



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



ANNUAL REPORT

2025/2026

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PART

A

GENERAL INFORMATION

1. PUBLIC ENTITY'S GENERAL INFORMATION

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EXTERNAL AUDITORS: Auditor-General of South Africa
PO Box 446
Pretoria
0001

BANKERS: Standard Bank

CHAIRPERSON OF THE BOARD: Dr Reno Morar

CHIEF EXECUTIVE OFFICER: Dr Siphiwe Mndaweni

COMPANY/ BOARD SECRETARY: Adv Karabo Sibanyoni

2. LIST OF ABBREVIATIONS/ACRONYMS

AGSA	Auditor-General of South Africa
AI	Artificial Intelligence
APP	Annual Performance Plan
AR	Annual Returns
ARF Committee	Audit, Risk and Finance Committee
AU	African Union
B-BBEE	Broad-Based Black Economic Empowerment
BHF	Board of Healthcare Funders
CAU	Complaints Assessment Unit
CCC	Complaints Call Centre
CEC	Certification and Enforcement Committee
CEO	Chief Executive Officer
CHCs	Community Health Centers
CIU	Complaints Investigation Unit
CPD	Continuous Professional Development
DGMAH	Dr George Mukhari Academic Hospital
DMA	Disaster Management Act
DRP	Disaster Recovery Plans
EC	Eastern Cape
EMS	Emergency Medical Services
EWS	Early Warning System
FS	Free State
GBAC	Group Based Access Control
GCIS	Government Communication and Information System
GPs	General Practices
GPS	General Practitioner Surveillance
HASA	Hospital Association of South Africa
HEs	Health Establishments
HR	Human Resources
HO	Health Ombud
HoD	Head of Department
HPCSA	Health Professions Council of South Africa
HRREM Com	Human Resource and Remuneration Committee
HSDAS	Health Standards Design, Analysis and Support
HWSETA	Health Welfare Sector Education and Training Authority
ICT	Information and Communication Technology
IRFA	Intergovernmental Relations Framework Act
KZN	KwaZulu-Natal
MEC	Member of the Executive Council
MTDP	Medium Term Development Plan
NCMHH	Northern Cape Mental Health Hospital

NDoH	National Department of Health
NDP	National Development Plan
NHA	National Health Act
NHAA	National Health Amendment Act
NHI	National Health Insurance
NHLS	National Health Laboratory Service
NPM	National Preventive Mechanism
NPQ	National Policy on Quality
NW	North West
OEM	Original Equipment Manufacturer
ODMWA	Occupational Diseases in Mines and Works Act
OHSC	Office of Health Standards Compliance
PAIA	Promotion of Access to Information Act
PAJA	Promotion of Administrative Justice Act
PFMA	Public Finance Management Act
PHC	Presidential Health Compact Summit
POPIA	Protection of Personal Information Act
PPTH	Pietersburg Provincial Tertiary Hospital
PPFA	Preferential Procurement Policy Framework Act
QIPs	Quality Improvements Plans
RBI	Risk Based Inspection
RMSH	Robert Mangaliso Sobukwe Hospital
SANC	South African Nursing Council
SAS	Self-Assessment System
SLA	Service Level Agreement
SADTC	South African Dental Technicians Council
SAHPRA	South African Health Products Regulatory Authority
SAMLA	South African Medico-Legal Association
SCM	Supply Chain Management
SDA	Skills Development Act
SRTTT	Scientific and Research Technical Task Team
TWG	Technical Working Group
UFPF	Unity Forum of Family Practitioners
UHC	Universal Health Coverage
WDGMC	Wits Donald Gordon Medical Centre



Dr Reno Morar

Chairperson of the Board

3. FOREWORD BY THE CHAIRPERSON

The Board of the Office of Health Standards Compliance (OHSC) commenced its new term of office in February 2026, at an important moment in South Africa's healthcare journey. As the country continues to pursue universal access to quality healthcare, the role of an independent, credible and effective health regulator has never been more important.

Although this Board was appointed towards the end of the reporting period, we are pleased to present the Annual Report of the OHSC for the 2025/2026 financial year. This report reflects the organisation's performance during a period characterised by significant opportunity, increasing public expectations, fiscal constraint and a rapidly evolving healthcare environment. It also provides a platform from which the newly constituted Board can articulate its strategic priorities and reaffirm its commitment to strengthening governance, organisational capability and regulatory excellence.

The Board fully recognises the statutory responsibilities entrusted to the OHSC under the National Health Amendment Act, 2013. The organisation occupies a unique and essential position within South Africa's health system, safeguarding the rights of health service users by monitoring and enforcing compliance with prescribed norms and standards for healthcare establishments. Through this mandate, the OHSC contributes directly to improving patient safety, promoting accountability

and strengthening public confidence in both the public and private health sectors.

During the year under review, the OHSC continued to demonstrate resilience despite operating within a constrained fiscal environment. The organisation maintained overall organisational performance reflecting continued operational stability while also highlighting important areas requiring strategic attention and institutional strengthening. The new Board views this performance not only as a measure of organisational achievement but also as an opportunity to drive continuous improvement and position the OHSC for greater impact in the years ahead.

Notable progress was made across the organisation's core regulatory functions. The OHSC continued to strengthen the development and implementation of health standards, certification processes and regulatory enforcement activities. A significant milestone was the successful implementation of the General Practices' inspection tool during the 2025/2026 financial year, extending regulatory oversight to an important component of primary healthcare. During the reporting period, the organisation inspected 975 health establishments, comprising 762 public sector and 213 private sector facilities, thereby continuing to promote compliance with national norms and standards across the healthcare system.

The Board also welcomes the progress made towards enhancing the long-term sustainability of the organisation. The development of a proposed revenue-generation model and the drafting of supporting regulations represent important steps towards strengthening the OHSC's financial resilience, consistent with its legislative mandate. Once approved, these measures will contribute to a more sustainable funding model capable of supporting the organisation's expanding regulatory responsibilities.

As we look ahead, the Board recognises that the healthcare regulatory landscape is becoming increasingly complex. To remain an effective regulator, the OHSC must continue to strengthen its institutional capability through strategic investment in digital transformation, data analytics, information management and specialised human capital. These capabilities will enable more responsive regulation, improved risk identification and evidence-informed decision-making, while enhancing transparency and public confidence in the organisation's work.

Equally important is the development of a future-focused workforce. The Board has identified the formulation of a comprehensive Human Resource Strategy as a priority to ensure that the organisation attracts, develops and retains the highly specialised expertise required of a modern health regulator. Building organisational capability will be fundamental to achieving regulatory excellence and sustaining long-term institutional performance.

The Board firmly believes that effective regulation depends not only on statutory authority but also on constructive partnerships. We therefore remain committed to strengthening relationships with the National Department of Health (NDoH), provincial health departments, healthcare establishments, professional councils, organised civil society and all stakeholders who share responsibility for improving

healthcare quality in South Africa. Transparency, accountability and meaningful stakeholder engagement will remain central principles guiding the work of the OHSC.

Looking forward, our vision is for the OHSC to become an agile, innovative and intelligence-driven regulator that contributes meaningfully to strengthening South Africa's health system. We see the organisation not only as an enforcer of standards, but as a trusted partner in advancing a culture of quality improvement, patient safety and organisational learning across the healthcare sector.

On behalf of the Board, I wish to express our sincere appreciation to the Minister of Health, the Deputy Minister of Health, the Director-General of Health, our regulatory partners, healthcare establishments, organised stakeholders and the South African public for their continued support and engagement. I also acknowledge the commitment of the Chief Executive Officer (CEO), executive management and every employee of the OHSC, whose professionalism and dedication continue to advance the organisation's important mandate.

Together, we have an opportunity to strengthen public confidence in our healthcare system and ensure that every person in South Africa receives healthcare that is safe, respectful and of the highest possible quality. The Board looks forward to working collaboratively with all stakeholders as we build a stronger, more accountable and more resilient health system for present and future generations.



Dr Reno Morar
Chairperson of the Board
Office of Health Standards Compliance

Date: 31 July 2026



Dr Siphiwe Mndaweni

Chief Executive Officer

4. CHIEF EXECUTIVE OFFICER'S OVERVIEW

The 2025/2026 financial year represented a period of progress, reflection, and strategic recalibration for the OHSC. Operating within a constrained fiscal environment and an increasingly complex healthcare landscape, the OHSC remained committed to its core mandate of protecting and promoting the quality and safety of healthcare services through effective regulation and oversight.

During the year under review, the OHSC achieved 72% (18/25) of its planned targets, demonstrating continued progress across key programmes while acknowledging areas for improvement. It is important to consider these outcomes against a backdrop of rising demand for regulatory oversight, heightened public expectations, and the necessity to modernise systems to keep pace with the evolving healthcare sector.

The OHSC continued to maintain strong inspection coverage across both public and private health establishments, demonstrating the OHSC's commitment to ensuring adherence to prescribed norms and standards. During the reporting period, the OHSC inspected 975 health establishments, including 762 public and 213 private facilities.

A significant milestone was the implementation of the General Practitioner inspection tool for the first time during the 2025/26 financial year, extending oversight into previously unregulated segments

of the healthcare sector and strengthening the comprehensiveness and consistency of inspections.

Reviewing and refining norms and standards remained a strategic focus. This work is vital to keeping regulatory frameworks aligned with emerging healthcare challenges, technological advancements, and evolving service-delivery models. Alongside this, the organisation continued to develop regulatory tools and methodologies to enhance the effectiveness and consistency of inspection and monitoring efforts.

In support of continuous quality improvement within health establishments, the OHSC intensified initiatives around self-assessments, Quality Improvement Plans (QIPs), guidance workshops, and the implementation of Early Warning Systems (EWS). These interventions are intended not only to strengthen compliance but also to promote a proactive culture of quality improvement and patient safety across the healthcare system.

The improvements in digital integration and workflow automation improved turnaround times and operational efficiency in certification and enforcement processes. This progress highlights the importance of utilising technology to bolster regulatory effectiveness and organisational adaptability. Similarly, the OHSC continued to provide critical technical expertise and to strengthen

its ability to respond to emerging risks and evolving healthcare challenges.

The financial environment remained constrained throughout the year, limiting the pace at which certain strategic initiatives could be implemented. Nevertheless, the OHSC maintained prudent financial management practices and continued to strengthen governance and accountability systems. During the reporting period, the organisation also finalised a proposed revenue-generation model and draft fee regulations to enable the OHSC to generate revenue from services rendered, in accordance with its enabling legislation. The Regulations on Fees Payable have been developed and submitted to the Ministry for ratification and approval. This initiative represents an important step toward strengthening the organisation's long-term financial sustainability.

The process of reviewing the Integrated HR Strategy commenced during the period under review, with the building blocks, such as the Organisation Structure, foregrounded within a Business Operating Model that enables effective management and leadership, appropriate institutional design, and a strong performance culture underpinned by effective rewards and sanctions. Organisation Culture with a set of nuanced indicators on employee wellness (across staffing levels) gauged through regular staff satisfaction surveys and underpinned by a Change Management programme.

The OHSC also made important strides in modernising its Information and Communication Technology (ICT) environment through increased automation and digital transformation initiatives. The continued integration of digital systems across core regulatory functions is expected to improve operational efficiency, strengthen data management and analytics capabilities, and support more responsive and evidence-based decision-making.

The OHSC will continue to focus on strengthening institutional capacity in areas that directly impact service delivery and regulatory effectiveness. Key priorities include investing in human capital, enhancing data analytics and intelligence capabilities, accelerating digital transformation, and improving the efficiency and responsiveness of complaints management processes.

The OHSC remains committed to advancing toward a more integrated, data-driven, and high-performing regulatory model aligned with the principles of a

Highly Reliable Organisation. Achieving this vision will require sustained focus, disciplined execution, innovation, and continued collaboration with stakeholders across the healthcare sector.

General financial review

The total revenue increased by 5% from R184 540 580 in 2024/25 to R194 533 566 in 2025/26. The OHSC is permitted to generate income by raising fees through the services it renders. During the year under review, the OHSC finalised the development of the proposed revenue generation model and draft regulations for consideration by the Executive Authority. The main objective of the revenue generation model is to increase OHSC's revenue streams to be commensurate with the size of its mandate.

The NHI Act has been promulgated and designates the OHSC as one of the key stakeholders in its implementation, requiring all health establishments to obtain certification to participate in the NHI fund. Taking this into account, the OHSC's scope of work is enormous and requires sufficient funding to be able to be executed efficiently. Currently, the OHSC faces human resource capacity constraints due to limited funding, which may affect its ability to fulfil its mandate.

Discontinued key activities/activities to be discontinued

There were no discontinued key activities in the OHSC during the year under review.

Requests for rollover of funds

During the year under review, the OHSC requested the National Treasury to retain the surplus of R6.9 million for the 2024/25 financial year, and this was approved. The surplus was largely used to fund the employment of staff on short-term contracts to supplement existing capacity, as well as other operational activities committed prior to the end of the financial year.

Supply chain management

The OHSC has in place supply chain management policies and procedures for procurement activities and applies the National Treasury prescripts to ensure compliance with legislative requirements.

All concluded unsolicited bid proposals for the year under review

No unsolicited bid proposals were concluded for the year under review. Measures put in place to prevent and detect irregular expenditure included revised and optimised procurement delegations and the continuous review of Supply Chain Management (SCM) policies and procedures to align with new directives issued by the National Treasury.

Audit report matters from the previous year, and how they would be addressed

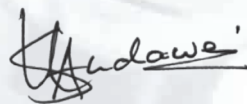
During the review period, the OHSC implemented its Internal Audit Charter, requiring the Internal Audit function to assess the effectiveness of governance, internal controls, performance, and risk management. The OHSC's risk management policy mandates periodic risk assessments to evaluate internal control effectiveness and identify emerging risks. A strategic risk assessment was conducted, resulting in updated operational and strategic risk registers that identified major risks facing the OHSC and corresponding control strategies.

Challenges experienced and how they will be resolved

The OHSC has faced challenges due to limited human and financial resources, which have affected operations across all programmes. The current situation is that the OHSC is underfunded and unable to fully execute its mandate as envisaged in the founding legislation.

The most significant operational challenges during the year were experienced within the Complaints Management and the Health Ombud programme. The increasing volume and complexity of complaints significantly strained resources and affected case resolution turnaround times. This trend reflects growing public awareness of the OHSC's role and broader systemic challenges within the health sector. In response, the Health Ombud is prioritising process optimisation, improved case management systems, and strengthening operational capacity to improve responsiveness and service delivery.

In conclusion, I extend my sincere appreciation to both the previous and current Boards for their strategic leadership and guidance, and to all OHSC management and staff for their dedication, professionalism, and resilience during a demanding year. I also acknowledge the valuable cooperation and support of stakeholders across the health sector, whose partnership remains essential in our collective pursuit of safer, higher-quality healthcare services for all people in South Africa.



Dr Sipiwe Mndaweni
Chief Executive Officer
Office of Health Standards Compliance

Date: 31 July 2026

5. STATEMENT OF RESPONSIBILITY AND CONFIRMATION OF ACCURACY OF THE ANNUAL REPORT

To the best of my knowledge and belief, the following is correct:

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

The annual report is complete, accurate, and free from any omissions.

The annual report has been prepared in accordance with the guidelines on the annual report as issued by the National Treasury.

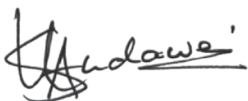
The Annual Financial Statements (Part F) have been prepared in accordance with the Generally Recognised Accounting Practice standards applicable to the public entity.

The Accounting Authority is responsible for the preparation of the annual financial statements and for the judgments made in this information.

The Accounting Authority is responsible for establishing and implementing a system of internal control designed to provide reasonable assurance regarding the integrity and reliability of the performance information, the human resources information, and the annual financial statements.

The external auditors are engaged to express an independent opinion on the annual financial statements. In our opinion, the annual report fairly reflects the operations, performance information, human resources information, and financial affairs of the public entity for the financial year ended 31 March 2026.

Yours faithfully



Chief Executive Officer
Dr Siphwe Mndaweni

Date: 31 July 2026



Chairperson of the Board
Dr Reno Morar

Date: 31 July 2026

OHSC HIGHLIGHTS FY 2025/26



975

HEs INSPECTED
762 Public
213 Private



906

**COMPLIANCE
CERTIFICATES ISSUED**
within 15 DAYS



1

**INSPECTED TOOL (GP)
HAS BEEN
FINALISED**



4 955

**HEs REGISTERED
& PROFILED**



72% **YEAR-END OUTPUT
PERFORMANCE ACHIEVEMENT**

18 of 25 Indicators Achieved



14

**ENFORCEMENT ACTIONS
TAKEN AGAINST
NON-COMPLIANT HEs**



23,68%

(18/76)

**OF COMPLAINTS WERE
RESOLVED WITHIN 24 MONTHS
THROUGH INVESTIGATION**



30

**GUIDANCE AND
SUPPORT WORKSHOPS
WERE CONDUCTED**



4,8%

**VACANCY RATE
ACHIEVEMENT**

OVERALL 2025/26 ANNUAL PERFORMANCE REPORT

72%

PERFORMANCE ACHIEVED



18 of 25 Indicators Achieved



**SUPPORT
PROGRAMMES**

38.9%

**7 of 18 Indicators
Achieved**



**CORE
PROGRAMMES**

61.1%

**11 of 18 Indicators
Achieved**

PERFORMANCE BY PROGRAMME



Programme 1

78%
(7/9)



Programme 2

75%
(3/4)



Programme 3

20%
(1/5)



Programme 4

100%
(3/3)



Programme 5

100%
(4/4)



The OHSC achieved eighteen (18) of the twenty-five (25) output indicators. This translates to a service delivery performance of 72% (18/25); seven (7) of the twenty-five (25) planned targets were not achieved, equating to 28%. Notably, support programmes accounted for 38.9% (7 out of 18) of the indicators achieved, while core programmes accounted for 61.1% (11 out of 18).

6. STRATEGIC OVERVIEW



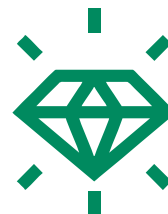
6.1. VISION

Assuring safe and quality healthcare for all.



6.2. MISSION

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



6.3. VALUES

The OHSC's value statements are reflected below. The OHSC will endeavour to:

Table 1: OHSC Core Values

	Human dignity	Respect for human individuality and treat each individual as a unique human being.
	Accountability	Take responsibility for our results and outcomes.
	Transparency	Operate in a way that creates openness between managers and employees as well as OHSC stakeholders.
	Safety	Maintain a safe and healthy workplace for all employees in compliance with all applicable laws and regulations. Promote a positive attitude towards safety.
	Integrity	Conduct ourselves with openness, honesty, and respect for all stakeholders.

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

7. LEGISLATIVE AND OTHER MANDATES

The OHSC was established under the National Health Amendment Act (No 12 of 2013) (NHAA) to promote and protect the health and safety of users of health services. The OHSC is listed as a Schedule 3A public entity under the Public Finance Management Act (PFMA).

The organisation derives its mandate from the Constitution – particularly sections 9, 12 and 27, the NHAA and various other national laws, regulations, and policies. These are briefly described below.

7.1 LEGISLATIVE MANDATES

7.1.1 The Constitution of the Republic of South Africa (Act No 108 of 1996)

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

The regulation of health service quality requires all health establishments to comply with policy priorities and adhere to minimum standards of care. In this manner, the regulation of quality contributes directly to the government's progressive realisation of its constitutional obligations. The OHSC conducts its work with due regard for the fundamental rights outlined in the Constitution and other relevant legislation.

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

The National Health Act, 2003 (Act No. 61 of 2003) (NHA) reaffirms the constitutional rights of users to access health services and just administrative action. As a result, Section 18 allows any user of health services to lay a complaint about how he or she was treated at a health establishment. The NHA further

obliges Members of the Executive Councils (MECs) to establish procedures for handling complaints within their respective areas of jurisdiction. Complaints provide useful feedback on areas within health establishments that do not comply with prescribed standards or pose a threat to the health and safety of users and healthcare staff.

The NHA provides the overarching legislative framework for a structured and uniform national healthcare system. The Act highlights the rights and responsibilities of healthcare providers and users. It ensures broader community participation in healthcare delivery from health facilities to the national level.

The objects of the OHSC in Section 78 of the National Health Act, 2003 (Act No. 61 of 2003) ("the Act"), as amended to protect and promote the health and safety of users of health services by:

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

In terms of Section 79 of the NHA, **the OHSC must:**

- Advise the Minister on matters relating to norms and standards for the national health system and the review of such norms and standards or any other matter referred to it by the Minister;

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

In addition, **the OHSC may:**

- Issue guidelines for the benefit of health establishments on the implementation of prescribed norms and standards;
- Collect or request any information relating to prescribed norms and standards from health establishments and users;
- Liaise with any other regulatory authority, and without limiting the generality of this power, request information from, exchange information with, and receive information from any such authority in respect of matters of common interest or a specific complaint or investigation; and
- Negotiate cooperative agreements with any regulatory authority to coordinate and harmonise the exercise of jurisdiction over health norms and standards and ensure the consistent application of the principles of the Act.

7.1.3 Norms and standards applicable to different categories of Health Establishments, 2018

The Minister of Health promulgated the Norms and Standards Regulations in February 2018. The Norms and Standards Regulations, in terms of section 90 (1) (b) and (c) of the National Health Act, 2003 (Act No. 61 of 2003), are applicable to certain categories of health establishments and came into operation in 2019.

They apply to the following categories of health establishments:

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

These regulations will apply to other categories of health establishments contemplated in section 35 of the Act, once the Minister has prescribed specific norms and standards for such categories. The minimum requirements for different types of health establishments in South Africa are detailed in the Norms and Standards Regulations of the National Health Act, 2003. These regulations aim to ensure that health services are delivered in a safe, effective, and patient-centred manner. The key areas covered by these regulations include:

- User Rights;
- Clinical Governance and Clinical Care;
- Clinical Support Services;
- Facilities and Infrastructure; and
- Governance and Human Resources.

7.1.4 Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and Handling of Complaints by the Ombud, 2016

The procedural regulations guide the operations and exercise of the powers conferred on OHSC, the Board,

and the Office of the Health Ombud. The procedural regulations cover the following areas:

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

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

Section 50 of the Public Finance Management Act, 1999 (Act 1 of 1999) (PFMA) sets out the fiduciary duties of accounting authorities. Section 51 sets out the responsibilities of accounting authorities. The PFMA regulates public sector managers to manage and improve accountability by eliminating waste and corruption in the use of public funds. The act enables public sector managers to manage and improve accountability in terms of eliminating waste and corruption in the use of public funds. OHSC is listed as a Schedule 3A public entity.

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

The purpose of the Protection of Personal Information Act, 2013 (Act No. 4 of 2013) (PoPI Act) is to ensure that all South African institutions, including the OHSC, conduct themselves in a responsible manner when collecting, processing, storing, and sharing personal information by holding them accountable

should they abuse or compromise such information in any way. The PoPI Act regards personal information as “precious goods” and gives owners of personal information certain rights of protection and the ability to exercise control over:

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

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

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

The objectives of the PAIA are to:

- Ensure that the state promotes a human rights culture and social justice;
- Encourage openness and establish voluntary and mandatory mechanisms;
- Establish procedures for the right to access information quickly, effortlessly, cost-effectively, and as reasonably as possible;
- Promote transparency, accountability, and effective governance of all public and private bodies by empowering and educating everyone

to understand their rights in terms of the PAIA and to public and private bodies;

- Create an understanding of the functions and operation of public bodies; and
- Encourage the scrutiny of and participation in decision-making by public bodies that affect individual/public rights.

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

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

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

7.1.9 Disaster Management Act, 2002 (Act No 57 of 2002)

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

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

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

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

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

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

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

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

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

7.2 POLICY MANDATES

Several national health and development policies play a significant role in the way the OHSC interprets and implements its mandate. Such policies are, in some cases, aligned with regional and global health and development imperatives.

7.2.1 National Health Insurance Programme

In pursuit of universal health coverage, the South African government has embarked on a fundamental transformation of the health system. Its chosen approach is the National Health Insurance (NHI) financing model, which aims to distribute health resources more equitably and ensure all citizens have access to quality, essential health services regardless of their socio-economic status and ability to pay for healthcare.

The NHI Act provides for mandatory prepayment for healthcare services. It establishes the NHI Fund as a centralised mechanism for distributing healthcare resources and sets out the fund's powers, functions, and governance structures. The NHI Act recognises

the socio-economic injustices of the past, the persistent inequalities that they have caused, and the need to heal historic divisions by building a society based on democratic values, social justice, and fundamental human rights.

7.2.2 National Development Plan Vision 2030

The National Development Plan (NDP) Vision 2030 states that a health system with positive health outcomes for the country are possible and will:

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

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

7.2.3 Medium-Term Development Plan (2024 – 2029)

The OHSC took into account the Medium-Term Development Plan (MTDP) 2024-2029 in the execution of its mandate, which succeeded the Medium-Term Strategic Framework (MTSF). As a result, the MTDP serves as the execution framework for the National Development Plan (NDP): Vision 2030, South Africa's long-term strategy towards 2030.

The seventh Administration of Government focused on three Strategic Priorities under the MTDP, namely:

- i) Strategic Priority 1: Inclusive growth and job creation;
- ii) Strategic Priority 2: Reduce poverty and tackle the high cost of living; and
- iii) Strategic Priority 3: A capable, ethical, and developmental state.

The office is classified under Outcome 3, which is part of Priority 2 in the MTDP. Outcome 3 focuses on enhancing access to high-quality and affordable healthcare services. The OHSC is crucial in ensuring that health establishments meet the required quality standards. Its mandate is to monitor and enforce compliance by health establishments with norms and standards prescribed by the Minister of Health in relation to the national health system.

The OHSC management and Board identified eight key policy priorities for implementing the strategic plan. These priorities are crucial for healthcare quality assurance and safety in South Africa.

7.2.4 National Policy on Quality in Healthcare, 2007

The 2001 National Policy on Quality (NPQ) was revised in 2007. The policy identifies mechanisms to improve healthcare quality across the public and private sectors. It highlights the need to involve health professionals, communities, patients, and the broader healthcare delivery system (National Department of Health, referred to as the NDoH) in capacity-building efforts and quality initiatives.

The objectives of the NPQ are to:

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

7.2.5 Batho Pele and the Patients' Rights Charter

The *Batho Pele* principles govern all public services and seek to put "people first" by encouraging a service-oriented culture among public servants. The Batho Pele principles are:

- Regular consultation with service users;
- Setting of service standards;
- Increasing access to services;
- Ensuring higher levels of courtesy;

- Providing more and better information about services;
- Increasing transparency about services;
- Remedying failures and mistakes; and
- Giving the best possible value for money

The complementary Patient's Rights Charter lists a range of rights, including confidential care, provision of information about one's health condition, informed choice regarding treatment, continuity of care, and having service complaints addressed.

7.2.6 Presidential Health Compact Summit, 2023

The Presidential Health Compact (PHC) is an agreement and commitment by key stakeholders, signed in July 2019, to identify primary focus areas for establishing a unified, integrated, and responsive health system. Partners committed themselves to a five-year programme to partner with the government to improve health care services in our country. In 2024, the second Presidential Health Compact (2024 - 2029) was adopted. The Health Compact has 10 Pillars to advance the implementation of National Health Insurance (NHI), which is essential for preparing the health system to serve the entire population and ensure access to quality healthcare.

The summit brought together various stakeholders, including government officials, health professionals, and civil society, to discuss and develop solutions to improve healthcare delivery and achieve Universal Health Coverage (UHC) and sustainable development. A key focus was the implementation of the NHI and the establishment of a National Public Health Institute. In relation to the OHSC, the summit emphasised the importance of maintaining high standards in healthcare facilities across the country.

The OHSC plays a crucial role in ensuring healthcare providers adhere to quality standards and regulations, which are essential for implementing the NHI. Discussions highlighted the need for robust monitoring and evaluation mechanisms to ensure compliance and improve overall healthcare quality. However, several objectives from the 2018 summit remain unresolved. The Health Department missed 60% of its goals, including issues with Pillar 6 (Health Financing: Securing sustainable funding for healthcare services). The Health Ombud's office lacks sufficient funding for the next five years. Provinces are still struggling with payment backlogs, and a plan to improve services at central hospitals by 2022 failed.

7.2.7 African Union Agenda 2063

African Union Agenda 2063 envisages an integrated, peaceful continent where prosperity is achieved through inclusive growth and sustainable development, and human rights and democratic practices are observed. It recognises that the health and nutrition of the population contribute to growth, and that capable institutions are necessary to build a rights-based culture.

7.2.8 Sendai Framework for Disaster Risk Reduction, 2015-2030

The Sendai Framework is a non-binding, voluntary framework adopted at the UN's third global conference in 2015 that aims to enhance countries' disaster preparedness, resilience, and recovery to reduce loss of life, livelihoods, health, and social assets.

7.3 OTHER RELATED LEGISLATIONS

Given the complexity of the environment in which the OHSC operates, it is necessary to outline the related legislation that influences and shapes its functioning:

7.3.1 Medical Schemes Act (Act No 131 of 1998)

The Medical Schemes Act, 1998 (Act No 131 of 1998) regulates the medical schemes industry. The Act plays a crucial role in the regulatory framework within which the OHSC operates. The OHSC, as a regulatory authority overseeing healthcare quality and patient safety, aligns its mandate with the Act's provisions to ensure that healthcare facilities adhere to national health standards. Through its inspections, compliance monitoring, and enforcement actions, the OHSC contributes to upholding the objectives of the Medical Schemes Act and ensuring that beneficiaries receive safe, high-quality healthcare services.

7.3.2 Medicines and Related Substances Act, 1965 (Act No 101 of 1965), as Amended

The Medicines and Related Substances Act, 1965 (Act No. 101 of 1965) regulates, controls, and registers medicines and related substances in South Africa, ensuring their safety, efficacy, and quality, and providing for pricing transparency. It establishes

and defines the mandate of the South African Health Products Regulatory Authority (SAHPRA). The Act ensures that health establishments comply with the legal requirements for the safe and ethical handling, storage, and dispensing of medicines. The OHSC inspects health establishments to ensure that medications are stored appropriately, prescriptions are handled by qualified professionals, and patients receive medications in line with regulatory standards. By enforcing compliance with this Act, the OHSC helps safeguard public health, promote the responsible use of medicines, and reduce the risks of medication errors, thereby ensuring safe and effective healthcare delivery.

7.3.3 National Health Laboratory Service Act (Act No 37 of 2000)

The National Health Laboratory Service Act (Act No. 37 of 2000) establishes the National Health Laboratory Service (NHLS) in South Africa. The Act provides the mandate for the National Health Laboratory Service, supplier of laboratory services to the public health sector and any private health care provider that requests such services. The OHSC, which is responsible for monitoring and enforcing compliance with health standards, relies on the integrity and efficiency of laboratory services for accurate disease surveillance, diagnosis, and reporting.

7.3.4 Health Professions Act, 1974 (Act No 56 of 1974)

The Health Professions Act, 1974 (Act No. 56 of 1974) establishes the Health Professions Council of South Africa (HPCSA) and governs the regulation and registration of healthcare professionals. This Act is vital in ensuring that healthcare professionals operating within health establishments are qualified, competent, and adhere to ethical standards. The OHSC verifies that practitioners meet professional requirements during inspections. This verification supports the OHSC's mandate to promote patient safety and ensure that health establishments maintain high standards in service provision through appropriately regulated health personnel.

7.3.5 Pharmacy Act, 1974 (Act No 53 of 1974)

The Pharmacy Act, 1974 (Act No 53 of 1974) regulates the pharmacy profession through the Pharmacy Council of South Africa. This Act plays an important role in ensuring that pharmaceutical

services within health establishments comply with legal and professional standards. The OHSC assesses whether pharmacies comply with the Act's provisions, including proper storage, dispensing, and record-keeping of medicines, as well as ensuring the presence of qualified personnel.

7.3.6 Nursing Act, 2003 (Act No 33 of 2005)

The Nursing Act, 2005 (Act No. 33 of 2005) governs the nursing profession in South Africa through the South African Nursing Council (SANC), which is responsible for the regulation, registration, and oversight of nurses and midwives. This Act is significant in ensuring that nurses working in the health establishments are properly trained and professionally registered. The OHSC evaluates compliance with health standards, including professional registration of nursing staff with SANC, as part of its inspections and monitoring processes. By aligning with the Nursing Act, the OHSC helps uphold quality patient care, professional accountability, and ethical nursing practices, which are essential for maintaining safe and effective healthcare services across the country.

7.3.7 Allied Health Professions Act (No 63 of 1982)

The Allied Health Professions Act, 1982 (No 63 of 1982) regulates health practitioners such as chiropractors, homeopaths and others through the Allied Health Professions Council of South Africa. The Act is significant in ensuring that all allied health professionals practising in health establishments are properly registered, qualified, and adhere to ethical standards.

7.3.8 Dental Technicians Act (Act No 19 of 1979)

The Dental Technicians Act, 1979 (Act No. 19 of 1979) regulates dental technicians by establishing the South African Dental Technicians Council (SADTC). It regulates the profession of dental technicians and technologists in South Africa and supports the mandate of the OHSC to ensure compliance with health standards and professional regulation in healthcare settings.

7.3.9 Hazardous Substances Act (Act No 15 of 1973)

The Hazardous Substances Act (Act No. 15 of 1973) controls the import, manufacture, sale, use, handling

and disposal of hazardous substances, particularly those that emit radiation. This Act plays a crucial role in ensuring the safety of patients, healthcare workers, and the environment within the healthcare establishments.

7.3.10 Foodstuffs, Cosmetics and Disinfectants Act (Act No 54 of 1972)

The Foodstuffs, Cosmetics and Disinfectants Act (Act No. 54 of 1972) regulates foodstuffs, cosmetics and disinfectants and sets quality and safety standards for their manufacturing, importation, and sale to ensure they are safe for human use and consumption.

7.3.11 Occupational Diseases in Mines and Works Act (Act No 78 of 1973)

The Occupational Diseases in Mines and Works Act (ODMWA), Act No. 78 of 1973, provides for the medical examination of persons who may have

contracted occupational diseases, especially in the mining sector, and for relevant compensation.

7.3.12 Occupational Health and Safety Act (Act No 85 of 1993)

The Occupational Health and Safety Act (Act No. 85 of 1993) protects the health and safety of persons at work and other persons exposed to health and safety hazards related to activities of persons at work. The Occupational Health and Safety Act underpins the OHSC's role in promoting health and safety compliance in healthcare settings, protecting both workers and the public from preventable harm.

7.3.13 Labour Relations Act (Act No 66 of 1995)

The Labour Relations Act, 1995 (Act No. 66 of 1995) gives effect to the constitutional right of employees and employers to fair labour practices, collective bargaining, and the resolution of labour disputes.



8. ORGANISATIONAL STRUCTURE

The current operational structure of the OHSC was approved by the Board following a comprehensive organisational development and design process. This process aimed to ensure the structure remained aligned with the organisation's evolving needs and strategic objectives. The revised structure is underpinned by key design principles of consistency, continuity, accountability, flexibility, and efficiency. The OHSC strives to ensure that it has the right people, with the right skills and competencies, available at the right time and at the appropriate level to deliver on its mandate.

Ensuring consistency and continuity in operations remains a key priority for the OHSC. In pursuit of this objective, the OHSC will initiate a comprehensive Workforce Planning exercise that incorporates both quantitative and qualitative scenario forecasting. This initiative will identify the organisation's specific resourcing needs over the medium to long term, which will be documented in a formal Workforce and Strategic Sourcing Plan. The organogram presented below outlines the OHSC's current organisational structure. It sets out the operational structures, based on the OHSC's Strategy, which will best enable the organisation to deliver on its mandate.

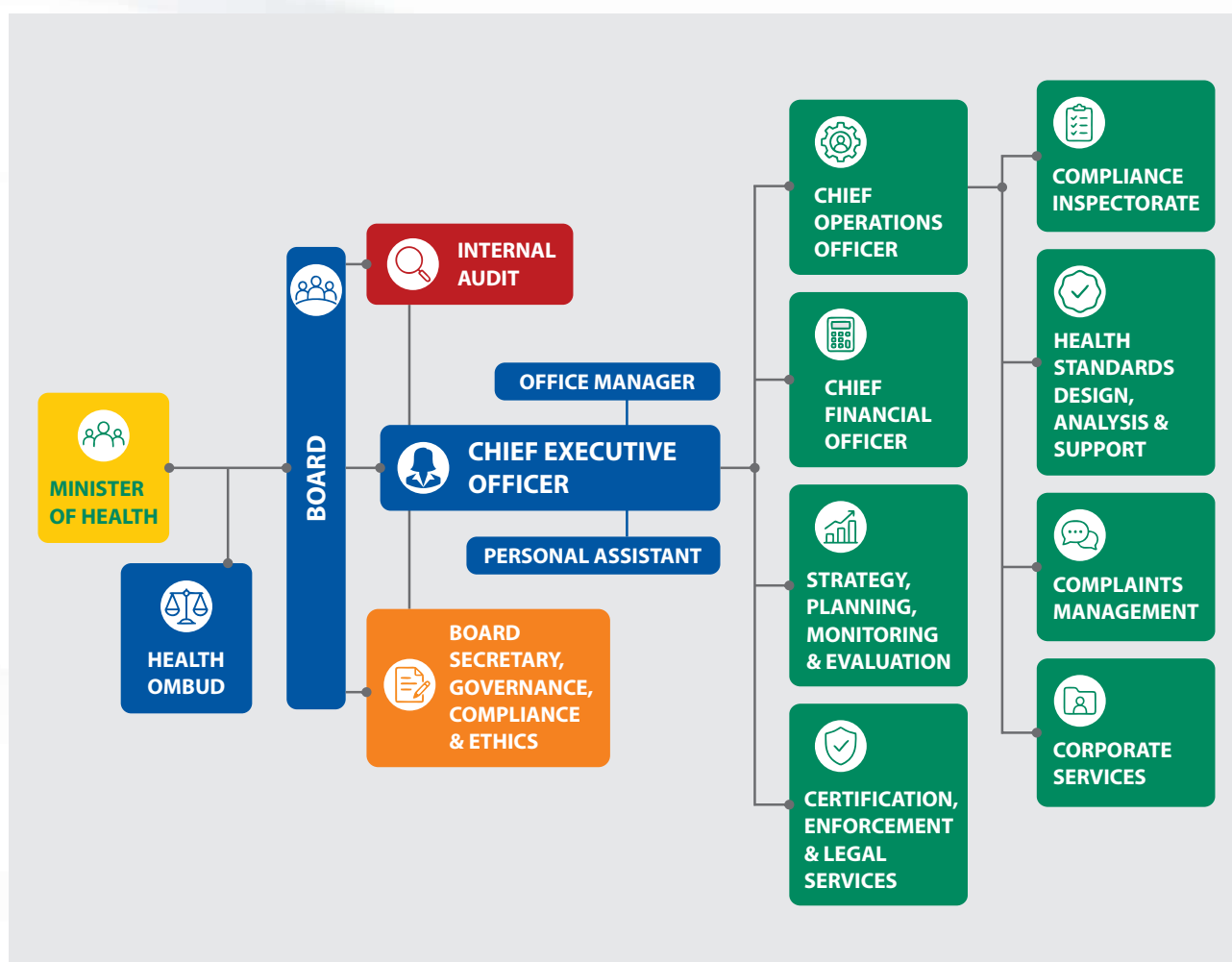


Figure 1: Approved organisational structure.

Functionally, the reporting line is to an accounting authority (i.e. Board of Directors), the executive management and the management committee consisting of senior management level as follows:

Executive Management: Executive Management comprises the Chief Executive Officer (CEO), the Chief Operations Officer (COO), five Executive Managers (Complaints Management and the Ombud, Corporate Services, HSDAS, Compliance Inspectorate and the Chief Financial Officer (CFO). The CEO reports to the Board on all strategic matters affecting the organisation, while the COO and CFO report directly to the CEO.

Senior Management: The operational management level, comprising senior managers designated as unit heads.

The current approved structure consists of 323 posts. Of the 323 posts on the current structure, 180 posts are unfunded. The OHSC has 143 funded posts on the approved organisational structure. As of 31 March 2026, 136 posts were filled, and seven (7) were vacant, equating to a vacancy rate of 4.9%. Among the filled posts, 38% (51/136) are occupied by males, and 62% (85/136) by females. In a nutshell, the OHSC attracted suitably qualified and experienced staff to fill its vacancies, resulting in an efficient, well-equipped workforce working towards the OHSC's strategic goals and objectives. The representation of persons with disabilities is 0% (0/136). The staff distribution reveals a mix of age groups, with 12.5% (17) comprising youth employees. The distribution of posts by gender is demonstrated below:

OHSC DISTRIBUTION OF POSTS BY GENDER 2025/26 FY

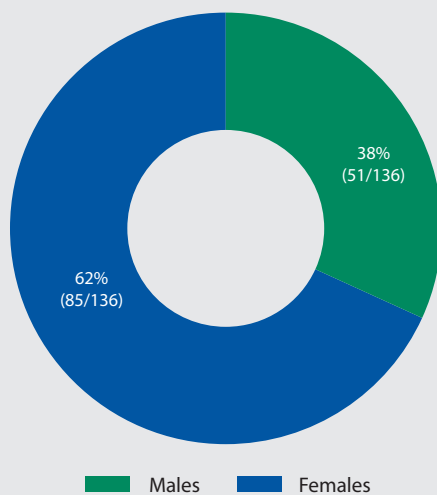


Figure 2: OHSC distribution of posts by gender 2025/26 FY





PART

B

PERFORMANCE INFORMATION

9. AUDITOR'S REPORT: PREDETERMINED OBJECTIVES

The Auditor-General of South Africa (AGSA) conducts the necessary audit procedures on performance information to provide reasonable assurance through an audit conclusion. The conclusion on performance against predetermined objectives is included in the report to management, with no material findings regarding the reported performance information for the selected material performance indicators.

Refer to page 91 of the Auditors' Report, published as Part F: Financial Information.

10. OVERVIEW OF PERFORMANCE

10.1. SERVICE DELIVERY ENVIRONMENT

The OHSC reports on the overall progress achieved in implementing its 2025/26 Annual Performance Plan (APP). During the period under review, twenty-five (25) output indicators were monitored and reported. The OHSC achieved eighteen (18) of the twenty-five (25) output indicators. This translates to a service delivery performance of 72% (18/25); seven (7) of the twenty-five (25) planned targets were not achieved, equating to 28%. Notably, support programmes accounted for 38.9% (7 out of 18) of the indicators achieved, while core programmes accounted for 61.1% (11 out of 18).

The OHSC embarked on a review of the norms and standards regulations (for quality and safety) emanating from the recommendation report submitted in January 2022 to the NDoH, proposing revisions to the Norms and Standards Regulation promulgated in 2018. This was followed by the proposal presentation to the NDOH Senior Management Team on 24 August 2024, at which consensus was reached to proceed with a structured review process. The OHSC initiated a comprehensive national review of the 2018 norms and standards regulations by establishing a multi-stakeholder National TWG comprising representatives from both the public and private sectors.

This process is led by a Technical Working Group (TWG) convened by the OHSC, with active participation from key stakeholders across the health sector (both public and private). This inclusive approach reflects a commitment to collaboration, transparency, and shared accountability, key principles underpinning

high-performing and reliable health systems. The first draft of the regulations marks a significant advance; the next step is to share it with provincial health departments and the private sector for further review and additional input.

To date, eight (8) inspection tools have been finalised: Clinics, Community Health Centres (CHCs), District Hospitals, Regional Hospitals, Central Hospitals, Tertiary Hospitals, General Practices (GPs), and Private Acute Hospitals. To this extent, certain categories of health establishments, particularly specialised health services and sectors, will have inspection tools finalised only once the standards have been developed. Inspection tools for Emergency Medical Services (EMS) and Mental Health establishments are currently under development, with the EMS tool at an advanced stage and scoping visits for the Mental Health tool underway.

All tools were developed through a consultative process involving key stakeholders, including representatives from the relevant HEs. The inspection tools are pilot-tested, and the input of health establishments is considered before finalisation and approval.

The OHSC's approach to developing inspection tools is incremental across the different categories of health establishments and various levels of care.

The OHSC developed and submitted a detailed recommendations report outlining key issues impacting the quality and safety of healthcare services. The report draws from multiple data sources, including Annual Returns, Early Warning Systems (EWS), and Inspection Reports. The report evaluates

performance against the Norms and Standards Regulations. It highlights areas of both compliance and non-compliance, offering a clear picture of how health facilities are functioning relative to regulatory expectations, and identifies patterns and trends in the data.

Furthermore, the report provides strategic recommendations to address systemic risks affecting the quality, safety, and reliability of healthcare services. These risks include gaps in governance, infrastructure challenges, human resource constraints, and inconsistencies in adherence to norms and standards. By outlining actionable steps for improvement, the report supports provinces in strengthening oversight, enhancing accountability, and prioritising patient-centred care. Ultimately, it serves as a critical tool for continuous quality improvement and for advancing equitable, safe, and effective healthcare delivery across the country. The Early Warning System (EWS) surveillance has strengthened the sector's ability to proactively identify and monitor indicators associated with serious non-compliance with prescribed norms and standards. The EWS is a surveillance system designed to collect information on eleven (11) key indicators and forms part of the broader framework for monitoring risks linked to breaches of norms and standards regulations. It provides a consolidated overview of EWS incidents reported directly to the Office of Health Standards Compliance (OHSC) by health establishments, as well as those identified through external sources such as media reports. This enables more comprehensive visibility of risks across the health system.

A total of 1 020 General Practices (GPs) were registered through the OHSC online platform. In addition, 3 935 public health establishments were registered and profiled using information obtained from the Annual Returns and the Ideal Facility Framework. Analysis of the Annual Returns data provides an essential health system context within which hospitals operate, reflecting the various system inputs and their influence on the quality of healthcare services and the overall health system performance. Furthermore, the analysis seeks to identify factors that may either facilitate or hinder compliance with norms and standards regulations and ultimately affect the delivery of quality healthcare services. The EWS system was enhanced to improve its functionality and responsiveness. These enhancements included improved data capture processes, automated alert systems, and integration with existing health

information systems to streamline data flow. The enhancements are intended to enable timely and accurate reporting of EWS indicators by health establishments and to support real-time monitoring through interactive dashboards. Collectively, these improvements are expected to strengthen oversight, enhance decision-making, and support a more proactive, risk-based approach to ensuring compliance with health standards.

The OHSC rolled out the Self-Assessment System (SAS) for private acute hospitals. The performance of SAS for private acute hospitals during the 2025/2026 financial year demonstrates notable growth, strong compliance levels, and increased user engagement across the sector. The number of participating health establishments expanded to 223 private acute hospitals, while registered users increased significantly to approximately 4,500, reflecting improved uptake and active utilisation of the system. This represents a marked improvement from the 2024/2025 financial year, during which 2,500 users were registered across 220 health establishments, with 210 self-assessments conducted. In the current reporting period, 212 of 223 registered establishments completed their self-assessments, resulting in a 97.5% completion rate. The remaining establishments were identified, contacted, and encouraged to submit their applications before the 31 March 2026 deadline, demonstrating proactive system management and follow-up.

Thirty (30) targeted guidance and support workshops were conducted during the reporting period. These workshops sought to strengthen the capacity of healthcare providers responsible for implementing the inspection tools and to build system-wide understanding, leading to improved consistency in the application of prescribed norms and standards across health establishments. The OHSC proactively identified areas requiring targeted training and support, ensuring that implementation challenges were addressed in a structured and responsive manner.

There are 43 inspectors within the OHSC, all of whom have completed the required training as approved by the Board. An external Tertiary Institution service provider conducted the initial training of Inspectors. An in-house training has been developed and approved by the Board.

The training of newly appointed inspectors with the in-house curriculum was conducted in-house over ten (10) days, commencing on 20 October 2025 and concluding as planned on 31 October 2025.

During the training programme, nine (9) modules were delivered, including eight (8) core modules facilitated by various OHSC units, with additional input from external facilitators from the National Department of Health on the Health System and National Health Insurance. Additional modules on Ethics, Professionalism, Accountability, and the Code of Conduct for Inspectors were presented by an external facilitator from the South African Nursing Council. OHSC inspectors will be qualified and certified to perform their duties effectively and in full compliance with the National Health Act.

The OHSC is responsible for conducting routine compliance inspections and additional: re-inspections in different categories of health

establishments, both in the public and private sectors. This function aligns with the broader mandate of the OHSC to monitor compliance with regulated norms and standards. During the 2025/26 financial year (FY), the OHSC conducted 762 routine inspections at public HEs, slightly exceeding the target of 761. In addition, 63 re-inspections were carried out in public HEs to determine whether the previously identified areas of non-compliance with minimum regulatory requirements had been adequately addressed.

As a result, HEs that did not meet the minimum compliance requirements were issued with compliance notices outlining the areas of breach to be addressed. Furthermore, the OHSC conducted three risk based inspections at public hospitals; namely, Embekweni District Hospital, Dora Nginza Hospital, and Tembisa Provincial Tertiary Hospital. The figure below, illustrates the total number of routine inspections conducted in the public sector.

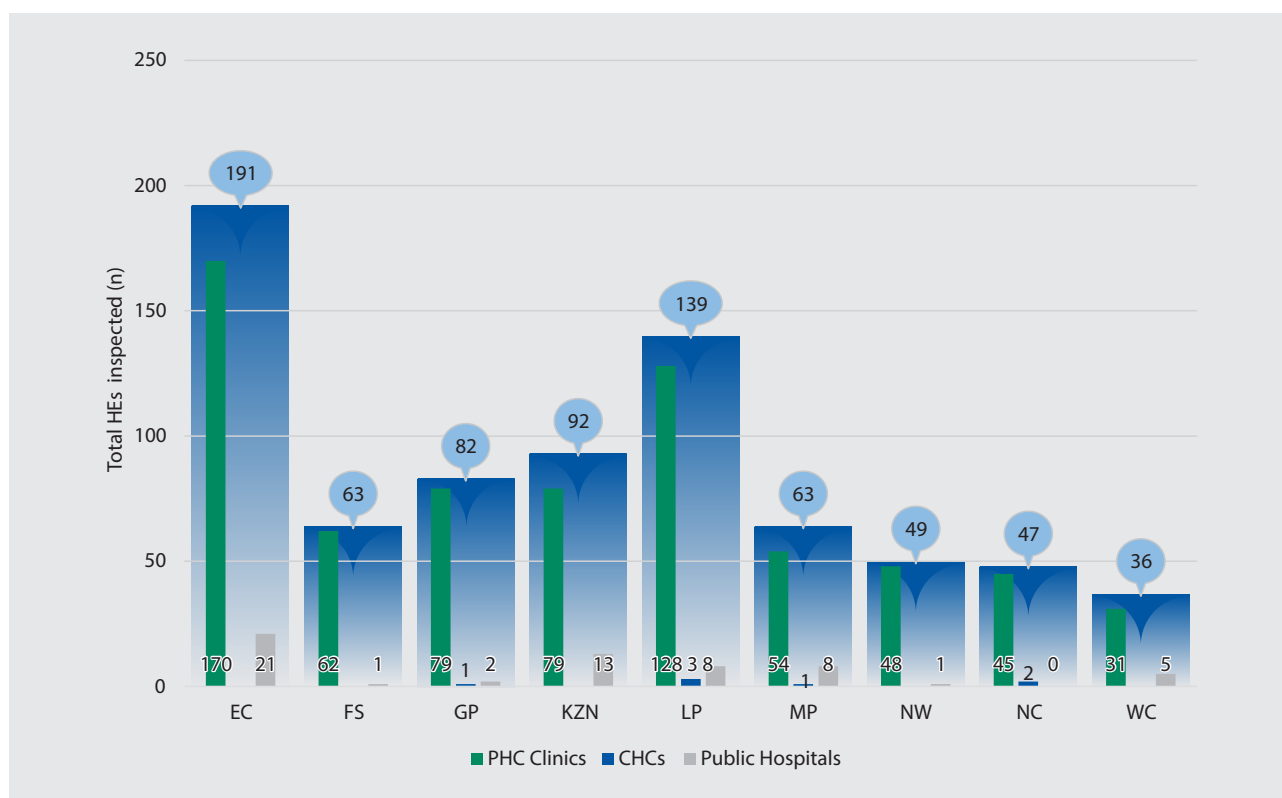


Figure 3: Total public HEs inspected by the OHSC per province, 2025/26 financial year

During the period under review, a total of 213 inspections were conducted in the private sector (General Practices), against a target of 210 across all nine provinces in the country.

The table below shows the total number of private health establishments inspected per province.

Table 2: Total private HEs inspected by the OHSC per province, 2025/26 financial year

Provinces	Total GPs inspected
Eastern Cape	19
Free State	10
Gauteng	105
KwaZulu-Natal	35
Limpopo	4
Mpumalanga	12
North West	7
Northern Cape	10
Western Cape	11
Grand Total	213

A total of 906 health establishments met compliance requirements and against persistently non-compliant HEs were issued with Certificates of Compliance within 15 days of the final inspection report and inspector's recommendation. This resulted in 100% compliance certificates being issued (906/906). This outcome highlights enhanced efficiency in certificate processing and stronger

internal workflows. Fourteen (14) enforcement actions were taken against persistently non-compliant HEs within 30 days of the final inspection report. In addition, 11 out of 11 enforcement actions were resolved within 90 working days. These results demonstrate improved responsiveness in addressing non-compliance and reinforce the OHSC's regulatory role in promoting accountability and corrective action within HEs.

A key enabler of improved performance during the reporting period was the automation and utilisation of the of the online Certification and Enforcement Module. The module strengthened operational efficiency by supporting the tracking, processing, verification, and endorsement of certification and enforcement matters. It also improved the turnaround times and supported better oversight of cases requiring certification decisions or enforcement action. The use of the module contributed to more consistent workflow management and enhanced the programme's ability to meet regulated performance timelines. The graph below shows the number of certified health establishments per province.

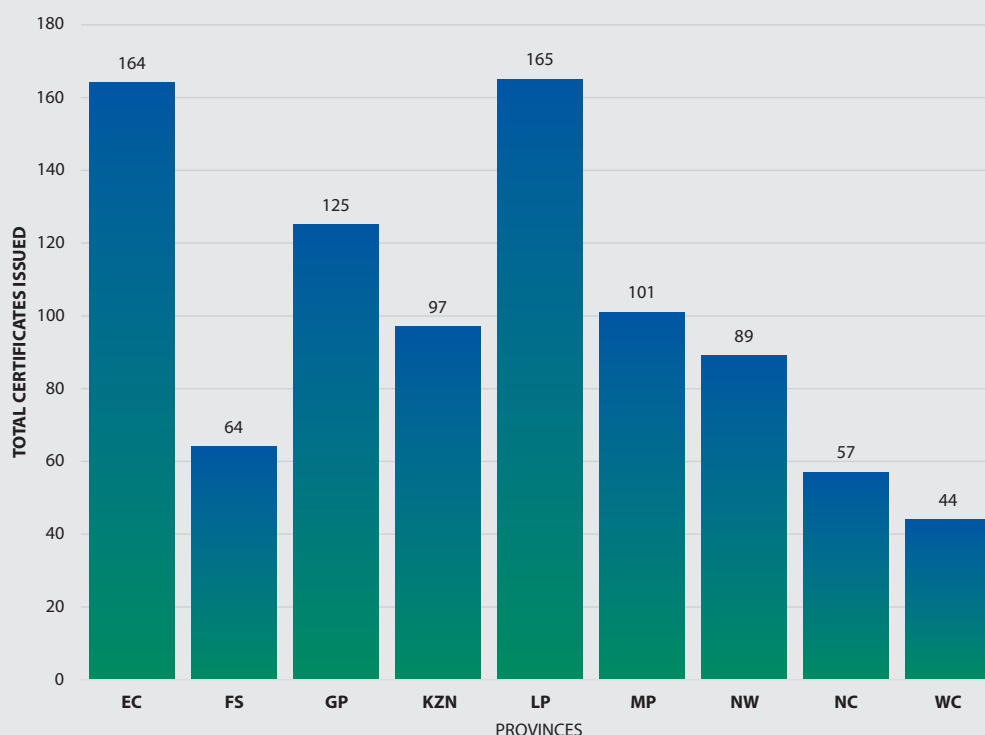


Figure 4: Total number of compliance certificates issued per province, financial year 2025/26

The Health Ombud received a total of 4,297 new complaints were received during the reporting period. The complaints are risk-rated as low, medium, high and extreme cases. The Health Ombud facilitated the closure of 79.06% (3 288/4 159) low-risk-rated complaints within 25 working days.

A total of 48 medium-risk-rated complaints received information from the health establishment and/or the complainant, and 21 were resolved within the Service Level Agreement (SLA) of 60 working days. The graph below shows the number of cases received and resolved at the complaints call centre.

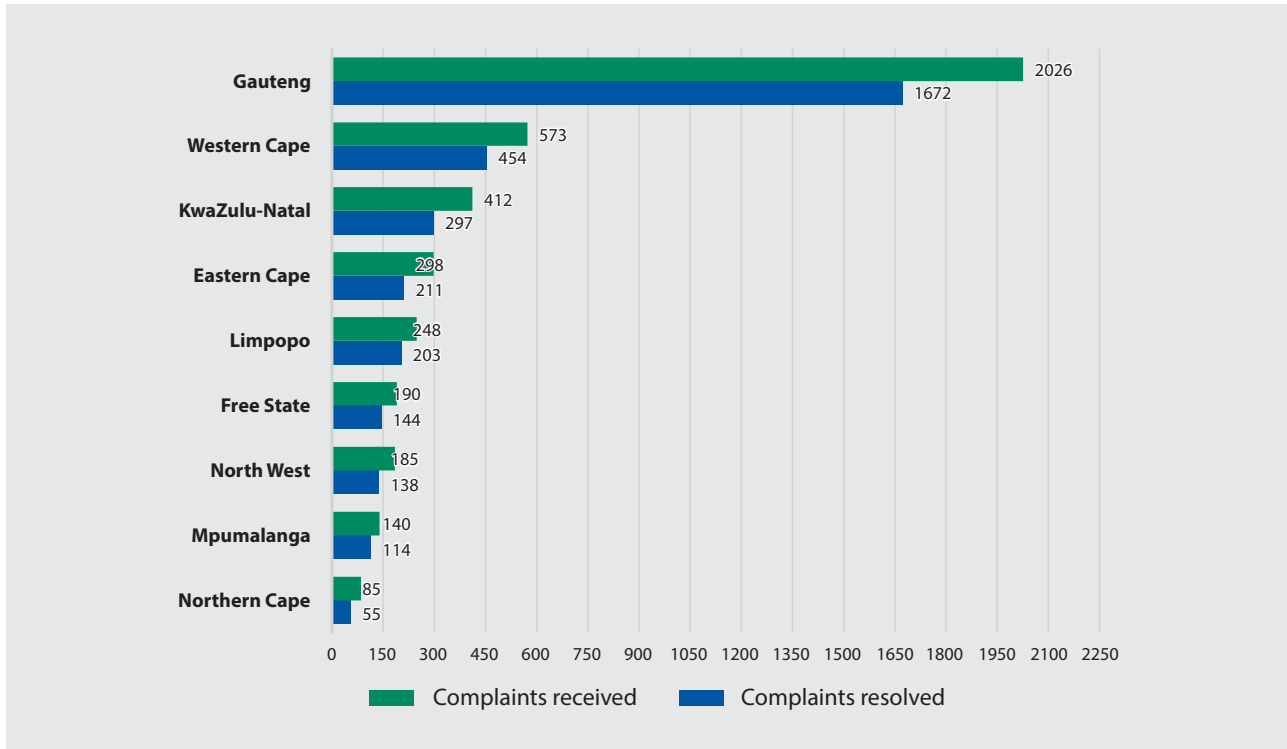


Figure 5: The number of low-risk case complaints received and resolved per Province, FY 2025/26

The Health Ombud received 87 new high- and extreme-risk-rated cases. A total of 38 cases (22 high-risk and 16 extreme-risk-rated cases) were closed across the nine (9) provinces. Of these, 10 were resolved within 6 months, 18 within 24 months and 10 beyond 24 months. The highest number of resolved cases recorded was in Gauteng (16), followed by KwaZulu-Natal (8) and the Western Cape (4). Limpopo Province and the Northern Cape each accounted for three (3) resolved complaints, while the Eastern Cape recorded two (2).

The North West and Free State provinces each reported one case. It is worth noting that the bulk of complaints (approximately 81,57%) originated in the public health sector, while 18,43% originated in the private health sector. Of the 38 cases finalised, 5 were publicly released; these included 2 cases involving private health establishments and 3 involving public health establishments. The table below shows high- and extreme-risk case complaints received and resolved by the province.

Table 3: The number of high and extreme-risk case complaints received and resolved per Province, FY 2025/26

Provinces	Resolved within 6 months	Resolved within 24 months	Resolved beyond 24 months	Total Resolved
Gauteng Province	4	4	8	16
Eastern Cape	0	2	0	2
Free State	0	1	0	1
Kwa-Zulu Natal	4	2	2	8
Limpopo	1	2	0	3
Mpumalanga	0	0	0	0

Provinces	Resolved within 6 months	Resolved within 24 months	Resolved beyond 24 months	Total Resolved
North West	0	1	0	1
Northern Cape	1	2	0	3
Western Cape	0	4	0	4
Total	10	18	10	38

The Health Ombud publicly released six (6) investigation reports through the media. The first investigation, was published on 30 July 2025, relates to the treatment, complications and subsequent deaths of two (2) psychiatric patients at Northern Cape Mental Health Hospital (NCMH) and Robert Mangaliso Sobukwe Hospital (RMSH), respectively. Two further investigations were released on 3 December 2025 and were conducted at Wits Donald Gordon Medical Centre (WDGMC) and Pietersburg Provincial Tertiary Hospital. These investigations focused on the medical care provided to a patient before his death at WDGMC in Gauteng Province and the death of a patient from alleged medical negligence at Pietersburg Provincial Tertiary Hospital (PPTH) in Limpopo Province. The fourth and fifth reports were published on 23 March 2026. The first was on an investigation into the death of a baby from alleged administration of incorrect medication at the Netcare Femina Hospital.

The final investigation report relates to the circumstances surrounding the care and death of a mental healthcare user at Dr George Mukhari Academic Hospital (DGMH). The full details of the investigations, including the findings and recommendations, are available on the OHO website.

The Health Ombud hosted a two-day Inaugural Biennial Health Ombud Conference on 11–12 September 2025 under the theme “Health and Healthcare as a Human Right.” The conference brought together key stakeholders from across Africa, including the health sector, oversight bodies, regulatory institutions, academia, and Ombudsman institutions. This provided a platform to deliberate on strengthening the national complaints management systems, enhancing accountability, and improving governance (to contribute to improved quality of services) within the healthcare sector. Key discussions focused on improving turnaround times in complaint resolution, addressing case backlogs, and strengthening the implementation of Ombud recommendations.

The hounourable, Minister of Health, Dr Aaron Motsoaledi delivered a keynote address, emphasizing the contribution of the OHO to a gradual but meaningful transformation in how our health system responds to complaints and upholds the dignity of those it serves. The conference outcomes reaffirmed the Office’s critical role in promoting accountability and improving the quality of healthcare services, while highlighting the need for continued institutional strengthening, capacity development, and strategic partnerships.

Challenges encountered by OHSC during the FY 2025/26

The limited financial and human resources were significant challenges during the year under review. A key senior management position was vacant at the end of the 2025/26 FY. Despite this constraint, the OHSC continued to deliver on its mandate; however, the increasing scope and complexity of activities require additional capacity to ensure optimal alignment between workload and available resources. In addition, expanding human resource capacity (would enable the expansion of inspection coverage in both the public and private sector), providing opportunities to evaluate and continuously improve the effectiveness of the inspection tools in practice.

The OHSC also experienced increased technical demands associated with the review of inspection reports, certification recommendations, enforcement matters, and compliance evidence submitted by HEs. The need to ensure procedural fairness, legal defensibility, consistency, and alignment with the National Health Act, 2003 (Act No. 61 of 2003) and the Procedural Regulations Pertaining to the Functioning of the OHSC and handling of complaints by the Health Ombud (2016) placed additional pressure on the limited technical capacity.

The OHSC experienced challenges due to health establishments failing to inform the OHSC in advance of inspection week when undergoing renovations, or when merging or ceasing operations.

Additionally, some General Practitioners requested rescheduling of inspections during the inspection week, while others showed reluctance and reluctant behaviour toward the inspection process. This led to unnecessary inconvenience.

Limitations in the EWS's system functionality required enhancements, including adding features to improve efficiency and strengthen the OHSC's monitoring and response capacity by enabling a streamlined data collection process.

The Health Ombud has been managing a substantial volume of complex complaints, many of which require expert clinical input to ensure accurate and fair resolution. Compounding this challenge is a historical backlog, which has placed additional pressure on available resources. The resolution process for these complaints is highly labour-intensive, requiring thorough examination of extensive evidentiary materials, such as medical records, reports, and audio-recorded interviews.

The Call Centre recorded a 9% increase in the number of complaints lodged between FY 2024/25 (3938 cases) and 2025/26 (4297 cases). The complexity of medium, high, and extreme-risk cases (particularly those involving multiple health institutions) also exacerbates the office's challenges, as they are resource-intensive and require extended investigation periods. Moreover, delays in obtaining information from health establishments (HEs) and/or complainants, high-volume information from HEs, and cases that require external expert opinion prolong turnaround times, significantly delay case finalisation, and further exacerbate the backlog.

10.2. ORGANISATIONAL ENVIRONMENT

The OHSC maintained its operations in a legally compliant, transparent, and efficient manner. The Board ensured that financial and risk management, along with internal controls, are effective as mandated by the PFMA. The Board appointed the Board Secretary during the period under review, and the Board Charter and Terms of Reference for the Board Committees of the OHSC were reviewed in alignment with the PFMA and the newly enacted King Report, Vol V.

The remuneration of the Board is prescribed by the National Treasury Regulations and directives, which are reviewed annually. In addition to the prescribed

remuneration requirements. The Board, through the Board Secretary, developed and approved the Board Remuneration Policy. The policy serves as a governance instrument that sets out the principles, framework, and processes for compensating members of a board of directors or board committees, ensuring remuneration is fair, transparent, lawful, and aligned with the organisation's strategic objectives and governance obligations.

The outgoing Board at end of February 2025, developed a comprehensive Board hand over report for the onboarding of the new OHSC Board which took office in March 2026. The purpose of the handover was to report on the Board's milestones and (other strategic matters for consideration) during its tenure and to ensure a seamless transition for the incoming Board by highlighting any pending strategic matters.

The newly appointed Board underwent an induction and training session facilitated by the Institute of Directors of Southern Africa, during which members were trained on their strategic role in relation to the OHSC, their fiduciary duties, and their overall functions in relation to the Minister of Health. The new Board also received an induction on the legislative mandate and the various functions of units within the OHSC to better understand the OHSC's positioning and functioning.

A workshop and training on the Protection of Personal Information Act (POPIA) was conducted for senior staff members of the OHSC. The purpose of which was for members to understand and implement the provisions of POPIA in their respective standard operating procedures.

As at the end of the 2025/26 FY, the OHSC attained a 95.10% occupancy rate, filling 136 of 143 funded positions. The vacancy rate was 4.9%, against a planned target of 6%. The target was exceeded due to streamlined, effective recruitment processes for positions below the senior management level. This is despite the challenges experienced in recruiting suitably qualified candidates for senior management positions. Multiple initiatives have been undertaken to fill senior management roles by adopting a multi-faceted recruitment approach, including the concurrent use of various methods such as employment agencies, headhunting and professional platforms like PNet.

The organisation continues to strive to increase the appointment of youth, persons with disabilities,

and women to senior management positions. As of 31 March 2026, out of the 136 filled posts, 38.9% (7/18) are women in senior management positions, 0% (0/136) are people living with disabilities, and 12.5% (17/136) are youth employees. However, the targets could not be met due to ongoing difficulties in attracting and appointing suitably qualified candidates from these target groups.

The organisation outsourced the employee wellness programme to a service provider to maintain confidentiality and ensure that employees receive professional support tailored to their specific needs and challenges. During the year under review, the wellness programme delivered three (3) engaging sessions on key topics, including workplace harassment, bullying, financial management, post-retirement debt counselling, and achieving a work-life balance. However, no health risk assessments were carried out due to several factors. These included employees working remotely during the transition to the new building and continued remote working arrangements when the new landlord commenced external building renovations. The OHSC continued to prioritise the training and development of its employees and established a Training and Development Plan to this end.

The implementation of the plan resulted in employees attending short courses, conferences and seminars as part of skills development. Furthermore, capacity-building for newly appointed Inspectors was facilitated through the OHSC's structured in-house training. Additionally, the OHSC provided study assistance bursaries to eight (8) employees to enhance their qualifications in their respective fields. The OHSC successfully migrated all ICT infrastructure from the Pretoria office to the new Centurion premises with minimal operational downtime. The well-coordinated migration also gave credence to the organisation's disaster recovery plans (DRP) that are in place. The regular scheduled maintenance and updates to optimise the performance and security of the core applications were performed. These well-planned activities were carried out during off-peak hours to minimise any impact on the users.

The OHSC successfully addressed ICT internal audit findings, cybersecurity issues, and penetration testing results. This improved the organisation's overall security posture and enabled the implementation of enhanced controls, including Two Factor Authentication. The OHSC has adopted a hybrid-by-design cloud approach, and the ongoing growth of

services and users requires scaling to a larger cloud hosting platform. The increasing complexity of ICT often outpaced the available human resources and technical expertise. The need to build internal capacity to sustain key projects, core to the OHSC, and to invest in ongoing ICT staff development and certifications. The need to refresh technology in alignment with product life cycles and budget availability is crucial to sustain ICT projects.

The OHSC has continued to maintain the trend of obtaining an unqualified (clean) audit opinion from the Auditor-General of South Africa (AGSA), demonstrating good corporate governance. The OHSC has in place a risk management policy and risk management strategy that require management to conduct regular risk assessments to determine the effectiveness of the OHSC's risk management strategy and to identify new and emerging risks. The Board has approved the revised Risk Management Policy and Risk Management Strategy. A strategic risk assessment was conducted, resulting in an update of the existing strategic risk register. The internal auditors facilitated the strategic risk assessment workshops with the internal management team in September 2025 and thereafter with the Board. Following deliberations, the Board approved a Strategic Risk Register in January 2026 for inclusion in the 2026/2027 Annual Performance Plan.

A fraud and corruption prevention plan is in place to create awareness and guide employees on how to report suspected cases of fraud and corruption. The management is confident that the employees and stakeholders will use the relevant reporting channels, including a fraud hotline. The fraud and corruption prevention plan establishes an internal control system to detect and prevent fraud and corruption. The OHSC maintained its operations in a legally compliant, transparent, and efficient manner, guided by the approved Board Charter. The Charter ensures that financial and risk management, along with internal controls, are effective as mandated by the PFMA.

Key policy developments and legislative changes

There were no policy developments or legislative changes that may have affected the OHSC's operations.

10.3. PROGRESS TOWARDS ACHIEVEMENT OF INSTITUTIONAL IMPACTS AND OUTCOMES

Impact	Safe and quality healthcare services	
2024-29 Medium-Term Development Plan	OHSC Outcome	Progress
Strategic Priority 2: Reduce Poverty and tackle the high cost of living	Highly effective and financially sustainable OHSC	<ul style="list-style-type: none"> The OHSC obtained an unqualified audit opinion during the year under review, reflecting strong governance practices. The OHSC is in the process of introducing service fees. The revenue generation model and fees regulations have been developed and submitted to the executive authority for consideration. The new Board was appointed in February 2026 and inducted on 12-13 March 2026.
	Increased communication initiatives in profiling OHSC programmes	<ul style="list-style-type: none"> The OHSC collaborated with the GCIS and various community-based organisations and implemented structured community engagement initiatives during the 2025/26 FY to strengthen public awareness, accessibility, and participation in healthcare oversight processes. Twenty-four (24) community engagements were conducted to further profile the OHSC programmes and raise public awareness of the OHSC and the Health Ombud's roles and mandates. The OHSC, with the Health Ombud, implemented 45 targeted media engagement strategies to enhance public awareness, improve transparency, and increase the visibility of regulatory and complaint-resolution functions within the health sector. A total of 44 digital campaigns to profile OHSC programmes were conducted, which included community engagement initiatives and media interviews.
	Improved coverage of HEs	<ul style="list-style-type: none"> The OHSC inspects health establishments against the regulated norms and standards. A total of 975 HEs were inspected during the 2025/26 FY, this includes 762 public and 213 private HEs. Alongside a total of 63 HEs were reinspected across all provinces. The OHSC implemented the GP inspection tool with regulated norms and standards. The GP inspection tool covered administrative and clinical governance aspects of the regulated norms and standards.

Impact	Safe and quality healthcare services	
2024-29 Medium-Term Development Plan	OHSC Outcome	Progress
	Improved quality of healthcare services and patient safety through the implementation of Ombuds' recommendations	<ul style="list-style-type: none"> The Health Ombud closed 79.06% (3 288/ 4 159) low-risk complaints within 25 working days. A total of 43.75% (21/48) medium-risk-rated complaints were resolved within the Service Level Agreement (SLA) of 60 working days. The Health Ombud conducted a total of 17 unannounced NPM visits across 4 provinces (KZN, EC, FS and NW) during the period under review. A total of 21.74% (10/46) of Complaints were resolved within 6 months and 23.68% (18/76) were resolved within 24 months through investigation. As at the end of the FY 2025/26, a total of 7.69% (10/130) of complaints were resolved older than 24 months through investigation.
	Improved access to health care services through registering and profiling of health facilities	<ul style="list-style-type: none"> As at the end of the 2025/26 FY, a total of 4,955 HEs were registered and profiled, which included 3,935 public HEs and 1,020 private HEs. With 30 guidance workshops conducted aimed at improving healthcare quality and safety. A comprehensive quality recommendation report developed for relevant authorities.
	Enhanced public trust in safety and quality of healthcare services	<ul style="list-style-type: none"> The OHSC certifies health establishments (HEs) that comply with the required norms and standards, with a total of 906 HEs certified to date. A key enabler of improved performance during the reporting period was the utilisation of the newly introduced online Certification and Enforcement Module. Enforcement actions were taken against HEs that were persistently non-compliant with norms and standards. A total of fourteen (14) HEs were issued written warnings within 30 days of the final inspection report. In addition, all 11 enforcement actions were successfully resolved within 90 working days.

11. INSTITUTIONAL PROGRAMME PERFORMANCE INFORMATION

The non-achieved output indicators are indicated below:

Programme	Status
Programme 1: Administration 1.1. Integrated Human Resource Strategy. 1.2. Percentage representation of women in SMS positions.	Targets not achieved
Programme 2: Compliance Inspectorate 2.1 Number of annual reports that set out the compliance status of all health establishments and summarise the number and nature of the compliance notices issued and published.	Target not achieved
Programme 3: Complaints Management and Office of the Ombud 3.1 Percentage of user complaints resolved through assessment within 30 working days of receipt of a response from the complainant and/or the health establishment. 3.2 Percentage of medium risk-rated complaints resolved within 60 working days. 3.3 Percentage of complaints resolved within 6 months through investigation. 3.4 Percentage of complaints resolved older than 24 months through investigation.	Targets not achieved

PROGRAMME 1: ADMINISTRATION

To provide the leadership and administrative support necessary for the OHSC to deliver on its mandate and comply with all relevant legislative requirements.

SUB-PROGRAMMES

Key corporate functions are fulfilled through the following sub-programmes:

- **Sub-programme 1.1:** Human Resource Management
- **Sub-programme 1.2:** Finance and Supply Chain Management
- **Sub-programme 1.3:** Information and Communication Technology
- **Sub-programme 1.4:** Communication and Stakeholder Relations

SUB-PROGRAMME: HUMAN RESOURCE MANAGEMENT

The Human Resource Management unit provides integrated human resource services to ensure that the OHSC achieves its strategic objectives by creating a conducive and harmonious working environment. To give effect to this, the unit recruits, develops and seeks to retain skilled employees. The unit also deals with all other facets of HR including labour relations

matters as well as performance management, service benefits, skills development and training, employment equity and facility management.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievement

By the end of 31 March 2026, 136 of the 143 (95.10%) funded positions were filled. This translated into a vacancy rate of 4.9%, exceeding the strategic target of 6%. Of the 136 filled posts, 130 (95,58%) are Africans, 3 White (2,2%), 2 Coloured (1,47%), 1 Indian (0,73%). Senior management level, 7/18 (38.9% females), whilst males are 11/18 (61.1%). For the two vacant posts, (Executive Manager Complaints Management and Senior Manager Health Systems Data Analysis and Research), priority will be given to female candidates to improve equity. The OHSC has 0% of its staff registered as disabled, since losing one to retirement. The OHSC will endeavour to utilise various methods to recruit people with disabilities. On youth employment, 17/136 (12,5%) of our staff are young people. The entity endeavours to attract more young people, persons with disabilities and women in senior management positions. This performance reflects a concerted effort to reduce vacancies, ensuring that consistent staffing levels drive organisational effectiveness and service delivery.

In pursuit of capacitating and enhancing employees' skills, the OHSC established a training and development plan, which was implemented during the year under review. A total of 42 training sessions, short courses, conferences and seminars were conducted and attended by employees as part of skills development. An in-house inspector training was conducted for newly appointed Inspectors, with great success. Additionally, the OHSC provided study assistance bursaries to eight (8) employees to enhance their qualifications in their respective fields. The employee wellness function is outsourced to a service provider to ensure employee confidentiality and to provide professional assistance that addresses employees' specific challenges and needs. The wellness programme offered three intriguing discussions during the financial year, covering workplace harassment and bullying, financial and post-retirement debt counselling, and work-life balance.

The wellness programme offered three intriguing discussions to staff during the financial year, covering workplace harassment and bullying, financial and post-retirement debt counselling, and work-life balance.

The OHSC dealt with several grievances and complaints during the period under review, and four (4) disciplinary cases were recorded, of which two (2) were concluded, and two (2) will be concluded in the new financial year. HR policies reviewed during the year were consulted in the Bargaining forum and shared with employees for input, to ensure their sentiments were considered before the policies were approved for implementation. Some policies dealt with in the past financial year are as follows: Internship Policy, Leave Policy, Conditions of Service Policy, Acting Allowance Policy, Recognition of Long Service Policy, Bargaining Forum Constitution, and Organisational Rights Agreement.

Challenges encountered by Human Resource Management during FY 2025/26

During the year under review, the OHSC is developing a comprehensive Human Resources strategy that should focus on retention and make the OHSC an organisation of choice for potential employees. However, the process had to be delayed due to the strained employer-employee relations following the office relocation in 2025.

The OHSC experienced strained labour relations (employer-employee) due to disputes around the relocation to the new building. This dispute escalated into various forms of industrial action, including picketing and a protest march to the National Department of Health, prompting management to devote much of its time to rebuilding the relationship with employees. As a result, some of the programmes planned for the year under review were severely affected. However, relations improved in the last quarter of the reporting year.

An online staff satisfaction survey was conducted during the third quarter of the reporting period. Due to low staff response rate, the employee satisfaction survey was repeated for the second time during the latter part of the first quarter of the new financial year. It is hoped that employees will co-operate in participating more enthusiastically during the second round of the survey.



Sub-programme: Human Resources Management							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Highly effective and financially sustainable OHSC						
1.1 Approved integrated Human Resource Strategy	1.1.1 Integrated Human Resource Strategy	New Indicator	New Indicator	1	0 Target was not achieved; however, 2 workshops led by the Department of Public Service and Administration (DPSA) were held on the Organisational Design and Operation Model to inform the organogram and strategy developed.	-1	OHSC experienced strained employer-employee relations following the office relocation in 2025, and management devoted much of its time and effort solely to managing the resulting disputes. As a result, the Integrated Human Resource strategy development stalled. The Integrated HR Strategy will be finalised in the next financial year 2026/27.
1.2 Vacancies filled per annum	1.2.1 Percentage vacancy rate	4,55% (6/132)	3,5% (5/142)	6%	4,9% (7/143)	+1,1	The target was exceeded due to streamlined and effective recruitment processes for positions below the senior management level.
1.3 Women in SMS level	1.3.1 Percentage representation of women in SMS positions	New Indicator	New Indicator	50%	38,9% (7/18) SMS positions were occupied by females.	-11,1%	The OHSC had twenty-one (21) SMS funded positions, and three were not filled by the end of the financial year. Performance against the target was not achieved due to difficulties in finding suitable candidates for the vacant positions, despite multiple rounds of advertising, the use of recruitment agencies and headhunting efforts. Furthermore, some job profiles for vacant SMS posts have been revisited and reconfigured to better align with current needs within the OHSC. It is hoped that these posts will be filled in the 2026/27 financial year. Although the target was not met in the 2025/26 financial year, progress has been made with the appointment of a female Executive Manager who assumed duty in the first quarter of the new financial year (2026/27).

Strategy to overcome areas of underperformance

Three (3) of the SMS positions were vacant as of 31 March 2026. One of the three posts was filled on 1 April 2026, and the two posts are anticipated to be filled within the new financial year. The OHSC is currently busy realigning key job profiles and reconfiguring them to target more suitable candidates who meet current needs. A campaign will be conducted to encourage all employees to disclose their disability status. A concerted effort will be made to complete the development of the integrated HR strategy, which will require staff participation. It is anticipated that this will be feasible in the new financial year, since the strained management and labour relations have improved. As a result, it should be possible to focus on strategy development.

SUB-PROGRAMME: INFORMATION AND COMMUNICATION TECHNOLOGY

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

Outcomes, Outputs, Output Indicators, Targets and Actual Achievement

The OHSC contributed to an effective and efficient ICT service by ensuring that its systems were reliable, secure, and capable of supporting the organisation's operational and strategic needs. The uptime of critical systems at OHSC exceeded the planned target, primarily due to efficient operations and close monitoring, which ensured minimal downtime and uninterrupted service delivery. This performance highlights the robustness of the ICT infrastructure and the effectiveness of proactive system management in maintaining reliability and supporting the OHSC's mandate. The OHSC enhanced its core systems to support functionality. This included the upgrading of three critical systems: Group-Based Access Control (GBAC), the Certification and Enforcement Module, and the General Practice (GP) online registration system. These enhancements provided the OHSC with

improved tools for managing information, enforcing compliance, and streamlining administrative processes. In addition, the enhancements enabled the OHSC to collect information on services provided to the HEs and contact details, strengthened security, and enhanced enforcement and certification on the OHSC information system. The ICT improvements were to ensure that the systems are secure, reliable, and capable of supporting the organisation's operational and strategic needs. This achievement demonstrates the organisation's commitment to leveraging ICT improvements to support functionality and efficiency.

Through proactive planning, phased implementation, and risk based prioritisation, the OHSC managed resources and budget constraints effectively, sustaining high performance while mitigating infrastructure risks through the upgrading and support of ICT infrastructure. This resulted in a resilient ICT environment that underpins reliability, enhances functionality, and supports the OHSC's mandate. Amongst measures instituted was an external penetration test to evaluate vulnerabilities in the security systems. Of the 12 identified risks/findings, 10 have been fully addressed, with the remaining 2 receiving attention. Other measures include successful advancements in systems and processes implemented following Internal Audit findings in the 2024/'25 financial year; and positive outcomes from the SITA Maturity Assessment conducted in 2025/'26, which identified only one risk: the lack of an approved Business Continuity Plan for the OHSC.

Challenges encountered by the ICT during FY 2025/26

Despite maintaining a stable ICT environment, ICT systems have an inherent risk of exposure to external threats such as cybersecurity incidents, as well as dependence on ageing infrastructure components that require ongoing proactive management to prevent unplanned service disruptions. Managing infrastructure upgrades while ensuring service continuity, integrating new technologies, and addressing resource and budget constraints. The steady growth in system usage has placed increased demands on monitoring and support capacity, requiring continued attention to ensure sustained service delivery. The SITA Maturity Assessment Report of 2025/2026 highlighted the absence of an approved Business Continuity Plan as a weakness in the maturity model and a strategic risk for the OHSC to address.

Sub-programme: Information and Communication Technology							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Highly effective and financially sustainable OHSC						
1.4 An effective and efficient IT service provided	1.4.1 Percentage of uptime of critical systems.	New Indicator	New Indicator	96%	99.88%	+3.88%	The planned target was exceeded primarily due to the efficient operations of critical systems supported by close monitoring of existing systems.
1.5 Enhancement of supports system functionality	1.5.1 Number of enhanced systems to support functionality	New Indicator	New Indicator	3	3 The General Practice online registration system, Certification and Enforcement Module and Group-Based Access Control (GBAC) were upgraded. The GBAC is a way to manage staff access to systems and information in a simple, controlled, and consistent way across the entire organisation.	0	The planned target was achieved. The enhanced systems enable the OHSC to collect information on services provided and contact details, strengthen security, ensure consistent enforcement of access controls across the OHSC information system, and make administration manageable.

Strategy to overcome areas of underperformance.

No areas of underperformance were recorded during the reporting period. The ICT will continue to implement continuous improvement and proactive risk management measures to sustain and enhance performance. These include ongoing system monitoring, strengthened preventative maintenance, enhanced Original Equipment Manufacturer (OEM) support arrangements, continued security hardening, capacity planning, and the prioritisation of critical system upgrades to mitigate emerging risks and ensure the sustained resilience and reliability of essential ICT systems.

Whilst APP targets were achieved, all technology-enabled organisations, such as the OHSC, must remain vigilant to manage risk across their comprehensive digital environment. The ICT Steering Committee and the Audit Risk and Finance Committee continuously review the measures in place to safeguard the OHSC's cybersecurity. Amongst vulnerability tests undertaken during the period under review was the independently conducted penetration test, which demonstrated a more than satisfactory system of

measures covering key and substantive defences. Secondly, there was the SITA Maturity Assessment, which covered the full spectrum of ICT systems in the OHSC, from governance systems to tried-and-tested disaster recovery plans.

The OHSC will build on work already done (such as the draft BCP framework, ICT Disaster Recovery Plan, and ICT Policies reviewed by Internal Audit) to develop and finalise a comprehensive Business Continuity Plan.

SUB-PROGRAMME: COMMUNICATION AND STAKEHOLDER RELATIONS

The sub-programme aimed to increase awareness of and strengthen understanding among stakeholders and the public of the roles, powers, and mandates of the OHSC and the Health Ombud. This objective was achieved through strategic communication, structured stakeholder engagement, and the development of collaborative partnerships to support the effective and efficient fulfilment of the OHSC's mandate.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

The OHSC and the Health Ombud operated a performance-driven framework that emphasised accountability, transparency, and measurable impact in improving the quality and safety of healthcare services. The sub-programme played a critical role in the execution of the OHSC and Health Ombud mandates through strategic communication, stakeholder engagement, and partnership development. To meet national planning and reporting requirements, this framework was structured around clearly defined outcomes, outputs, output indicators, targets, and actual achievements, enabling effective monitoring and evaluation of organisational performance during the 2025/26 financial year. At an outcome level, the sub-programme sought to increase awareness, understanding, and trust among stakeholders and the public regarding the roles, powers, and functions of the OHSC and the Health Ombud. These outcomes were essential in promoting a culture of accountability, encouraging the use of complaint mechanisms, and strengthening public confidence in the health system.

To achieve these outcomes, the sub-programme implemented a range of activities, including communication campaigns, stakeholder engagement initiatives, public education programmes, media relations efforts, and the establishment of strategic partnerships. These activities were directly managed by the sub-programme and crafted to ensure key messages were delivered effectively and consistently to diverse audiences.

The OHSC, in collaboration with the Government Communication and Information System (GCIS) and various community-based organisations, implemented structured community engagement initiatives during the 2025/26 financial year to strengthen public awareness, accessibility, and participation in healthcare oversight processes. These engagements were to ensure that communities were informed about the compliance requirements for HEs regarding quality health standards. This included providing information on patient rights, mechanisms for raising concerns, and processes for lodging and resolving complaints through the Health Ombud, the engagements highlighted the role of public participation in enhancing the quality and safety of care. The expected outcomes of these engagements included conducting community outreach sessions in targeted districts and provinces, encouraging active participation by community members and relevant stakeholders, and distributing accessible

information on the functions of the OHSC and the Health Ombud.

Targets were set for the year and monitored quarterly to ensure that planned engagements were delivered effectively and within scope. From a performance management perspective, actual achievement was assessed against these targets to determine the effectiveness, coverage, and quality of engagement activities. Through these engagements, the OHSC and the Health Ombud reinforced a culture of transparency, accountability, and continuous improvement in the quality and safety of healthcare services. As a result, 24 community engagements were conducted to profile OHSC programmes and raise public awareness of the OHSC and the Health Ombud's roles and mandates. The OHSC conducted community engagements in various provinces, including Gauteng, KwaZulu-Natal, Mpumalanga, the Northern Cape, North West, the Western Cape, and the Free State, ensuring broad geographic reach and inclusive stakeholder engagement.

The OHSC and Health Ombud participated in various health conferences, professional platforms, and webinars, enabling the organisation to connect with targeted professional and institutional stakeholders. These engagements included platforms and fora organised by various organisations and gatherings, such as the South African Medico-Legal Association (SAML), the Board of Healthcare Funders (BHF), the Hospital Association of South Africa (HASA), the South African Pharmaceutical Exhibition (SAPHEX), Clinix Health Group, Nedbank Health, the South African nursing community, the KwaZulu-Natal Doctors Coalition, the Rand Easter Show, and related fora.

During this reporting period, a significant milestone was achieved with the Health Ombud hosting its inaugural symposium, which brought together experts and professionals to discuss important healthcare issues. Collectively, these engagements increased the visibility of the entity's programmes, strengthened relationships with key stakeholders, and enhanced understanding of complaint resolution processes along with the regulatory mandates of both the OHSC and the Health Ombud.

The OHSC, in partnership with the Health Ombud, implemented 45 targeted media engagement strategies to enhance public awareness, improve transparency, and increase the visibility of regulatory and complaint-resolution functions within the

health sector. This approach involved the proactive, coordinated use of various media platforms to communicate important messages from the OHSC and the Health Ombud, including health standards compliance requirements, patient rights, and complaint resolution processes. This ensured that timely and accurate information reached the public and key stakeholders.

The OHSC utilised a range of media platforms, including broadcast, print, digital, and social media, through press releases, interviews, media briefings, and responses to public enquiries. These efforts supported consistent and transparent communication.

As a result of these engagements, regulatory activities became more visible, public understanding of the complaint processes improved, institutional credibility strengthened, and information promoting accountability within the health system was distributed more broadly.

Overall, the media engagement activities during the 2025/26 financial year significantly enhanced public awareness, expanded outreach to diverse audiences, and reinforced the OHSC and Health Ombud's commitment to transparency, accountability, and continuous improvement in healthcare oversight.

To enhance awareness and support compliance with health standards, the OHSC strengthened its digital communication by producing the OHSC bulletin, a quarterly digital newsletter. This platform shares timely, relevant information on regulatory activities, compliance requirements, and guidance for improvement. It translates complex regulatory information into accessible content for health establishments, medical professionals, and healthcare workers through 44 initiatives, including the production of content, ensuring critical updates reach those responsible for healthcare delivery. By promoting understanding of compliance expectations and quality improvement practices, the bulletin fosters stakeholder engagement, enhances transparency, and supports continuous learning within the healthcare system.

During the review period, OHSC enhanced its digital communication through its official website and social media platforms, facilitating timely information dissemination and stakeholder engagement. The revamped website became a central resource, offering easy access to regulatory frameworks,

inspection updates, and relevant documents, while prioritising accessibility and usability.

Simultaneously, OHSC boosted its presence on Facebook, X, LinkedIn, YouTube, and Instagram to engage healthcare workers, health establishments, and the public. These platforms were used to share updates, awareness messages, and regulatory announcements, increasing visibility for OHSC and the Health Ombud. Overall, these efforts improved access to compliance information, raised public awareness of OHSC services, and strengthened stakeholder engagement, with performance tracked through digital engagement metrics such as website traffic and social media activity.

Challenges encountered by Communication and Stakeholder Relations during the FY 2025/26

Over the 2025/26 financial year, the OHSC faced several operational and contextual challenges that hindered the optimal delivery of communication, engagement, and stakeholder management activities. These challenges are typical of a multi-stakeholder regulatory environment and were addressed through adaptive strategies and continuous improvement efforts.

The OHSC experienced severe constraints in budget availability, staffing capacity, and logistical support, which significantly and adversely affected its ability to fulfil its mandate effectively. These limitations materially restricted the scale, reach, and frequency of community outreach programmes, media engagements, and stakeholder fora, compromising efforts to build public awareness, sustain stakeholder confidence, and ensure consistent communication. If unaddressed, these constraints pose a substantial risk to achieving communication objectives and to the broader execution of the OHSC's regulatory and oversight responsibilities.

There is a persistent lack of understanding among certain stakeholder groups regarding the role of the OHSC and the Health Ombud, which affects the uptake of complaint mechanisms and engagement initiatives. Reaching geographically dispersed and underserved communities poses challenges, especially in areas with limited digital access, language barriers, and low health literacy.

This requires ongoing reliance on in-person engagements and multilingual communication strategies. Despite these challenges, the OHSC is enhancing its communication systems and stakeholder engagement. Improvements in digital communication and targeted strategies are anticipated to boost effectiveness in the 2026/27 cycle. Effective engagement demands coordination among various partners, which can sometimes complicate alignment and scheduling of joint initiatives.

During the 2025/26 financial year, the OHSC experienced a rise in communication support requests from internal and external stakeholders. These requests involved stakeholder engagements, communication materials, awareness campaigns, media engagement, and events related to the review of the Norms and Standards Regulations for health establishments. This uptick stemmed from improved understanding and increased stakeholder interest

in regulatory processes and consultation activities. Requests mainly focused on promoting consultation sessions, developing awareness materials, providing media support, and coordinating communication campaigns to enhance stakeholder participation and feedback. This trend indicated a growing demand for clear communication on regulatory processes, necessitating better prioritisation and coordination to maintain consistency and accuracy.

The increase in requests included invitations to health conferences, requests for presentations, and digital engagement, reflecting improved stakeholder trust. However, additional pressures arose from organisational austerity measures that restricted budgets, travel, and essential staffing, disrupting planned activities. These challenges hindered the ability to effectively meet stakeholder demand and jeopardised its communication and engagement efforts.

Sub-programme: Communication and Stakeholder Relations							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Highly effective and financially sustainable OHSC						
1.6 Engagements to profile OHSC programmes	1.6.1 Number of engagements to profile OHSC programmes	New Indicator	New Indicator	24	24	0	The OHSC participated in a series of community outreach initiatives across various locations, continued to strengthen strategic partnerships, and reinforced its role in advancing quality and safety within health establishments.
1.7 Media initiatives to increase awareness of OHSC programmes	1.7.1 Number of media initiatives to increase awareness of OHSC programmes	New Indicator	New Indicator	4	45	+41	The target was overachieved due to the release of the Health Ombuds' Investigation reports, which attracted media and public attention.
1.8 Digital campaigns to profile OHSC programmes	1.8.1 Number of digital campaigns to profile OHSC programmes	New Indicator	New Indicator	24	44	+20	The target was overachieved due to increased activity during the period, including community engagement initiatives and media interviews. increased activity during the period, including community engagement initiatives and media interviews.

Strategy to overcome areas of underperformance

None, due to resource constraints and the implementation of organisational austerity measures during the reporting period.

SUB-PROGRAMME: FINANCE AND SUPPLY CHAIN MANAGEMENT

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

Outcomes, Outputs, Output Indicators, Targets and Actual Achievement

The OHSC’s enabling legislation stipulates that the OHSC is funded by fees appropriated by Parliament and potential fees for services rendered. The

management developed a revenue-generation model and accompanying fee regulations, and the Board has approved the revenue-generating model for fees for services rendered by the OHSC. The OHSC drafted the proposed regulations for the revenue-generation model, which would then be submitted to the Executive Authority in the Ministry of Health for consideration and consultation with relevant stakeholders.

Challenges encountered by the Finance and Supply Chain Management during the FY 2025/26

The mandate of the OHSC is significant given the scope of the country’s health sector, and it requires commensurate resources to enable the OHSC to achieve its objectives. The current financial resources are inadequate to meet the mandate’s demands, given the recently approved National Health Insurance Act 20 of 2023. In addition, the capacity of support functions, such as Finance and Supply Chain Management, has not increased in line with the complexity of the OHSC over the years.

Sub-programme: Finance and Supply Chain Management							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Highly effective and financially sustainable OHSC						
1.9 Unqualified audit opinion achieved by the OHSC	1.9.1 Unqualified audit opinion achieved by the OHSC	Unqualified audit opinion achieved by the OHSC	Unqualified audit opinion achieved by the OHSC	Unqualified audit opinion achieved by the OHSC	Unqualified audit opinion achieved by the OHSC	None	target achieved

Strategy to overcome areas of underperformance.

The approval of the draft revenue generation framework by the Executive Authority will enable the OHSC to generate revenue from services rendered to health establishments, thereby reducing the financial constraints it currently faces.

PROGRAMME 2: COMPLIANCE INSPECTORATE

The purpose of the Compliance Inspectorate is to manage the inspection of health establishments to

assess their compliance with norms and standards regulations for quality and safety, as prescribed by the Minister of Health.

The Compliance Inspectorate programme is responsible for conducting routine and re-inspections. Routine inspections are planned inspections conducted as outlined in the Annual Inspection Strategy. Additional inspections comprise risk-based, re-inspections as well as pilot inspections. Risk-based inspections are ad-hoc, triggered by the Early warning System and media alert, while pilot inspections are conducted during the inspection tool development process in partnership with HSDAS (Programme 4).

Re-inspections are conducted for all health establishments which were found to be non-compliant during routine inspections. Such an inspection is conducted to check whether non-compliance has been remedied.

The outcomes of inspections are communicated to the Certification and Enforcement Unit (Programme 5). All health establishments found to be compliant are recommended for certification, while those found non-compliant are issued compliance notices. Health establishments that are found to be non-compliant after a re-inspection are recommended for enforcement action.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

The OHSC develops an Inspection Strategy at the beginning of each financial year to guide inspection activities, including inspection targets. The annual inspection strategy outlines the inspections to be conducted, the health establishments to be inspected, the inspection methodology, and the inspection procedures. The yearly inspection strategy includes prioritising, scheduling inspections, conducting them, and allocating resources for implementation. The Board approved the 2025/26 annual inspection strategy as mandated by Regulation 12 of procedural regulations on the function of the OHSC and handling complaints by the Ombud, 2016. The OHSC conducted inspections of HEs across both the public and private sectors in accordance with the approved 2025/26 annual inspection strategy. The inspections were conducted in line with the mandate of the OHSC as contemplated in Section 78 of the National Health Act, 2003 (Act No. 61 of 2003). A total of 975 HEs, including 762 public and 213 private health establishments, were inspected during the period under review.

The OHSC implemented the GP inspection tool for the first time in the third quarter of the 2025/26 FY, in line with regulatory norms and standards. The GP inspection tool covered administrative and clinical governance aspects of the regulated norms and standards. Generally, the sector welcomed the inspection, though with expected anxiety about being inspected for the first time. The OHSC also conducted road shows on media platforms to raise public awareness of the OHSC's and the Health Ombud's roles, including participation in other stakeholder conferences.

A total of 63 HEs were reinspected across all provinces. They were linked to the same schedule for routine inspections to improve cost-effectiveness and resource utilisation. Furthermore, three (3) risk based inspections (RBI) were conducted at Tembisa Tertiary Hospital in Gauteng Province following the fire outbreak in the outpatient department, Embekweni Hospital in Free State Province, which was triggered by an EWS report about severe staff shortage and lastly at Dora Ngiza Regional Hospital in Eastern Cape Province following the media report of the two (2) abducted newborns in the hospital. All reports were released to the person in charge of health establishments. RBIs arise from the Early Warning System (EWS) triggers and serve to monitor indicators of risks related to serious breaches of norms and standards regulations. The RBIs are mainly qualitative inspections that establish the root causes of the breaches of the norms and standards regulations.

During the period under review, a virtual verification Standard Operating Procedure (SOP) was developed and approved. Virtual verification is a remote process of assessing and confirming a health establishment's compliance with norms and standards regulations through virtual engagements. The SOP is intended to promote cost effectiveness and improve the efficient utilisation of resources during the reinspection process. It will be applied when conducting reinspection of HEs that previously attained satisfactory, good, or excellent grading. The virtual verification SOP will be used to assess the implementation of improvement plans and to verify the closure of gaps identified during routine inspections. This approach is expected to streamline verification processes while maintaining oversight and quality assurance standards.

Challenges encountered by the Compliance Inspectorate programme FY 2025/26

The OHSC experienced challenges due to some General Practitioners requested rescheduling of inspections during the inspection week, while others showed reluctance and uncooperative behaviour toward the inspection process. This led to unnecessary inconvenience and incurred costs when inspectors had to reschedule an inspection and visit another HE. The annual inspection report was not completed timeously, due to the lengthy internal quality control processes and the high volume of data to be analysed as well as communication with facilities.

Programme 2: Compliance Inspectorate							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Improved inspection coverage of HEs						
2.1 Public health establishments are inspected for compliance with norms and standards	2.1.1 Percentage of public health establishments inspected for compliance with the norms and standards	19.62% (734/3741)	19.11% (715/3741)	100% (761/761)a	100,13 % (762/761)	+1 (0.13%)	The target was achieved with one additional HE inspected in Gauteng Province
2.2 Private Health Establishments are inspected for compliance with the norms and standards	2.2.1 Percentage of private health establishments inspected for compliance with the norms and Standards	11.4% (60/526)	18.44% (97/526)	100% (210/210)	101,42% (213/210)	+3 (1.42%)	The target was overachieved with three additional inspections conducted.
2.3 Additional inspection is conducted in health establishments where non-compliance was identified	2.3.1 Percentage of additional inspections (re-inspection) conducted in public and private health establishments that have completed the regulated reporting period and where non-compliance was identified	100%	100% (92/92)	60%	97,05% (33/34)	+37.05%	The target was exceeded by one additional re-inspection conducted due to the integration of the schedule for routine and re-inspections.
2.4 Regulated annual inspection report published	2.4.1 Number of annual reports that set out the compliance status of all health establishments and summarise the number and nature of the compliance notices issued published	0	0	1	0	-1	<p>The annual inspection report was not completed timeously, due to the lengthy internal quality control processes and the high volume of data to be analysed as well as the to and from communication with the health establishments.</p> <p>However, the report was completed and approved by the Board on 29 April 2026.</p>

Strategy to overcome areas of underperformance

The OHSC will strengthen its annual inspection reporting processes and to ensure quality assurance is improved.

PROGRAMME 3: COMPLAINTS MANAGEMENT AND OFFICE OF THE HEALTH OMBUD

The purpose of the Complaints Management Programme and Office of the Health Ombud is to consider, investigate and dispose of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical, and expeditious manner. The programme comprises three sub-programmes:

- **Complaints Call Centre (CCC)** – Call centre operators are employed by OHSC to receive complaints from the public through calls, emails, and written letters. They register, record and screen all complaints received and refer to the next level as appropriate. All low-risk complaints are addressed at the level of the call centre.
- **Complaints Assessment Unit (CAU)** – All complaints that receive a medium and high-risk rating are referred to the CAU. OHSC employs assessors to analyse and assess medium and high-risk-rated complaints. Cases that are assessed as high are further escalated to the Investigation Unit to be investigated.
- **Complaints Investigation Unit (CIU)** – All complaints that receive a high and extreme risk rating are referred to the Complaints Investigation Unit. Investigators are employed to investigate high and extreme-risk-rated complaints. These mainly require on-site visits to the Health Establishments and robust analysis of evidentiary documents.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievement

During the reporting period, the Health Ombud received a total of 4297 new complaints, of which 4159 were low-risk-rated complaints. The former was in addition to the 101 cases carried over from the previous financial year (FY 2024/25).

The Health Ombud closed 3288 low-risk complaints within 25 working days. The annual performance was 79.06%, a 10.94% deviation from its annual target of 90%.

A total of 48 medium-risk-rated complaints received information from the health establishment and/or the complainant, and 21 were resolved within the Service Level Agreement (SLA) of 60 working days. This brought the performance to 43.75%, with the negative deviation of 6.25% from the annual target of 50%.

As a crucial part of the National Preventive Mechanism (NPM), which is mandated to strengthen the protection of persons who are or may be deprived of their liberty in places of deprivation of liberty, the Health Ombud and representatives from the legal unit conducted a total of 17 unannounced NPM visits across 4 provinces, namely, KwaZulu-Natal, Eastern Cape, Free State and North West. These facilities included psychiatric facilities, police stations and correctional centres. The overall performance of the Health Ombud has been captured in a draft annual report, which is currently under review and finalisation.

Backlog complaints have been systematically mapped, assigned, and monitored through weekly reviews by the Health Ombud and monthly progress meetings. Regular updates have been provided to the Minister of Health on the status of both backlog and new complaint investigations. A request for guidance regarding the 130 backlog complaints was submitted to the Minister of Health in June 2025, in accordance with Procedural Regulation 47(1), which pertains to the functioning of the Office of Health Standards Compliance and the handling of complaints by the Health Ombud.

Thirteen (13) appeals have been against the Health Ombud reports since 2022, including one (1) received in February 2026. Seven (7) appeal cases have been finalised as follows: four (4) appeals were adjudicated in favour of the Ombud, and two (3) against the Health Ombud. Two (2) appeals have been withdrawn by the Appellants for personal reasons. Four (4) appeal cases are pending finalisation. Of the 4 appeals, 3 but one (1) are pending the appointment of an independent Tribunal to adjudicate on the matters.

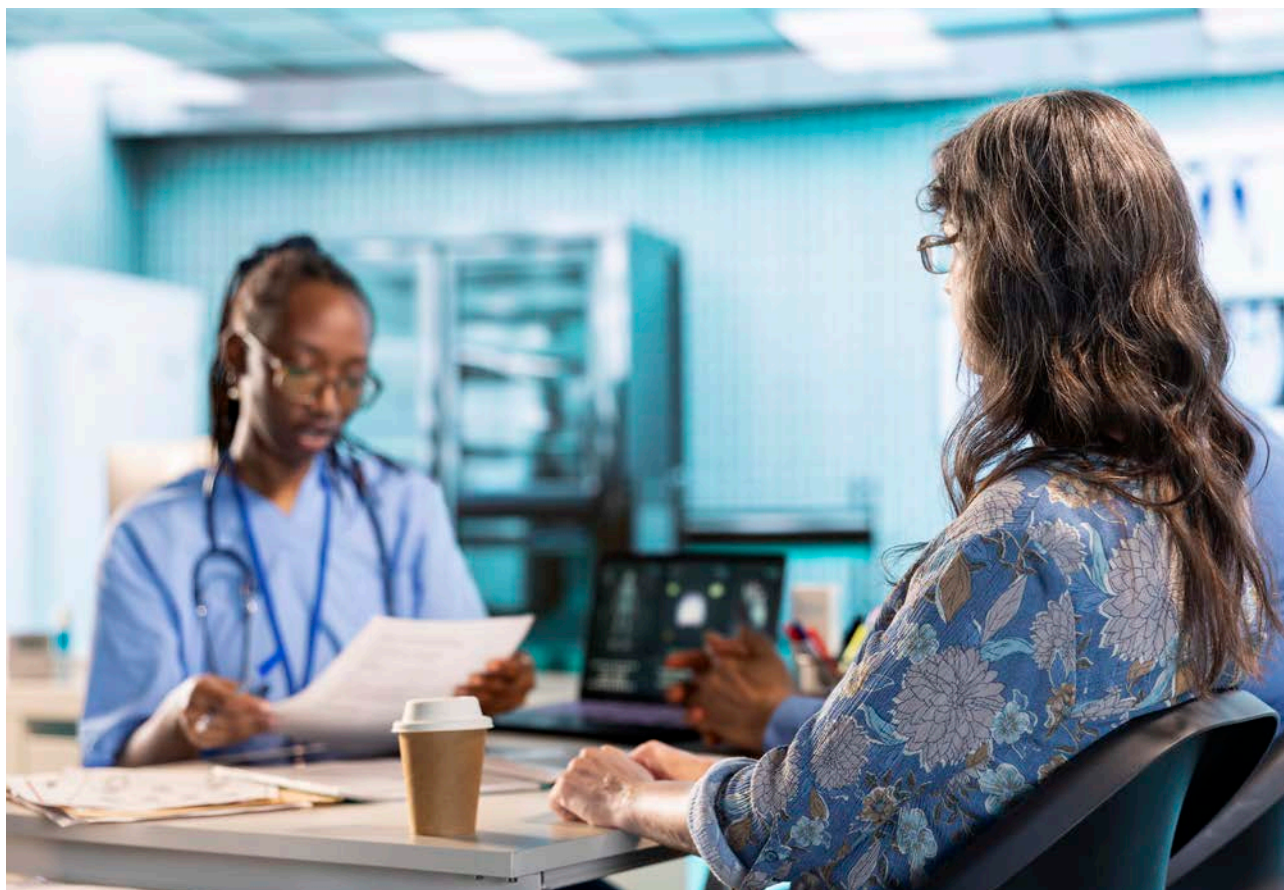
During the reporting period, a significant milestone was reached with the enhancement and relaunch of the Health Ombud website. The redesigned platform aims to improve accessibility, user experience, and public interaction, focusing on clarity, responsiveness, and inclusivity. Key enhancements include a more intuitive interface, simplified navigation, improved multilingual content, and user-friendly guidance for lodging complaints.

Additionally, the website features better feedback mechanisms, allowing users to track enquiries, access information more efficiently, and engage more meaningfully with the Ombud's office. This digital transformation marks a deliberate shift toward more accessible, patient-centred communication channels that facilitate timely reporting and learning within the system. Central to communication strategy is the intentional use of multiple platforms to empower patients and communities with knowledge of their rights, enhance access to reporting mechanisms, and emphasise the importance of speaking out about unsafe or poor-quality care.

Challenges encountered by the Complaints Management and Office of the Health Ombud during FY 2025/26

The Health Ombud experienced a persistent increase in caseload volumes. The Call Centre recorded a 9% increase in the number of complaints lodged between FY 2024/25 (3938 cases) and 2025/26 (4297 cases). The complexity of medium-, high-, and extreme-risk cases (particularly those involving multiple health institutions) also exacerbates the office's challenges, as they are resource-intensive and require extended investigation periods. Moreover, delays in obtaining information from health establishments (HEs) and/or complaints, high-volume information from HEs, and cases that require external expert opinion prolong turnaround times, significantly delay case finalisation, and further exacerbate the backlog.

The Health Ombud also has the additional role of conducting investigations within its NPM duties, including report writing on investigation and inspection findings, which creates competing operational priorities. Lastly, the Health Ombud is historically underfunded, which compounds the increasing caseload and resulting underperformance.



Programme 3: Complaints Management and Office of the Health Ombud							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Improved quality of healthcare services and patient safety through the implementation of Ombuds recommendations						
3.1 Low risk complaints resolved within twenty-five working days of lodgement in the call centre	3.1.1 Percentage of low-risk complaints closed within twenty-five working days of lodgement in the call centre	96.6% (2 308 / 2 389)	90% (3 645 / 3 810)	90%	79.06% (3 288 / 4 159)	-10.94%	The target was not achieved due to a steady increase in complaint cases, placing additional strain on case management.
3.2 User complaints resolved within 60 working days through assessment after receipt of a response from the complainant and/or the health establishment	3.2.1 Percentage of medium risk-rated complaints resolved within 60 working days	New Indicator	New Indicator	50%	43.75% (21/48)	-6.25%	Performance was affected by prioritising high- and extreme-risk-rated complaints due to their severity, which required immediate resource allocation. This was further influenced by the capacity constraints arising from a shortage of assessors, which limited the Health Ombud ability to finalise medium-risk complaints within the planned timeframes.
3.3 Complaints resolved within 6 months through investigation	3.3.1 Percentage of complaints resolved within 6 months through investigation	21.4% (3/14)	48,78% (20/41)	50%	21,74% (10/46)	-28.26%	The 50% target was not achieved primarily due to sustained intake of High- and extreme-risk-rated cases, which are inherently complex and require comprehensive investigation. Considerable progress was made; however, some cases could not be concluded within the year because they were in advanced stages, particularly in report writing and internal quality assurance processes.
3.4 Complaints resolved within 24 months through investigation	3.4.1 Percentage of complaints resolved within 24 months through investigation	42.9 % (12/28)	50% (16/32)	20%	23,68% (18/76)	+3,68%	The Health Ombud exceeded the target as a result of sustained efforts to progress and finalise cases within the extended investigation timeframe. Improved case progression and monitoring led to more matters being concluded within the 24-month period.

Programme 3: Complaints Management and Office of the Health Ombud							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Improved quality of healthcare services and patient safety through the implementation of Ombuds recommendations						
3.5 Complaints resolved beyond 24 months resolved through investigation	3.5.1 Percentage of complaints resolved beyond 24 months resolved through investigation	18 % (29/161)	10,56% (15/142)	12%	7.69% (10/130)	-4,31%	Performance was below target due to the complexity and evidentiary demands of long-outstanding cases, which require additional time for thorough review and information consolidation. Although progress has been made, a number of these matters could not be finalised within the reporting period.

Strategy to overcome areas of underperformance

As financial constraints limit the Health Ombud's performance, additional funding has been sought from the Health and Welfare Sector Education and Training Authority (HWSETA), on the advice of the Parliamentary Portfolio on Health, to specifically support the legacy/backlog cases. The outcome thereof is still pending, and further funding opportunities are being explored, including the National Treasury and the National Department of Health. This funding will augment investigative capacity through the appointment of additional investigators and/or the strategic use of temporary or contract (human) resources to stabilise caseload pressures under a proposed 24-month project named the Letsema project.

To focus resources on valid cases, the Call Centre has adopted strategies such as case screening and redirecting complaints outside the Health Ombud's mandate. The HO also strategically prioritises cases according to complaint SLA and assessment plans and those that are high-impact and actionable, particularly those of significant public interest or involving serious breaches of norms and standards. This reinforces accountability and elevates the officer's national visibility, with a measured impact on overall throughput/ increased new case volumes. The Health Ombud have also filled the vacant complaint officer (1) and investigator (1) posts.

To further improve efficiency, the Health Ombud is exploring options to introduce digital solutions, such as Artificial Intelligence (AI), to automate and simplify

certain processes. In the meantime, managers have taken on the additional role of assisting with case handling. The senior legal investigators have endeavoured to intensify oversight and monitoring of investigators' performance through regular reviews of weekly progress reports and monthly and quarterly internal performance review sessions. This approach is aimed at early identification of challenges affecting investigations and to facilitate timely guidance, support, and intervention where necessary.

PROGRAMME 4: HEALTH STANDARDS DESIGN, ANALYSIS AND SUPPORT

The purpose of the Health Standards Design, Analysis, and Support Programme is to provide technical support to the office through research, health systems analysis, development of data collection tools, training in the use of these tools, and analysis and interpretation of the data collected. The Programme also drives the establishment of stakeholder networks for capacity building and the co-creation of information management systems. The Programme has two sub-units:

- Health Standards Development and Training.
- Health systems, Data Analysis and Research.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievements

General Practice Inspections: The OHSC commenced inspections of General Practices for the first time in 2025. To support this initiative, an online

GP registration system was developed, enabling practitioners to register and profile their practices electronically. The enhanced system allows the OHSC to collect essential information, including services offered and their contact details. General Practitioners were supported through targeted guidance and capacity-building workshops designed to enhance their understanding of the requirements outlined in the inspection tool and to promote compliance with the prescribed norms and standards.

Health Establishments profiling: During the period under review, the registration and profiling of HEs included a self-registration process launched in May 2025, which enabled General Practitioners to register in the OHSC database. To enhance awareness and promote compliance with registration requirements among GPs, the OHSC participated in targeted conferences and symposia, including the Board of Healthcare Funders Conference, the South African Medico-Legal Association (SAML) Conference, and the Hospital Association of South Africa (HASA) Conference. The registration of the HEs contributed to an updated OHSC national health establishment register and the planning of general practices' inspections.

Continued Professional Development Support: The OHSC supported professional development by providing Continuous Professional Development (CPD) accreditation for GPs who attended the workshops. This initiative encouraged participation and reinforced the importance of compliance and quality improvement within clinical practice. Collectively, these efforts demonstrate a coordinated approach to capacity building, ensuring that both public and private sector stakeholders are adequately equipped to implement inspection tools effectively and maintain high standards of healthcare delivery.

Health Establishments Self-Assessments: The OHSC successfully implemented a self-assessment system for users in private acute hospitals. The performance of the Self-Assessment System for private acute hospitals demonstrated notable growth, strong compliance levels, and increased user engagement across the sector. The number of participating HEs expanded to 223 private acute hospitals, while registered users significantly increased to approximately 4 500, reflecting improved uptake and active utilisation of the system. This represents a marked improvement from the 2024/2025 FY, during which 2,500 users were registered across 220 HEs and 210 self-assessments

were conducted. During the reporting period, 212 of the 223 registered health establishments completed their Self-Assessments, achieving a high completion rate of 97.5%. The 11 establishments that had not submitted their Self-Assessments by the initial deadline were identified and proactively followed up, with six subsequently submitting their Self-Assessment reports. The remaining five establishments continue to be engaged and followed up to support timely completion and submission of Self-Assessments.

To further strengthen system effectiveness, refresher training was conducted from July 2025 to enhance user capacity, focusing on system access and navigation, completion of self-assessments, and the downloading and utilisation of Quality Improvement Plans (QIPs). In addition, a podcast was developed to communicate the objectives of the Self-Assessment process, complementing existing training videos and improving accessibility of learning resources. Continuous support was also provided to participating HEs following the OHSC's review of their submissions. Collectively, these interventions contributed to enhanced compliance, strengthened user engagement, and ongoing improvements in the implementation of the self-assessment system.

National Recommendations Report: The national quality assurance recommendations report developed for all provinces, draws from multiple data sources, including Annual Returns, Early Warning Systems (EWS), and inspection reports. This report evaluates performance against the Norm and Standards Regulations and presents a detailed analysis of various elements of compliance of inspected HEs across South Africa during the 2024–2025. The report identifies areas of both compliance and non-compliance, offering a clear picture of how health facilities are functioning relative to regulatory expectations, and identifies patterns and trends in the data.

The analysis of the report highlights systemic governance and operational challenges that continue to compromise the effective functioning of HEs across South Africa on the provision of safe and quality services. These include instability in senior management characterised by acting personnel and vacant critical posts, inadequate monitoring of compliance systems, insufficient emergency preparedness, and persistent infrastructure vulnerabilities, often exacerbated by disruptions to energy and water supplies, further compromising patient

care. These interconnected risks undermine service delivery and expose patients to potential harm, underscoring the urgency of coordinated, sustained corrective action.

By outlining actionable steps for improvement, the recommendations report supports provinces in strengthening oversight, enhancing accountability, and prioritising patient-centred care. The report further emphasises the need to institutionalise a culture of continuous quality improvement, strengthen regulatory oversight, and rebuild confidence in the healthcare system. Ultimately, it serves as a critical tool for continuous quality improvement and for advancing quality, equitable, safe, and effective healthcare delivery nationwide.

Development of Inspection Tools: In parallel, the OHSC continued to develop inspection tools for different categories of HEs through a consultative process involving key stakeholders and relevant HEs within each category. The inspection tools were piloted, tested, and inputs from HEs were incorporated before finalisation and approval. To date, eight (8) inspection tools have been finalised, namely for Clinics, Community Health Centres (CHCs), District Hospitals, Regional Hospitals, Central Hospitals, Tertiary Hospitals, General Practices (GPs), and Private Acute Hospitals. The OHSC Standards Development team is currently developing the inspection tools focused on psy-chiatric hospitals in both the public and private sectors, as well as Emergency Medical Services across both sectors. These activities reflect, continued commitment to expanding regulatory coverage and improving the quality and safety of healthcare services.

Guidance Support workshops: The OHSC conducted thirty (30) guidance and support workshops for better understanding and in support of the implementation of the norms and standards regulations for quality and safety. The OHSC proactively identified areas requiring targeted training and support, ensuring that implementation challenges were addressed in a structured and responsive manner. In addition, districts, hospitals, and provincial Health Departments actively engaged the OHSC, requesting further training sessions to strengthen the capacity of implementers responsible for applying the inspection tools. This collaborative approach strengthened system-wide understanding and improved consistency in the application of prescribed norms and standards across facilities.

Early Warning System: The continued implementation of the EWS enabled the identification and monitoring of indicators related to serious breaches of norms and standards regulations, which posed risks to the health and safety of users within HEs. The EWS forum meetings convened either triggered escalation of matters to Heads of Department (HOD), routine or risk-based inspections, depending on the recommendations arising from reported EWS incidents. National and Provincial EWS Recommendation Reports were developed, highlighting trends in breaches of norms and standards related to patient safety and overall health system weaknesses, and providing recommendations to address these weaknesses. Enhancement of the EWS system by the appointed service provider has commenced. The enhancements are to ensure timely reporting of EWS indicators by HEs and real-time monitoring of the system.

Annual Returns: The Annual Returns provide important information on health system inputs, such as finances, human resources, and infrastructure, that affect the ability of HEs to provide appropriate and safe quality care. The 2025 Annual Returns submissions were successfully coordinated, and support was provided to HEs as required throughout the reporting period. However, ongoing engagements were undertaken to address user challenges and encourage timely submission completion. National and Provincial 2025 Annual Returns Recommendation Reports were developed, and highlighted areas requiring improvement. These reports provided recommendations to strengthen compliance with applicable norms and standards across HEs.

Analytical reports to support evidence-based recommendations were developed for the Annual Returns and EWS Recommendation reports. The Data Analysis team was requested to refine the Data and Risk Management module for the Inspector Training programme held in October 2025. The module was contextualised with context and practical examples drawn from the OHSC inspection data system. The terms of reference for the establishment of the Data Governance Committee were developed to provide a framework for promoting data quality and integrity, and for standardising data management practices across the organisation.

Research: As an advisory body that provides strategic advice and guidance to the OHSC on promoting and strengthening the implementation of its research mandate, the Scientific & Research Technical Task

Team (SRTTT) convened meetings, including sub-committee meetings, during the period under review. The sub-committee was tasked with reviewing the EWS Risk Rating Matrix and identifying criteria for classifying high-risk health establishments. Work to refine the matrix has commenced, with the sub-committee currently focusing on improving the scoring methodology. Additionally, the research policy was reviewed following inputs received from the SRTTT and the OHSC Policy Committee.

The OHSC embarked on a national project of reviewing the norms and standards regulations, promulgated in 2018 by the Minister of Health, which are essential to its role as a healthcare quality assurance regulator. A multi-stakeholder Technical Task Team (TTT) with clearly defined terms of reference was established, comprising representatives from OHSC, NDoH, including all nine (9) provincial Departments of Health, private hospital groups and the Unity Forum of Family Practitioners (UFPF). The primary objective of the review is to strengthen the regulatory framework by addressing identified gaps and limitations, ensuring that the norms and standards are robust, risk-informed, and responsive to the evolving healthcare environment. Particular emphasis is being placed on enhancing the comprehensiveness and applicability of the regulations across a wider range of health establishment categories, including the measurement of health outcomes. This will enable the development of standardised, risk-based inspection tools that can be applied consistently across services, reducing fragmentation and regulatory duplication.

This review aims to reinforce a proactive approach to risk identification and mitigation, promote consistency in quality and safety practices, and support continuous improvement across all levels of care. A streamlined, coherent regulatory framework will not only improve compliance and oversight but also reduce financial and operational burdens on health establishments and the broader health system.

A technical expert was appointed to conduct a desktop benchmarking with other regulators on norms and standards, regulations and health outcomes. This inclusive approach reflects a commitment to collaboration, transparency, and shared accountability and is underpinned by key principles that support high-performing, reliable health systems.

Challenges encountered by the Health Standards Design, Analysis and Support during FY 2025/26

Delays in certain stakeholder processes have impacted the timelines for completing inspection tools. Low GP registration compliance, including incomplete or inaccurate data provided by the HEs that require follow-up and verification, has been a challenge. Similarly, the late submission of annual returns by certain public and private HEs led to extensions being granted. The issues of limited capacity, research funding and competing operational priorities constrain the conduct of research activities and the production of peer-reviewed. The HSDAS unit has limited capacity to undertake all the required activities simultaneously and to achieve the overall OHSC mandate.



Programme 4: Health Standards Design, Analysis and Support							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Improved access to health care services through registering and profiling of health facilities						
4.1 Recommendation report for improvement in the health sector completed and shared with relevant authorities, to ensure compliance with prescribed norms and standards	4.1.1 Number of quality recommendation reports developed for relevant authorities	3	3	1	1	0	The target was achieved. The recommendations report highlights key areas affecting the quality and safety of healthcare services.
4.2 Guidance workshops to facilitate implementation of the norms and standards regulations	4.2.1 Number of Guidance workshops conducted	29	43	30	30	0	The target was achieved. Guidance workshops were aimed at improving healthcare quality and safety.
4.3 Health establishments registered and profiled	4.3.1 Number of health establishments registered and profiled	New Indicator	New Indicator	Public: 3 935 Private: 1 020	Public: 3 935 Private: 1 020	0	The planned target was achieved. 1020 GPs were registered via the OHSC online platform. 3935 Public HEs registered and profiled were received from Annual Returns and from the ideal facility framework

Strategies to address underperformance

Technical Task Teams were established for each inspection tool to support structured development and review of standards. The Technical Task Teams, comprising experts from various clinical and technical disciplines, provided valuable input into the development and refinement of inspection tools. Going forward, the composition of these groups will be further strengthened through the inclusion of additional technical expertise in tool development to enhance quality, consistency and efficiency of the tool development process.

A central master database of all measures will be established and maintained to improve consistency, standardisation and accessibility of inspection related information. Inspection tools will progressively be digitised and developed directly within the central database, reducing reliance on Word-based documents and improving version control, accessibility and data integrity. Training approaches

will also be strengthened through the development of innovative and user-friendly learning materials, with expanded dissemination through appropriate digital and social media platforms.

Stakeholder communication and awareness initiatives will be strengthened to promote compliance with mandatory registration requirements. This will include enhanced collaboration with provincial health departments and relevant professional bodies to improve awareness and compliance. Periodic data verification exercises will be undertaken to improve the accuracy and completeness of the national register. To support the timely submission of annual returns, stakeholders will receive early communication of submission timelines, supported by user guides and ongoing assistance throughout the submission period.

The establishment of a Data Governance Committee will strengthen oversight of data quality, integrity

and governance across the OHSC. In parallel, staff analytical capabilities will be enhanced through targeted training and capacity building initiatives, enabling more effective use of data for planning, monitoring, evaluation and decision making.

Resources and strategic partnerships will be mobilised to support the implementation of priority research projects identified in the OHSC Research Agenda. Greater emphasis will be placed on identifying and undertaking secondary research projects using existing organisational data. Staff who participated in scientific research and report writing training will be encouraged and supported to contribute to these projects, with the longer term objective of generating publishable research outputs in peer reviewed journals. This approach will strengthen the OHSC's evidence base and promote a culture of continuous learning knowledge generation.

PROGRAMME 5: CERTIFICATION AND ENFORCEMENT

The purpose of the Certification and Enforcement programme is to certify compliant health establishments and take enforcement action against non-compliant health establishments. The programme is required to publish information on certificates of compliance issued and enforcement action taken.

Outcomes, Outputs, Output Indicators, Targets and Actual Achievement

During FY 2025/26, the OHSC achieved all its planned annual targets for Certification and Enforcement. A total of 906 HEs were compliant and issued certificates of compliance within the prescribed timeframe of 15 days from the date of the final inspection report and recommendation by an inspector, resulting in 100% (906/906) achievement. This performance reflects improved efficiency in processing certificates and strengthened internal workflow controls.

The OHSC was able to take enforcement actions where required. Enforcement action follows where there is persistent non-compliance with norms and standards regulations for quality and safety post re-inspections of previously non-complaint health establishments.

Enforcement action was taken against 14 out of 14 HEs within 30 days of the final inspection report, achieving 100% against the annual target of 90%. In addition, 11 out of 11 enforcement actions were resolved within 90 working days, achieving 100% against the annual target of 80%.

These results demonstrate improved responsiveness in addressing non-compliance and reinforce the OHSC's regulatory role in promoting accountability and corrective action within HEs.

The OHSC further generated two biannual reports for publication on the OHSC website. The bi-annual report covers all inspections conducted and compliance certificates issued, including the names and locations of HEs, compliance-related outcomes, and complaints received and resolved. The development of these reports supports transparency and public access to information on HEs' compliance status.

The Enforcement Policy has been generated and approved. The Enforcement Policy set out the approach to be followed by the OHSC in enforcing compliance by HEs with the prescribed norms and standards. Risk-based enforcement strategy has been incorporated to guide future regulatory action. This enhancement enables more precise differentiation of enforcement responses based on risk severity, strengthens alignment with the Risk-Based Inspection (RBI) methodology, and ensures coherence with the evolving requirements of NHI Conditional Accreditation.

In addition to certification and enforcement activities, the OHSC continued to implement pre-enforcement consultative sessions as a proactive regulatory intervention. These sessions were aimed at engaging HEs and relevant authorities before escalating to more formal enforcement measures, where appropriate. The approach supports early awareness of compliance gaps, promotes corrective action, and strengthens the relationship between regulatory oversight and continuous quality improvement.

Challenges encountered by the Certification and Enforcement during FY 2025/26

Although all annual performance targets were achieved, the programme continued to operate under significant capacity and resource constraints. The Certification and Enforcement function carries an

expanding workload, including increased inspection outputs, certification decisions, enforcement matters, pre-enforcement engagements, obligations, and emerging regulatory expectations associated with broader health system reforms. The available human resources remained limited when compared with the scale and complexity of the programme's mandate.

The automation and use of the Certification and Enforcement Module improved efficiency; however, system-related refinements and user adaptation remained areas requiring ongoing attention. As with any newly implemented workflow system,

continued enhancements are required to ensure that the module fully supports operational needs, reporting requirements, audit trails, and seamless coordination within the OHSC. Budgetary constraints also affected the OHSC's ability to expand pre-enforcement consultative sessions and related stakeholder engagements to the desired scale.

These engagements are important because they help HEs and relevant authorities understand compliance expectations and address identified gaps before matters escalate to more severe enforcement action.

Programme 5: Certification and Enforcement							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Enhanced public trust in the safety and quality of healthcare services						
5.1 Compliant health establishments are issued with a certificate of compliance	5.1.1 Percentage of health establishments issued with a certificate of compliance within 15 days from the date of the final inspection report and a recommendation by an Inspector	91.0% (563/618)	91.19% (1 252/1 373)	100%	100% (906/906)	0	The utilisation of the online Certification and Enforcement (C&E) Module contributed to enhanced operational efficiency and improved turnaround times.
5.2 Enforcement action is taken against non-compliant health establishments	5.2.1 Percentage of health establishments against which enforcement action has been taken within 30 days from the date of the final inspection report	New Indicator	New Indicator	90%	100% (14/14)	+10%	The utilisation of the Certification and Enforcement (C&E) Module, which contributed to improved operational efficiency and turnaround times.
	5.2.2 Percentage of enforcement action taken against non-compliant health establishment resolved within 90 working days	New Indicator	New Indicator	80%	100% (11/11)	+20%	The utilisation of the C&E Module contributed to improved operational efficiency and turnaround times.

Programme 5: Certification and Enforcement							
Output	Output Indicator	Audited Actual Performance 2023/2024	Audited Actual Performance 2024/2025	Planned Annual Target 2025/2026	Actual Achievement 2025/2026	Deviation from planned target to Actual Achievement 2025/2026	Reasons for deviations
Outcome	Enhanced public trust in the safety and quality of healthcare services						
5.3 Health establishment compliance status reports published every six months	5.3.1 Number of bi-annual reports developed for publication on the OHSC website	2	2	2	2	0	The bi-annual report covers all inspections conducted, compliance certificates issued, the names and locations of health establishments , and Complaints received and resolved.

Strategies to address underperformance.

To sustain performance and strengthen the Certification and Enforcement processes, the OHSC will continue to improve the use of the online Certification and Enforcement Module, including refinement of workflows, reporting functionality, audit trails, and case tracking.

The programme will also continue strengthening internal standard operating procedures, decision-making tools, and quality assurance mechanisms to support consistency, procedural fairness, and legal defensibility in certification and enforcement decisions. This will include continued refinement of templates, registers, decision records, and reporting tools to ensure that certification and enforcement actions are properly documented and auditable.

In the interim, the programme will continue applying risk-based prioritisation, improved internal coordination, and structured case-tracking mechanisms to ensure that statutory and performance timelines are met.

The programme will further strengthen collaboration with the Compliance Inspectorate, Health Standards Design, Analysis and Support, Legal Services, ICT, and relevant provincial authorities to ensure that inspection outcomes, certification decisions, enforcement actions, corrective measures are managed and monitored in an integrated manner. This will support timely decision-making and improve the link between inspection findings, certification, enforcement, and quality improvement.

Pre-enforcement consultative sessions will be further institutionalised as a proactive compliance support mechanism. This approach will assist in im-

proving understanding of regulatory requirements, promoting early corrective action, reducing repeat non-compliance, and supporting improved quality and safety outcomes across health establishments. The programme will continue to monitor the quality improvement plans to improve the quality outcomes of the HEs.



PART

C

GOVERNANCE

12. INTRODUCTION

Corporate governance embodies the processes, practices, and systems by which public entities are directed and governed to ensure they achieve their objectives. In addition to legislative requirements of the National Health Amendment Act, 12 of 2013 (NHAA), the OHSC is also governed by the precepts of the Public Finance Management Act, 1 of 1999 (PFMA). In addition, the OHSC abides by the principles contained in the King's Report on Corporate Governance. Parliament, the Executive and the Accounting Authority of the public entity are responsible for the oversight of corporate governance.

13. PORTFOLIO COMMITTEES

The Parliamentary Portfolio Committee on Health exercises oversight over the service delivery performance of the public entities reporting to the Health Department. The OHSC appeared before the Parliamentary Portfolio Committee on Health on the dates set out below:

Table 4: Portfolio committees' meetings

Date	Parliamentary Structure	Activity/Focus
22 April 2025	Portfolio Committee on Health	Presentation of the 2025-2030 Strategic Plan and 2025-2026 financial year Annual Performance Plan.
07 October 2025	Portfolio Committee on Health	Presentation of the Annual Report for financial year 2024-2025.

14. EXECUTIVE AUTHORITY

In line with statutory requirements, the OHSC submitted to the National Department of Health, the below mentioned reports during the 2025/2026 financial year.

Table 5: Reports submitted during 2025/26 FY

Report/document type	Date submitted	Executive authority comment
Quarter 4: 2024/2025 Performance Information Report	30 April 2025	None
Quarter 1: 2025/2026 Performance Information Report	31 July 2025	None
Quarter 2: 2025/2026 Performance Information Report	31 October 2025	None
Quarter 3: 2025/2026 Performance Information Report	30 January 2026	None

15. THE ACCOUNTING AUTHORITY / BOARD

The Board of the OHSC is appointed in terms of Section 79B (1) of the NHA to serve as the Accounting Authority of the OHSC. During the period under review, the Board performed its functions in terms of Section 79A (3) (a) - (c), to determine the policy of the OHSC, do the necessary planning in connection with the functions of the OHSC, and perform other functions as determined by the Act. The Board was appointed on the 7th of February 2023, for a period of three (3) years, ending on the 11th of February 2026. The previous Board therefore served for eleven (11) months of the 2025/2026 financial year.

The Minister of Health after the end of tenure of the previous Board has since appointed a new Board has since appointed a new Board for the prescribed period of 3 years, effective from the 12th of February 2026 to the 12th of February 2029.

The role of the Board, specifically, is to:

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

Board Charter

The Board operates under an approved Board Charter and ensures that financial and risk management, and internal controls are effective as required by the PFMA.

Board activities are undertaken in accordance with the Board Charter, developed in line with legislative prescripts, codes of good practice, and principles of governance. The Charter identifies the roles and responsibilities of the Board in its interactions with management and sets out the fiduciary duties of individual Board members and the role of the Chairperson of the Board.

The Board Charter also addresses the management of conflicts of interest to ensure that the interests of the OHSC remain paramount in its decision-making. The Board monitors compliance with the Constitution by Board members and addresses conflicts in accordance with the Constitution. The Board Constitution is reviewed annually and was recently reviewed by the Board on the 31 January 2026.

Composition of the Board

The Board is comprised of twelve (12) non-executive Board members appointed by the Minister of Health in terms of Section 79B of the NHA. The CEO and the CFO are ex officio members of the Board (executive directors).

A new Board consisting of eleven (11) members was appointed by the Minister of Health on 12th of February 2026, for a term of 3 years. There is diversity in the Board in terms of skills and competencies as prescribed by Section 79B of the NHA.

Below is the list of current Board members appointed by the Minister of Health to serve with effect from 12th of February 2026, for a period of three (3) years. There is diversity in the Board in terms of skills and competencies as prescribed by Section 79B of the NHAA.

List of board members appointed by the Minister of Health:

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Term ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Ernest Kenoshi	Chairperson	7 February 2020	11 February 2026	MBChB, DTM&H, Advanced Certificate in Healthcare Management, Certificate in Improving the Quality of Health Services, Master's in public health (Hospital Management, Financial Management for non-financial managers, Project Management, Primary Emergency Medicine, Hospital Major Incident Management, Departmental Leadership.	Public Health	MDB: HPCSA	Health Portfolio Committee	15
Dr Reno Morar*	Vice-Chairperson	12 February 2023	Reappoint- ed	Certificate In Professional Coaching Practice, Public Health Medicine Specialist, and registered Fellow of the College of Public Health Medicine of South Africa [FCPHM (SA)], Master of Medicine in Community Health [MMed] Comm H, Post Graduate Diploma in Health Management, Economics and Financial Planning (DHMEF), Medical Doctor MBChB (Bachelor of Medicine and Bachelor of Surgery).	Public Health	Chairperson of the Advisory Committee: National Health Reference Price List (NHRPL) Chairperson of the Board of Trustees of Coma CARE	HR REMCO, ARF Com, Health Portfolio Committee	13
Prof Rajesh Mahabeer*	Member	12 February 2023	Reappoint- ed to 2nd term	CA(SA), FCMA, CGMA, FCA (England & Wales), BFP, FCCA, CIA, FIASA, M.Inst.D, SARIPA, INSOL, MBA (Derby), MCom (UKZN), Post Grad Dip Acc (UKZN), N Dip Cost Acc (DUT), PhD (Candidate) (WITS).	Accounting, Auditing, and Finance	SAHPRA REPSSI; OBP	Chairperson of ARF Com, Health Portfolio Committee	15
Prof Usuf Chikte	Member	7 February 2020	11th February 2026	PhD (Community Health), MSc (Dental Public Health), MDent (Community Dentistry), DHSM, BChD.	Education	None	Chairperson of HR REMCO, CEC, Health Portfolio Committee	15
Prof Lilian Dudley*	Member	12 February 2023	Reappoint- ed to 2nd term	PhD Public Health, Fellow of College of Public Health Medicine (FCPHM), M.Sc Health Policy, Planning and Financing, Diploma in Child Health, MB,ChB, BSc Medical Microbiology.	Public Health Medicine Specialist	None	Chairperson of CEC, Health Portfolio Committee	13

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Term ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Maria Peenze	Member	7 February 2020	11th February 2026	Doctor Technologiae: Business Administration, Magister Legum: Human Rights, Baccalaureus Legum, Baccalaureus Iuris, Certified Fraud Examiner, Africa Directors Programme, Ethics in the Public Service.	Law: Human Rights, Governance	International Association of Certified Fraud Examiners Advisory Council, Road Accident Fund, South African Institute for Drug-Free Sport	ARF Com, HR REMCO	17
Prof Mohambry Chetty	Member	7 February 2020	11th February 2026	MBChB, PhD, MPH (US) MFamMed, DTM&H; DOH; DHSM, IAQS	Quality- Standards Setting and Best Practice Initiatives	KZN Doctor Healthcare Coalition, IPA Foundation of SA. and UKUSA Healthcare Consultants	ARF Com, HR REMCO	17
Ms Ritta Msibi	Member	7 February 2020	11th February 2026	Degree in Nursing Administration and Education, National Higher Diploma as a registered nurse in (General, Midwifery, Psychiatry) and Community health, National Diploma in Unit Management, National Diploma in Primary health care, Advanced University Diploma in Health Service Management, The Integrated Management of TB, HIV, &STI, Advanced University Diploma in Unit Management.	Labour	None	HR REMCO	11
Mr Anele Yawa*	Member	12 February 2023	Reappoint- ed to 2nd term	Certificate in Occupational Safety, Health and Environment, Certificate in Safety Precautions and Oxy-Acetylene Flame Cutting, Certificate in Operation and Safety Procedure of Portable Pneumatic Grinders, Certificate - IAVI's ADVANCE Programme: Community engagement and learning: perspectives from researchers and Communities, IAVI Leadership Development Programme, Diploma in School Management.	Public Health	General Secretary: Treatment Action Campaign; SANAC Civil Society Forum; Eastern Cape Health Crisis Action Coalition.	ARF, CEC, HR REMCO	19
Ms Palesa Santho*	Member	12 February 2023	Reappoint- ed to 2nd term	B-Pharm; Dip: Business Man.	Public Health	SAAHIP; SAPC, SANC.	CEC, Health Portfolio Committee	13

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Term ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g: Audit committee / Ministerial task team)	No. of Meetings attended
Ms Sizeni Mchunu**	Member	12 February 2023	Reappointed to 2nd term	Master of Arts Degree (Nursing Education), Hons. Degree in Nursing Science, Bachelor of Arts Degree in Nursing Science (Nursing Administration/ Management and Community Health Nursing), Diploma in General Nursing and Midwifery, Diploma in Advanced Basic Education and Training, Certificate in Community Development	Nursing Education	2014 - Interim Council of the Sefako Makgatho Health Interim and Substantive Council of the SMU Member of the SA Nursing Council, 2015 member of the substantive Council of SMU.	Inclusion of the ARFIT	17
Dr Guin Lourens*	Member	20 July 2023	Reappointed to 2nd term	PhD: Public Management, Master's Degree: Nursing, Palliative Care Homecare, Certificate in Occupational Health Nursing, Postgraduate Diploma in Nursing Education, Postgraduate Diploma in Health Services Management, Certificate in Primary Health Clinical Curative Care and Treatment, B-Cur (General Nursing, Community Health Nursing, Midwifery and Psychiatric Nursing).	Public Health	Paarl Hospital board member Board Director on Bergzicht Training NGO	CEC, Health Portfolio Committee	13
Newly appointed Members as of 12 February 2026								
Dr Terence Carter	Member	12 February 2026		MB,CHB. University on Natal, Post Graduate Diploma in Child Health: College of Medicine of South Africa, Post Graduate Diploma in Health Management: University of Cape Town, Certificate in Coaching and Mentoring in the Public Sector: University of Stellenbosch	Public Health			1

Name	Designation (in terms of the Public Entity Board structure)	Date appointed	Term ended	Qualifications	Area of Expertise	Board Directorships (List the entities)	Other Committees or Task Teams (e.g: Audit committee / Ministerial task team)	No. of Meetings attended
Dr Geraldine Timothy	Member	12 February 2026		Postgraduate Diploma in Management Practice, Fellowship with the College of Public Health Medicine (FCPHM), Bloemfontein, Master of Medicine (Community Health), Johannesburg, Diploma in Anaesthetics (DA), Durban, Bachelor of Medicine and Surgery (MBChB)	Public Health	Clinical Advisory Board- Health Quality Assessment (HQA), Clinical Executive Committee (Clinical Exco); Discovery Health, Council for Medical Schemes' Industry Technical Advisory Panel (ITAP), NDOH Ministerial appointed Adult Hospital Level Expert Review Committee of the National Essential Medicines List Committee (NEMLC)		1
Adv/Dr Bukhosi Mtukushe	Member	12 February 2026		Advanced Mediation, LLM (Banking Law), LLB, Diploma in Anaesthesia, MBChB	Law			1
Mr Simphiwe Gada	Chairperson of Human Resources and Remuneration Committee	12 February 2026		Postgraduate Diploma in Labour Law (PGDLL), Post Graduate Diploma in Health Systems Management for Executive Leadership, Bachelor of Nursing (BCur)	Public Health	DENOSA National Executive Committee (NEC) – Member, PSCBC Executive Committee (EXCO) – Member, PHSDSBC Gauteng Chamber – Former Chairperson, Hospital Executive and Governance Committees – Chair and Member		1

** Dr R Morar – reappointed to the 2nd term, serving as Chairperson of the Board

**Ms S Mchunu – reappointed to the 2nd term, serving as Vice Chairperson of the Board

*Members reappointed to the 2nd term.

Board Committees

Below is the list of the attendance of committees for the period 1 April 2025 until 31 March 2026. Committees attended by the Board Members for the period 01 April 2025 until 31 March 2026.

All Board EXCO Committee matters, were processed and resolved upon by the Board of the OHSC.

Table 6: Certification and Enforcement Committee (CEC)

The CEC met 4 times from 01 April 2025 until 31 March 2026.

Committee	No. of meetings held	No. of members	No. of meeting attended	Name of members
Certification and Enforcement Committee (CEC)	3 Ordinary Meetings 1 Special Meeting	7	3 Ordinary Meetings 1 Special Meeting	Prof Lilian Dudley (Chairperson)
			2 Ordinary Meetings 1 Special Meeting	Prof Mohambry Chetty (Member)
			3 Ordinary Meetings 1 Special Meeting	Ms Sizeni Mchunu (Member)
			3 Ordinary Meetings 1 Special Meeting	Professor U Chikte (Member)
			3 Ordinary Meetings 1 Special Meeting	Mr Anele Yawa (Member)
			3 Ordinary Meetings 1 Special Meeting	Ms Palesa Santho (Member)
			3 Ordinary Meetings 1 Special Meeting	Dr Guin Lourens (member)

Table 7: Human Resource and Remuneration Committee (HRREM Com)

The HRREM Com met 3 times from 01 April 2025 until 31 March 2026.

Committee	No. of meetings held	No. of members	No. of meeting attended	Name of members
Human Resource and Remuneration Committee (HRREM Com)	3 Ordinary meetings	4	3 Ordinary meetings	Professor U Chikte Member (Chairperson)
			3 Ordinary meetings	Adv/Dr MC Peenze (Member)
			3 Ordinary meetings	Dr R Morar (Member)
			3 Ordinary meetings	Ms. R Msibi (Member)

Table 8: Audit, Risk and Finance Committee (ARF Com)

The ARF Com met 5 times from 01 April 2025 until 31 March 2026.

Committee	No. of meetings held	No. of members	No. of meetings attended	Names of members
Audit, Risk and Finance Committee (ARF Com)	4 Ordinary meetings 1 Special meetings	4	4 Ordinary meetings	Prof Rajesh Mahabeer (Chairperson)
			4 Ordinary meetings 1 Special meetings	Dr MC Peenze (Member)
			4 Ordinary meetings 1 Special meetings	Mr Anele Yawa (Member)
			2 Ordinary meetings	Dr Reno Morar (Member)
			3 Ordinary meetings	Ms S Mchunu (Member)

Remuneration of Board members

Board members are remunerated in terms of National Treasury tariffs for office-bearers of certain statutory and other institutions. The OHSC Board is classified under Category A, Sub-category A2 of the National Treasury tariffs. Remuneration is approved for meeting preparation and attendance in line with National Treasury hourly tariffs for sub-category A2 entities.

The remuneration paid to each Board member for the year under review is included in the Annual Financial Statements under "Related Parties Transactions" (Note 23). Employees of National, Provincial, and Local Government, or Agencies and Entities of Government, are not charged any fees and are paid only for disbursements.

16. RISK MANAGEMENT

The OHSC has in place the risk management policy and strategy, which require management to conduct regular risk assessments to determine the effectiveness of the OHSC risk management strategy and identify new and emerging risks. A strategic risk assessment was conducted, resulting in an update of the existing strategic risk register. Major strategic risks facing the OHSC were identified, along with controls and measures to mitigate them. There is continuous monitoring for effectiveness and new control measures are introduced where inadequacies are identified. The internal audit function is in place and plays an important role in conducting risk-based audits, enabling management to take action to address any identified gaps.

As the Accounting Authority, the Board is ultimately responsible for risk management and has undertaken the following:

- evaluating the risk profile of the OHSC.
- monitoring and reviewing the extent to which management has established effective risk management measures in all units.
- ensuring that management implements ongoing processes to identify, assess and manage risks.
- forming an opinion about the effectiveness of risk management processes and providing guidance to management.
- ensuring the risk management process is formally evaluated on an annual basis.

The ARF Committee advises the Board on risk management and independently monitors the effectiveness of the risk management system in use.

Materiality and significance framework

The Board has, in accordance with Treasury Regulations, developed a materiality and significance framework appropriate to the size and operations of the OHSC.

Materiality

Taking into account the guidelines in National Treasury's Practice Note on Applications under Section 54 of the PFMA by Public Entities, the OHSC materiality amount was set at R 1, 644, 495 – that is, 1% the total revenue of R 164, 449, 593 in the 2023/24 financial year.

Significance

The Board has decided that the following transactions and/or events will be reported:

1. establishment or participation in the establishment of a company or public entity.
2. participation in a significant partnership, trust, unincorporated joint venture, public-private partnerships or similar arrangement.
3. acquisition or disposal of a significant shareholding in a company.
4. acquisition or disposal of a significant asset that would significantly affect the operations of the OHSC.
5. commencement or cessation of significant business activity.
6. a significant change in the nature or extent of its interest in a significant partnership, trust, or unincorporated association.
7. formation of a joint venture or similar arrangement.
8. a material infringement of legislation that governs the OHSC.
9. material losses resulting from criminal or fraudulent conduct in excess of the materiality parameters.
10. All material facts and/or events, including those reasonably discoverable, which may in any way influence the decisions or actions of the executive authority.

17. INTERNAL CONTROL

Internal control systems serve to create confidence in the financial position of the OHSC, safeguard assets (including information) and ensure compliance with applicable laws, regulations and government policy prescripts. Internal auditors report on the functioning and effectiveness of internal control systems and make recommendations to management and the ARF Committee. The latter reports to the Board on the internal control environment in the OHSC and monitors the implementation of the audit recommendations for internal control.

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

The AGSA and internal auditors considered the internal control systems as part of their audits and identified some deficiencies. In response, management implemented action plans to address the deficiencies and reported progress to the ARF Committee with the aim of achieving an acceptable audit outcome in the financial year.

Furthermore, the OHSC developed new policies, as well as reviewed existing policies to strengthen the existing internal control environment.

18. INTERNAL AUDIT AND AUDIT, RISK AND FINANCE COMMITTEE

The internal audit function has been outsourced to an external auditing firm. Internal audit provides independent assurance to the Board about the internal control environment in relation to business operations.

- The internal audit function operates in terms of the internal audit charter adopted by the Board on the recommendation of the ARF Committee. This outlines the scope of the function and defines the role, responsibilities and authority. The internal audit function operates under the guidance and support of the ARF Committee. However, the OHSC recognises that internal

auditing is an independent, objective activity designed to add value through a systematic approach to evaluating and improving the effectiveness of risk management, control and governance processes.

- The ARF Committee provides assurance to the Board about the internal control environment, governance, risk management and financials, including budgeting, and is responsible for:
- Reviewing the internal audit charter, including the scope of work, audit structure and budget.
- Ensuring effective coordination between internal audit and management, including the monitoring, evaluation and review of significant findings and recommendations by internal audit, management's responses and implementation of remedial action.
- Reviewing the external auditor's proposed annual audit scope, approach and fees to ensure proper coordination between external and internal auditors.
- Reviewing management requests for the provision of non-audit services to ensure these do not impair the independence of the auditors.
- Reviewing the adequacy of the internal control environment, including information and communications technology, security and control.
- Monitoring the implementation of the risk management framework and reviewing significant changes to the risk profile of the OHSC.
- Providing regular feedback to the Board about the adequacy and effectiveness of risk mitigation and management in the OHSC, including recommendations for improvement.
- Appropriately addressing:
 - Financial reporting risks, including the risk of fraud.
 - Internal financial controls.
 - IT risks as they relate to financial reporting.
- Review whether management has considered legal and compliance risks as part of OHSC risk assessments and the effectiveness of the system for monitoring compliance.

- Obtaining reports from management, the internal auditors and external auditors regarding compliance with all applicable legal and regulatory requirements and acting on them.
- Reviewing the entity's compliance with the National Treasury framework for managing programme performance information and reporting systems and acting on them.
- Evaluating the appropriateness of accounting policies and practices and changes to these, as well as compliance with applicable accounting standards and legal requirements.
- Assessing whether the financial statements present a balanced and understandable assessment of the entity's financial position and performance, and whether they are complete and consistent with prescribed accounting and information known to ARF Committee members.
- Reviewing with management and the external auditors the results of the external audit, including any significant issues identified, and acting on them.
- Reviewing the Annual Report and other regulatory reports before release and considering the accuracy and completeness of the information.
- Reviewing the "going concern" assumptions.

The table below discloses relevant information on the audit committee members

Name	Qualifications	Internal or external	If internal, position in the public entity	Date appointed	Date Resigned	No. of Meetings attended
Prof Rajesh Mahabeer	CA(SA), FCMA, CGMA, FCA (England & Wales), BFP, FCCA, CIA, FIIRSA, M.Inst.D, SARIPA, INSOL, MBA (Derby), MCom (UKZN), Post Grad Dip Acc (UKZN), N Dip Cost Acc (DUT), PhD (Candidate) (WITS)	External	N/A	12 February 2023	current	4 Ordinary meetings 1 Special meetings
Dr Maria Peenze	Doctor Technologiae: Business Administration, Magister Legum: Human Rights, Baccalaureus Legum, Baccalaureus Iuris, Certified Fraud Examiner, Africa Directors Programme, Ethics in the Public Service	External	N/A	7 February 2020	Serving 2nd term	4 Ordinary meetings 1 Special meetings
Dr Reno Morar	Public Health Specialist and registered Fellow of the College of Public Health Medicine of South Africa [FCPHM (SA)] Master of Medicine in Community Health [MMed] [With Sub-courses: Diploma in Occupational and Environmental Health (First class pass) and M.Phil. (Epidemiology and Biostatistics)] Post Graduate Diploma in Health Management, Economics and Financial Planning	External	N/A	12 February 2023	current	2 Ordinary meetings
Mr Anele Yawa	Certificate in Occupational Safety, Health and Environment, Certificate in Safety Precautions and Oxy-Acetylene Flame Cutting, Certificate in Operation and Safety Procedure of Portable Pneumatic Grinders, Diploma in School Management.	External	N/A	12 February 2023	current	4 Ordinary meetings 1 Special meetings
Ms Sizeni Mchunu	Master of Arts Degree (Nursing Education), Hons. Degree in Nursing Science, Bachelor of Arts Degree in Nursing Science (Nursing Administration/Management and Community Health Nursing), Diploma in General Nursing and Midwifery, Diploma in Advanced Basic Education and Training, Certificate in Community Development	External	N/A	31st of July 2025	Current	3 Ordinary meetings

19. COMPLIANCE WITH LAWS AND REGULATIONS

The OHSC is committed to working within the prescripts of laws and regulations governing it to ensure compliance with regulations. Adherence and compliance with applicable laws and regulations remain a Board responsibility. The OHSC is also governed by legislation other than its founding legislation, the NHA. As a Schedule 3A public entity, the OHSC is governed by the PFMA and National Treasury Regulations published under the PFMA and other legislative prescripts referred to hereinabove. The Board, to give effect to its commitment to compliance, has approved the Compliance Framework document, which together with the Risk Management Strategy, guide the strategy of the OHSC and support its business processes as part of its overall governance, risk and compliance obligations. A PFMA compliance checklist is used to monitor compliance with the PFMA. The checklist is part of management's reporting responsibilities to the Board through the ARF Committee.

20. FRAUD AND CORRUPTION

The Board is committed to combatting all forms of fraud and corruption. A fraud and corruption prevention plan is in place to create awareness and guide employees on how to report suspected cases of fraud and corruption. The Board is assured that the employees and stakeholders will use the relevant reporting channels, including a fraud hotline managed by an external service provider.

The fraud and corruption prevention plan establishes a system of internal controls to help prevent and detect fraud and corruption. Elements of the system include creating a fraud awareness culture, developing policies and procedures, implementing segregation of duties in business transactions, conducting internal auditing, conducting ongoing risk assessments, and reporting and monitoring allegations of fraud and corruption. The Board, through the ARF Committee, monitors and reviews fraud and corruption risks quarterly.

21. MINIMISING CONFLICT OF INTEREST

The Board has a Board Charter in place and procedures to manage issues of conflict of interest (perceived, potential, or actual). During the period under review, the Board approved a Conflict-of-Interest Policy. On an annual basis, Board members and OHSC employees are required to disclose their financial interests. Furthermore, at every OHSC senior management and Board meeting, members sign declarations of interest registers indicating any potential conflict of interest related to any agenda item, in which case they must recuse themselves during discussion of that item.

22. CODE OF CONDUCT

The Board charter includes a code of conduct for Board members. This is based on principles of honesty, integrity and ethical leadership and serves as a guide to Board members in protecting OHSC assets and information, as well as managing conflicts of interest.

The OHSC code of conduct for employees is premised on the same principles and aims to protect the Office's reputation by guiding employees in their interactions with one another and the public. OHSC inspectors, who possess considerable authority over health establishments, are required to sign a code of conduct for inspectors. During the year under review, there were no reported instances of ethical breaches by Board members or employees.

Disciplinary measures are to be taken by the OHSC against any employee who breaches the applicable code, while unethical conduct by a Board member is referred to the Minister of Health for appropriate action.

23. HEALTH, SAFETY AND ENVIRONMENTAL ISSUES

The OHSC has established the required occupational health and safety structures to ensure a work environment that is conducive to the health of all staff members. The new health and safety committee comprises representatives of employees and management as well as a union representative. The committee holds quarterly meetings.

24. BOARD SECRETARY

The Board Secretary manages and provides secretariat services and administrative support to the OHSC Board and Committees to ensure their effective and efficient functioning. The Board Secretary also provides legal advice to the Board and Committees when called upon. The review and update of the Board Constitution and Terms of Reference for the Board's and Committees' functioning fall under the purview and responsibility of the Board Secretary.

The Board appointed a Board Secretary on a permanent basis on the 1st of August 2025.

25. SOCIAL RESPONSIBILITY

No activities were undertaken during the period under review.

26. AUDIT, RISK AND FINANCE COMMITTEE REPORT

We are pleased to present our report for the financial year ended 31 March 2026.

Audit Risk and Finance Committee Responsibility

During the review period, the ARF Committee complied with its responsibilities in terms of section 51(1) (a) (ii) of the PFMA and Treasury Regulation 27.1, adopted appropriate formal terms of reference as its charter, regulated its affairs in compliance with the charter and discharged the responsibilities described therein.

The Effectiveness of Internal Control

The ARF Committee conducted its review of the internal audit function's findings, based on risk assessments conducted in the OHSC.

The following internal audit work was completed during the year under review:

- Audit of performance information
- Compliance Inspectorate review
- Human Resources and Payroll review
- Complaints Management and Ombud review

- Supply Chain Management review
- Certification and Enforcement review
- Legal Services review
- Cyber Security review
- IT General Controls review
- Finance Management review
- Financial Reporting (Review of the Annual Financial Statements)
- Risk Management Self-Assessment Facilitation
- Strategic Risk Assessment Facilitation

The main areas of concern were largely around information technology, general controls review, and cybersecurity. The ARF Committee will continue to monitor the implementation of the recommendations and internal control measures emanating from internal audits.

In-Year Management and Monthly/Quarterly Report

The public entity has submitted monthly and quarterly reports to the Executive Authority, as recommended by the ARF Committee to the Board.

Evaluation of Financial Statements

The ARF Committee reviewed the annual financial statements prepared by the public entity before submission to the external auditors and was satisfied that the financial statements reflected all disclosures required in terms of accounting policies and standards.

The audit of the financial statements also confirmed that the statements submitted were prepared in accordance with the prescribed financial reporting framework as required by section 55(1) (a) and (b) of the PFMA.

The outcome of the audit of the financial statements indicated the OHSC's commitment to good governance, accountability and continuous improvement, which builds on the foundation that has been laid in prior years.



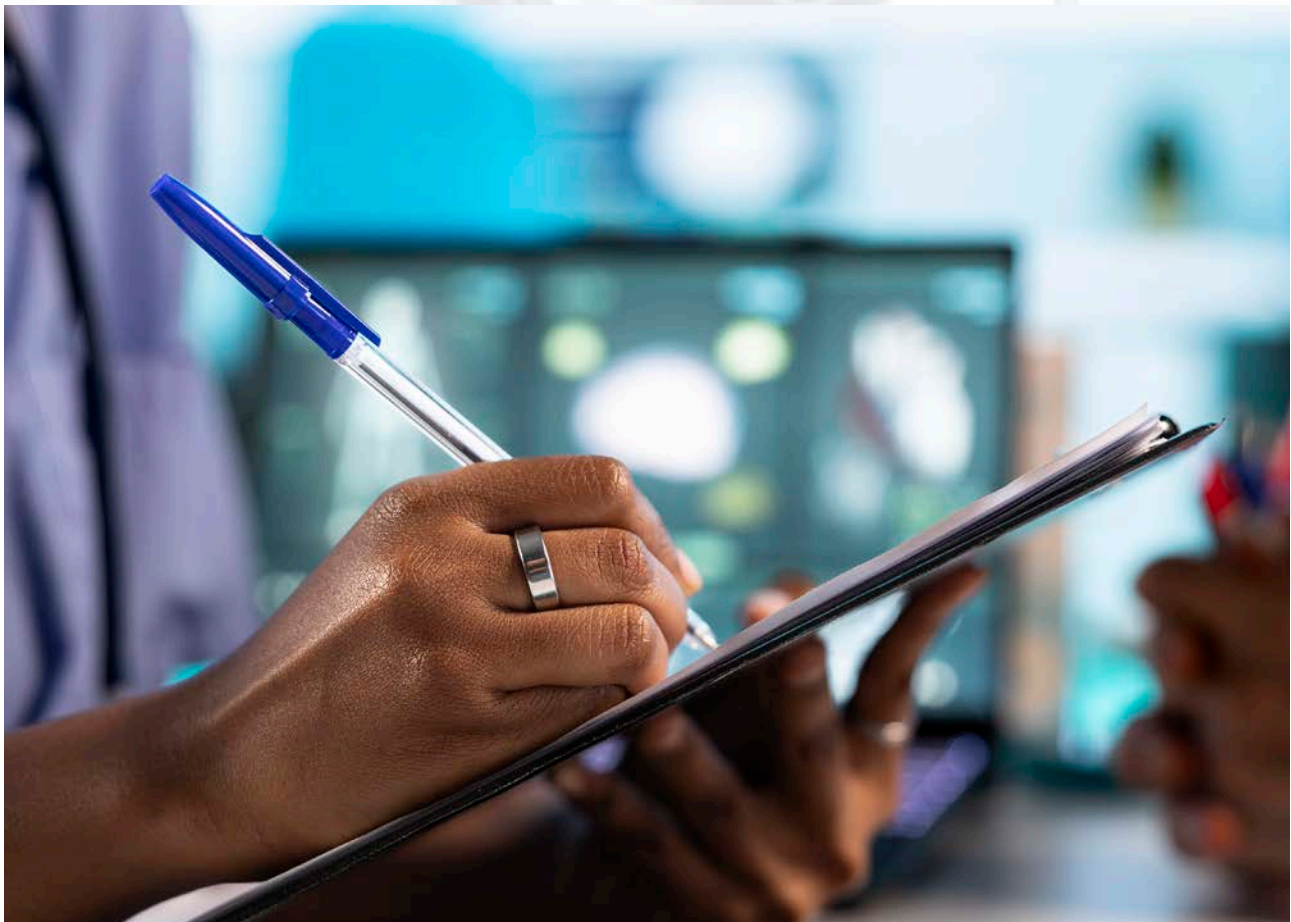
Prof Rajesh Mahabeer

Chairperson of the Audit, Risk and Audit Committee

27. B-BBEE COMPLIANCE PERFORMANCE INFORMATION

The following table has been completed in accordance with the compliance with the BBBEE requirements of the BBBEE Act of 2013 and as determined by the Department of Trade, Industry and Competition.

Has the Department/Public Entity applied any relevant Code of Good Practice (B-BBEE Certificate Levels 1 – 8) with regards to the following:		
Criteria	Response Yes / No	Discussion (include a discussion on your response and indicate what measures have been taken to comply)
Determining qualification criteria for the issuing of licences, concessions or other authorisations in respect of economic activity in terms of any law?	No	Not applicable to OHSC
Developing and implementing a preferential procurement policy?	Yes	OHSC supply chain management policy outlines the process to be followed to contribute to the implementation of the Preferential Procurement Policy Framework Act.
Determining qualification criteria for the sale of state-owned enterprises?	No	Not applicable to OHSC
Developing criteria for entering into partnerships with the private sector?	No	Not applicable to OHSC
Determining criteria for the awarding of incentives, grants and investment schemes in support of Broad Based Black Economic Empowerment?	No	Not applicable to OHSC







PART

D

HUMAN RESOURCE MANAGEMENT



28. INTRODUCTION

28.1 OVERVIEW OF HUMAN RESOURCES (HR) MATTERS AT THE PUBLIC ENTITY

The Human Resources Management unit plays a crucial role in cultivating an environment where employees can effectively contribute to the OHSC's strategic aims. This section provides an overview of the programmes executed over the past year, aligned with the outlined HR priorities.

28.2 HR PRIORITIES AND THEIR IMPACT FOR THE YEAR UNDER REVIEW

During the reporting period, a series of HR programmes were prioritised to facilitate the organisation's strategic achievements. These initiatives encompassed vital areas such as staff recruitment, employee wellness, professional development, policy refinement and establishment, and performance management. Their accomplishments are presented in the following sections.

28.2.1. Recruitment programme

By the end of 31 March 2026, 136 of the 143 (95.10%) funded positions were filled. The recorded vacancy rate of 4.9% not only met but exceeded the strategic target of 6%. These figures reflect a concerted effort to reduce vacancies, ensuring that consistent staffing levels drive organisational effectiveness. The organisation continues to strive to increase the number of youth, persons with disabilities and women in management who are appointed; being mindful at the same time of the challenges and limitations in this pursuit, due to various factors including no suitable candidates from the target groups being found and fluctuating numbers within these targets, due to resignations of persons from the target groups, which cannot be predicted or controlled.

28.2.2. Employee Wellness Programme

The function relating to employee wellness remains outsourced to a service provider in order to ensure confidentiality for employees and to offer professional assistance which meets employees' specific challenges and needs. The wellness programme offered three interesting talks during

the year and covered relevant topics, including Workplace harassment and bullying, Financial and post-retirement debt counselling, and Work-life balance. No health risk assessments were conducted due to a myriad of reasons ranging from employees working from home during the move to the new building, discontented employees (with the move) which consumed much time of the HR unit, at the expense of normal operations as well as working from home when the new landlord began building renovations on the outside of the building.

28.2.3. Training and development.

The Training and Development Plan was developed for career growth and capacity building of employees. Some employees attended short courses, conferences, seminar etc as part of skills development. However, the full implementation of the plan was impacted by the limited funding during the course of the year under review. This was occasioned by the move to the new office, in which funding meant for training had to be redirected to cover move-related costs. Procurement of service providers for Training was put on hold for some months during the move. Study assistance, however, was provided to eight employees to improve their qualifications in their respective fields. Critical Inspector Training was conducted for newly appointed Inspectors, which was done "in-house" with great success.

28.2.4. Employee performance management framework

A new performance management policy with updated templates was approved during the year under review and will be fully implemented in the new performance cycle. The new templates and policy seek to simplify and streamline processes, encouraging greater understanding of the system and higher compliance.

28.2.5. Policy frameworks

During the reporting period, the organisation focused on the comprehensive review of several key HR policies. This process involved extensive consultation with internal stakeholders. Consultations, which still to be finalised, are with organised labour and are scheduled to take place in the first quarter of the current financial year. The policies reviewed or developed include the following:

- Core Employment: Conditions of Service, Leave and Recruitment and Selection.
- Compensation & Benefits: Remuneration, Acting Allowance and Recognition of Long Service Awards.
- Development & Conduct: Internship and the Disciplinary policy.
- Labour Relations: Revised Organisational Rights Agreement and the Bargaining Forum Constitution were developed.

It is envisaged that the above policies will be approved and implemented during the current financial year.

28.2.6 Labour Relations

During the year under review, the Labour Relations sub-unit dealt with several grievances and complaints, which were referred to the relevant units for involvement and resolution by the manager. In terms of disciplinary cases, four were dealt with during the year, of which two were concluded and two will be concluded in the first quarter of the new financial year. HR policies that were reviewed during the year were consulted in the Bargaining forum and shared with employees for input, to ensure their sentiments were considered before these policies were approved for implementation. Some policies dealt with in the past financial year are as follows: Internship Policy, Leave Policy, Conditions of Service Policy, Acting Allowance Policy, Recognition of Long Service Policy, Bargaining Forum Constitution, and Organisational Rights Agreement.

28.2.7 Facility Management

The OHSC moved to a new office building during August 2025. This was, by its very nature, rather disruptive and unsettling for staff members and impacted on work output in all units and presented some logistical challenges. The landlord at the new office premises is responsible for the building maintenance and security services with the OHSC responsible for the cleaning of the building.

29. CHALLENGES ENCOUNTERED

29.1 LIMITED PERSONNEL BUDGET

The OHSC has developed a revenue generation model and accompanying fees which have been submitted to the Executive Authority and will undergo the relevant. The OHSC has struggled with a limited budget and therefore insufficient funds to expand the number of posts in various units. This has compromised the organisation's ability to fulfil its mandate. Contract workers, however, have been utilised to fill some of the gaps.

29.2 RELUCTANCE OF EMPLOYEES TO MOVE TO THE NEW OFFICE BUILDING

The OHSC relocated offices due to the expired lease agreement at its old premises. The move to new premises was also in keeping with an established government practice to rotate suppliers. The most suitable premises were found in the Centurion area, much to the dissatisfaction of some employees, as can be expected. The level of effort required to attend to complaints associated with the move, mostly owing to apprehension by staff worried about the distance to travel, took a considerable time from the Human Resource team.

As a result, a number of planned targets such as Review of the Organisational Structure and Development of an Integrated HR strategy were delayed. Whilst strides were made and progress registered in resolving such concerns, the organization is still focused on these aspects to build a coherent team.

29.3 STRAINED EMPLOYER – EMPLOYEE RELATIONSHIP

During the year under review, the OHSC experienced extremely strained labour relations with employees due to disputes around the move to the new building. At some point, this dispute may have escalated into a strike and management had to devote much of its time to managing and rebuilding the relationship with employees.

As a result, some of the programmes planned for the year under review were severely affected. However, relations improved in the last quarter of the reporting year; by then, it was too late for programmes that required intensive consultation processes, such as the review of the business model, organisational structure, and integrated human resources strategy, to gain traction.

30. FUTURE HR PLANS/GOALS

For 2026/27, the OHSC will prioritise the following:

- Automation of the performance management system.
- Finalise the review of the business model and organisation structure aligned to such model.
- Finalise the review of human resources management policies and develop new policies where gaps are identified.

31. HUMAN RESOURCE OVERSIGHT STATISTICS

31.1. PERSONNEL-RELATED EXPENDITURE

Personnel Cost by programme/ activity/ objective

Programme	Total Expenditure for the entity	Personnel Expenditure	Personnel exp. as a % of total exp.	No. of employees	Average personnel cost per employee
Administration	88,845,423	42,972,598	31%	38	1,130,858
Compliance Inspectorate	63,096,630	48,299,349	35%	52	928,834
Complaints Management and Office of the Ombud	33,772,889	30,495,606	22%	30	1,016,520
Health Standards Design, Analysis and Support	15,085,002	13,974,593	10%	12	1,164,549
Certification and Enforcement	5,039,296	4,241,203	3%	4	1,060,301
Total	205,839,241	139,983,349	100%	136	1,029,289

Personnel cost by salary band

Level	Personnel Expenditure	% of personnel exp. to total personnel cost	No. of employees	Average personnel cost per employee
Top Management	13,932,192	10%	6	2,322,032
Senior Management	16,723,417	12%	12	1,393,618
Professional qualified	44,936,987	32%	33	1,361,727
Skilled	46,862,559	33%	61	768,239
Semi-skilled	17,528,196	13%	24	730,341
Unskilled	-	-	-	-
Total	139,983,349	100%	136	1,029,289

Performance Rewards

Level	Performance rewards	Personnel Expenditure	% of performance rewards to total personnel cost
Top Management	-	13,932,192	0%
Senior Management	-	16,723,417	0%
Professional qualified	-	44,936,987	0%
Skilled	-	46,862,559	0%
Semi-skilled	-	17,528,196	0%
Unskilled	-	-	-
Total	-	139,983,349	0%

Training Costs

Activity	Personnel Expenditure	Training Expenditure	Training Expenditure as a % of Personnel Cost	No. of employees trained	Average training cost per employee
Training expenditure	139,983,349	645,869	0%	32	20,183

Employment and vacancies per programme

Programme/activity/objective	2025/2026 Approved Posts	2025/2026 No. of Employees	2025/2026 Vacancies	% of vacancies
Administration	39	38	1	2,6%
Compliance Inspectorate	54	52	2	3,7%
Complaints Management and Ombud	33	30	3	9%
Health Standards Design, Analysis and Support	13	12	1	8%
Certification and Enforcement	4	4	0	0%
Total	143	136	7	4,9%

Employment and vacancies per post level

Level	2024/2025 No. of Employees	2025/2026 Approved Posts	2025/2026 No. of Employees	2025/2026 Vacancies	% of vacancies
Top Management	7	8	6	2	22,2%
Senior Management	11	13	12	1	8,3%
Professional qualified	34	34	33	1	2,9%
Skilled	60	63	61	2	3,17%
Semi-skilled	25	25	24	1	4%
Unskilled	0	0	0	0	0%
Total	137	143	136	7	4,9%

Employment changes:

The number of funded permanent posts increased from the previous reporting period from 142 to 143 with one contract post being converted to a permanent post as a result of additional funding being received. Of the 143 posts, only 7 were not filled as of 31 March 2026, giving a vacancy rate of 4,9% which exceeded the target of 6%.

Employment changes by post level

Salary Band	Employment at beginning of period	Appointments	Terminations	Employment at end of the period
Top Management	7	0	1	6
Senior Management	11	1	0	12
Professional qualified	34	0	1	33
Skilled	60	4	3	61
Semi-skilled	25	1	2	24
Unskilled	0	0	0	0
Total	137	6	7	136

Reasons for staff leaving

Reason	Number	% of total no. of staff leaving
Death	0	0%
Resignation	6	85,8%
Dismissal	1	14,2%
Retirement	0	0%
Ill health	0	0%
Expiry of contract	0	0%
Other	0	0%
Total	7	100%

Explanations:

There were seven terminations during the reporting period of which six were resignations by employees who were offered other career opportunities or took other career paths and one employee was dismissed.

Labour Relations: Misconduct and disciplinary action

Nature of disciplinary Action	Number
Verbal Warning	0
Written Warning	1
Final Written warning	0
Dismissal	1
Total	2

It should be noted that one employee received a written warning and one employee was dismissed from employment.

Equity Targets and Employment Equity Status by Males

Levels	MALE							
	AFRICAN		COLOURED		INDIAN		WHITE	
	Current	Target	Current	Target	Current	Target	Current	Target
Top Management	3	2	0	0	0	0	0	0
Senior Management	7	6	0	1	1	1	0	0
Professional qualified	14	12	1	1	0	0	0	0
Skilled	14	13	0	1	0	0	1	1
Semi-skilled	10	10	0	1	0	0	0	1
Unskilled	0	0	0	0	0	0	0	0
Total	48	43	1	4	1	1	1	2

Equity Targets and Employment Equity Status by Females

Levels	FEMALE							
	AFRICAN		COLOURED		INDIAN		WHITE	
	Current	Target	Current	Target	Current	Target	Current	Target
Top Management	3	3	0	1	0	1	0	1
Senior Management	3	3	0	1	0	1	1	1
Professional qualified	17	14	0	0	0	1	1	1
Skilled	45	44	1	1	0	0	0	0
Semi-skilled	14	10	0	0	0	0	0	1
Unskilled	0	0	0	0	0	0	0	0
Total	82	74	1	3	0	3	2	4

Equity Targets and Employment Equity Status by disability (males & females)

Levels	Disabled Staff			
	Male		Female	
	Current	Target	Current	Target
Top Management	0	0	0	0
Senior Management	0	0	0	0
Professional qualified	0	0	0	0
Skilled	0	1	0	1
Semi-skilled	0	0	0	1
Unskilled	0	0	0	0
Total	0	1	0	2

During the year under review, the key focus was to ensure that the workforce composition reflects the national demographics of the country. As should be noted, the current race and gender spread of employees fluctuates due to resignations making it challenging to maintain certain targets. Furthermore, it is not always possible to find suitable candidates to appoint who meet the required target group.





PART

E

PFMA COMPLIANCE REPORT

32. IRREGULAR, FRUITLESS AND WASTEFUL EXPENDITURE AND MATERIAL LOSSES

32.1. IRREGULAR EXPENDITURE

a) Reconciliation of irregular expenditure

Description	2025/2026	2024/2025
	R'000	R'000
Opening balance	-	-
Add: Irregular expenditure confirmed	-	-
Less: Irregular expenditure condoned	-	-
Less: Irregular expenditure not condoned and removed	-	-
Less: Irregular expenditure recoverable	-	-
Less: Irregular expenditure not recovered and written off	-	-
Closing balance	-	-

No irregular expenditures were incurred in the current and prior years

Reconciling notes

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure that was under assessment in 2025/26	-	-
Irregular expenditure that relates to 2024/25 and identified in 2025/26	-	-
Irregular expenditure for the current year	-	-
Total	-	-

b) Details of current and previous year irregular expenditure (under assessment, determination, and investigation)

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure under assessment	-	-
Irregular expenditure under determination	-	-
Irregular expenditure under investigation	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior years

c) Details of current and previous year irregular expenditure condoned

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure condoned	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior years

d) Details of current and previous year irregular expenditure removed - (not condoned)

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure NOT condoned and removed	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior years

e) Details of current and previous year irregular expenditure recovered

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure recoverable	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior years

f) Details of current and previous year irregular expenditure written off (irrecoverable)

Description	2025/2026	2024/2025
	R'000	R'000
Irregular expenditure written off	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior years

Additional disclosure relating to Inter-Institutional Arrangements

g) Details of non-compliance cases where an institution is involved in an inter-institutional arrangement (where such institution is not responsible for the non-compliance)

Description	2025/2026	2024/2025
	R'000	R'000
None	-	-
	-	-
Total	-	-

No irregular expenditures were incurred in the current and prior year

h) Details of current and previous year disciplinary or criminal steps taken as a result of irregular expenditure

Disciplinary steps taken
None

32.2. FRUITLESS AND WASTEFUL EXPENDITURE

a) Reconciliation of fruitless and wasteful expenditure

Description	2025/2026	2024/2025
Opening balance	56,434	64,909
Add: Fruitless and wasteful expenditure confirmed	-	-
Less: Fruitless and wasteful expenditure written off	(56,434)	-
Less: Fruitless and wasteful expenditure recoverable	-	(8,475)
Closing balance	-	56,434

The fruitless and wasteful expenditure pertains to overpayment of leave credit. Payment arrangements have been made with concerned former employee.

The fruitless and wasteful expenditure resulted from a salary payment made to a resigned employee at the beginning of the financial year. The affected employee has acknowledged the debt and is repaying the amount.

Reconciling notes

Description	2025/2026	2024/2025
Fruitless and wasteful expenditure that was under assessment in 2025/26	-	-
Fruitless and wasteful expenditure that relates to 2024/25 and identified in 2025/26	-	-
Fruitless and wasteful expenditure for the current year	-	-
Total	-	-

b) Details of current and previous year fruitless and wasteful expenditure (under assessment, determination, and investigation)

Description	2025/2026	2024/2025
Fruitless and wasteful expenditure under assessment	-	-
Fruitless and wasteful expenditure under determination	-	-
Fruitless and wasteful expenditure under investigation	-	-
Total	-	-

None

c) Details of current and previous year irregular expenditure recovered

Description	2025/2026	2024/2025
None	-	-
Total	-	-

None

d) Details of current and previous year irregular expenditure not recovered and written off

Description	2025/2026	2024/2025
None	-	-
Total	-	-

No irregular expenditures were written off during the year under review.

e) Details of current and previous year disciplinary or criminal steps taken as a result of fruitless and wasteful expenditure

Disciplinary steps taken
None

32.3. ADDITIONAL DISCLOSURE RELATING TO MATERIAL LOSSES IN TERMS OF PFMA SECTION 55(2)(B)(I) &(III)

a) Details of current and previous year material losses through criminal conduct

Material losses through criminal conduct	2025/2026	2024/2025
Theft	-	-
Other material losses	-	-
Less: Recovered	-	-
Less: Not recovered and written off	-	-
Total	-	-

None

b) Details of other material losses

Nature of other material losses	2025/2026	2024/2025
	R'000	R'000
None	-	-
	-	-
Total	-	-

None

c) Other material losses recovered

Nature of losses	2025/2026	2024/2025
	R'000	R'000
None	-	-
Total	-	-

d) Other material losses written off

Nature of losses	2025/2026	2024/2025
	R'000	R'000
None	-	-
Total	-	-

33. LATE AND/OR NON-PAYMENT OF SUPPLIERS

Description	Number of invoices	Consolidated Value
Valid invoices received	586	51,615,065.72
Invoices paid within 30 days or agreed period	586	51,615,065.72
Invoices paid after 30 days or agreed period	-	-
Invoices older than 30 days or agreed period (unpaid and without dispute)	-	-
Invoices older than 30 days or agreed period (unpaid and in dispute)	-	-
Invoices submitted late to finance for payment	-	-

34. SUPPLY CHAIN MANAGEMENT

34.1. PROCUREMENT BY OTHER MEANS

Project description	Name of supplier	Type of procurement by other means	Value of contract R'000
2026 Saphex Hospital Show- Exhibition Stands	Future Publishing	DEVIATION	30,000.00
Relocation of ICT Infrastructure	AE Software Solutions	DEVIATION	326,830.00
Relocation of the HALO and PABX Voice infrastructure to the new office in Centurion	Gijima	DEVIATION	36,524.00
CPD accreditation points for the speakers/presenters at the inaugural Health Ombud Conference 2025.	South African Medical Association (SAMA)	DEVIATION	3,845.60
Membership of 2025/2026	International Ombudsman Institute	DEVIATION	6,937.88
Annual renewal of OHSC's institutional membership for 2025/2026	ISQUA	DEVIATION	17,230.00
Total			421,367.48

34.2. CONTRACT VARIATIONS AND EXPANSIONS

Project description	Name of supplier	Contract modification type (Expansion or Variation)	Original contract value	Value of previous contract expansion/s or variation/s (if applicable)	Value of current contract expansion or variation
			R'000	R'000	R'000
To accommodate the additional 25 participants during the pre-enforcement session in Mbombela	Khayalami Hotel Mbombela	VARIATION			11,250.00
To exchange the outdated transcripts for the new, fully functional version	Tamo Group	VARIATION			1,554.85
Relocation to the new office in Centurion was postponed for 3 Months. The Project Manager has to be part of the relocation. The extension is to align the Project management team with the relocation to Centurion. A need for a quality survey was also identified. Agora was appointed since they have in-depth knowledge of the project	Agora Africa	VARIATION			264,500.00
The number of delegates was reduced from 300 to 150 due to financial constraints	Emperors Palace	VARIATION			164,062.03
To pay for the extra cost of layout, design, and printing of the Health Ombud Northern Cape Investigation Report.	Office Haven	VARIATION			10,444.50
To finalise the disposal process for the goods/ assets stored in the storage	Biddulphs	VARIATION			74,413.46
To finalise the disposal process for the goods/ assets stored in the storage	Biddulphs	VARIATION			87,000.00
To facilitate electronic payments for the payroll system	Breitech	VARIATION			248,708.00
Handling fee on the storage facility	Biddulphs	VARIATION			16,675.00
To be used during the Ombud's exhibition Hospital show	GL Events South Africa	VARIATION			4,945.00
Changed the scope of training conducted	IODSA	VARIATION			56,885.00
Total					612,313.78





PART

F

FINANCIAL INFORMATION

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

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Report of the auditor-general to Parliament on Office of Health Standards Compliance

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

1. I have audited the financial statements of Office of Health Standards Compliance set out on pages 91 to 134, which comprise the statement of financial position as at 31 March 2026, statement of financial performance, statement of changes in net assets, cash flow statement and statement of comparison of budget information with actual information for the year then ended, as well as notes to the financial statements, including a summary of significant accounting policies.
2. In my opinion, the financial statements present fairly, in all material respects, the financial position of Office of Health Standards Compliance as at 31 March 2026 and its financial performance and cash flows for the year then ended in accordance with Standards of Generally Recognized Accounting Practice (GRAP) and the requirements of the Public Finance Management Act 1 of 1999 (PFMA).

Basis for opinion

3. I conducted my audit in accordance with the International Standards on Auditing (ISAs). My responsibilities under those standards are further described in the responsibilities of the auditor-general for the audit of the financial statements section of my report.
4. I am independent of the public entity in accordance with the International Ethics Standards Board for Accountants' International Code of Ethics for Professional Accountants (including International Independence Standards) (IESBA code) as well as other ethical requirements that are relevant to my audit in South Africa. I have fulfilled my other ethical responsibilities in accordance with these requirements and the IESBA code.
5. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Responsibilities of the accounting authority for the financial statements

6. The accounting authority is responsible for the preparation and fair presentation of the financial statements in accordance with GRAP and the requirements of the PFMA; and for such internal control as the accounting authority determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.
7. In preparing the financial statements, the accounting authority is responsible for assessing the public entity's ability to continue as a going concern; disclosing, as

applicable, matters relating to going concern; and using the going concern basis of accounting unless the appropriate governance structure either intends to liquidate the public entity or to cease operations or has no realistic alternative but to do so.

Responsibilities of the auditor-general for the audit of the financial statements

8. My objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error; and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with the ISAs will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.
9. A further description of my responsibilities for the audit of the financial statements is included in the annexure to this auditor's report. This description, which is located at page 94 to 95, of the annexure forms part of my auditor's report.

Report on the audit of the annual performance report

10. In accordance with the Public Audit Act 25 of 2004 (PAA) and the general notice issued in terms thereof; I must audit and report on the usefulness and reliability of the reported performance against predetermined objectives for the selected material performance indicators presented in the annual performance report. The accounting authority is responsible for the preparation of the annual performance report.
11. I selected the following material performance indicators related to Programme 3: Complaints Management and Office of the Health Ombud presented in the annual performance report for the year ended 31 March 2026. I selected those indicators that measure the Public Entity's performance on its primary mandated functions and that are of significant national, community or public interest.
 - Percentage of low-risk complaints closed within twenty-five working days of lodgement in the call centre
 - Percentage of medium risk-rated complaints resolved within 60 working days
 - Percentage of complaints resolved within 6 months through investigation
 - Percentage of complaints resolved within 24 months through investigation

- Percentage of complaints resolved beyond 24 months resolved through investigation
12. I evaluated the reported performance information for the selected material performance indicators against the criteria developed from the performance management and reporting framework, as defined in the general notice. When an annual performance report is prepared using these criteria, it provides useful and reliable information and insights to users on the public entity's planning and delivery on its mandate and objectives.
13. I performed procedures to test whether:
- The indicators used for planning and reporting on performance can be linked directly to the public entity's mandate and the achievement of its planned objectives
 - all the indicators relevant for measuring the department's performance against its primary mandated and prioritised functions and planned objectives are included
 - the indicators are well defined to ensure that they are easy to understand and can be applied consistently, as well as verifiable so that I can confirm the methods and processes to be used for measuring achievements
 - the targets can be linked directly to the achievement of the indicators and are specific, time bound and measurable to ensure that it is easy to understand what should be delivered and by when, the required level of performance as well as how performance will be evaluated
- the indicators and targets reported on in the annual performance report are the same as those committed to in the approved initial or revised planning documents
 - the reported performance information is presented in the annual performance report in the prescribed manner and is comparable and understandable
 - there is adequate supporting evidence for the achievements reported and for the reasons provided for any over- or underachievement of targets.
14. I performed the procedures for the purpose of reporting material findings only; and not to express an assurance opinion or conclusion.
15. I did not identify any material findings on the reported performance information for the selected programmes.
- Other matters**
16. I draw attention to the matters below.
- Achievement of planned targets
17. The annual performance report includes information on reported achievements against planned targets and provides explanations for over- or under achievements.
18. The tables that follow provides information on the achievement of planned targets and list the key indicators that were not achieved as reported in the annual performance report. The reasons for any underachievement of targets are included in the annual performance report on pages 47 - 48.

Programme 3 – Complaints Management and office of Ombud

Target achieved: 20%		Budget spent: 104%	
Key indicator not achieved	Planned target	Reported achievement	Reason for Deviation
The Percentage of low-risk complaints closed within twenty-five working days of lodgement in the call centre	90%	79.06%	The target was not achieved due to a steady increase in complaint cases, placing additional strain on case management. The office will reject complaints outside the Ombud's mandate to focus resources on valid cases
The percentage of medium-risk complaints resolved within 60 working days	50%	43.75%	Performance was affected by prioritising high- and extreme-risk-rated complaints due to their severity, which required immediate resource allocation. This was further influenced by the capacity constraints arising from a shortage of assessors, which limited the OHSC's ability to finalise medium-risk complaints within the planned timeframes.
The percentage of complaints resolved within 6 months through investigation	50%	21.74%	The 50% target was not achieved primarily due to sustained intake of High- and extreme-risk-rated cases, which are inherently complex and require comprehensive investigation. Considerable progress was made; however, some cases could not be concluded within the year because they were in advanced stages, particularly in report writing and internal quality assurance processes.

Key indicator not achieved	Planned target	Reported achievement	Reason for Deviation
The percentage of complaints resolved beyond 24 months resolved through investigation	12%	7.69%	Performance was below target due to the complexity and evidentiary demands of long-outstanding cases, which require additional time for thorough review and information consolidation. Although progress has been made, a number of these matters could not be finalised within the reporting period.

Report on compliance with legislation

19. In accordance with the PAA and the general notice issued in terms thereof, I must audit and report on compliance with applicable legislation relating to financial matters, financial management and other related matters. The accounting authority is responsible for the department's compliance with legislation.
20. I performed procedures to test compliance with selected requirements in key legislation in accordance with the findings engagement methodology of the Auditor-General of South Africa (AGSA). This engagement is not an assurance engagement. Accordingly, I do not express an assurance opinion or conclusion.
21. Through an established AGSA process, I selected requirements in key legislation for compliance testing that are relevant to the financial and performance management of the Public Entity, clear to allow consistent measurement and evaluation, while also sufficiently detailed and readily available to report in an understandable manner. The selected legislative requirements are included in the annexure to this auditor's report.
22. I did not identify material findings non-compliance with the selected legislative requirements.

Other information in the annual report

23. The accounting authority is responsible for the other information included in the annual report which includes the chairperson's foreword, chief executive officer's overview, audit committee's report and human resources management. The other information does not include the financial statements, the auditor's report and those selected material indicators in the scoped-in programme presented in the annual performance report that have been specifically reported on this report.
24. My opinion on the financial statements and my reports on the audit of the annual performance report and compliance with legislation do not cover the other information included in the annual report and I do not express an audit opinion or any form of assurance conclusion on it.
25. My responsibility is to read this other information and, in doing so, consider whether it is materially inconsistent with the financial statements and the selected programme presented in the annual performance report or my knowledge obtained in the audit, or otherwise appears to be materially misstated.

26. I did not receive the other information prior to the date of this auditor's report. When I do receive and read this information, if I conclude that there is a material misstatement therein, I am required to communicate the matter to those charged with governance and request that the other information be corrected. If the other information is not corrected, I may have to retract this auditor's report and re-issue an amended report as appropriate. However, if it is corrected this will not be necessary.

Internal control deficiencies

27. I considered internal control relevant to my audit of the financial statements, annual performance report and compliance with applicable legislation; however, my objective was not to express any form of assurance on it.
28. I did not identify any significant deficiencies in internal control.

Auditor-General.

Pretoria

31 July 2026



AUDITOR - GENERAL
SOUTH AFRICA

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Annexure to the Auditor's Report

The annexure includes the following:

- The auditor-general's responsibility for the audit
- The selected legislative requirements for compliance testing

AUDITOR GENERAL'S RESPONSIBILITY FOR THE AUDIT

Professional judgement and professional scepticism

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

Financial statements

- In addition to my responsibility for the audit of the financial statements as described in this auditor's report, I also:
- identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error; design and perform audit procedures responsive to those risks; and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the department's internal control.
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made.
- conclude on the appropriateness of the use of the going concern basis of accounting in the preparation of the financial statements. I also conclude, based on the audit evidence obtained, whether a material uncertainty exists relating to events or conditions that may cast significant doubt on the ability of the department to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial statements about the material uncertainty or, if such disclosures are inadequate, to modify my opinion on the financial statements. My conclusions are based on the information available to me at the date of this auditor's report. However, future events or conditions may cause the department to cease operating as a going concern.
- evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and determine whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- plan and perform the group audit to obtain sufficient appropriate audit evidence regarding the financial information of the entities or business units within the group as a basis for forming an opinion on the consolidated financial statements. I am responsible for the direction, supervision and review of audit work performed for purposes of the group audit. I remain solely responsible for my audit opinion.

Communication with those charged with governance

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

I also provide the accounting officer with a statement that I have complied with relevant ethical requirements regarding independence and communicate with them all relationships and other matters that may reasonably be thought to bear on my independence and, where applicable, actions taken to eliminate threats or safeguards applied.

COMPLIANCE WITH LEGISLATION – SELECTED LEGISLATIVE REQUIREMENTS

The selected legislative requirements are as follows:

Legislation	Sections or regulations
Public Finance Management Act 1 of 1999 (PFMA)	Section 51(1)(b)(i); 51(1)(b)(ii); 51(1)(e)(iii); 53(4) Section 54(2)(c); 54(2)(d); 55(1)(a); 55(1)(b) Section 55(1)(c)(i); 56(1); 57(b); 66(4)
Treasury Regulation	Regulation 8.2.1; 8.2.2; 16A3.2; 16A3.2(a) Regulation 16A6.1; 16A6.2(a); 16A6.2(b) Regulation 16A6.3(a); 16A6.3(b); 16A6.3(c) Regulation 16A6.3(e); 16A6.4; 16A6.5; 16A6.6 Regulation 16A7.1; 16A7.3; 16A7.6; 16A7.7 Regulation 16A8.3; 16A8.4; 16A9.1(b)(ii) Regulation 16A9.1(d); 16A9.1(e); 16A9.1(f) Regulation 16A9.2; 16A9.2(a)(ii); 30.1.1 Regulation 30.1.3(a); 30.1.3(b); 30.1.3(d); 30.2.1 Regulation 31.1.2(c); 31.2.1; 31.2.5; 31.2.7(a) Regulation 33.1.1; 33.1.3
Preferential Procurement Regulations of 2017 (PPR)	Paragraph 4.1; 4.2; 5.1; 5.3; 5.6; 5.7; 6.1; 6.2 Paragraph 6.3; 6.5; 6.6; 6.8; 7.1; 7.2; 7.3; 7.5 Paragraph 7.6; 7.8; 8.2; 8.5; 9.1; 10.1; 10.2 Paragraph 11.1; 11.2
Second amendment National Treasury Instruction No. 5 of 2021	Paragraph 1
Erratum National Treasury Instruction No. 5 of 2021/21	Paragraph 2
National Treasury Instruction No. 5 of 2020/21	Paragraph 4.8; 4.9; 5.3
National Treasury Instruction No. 1 of 2021/22	Paragraph 4.1
National Treasury Instruction No. 4 of 2015/16	Paragraph 3.4
National Treasury SCM Instruction No. 4A of 2016/17	Paragraph 6
National Treasury SCM Instruction No. 03 of 2021/22	Paragraph 4.1; 4.2(b); 4.3; 4.4(a); 4.17; 7.2; 7.6
National Treasury SCM Instruction No. 11 of 2020/21	Paragraph 3.4(a); 3.4(b); 3.9
National Treasury SCM Instruction No. 2 of 2021/22	Paragraph 3.2.1; 3.2.4; 3.2.4(a); 3.3.1
Practice Note 11 of 2008/9	Paragraph 2.1; 3.1(b)
Practice Note 5 of 2009/10	Paragraph 3.3
Practice Note 7 of 2009/10	Paragraph 4.1.2
Preferential Procurement Policy Framework Act 5 of 2000	Section 1; 2.1(a); 2.1(f)
Preferential Procurement Regulations, 2022	Paragraph 4.1; 4.2; 4.3; 4.4; 5.1; 5.2; 5.3; 5.4
Preferential Procurement Regulations, 2017	Paragraph 4.1; 4.2; 5.1; 5.3; 5.6; 5.7; 6.1; 6.2 Paragraph 6.3; 6.5; 6.6; 6.8; 7.1; 7.2; 7.3; 7.5 Paragraph 7.6; 7.8; 8.2; 8.5; 9.1; 10.1; 10.2 Paragraph 11.1; 11.2
Prevention and Combating of Corrupt Activities Act 12 of 2004	Section 34(1)

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Accounting Authority's Responsibilities and Approval

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

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

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

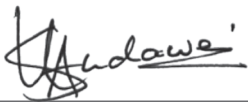
The Accounting Authority acknowledge that they are ultimately responsible for the system of internal financial control established by the entity and place considerable importance on maintaining a strong control environment. To enable the members to meet these responsibilities, the accounting authority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

The Accounting Authority are of the opinion, based on the information and explanations given by management, that the system of internal control provides reasonable assurance that the financial records may be relied on for the preparation of the annual financial statements. However, any system of internal financial control can provide only reasonable, and not absolute, assurance against material misstatement or deficit.

The Accounting Authority have reviewed the entity's cash flow forecast for the year to 31 March 2027 and, in the light of this review and the current financial position, they are satisfied that the entity has or has access to adequate resources to continue in operational existence for the foreseeable future.

The annual financial statements are prepared on the basis that the entity is a going concern and that the entity has neither the intention nor the need to liquidate or curtail materially the scale of the entity.

The annual financial statements set out on page 97, which have been prepared on the going concern basis, were approved by the accounting authority on 30 July 2026 and were signed on its behalf by:



Dr. S. Mndaweni
Chief Executive Officer



Dr. R. L. Morar
Chairperson of the Board

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Accounting Authority's Report

The members submit their report for the year ended 31 March 2026.

1. INCORPORATION

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

2. REVIEW OF ACTIVITIES

Main business and operations

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

Net deficit of the entity was R 6,054,830 (2025: deficit R 8,283,071). The deficit was funded from the 2024-2025 financial year surplus of R6.8 million as approved by National Treasury.

3. GOING CONCERN

We draw attention to the fact that at 31 March 2026, the entity had an accumulated surplus of R 10,259,872 and that the entity's total assets exceed its liabilities by R 10,259,872.

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

4. SUBSEQUENT EVENTS

The Accounting Authority are not aware of any matter or circumstance arising since the end of the financial year.

5. ACCOUNTING POLICIES

The annual financial statements prepared in accordance with the South African Statements of Generally Recognised Accounting Practice (GRAP), issued by the Accounting Practices Board, as the prescribed framework by National Treasury.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Statement of Financial Position as at 31 March 2026

Figures in Rand	Note(s)	2026	2025 Restated*
Assets			
Current Assets			
Receivables from exchange transactions	3	1,518,451	2,323,223
Receivables from non exchange transactions	4	201,701	56,997
Cash and cash equivalents	5	19,035,379	19,286,122
		20,755,531	21,666,342
Non Current Assets			
Property, plant and equipment	6	5,583,825	7,929,503
Total Assets		26,339,356	29,595,845
Liabilities			
Current Liabilities			
Payables from exchange transactions	7	15,615,354	13,335,136
Provisions	8	322,717	322,717
Operating lease liability	9	141,413	-
Total Liabilities		16,079,484	13,657,853
Net Assets		10,259,872	15,937,992
Accumulated surplus		10,259,872	15,937,992
Total Net Assets		10,259,872	15,937,992

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Statement of Financial Performance

Figures in Rand	Note(s)	2026	2025 Restated*
Revenue			
Revenue from exchange transactions			
Interest received investment	10	2,611,543	2,892,170
Revenue from non exchange transactions			
Transfer revenue			
Government grants & subsidies	11	191,749,000	181,599,000
Other Income	12	173,023	49,410
Total revenue from non exchange transactions		191,922,023	181,648,410
Total revenue	13	194,533,566	184,540,580
Expenditure			
Board fees and related costs	14	(1,654,476)	(2,199,721)
Employee related costs	15	(139,983,349)	(131,609,248)
Depreciation	16	(3,672,178)	(3,399,839)
Operating expenses	17	(55,278,393)	(55,614,843)
Total expenditure		(200,588,396)	(192,823,651)
Deficit for the year		(6,054,830)	(8,283,071)

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Statement of Changes in Net Assets

Figures in Rand	Accumulated surplus / deficit	Total net assets
Balance at 01 April 2024	24,221,063	24,221,063
Deficit for the year	(8,283,071)	(8,283,071)
Total changes	(8,283,071)	(8,283,071)
Restated* Balance at 01 April 2025	15,937,992	15,937,992
Revaluation of surplus	376,710	376,710
Net income (losses) recognised directly in net assets	376,710	376,710
Deficit for the year	(6,054,830)	(6,054,830)
Total recognised income and expenses for the year	(5,678,120)	(5,678,120)
Total changes	(5,678,120)	(5,678,120)
Balance at 31 March 2026	10,259,872	10,259,872

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Cash Flow Statement

Figures in Rand	Note(s)	2026	2025 Restated*
Cash flows from operating activities			
Receipts			
Grants		191,749,000	181,599,000
Interest income		2,611,543	2,892,170
Other income		64,823	49,410
		194,425,366	184,540,580
Payments			
Employee costs		(138,838,745)	(130,943,805)
Suppliers		(52,844,779)	(54,277,009)
Board payments		(1,654,475)	(2,199,721)
		(193,337,999)	(187,420,535)
Net cash flows from operating activities	20	1,087,367	(2,879,955)
Cash flows from investing activities			
Purchase of property, plant and equipment	6	(1,338,110)	(876,844)
Net increase/(decrease) in cash and cash equivalents		(250,743)	(3,756,799)
Cash and cash equivalents at the beginning of the year		19,286,122	23,042,921
Cash and cash equivalents at the end of the year	5	19,035,379	19,286,122

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Statement of Comparison of Budget and Actual Amounts

Budget on Cash Basis

Figures in Rand	Approved budget	Adjustments	Final Budget	Actual amounts on comparable basis	Difference between final budget and actual	Reference
Statement of Financial Performance						
Revenue						
Revenue from exchange transactions						
Interest received investment	-	-	-	2,611,543	2,611,543	31.1
Revenue from non exchange transactions						
Transfer revenue						
Government grants & subsidies	191,749,000	6,888,224	198,637,224	191,749,000	(6,888,224)	31.2
Other income	-	-	-	173,023	173,023	
Total revenue from non exchange transactions	191,749,000	6,888,224	198,637,224	191,922,023	(6,715,201)	
Total revenue	191,749,000	6,888,224	198,637,224	194,533,566	(4,103,658)	
Expenditure						
Employee related costs	(135,255,929)	(4,732,554)	(139,988,483)	(139,983,349)	5,134	31.3
Board fees and related costs	(2,111,526)	-	(2,111,526)	(1,654,476)	457,050	31.4
Operating expenses	(49,591,545)	(1,035,847)	(50,627,392)	(55,278,393)	(4,651,001)	31.5
Total expenditure	(186,959,000)	(5,768,401)	(192,727,401)	(196,916,218)	(4,188,817)	
Deficit before taxation	4,790,000	1,119,823	5,909,823	(2,382,652)	(8,292,475)	
Actual Amount on Comparable Basis as Presented in the Budget and Actual Comparative Statement	4,790,000	1,119,823	5,909,823	(2,382,652)	(8,292,475)	
Reconciliation						
Basis difference						
Depreciation				(3,672,178)		
Actual Amount in the Statement of Financial Performance				(6,054,830)		

Basis of accounting

The approved budget is on cash basis, thus recognising transactions and other events only when cash is received or paid. The actual amounts were based on the accrual basis of accounting and were adjusted to be comparable to the budget which is on cash basis.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Statement of Comparison of Budget and Actual Amounts

Figures in Rand	Approved budget	Adjustments	Final Budget	Actual amounts on comparable basis	Difference between final budget and actual	Reference
Statement of Financial Position						
Assets						
Current Assets						
Receivables from exchange transactions	-	-	-	1,518,451	1,518,451	
Receivables from non exchange transactions	-	-	-	201,701	201,701	
Cash and cash equivalents	-	-	-	19,035,379	19,035,379	
	-	-	-	20,755,531	20,755,531	
Non Current Assets						
Property, plant and equipment	730,000	620,143	1,350,143	5,583,825	4,233,682	
Intangible assets	4,060,000	499,680	4,559,680	-	(4,559,680)	
	4,790,000	1,119,823	5,909,823	5,583,825	(325,998)	
Total Assets	4,790,000	1,119,823	5,909,823	26,339,356	20,429,533	
Liabilities						
Current Liabilities						
Operating lease liability	-	-	-	141,413	141,413	
Payables from exchange transactions	-	-	-	15,615,349	15,615,349	
Provisions	-	-	-	322,717	322,717	
	-	-	-	16,079,479	16,079,479	
Total Liabilities	-	-	-	16,079,479	16,079,479	
Net Assets	4,790,000	1,119,823	5,909,823	10,259,877	4,350,054	
Net Assets						
Net Assets Attributable to Owners of Controlling Entity						
Reserves						
Accumulated surplus	4,790,000	1,119,823	5,909,823	10,259,872	4,350,049	

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Significant Accounting Policies

1. SIGNIFICANT ACCOUNTING POLICIES

The significant accounting policies applied in the preparation of these annual financial statements are set out below.

1.1 Basis of preparation

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

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

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

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

These accounting policies are consistent with the previous period, except for the changes set out in note 34 Changes in accounting policy.

1.2 Presentation currency

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

1.3 Going concern assumption

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

1.4 Significant judgements and sources of estimation uncertainty

In preparing the annual financial statements, management is required to make estimates and assumptions that affect the amounts represented in the annual financial statements and related disclosures. Use of available information and the application of judgement is inherent in the formation of estimates. Actual results in the future could differ from these estimates which may be material to the annual financial statements. Significant judgements include:

Impairment testing

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

Provisions

Provisions were measured based on the probable estimated future cash outflows that may be needed to settle the obligation that may arise. Additional disclosure of these estimates of provisions are included in note 8 Provisions.

Effective interest rate

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

Significant Accounting Policies

Impairment – expected credit losses (ECL)

The entity measures expected credit losses (ECL) on financial assets measured at amortised cost, using the requirements in GRAP 104.5.17–5.35. Financial assets measured at cost (i.e. investments in residual interests where fair value cannot be measured reliably) are subject to a separate impairment model. ECL measurement involves significant judgement, including in:

- defining “default” and segmenting exposures into appropriate groups;
- estimating probabilities of default, loss given default and exposures at default; and
- incorporating forward looking information and any post model adjustments where model outputs do not fully capture emerging risks.

Depreciation

Depreciation amount on property, plant and equipment, was calculated based on expected useful lives of the underlying assets. The estimation of the assets’ useful lives is based on the management judgement related to the assets condition at the end of the period use. The estimates take into account the nature of the OHSC’s business and how the assets will be utilised in the normal operation of the OHSC, including the impact of advancing technology.

1.5 Property, plant and equipment

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

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

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

Property, plant and equipment is initially measured at cost.

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

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

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

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

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

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

Property, plant and equipment is carried at cost less accumulated depreciation and any impairment losses except for Motor vehicles, IT equipment and Office equipment which is carried at revalued amount being the fair value at the date of revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses.

Revaluations are made with sufficient regularity such that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period.

OFFICE OF HEALTH STANDARDS COMPLIANCE

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Significant Accounting Policies

When an item of property, plant and equipment is revalued, any accumulated depreciation at the date of the revaluation is eliminated against the gross carrying amount of the asset and the net amount restated to the revalued amount of the asset.

Any increase in an asset's carrying amount, as a result of a revaluation, is credited directly to a revaluation surplus. The increase is recognised in surplus or deficit to the extent that it reverses a revaluation decrease of the same asset previously recognised in surplus or deficit.

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

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

Item	Depreciation method	Average useful life
Furniture and fixtures	Straight line	10 years
Motor vehicles	Straight line	5 years
Office equipment	Straight line	5 years
IT equipment	Straight line	4 5 years
Leasehold improvements	Straight line	Lease period

1.6 Financial instruments GRAP 104 (revised 2019) current policy

A financial instrument is any contract that gives rise to a financial asset of one entity and a financial liability on another entity.

A financial asset is cash, a contractual right to receive cash or another financial asset from another entity or exchange financial assets or financial liabilities with another entity under conditions that are potentially favourable to the Institution.

A financial liability is any liability that is a contractual obligation to deliver cash or another financial asset to another entity or exchange financial assets or financial liabilities under conditions that are potentially unfavourable to the Institution.

Initial Recognition

The entity recognises a financial asset or a financial liability in its statement of financial position when it becomes a party to the contractual provisions of the instrument. As a consequence, has a legal right right to receive, or a legal obligation to pay cash, using trade date accounting.

The entity's financial assets mainly comprise the following:

Receivables from exchange transactions which are composed of trade and other receivables from exchange transactions. Financial assets exclude statutory receivables, however, receivables recognised as a result of contractual non exchange revenue transactions are subsequently measured, derecognised, presented and disclosed as financial instruments.

The deposits mainly comprises of cash and cash equivalents in the form of short term, highly liquid investments, readily convertible into known amounts of cash that are held with registered banking Institutions with maturities of three months or less and are subject to an insignificant risk of change in value as well as cash on hand.

The entity's financial liabilities mainly comprise the following:

Payables from exchange transactions in the form of trade and other payables from exchange transactions that include trade payables, accruals and lease liability.

When the Institution first recognises a financial asset or financial liability, it classifies financial assets by considering the management model for holding the financial assets and the characteristics of their contractual cash flows and has not opted to designate its financial assets or financial liabilities at fair value through surplus or deficit and thus classifies them as subsequently measured at amortised cost.

Significant Accounting Policies

Classification

Classification of Financial Assets

The entity classifies financial assets as subsequently measured at amortised cost or fair value through surplus or deficit on the basis of both:

- (a) the entity's management model for managing the financial assets; and
- (b) the contractual cash flow characteristics of the financial asset.

A financial asset is measured at amortised cost if both of the following conditions are met:

- (a) the financial asset is held within a management model whose objective is to hold financial assets in order to collect contractual cash flows; and
- (b) the contractual terms of the financial asset give rise on specified dates to cash flows that are solely payments of principal and interest on the principal amount outstanding.

A financial asset is measured at fair value through surplus or deficit unless it is measured at amortised cost or cost.

Classification of Financial Liabilities

The entity classifies all financial liabilities as subsequently measured at amortised cost:

Measurement

Initial measurement

The entity measures a financial asset or financial liability at its fair value plus transaction costs that are directly attributable to the acquisition or issue of the financial asset or financial liability.

However, if the fair value of the financial asset or financial liability at initial recognition differs from the transaction price, the entity applies the relevant paragraphs in GRAP 104 (revised 2019).

Despite the above, at initial recognition, the entity measures receivables and payables at their transaction price if they do not contain a material financing transaction.

Subsequent measurement of financial assets and financial liabilities

Subsequent to initial measurement, the Institution measures all financial assets and financial liabilities at amortised cost.

Amortised cost is the amount at which a financial asset or financial liability is measured at initial recognition minus principal repayments, plus or minus the cumulative amortisation using the effective interest method of any difference between that initial amount and the maturity amount, and for financial assets, this is adjusted for any loss allowance.

Loss allowance is the allowance for expected credit losses on financial assets subsequently measured at amortised cost.

A credit loss is the difference between all contractual cash flows that are due to the Institution in accordance with the contract and all the cash flows that the Institution expects to receive (i.e. all cash shortfalls), discounted at the original effective interest rate. Cash flows are estimated by considering all contractual terms of the financial instrument (for example, prepayment and extension) through the expected life of that financial instrument. The cash flows that are considered include cash flows that are integral to the contractual terms.

Expected credit losses are the weighted average of credit losses with the respective risks of a default occurring as the weights. The entity uses a simplified approach to measure and recognise ECL on a lifetime basis for trade receivables.

At each reporting date, the Institution measures the loss allowance for financial assets at an amount equal to the lifetime expected credit losses for receivables.

Lifetime expected credit losses are the expected credit losses that result from all possible default events over the expected life of a financial instrument.

OFFICE OF HEALTH STANDARDS COMPLIANCE

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Significant Accounting Policies

Credit risk is the risk that a party to a financial instrument will cause a financial loss for the Institution by failing to discharge its payment obligations.

Determining significant increases in credit risk

At each reporting date, the entity assesses whether the credit risk on a financial instrument has increased significantly since initial recognition. When making the assessment, the entity uses the change in the risk of a default occurring over the expected life of the financial instrument instead of the change in the amount of expected credit losses. To make that assessment, the entity compares the risk of a default occurring on the financial instrument as at the reporting date with the risk of a default occurring on the financial instrument as at the date of initial recognition and consider reasonable and supportable information, that is available without undue cost or effort, that is indicative of significant increases in credit risk since initial recognition.

Measurement of expected credit losses

Expected credit losses are the weighted average of credit losses with the respective risks of a default occurring as the weights and are measured in a way that reflects:

- (a) an unbiased and probability weighted amount that is determined by evaluating a range of possible outcomes;
- (b) the time value of money; and
- (c) reasonable and supportable information that is available without undue cost or effort at the reporting date about past events, current conditions and forecasts of future economic conditions.

A gain or loss on a financial asset that is measured at amortised cost is recognised in the surplus or deficit when the financial asset is derecognised, reclassified, through the amortisation process or in order to recognise impairment gains or losses. A gain or loss on a financial liability that is measured at amortised cost is recognised in surplus or deficit when the financial liability is derecognised and through the amortisation process.

Offsetting a financial asset and a financial liability

A financial asset and a financial liability may be offset and the net amount presented in the statement of financial position when, and only when, the Institution:

- (a) currently has a legally enforceable right to set off the recognised amounts; and
- (b) intends either to settle on a net basis, or to realise the asset and settle the liability simultaneously.

Offsetting financial a asset and a financial liability does not give rise to recognition of a gain or loss.

Derecognition

Derecognition of financial assets

The entity derecognises financial assets using trade date accounting.

The entity derecognises a financial asset only when:

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

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Significant Accounting Policies

Waiver of rights relating to financial assets

The entity may waive the right to receive contractual receipts under the terms of an existing arrangement. The following outline scenarios of when a waiver of rights may arise:

- (a) The entity may waive the right to receive contractual receipts under the terms of an existing arrangement in compliance with its Loss Control policy.

Derecognition of financial liabilities

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

The difference between the carrying amount of a financial liability (or part of a financial liability) extinguished or transferred to another party and the consideration paid, including any non cash assets transferred or liabilities assumed, is recognised in surplus or deficit. Any liabilities that are waived, forgiven or assumed by another entity by way of a non exchange transaction, are accounted for in accordance with GRAP 23.

1.7 Financial instruments GRAP 104 (Previous policy applied in comparative period)

In the course of the OHSC operations it is exposed to interest rate, credit, liquidity and market risk. The OHSC does not anticipate the probability of expected credit losses. The risk management process relating to each of these risks is discussed under the headings below.

Credit risk

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

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

Market risk

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

Liquidity risk

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

Fair values

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

Investments

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

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

Cash and cash equivalents

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

Significant Accounting Policies

Other receivables from exchange transactions

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

Trade and other receivable

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

Trade and other payables

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

Derecognition

Financial assets

The entity derecognises financial assets using trade date accounting. The entity derecognises a financial asset only when:

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

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

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

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

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

OFFICE OF HEALTH STANDARDS COMPLIANCE

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Significant Accounting Policies

Financial liabilities

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

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

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

1.8 Tax

Tax expenses

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

1.9 Leases

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

Operating leases - lessee

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

1.10 Employee benefits

Short term employee benefits

Recognition and measurement

All short term employee benefits

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

Defined contribution plans

Recognition and measurement

Payments to defined contribution retirement benefit plans are charged as an expense as they fall due.

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

1.11 Provisions and contingencies

Provisions are recognised when:

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

OFFICE OF HEALTH STANDARDS COMPLIANCE

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Significant Accounting Policies

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

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

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

A provision is used only for expenditures for which the provision was originally recognised.

Provisions are not recognised for future operating surplus.

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

Contingent assets and contingent liabilities are not recognised. Contingencies are disclosed in note 24.

1.12 Commitments

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

1.13 Revenue from exchange transactions

Revenue from exchange transactions refers to revenue that accrued to the entity directly in turn for services rendered or goods sold. The value of which approximates the consideration received or receivable. Revenue is recognised to the extent that is probable that the economic benefit will flow to the OHSC and revenue can be reliably measured. Revenue is measured at fair value of the consideration receivable on an accrual basis. Revenue included investments and nonoperating income exclusive of rebates and discounts.

Measurement

Revenue is measured at the fair value of the consideration received or receivable, net of trade discounts and volume rebates.

Interest received

Revenue arising from the use by others of entity assets yielding interest, royalties and dividends or similar distributions is recognised when:

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

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

1.14 Revenue from non exchange transactions

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

Government grants

Apart from Services in kind, which are not recognised, the entity recognises an asset in respect of transfers when the transferred resources meet the definition of an asset and satisfy the criteria for recognition as an asset.

Significant Accounting Policies

The entity recognises an asset in respect of transfers when the transferred resources meet the definition of an asset and satisfy the criteria for recognition as an asset.

Government grants

Government grants are recognised as revenue when:

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

1.15 Fruitless and wasteful expenditure

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

1.16 Irregular expenditure

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

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

National Treasury practice note no. 4 of 2022/2023 which was issued in terms of sections 76(1)(b), (e) and (f), (2)(e) and (4)(a) and (c) of the PFMA requires the following (effective from 03 January 2023):

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

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

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

1.17 Budget information

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

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

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

The approved budget covers the fiscal period from 01/04/2025 to 31/03/2026.

The budget for the economic entity includes all the entities approved budgets under its control.

The annual financial statements and the budget are on the same basis of accounting therefore a comparison with the budgeted amounts for the reporting period have been included in the Statement of comparison of budget and actual amounts.

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

The annual financial statements and the budget are not on the same basis of accounting therefore a reconciliation between the statement of financial performance and the budget have been included in the annual financial statements. Refer to note 29.

1.18 Related parties

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

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

The following parties are deemed to be related parties of the OHSC:

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

1.19 Events after reporting date

Events after reporting date are those events, both favourable and unfavourable, that occur between the reporting date and the date when the financial statements are authorised for issue. Two types of events can be identified:

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

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

Significant Accounting Policies

1.20 Segment reporting

A segment is an activity of an entity:

- that generates economic benefits or service potential (including economic benefits or service potential relating to transactions between activities of the same entity);
- whose results are regularly reviewed by management to make decisions about resources to be allocated to that activity and in assessing its performance; and
- for which separate financial information is available.

The OHSC operates from one office located in Pretoria, South Africa.

1.21 Comparative figures

Where prior period accounting errors are identified in the current period, prior year comparative figures are restated retrospectively to align to changes in the current period. The presentation and classification of both the prior period and current period are consistent, and the nature and the reason of the classification and/or restatement are disclosed in the annual financial statements.

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

Property, plant and equipment is carried at revalued amount, being the fair value at the date of revaluation less any subsequent accumulated depreciation and subsequent accumulated impairment losses. Revaluations are made with sufficient regularity such that the carrying amount does not differ materially from that which would be determined using fair value at the end of the reporting period.

Any increase in an asset's carrying amount, as a result of a revaluation, is credited directly to a revaluation surplus. The increase is recognised in surplus or deficit to the extent that it reverses a revaluation decrease of the same asset previously recognised in surplus or deficit.

Any decrease in an asset's carrying amount, as a result of a revaluation, is recognised in surplus or deficit in the current period. The decrease is debited in revaluation surplus to the extent of any credit balance existing in the revaluation surplus in respect of that asset.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025 Restated*
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2. NEW STANDARDS AND INTERPRETATIONS

2.1 Standards and interpretations effective and adopted in the current year

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

Standard/ Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 104 (Revised): Financial Instruments	01 April 2025	Not expected to impact results, refer to note 34 changes in accounting policy

2.2 Standards and interpretations not yet effective or relevant

The following standards and interpretations have been published and are mandatory for the entity's accounting periods beginning on or after 01 April 2026 or later periods but are not relevant to its operations:

Standard/ Interpretation:	Effective date: Years beginning on or after	Expected impact:
GRAP 1: Presentation on Financial Statements	01 April 2026	Not expected to impact results but may result in additional disclosure
GRAP 103: Heritage assets	01 April 2026	Not expected to impact results but may result in additional disclosure
GRAP 105: Transfer of function between entities under common	01 April 2026	Not expected to impact results but may result in additional disclosure
GRAP 106: Transfer of function between entities not under common	01 April 2026	
GRAP 107: Mergers	01 April 2026	Not expected to impact results but may result in additional disclosure
Amendments: Improvements to standards of GRAP	01 April 2026	Not expected to impact results but may result in additional disclosure

3. RECEIVABLES FROM EXCHANGE TRANSACTIONS

Receivables from exchange transactions

Prepaid expenses	1,518,451	2,323,223
Total receivables from exchange transactions	1,518,451	2,323,223

Split between non current and current portions

Non current assets	-	-
Current assets	1,518,451	2,323,223
	1,518,451	2,323,223

Split between financial instruments and non financial instruments

Non financial instruments related	1,518,451	2,323,223
Carrying amount of non financial instruments	1,518,451	2,323,223
Total split between financial instruments and non financial instruments	1,518,451	2,323,223

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
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4. RECEIVABLES FROM NON EXCHANGE TRANSACTIONS

Sundry debtors	201,701	56,997
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Split between current and non current portions

Non current assets	-	-
Current assets	201,701	56,997

Total receivables from non exchange transactions**201,701 56,997****Split between financial instruments and non financial instruments**

Carrying amount of financial instruments	201,701	56,997
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Split of carrying amount of financial instruments into categories

Financial assets measured at amortised cost	201,701	56,997
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Financial instrument disclosure

Additional information on the financial instrument components of this note, as required by GRAP 104, is provided in note 21 Financial Instruments.

5. CASH AND CASH EQUIVALENTS

Cash and cash equivalents consist of:

Cash on hand	4,420	4,420
Bank balances	3,554,595	1,016,881
Short term deposits	15,476,364	18,264,821
	19,035,379	19,286,122

Split between financial instruments and non financial instruments

Carrying amount of financial instruments	19,035,379	19,286,122
--	------------	------------

Split of carrying amount of financial instruments into categories

Financial assets measured at amortised cost	19,035,379	19,286,122
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Financial instrument disclosure

Additional information on the financial instrument components of this note, as required by GRAP 104, is provided in note 21 Financial Instruments.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements**6. PROPERTY, PLANT AND EQUIPMENT**

	2026			2025		
	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value	Cost / Valuation	Accumulated depreciation and accumulated impairment	Carrying value
Office equipment	1,008,033	(497,729)	510,304	3,442,158	(2,528,173)	913,985
Furniture and fixtures	5,718,046	(4,326,574)	1,391,472	6,298,812	(4,337,813)	1,960,999
Motor vehicles	1,000,000	(600,000)	400,000	1,000,000	(400,000)	600,000
IT equipment	6,612,066	(3,330,017)	3,282,049	12,766,859	(8,312,340)	4,454,519
Total	14,338,145	(8,754,320)	5,583,825	23,507,829	(15,578,326)	7,929,503

Reconciliation of property, plant and equipment 2026

	Opening balance	Additions	Disposal	Revaluations	Depreciation	Total
Office equipment	913,985	234,966	(140,567)	56,456	(554,536)	510,304
Furniture and fixtures	1,960,999	-	(102,830)	220,318	(687,015)	1,391,472
Motor vehicles	600,000	-	-	-	(200,000)	400,000
IT equipment	4,454,519	1,103,144	(144,923)	99,936	(2,230,627)	3,282,049
	7,929,503	1,338,110	(388,320)	376,710	(3,672,178)	5,583,825

Reconciliation of property, plant and equipment 2025

	Opening balance	Additions	Depreciation	Total
Office equipment	1,402,136	137,103	(625,254)	913,985
Furniture and fixtures	2,562,583	7,999	(609,583)	1,960,999
Motor vehicles	800,000	-	(200,000)	600,000
IT equipment	5,669,046	731,742	(1,946,269)	4,454,519
Leasehold improvements	18,733	-	(18,733)	-
	10,452,498	876,844	(3,399,839)	7,929,503

Revaluations

The effective date of the revaluations was 31 March 2026. Revaluations were performed by independent valuer, Synergy (Pty) Ltd member of Southern African Asset Management Association. Synergy (Pty) Ltd are not connected to the entity.

The valuation was performed using arms length market transactions for similar property, plant and equipment.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
7. PAYABLES FROM EXCHANGE TRANSACTIONS		
Trade payables	2,106,566	259,707
Accrued leave pay	7,537,882	6,626,083
Service bonus	3,350,006	3,117,201
Accrued expenses	2,620,900	3,332,145
	15,615,354	13,335,136

Split between financial instruments and non financial instruments

Other non financial instruments related	10,887,888	9,743,284
Carrying amount of non financial instruments	10,887,888	9,743,284
Carrying amount of financial instruments	4,727,466	3,591,852
Total split between financial instruments and non financial instruments	15,615,354	13,335,136

Split of carrying amount of financial instruments into categories

Financial liabilities measured at amortised cost	4,727,466	3,591,852
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Financial instrument disclosure

Additional information on the financial instrument components of this note, as required by GRAP 104, is provided in Note 21 Financial Instruments.

8. PROVISIONS

Reconciliation of provisions 2026	Opening Balance	Total
Provision for motor vehicle repairs	322,717	322,717

Reconciliation of provisions 2025	Opening Balance	Total
Provision for motor vehicle repairs	322,717	322,717

Provision for motor vehicles repairs

The five vehicles were damaged by the OHSC employee, including one Avis rental car and four Hertz rental cars. The OHSC is obligated to reimburse rental car companies for the damages incurred. It is uncertain when payment will be made. An investigation is currently underway into the matter at hand.

The expected reimbursement concerning this provision will be ascertained subsequent to the conclusion of the investigation and other internal processes.

9. OPERATING LEASE ASSET (LIABILITY)

Current liabilities	141,413	-
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OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
10. INVESTMENT REVENUE		
Interest received - investments		
Bank	2,611,543	2,892,170
Interest from call investment account.		
Financial instrument disclosure		
Additional information on the financial instrument components of this note, as required by GRAP 104, is provided in note 21 Financial Instruments.		
11. GOVERNMENT GRANTS & SUBSIDIES		
Operating grants		
Government grant	191,749,000	181,599,000
12. OTHER INCOME		
Insurance refunds	171,900	47,971
Administration fees	1,123	1,439
	173,023	49,410
13. REVENUE		
Interest received investment	2,611,543	2,892,170
Government grants & subsidies	191,749,000	181,599,000
Other income	173,023	49,410
	194,533,566	184,540,580
The amount included in revenue arising from exchanges of goods or services are as follows:		
Interest received investment	2,611,543	2,892,170
The amount included in revenue arising from non exchange transactions is as follows:		
Transfer revenue		
Government grants & subsidies	191,749,000	181,599,000
Other income	173,023	49,410
	191,922,023	181,648,410
14. BOARD FEES AND RELATED COSTS		
Board fees and reimbursement	1,213,973	1,729,073
Other expenditure	440,503	470,648
	1,654,476	2,199,721

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
15. EMPLOYEE RELATED COSTS		
Basic	102,103,950	94,839,119
Service bonus	6,733,246	6,349,146
Medical aid company contributions	4,903,645	4,407,032
Unemployment Insurance Fund	319,390	317,571
Compensation fund	240,856	217,970
Leave paid and provided for	1,409,543	1,888,726
Pension fund employer contribution	11,765,195	11,086,106
Overtime payments	-	25,728
Long service awards	8,724	26,617
Other non pensionable allowances	11,646,340	11,104,880
Inconvenience allowances	852,460	966,836
Termination benefits	-	379,517
	139,983,349	131,609,248
16. DEPRECIATION		
Property, plant and equipment	3,672,178	3,399,839

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
17. GENERAL EXPENSES		
Advertising	366,859	104,500
Auditors costs (Refer to Note 18)	1,956,852	1,577,213
Bank charges	16,077	91,683
Cleaning	1,208,594	731,150
Consulting and professional fees	1,613,408	2,093,792
Consumables	615,988	586,206
Legal fees	1,250,307	208,338
Insurance	242,876	344,838
IT maintenance and support	6,082,269	6,994,970
Marketing and publication	971,182	508,103
Motor vehicle expenses	191,363	192,038
Staff relocation	2,434,530	218,673
Postage and courier	13,575	29,311
Printing and stationery	181,613	499,312
Security expenses	1,080,389	887,135
Subscriptions and membership fees	59,352	201,645
Telephone and fax	1,659,952	1,844,375
Training and skills development	645,869	1,513,555
Travel, subsistence and accommodation (Refer to note 19)	17,386,868	20,349,322
Water, electricity, rates and water	3,447,263	3,291,696
Repairs and maintenance	316,466	-
Catering services	246,188	169,310
Lease costs	7,639,978	8,553,723
Llense fees	3,822,949	3,780,379
Bad debts written off	56,434	-
Loss assets written off	388,320	-
Venue and facilities	1,382,872	843,576
	55,278,393	55,614,843
18. AUDITOR'S REMUNERATION		
Internal audit	993,002	652,293
External audit	963,850	924,920
	1,956,852	1,577,213

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
19. TRAVEL, SUBSISTENCE AND ACCOMODATION		
Travel	9,361,846	10,451,411
Accommodation	5,601,277	6,923,406
Subsistence	2,423,745	2,974,505
	17,386,868	20,349,322

20. CASH GENERATED FROM (USED IN) OPERATIONS

Deficit	(6,054,830)	(8,283,071)
Adjustments for:		
Depreciation	3,672,178	3,399,839
Movements in operating lease assets and accruals	141,413	-
Loss on asset written off	388,320	-
Changes in working capital:		
Receivables from exchange transactions	804,772	948,233
Other receivables from non exchange transactions	(144,704)	19,279
Payables from exchange transactions	2,280,218	1,035,765
	1,087,367	(2,879,955)

21. FINANCIAL INSTRUMENTS**Significance of financial instruments for financial position and financial performance****Statement of financial position****Categories of financial assets and financial liabilities****Carrying amounts of financial assets**

Class of financial instrument 2026	Note(s)	At amortised cost	Total
Other receivables from non exchange transactions	4	201,701	201,701
Cash and cash equivalent	5	19,035,379	19,035,379
Total carrying amounts		19,237,080	19,237,080

Class of financial instrument 2025	Note(s)	At amortised cost	Total
Other receivables from non exchange transactions	4	56,997	56,997
Cash and cash equivalents	5	19,286,122	19,286,122
Total carrying amounts		19,343,119	19,343,119

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand		2026	2025
Carrying amounts of financial liabilities			
Class of financial instrument 2026	Note(s)	At amortised cost	Total
Payables from exchange transactions	7	4,727,466	4,727,466
Operating lease liability	9	141,413	141,413
Total carrying amounts		4,868,879	4,868,879
Class of financial instrument 2025			
Payables from exchange transactions	7	3,591,852	3,591,852

Statement of financial performance**Items of revenue, expenses, gains or losses****2026**

Interest revenue and interest expense Interest received	2,611,543	2,611,543
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2025

Interest revenue and interest expense Interest received	2,892,170	2,892,170
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22. FINANCIAL INSTRUMENTS DISCLOSURE – PRE REVISED GRAP 104**Categories of financial instruments****2025**

Financial assets	At amortised cost	Total
Trade and other receivables from exchange transactions	56,997	56,997
Cash and cash equivalents	19,286,122	19,286,122
	19,343,119	19,343,119
Financial liabilities		
	At amortised cost	Total
Trade and other payables from exchange transactions	3,591,852	3,591,852

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
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23. COMMITMENTS

Authorised capital expenditure

Already contracted for but not provided for

• Property, plant and equipment	182,743	620,143
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Total capital commitments

Already contracted for but not provided for	182,743	620,143
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The above capital commitments were made by year end, but the service will only be rendered after the end of the financial year. The prior years amount was restated due to reclassification of intangible assets to prepayments.

Operating leases Office space

Minimum lease payments due

within one year	7,282,748	9,132,764
in second to fifth year inclusive	2,427,583	12,475,681
	9,710,331	21,608,445

The OHSC has entered into a lease agreement with JR 209 Investment (Pty) Ltd for the period of two years commencing from 01 August 2025 to 31 July 2027. The annual escalation rate is 6%.

Operating leases photocopying machine

- within one year	73,288	191,221
- in second to fifth year inclusive	-	73,288
	73,288	264,509

24. CONTINGENCIES

Retention of the surplus

Based on the National Treasury's retention of surplus calculation, the OHSC had a surplus of R2,656,003.19 which is the difference between current assets, liabilities and commitments. In accordance with Section 53(3) of the PFMA, a request to retain the 2025/2026 financial year surpluses of R2,656,003.19 will be submitted to National Treasury for approval.

Alleged unfair suspension

One employee was suspended, and she took the matter to the Commission for Conciliation, Mediation and Arbitration (CCMA), where the CCMA ruled in favour of the employee. The OHSC was ordered to pay an employee two months salary amounting to a R207,538.31 in total for employees. The OHSC lodged a Labour Court review application on the ruling. The matter was held on 21 January 2026. We are awaiting judgement by the Labour Court.

Alleged unfair dismissal

Following an internal disciplinary process, an employee was dismissed. The employee took the matter to the CCMA and the CCMA ruled in favour of the OHSC. The employee has taken the matter to the Labour Court for a review.

Alleged unfair suspension

One employee was suspended, and she took the matter to the Commission for Conciliation, Mediation and Arbitration (CCMA), and matter awaiting arbitration set down date to be determined by CCMA after conciliation failed.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand	2026	2025
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Alleged constructive dismissal

Following an internal disciplinary process, an employee was dismissed. The employee took the matter to the CCMA and matter awaiting arbitration set down date to be determined by CCMA after conciliation failed.

25. RELATED PARTIES

Relationships

Controlling entity

National Department of Health

Remuneration of management

Remuneration of management: Non Executive Members

2026	Board fees	Reimbursement	Total
Name			
Dr. R. Morar (Chairperson of the Board)	88,930	-	88,930
Ms. S. Mchunu (Vice Chairperson of the Board)	117,070	1,653	118,723
Prof. R. Mahabeer	114,903	2,323	117,226
Ms. P. Santho	95,623	208	95,831
Mr. A. Yawa	145,621	1,400	147,021
Dr. G. Lourens	76,619	-	76,619
Prof. L. Dudley	89,992	-	89,992
Dr B. Mtukushe*	11,802	889	12,691
Dr G. Timothy*	11,802	729	12,531
Dr P.T. Carter*	11,802	-	11,802
Mr S. D. Gada*	-	-	-
Dr. M.E. Kenoshi**	149,874	3,052	152,926
Dr. M. Peenze**	120,862	-	120,862
Prof. U Chikte**	111,320	-	111,320
Ms. T Msibi**	-	6,027	6,027
Prof. M. Chetty**	51,472	-	51,472
	1,197,692	16,281	1,213,973

* The Board Members were appointed on 12 February 2026

** The Board Members term of office ended on 11 February 2026.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand		2026	2025
2025	Board fees	Reimbursement	Total
Name			
Dr. M.E. Kenoshi (Chairperson of the Board)	207,804	7,619	215,423
Dr. R. Morar (Vice Chairperson of the Board)	111,475	-	111,475
Dr. M. Peenze	161,677	207	161,884
Prof. U Chikte	201,180	-	201,180
Ms. T Msibi	-	17,410	17,410
Prof. M. Chetty	95,006	-	95,006
Prof. L. Dudley	140,079	-	140,079
Ms. P. Santho	140,059	476	140,535
Ms. S. Mchunu	156,147	2,701	158,848
Prof. R. Mahabeer	178,766	4,161	182,927
Mr. A. Yawa	183,464	2,550	186,014
Dr. G. Lourens	118,292	-	118,292
	1,693,949	35,124	1,729,073

Remuneration of management: Executive Members

2026	Basic salary	Pension fund	Non pensionable allowance and other payments	Service bonus	Reimbursement	Total
Name						
Dr. S. Mndaweni (Chief Executive Officer)	1,763,976	229,317	766,900	-	15,944	2,776,137
Dr. M. Mathebula (Chief Operations Officer)	1,429,775	185,871	309,867	119,148	28,372	2,073,033
Prof. T. Mokoena (Ombud)	2,650,233	-	2,125	-	11,960	2,664,318
Mr. J. Mapatha (Chief Financial Officer)	1,207,474	156,972	262,020	100,726	2,643	1,729,835
Dr. D. Jacobs (Executive Manager: Complaints Management)*	729,826	94,877	326,831	-	12,117	1,163,651
Mrs. W. Moleko (Executive Manager: HSDAS)	1,782,149	-	2,125	-	8,453	1,792,727
Mr. T. Ntsoane (Executive Manager: Corporate Service)	1,211,431	157,486	262,871	100,703	-	1,732,491
	10,774,864	824,523	1,932,739	320,577	79,489	13,932,192

*Dr. D. Jacobs resigned on 30 October 2025.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand				2026	2025	
2025	Basic salary	Pension fund	Non pensionable allowance and other payments	Service bonus	Reimbursement	Total
Name						
Dr. S. Mndaweni (Chief Executive Officer)	1,637,042	212,815	754,531	-	13,536	2,617,92
Dr. M. Mathebula (Chief Operations Officer)	1,373,463	178,550	297,747	114,455	8,520	1,972,735
Prof. T. Mokoena Ombud	2,545,854	-	2,125	-	22,940	2,570,919
Mr. J. Mapatha (Chief Financial Officer)	1,204,979	156,647	404,353	99,220	4,165	1,869,364
Dr. D. Jacobs (Executive Manager: Complaints Management)	1,201,853	156,241	360,964	-	2,400	1,721,458
Mrs. W. Moleko (Executive Manager: HSDAS)	1,103,155	143,410	359,723	91,323	6,628	1,704,239
Mr. T. Ntsoane (Executive Manager: Corporate Service)	1,149,353	149,416	249,510	63,853	3,538	1,615,670
	10,215,699	997,079	2,428,953	368,851	61,727	14,072,309

26. RISK MANAGEMENT GRAP 104 (REVISED)

Financial risk management

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

Liquidity risk

The entity's risk to liquidity is a result of the funds available to cover future commitments. The entity manages liquidity risk through an ongoing review of future commitments and credit facilities. The bank balance of R19,035,379 .is available to cover future commitments

Liquidity risk is the risk that the Institution may have difficulties in meeting its obligations to settle its financial liabilities through deliver of cash or another financial asset upon contractual maturity of its financial liabilities.

A significant percentage of the Institution's liabilities consist of trade creditors arising from procurement of budgeted goods and services during the normal course of its operations. Monthly expenditure reports analysis, net assets position and cash flow forecasts enable the Institution to ensure that adequate cash will be available to meet its obligations. Liquidity risk is regarded as being low.

The table below analyses the entity's financial liabilities and net settled derivative financial liabilities into relevant maturity groupings based on the remaining period at the statement of financial position to the contractual maturity date. The amounts disclosed in the table are the contractual undiscounted cash flows. Balances due within 12 months equal their carrying balances as the impact of discounting is not significant.

OFFICE OF HEALTH STANDARDS COMPLIANCE

Annual Financial Statements for the year ended 31 March 2026

Notes to the Annual Financial Statements

Figures in Rand			2026	2025
At 31 March 2026	Less than 30 days	Between 31 and 90 days	Between 91 and 120 days	Over 121 days
Payables from exchange transactions	4,727,466	-	-	-
liability	141,413	-	-	-

At 31 March 2025	Less than 30 days	Between 31 and 90 days	Between 91 and 120 days	Over 121 days
Payables from exchange transactions	3,591,852	-	-	-

Credit risk

Credit risk consists mainly of cash deposits, cash equivalents, derivative financial instruments and trade debtors as per note 3,4 and 5. The entity only deposits cash with major banks with high quality credit standing and limits exposure to any one counter party. As well as the South African Reserve bank and assesses their credit risk as low.

Trade receivables comprise of prepayment expenses, therefore, credit risk is managed on an ongoing basis.

No credit limits were exceeded during the reporting period, and management does not expect any surplus from non performance by these counterparties.

Financial assets exposed to credit risk at year end were as follows:

Financial instrument	2026	2025
Receivable from exchange transaction	308,401	1,202,958
Receivable from non exchange transaction	201,701	56,997
Cash and cash equivalents	19,035,379	19,286,122

Market risk

Interest rate risk

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

Cash flow interest rate risk

Financial instrument	Current interest rate	2026
Interest received CPD	6.75%	2,611,543

Interest rate sensitivity analysis

The following sensitivity analysis has been prepared using a sensitivity rate which represents management's assessment of the reasonably possible change in interest rates. The OHSC maintains an investment account with the South African Reserve Bank, through which interest revenue is earned. The interest rate applicable is a floating rate which changes regularly when the South African Reserve Bank Monetary Policy Committee reviews the repo rate. According to historical trends, the South African Reserve Bank has generally adjusted the repo rate upwards or downwards by 25 basis points, which subsequently leads to the OHSC's interest rate changing by the same margin. As at 31 March 2026, the interest rate granted by the South African Reserve Bank on the OHSC investment account was 6.75%, with a cash balance exposure of R15,476,364.

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The OHSC has thus estimated its interest rate sensitivity using the general trend of ± 25 basis point of the South African Reserve Bank at the reporting date would have increased/(decreased) the deficit/surplus for the year by the amounts shown below.

Sensitivity analysis

Increase or decrease in rate:

Impact on surplus:	2026 Increase	2026 Decrease
Interest recieved CPD	1,083,345	(1,005,964)

Foreign exchange risk

The entity does not hedge foreign exchange fluctuations.

OHSC exposure to foreign exchange risk is limited to the payment of Microsoft license fees and international membership fees, the transaction volume is limited to four suppliers per year. The foreign exchange risk is related to the fluctuation of the Rand and foreign currency purchase rates.

The entity reviews its foreign currency exposure, including commitments on an ongoing basis. The entity expects its foreign exchange suppliers to hedge foreign exchange exposure.

27. GOING CONCERN

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

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

28. IRREGULAR AND FRUITLESS AND WASTEFUL EXPENDITURE

Irregular expenditure	-	-
Fruitless and wasteful expenditure	-	-
Closing balance	-	-

*Refer to reconciling notes in the annual report

29. RECONCILIATION BETWEEN BUDGET AND STATEMENT OF FINANCIAL PERFORMANCE

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

Net deficit per the statement of financial performance	(6,054,830)	(8,283,071)
Adjusted for:		
(over)/under collection	4,103,658	9,031,682
Over/(under) budget expenditure	7,843,595	5,543,374
Net surplus per approved budget	5,892,423	6,291,985

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30. SEGMENT INFORMATION

General information

Identification of segments

As per the strategic plan and annual performance plan, the OHSC is structured around its core mandate as stipulated in the National Health Act, 2003. The objective of the OHSC are to protect and promote the health and safety of users of health services, by monitoring and enforcing compliance by health establishments with prescribed norms and standards, as well as ensuring consideration and disposal of complaints relating to non compliance with norms and standards. As a results, all financial resources and risks are allocated to the OHSC as a whole to deliver on the core mandate of the OHSC.

Although the OHSC, through its mandate, renders a service to the entire Republic of South Africa, it operates from a single location based in Pretoria, South Africa. It is against this background that management considers the entity as a single segment, whose financial results and position have been adequately disclosed in the annual financial statements.

31. BUDGET DIFFERENCES

Material differences between budget and actual amounts

31.1 Interest received

- The OHCS maintains an investment account with the South African Reserve Bank, which contributed to receipt of interest income to supplement the overall revenue of the OHSC.

31.2 Government grants and subsidies

- The National Treasury approved the retention of the 2024/25 surplus of R6 888 224 which was meant to cover compensation of employees on short term contracts, as well as other contracted operational expenditure.

31.3 Compensation of employees

- There were no significant differences between the budget and the actual amounts. Savings on vacancies contributed to funding additional cost of living adjustments.

31.4 Board fees and related costs

- There were no significant differences between the budget and actual amounts During the year under review, most Board activities were also undertaken through virtual means.

31.5 Operating expenses

- Major operating costs comprise largely of travel, subsistence and accommodation, IT maintenance and support, as well as easing of office space. In general, operating expenditure was contained within the overall allocated budget, supplemented by interest received on investments, as well as prior year surplus as approved by the National Treasury.

32. BBBEE PERFORMANCE

Information on compliance with the B BBEE Act is included in the annual report under the section titled B BBEE Compliance Performance Information.

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33. CHANGE IN ESTIMATE

Property, plant and equipment

Furniture and fitting

The useful life of furniture and fitting was estimated to be 10 years. In the current period management have revised their estimate to be between 11-19 years. The effect of this revision has decreased the depreciation and accumulated depreciation the for furniture and fitting the current and future periods by net of R127,876.26.

Office equipment

The useful life of office equipment was estimated to be 5 years. In the current period management have revised their estimate to be between 6-15 years. The effect of this revision has decreased the depreciation and accumulated depreciation the office equipment for the current and future periods by net of R41,141.59.

IT equipment

The useful life of IT equipment was estimated to be 4-5 years. In the current period management have revised their estimate to 3-15 years. The effect of this revision has increased the depreciation and accumulated depreciation the IT equipment for the current and future periods by net of R7,160.10.

34. CHANGES IN ACCOUNTING POLICY

The annual financial statements have been prepared in accordance with Standards of Generally Recognised Accounting Practice on a basis consistent with the prior year except for the adoption of the following new or revised standards.

Financial Instruments (GRAP 104, revised 2019)

Nature of change

During the current reporting period, the entity applied the revised Standard of GRAP on Financial Instruments (GRAP 104, revised 2019) for the first time.

The revised Standard introduces, inter alia:

- A new classification model for financial assets and financial liabilities, based on the entity's management model for managing financial assets and on the characteristics of the contractual cash flows (Solely Payments of Principal and Interest condition).
- A new expected credit loss (ECL) model for the impairment of financial assets measured at amortised cost, certain loan commitments, financial guarantee contracts and lease receivables.
- Revised requirements for the presentation of own credit risk on financial liabilities designated at fair value through surplus or deficit; and
- Specific guidance on residual interests (including measurement at cost as a practical expedient when fair value is not reliably measurable).

The revised Standard became effective for the entity on 1 April 2025.

Transitional provisions

The entity applied the Standard of GRAP on Financial Instruments (GRAP 104) (2019) retrospectively, in accordance with GRAP 3, except as specified otherwise in the transitional provision. GRAP 104 (2019) was not applied to items that have already been derecognised at the date of initial adoption.

Despite the requirement to apply the Standard of GRAP on Financial Instruments (GRAP104) (2019) retrospectively, the entity was not required to restate prior periods.

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The entity did not restate prior periods, and recognised any difference between the previous carrying amount and the carrying amount at the beginning of the reporting period that includes the date of initial adoption in the opening accumulated surplus or deficit (or other component of net assets, as appropriate) of the annual reporting period that includes the date of initial adoption.

Impairment – Expected credit losses (ECL)

The entity applied the impairment requirements in paragraphs 5.17 to 5.36 of GRAP 104 (2019) retrospectively in accordance with GRAP 3.

As entities are not required to restate comparative information, applying the impairment requirements retrospectively means that the entity measured impairment losses using expected credit losses on the date of adoption.

At the date of initial adoption, the entity used reasonable and supportable information that is available without undue cost or effort to determine the credit risk at the date that a financial instrument was initially recognised (or for loan commitments and financial guarantee contracts at the date that the entity became a party to the irrevocable commitment in accordance with paragraph 5.21 of GRAP 104 (2019)) and compared that to the credit risk at the date of initial adoption of the Standard.

On transition, the entity sought to approximate the credit risk on initial recognition by considering all reasonable and supportable information that was available without undue cost and effort. The entity is not required to undertake an exhaustive search for information when determining, at the date of transition, whether there have been significant increases in credit risk since initial recognition.

When determining whether there has been a significant increase in credit risk since initial recognition, the entity applied:

- (a) the requirements in paragraphs 5.25 and Appendix A paragraphs AG5.81 to AG5.83 of GRAP 104 (2019);
- (b) the rebuttable presumption in paragraph 5.26 of GRAP 104 (2019) for contractual payments that are more than 30 days past due if the entity applied the impairment requirements by identifying significant increases in credit risk since initial recognition for those financial instruments on the basis of past due information.

Where, at the date of initial adoption, determining whether there has been a significant increase in credit risk since initial recognition required undue cost or effort, the entity recognises a loss allowance at an amount equal to lifetime expected credit losses at each reporting date until that financial instrument is derecognised (unless that financial instrument is low credit risk at a reporting date, in which case the relevant requirements apply).

Impact on the financial statements

Reconciliation of impairment allowances/provisions to opening loss allowances – at the date of initial adoption

2026

Class of instrument	GRAP 104 (2009) category	GRAP 104 (2019) category
Impairment loss receivables from non exchange transactions	-	-

No impairment allowance was incurred during the year.

Qualitative disclosures

2026

No class of financial instrument was changed as a result of applying the standards.

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Summary of effect on accumulated surplus/net assets		
As a result of applying GRAP 104 (revised 2019), the entity recognised a R0.00 decrease/increase of in opening accumulated surplus or deficit on the date of initial adoption, comprising:		
<ul style="list-style-type: none">An increase/decrease of R0.00 - from changes in classification/measurement categories; andAn increase/decrease of R0.00 - from applying the expected credit loss impairment requirements rather than the previous incurred loss model.		
The aggregate effect of the changes in accounting policy on the annual financial statements for the year ended 31 March 2026 is as follows:		
Statement of Financial Position		
Receivables from non exchange transactions		
Previously stated	201,701	56,997
Adjustment	-	-
	201,701	56,997
Cash and cash equivalents		
Previously stated	19,035,379	19,286,122
Adjustment	-	-
	19,035,379	19,286,122
Trade payable from exchange transactions		
Previously stated	15,938,071	6,709,053
Adjustment	-	-
	15,938,071	6,709,053
Statement of Financial Performance		
Interest income		
Previously stated	2,611,543	2,892,170
Adjustment	-	-
	2,611,543	2,892,170
Impairment loss		
Previously stated	-	-
Adjustment	-	-
	-	-

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35. PRIOR YEAR ADJUSTMENTS

Presented below are those items contained in the statement of financial position, statement of financial performance and cash flow statement that have been affected by prior year adjustments:

Statement of financial position

2025	Note	As previously reported	Reclassification	Restated
Intangible assets		1,120,265	(1,120,265)	-
Receivables from exchange transactions		56,997	1,120,265	1,177,262
Provisions		6,948,800	(6,626,083)	322,717
Payables from exchange transactions		6,709,053	6,626,083	13,335,136
		14,835,115	-	14,835,115

Statement of financial performance

2025	Note	As previously reported	Reclassification	Restated
Depreciation		7,180,218	(3,780,379)	3,399,839
Operating expenditure		51,834,464	3,780,379	55,614,843
		59,014,682	-	59,014,682

Cash flow statement

2026	Note	As previously reported	Reclassification	Restated
Cash flow from operating activities Suppliers		51,171,667	3,105,342	54,277,009
Cash flow from investing activities				
Purchase of other intangible assets		3,105,342	(3,105,342)	-

Reclassifications

The following reclassifications adjustment occurred:

Reclassification 1

Receivable from exchange transactions (Prepayments)

The prepayments were incorrectly classified as intangible assets in prior year and it was corrected in the current year.

Reclassification 2

Payable from exchange transactions

The leave accrual was incorrectly classified as leave provision in prior year and it was corrected in the current year.

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36. COMPARATIVE FIGURES

Certain comparative figures have been reclassified:

The prepayments were incorrectly classified as intangible assets in prior year and it was corrected in the current year.

The leave accrual was incorrectly classified as leave provision in prior year and it was corrected in the current year.

The effects of the reclassification are in note 35.

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