularly to prevent situations where employees are unduly deprived of leave benefits or granted leave benefits not due to them.

2.2. LEAVE APPLICATIONS (EXCLUDING TEMPORARY INCAPACITY LEAVE)

2.2.1. Employees having access to the Employee Self Service facility on the IFMS must apply electronically for their leave. Supervisors/Managers/Heads of Department and/or their delegates are required to recommend/not recommend and/or approve/not approve these leave applications electronically. Where employees do not have access to the Employee Self Service, they should apply on manual leave application forms which the Minister for the Public Service and Administration will determine from time to time. The latter arrangement will apply in respect of those departments where the IFMS is not implemented.

2.2.2. An employee may be granted annual leave as part of a day or on a pro rata basis as per paragraph 7 of Part 4 of this Determination and Directive. Employees having access to the Employee Self Service facility may apply for leave for part of a day or on a pro rata basis electronically, i.e. annual leave, normal sick leave, family responsibility leave, pre-natal leave, shop stewards leave contemplated in Part 4 of this Determination and Directive. Where employees do not have access to the Employee Self Service facility in departments where the IFMS is implemented, such employees should apply for such leave on the new Z1 (a) leave form for capturing on the IFMS. Departments that are not on the IFMS should continue to keep manual records in instances where the employee utilises leave for part of a day or on a pro rata basis. No formal applications for such annual leave were determined in the past. For purposes of proper administration and management of annual leave utilised for part of a day or on a pro rata basis employees should in future apply for such leave on the new Z1(a) leave form.

PART 3: IMPLEMENTATION NOTES ON THE APPLICATION OF THE DETERMINATION AND DIRECTIVE ON LEAVE OF ABSENCE IN THE PUBLIC SERVICE

1. GENERAL

1.1. Additional definitions were added, i.e. commissioning parent, month, surrogate mother, surrogate motherhood agreement and work day to assist with the interpretation and application of this Determination and Directive.

2. ANNUAL LEAVE

2.1. GENERAL

2.1.1. Additional provisions were included to improve the effective and efficient management of annual leave generally and in particular that of shift workers.

2.2. ANNUAL LEAVE ENTITLEMENT

2.2.1. It has been agreed in PSCBC Res 1 of 2012 that as part of long service recognition at attaining 10 years service an employee's annual leave entitlement increases from 26 to 30 working days in the leave cycle. Annexure A to this Determination and Directive has been amended to this extent.

2.2.2. Employees appointed prior to 1 July 1966 and employees of the former Provincial Administrations and Development Boards (excluding nursing staff) who were taken over by the Public Service in 1986, 1987 and 1989 respectively and who previously qualified for 36 days annual leave in terms of the Special PAS" were entitled to 26 working days annual leave. In the light of the increase of the annual leave entitlement to 30 working days, the paragraph that dealt with the annual leave of employees who were taken over from the former Provincial Administrations and Development Boards and this leave category in Annexure A became superfluous and is thus deleted.

2.2.3. Employees who have completed 10 years service on a date prior to the signing of PSCBC Res 1 of 2012 are also eligible to 30 working days as depicted in Annexure A.

2.2.4. Since the annual leave entitlement is increased in the course of the 2012 annual leave cycle, Departments are urged to review leave schedules with the aim of ensuring that employees utilise their leave entitlement before the end of June 2013 (that is the end of the grace period for the 2012 leave cycle) and to avoid unnecessary claims for leave payouts.

2.3. ANNUAL LEAVE WITH FULL PAY GRANTED IN EXCESS

2.3.1. This Determination and Directive provides that if due to a bona fide error, an employee had been granted annual leave with full pay in excess of that which stood to his/her credit at that time; such over-grant must be deducted from the subsequent leave cycle. In order for such a correction to be effected on PERSAL and IFMS, the Head of Department must have certified that the error was bona

fide in nature. A copy of this letter or submission must be presented with the system change control for the correction of the error.

3. NORMAL SICK LEAVE AND INCAPACITY LEAVE

3.1. Additional provisions are included to improve the effective and efficient management of normal sick leave and incapacity leave generally. To this end your attention is drawn to the-

3.1.1. time frames included for supervisors to dispose of sick and incapacity leave applications;

3.1.2. provisions in respect of the management of shift workers' sick and incapacity leave;

3.1.3. management of sick leave credits on transfer and change in employment status; and

3.1.4. management of incapacity leave applications of deceased employees.

4. ADOPTION LEAVE

4.1. Part 4 of this Determination and Directive provides amongst others that an employee, who adopts a child that is younger than two years, shall qualify for adoption leave to a maximum of 45 working days. For purposes of the interpretation and application of this provision specific attention is drawn to section 228 of the Children's Act, 2005 which stipulates that a child is adopted if the child has been placed in the permanent care of a person in terms of a court order that has the effects contemplated in section 242. Section 242 of the Children's' Act, 2005 stipulates amongst others that -

4.1.1. An adoption order, amongst others, confers-

(a) full parental responsibilities and rights in respect of the adopted child upon the adoptive parent; and

(b) the surname of the adoptive parent on the adopted child, except when otherwise provided in the order.

4.1.2. An adopted child must for all purposes be regarded as the child of the adoptive parent and an adoptive parent must for all purposes be regarded as the parent of the adopted child.

4.2. Therefore, an eligible employee should provide the Department with a certified copy of the adoption order to access the adoption leave benefits.

5. SURROGACY LEAVE

5.1. Part 4 of this Determination and Directive provides amongst others that an employee, who is a commissioning parent in terms of a surrogate motherhood agreement confirmed by the High Court as contemplated in the Children's Act, 2005, is entitled to four consecutive months paid leave commencing from the date of the birth of the child. For purposes of the interpretation and application of this provision specific attention is drawn to section 292 of

the Children's Act, 2005 which stipulates that any child born of a surrogate mother in accordance with the agreement is for all purposes the child of the commissioning parent or parents from the moment of the birth of the child concerned that has the effects contemplated in section 297.

5.2. Section 297 of the Children's' Act, 2005 stipulates amongst others that the effect of a valid surrogate motherhood agreement is that-

5.2.1. any child born of a surrogate mother in accordance with the agreement is for all purposes the child of the commissioning parent or parents from the moment of the birth of the child concerned;

5.2.2. the surrogate mother is obliged to hand the child over to the commissioning parent or parents as soon as is reasonably possible after the birth;

5.2.3. the surrogate mother or her husband, partner or relatives has no rights of parenthood or care of the child;

5.2.4. the surrogate mother or her husband, partner or relatives have no right of contact with the child unless provided for in the agreement between the parties;

5.2.5. subject to sections 292 and 293, the surrogate motherhood agreement may not be terminated after the artificial fertilisation of the surrogate mother has taken place; and

5.2.6. the child will have no claim for maintenance or of succession against the surrogate mother, her husband or partner or any of their relatives.

5.3. In terms of section 292 (1) of the Children's Act, 2005 no surrogate motherhood agreement is valid unless –

5.3.1. The agreement is in writing and is signed by all the parties thereto;

5.3.2. The agreement is entered into in the Republic;

5.3.3. At least one of the commissioning parents, or where the commissioning parent is a single person, that person, is at the time of entering into the agreement domiciled in the Republic;

5.3.4. The surrogate mother and her husband or partner, if any, are at the time of entering into the agreement domiciled in the Republic; and

5.3.5. The agreement is confirmed by the High Court within whose area of jurisdiction the commissioning parent or parents are domiciled or habitually resident.

5.4. Any surrogate motherhood agreement that does not comply with the provisions of this Act is invalid and any child born as a result of any action taken in execution of such an arrangement is for all purposes deemed to be the child of the woman that gave birth to that child.

5.5. Therefore, an eligible employee should provide the Department with a certified copy of the surrogate motherhood agreement confirmed by the High Court to access the surrogate leave benefits.

6. LEAVE FOR OFFICE BEARERS OR SHOP STEWARDS OF RECOGNISED EMPLOYEE ORGANISATIONS

6.1. With effect from 1 January 2013 the provisions in paragraph 25.1 of Part 4 of this Determination and Directive will cease to exist. Henceforth office bearers and shop stewards of recognised employee organisations shall receive 15 working days paid leave per annum for activities related to his/her union position.

6.2. The 15 working days shall be pooled per recognised trade union. Office bearers or shop stewards belonging to the same recognised trade union may apply for leave days from the pool.

6.3. In other words if there are 10 shop stewards in the Department of which 4 belong for example to the PSA and 6 to NEHAWU-

6.3.1. The 15 working days of each of the 4 shop stewards belonging to the PSA will be pooled into a pool of 60 working days (4 x15); and

6.3.2. The 15 working days of each of the 6 shop stewards belonging to NEHAWU will be pooled into a pool of 90 working days (6x15).

6.4. With effect from 8 June 2018, if a shop steward of a recognised employee organisation has to perform union activities while on annual leave with full pay, such annual leave shall be converted to shop steward leave, provided that a formal request with supporting documentatary evidence are submitted substantiating that he/she had to perform union activities.

PART 4: DETERMINATION AND DIRECTIVE ON LEAVE OF ABSENCE IN THE PUBLIC SERVICE

1. SCOPE

1.1. Except for explicit exclusions by the Basic Conditions of Employment Act, 1997, this Determination and Directive is applicable to all those that are employed either on full-time, part-time, permanent or temporary basis in terms of the Public Service Act and fall within the scope of the PSCBC.

1.2. This Determination and Directive gives effect to clause 7 of PSCBC Resolution 7 of 2000, as amended by PSCBC Resolutions 5 of 2001, 15 of 2002; 1 of 2007, 1 of 2012 and 2 of 2015.

2. AUTHORISATION

This Determination and Directive is made by the Minister for the Public Service and Administration in terms of the provisions of section 3(5) (a) and 5 (6) (b) of the Public Service Act, 1994 as amended.

3. PURPOSE

3.1. The purpose of this Determination and Directive is to give effect to, elucidate or supplement relevant collective agreements on–

3.1.1. the types of leave and circumstances under which the employer may consider authorizing an employee's absence from work; and

3.1.2. an employee's leave entitlement and conditions that the employee must adhere to access the said entitlement.

4. DEFINITIONS

4.1. "Annual leave cycle" or "Calendar year" means from 1 January to 31 December of each year;

4.2. "Calendar month(s)" means a calendar month as defined in section 1 of the Public Service Act, 1994.

4.3. "Casual worker' means a person employed on a day-to-day basis who is paid a daily wage and who does not work more than 24 hours a month.

4.4. "Commissioning parent" means a person who enters into a surrogate motherhood agreement with a surrogate mother.

4.5. "Contract worker" means a person employed on a temporary basis[2].

[2] Refer also to clause 11 of PSCBC Res 1 of 2007

4.6. "Head of Department" means the Head of Department or his/her delegated authority or his/her designated office responsible for leave related matters and/or investigations.

4.7. "Month" means a month as defined in section 1 of the Public Service Act, 1994.

4.8. "Remuneration" means-

4.8.1. in respect of employees on level 1 to 10 or equivalent Occupational Specific Dispensation levels: –

4.8.1.1. for purposes of calculating pay for unused annual leave and severance pay, remuneration means the employee's annual basic salary PLUS 37% of his/her annual basic salary; and

4.8.1.2. for purposes of calculating capped leave and unpaid leave, remuneration means the employee's annual basic salary.

4.8.2. in respect of a member of the Middle Management Service (MMS or equivalent Occupational Specific Dispensation levels):

4.8.2.1. for purposes of calculating pay for unused annual leave, unpaid leave and severance pay, remuneration means the employee's all inclusive remuneration package; and

4.8.2.2. for purposes of calculating capped leave, remuneration means the employee's annual basic salary.

4.9. "Surrogate mother" means an adult woman who enters into a surrogate motherhood agreement with the commissioning parent.

4.10. "Surrogate motherhood agreement" means a valid agreement in terms of section 292 of the Children's Act between a surrogate mother and a commissioning parent in which it is agreed that the surrogate mother will be artificially fertilised for the purpose of bearing a child for the commissioning parent and in which the surrogate mother undertakes to hand over such a child to the commissioning parent upon its birth, or within a reasonable time thereafter, with the intention that the child concerned becomes the legitimate child of the commissioning parent.

4.11. "Work day" equates to the employee's number of daily official working hours.

5. ANNUAL LEAVE

5.1. Employees are entitled to annual leave with full pay during each leave cycle of 12 months, commencing on 1 January of each year, in terms of Annexure A[3], except if appointed after 1 January of each year. The annual leave entitlement of an employee appointed after 1 January of each year shall be calculated proportionally in relation to each full month of service at a rate of 1, 83 working days if entitled to 22 working days and 2, 5 working days if entitled to 30 working days annual leave in a leave cycle.[4]

[3] Refer to Part 2 for the explanatory note on the application of this provision in relation to the IFMS and Part 3 for implementation notes.
[4] Circular E/1/2/2/P dated 18 April 2001.

5.2. Annual leave should be planned and scheduled at least at the start of a leave cycle, i.e. January of each year.

5.3. For each 15 consecutive calendar days leave taken without pay, the employees' annual leave entitlement shall be reduced by 1/24th.

5.4. For the purpose of granting annual leave, working days shall mean Monday to Friday except for a shift worker for whom a working day means the day(s) she/he is scheduled for a shift in terms of their shift roster inclusive of Public Holidays, Saturdays and Sundays.

5.5. At least 10 working days must be taken as leave days during the annual leave cycle. The utilisation of this leave must take the service delivery requirements of a department into account. NOTE: Annual leave should, as far as possible, be taken as consecutive working days.

5.6. The remaining leave days, if any, must be taken no later than 6 months after the expiry of the relevant leave cycle, where after unused leave credits shall be forfeited.

5.7. An employee must submit his/her application for annual leave in advance, unless unforeseen circumstances prevent him/her from doing so.[5]

5.8. If confronted with unforeseen circumstances which necessitate the utilization of annual leave, the employee must personally notify his/her supervisor/manager immediately. A verbal message to the supervisor/manager by a relative, fellow employee or friend is only acceptable if the nature and/or extent of the unforeseen circumstances prevents the employee from informing the supervisor/manager personally.

5.9. An employee must submit an application for annual leave personally or through a relative, fellow employee within 5 working days after the first day of absence. If the employee fails to submit the application on time or compelling reasons why an application cannot be submitted, the supervisor/manager must immediately-

5.9.1. notify the employee that if such application is not received within 2 working days, the leave period will be regarded as unpaid leave; and

5.9.2. inform the Human Resource division, should the employee default on the notification referred to in par 5.9.1, above,

and the relevant authority shall approve such absence as unpaid leave. The employee's supervisor/manager/ Head of Department and/or his/her delegate must within two working days from receipt of the leave application form recommend/not recommend and/or approve/disapprove this leave application and submit to the relevant Human Resource division in the department.

5.10. Failure by the employee to submit his/her application form within the stated periods, or failure by the supervisor/manager to properly manage it, must be viewed in a serious light and disciplinary steps against the employee and/or supervisor/manager should be taken.

5.11. Employees must be cautioned timeously if, at the end of the relevant leave cycle, they have not utilised their leave entitlements.

[5] Refer to Part 2 for the explanatory note on the application of this provision in relation to the IFMS

5.12. An employee's application for annual leave should not be unreasonably refused. An application for annual leave should take the service delivery requirements of a department into account.

5.13. Any refusal of annual leave must be confirmed in writing, stating the reasons and arrangements for rescheduling of the annual leave.

5.14. If, due to the employer's service delivery requirements, an employee's application for leave is denied and not rescheduled, such leave must, upon request, be paid out to the employee at the end of the 6 months' period referred to in 5.6 above. Employee requests for payment of unused leave credits must be:

5.14.1. in writing; and

5.14.2. accompanied by written proof of refusal of leave by the Head of Department.

5.15. With effect from 31 January 2018 employees, suspended as a precautionary measure while investigations into allegations of misconduct are being completed or employees who have been suspended as a sanction as a result of misconduct within the 6 months (paragraph 5.6 above refers) after the expiry of the relevant leave cycle and who could not utilise their unused annual leave credits, must upon request, be paid out such annual leave credits at the end of the 6 months' period referred to in 5.6 above. Employee requests for payment of unused leave credits must be-

5.15.1. in writing; and

5.15.2. accompanied by written proof of suspension.

5.16. Heads of Department shall, at the end of the relevant 18 months' period, report to the relevant legislature on the number of employees denied annual leave, reasons for such denial and the amount paid in this regard.

5.17. The 50% leave entitlement, or any portion thereof, which was due to employees for the period 1 July 2000 to 31 December 2000, and which could not be utilised before 30 June 2001, shall be added to the number of leave days accrued prior to 1 July 2000. This provision is a once off arrangement only in respect of those cases where no leave payouts have been effected.

6. LEAVE FOR NON-TEACHING STAFF AT SCHOOLS AND TRAINING INSTITUTIONS (Employed in the various Departments of Education)

6.1. All non-teaching staff at schools and training institutions is, for purposes of annual leave, accommodated in category 3 of Annexure A.

6.2. Non-teaching staff at schools and training institutions must take at least 22 of the 27 or 30 working days annual leave, whichever is applicable, during the period for which a school/training institution closes for the holidays. The remaining 5 or 8 days, whichever is applicable, may be taken when the institution is in operation.

6.3. The annual leave entitlement should, in these circumstances, be regarded as the minimum. Therefore, if an employee is not required at the institution during the period(s)

when the institution closes for holidays, an employee may utilise his/her annual leave entitlement and/or paid time off granted by the employer.

6.4. The head of the institution should ensure that his/her decisions are based upon the principles of fairness and equality in determining the leave roster for the employees concerned.

6.5. With due regard to the principles of fairness and equality-

6.5.1. Annual leave and holidays constituting time off should be planned and scheduled for at least at the beginning of a leave cycle, i.e. January of each year.

6.5.2. Considering that most schools/training institutions do their strategic planning and year programmes for the subsequent year usually towards the end of the previous leave cycle. The planning and scheduling of annual leave and holidays constituting time off can also commence at that stage.

6.5.3. Planning and scheduling should take place in collaboration with the head of the institution and the employees concerned.

6.5.4. As for periods of time off during institution holidays the following could be taken into account-

6.5.4.1. For the concept of 'if an employee is not required at the institution during the period(s)' refer to paragraph 6.3. If an employee is not required during the institution holidays, the institution may not require from that employee to report for duty, except in extenuating circumstances which have a direct bearing on operational/ service delivery requirements of that institution.

6.5.4.2. Attention needs to be given to activities or services that need to take place or be delivered during the period when the school/institution closes for holidays.

6.5.4.3. It could be considered to schedule and present formal training for all non-teaching members of staff during some of these periods.

6.5.4.4. A roster of time off should be developed to give each member of staff a fair opportunity to time off, in the event where activities are to take place or services have to be rendered.

6.5.4.5. Tasks should as far as possible be rotated between non-teaching members of staff and retain where possible only a minimum service delivery staff complement if their services are required during the period when the school/institution closes for holidays.

6.5.4.6. Heads of institutions should ensure that duties and responsibilities assigned to the employees concerned (during these holidays) may only relate to their normal assigned duties and responsibilities as contemplated in their job descriptions, **unless arranged by mutual consent**.

6.5.4.7. It is important to make sure that non-teaching staff is retained on duty during institution holidays, only for valid official duty.

6.5.5. For purposes of paragraphs 6.1 to 6.4 above, the employer shall ensure in the case of an institution presenting **a combination of courses e.g. semester and trimester courses**, that the annual leave and periods of time off of non-teaching staff rendering a support service to the academic staff, will be aligned with the dispensation applicable to the said academic staff.

7. THE GRANTING OF ANNUAL LEAVE ON A PRO RATA BASIS

7.1. Employees who are appointed after the commencement of an annual leave cycle shall be entitled to annual vacation leave on a pro rata basis determined as a fraction of the entitlement as per Annexure A.

7.2. For purposes of utilising leave entitlements, fractions or decimals must be utilised as they are. In other words fractions or decimals must not be rounded off.

7.3. Departments must keep manual records of the utilisation of annual leave taken for part of a day. After reaching the prescribed daily number of working hours, the employee must complete and submit a leave form.[6]

7.4. For purposes of converting fractions/decimals of leave entitlements into working hours the following formula(s) should apply:

Converting fractions into hours:

A x B = C

Where-

A = represents the number or working hours in a day

B = represents the fraction

C = represents the credit in hours

For example: Employee with 7, 45 leave credits on an 8 hour working day:

8 x 0.45 = 3.6 hours

Converting fractions into minutes:

60 x B = C

Where-

60 = represents the minutes in an hour

B = represents the fraction

C = total credit in minutes

For example: Employee with 3,6 hours leave credit (see example above)

60 min x 0.60 = 36 minutes

In other words the employee with 7,45 days' leave credits has 7 days, 3 hours and 36 minutes leave

[6] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS

7.5. For purposes of leave payouts, fractions or decimals must be used as they are in the formula provided for in paragraphs 9.4 and 10.4 of this Determination and Directive.

7.6. Unused fractions and decimals lapse at the end of the six months period referred to in paragraph 5.6 above.

7.7. If an employee's annual leave entitlements changes, e.g. from 22 to 30 working days per annum after ten years satisfactory service, the unused fractions or decimals must also be carried over to the new leave category and be administered manually.

8. MANAGEMENT OF ANNUAL LEAVE FOR SHIFT WORKERS

8.1. The provisions contained in the paragraphs above apply mutatis mutandis to shift workers, suffice to indicate that specific provisions are required to enable departments employing shift workers to manage their annual leave more efficiently and effectively given their peculiar working hour arrangements.

8.2. Annual leave should be planned and scheduled, as far as possible, at the beginning of a leave cycle, i.e. January of each year in conjunction with the shift roster.[7]

8.3. As in the case of other employees, utilising annual leave counts towards the completion of an employee's prescribed work week.

8.4. If an employee takes unplanned annual leave for a day(s) he/she was scheduled for a shift-

8.4.1. the employee's annual leave is counted according to the work days the employee is scheduled for shifts;

8.4.2. he/she does not forfeit the off duty periods (conversely referred to as off days) that results from the design of the shift roster.

8.5. If the employee applies for annual leave in advance in accordance with the leave schedule such leave must be taken into account in the scheduling of shifts. The employee must not be scheduled for (a) shift(s) for the duration of the period of annual leave in which case the granting of annual leave will be counted as working days which shall mean Monday to Friday.

9. ANNUAL LEAVE AND PAYOUTS

9.1. Employees shall be paid a cash value in respect of unused leave credit upon termination of service and in terms of paragraph 5.14 and 5.15 above. The payment will be limited to a maximum number of days, equivalent to the annual leave entitlements in Annexure A.

9.2. The leave cycle remains unchanged, therefore, requests and motivations for leave payments in respect of leave credits mentioned in 5.14 and 5.15 above shall be lodged by no later than 31 July in respect of each year. If an employee failed to apply for the payment of such unused leave credits at the aforementioned due date such unused leave credits shall be forfeited.

[7] Refer to Part 2 for the explanatory note on the application of this provision in relation to the IFMS

9.3. Payment of annual leave credits shall be calculated using the employee's remuneration.

9.4. For all terminations in respect of personnel without any capped leave, leave pay-outs shall be computed in terms of the following formula:

$$\frac{\{(A - B) + (C - D)\} \times E}{260.714}$$

Where-

A = represents the full annual or pro rata leave entitlement in the previous leave cycle. Pro rata entitlement calculated as

$$\frac{X \times Y}{12}$$

Where –

X = number of completed months of service; and

Y = annual leave entitlement per leave cycle as per Annexure A.

B = represents the leave taken in the previous leave cycle.

C = represents the pro rata leave entitlement in the current leave cycle (Calculated according to the formula in A above).

D = represents the leave taken in the current leave cycle.

E = represents the employee's remuneration (levels 1 to 10: annual basic salary plus 37% and MMS, the all inclusive package) at the last day of duty or at the end of the 6 months period mentioned in 5.6 above.

9.5. For personnel who still have unused leave credits at the expiry of the 6 months period mentioned in 5.6 above and who complied with the provisions of paragraph 5.14 and 5.15 above, leave pay-outs shall be computed in terms of the following formula:

$$\frac{(A - B) \times C}{260.714}$$

Where-

A = represents the full annual or pro rata leave entitlement in the previous leave cycle. Pro rata entitlement calculated as

$$\frac{X \times Y}{12}$$

Where –

X = number of completed months of service; and

Y = annual leave entitlement per leave cycle as per Annexure A

B = represents the leave taken in the previous leave cycle

C = represents the employee's remuneration (levels 1 to 10: annual basic salary plus 37% and the MMS the all inclusive package) at the last day of duty or at the end of the 6 months period mentioned in 5.6 above.

NOTE: For computed EXAMPLES, please refer to Annexure B

9.6. Employees who have been on suspension-

9.6.1. On or after 31 July 2016 and who has unused annual leave credits which s/he could not use as a result of the suspension in respect of the previous leave and/or expired previous leave cycles may make a written request for a leave payout in respect of such unused annual leave credits; and/or

9.6.2. Subsequently, dismissed shall also receive a leave payout for the unused annual leave credits in respect of the previous leave and/or expired previous leave cycles which s/he could not use as a result of the suspension.

9.6.3. Effective from 31 January 2018.

10. ANNUAL LEAVE ACCRUED PRIOR TO 1 JULY 2000

10.1. Employees shall retain all audited leave credits accrued prior to 1 July 2000.

10.2. The number of accrued leave days prior to 1 July 2000 shall be converted to working days using the following formula:

$$\frac{A \times 5}{7}$$

Where -

A = represents the number of audited leave credits

10.3. The payouts in respect of such leave credits shall be made in the event of:

10.3.1. Death;

10.3.2. Retirement; or

10.3.3. Medical boarding.

10.4. The leave payout in respect of personnel with capped and audited leave credits shall be determined in the following manner:

$$\frac{\{[(A-B) + (C-D)] \times E + (F \times G)\}}{260.714}$$

Where:

A = represents the full annual or pro-rata leave entitlement in the previous leave cycle.

B = represents the leave taken in the previous leave cycle.

C = represents the pro rata leave entitlement in the current leave cycle.

D = represents the leave taken in the current leave cycle.

E = represents the employee's remuneration (levels 1-10 annual basic salary plus 37% and MMS the all inclusive remuneration package) as at the last day of duty.

F = represents the capped leave.

G = represents the employee's remuneration (levels 1-10 and MMS the annual basic salary only) as at the last day of duty.

NOTE: For computed EXAMPLES, please refer to Annexure B.

10.5. The Head of Department shall determine whether there are periods, which are unaudited, and in such instances, the employee's leave payout shall be paid on the basis of 6 days per completed year of service up to a maximum of 180 days in respect of the unaudited leave period. The formula in calculating the payout in respect of these days shall be as per paragraph 10.4 above.

10.6. The Head of Department shall determine procedures and measures in keeping with service delivery needs, on how employees will be allowed to utilise their leave credits accrued prior to 1 July 2000 over and above the normal annual leave entitlements as per Annexure A.

11. NOMINATION OF BENEFICIARIES AND LEAVE PAYOUTS

11.1. Employees may, if they so desire, designate one or more beneficiaries to whom their leave payout may be paid in the event of their death. Departments should actively promote the nomination of beneficiaries in order to avoid any hardship of such beneficiaries.

11.2. If an employee dies and has not nominated a beneficiary, the leave payout may be paid:

11.2.1. In full to the spouse/life partner of that employee; or

11.2.2. If there is no spouse/life partner, in equal shares for the benefit of minor and other children (including legally adopted children) of the deceased who, at the time of his/her death, were fully dependent on the employee; or

11.2.3. If there are no children, to the employee's estate.

12. ANNUAL LEAVE WITH FULL PAY GRANTED IN EXCESS

12.1. An employee may not be granted annual leave with full pay in excess of that which the employee is entitled to in terms of Annexure A plus capped leave in respect of persons who were in service prior to 1 July 2000.

12.2. If due to a bona fide error, an employee had been granted annual leave with full pay in excess of that which stood to his/her credit at that time, such over-grant must be deducted from the subsequent leave cycle.[8]

12.3. If an employee who has been over-granted annual leave with full pay exits the Public Service, that portion of the over-grant, which exceeded his/her normal annual, leave credit on his/her last day of duty must be regarded as an overpayment that must be recovered from him or her. The latter overpayment should be determined according to the following formula:

$$\frac{A \times B}{260{,}714}$$

Where-

A = represents the employee's remuneration (Levels 1-10: annual basic salary plus 37% and MMS the, all-inclusive package)

B = represents the number of days annual leave over-granted

260.714 = represents the number of working days in a year

NOTE: For a computed example, please refer to Annexure B

12.4. If an employee exits the Public Service during an annual leave cycle after utilising all his/her annual leave for the leave cycle, the provisions of 12.3 above shall apply.

13. ANNUAL LEAVE: GENERAL PROVISIONS

13.1. An employee retains all his/her annual leave credits, when he/she is transferred within or between departments, due to him/her at that point in time. The employee retains likewise the leave category as reflected in Annexure A. The utilisation of these leave credits are subject to the provisions of this Determination and Directive.

13.2. If an employee transfers to an occupational class to which a different leave category applies, he/she adopts the new leave category for that occupational class. The employee will retain the leave credits due to him/her of the old occupational class. The utilisation of these leave credits is subject to the provisions of this Determination and Directive.

13.3. The provisions in paragraphs 13.1 and 13.2 apply mutatis mutandis in the case of employees who are appointed on contract and who secures a permanent appointment in the Public Service and vice versa.

13.4. In the event where an employee qualifies after completion of ten years of service after the first day of the month for the higher leave category in Annexure A, the higher pro rata portion of the new leave category should be calculated from the first day of the next month. The same principle also applies to employees referred to in paragraph 13.2 if they qualify after the first day of the month for the new category of leave.

[8] Refer to Part 3 for implementation notes.

14. NORMAL SICK LEAVE[9]

14.1. An employee is entitled to 36 working days sick leave with full pay over a three-year cycle. Any unused sick leave credits shall lapse at the expiry of the three-year cycle.

14.2. It is incumbent on the employee to utilise and manage his/her normal sick leave responsibly and with circumspect.

14.3. An employee must submit his/her application for sick leave in respect of clinical procedures in advance, unless the treating practitioner certifies that such procedures have to be conducted as an emergency.

14.4. If overcome by a sudden illness or injury, the employee must personally notify his/her supervisor/manager immediately. A verbal message to the supervisor/manager by a relative, fellow employee or friend is only acceptable if the nature and/or extent of the illness/injury prevents the employee to inform the supervisor/manager personally.

14.5. An employee must submit an application for sick leave personally or through a relative, fellow employee within 5 working days after the first day of absence. The employee's supervisor/manager/ Head of Department and/or his/her delegate/must within two working days from receipt of the leave application form recommend/not recommend and/or approve/disapprove the application and submit to the relevant Human Resource division in the department.

14.6. If the employee fails to submit an application within the period indicated in paragraph 14.5, above, the following arrangements apply:

14.6.1. The employee's manager/supervisor must immediately notify the employee that if such application is not received within 2 working days, the leave period will be regarded as unpaid leave or annual leave. If the employee fails to submit the application on time or compelling reasons why an application cannot be submitted, the supervisor/manager must immediately inform the Human Resource division and the relevant authority shall approve such absence as unpaid leave or annual leave if the employee consents. The employee's supervisor/manager/ Head of Departments and/or his/her delegate must within two working days from receipt of the leave application form recommend/not recommend and/or approve/disapprove this leave application and submit to the relevant Human Resource division in the department.

14.6.2. Failure by the employee to submit his/her application form within the stated periods, or failure by the supervisor/manager to properly manage it, must be viewed in a serious light and disciplinary steps against the employee and/or supervisor/manager should be taken.

14.7. An employee must submit a medical certificate in respect of his/her sick absence for every occasion of 3 or more sick leave days, issued and signed by a practitioner or person listed in paragraph 17.1 hereunder.

[9] Refer to Part 3 for implementation notes.

14.8. If -

14.8.1. the employer establishes a pattern/trend in the employee's utilisation of normal sick leave, the employer must require the employee to submit a medical certificate from a practitioner or person listed in paragraph 17.1 hereunder, for periods of sick absences of less than 3 days; and

14.8.2. an employee during his/her normal sick leave period, **who has been absent from work on more than two occasions during an eight-week period,** must regardless of the duration of the sickness or injury, submit a medical certificate stating that the employee was unable to work for the duration of the employee's absence on account of sickness or injury. The 8-week period shall be a calendar period and commences on the first day of an employee's absence due to sickness or injury. Any subsequent day of absence due to sickness or injury after the above-mentioned period must then be regarded as the first day of the next 8-week period. If the employee fails to submit the required medical certificate, the Head of Department must notify the employee that if the prescribed medical certificate is not received within 2 working days, the sick leave period will be regarded as unpaid leave or annual leave. If the employee fails to submit the medical certificate on time, the relevant absence must be covered by annual leave (with the employee's consent) and/or unpaid leave if insufficient annual leave credits are available or if the employee failed to notify the Head of Department of his/her choice. Failure by the employee to submit his/her medical certificate within the stated period must be viewed in a serious light and disciplinary steps against the employee should be taken.

14.8.3. Sick leave may also be granted in respect of periods where an employee must be quarantined or isolated for at least 10 consecutive days.

14.9. If an employee falls ill while on annual leave with full pay, such leave may be converted to sick leave provided that a certificate from a registered medical practitioner or person listed in paragraph 17.1 hereunder is submitted to substantiate that he/she is ill.

14.10. For every 15 consecutive calendar days leave taken without pay, an employee's sick leave entitlement must be reduced by 1/72nd per sick leave cycle.

15. TEMPORARY INCAPACITY LEAVE

15.1. Incapacity leave is not an unlimited number of additional sick leave days at an employee's disposal. Incapacity leave is additional sick leave granted conditionally at the employer's discretion, read with the *Policy and Procedure on Incapacity Leave for Ill-health Retirement* determined by the Minister for Public Service and Administration in terms of the Public Service Act, 1994, (hereafter referred to as PILIR).

15.2. An employee who has exhausted his/her normal sick leave, referred to in paragraph 14 above, during the prescribed sick leave cycle and who according to the treating medical practitioner requires to be absent from work due to a temporary incapacity, may apply for temporary incapacity leave with full pay on the applicable application form prescribed in terms of PILIR in respect of each occasion.

15.3. For an employee's application for temporary incapacity leave to be considered, the-

15.3.1. employee must submit sufficient proof that she/he is too ill or injured to perform his/her work satisfactorily;

15.3.2. application form must, regardless the period of absence, be accompanied by a medical certificate issued and signed by a medical practitioner that certifies his/her condition as temporary incapacity and if the employee has consented, the nature and extent of the illness or injury. Please also refer to paragraph 17 in respect of the acceptance of medical certificates;

15.3.3. employee is in accordance with item 10(1) of Schedule 8 to the Labour Relations Act, 1995, afforded the opportunity to submit together with his/her application form-

a) any medical evidence related to the medical condition of the employee, such as (a) medical report(s) from a specialist, blood tests results, x-ray results or scan results, obtained at the employee's expense; and

b) any additional written motivation supporting his/her application; and

15.3.4. employee is requested to give his/her consent that medical information/records be disclosed to the employer and/or its Health Risk Manager[10] and to undergo further medical examinations in terms of the assessment process described in PILIR.

15.4. An employee must submit his/her application for temporary incapacity leave in respect of clinical procedures in advance, unless the treating medical practitioner certifies that such procedures have to be conducted as an emergency.

15.5. If overcome by a sudden illness or injury, the employee must personally notify his/her supervisor/manager **immediately**. A verbal message to the supervisor/manager by a relative, fellow employee or friend is only acceptable if the nature and/or extent of the illness or injury prevents the employee to inform the supervisor/manager personally.

15.6. An employee must submit an application for temporary incapacity leave personally or through a relative, fellow employee or friend within 5 working days after the first day of absence. The employee's supervisor or delegate must within two working days from receipt of the leave application form recommend/ not recommend the application and submit to the relevant Human Resource division in the department.

15.7. If the employee fails to submit an application within the period indicated in paragraph 15.6, the following arrangements apply:

15.7.1. The employee's manager/supervisor must immediately notify the employee that if such application is not received within 2 working days, the sick leave period will be regarded as unpaid leave or annual leave. If the employee fails to submit the application on time or compelling reasons why an application cannot be submitted, the supervisor/manager must immediately inform the Human Resource division and the relevant authority shall approve such absence as unpaid leave or annual leave if the employee consents. The employee's supervisor/manager/ Head of

[10] The Health Risk Manager is a company of multi-disciplinary medical experts, specializing in occupational medicine, which will be appointed by the dpsa and National Treasury. The Health Risk Manager will assess and advice the HOD in respect of an employee's application for *inter alia* incapacity leave.

Department and/or his/her delegate must within two working days from receipt of the leave application form recommend/not recommend and/or approve disapprove this leave application and submit to the relevant Human Resource division in the department.

15.7.2. Failure by the employee to provide his/her application form within the stated periods, or failure by the supervisor/manager to properly manage it, must be viewed in a serious light and disciplinary steps should be taken.

15.8. The Head of Department, must within 5 working days from the receipt of the employee's application for temporary incapacity leave-

15.8.1. conditionally grant a maximum of 30 consecutive working days temporary incapacity leave with full pay subject to the outcome of his/her investigation into the nature and extent of the employee's illness/injury; and

15.8.2. refer the application with all the supporting evidence immediately to its Health Risk Manager in accordance with the PILIR for an assessment and advice-

(a) on whether the employee's illness or injury justifies the granting of incapacity leave *; and*

(b) which steps, if any, in accordance with the procedures contained in item 10(1) of Schedule 8 to the Labour Relations Act, 1995, read with clause 7.5.1 of PSCBC Resolution 7 of 2000, as amended by PSCBC Resolutions 5 of 2001 and 15 of 2002, are necessary;

15.9. The Head of Department may request the employee, if s/he has consented thereto in his/her application form, as part of the process contemplated in sub-paragraph 15.8.2, above, to subject him/herself for one or more medical examinations by medical practitioners of the employer's choice and for the employer's account. If the employee fails to honour the appointments for such medical examinations, the employee shall be held responsible for any fruitless expenses incurred.

15.10. The Head of Department must within 30 working days after receipt of both the application form and medical certificate referred to in paragraph 15.3.2, approve or refuse the temporary incapacity leave granted conditionally. In making a decision, the Head of Department must apply his/her mind to the medical certificate (with or without describing the nature and extent of the illness or injury) contemplated in paragraph 15.3.2, medical information/records contemplated in paragraph 15.3.4 (if the employee consented to disclosure), the Health Risk Manager's advice, the information supplied by the employee in terms of paragraph 15.3.3 (if any) and all other relevant information available to the Head of Department and based thereon approve or refuse the temporary incapacity leave granted conditionally, on conditions that the Head of Department may determine, e.g. to return to work, etc.

15.11. The Head of Department may on the basis of medical evidence gathered during its investigation approve the granting of additional incapacity leave days on conditions that he or she shall determine. The Head of Department may for this purpose grant conditionally further temporary incapacity leave.

15.12. The Head of Department, if applicable and as soon as possible, must after the receipt of the Health Risk Manager's advice, decide on the possibility of securing alternative employment for the employee, or adapting his/her duties or work circumstances to accommodate his/her incapacity or alternative employment and, as soon as possible, approve and implement an action plan for this purpose.

15.13. If the Head of Department-

15.13.1. approves the temporary incapacity leave granted conditionally, such leave must be converted into temporary incapacity leave; or

15.13.2. refuses the temporary incapacity leave granted conditionally, s/he must notify the employee in writing-

(a) of the refusal;

(b) of the reasons for the refusal;

(c) that s/he must notify the Head of Department in writing within 5 working days of the date of the notice to him/her, whether or not the period of conditional incapacity leave must be covered by annual leave (to the extent of the available annual leave credits) or unpaid leave and that, if s/he fails to notify the Head of Department of his/her choice, the period will be covered by unpaid leave; and

(d) the employee may, if he/she is not satisfied with the Head of Department's decision, lodge a grievance in terms of section 35 of the Public Service Act.

15.14. The Head of Department must cover the period of absence, referred to in paragraph 15.13.2 (c) in accordance with the employee's written notification or, if the employee fails to notify that the Head of Department in terms of that paragraph or the annual leave credits are insufficient, the relevant period of absence must be covered by unpaid leave.

15.15. In instances where incapacity leave is declined which originated in the previous leave cycle, an employee has the option to have the period covered by unpaid leave or to request that annual leave of the current leave cycle be utilised to offset the declined incapacity leave.

15.16. As regards the management of shift workers pertaining to normal sick leave and temporary incapacity leave the provisions contained in paragraph 8, above, apply *mutatis mutandis*.

15.17. If an employee passes away after submitting an application for temporary incapacity leave a decision on such application must be made where the information provided is sufficient. However, where a decision cannot be made due to a lack of information the Head of Department or his/her delegate must approve such application for temporary incapacity leave and close the application. Any decision must take into account the recommendation from the Health Risk Manager.

16. PERMANENT INCAPACITY LEAVE

16.1. An employee shall not directly access or apply for permanent incapacity leave. The Head of Department may grant an employee up to a maximum of 30 working days' permanent incapacity leave once she/he has, following the assessment and investigations contemplated in par. 15.8.2, determined that the employee's condition is of a permanent nature.

16.2. The Head of Department must during the period referred to in paragraph 16.1 and in accordance with the advice from its Health Risk Manager ascertain the feasibility of and implement its plan of action contemplated in paragraph 15.12., above, in respect of-

16.2.1. alternative employment; or

16.2.2. adapting duties or work circumstances to accommodate the employee.

16.3. An employee, whose degree of incapacity has been certified as permanent but who can still render a service, may be transferred to an alternate appropriate vacant post without a reduction in benefits.

16.4. In instances where the employee's transfer entails retraining or retooling, the employer must take requisite resources (time and financial) and potential returns into consideration before approving transfer.

16.5. The transfer of an employee should ensure the optimal utilisation of his/her competencies and must not compromise service delivery.

16.6. If both the Head of Department and employee are convinced that the employee will never be able to render an effective service, the employee/employer may proceed with the process of termination of service on account of continued ill-health in terms of section 17(2)(a) of the Public Service Act, as amended.

16.7. The Head of Department may extend the period of permanent incapacity leave referred to in paragraph 16.1 by a further 30 working days in order to finalise processes already commenced. If the processes set out in this Determination and Directive is not completed within the 60 working days, the Head of Department must report the case to the Director-General: Public Service and Administration together with a report explaining the reasons for the delay.

17. ACCEPTANCE OF MEDICAL CERTIFICATES

17.1. For purposes of normal sick leave medical certificates issued and signed by the practitioners and persons **who are certified to diagnose and treat patients and who are registered with the following professional councils** established by an Act of Parliament shall be accepted:

17.1.1. The Health Professions Council of South Africa.

17.1.2. The Allied Health Professions Council of South Africa.

17.1.3. The South African Nursing Council.

17.2. The registration details of service providers could be confirmed with the above-mentioned councils.

17.3. A medical certificate must contain the following information:

17.3.1. The name, address and qualifications of the practitioner or person.

17.3.2. The name of the patient.

17.3.3. The employment number of the patient (if applicable).

17.3.4. The date and time of examination.

17.3.5. Whether the practitioner is issuing the certificate as a result of personal observations during an examination or as the result of information received from the patient and which is based upon acceptable medical grounds.

17.3.6. If the patient has given informed consent for it to be disclosed, a description of the nature and extent of the illness or injury in layperson's language.

17.3.7. Whether the patient is totally indisposed for duty or whether the patient will be able to perform less strenuous duties in the work situation.

17.3.8. The exact period of recommended sick leave.

17.3.9. The date of issue of the certificate of illness.

17.3.10. A clear indication of the identity of the practitioner or person who issued the certificate.

17.3.11. The initial and surname in block letters, and the registration or practice number of the practitioner who issued the certificate.

17.4. If the practitioner or person uses pre-printed medical certificates, wording not applicable to the patient must be deleted.

17.5. The Head of Department must accept medical certificates that do not describe the nature and extent of an employee's illness for sick leave taken **during the normal sick leave cycle**, i.e. 36 working days in a 3-year cycle. The employer may request from the employee a medical certificate describing the nature and extent of the illness before granting sick leave, if the employee abuses the system during the normal sick leave period of 36 working days (e.g. a pattern of regular sick leave on Mondays or Fridays). If the employee fails to submit the required medical certificate, the Head of Department must notify the employee that if the prescribed medical certificate is not received within 2 working days, the sick leave period will be either regarded as unpaid leave or annual leave. If the employee fails to submit the medical certificate on time, the relevant absence must be covered by annual leave (with the employee's consent) and/or unpaid leave if insufficient annual leave credits are available and if the employee failed to notify the Head of Department of his/her choice. Failure by the employee to submit his/her medical certificate within the stated period must be viewed in a serious light and disciplinary steps against the employee should be taken.

17.6. For purposes of temporary incapacity leave the employer only accepts medical certificates issued and signed by practitioners registered with the Health Professional Council of South Africa and who are legally certified to diagnose and treat patients. Such medical certificates must describe that the illness or injury is temporary and, if the employee has given his/her informed consent, the nature and extent of the employee's illness or injury. The provisions contained in paragraph 17.3 above, applies *mutatis mutandis* in respect of such medical certificates.

17.7. ***The employer must, in accordance with the constitutional rights to privacy, the Code of Conduct in the Public Service Regulations treat at all times any information regarding the medical condition of an employee with the necessary respect and confidentiality.*** Such information may therefore not be disclosed to any other person(s) not authorised to receive such information. If an employee discloses such confidential information of one employee to any other unauthorized person, it must be viewed in a serious light and disciplinary steps against the transgressing employee should be taken.

18. GENERAL: SICK LEAVE

18.1. In the event where an employee has to –

18.1.1. consult a doctor, therapist, etc. for reasons related to the employees health/wellness, or

18.1.2. go for training related to a disability, e.g. a blind employee who has to get training with his/her guide dog, or

18.1.3. go for maintenance work for equipment used as a result of his/her disability, the Head of Department may grant such employees time off in terms of the sick leave provisions. [11]

18.2. Where an employee is absent for a part of the day, the Head of Department could manually record such time off until a full day is completed as sick leave. [12]

18.3. The Head of Department may require the necessary proof of such events or occurrences to properly monitor the utilisation of sick leave.

18.4. Fractions of sick leave entitlements may be converted using the formula in par.7.4 above.

18.5. An employee shall retain his/her sick leave credits in respect of a particular sick leave cycle, when the employee-

18.5.1. is transferred within a department or between departments; or

18.5.2. is appointed in terms of the Public Service Act, 1994 without a break in service.

[11] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS
[12] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS

19. LEAVE FOR OCCUPATIONAL INJURIES AND DISEASES

19.1. An employee who, as a result of his/her work, suffers an occupational injury or contracts an occupational disease, shall be granted occupational and disease leave for the duration of the period they cannot work.

19.2. If an employee suffers a work-related injury as a result of an accident involving a third party, the Head of Department shall grant him or her occupational injury leave provided that the employee:

19.2.1. brings a claim for compensation against the third party; and

19.2.2. undertakes to use compensation (in terms of the Compensation for Occupational Injuries and Diseases Act of 1993) received to recompense as far as possible for the cost arising from the accident.

19.3. The Head of Department shall take reasonable steps to assist an employee to claim compensation according to 19.2 above.

19.4. When an employee is injured on duty or contracted an occupational disease the employer must pay the employee's medical expenses in terms of the provisions of the Compensation on Occupational and Injury and Disease Act, The employer may, depending on the circumstances, recover certain expenses in the event where a third party was involved in the accident. Please refer to the guide: "*Application of the Compensation for Occupational Injuries and Diseases Act (COIDA) In the Workplace: A Guide for Government Departments*" for further details.

20. PRE-NATAL LEAVE (EFFECTIVE FROM 1 JANUARY 2013 ONLY)

20.1. A pregnant employee will be entitled to 8 working days pre-natal leave, per pregnancy, allowing the employee to attend medical examinations by a medical practitioner or midwife, and tests related to the pregnancy.

20.2. An employee can utilise a full day or part of a day for pre-natal leave. The Head of Department shall maintain a system to record episodes where the employee utilised part of a day. One day's pre-natal leave shall be deducted once the duration of absences equates the employee's prescribed daily working hours.[13]

20.3. An application for pre-natal leave should be supported by reasonable proof that the employee attended a doctor's appointment and/or went for tests related to the pregnancy.

20.4. An employee who has used all her pre-natal leave may, subject to the approval of the Head of Department, apply to use available annual leave and/or unpaid leave.

20.5. Absences related to medical complications during the pregnancy will be covered by sick leave.

20.6. All other maternity leave provisions, as defined in this Determination and Directive on Leave of Absence, remain applicable.

[13] Refer to Part 2 for the explanatory note on the application of this provision in relation to the IFMS.

21. MATERNITY LEAVE

21.1. Employees are entitled to 4 consecutive calendar months' maternity leave to commence:

21.1.1. at any time from four weeks before the expected date of birth; or

21.1.2. on a date from which the attending medical practitioner certifies that it is necessary for the employee's health or that of the unborn child.

21.2. It is preferable that an employee commences her maternity leave at least two weeks prior to the expected date of birth. However, the service delivery requirements of a particular Sector may require different arrangements with regard to the period and stage at which maternity leave, with due consideration of the employee and her unborn child's health and safety, should commence.

21.3. For at least six weeks after the birth, no employee may commence with normal official duty unless the attending practitioner certifies that the employee is fit to do so.

21.4. Maternity leave may only be interrupted if-

21.4.1. the baby is born prematurely and is hospitalised during maternity leave; or

21.4.2. the baby becomes ill and is hospitalised for a period longer than a month during the maternity leave.

21.5. The provisions contained in paragraph 21.4 are only applicable to an employee, who chooses to interrupt her maternity leave in these circumstances.

21.6. If an employee referred to in paragraph 21.4.1 and 21.4.2 above, chose to interrupt her maternity leave and failed to return to work after the six weeks mentioned in paragraph 21.3 above, such a period must be covered with annual leave or unpaid leave if she does not have enough annual leave available.

21.7. Maternity leave may be extended upon application by:

21.7.1. the granting of sick leave as a result of a medical complication;

21.7.2. the granting of up to 184 calendar days unpaid leave; or

21.7.3. the granting of annual leave.

21.8. Employees, who, during the third trimester of their pregnancy, experience a miscarriage, still birth or termination of the pregnancy on medical grounds, shall be eligible for six consecutive week's maternity leave[14] where after, 21.7.1 shall apply in the event of a medical complication.

21.9. Provisions in 21.8 above shall also apply to an employee who experiences a miscarriage, stillbirth or termination of pregnancy on medical grounds after the commencement of maternity leave. The period prior to the miscarriage, stillbirth or termination of pregnancy shall be regarded as special leave with full pay.

[14] Leave to begin after the miscarriage, stillbirth or the termination of pregnancy.

22. ADOPTION LEAVE[15]

22.1. An employee, who adopts a child that is younger than two years, shall qualify for adoption leave to a maximum of 45 working days, where after, 21.7.2 and 21.7.3 shall apply.

22.2. If both spouses or life partners are employed in the Public Service, both partners will qualify for adoption leave provided that the combined leave taken does not exceed the 45 working days mentioned in 22.1 above.

23. SURROGACY LEAVE

23.1. **Commissioning Parent**

23.1.1. With effect from 8 June 2018 an employee who is a commissioning parent in terms of a surrogate motherhood agreement confirmed by the High Court as contemplated in the Children's Act, 2005, is entitled to four (4) consecutive calendar months paid leave commencing from the date of the birth of the child.

23.1.2. The employee referred to in paragraph 23.1, above, must notify an employer in writing at least one (1) calendar month before a child is expected to be born as a result of a surrogate motherhood agreement, of the date on which the employee intends to commence with surrogacy leave.

23.1.3. If both commissioning parents are employed in the public service, only one (1) such parent will qualify for the surrogacy leave.

23.1.4. An application for surrogacy leave shall be supported by a surrogate motherhood agreement.

23.2. **Surrogate Mother**

23.2.1. An employee who is a surrogate mother, in terms of a surrogate motherhood agreement is entitled to six (6) consecutive weeks maternity leave.

23.2.2. An employee who is a surrogate mother may commence with normal official duty within the six (6) week period only if the attending practitioner certifies that the employee is fit to do so.

23.2.3. It is incumbent on the employee to notify the employer of the surrogate motherhood agreement and submit a copy thereof as soon as it has been confirmed by the High Court.

23.2.4. The employee's application for leave shall be supported by the surrogate motherhood agreement.

24. FAMILY RESPONSIBILITY LEAVE

24.1. Employees shall be granted 3 working days leave per annual leave cycle for utilisation if:

24.1.1. The employee's spouse or life partner gives birth to a child; or

[15] Refer to Part 3 for implementation notes.

24.1.2. The employee's child, spouse or life partner is sick.

24.2. Employees shall be granted 5 working days leave per annual leave cycle for utilisation if:

24.2.1. The employee's child, spouse or life partner dies; or

24.2.2. An employee's immediate family member dies.

24.3. The number of family responsibility leave days taken according to 24.1 and 24.2 above shall not exceed five (5) days in an annual leave cycle, unless special circumstances warrant further leave at the discretion of the Head of Department.

24.4. With effect from 1 January 2013 the provisions in paragraph 24.1 to 24.3 will cease to exist. Employees would henceforth be entitled to the following family responsibility leave benefits:

24.4.1. 5 working days family responsibility leave per annual leave cycle for utilisation if the employee's spouse or life partner gives birth to a child; or the employee's child, spouse or life partner is sick.

24.4.2. "Child" for purposes of paragraph 24.4.1 means the employee's son or daughter, who is under 18 years of age.

24.4.3. 5 working days leave per annual leave cycle for utilisation if the employee's child, spouse or life partner or an employee's immediate family member dies.

24.5. Immediate family member for purposes of paragraph 24.4.3 means the employee's parent, adoptive parent, step-parent, parents-in-law, sister- and brother-in-law, grandparent, child, adopted child, stepchild, grandchild or sibling. For the purposes of this provision "child" means the employee's son or daughter, and where applicable son- or daughter-in-law, of any age. The granting of family responsibility leave must be taken with due consideration of the employee's cultural responsibilities.

24.6. An application for family responsibility leave shall be supported by reasonable proof.

24.7. With effect from 20 May 2015 an employee who has a child(ren) with severe special needs shall be granted five (5) working days family responsibility leave per calendar year.

24.7.1. For the purposes of paragraph 24.7, a child with severe special needs is a child who has a mental, emotional or physical disability, certified by a medical practitioner, which requires health and related services of a type or amount beyond that required by children generally. For the purposes of this provision "child" means the employee's son or daughter of any age.

24.7.2. An application for family responsibility leave should be supported by reasonable proof to demonstrate the severe special needs of the employee's child.

24.8. Employees who have used all their family responsibility leave may, subject to the approval of the Head of Department, apply to:

24.8.1. use available annual leave; or

24.8.2. use up to 184 calendar days of unpaid leave.

24.9. Family responsibility leave may be taken for part of a day. For example an employee who takes three hours off to attend to a family responsibility would use only three hours of their family responsibility leave entitlements.

24.10. For purposes of utilising family responsibility leave entitlements, fractions or decimals must be utilised as they are. In other words fractions or decimals must not be rounded off.

24.11. Departments must keep manual records of the utilisation of family responsibility leave taken for part of a day. After reaching the daily number of working hours of attendance prescribed the employee must complete and submit a leave form. [16]

24.12. For purposes of converting fractions/decimals of family responsibility leave entitlements into working hours the formula in paragraph 7.4 above must be utilised.

25. PATERNITY LEAVE

25.1. With effect from 20 May 2015 an employee shall be granted three (3) working days paternity leave per calendar year for utilisation if the employee's spouse or life partner gives birth to a child or adopts a child not older than two (2) years.

25.2. An employee who has used all his/her paternity leave may, subject to the approval of the Head of Department, apply to:

25.2.1. use his/her part or all of 5 working days family responsibility leave provided for in paragraph 24.4.1, above; or

25.2.2. use available annual leave; or

25.2.3. use up to 184 calendar days of unpaid leave.

25.3. An application for paternity leave shall be supported by reasonable proof.

26. SPECIAL LEAVE

26.1. A special leave policy shall be negotiated in the relevant sectoral bargaining council.

26.2. The policy mentioned in 26.1 above shall define:

26.2.1. circumstances and conditions under which special leave is granted; and

26.2.2. as far as possible, events for which employees shall be granted special leave.

26.3. The policy may provide paid leave for such requirements as study, examinations, military service, resettlement due to a transfer, collective bargaining or other labour relations requirements, participation in sports, sabbaticals where appropriate or any other purpose.

[16] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS

27. LEAVE FOR OFFICE BEARERS OR SHOP STEWARDS OF RECOGNISED EMPLOYEE ORGANISATIONS

27.1. Office bearers or shop stewards of recognised employee organisations shall receive up to 10 working days paid leave per annum for activities related to his/her union position.

27.2. With effect from 1 January 2013 the entitlement for shop stewards contained in paragraph 27.1 will be increased to 15 working days.[17]

27.3. The 15 working days shall be pooled per recognised trade union. Office bearers or shop stewards belonging to the same recognised trade union may apply for leave days from the pool. A list of the recognised employee organisations are attached at Annexure C.

27.4. The Head of Department shall appoint an administrator of the pool. The administrator should preferably be the Human Resource Manager of the Department. The Head of Department shall develop standard operating procedures to ensure that the utilisation of the pool is properly managed, recorded and monitored to ensure that the leave days available in the pool is not exceeded and/or abused.

27.5. A shop steward may apply for leave from the pool in respect of the recognised employee organisation she/he belongs to only. An individual shop steward may apply due to the union activities attached to his/her union position for either less than or more than 15 working days in a leave cycle. However, the shop stewards accessing the same pool of leave may not exceed the total number of leave days available in the pool.

27.6. Shop steward leave may only be utilised for activities related to the employee's union position. All applications for this type of leave must be submitted in writing on the prescribed leave application form or electronically[18], together with supporting documentation.

27.7. If a shop steward of a recognised employee organisation has to perform union activities while on annual leave with full pay, such annual leave shall be converted to shop steward leave, provided that a formal request with supporting documentatary evidence are submitted substantiating that he/she had to perform union activities.

27.8. The employee's supervisor shall liaise with the Labour Relations Manager and Human Resource Manager to validate the employee's involvement in a union activity/business and whether sufficient credits are available in the leave pool.

27.9. Approved applications shall be captured on PERSAL or the IFMS, whichever system is in use in the Department.

28. UNPAID LEAVE

28.1. If an employee has utilised all his/her annual leave with full pay, the Head of Department may grant him or her unpaid leave.

28.2. Only in exceptional circumstances shall the Head of Department grant the employee more than 184 calendar days of unpaid leave in a period of 18 months.

[17] Refer to Part 3 for implementation notes.
[18] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS

28.3. Unpaid leave should be regarded as calendar days.

28.4. For purposes of calculating unpaid leave, the following formula applies:

$$\frac{A \times B}{365}$$

Where -

A = represents the employee's remuneration Levels 1-10: annual basic salary and MMS, the all-inclusive package)

B = represents the number of days annual leave without pay (i.e. **calendar** days)

365 = represents the number of **calendar** days in a year

Note: For computed EXAMPLES please refer to Annexure B.

29. LEAVE PROVISIONS FOR A CASUAL WORKER

29.1. A casual worker as defined in this Determination and Directive is in terms of the Basic Conditions of Employment Act, 1998, as amended not eligible to leave.

29.2. Departments are urged to ensure that the employment of casual workers is in terms of the agreement. Existing employees appointed as casual workers for longer than 24 hours per month, must be translated to temporary employees[19] with immediate effect.

30. LEAVE PROVISIONS FOR TEMPORARY[20] EMPLOYEES[21]

A temporary employee is eligible to the following types of leave on a pro rata basis linked to the duration of his/her contract. The utilisation of these leave types is subject to the rules that govern the relevant type of leave:

30.1. Annual leave:

A temporary employee shall at the beginning of his/her contract period be granted annual leave that is proportional to his/her term of employment at a rate of one-twelfth of the annual leave credit applicable to the employee category (as per Annexure A), per calendar month of service.

30.2. Normal Sick Leave:

A temporary employee shall at the beginning of his/her contract period be granted normal sick leave that is proportional to his/her term of employment at a rate of 1 days normal sick leave per calendar month of service.

[19] Refer to clause 11 of PSCBC Res 1 of 2007
[20] Refer to clause 11 of PSCBC Res 1 of 2007
[21] Refer also to the Determination on Interns and Learners

30.3. Maternity Leave:

30.3.1. A temporary employee shall be granted paid maternity leave that is proportional to her term of contract at a rate of 10 calendar days maternity leave with full pay calculated at each calendar month of her term of contract to a maximum of 4 calendar months, where after maternity leave without pay shall be granted. The total period granted in respect of maternity leave shall not exceed four consecutive calendar months.

30.4. Adoption

30.4.1. A temporary employee who adopts a child that is younger than two years, shall qualify for adoption leave at a rate of 4 working days paid leave for each calendar month of his/her term of contract to a maximum of 45 working days.

30.5. Surrogacy Leave

30.5.1. With effect from 8 June 2018 a temporary employee who is a commissioning parent in terms of a surrogate motherhood agreement confirmed by the High Court as contemplated in the Children's Act, 2005, shall be granted paid surrogacy leave that is proportional to his/her term of contract at a rate of ten (10) calendar days surrogacy leave with full pay calculated at each calendar month of his/her term of contract to a maximum of four (4) calendar months, where after surrogacy leave without pay shall be granted. The total period granted in respect of surrogacy leave shall not exceed four (4) consecutive calendar months.

30.5.2. A temporary employee who is a surrogate mother in terms of a surrogate motherhood agreement, confirmed by the High Court, provided for in the Children's Act, 2005, shall be granted paid maternity leave that is proportional to her term of contract at a rate of 3.5 calendar days maternity leave with full pay calculated at each calendar month of her term of contract to a maximum of six (6) consecutive weeks where after maternity leave without pay shall be granted.

30.6. Pre-Natal Leave (Effective from 1 January 2013 only)

30.6.1. A temporary employee who is pregnant shall qualify for pre-natal leave at a rate of 1 working day paid leave for each calendar month of her term of contract to a maximum of 8 working days.

30.7. Paternity Leave

With effect from 20 May 2015 a temporary employee who's spouse or life partner gives birth to a child or adopts a child not older than two (2) years shall qualify for paternity leave at a rate of 1 working day paid leave for each calendar month of his/her term of contract to a maximum of 3 working days.

30.8. Other Provisions:

The terms and conditions attached to the granting of the above types of leave, as well as the provisions contained in: paragraph(s) 10, 11, 12, 15, 16 (where applicable), 17 (where applicable), 19, 24, 26 and 31 apply *mutatis mutandis* to a contract worker.

31. GENERAL PROVISIONS

31.1. Except in exceptional circumstances, the employee may not stay away from his/her place of duty unless an application for leave of absence has been lodged in writing or electronically[22] and he/she has been informed by the Head of Department that the application has been approved.

31.2. Heads of Department must ensure that:

31.2.1. Leave forms are submitted for all absences and all outstanding leave forms are followed up.

31.2.2. All leave taken is captured on a daily basis and there are no backlogs in respect of each annual leave cycle.

31.2.3. Individual utilisation of leave is communicated to employees at the end of each annual leave cycle in respect of annual vacation leave.

31.3. **Duration of Employment**

31.3.1. For purposes of determining the length of an employee's employment with an employer for purposes of annual leave, normal sick leave and family responsibility leave, previous employment in the public service must be taken into account if the break between the periods of employment is less than one year. This principle applies in respect of each break in service that occurs in the career of an employee.

31.3.2. The leave entitlement of the employee referred to in paragraph 31.3.1 in respect of annual leave, normal sick leave and family responsibility leave should be reduced with the leave benefit granted (annual leave payouts included) plus the pro rata portion for the duration of the break in service.

31.3.3. For example -

31.3.3.1. If an employee with 10 years' service terminated his/her services on 30 April 2012 and is reappointed in the public service on 1 August 2012, she/he will be grouped in the leave category applicable to employees with 10 and more years' service, i.e. 30 working days.

(a) The 30 working days are reduced by-

i) the number of annual leave days the employee either utilised prior to his/her termination of service and/or received as a leave payout. Assuming for purposes of this example the employee received a leave payout in respect of unused annual leave for the period 1 January to 30 April 2012 amounting to 8.64 working days (2.16[23] x 4 months); and

[22] Refer to Part 2 for an explanatory note on the application of this provision in relation to the IFMS on page 7
[23] At the time of that the leave payout was made the employee was only entitled to 26 working days.

ii) the pro rata portion equivalent to the break in service. In this example it would amount to 6.48 working days.

(b) The remaining leave credits, if any, will then be available to the employee for the remainder of the leave cycle. In this example the employee would be eligible to 14.88 working days annual leave. (15.12 – 30 = 14.88).

31.3.3.2. In respect of normal sick leave it is assumed for purposes of this example that the employee referred to in paragraph 31.3.3.1 utilised 15 working days normal sick leave prior to his/her termination of service. The pro rata portion equivalent to the period in break in service amounts 3 working days. The employee is thus eligible to 18 working days normal sick leave for the remainder of the sick leave cycle at reappointment. (i.e. 18-36=18)

31.3.3.3. If the employee referred to in paragraph 31.3.3.1 have not utilised any family responsibility leave prior to his/her termination of service, this entitlement will be reduced with 1.25 working days representing the pro rata portion of his/her break in service. The employee will thus be eligible to 3.75 working days' family responsibility leave for the remainder of the leave cycle.

31.4. **Training of disabled employees**

31.4.1. Disabled employees must be afforded the opportunity to undergo training to manage their disability. Training required to be able to utilise equipment or the like to access the workplace and to perform the job, should be treated the same as other official training provided to equip employees with the knowledge and skills to do their jobs. The employee with a disability should therefore be offered the relevant training while on official duty.

31.5. **Fitment, adjustment or maintenance of equipment of disabled employees**

31.5.1. If a disabled employee needs periods or time off to fit, adjust or maintain equipment to enable the employee to perform his/her job, it should be treated in terms of paragraph 18 above.

ANNEXURE A

Leave Entitlements

	EMPLOYEE CATEGORY	ANNUAL LEAVE EXPRESSED AS WORKING DAYS
1.	Institution-based educators	As per ELRC Res.7/2001
2.	Office-based educators	As per ELRC Res.7/2001
3.	Non-teaching staff based at schools/institutions	
	Less than 10 years service	27
	10 or more years service	30
4.	Nursing personnel in institutions that provide 24 hour service	
4 (a)	Student and pupil nurses	22
4 (b)	Part-time nurses:	
	Less than 10 years service	22
	10 or more years of service	30
4 (c)	Registered/enrolled nurses and nursing assistants:	
	Less than 10 years service	22
	10 or more years of service	30
5.	Other employees:	
	Less than 10 years service	22
	10 or more years of service	30

COMPUTED EXAMPLES

Calculating Annual Leave at Termination of Service

EXAMPLE 1: Employees Levels 1 – 10

The employee resigns with effect from 1 April 2008, the employee's remuneration on the last day of duty is R102 750 (in other words R 75 000 (annual basic salary) + R27 750 (in respect of the 37%)), s/he falls in the 22 working day leave category and has taken at least 10 working days' leave.

The cash value in respect of unused leave credits should be computed in the following manner:

$$\frac{\{(A - B) + (C - D)\} \times E}{260{,}714}$$ [24]

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

B = represents the leave taken in the previous leave cycle

C = represents the pro rata leave entitlement in the current leave cycle (Calculated according to the formula in A above)

D = Leave taken in the current leave cycle

E = Represents the employee's remuneration (i.e. annual basic salary plus 37%)

STEP 1

Use the given information on the employee's leave category to determine A. In the event of a full annual leave entitlement, use Annexure A and in the event of a pro rata leave entitlement (in the previous leave cycle)[25], use the formula in STEP 3 below.

[24] This formula is in terms of paragraph 9.6 of the Determination issued by the MPSA.

[25] The pro rata leave entitlement in this regard is in respect of employees appointed after a leave cycle has commenced

STEP 2

Use the given information to determine B (Leave taken in the previous leave cycle) and D (Leave taken in the current leave cycle).

STEP 3

Use the formula in STEP 1 above to determine C (pro rata leave entitlement in the current leave cycle beginning 1 January 2008 up to and including the last day of duty).

$$\frac{X \times Y}{12}$$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

In other words: $= \frac{3 \times 22}{12}$

$= \underline{5.5 \text{ days}}$

STEP 4

Use the given information to determine E

STEP 5

Compute the cash value of leave credits available in the following manner:

$$\frac{\{(A - B) + (C - D)\}^{26} \times E}{260.714}$$

Cash value $= \frac{\{(22 - 10) + (5.5 - 0)\} \times R\ 102\ 750}{260.714}$

$= \frac{(12 + 5.5) \times R\ 102\ 750}{260.714}$

$= \frac{17.5 \times R\ 102\ 750}{260.714}$

$= \underline{R6\ 896.92}$

[26] The sum total of A – B and C - D must not exceed the maximum number days annual leave an employee is entitled to as depicted in Annexure A to this Determination.

NOTE:

The pro rata leave credits in this EXAMPLE derive from the leave credits in the current leave cycle beginning from 1 January 2008 to 31 March 2008.

EXAMPLE 2: Middle Management Service (MMS) employees

The member resigns with effect from 1 November 2007, the all-inclusive salary package on the last day of duty is R369 000 per annum, he falls in the 30 working day leave category and taken at least 5 working days' leave.

The cash value in respect of unused leave credit should be computed in the following manner:

$$\frac{\{(A - B)^{27} + (C - D)\} \times E}{260.714}$$

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A;

B = represents the leave taken in the previous leave cycle

C = represents the pro rata leave entitlement in the current leave cycle (Calculated according to the formula in A above)

D = Leave taken in the current leave cycle

E = Represents the employee's remuneration (i.e. annual inclusive package)

STEP 1

Determine C using the following formula:

$$\frac{X \times Y}{12}$$

Where –

X = Number of completed months of service in the leave cycle.

Y = Normal annual entitlement as per Annexure A.

[27] Since the termination of service happens after the expiry of the 6 months period, information on A and B will be represented by 0.

In other words: = $\frac{10 \times 30}{12}$

= 25 days

STEP 2

Use the given information to determine D. (Leave taken in the current leave cycle).

STEP 3

Compute the cash value of available leave credits using the following formula:

Cash value = $\frac{\{(A - B) + (C - D)\}^{28} \times E}{260.714}$

= $\frac{((0 - 0) + (25 - 5)) \times R369\,000}{260.714}$

= $\frac{20 \times R369\,000}{260.714}$

= R 28 306.88

[28] The sum total of A – B and C – D must not exceed the maximum number of days annual leave entitlement as depicted in Annexure A of this Determination.

Calculating Annual Leave: Leave Payout of Unused Leave at the Expiry of the 6 Month Grace Period of a Leave Cycle

EXAMPLE 3: Employees Levels 1 – 10

The employee has unused leave credits at the expiry of the 6 months period at the end of 30 June 2008, the employee's remuneration on the last day of June is R102 750 (in other words R 75 000 (annual basic salary) + R27 750 (in respect of the 37%)), s/he falls in the 22 working day leave category and has taken at least 10 working days' leave.

The cash value in respect of unused leave credits should be computed in the following manner:

$$\frac{(A - B) \times C}{260{,}714}$$ [29]

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

B = represents the leave taken in the previous leave cycle

C = Represents the employee's remuneration (i.e. annual basic salary plus 37%)

STEP 1

Use the given information on the employee's leave category to determine A. In the event of a full annual leave entitlement, use Annexure A and in the event of a pro rata leave entitlement (in the previous leave cycle)[30], use the formula in STEP 3 below.

STEP 2

Use the given information to determine B (Leave taken in the previous leave cycle)

[29] This formula is in terms of paragraph 9.7 of the Determination issued by the MPSA

[30] The pro rata leave entitlement in this regard is in respect of employees appointed after a leave cycle has commenced

STEP 3

Compute the cash value of leave credits available in the following manner:

$$\frac{(A - B) \times C}{260.714}$$

Cash value = $\frac{(22 - 10) \times R\ 102\ 750}{260.714}$

= $\frac{12 \times R\ 102\ 750}{260.714}$

= R 4729.32

EXAMPLE 4: Middle Management Service (MMS)

The employee has unused leave credits at the expiry of the 6 months period at the end of 30 June 2008, the all-inclusive salary package on the last day of duty is R369 000 per annum, he falls in the 26 working day leave category and taken at least 10 working days' leave.

The cash value in respect of unused leave credit should be computed in the following manner:

$$\frac{(A - B) \times C}{260.714}$$

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

B = represents the leave taken in the previous leave cycle

C = Represents the employee's remuneration (i.e. annual inclusive package)

STEP 1

Use the given information on the employee's leave category to determine A. In the event of a full annual leave entitlement, use Annexure A and in the event of a pro rata leave entitlement (in the previous leave cycle)[31], use the formula in STEP 3 below.

STEP 2

Use the given information to determine B. (Leave taken in the current leave cycle).

STEP 3

Compute the cash value of available leave credits using the following formula:

$$\text{Cash value} = \frac{(A - B) \times C}{260.714}$$

$$= \frac{(26 - 10) \times R369\,000}{260.714}$$

$$= \frac{16 \times R369\,000}{260.714}$$

$$= R\,22\,645.50$$

[31] The pro rata leave entitlement in this regard is in respect of employees appointed after a leave cycle has commenced

Calculating Capped Leave

EXAMPLE 5: Employees levels 1 - 10

The employee retires or dies or is medically boarded with effect from 1 August 2007, the employee's remuneration on the last day of duty is R268 520 (in other words R 196 000 (annual basic salary) + R72 520 (in respect of the 37%)), s/he falls in the 26 working day leave category and has taken at least 10 working days' leave with 200 days of capped leave which has already been converted into working days

The cash value payable in respect of capped and audited leave at termination of service should be computed as follows:

$$\frac{\{[(A-B) + (C-D)] \times E + (F \times G)\}}{260.714}$$

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

B = represents the leave taken in the previous leave cycle

C = represents the pro rata leave entitlement in the current leave cycle (Calculated according to the formula in A above)

D = Leave taken in the current leave cycle

E = Represents the employee's remuneration (i.e. annual basic salary plus 37%)

F = represents the capped leave

G = represents the employee's remuneration (levels 1-10 the annual basic salary only) as at the last day of duty

STEP 1

Use the given information on the employee's leave category to determine A. In the event of a full annual leave entitlement, use Annexure A and in the event of a pro rata leave entitlement (in the previous leave cycle)[32], use the formula in STEP 3 below.

STEP 2

Use the given information to determine B (Leave taken in the previous leave cycle) and D (Leave taken in the current leave cycle).

STEP 3

Use the formula in STEP 1 above to determine C (pro rata leave entitlement in the current leave cycle beginning 1 January 2007 up to and including the last day of duty).

$$\frac{X \times Y}{12}$$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

In other words: $= \frac{7 \times 26}{12}$

$= 15.16$ days

STEP 4

Use the given information to determine E

STEP 5

Use the given information to determine F. Convert capped leave into working days using the following formula (if not programmatically done already):

$$\frac{A \times 5}{7}$$

Where -

A = Number of audited leave credits

STEP 6

Use the given information to determine G

[32] The pro rata leave entitlement in this regard is in respect of employees appointed after a leave cycle has commenced

STEP 7

Compute the cash value of leave credits available in the following manner:

$$\frac{\{[(A-B) + (C-D)] \times E + (F \times G)\}}{260.714}$$

Cash value = $\frac{\{[(0 - 0) + (15.16 - 10)] \times R268\,520 + (200 \times R196\,000)\}}{260.714}$

$$= \frac{\{[(0 + 5.16)] \times R268\,520 + (R39\,200\,000)\}}{260.714}$$

$$= \frac{(5.16 \times R268\,520 + (R39\,200\,000))}{260.714}$$

$$= \frac{R1\,385\,563.20 + R39\,200\,000}{260.714}$$

$$\frac{40\,585\,563.20}{260.714}$$

R155 670.82

EXAMPLE 6: Middle Management Service (MMS) Employees

The employee retires or dies or is medically boarded with effect from 1 August 2007, the employee's remuneration on the last day of duty is R369 000 (all inclusive package), s/he falls in the 26 working day leave category and has taken at least 10 working days' leave with 200 days of capped leave which has already been converted into working days

The cash value payable in respect of capped and audited leave at termination of service should be computed as follows:

$$\frac{\{[(A-B) + (C-D)] \times E + (F \times G)\}}{260.714}$$

Where:

A = represents the full annual or pro rata leave entitlement in the previous leave cycle (Pro rata leave entitlement calculated as $\frac{X \times Y}{12}$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

B = represents the leave taken in the previous leave cycle

C = represents the pro rata leave entitlement in the current leave cycle (Calculated according to the formula in A above)

D = Leave taken in the current leave cycle

E = Represents the employee's remuneration (i.e. annual inclusive package)

F = represents the capped leave

G = represents the employee's remuneration (MMS - the annual basic salary only) as at the last day of duty

STEP 1

Use the given information on the employee's leave category to determine A. In the event of a full annual leave entitlement, use Annexure A and in the event of a pro rata leave entitlement (in the previous leave cycle)[33], use the formula in STEP 3 below.

[33] The pro rata leave entitlement in this regard is in respect of employees appointed after a leave cycle has commenced

STEP 2

Use the given information to determine B (Leave taken in the previous leave cycle) and D (Leave taken in the current leave cycle).

STEP 3

Use the formula in STEP 1 above to determine C (pro rata leave entitlement in the current leave cycle beginning 1 January 2007 up to and including the last day of duty).

$$\frac{X \times Y}{12}$$

Where:

X = represents the number of completed months in the current leave cycle; and

Y = represents the annual leave entitlement per leave cycle as per Annexure A)

In other words: $= \frac{7 \times 26}{12}$

$= 15.16$ days

STEP 4

Use the given information to determine E

STEP 5

Use the given information to determine F. Convert capped leave into working days using the following formula (if not programmatically done already):

$$\frac{A \times 5}{7}$$

Where -

A = Number of audited leave credits

STEP 6

Use the given information to determine G

STEP 7

Compute the cash value of leave credits available in the following manner:

$$\frac{\{[(A-B) + (C-D)] \times E + (F \times G)\}}{260.714}$$

$$\text{Cash value} = \frac{\{[(0 - 0) + (15.16 - 10)] \times R369\,000 + (200 \times R280\,440)\}}{260.714}$$

$$= \frac{\{[(0 + 5.16)] \times R369\,000 + (R56\,088\,000)\}}{260.714}$$

$$= \frac{(5.16 \times R369\,000 + (R56\,088\,000))}{260.714}$$

$$= \frac{R1\,904\,040 + R56\,088\,000}{260.714}$$

$$\frac{R57\,992\,040}{260.714}$$

R222 435.46

Calculating Over-Granted Annual Leave

EXAMPLE 7: Employees level 1 - 10

An employee has been over-granted 10 days leave. The employee's annual basic salary plus 37% at that stage is R83 656:

$$\frac{A \times B}{260.714}$$

Where-

A	=	Represents the employee's remuneration
B	=	represents the number of days annual leave over-granted
260.714	=	represents the number of working days in a year

STEP 1

$$\frac{R\ 83\ 656 \times 10 \text{ days}}{260.714}$$

STEP 2

$$\frac{R\ 836\ 560}{260.714}$$

= R3 208.72 (value in Rand of leave days being over-granted)

Note: The value in Rand must not be rounded off. Annual leave over-granted is calculated as working days.

EXAMPLE 8: Middle Management Service (MMS) employees

A member has been over-granted 10 days leave. The member's all-inclusive salary package at that stage is R 369 000

$$\frac{A \times B}{260.714}$$

Where-

A	=	represents the employee's remuneration (i.e. all inclusive package)
B	=	represents the number of days annual leave over-granted
260.714	=	represents the number of working days in a year

STEP 1

R 369 000 X 10 days = R3 690 000

STEP 2

$$\frac{\text{R3 690 000}}{260.714}$$

= R14 153.44 (value in Rand of leave days being over-granted)

Note: **The value in Rand must not be rounded off. Annual leave over-granted is calculated as working days.**

Calculating Unpaid Leave

EXAMPLE 9: Employees levels 1 - 10

An employee has taken 15 calendar days unpaid leave. The employee's annual basic salary at that stage is R83 656:

$$\frac{A \times B}{365}$$

Where-

A = Represents the employee's remuneration (i.e. annual basic salary)

B = represents the number of days annual leave without pay (i.e. calendar days)

365 = number of calendar days in a year

STEP 1

$$\frac{R83\,656 \times 15 \text{ days}}{365}$$

STEP 2

$$\frac{R1\,254\,840}{365} = R3\,437.91 \text{ (value in Rand of leave taken without pay)}$$

Note: The value in Rand must not be rounded off. Leave without pay is calculated as calendar days

EXAMPLE 10: Middle Management Service (MMS) Employees

A member has taken 15 calendar days unpaid leave. The member's all-inclusive remuneration package at that stage is R 369 000:

$$\frac{A \times B}{365}$$

Where-

A = Represents the employee's remuneration (i.e. the all inclusive package)

B = represents the number of days annual leave without pay (i.e. calendar days)

365 = number of calendar days in a year

STEP 1

$$\frac{\text{R 369 000 x 15 days}}{365}$$

STEP 2

$$\frac{\text{R5 535 000, 00}}{365}$$

= R15 164, 38 (value in Rand of leave taken without pay)

Note: **The value in Rand must not be rounded off. Leave without pay is calculated as calendar days.**

ANNEXURE C

LIST OF THE RECOGNISED EMPLOYEE ORGANISATIONS

DENOSA/SAMA

HOSPERSA/NATU/NUPSAW

NAPTOSA/SAOU

NEHAWU/PAWUSA

POPCRU/SASAWU

PSA/UNIPSAWU/NPSWU

SADTU/CTPA

SAPU/PEU

Annexure

DATE: 23/06/2021

DEPARTMENT: WARD 16B

GRIEVIENCE FOR WARD 16B STAFF

We, the staff of ward 16B, complaining of the following working conditions:

1. Overcrowded

According to the geographical layout of ward 16B, Bed occupancy is equals to 35, but we are always having +- 72-80 patients. Our ward statistics is always on the minus, whereas the number of staff to render patient care has never been increased leading to overwhelming and burnout of nursing staff which may aggravate high absenteeism. There is no enough space in the cubicles for social distance between babies and worse during visiting time when mothers for all those babies have to visit, that place nurses and other allied workers risk of contacting infections.

2. Shortage of equipment

Due to a massive influx of patients that were supposed to be attended to at Charlotte Maxeke Johannesburg Academic Hospital (CMJAH), no extra equipment was provided during crisis to provide quality patient care, causing conflict amongst the Nursing Staff and the Doctors.

3. Broken incubators, cribs, infusion pumps, baxter machine and monitors

We have lots of equipment that have been broken for a long time and lying in the unit without being condemned or replaced. Also when other equipment took long time when send for service. How long does equipment take to be serviced?

4. Suppliers or stock

We are having a major problem with shortage of stock, preventing us from performing our duties. Ever since we have patients from CMJAH, we always run out of stock and some have been out for a long period

5. Shortage of Staff

Staff shortage poses a major threat on the staff that will be working We have been experiencing high shortage of staff almost every day. High absenteeism rate due to sick, personal and family matters and burnout. Nursing staff that were provided from CMJAH are not useful enough, coming late and going off early, others absconding, absent and/or reporting sick putting strain on the remaining staff, leading to exhaustion and absenteeism.

6. Covid-19 patients

As we are admitting Covid-19 patients under investigation, they are mixed with non-PUI patients in the same Cubicle. How are we supposed to nurse those patient? According to acquity of Covid-19 patients or Patients under Investigation is to be nursed alone by one staff member, but in our unit one staff member is allocated to nurse all patient.

Recently we had to receive three babies from Kangaroo Mother Care ((KMC), who were with their mothers who tested positive for Covid-19 in Cubicle six mixed together with babies from PICU who are not under investigation. This is risk to other patient and staff.

7. Staff-patient ratio

Since ward 16B is a Neonatal ward with 9 cubicles, four of those cubicles accommodate 12-16 babies, how many staff are supposed to be allocated to Nurse those patients? We need acquity of neonates.

8. Nursing patient on Nasal C PAP

Nasal CPAP is an ICU case. In every Neonatal ICU, there is under no circumstance that a nurse can be allocated to nurse more than two (2) babies on NCPAP, but in ward 16B one professional Nurse and Enrolled Nurse or assistant nurse to nurse 3-4 NCPAP plus other 10-12 babies on Blender or Room Air. Why babies on NCPAP or Blender oxygen not nursed on monitor? Because in ICU all babies including Room Air are on monitors. What is the difference between babies nursed on Nasal CPAP in Ward 16B and babies in ICU?

We need separate cubicle(s) for all ICU cases, like NCPAP and cooling babies with their own staff and same ratio with ICU as they are regarded as critical high care patients.

9. X-RAY

We need to know whose responsibility is to wear LED apron? Because it is not stated in our scope of practice. The responsibility of the nurse duding radiation is to assist pre radiation and post radiation only with critical babiesand not to be

exposedby radiation unnecessary. Wearing of LED apron is stated clearly in the Scope of practice of Radiographer not of nurses. Re-scope of practice.

10. Re-structuring of Labour Admission

Labour Admission have only two monitors and two blender oxygen which means that it can only accommodate two babies at a time, but we usually receive more than that not knowing where to place other babies that needed oxygen and monitors. We are requesting that two (2) professional Nurse and other enrolled or auxiliary nurse to work there. It is very difficult for one professional Nurse to be responsible alone in Labour Admission like: commencing NCPAP, administering medication, commencing intravenous fluids, compiling a file for admission, entering of babies in the register, transporting, monitoring babies writing report, feeding, resuscitating, assisting with intubation, commencement of cooling, phototherapy , running around looking for equipment and attending to babies that came for immunizations from Nelson Mandela Children Hospital,

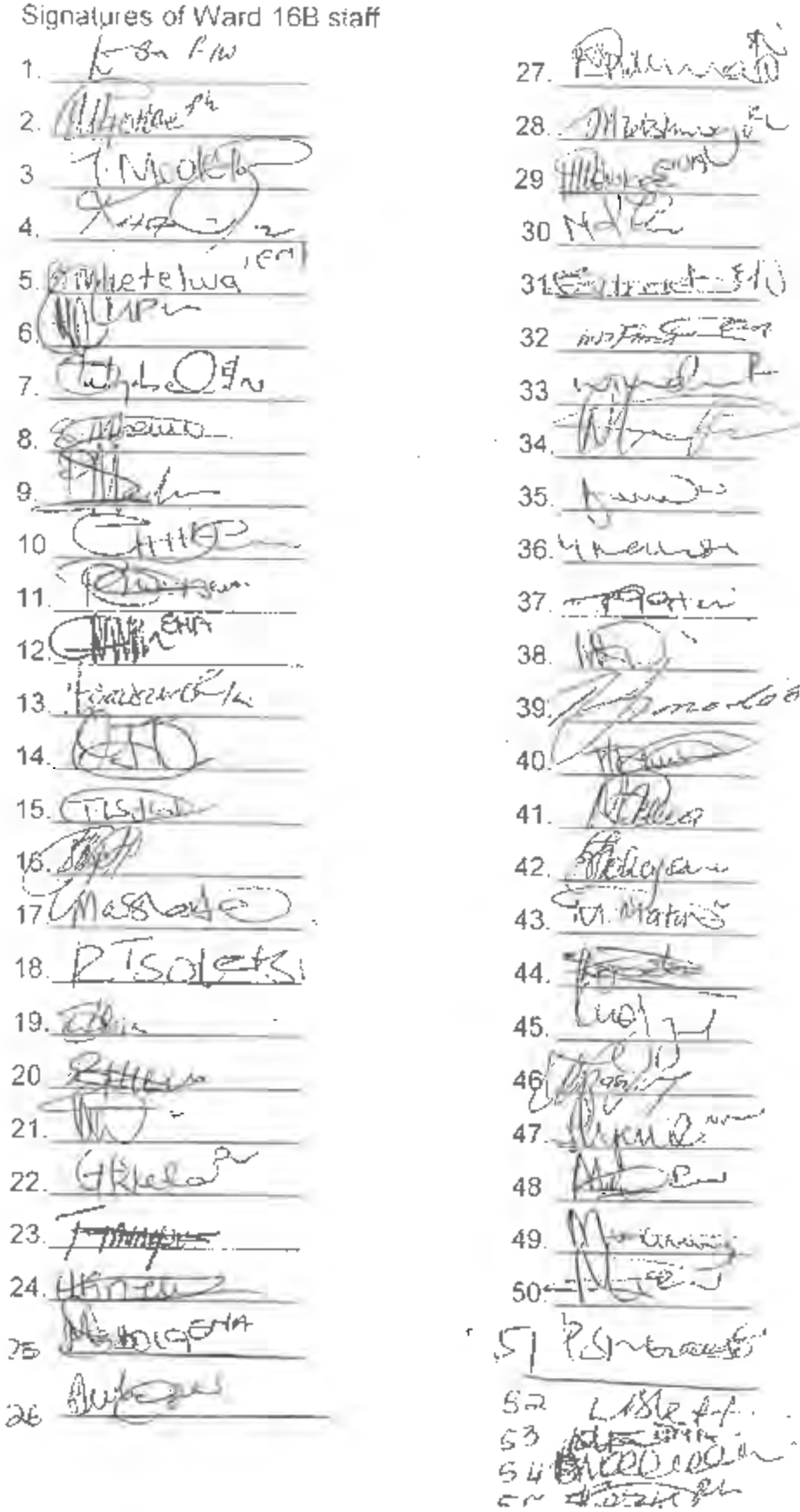
11. Environment

It is very cold in the unit, since steam pipes are not working, babies and staff are freezing which makes us difficult to work and expose us to cold and flu. We are not allowed to work with jerseys to keep us warm and babies are cold, we always short of linens and bunny blankets. May we please have enough heaters. One of our right as nurses is to work in a safe conducive environment.

Signed at: Rahima Moosa Mother and Child Hospital

Date: 2021

Signatures of Ward 16B staff



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Annexure

CLINICAL Unit – ORTHOPAEDIC

R 1 234 ... – R 1 ... 000.00 (all-inclusive remuneration package of which a portion could be structured according to the individual's needs)
R 1 ... – R 2 ... 000.00 (all-inclusive remuneration package of which a portion could be structured according to the individual's needs)
Helen Joseph Hospital
Academic involvement. Minimum five (5) years' ... as specialist/sub-specialty. Registration with ... Specialist or in Orthopaedic, subspecialty for a ... registration with HPCSA as Orthopaedic Specialist ... to do prescribed overtime. Must be part of WITS ... Added Advantage: registration in any Orthopaedic ... 3 years.
... and offer good quality comprehensive Orthopaedic ... actively manage administrative functions, including ... Optimally supervise, instruct and lead ... registrars, medical officers, interns as well as Allied ... render outreach and support services to other ... Participate in academic activities at undergraduate level as required, including outside the Department. ... conduct research, and publish articles regularly. South African Orthopaedic Association Annual ... continuing medical education, as required by the ... of South Africa. Support and initiate research ...
... Gaulajwe Tel: 011 489 0892

DEPUTY DIRECTOR GENERAL: CORPORATE SERVICES
(5 year fixed term contract appointment based on performance)
Corporate Services
DDGRE.../2020
R1 5... per annum (all-inclusive remuneration package)
... a recognised undergraduate NQF level 7 tertiary ... Management/Public Administration/ Public ... plus a post graduate NQF level 8 ... by SAQA. A minimum of 8-10 years' relevant ... Management Level. A valid Driver's Licence. ... Office packages (Word, Excel and Power-point). Must ... knowledge of the Basic Conditions of Employment Act, Employment Equity Act, PFMA, Intergovernmental ... and etc. skills: Strong strategic capability and ... management, project management and people ... presentation and excellent report writing skills.
... candidate will be responsible for providing strategic ... in relation to Legal Services, ICT, Communications, ... Security services, Strategic Planning and ... Manage the coordination of strategic planning ... Standards and customer care. Manage the ... monitoring and evaluation services. Ensure ... development and management of the strategic and ... Department. Ensure provisioning of human ... services. Management of human resources ... relations services. Management of human ... and human resources planning, strategy and systems. ... the provisioning of employee wellness and related ... organisational design services. Management of ... of change management initiatives. Ensure ... the development of transformation policies ... Manage development of HR policies and ... capital challenges. Implement effective recruitment ... to attract and retain highly talented managers and ... development and implementation of Employment ... and Service Delivery Improvement plans. Implementation ... management and development strategy in the ... of overall departmental Information ... Technology services. Manage the development, ... ICT policies, processes and procedures. ... of ICT administrative systems and data ... support service. Oversee physical security ... implementation of information technology ... provisioning of vetting services. Manage ... services. Provide sound legal advice and ... department. Oversee provisioning of legal opinions, ... litigation matters. Manage drafting of service level ... provisioning of internal and external communication ... development and implementation of knowledge ... provisioning of media liaison services. Manage ... mental communications and outreach programmes. ... of shared ancillary services. Ensure sound records ... Manage development of policies and processes for ... services. Manage the Corporate Services Branch's ... Responsible for the management, maintenance and ... departmental assets.
... LA Maloiane Tel: 082 607 5967

CHIEF DIRECTOR: HUMAN RESOURCE MANAGEMENT
H.../2020
R1 251 183 per annum (all-inclusive remuneration package, of which a portion could be structured according to the individual's needs)
Central Office, Johannesburg
... recognised SAQA-recognised undergraduate ... (NQF level 7) in Human Resource Management or Social ... qualification (NQF level 8) in Human Resource ... an added advantage. Five (5) years' experience in ... management at a Senior Management level preferably in ... of Health Sector. Driver's licence. Proven experience ... of the human resources management value chain ... understanding of HR business partnering. Competencies ... capability and leadership. Financial management. Project ... leadership and management. Problem solving. Client ... management. Policy analysis and development. Solid ... communication skills. Report writing. Negotiation and ... knowledge of Microsoft Excel, Word and Project ... and Understanding of the legislative framework ... service, e.g. Public Service Act, 1994; Public Service ... PFMA, 1999 & Regulations; Basic Conditions of ... Labour Relations Act, 1995; Employment Equity Act, ... Act, 1998, OHSA, 1993 and all PSCBC & GPSSBC ... National Health Act of 2003. Knowledge of dynamics ... Governance Systems and Operations, relevant to ... Knowledge of the PFMA. Good understanding of ... Service Human Resource Regulatory framework ... functions projects/plans. Excellent coordination and ... Knowledge of Government policies and initiatives ...

provinces. Development, implementation and monitoring of a framework for harmonised standards, policies and Clinical Practice Guidelines in EMS including standardisation of emergency centres and implementation of policies. Proper understanding of ICT environment ... is critical for the optimal delivery of EMS as well. Formulate and execute strategic and operational policies and plans for the Chief Directorate in line with departmental priorities is essential. Coordination and liaison with allied stakeholders including planning, coordination and monitoring of all radio communication in the Province. Utilisation of Information Technology and other Information management systems to enhance service delivery and cost effectiveness in all areas of EMS. Representing the Gauteng Department of Health nationally, regionally and internationally is a key requirement of the post. Compilation of monthly reports to Executive management as well as presenting to Legislature from time to time. Liaise with key stakeholders in order to achieve key strategic goals of the Department. Comprehensive understanding of financial management and supply chain management are key requirements. Identifying and implementing the most suitable work procedures to attain efficiency. Developing, implementing and monitoring Health and Safety guidelines and channels for EMS. Guide and stimulate the Chief Directorate to be innovative and achieve optimal use of funds. Facilitating the development and implementation of an EMS research and development competency within EMS for best practices in Emergency Medical and ethical care management and training processes of EMS managers and practitioners.
ENQUIRIES: Mr. LA Maloiane Tel: 082 607 5967

POST: **CHIEF EXECUTIVE OFFICER (3 POSTS)**
(5-Year Fixed Term Contract Appointment Based on Performance)
REFERENCE: Helen Joseph hospital: CEOHJH/GDOH/05/2020
Thelle Mogoerane hospital: CEOTMH/GDOH/05/2020
Rahima Moosa Mother & Child hospital: CEORMMCH/GDOH/05/2020
SALARY: R1 251 183 per annum (all-inclusive remuneration package, of which a portion can be structured according to the individual's needs)
(Helen Joseph Hospital)
R 1 057 326 per annum (all-inclusive remuneration package, of which a portion can be structured according to the individual's needs)
CENTRE: Thelle Mogoerane hospital, Helen Joseph Hospital, Rahima Moosa Mother and Child Hospital
REQUIREMENTS: A degree in a health-related field, registration with the relevant professional body, a post graduate degree in management will be an added advantage, management experience in the health environment is required. A valid driver's licence is an inherent requirement.
COMPETENCIES: Knowledge of relevant legislation such as National Health Act, Public Finance Management Act (PFMA), Public Service Act and related Regulations and policies. Core Competencies: Strategic capability and leadership. Programme and project management, Financial Management, Change management, People management and empowerment. Process Competencies: Service delivery innovation, Knowledge management, Problem solving and analysis, Communication, Client orientation and customer focus.
DUTIES: Job Purpose: to plan, direct, coordinate and manage the efficient and effective delivery of clinical and administrative support services through working with the key executive management team of the hospital within the legal and regulatory framework, to represent the hospital authoritatively at provincial and public forums, to provide strategic leadership to improve operational efficiency within the health establishment to improve health outcomes. Strategic Planning: prepare a strategic plan for the hospital to ensure that it is in line with the 10-point plan, national, provincial, regional and district plans. Financial Management: maximise revenue through collection of all income due to the hospital, ensure that the hospital is managed within budget in line with the PFMA and relevant guidelines, ensure that adequate policies, systems and procedures are in place to enable prudent management of financial resources, planning of financial resource mobilisation, monitoring and evaluation and asset and risk management. Facility Management: ensure business support and systems to promote optimal management of the institution as well as optimal service delivery, ensure that systems and procedures are in place to ensure planning and timeous maintenance of facilities and equipment. Human Resource Management: develop, implement and maintain human resource management policies and guidelines, systems and procedures that will ensure effective and efficient utilisation of human resources; promote a safe and healthy working environment through compliance with relevant legislation including occupational health and safety committees. Ensure continuous development and training of personnel and implement monitoring and evaluation of performance. Procurement and Management of Equipment and Supplies: implement a procurement and provisioning system that is fair, transparent, competitive and cost effective in terms of provincial delegated authority and in line with the PFMA, ensure that goods and services are procured in a cost effective and timely manner. Clinical and Corporate Governance: oversee clinical governance to ensure high standards of patient care; establish community networks and report to the Hospital Board. Responsible for corporate governance inclusive of infrastructure planning and maintenance as well as occupational health and safety; manage the institution's risks to ensure optimal achievement of health outcomes, report writing skills. Willing to work after hours, standby or on call basis.
ENQUIRIES: Dr A Mochaba Tel: 011 721 5501

POST: **CHIEF EXECUTIVE OFFICER (2 POSTS)**
(5-Year Fixed Term Contract Appointment Based on Performance)
REFERENCE: Tshwane District Hospital: CEOTDH/GDOH/05/2020
Heidelberg Hospital: CEOHH/GDOH/05/2020
SALARY: R 869 007 per annum (all-inclusive remuneration package, of which a portion could be structured according to the individual's needs)
CENTRE: Tshwane District Hospital, Heidelberg Hospital
REQUIREMENTS: Degree in health-related field and registration with the relevant professional body. A post-graduate qualification in Management. Strong Management experience in health environment is required. Strong behavioural attributes with the ability and stature to manage KPAs of highly qualified health specialists. Demonstrate excellent knowledge of the public health sector. COMPETENCIES: Knowledge of relevant legislation such as National Health Act, Public Finance Management Act (PFMA), Public Service Act and related regulations and policies. Core Competencies: Strategic capability and leadership. Programme and project management, Financial Management, Change management, People management and empowerment. Process Competencies: Service delivery innovation, Knowledge management, Problem solving and analysis, Communication, Client orientation and customer focus.
DUTIES: Job Purpose: to plan, direct, co-ordinate and manage the efficient and effective delivery of clinical and administrative support services through working with the key executive management team of the hospital within the legal and regulatory framework, to represent the hospital authoritatively at provincial and public forums, to provide strategic leadership to improve operational efficiency within the health establishment to improve health outcomes. Strategic Planning: prepare a strategic plan for the hospital to ensure that it is in line with the 10-point plan, national, provincial, regional and district plans. Financial Management: maximise revenue through collection of all income due to the hospital; ensure that the hospital is managed within budget in line with the PFMA and relevant guidelines; ensure that adequate policies, systems and procedures are in place to enable prudent management

Annexure

DEPARTMENT: PUBLIC SERVICE AND ADMINISTRATION
REPUBLIC OF SOUTH AFRICA
Private Bag X916, Pretoria, 0001. Tel: (012) 314 7911. Fax (012) 323 2388 or (012) 324 5616
Private Bag X9148, Cape Town, 8000. Tel: (021) 467 5140. Fax: (021) 462 2299

Inquiry A Fourie
Telephone 3147367
File : 1/8/8/18

TO NATIONAL DEPARTMENT OF HEALTH/ ALL PROVINCIAL ADMINISTRATIONS

BENCHMARK JOB DESCRIPTION FOR CHIEF EXECUTIVE OFFICERS OF HOSPITALS

1. To assist Provincial Administrations with the establishment and grading of posts of CEOs of hospitals, this Department developed a benchmark job description for three levels of CEO jobs to serve as advice to departments in accordance with Public Service Regulations Chapter 1, Part III. I. 4. The job evaluation system was applied to the information in the job description to determine the job weights and grading levels of the jobs. The results obtained through this process were subjected to a process of quality assurance with a panel of representatives from the National Department of Health, provincial health departments, "CEOs" of hospitals and the DPSA. Three levels of CEO were identified by classifying hospitals into District, Regional and Central hospitals.

2. The distinction between the different levels of hospitals (see Annexure A for the classification) was, inter alia, made on the basis of the complexity of the operating environment, the demands placed on the incumbent by this work environment, and the different levels of knowledge and skills required to function in the relevant jobs. The benchmark job description and job evaluation results for CEO jobs in District, Regional and Central hospitals are attached as Annexures B, C, D and E respectively. Departments can utilise this information as guidelines to create posts of CEO of hospitals. It should be noted that the job description is based on a model that is currently applied in the Gauteng Province. It is generally accepted as a good model and no role players in the consulting process objected to the usage of this model. It should, however, be applied taking the guidelines set out in paragraph 3 below into consideration.

3. With regard to the benchmark job description and job evaluation results, the following should be noted:

(a) The key performance areas of CEOs are set out in the job description. Where key performance areas at hospitals differ significantly from that contained in the benchmark job description, due to for example, the size of the institution or field of speciality of services rendered, the job description should be amended accordingly. If a new job description is developed, the job should be evaluated to determine the appropriate grading of the post. Departments may use the attached job evaluation results and only change the responses to questions on aspects of the job which are different to the benchmark job evaluation results.

(b) The primary purpose of a CEO is to manage the institution efficiently and effectively, in terms of the management framework of the Public Service and in accordance with the strategic direction of the National/Provincial Health Department. Persons who are substantially qualified as a manager or have strong management experience in the Health environment, should be appointed as CEO. CEOs should therefore be appointed on the basis of their management ability rather than their medical background or ability.

(c) The results of the job evaluation process referred to above are as follows:

POST	JE RESULT	GRADE THAN CAN BE ALLOCATED
CEO: Level 3 Hospital (Central or equivalent)	14	Grade 14 (Chief Director or equivalent).
CEO: Level 2 Hospital (Regional or equivalent)	13+	Grade 14 (Chief Director or equivalent) or Grade 13 (Director or equivalent).
CEO: Level 1 Hospital (District or equivalent)	12 +	Grade 13 (Director or equivalent) or Grade 12 (Deputy Director or equivalent).

Decisions on the grades to be allocated can be based on factors such as organisational requirements and budgetary provisions. Please note that the gradings indicated above apply to full-time CEOs who function in accordance with the key performance areas and other requirements set out in the benchmark job description. Where other functions or a combination of functions are performed, the jobs should be evaluated individually.

(d) The benchmark exercise did not address the position of CEOs of Provincial: Tertiary or Specialised Hospitals. Job descriptions for CEOs of these hospitals should be developed and graded on an individual basis.

ACTING DIRECTOR-GENERAL
DATE: 20 APRIL 2004

ANNEXURE B

BENCHMARK JOB DESCRIPTION

A. JOB INFORMATION SUMMARY

Name of jobholder:	:	
Job title	:	Chief Executive Officer: Hospital Management
Core code	:	
Post level and salary code	:	
Occupational class code	:	
Name of component	:	
Location	:	
Posts reports to	:	
Date of appointment	:	

B. JOB PURPOSE

To plan, direct, co-ordinate and manage the efficient and effective delivery of health/medical and administrative support services at the hospital within the prevailing legal and statutory framework (Annexure A).

KEY PERFORMANCE AREAS

1. **Ensure the effective and efficient overall management of the hospital in terms of relevant acts and delegations.**

   (a) **Financial Management**

   * Ensure that the hospital's statutory responsibilities in terms of the Public Finance Management Act (PFMA) are adhered to through:

     - The maximisation of revenue.
     - The collection of all income due to the hospital.
     - The management of creditors/debtors.
     - The management of irregular, fruitless and wasteful expenditure.
     - The management of Public–Private partnerships

* Ensure that the hospital is managed within budget and in accordance with the PFMA, other legislation and National and Provincial guidelines.

* Ensure that adequate policy, management systems and procedures are in place, to enable the management of financial resources on a decentralised basis (cost centres), to safeguard public funds and maintain financial control.

* Develop, implement and maintain financial systems and procedures that will enable the timeous preparation of financial statements of the hospital's financial affairs.

(b) **Human Resource Management and People Development**

* Develop, implement and maintain human resource management strategy, policies, systems and procedures to ensure the effective and efficient utilisation of human resources in order to improve service delivery within the Public Service regulatory framework and relevant delegations.

* Ensure effective communication arrangements within the hospital for all personnel in all disciplines.

* Monitor and review the hospital's organisational structure to address service delivery requirements within budgetary constraints.

* Ensure the filling of vacant posts, within budgetary constraints, with the appointment of competent personnel.

* Develop, implement and maintain an attendance management policy, system and procedures to ensure the optimal utilisation of personnel within the budget. Manage overtime within budgetary constraints.

* Ensure that policy, systems and procedures to manage performance effectively, including rewards and incentives to deserving personnel, are in place and adhered to.

* Ensure sound employee relations in terms of the applicable labour legislation.

* Ensure that policy, systems and procedures to manage discipline are implemented and maintained.

* Implement a human resource development strategy for the hospital.

* Build effective teams.

* Build capacity through the management of continuous training and development programmes for all categories of staff.

* Ensure that the structured training programmes for all Health Care Professionals are maintained and supervised.

* Develop, implement and maintain policy and procedures to manage employee assistance and well - being programmes.

* Promote a safe and healthy working environment through compliance with Occupational Health and Safety standards, and the establishment of Occupational Health and Safety Committees.

* Monitor entry and exit rates of staff, including a system of exit interviews to ascertain reasons for staff loss.

(c) **Hospital Management and Planning**

* Prepare a strategic plan for the hospital to ensure that its services are in line with the National, Provincial, Regional and District strategies and plans.

* Develop and promote the vision, mission and objectives of the hospital.

* Develop and implement an annual business plan for service delivery based on current and future needs assessment and priorities within the parameters of the package of care that is to be provided at the hospital.

* Develop, implement and maintain a contingency plan to deal with any emergency that the hospital may have to deal with.

* Establish and maintain a consultative structure in the hospital to ensure that all stakeholders can provide input into the operational and strategic planning processes.

* Ensure that activities are monitored, recorded and analysed to facilitate the identification and planning for current and future needs.

* Develop, implement and maintain a framework/programme against which the hospital's performance can be evaluated and monitored.

* Within the National and Provincial framework, develop hospital specific referral criteria and guidelines for referral of patients to and from the hospital.

* Ensure the development of a comprehensive risk management strategy.

(d) **Corporate Governance**

* Ensure accountability to the Hospital Board, as the representatives of the community.

* Ensure that Board members are provided with the required information assisting their understanding and decision making to enable them to effectively contribute to the management of the hospital.

* Enhance the profile and promote the work of the hospital through activities focusing on the promotion of community health and other public relations activities.

* Liase with key stakeholders to establish sound hospital/community relationship and ensure that the hospital addresses the community needs.

(e) **Procurement and the management of equipment and facilities**

* Implement an appropriate procurement and provisioning system, which is fair, equitable, transparent, competitive and cost effective, in terms of the Provincial delegations and as required by the PFMA.

* Ensure that goods and services are provided to the hospital in a cost effective and timely manner.

* Ensure the safe and effective use of the hospital's facilities and equipment through the appropriate maintenance of facilities and equipment.

* Ensure that systems and procedures are in place to ensure the maintenance of facilities and equipment.

* In conjunction with the Provincial Department of Health, identify services appropriate for market testing and evaluate potential suppliers to ensure value for money.

* Ensure that value for money audits are undertaken of the services provided at the hospital (including services that are contracted out to external suppliers).

* Develop and maintain a comprehensive equipment plan for the hospital to ensure that the hospital has the necessary equipment to render the required services cost effectively.

* Develop, implement and maintain an assets register for the hospital.

* Implement a system to monitor and oversee that equipment/technology is effectively and efficiently utilised.

(f) **Implement and manage an information technology policy, systems and procedures to support the effective and efficient delivery of services**

* Ensure proper record - keeping in the hospital through the utilisation of paper based and electronic systems.

* Implement and utilise the prescribed transverse Public Service information systems (e.g. PERSAL).

* Ensure that information risk management, security and support protocols are implemented and adhered to.

* Ensure that the hospital can timeously provide information on minimum data sets as required.

* Continuously assess opportunities for improvement in service delivery through automation of processes and the introduction of information technology systems.

(g) **Manage all aspects of patient care and ensure high standards of patient care.**

* Ensure that the hospital adheres to, and promotes the Batho Pele principles in the delivery of its services (e.g. service delivery standards and the investigation of complaints in a honest, open and timely manner).

* Ensure that policies, systems and procedures are developed and maintained to render an effective and efficient patient administration service.

* Ensure that clinical staff adheres to the National, Provincial and Hospital policy/standards when treating patients.

* Ensure that the provision of patient services is in line with the National norms and standards, the Provincial strategy and programmes, the requirements of the community, and the needs of the patients and their families.

* Institute arrangements and structures for managing clinical services as contained in the Patients Rights Charter.

* Develop and maintain a comprehensive quality assurance programme based on the principles of continuous quality improvement.

* Ensure the collection, analysis and provision of accurate statistical patient data for both statutory external requirements as well as internal management purposes.

2. **Serve on various internal and external committees, and provide input into the development of Provincial policy and strategy on the provision of health/medical care.**

* Suggest policy, operational and procedural improvements by ensuring a good knowledge of national and international trends, community needs and possible legislative changes.

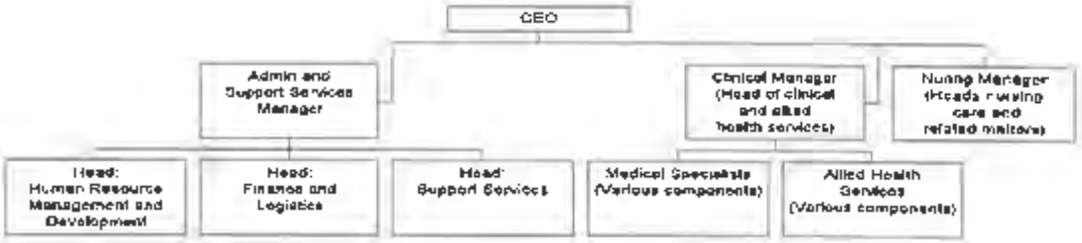
EXAMPLE OF TYPICAL POSITION IN THE ORGANISATION AND TYPICAL ORGANISATION STRUCTURE

NOTE:

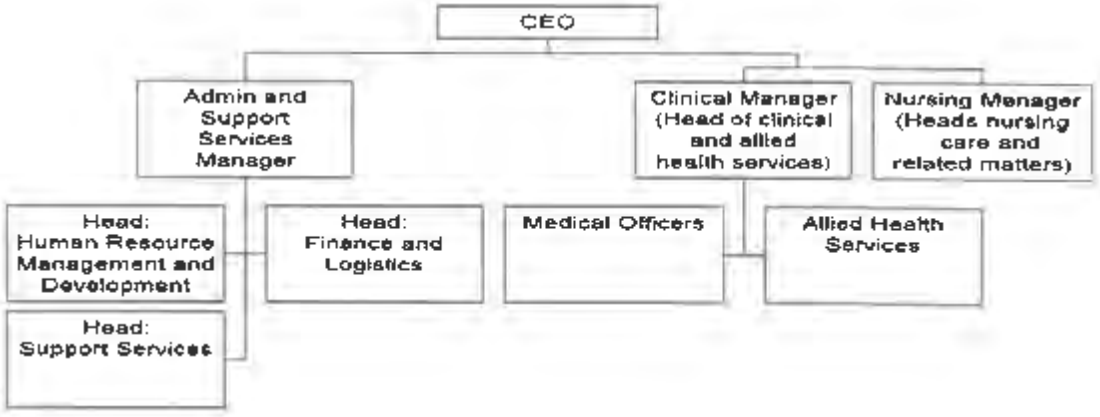
These organisational structures serve as **examples only**. Each department / hospital should design its organisational structure to suit its specific needs and circumstances. Please note the old adage that structure follows strategy.

1. CENTRAL HOSPITAL

2. REGIONAL HOSPITAL



3. DISTRICT HOSPITAL



INHERENT REQUIREMENTS OF THE JOB

NOTE:

Although the following is not a comprehensive list of competencies that may be required to function as a CEO of a hospital, it should be noted that the competencies set out below was consulted with a reference group during quality

assurance. If departments feel that additional competencies are required, or that certain competencies that have been identified are not essential, the amended competence profile should be reflected in the final job description. Cognisance should also be taken of the competency framework for the SMS at http://www.dpsa.gov.za/Projects/competency-profile/competencyFrameworkSMS.pdf and the draft competency framework for middle managers at http://www.dpsa.gov.za/employmentpractice_cd/documents/MMCFDictionaryConsolidated18July.doc

TYPICAL COMPETENCIES REQUIRED	EXAMPLES OF APPLICATION OF COMPETENCIES
LEADERSHIP AND MANAGEMENT COMPETENCIES	
Decision Making	Has the ability to evaluate/analyse information and to select an alternative that best meets the needs of the impending situation. Contribute to effective and efficient delivery of health/medical care by identifying short and long term issues that must be addressed; recommend changes to work processes and/or policy directives to meet new challenges.
Honesty, Integrity and Ethics	Has the ability to balance ethical, religious, cultural and other concerns in the application of required treatment. Ensure those minimum standards, regulations and professional ethics are complied with. Has the ability to display and built the highest standards of ethical and moral conduct in order to promote confidence and trust in health care management.
Initiative	Has the ability to take the initiative and to develop new ideas/understanding based on rational consideration and assessment of issues at hand, whilst managing costs and risks.
Judgement	Has the ability to identify issues and to grasp the complexities that tend to be overlooked by others. Think through problems from various angles and analyses them dispassionately and objectively. Has the ability to select the most suitable/appropriate alternative/option amongst a number of alternatives

TYPICAL COMPETENCIES REQUIRED	EXAMPLES OF APPLICATION OF COMPETENCIES
Managing in the Political-Cultural context	Has the ability to understand the conventions, structures, functions and objectives of Government, and the wider cultural, economic and social environment in which the hospital operates. Exhibits awareness of internal and external political influences and displays sensitivity towards issues of culture and religion.
Negotiation	Has the ability to take the initiative and manages a consultation process tactfully for an optimal solution for all parties.
Problem Solving and Analysis	Has the ability to devise and implement the most effective and efficient solutions to manage health/ medical care programs within the approved budget and in terms of strategic objectives. Has the ability to systematically identify, analyse and resolve existing and anticipated problems in order to reach optimum solutions in a timely manner.
People Management and Empowerment	Has the ability to manage and encourage people, optimise their outputs and effectively manage relationships in order to achieve the hospital's goals.
Programme and Project Management	Has the ability to manage, monitor and evaluate specific activities/projects in order to deliver the desired outputs.
Public Service Knowledge	Has the ability to manage, co-ordinate and implement Government policy with regard to health/medical care at hospital level within the Public Service statutory frameworks.
Strategic Capability and Leadership	Has the ability to provide a vision, set the direction for the organisation and inspire others in order to deliver on the hospital's mandate.
Strategic Orientation	Has the ability to implement provincial health care strategy in terms of the hospital business plan through the identification of outcomes and returns. Recommend appropriate courses of action in relation to the hospital's strategic objectives.
Time Management	Has the ability to effectively prioritise demands on available time.
Applying Technology	Must be able to utilise appropriate technology in the work place to enhance productivity and efficiency.

TYPICAL COMPETENCIES REQUIRED	EXAMPLES OF APPLICATION OF COMPETENCIES
ORGANISATIONAL COMPETENCIES	
Builds Relationships	Has the ability to develop and maintain a wide network of strategic internal and external relationships that build confidence, trust and respect with others, which increases the hospital's ability to deliver its services as effective and efficient as possible.
Client Orientation and Customer Focus	Has the ability to ensure that services provided at the hospital are effectively and efficiently delivered in order to put the spirit of customer service (Batho Pele) into practice.
Development of people	Has the ability to implement systems and procedures that will enable the optimal utilisation and development of people. Has a strongly developed ability to recognise the value of diversity in the workforce and to promote it within the South African context.
Financial Analysis	Has the ability to apply financial concepts and processes to determine the financial impact of business decisions.
Financial Management	Has the ability to manage budgets, control cash flow, institute risk management and administer tender procurement processes in accordance with the generally recognised financial practices in order to ensure the achievement of strategic hospital objectives. Has the ability to successfully initiate and develop revenue-generation projects.
Knowledge Management	Has the ability to promote the generation and sharing of knowledge and learning in order to enhance the collective knowledge of the hospital.
Resource Management	Has the ability to allocate resources (internal and external) appropriately to meet strategic objectives of the hospital within budgetary constraints.
Service Delivery Innovation	Has the ability to implement new ways of delivering services that contribute to the improvement of organisational processes in order to achieve organisational goals.

TYPICAL COMPETENCIES REQUIRED	EXAMPLES OF APPLICATION OF COMPETENCIES
INTERPERSONAL COMPETENCIES	
Adaptability	Has the ability to work effectively in an environment of change and responds resourcefully to new demands or circumstances to achieve better results. Has the ability to function well under pressure.
Assertiveness	Has the ability to work independently, or as a member of a team that is results orientated. Confident of own abilities to influence team members to ensure implementation of strategic objectives.
Change Management	Has the ability to initiate and support organisational transformation and change in order to successfully implement new initiatives and deliver on service delivery commitments.
Communication	Has the ability to exchange information and ideas, verbally or in writing, in a clear, concise manner appropriate for the audience, in order to explain, persuade, convince and influence others to achieve the desired outcomes. Demonstrates effective presentation skills.
Conflict Resolution	Has the ability to effectively manage conflict.
Cultural Understanding	Has the ability to manage the hospital effectively and efficiently through the management of diverse teams.
Influencing skills	Has the ability to interact with persons in Government, Public Service, Private Sector Organisations and Academic Institutions in such a manner that they will understand and contribute to the effective and efficient delivery of health/medical care services.
Team Player	Has the ability to function in a collaborative and collegial environment. Should be able to manage a diverse team of professionals and provide guidance and management support to professionals that may be remunerated at higher levels than the incumbent.

C. APPOINTMENT REQUIREMENTS

1. Formal 3 year or higher tertiary qualification in Management or a related Health/Medical Sciences qualification; and

2. Strong business orientation with proven skills and abilities in Health management; and

3. Proven management competencies with specific reference to the health care environment.

Please note that the management of hospitals at levels 2 and 3 may require an incumbent that has further postgraduate qualifications and more comprehensive experience at management level.

D. **CAREER PATHING**

Compliance with the requirement of higher posts.

E. **AMENDMENTS TO JOB DESCRIPTION**

The Head of Department or his/her nominee reserves the right to make changes and alterations to this job description, as he/she may deem reasonable, after due consultation with the post holder.

F. **PERFORMANCE AGREEMENT**

The Performance Agreement of the incumbent, which contains a workplan and specific target dates, should be read as an extension of this job description. The performance agreement may also contain an annexure outlining any standard operating procedures that the incumbent should adhere to during the execution of his/her key performance areas.

G. **JOB DESCRIPTION AGREEMENT**

SIGNATURE OF POSTHOLDER **SIGNATURE OF MANAGER**

DATE: **DATE:**

ANNEXURE A

NOTE:
This list was obtained from the Western Cape Provincial Department of Health. The list is comprehensive but there may be acts that apply to specific hospitals that do not appear in the list. Similarly, some of the Acts in the list may not apply to all hospitals. **Also note that the status of some of the Acts may have changed.**

1. **ACADEMIC HEALTH CENTRES ACT, 86 OF 1993**

(Commencement 1 October 1993)

To provide for the establishment of academic health centres and for the control, administration and management thereof; and for matters connected therewith.

2. **AGED PERSONS ACT, 81 OF 1967**

(Commencement 1 October 1968)

To provide for the protection and welfare of certain aged and debilitated persons, for the care of their interests, for the establishment and registration of certain institutions, for the accommodation and care of such persons in such institutions, for the payment of old age pensions and certain allowances to or in respect of certain aged persons, and for matters incidental thereto.

Note :

1) This Act has been repealed by section 21 of the Social Pensions Act 37 of 1973 in so far as it relates to pension matters.

2) The administration of the whole of this Act, excluding sections 5, 6 and 16, has been assigned to the provinces by Proclamation R7 in Government Gazette 16992 of 23 February 1996.

3. **ASSOCIATED INSTITUTIONS PENSION FUND ACT, 41 OF 1963**

(Commencement 10 May 1963)

To provide for pensions for the employees of certain institutions and for other incidental matters.

4. **ATMOSPHERIC POLLUTION PREVENTION ACT, 45 OF 1965**

(Commencement 21 April 1965)

To provide for the prevention of the pollution of the atmosphere, for the establishment of a National Air Pollution Advisory Committee, and for matters incidental thereto.

5. **BASIC CONDITIONS OF EMPLOYMENT ACT, 75 OF 1997**

(Commencement 1 December 1998 in full)

To give effect to the right to fair labour practices referred to in section 23(i) of the Constitution by establishing and making provision for the regulation of basic conditions of employment; and thereby to comply with the obligations of the Republic as a member state of the International Labour Organisation, and to provide for matters connected therewith.

6. **BIRTHS AND DEATHS REGISTRATION ACT, 51 OF 1992**

(Commencement 1 October 1992)

To regulate the registration of births and deaths; and to provide for matters connected therewith.

7. **CHILD CARE ACT, 74 OF 1983**

(Commencement 1 February 1987)

To provide for the establishment of children's courts and the appointment of commissioners of child welfare; for the protection and welfare of certain children; for the adoption of children; for the establishment of certain institutions for the reception of children and for the treatment of children after such reception; and for the contribution by certain persons towards the maintenance of certain children; and to provide for incidental matters.

8. **CHILDRENS ACT, 33 OF 1960**

(Commencement 14 April 1960)

Note : The whole of this Act was repealed by s63(1) of Act 74 of 1983 (Child Care Act), except in so far as it relates to the appointment of probation officers and the establishment, maintenance and management of schools of industries and reform schools.

9. **CHILDRENS STATUS ACT, 82 OF 1987**

(Commencement 14 October 1987)

To amend the law relating to paternity, guardianship and the status of certain children; and to provide for matters connected therewith.

10. **CHIROPRACTORS, HOMEOPATHS AND ALLIED HEALTH SERVICE PROFESSIONS ACT, 63 OF 1982**

(Commencement 1 August 1982)

To provide for the control of the practice of the professions of chiropractor and homeopath and allied health professions, and for that purpose to establish a Chiropractors, Homeopaths and Allied Health Service Professions Interim Council and to determine its functions; and for matters connected therewith.

11. **CHOICE ON TERMINATION OF PREGNANCY ACT, 92 OF 1996**

(Commencement 1 February 1997)

To determine the circumstances in which and conditions under which the pregnancy of a woman may be terminated; and to provide for matters connected therewith.

12. **CIVIL PROTECTION ACT, 67 OF 1977**

(Commencement 26 May 1977)

To confer upon provincial councils the power to make ordinances in connection with civil protection in a state of emergency or disaster; and to provide for incidental matters.

N.B.: See Proclamation R153 in Government Gazette 16049 of 31 October 1994 concerning the extent of the assignment of the administration of this Act to the provinces.

13. **COMPENSATION FOR OCCUPATIONAL INJURIES AND DISEASES ACT, 130 OF 1993**

(Commencement 1 March 1994)

To provide for compensation for disablement caused by occupational injuries or diseases sustained or contracted by employees in the course of their employment, or for death resulting from such injuries or diseases; and to provide for matters connected therewith.

14. **CONSTITUTION OF REPUBLIC OF SOUTH AFRICA, 108 OF 1996**

(Commencement 4 February 1997)

To introduce a new Constitution for the Republic of South Africa and to provide for matters incidental thereto.

15. **CONTROL OF ACCESS TO PUBLIC PREMISES AND VEHICLES ACT, 53 OF 1985**

(Commencement 8 May 1985)

To provide for the safeguarding of certain public premises and vehicles and for the protection of the people therein or thereon, and for matters connected therewith.

16. **DANGEROUS WEAPONS ACT, 71 OF 1968**

(Commencement 3 July 1968)

To provide for certain prohibitions and restrictions in respect of the possession, manufacture, sale or supply of certain objects; to provide for the imposition of prescribed sentences where dangerous weapons or firearms have been used in the commission of offences involving violence; to repeal sections *10* and *10bis* of the General Law Amendment Act, 1949; and to provide for incidental matters.

17. **DOMESTIC VIOLENCE ACT, 116 OF 1998**

(Commencement 15 December 1999)

To provide for the issuing of protection orders with respect to domestic violence, and for matters connected therewith.

18. **DRUGS AND DRUG TRAFFICKING ACT, 140 OF 1992**

(Commencement 30 April 1993)

To provide for the prohibition of the use or possession of, or the dealing in, drugs and of certain acts relating to the manufacture or supply of certain substances or the acquisition or conversion of the proceeds of certain crimes; for the obligation to report certain information to the police; for the exercise of the powers of entry, search and seizure and detention in specified circumstances, for the recovery of the proceeds of drug trafficking; and for matters connected therewith.

19. **EMPLOYMENT EQUITY ACT, 55 OF 1998**

(Commencement of Chapter II, certain sections and Schedules 2 and 3 : 9 August 1999)

To provide for employment equity; and to provide for matters incidental thereto.

20. **ENVIRONMENT CONSERVATION ACT, 73 OF 1989**

(Commencement 9 June 1989)

To provide for the effective protection and controlled utilisation of the environment and for matters incidental thereto.

N.B. See proclamation R29 in Government Gazette 16346 of 7 April 1995 and Proclamation R43 in Government Gazette 17354 of 8 August 1996 concerning the extent of the assignment of the administration of this Act to the provinces.

21. **EXCHEQUER ACT, 66 OF 1975**

(Commencement 1 April 1976)

To provide for the regulation of the collection, receipt, control and issue of State moneys and the receipt, custody and control of other State property; the raising and repayment of loans by the State; the granting of certain loans from the State Revenue Fund and the terms and conditions in regard to the repayment of such loans; the duties and powers of the Treasury; and the granting of certain guarantees to the South African Reserve Bank; and matters connected therewith.

22. **FOODSTUFFS, COSMETICS AND DISINFECTANTS ACT, 54 OF 1972**

(Commencement 1 January 1973)

To control the sale, manufacture and importation of foodstuffs, cosmetics and disinfectants; and to provide for incidental matters.

23. **FUND-RAISING ACT, 107 OF 1978**

(Commencement 1 September 1979)

To provide for the control of the collection of contributions from the public; the appointment of a Director of Fund-Raising; the establishment of a Disaster Relief Fund, a South African Defence Fund and a Refugee Relief Fund; the declaration of certain disastrous events as disasters; and other matters connected therewith. (Partially repealed by the Non-profit Organisations Act, 71 of 1997).

24. **GOVERNMENT SERVICE PENSIONS ACT, 57 OF 1973**

(Commencement 1 July 1973)

To provide for the pensions and other financial benefits for certain persons in the employ of the Government or of the provincial administrations and for their dependants; to repeal certain pension laws; and to provide for certain incidental matters.

NOTE : The whole of this Act has been repealed by s34(1)(a) of the Government Employees Pension Law, 1996 (Proclamation 21 of 1996), a provision which will come into operation on a date to be determined by the Minister (see s14(1) of Proclamation 21 of 1996).

25. **HAZARDOUS SUBSTANCES ACT, 15 OF 1973**

(**Commencement** : The provisions of this Act relating to **Group I** hazardous substances came into operation on **25 March 1977**, the provisions relating to **Group II** hazardous substances came into operation on **21 December 1984**, the provisions relating to **Group III** hazardous substances came into operation on **24 December 1976**, and the provisions relating to **Group IV** hazardous substances came into operation on **1 March 1993**).

To provide for the control of substances which may cause injury or ill-health to or death of human beings by reason of their toxic, corrosive, irritant, strongly sensitising or flammable nature or the generation of pressure thereby in certain circumstances, and for the control of certain electronic products; to provide for the division of such substances or products into groups in relation to the degree of danger; to provide for the prohibition and control of the importation, manufacture, sale, use, operation, application, modification, disposal or dumping of such substances and products; and to provide for matters connected therewith.

26. **HEALTH ACT, 63 OF 1977**

(Commencement 1 September 1977)

To provide for measures for the promotion of the health of the inhabitants of the Republic; to that end to provide for the rendering of health services; to define the duties, powers and responsibilities of certain authorities which render health services to the Republic; to provide for the co-ordination of such health services; to repeal the Public Health Act, 1919; and to provide for incidental matters.

N.B. See Proclamation R152 in Government Gazette 16049 of 31 October 1994 concerning the extent of the assignment of the administration of this Act to the provinces.

27. **HEALTH DONATIONS FUND ACT, 11 OF 1978**

(Commencement 10 March 1978)

To provide for the establishment of a Health Donations Fund; the control and utilisation of moneys standing to the credit of that fund; and incidental matters.

28. **HEALTH PROFESSIONS ACT, 56 OF 1974**

(Previously called Medical, Dental and Supplementary Health Service Professions Act : Commencement 21 February 1975)

To establish the Health Professions Council of South Africa, to provide for control over the training of and for the registration of medical practitioners, dentists and practitioners of supplementary health service professions; to provide for the control over the training of and for the registration of psychologists; and to provide for matters incidental thereto.

29. **HUMAN RIGHTS COMMISSION ACT, 54 OF 1994**

(Commencement 15 September 1995)

To regulate matters incidental to the establishment of the Human Rights Commission by the Constitution of the Republic of South Africa, 1996; and to provide for matters connected therewith.

30. **HUMAN TISSUE ACT, 65 OF 1983**

(Commencement 12 July 1985)

To provide for the donation or the making available of human bodies and tissue for the purposes of medical or dental training, research or therapy or the advancement of medicine or dentistry in general; for the post-mortem examination of certain human bodies; for the removal of tissue, blood and gametes from the bodies of living persons and the use thereof for medical or dental purposes; for the control of the artificial fertilisation of persons; and for the regulation of the import and export of human tissue, blood and gametes; and to provide for matters connected therewith.

31. **INCOME TAX ACT, 58 OF 1962**

(Commencement 1 July 1962 and amended ± annually)

To consolidate the law relating to the taxation of incomes and donations; to provide for the recovery of taxes on persons and the incomes of persons levied by the provinces on income tax payers; to provide for interest to be paid on late payments of such provincial taxes, to provide for certain provisions to be applied for the purposes of any ordinance of a provincial council imposing a tax on persons or on the incomes of persons, to provide for the deduction by employers of amounts from the remuneration of employees in respect of certain tax liabilities of employees, and to provide for the making of provisional tax payments and for the payment into the Consolidated Revenue Fund and the various provincial revenue funds of portions of the normal tax and the said provincial taxes (excluding the normal tax imposed on companies) and interest and other charges in respect of such taxes.

32. **INQUESTS ACT, 58 OF 1959**

(Commencement 1 January 1960

To provide for the holding of inquests in cases of deaths or alleged deaths apparently occurring from other than natural causes and for matters incidental thereto, and to repeal the Fire Inquests Act, 1883 (Cape of Good Hope) and the Fire Inquests Law, 1884 (Natal).

33. **INTEGRATION OF LABOUR LAWS ACT, 49 OF 1994**

(Commencement 1 March 1995, 1 May 1995, 1 September 1995, 1 October 1995, 1 July 1996 and 1 October 1997).

To provide for the repeal of the labour laws mentioned in Schedule 1 (TBVC etc.); the extension of the labour laws mentioned in Schedule 2 to the whole of the national territory of the Republic referred to in section 1 of the Constitution of

the Republic of South Africa, 1993; and to provide for powers of regulation to regulate transitional matters.

34. **INTERNATIONAL HEALTH REGULATIONS ACT, 28 OF 1974**

(Commencement 15 March 1974)

To apply the International Health Regulations, adopted by the World Health Assembly, in the Republic, and to provide for incidental matters.

35. **JUSTICES OF THE PEACE AND COMMISSIONERS OF OATHS ACT, 16 OF 1963**

(Commencement 1 December 1964)

To consolidate and amend the law relating to the appointment, powers and duties of justices of the peace and commissioners of oaths, and to provide for matters incidental thereto.

36. **LABOUR APPEAL COURT SITTING AS SPECIAL TRIBUNAL ACT, 30 OF 1995**

(Commencement 1 September 1995)

To enable the labour appeal court to act as a special tribunal in determining claims and disputes of right which arise out of the implementation of the transitional arrangements on public administration and the rationalisation of the public administration as contemplated in sections 236 and 237 of the Constitution; and to provide for matters connected therewith.

37. **LABOUR RELATIONS ACT, 66 OF 1995**

(Commencement 11 November 1996)

To change the law governing labour relations and, for that purpose –

- to give effect to section 27 of the Constitution;
- to regulate the organisational rights of trade unions;
- to promote and facilitate collective bargaining at the workplace and at sectoral level;
- to regulate the right to strike and the recourse to lock out in conformity with the Constitution;
- to promote employee participation in decision-making through the establishment of workplace forums;
- to provide simple procedures for the resolution of labour disputes through statutory conciliation, mediation and arbitration (for which purpose the Commission for Conciliation, Mediation and Arbitration is established), and through independent alternative dispute resolution services accredited for that purpose;
- to establish the Labour Court and Labour Appeal Court as superior courts, with exclusive jurisdiction to decide matters arising from the Act;

- to provide for a simplified procedure for the registration of trade unions and employers' organisations, and to provide for their regulation to ensure democratic practices and proper financial control;
- to give effect to the public international law obligations of the Republic relating to labour relations;
- to amend and repeal certain laws relating to labour relations; and
- to provide for incidental matters.

38. **MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS ACT, 56 OF 1974**

(Now called Health Professions Act – after being amended by Act 89 of 1997)

(Commencement 21 February 1975)

To establish the Health Professions Council of South Africa; to provide for control over the training of and for the registration of medical practitioners, dentists and practitioners of supplementary health service professions; to provide for the control over the training of and for the registration of psychologists; and to provide for matters incidental thereto.

39. **MEDICAL, DENTAL AND SUPPLEMENTARY HEALTH SERVICE PROFESSIONS AMENDMENT ACT, 89 OF 1997**

(The principal Act is now known as the Health Professions Act, 56 of 1974)

(Commencement 23 April 1999 except for section 50)

To amend the Medical, Dental and Supplementary Health Service Professions Act, 1974, so as to insert certain definitions and to delete others; to provide for the establishment of the Health Professions Council of South Africa and professional boards for health professions; to abolish the Interim National Medical and Dental Council of South Africa; to provide for control over the education, training, registration and practices of health professionals; and to provide for matters connected therewith.

40. **MEDICAL SCHEMES ACT, 131 of 1998**

(Commencement 1 November 1999)

To consolidate the laws, relating to registered medical schemes; to provide for the establishment of the Council for Medical Schemes as a juristic person; to provide for the appointment of the Registrar of Medical Schemes; to make provision for the registration and control of certain activities of medical schemes; to protect the interests of members of medical schemes; to provide for measures for the co-ordination of medical schemes; and to provide for incidental matters.

41. **MEDICINES AND RELATED SUBSTANCES CONTROL ACT, 101 of 1965**

(Commencement 1 April 1966)

To provide for the registration of medicines intended for human and for animal use, for the registration of medical devices, for the establishment of a Medicines Control Council, for the control of medicines, Scheduled substances and medical devices and for matters incidental thereto.

42. **MENTAL HEALTH ACT, 18 OF 1973**

(Commencement 27 March 1975)

To provide for the reception, detention and treatment of persons who are mentally ill; and to provide for incidental matters.

43. **NATIONAL ECONOMIC DEVELOPMENT AND LABOUR COUNCIL ACT, 35 OF 1994**

(Commencement 5 May 1995)

To provide for the establishment of a national economic, development and labour council; to repeal certain provisions of the Labour Relations Act, 1956; and to provide for matters connected therewith.

44. **NATIONAL HEALTH LABORATORIES SERVICE ACT, 37 OF 2000**

(Commencement 10 May 2001 – certain sections only)

To provide for the establishment of a juristic person to be known as the National Health Laboratory Service; to provide for the abolition of the South African Institute for Medical Research, the National Institute for Virology, the National Centre for Occupational Health, certain forensic chemistry laboratories and all provincial health laboratory services; and to provide for matters connected therewith.

45. **NATIONAL POLICY FOR HEALTH ACT, 116 OF 1990**

(Commencement 16 November 1990)

To provide for control measures with a view to promoting the health of the inhabitants of the Republic, and for that purpose to provide for the determination of a national policy for health, for the establishment of a Health Matters Committee and a Health Policy Council, and for matters connected therewith.

46. **NATIONAL WELFARE ACT, 100 OF 1978**

(Commencement 1 September 1979)

To provide for the establishment and constitution of a South African Welfare Council and of regional welfare boards and certain committees; and to define their powers and functions; to provide for welfare programmes and for the registration of welfare organisations; and to provide for incidental matters.

N.B. Certain sections of this Act have been assigned to the provinces by proclamation R7 in Government Gazette 16992 of 23 February 1996.

47. **NATURAL FATHERS OF CHILDREN BORN OUT OF WEDLOCK ACT, 86 OF 1997**

(Commencement 4 September 1998)

To make provision for the possibility of access to and custody and guardianship of children born out of wedlock by their natural fathers; to provide for the limitation on the publishing of certain particulars of certain applications and enquiries; to provide for the notification of natural fathers of any intended adoption of their children born out of wedlock; to amend the Mediation in Certain Divorce Matters Act, 1987, so as to effect certain consequential amendments; and to amend the Births and Deaths Registration Act, 1992, so as to further regulate the alteration of the surname of certain minors; and to provide for matters connected therewith.

48. **NON-PROFIT ORGANISATIONS ACT, 71 OF 1997**

(Commencement to be proclaimed)

To provide for an environment in which non-profit organisations can flourish; to establish an administrative and regulatory framework within which non-profit organisations can conduct their affairs; to repeal certain parts of the Fund-Raising Act, 1978; and to provide for matters connected therewith.

49. **NUCLEAR ENERGY ACT, 46 OF 1999**

(Commencement 24 February 2000)

To provide for the establishment of the South African Nuclear Energy Corporation; to provide for responsibilities for the implementation and application of the Safeguards Agreement entered into by the Republic and the International Atomic Energy Agency in support of the Nuclear Non-Proliferation Treaty; to regulate the acquisition and possession of nuclear fuel, certain nuclear related material, as well as the importation and exportation of that fuel, material and equipment in order to comply with the international obligations of the Republic; to prescribe measures regarding the discarding of radioactive waste and the storage of irradiated nuclear fuel; and to provide for incidental matters.

50. **NURSING ACT, 50 OF 1978**

(Commencement 28 July 1978)

To consolidate and amend the laws relating to the professions of registered or enrolled nurses, nursing auxiliaries and midwives; and to provide for matters incidental thereto.

51. **OCCUPATIONAL HEALTH AND SAFETY ACT, 85 OF 1993**

(Commencement 1 January 1994)

To provide for the health and safety of persons at work and for the health and safety of persons in connection with the use of plant and machinery; the protection of persons other than persons at work against hazards to health and safety arising out of or in connection with the activities of persons at work; to

establish an advisory council for occupational health and safety; and to provide for matters connected therewith.

52. **PENSION FUNDS ACT, 24 OF 1956**

(Commencement 1 January 1958)

To provide for the registration, incorporation, regulation and dissolution of pension funds and for matters incidental thereto.

53. **PHARMACY ACT, 53 OF 1974**

(Commencement 21 February 1975)

To establish the Interim Pharmacy Council of South Africa; to provide for the training and registration of pharmacists, pharmacist interns, pharmacy students, unqualified assistants and pharmaceutical technicians; to provide for the control of the practice of the pharmaceutical profession; and to provide for matters incidental thereto.

54. **POPULATION REGISTRATION ACT REPEAL ACT, 114 OF 1991**

(Commencement 28 June 1991)

To repeal the Population Registration Act, 1950; to amend or repeal certain laws so as to abolish the distinction made therein between persons belonging to different races or population groups; and to provide for matters connected therewith.

55. **PREFERENTIAL PROCUREMENT POLICY FRAMEWORK ACT, 5 OF 2000**

(Commencement by proclamation in Government Gazette)

To give effect to section 217 (3) of the Constitution by providing a framework for the implementation of the procurement policy contemplated in section 217(2) of the Constitution; and to provide for matters connected therewith.

56. **PREVENTION AND TREATMENT OF DRUG DEPENDENCY ACT, 20 OF 1992**

(Commencement 30 April 1993)

To provide for the establishment of a Drug Advisory Board; the establishment of programmes for the prevention and treatment of drug dependency; the establishment of treatment centres and hostels; the registration of institutions as treatment centres and hostels; the committal of certain persons to and their detention, treatment and training in such treatment centres or registered treatment centres; and incidental matters.

57. **PREVENTION OF FAMILY VIOLENCE ACT, 133 OF 1993**

(Commencement 1 December 1993)

To provide for the granting of interdicts with regard to family violence; for an obligation to report cases of suspected ill-treatment of children; that a husband can be convicted of the rape of his wife; and for matters connected therewith.

58. **PREVENTION OF PUBLIC VIOLENCE AND INTIMIDATION ACT, 139 OF 1991**

(Commencement 17 July 1991)

To provide for the prevention and control of public violence and intimidation; and for matters connected therewith.

59. **PROMOTION OF ACCESS TO INFORMATION ACT, 2 OF 2000**

(Commencement : 9 March 2001 with the exception of sections 10, 14, 16 and 51).

To give effect to the constitutional right of access to information held by the State and any information that is held by another person and that is required for the exercise or protection of any rights; and to provide for matters connected therewith.

60. **PROMOTION OF ADMINISTRATIVE JUSTICE ACT, 3 OF 2000**

(Commencement 30 November 2000)

To promote an efficient administration and good governance and create a culture of accountability, openness and transparency in the public administration or in the exercise of a public power or the performance of a public function, by giving effect to the right to just administrative action.

61. **PROMOTION OF EQUALITY AND PREVENTION OF UNFAIR DISCRIMINATION ACT, 4 OF 2000**

(Commencement by proclamation in the Government Gazette).

To give effect to section 9 read with item 23(1) of Schedule 6 to the Constitution of the Republic of South Africa, 1996, so as to prevent and prohibit unfair discrimination and harassment; to promote equality and eliminate unfair discrimination; to prevent and prohibit hate speech; and to provide for matters connected therewith.

62. **PROMOTION OF NATIONAL UNITY AND RECONCILIATION ACT, 34 OF 1995**

(Commencement 1 December 1995)

To provide for the investigation and the establishment of as complete a picture as possible of the nature, causes and extent of gross violations of human rights committed during the period from 1 March 1960 to the cut-off date contemplated in the Constitution, within or outside the Republic, emanating from the conflicts of the past, and the fate or whereabouts of the victims of such violations; the granting of amnesty to persons who make full disclosure of all the relevant facts relating to acts associated with a political objective committed in the course of the conflicts of the past during the said period; affording victims an opportunity to relate the violations they suffered; the taking of measures aimed at, the granting of reparation to, and the rehabilitation and restoration of the human and civil dignity of, victims of violence of human rights; reporting to the Nation about such violations and victims; the making of recommendations aimed at the

prevention of the commission of gross violations of human rights; and for the said purposes to provide for the establishment of a Truth and Reconciliation Commission, comprising a Committee on Human Rights Violations, a Committee on Amnesty and a Committee on Reparation and Rehabilitation; and to confer certain powers on, assign certain functions to and impose certain duties upon that Commission and those Committees; and to provide for matters connected therewith.

63. **PROTECTED DISCLOSURES ACT, 26 OF 2000**

(Commencement by proclamation in Government Gazette)

To make provision for procedures in terms of which employees in both the private and the public sector may disclose information regarding unlawful or irregular conduct by their employees or other employees in the employ of their employers; to provide for the protection of employees who make a disclosure which is protected in terms of this Act; and to provide for matters connected therewith.

64. **PUBLIC FINANCE MANAGEMENT ACT, 1 OF 1999**

(Commencement 1 April 2000 except Chapter II and section 93(4), which took effect on publication of the Act, and certain provisions which will take effect on a date not later than 1 April 2003 by notice in the Government Gazette).

To regulate financial management in the national government and provincial governments; to ensure that all revenue, expenditure, assets and liabilities of those governments are managed efficiently and effectively; to provide for the responsibilities of persons entrusted with financial management in those governments; and to provide for matters connected therewith.

65. **PUBLIC HOLIDAYS ACT, 36 OF 1994**

(Commencement 1 January 1995)

To make provision for a new calendar of public holidays; to provide that the public holidays be paid holidays; and for matters incidental thereto.

66. **PUBLIC SERVICE ACT, 1994**

(Commencement 3 June 1994)

To provide for the organisation and administration of the public service of the Republic, the regulation of the conditions of employment, terms of office, discipline, retirement and discharge of members of the public service, and matters connected therewith.

67. **PUBLIC SERVICE COMMISSION ACT, 65 OF 1984**

(Previously Commission for Administration Act)

(Commencement 30 May 1984)

68. **SEXUAL OFFENCES ACT, 23 OF 1957**

(Commencement 12 April 1957)

To consolidate and amend the laws relating to brothels and unlawful carnal intercourse and other acts in relation thereto.

69. **SKILLS DEVELOPMENT ACT, 97 OF 1998**

(Commencement 2 November 1998)

To provide an institutional framework to devise and implement national, sector and workplace strategies to develop and improve the skills of the South African workforce; to integrate those strategies within the National Qualifications Framework contemplated in the South African Qualifications Authority Act, 1995; to provide for learnerships that lead to recognised occupational qualifications; to provide for the financing of skills development by means of a levy-grant scheme and a National Skills Fund; to provide for and regulate employment services; and to provide for matters connected therewith.

70. **SKILLS DEVELOPMENT LEVIES ACT, 9 OF 1999**

(Commencement by proclamation in the Government Gazette)

To provide for the imposition of a skills development levy; and for matters connected therewith.

71. **SOCIAL ASSISTANCE ACT, 59 OF 1992**

(Commencement 1 March 1996)

To provide for the rendering of social assistance to persons, national councils and welfare organisations; and to provide for matters connected therewith.

N.B. The administration of the whole of this Act, excluding section 13, was assigned to the provinces by Proclamation R7 in Government Gazette 16992 of 23 February 1996.

72. **SOCIAL SERVICE PROFESSIONS ACT, 110 OF 1978**

(Commencement 1 September 1979)

To provide for the establishment of a South African Council for Social Service Professions and to define its powers and functions; for the registration of social workers, student social workers and social auxiliary workers and persons practising other professions in respect of which professional boards have been established; for control over the professions regulated under this Act; and for incidental matters.

73. **SOUTH AFRICAN MEDICAL RESEARCH COUNCIL ACT, 58 OF 1991**

(Commencement 19 July 1991)

To provide for the continued existence of the South African Medical Research Council and for the management thereof by a Board; and for matters connected therewith.

74. **SOUTH AFRICAN MEDICINES AND MEDICAL DEVICES REGULATORY AUTHORITY ACT, 132 OF 1998**

This Act was put into operation by Proclamation R49 of 30/04/1999 (GG 20024) with effect from 30/04/1999. The scheduled medicines under the Act were published in GN R567 of 07/05/1999 (GG 20025). Towards the end of May 1999 application was made by inter alia the President and the Minister of Health to the High Court to set aside the Proclamation and Government Notices. The Court refused to grant the application. But in July 1999 the full bench of the High Court on appeal overruled this judgement. The result is that Act 132 of 1998 and the regulations in GN 567 have not taken effect at all. A further result is that the Medicines and Related Substances Control Act, 101 of 1965 remains fully in force and that none of the provisions of Act 90 of 1997 have been repealed (although the latter Act has not yet been put into effect). In February 2000 the Constitutional Court confirmed the judgement of the full bench.

75. **SOUTH AFRICAN POLICE SERVICE ACT, 68 OF 1995**

(Commencement 15 October 1995)

To provide for the establishment, organisation, regulation and control of the South African Police Service; and to provide for matters in connection therewith.

76. **STANDARDS ACT, 29 OF 1993**

(Commencement 1 April 1993)

To provide for the promotion and maintenance of standardisation and quality in connection with commodities and the rendering of services and for that purpose to provide for the continued existence of the South African Bureau of Standards, as the national institution for the promotion and maintenance of standardisation; and the control thereof by a council, and for matters connected therewith.

77. **STERILIZATION ACT, 44 of 1998**

(Commencement 1 February 1999)

To provide for the right to sterilisation; to determine the circumstances under which sterilisation may be performed and in particular the circumstances under which sterilisation may be performed on persons incapable of consenting or incompetent to consent due to mental disability; and to provide for matters connected therewith.

78. **TEMPORARY EMPLOYEES PENSION FUND ACT, 75 OF 1979**

(Commencement 1 October 1979)

To provide for the payment of pensions and other financial benefits to certain temporary employees and their dependants; and to provide for matters connected therewith.

79. **TOBACCO PRODUCTS CONTROL AMENDMENT ACT, 12 OF 1999**

(Commencement 1 October 2000)

To amend the Tobacco Products Control Act, 1993, so as to amend and insert certain definitions; to provide for the prohibition of advertising and promotion of tobacco products, and promotion of tobacco products in relation to sponsored events; to prohibit the free distribution of tobacco products and the receipt of gifts or cash prizes in contests, lotteries or games; to provide for the prescription of maximum yields of tar, nicotine and other constituents in tobacco products; to increase fines; and to provide for matters connected therewith.

80. **UNEMPLOYMENT INSURANCE ACT, 30 OF 1966**

(Commencement 1 January 1967)

To consolidate the laws relating to the Unemployment Insurance Fund, the payment of benefits to certain persons, the payment of certain amounts to dependants of certain deceased persons, the combating of unemployment and matters incidental thereto.

Annexure

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Dr NP Mkabayi

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Department: **REGISTRAR'S OFFICE**

Designation: Health Committee: Coordinator
Ms B Malambe

Reference: **DR NP MKABAYI:MP0433764**

Date: 12 December 2017

Dear Dr Mkabayi,

HEALTH COMMITTEE – DR NP MKABAYI / MP0433764

Kindly be informed that your matter was discussed at the Health Committee meeting that was held on 28-29 November 2017.

The Committee **RESOLVED** that based on the information received it could not find any evidence to declare you an impaired practitioner in terms of section 51 of the Health Professions Act of 1974 (Act No 56 of 1974, as amended). Therefore, your matter has been closed.

I trust that you will find the above in order.

Yours sincerely

pp REGISTRAR

Annexure

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Mr D Maphetho
Office of Health Ombuds
79 Steve Biko Road
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0007

Department: OFFICE OF THE REGISTRAR
Designation: Registrar/CEO
Reference: MP 0433764
Date: 12 December 2022

Per Email: dmapheto@ohsc.org.za

Dear Maphetho

RE: DR NOZUKO PRECIOUS MKABAYI - 0433764

2.1 Your correspondence dated 6 December has reference.

2.2 Dr N. Mkabayi (MP 0433764) was under investigation by the Health Committee of the Health Professions Council of South Africa (Committee) in 2017, where it was resolved that, based on the available information, there is no evidence of impairment in terms of regulations defined by section 51 of the Health Professions No. 56 of 1974 (Regulations), as such the health impairment investigation was closed.

2.3 In March 2021, the Committee again received new allegations regarding Dr N. Mkabayi (MP 0433764) alleging that she might be an impaired practitioner.

2.4 Based on 2.3 above, the Committee commenced a new investigation to determine if there is health impairment in terms of regulations.

2.4 At the meeting held on 7 December 2022, the Committee resolved that Dr N. Mkabayi (MP 0433764) should be informed that the Committee has intentions to suspended her from practicing the profession in South Africa on the basis of health impairment.

2.5 Feedback from Dr N. Mkabayi (MP 0433764) is expected to reach the Committee within 14 days of receipt of Committee's correspondence, which is to be the 22nd of December 2022.

2.6 Post receipt of the feedback from Dr N. Mkabayi (MP 0433764), the Committee will consider and resolve on the case.

Yours Sincerely

Signed by: Thabo meshack Pinkoane
Signed at: 2022-12-13 08:30:04 +02:00
Reason: I approve this document

DR TM PINKOANE
(ACTING REGISTRAR) REGISTRAR / CEO

Annexure


TCL
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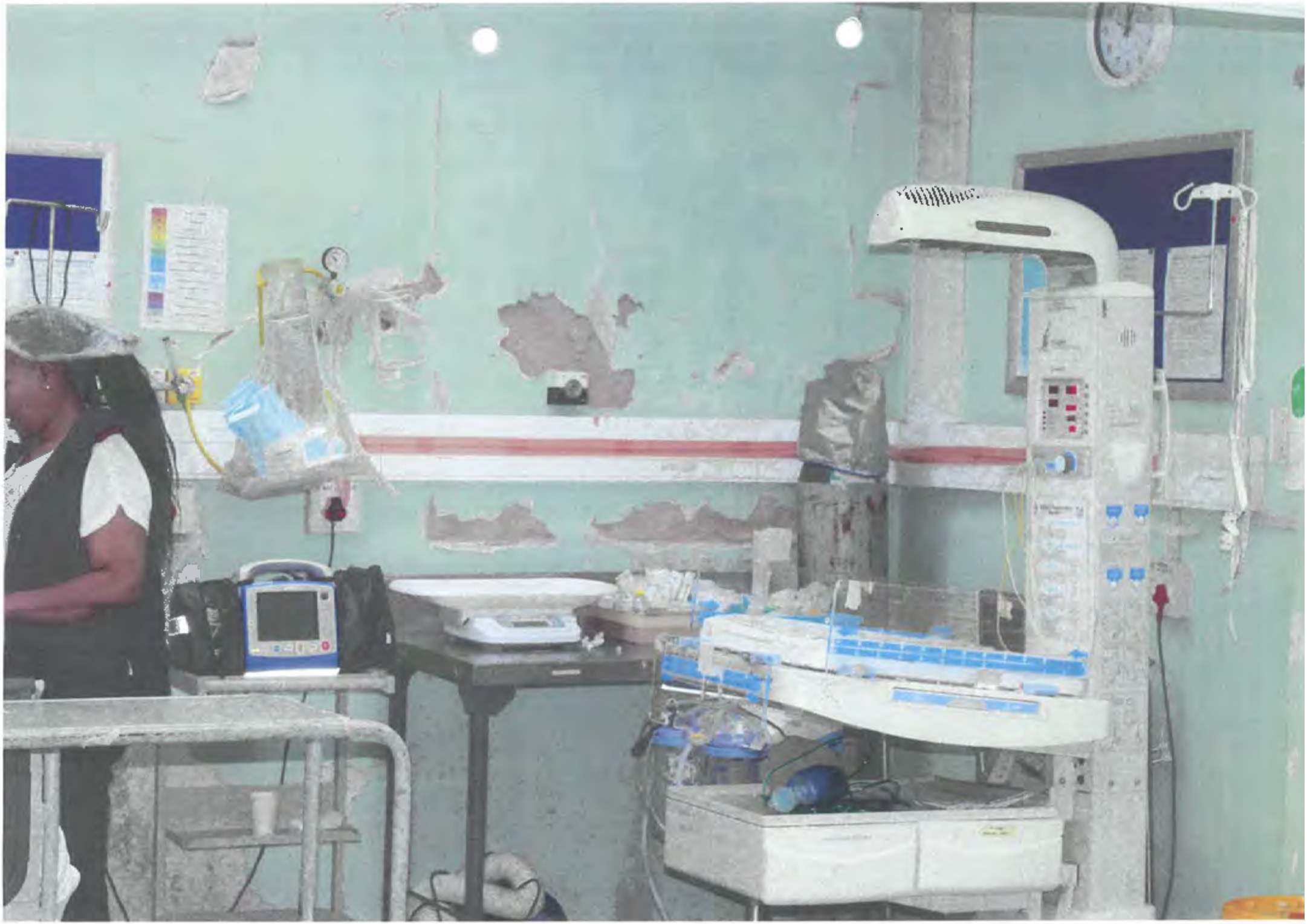
Annexure T


CASUALTY
AMBULANCE



Annexure

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquiries: Muriel Seapela / Zanele Radebe
Tel. number: 082 457 6854
Email: Muriel.Seapela@gauteng.gov.za / Zanele.Radebe@gauteng.gov.za

The Chief Executive Officer: Rahima Moosa Mother and Child Hospital

Dear Dr F Benson

Request for BAC to approve the replacement of the 16 Slice CT Scanner

You are hereby advised that your request was tabled to the Departmental Bid Adjudication Committee (DBAC), at the meeting held on the 20th August 2020.

Background:

Imaging services play a fundamental role and remains the key clinical component to effective healthcare delivery The current CT was purchased in 2006, end of production of this model was in Dec 2014 and the end of life date is 31 December 2023. After which no service parts will be available and no maintenance service contract will be offered by the service provide.

CT is a high priority imaging modality and critical to imaging Paediatrics emergency patients as well as Gynae patients and emergency suspected pulmonary embolus in pregnant patients. The CT scanner is now reaching the end of its acceptable serviceable life creating a reliability issue, the impact of which would be a total reduction in capacity. Due to the age of this equipment it is inevitable that image quality will deteriorate, speed of acquisition and reconstruction will be subject to degradation thus imposing a significant clinical risk of misdiagnosis. As its age increases it is inevitable that this will result in higher maintenance costs. A new scanner would enable quality improvements to be realised, offering more diverse diagnostic imaging to referring clinicians.

An ageing scanner is also more prone to periods of service and breakdown closure. The closure of the scanner results, due to breakdowns results in emergency paediatric patients having to be transferred to Charlotte Maxeke Academic Hospital and adult patients to Helen Joseph Hospital. On analysis of demand, the CT service has been subject to increases in referrals year on year over the last three years equating to an additional 1200 patients scanned per year. The scanner is now operating for 8-10 hours a day and often over weekends which is increasing the rate of deterioration of the scanner

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

DBAC Resolution:

DBAC has recommended the HOD to grant approval to procure 16 slice CT scanner for the cost of R10 607 700 to the total cost, inclusive of a 5-year service maintenance contract is R14 085 279,00.

DR F. BENSON

ACTING CHAIRPERSON: BAC

DATE: 2020/8/25

APPROVED/ NOT APPROVED/ APPROVED WITH AMENDMENTS

The procurement must follow PFM framework

PROF M LUKHELE

HOD: GAUTENG DEPARTMENT OF HEALTH

DATE: 2020/08/26

Request for BAC to approve the replacement of the 16 Slice CT Scanner

V

Annexure

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

Enq: Mrs. S. Jordaan
Tel: (011) 470- 9034
Cell: 082 772 1119
Email: sjordaan@icon.co.za

TO: DR. ME. KENOSHI

FROM: MRS. S. JORDAAN
RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

DATE: 2 OCTOBER 2017

RE: NURSING CRISIS AT RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

PURPOSE:

1. To obtain approval for a resolution to the nursing crisis at Rahima Moosa MCH.

BACKGROUND:

2. Rahima Moosa MCH is facing a nursing crisis due to more than 350 vacancies in its staff establishment of 1412.

3. This crisis will lead to maternal and neonatal deaths if it remains unattended, which will further lead to more litigation against the institution and the department.

4. It has led to severe staffing problems in the Labour and Neonatal unit. Both these units depend on skilled staff, such as advanced midwifes, paediatric ICU nurses and theatre trained nurses.

5. The hospital has a 9 bedded Labour Ward and a 10 bedded Labour Admission Ward, but constantly had 30-50 admission per day for the last two months. It similarly has a 35-bedded neonatal unit with 48-60 admissions per day.

6. To provide these services we have been dependent on Nursing Agencies because of an inadequate number of these professionals on our staff establishment. However, over

the last 2 months the Agencies have not been paid because their services are not regarded as non-negotiable.

7. Since the crisis started the number of midwifes we have to attend to the above patients have been between 6 and 7; when we should have had 14 during the day and night shifts.

8. The numbers of theatres that we are able to run to accommodate the number of patients that need caesarian sections have been cut down from three to one which has translated into patients needing emergency surgery not being attended to.

9. This has led to a situation where we expect maternal and neonatal deaths to occur.

RECOMMENDATIONS:

10. The Acting HOD's approval of the urgent restructure RMMCH beds with the close down wards with lower occupancies, namely wards 2 and 4, and redistributing staff to labour wards and theatre, in order to meet service demands, is sought.

11. Management strongly and urgently request the Acting HOD to assist by paying the Nursing Agencies for the services rendered.

12. As a more medium long term measure to fill the vacancies at RMMCH that have been identified by the Quality Assurance Directorate in a recent evaluation.

Jordaan

MRS. S. JORDAAN (CEO)
RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

SUPPORTED / SUPPORTED AS AMENDED / NOT SUPPORTED

Dr. S. MFENYANA
DDG: HOSPITAL SERVICES

APPROVED / APPROVED AS AMENDED / NOT APPROVED

DR. M.E. KENOSHI
ACTING HOD: GAUTENG DEPARTMENT OF HEALTH

APPROVED / APPROVED AS AMENDED / NOT APPROVED

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

Office of the Chief Executive Officer
Rahima Moosa Mother and Child Hospital
P/Bag X 20
Newclare
2112
sjordaan@icon.co.za
Tel: 011-470-9034
Fax: 011-673-5658

Mrs J More
QA – Dept Health
Lisbon Building

Dear Mrs More,

Shortage of nursing staff

Nursing Posts: 288 approved Prof Nursing posts

Filled 195
Vacant 93 – not showing on the system currently due to no budget and vacant for longer than 24 months.

Budget for nursing agencies – R21,160,000-00 (at G+S)
If we transfer the money to COE then we can fill the following:

10 Speciality Prof Nurses (AICU + PICU)
20 Speciality Prof Nurses (Theatre)
10 Prof Nurses (wards)

Enclosed financial printout, shifts for Labour ward, Labour ward admissions and Theatre.

If we can fill 40 posts we will be able to limit the using of agency staff.

Hope this will assist you and help us to resolve our problem with nursing agencies and shortages.

Regards,

CEO
19 July 2017

Annexure

Gauteng Department of Health

EX-POST FACTO APPLICATION

Best interest considerations

Assuming that urgency was the primary reason for the occurrence of deviant action by the Directorate/Institution, the following applying conditions shall be considered together with motivating circumstances by **DBAC**.

Applying conditions	Motivating conditions
1. Reason why this was in the best interest of the Department.	Staff burnout, staff morale, staff absenteeism, and prevention of complaints, errors and litigation.
2. If there was urgency to obtain material advantage for the Department, where time did not allow for prior approval from **DBAC** or following proper procedures or lack of action could have harmed the esteem or image of the Department, how does the Directorate/Institution satisfy DBAC on the following concerns: o Action did not originate out of negligence o Action taken was not reasonable. o No fruitless expenditure has been incurred. o Action did not irrevocably commit the Department to a contract.	There was no negligence. Was reasonable. No fruitless expenditure was incurred, within Budget. No contract. Was on Adhoc Basis.
2. State negative result that could have occurred had normal course of procurement processes been followed	Staff burnout, staff morale, staff absenteeism, and prevention of complaints, errors and increase in litigation.
3. What better results had been derived from deviant action over normal procurement processes.	Quality patient care, reduced complaints, staff morale improved, and staff burnout reduced.
5. Details of time constraints experienced.	Internal factors.
6. Details of attempts made to obtain prior approval from **DBAC**, or HOD.	Department of health were contacted to make use of the Covid 19 nurses contract for professional nurses, but there were none available.
7. Details of procurement processes followed.	The application for additional staff was not addressed since 2005.
8. Prevailing or applicable conditions.	Challenges will prevail until staff structure challenges has been addressed.
9. Process of price comparison or analysis used.	Previous experience with nursing agencies that was costly and could not supply Speciality of experienced nurses.

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquiries: Estelle Roux
Tel number: 060 982 4296
Email: Estelle.Roux@gauteng.gov.za

The Chief Executive Officers.

Dear Colleagues

NURSING AGENCIES:
REQUESTS FOR PAYMENTS FOR THE VARIOUS NURSING AGENCIES UTILISED AT GDOH FACILITIES.

You are hereby advised that the afore-mentioned case was tabled by the Departmental Bid Adjudication Committee (DBAC), at the meeting held on the 27 February 2020.

Background:
DBAC have had noticed that there are various Hospitals who are utilizing the services of Nursing Agencies without proper approval granted.
After various engagement it was also discovered that other institutions have engaged on contract with Nursing Agencies, but the contracts are not properly done whilst others are sourcing them via RFQ
This has resulted on Nursing Agencies not being paid timeously.

Recommendations:

- DBAC has recommended that all institutions who are utilising the services of Nursing Agency and have outstanding payments are requested to compile the submission to present to DBAC to request approval for payment of such services.
- The submission must include the following
- Submission must clearly request aporoval of the ex- post facto payment indicating the outstanding amount as well as the name of the Nursing Agency utilised per institution
- Supporting documents must also be attached to validate the services provided.

MS K LEHLOENYA
CHIEF FINANCIAL OFFICER
DATE: 03/03/2020

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

RAHIMA MOOSA MOTHER AND CHILD HOSPITAL

Enquiries: Lesley Rose

Tel: (011) 470-9037

Email: Lesley.Rose@gauteng.gov.za

BAC SUBMISSION

TO	:	**BID ADJUDICATION COMMITTEE**
FROM	:	**Matron L. Rose**
		Nursing Manager
ASSISTED	:	**Procurement Manager: Mr T. Wessels**
		Financial Manager: Mr T. Van Wyk
DATE	:	**Request as from 1 November 2021 to 31 March 2022**
SUBJECT	:	**REQUEST FOR BAC APPROVAL TO UTILISE NURSING AGENCIES ON ADHOC BASIS FOR 2021/2022 FINANCIAL YEAR AS THE NEED ARISES.**

PURPOSE:

To apply for approval to use nursing agencies on an ad hoc basis as the need arises for the rest of the financial year from 1 November 2021 to 31 March 2022, in order to assist with quality patient care and prevent possible litigation.

BACKGROUND:

Rahima Moosa Mother and Child Hospital is a large Regional Hospital that renders a unique service. We are the only hospital in Gauteng that renders a service to only women and children. The hospital was opened in March 1943 and is currently 78 Years old.

The hospital has an establishment of 1255 posts and has 338 approved beds with 353 in use and a ***bed occupancy rate of 150% in obstetrics and neonates.***

There is therefore a high demand for services and an acute shortage of beds at the institution. The staff numbers have not been adjusted to meet service demands since 2005, which has translated into severe staff shortages and dependency on agency staff. We also have the challenge that 40% of the patients are foreign patients.

Patients are referred from other hospitals like: Carletonville, Helen Joseph, Potchefstroom, Klerksdorp, Leratong, Dr Yusuf Dadoo, Discovery Clinic etc. ***for Tertiary Clinical service.***

It should be noted that the hospital is categorised a Regional hospital but has always rendered Tertiary Clinical Services from its inception. Currently the three Academic Heads of Paediatrics, Radiology and Obstetrics & Gynaecology base at Rahima Moosa Mother and Child Hospital. The Hospital has never received any Tertiary funding for services rendered.

Rahima Moosa Hospital (2021-2022)

Approved Beds	338	Apr	May	Jun	Jul	Aug	Sep	Oct	Average	
Wards Current Bed		286	286	288	288	288	288	288	286	
Paeds Beds	104	104	104	104	104	104	104	104	104	
Bed Occupancy		54%	73%	71%	54%	56%	58%	62%	61%	
Admissions		1 678	2 349	2 218	1 743	1 803	1 816	1 989	1 942	
Paeds ICU	10	10	10	10	10	10	10	10	10	
Bed Occupancy		94%	87%	95%	86%	92%	87%	88%	90%	
Admissions		283	270	286	266	285	262	273	275	
Neonates (16B)	35	35	35	35	35	35	35	35	35	
Bed Occupancy		130%	144%	169%	131%	145%	145%	147%	144%	
Admissions		1 364	1 561	1 772	1 426	1 575	1 527	1 591	1 545	
KMC	12	12	12	12	12	12	12	12	12	
Bed Occupancy		68%	101%	66%	81%	67%	111%	90%	86%	
Admissions		316	374	238	303	248	399	333	316	
Obstetrics	123	123	123	123	123	123	123	123	123	
Bed Occupancy		140%	178%	158%	145%	128%	130%	129%	144%	
Admissions		5 155	6 774	5 835	5 517	4 886	4 812	4 919	5 414	
Gynaecology	44	44	44	44	44	44	44	44	44	
Bed Occupancy		68%	71%	68%	62%	67%	73%	68%	68%	
Admissions		898	964	904	848	916	969	933	919	
Adult High Care	4	4	4	4	4	4	4	4	4	
Bed Occupancy		85%	135%	107%	60%	77%	64%	76%	83%	
Admissions		78	168	126	74	96	77	94	102	
Total	332	332	332	332	332	332	332	332	332	
Ave Bed Occ		95%	120%	111%	93%	94%	99%	98%	97%	Ave.
Total Admission		9 772	12 366	11 381	10 177	9 806	9 862	10 132	10 513	Current Ave.
									126 156	*Projected Admissions Per Annum*

MOTIVATION:

Currently Rahima Moosa Hospital has the second largest Obstetric Department in the country. In comparison to Chris Hani Baragwanath Hospital which has 3000 deliveries a month, Rahima Moosa Hospital has an access of 1400 deliveries a month and it is increasing.

Rahima Moosa Hospital has had a staff establishment that was never reviewed since 2005 with is not correlating in the increasing patient influx. Minimal number of Speciality Posts and

Professional Nurses posts on the staff establishment. No designated personnel delegated for quality assurance, infection control, OHS.

Due to ***lack of Speciality Posts within the staff establishment***, huge pressure is place on the shoulders of the Area Mangers (Nursing Managers) to perform these duties, resulting in lack of institutional supervision.

The Hospital sends nurses for Speciality Training e.g. Critical Care, Trauma and Advanced Midwifery. When these highly skilled nurses are successful with their courses, the hospital cannot accommodate them due to the lack of Speciality Posts. This results in highly skilled nurses taking up employment somewhere else, resulting in the utilisation of nursing agencies to fulfil quality patient care.

Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Total	Projection
Normal Deliveries	805	1 026	878	884	752	718	647	5 708	9 785
Caesarean Section	578	664	556	429	400	408	412	3 447	5 909
Forceps Deliveries (Assist)	6	9	4	8	11	9	10	57	98
Total	1 389	1 699	1 436	1 321	1 163	1 135	1 069	9 212	15 792

This is the Statistics over a 7 month period
Average deliveries per day = 43
Average deliveries per month = 1316
Projected deliveries for the year = 15792

THE BENEFIT:

Alleviates the pressure and workload of the nursing staff during the increasing patient influx. Promotes care for the patient. Minimises litigation.

FINANCIAL IMPLICATIONS:

2021-2022 Financial year budget allocation = R 11,505,000

Allocation Codes

Fund	VOTED FUNDS	38948
Project (Order)	NO PROJECTS	18949
Objective (Functional Area)	NURSING ADMIN (GHS)	30334949
Responsibility (Cost Centre)	RAHIMA MOOSA HOSPITAL	30518949
Infrastructure	NON INFRA/ST ALONE:CURRENT	49949
Assets	NON-ASSETS RELATED	22949
Regional ID	JHB CITY OF JOHANNESBURG	30002949
Item (GL Account)	ASS/OIS:NURSING STAFF	1488949

		Budget
a. Allocated budget		11 505 000
b. Expenditure to	2021/10/19	8 180 946
c. Committed to	2021/10/19	2 343 891
d. Sub Total (a - (b+c))		**5 980 163**
e. Requested expenditure in submission		0
f. Total availability (d-e)		5 980 163

2021-2022 Budget Committed as at 19 October 2021 = R 2,343,891

Ex Post Facto was requested as at the end of October 2021 = R 2,000,000

Budget requested to use the Nursing Agencies on an AdHoc basis for the remainder of the 2021-2022 financial year is hereby requested.

Budget Requested on AdHoc Basis to be used till 31 March 2022 = R 5,324,000

Nursemate Nursing Agency R 5,324,000

This request is based on the Current usage whereby we have asked permission for Ex Post Facto as see below:

Ex Post Facto Request:

NURSEMATE NURSE SERVICES VENDOR No. 1100 155 844 DATE UPDATED: 13 OCTOBER 2021

RAHIMA MOOSA Mother and Child HOSPITAL			
TAX INVOICE No.s	DATE	INVOICE PERIOD	AMOUNT OUTSTANDING
RMH00099	16-07-2021	05-07-2021 TO 11-07-2021	R 178 113,07
RMH00099	12-08-2021	02-08-2021 TO 08-08-2021	R 220 520,33
RMH00100	18-08-2021	09-08-2021 TO 15-08-2021	R 365 603,45
RMH00101	25-08-2021	16-08-2021 TO 22-08-2021	R 197 806,86
RMH00102	31-08-2021	23-08-2021 TO 29-08-2021	R 217 273,56
RMH00103	07-09-2021	30-08-2021 TO 05-09-2021	R 190 913,02
RMH00104	14-09-2021	06-09-2021 TO 12-09-2021	R 244 282,58
RMH00105	21-09-2021	13-09-2021 TO 19-09-2021	R 232 678,26
RMH00106	28-09-2021	20-09-2021 TO 26-09-2021	R 251 375,73
RMH00107	05-10-2021	27-09-2021 TO 03-10-2021	R 146 715,28
RMH00108	12-10-2021	04-10-2021 TO 10-10-2021	R 169 788,24
TOTAL OUTSTANDING AWAITING P.O			R 2 343 891,85

15719735
RP020UBS

BAS
GP: HEALTH
EXPENDITURE CONTROL (COMMITMENTS)
FOR FINANCIAL YEAR UP TO 30/09/2021

DATE: 20/10/2021
TIME: 09:04:12
PAGE: 2

SELECTION CRITERIA : TYPE / DETAIL

TYPE	DETAIL
ITEM	ALL
FUND	VOTED FUNDS
OBJECTIVE	ALL
INFRASTRUCTURE	ALL
ASSETS	ALL
PROJECT	ALL
RESPONSIBILITY	RAHIMA MOOSA HOSPITAL
REGIONAL IDENTIFIER	ALL

SORT CRITERIA	: I Z O S A P R M
TOTALS	: 10003 10004 00010
PAGE BREAK	: NONE
PROFILE	: SECURITY
ECONOMIC CLASS	: ALL
TOT ON ECON CLASS	: NO
LAST CLOSED MONTH	: 09/2021

	TYPE LEVEL	DESCRIPTION	EXPENSES	COMMITMENTS	BUDGET	AVAILABLE BUDGET
	I 004	AGENCY&SUPPT/OUTSOURCED SERVICES				
TOTAL	O 010	ADMISSIONS (GHS)	202,9?0.85	0.00	188,000.00	11,0?7,85-
TOTAL	O 010	CLEANING (CHS)	1,942,006.70	0.00	4,010,000.00	2,068,993.30
TOTAL	O 010	NURSING ADMIN (GHS)	3,180,946.04	0.00	12,505,000.00	9,324,053.96
TOTAL	I 004	AGENCY&SUPPT/OUTSOURCED SERVICES	5,325,923.59	0.00	16,704,000.00	11,378,076.41

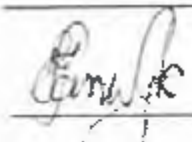
**** END OF REPORT RP020UBS ****

Nursing Admin = Nursing Agency Budget and Expenditure

RECOMMENDATION:

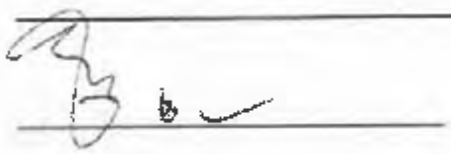
Herewith we request permission to use nursing agency (Nursemate) as the need arises till the end of 2021/2022 financial year.

Mr. T. Wessels
Procurement Manager: Rahima Moosa Mother and Child Hospital
Date: 19/10/2021
Supported/ ~~Not Supported/ Supported with amendments~~

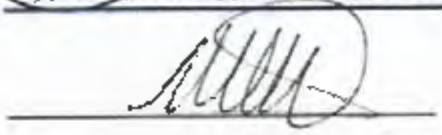


Mr. T. Van Wyk
Financial Manager: Rahima Moosa Mother and Child Hospital
Date: 19/10/2021
Supported/ ~~Not Supported/ Supported with amendments~~

Matron L. Rose
Nursing Manager: Rahima Moosa Mother and Child Hospital
Date: 19/10/2021
Supported/ ~~Not Supported/ Supported with amendments~~



Dr F. Benson
Clinical Manager: Rahima Moosa Hospital
Date: 19/10/2021
Supported/ ~~Not Supported/ Supported with amendments~~



Dr N. Mkabayi
CEO: Rahima Moosa Hospital
Date: 19/10/20210
Supported/ Not Supported/ Supported with amendments

Gauteng Department of Health

ADHOC APPLICATION

Recommended Approval/ Not approved DATE:
Mr. L.R. Serongwa
Directorate: Nursing Practice
Signature:

Recommended Approval/ Not approved DATE:
Ms Lerato Madyo
Chairperson of DBAC
Signature:

Approved/Not Approved DATE:
Prof. M. Lukhele
Head of Department: Health
Signature:

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquiries: Estelle Roux
Tel. number: 060 882 4296
Email: Estelle.Roux@gauteng.gov.za

The Chief Executive Officers.

Dear Colleagues

NURSING AGENCIES:
REQUESTS FOR PAYMENTS FOR THE VARIOUS NURSING AGENCIES UTILISED AT GDOH FACILITIES.

You are hereby advised that the afore-mentioned case was tabled by the Departmental Bid Adjudication Committee (DBAC), at the meeting held on the 27 February 2020.

Background:
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After various engagement it was also discovered that other institutions have engaged on contract with Nursing Agencies, but the contracts are not properly done whilst others are sourcing them via RFQ.
This has resulted on Nursing Agencies not being paid timeously.

Recommendations:

- DBAC has recommended that all institutions who are utilising the services of Nursing Agency and have outstanding payments are requested to compile the submission to present to DBAC to request approval for payment of such services.
- The submission must include the following
- Submission must clearly request approval of the ex- post facto payment indicating the outstanding amount as well as the name of the Nursing Agency utilised per institution
- Supporting documents must also be attached to validate the services provided.

MS K LEHLOENYA
CHIEF FINANCIAL OFFICER
DATE: 03 03 2020

Annexure

STATS FROM JAN 2018 TO DEC 2018

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1483	679	210	180	320	30
FEBRUARY	1322	550	309	150	410	15
MARCH	1431	609	410	90	150	43
APRIL	1349	546	490	50	75	110
MAY	1320	558	385	130	203	10
JUNE	1321	490	306	225	112	13
JULY	1388	575	282	106	68	27
AUGUST	1342	587	325	92	167	65
SEPTEMBER	1373	550	190	58	380	48
OCTOBER	1355	604	256	79	56	36
NOVEMBER	1329	585	135	87	99	64
DECEMBER	1402	637	179	42	89	52

STATS FROM JAN 2019 TO DEC 2019

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1448	607	360	76	82	55
FEBRUARY	1299	564	250	115	107	25
MARCH	1514	605	246	103	122	18
APRIL	1525	633	305	65	310	45
MAY	1512	609	198	79	140	109
JUNE	1482	631	214	100	107	163
JULY	1528	686	189	93	65	86
AUGUST	1505	659	308	94	83	78
SEPTEMBER	1551	621	265	135	180	125
OCTOBER	1541	677	230	142	117	96
NOVEMBER	1571	694	152	85	80	48
DECEMBER	1636	742	112	65	154	135

STATS FROM JAN 2020 TO DEC 2020

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1686	724	320	95	174	56
FEBRUARY	1575	638	160	105	96	48
MARCH	1822	791	265	78	123	105
APRIL	1545	675	180	56	102	68
MAY	1581	709	172	135	88	26
JUNE	1566	726	230	158	152	10
JULY	1516	728	113	69	138	36
AUGUST	1573	747	280	70	100	84
SEPTEMBER	1630	686	156	182	75	117
OCTOBER	1559	560	106	54	115	36
NOV	1492	578	246	49	147	97
DEC	1423	538	195	169	91	110

STATS FROM JAN 2021 TO DEC 2021

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1342	502	325	52	215	30
FEBRUARY	1307	485	256	96	189	56
MARCH	1484	512	214	163	156	98
APRIL	1605	591	136	182	95	105
MAY	1970	739	82	75	36	165
JUNE	1770	627	186	37	168	89
JULY	1744	564	108	193	143	112
AUGUST	1481	479	290	122	83	93
SEPTEMBER	1355	678	95	85	154	45
OCTOBER	1303	575	174	163	79	177
NOVEMBER	1380	593	185	108	87	109
DECEMBER	1393	673	163	64	155	189

STATS FROM JAN 2022 TO DEC 2022

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1248	594	298	263	296	98
FEBRUARY	1296	651	183	158	341	16
MARCH	1441	627	116	95	287	52
APRIL	1280	569	85	179	196	105
MAY	1408	639	102	68	56	66
JUNE	1229	562	78	185	118	97
JULY	1326	602	174	109	69	120
AUGUST	1319	651	254	110	174	148
SEPTEMBER	1296	528	196	59	138	75
OCTOBER						
NOVEMBER						
DECEMBER						

STATS FROM JAN 2022 TO DEC 2022

MONTHS	ADMISSIONS	FOREIGNERS
JANUARY	1248	594
FEBRUARY	1296	651
MARCH	1441	627
APRIL	1280	569
MAY	1408	639
JUNE	1229	562
JULY	1326	602
AUGUST	1319	651
SEPTEMBER	1296	528
OCTOBER		
NOVEMBER		
DECEMBER		

STATS FROM JAN 2018 TO DEC 2018

MONTHS	ADMISSIONS	FOREIGNERS
JANUARY	1483	679
FEBRUARY	1322	550
MARCH	1431	609
APRIL	1349	546
MAY	1320	558
JUNE	1321	490
JULY	1388	575
AUGUST	1342	587
SEPTEMBER	1373	550
OCTOBER	1355	604
NOVEMBER	1329	585
DECEMBER	1402	637

STATS FROM JAN 2019 TO DEC 2019

MONTHS	ADMISSIONS	FOREIGNERS
JANUARY	1448	607
FEBRUARY	1299	564
MARCH	1514	605
APRIL	1525	633
MAY	1512	609
JUNE	1482	631
JULY	1528	686
AUGUST	1505	659
SEPTEMBER	1551	621
OCTOBER	1541	677
NOVEMBER	1571	694
DECEMBER	1636	742

STATS FROM JAN 2020 TO DEC 2020

MONTHS	ADMISSIONS	FOREIGNERS
JANUARY	1686	724
FEBRUARY	1575	638
MARCH	1822	791
APRIL	1545	675
MAY	1581	709
JUNE	1566	726
JULY	1516	728
AUGUST	1573	747
SEPTEMBER	1630	686
OCTOBER	1559	560
NOV	1492	578
DEC	1423	538

STATS FROM JAN 2021 TO DEC 2021

MONTHS	ADMISSIONS	FOREIGNERS
JANUARY	1342	502
FEBRUARY	1307	485
MARCH	1484	512
APRIL	1605	591
MAY	1970	739
JUNE	1770	627
JULY	1744	564
AUGUST	1481	479
SEPTEMBER	1355	678
OCTOBER	1303	575
NOVEMBER	1380	593
DECEMBER	1393	673

STATS FROM JAN 2018 TO DEC 2018

MONTHS	ADMISSIONS	~~FOREIGNERS~~ NON-SA	BLACK	INDIAN	COLOURED	WHITE
JANUARY	1483	679	210	180	320	30
FEBRUARY	1322	550	309	150	410	15
MARCH	1431	609	410	90	150	43
APRIL	1349	546	490	50	75	110
MAY	1320	558	385	130	203	10
JUNE	1321	490	306	225	112	13
JULY	1388	575	282	106	68	27
AUGUST	1342	587	325	92	167	65
SEPTEMBER	1373	550	190	58	380	48
OCTOBER	1355	604	256	79	56	36
NOVEMBER	1329	585	135	87	99	64
DECEMBER	1402	637	179	42	89	52

STATS FROM JAN 2019 TO DEC 2019

MONTHS	ADMISSIONS	~~FOREIGNERS~~	BLACK	INDIA	COLOURED	WHITE
JANUARY	1448	607	360	76	82	55
FEBRUARY	1299	564	250	115	107	25
MARCH	1514	605	246	103	122	18
APRIL	1525	633	305	65	310	45
MAY	1512	609	198	79	140	109
JUNE	1482	631	214	100	107	163
JULY	1528	686	189	93	65	86
AUGUST	1505	659	308	94	83	78
SEPTEMBER	1551	621	265	135	180	125
OCTOBER	1541	677	230	142	117	96
NOVEMBER	1571	694	152	85	80	48
DECEMBER	1636	742	112	65	154	135

STATS FROM JAN 2020 TO DEC 2020

MONTHS	ADMISSIONS	FOREIGNERS	BLACK	INDIA	COLOURED	WHITE
JANUARY	1686	724	320	95	174	56
FEBRUARY	1575	638	160	105	96	48
MARCH	1822	791	265	78	123	105
APRIL	1545	675	180	56	102	68
MAY	1581	709	172	135	88	26
JUNE	1566	726	230	158	152	10
JULY	1516	728	113	69	138	36
AUGUST	1573	747	280	70	100	84
SEPTEMBER	1630	686	156	182	75	117
OCTOBER	1559	560	106	54	115	36
NOV	1492	578	246	49	147	97
DEC	1423	538	195	169	91	110

STATS FROM JAN 2021 TO DEC 2021

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MARCH	1484	512	214	163	156	98
APRIL	1605	591	136	182	95	105
MAY	1970	739	82	75	36	165
JUNE	1770	627	186	37	168	89
JULY	1744	564	108	193	143	112
AUGUST	1481	479	290	122	83	93
SEPTEMBER	1355	678	95	85	154	45
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OCTOBER						
NOVEMBER						
DECEMBER						

Annexure

JOINT REPORT ON THE CAPACITY OF RAHIMA MOOSA MOTHER AND CHILD HOSPITAL FOR DELIVERIES AND CARE OF MOTHERS AND NEWBORNS

A Hospital Under Stress

Professors AH Coovadia/H Lombaard

22 February 2021

This report that has been jointly prepared by the departments of Obstetrics & Gynaecology and Paediatrics & Child Health at the Rahima Moosa Mother and Child Hospital. It is a follow up on a report submitted to hospital management in 2017, attached. This document was discussed in person by Prof Coovadia and Prof Lombaard with the then Director of Hospital Services in Gauteng, Dr Richard Lebethe at the Gauteng Provincial Dept of Health offices at Bank of Lisbon. A document was also sent on the 27 August 2018 to the Head of the Cluster.

The following sections of the report have been prepared.

1. Current Multidrug Resistant Organism Outbreak in Neonates
2. Current capacity in the neonatal division and bed occupancy rates
3. Required capacity for the neonatal unit
4. Neonatal Statistics
5. Statistics of the Dept of O&G
6. Challenges in Obstetrics
7. Risk Assessment - Current and future risks
8. Proposals - Possible Solutions and Remedial Actions

1. Current Multidrug Resistant Organism Outbreak in the Neonatal Unit

In September 2020 there was a 3-fold increase in the number of *Acinetobacter baumannii* cases heralding the start of the Multidrug Resistant Organism (MDRO) outbreak in the neonatal wards at Rahima Moosa Mother & Child hospital (RMMCH). The monthly *Acinetobacter baumannii* cases had increased to 9 cases from the monthly average of 3 cases (see figure 1). This occurred amidst a backdrop of emerging *Candida auris* cases, a multidrug resistant fungal infection not seen in the neonatal unit before March 2018 (see figure 2).

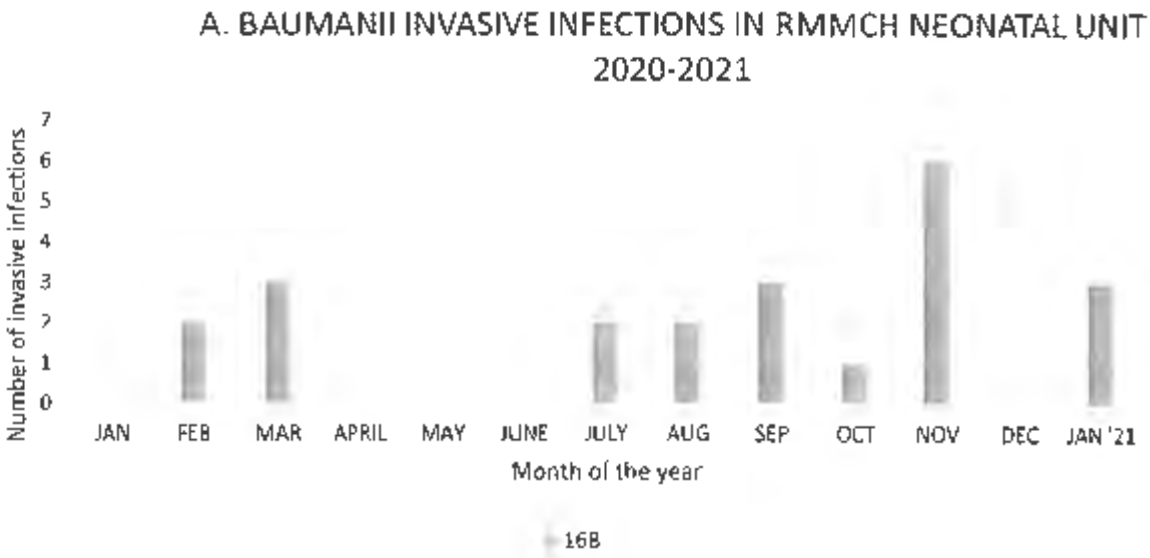


Figure 1

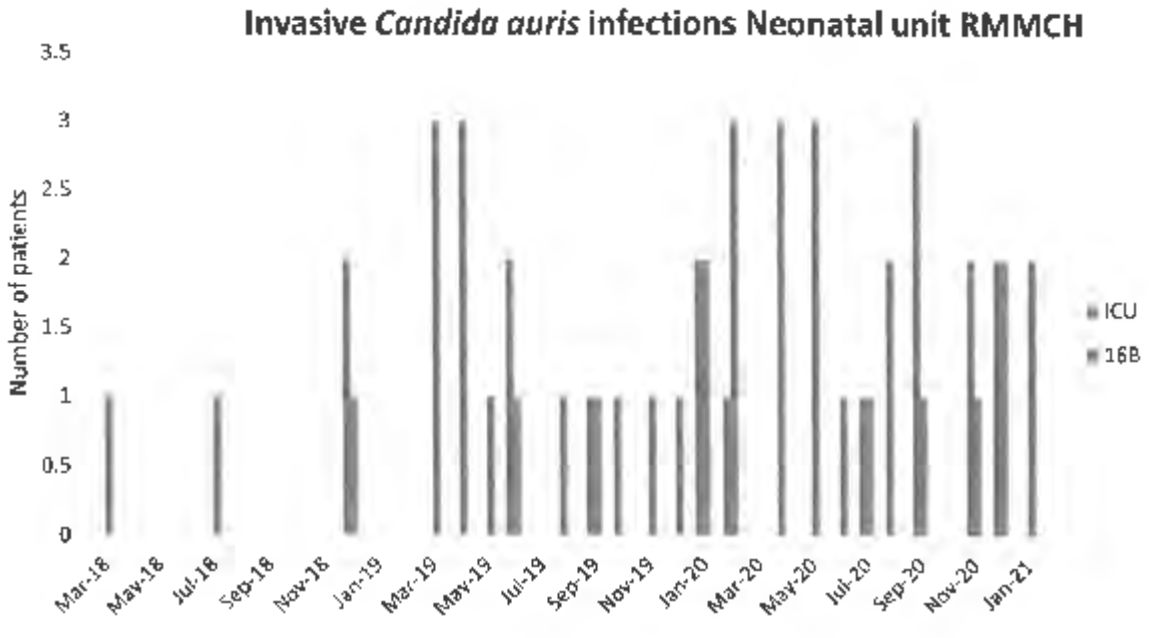


Figure 2

Clinicians together with NHLS representatives and the hospital's Infection Prevention & Control (IPC) committee met monthly from October 2020 in an effort to curb the outbreak. The following reasons were cited as likely causes of the ongoing outbreak:

I. Overcrowding in the unit – particularly 16B
II. Insufficient isolation areas
III. Increased patient to nurse ratios
IV. Insufficient equipment – e.g. one oxygen saturation probe for multiple patients
V. Poor hand hygiene practices
   - insufficient hand sanitizer (bottles were disappearing with the COVID pandemic)
   - broken towel dispensers
VI. Failing infrastructure
   - leaking pipes led to closure of some cubicles thus less isolation cubicles
   - insufficient oxygen and plug points in certain cubicles led to underutilization of these cubicles
   - on at least 3 occasions, pipes burst leading to flooding of the ward and babies with proven infection shared cubicles with babies without infection
   - in October and November 2020 the hospital had periods of no running water for days on end

In an attempt to cohort infections, a decision was made to screen every neonate in the ward for colonization by performing skin and rectal swabs. It soon became apparent that > 30% of neonates were either colonized with *A. baumannii* or *C. auris* (see figure 3 & 4). This further exasperated the shortage of isolation cubicles, complicated by the need to also isolate infants to moms with COVID as well as infants with other organisms e.g., Klebsiella, MRSA etc. This unfortunately also led to the underutilization of Kangaroo Mother Care (KMC) as many infants were either colonized with MDRO or their mothers were found to be COVID positive on testing and hence unable to be admitted to KMC.

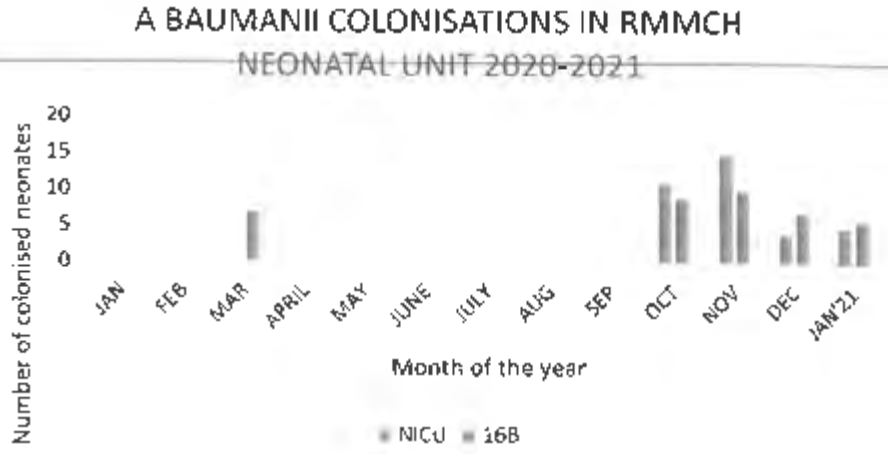


Figure 3

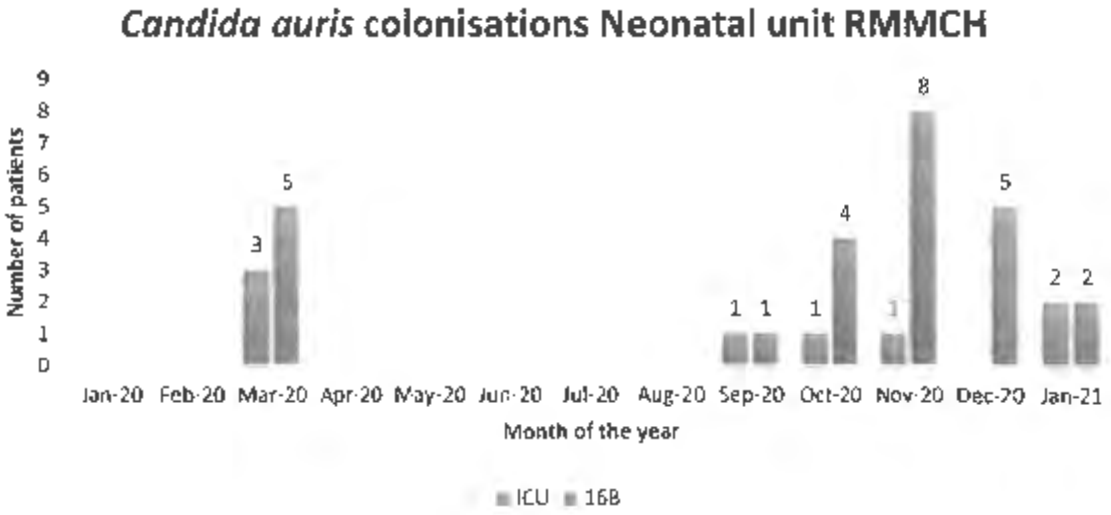


Figure 4

Conclusion: The RMMCH neonatal unit has ongoing outbreaks of multidrug resistant organisms

2. Current Neonatal Bed Capacity and Occupancy Rates

The neonatal division of the Dept. of Paediatrics and Child Health has four in-patient areas that serve the neonatal population at RMMCH. These four areas, their capacity and occupancy rate is provided below:

Area	Number of beds	Occupancy Rate in 2020
Neonatal/Paediatric ICU	6	Usually 100%
High Care	4	Usually 100%
Neonatal Intermediate Care – Ward 168	35	Usually > 150%
KMC	16	Usually > 50%
Total	**61**	

In 2020 the neonatal unit provided beds for the following deliveries:

Centre	Number of Deliveries (incl. BBAs) in 2020
RMMCH	16 600
OR Tambo Clinic	6 000
Discovery Clinic	1 700
Total	**24 300**

Conclusion: RMMCH has 61 neonatal beds for 24 300 annual deliveries.
Bed occupancy rates exceed 150%.

3. **Required capacity for the neonatal unit**

Required capacity is calculated on number of deliveries at an institution and their referral clinics.

When calculating RMMCH as a Level II hospital and accounting for clinic deliveries:

Bed requirements = 3-4 X12 (24 000 births) + 2-3 X 12 (24 000 births)

= 72/96 + 48/72

= **120- 168 beds (minimum – actual bed requirement)**

Bed Distribution:

Bed distribution at (Regional) level II: **KMC: IC: HC: ICU**

4: 3: 2: 1

Bed distribution at Tertiary Level III level (more accurately reflects how RMMCH functions)

KMC: IC: HC: ICU

2: 3: 3: 2

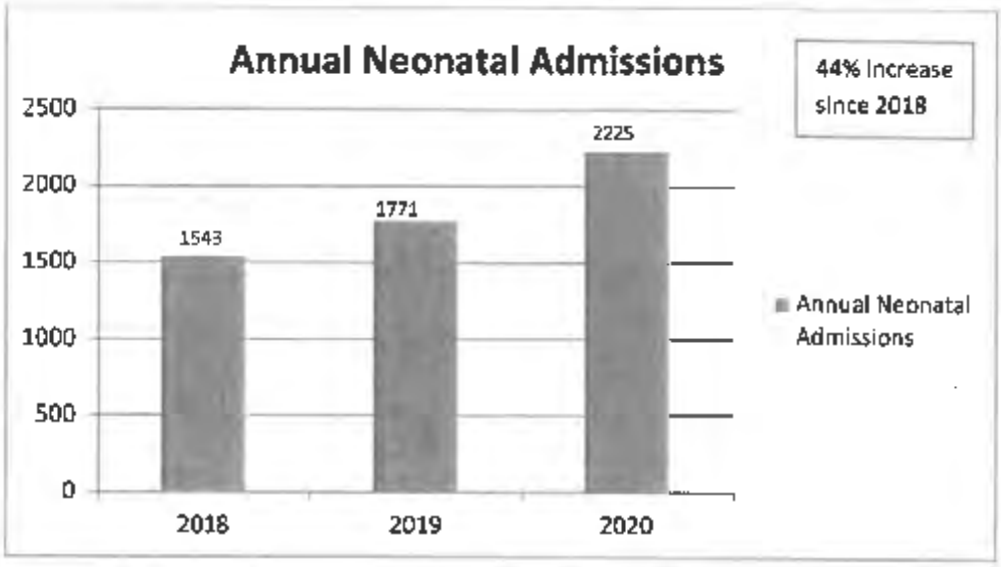
	Current Bed Status at RMMCH	National recommendation for Level II Hospital (minimum- actual requirement)	National recommendation for Level III Hospital (minimum- actual requirement)
ICU	6	12- 17	24- 34
High Care	4	24- 34	36- 50
Intermediate Care	35	36- 50	36- 50
KMC	16	48- 67	24-34
Total Beds	61	120- 168	120- 168

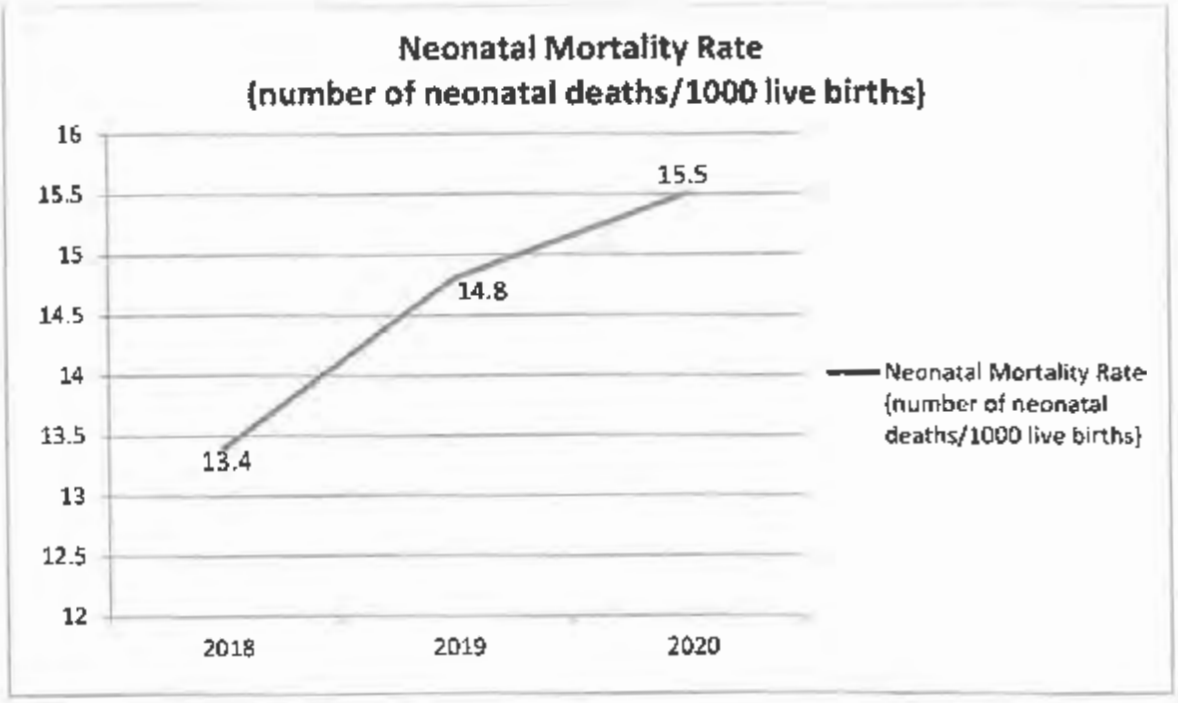
Space Requirements for Neonatal Patient Care

The crowding of babies within the cubicles of ward 16b is a concern as this relates to the risk of healthcare associated infections (HAIs) and thus outbreaks. As can be shown in the table below, we are falling short of national recommendations and this is a matter that needs addressing through managing the overall numbers of neonates the unit can handle.

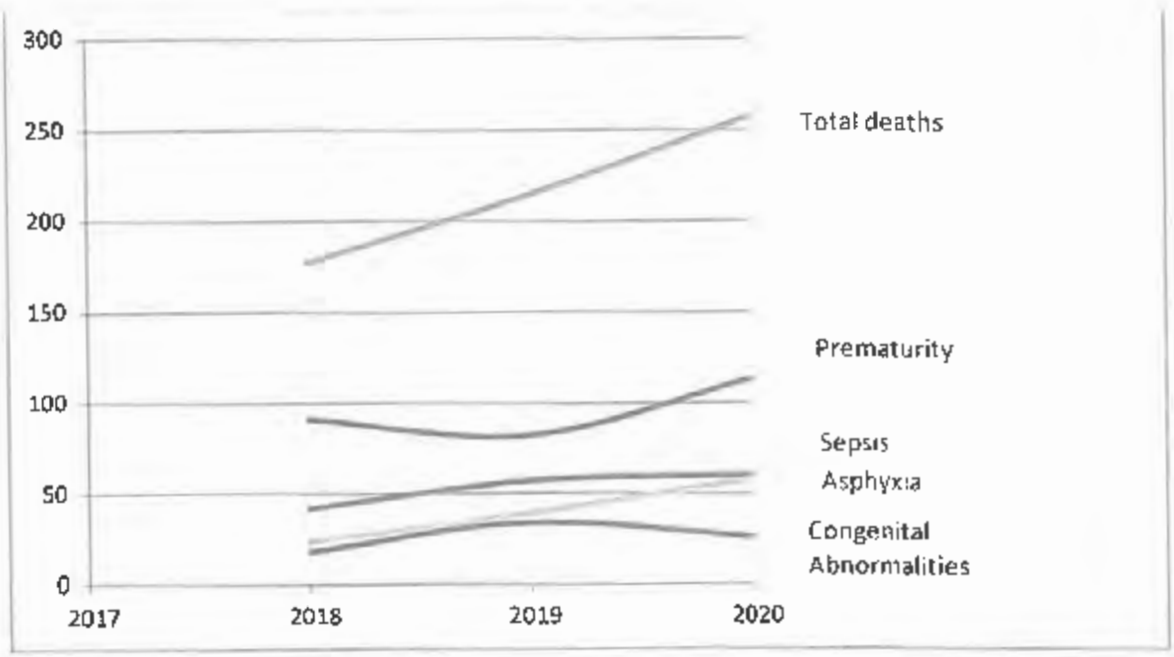
Level of Care	National Recommendation (m2/baby)	RMMCH
Intensive Care Unit	5.4m^2 - 7.2 m^2	4 m^2
High Care Unit	5.4m^2 - 7.2 m2	3 m^2
Intermediate Care Unit	3.6m^2	1.5m^2 – 2m^2
Kangaroo Mother Care Unit	7.2m^2	7m^2

Conclusion: RMMCH neonatal unit has 50%of the minimum bed requirement and 35% of the actual bed requirement needed to service the number of deliveries. The unit is perpetually overcrowded. Overcrowding is the rule and not the exception.



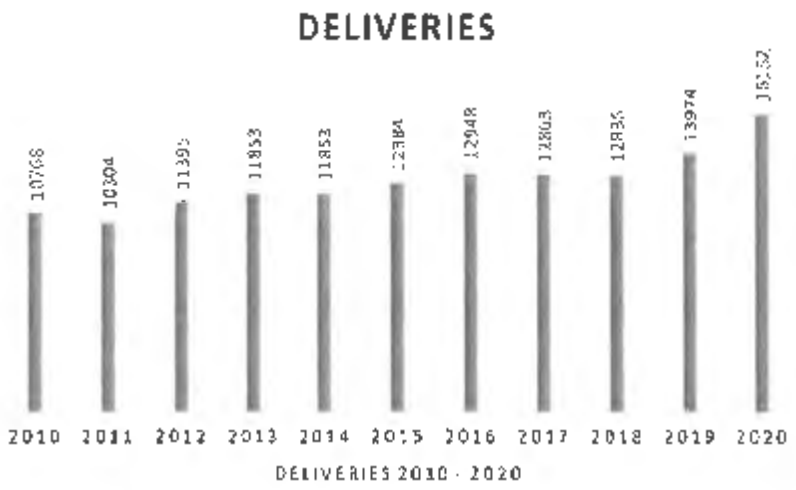


Number of Neonatal Deaths by Cause



Conclusion: The number of neonatal admissions have increased by 44% since 2018. The neonatal mortality rate (number of neonatal deaths/1000 deliveries) has been increasing since 2018. Preventable causes of death like asphyxia and sepsis are rising.

5. Statistics of the Dept of O&G



This is an average of 44 deliveries per day. This means a 50% increase over time, and should be seen in the light that during the staffing crisis in 2017 patients were being sent out.

The PMMR for 2017 was 33.4 and for Jan to Aug 2018 it was 28.6/1000 deliveries. The iMMR for 2017 was 47/100 000 compared to the total Gauteng data of 128.78/100 000. The iMMR for 2018 to end of August was 48.1/100000 deliveries. The iMMR increased to 87/100 000. In this period there was 3 deaths related to COVID-19, If these deaths are removed the iMMR was 69/100 000. It is clear that the increase in deliveries had an increase in the risk of maternal deaths.

6. Challenges in Obstetrics

The biggest problem is in Obstetrics because that affects what happens in neonatology.

Looking at Maternity Care guidelines it is stated that low risk women should be managed by midwifes. We should get the number of midwifes cases delivered. Currently we do not have sufficient Midwife Obstetrics Units to take the load of Rahima Moosa Mother and Child Hospital. According to the national Maternity Care Guidelines and the 2015 document stated the same, in low-risk women or midwife cases the fetal well-being should be assessed with fetal stethoscope or Doptone every 30 minutes after a contraction. This is not done due to staff shortage and these patients are monitored by CTG. All studies including large studies and recommendations by the WHO and other international bodies show that CTGs do not change the outcome at all for low-risk women but it increases the caesarean section rate. Studies further showed that if low risk women are not managed by midwifes the intervention rate goes up without any benefit to mother or baby and only an increase in high-risk patients in the future. Our current situation is that due to staff shortage and shortage of MOU's we make low risk patients a higher

risk patient and delay the patient flow because uncomplicated low risk women, especially when not in labour get a CTG and needs discharge by a doctor while a midwife should be dealing with the patient.

We have implemented a triage system in Ward 6. This has reduced the pressure on ward 6 and reduced the number of patients to be seen. Irrespective of whether she has a urinary tract infection, pneumonia or if she has a complication of pregnancy. The first two conditions should actually be managed by general practitioners or other specialties and not by Obstetricians. This means that patient care is diluted and real emergencies in Obstetrics are not addressed because all other cases need to be seen and sorted out. The triage system that was started in 2018 started to address the problem.

Staff shortages therefore leads to overcrowding of ward 6, delay in patient flow, over servicing by ordering special tests to make up for the staff shortage and then over intervention. This leads to a point where the registrars ends up doing caesarean sections all the time and are not available to attend to the ill obstetrics patients and to assess the women in labour who need a doctors assessment. This is then left in the hands of interns. Further the workload causes the specialist to be more hands-on doing ward rounds and therefore they have less time to properly triage the patients, train the doctors and be involved with specialist care that will improve the workflow of the patients.

Lack of midwifes often result in a scenario where not all 9 labour rooms can be utilized. This means that women remain in ward 6 during active phase of labour until she is fully dilated or until a labour room opens up. This increases the pressure on the staff in ward 6 and exposes the hospital to potential adverse outcomes and to litigation. This means a number of the deliveries are mostly unmonitored labours.

The Department of Obstetrics and Gynecology at RMMCH is amongst the top 3 busiest O&G departments in Gauteng. Since 2010 there was a steady increase in the workload. The delivery statistics is in support of this statement. If Chris Hani Baragwanath Academic Hospital the busiest in the country is any yardstick we are under-staffed according to them. For the year 2020 Chris Hani Baragwanath Hospital (CHBAH) had 19,387 deliveries meaning that RMMCH did 83% of the work CHBAH did with about half the staff or less. Over the last couple of years the specialist/consultant staffing component was constantly reduced. Currently we could appoint two additional specialist/Senior Medical Officers. Both were on the COVID budget. The one post terminates the end of March 2021 and the other in November 2021. The person in the post until the end of November is the intensivists which the hospital desperately needs. We need to employ the intensivist as a full-time consultant to allow the Hospital to establish an adult ICU. A hospital delivering 16 000 deliveries per year, with a gynae oncology and maternal and fetal medicine unit cannot function without an ICU. Literature and standard practice of care showed that the critical ill patient should be moved directly into ICU and the more stable patient transferred out. Without an ICU it often happens that due to lack of trained ICU staff patients are ventilated in theater until they can get an ICU bed or until the patient can be extubated. The hospital has six ventilators available and at times manages to ventilate patients for 36 to 48 hours. The mortality of the patients is increased if the patient is transferred in the unstable situation.

We really need a 5-firm system in Obstetrics to be able to deal with this workload. This will mean that the antenatal clinics are spread over 5 days. We have already starting to spread the clinic over 5 days.

With a booking system, a 5-day antenatal clinic and outreach we have reduced the ante natal clinic numbers for 150-200 patients per day to 110 – 150 patients per day. With the outreach we see 40 new patients per week. The hospital with the outreach on average sees a 140 new patients per week. This is mainly because we are the only referring hospital for the area we serve. The reduction in numbers has the following positive effects. It means that the clinic finishes at 15h00 allowing all patients to get their medicine on the day of the clinic and it allows for doctors to spend more time with patients.

The area consists out of 25 clinics of which two are Community Health Centers and the others are under provisional and local government authority. The fact that only two CHC's can take referrals means that the hospital also does the work of a CHC including low risk deliveries. It will reduce the potential number of patients seen per day but improve the quality of care the women receive in antenatal care and allow that patients can be properly assessed and triaged and sent back to their local clinics when needed.

For a 5-firm system to function optimally we need 5 Obstetrics consultants, 5 Obstetric registrars and 5 medical officers at community service or registrar level all the time. That probably needs more than 5 registrars and medical officers at this level to cover for leave periods. This will mean that in Obstetrics we have a consultant, a registrar and a medical officer on call. The medical officer can perform the straightforward caesarean sections and the registrar can provide the care with the consultant needed by the patients. This will improve cover by the doctors in labour ward.

We need more midwifes in Ward 15 and Ward 6 and labour ward to take care of patients. It is important to realize that once a patient is in labour and especially in active labour she needs to be assessed every 30 minutes. This is very difficult for one midwife to look after 2 patients. If this is the situation, then we need more lower-level nursing assistance to do some of the basic work to free the midwifes up to do the obstetrical evaluation like fetal heart monitoring and abdominal palpations.

Our theaters need to operate more efficiently. We struggle to achieve 20 operative cases with two theaters running in 24 hours. This results in a backlog of patients waiting for caesarean sections. We implemented a system a couple of years ago by which elective obstetrics patients are admitted on the morning of the caesarean section. During October to December, there were on average 20 patients daily waiting on the elective lists. The result of this was far reaching. We started operating elective cases 24 hours a day when there was space on the elective list. That meant that both registrars on call were in theatre most of the time if there was enough theater staff two run two theatres. The case with the emergency theatres at night is that they often run in a staggered way and not two theatres consecutively. This is often due to understaffing of theatre sisters, nurses, cleaners, and porters. There is further not enough anesthetists and registrars, medical officers and interns to be able to run an elective caesarean section list on a Saturday separately from the two emergency theatres. The doctors will work more than the allocated theatre time. The delays in performing elective caesarean sections, the high number of emergencies caesarean section cases and the lack of optimal theatre time utilization due to the factors mentioned above led to a number of adverse outcomes resulting in fresh stillborn babies. This is probably the second worst tragedy of labour with maternal death being the most.

This has a further spinoff effect. Patients admitted from ward 6 and the antenatal clinic can't get beds when they are admitted. Patients often spend up to 72 hours on chairs in ward 6 and 48 hours on

benches in ward 15 before allocated a bed. This means that patients that need tertiary services and care are not provided the care they need. This is not to mention the fact that they have to sleep in chairs and benches. It also results in adverse events not recognized in time that result in adverse outcome.

There is total overcrowding of obstetrics patients in all the wards. This also has an impact on gynecological services and the availability of beds.

I (Prof Lombaard) am also of the opinion that a hospital cannot function optimally if all levels of staff are not filled. If there are staff shortages in HR, procurement, infra structure and development or facilities, cleaning department porters or kitchen staff the effect will filter through and have a negative impact on patient care.

Another area that needs to be addressed in the cluster is the issue of referral of gynaecology patients. GOPD is often overrun by primary level care cases that should be managed at level one but is referred up. This means that patients who require higher level care do not get the care they deserve.

In light of the above situation, the following negative effects are being experienced:

- increase risk of perinatal deaths including fresh stillbirths
- increase risk in maternal deaths..
- increase in adverse outcomes for mothers for example a patient awaiting elective surgery ending up with a uterine rupture and subsequent hysterectomy
- delay in patients not getting appropriate medication since we don't have a 24-hour pharmacy services.
- delay in getting blood results because there is not an onsite 24-hour laboratory services.
- delay in getting blood products because the lack of a 24-hour onsite blood bank
- increased mortality due to the absence of a fully functioning ICU at the hospital.

7. Risk Assessment - Current and future risks

What risks do we take if we don't have enough nursing staff, midwifes, doctors or equipment?

1. Increase risk of adverse outcomes. This includes maternal and perinatal morbidity and mortality. Pregnancy and childbirth should be a time of joy and excitement. If it ends with a damaged mother or child or a dead mother or child it is a tragedy.
2. Decrease in staff morale. I am of the opinion there is a concept of compassion fatigue. People continue day after day and at some point they stop caring. The worst we can do is to allow our staff to work without caring.
3. Staff burnout and absenteeism.
4. Decrease in the number of staff and subsequent decrease in staff applications.
5. Poorer quality staff. This should be an institution where people should fight to work at and not fight because they work here. With fight I mean the struggle to provide service to too many people.
6. Increased in litigation. I want to put this last because I don't believe in defensive medicine but this is the one part were we can actually put a cost at. This will cost us millions of rands, probably more than what the solution will cost us.

7. The increase in perinatal mortality and even some perinatal deaths in the early part of this year may likely be the result of an overstretched system and may put the hospital in an indefensible position.

8. Proposals - Possible Solutions and Remedial Actions

A. Immediate

a. Alert the Provincial Head Office of the current crisis and request assistance with remedial action.
b. Multidisciplinary team meeting to be convened urgently involving the two medical departments with medical and nursing staff and senior management to look at the overall problem and consider immediate steps to address the crisis.
c. Establish an adult ICU as soon as possible as a top priority.
d. To increase the number of midwifes in all the wards. The staffing in labor ward should be increased such that all the labor wards can be active 24hours per day.
e. To increase the staff establishment to a total of 19 registrar posts and 7 medical officer posts in O&G and to 12 registrar posts and 6 medical officer posts I Paediatrics.
f. To employ two additional consultants, four ICU consultants which is shared between Obstetrics and Gynecology
g. The pharmacy should have extended hours.
h. Negotiation to establish a level 1 hospital to take some of the work from Rahima Moosa.
i. Establish the 24-hour laboratory and blood bank – has been on the cards for more than last 6-7 years now
j. Establishment of another ward for neonates and expedite optimal use of 16 complex
k. Proper triage of all patients presenting to hospital by the Emergency Department working with the O&G Dept,

B. Medium Term

a. To commission the Recreation Hall as a low-risk post-partum ward.
b. The development of a Midwife Obstetrics Unit onsite or in close proximity from the hospital.
c. Doubling the size of the NICU and High Care facility to ensure that this matches the need for the institution
d. Review of what MOUs in the catchment area of RMMCH are doing and which cases need to be referred.
e. Review of the role of Discoverer's CHC and its referral pattern
f. Review of medical and nursing staffing for financial year 2021/2022
g. Review of critical equipment required for financial year 2021/2022 that will make a specific difference to maternal and neonatal outcomes.
h. Confirmation as Tertiary Status to permit increased funding.
i. Establishment of a forum of maternity and paediatric service providers in our region to meet on a regular basis (at least quarterly). This would involved RMMCH and the

regional and district hospitals in our area such as Leratong, Yusuf Dadoo, Carltonville, Discoverers CHC.

C. **Long Term**
    a. Renovation of entire hospital infrastructure now close to 80 years old
    b. Review of entire staffing establishments to look at next 5-year needs
    c. Possible establishment of another hospital in the area – but first to ensure optimal utilization of current CHCs and clinics.

Report Jointly compiled by

Professors Ashraf Coovadia (Paediatrics and Child Health) and **Hennie Lombaard** (Obstetrics & Gynaecology)

22 February 2021

7

Annexure

JOINT REPORT ON THE CAPACITY OF RAHIMA MOOSA MOTHER AND CHILD HOSPITAL FOR DELIVERIES AND CARE OF NEWBORNS

An Unsafe Hospital

Professors AH Coovadia/H Lombaard

2 DECEMBER 2016

Updated 21 Feb 2017

This report that has been jointly prepared by the departments of Obstetrics & Gynaecology and Paediatrics & Child Health at the Rahima Moosa Mother and Child Hospital. Whilst this report is long overdue in presenting the challenges the institution has been facing over a prolonged period of time it has become an urgent matter now with the occurrence of an outbreak of a hospital acquired infection in the neonatal nursery that is directly related to the capacity issues being experienced.

The following sections of the report have been prepared.

1. Current MRSA outbreak in the neonatal nursery
2. Capacity in the neonatal division of the Department of Paediatrics and Child Health
3. Required capacity for the neonatal unit
4. Increasing trend of utilization of neonatal services at RMMCH
5. Statistics of the Dept of O&G
6. Challenges in Obstetrics
7. Risk Assessment - Current and future risks
8. Proposed solutions and Remedial Actions

Current MRSA outbreak in the neonatal nursery (Reported first in Dec

On Tuesday the 29th of November 2016 a meeting was held within the Dept of Paediatrics and Child Health from 11:30 -12:30pm at the request of the Infection Prevention and Control (IPC) unit led by Matron Ollyn. The meeting was called in response to the finding that in the last month (November) there was a dramatic increase in the number of Methicilin-Resistant Staphylococcus aureus (MRSA) infections in the neonatal patient population. Prof Coovadia in response to this call convened an urgent meeting of members of his department specifically from the neonatal division as well as the Paediatric Infectious disease specialist, Dr Gary Reubenson. In addition the members of the IPC as well as the neonatal nursery and NICU were invited.

The following facts were established at this meeting which was followed by much discussion on the possible causes and likely solutions to be attempted.

1. In the month of October there were 7 confirmed cases of MRSA in the neonatal unit and in November so far this number was 8 confirmed cases. (See Appendix 4)

2. This number of MRSA for the last two months represented an almost 3-4 fold increase in incidence rate. The unit normally has 2-3 cases per month of this organism.
3. There has been a significant increase in the overall mortality rate in the unit in the last month (See Appendix 2 and 3)
4. Statistics of admissions to the unit were presented and the trend over the last several year indicated the problems of regularly and almost constantly on the brink of capacity and often exceeding current capacity within the unit in terms of incubators and cribs. (See Appendix 1 – Bed Occupancy Rates)
5. Given the current capacity constraints the unit was not in a position to isolate all infected infants confirmed to have a hospital acquired infection such as MRSA or ESBL Klebsiella (Extended spectrum beta-lactamase producing) or Candida parapsilosis.
6. Related to the problem above in point 5, the unit is unable to cohort manage all MRSAs in one area as per recommendations.

Discussion over likely causes for this outbreak was held and the following factors were considered pertinent. Although no data presented the staff cited these as likely factors.

I. Overcrowding of the unit – particularly 168
II. In-sufficient isolation areas
III. Reduced numbers of nursing staff so ratio of nurses to babies was lower than it should be
IV. Poor hand hygiene practices – ie dept hand hygiene policy not being adhered to.
V. Dept policy of nothing below the elbows (eg bracelets, watches, rings, sleeves etc) not adhered to.
VI. Insufficient equipment cited – for example having a single oxygen saturation probe for multiple patients poses a serious risk of infection from one patient to another.
VII. Not always having paper towels available – discourages hand-washing.
VIII. Unnecessary procedures on babies – ie blood glucose checks being done more frequently than necessary.
IX. Unnecessary movement of babies from their incubators or cribs to the procedure room for procedures like a drip or lumbar puncture etc that encourages a common 'infectious' area for spread of infection.
X. Overworked staff with low morale and possible lapses in infection control procedures.

Capacity in the neonatal division of the Department of Paediatrics and Child Health

The neonatal division of the Dept of Paediatrics and Child Health has four in-patient areas that serve the neonatal population at RMMCH. These four areas and their capacity are provided below.

1. Neonatal/Paediatric ICU – 6 beds (usually >80% occupancy rate)
2. High Care – 4 beds (usually >80% occupancy rate)
3. Neonatal Ward (Ward 16B) – 35 beds (usually >90% occupancy rate, often beyond 100%)
4. KMC ward – 12 beds (usually >50% occupancy rate)

Hence the average in-patients at any one time range between 50 -70 patients.

Required capacity for the neonatal unit (See Appendix 6, 7, 8)

Neonatal and Perinatal Mortality Rates for the year 2015

Hospitals	tive Births	Stillbirths or stillbirth rate (#/)	Neonatal Deaths	NMR/1000[1]	PMR/1000[2]
Phoiosong	5083	20/	80	16.1	36.1
Far East Rand	7012	7.2/	78	11.3	18.5
Tambo Memorial	6038	132	68	11.5	28.7
Edenvale	4044	74	36	9.1	26.2
Bertha Gxowa	4751	12.5/	45	9.4	21.9
CMJAH	**9363**	**240**	**256**	**28.1**	**47.0**
Rahima Moosa	12279	143	209	17.2	24.1
Leratong	**5759**	**98**	**159**	**28.1**	**44.6**
Dr Yusuf Dadoo	3631	59	29	6.3	19.0
Carltonville	2351	15	15	6.7	12.7

Calculating the Neonatal Bed Requirement For RMMCH:

RMMCH current bed status: 57 beds (ICU 6, H/C 4, 16B 35, KMC 12)

When calculating RMMCH as a Level II hospital and only accounting for our deliveries (AND NOT OUR CATCHMENT AREA)

Bed requirements = 3-4 X12 (12 000 births) + 2-3 X 12 (12 000 births)

= 36/48 + 24/36

= **60 -84 beds (Minimum Requirement)**

To calculate AS PER ABOVE national recommendations, our catchment area must be included.

When including our district and sub-district births, Leratong, Dr Yusuf Dadoo and Carletonville (however excluding the clinics, as data is missing):

The district and sub-district requirements are calculated on at least 24000 deliveries:

Bed requirements = 3-4 X 24 (24 000 births) + 2-3 X 24 (24 000 births)

= 72/96+ 48/72

= **120 – 168 beds (Actual Requirement)**

Bed Distribution:

Bed distribution at (Regional) level II level: **KMC : IC :HC: ICU**

4: 3: 2: 1

i.e. 48:36:24:12

Bed distribution at Tertiary Level III level (which more accurately reflects how our neonatal institution functions)

KMC : IC :HC: ICU

2 :3: 3: 2

i.e. 24: 36: 36:24

	Current Bed Status at RMMCH	National recommendation for Level II Hospital	National recommendation for Level III Hospital
NICU	6	12	24
Adult High Care	4	24	36
Intermediate Care	35	36	36
KMC	12	48	24

Space Requirements for Neonatal Patient Care

The crowding of babies within the cubicles of Ward 16B is a concern as this relates to the risk of hospital acquired infections and these outbreaks too. As can is shown in the table below we are falling short of national recommendations and this is a matter that needs addressing through managing the overall numbers of neonates the unit can handle.

Level of Care	National Recommendation (m2/baby)	RMMCH
Intensive Care Unit	5.4m2 - 7.2 m2	4 m2
High Care Unit	5.4m2 - 7.2 m2	3 m2
Intermediate Care Unit	3.6m2	1.5m2 – 2m2
Kangaroo Mother Care Unit	7.2m2	5m2

Conclusion:

RMMCH has less than 50% of the beds required for our delivery rate and catchment area. The hospital has been forced to crowd babies in the limited space we have which puts all babies at risk.

Increasing trend of utilization of neonatal services at RMMCH

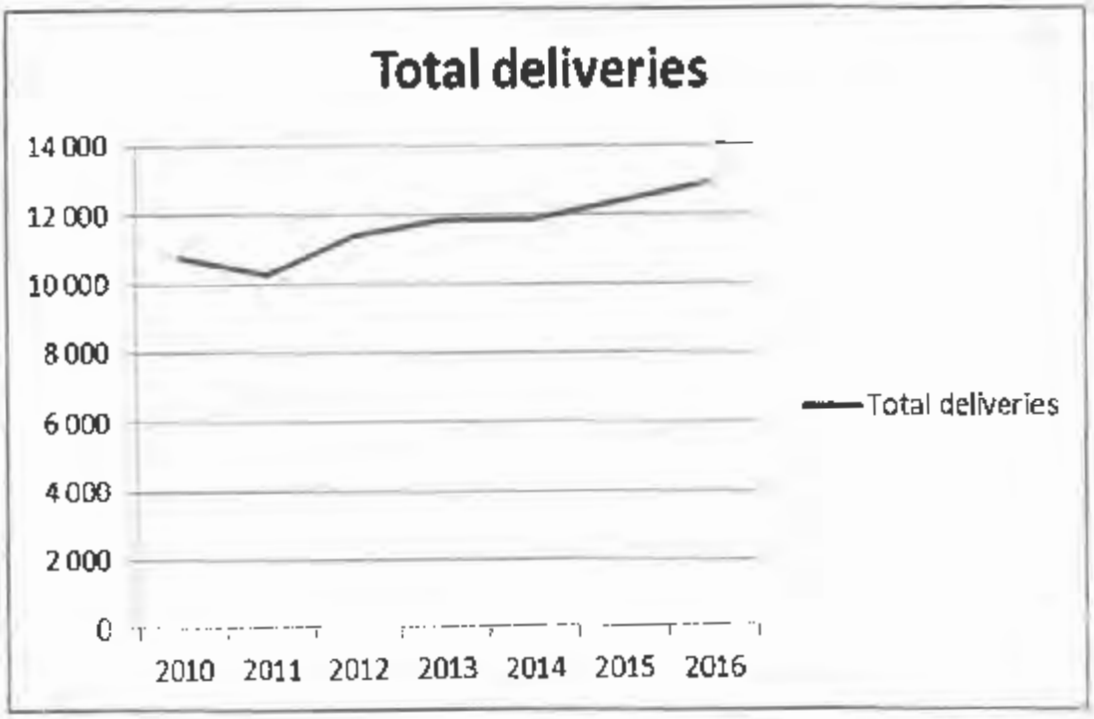
Statistics collected by the Departments of Paediatrics & Child Health and O&G confirm the increasing trend of number of deliveries being performed at RMMCH over the last few years.

These numbers demonstrate the problem the hospital is facing given the lack of concomitant increase in capacity to keep pace with these numbers.

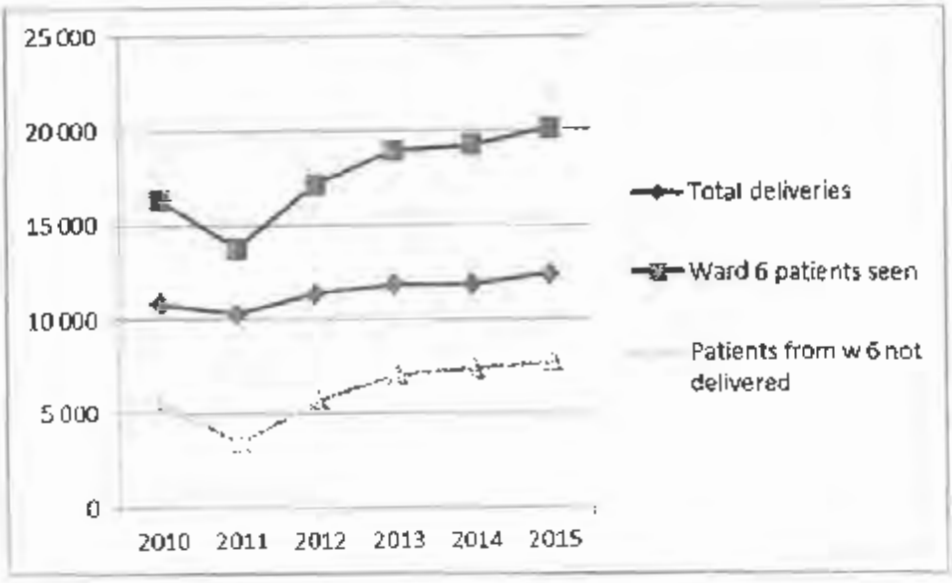
Over the last 5-10 years there has not been an increase in numbers of staff (medical or nursing) and nor has there been an increase in bed capacity in the neonatal nursery (16B). The NICU/PICU has added a high care area with four more beds for non-ventilated high care neonates. Whilst this has helped with the load on both ICU and 16B this is far from sufficient and lacks adequate equipment.

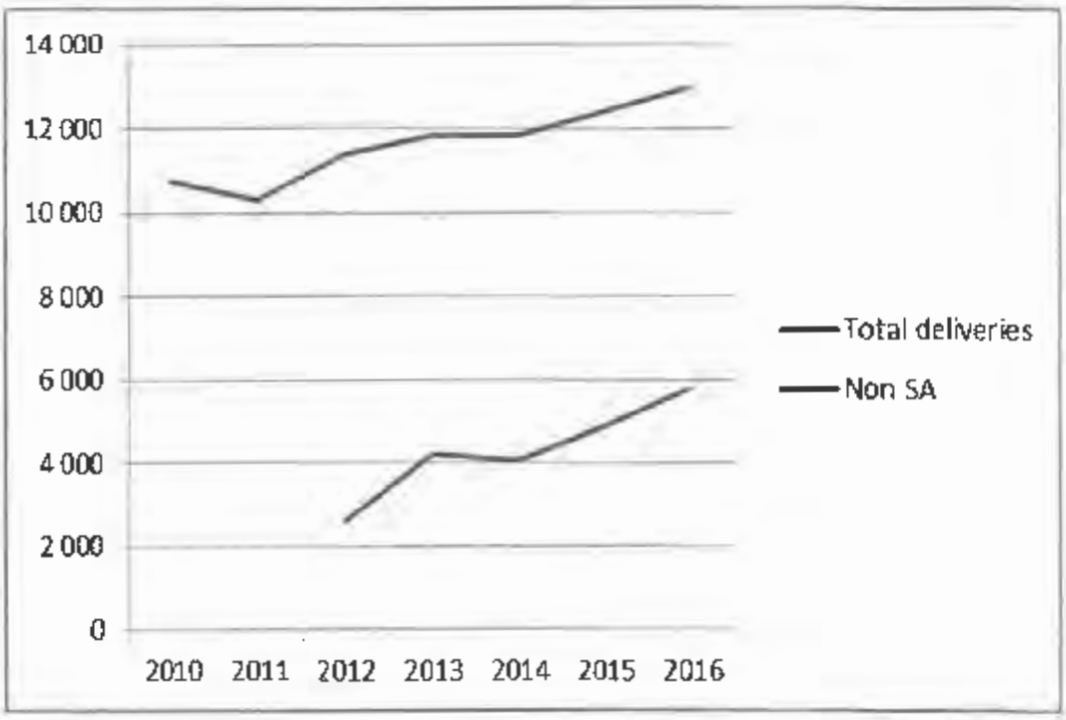
Statistics of the Dept of O&G

In the past 5 years the deliveries went up by 15%. Below are graphs to high light our current work load.

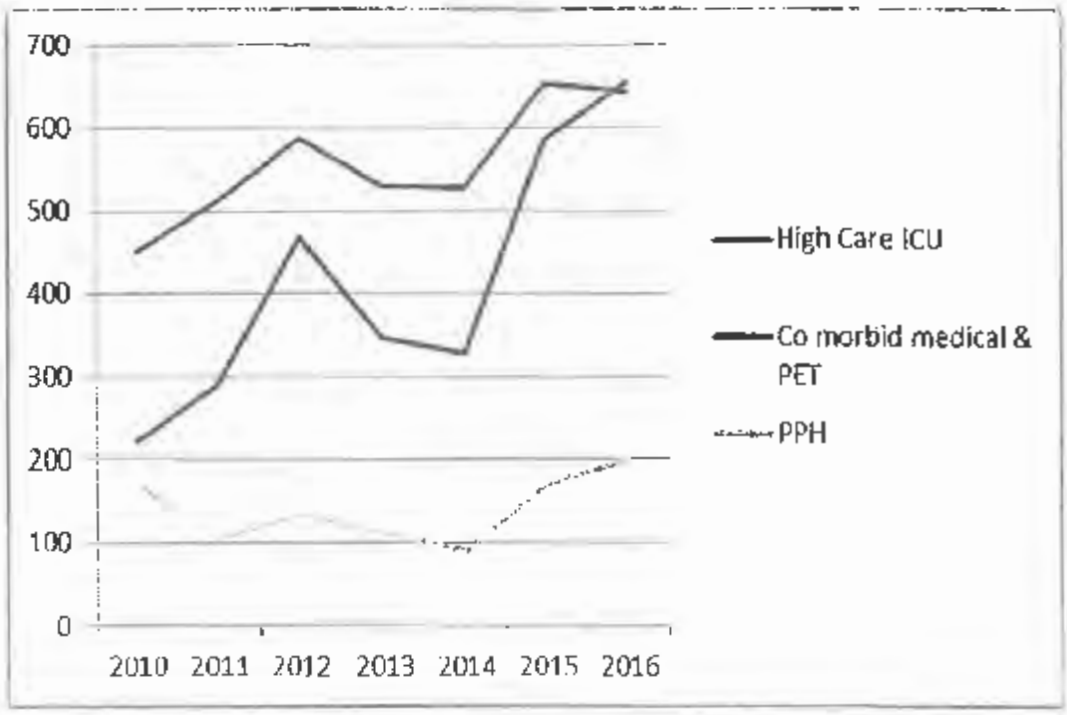


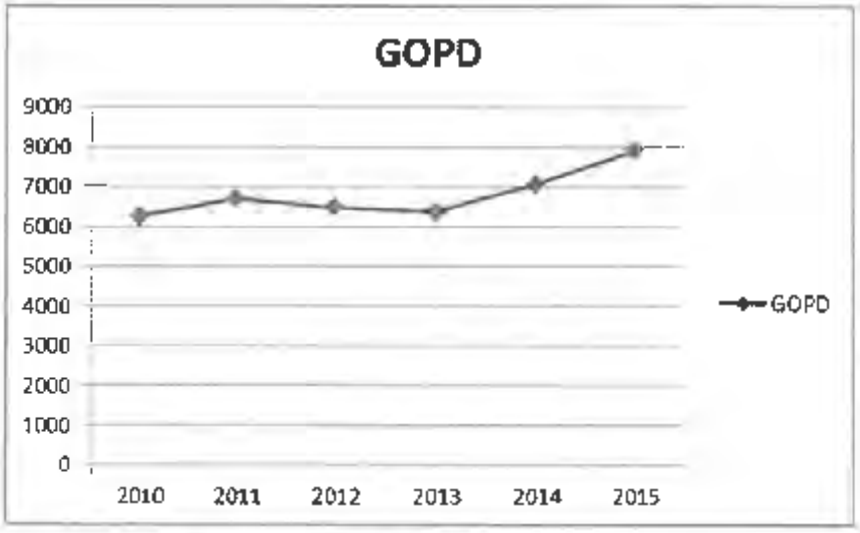
20.2% increase since 2010



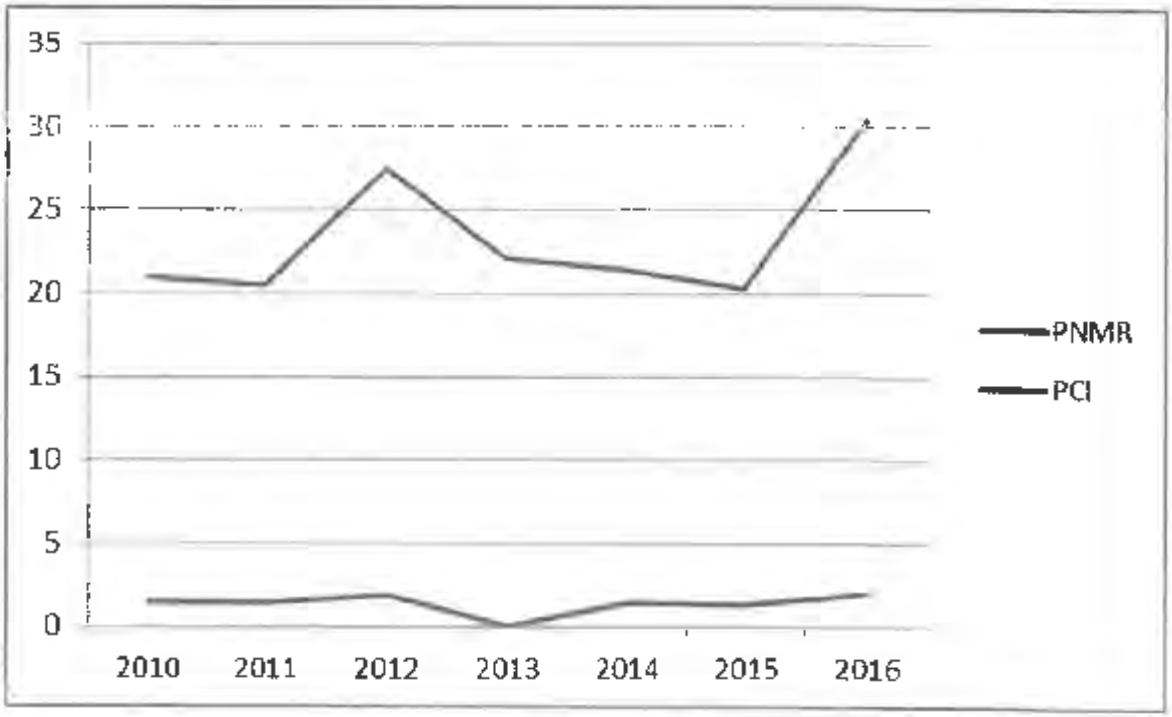


120% increase

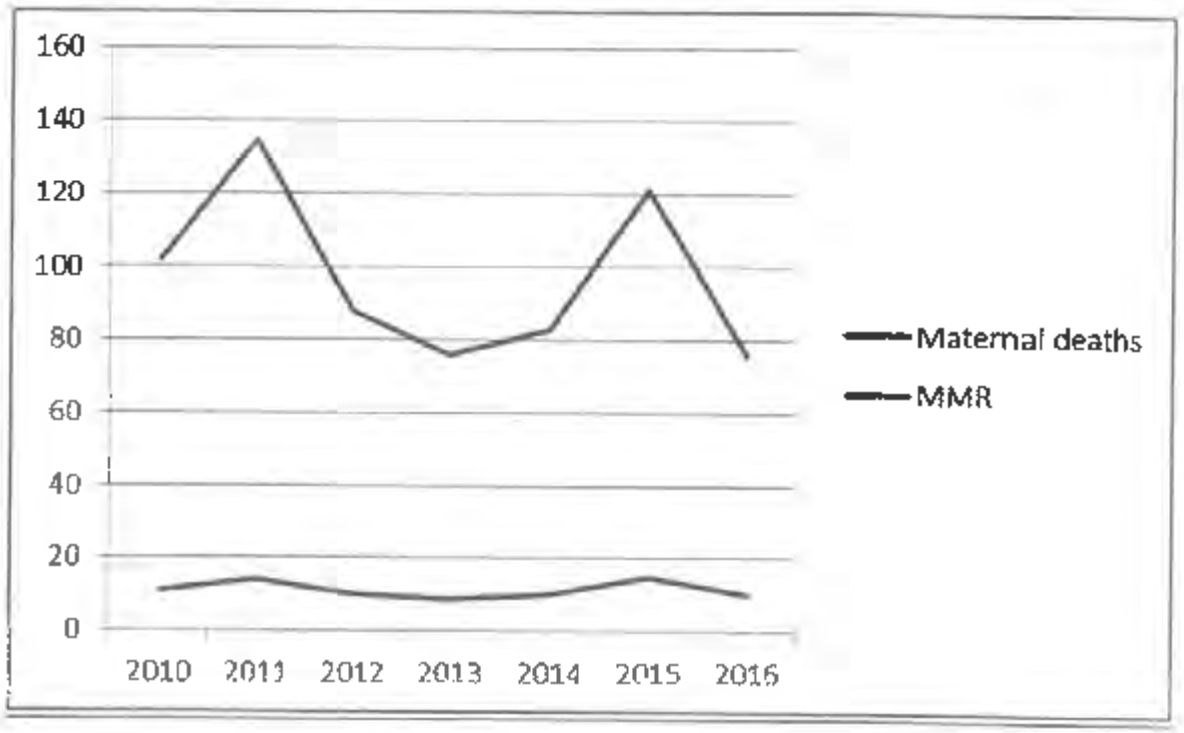




Perinatal Mortality Rate:



Maternal Mortality Rate:



In ward 11 the Gynae emergency ward there was a total of 10876 patients seen. The total emergency patients (based on emergency admissions and manual vacuum aspirations performed were 3636. Ward 11 (emergency Gynae admissions ward) saw 7240 patients in 2015 that did not need admission. We can therefore argue that GOPD is at over 15 000 patients per year. Many of these patients can be sorted out in a poly clinic and don't need gynecological care. If we continue to see this number of patients we do not provide a Gynae service to our patients but just a glorified clinical service.

Challenges in Obstetrics

Our biggest problem is in Obstetrics because that will affect what happens in Neonatology.

If we look at Maternity Care guidelines it is stated that low risk women should be managed by midwifes. We should get the number of midwifes cases delivered. Currently we do not have sufficient Midwife Obstetrics Units to take the load of Rahima Moosa Mother and Child Hospital. According to the national Maternity Care Guidelines and the 2015 document stated the same, in low risk women or midwife cases the fetal well being should be assessed with fetal stethoscope or doptone every 30 minutes after a contraction. This is not done due to staff shortage and these patients are monitored by CTG. All studies including large studies and recommendations by the WHO and other international bodies stated that CTG did not change the outcome at all for low risk women it only increased the caesarean section rate. Studies further showed that if low risk women are not managed by midwifes the intervention rate goes up without any benefit to mother or baby and only an increase in high risk patients in the future. Our current situation is that due to staff shortage and shortage of MOU's we make low risk patients a higher

risk patient and delay the patient flow because uncomplicated low risk women, especially when not in labour get a CTG and needs discharge by a doctor while a midwife should be dealing with the patient. We currently have no proper triage system for Ward 6. A patient present to casualty and because she I pregnant more than 20 – 24 weeks she is send straight up to ward 6. Irrespective of whether she has a urinary tract infection, pneumonia or if she has a complication of pregnancy. The first two conditions should actually be managed by general practitioners or other specialties and not by Obstetricians. This means that patient care is diluted and real emergencies in Obstetrics are not addressed because all other cases need to be seen and sorted out.

Staff shortage therefore lead to overcrowding of ward 6, delay in patient flow, over servicing by special test to make up for the staff shortage and then over intervention. This leads to a point where the registrar end up doing caesarean section all the time and is not available to attend to the ill obstetrics patients and to assess the women in labour who needs assessment by a doctor. This is the left in the hands of interns. Further the workload causes the specialist to be more hands on doing ward rounds and therefore they have less time to properly triage the patients, train the doctors and be involved with specialist care that will improve the workflow of the patients.

We really need a 5 firm system in Obstetrics to be able to deal with this workload. This will mean that the antenatal clinics are spread over 5 days. It will reduce the potential number of patients seen per day but improve the quality of care the women receive in antenatal care an d allow that patients can be properly assessed and triage and send back to their local clinics when needed. For a five firm system to function optimally we need 5 Obstetrics consultants, 5 Obstetric registrars and 5 medical officers at community service or registrar level all the time? That probably needs more than 5 registrars and medical officers at this level to cover for leave periods. This will mean that in Obstetrics we have a consultant, a registrar and a medical officer on call. The medical officer can perform the straight forward caesarean sections and the registrar can provide the care with the consultant needed by the patients. This will improve cover by the doctors in labour ward.

We need more midwifes in Ward 15 and Ward 6 and labour ward to take care of patients. It is important to realize that once a patient is in labour and especially in active labour she needs to be assessed every 30 minutes. This is very difficult for one midwife to look after 2 patients. If this is the situation, then we need more lower level nursing assistance to do some of the basic work to free the midwifes up to do the obstetrical evaluation like fetal heart monitoring and abdominal palpations.

Currently we have 7 midwifes at any given time in labour ward. Ideally one midwife should be with one patient in active labour. That will allow 3 deliveries per midwife in 24 hours, therefore a total of 21 deliveries. It is important that an emergency cesarean section form labour ward is also covered by the midwife from labour ward. We can do about between 18 and 22 elective caesarean sections per week. Average about 20. That is 8665 deliveries per year or 722 per month.

We are currently doing about 12 000 deliveries pa, therefore 50% more than what we can and should reduce by 30% with our current staffing.

We need adequate amount of equipment like CTG's and dynamaps to do proper observations. This includes the induction of labour patients in ward 15.

We need an onsite 24 hours laboratory service to be able to look after the ill patients we see. For example, if we are dealing with a patient with a severe post-partum hemorrhage, certain blood test must be repeated hourly and the results must be available soon after the tests. Delay in getting the results will cause a delay in management which will increase the change of maternal death or prolonged ICU admission. A hospital with this amount of deliveries and severely ill women also need a 24 hour blood bank and a permanent adult ICU.

Risk Assessment - Current and future risks

What risks do we take if we don't have enough nursing staff, midwifes, doctors or equipment?

1. Increase risk of adverse outcomes. This includes maternal and perinatal morbidity and mortality. Pregnancy and child birth should be a time of joy and excitement. If it ends with a damaged mother or child or a dead mother or child it is a tragedy.
2. Decrease in staff morale. I am of the opinion there is a concept of compassion fatigue. People continue day after day and at some point they stop caring. The worst we can do is to allow our staff to work without caring.
3. Staff burnout and absenteeism.
4. Decrease in the number of staff and subsequent decrease in staff applications.
5. Poorer quality staff. This should be an institution were people should fight to work at and not fight because they work here. With fight I mean the struggle to provide service to too many people.
6. Increased in litigation. I want to put this last because I don't believe in defensive medicine but this is the one part were we can actually put a cost at. This will cost us millions of rands, probably more than what the solution will cost us.
7. The increase in perinatal mortality and even some perinatal deaths in the early part of this year may likely be the result of an overstretched system and may put the hospital in an indefensible position.

Possible Solutions and Remedial Actions

A. **Immediate**
   a. Multidisciplinary team meeting to be convened urgently involving the two medical departments with medical and nursing staff and senior management to look at the overall problem and consider immediate steps to address the crisis.
   b. Review of admission policy to RMMCH maternity
   c. Review of admission policy to 16 complex – with stricter criteria for admission, possible lowering of discharge criteria.
   d. Review what neonatal cases can be managed in ward 16C (KMC)
   e. Review of what neonatal cases can be managed in the postnatal wards
   f. Review of indications, frequency and instructions on procedures for neonates
   g. Review of infection control procedures and staff adherence to these including use of aprons.
   h. Opening up of a ward or part of a ward to permit cohorting of hospital acquired infections such as MRSA babies together
   i. Alert the Provincial Head Office of the current crisis and request assistance with remedial action.
   j. Transfer cases requiring only phototherapy to ward 1

B. Medium Term
   a. Establishment of another ward for neonates
   b. Doubling the size of the NICU and High Care facility to ensure that this matches the need for the institution (note 12,000 deliveries per annum which is about 50% of what CHBAH carries out yet we have less than 20% of the facilities of CHBAH to manage this load)
   c. Review of what MOUs in the catchment area of RMMCH are doing and which cases need to be referred.
   d. Review of the role of Discoverer's CHC and its referral pattern
   e. Review of medical and nursing staffing for financial year 2017/2018
   f. Review of critical equipment required for financial year 2017/2018 that will make a specific difference to maternal and neonatal outcomes.
   g. Establish the 24 hour laboratory and blood bank – has been on the cards for the last 2-3 years now.
   h. Establish an adult ICU as soon as possible as a top priority.
   i. Confirmation as Tertiary Status to permit increased funding.
   j. Establishment of a forum of maternity and paediatric service providers in our region to meet on a regular basis (at least quarterly). This would involve RMMCH and the regional and district hospitals in our area such as Leratong, Dr Yusuf Dadoo, Carletonville, and Discoverers CHC.

C. **Long Term**

a. A dedicated MOU (Midwifes Obstetrics Unit) even if that is then with in the hospital.
b. Proper triage of all patients presenting to hospital by the Emergency Department working with the O&G Dept, The ED needs an Emergency Medicine specialist to run this dept.
c. A discharge lounge

Report jointly compiled by

Professors Ashraf Coovadia (Paediatrics and Child Health) and **Hennie Lombaard** (Obstetrics & Gynaecology)

21 February 2017

Annexure

DR. NP MKABAYI – 18337104 (01/01/2021 till 31/12/2022)

	PUBLIC HOLIDAYS	**WEEKENDS**	**LEAVE UTILISED**
YEAR 2021 **365** DAYS	9	104	43
TOTAL: 365 days	**9**	**104**	**43**
365 – 113 = 252 (Number of days worked minus P/H and Weekends)			
252 - 43 (Number of days worked minus leave utilised) = 209 **DAYS WORKED (01/01/2021 till 31/12/2022)**			

NB: Leave utilised include leave days taken according to delegation letters **but no leave forms** submitted to HR for capturing.

Annexure

Thethiwe Maja

From: Basani Malambe
Sent: Thursday, December 10, 2020 7:55 PM
To: Thethiwe Maja
Subject: FW: Self declaration MP 0433764

Please new case- MDB

(Ms) Basani Malambe
Health Committee Coordinator
HEALTH PROFESSIONS COUNCIL OF SOUTH AFRICA
553 Madiba Street, Arcadia, 0083
PO Box 205, PRETORIA, 0001
Tel: +27 (0) 12 338 3963
Fax: +27 (0) 12 338 3963
Web: http://www.hpcsa.co.za
Email: BasaniM@hpcsa.co.za/HealthCommittee@hpcsa.co.za

From: Nozuko Mkabayi <nmkabayi@gmail.com>
Sent: Thursday, 10 December 2020 16:10
To: HealthCommittee <HealthCommittee@hpcsa.co.za>
Subject: Self declaration MP 0433764

Good day

I am writing to report my recent admission at a psychiatric unit in Cape Town for bipolar mood disorder type 1.

I have lived with the condition for 21 years but had multiple psychosocial issues ; hence the relapse .

I am compliant on medication and psychotherapy.

I am seeing my psychiatrist tomorrow on 11 December 2020 for review .

Kind regards

Dr Nozuko Precious Mkabayi

Annexure

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

Enq: Hospital Services
Tel: 011 355 3330
Cell: 079 515 3077

TO: CEOS OF CHRIS HANI BARAGWANATH ACADEMIC, RAHIMA MOOSA MOTHER AND CHILD, AND CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITALS

CLINICAL HEADS OF DEPARTMENTS OF OBSTETRICS AND GYNAECOLOGY AT CHRIS HANI BARAGWANATH ACADEMIC, RAHIMA MOOSA MOTHER AND CHILD, AND CHARLOTTE MAXEKE JOHANNESBURG ACADEMIC HOSPITALS

CEO OF EMERGENCY MEDICAL SERVICES GAUTENG PROVINCE

CHIEF DIRECTOR: DISTRICT HEALTH SERVICES CENTRAL OFFICE

CHIEF DIRECTOR: JOHANNESBURG DISTRICT

FROM: CHIEF DIRECTOR: HOSPITAL SERVICES

SUBJECT: PROTOCOL FOR AMBULANCE DIVERSION OF MATERNITY UNITS AT THREE JOHANNESBURG ACADEMIC HOSPITALS IN JOHANNESBURG DISTRICT

1. Background

At times, because of service overload at Chris Hani Baragwanath Academic Hospital (CHBAH), Charlotte Maxeke Johannesburg Academic Hospital (CMJAH) or Rahima Moosa Mother and Child Hospital (RMMCH), these hospitals' maternity services may be placed 'on ambulance divert' so that the Emergency Medical Services (EMS) do not present them with emergency patients. The EMS will then transport patients to the other academic hospitals.

2. Decision to temporarily divert ambulances

The decision for a hospital to be placed on divert is made by the Superintendent on call of the hospital in consultation with the Consultant and/or Registrar on Call. The Superintendent on call will then consult the Medical Managing Officer (MMO) on call for the Gauteng Department

of Health. The Obstetrics and Gynaecology department's consultant or registrar on call is then informed of the decision by the Superintendent on call.

3. Actions to be taken by hospital clinicians:

The obstetric registrar on call at the diverting hospital will telephonically inform the registrars on call at each of the other two hospitals about the diversion and for how long it will be in force. The clinical staff at those two hospitals will then accept all transfers from the Community Health Centres (CHCs) normally served by the diverting hospital, for the duration of the diversion.

4. Actions to be taken by the CHCs and EMS:

Midwives at CHCs who intend to transfer urgent maternity patients will call the EMS, who will inform the midwives that their referral hospital is on divert and that their patients will be transferred to another hospital. The academic hospital of closest proximity should be the first for referral when other hospitals are on divert. EMS will also ensure through Metro Control that the patient referrals during diverts are equitably distributed to other receiving hospitals. The midwives transferring the women will <u>not</u> be required to make telephonic arrangements with the doctors of the destination hospitals, unless there is reason to warn in advance about an exceptionally ill patient.

N.B Patients and their families must be kept informed of non-routine transfer arrangements as a result of diversions.

5. Limitation

This protocol is limited to the three academic hospitals in the Johannesburg District – CHBAH, CMJAH, RMMCH. It is however the intention of the Department to centralize and harness the referral of maternity patients throughout the province.

6. Management of maternity emergencies during temporary ambulance diversion

If, for whatever reason, an EMS ambulance arrives with an emergency patient at the maternity unit of a hospital that has been placed on divert, the hospital's maternity staff <u>must</u> accept the patient and attend to the emergency. AMBULANCES ARE NOT TO BE TURNED AWAY FROM HOSPITALS. If the patient then requires transfer to one of the non-diverting hospitals, this should be treated as a hospital-to-hospital transfer, with all the usual arrangements made, including telephonic discussion with a doctor at the destination hospital. Such occurrences should be seen as exceptional.

N.B The decision to place a hospital on divert must be respected by the EMS staff and no one must take advantage of this arrangement. It should be used strictly for emergency interventions.

7. General reference

This notification is made in the context of, and covered by, detailed instructions in Circular 1 of 2003 – "EMERGENCY MEDICAL SERVICES: AMBULANCE DIVERSION PROCEDURE"

This Memo has been drafted in consultation and with the assistance of the Heads of Departments of O and G of the three hospitals mentioned above, their leadership and contribution is appreciated.

DR N M MAZAMISA
GAUTENG CLINICAL SERVICES
DATE: 130913

CC: Dr H D Gosnell, HOD Gauteng Health

DD

Annexure

GAUTENG PROVINCE

REPUBLIC OF SOUTH AFRICA

Enquires: Ms. Basani Baloyi
Contact: 0635046697

Dr Nozuko Mkabayi
Chief Executive Officer
Rahima Moosa Mother and Child Hospital

Dear Dr Mkabayi

TRANSFER TO THE POST OF DIRECTOR IN THE HEALTH PROGRAMMES CHIEF DIRECTORATE IN CENTRAL OFFICE

1. It gives me pleasure to inform you that, your request for transfer to the HR Chief Directorate in Department of Health has been approved.

2. Your transfer and conditions of service remain the same and will be governed by the Public Service Act, 1994 as amended, the Labour Relations Act, 1995 as amended, the Public Finance Management Act, 1999 and the Public Service Regulations, 2016 as amended, SMS Handbook, Collective Agreements and any present or future amendments to the aforementioned Acts, Regulations and Instructions, including the Code of Conduct for employees in the Public Service.

3. You will be required in terms of Regulation II of Chapter 4 of the Public Service Regulations to enter into a performance agreement with your supervisor.

4 Your employment may be terminated under the following circumstances:

4.1 On reaching the end date of your term of contract.

4.2 Discharge in terms of Section 17 of the Public Service Act, 1994 as amended.

4.3 Voluntary resignation, giving at least one (1) month's written notice of service termination.

5. The Department wishes you success in your new work environment.

Yours faithfully

Prepared by:

MS B BALOYI
DDG: CORPORATE SERVICES
DATE: 2022 - 11 - 11

Recommended /not Recommended/ Recommended as amended

DR N NOLUTSHUNGU
HOD: HEALTH AND WELLNESS
DATE: 11/11/2022

Approved

MS N. NKOMO-RALEHOKO (MPL)
MEC FOR HEALTH
DATE:14-11-2022

Address: Office of The Health Ombud,
79 Steve Biko Road, Pretoria, 0084
Tel: 012 942 7700

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