KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE

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OFFICE OF THE HEAD OF DEPARTMENT

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Honourable M Govender
Chairperson: Standing Committee on Public Accounts
KwaZulu-Natal Provincial Legislature
Private Bag X9112
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Attention: Mr KP Mkhwanazi

STANDING COMMITTEE ON PUBLIC ACCOUNTS HEARING ON THE REPORT OF THE AUDITOR-GENERAL TO THE KWAZULU-NATAL PROVINCIAL LEGISLATURE ON THE FINANCIAL STATEMENTS OF VOTE 7: DEPARTMENT OF HEALTH FOR THE YEAR ENDED 31 MARCH 2023

1. The report of the Auditor-General in respect of the 2022/23 Regularity Audit of the KwaZulu-Natal Department of Health, has reference.

2. The Auditor-General had reported in the Departments 2022/23 Audit Report that *"the financial statements present fairly, in all material respects, the financial position of the Department of Health as at 31 March 2023"* resulting in the Department receiving an Unqualified Audit Opinion in the 2022/23 financial year.

3. Appended are the responses of the Department relative to the following:

   PART A - Final Audit Report of the Auditor-General in respect of the 2022/23 Regularity Audit (Please note that the appended numbering is as per the items on the Audit Report)
   PART B - Audit Improvement Plan
   PART C - Other Reports
   C1 - Report on the Condonation of Irregular expenditure.
   C2 - Consequence management.
   C3 - Report on payment of KZN Project invoice owed to KZN SIU.

4. Should further clarity be sought regarding the response, you are kindly requested to contact my office.

Yours sincerely

DR SC TSHABALALA
HEAD OF DEPARTMENT: HEALTH
KWAZULU-NATAL

DATE:

PART A - FINAL AUDIT REPORT OF THE AUDITOR-GENERAL IN RESPECT OF THE 2022/23 REGULARITY AUDIT. (Please note that the appended numbering is as per the items on the Audit Report).

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

OPINION

1. *I have audited the financial statements of the Department of Health set out on pages x to x, which comprise the appropriation statement, statement of financial position as at 31 March 2023, statement of financial performance, statement of changes in net assets, and cash flow statement 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 the Department of Health as at 31 March 2023, and its financial performance and cash flows for the year then ended in accordance with the Modified Cash Standards (MCS) as prescribed by the National Treasury and the requirements of the Public Finance Management Act of South Africa,1999 (Act No. 1 of 1999) (PFMA) and the Division of Revenue Act of South Africa, 2022 (Act No. 5 of 2022) (Dora).*

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 department 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.*

EMPHASIS OF MATTERS

6. *I draw attention to the matters below. My opinion is not modified in respect of these matters.*

UNCERTAINTY RELATING TO THE FUTURE OUTCOME OF LITIGATION

7. *The department is a defendant on various litigation matters relating to medical negligence and claims against the state amounting to R7,87 billion as disclosed in note 19.1 to the financial statements. The ultimate outcome of these matters could not be determined and no provision for any liability that may result was made in the financial statements.*

RESPONSE OF THE DEPARTMENT

It should be noted that medico-legal claims are extremely complex and involves the "Determination of Liability" as well as the "Determination of the Quantum" of the claims.

Unfortunately, the Department is not in control of decisions made by the judge as well as which cases will be actively pursued by the plaintiff and which ones will be withdrawn, hence the uncertainty. The reported litigation amount is based on best estimate and not on the claim amounts. It is based on the

analysis of settlement trends, active and non-active cases, and the probabilities of successful defence of the cases.

The Department is in the process of assessing the merits of cases with summons that remain inactive (not progressing) and has updated these with adjusted probabilities. It should be noted that the assessment of merit to new and active cases with summons will take at least two (2) years and will provide a more accurate assessment of liability; however, there will always be a degree of uncertainty.

The Legal Services Unit is ensuring that the liabilities schedule is complete and adequately refers to the legal files being maintained. The unit continuously reviews the Letters of Demand and Summons to validate and update the status of the matters and has closed files that have been prescribed. This process ensures that the contingent liabilities listing is accurate and complete.

ADDITIONAL RESPONSE

The Department has a total of one thousand seven hundred (1700) summonses that are active, fifty-six (56) of which were received by the Department in 2023.

PAYABLES

8. *As disclosed in note 21.2 to the financial statements, payables not recognised of R212,05 million exceeded the payment term of 30 days, as required by treasury regulation 8.2.3. This amount, in turn, exceeded the R5,90 million of voted funds to be surrendered by R206,15 million as per the statement of financial performance. The amount of R206,15 million would therefore have constituted unauthorised expenditure had the amounts due been paid on time.*

RESPONSE OF THE DEPARTMENT

In terms of the Unauthorised Expenditure Framework, unauthorised expenditure only occurs when a payment has been processed. The payables not recognised to the value of R 212,05 million had not been processed as of year-end and therefore these may not fall within the definition of unauthorised expenditure. There are various mechanisms employed by the Provincial Treasury to prevent overspending including cash blocking which is aimed at ensuring that departments remain within their budget allocations.

However, it must be noted that recurrent budget cuts are putting a lot of pressure on the delivery of services and the corresponding spending. The Department has been engaging the Provincial Treasury on the impact that the budget cuts has had on service delivery, and these discussions are ongoing.

OTHER MATTERS

NATIONAL TREASURY INSTRUCTION NO. 4 OF 2022/2023: PFMA COMPLIANCE AND REPORTING FRAMEWORK

10. *On 23 December 2022 National Treasury issued Instruction Note No. 4: PFMA Compliance and Reporting Framework of 2022-23 in terms of section 76(1)(b), (e) and (f), 2(e) and (4)(a) and (c) of the PFMA, which came into effect on 3 January 2023. The PFMA Compliance and Reporting Framework also addresses the disclosure of unauthorised expenditure, irregular expenditure and fruitless and wasteful expenditure. Among the effects of this framework is that irregular and fruitless and wasteful expenditure incurred in previous financial years and not addressed is no longer disclosed in the disclosure notes of the annual financial statements, only the current year and prior year figures are disclosed in note 25 to the financial statements. The movements in respect of irregular expenditure and fruitless and wasteful expenditure is no longer disclosed in the notes to the annual financial statements of the Department of Health. The disclosure of these movements (e.g. condoned, recoverable, removed, written off, under assessment, under determination and under investigation) are now required to be included as part of other information in the annual report of the auditees.*

RESPONSE OF THE DEPARTMENT

It should be noted that the change in the disclosure was determined by the National Treasury as the sole Accounting Authority of the Modified Cash Standard as the Department's reporting standard. Departments are obliged to fully comply with the standard as determined by the National Treasury as these are used by the Auditor-General when undertaking the audits.

UNAUDITED SUPPLEMENTARY SCHEDULES

RESPONSIBILITIES OF THE ACCOUNTING OFFICER FOR THE FINANCIAL STATEMENTS

13. *The accounting officer is responsible for the preparation and fair presentation of the financial statements in accordance with the MCS and the requirements of the PFMA and Dora, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.*

14. *In preparing the financial statements, the accounting officer is responsible for assessing the department'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 department or to cease operations, or has no realistic alternative but to do so.*

RESPONSE OF THE DEPARTMENT

The Department has been set up in line with the Constitution to provide healthcare to all the citizens of the country; hence, the going concern for the basis of accounting is not applicable. In this regard, the Department is fully funded by both an equitable share and from conditional grants. It is not envisaged that the Department whose mandate is to provide health care services will face liquidation without the National Treasury's intervention.

The Department prepares its Annual Financial Statements in line with the relevant reporting standards, and this may include an assessment of the ability to continue as a going concern. The Department did not use a going concern basis for reporting as based on the information at hand and the Department will continue to operate and therefore no liquidation is expected.

REPORT ON THE AUDIT OF THE ANNUAL PERFORMANCE REPORT

22. *The material findings on the performance information of the selected programmes are as follows:*

DISTRICT HEALTH SERVICES

VARIOUS INDICATORS

23. *Some supporting evidence was not provided for auditing; and, where it was, I identified material differences between the actual and reported achievements. Consequently, the achievements might be more or less than reported and were not reliable for determining if the targets had been achieved.*

Indicator Description	***Planned Target***	***Reported Achievement***
Child under 5 years pneumonia case fatality rate – District hospital	*1,7%*	*1,3%*
All DS-TB client treatment success rate	*85%*	*82,6%*
ART Adult viral load suppressed rate (12 months)	*90%*	*91%*
ART Child viral load suppressed rate (12 months)	*90%*	*66,3%*
HIV positive 15-24 year olds (excl ANC) rate	*2,9%*	*1,8%*
All DS-TB client lost to follow up rate	*6,0%*	*9,1%*

Indicator Description	Planned Target	Reported Achievement
ART adult remain in care rate (12 months)	*90%*	*67,5%*
Infant PCR test positive around 10 weeks rate	*0,5%*	*0,35%*
Child under 5 years Pneumonia case fatality rate – total	*2,0%*	*1,9%*
Antenatal 1st visit before 20 weeks rate	*77%*	*73,8%*
Mother postnatal visit within 6 days rate	*90%*	*83,5%*
Couple year protection rate	*62,5%*	*56,7%*
Immunisation under 1 year coverage	*90%*	*92,2%*
Measles 2nd dose coverage	*94%*	*89,5%*

RESPONSE OF THE DEPARTMENT

It should be noted that where the Department was unable to provide the necessary information during the audit, activities have been identified following a post audit visit to the audited facilities. These activities have been implemented to ensure the validity of the data presented in the Annual Report and are part of an Audit Improvement Plan that has been implemented at a District and facility level. Refer to the Audit Improvement Plan which is included in Part 2 of this report.

As extracted from the plan, the Department is committed to the following:

- Facilities to ensure that the Date of Birth (DOB) / HPRN filing system is fully implemented and functional.
- Facilities to revive the Health Patient Registration System (HPRS) as their standard registration system, where applicable, which is dependent on a stable internet connectivity. This will assist in reducing the duplication and easy retrieval of files.
- Each patient will have only one patient folder/clinical record and will be always available in the facility by ensuring that the filing system is up to date and accurately maintained.
- Systems Managers to ensure that the archiving and disposal plan for patient records is implemented at their institutions on an annual basis in order to ensure that the storage area and capacity is well maintained for effective filing and retrieval practices.
- In respect of where the Department did provide the necessary evidence during the audit, a vast improvement in the reduction of the error rates was noted during this financial year. This has been attributed to additional training sessions, standardised tools as well as one on one facility support visits that were undertaken. Notwithstanding this, the following actions will be undertaken in order to ensure the accuracy and reliability of the data presented in the Annual Report.
- An audit improvement plan, focussing on compliance measures and gaps identified, was implemented at district and facility level. Progress on this report will be monitored on a monthly basis. Feedback to be provided to districts where poor progress is noted.
- As part of this action plan, facilities will be intensifying daily, weekly and monthly data verification between the source documents, the summary forms and the system. Supporting evidence will be maintained to prove that the verification procedures were undertaken.
- CEO's / Facility Managers and District Directors to complete and submit the revised data sign-off tools that were implemented in August 2023.
- Facility support visits to be carried out (considering financial limitations) where mini audits will be conducted looking at quarterly data.

Further to the above the Department will ensure:

- That the Annual Performance Report is aligned to the underlying records / data, prior to the system close off and submission.
- All facilities in the Department will be required to conduct at least one audit during the financial year. This should mimic an actual audit with intentions of identifying gaps and addressing them accordingly.

IDEAL CLINIC STATUS RATE

24. *An achievement of 93,4% was reported against a target of 80,1%. I could not determine if the reported achievement was correct, as adequate supporting evidence was not provided for*

auditing. Consequently, the reported achievement might be more or less than reported and was not reliable for determining if the target had been achieved.

RESPONSE OF THE DEPARTMENT

In addressing the finding, and in preparation of the 2023/24 audit, the Departments District Health Services met with the Auditor-General to explain the processes undertaken when conducting Ideal clinic assessments. Subsequently, an Ideal Clinic assessment was undertaken and during this assessment, the Auditor-General was invited to observe the processes undertaken. This engagement was undertaken in the interest of fostering a closer working relationship with the Auditor-General, as well as to gain a better understanding of how the audit of the Ideal Clinic assessment will be undertaken. Further to the above, the Auditor-General has since undertaken three (3) assessments and has provided the Department with insight as to the findings.

A Standard Operation Procedure (SOP) has since been developed, that guides assessors on conducting assessments, when utilising the on-line and off-line versions ***(Annexure A)***. An orientation session for the District Ideal Clinic Realisation and Maintenance Programme (ICRM) teams has been scheduled for 11 - 12 October 2023. The session is aimed at standardising the assessment practice across the Department.

PROVINCIAL HOSPITAL SERVICES

VARIOUS INDICATORS

25. *Based on audit evidence, the actual achievements for two indicators did not agree to what was reported. I could not determine the actual achievements, but I estimated them to be materially more.*

Indicator Description	***Planned Target***	***Reported Achievement***
Child under 5 years diarrhoea case fatality rate – Regional hospital	*1,6%*	*2,6%*
Child under 5 years pneumonia case fatality rate – Regional hospital	*2,2%*	*2,0%*

RESPONSE OF THE DEPARTMENT

The Department acknowledges the finding and the impact that this has had on the performance of the Department. The contributing factors are common with the above finding number 23.

In addressing the finding the Department will ensure that:

- Facilities undertake regular tests to confirm adequate implementation and operational effectiveness of the SOP's. This will be done in line with the verification processes mentioned above.
- Reconciliations, reviews and monitoring will be undertaken between the source data and information captured on the system. This will be done to enhance the credibility and reliability of the collection of data relating to the indicators mentioned above, among others.
- All registers will be reviewed to ensure that accurate performance statistics are produced, and the relevant information/clerical staff will ensure that the review of the registers is carried out adequately to produce accurate performance statistics. This cadre of staff will also ensure that all patient details, along with the relevant diagnosis as per the patient file, are recorded in the register.

The above will be monitored during the facility support visits that will be carried out by the different oversight structures. The District and Provincial information units are to conduct a minimum of four (4) visits a month to random facilities to test for compliance using a performance assessment tool. All issues of non-compliance will be communicated to the relevant facility / Directorate.

OTHER MATTERS

ACHIEVEMENT OF PLANNED TARGETS

28. *The department plays a key role in delivering services to South Africans. The annual performance report includes the following service delivery achievements against planned targets:*

Key Service Delivery Indicators Not Achieved	***Planned Target***	***Reported Achievement***
District health services *Targets achieved: 49,3%* *Budget spent: 100%*		
Child under 5 years severe acute malnutrition case fatality rate – District hospital	*6,1%*	*8,8%*
All DS-TB client treatment success rate	*85,0%*	*82,6%*
ART Child viral load suppressed rate (12 months)	*90,0%*	*66,3%*
All DS-TB client lost to follow up rate	*6,0%*	*9,1%*
ART adult remain in care rate (12 months)	*90,0%*	*67,5%*
ART child remain in care rate (12 months)	*90,0%*	*77,7%*
Live Birth under 2 500g in facility rate – Total	*11,3%*	*12,7%*
Child under 5 years severe acute malnutrition case fatality rate – total	*5,5%*	*9,2%*
Couple year protection rate	*62,5%*	*57,6%*
Antenatal 1st visit before 20 weeks rate	*77,0%*	*73,8%*
Mother postnatal visit within 6 days rate	*90,0%*	*83,5%*
Measles 2nd dose coverage	*94,0%*	*89,5%*
Malaria case fatality rate	*0%*	*1,7%*
Provincial hospital services *Targets achieved: 36,4%* *Budget spent: 100%*		
Child under 5 years diarrhoea case fatality rate – Regional hospital	*1,6%*	*2,6%*
Child under 5 years severe acute malnutrition case fatality rate – Regional hospital	*5,9%*	*10,3%*

RESPONSE OF THE DEPARTMENT

In addressing the finding, the following will be undertaken:

- Managers will engage in realistic target setting.
- Target setting to be in line with budget allocations.
- Quarterly reviews are being undertaken to monitor target achievements and implement interventions to improve specific programme performance to realise such targets.

However, consideration should be taken of the fact that the National Department of Health also sets targets for key programmes which may not be attainable within the current financial constraints.

MATERIAL MISSTATEMENTS

29. I identified material misstatements in the annual performance report submitted for auditing. These material misstatements were in the reported performance information of district health services and provincial hospital services programmes. Management did not correct all of the misstatements and I reported material findings in this regard.

RESPONSE OF THE DEPARTMENT

In this regard, it should be noted that all material misstatements in respect of the reported performance information regarding district health services and the provincial hospital services programmes were addressed.

REPORT ON COMPLIANCE WITH LEGISLATION

33. *The material findings on compliance with the selected legislative requirements, presented per compliance theme, are as follows:*

EXPENDITURE MANAGEMENT

34. *Effective and appropriate steps were not taken to prevent irregular expenditure, as required by section 38(1)(c)(ii) of the PFMA and treasury regulation 9.1.1. The majority of the irregular expenditure disclosed in the financial statements was as a result of the continued use of and payments made on expired contracts.*

RESPONSE OF THE DEPARTMENT

The delays in the finalisation of month-to-month contracts are mainly due to factors outside the control of the Department and these include court orders etc. The work towards the finalisation of various contracts is underway and is expected to be finalised before 31 March 2024.

35. *Payments were not made within 30 days or an agreed period after receipt of an invoice, as required by treasury regulation 8.2.3.*

RESPONSE OF THE DEPARTMENT

The Department has always endeavoured to process all invoices received within the prescribed 30-day period and to this effect, 96% of invoices were paid within 30 days in the 2022/23 financial year. Furthermore, as part of its proactive efforts, the Departments Accounts Payables Directorate distributes the Payment Cycle Report on a monthly basis to all Head Office Managers as well as the District Finance Managers with clear instructions that they liaise with the Finance Managers within their Districts to investigate any delays in payments so that they can identify and address the cause(s) of late payments thus ensuring that future payments are made within 30 days, in compliance to Section 38(1)(f) of the Public Finance Management Act (PFMA).

Further, the Department is in the process of rolling out the Logistical Information System (LOGIS) at various facilities. The rollout of LOGIS will assist the Department in addressing this finding as LOGIS is able to provide an early warning of invoices that are about to reach 30 days on the system.

PROCUREMENT AND CONTRACT MANAGEMENT

36. *I was unable to obtain sufficient appropriate audit evidence that all contracts were awarded in accordance with the legislative requirements as a result of poor records management. Similar limitations were also reported in the prior year.*

RESPONSE OF THE DEPARTMENT

The Department had embarked on an extensive process of digitising as many records as possible. Whilst the situation has improved significantly, there are some pockets across the province where the lack of physical space to efficiently store documents is still a challenge.

The process of procuring industrial scanners is well underway which will ensure that electronic records are kept safe for auditing purposes across the province. Proper filing controls have also been implemented at each stage of the Supply Chain Management (SCM) processes to ensure that documents are filed chronologically or in a manner that will enable efficient retrieval of the documents.

37. *Some of the quotations were not awarded in an economical manner and the prices of the goods or services were not reasonable as required by PFMA 38(1)(b) and PFMA 45(b).*

RESPONSE OF THE DEPARTMENT

As part of the latest Standard Operating Procedure (SOP), the awarding authority is mandated to confirm and assess whether the price offered for the goods or services is within the reasonable limits. Where the most responsive bidder is deemed to be excessively priced, price negotiations are now part of the normal process to reduce costs.

38. *Some of the goods and services of a transaction value above R1 000 000 were procured without inviting competitive bids and deviations were approved by the accounting officer but it was practical to invite competitive bids, as required by Treasury Regulation 16A6.1, paragraph 3.3.1 of NTI 02 of 2021-22, paragraph 4.1 of NTI 03 of 2021-22 and TR 16A6.4. Similar non-compliance was also reported in the prior year.*

RESPONSE OF THE DEPARTMENT

The Department had followed due process for the authorisation of deviations based on the assessment of each circumstance in relation to service delivery and/or threat to life. The Department will continue to minimise the number of deviations and the demand management section within the SCM Unit, has increased its capacity to more accurately forecast the utilisation and need for the various services.

39. *Some of the contracts were awarded to bidders based on evaluation criteria that were not stipulated and/or differed from those stipulated in the original invitation for bidding and quotations as required by Treasury Regulation 16A6.3(a) and (b).*

RESPONSE OF THE DEPARTMENT

The training of bid committees has already taken place at the head office level to capacitate officials on various aspects of Supply Chain Management. There are now also increased forums at a district and hospital level to do the same for all the SCM practitioners.

ADDITIONAL RESPONSES

On perusal of the various audit reports raised by the Auditor-General, it was identified that this finding was reported for the first time in the 2022/23 financial year. In addressing the finding, and as part of the corrective actions, the various deficiencies are being addressed using extensive checklists that have been developed which cover the entire SCM process from start to finish.

Officials in the Department are being continually trained on the implementation of these checklists. Further, extensive training sessions have been conducted across the province on the new Standard Operating Procedures (SOPS) and SCM Policy.

40. *The preference point system was not applied in some of the procurement of goods and services as required by section 2(a) of the Preferential Procurement Policy Framework, 2000 (Act No. 5 of 2000) and Treasury Regulation 16A6.3(b). Similar non-compliance was also reported in the prior year.*

RESPONSE OF THE DEPARTMENT

An updated SOP was implemented, and roadshows were held to disseminate the information. The training of bid committees has already taken place at head office level to capacitate officials on various aspects of SCM. There are now also increased forums at a district and hospital level to do the same for all the SCM practitioners.

41. *I was unable to obtain sufficient appropriate audit evidence that construction contracts were awarded to contractors that were registered with the Construction Industry Development Board*

(CIDB) and qualified for the contract in accordance with section 18(1) of the CIDB Act and CIDB Regulations 17 and 25(7A).

RESPONSE OF THE DEPARTMENT

It is now mandatory that as part of the document management process, the CIDB registration printouts are kept in the project files for audit purposes.

42. *Bid documentation or invitation to tender for procurement of commodities designated for local content and production, did not stipulated the minimum threshold for local production and content as required by the 2017 procurement regulation 8(2). Similar non-compliance was also reported in the prior year.*

RESPONSE OF THE DEPARTMENT

The new regulations no longer have this requirement.

43. *Persons in service of the department who had a private or business interest in contracts awarded by the department failed to disclose such interest, as required by Treasury Regulation 16A8.4 and the Public Service Regulations 18(1). Similar non-compliance was reported in the previous year and disciplinary action was not taken against the officials involved.*

RESPONSE OF THE DEPARTMENT

All the officials of the Department are required to make the appropriate declarations as per the Department of Public Service and Administration (DPSA) directives. The latest SOP now stipulates that prior to all awards, the officials must confirm with the CSD report that no conflict of interest exists.

ADDITIONAL RESPONSE *(Findings 43 and 44)*

The Department has taken steps to monitor compliance with the legal prescripts relating to the prohibition of officials doing business with the state.

In this regard, the Department has implemented a mandatory checklist that must be adhered to in the preparation of all bid/quotation documentation. The checklist requires the downloading of a CSD report to reflect the status of the bidder on the actual day of approval of award.

The CSD is checked for, amongst various things, the listing of the directors/members of the entity. The names of the directors/members and then checked with the Department of Public Service and Administration's tool on its website whether they are in the employ of the state or not. It is important to note, however, that only officials employed through "DPSA employment" will appear on this website. Officials employed in municipalities and other public entities are not able to be verified.

In respect of the instances where the Auditor-General had through their Computer Assisted Auditing Techniques identified officials where there was a conflict of interest due to them doing business with the state, these cases are being investigated and will thereafter be referred to the Departments Labour Relations for the implementation of consequence management.

In this regard, a total of 15 cases were referred for investigations, 4 were completed, 11 are still under investigation and once finalised will be referred to the respective institutions for the implementation of disciplinary action. In these matters, Investigating Officers are appointed to investigate the allegations and where the transgression is proved, disciplinary action is instituted against the implicated official/s.

As part of the proactive measures taken by the Department, workshops are held in all Districts where employees are extensively engaged on the Regulations pertaining to Conducting Business with the State and the Department is utilising the intranet to keep employees constantly aware of these

Regulations. Awareness of the requirements by Service Providers in terms of completing the SBD4 form completely and honestly will be strengthened by the Supply Chain Management Unit.

44. *Persons in service of the department whose close family members, partners or associates had a private or business interest in contracts awarded by the department failed to disclose such interest, as required by Treasury Regulation 16A8.4. Similar non-compliance was reported in the previous year and disciplinary action was not taken against the officials involved.*

RESPONSE OF THE DEPARTMENT

The Department does not have the tools to verify this information prior to the award of contracts; however, when such information is identified by the Auditor-General, appropriate action is taken in respect of all applicable cases. The office of the Head of Department has taken on the responsibility to follow-up with all the affected officials.

CONSEQUENCE MANAGEMENT

45. *I was unable to obtain sufficient appropriate audit evidence that disciplinary steps were taken against officials who had incurred unauthorised, irregular as well as fruitless and wasteful expenditure as required by section 38(1)(h)(iii) of the PFMA. This was due to proper and complete records that were not maintained as evidence to support the investigations into unauthorised, irregular as well as fruitless and wasteful expenditure.*

RESPONSE OF THE DEPARTMENT

The investigations that recommended disciplinary processes against employees were implemented. Further, the fact that should a transaction be reported as fruitless and wasteful, it does not automatically suggest that a wrongdoing had occurred, and example of which is where the Department is obliged to keep minimum quantities of snake-bite serum / medication per facility, in cases of snake bites. The likelihood of these medications expiring is always high as snake bites rarely occur. Unfortunately, the reporting framework is such that when examples of such medication expire, they should be reported as fruitless and wasteful expenditure.

ADDITIONAL RESPONSE

In addressing the finding and more specifically the issues regarding document management, the Department has implemented measures to strengthen document control systems which will amongst other measures ensure that all supporting documentation to be uploaded timeously. Further, it should be noted that consequence management is both corrective and punitive and in this regard, as indicated in the various responses, extensive training has been undertaken to address any control deficiencies.

Further, in respect of Irregular Expenditure and Fruitless and Wasteful Expenditure, the following is being undertaken.

a. Irregular Expenditure

In this regard, and in compliance with the Irregular Expenditure Framework, the Department has commenced with the undertaking of determination tests on all irregular expenditure that was disclosed, to analyse the particulars of non-compliance and to establish the facts and losses, if any, relating to the transactions and to collect information related to the identification of the:

- Root causes that led to the transgression.
- Employee(s) responsible for the irregular expenditure.
- Loss suffered.
- Any breakdown in the designed internal controls.

Once this has been finalised, an investigation will be undertaken if it is suspected that there was any possibility of fraudulent, corrupt or criminal acts emanating from the incurrence of irregular expenditure. The investigation will then provide the Head of Department with at least the following facts about the transactions as well as information relating to the:

- Root causes that led to the transgression.
- Impact of the transgression.
- Information on fraudulent, corrupt or criminal related act(s)
- Employee(s) responsible for the irregular expenditure.
- Loss suffered by the Department.
- Whether the matter must be referred to the law enforcement agencies; and
- Any breakdowns in the designed internal controls and the impact thereof.

If the investigations conclude that an official/s was found to be liable, the relevant consequence management processes will be implemented, and appropriate actions taken against the responsible officials.

Further, cognisance should be taken of the fact that the Department applies the consequence management framework to address any incidents of misconduct, fraud, corruption, unethical behaviour and poor performance and to achieve this, the Department has instituted disciplinary action against officials implicated in fraud, corruption, unethical conduct or financial mismanagement.

In response to the prevalence of fraud, corruption and mismanagement of financial resources, the Department has sought and implemented a number of remedies to curb these transgressions by reviewing its policies, embarking on proper management of records and developing Standard Operating Procedures (SOPs).

b. Fruitless and Wasteful Expenditure

In this regard, the following is being undertaken:

- All valid Fruitless and Wasteful transactions to be presented to the Internal Loss Control Committee.
- Institutions to liaise with Municipalities to reverse any interest once capital amounts are paid.
- Ensure compliance to the SOPs.

However, cognisance should be taken of the fact strict controls are implemented over the management of pharmaceuticals. In this regard, regular monitoring checks are undertaken relative to the expiry dates on medicines and the moving of short-dated stock to other facilities.

Notwithstanding this, it should be noted that there are certain medication / drugs, e.g. Oncology Drugs which are purchased specifically for a patient and should that patient decease, those drugs cannot be used on any other patient and has to be disposed of. Unfortunately, this cannot be avoided and leads to the incurring of wasteful expenditure.

STRATEGIC PLANNING AND PERFORMANCE MANAGEMENT

46. Specific information systems were not implemented to enable the monitoring of progress made towards achieving targets, core objectives and service delivery as required by public service regulation 25(1)(e)(i) and (iii).

RESPONSE OF THE DEPARTMENT

On review of the finding, the Department had identified that this finding relates to the non-compliance to the Standard Operating Procedures at a facility level which is linked to finding number 23 above. Whilst the Department has implemented several measures to address this finding and to ensure the verification and validation of information captured, there are still areas that need more structured support in the form of resources, mentoring, records management and IT services (poor connectivity).

In addressing this finding, the Department has actioned the following:

- The Audit Improvement Plan to be implemented at district and facility levels. The status of implemented actions of the Audit Improvement Plans will be monitored on a quarterly basis and feedback will be provided accordingly if slow progress is noted.
- Facilities undertake regular tests to confirm adequate implementation and operational effectiveness of the SOP's. This will be done in line with the verification processes mentioned above.
- Facilities to revive the Health Patient Registration System (HPRS) as the standard registration system, where applicable.
- Facilities to ensure that the Date of Birth (DOB) / HPRN filing system is fully implemented and functional.
- The above will also be monitored during the facility support visits that will be carried out by the different oversight structures. All issues of non-compliance will be communicated to the relevant facility / Directorate.

Further, in addressing the poor connectivity at a facility level, an initiative for the installation of the secondary network through Telkom SA was initiated to improve connectivity and broadband on the SITA-provided primary network. The project included upgrading the local area network (onsite cabling, new switches and routers, and additional network points), which was completed by the end of June 2023. The second phase of the project entails connecting forty-two (42) hospitals to the WAN via fibre or microwaves, whichever is feasible, activating and providing secondary broadband speeds of up to 100 megabytes per facility.

In May 2023, a request for a deviation approval was submitted to the office of the Minister of Communications and Digital Technologies, due to the SITA Act mandatory nature of the WAN provision; however, to date, there has been no response despite numerous discussions and reminders sent to the officials of the National Department.

INTERNAL CONTROL DEFICIENCIES

53. *Leadership did not provide adequate oversight and monitoring to ensure that action plans were implemented to fully address previous audit findings on predetermined objectives and compliance with legislation. Furthermore, consequence management was not effectively implemented for transgressions of legislation.*

RESPONSE OF THE DEPARTMENT

Leadership in the Department has always endeavoured to ensure that approved policies and action plans were developed and implemented to fully address previous findings emanating from audits undertaken on the financial statements, predetermined objectives and compliance with legislation.

Through these efforts, over the past three (3) financial years, the Department had overturned the following prior year audit qualifications:

- Commuted Overtime
- Capital Commitments
- Capital Work-In-Progress
- Contingent Liabilities
- Accruals and Payables Not Recognised
- Goods and Services
- Irregular Expenditure
- Asset Management

The various initiatives undertaken over the past few financial years has culminated in the Department obtaining an unqualified audit opinion in the 2022/23 financial year. Notwithstanding this, management in the Department will be intensifying its efforts in maintaining the unqualified audit opinion in the 2023/24 financial year as well as moving towards achieving a clean audit in the outer years by ensuring that:

- Strengthening and enforcing compliance with legislation within finance, supply chain management, asset management, expenditure management, human resources management, predetermined objectives, etc.
- Intensify Internal Control Assessments on the above focus areas.
- Monitor the implementation of the actions on the Audit Improvement Plan.
- Consequence management to be effectively implemented for any transgressions of legislation.

54. *Management did not effectively implement a proper document management and record keeping systems to ensure that complete, relevant and accurate information is accessible and available to support performance reporting and compliance with legislation. In addition, the overall information technology (IT) control environment requires intervention due to inadequate IT governance, IT security management, user access management, IT service continuity, program change management and cybersecurity.*

RESPONSE OF THE DEPARTMENT

The Department has in place a Records Management Policy and has issued numerous circulars in respect of best practices which are aligned to the various prescripts and policies. In addition, the Corporate Services Unit, through the Records and Document Management section, has been intensifying its efforts by conducting inspections at facilities which are aimed at identifying instances of non-compliance and have made recommendations to strengthen the control environment. Further, support is also provided to all facilities through training and development workshops relative to records and document management.

Cognisance should be taken of the fact that records management in the Department is paper based which has resulted in all institutions experiencing a shortage of storage space. This has often necessitated records being maintained at different sites within the facility.

In addressing this challenge, the Department has embarked on the implementation of an electronic record management system, and it is anticipated that this will improve records management as well as facilitate the easy access to records when these are required for service delivery purposes. This will also address the issues regarding the need for storage space.

In strengthening the Information Technology (IT) control environment relative to IT governance, IT security management, user access management, IT service continuity, program change management and cybersecurity the Department has commenced with the recruitment process for the appointment of a Cyber Security Manager. Further, IT Governance policies and SOP's, as well as the IT Strategic Framework is being developed. To ensure that oversight over IT Matters is maintained, the IT Steering Committee meets quarterly to discuss all relevant matters.

MATERIAL IRREGULARITIES

PROCUREMENT OF SANITISER DETERGENT AT PRICES HIGHER THAN PERMISSIBLE

56. *Through an emergency procurement process on 25 March 2020, the department ordered 40 000 units of 1L hand sanitiser at R143 per unit. The total value of the order and payments made were R5,72 million.*

57. *The department did not comply with paragraph 3.7.6(ii) of National Treasury Instruction note 8 of 2019-20 which states that institutions may approach any other supplier to obtain quotes and may procure from such suppliers on condition that the prices are equal to or lower than the prices in Annexure A. The price in Annexure A for sanitisers as at 24 March 2020 was R110.40 per unit of 1 litre. The non-compliance resulted in a material financial loss amounting to R1,3 million for the department as the sanitiser was procured at prices which were excessive.*

58. *The accounting officer was notified of the material irregularity on 12 February 2021 and the matter was investigated by the Special Investigations Unit (SIU) from which R1,1 million of the material*

financial loss was recovered from the supplier. Furthermore, responsible officials from the department were issued with warning letters.

59. *The actions taken by the accounting officer were considered sufficient and appropriate in addressing the material irregularity.*

RESPONSE OF THE DEPARTMENT

In this regard, the matter was investigated by the Special Investigations Unit (SIU). Emanating from this investigation, the recovery of the financial loss from the supplier was effected via the Special Investigations Unit. In addition, consequence management was implemented, with the responsible officials from the Department being issued with letters of warning.

This was communicated with the Auditor-General and the Auditor-General has since reported that the actions taken by the Accounting Officer were considered sufficient and appropriate in addressing the material irregularity.

MATERIAL IRREGULARITIES IDENTIFIED DURING THE AUDIT

INTEREST ON OVERDUE ACCOUNT

60. *The department did not comply with treasury regulation 8.2.3 which indicates that unless determined otherwise in a contract or other agreement, all payments due to creditors must be settled within 30 days from receipt of an invoice or, in the case of civil claims, from the date of settlement or court judgement.*

61. *The department incurred a financial loss of R2,09 million in relation to interest paid on overdue accounts. The interest was imposed as a result of the department not paying within 30 days of receiving invoices and statements. This amounted to a non-compliance with treasury regulation 8.2.3.*

62. *The accounting officer was notified of the material irregularity on 26 August 2022 and invited to make a written submission on the actions taken or to be taken to address the matter. An investigation into this material irregularity was undertaken and it was noted that a portion of this interest was incorrectly charged by the service provider.*

63. *Furthermore, the interest that was incorrectly calculated amounting to R1,45 million was refunded back to the department. The department is currently conducting an enquiry/ investigation on the remaining balance amounting to R0,64 million.*

64. *I will follow up on the outcome of the investigation in the next audit.*

RESPONSE OF THE DEPARTMENT

The Material Irregularity as reported by the Auditor-General was investigated by the Departments Audit and Internal Control Component and subsequently, it was concluded that the actual interest that should have been charged by the contractor was R 635,391.59 and not R 2,087,006.74, which was originally paid by the Department.

Subsequently, the Department engaged with the contractor and the overcharged amount of R 1,451,615.14 was refunded to the Department. Further, the contractor has since communicated with the Department via a letter in August 2023 and has confirmed that they will be refunding the remaining amount of R 635,391.59, being the default interest charges that was levied against the Department and this amount will be deducted from their final invoice.

This has been reported to the Auditor-General, and considering the above, this matter will be closed once the final amount / refund has been received by the Department.

OTHER REPORTS

66. *The special investigations unit at the department, other appointed service providers and Office of the Premier are performing investigations relating to allegations of incorrect awarding of certain contracts, accusations of theft, employees performing unauthorised remunerative work outside the public service and the misappropriation of inventory. The investigations cover the period 1 July 2008 to 31 March 2023 and were still in progress at the date of this report.*

RESPONSE OF THE DEPARTMENT

The Departmental Investigation Services has a total of two hundred and five (205) registered cases, as appended.

NO	DESCRIPTION	NO. CASES	LEGENDS
1	Preliminary	2	Investigating team establishing grounds to warrant comprehensive examination
2	Examination	38	Matters allocated for full investigation.
3	Reporting	29	Examination has been completed and the investigating team is working on the final report. They include reports that are going through quality assurance.
4	Completed	94	Matters completed and referred to Labour Relations or Institution for implementation of corrective actions. Maybe inclusive of matters referred for criminal investigation.
5	Closed	22	Matters which did not materialize after the preliminary stage; they may include matters where allegations were refuted at examination stage
6	Finalised	20	Matters which have been subjected to and completed at disciplinary hearing stage.
	TOTAL	**205**	

The accumulative recoveries related to Other Remunerative Work Outside Public Service (ORWOPS) is ongoing on several cases across various institutions; and debt management is updating the status on a monthly basis.

PART B - AUDIT REPORT IMPROVEMENT PLAN

Attached is a copy of the Audit Improvement Plan that was developed to address the 2022/23 Audit Report findings.

PART C - OTHER REPORTS

C1 - REPORT ON THE CONDONATION OF IRREGULAR EXPENDITURE

The recent meeting between the KZN Department of Health and the Provincial Treasury on the condonation of Irregular Expenditure emphasized the need for the two Departments to work closely in order to expedite the process of condoning the reported Irregular Expenditure. Further, the Provincial Treasury has agreed to prioritise the condonation of irregular expenditure incurred by the Independent Development Trust (IDT) as an implementing agent for the construction of the Dr Pixley Ka Isaka Seme Memorial Hospital. The two Departments have agreed that the said Irregular expenditure should not be carried by the Department as the Department was not involved in the SCM processes at IDT. In light of the aforementioned, the Provincial Treasury will present the irregular expenditure for condonation at the next meeting of the Condonation Committee.

The Provincial Treasury has requested additional information on the condonation of other irregular expenditure that has been reported and some information has already been provided and the remaining information is being processed. The Department is confident that the good working relationships recently established between the two Departments should soon yield positive results, for example, the Provincial Treasury has allocated a resource to work with the Department in finalising the condonations that was submitted.

C2 - CONSEQUENCE MANAGEMENT

The investigations that recommended disciplinary processes against employees were implemented. Further, cognisance should be taken of the fact that should a transaction be reported as fruitless and wasteful, it does not automatically suggest that a wrongdoing had occurred, an example of which is where the Department is obliged to keep minimum quantities of snake-bite serum / medication per facility, in cases of snake bites. The likelihood of these medications expiring is always high as snake bites rarely occur. Unfortunately, the reporting framework is such that when examples of such medication expire, they should be reported as fruitless and wasteful expenditure.

C3 - REPORT ON PAYMENT OF KZN PROJECT INVOICE OWED TO KZN SIU

The Department acknowledges that the amount of R 4,042,768.75 is owed to the KwaZulu-Natal Provincial Special Investigating Unit. In this regard, it should be noted that the Department had effected a payment on 11 September 2023 in the amount of R 829,446.25; however, in light of the dire financial constraints being faced by the National Treasury and as a consequence thereof, the Department has not been able to effect payments thereafter.

However, every effort will be made effect payments to the Special Investigating Unit in the 2023/24 financial year.