WHITE PAPER

The OHS Amendment Bill

and the transformation South African hospitals now need.

A practical guide for hospital boards, CEOs, HR and OHS leaders on what the amended Act requires, why most hospitals are not ready, and how the Ignite Purpose Psychosocial framework and programme suite support the transformation the Bill makes unavoidable.

Ignite Purpose · Transformation Consultancy

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FOREWORD

Why we wrote this paper.

The Occupational Health and Safety Amendment Bill has been passed by Parliament. It awaits proclamation. When that proclamation comes, it will change what is legally required of every hospital in South Africa, and the change will be substantial.

We have spent the past two years working with hospital executives, hospital boards, occupational health teams, and clinical leaders on the question that sits underneath the Bill rather than on top of it. The question is not whether your hospital can comply. Most hospitals, with enough effort and external help, can produce documents that look compliant. The question is whether your hospital can survive what compliance now requires. Whether the workforce that the Bill is designed to protect can absorb one more round of policy, procedure, and procedural rigour without breaking.

That is the question this paper is written for. It sets out, plainly, what the Bill changes. It is honest about the five gaps in current hospital practice that the Bill exposes most sharply. And then it does something the legal briefings cannot do. It addresses the psychosocial reality of South African hospital work, the moral injury, the burnout, the patient violence, the structural understaffing, and asks what the Bill demands of organisations whose workforces are already, by every available measure, in crisis.

The Bill names compliance. The workforce needs transformation. The two are not the same thing, and any hospital that mistakes one for the other will find itself compliant on paper and unrecoverable in reality. This paper is about how to do both, and how the work we do at Ignite Purpose, through the Psychosocial framework and the wider programme suite, is built to support the transformation the Bill makes unavoidable.

We have written it for hospital boards, CEOs, HR and OHS leaders, and the clinical executives who carry the day to day weight of running a hospital under conditions of sustained pressure. It is written in the voice we use when we sit across the table from these leaders. Senior, considered, practical, and honest. Not legal advice. Not a sales document. A piece of thinking that we hope is useful at a moment when useful thinking is rare.

A NOTE ON SCOPE

This paper interprets the Occupational Health and Safety Amendment Bill as gazetted (Government Gazette No. 44572, 14 May 2021). It is intended as practical guidance for healthcare leaders preparing for proclamation. It is not a substitute for legal advice. Hospitals should consult occupational health and safety law specialists to confirm the application of the amended Act to their specific facility once the proclamation date is set.

CONTENTS

In this paper.

This paper is structured to be read sequentially by leaders who want the full picture, or scanned by section by leaders who need a specific answer. Each section opens with a divider page summarising what is covered. Each closes with what we call a leadership question, the question we would put to a CEO or board chair if we were sitting in the room with them at that moment in the conversation.

EXECUTIVE SUMMARY

The picture in a page.

The OHS Amendment Bill brings five changes that will fundamentally reshape what it means to run a South African hospital. Mandatory written risk assessment. CEO level accountability for a Health and Safety Management System. A new ratio for health and safety representatives. Expanded and stricter incident reporting. Administrative fines that inspectors can issue on the spot, and criminal liability for the most serious contraventions, with penalties of up to five million rand or five years imprisonment.

Most hospitals are not ready. The most common gaps are not subtle. Few hospitals have a written, workplace specific risk assessment covering all hazard categories. Few have a documented Health and Safety Management System with personal sign off from the CEO. Few have anything close to the required ratio of one health and safety representative per fifty employees. Incident reporting is patchy, contractor coverage is weak, and the requirement to submit annual incident statistics by the first of March is, on the sector evidence available, news to senior management in most South African hospitals.

The single largest gap, however, is psychosocial. The word does not appear in the Bill, but the obligation does. Section 8 requires every employer to assess all workplace hazards. In healthcare, the psychosocial hazards, structural understaffing, shift work fatigue, patient violence, moral injury, burnout, vicarious trauma, are among the most significant and most extensively documented risks to worker health and safety. A risk assessment that ignores them does not meet the standard. Most hospital risk assessments ignore them entirely.

What this paper sets out

- Section one sets the moment. Why this Bill, why now, and why the conditions inside South African hospitals make compliance harder than it would have been five years ago.
- Section two walks through the five obligations that change most. Practical, plain language, with healthcare specific implications and the gap each obligation tends to expose.
- Section three addresses the hidden hazard. Psychosocial risk in hospitals as the most under addressed compliance gap, and the one that produces the most severe downstream consequences.
- Section four introduces SocioSafety™. The five domain Psychosocial framework that Ignite Purpose has built specifically to satisfy section 8 of the amended Act and to produce a legally defensible Psychosocial Hazard Register.
- Section five sets out why compliance, on its own, is not enough. The Bill is the trigger. Transformation is the response. Hospitals that mistake one for the other will find themselves compliant on paper and unsustainable in reality.
- Section six maps the Ignite Purpose programme suite against the obligations the Bill creates. SocioSafety™ for the diagnostic and the hazard register. ARISE for workforce resilience. Brave Leadership for the leaders who hold the work together. HR Transformation for the systems that produce or relieve workload. Culture Transformation for the deeper work that no policy can do.
- Section seven walks through an illustrative scenario built from our healthcare workforce research and the sector evidence base. What a SocioSafety™ diagnostic would typically surface in a South African private hospital group of this size, what the integrated response would set out to do, and the kind of movement the published research predicts the work produces.

- Section eight sets out the twelve month path forward, the three questions every hospital board should be asking now, and the partnership model we have designed for engagements of this kind.

SECTION 01

The moment.

Why the Bill changes everything, and why this is harder than legal compliance.

IN THIS SECTION

SECTION 1.1

What the Bill is. What it does. When it begins.

The Occupational Health and Safety Amendment Bill is the most significant change to South African occupational health law in three decades. It amends the Occupational Health and Safety Act of 1993, which has governed workplace safety in this country for the entire democratic era. The Bill has been passed by Parliament. It has not yet been proclaimed. When the President signs the proclamation, the commencement date is set, and the amended Act becomes law.

The Bill does not introduce new occupational health and safety obligations from nothing. The 1993 Act has always required employers to provide and maintain a safe working environment, to identify hazards, and to protect employees from harm. What the Bill does is sharpen those obligations, formalise the documentation required to evidence them, elevate accountability to the CEO and to the board, and arm inspectors with new powers and new penalties to enforce them.

Five changes matter most for hospitals. We will walk through each in section two. Before we do, it is worth being clear about what the Bill is not. It is not a new piece of legislation about wellness, or psychosocial safety, or mental health. The word psychosocial does not appear in the Bill at all. It is a tightening of an existing law that has always required employers to assess all hazards, to take reasonably practicable steps to address them, and to be accountable for the conditions in which their employees work. The tightening is what is new. The underlying obligations are not.

This matters because the most common misunderstanding, in hospital boardrooms and executive committee discussions of the Bill, is that it creates a new compliance task that can be added to the existing portfolio and managed alongside other regulatory obligations. It does not. It exposes the gap between what existing law has always required and what hospitals have actually been doing. That gap, on the sector evidence available, is substantial in most South African hospitals.

THE BILL AT A GLANCE

Act being amended: Occupational Health and Safety Act 85 of 1993

Source: Government Gazette No. 44572, 14 May 2021

Status: Passed by Parliament, awaiting Presidential proclamation

Scope: All employers, including public and private hospitals, clinics, primary care facilities, academic health complexes

SECTION 1.2

Why hospitals are at the front of the regulatory queue.

When the Department of Employment and Labour begins to enforce the amended Act in earnest, hospitals will be among the earliest and most thorough inspection targets. We say this not as speculation but as informed expectation, drawing on the patterns visible in three places. The Department's published enforcement priorities. The way comparable regimes have rolled out in other jurisdictions. And the political climate around South African healthcare in 2026.

Three factors place hospitals at the front of the queue.

Visibility of harm

Healthcare worker injury, illness, and death are visible in ways that injury in many other industries is not. Needlestick injuries that produce HIV seroconversion. Tuberculosis transmission to staff. Patient assaults that send nurses to emergency departments as patients themselves. Healthcare worker suicide, which has had specific media attention in this country over the past two years. The harm is real. It is documented. And it is increasingly being connected to the working conditions inside hospitals rather than treated as an unavoidable feature of clinical work.

Concentration of regulated workers

A single five hundred bed hospital employs more workers than most factories. The workforce is professionally regulated, often unionised, and visible. When something goes wrong, it travels. The inspector who walks into a hospital does not encounter a single contained workplace. They encounter the wards, the theatres, the intensive care units, the emergency department, the laboratories, the kitchens, the laundries, the medical waste facility, the maintenance workshop, the parking lot, the administrative offices. Each of these is a workplace under the Act. Each carries its own hazards. The inspector who walks out has, in a single visit, gathered evidence across what would in other contexts be a dozen separate inspections.

Patient safety overlap

This is the factor that hospitals tend to underestimate. Patient safety regulation, under the Health Professions Council, the Office of Health Standards Compliance, and the relevant clinical bodies, has been tightening for years independently of the OHS Bill. The interaction matters. When a psychosocial failure inside a hospital, an exhausted nurse working a double shift, an under supervised intern, a moral injury producing decision, results in a clinical incident, the incident now risks producing findings under both regimes. Occupational health law for the conditions that produced the exhaustion. Patient safety law for the harm to the patient. The hospitals that survive this interaction will be the ones whose documentation is defensible across both regimes simultaneously. The hospitals that do not will face findings on both sides of the same event.

WHAT THIS LOOKS LIKE IN PRACTICE

Consider a single event. A nurse on her sixteenth consecutive shift in a ward where vacancies have been unfilled for four months administers the wrong dose of a high risk medication. The patient is harmed.

Under existing patient safety law, the investigation focuses on the medication error, the nurse's competence, the systems for medication checking, and the supervision in place.

Under the amended OHS Act, an inspector arrives separately. The investigation focuses on the working conditions that produced the error. The vacancy rate. The shift patterns. The risk assessment that should

have identified shift fatigue as a hazard. The Health and Safety Management System that should have produced controls.

Two investigations. Two regimes. One event. The hospital must be defensible under both.

SECTION 1.3

The conditions inside South African hospitals in 2026.

We need to be honest about the conditions the Bill is landing into. This is not a piece of legislation arriving in a workforce ready to absorb it. It is arriving in a workforce already, by every available measure, in crisis.

The public sector vacancy rate for nursing posts sits, depending on the province and the categorisation, between fifteen and twenty eight percent. Some specialist disciplines, theatre, intensive care, oncology nursing, sit higher. The vacancies are not new. Most have been unfilled for periods exceeding twelve months. The workload that should have been carried by those vacant posts has been absorbed by the remaining staff. That absorption is the hidden subsidy that keeps public hospitals functioning. The Bill changes the calculus of that subsidy.

In the private sector the picture is different but not better. Vacancy rates are lower. Turnover is higher. The age profile of the senior nursing workforce is rising and the pipeline to replace it is thinner than it was a decade ago. The pressure on private hospitals comes not from absent posts but from the cost containment pressure of medical schemes, the rising acuity of admitted patients, and the increasing complexity of the clinical work in environments where the staffing ratios have not moved to match.

Across both sectors, three things are visible to anyone willing to look.

1. Burnout, on every validated measure, sits at levels comparable to the worst published cohorts in international literature. The 2024 South African Healthcare Workforce Wellbeing Study found that sixty one percent of clinical staff sampled met diagnostic threshold for moderate to severe burnout, and that twenty three percent met threshold for severe burnout alone.
2. Moral injury, the harm caused when staff are required to act against their professional judgment due to systemic constraints, is now being recognised as a discrete psychosocial hazard category in healthcare globally. The South African data, where it exists, suggests prevalence rates higher than the international average. Staff are not just tired. They are carrying the cumulative weight of having provided care they know was below the standard their training demands.
3. Patient and family aggression, including physical assault, is reported in over forty percent of emergency department staff annually. In psychiatric units the figure is higher. The reporting itself is patchy. The actual rate is almost certainly higher than the reported one.

This is the workforce the Bill is asking hospitals to protect. It is also, increasingly, the workforce that is no longer able to absorb the structural failures that have made hospital functioning possible. When a hospital implements a new compliance regime in a workforce already this depleted, it can produce one of two outcomes. The compliance regime becomes the additional weight that pushes the workforce past breaking. Or the compliance regime becomes the lever through which the structural conditions are finally addressed. Which outcome occurs depends entirely on how the work is approached.

61%

of clinical staff in the 2024 South African Healthcare Workforce Wellbeing Study met diagnostic threshold for moderate to severe burnout. Twenty three percent met threshold for severe burnout alone.

SECTION 1.4

Why compliance alone is the wrong target.

The most natural response, when a new compliance regime is on the horizon, is to organise the response around compliance. To commission a gap analysis. To produce a project plan. To delegate the work to legal, compliance, and OHS functions. To deliver, by the proclamation date, a set of documents that demonstrate that the hospital has met its obligations.

This is the pattern the published research on compliance led organisational change consistently documents. The documents get produced. The Health and Safety Management System is written. The risk assessment is completed by a competent person from a consultancy. The Health and Safety Committee is constituted. The annual statistics are submitted by the first of March. The hospital is compliant on paper.

And then, six months later, a needlestick injury occurs. The investigation reveals that the risk assessment named the hazard but the controls were never implemented. Or a patient assault sends two nurses to hospital. The investigation reveals that the Health and Safety Committee met three times in the year, that violence prevention protocols existed on paper, but that nobody on the ward had been trained in them. Or the inspector arrives unannounced and asks a single question that the executive team cannot answer. Where is your Psychosocial Hazard Register?

Compliance, on its own, is the wrong target because it confuses the artefact with the work. The documents are not the protection. The documents evidence the protection. The protection is the actual work done inside the hospital, by leaders who know how to lead under pressure, by HR systems that produce sustainable staffing, by cultures that surface incidents rather than suppress them, by workforces with the resilience to carry the work the work itself demands. That work cannot be commissioned by a consultancy and delivered by the proclamation date. That work is transformation.

The Bill, properly understood, is not a compliance prompt. It is a transformation prompt. The hospitals that will come out of this regulatory shift in better condition than they entered it are the ones that take the prompt seriously. They use the documentation requirements as the discipline that forces the structural conversations that have been deferred for years. They use the CEO accountability provision to elevate workforce conditions from an HR concern to a board level governance matter. They use the Psychosocial Hazard Register requirement as the first piece of evidence based diagnostic work their organisation has ever commissioned.

This paper is written for the hospitals that want to be in that group. For the boards and CEOs who recognise, when they look honestly at their workforce, that the conditions they are running can no longer be sustained on willpower alone. For the leaders who want a regulatory shift to be the catalyst for the deeper work rather than the latest layer of work piled on top of a workforce that cannot carry another layer.

> *The hospitals that will come through this regulatory shift well are not the ones whose compliance projects are best run. They are the ones whose leaders use the regulatory shift as permission to do the work the workforce has needed for years.*

LEADERSHIP QUESTION

If your hospital's response to the Bill is being managed primarily as a compliance project, with project artefacts as the success measure, ask whose accountability is being protected by that framing. The CEO

> *whose name will appear on the Health and Safety Management System? The board whose minutes will record the compliance work? Or the workforce whose conditions the Bill was written to protect?*

SECTION 02

What the Bill requires.

The five obligations that change most for hospitals, and the compliance gap each exposes.

IN THIS SECTION

OBLIGATION 01 · SECTION 8 AMENDED

Mandatory written risk assessment.

What the Bill requires

Every healthcare employer must conduct a workplace specific risk assessment before work commences or before any change to work processes. The obligation is unambiguous, non delegable, and applies to every facility from the largest academic hospital to the smallest primary healthcare clinic.

The risk assessment must be conducted by a competent person, meaning someone with the knowledge, training, and experience appropriate to the hazards being assessed. It must produce a written risk management plan. And it must cover all workplace hazards relevant to the specific facility.

All workplace hazards. Not selected categories. The word all carries the full weight of the obligation.

Healthcare specific implication

Hospitals face the most complex hazard profile of any industry. A complete risk assessment for a hospital must address four distinct hazard categories, each of which would, in many other industries, constitute the entire risk assessment on its own.

Biological hazards. Needlestick and sharps exposure, airborne pathogens including tuberculosis, blood borne pathogens including HIV and hepatitis, and healthcare associated infections.

Chemical hazards. Disinfectants and sterilants, anaesthetic gases, cytotoxic drugs in oncology and chemotherapy preparation, and laboratory reagents.

Physical hazards. Ionising radiation in imaging departments, manual handling of patients, slips and trips and falls in wet environments, and noise exposure in technical areas.

Psychosocial hazards. Shift work and fatigue, patient and family violence and aggression, moral injury, burnout and compassion fatigue, and vicarious trauma. The category the Bill names by implication rather than by name, and the category most hospital risk assessments ignore.

THE GAP THIS OBLIGATION EXPOSES

Most hospitals do not currently hold a written, workplace specific risk assessment that comprehensively covers all four hazard categories. The risk assessments we encounter in the work tend to be one of three things. Generic templates borrowed from another facility, sometimes still bearing the prior facility's name. Infection control documents misdescribed as risk assessments. Or partial documents covering biological hazards only, with physical hazards covered through separate health and safety inspections and psychosocial hazards absent entirely.

Under the amended Act, none of these will be acceptable. The competent person standard means the assessment must be defensible against expert challenge. The all workplace hazards standard means category omissions are themselves a contravention. The single largest gap, in our experience, is the absence of psychosocial hazards. We return to this gap in section three.

OBLIGATION 02 · SECTION 16 AMENDED

CEO accountability for the Health and Safety Management System.

What the Bill requires

Section 16 places direct, personal, non delegable accountability on the Chief Executive Officer to develop, implement, and continuously review a Health and Safety Management System for the organisation.

Three words in that sentence matter. Personal. The CEO is named individually. Non delegable. The accountability cannot be sub delegated to the HR director or the head of OHS or the chief operating officer. Continuously. The HSMS is not a static document produced once and shelved. It must be subject to ongoing review and update, with evidence that the review is taking place.

The HSMS itself must be documented. It must be reviewable. It must integrate the risk assessment, the controls, the reporting, the committee structure, and the continuous improvement processes into a coherent whole. It is not a collection of policies. It is an integrated management system.

Healthcare specific implication

In healthcare, the CEO carries a specific definition under the Bill. For public hospitals, the CEO is typically the hospital CEO or Medical Superintendent. For provincial health departments, accountability may extend to the Head of Department. For private hospital groups, the obligation rests with the CEO of the group as the primary employer.

The implication is that occupational health and safety is no longer a function that can be delegated to a director two or three levels below the CEO and reviewed at executive committee twice a year. It is a board level governance matter that the CEO must personally own.

This is, in our experience, the change that hospital boards are slowest to internalise. Many CEOs still treat OHS as a compliance function, comparable to fire safety or building maintenance. The amended Act forces the elevation. The board agendas need to change. The CEO's reporting needs to change. The accountability conversations need to change.

THE GAP THIS OBLIGATION EXPOSES

Most South African hospitals, on the sector evidence available, hold collections of OHS policies, procedures, and programmes rather than integrated Health and Safety Management Systems. The policies exist. They have been written, often well, over years. But they are not integrated. They do not flow from a single risk assessment. They are not subject to the kind of continuous review the amended Act now requires. And they have not been formally signed off by the CEO with personal accountability accepted.

The fix is not a rewriting exercise. It is a structural reorientation. The hospital's existing OHS material needs to be consolidated, integrated, gap analysed against the new requirements, brought to the CEO for personal review and sign off, and put on a continuous review cycle with named accountabilities and review dates. Most hospitals will need external support to do this competently and at the standard inspectors will expect.

OBLIGATION 03 · SECTIONS 17 TO 20 AMENDED

Health and Safety Representatives and Committees.

What the Bill requires

Any hospital with more than twenty employees must designate health and safety representatives. The ratio is set at one representative per fifty employees for healthcare facilities, which fall under the other workplaces category rather than the shops and offices category. Health and Safety Committees must meet every two months, reduced from the three monthly cadence under the prior Act. Committees must identify which OHS regulations apply to their specific workplace and ensure compliance with each.

Healthcare specific implication

A five hundred bed hospital with twelve hundred employees needs twenty four health and safety representatives. On the sector evidence available, most South African hospitals have between three and ten. The gap is structural, not administrative.

The representatives must be spread across the work areas where the hazards exist. Wards, intensive care, theatres, emergency, radiology, laboratories, pharmacies, laundries, kitchens, maintenance, administration. Each area carries its own hazard profile. Each needs representation that knows the area.

Representatives need protected time to perform their duties. Training in OHS principles and in the specific regulations applicable to their area. The authority to identify hazards and to require management response. The right to attend committee meetings without loss of pay.

Committee meetings every two months is a significant lift from the prior cadence. Six meetings per year, each requiring documented minutes, action items, follow through, and reporting. The committee structure becomes one of the primary governance mechanisms through which the amended Act is implemented.

THE GAP THIS OBLIGATION EXPOSES

Most hospitals fall short on three dimensions of this requirement simultaneously. The number of representatives is below the required ratio. The committee meeting cadence is below the required frequency. And the identification of applicable regulations, the General Safety Regulations, the Asbestos Regulations, the Biological Agents Regulations, the Noise Regulations, and the others, has not been systematically performed.

Closing this gap is more than an administrative task. It requires the hospital to constitute a network of trained, supported, and authorised representatives spread across the work areas, and a committee structure with the cadence and discipline to meet six times a year with real agendas and real follow through. For most hospitals this is a multi month implementation, not a one off appointment.

OBLIGATION 04 · SECTION 24 AMENDED

Incident reporting, including contractors.

What the Bill requires

The amended Act expands what counts as a reportable incident. Death and permanent disablement remain triggers, as they have always been. New triggers include occupational disease, dangerous substance exposure, machinery failure, and any incident that could have caused serious injury, which captures near miss events as well as completed incidents.

The expansion most significant for hospitals is the inclusion of contractor incidents. Agency nurses, locum doctors, cleaning contractors, security contractors, catering contractors, maintenance contractors, medical waste contractors. Each is a non employee whose injury or illness on the hospital premises now falls under the hospital's reporting obligation.

Annual incident statistics must be submitted to the Department of Employment and Labour by the first of March each year. This is a new reporting obligation. It is also the obligation most hospitals are completely unaware of.

Healthcare specific implication

Hospitals under report incidents on a scale that, in our experience, would surprise the Department of Employment and Labour. Needlestick injuries are often managed informally through occupational health without reaching the formal incident reporting system. Patient assaults on staff are routinely treated as part of the job and not reported externally. Slips, trips, and falls are recorded for workers compensation purposes but not consistently captured as OHS incidents. Near miss events, medication errors that did not reach the patient, equipment failures, contractor injuries on hospital premises, are rarely captured at all.

The Bill changes the calculus. Under reporting now exposes the hospital to administrative fines, to criminal liability when an under reported incident later produces serious harm, and to inability to demonstrate compliance during inspection.

Contractor inclusion in particular requires a structural change. Most hospital OHS systems are built around the directly employed workforce. Contractor OHS is typically managed through procurement and facilities, with no integration to the OHS reporting system. The amended Act requires this integration.

THE GAP THIS OBLIGATION EXPOSES

Three gaps appear consistently across the South African hospital sector on the evidence available. The incident reporting system does not capture all the categories the Bill names. Contractor incidents are not integrated. And annual statistics are not submitted to the Department, often because nobody senior is aware that submission is required.

Closing these gaps requires a redesigned incident reporting system that captures all reportable incidents, including near misses and contractor incidents, generates the data needed for annual statistical submission, and integrates with the broader OHS Management System rather than operating as a stand alone process. The clinical incident reporting system that hospitals run for patient safety purposes is separate, and should remain separate, but the two need to be operated in parallel rather than confused.

OBLIGATION 05 · SECTIONS 37A TO 37F, SCHEDULES 1 AND 2

Administrative fines and criminal liability.

What the Bill requires

The amended Act introduces two new enforcement mechanisms. Administrative fines and criminal liability for contraventions causing serious harm. Both fundamentally change the risk profile of non compliance.

Administrative fines can be issued on the spot by inspectors without going to court. Schedule 2 sets out the fine ranges, from twenty five thousand rand for certain contraventions, including failure to report incidents, up to fifty thousand rand for more serious contraventions, including failure to designate health and safety representatives, failure to establish committees, and failure to keep prescribed records.

Criminal liability under section 37B applies when a contravention causes death, permanent disablement, or illness. Charges can be laid against the employer as an organisation and against responsible individuals personally. Maximum penalties under Schedule 1 reach five million rand or five years imprisonment or both.

Healthcare specific implication

Consider a scenario familiar to anyone who has worked in a South African hospital. A nurse suffers a needlestick injury in an emergency department while recapping a needle. The needle came from a patient with known HIV infection. The nurse seroconverts.

Investigation reveals that the hospital had no written risk assessment specifically addressing needlestick injuries. No sharps safety devices had been provided. No training on safe sharps handling had been conducted in the past two years. The incident was not reported to the Department of Employment and Labour.

Under the amended Act, this single event could trigger an administrative fine of twenty five thousand rand for the failure to report. Criminal charges under section 8 for failure to conduct a risk assessment and under section 37B for the contravention causing illness. Maximum penalty of five million rand or five years imprisonment.

The criminal charges name individuals. The CEO. The OHS manager. The head of the emergency department. Each could face personal liability separately from the organisation.

This is not a theoretical risk. The pattern in the scenario, no risk assessment, no controls, no training, no reporting, then a serious incident, is the most common pattern we encounter in our diagnostic work in South African hospitals. The amended Act makes clear that this pattern, when it produces harm, now carries financial and criminal consequences for both the organisation and the individuals responsible for it.

THE GAP THIS OBLIGATION EXPOSES

Most hospital executives have not internalised the personal liability risk. The conversations we have with hospital CEOs about the Bill typically begin with organisational implications and only reach the personal liability question late in the conversation, sometimes only when we raise it. The personal liability question is, in our judgement, the conversation that should come first.

Boards in particular need to understand that the Bill creates personal liability that cannot be transferred to the organisation or insured against fully. Director and officer liability insurance has carve outs for wilful or grossly negligent breach of statutory duty. The amended Act creates exactly the kind of statutory duty that those carve outs apply to. Boards that take this lightly are taking their own legal exposure lightly.

SECTION 2.6

Penalties at a glance.

The table below summarises the maximum penalties under the amended Act. Administrative fines, in the bottom three rows, can be issued on the spot by an inspector. The remaining rows attract criminal liability when the contravention causes death, permanent disablement, or illness. The criminal liability applies to the employer organisation and to responsible individuals personally.

SECTION	OBLIGATION	MAX FINE	PRISON
Section 8	Failure to conduct risk assessment and implement controls	**R5 000 000**	**5 years**
Section 9	Failure to protect non employees from hazards	**R5 000 000**	**5 years**
Section 16	CEO failure to develop and review HSMS	R1 000 000	3 years
Section 17	Failure to designate H&S representatives	R1 000 000	3 years
Section 18	Failure to establish H&S committee	R1 000 000	3 years
Section 24	Failure to report incidents (admin fine)	R25 000	—
Section 25	Failure to investigate incidents (admin fine)	R50 000	—
Section 34	Failure to comply with inspector notice	**R5 000 000**	**5 years**
Section 37	Obstructing an inspector	**R5 000 000**	**5 years**
Section 38	Providing false information to inspector	**R5 000 000**	**5 years**

The figure in the top two rows, five million rand and five years imprisonment, applies specifically to sections 8 and 9. The risk assessment obligation and the obligation to protect non employees from hazards. These are the two obligations that, in healthcare, are most directly engaged when a needlestick, an assault, an exposure, or an occupational illness produces harm. The penalty is not theoretical.

SECTION 03

The hidden hazard.

Psychosocial risk is the most under addressed compliance gap in South African healthcare. The Bill does not name it. Section 8 still requires it to be assessed.

IN THIS SECTION

SECTION 3.1

The word that does not appear, and the obligation that does.

The most common question we are asked when we present on the Bill is whether it requires hospitals to address psychosocial hazards. The questioners usually expect a yes or no answer. The honest answer is more careful than that, and the carefulness matters.

The word psychosocial does not appear anywhere in the Bill. Search the gazetted text. The word is not there. This is the basis on which some hospital executives, and some legal advisors, have argued that the Bill does not require psychosocial hazards to be addressed. The argument is wrong. It is wrong in a way that will produce serious consequences for the hospitals that act on it.

The argument is wrong because section 8 of the amended Act requires employers to assess all workplace hazards. Not all physical hazards. Not all hazards named in the regulations. All workplace hazards. The word all carries the full weight of the obligation. A hazard is any condition that has the potential to cause harm, injury, illness, or adverse health effects to persons. Psychosocial conditions, when they meet that test, are hazards. The Bill does not exempt them. The Bill names a standard, and the standard includes them by definition.

This reading is consistent with the way occupational health and safety law has developed internationally. The International Labour Organisation framework, the European Union directive on occupational safety, the Australian and United Kingdom approaches, all treat psychosocial hazards as a category of workplace hazard that falls within general duty of care obligations rather than as something requiring separate naming. South African law, properly interpreted, sits in the same tradition.

The legal argument that psychosocial hazards are out of scope because the word is absent from the Bill is the kind of argument that will collapse the first time it is tested in front of an inspector who has read the literature, or a court that takes the section 8 obligation seriously, or a journalist who can read the section 8 text and the psychiatric morbidity data side by side. The collapse will happen at exactly the moment a hospital most needs the argument to hold. After harm has occurred.

THE SECTION 8 TEST

A psychosocial hazard must be addressed if three things are true.

It is foreseeable. The condition is known or could be known to exist in the workplace.

Its impact on health and safety is known. There is evidence that it causes harm.

Reasonably practicable steps to address it exist. Action is available that is not grossly disproportionate to the risk.

In healthcare, all three tests are met for every psychosocial hazard category named in this section. The obligation is not contingent on the Bill using the word.

SECTION 3.2

The five psychosocial hazards present in every South African hospital.

In two years of diagnostic work with South African hospitals, public and private, urban and rural, large and small, we have found five psychosocial hazards present in every hospital we have assessed. Not most. Every one. The expression varies. The severity varies. The mix varies. The presence does not.

01. Structural workload and shift fatigue

The single most consistent finding in healthcare psychosocial assessment is workload sitting in the critical band. Driven by structural understaffing, by shift patterns that the human body is not built to sustain over years, and by the impossibility of completing the work to the standard the work itself demands. The downstream consequences include cognitive impairment that produces clinical errors, physical injury rates that rise with shift length, and resignation rates that strip the workforce of its most experienced practitioners.

02. Patient and family violence and aggression

Physical and verbal aggression directed at staff. Emergency departments, psychiatric units, and acute medical wards are the highest exposure areas, but no department is exempt. The injuries range from bruises to fractures to head injuries to psychological trauma that produces post traumatic stress disorder. Reporting is poor. The actual rate of incidents is materially higher than the reported rate, often by an order of magnitude.

03. Moral injury

Moral injury is the harm caused when staff are required to act against their professional judgement due to systemic constraints. In healthcare, the constraints include staff shortages, equipment failures, medication stockouts, and the structural inability of the system to provide care to the standard staff have been trained to provide. The injury accumulates. The cumulative weight is one of the strongest predictors of resignation among the most experienced clinical staff.

04. Burnout and compassion fatigue

Endemic in the South African public health sector and now spreading materially in the private sector. The three components, emotional exhaustion, depersonalisation, and reduced sense of personal accomplishment, are well documented in the literature and well captured in the available South African data. The 2024 South African Healthcare Workforce Wellbeing Study found prevalence rates comparable to the worst cohorts in international literature. The downstream consequences include medical errors, staff turnover, and rates of suicidal ideation among healthcare workers that exceed those of any comparable workforce in this country.

05. Vicarious trauma

Cumulative exposure to patient suffering, patient death, mass casualty events, and the kinds of clinical experiences that, in any other workplace, would trigger formal critical incident debriefing. In healthcare these events are often the daily texture of the work. The cumulative psychological impact is real, well documented, and almost universally inadequately addressed.

These five hazards are foreseeable. Their impact on health and safety is documented. Reasonably practicable steps to address them exist. They meet the section 8 test in every respect. A hospital risk assessment that does not address them does not meet the standard the amended Act requires.

SECTION 3.3

Why hospital risk assessments fail this test.

The reason most hospital risk assessments fail the psychosocial hazard test is not malice and not negligence. It is method. The risk assessment methodology most hospitals have used, and that most occupational health consultancies still apply, is built for physical and chemical hazards. The methodology asks the right questions for needlesticks. It asks no useful questions for moral injury.

Physical hazard assessment is essentially observational. The hazard is visible. The exposure pathway is direct. The control is engineering, substitution, or personal protective equipment. The risk assessor walks the workplace, identifies the hazards, evaluates the controls, documents the residual risk. The methodology has been refined over a century of industrial practice.

Psychosocial hazard assessment is fundamentally different. The hazard is rarely observable to a visitor walking the workplace. The exposure pathway is the structural conditions of the work itself, not a discrete physical interaction. The control is rarely a piece of equipment. The methodology has to be different because the hazards are different.

What competent psychosocial hazard assessment requires

- **Quantitative measurement.** A validated survey instrument that assesses the workplace against established psychosocial risk domains, completed by staff anonymously, with response rates sufficient to support inference. Without quantitative data, the assessment relies on impression and is not defensible against expert challenge.
- **Qualitative depth.** Structured interviews, focus groups, and listening circles that surface the lived experience the survey cannot capture. The qualitative work is where moral injury, the specific texture of the work, and the patterns the workforce knows about but management does not, become visible.
- **Independent execution.** The assessment must be conducted by parties who do not depend on the hospital's management for their continued employment or commercial relationship. Internal HR functions can support the work but cannot defensibly produce the assessment alone. The conflict of interest is structural.
- **Formal documentation.** A Psychosocial Hazard Register that meets the standard of a workplace risk register. Each hazard named. Severity rated. Evidence cited. Controls in place documented. Residual risk evaluated. Re assessment date scheduled. This is the document an inspector will ask for. Most hospitals cannot produce one.
- **Continuous review.** Psychosocial conditions change. A baseline assessment is not a permanent assessment. The amended Act's continuous review requirement under section 16 applies to the psychosocial domain as it does to every other. The hospital needs a mechanism for ongoing monitoring, not just a one off snapshot.

This is the methodology gap most hospitals do not yet recognise. The OHS consultancy that produced last year's risk assessment may have done excellent work on the physical and chemical hazards. The same consultancy is, in most cases, not equipped to produce defensible psychosocial assessment. The skill set is different. The instruments are different. The qualitative methodology is different. The reporting standard is different.

LEADERSHIP QUESTION

If your hospital's risk assessment was produced by the same consultancy or function that produced your physical hazard assessment three years ago, ask whether they applied a validated psychosocial

measurement instrument, conducted qualitative depth work, and produced a formal Psychosocial Hazard Register. If the answer to any of those questions is no, your risk assessment does not meet the section 8 standard regardless of how complete it appears on the physical and chemical side.

SECTION 04

The Psychosocial framework.

SocioSafety™. A five domain assessment methodology built specifically to satisfy section 8 of the amended Act and to produce a legally defensible Psychosocial Hazard Register.

IN THIS SECTION

SECTION 4.1

What SocioSafety™ is, and why we built it.

SocioSafety™ is the Psychosocial framework Ignite Purpose has built to address the gap section three describes. It is the diagnostic methodology that produces, as its formal output, a Psychosocial Hazard Register that satisfies section 8 of the amended Act and stands up to inspector challenge.

We built it because we could not find an existing instrument that did what the work required. The international psychosocial assessment literature is rich. The validated quantitative instruments, from the Copenhagen Psychosocial Questionnaire to the Health and Safety Executive Management Standards, are well established. But none of them, on their own, produce the deliverable South African law now requires. They produce data about psychosocial conditions. They do not produce a hazard register. They do not integrate qualitative depth in the way the South African context demands. And they were not built for the specific regulatory environment the amended Act creates.

SocioSafety™ takes the best of the international quantitative literature, adds the qualitative methodology required for genuine depth, and produces a Psychosocial Hazard Register formatted for direct integration into a Health and Safety Management System. It is built for the work that needs doing here, in this regulatory environment, in this workforce, at this moment.

In healthcare specifically, SocioSafety™ is built around an understanding of the five psychosocial hazards section three names. Workload. Autonomy. Relational climate. Role design. Leadership behaviour. The five domains are derived from the international literature, validated against South African workforce data, and structured to surface the patterns that healthcare specifically produces. Moral injury appears as a recurring qualitative theme across domains. Patient violence appears in the relational climate domain. Shift fatigue and structural understaffing appear in the workload domain. The framework is designed to surface what healthcare actually produces, not to apply a generic instrument and hope the patterns emerge.

WHAT SOCIOSAFETY™ DELIVERS

A 40 item validated quantitative survey across the five domains, calibrated to South African workforce norms.

Qualitative depth through leadership interviews, staff Listening Circles, and where appropriate cultural artefact review.

A formal Psychosocial Hazard Register formatted for legal compliance, with severity ratings, evidence, dates, and recommended controls.

A Culture Assessment Report suitable for board review and external inspection.

A 12 month re assessment schedule. Baseline, six month pulse, twelve month full re assessment. Continuous review built in.

A defensible audit trail from assessment through intervention to re assessment, designed to be presented to an inspector.

SECTION 4.2

The five domains.

Each of the five SocioSafety™ domains is a specific category of psychosocial risk that the international literature has established, that South African workforce data has validated, and that hospital data consistently produces. The pages that follow describe each domain. What it covers. How it shows up in hospital environments. What the data signals look like when the domain is in the critical band.

DOMAIN 01

Workload.

The workload domain assesses the volume, intensity, pace, and structural sustainability of the work demanded of staff. It captures whether the work can be completed in the time available, at the standard required, with the resources provided.

What this looks like in hospitals

In hospitals, the workload domain is almost universally in the critical band. The drivers are structural understaffing, shift patterns the human body is not built to sustain, and the impossibility of completing clinical work to the standard the work itself demands. The expression varies between public and private settings, but the underlying signal is consistent.

Signals that surface in the data

- Vacancy rates in clinical categories above ten percent for periods exceeding three months, with remaining staff absorbing the workload rather than the service being scaled down.
- Shift patterns including consecutive shifts above the recommended maximum, double shifts as a routine feature rather than exception, and recovery windows shorter than physiological requirements.
- Sick leave concentrated in specific units rather than evenly distributed, signalling that the unit specific conditions are driving the leave.
- Resignation rates among newly qualified staff above twenty percent in the first twenty four months, suggesting orientation and early career support are inadequate to the workload demanded.
- Internal incident reports describing unsafe staffing or inadequate cover that have not produced visible structural change.

DOMAIN 02

Autonomy.

The autonomy domain assesses the degree of meaningful control staff have over how they perform their work. Decision authority. Scope to apply professional judgement. The ability to influence the conditions of work, including pace, sequence, and approach.

What this looks like in hospitals

In hospitals, the autonomy domain shows a distinctive pattern. Clinical staff, particularly nurses and allied health professionals, often score low on autonomy. The drivers are the layered hierarchy of healthcare, the limited authority for those closest to patient care, the procedural rigidity of clinical pathways, and the high consequence environment that constrains professional judgement. Senior clinical staff often score higher, but the pattern is uneven and unit specific.

Signals that surface in the data

- Layered hierarchy with multiple levels of supervision before a clinical decision can be made, particularly in academic and public sector settings.
- Procedural rigidity that prevents experienced clinicians from adapting protocols to specific patient circumstances.
- Decision rights concentrated at senior levels, with staff closest to patient care lacking authority over the conditions that affect their day to day work.
- Restricted ability to adjust pace, sequence, or approach in response to workload pressure, even when adjustment would improve safety.
- Specific qualitative theme of staff feeling they cannot raise concerns about clinical decisions made above them without professional consequence.

DOMAIN 03

Relational Climate.

The relational climate domain assesses the quality and safety of relationships in the workplace. Peer support. Hierarchical relationships. The presence or absence of bullying, harassment, aggression, and discrimination. Psychological safety in the strict sense, the ability to speak up without negative consequence.

What this looks like in hospitals

In hospitals, the relational climate domain often shows two distinct profiles within the same organisation. Strong peer support within teams, often the strongest score in the entire assessment, sitting alongside significant tension across hierarchical lines. Patient and family aggression appears here as a specific signal. The exposure varies dramatically by department.

Signals that surface in the data

- Patient and family aggression rates, including physical assault, in emergency departments, psychiatric units, and acute medical wards. The reported rate is materially lower than the actual rate.
- Tension between clinical and administrative hierarchies, often producing the largest perception gap in the assessment.
- Strong peer support within teams, particularly in units with stable staffing, sitting alongside significant hierarchical tension.
- Specific patterns of bullying or harassment in named units, often historical and known to staff but not formally reported or addressed.
- Whistleblower complaints, internal or external, about specific units, specific managers, or systemic patterns of relational harm.

DOMAIN 04

Role Design.

The role design domain assesses the structural clarity, boundaries, and integrity of staff roles. Whether roles are well defined. Whether the work demanded matches the role description. Whether role boundaries hold under pressure, or whether they collapse into role creep and chronic boundary erosion.

What this looks like in hospitals

In hospitals, role design varies dramatically between settings. Private healthcare often scores in the developing or progressing band, with reasonable role clarity for most positions. Public healthcare often sits in the critical band, with role creep and boundary erosion as endemic features. Senior nurses doing junior doctor work. Junior doctors doing consultant work. Allied health professionals carrying responsibilities outside their formal scope. The boundary erosion is often unrecognised at senior management level because, for the system to function at all, it has had to become the new normal.

Signals that surface in the data

- Role descriptions that have not been reviewed in three or more years, with the actual work performed materially different from the documented role.
- Senior staff routinely performing work that should be the responsibility of more junior staff, due to vacancies or skill gaps that have not been addressed.
- Junior staff performing work above their scope of practice, often with limited supervision, particularly in lower resourced settings.
- Allied health professionals carrying responsibilities outside their formal scope of practice as a routine feature of the work.
- Specific qualitative theme of staff describing the gap between their job description and the work they actually do, with the gap often growing rather than shrinking over time.

DOMAIN 05

Leadership Behaviour.

The leadership behaviour domain assesses how leaders, at every level from line manager to executive, behave in ways that protect or undermine psychological safety. Communication. Recognition. The handling of mistakes. Visibility. Consistency. The match between stated values and observed action.

What this looks like in hospitals

In hospitals, the leadership behaviour domain shows the most significant perception gap of any sector we work in. Clinical leaders are often technically expert but undertrained in the leadership behaviours that protect psychological safety. The gap between intention and impact is wide. Staff and leaders score the leadership behaviour domain very differently. The gap itself is one of the strongest signals in the entire assessment.

Signals that surface in the data

- Large perception gap between staff and leadership scores on the leadership behaviour domain, often exceeding two standard deviations.
- Clinical leaders promoted on technical expertise without leadership development, producing leaders who are competent clinicians and undertrained managers.
- Inconsistent handling of mistakes, with some leaders surfacing and learning from errors while others blame, shame, or suppress, often in the same organisation.
- Specific qualitative theme of staff describing leaders who 'mean well' but produce harm through behaviour they are unaware of.
- Low visibility of senior leadership in clinical areas, with the gap between executive and frontline producing both real and perceived disconnection.

SECTION 4.3

The methodology.

SocioSafety™ uses a mixed methods approach. Neither the quantitative work nor the qualitative work, on their own, produces the depth a defensible Psychosocial Hazard Register requires. The two are designed to work together. The survey identifies the pattern. The qualitative work surfaces the texture.

The quantitative core

A 40 item validated survey calibrated to South African workforce norms, administered anonymously to all staff with response rates targeted at sixty percent or higher to support inferential analysis. Eight items per domain. The survey produces a numerical score for each domain at the organisational level, with disaggregation possible by department, role band, tenure, and demographic categories where the response rate supports it.

The scoring follows a five band rubric. Foundational. Developing. Progressing. Strong. Critical. The naming is deliberately neutral. The critical band is the one that triggers immediate hazard register inclusion and intervention design. The strong band indicates a domain where the conditions are working. The intermediate bands describe degrees in between.

The qualitative depth

Structured leadership interviews. Staff Listening Circles. Targeted focus groups in units flagged by the quantitative data. Where appropriate, cultural artefact review, the documents, the symbols, the rituals that the organisation has built around itself, often containing more information about culture than the survey can capture.

The qualitative work is conducted by experienced practitioners trained in trauma informed interviewing. In healthcare specifically, the experience of being asked about working conditions can itself surface distress. The methodology accommodates this. The qualitative practitioners hold a holding stance, not an extractive one. The data emerges from the encounter rather than being mined from it.

The integration

Survey and qualitative findings are integrated into a single Psychosocial Hazard Register. Each hazard named. The evidence for it, drawn from both quantitative and qualitative sources, documented. Severity rated against a clinical scale. Controls in place evaluated. Residual risk assessed. Recommended controls specified, with the corresponding programme intervention named where one exists. Re assessment date scheduled.

The hazard register is the document an inspector will ask for. It is formatted to satisfy that question. It is also the document that drives the intervention design that section six describes. Diagnosis to intervention to re assessment is a single integrated cycle in the framework, not three separate activities.

SECTION 4.4

How SocioSafety™ satisfies the Bill.

The framework is built to satisfy specific provisions of the amended Act. The mapping is direct and intentional. The list below sets out, for each major Bill obligation, the SocioSafety™ deliverable that addresses it.

BILL OBLIGATION	SOCIOSAFETY DELIVERABLE
Section 8. Written workplace specific risk assessment by a competent person, covering all hazards.	Mixed methods assessment producing the psychosocial component of the hospital's overall risk assessment. Conducted by competent practitioners. Formally signed off.
Section 8. Identification and assessment of psychosocial hazards as part of all workplace hazards.	Five domain validated survey plus qualitative depth, surfacing the psychosocial hazards specific to the facility, severity rated and evidence supported.
Section 16. Health and Safety Management System integrating risk assessment, controls, and continuous review.	Psychosocial Hazard Register formatted for direct integration into the hospital HSMS. Six month pulse and twelve month full re assessment built in.
Section 16. CEO accountability requiring continuous review.	Twelve month re assessment cycle with executive summary reporting suitable for board level review.
Section 18. Health and Safety Committee identification of applicable regulations.	Hazard register identifies specific regulations applicable to each hazard category, including the Hazardous Biological Agents Regulations, the General Safety Regulations, and the Code of Good Practice on the Handling of Sexual Harassment Cases.
Inspector challenge. Defensibility against expert examination.	Methodology defensible against expert challenge. Survey instrument validated. Qualitative protocol documented. Practitioner qualifications evidenced. Audit trail complete.

The framework is not the only way to satisfy section 8. It is one defensible way. Other rigorous methodologies exist, particularly in the international literature. What does not satisfy section 8 is the application of generic risk assessment methodology to the psychosocial domain, the use of unvalidated survey instruments, the absence of qualitative depth, or the absence of a formal Hazard Register as the deliverable. Hospitals choosing alternative methodologies should test their methodology against the four requirements section 3.3 sets out.

LEADERSHIP QUESTION

Ask your management team to show you, in writing, the methodology behind your hospital's psychosocial assessment. The survey instrument used. The qualitative protocol. The practitioner qualifications. The Hazard Register format. If any of these cannot be produced, the assessment will not survive inspector challenge. The conversation needs to happen now, not after the proclamation date.

SECTION 05

Compliance is not transformation.

Why the documentation a hospital produces will not, on its own, protect the workforce. And why the work that does protect the workforce takes longer than a proclamation date allows.

IN THIS SECTION

SECTION 5.1

Compliance produces documents. Documents do not protect workforces.

There is a particular kind of conversation we have come to recognise in hospital boardrooms. The CEO has been briefed on the Bill. The executive team has identified the gaps. A compliance project has been commissioned. The project has a budget. It has a project manager. It has a deadline timed to the expected proclamation date. The board is reassured.

Six months later, the documents arrive. The Health and Safety Management System is bound and presented. The risk assessment is complete. The Health and Safety Committee has been constituted. The training records have been organised. The annual incident statistics process has been designed. The hospital is, by every reasonable interpretation, compliant on paper. The compliance project is signed off as a success.

And then nothing changes inside the hospital. The vacancy rates do not move. The shift patterns do not change. The patient violence rates do not fall. The burnout scores do not improve. Six months after that, the first inspection happens. The inspector reviews the documents. They are well produced. The inspector asks for the Psychosocial Hazard Register. The hospital produces one. The inspector asks for evidence that the controls in the register have been implemented. The conversation pauses.

This is the gap between compliance and transformation. Compliance produces documents. Transformation produces the conditions the documents describe. The amended Act, in its severity provisions, requires both. The documents and the conditions. The fines for non compliance with the document obligations are administrative and capped. The penalties for the contraventions that cause death, permanent disablement, or illness reach five million rand and five years imprisonment. The harm is what triggers the severe penalty. The harm comes from the conditions, not from the documents.

> *The documents are not the protection. The documents evidence the protection. The protection is the actual work done inside the hospital, by leaders who know how to lead under pressure, by HR systems that produce sustainable staffing, by cultures that surface incidents rather than suppress them, by workforces with the resilience to carry the work the work itself demands.*

SECTION 5.2

The four levels of change the Bill exposes.

The work that produces actual protection, rather than evidenced protection, operates at four levels. Each level requires different work. Each level has different time horizons. Each is necessary. None is sufficient on its own.

Level one. Compliance.

The document level. Risk assessment. Hazard register. Health and Safety Management System. Committee structure. Reporting cadence. Annual statistics. This level can be completed within six to nine months with external support. It is necessary. It is also the easiest level, and the level most hospitals are currently treating as the entire scope of the work.

Level two. Capability.

The leader and workforce level. Leaders trained in the behaviours that protect psychological safety. Workforces equipped with the resilience to carry sustained pressure. Health and Safety representatives competent to perform their statutory functions. Specific clinical capabilities, debriefing after critical incidents, violence prevention, fatigue management, embedded in the workforce. This level takes twelve to eighteen months and is the level most hospital compliance projects do not address.

Level three. Systems.

The HR and operating model level. The staffing model that produces sustainable workload. The shift patterns that the human body can sustain. The role design that holds boundaries under pressure. The recruitment and retention systems that produce a pipeline rather than a leaking bucket. The decision rights and delegation framework that gives clinical staff appropriate autonomy. This level requires structural change. The horizon is eighteen to thirty six months and the work is genuinely transformational.

Level four. Culture.

The deepest level. The shared mental models, the unwritten rules, the cultural artefacts that determine how the organisation actually behaves regardless of what the policies say. The culture that surfaces incidents rather than suppressing them. The culture that treats safety as a value rather than a compliance obligation. The culture that holds the difficult conversations rather than avoiding them. This level cannot be project managed. It can only be cultivated. The horizon is three to five years and the work is never finished.

All four levels are required for the workforce to be genuinely protected. All four levels are required for the documentation to remain defensible over time. A hospital that addresses level one alone will pass the first inspection and fail the second. A hospital that addresses levels one and two will fare better but will not produce the structural conditions that the workforce needs. A hospital that addresses all four is doing the work the Bill is, in its deeper sense, asking for.

SECTION 5.3

Why the timing matters more than the deadline suggests.

The proclamation date, when it comes, will create a single visible deadline. The compliance project plans will be built around that date. The board reporting will be timed to it. The vendor selection processes will be procured against it.

This framing is correct for the compliance work. It is wrong for the transformation work. The transformation work cannot be timed to the proclamation date. It must begin earlier, and it must continue long after.

The reason is straightforward. The risk assessment that the Bill requires is a snapshot of conditions at a moment in time. If the assessment is conducted close to the proclamation date in a hospital that has not yet begun the transformation work, the assessment will surface the structural conditions that exist at that moment. Critical workload. Endemic burnout. Patient violence. Moral injury. The hazard register will name these hazards. The hazard register will then sit in the Health and Safety Management System as evidence that the hospital is aware of conditions it has not yet addressed.

This is a dangerous position. Inspector arrival, a serious incident, or a labour court application, can all then produce findings that the hospital knew about the hazards, documented the knowledge, and failed to act. The hazard register becomes evidence against the hospital rather than evidence for it.

The hospitals that come through this regulatory shift well are the ones that begin the transformation work twelve to eighteen months before they commission the formal assessment. They use the early period to put in place the structural changes that move the needle on workload, leadership behaviour, and culture. They commission the assessment after some of the structural work is visible. The assessment then surfaces conditions that the hospital is already addressing. The hazard register documents both the conditions and the controls already in place. The defensibility is fundamentally different.

This is not a strategy to avoid surfacing hazards. The hazards are real. They need to be named. What matters is that they are named alongside the work being done to address them. The Bill does not require hospitals to be perfect. It requires them to be acting in good faith on what they know. A hazard register that names hazards and corresponding action is defensible. A hazard register that names hazards and corresponding inaction is not.

> THE WORK ORDER MATTERS
>
> *Begin the transformation work now, in advance of the proclamation date. Commission the assessment after the early structural work is visible. The assessment becomes a defensible snapshot of an organisation in motion, rather than an undefended snapshot of an organisation at rest.*

SECTION 06

The Ignite Purpose response.

How the programme suite maps to the obligations the Bill creates, and to the four levels of change section five describes.

IN THIS SECTION

SECTION 6.1

The architecture. One framework, six programmes.

The Ignite Purpose response to the OHS Amendment Bill is built on a single architectural premise. The Bill creates obligations at four levels of organisational change. No single programme addresses all four. The response must be integrated, sequenced, and designed to produce the conditions the documentation evidences rather than the documentation alone.

The architecture has six components. Five programmes and an integration framework. Each programme addresses specific obligations and specific levels of change. The integration framework sequences the programmes into a coherent twelve to thirty six month engagement that produces defensible compliance alongside actual transformation.

How the six components map to the four levels of change

LEVEL OF CHANGE	PROGRAMMES THAT ADDRESS IT
Level 1. Compliance. Documents and regulatory artefacts.	SocioSafety™ assessment. HR Transformation policy and system design.
Level 2. Capability. Leader and workforce capacity.	ARISE Resilience. Brave Leadership. Specific clinical capability work.
Level 3. Systems. HR operating model and structural systems.	HR Transformation. SocioSafety™ control design.
Level 4. Culture. Deep cultural patterns and shared mental models.	Culture Transformation. The IGNITE PURPOSE Transformation Framework as the integration vehicle.

The pages that follow describe each component, what it is, what it does, what it produces, and which obligations of the Bill it addresses. The descriptions are at briefing depth. Full programme briefings exist for each and are available on request.

PROGRAMME 01

SocioSafety™

The diagnostic that produces the Psychosocial Hazard Register.

What it is

SocioSafety™ is the Psychosocial framework described in detail in section four. It is the diagnostic component of the wider response. The five domain assessment, the qualitative depth work, and the formal Hazard Register that integrates into the hospital's Health and Safety Management System.

In healthcare specifically, SocioSafety™ is calibrated for the patterns the sector produces. Moral injury as a recurring theme. Patient violence in the relational climate domain. Structural understaffing in the workload domain. The five domains hold across sectors. The calibration to healthcare gives the assessment the specificity inspector challenge will require.

What it does for the hospital

Produces a competent person psychosocial risk assessment that meets the section 8 standard. Conducted by trained practitioners, integrating validated quantitative methodology and rigorous qualitative depth, signed off by the assessment lead with the qualifications and audit trail required for defensibility.

Surfaces the specific psychosocial hazards present in the facility, with the severity ratings, the evidence base, and the recommended controls each requires. Where controls reference other Ignite Purpose programmes, the relationship is explicit. The Hazard Register sits at the heart of the wider engagement architecture.

Establishes the baseline against which the rest of the work is measured. Six month pulse and twelve month full re assessment built in, demonstrating the continuous review the amended Act's section 16 requires.

Deliverables

- Psychosocial Hazard Register formatted for integration into the Health and Safety Management System
- Culture Assessment Report suitable for board level review and external inspection
- Executive summary suitable for board minutes and HSMS sign off
- Domain by domain findings with department level disaggregation where data supports it
- Recommended controls register with named intervention pathways
- Twelve month re assessment schedule with documented review dates

BILL OBLIGATIONS ADDRESSED

Section 8. Workplace specific risk assessment by a competent person, covering all hazards including psychosocial.

Section 16. Continuous review obligation through the built in re assessment cycle.

Section 18. Identification of applicable regulations through the Hazard Register's regulatory mapping.

PROGRAMME 02

ARISE Resilience.

Workforce capability that carries the work.

What it is

ARISE is the workforce resilience programme. Originally validated with healthcare professionals through the 2024 Ignite Purpose Resilience Study and now delivered across industries, ARISE is a multi component intervention combining digital learning, group coaching, reflective practice, and real time tools. Ten weeks in the primary format. Adaptable to alternative configurations including full day intensive, online half day blocks, and app supported micro practice.

The clinical anchor is the Connor Davidson Resilience Scale, validated quantitative measurement of resilience capability. The 2024 study showed an average eleven point uplift on the scale across the participant cohort, with reductions in burnout, increases in psychological flexibility, and qualitative themes of restored sense of meaning and reduced moral injury.

The ten module curriculum covers Start Strong, Mindfulness, Expanding Self Awareness, The Armour We Wear (including the Nine Personas Framework), Rewriting the Inner Narrative, The Power of Acceptance, Rediscovering and Embracing You, Navigating Communication, Rewriting Your Story, and The Power of Teaming (including the HIVE model).

What it does for the hospital

Builds the individual emotional and cognitive capacity staff need to sustain work under conditions of pressure. The capacity that, in its absence, produces the burnout, moral injury, and disengagement the SocioSafety™ assessment surfaces. The capacity that, in its presence, allows staff to remain effective in conditions that would otherwise produce harm.

Provides the control measure that the Hazard Register names in response to specific workload, vicarious trauma, and emotional exhaustion findings. The Bill requires reasonably practicable controls. ARISE is one of the most evidenced and reasonably practicable controls available for this category of hazard.

Equips clinical staff with the specific resilience capabilities, the cognitive behavioural pathways, the acceptance and psychological flexibility, the positive psychology strengths, and the narrative identity work, that the international literature has established as the foundations of sustainable practice in high demand healthcare environments.

Deliverables

- Ten week programme with app supported micro practice, group coaching circles, and real time tools
- CD RISC baseline and outcome measurement, plus supplementary instruments
- Facilitator led group coaching with experienced practitioners
- Optional 1:1 coaching stream for participants requiring deeper individual work
- Programme completion report with cohort level outcomes for HSMS integration
- Alternative modalities available, full day intensive, online half day blocks, app plus coaching

BILL OBLIGATIONS ADDRESSED

Section 8. Reasonably practicable controls for workload, burnout, vicarious trauma, and emotional exhaustion hazards.

Section 9. Protection of staff from hazards arising from work activities, where the workforce capability is the protection.

PROGRAMME 03

Brave Leadership.

The leaders who hold the conditions.

What it is

Brave Leadership is the flagship leadership development programme. It develops the leadership behaviours that protect psychological safety, that hold space for difficult conversations, and that lead under pressure without producing harm through the leadership itself. The programme integrates ARISE pillars, BRAVE lessons, the six Ignite Purpose Domains, and the change journey into a single coherent leadership development architecture.

The six Ignite Purpose Domains, Ignite Respect, Clarity, Direction, Connection, Courage, and Growth, structure the development work. The four stage journey, Recognition, Practice, Integration, Becoming, paces the development. The three instruments, the 360, the Behaviour Profile, and HIVE, provide the diagnostic and measurement infrastructure.

In healthcare specifically, Brave Leadership is calibrated for the leadership challenges the sector produces. Clinical leaders promoted on technical expertise. Wide perception gaps between leaders and staff. The integration of clinical authority and managerial accountability. The specific behavioural work that leaders need to do in environments where the consequences of error are profound and the workforce conditions are sustained.

What it does for the hospital

Develops the leadership behaviours that the SocioSafety™ Leadership Behaviour domain assessment surfaces as gaps. Listening. Acknowledgement. Recognition. Honest conversation. The handling of mistakes. The visibility of leadership in the work the workforce is doing.

Closes the perception gap between leaders and staff that the healthcare assessment data consistently produces. The gap itself is one of the strongest predictors of disengagement, resignation, and incident under reporting. Closing it changes the structural conditions of the workforce in ways no policy can.

Equips leaders to lead the structural conversations the Bill makes unavoidable. The workload conversation. The vacancy conversation. The shift pattern conversation. The patient violence conversation. The conversations that, when leaders cannot hold them, become the conditions the workforce experiences as moral injury.

Deliverables

- Modular development programme across three delivery formats. Coaching, team work, full programme
- 360 degree assessment with debrief and growth plan facilitation
- Behaviour Profile assessment for development and team composition work
- HIVE assessment for collective leadership and team dynamics
- Mirror Sessions for senior leadership teams
- Programme completion report with cohort level leadership development outcomes

BILL OBLIGATIONS ADDRESSED

Section 8. Reasonably practicable controls for the Leadership Behaviour domain hazards surfaced in the Hazard Register.

Section 16. Development of the leadership capability the CEO accountability provision requires to be exercised meaningfully.

PROGRAMME 04

HR Transformation.

The structural systems that produce or relieve workload.

What it is

HR Transformation is the operating model and structural systems work. The HR architecture that produces or relieves the conditions the SocioSafety™ assessment surfaces. The four pillar framework, addressing operating model, talent architecture, capability and culture, and systems and rhythms, integrated through a three phase delivery sequence.

In hospitals, HR Transformation addresses the structural drivers behind the workload, autonomy, and role design findings. The staffing model. The shift architecture. The role design and scope of practice. The recruitment and retention pipeline. The decision rights framework. The performance and accountability systems. The work that the workforce cannot do, and that policy on its own cannot produce.

The programme draws on the Ignite Purpose HR Transformation framework, refined across engagements in family business and corporate contexts, and calibrated for healthcare through the methodology development work the OHS Amendment Bill has accelerated. The illustrative scenario in section seven describes how the structural HR work would land in a hospital setting.

What it does for the hospital

Redesigns the HR operating model to produce sustainable workforce conditions. Staffing levels that the demand justifies. Shift patterns that the human body can sustain. Role design that holds boundaries under pressure rather than producing chronic role creep.

Addresses the recruitment and retention systems that, in their current form, are unable to keep pace with the workforce attrition healthcare experiences. The pipeline. The orientation. The early career support. The career architecture. The conditions that produce retention rather than producing the conditions that produce resignation.

Establishes the systems and rhythms that the Health and Safety Management System needs to function. Incident reporting. Health and Safety Committee operations. Annual statistical reporting. Continuous review processes. The infrastructure that turns the documentation requirements into living systems rather than static documents.

Deliverables

- HR operating model design with named accountabilities, decision rights, and reporting rhythms
- Staffing model with workload calibration and shift architecture review
- Role design and scope of practice review for all role bands
- Recruitment pipeline and retention systems design
- Performance and accountability framework redesign
- HSMS systems integration, incident reporting, committee operations, annual statistics

BILL OBLIGATIONS ADDRESSED

Section 8. Reasonably practicable controls for workload, role design, and autonomy domain hazards.

Section 16. HR systems that produce the continuous review and continuous improvement the amended Act requires.

Section 17 to 20. Health and Safety representative and committee infrastructure integrated into HR operating model.

Section 24. Incident reporting systems including contractor incident integration and annual statistical reporting.

PROGRAMME 05

Culture Transformation.

The deeper work that no policy can do.

What it is

Culture Transformation is the deepest level of the work. The shared mental models, the unwritten rules, the cultural patterns that determine how the organisation actually behaves regardless of what the documents say. In hospitals, the cultural work is what produces the difference between a hospital that surfaces incidents and learns from them and a hospital that suppresses incidents and repeats them. The difference between a hospital that holds difficult conversations and a hospital that avoids them.

The five phase methodology, drawn from the Ignite Purpose Culture Transformation Programme, paces the work over eighteen to thirty six months. Diagnostic. Architecture. Activation. Integration. Sustainment. Each phase has its own methodology, its own deliverables, and its own evidence base. The work is informed by anonymised South African engagements in family business and corporate contexts.

What it does for the hospital

Addresses the cultural patterns the SocioSafety™ Relational Climate domain assessment surfaces. Bullying. Hierarchical tension. Suppressed incident reporting. The cultural patterns that produce the perception gaps the Leadership Behaviour domain documents. The work that, when it succeeds, changes the texture of daily life in the workplace.

Builds the cultural conditions that the Bill, in its deeper sense, is asking for. The culture that treats safety as a value rather than a compliance obligation. The culture that surfaces hazards rather than hiding them. The culture that produces leaders who can have difficult conversations and workforces willing to bring difficult information forward.

Establishes the cultural infrastructure that protects the workforce in ways that policy and process cannot. The Bill creates documents. Culture creates conditions. The conditions are the protection.

Deliverables

- Culture diagnostic integrating qualitative depth, artefact review, and structured interviews
- Culture architecture document describing the target cultural state and the journey to it
- Activation work with executive leadership, middle management, and frontline teams
- Integration work building the cultural patterns into the daily rhythms of the organisation
- Sustainment work establishing the ongoing cultural maintenance the work requires
- Eighteen to thirty six month programme with named milestones and evidence based progression

BILL OBLIGATIONS ADDRESSED

Section 16. The Health and Safety Management System needs the cultural conditions to function. Culture work is the precondition for the HSMS to live rather than to be archived.

Section 24. Incident reporting requires a culture that surfaces incidents. Cultural transformation is the precondition for the reporting system to capture what the workforce knows.

All sections. The cultural conditions determine whether the documented compliance work translates into actual protection. Culture is the meta level on which all other compliance obligations depend.

PROGRAMME 06

The IGNITE PURPOSE Transformation Framework.

The integration vehicle for the whole response.

What it is

The IGNITE PURPOSE Transformation Framework is the architecture that integrates the five programmes into a single coherent engagement. It is the framework through which the diagnostic informs the intervention, the intervention informs the re assessment, and the re assessment informs the next phase of work.

The five phases, Ignite, Engage, Enable, Embed, and Evolve, pace the work over twelve to thirty six months. Each phase has named deliverables, named accountabilities, and named transitions. Each phase integrates the relevant programmes at the right depth and at the right time. The framework is what turns five separate programmes into one transformation engagement.

For hospitals responding to the OHS Amendment Bill, the framework provides the integration that the Bill itself does not. The Bill creates obligations at four levels. The framework sequences the work across those levels in a way that produces defensible compliance alongside actual transformation, with the sequencing calibrated to the proclamation timeline and the workforce's capacity to absorb the change.

What it does for the hospital

Sequences the response work into a coherent engagement that addresses all four levels of change in the right order, at the right pace, with the right resources.

Provides the governance architecture, the executive sponsorship, the steering committee, the working group structure, the reporting rhythms, the milestone reviews, that the work requires to land rather than to dissipate.

Integrates the work into the existing operating rhythms of the hospital. Board reporting. Executive committee reporting. Health and Safety Committee operations. The framework does not bolt onto the hospital. It integrates with it.

Provides the evidence base for the work over time. The phase by phase outputs, the milestone reviews, the re assessment cycles, the cumulative evidence that the hospital has been acting in good faith on what it knows. The defensibility under inspector challenge that the work requires.

Deliverables

- Twelve to thirty six month engagement architecture with named phases, milestones, and accountabilities
- Executive sponsorship structure with monthly steering committee operations
- Phase by phase delivery with integrated programme sequencing
- Quarterly executive reporting suitable for board level review
- Annual milestone reviews with re assessment cycles built in
- Continuous improvement architecture for sustainment beyond the initial engagement

BILL OBLIGATIONS ADDRESSED

Section 16. The framework provides the continuous review architecture the CEO accountability provision requires.

All sections. The framework is the integration through which compliance with the Bill becomes a single coherent programme of work rather than a fragmented set of activities.

SECTION 07

An illustrative scenario.

Built from our healthcare workforce research and the sector evidence base. What a SocioSafety™ diagnostic would typically surface in a South African private hospital group of this size. What the integrated response would set out to do. And what the published research suggests the work produces.

IN THIS SECTION

HOW TO READ THIS SECTION

An illustrative scenario, not a case study.

The pages that follow describe what a SocioSafety™ engagement in a South African private hospital group would look like. The scenario is illustrative. The hospital described is not real. The findings described have not been produced by a single assessment of a single facility. The eighteen month outcomes described have not been measured against a specific engagement timeline. We want to be explicit about all of this at the outset, because the substance of what follows depends on the reader trusting the framing.

What is real is the underlying material. The five domain pattern. The conditions inside South African private hospitals as the published healthcare workforce research and our own sector evidence describes them. The structural features that make psychosocial risk in healthcare different from psychosocial risk in other sectors. The components of an integrated response that the OHS Amendment Bill and the published intervention research together suggest is the right architecture. The kind of movement the published evaluations of workforce condition interventions in healthcare consistently document.

We have written the scenario as a continuous narrative rather than as a research summary because that is how a hospital CEO or board chair encounters this work in practice. The diagnostic produces a story about the hospital. The story has a workforce in it. The story has leaders in it. The story has consequences. Presenting the research base only as ranges and percentages would obscure the lived texture the diagnostic actually surfaces, and would understate what a real engagement requires the leadership team to absorb. The lived texture is part of the work.

What the reader will find in this section

- A hospital group profile that reflects the typical structural conditions a SocioSafety™ assessment would engage with in South African private healthcare.
- Domain by domain findings that mirror the international healthcare workforce research and the patterns the wider sector evidence describes consistently.
- A response architecture sequenced as the IGNITE PURPOSE Transformation Framework would sequence it in a real engagement of this complexity.
- Eighteen month projections grounded in the published evaluations of comparable interventions, expressed as ranges with the basis named rather than as point estimates.

What this section is not. It is not a case study. It is not anonymised reporting from a specific delivered engagement. It is not a marketing document dressed as a case study. It is a research grounded illustration of what the work this paper describes looks like when it lands inside a real organisation.

THE EVIDENCE BASE

The scenario draws on three streams of evidence. The international healthcare workforce research on psychosocial risk and the structural conditions of clinical work. The published intervention research on what produces measurable improvement in healthcare workforce conditions over twelve to thirty six month windows. And our own framework and methodology development, which has been built and refined across transformation engagements in a range of sectors and contexts. Specific citations and the underlying research base are available on request.

THE SCENARIO

A mid sized private hospital group, three facilities, twelve hundred staff.

The hospital group in this scenario operates three acute care facilities across two South African provinces. Twelve hundred clinical and support staff. The group is mid sized by South African private healthcare standards. The conditions described match what the sector evidence consistently describes for groups of this size and operating model. Rising resignations among nursing leadership. A measurable uptick in serious incident reports through the clinical risk system. A board level conversation about culture that has been circling for two cycles without resolution. A CEO recently appointed, the second incumbent in three years, inheriting both the strategic priorities and the conditions that produced the previous turnover.

The trigger for an engagement of this kind typically comes through a board paper or a board level question that the executive team cannot cleanly answer. In our scenario, the board chair, reviewing the clinical risk dashboard, asks whether the rising incident rate is a function of better reporting, worse practice, or worse conditions. The executive team's instinct is to attribute it to better reporting. The data does not support that interpretation. This is the question that, in the healthcare workforce research, consistently surfaces when an organisation is operating at the edge of its workforce capacity but has not yet recognised that this is what is happening.

The starting conditions in the scenario mirror what the sector evidence describes as typical. A General Manager Human Resources holding the workforce wellbeing portfolio alongside the rest of the people function. An Occupational Health and Safety Manager based at the largest facility, with two part time coordinators across the other two. A Health and Safety Committee that meets quarterly. A risk assessment document several years out of date, covering physical and chemical hazards, with no psychosocial component. Safety representative coverage well below the Section 17 ratio. An Employee Assistance Programme with utilisation rates below the published industry benchmarks. A leadership team aware of the OHS Amendment Bill but treating it as a future problem rather than a present one. None of this is unusual in the South African private healthcare sector at present. It is the norm.

What the executive team would typically think the problem was

- A retention problem in senior nursing, particularly in theatre and intensive care, where market salary pressure from the Middle East and the United Kingdom is well documented and acute.
- A culture problem identified through staff survey work but resistant to the interventions previously commissioned.
- A clinical risk problem the quality and risk function is managing within the standard frameworks, but with diminishing returns.
- A compliance problem with the amended Act, sitting at low priority because the proclamation date is not yet announced.

These four framings are each accurate in part. None of them, individually or together, names what a SocioSafety™ diagnostic would surface. In the scenario, as in the underlying research pattern, the four problems are not four problems. They are four surfaces of the same underlying problem. And that problem is psychosocial, structural, and well documented in the international healthcare workforce research, but not yet named in the group's internal conversation.

> THE QUESTION THE BOARD CHAIR WOULD TYPICALLY ASK

Is the rising incident rate a function of better reporting, worse practice, or worse conditions?

The answer the research suggests is consistent across this pattern of conditions. It is all three. The reporting has improved. The practice has degraded. The conditions have deteriorated. The three are connected. The deterioration in conditions produces the practice degradation. The practice degradation produces the incidents. The reporting improvements simply reveal what was already happening. Naming this connection is the first piece of work the diagnostic does.

THE DIAGNOSTIC

What SocioSafety™ would typically surface across the three facilities.

A SocioSafety™ assessment in a hospital group of this scale would run over approximately eleven weeks. A validated quantitative survey instrument completed by the workforce, with the methodology calibrated to achieve a response rate above the threshold for representative findings, which in our experience is around seventy percent in healthcare settings where the leadership team actively supports participation. Forty or so qualitative interviews across clinical, nursing, allied health, and support functions. Fifteen to twenty focus groups stratified by department and shift pattern. Document review across the clinical risk register, the HR exit interview corpus from the preceding eighteen months, the existing risk assessment, and the Health and Safety Committee minutes for the same period.

The findings the diagnostic would produce in this scenario would mirror what the international healthcare workforce research consistently documents in private hospital groups operating under the structural conditions described. The headline pattern, typically common across all facilities though usually most acute at the largest, is a workforce operating at the edge of its capacity, with leadership behaviours that are themselves a function of that capacity strain, in a relational climate that has narrowed to transactional exchange because the conditions do not permit anything more. Each of the five SocioSafety™ domains would surface a specific pattern of findings. What follows draws on the published research and the typical patterns the methodology surfaces in this kind of setting.

Workload domain. Severe.

In hospital groups of this profile, the international research consistently documents nurse to patient ratios on night shifts substantially above the safe standard, often running at one to twelve or higher in general wards against an internal standard of one to eight. Theatre lists expanding year on year without corresponding increases in scrub nurse establishment. Handover times compressed to absorb operational pressure. The cumulative effect surfaces in the qualitative work in language that recurs across the research base. Staff describe the work as no longer being the work they trained for. The phrase production line is one that healthcare workforce researchers have documented appearing spontaneously in theatre teams under sustained capacity strain.

Autonomy domain. Moderate to severe.

Clinical decision making in groups of this profile has typically become increasingly mediated by protocols designed for risk management purposes. The intent of the protocols is defensible. The cumulative effect on the workforce, well documented in the autonomy and professional judgement research, is that experienced clinicians feel their professional judgement is being treated with suspicion. The escalation pathways for protocol exceptions become slow and procedurally heavy. The workforce response is a quiet narrowing of practice to the protocol envelope, with the cases that do not fit being managed through informal workarounds rather than escalation. This is one of the strongest predictors of long term clinical risk that the published research identifies, and one of the patterns most consistently missed by clinical risk frameworks that focus on incident reporting rather than on the conditions that produce incidents.

Relational climate domain. Severe at the largest facility, moderate at the others.

Patient violence and aggression in South African healthcare settings is a documented and escalating concern, particularly in emergency departments serving high acuity populations. In a hospital group of this profile, the diagnostic would typically surface eighty to one hundred documented incidents in the preceding twelve months at the largest facility's emergency department, with ten to fifteen percent resulting in physical injury to staff. The pattern is, in our sector experience and in the published research, typically being treated as a security and

infrastructure issue. The psychological impact on the affected staff is rarely being addressed systematically. Debriefing is ad hoc. Time off after serious incidents is discretionary. The qualitative work surfaces, with painful consistency, the workforce conclusion that the published research has documented in healthcare settings worldwide. That the patient matters, the doctor matters, and the nurse who was assaulted on Tuesday does not.

Role design domain. Moderate.

In hospital groups of this profile, role boundaries have typically blurred over recent years as administrative support has been reduced and the resulting work absorbed into clinical roles. Ward managers carry procurement, rostering, complaints handling, and incident investigation alongside their clinical leadership responsibilities. The job descriptions do not reflect the actual work. Performance conversations are therefore disconnected from what is actually being done. Moral injury, a construct that has moved to the centre of the healthcare workforce research in the post pandemic period, surfaces consistently in the qualitative work, particularly among middle level clinical leaders who describe being asked to deliver standards they no longer have the resources to support.

Leadership behaviour domain. Moderate.

Executive level leadership in scenarios of this kind is typically not the surfaced problem. The pattern is more specific and more structural. Middle level clinical leaders, the unit managers and shift leaders, have been promoted into roles that have expanded faster than their development. The group has not invested in clinical leadership development at this level. The behaviours the assessment surfaces are not pathological. They are the behaviours of leaders who have not been equipped for the role the conditions now require of them. The published research on perception gaps between executive and frontline assessment of workplace conditions in healthcare puts the typical gap, in organisations under structural strain, at between twenty and thirty percentage points. The diagnostic would surface a gap in that range, with the specific value depending on the conditions in the particular group.

THE INTEGRATION

What the findings would mean when read together.

The Psychosocial Hazard Register would typically list fifteen to twenty named hazards across the five domains in a group of this size, each with severity rating, evidence base, and recommended control pathway. The Culture Assessment Report would read them as a single pattern. The four surfaces the executive team had been managing separately, retention, culture, clinical risk, and compliance, are the visible expressions of the underlying pattern the diagnostic surfaces.

The retention problem in senior nursing is not primarily a salary problem. It is a conditions problem expressing itself through salary comparison. Staff who leave for the Middle East or the United Kingdom cite salary in their exit interviews. The qualitative work surfaces a different account. Staff leave because the work has stopped being recoverable at the end of a shift. The salary is the reason they can give. The conditions are the reason they go. The healthcare retention research is unambiguous on this point. Salary is the surface variable. Conditions are the driver.

The culture problem is not primarily a values or behaviour problem. It is a structural problem expressing itself through cultural symptoms. The values and behaviours have narrowed because the conditions have narrowed what is possible. Previous culture interventions have targeted the symptoms. The diagnostic would surface the structural cause.

The clinical risk problem is not primarily a practice problem. It is a conditions problem expressing itself through practice degradation. Staff working at the edge of their capacity, in a relational climate that has transactionalised, with role boundaries that have blurred, under leaders who have not been equipped for the role the conditions require, produce the incident pattern the dashboard shows. The clinical risk function has been correctly recording the symptoms. The cause is upstream of clinical risk. This is the most consistent finding in the healthcare workforce safety research over the past decade, and the one that most predictably reorients an executive team's view of the work.

The compliance problem is not a future problem. It is a present problem the Bill is about to make visible. The risk assessment does not meet the Section 8 standard. The Health and Safety Management System does not exist in the form Section 16 requires. The representative ratio is half what is required. The incident reporting does not meet the reportable definition the amended Act expands. The administrative fine exposure alone is material. The criminal liability exposure, given the documented incidents and the documented absence of controls, is more material than the executive team typically appreciates before the diagnostic surfaces the connection.

THE RESPONSE

The eighteen month integrated programme.

The response in a scenario of this kind would be structured through the IGNITE PURPOSE Transformation Framework. Five phases, eighteen months to the first major milestone, with the engagement architecture sequenced to match the workforce's capacity to absorb the work and the proclamation timeline as it became visible. The five programmes would sit within the framework, each addressing the surfaces the diagnostic had named, each timed to enter at the right depth at the right moment. What follows is the architecture we would propose for a hospital group of this scale and complexity, calibrated to the findings the diagnostic would surface.

Phase one. Ignite. Months one to three.

Executive sponsorship structure established with monthly steering committee chaired by the CEO. The CEO takes personal accountability for the Health and Safety Management System development, as Section 16 requires. The board receives the Culture Assessment Report and the Psychosocial Hazard Register, formally adopts the hazard findings, and approves the response architecture. The General Manager Human Resources and the Occupational Health and Safety Manager are positioned as co leads, with named working group sponsorship across the five programmes. The framing language across the group shifts from culture project to workforce transformation, with the OHS Amendment Bill named as one driver among several rather than the primary driver. This is deliberate. Hospitals that frame the work as compliance produce compliance documents. Hospitals that frame it as transformation produce both.

Phase two. Engage. Months two to six.

ARISE Resilience enters first at the workforce capability layer, with the healthcare calibrated cohort design described in section six of this paper. The first cycle typically targets four hundred or so staff in a workforce of this size, with theatre, ICU, emergency, and maternity prioritised on the basis of the diagnostic findings. The early cohorts are used to validate the healthcare calibration of the programme content for the specific facility. Feedback informs the design of subsequent cycles. Brave Leadership enters at the middle leader layer simultaneously. Around sixty unit managers, shift leaders, and clinical educators enrolled in the development programme. The combination, capability work below and leadership work above, is the structural intervention the relational climate domain requires. The clinical risk function is integrated into the response architecture rather than left to operate in parallel, with the incident reporting pathway redesigned to surface the psychosocial dimension of clinical incidents that the previous taxonomy obscured.

Phase three. Enable. Months four to twelve.

HR Transformation enters at month four. The role design work is typically the immediate priority, with the ward manager role specifically redesigned to remove the procurement, rostering complexity, and complaints administration that has accumulated. The administrative support that has been removed in recent years is, in part, restored. The performance management framework is redesigned to align with the work actually being done. The shift pattern work, which the workload domain findings would flag as severe, is renegotiated facility by facility, with the night shift ratios returning to one to ten as an interim target and one to eight as the twelve month target. The new representative structure is established, with elected representatives at the one in fifty ratio across the facilities, with protected time and committee operations reset to the two monthly cadence the amended Act requires. The Health and Safety Management System is developed, signed off by the CEO, and integrated into the board reporting rhythm.

Phase four. Embed. Months nine to fifteen.

Culture Transformation enters at month nine. By this point the structural conditions have shifted sufficiently that culture work can land. Patient violence protocols are rebuilt with mandatory debriefing, paid recovery time after serious incidents, and a Patient Aggression Response Team operating across the largest facility's emergency

department. The leadership cohort reaches the integration phase of the Brave Leadership programme and carries the cultural conditioning work back into the units. The board reporting cycle now includes a quarterly workforce conditions report alongside the clinical risk report, with the two reports read together. The first six month SocioSafety™ pulse re assessment is completed at month twelve. The research suggests headline findings at this point would typically show measurable movement in the workload, relational climate, and role design domains, with leadership behaviour and autonomy still in motion.

Phase five. Evolve. Months fifteen and beyond.

The first full SocioSafety™ re assessment is scheduled for month eighteen, with the second twelve months later, establishing the continuous review architecture Section 16 requires. The engagement architecture transitions at month eighteen to a sustainment model with named milestone reviews at six, twelve, twenty four, and thirty six months. The Health and Safety Management System has named annual review cycles tied to the re assessment dates. The clinical risk register and the Psychosocial Hazard Register operate as integrated documents read together at board level. The framework is no longer being imposed on the group. It has become the way the group operates.

THE RESEARCH GROUNDED OUTLOOK

What the published evidence suggests this work produces.

This is the section that, in a delivered case study, would report the measured outcomes at the eighteen month milestone. Because this scenario is illustrative rather than retrospective, what follows is different in kind. It is what the published research on comparable interventions in healthcare workforces suggests this combination of work produces. The ranges are drawn from the international healthcare workforce intervention literature, calibrated where relevant for the South African context, and presented honestly as projections rather than measured outcomes. They are not promises. They are what the evidence base supports as realistic expectations of what the work can produce when it lands well.

Three caveats matter at the outset. First, ranges in the research vary considerably depending on starting conditions, depth of executive sponsorship, and the fidelity with which the response architecture is delivered. A hospital with a more engaged CEO and a more receptive workforce can produce movement at the upper end of these ranges. A hospital with a contested executive team and a workforce that has been through previous failed interventions can produce movement at the lower end, or none. Second, the eighteen month window is short for some of this work. Workload and autonomy improvements typically continue accruing into months twenty four to thirty six. Third, what gets measured matters. The published research measures different things differently. We have chosen, in what follows, the indicators that the healthcare workforce intervention research most consistently reports.

What the structural compliance work would deliver

- **Section 8 risk assessment.** A workplace specific written risk assessment in place across the three facilities, integrating physical, chemical, biological, and psychosocial hazards. Conducted by competent persons, signed off, with the Psychosocial Hazard Register integrated. Defensible under inspector challenge.
- **Section 16 Health and Safety Management System.** A documented HSMS with CEO sign off, board level reporting rhythm established, continuous review architecture in place with the re assessment cycles built in. The CEO accountability the amended Act requires is structurally embedded rather than nominally claimed.
- **Section 17 representative ratio.** Representatives at the one in fifty ratio across the three facilities, elected, trained, with protected time and committee operations on the two monthly cadence. The structural compliance gap is closed.
- **Section 24 incident reporting.** Incident reporting pathway redesigned, contractor incidents included, annual statistics process established with the March deadline embedded in the operating calendar. Reportable incident definition aligned to the amended Act's expanded scope.
- **Workforce capability.** Six hundred or so staff through ARISE Resilience across the first two cycles in a workforce of this size. A workforce that has language and tools for the conditions it is working in.
- **Leadership development.** Sixty middle leaders through the Brave Leadership programme. The qualitative work surfacing the change in relational climate the leadership behaviour shift produces.

What the research predicts the work produces

The figures that follow are the typical ranges reported in published evaluations of comparable healthcare workforce interventions. They are presented here as research grounded projections, not as outcomes from a delivered engagement. The specific value a real engagement would produce depends on the starting conditions, the depth of executive sponsorship, and the fidelity of delivery. The basis for each range is named below the figure.

20 to 40%

Typical range of reduction in voluntary nursing resignations the healthcare retention intervention research reports for integrated programmes of this kind over an eighteen month window. The published evaluations of comparable workforce condition interventions in healthcare consistently produce movement in this range, with the upper end achieved where the structural workload work lands fully.

10 to 15 pp

Typical range of narrowing in the perception gap between executive leadership and frontline staff on workplace conditions, drawn from the published healthcare leadership intervention research. The remaining gap is typically the next phase of work and continues to narrow over months eighteen to thirty six.

15 to 25%

Typical range of reduction in serious clinical incidents the healthcare workforce condition intervention research reports, particularly where the patient violence protocols and the workload domain work land together. The steepest improvement is usually documented in the high acuity departments where the protocols are redesigned first.

Citation note. The specific publications underlying these ranges, including the meta analytic work on healthcare workforce interventions, the published evaluations of comparable integrated programmes, and the South African context literature, are available on request as a supporting reference list. We have not included specific citations in the body of this paper because the paper is positioned for hospital executive audiences rather than for academic review. The research base is, however, substantial and would form part of any formal engagement scoping discussion.

What would still be in motion at month eighteen

- The workload domain is typically the most stubborn. Night shift ratio targets are rarely fully reached within eighteen months. The recruitment market for senior nurses in South Africa is what it is. The work to reduce reliance on agency cover continues into months twenty four and beyond.
- The autonomy domain typically improves more slowly than the others. The protocol envelope work is genuinely difficult. Months twelve to twenty four focus specifically on the escalation pathway redesign and on the development work that builds protocol exception judgement among middle clinical leaders.
- Patient violence work typically reduces incidents materially at the facility where the protocols are redesigned first. Extending the protocols across the other facilities is a second phase of work, usually running months fifteen to twenty four.

- The clinical risk integration with the Psychosocial Hazard Register is typically functional but not yet seamless at month eighteen. The two registers are read together at board level. The operational integration at unit level usually requires further development. This is genuinely difficult integration work and is where the sustainment phase focuses.

What we would expect the leadership team to be saying at month eighteen

> *The pattern is consistent across the published evaluations of integrated programmes of this kind. At month eighteen, the leadership conversation has typically shifted from one that treats workforce conditions as a problem of the HR function to one that treats workforce conditions as a board level governance matter. The CEO is more confident under inspector challenge. The board is reading the workforce conditions report alongside the clinical risk report. The executive team is treating workforce sustainability as core to clinical quality rather than as a separate workstream. This is the structural shift the work is designed to produce. It is what we would expect to see in a real engagement of this design.*

LEADERSHIP QUESTION

If your hospital received a SocioSafety™ assessment in the next ninety days, what is the question you would most want it to answer, and what is the question you would most fear it asked? The two are usually the same question. The honesty of that recognition is the starting point for the work this paper describes.

SECTION 08

The path forward.

Twelve months, three questions, one partnership. What hospital boards should be doing now, before the proclamation date, and what the engagement model looks like in practice.

IN THIS SECTION

THE TIMING

Twelve months to the proclamation date is not a long time.

The amended Act has been passed by Parliament. The proclamation date has not, at the time this paper is being written, been announced. The conventional assumption inside hospital management teams is that the proclamation will happen with notice and that the notice period will be sufficient to prepare. The historical pattern, across multiple South African regulatory regimes, suggests that this assumption deserves more scrutiny than it usually receives. The Mine Health and Safety amendments came with shorter notice than the sector expected. The POPI Act commencement was telegraphed for years and then proceeded on a timeline that surprised many organisations. The pattern is that the proclamation arrives when the regulatory readiness allows, not when the regulated sector requests.

The realistic working assumption is that hospitals have between six and eighteen months. The lower end of that range is the proclamation scenario most hospitals are not prepared for. The upper end is the scenario that allows for genuine transformation work to be in motion at the point of commencement. The work this paper has described, the Section 8 risk assessment, the Section 16 HSMS, the representative restructure, the incident reporting redesign, and the underlying transformation work the diagnostic surfaces, does not compress neatly into six months. Some of it can. The full architecture cannot.

What is realistic in twelve months

- Full SocioSafety™ diagnostic completed, Psychosocial Hazard Register integrated into the HSMS, Section 8 standard met. This is the highest priority because it is the foundation everything else builds on, and because the timeline pressure on the diagnostic is the lowest. Eight to twelve weeks of fieldwork, four to six weeks of analysis and reporting.
- Section 16 Health and Safety Management System documented, signed off by the CEO, integrated into board reporting. This can be done in parallel with the diagnostic work and the documentation can be substantially complete within four months.
- Section 17 representative structure rebuilt to the one in fifty ratio, with training and protected time. Three to six months depending on the size of the workforce and the existing election infrastructure.
- Section 24 incident reporting redesigned to the expanded reportable definition, with contractor coverage and annual statistics process embedded. Three to four months to redesign and embed.
- ARISE Resilience entered with the priority cohorts. First cohort enrolled and in delivery within three to four months. First full cohort cycle complete within nine months.
- Brave Leadership entered with the middle leader cohort. First cohort enrolled within four months. First cycle complete within ten months.

What is not realistic in twelve months

- Full HR Transformation across role design, performance management, workforce planning, and the integration with the workforce wellbeing architecture. This is twelve to eighteen month work in its own right. It enters in the first twelve months. It does not complete in the first twelve months.
- Full Culture Transformation. Culture work requires the structural conditions to be moving before culture work itself can land. This is eighteen to thirty six month work. It enters at month nine or ten of the first twelve, not at month one.
- Full closure of the perception gap between leadership and frontline. The perception gap closes as the conditions close. Both take time. Eleven to twelve months of integrated work produces measurable narrowing. The full closure is two to three year work.

- Resolution of the structural workload constraints that the workforce market and the funding environment produce. These are sector level constraints that no single hospital can resolve alone. The work is to operate inside the constraints in a way that protects the workforce. Resolution is not on the table for any single hospital in any twelve month window.

The implication of the realistic and not realistic columns is that the twelve month window allows hospitals to meet the compliance obligations of the amended Act and to be visibly in motion on the transformation work, with credible evidence that the transformation work has been entered in good faith. The defensibility under inspector challenge that this combination produces is, in our experience, the practical target for the first twelve months. It is not the same as full transformation. It is the position from which full transformation continues to be built.

THE BOARD CONVERSATION

Three questions every hospital board should ask now.

These three questions are the questions that, in our experience, separate hospitals that will be ready at proclamation from hospitals that will not. They are not legal questions. They are governance questions. They are questions the board itself needs to answer, not questions the board needs management to answer on its behalf. The distinction matters. Section 16 of the amended Act puts personal accountability on the CEO. The governance accountability for ensuring the CEO is positioned to discharge that responsibility sits with the board.

QUESTION ONE

Does our CEO have a signed, documented Health and Safety Management System, and is it under continuous review?

The amended Act's section 16 is unambiguous. The CEO develops, implements, and continuously reviews the HSMS. The accountability is personal and cannot be sub delegated. The board's question is whether the CEO is positioned to do this, and whether the HSMS exists in a form that would survive inspector review.

- **Answer that indicates readiness.** Yes, the HSMS is documented, signed by the CEO, presented quarterly to the board, and reviewed at minimum annually. The CEO can produce it within an hour of an inspector arriving on site.
- **Answer that indicates a gap.** We have OHS policies and procedures, and the CEO has signed off on the OHS framework. Variant. We are working on it and expect to have it in place within X months.
- **Answer that indicates a serious gap.** The Occupational Health and Safety Manager handles this. The HSMS is in the OHS department.

QUESTION TWO

Does our written risk assessment include psychosocial hazards, with documented controls for each, conducted by competent persons using validated methodology?

Section 8 of the amended Act requires the risk assessment to cover all workplace hazards. Psychosocial hazards are workplace hazards. The board's question is whether the assessment that has been done meets the standard, not whether an assessment exists in some form.

- **Answer that indicates readiness.** Yes, the assessment was completed by a qualified practitioner, included a validated psychosocial measurement instrument and qualitative depth work, produced a formal Psychosocial Hazard Register that is integrated into the HSMS, and has named re assessment dates.
- **Answer that indicates a gap.** We have a risk assessment. The psychosocial component is being developed. Variant. We do staff surveys annually and that covers wellbeing.
- **Answer that indicates a serious gap.** The risk assessment covers physical and chemical hazards. Psychosocial sits with HR and the Employee Assistance Programme.

QUESTION THREE

Are we submitting annual incident statistics to the Department of Employment and Labour by the first of March, with contractor incidents included?

Section 24 of the amended Act requires annual incident statistics to be submitted by the first of March each year. Contractor incidents must be included. The board's question is whether this is happening, and whether the underlying incident reporting captures what the amended definition requires.

- **Answer that indicates readiness.** Yes, the annual statistics were submitted by the first of March, contractor incidents are captured in the reporting system, and the executive team reviews the data quarterly. We can show you the submission confirmation.
- **Answer that indicates a gap.** We report serious incidents to the Department. The annual statistics submission process is being established. Variant. We are aware of the requirement and are working on it.
- **Answer that indicates a serious gap.** I would need to check whether that submission has been made. Variant. The OHS Manager would know. Variant. Contractor incidents are managed through the contractor's own employer.

THE PARTNERSHIP

How an Ignite Purpose engagement begins.

The engagement model has been built and refined through transformation work across a range of sectors and contexts, with the healthcare specific calibration developed through the methodology work the amended Act has accelerated. The starting point is a structured discovery conversation that produces the framing for the engagement before the engagement formally begins. The conversation is not a sales conversation. It is the first piece of the diagnostic. It is, in our experience, the conversation that determines whether the work that follows will land.

Step one. The discovery conversation.

Ninety minutes, with the CEO, the General Manager Human Resources, and the Occupational Health and Safety Manager. Conducted at the hospital, ideally with a walk through the facility before the conversation. The agenda covers the current state of the OHS architecture, the current state of the workforce conditions as the leadership team sees them, the strategic priorities the response needs to integrate with, and the partnership model that fits the hospital's context. The output is a structured discovery note that frames the engagement options and the realistic timelines.

Step two. The board orientation.

Optional, but recommended for hospitals where the board has not yet been formally engaged on the amended Act and its implications. A ninety minute board paper and presentation that frames the regulatory context, the hospital's current readiness position, and the strategic choices the response architecture invites. This is not the engagement itself. It is the orientation that allows the board to formally adopt the response architecture once the engagement begins.

Step three. The engagement architecture.

Drawing on the discovery output, the engagement architecture is proposed in writing. The phases. The programmes. The timeline. The investment. The accountabilities. The governance. The proposal is structured to be read by a hospital board and approved as a single piece of work, not as a series of separate procurement decisions. The intent is to make the integration the engagement requires visible at the procurement stage, not to leave it to emerge later.

Step four. The SocioSafety™ diagnostic.

The diagnostic is the first formal phase of the engagement. Eight to twelve weeks of fieldwork. The output is the Psychosocial Hazard Register, the Culture Assessment Report, and the framing for the rest of the work. For hospitals that want to test the engagement before committing to the full architecture, the diagnostic can be commissioned as a standalone phase, with the rest of the architecture sequenced after the findings are known. Most hospitals contract the full architecture in advance with the understanding that the diagnostic findings will shape the detail of the subsequent phases.

Step five. The integrated programme delivery.

The five programmes enter in the sequence and at the depth the IGNITE PURPOSE Transformation Framework prescribes, calibrated to the diagnostic findings. The governance architecture, the executive sponsorship, the working group structure, the reporting rhythms, the milestone reviews, operate from month one. The board receives a quarterly workforce conditions report alongside the standard clinical risk report. The re assessment cycles operate at six and twelve months and become the continuous review architecture the amended Act requires.

WHAT WE BRING	WHAT THE HOSPITAL BRINGS
The framework, the diagnostic methodology, the programme curricula, the assessment instruments, and the engagement architecture, all calibrated for South African healthcare.	The CEO sponsorship, the executive sponsorship structure, the working group leadership, the operational coordination, and the willingness to move on what the diagnostic surfaces.
The practitioners, healthcare experienced, accredited where accreditation is relevant, with the qualifications inspector challenge requires.	The internal champions and the protected time the work requires from the workforce, particularly the safety representatives, the middle leaders, and the clinical educators.
The integration with the Health and Safety Management System, the Hazard Register, the clinical risk register, and the board reporting architecture.	The integration into the existing operating rhythms, the procurement and contracting infrastructure, and the strategic planning cycles.
The evidence base. The phase by phase outputs, the re assessment cycles, and the cumulative documentation the defensibility under inspector challenge requires.	The accountability for the work landing inside the organisation rather than the work sitting outside it. The transformation is the hospital's, not ours.

A CLOSING WORD

To the hospital boards and CEOs reading this paper.

The OHS Amendment Bill is going to land. The proclamation date will be set. The inspectors will arrive at hospitals across the country with the expanded powers the amended Act gives them. Administrative fines will be issued on the spot. Criminal liability will be tested in cases where serious harm has been caused and the prior absence of controls is documentable. The hospitals that have done the work in advance will be in a different position from the hospitals that have not. This is not speculation. It is the visible direction of the regulatory environment and it has been visible for some time.

The honest reading of where most South African hospitals sit today is that the work the amended Act requires has not been done**. The risk assessments do not meet the section 8 standard.** The HSMS does not exist in the form section 16 requires. The representative ratios are far below what section 17 specifies. Incident reporting is patchy, contractor coverage is weak, and the annual statistics submission is, in many cases, not happening. The psychosocial dimension is, in the majority of hospitals, entirely unaddressed.

This is not a criticism. It is an account of where the sector is. The amended Act will move the sector. The question is whether each hospital will be moved by the Act and the inspectors enforcing it, or whether each hospital will move itself in the time the proclamation timeline still allows.

Our position, drawing on the published healthcare workforce research and on the methodology work we have built across transformation engagements in a range of sectors, is that the hospitals that move themselves produce better outcomes for their workforce, better outcomes for their patients, better outcomes for their boards, and stronger evidence of good faith effort under inspector challenge. The hospitals that wait to be moved produce worse outcomes on every dimension. The amended Act is the trigger. The transformation is the response. The two are not the same thing, and the difference matters more than the deadline does.

If this paper has surfaced questions you do not yet have clean answers to, that is the right outcome. The next conversation is the discovery conversation described in section eight point three. We would be glad to have it.

With every good wish for the work ahead,

The Ignite Purpose team

Transforming workforces, leaders, and the conditions of care.

I G N I T E P U R P O S E

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T H E N E X T C O N V E R S A T I O N

A ninety minute discovery conversation with your CEO, GM Human Resources, and Occupational Health and Safety lead. Conducted at your facility. No obligation beyond the conversation itself.

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Contact: wilma@igitepurposeafrica.com to arrange a consultation.