REPORT of the AUDITOR GENERAL to the NOVA SCOTIA HOUSE OF ASSEMBLY

• • •2007

June

Office of the Auditor General

Our Vision

A relevant, valued, and independent audit office serving the public interest as the Legislature's primary source of assurance on government performance.

Our Mission

To serve the people of Nova Scotia and the House of Assembly by making a significant contribution to enhanced public sector accountability and performance.

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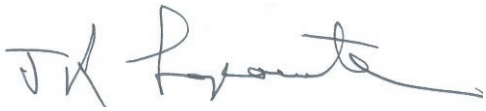
Honourable Cecil Clarke
Speaker
House of Assembly

Sir:

I have the honour to submit herewith an additional Report to the House of Assembly under Section 9A(1) of the Auditor General Act, to be laid before the House in accordance with Section 9A(2) of the Auditor General Act.

Respectfully submitted



JACQUES R. LAPOINTE, BA, CA•CIA
Auditor General

Halifax, Nova Scotia
May 11, 2007

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Introduction

1 INTRODUCTION AND CHAPTER SUMMARIES

MESSAGE FROM THE AUDITOR GENERAL

1.1 I am pleased to present my June 2007 Report to the House of Assembly on work completed by my Office in the first half of 2007.

1.2 In addition to this Report, I have also submitted the following this year:

- My 2007 Strategic Plan was distributed to Members of the House of Assembly and the Public Accounts Committee on April 13, 2007.
- My Report on the Estimates of Revenue for the fiscal year ending March 31, 2008, dated March 22, 2007, was included with the Budget Address tabled by the Minister of Finance on March 23, 2007.

1.3 As the Province's Auditor General, my goal is to work towards better government for the people of Nova Scotia. As an independent non-partisan officer of the House, I and my Office help to hold the government to account for its management of public funds and contribute to a well-performing public sector. I consider the needs of the public and the House, as well as practical realities facing management, in providing sound practical recommendations to improve the management of public sector programs.

1.4 My priorities, during my term of office, are: to focus audit efforts on areas of high risk that impact on the lives of Nova Scotians; to contribute to a more efficient, effective, and better performing public service for Nova Scotia; and to foster better financial and performance reporting to the Legislature and the people; all while promoting excellence and a professional and supportive workplace at the Office of the Auditor General. This Report reflects this service approach.

1.5 I wish to acknowledge the valuable efforts of my staff who deserve the credit for the work reported here. As well, I wish to acknowledge the cooperation and courtesy we received from staff in departments and agencies during the course of our work.

WHO WE ARE AND WHAT WE DO

1.6 The Auditor General is an officer of the Legislature, appointed by the House of Assembly for a ten-year term. He or she is responsible to the House and to the people of Nova Scotia for providing independent and objective assessments of the operations of government, the use of public funds and the integrity of financial and performance reports.

1.7 The Auditor General's mandate, responsibilities and powers are established by the Auditor General Act. The Act provides the Auditor General with the authority to require the provision of any documents required by the Auditor General in the performance of his/her duties. The Auditor General Act requires all public servants to provide the Auditor General free access to any and all information and explanations which he requires.

1.8 The Auditor General Act stipulates that the Auditor General shall provide an annual report and opinion on the government's financial statements; provide an opinion on the revenue estimates in the government's annual budget address; examine the management, use and control of public funds; and report to the House at least once, and up to three times annually, on the work of the Office.

1.9 The Office has a mandate under the Act to audit all parts of the Provincial public sector including government departments and all agencies, boards, commissions or other bodies responsible to the crown, such as Regional School Boards and District Health Authorities, as well as transfer payment recipients external to the Provincial public sector.

1.10 In its work, the Office of the Auditor General is guided by, and complies with, the professional standards established by the Canadian Institute of Chartered Accountants, otherwise known as Generally Accepted Auditing Standards (GAAS). We also seek guidance from other professional bodies and audit-related best practices in other jurisdictions.

1.11 This Report presents the results of the Office's audits and reviews conducted in 2006 and 2007 and completed in the first half of 2007 at a number of departments and agencies, as well as some comments on government financial reporting. Where appropriate, we make recommendations for improvements to government operations, processes and controls. Department or agency responses have been included for each chapter. We will follow up on the implementation of our recommendations in two years, with the expectation that significant progress will be made.

1.12 A separate booklet also provides highlights and summaries from this Report.

SIGNIFICANT ISSUES AND COMMON THEMES

1.13 In conducting our audits, we sometimes identify issues that may have broader applicability beyond the particular entities in which the issues emerged.

1.14 First, we found deficiencies this year in basic internal controls in some program areas. These weaknesses increase the risk of financial loss through error or fraudulent actions. In some cases, the internal controls had been designed properly but were not functioning as intended. In other cases, adequate controls did not exist. Some of the weaknesses related to manual controls such as authorizations and monitoring. Others, such as poor access controls, related to

computer systems. The importance of adequate internal controls, and the concept of management responsibility for internal controls, have gained international attention in recent years following several widely-publicized corporate failures, and the passing of the Sarbanes-Oxley Act in the United States. We urge the Nova Scotia government to focus on the design and proper functioning of internal controls.

1.15 Secondly, our audits of health-related programs identified the need for increased quality assurance on non-financial databases such as those which control access to programs or report wait time information. These databases produce information which is used as support for important decisions relating to access to health services; accuracy in this data is important.

1.16 Finally, we note that there is a need for clear accountability frameworks which define performance expectations for entities funded by the Province. The accountability frameworks may take different forms (such as service agreements, contracts, legislation or policies), but they should all include standard provisions such as:

- objectives;
- performance expectations and targets;
- reporting requirements for regular submission of both financial and non-financial performance information;
- monitoring provisions including audit access by the relevant Department and/or the Auditor General, depending on the circumstances; and
- the right of government to take corrective action if results do not meet expectations.

EXECUTIVE SUMMARY BY CHAPTER

1.17 The Report presents our findings, conclusions and recommendations resulting from audits and reviews in the following areas. Responses received from auditees have been included in the appropriate chapter.

Health

Chapter 2 Management of Diagnostic Imaging Equipment - Capital Health and Cape Breton District Health Authority

1.18 We conducted an audit of the management of MRIs and CT scanners at the Department of Health, Capital Health and the Cape Breton District Health Authority. This audit was conducted jointly with legislative auditors in several Canadian jurisdictions. The Auditor General of Ontario released his report from this audit to the Legislative Assembly of Ontario in December 2006 and other legislative auditors will issue reports in the future.

1.19 We found that the DHAs we audited generally had processes in place to provide for patient safety and prioritize patient access to required services. One of the factors

that impacts timely access to diagnostic services is whether the equipment is used for medically necessary, appropriate examinations. We believe the Department of Health and DHAs should incorporate use of clinical practice guidelines in their policies to decrease the risk that the ordered examination is not appropriate. We also recommend that the Department of Health take a more active role in assuring adequate quality assurance processes are in place for diagnostic imaging equipment throughout the Province.

1.20 The Department of Health does not have a formal capital planning process in place for medical equipment. A capital plan is necessary to ensure that high priority equipment needs are met on a Province-wide basis. Capital Health and the Cape Breton District Health Authority have adequate capital planning processes in place but have significant unmet equipment needs due to insufficient funding. Funding limitations for capital equipment at the District Health Authorities has been a recurring finding in prior audits.

Chapter 3 Emergency Health Services

1.21 We performed an audit of certain aspects of Emergency Health Services' ground ambulance program. EHS contracts the day-to-day operation of the program to EMC Emergency Medical Care Inc. - a wholly-owned subsidiary of Medavie Blue Cross.

1.22 The contract between EMC and the Province does not specifically address the right of the Office of the Auditor General to audit EMC's operations. EMC management agreed to our request to perform the audit. We believe that any significant service delivery contracts should include audit access for the Auditor General to ensure that the House of Assembly receives assurance that public funds are appropriately controlled and expended with regard to value for money.

1.23 EHS has adequate procedures to ensure EMC complies with the performance standards established in the ground ambulance contract. However, we made recommendations for improvements to EHS' monitoring practices for financial information and user fee collection.

1.24 We found EMC had paid retention bonuses to its senior management. Although the payments did not violate the company's agreement with the Province, the accounting treatment and disclosure highlight weaknesses in the accountability framework of this program. The Department of Health was unaware of the specific details of these payments although the amounts had been partially funded by the Department. This instance of unusual payments supports the need for increased financial monitoring by the Department of Health.

1.25 EMC uses sophisticated techniques to deploy ambulances across the Province and meet response times. There are two related issues which should be examined by government: delays at emergency rooms pose a risk that response times may not be achieved; and there is a risk that some ambulances may be deployed to communities which do not meet deployment criteria.

Chapter 4 Long-term Care - Nursing Homes and Homes for the Aged

1.26 The Department of Health's Long-term Care program has undergone a number of major changes in the past few years including introduction of Single Entry Access, the Cost of Care Initiative, the Continuing Care Strategy and the recent announcement of new and replacement beds. The legislation is outdated and needs to be amended to reflect these changes.

1.27 Our audit found a need to improve the accountability framework for nursing homes to more clearly set out performance expectations and reporting requirements. We also report weaknesses in documentation and processes related to the annual licensing and inspection process, which should be addressed to improve control over quality of care and ensure compliance with legislation in nursing homes.

1.28 A major objective of our audit was to review and assess the SEAscape computer system which is used to manage access to all nursing homes in the Province. We found instances of inaccurate information and, when we tested placement decisions for a small sample of clients, we found four situations where clients appear to have been placed in nursing homes in a manner that was not consistent with DOH placement policies. We acknowledge that circumstances may exist is specific situations which would warrant exceptions to the placement policy but, in these cases, there was no supporting documentation to explain the rationale for placement of these clients before others on the wait list. We believe there is a need to establish a quality control process over the data in the system and to document management approval of exceptions to policy.

Justice

Chapter 5 Maintenance Enforcement Program

1.29 The Maintenance Enforcement Program administers and enforces orders of the court requiring individuals to make spousal or child support payments. Some payments received are deposited to a trust account and then disbursed to recipients. Others flow through the Program to a recipient without being deposited to the trust account. We found trust account assets were not adequately safeguarded because of deficiencies in internal control, and the Department does not prepare annual audited financial statements or other information to demonstrate how it has discharged its fiduciary responsibility for the trust account. Similarly, there is a lack of performance information and reporting to demonstrate whether the Program is fulfilling its mandate in an efficient and effective manner.

1.30 We also note that collection processes are inadequate to ensure the full and timely collection and payment of maintenance orders. For example, confirmations of payer employment information were not documented in the majority of cases, making it difficult to determine if they are occurring. Also, there were many cases where a Federal notice of intercept was not in place.

1.31 We note that no professional accounting staff has been engaged to manage and control the financial operations of this Program and that there is a need to apply additional resources and expertise to this area. The current deficiencies negatively impact Program operations and pose a significant risk.

Community Services

Chapter 6 Regional Housing Authorities

1.32 The Housing Authorities manage the day-to-day operations of the public housing stock in the Province. We completed a performance audit at the Metropolitan Regional Housing Authority and the Cape Breton Island Housing Authority. The Housing Authorities receive direction and guidance from the Department of Community Services and function similarly to a division of the Department.

1.33 We found that system controls over the receipt, recording and depositing of revenues are adequate, but we identified instances of the use of inaccurate information in the calculation of rental charges. We also found weaknesses in controls over access to the Housing Authorities' computer system, and in control procedures relating to the processing of expenditures at both Housing Authorities. While certain controls over revenues, expenditures and the general computer environment are adequate, we identified a number of control weaknesses that increase the risk of financial loss, either through error or fraudulent actions.

Finance

Chapter 7 Government Financial Reporting

1.34 Significant steps have been taken towards preparing and presenting the government's revenue estimates in full compliance with generally accepted accounting principles (GAAP). Department of Finance and other staff are to be commended for the progress they have made in improving government's financial reporting.

1.35 However, we found it necessary to qualify the opinion on the government's revenue estimates in the budget, because the revenue estimates were not presented on the same consolidated basis as the Province's consolidated financial statements. The Department of Finance was also not able to provide support for third-party revenues of certain consolidated government units. Accordingly, we were unable to form an opinion on the reasonableness of these revenues or the support for the underlying assumptions.

1.36 The Department of Finance is planning to release the Province's March 31, 2007 consolidated financial statements before the end of August. This is earlier than the legislated date of September 30, 2007. We commend and support the Department of Finance in its efforts to improve the timeliness of the financial statements.

Performance Audits

2 MANAGEMENT OF DIAGNOSTIC IMAGING EQUIPMENT - CAPITAL HEALTH & CAPE BRETON DHA

BACKGROUND

2.1 Over the past several years, the issue of access to diagnostic imaging services in Canada has become a priority for the provinces and nationally. In September 2004, the First Ministers agreed on a 10-year plan to strengthen health care in Canada. That plan included a commitment to achieve meaningful reductions in wait times for diagnostic imaging services, and to report to citizens on progress made.

2.2 To support the 10-year plan for improving health services, the Federal government established a Diagnostic/Medical Equipment Fund in 2000 of $1 billion over two years, and announced an additional $1.5 billion over three years in 2003. In 2004, an additional $0.5 billion was announced. Nova Scotia's share totaled $92.1 million (2000 - $32.5 million, 2003 - $44.6 million, 2004 - $15 million). As of December 31, 2006, $19.6 million has yet to be spent. Of this unspent amount, $2.5 million has yet to be allocated for specific equipment purchases.

2.3 The issue of access to diagnostic imaging services is complex as described in the following excerpt from the Canadian Institute for Health Information's (CIHI) publication *Medical Imaging in Canada* 2005.

> *"When addressing the waiting time issue for diagnostic imaging in Canada, most people refer to the availability of equipment. However, this is only one dimension of the problem. More machines do not necessarily mean more imaging services. The machines could be under-used for a variety of reasons, such as funding limitations, human resources constraints, etc. Hence, the importance of considering the level of utilization of the imaging equipment and of assessing the efficiency of its operation."* (page 69)

2.4 According to CIHI's *Medical Imaging in Canada* 2005, two of the more expensive types of diagnostic imaging services are Magnetic Resonance Imaging (MRI) and Computed Tomography Scans (CT).

> *"Magnetic resonance imaging (MRI) uses three components to create detailed images of the inside of the body - hydrogen atoms in the tissues, a strong external magnet and intermittent radio waves... MRI can provide detailed images of all tissues except bone."* (page 25)

> *"Computed tomography (or CT), also known as 'computer assisted tomography' (or CAT), is used to create three-dimensional images of the structures within the body. CT scans use X-ray images processed by a computer to create virtual slices of the part of the body being examined. A computer then processes data to create images that show a cross-section of body tissues and organs."* (page 18)

> *"Expensive technologies such as MRI and CT scanners have high initial costs compared to common technologies such as X-rays and ultrasounds. An MRI scanner costs over*

> *$2 million, whereas the average cost of a CT scanner is about $1 million* [note that both figures exclude installation costs which may be significant] *. . .Viewed in another way, for the cost of one MRI scanner it would be possible to buy about five X-ray machines at about $340,000 each or 12 ultrasounds at about $160,000 each. Of course, making these choices would affect which types of patients would benefit, operating costs and many other factors."* (page 65)

2.5 Governments have invested heavily in acquisitions of MRIs and CTs over the last several years. In 1991, there were 22 MRIs in Canada (N.S. - 1), and the number had grown to 196 by 2006 (N.S. - 5). In 1991, there were 200 CT scanners in the country (N.S. - 7). By 2006, the figure had grown to 378 (N.S. - 15). (*Medical Imaging Technologies in Canada, 2006 - Supply, Utilization and Sources of Operating Funds,* Canadian Institute for Health Information, 2006, pages 23-24).

2.6 In 2006, there were four functioning publicly-funded MRIs in the Province; two at Capital Health (CDHA), one at the Cape Breton District Health Authority (CBDHA), and one at the IWK Health Centre. In addition, there was a privately-owned and operated MRI clinic in the Halifax Regional Municipality. There were fifteen publicly-funded CT scanners in the Province. Capital Health had six CT scanners, while the Cape Breton District Health Authority had two.

2.7 The Department of Health (DOH) provides funding, both capital and operating, to the nine District Health Authorities in the Province and the IWK Health Centre (collectively referred to as DHAs). Prior to 2000, DOH allocated funding between operating and capital. As of April 2000, the Department began to allocate capital equipment funding to the portable funding base. Consequently, the DHAs are responsible for determining the allocation of total funding between operating costs and capital requirements. The Department, as part of its business planning process, requires DHAs to submit requests for three major capital equipment purchases such as diagnostic imaging equipment. The Department may decide to separately fund certain of these requests through the Federal Medical Equipment Fund (see paragraph 2.2 above) or other available funds. In those cases, the DHAs are generally required to fund 25% of the cost from their own resources. In addition, DHAs may access equipment funds from Foundations or other non-government sources. DOH also provides funding for equipment purchases to DHAs in emergency situations.

2.8 According to Statistics Canada, approximately 4.3% of Canadians aged 15 and older had a non-emergency CT scan in the previous 12 months and 3.9% had a non-emergency MRI in the previous 12 months (*Medical Imaging Technologies in Canada, 2006 - Supply, Utilization and Sources of Operating Funds*, Canadian Institute for Health Information, 2006, page 12). Exhibits 2.1 and 2.2 show the number of MRI and CT exams per 1,000 population by province and Canada. Note that these exhibits show Nova Scotia's rate for MRIs was the same as the national rate, but the rate for CTs was higher.

2.9 In 2004, the Department of Health initiated a review of options for MRI service delivery in Nova Scotia. The report was released in August 2004 (*Magnetic Resonance*

Imaging Needs Assessment, Michael H. Barry, MD, FRCPC, August 2004, full document available at http://www.gov.ns.ca/health/downloads/mri_needs_assessment.pdf.) The report recommended purchase of three MRIs for rural District Health Authorities, and two to replace aging MRIs at Capital Health. In September 2005, the Department of Health conducted a Request for Proposals. A committee with representation from DOH and the DHAs determined the vendor, price and technical specifications of the MRIs to be acquired. The DHAs were to award the contracts for procurement of six MRIs. The first of the new MRIs was officially opened on September 15, 2006 in Yarmouth and the second opened February 1, 2007 in New Glasgow. The remaining four MRIs are targeted to open in 2007.

2.10 In 2004, a committee formed by the Department of Health recommended a target wait time for MRI and CT scans of between 3 and 28 calendar days depending on the priority assigned to the patient (*Report of the Provincial Wait Time Monitoring Project Steering Committee*, January 2004, page 19). The recommended target for priority 1 patients (most urgent) was 3 calendar days or less and the target for priority 3 patients (least urgent) was 15 to 28 calendar days. The Committee, comprised of representatives of the clinical and administrative communities at the Department of Health and District Health Authorities, noted that "*Target wait times are meant to be goals or objectives toward which the system can strive to better serve patients. They are not guarantees for service within particular lengths of time.*" (page 19)

2.11 In October 2005, the Department of Health established a website (http://www.gov.ns.ca/health/waittimes/default/htm) which "*provides information on Nova Scotia's plan to improve wait times, highlighting the progress to date, and sharing wait time information for publicly funded tests, treatments, and services across the province.*" Wait times for MRI and CT scans are included. As at December 2006, the wait time for MRI at Capital Health was reported to be 119 days while the Cape Breton District Health Authority reported a time of 37 days (see Exhibit 2.4). The wait time for CT scans was reported to be between 6 and 38 days at Capital Health (depending on the equipment location) and 59 days at the Cape Breton District Health Authority (see Exhibit 2.3).

2.12 In 2006, we conducted an audit of the management of MRIs and CT scanners at the Department of Health, Capital Health and the Cape Breton District Health Authority. This audit was conducted jointly with legislative auditors in several Canadian jurisdictions using a common audit plan. The audit was coordinated by a sub-committee of the Canadian Council of Legislative Auditors (Health Study Group). The Auditor General of Ontario released his report on this topic to the Legislative Assembly of Ontario on December 5, 2006. The legislative auditors of a number of other jurisdictions will issue reports on this subject in the future.

RESULTS IN BRIEF

2.13 The following are the principal observations from this audit.

- The Department of Health does not have a formal capital planning process in place. A capital plan is necessary to ensure that high priority equipment needs

are met on a Province-wide basis and that funds are spent with due regard for economy and efficiency.

- Capital Health (CDHA) and the Cape Breton District Health Authority (CBDHA) have adequate capital planning processes in place but have significant unmet equipment needs due to lack of funding. CDHA has estimated its unmet needs to be approximately $82 million while CBDHA has estimated about $57 million. Use of equipment that is beyond its useful life makes scheduling processes more difficult for District Health Authority staff, and has an impact on patient access to necessary services.

- We examined the processes for procurement of MRIs by the Department of Health and CBDHA. In both cases, we found procurement policies were followed but identified weaknesses in the way the proposals were evaluated. We have recommended improvements to ensure the best value for money is achieved in future procurements.

- One of the factors that impacts timely access to diagnostic services is whether the equipment is used for medically necessary, appropriate examinations. We believe that the Department of Health and DHAs should incorporate use of clinical practice guidelines in their policies to decrease the risk that the ordered examination is not appropriate. This is especially important as general practitioners are given the right to order more examinations. However, we recognize that implementation of clinical practice guidelines poses significant challenges for physicians and requires changes in expectations of some patients.

- Various statistical reports are produced and used to monitor aspects of diagnostic imaging services including wait times. However, many of the reports are prepared manually and require extensive effort to produce. In some cases, the information technology systems in use have the capacity to produce this performance information more efficiently but it is not utilized. We recommend that CDHA and CBDHA examine the computerized diagnostic imaging systems in use with a view towards automating statistical reports to the extent possible, and that requirements for statistical reporting be included in future information system procurements.

- The Department of Health should take a more active role in assuring adequate quality assurance processes are in place for diagnostic imaging equipment throughout the Province. The two DHAs examined had significantly different quality assurance processes. Diagnostic imaging equipment that is not appropriately functioning can provide risks to patients, including excessive exposure to radiation.

- At CDHA, we examined policies governing medical staff involvement in the private MRI clinic. We noted that CDHA does not have its own conflict of interest guidelines for medical staff although its by-laws refer to conflict of interest guidelines established by the College of Physicians and Surgeons. We

believe that such policies are necessary to ensure the interests of the Health Authority and the patient are protected when medical staff enter into other business arrangements such as involvement with privately-owned health facilities.

AUDIT SCOPE

2.14 The major objectives of our audit were to assess:

- due regard for economy, efficiency and effectiveness in the acquisition and maintenance of MRIs and CT scanners, and compliance with applicable purchasing policies and procedures;
- adequacy of processes and procedures to ensure that use of MRIs and CT scanners complies with applicable legislation and policies, and minimizes risk to patients;
- adequacy of scheduling processes for examinations and reporting systems for examination results to ensure timely access by patients;
- adequacy of policies and procedures for maintenance of MRIs and CT scanners to ensure compliance with standards and reduced risk to patients; and
- the government's policies relating to the privately-owned MRI clinic and CDHA's conflict of interest guidelines for medical staff involved in ownership of private clinics.

2.15 Our audit objectives and criteria were developed jointly by all jurisdictions participating in the audit.

2.16 Our audit approach included interviews with management and certain medical staff of DOH, CDHA and CBDHA as well as the examination of contracts, studies, reports and other documentation considered relevant. We performed such tests and other procedures as we deemed necessary.

PRINCIPAL FINDINGS

Results of Accreditation Process

2.17 District Health Authorities are accredited by the Canadian Council on Health Services Accreditation (CCHSA). We reviewed the most recent accreditation reports for CDHA and CBDHA to determine whether there were any significant recommendations related to Diagnostic Imaging equipment.

2.18 The Capital District Health Authority's most recent accreditation review was in late 2004. The report is available on CDHA's website at http://www.cdha.nshealth.ca/newsroom/uploads/FinalReport04.pdf. CDHA received an accreditation

recognition decision of "Accreditation with Focused Visit" (page 2) which means that there were significant issues that needed to be addressed in an urgent manner over the following 12 months. Of the three areas identified as the reason for the focused visit, two related to equipment: the urgent need to address capital equipment and physical plant deficiencies (page 16) and long wait times for certain diagnostic imaging procedures (page 19). The focused visit took place in early 2006 and the result was that CDHA had made adequate progress in addressing the high urgency recommendations.

2.19 The Cape Breton District Health Authority's most recent accreditation was in late 2005. CBDHA received an accreditation decision of "Accreditation" and no high urgency recommendations relating to equipment were identified.

Capital Planning Process

2.20 We assessed the medical equipment capital planning processes at DOH, CDHA and CBDHA to determine whether decision-making processes incorporate due regard for economy and efficiency. Adequate capital equipment planning includes identifying and prioritizing equipment needs based on the organization's strategic plan, and identifying strategies for financing. We concluded that adequate capital planning processes exist at the DHAs, but improvements are needed at the Department of Health. In addition, the lack of predictable funding has a significant impact on the effectiveness of capital planning at both the Department of Health and District Health Authorities.

2.21 As part of its business planning process, the Department of Health requests three capital equipment submissions from each DHA for Federal Medical Equipment funding. There is no formal process to prioritize these requests on a Province-wide basis and there is no plan to addresses the medical equipment needs of the Provincial system as a whole over a period of time. For example, DOH contracted a needs assessment for MRIs (see paragraph 2.9) but there was no formal assessment to support spending $12.5 million (DOH share of equipment and installation costs) on MRIs rather than other medical equipment needs. The needs assessment recommended locations for five new MRIs which the Department of Health addressed when placing the new equipment. However, an additional MRI was purchased and located in a community that had not been identified as a short-term priority (New Glasgow). This decision resulted in two of the new MRIs being located in close proximity (Antigonish and New Glasgow). The Department of Health should have a formal capital planning process in place to demonstrate that funds are being spent with due regard for economy and efficiency.

2.22 The Province provides annual operational funding to the DHAs which can be used to fund both operating and capital needs. Management at both DHAs indicated that cost pressures in operational areas result in limited Provincial funds available to address capital equipment needs. For example, in 2005-06, of the $563 million in Provincial funding provided to CDHA, $1 million was allocated to capital expenditures. Capital equipment purchases over the last several years have been funded either through the Federal Medical Equipment Fund (see paragraph 2.2),

Provincial funding in emergency situations, hospital Foundations, or other non-government sources of revenue (see Exhibit 2.7 for 2005-06 breakdown for CDHA and CBDHA).

2.23 The Federal government established the Diagnostic/Medical Equipment Fund to help the provinces address medical equipment needs. Nova Scotia's share of this fund is $92.1 million. Of the total funding spent by the Province to date, $29.4 million was allocated to CDHA, $7.0 million to CBDHA and $12.5 million to fund the MRI purchases (see paragraph 2.30). To access funding, each DHA was to submit a prioritized list of equipment requirements to DOH for approval, and all DHAs received funding. In 2005-06, CDHA submitted requests totalling $106 million and received $6.9 million; CBDHA submitted $5.4 million and received $650,000. The Province had no formal capital plan or funding criteria to support these funding allocations.

2.24 We acknowledge that medical equipment funding is a complex issue and that DOH has limited funds to address the significant needs identified by the DHAs. However, when funds are scarce, it is even more important that the highest priority items on a Province-wide basis are funded.

Recommendation 2.1

We recommend that DOH, in conjunction with the DHAs, develop a long-term Provincial medical equipment capital plan including criteria for assessing competing DHA needs on a Province-wide basis.

2.25 CDHA and CBDHA have annual processes in place to identify and prioritize medical equipment needs based on pre-established criteria. Both DHAs are currently in the process of reviewing the capital equipment process to ensure it is effective in prioritizing equipment needs. At both DHAs, input is solicited from all clinical areas. The two DHAs have identified significant long-term capital equipment requirements; in the range of $82 million at CDHA and $57 million at CBDHA.

2.26 Certain equipment at both DHAs is beyond its useful life. Outdated and inefficient equipment can impact patient care, efficiency, wait times and the ability of DHAs to attract specialist physicians. Exhibit 2.5 shows the age of the CT scanners used by CDHA and CBDHA, while Exhibit 2.6 shows the age distribution of equipment in use at Canadian hospitals. Across Canada, 4% of CT scanners in use in 2005 were more than 10 years old, while at CDHA and CBDHA, 25% were more than 10 years old. The two MRIs in use at CDHA were 10 and 12 years old as of January 1, 2006 while only 6% of the MRIs used in Canada were more than 10 years old. The Canadian Institute for Health Information (*Medical Imaging in Canada* 2005, page 80) notes that "*standards for evaluating ageing equipment in Canada have not been developed.*" However, it quotes work by the European Coordination Committee of Radiological and Electromedical Industries which indicates that equipment older than ten years is

"No longer state-of-the-art technology; not more than 10% of the installed base can be tolerated to be older than ten years; replacement is essential."

2.27 The aging equipment causes difficulties for DHA management. For example, management informed us that the image quality on MRIs at CDHA is not acceptable for certain types of examinations. This causes complexity in scheduling. For example, certain examinations must be completed on the IWK Health Centre's MRI to ensure acceptable image quality. CBDHA faces similar problems due to the age of its CT scanners - one is more than ten years old. Obtaining replacement parts for outdated equipment is difficult. We were informed of one case where CDHA procured two used ultrasound machines from a hospital in PEI which was disposing of them. The machines were 12 years old and procured at a cost of $4,999 each. Management indicated that CDHA used the machines for approximately one year.

2.28 Keeping pace with rapid changes in technology poses challenges for the Department of Health and DHAs. Technological advancements permit better image quality and more accurate diagnosis. Physicians require access to newer technologies to enhance patient care. Diagnostic imaging equipment is expensive and a systematic approach to technology refreshment should be built into capital equipment plans.

Planning and Procurement Process for New MRIs and CTs

2.29 We assessed documentation supporting the planning and procurement processes for the purchase of MRIs and CT scanners to determine whether there was compliance with procurement policies and whether the equipment was acquired in an economical manner using a competitive selection process. We concluded that procurement policies were followed but we have identified weaknesses in the way the MRI proposals were evaluated. We have recommended improvements to ensure the best value for money is achieved in future procurements.

2.30 DOH - In 2005, DOH managed the procurement process for the purchase of new MRIs to provide for equipment compatibility throughout the Province and economies of scale. As indicated in paragraph 2.9, the procurement process was preceded by a needs analysis performed by an external consultant. DOH created a committee to develop a Request for Proposals (RFP) and assess vendor submissions. Committee members included representatives from DOH, the Provincial Procurement Branch and technical expertise from various DHAs. Vendor submissions were analyzed using pre-established criteria and weightings. The winning vendor was awarded the right to supply six MRIs for $10.4 million.

2.31 Although the RFP process and assessment complied with the Government Procurement Policy, we note that lifecycle costs, such as annual maintenance and operating costs, were not explicitly considered in the quantitative analysis of proposals. Best practices would suggest that the present value of all costs, including acquisition, maintenance and operating costs, over the useful life of the equipment should be considered to ensure appropriate comparisons between

competing equipment and due regard for economy and efficiency. Staff of the Department of Health indicated that the decision to exclude lifecycle costs from the analysis process was reasonable because the difference between the various alternatives, in this case, was not significant.

2.32 The committee analyzed the proposals on the basis of a technical review (70% weighting) and cost to acquire five base unit MRIs (30% weighting). Based on the combined score, a winning proposal for base units was accepted. DOH management indicated that, because additional resources were available, a decision was made to purchase a sixth unit, three system upgrades and additional accessories such as special purpose coils. As a result, the six machines actually purchased were not all base units - three were enhanced units for use in tertiary care facilities. Additional accessories, such as special-purpose coils, were also excluded from the vendor cost comparisons but included in the final contract award. Submissions for the more costly enhanced units had been received from the vendors in response to the RFP but were not considered during the analysis process. The evaluation process should be enhanced to more specifically compare the costs of all equipment purchased to ensure value for money is achieved. We believe that planning for this project should have identified the specific equipment requirements prior to issue of the RFP and the process for assessment of vendor submissions should have included all equipment in the final contract. We recognize there were extenuating circumstances in this case because this was new technology for rural DHAs and committee members only reached a decision on the specific equipment requirements during the technical review process when they had the opportunity to see the equipment operate and compare image quality. We also understand the committee was given a timeline of approximately six months to request proposals and reach a decision which impacted its ability to introduce detailed specifications in the proposal document.

2.33 CBDHA - In 2003, the Cape Breton District Health Authority acquired a MRI at a cost of $3.1 million, including site renovations. A RFP process was conducted. CBDHA management informed us there was no formal scoring process for the bids received. Section 6 of the RFP document indicated the evaluation weighting would be based on 50% for technical specifications, 20% for service technology refresh and 30% for cost. Each vendor's submission included proposed pricing but there was no summary documentation of how the various bidders scored in relation to the evaluation weighting included in the RFP. A committee was formed to conduct a technical evaluation of the vendor submissions and a letter was prepared which recommended the preferred vendor. The letter included a rationale for the committee's choice. Management informed us that procurement staff began negotiations with the preferred vendor on a purchase price after the technical review had been completed and the negotiated price was less than the preferred vendor's original submission. Again, the present value of all lifecycle costs was not included in the quantitative analysis.

2.34 CDHA - In December 2005, CDHA purchased two CT scanners (16 slice and 64 slice). A competitive process was used which was compliant with CDHA and government procurement policies. CDHA uses a Best Value approach for the

procurement of expensive, highly technical equipment such as a CT scanner. The evaluation of bids also includes evaluation weightings based on technical specifications and cost. CDHA included the price of service agreements for four years for each vendor as part of its cost evaluation although not all lifecycle costs were included.

2.35 To ensure procurement practices are open and fair and best value for money is achieved, it is important that complete equipment requirements be identified prior to preparation of the RFP, the present value of lifecycle costs be included in the quantitative analysis, and the entire procurement process be appropriately documented.

Recommendation 2.2

We recommend the procurement processes at DOH and the DHAs be improved to include:
- **identification of all needs prior to issuing the RFP;**
- **inclusion of the present value of lifecycle costs in the quantitative analysis; and**
- **documentation of the entire procurement process including a detailed comparison of bids received according to criteria in the RFP document.**

Equipment Maintenance

2.36 We assessed the systems and processes in place at the DHAs to determine whether MRIs and CT scanners are supported by cost-effective preventive maintenance programs and required maintenance and repairs are performed in a timely and economic manner. Overall, we concluded that both CDHA and CBDHA had adequate systems in place but improvements could be made with respect to monitoring equipment downtime. Also, at CBDHA, we recommended establishment of a process to monitor maintenance performed by equipment manufacturers.

2.37 Annual preventive maintenance service contracts - Due to the technical complexity of MRIs and CT scanners, only the equipment manufacturer has the expertise to perform required repairs and maintenance. The DHAs' options for sourcing maintenance and repairs are limited. Annual preventive maintenance service contracts for MRIs and CT scanners are costly; for example, maintenance contracts for CDHA MRI and CT scanners range from $124,000 to $185,900 per year. CBDHA has an annual maintenance contract of $165,000 for the MRI and $230,000 for a single contract covering both CT scanners. Typically these contracts are inclusive of parts and labour with the exception of older equipment where the manufacturer may no longer be able to guarantee the availability of parts - the situation for one of CDHA's CT scanners.

2.38 Maintenance contracts include equipment up-time guarantees under which the manufacturer guarantees that the MRI or CT scanner will be up and running for a certain percentage of time excluding regular preventive maintenance. These

guarantees typically range from 95% to 97%. If this percentage is not achieved, the manufacturer is usually required to pay a financial penalty. Neither CDHA nor CBDHA were closely monitoring these percentages to ensure they were met. We performed an analysis of the actual up-time of a small sample of equipment and identified an instance where the guaranteed up-time was not being met. CDHA management then brought this to the attention of the manufacturer who agreed to remedy the situation by the end of the year or provide extra months of free service.

Recommendation 2.3

We recommend that CDHA and CBDHA actively monitor manufacturers' equipment up-time guarantees.

2.39 CDHA has established a database which is used to track and monitor preventive maintenance and required repairs to all diagnostic imaging equipment including MRI and CT scanners. CBDHA has not established a similar process and relies primarily on the equipment manufacturer to ensure that all required maintenance has been performed. Management of the CBDHA clinical engineering department indicated that it has identified the lack of monitoring of MRIs and CT scanners as an issue and that it is making progress in implementing AIMS software, described in paragraph 2.40, which will address the situation.

Recommendation 2.4

We recommend that CBDHA establish a process to track and monitor required maintenance and repairs to its MRI and CT scanners.

2.40 Equipment listings - Adequate control of capital assets requires entity-wide capital asset listings which should be periodically verified by comparing the list to equipment on hand. CDHA does not maintain a DHA-wide capital equipment ledger; each divisional head is responsible for separate capital equipment listings. The Diagnostic Imaging Department maintains a database of all its equipment. The main purpose of the database is to track preventive maintenance and repairs performed as well as inventory each piece of equipment. CBDHA does not maintain a capital asset subledger. Information on capital assets is maintained in several spreadsheets. CBDHA management approved the acquisition of software (AIMS.Net) which we understand is specifically designed for hospitals. Functionality includes equipment management, work order control, preventive maintenance performance and quality, and contract management. Operational implementation is planned for 2007-08. We understand that the Department of Health is examining the feasibility of a Province-wide solution which would utilize the relevant module of the SAP/R3 corporate financial management system if that system is adopted to meet the financial information needs of DHAs.

Recommendation 2.5

We recommend that CDHA and CBDHA implement formal capital asset ledgers to control all medical equipment.

Appropriate use of MRIs and CT scanners

2.41 We assessed the systems in place at CDHA and CBDHA to provide for timely access by patients to MRIs and CT scanners. One of the factors that determines timely access is whether the equipment is being used for medically necessary, appropriate examinations. We found that both DHAs rely on the professional expertise of radiologists to confirm appropriateness of examinations requested by referring physicians. We have recommended increased use of clinical practice guidelines to strengthen this process.

2.42 Appropriate use of MRIs and CT scanners is necessary to achieve due regard for economy and efficiency and patient safety. However, appropriate use is not always achieved as illustrated by the following quote from an October 2005 study conducted by a consortium of the Atlantic Health Sciences Centre, Canadian Association of Radiologists and Medicalis Inc. titled *Demand-Side Control of Diagnostic Imaging Through Electronic Clinical Decision Supports: A Pilot Using Appropriateness Guidelines.*

> *"The retrospective analysis, applying all available guidelines found that 86% of tests ordered were entirely appropriate. In 9% of orders a different test would have been more efficient; about half of those changes were to a simpler modality. Four percent of tests ordered were not required for patient management according to the full set of appropriateness guidelines. Although referring clinicians had the most difficulty in appropriately ordering advanced DI tests (CT, MRI, NM, and BD) the volume of basic tests (XR, US, FL, MM) (89%) made any inappropriate ordering in these categories costly to the health care system."* (page 2)

2.43 The Canadian Institute for Health Information, in *Medical Imaging in Canada* 2005, discusses challenges in achieving appropriate use.

> *"Medical imaging may be done for many reasons: screening patients at risk for a disease, reducing uncertainty about a diagnosis to reassure patients and caregivers, assisting with decisions about care choices, assessing treatments and prognoses and/or guiding surgery or other interventions.*
>
> *Deciding which is the best tool (or tools) to use in each of these contexts for different patients is challenging, particularly given the ongoing evolution of imaging technologies, research evidence and practice patterns. Often a particular type of imaging is of obvious, undisputed value for some groups of patients or types of research. Other cases are less clear. . . .*
>
> *More recent technology, such as CT and MRI, is increasingly used to investigate non-specific symptoms. Possible factors for the increase in utilization include growing*

patient demand and increased access to scanners, clinicians' concerns about missing a treatable illness and concerns about litigation if an important abnormality is not diagnosed. . . . Although millions of Canadians use imaging services each year, still relatively little is known about how these technologies are used and how they affect patient care and outcomes." (pages 6-7)

2.44 Diagnostic imaging procedures are not risk free. CT scans provide significantly higher doses of radiation to patients than X-rays. MRIs use strong magnetic fields and radio frequencies to produce images. Risk to the patient is another important reason for ensuring that all diagnostic imaging examinations performed are appropriate. (See paragraph 2.71 for discussion of risks and quality assurance).

2.45 Exhibits 2.1 and 2.2 show the number of MRI and CT exams per 1,000 population by province and Canada. Nova Scotia's rate for MRIs was the same as the national rate, but the rate for CTs was higher.

2.46 At both CDHA and CBDHA, only specialists can request appointments for MRIs. Both general practitioners and specialists can request CT scans. We understand that it is likely that general practitioners will be able to request MRIs when the new rural MRIs are functioning. For example, general practitioners can request MRIs at the new Yarmouth MRI which began operating in fall 2006.

2.47 A standard consultation form is completed by the referring physician, and all forms are to be reviewed by staff radiologists to ensure the exam requested is appropriate in the radiologist's professional opinion. Radiologists prioritize the requests based on pre-established categories of acuity. Although we were told that radiologists question the appropriateness and medical necessity of examinations requested by physicians, this process is not documented and, accordingly, we cannot conclude on the extent of the challenge that takes place.

2.48 The Canadian Association of Radiologists published *Diagnostic Imaging Referral Guidelines* in October 2005 which provide guidance regarding appropriateness of examinations from a clinical perspective. These guidelines are available to referring physicians but have not been formally adopted by the Department of Health and DHAs. Although software is available to assist in determining appropriateness (e.g., Precipio), these tools are not yet used in Nova Scotia. The Department of Health is currently investigating the use of this clinical decision software on a test basis to provide guidance to family physicians when ordering diagnostic imaging examinations. The software uses guidelines developed by the Canadian Association of Radiologists and is based on guidelines used in the United States and the United Kingdom. We believe that the Department of Health and DHAs should incorporate use of clinical practice guidelines, such as those issued by the Canadian Association of Radiologists or similar tools, in their policies to decrease the risk that the ordered examination is not appropriate. This is especially important as general practitioners are given the right to order more examinations.

2.49 Physicians at the DHAs informed us of significant challenges associated with the introduction of clinical practice guidelines. They indicated that use of such

software is perceived to increase the time required by fee-for-service physicians to order an examination and this time is currently not included in the fee schedule. Another impediment to implementation of clinical practice guidelines is patient demand for various types of diagnostic examinations which is often based on internet research. Physicians are sometimes reluctant to refuse services demanded by patients. Finally, they suggested that successful implementation of clinical practice guidelines would require changes to medical school curricula.

2.50 In late March 2007, subsequent to our audit, Health Canada and the Nova Scotia Department of Health announced a project to be funded through the Patient Wait Times Guarantee Trust Fund with the objective of improving efficiencies in diagnostic imaging. The Diagnostic Imaging Project was described in a Health Canada news release dated March 26, 2007 as follows:

> *"Diagnostic imaging services are a critical and frequently time-consuming juncture in a patient's care journey. Nova Scotia's "Improving Access to Diagnostic Imaging Services" project will help primary care physicians order the best diagnostic test for their patients, using appropriateness guidelines developed by the Canadian Association of Radiologists. It will also improve efficiencies in diagnostic imaging and support patient choice on where and when they receive care."*

Recommendation 2.6

We recommend that the Department of Health, in conjunction with radiologists, establish and implement clinical practice guidelines for use of MRIs and CT scans in the Province.

Booking Systems

2.51 One of the factors that plays a role in achieving timely access is adequacy of booking processes for CTs and MRIs. We examined the booking processes at CDHA and CBDHA and concluded that they are generally adequate for ensuring that priority patients receive access to the diagnostic equipment. However, we made some recommendations for improvement.

2.52 CDHA uses a computerized system (QuadRIS) to book both MRIs and CT scans. For CTs, each site books its own equipment separately - there is no centralized booking of all CDHA CT scanners. MRIs are booked centrally but, at the time of our audit, were only being booked until February 2007 when two new MRIs were planned to start operating. Management informed us that they are developing plans to book CTs centrally in the future. We encourage management to proceed with these plans to ensure all CTs are utilized for the highest priority patients and to ensure that a single patient does not appear on multiple wait lists.

Recommendation 2.7

We recommend that CDHA implement centralized booking for all CDHA's CT scanners.

2.53 At the time of our audit, CBDHA used a manual booking system for MRIs and examinations were only scheduled three days in advance of the procedure. CT scans were booked centrally using the Meditech system (Nova Scotia hospital Information System). We advised CBDHA that the Meditech system is available for booking of MRIs and should be used because it has the capability to generate useful wait time and performance information in addition to advance booking. Also, entering all requisitions into the system as they are received ensures better control than maintaining them in an unbooked requisitions file. Recently, CBDHA management indicated that MRIs are booked for a longer time frame and that the Meditech system is now being used.

2.54 The booking schedule includes time allocations for inpatients, outpatients and patients of various clinics, and emergencies. Patients are prioritized by radiologists (see paragraph 2.47 above). The booking schedule for MRIs at CDHA is also impacted by the age of the equipment and the image quality. As a result, certain types of examinations can only be performed on certain pieces of equipment. This complicates the booking process but should be rectified when the new equipment is operational. Finally, the schedules are impacted somewhat by the availability of radiologists as a radiologist must be present for certain types of examinations.

2.55 We examined procedures for dealing with cancellations and patients who do not present themselves for a scheduled examination (i.e., "no shows"). CDHA maintains cancellation lists and calls other patients when notice of cancellation is received while CBDHA does not maintain a cancellation list. "No show" rates are monitored by management through manual calculations while cancellation rates are generally not monitored because the resulting vacancies are filled by new bookings. We determined that CDHA's "no show" rate for MRI and CT appointments was 4.1% and 10.7%, respectively, for the 2005-06 fiscal year. We examined a sample of utilization records at each DHA and found that vacancies created by "no shows" were generally filled by other patients such as inpatients and emergencies so the impact of "no shows" on actual utilization is minimal.

2.56 CDHA's MRIs are available for scheduled patients weekdays from 7 a.m. to 8 p.m. and the Halifax Infirmary site is open on weekends from 8 a.m. to 8 p.m. CDHA also uses the MRI at the IWK Health Centre for 27 hours per week for adult patients. A technologist is available on call after hours for emergency patients. The CT scanners located at the Victoria General operate weekdays from 7 a.m. to 5 p.m. while those at the Halifax Infirmary operate 24 hours per day, 7 days a week. At CBDHA, CT scanners operate weekdays from 8 a.m. to 9 p.m. and staff are on call after 9 p.m. and on weekends. MRI hours had previously been 8 a.m. to 7 p.m. weekdays but have recently been reduced, because of staffing issues, to weekdays from 8 a.m. to 4 p.m. with no on-call or weekends. At both DHAs, the overall utilization rates for MRIs and CT scanners, both in total and for individual

equipment, are informally monitored. We believe that the DHAs should monitor their equipment utilization more formally, including establishing utilization standards and comparing actual utilization to standards to ensure that it is used as efficiently as possible. This would also provide useful input to the capital equipment planning process on levels of utilization of existing equipment.

Recommendation 2.8

We recommend that CDHA and CBDHA establish utilization standards for each MRI and CT scanner and monitor performance in achieving the standard.

Wait Time Data

2.57 Wait times data is an important indicator of patient access to diagnostic services. The Department of Health established a website in October 2005 which reports current information on MRI and CT wait times by DHA. This information is reproduced in Exhibits 2.3 and 2.4. In addition, management at both DHAs receive wait time reports on a regular basis.

2.58 We reviewed the systems to support production of MRI wait times information at CDHA and CBDHA and reported our findings in the December 2006 Report of the Auditor General (Chapter 4). We were unable to conclude on the adequacy of the system to support MRI wait times at both DHAs because certain supporting documentation was not available for our review after the wait time was calculated and reported. At that time, we made the following recommendations for improvements to CDHA's and CBDHA's systems for measuring and reporting this wait time information:

- *Recommendation 4.4 - We recommend that the Department of Health modify the definition of MRI wait times used on the website to ensure it is consistent with the information calculated and provided by the District Health Authorities.*
- *Recommendation 4.5 - We recommend that the Department of Health's website disclosure of the wait time for MRIs reflect more comprehensive information such as the specific wait times for major types of MRI examinations rather than just a single data point such as the average for all types.*
- *Recommendation 4.8 - We recommend that the Department of Health consider building the requirement for wait time information and reports into automated systems.*
- *Recommendation 4.9 - We recommend implementation of a formal quality control process for wait time data at both the District Health Authorities where the reports originate and the Department of Health.*
- *Recommendation 4.10 - We recommend that the Department of Health formally document policy guidance for how each wait time is to be calculated.*

- *Recommendation 4.11 - We recommend that the District Health Authorities retain, for at least one year, the support for all wait times reported to the Department of Health.*

2.59 Wait times for CT scans are calculated in a manner similar to MRIs so the recommendations above also apply.

2.60 CDHA has established a standard of 28 days for the wait time for elective CT scans and MRIs. This standard is consistent with the *Report of the Provincial Wait Time Monitoring Project Steering Committee* for examinations categorized as "least urgent" (page 19). CBDHA has not formally adopted a wait time standard. Exhibit 2.3 shows that, for CT scans, the target is exceeded at CBDHA and two of the three CDHA sites. Exhibit 2.4 shows that, for MRIs, the target is exceeded at both DHAs although the waits at CDHA are considerably longer.

2.61 The wait time for CT at CDHA is disclosed for each of the three sites with CTs (Queen Elizabeth II Health Sciences Centre, Dartmouth General Hospital and Cobequid Community Health Centre). The individual facilities perform a manual calculation to weight the calculation by body part but we were unable to determine the support for the weightings used. More comprehensive reporting of wait times such as expected wait time for each major type of examination, by facility, would improve the relevance and value to the user of the information.

2.62 At CBDHA, wait times for CT are calculated for those examinations requiring contrast medium and those that do not. It is the only DHA that reports its CT wait times to DOH in this way; other DHAs sometimes report by body part. CBDHA's figures show that there is a difference in wait times between contrast and non-contrast examinations; non-contrast examinations have a significantly longer wait time but are excluded in the Department of Health's website figures. We recognized the need for consistency and an increased level of detail in our December 2006 report and reiterate recommendations 4.5 and 4.10 noted in paragraph 2.58 above.

2.63 In March 2007, the Department of Health released a plan to improve wait times in the Province. *Timely Access to Healthcare in Nova Scotia: Improving Wait Times* 2007-2010 is available on the Department's website at http://www.gov.ns.ca/health/waittimes/Wait_Time_Strategy_2007.pdf

Reporting of Examination Results

2.64 We examined the DHAs' systems for ensuring that examination results are reported on a timely and accurate basis. We concluded that monitoring of turnaround times in relation to the expected standard should be improved.

2.65 When an MRI or CT scan is complete, the image is sent to a staff radiologist for analysis. The radiologist verbally dictates a report which is transcribed, either through use of a transcriptionist or electronically using voice recognition software. The radiologist reviews the accuracy of the transcribed report and signs it before it is sent to the referring physician. Physicians with access to PACS (the

computerized Picture Archiving and Communications System) can access reports through that system or reports will be transmitted either by fax or mail. We noted that, with the exception of the mammography pre-screening program, no independent, regular peer review of reports is performed prior to release.

2.66 CDHA has set a time standard of 24 hours from the time of the examination to the time when the radiologist's final report is available. CDHA reported the average turnaround time for the 2005-06 fiscal year was 44 hours, but varies by site. CBDHA informally tracks the time from examination to report. Management indicated that excess time may be attributable to delays in the transcription process and unavailability of radiologists to sign the final report.

Recommendation 2.9

We recommend that CBDHA set standard times for reporting of diagnostic imaging examination results and monitor progress in achieving the standard. CBDHA and CDHA should take action to ensure standard turnaround times are achieved.

Staffing

2.67 We examined the DHAs' processes for ensuring staff performing CT scans and MRIs are appropriately qualified and allocation of staff is reasonable. We concluded that there are processes to ensure appropriately qualified staff.

2.68 Technologists must be licensed by the Canadian Association of Medical Radiation Technologists and the Nova Scotia Association of Medical Radiation Technologists. Specialty training is required for operation of MRIs but not CTs. MRI training is not available in the Atlantic Provinces but is available through correspondence courses and requires passing a national certification examination. Educational requirements are included in the relevant position descriptions. Although CDHA had no vacancies for full-time CT and MRI staff at the time of our audit, no casual staff were available. There have been instances where examinations have had to be cancelled due to staff shortages when a technologist is sick or otherwise unavailable.

Performance Information

2.69 We examined the DHAs' systems for monitoring performance of the Diagnostic Imaging Department. We found that various useful statistical reports are produced on a regular basis. For example, the Diagnostic Imaging Department at CDHA produces a comprehensive monthly scorecard report. However, many of the reports are prepared manually and require extensive effort to produce. Manual preparation also increases the potential for error and we found errors in some of the calculations. The preparers of this information are often clinical staff and managers whose primary responsibility is for patient care and they are spending significant time preparing administrative reports.

2.70 In some cases, the information technology systems in use would have the capacity to produce this performance information more efficiently but the system's capabilities may not generally be recognized. For example, CBDHA had been booking MRIs manually. Therefore, the Meditech system's capabilities to produce performance information such as wait times were not used. In other cases, primarily at CDHA, the systems in use do not have the ability to produce the required information and this requirement should be considered when these are replaced in the future.

Recommendation 2.10

We recommend that CDHA and CBDHA examine the computerized diagnostic imaging systems in use to determine whether they can produce additional statistical information, such as wait times and utilization indicators, which are currently manually produced. We also recommend that requirements for statistical reports be included in future information system procurements.

Quality Assurance

2.71 We examined the quality assurance processes to determine whether there are quality standards in place, whether achievement of standards is monitored, and whether the processes attempt to minimize risk to patients. We concluded that CDHA has adequate quality control processes for CT scanners but that the processes relating to MRIs could be improved in some areas. CBDHA's processes for quality control for both MRIs and CT scanners should be improved. The documentation of policies and procedures related to diagnostic imaging quality assurance at both DHAs should be improved. We believe the Department of Health should take a more active role in assuring adequate quality assurance processes are in place for diagnostic imaging equipment throughout the Province.

2.72 Health Canada has published various safety codes related to X-ray equipment, including MRI's and CT scanners, but these guidelines were published several years ago and do not reflect current equipment. For example, the guideline related to CT scanners was issued in 1994 when 1-slice CT scanners were predominant. These would now be considered outdated technology due to the rapid advancements in CT technology over the last five years and the use of multi-slice scanners. CDHA management informed us that the most authoritative guidelines respecting the operation of MRIs and CT scanners are the quality control manuals published by the American College of Radiology. There are no national standards relating to maximum acceptable levels of exposure to radiation. However, CDHA is monitoring and attempting to reduce patient radiation levels.

2.73 The major quality assurance processes at CDHA are listed below.

- A diagnostic imaging quality assurance staff is headed by a Medical Physicist. Quality assurance staff perform quality control testing (for equipment other than MRIs) and acceptance testing of new equipment.

- A quality assurance committee and reporting process are in place for most aspects of the DHA's clinical operations. The results of these processes are reported to senior management and the DHA Board and the processes are examined as part of the CCHSA accreditation process.

- CDHA has a Radiation Safety program which includes a Radiation Safety officer and committee.

- A preventive maintenance program is in place as described in paragraph 2.37 above and new equipment is tested by the vendors.

- There is an incident reporting program for all aspects of the DHA's clinical operations.

- A Diagnostic Imaging Department quality assurance committee exists but its focus is limited at this time, and the scope does not cover all sites.

- The DHA subscribes to safety alerts issued by the Emergency Care Research Institute and follows up on relevant information received.

2.74 At CBDHA, the processes are similar to CDHA with the following major exception:

- CBDHA has no quality assurance staff to perform tests on diagnostic imaging equipment. Testing for conventional diagnostic imaging equipment has been contracted to the private sector, but there is no process in place to test CT scanners and MRIs. We were told that, in the past, the Provincial government had a process in place to test radiation levels from X-ray machines but that the process was discontinued.

2.75 Our audit procedures included documentation of the roles and responsibilities of the various participants in quality assurance, discussions with staff involved, and review of relevant documentation. Although there is extensive quality assurance activity taking place in the Diagnostic Imaging Department, there is limited documentation of policies and procedures. There is also a similar lack of documented policies relating specifically to patient safety at CDHA and CBDHA. Lack of documentation of policies and procedures increases the risk that not all necessary activities will take place as required.

Recommendation 2.11

We recommend that CDHA and CBDHA document policies and procedures relating to the quality assurance processes, including patient safety, for diagnostic imaging equipment and related testing of MRIs and CT scanners.

2.76 CDHA's quality assurance staff conducts tests of CT scanners annually. We reviewed files and concluded that the equipment testing is occurring as indicated. As noted above, there is no equivalent testing at CBDHA.

2.77 The American College of Radiology (ACR) has issued guidelines on Magnetic Resonance Safety. We reviewed the guidelines and used them as the basis for our audit of MRI safety practices. CDHA complies with the guidelines in all major respects. There were some minor deviations relating to such practices as security (e.g., locking of doors). We also found that documentation supporting the completion of patient safety questionnaires was not available in 3 of the 12 cases we examined. The questionnaire is essential for ensuring patient safety. A major focus of the questionnaire is to ensure that metal is not placed in proximity to the magnet. We found that CBDHA follows the ACR safety practices with minor exceptions (e.g., not all magnet-safe equipment is marked as such which could increase the risk for unsafe equipment to be brought in to the magnet site).

Recommendation 2.12

We recommend that CDHA ensure patient safety questionnaires are completed for all MRI patients and retained in the patients' files.

2.78 CDHA quality assurance staff does not perform tests on MRIs. The only testing is performed under the preventive maintenance arrangements with the original equipment manufacturers. We were informed that a Provincial quality assurance testing program for MRIs is being developed by CDHA quality assurance staff. The ACR *MRI Scanner Quality Control Manual* will be used as the basis for the program. We encourage the Department of Health and CDHA to implement this program to mitigate patient safety risk associated with MRIs operating in all areas of the Province. We also believe that the scope of the program should be expanded to CT scanners to ensure that appropriate quality assurance processes exist at all Provincial locations.

Recommendation 2.13

We recommend that the Department of Health and the DHAs establish and implement a quality assurance program for all MRIs and CT scanners in the Province.

Private MRIs

2.79 There is a private MRI clinic located in Halifax. It provides services to individuals and third-party payors for a fee. In 2006, the clinic was purchased by two radiologists on staff at the Capital District Health Authority (Cobequid Community Health Centre). The objective of our audit was to determine whether the Department of Health has policies and practices related to the operation of this clinic, and to determine whether the purchase of the clinic complied with relevant conflict of interest guidelines.

2.80 At the time of the purchase of the clinic, the Department of Health had no policies and procedures regarding private clinics. The clinic was not regulated by the

Department of Health, and the Department did not provide any type of funding for the clinic or the MRI examinations performed there.

2.81 The Department of Health compensates radiologists in the Province on a fee-for-service basis. Although radiologists on staff at CDHA were involved in reading the MRIs performed at the private clinic, they were not compensated for that service by DOH. The images were read on-site at the private clinic and the radiologists were paid by the clinic. We concluded that there was low risk that CDHA radiologists were compensated by public funds for work done at the private clinic. However, there is a risk that the radiologist hired by the private clinic to read an exam may not be the best qualified in the specific situation which could impact the patient's diagnosis. There is also a potential for conflicting opinions if the patient later seeks services from a DHA.

2.82 The Health Facilities Licensing Act received first reading in the House of Assembly on November 23, 2006 and has not yet been passed. The proposed legislation includes the following major provisions related to improved accountability.

- Health facilities providing diagnostic and surgical procedures or other designated services would require a licence from the Minister.
- Health facilities would be required to provide annual returns including financial statements to the Minister.
- Health facilities would be required to be accredited by the relevant professional body.
- The Minister of Health would be required to approve changes in ownership of health facilities.

2.83 The proposed legislation also includes provisions which would allow private health facilities to perform insured health services if certain specified criteria are met.

2.84 We inquired about conflict of interest policies that would relate to the purchase of the MRI clinic by CDHA radiologists. The CDHA has by-laws for medical staff which refer to conflict of interest guidelines established by the College of Physicians and Surgeons. CDHA does not have its own conflict of interest guidelines for its medical staff. We believe that CDHA should have its own policies in this area to ensure that its interests, and those of patients, are protected when medical staff enter into other business arrangements. We recognize that this is a complex area due to the myriad of arrangements that individual physicians may be involved with. Conflict of interest guidelines would help to ensure that the DHA has knowledge of other arrangements and their potential impact on DHA services. We also believe that DOH needs to play a role in the development and approval of these guidelines to ensure that the interests of patients are protected.

Recommendation 2.14

We recommend that CDHA and DOH establish conflict of interest guidelines for medical staff including policies on relationships with private facilities.

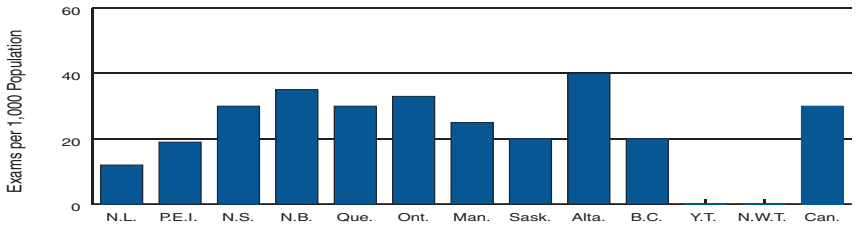
CONCLUDING REMARKS

2.85 This was our first audit of the acquisition, management and use of diagnostic imaging equipment. We found that the DHAs we audited generally had processes in place to provide for patient safety and prioritize patient access to required services. However, we made recommendations to improve management and efficiency of some aspects of these processes.

2.86 The Department of Health does not have a formal planning process for capital equipment. This increases the risk that decisions are not made with due regard for economy and efficiency and that funding may not be allocated to the highest priority needs on a Province-wide basis. The lack of funding for capital equipment for the District Health Authorities has been a recurring finding in our audits (for example, see paragraph 6.49 of December 2004 Report of the Auditor General). The Department of Health should make it a priority to ensure that required equipment is available to provide necessary services to patients.

Number of MRI Exams per 1,000 Population, by Jurisdiction and Canada, 2005-06

Exhibit 2.1



Source: National Survey of Selected Medical Imaging Equipment, Canadian Institute for Health Information, 2006.

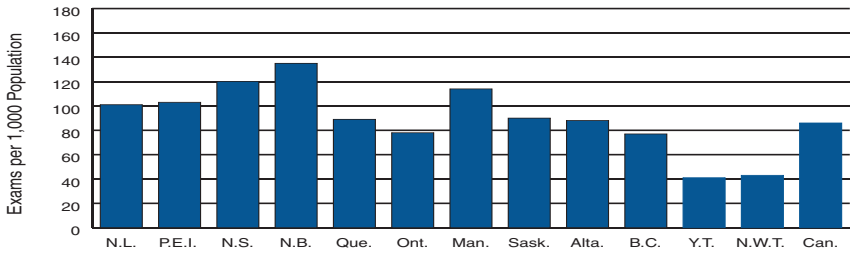
Notes:
a) Exams were not reported in Quebec for some MRI scanners in both hospitals and free-standing facilities. The number of exams for these scanners was estimated based on average exams per scanner in reporting hospitals and free-standing facilities in Quebec.

b) An exam is defined as a technical investigation using imaging technology to study one body structure, system or anatomical area that yields one or more views for diagnostic and/or therapeutic purposes (one exam can include more than on scan). Exceptions include routinely ordered investigations of multiple body structures, which by common practice or protocol are counted as one exam.

Source: *Medical Imaging Technologies in Canada, 2006 - Supply, Utilization and Sources of Operating Funds*, Canadian Institute for Health Information, 2006, page 11

Number of CT Exams per 1,000 Population, by Jurisdiction and Canada, 2004-05

Exhibit 2.2



Source: National Survey of Selected Medical Imaging Equipment, (2004-2005) Canadian Institute for Health Information, 2006; Statistics Canada.

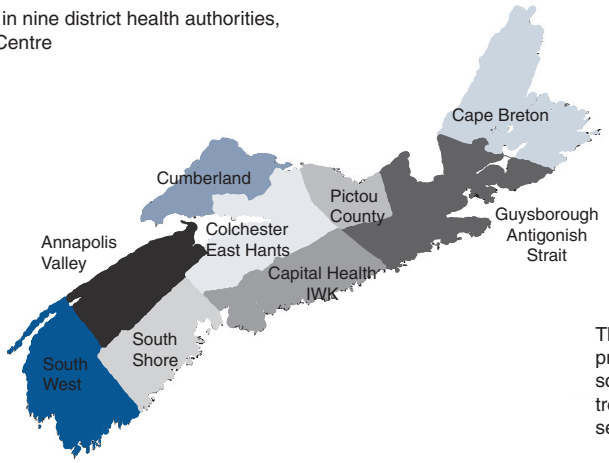
Note:
An exam is defined as a technical investigation using imaging technology to study one body structure, system or anatomical area that yields one or more views for diagnostic and/or therapeutic purposes (one exam can include more than on scan). Exceptions include routinely ordered investigations of multiple body structures, which by common practice or protocol are counted as one exam.

Source: *Medical Imaging in Canada, 2005*, Canadian Institute for Health Information, 2005, page 71

Exhibit 2.3

Wait Times Data – Diagnostic Services
CT Scan

CT Scans are provided in nine district health authorities, and at the IWK Health Centre



The wait times provided here are for scheduled tests, treatments and services only.

Expected Wait Times for CT Scans

District Health Authority	Community	Facility	Wait Times (Calendar Days)
Annapolis Valley	Kentville	Valley Regional Hospital	49
Cape Breton	Sydney	Cape Breton Regional Hospital	59
Capital Health	Halifax	Queen Elizabeth II Health Science Centre	38
	Dartmouth	Dartmouth General Hospital	36
	Lower Sackville	Cobequid Community Health Centre	6
Colchester East Hants	Truro	Colchester Regional Hospital	20
Cumberland	Amherst	Cumberland Regional Health Care Centre	26
Guysborough	Antigonish	St. Martha's Regional Hospital	34
IWK Health Centre	Halifax	IWK Health Centre	0
Pictou County	New Glasgow	Aberdeen Hospital	30
South Shore	Bridgewater	South Shore Regional Hospital	56
South West	Yarmouth	Yarmouth Regional Hospital	42

Data Source: DHA Diagnostic Imaging Departments, December 2006
Next update: End of January 2007

How do we measure wait times for a CT Scan?

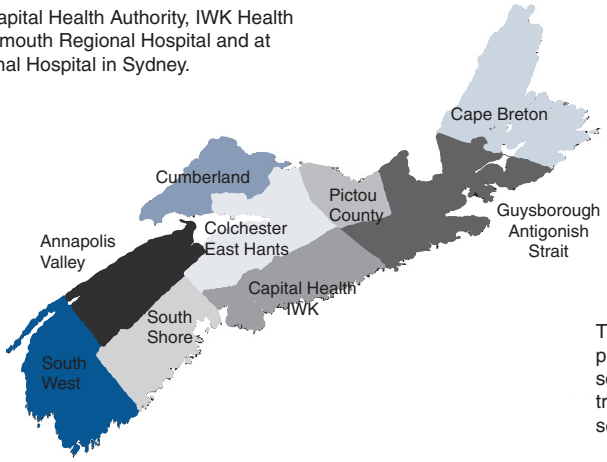
Wait times for CT Scans are measured by counting the number of calendar days from the day the request arrives in the diagnostic imaging department to the next available day with three open appointments.

Source: Department of Health website:
http://www.gov.ns.ca/health/waittimes/wt_treatment_service/diagnostic/ct_scan.htm

Wait Times Data - Diagnostic Services
Magnetic Resonance Imaging (MRI)

Exhibit 2.4

MRIs are provided at Capital Health Authority, IWK Health Centre, South West Yarmouth Regional Hospital and at the Cape Breton Regional Hospital in Sydney.



The wait times provided here are for scheduled tests, treatments and services only.

Expected Wait Times for MRIs

District Health Authority	Community	Facility	Wait Times (Calendar Days)
Cape Breton	Sydney	Cape Breton Regional Hospital	37
Capital Health	Halifax	Queen Elizabeth II Health Science Centre	119
IWK Health Centre	Halifax	IWK Health Centre	85*
South West	Yarmouth	Yarmouth Regional Hospital	55

Data Source: DHA Diagnostic Imaging Departments, December 2006
Next update: End of January 2007

* Patients under the age of 7 years requiring sedation may wait longer as special preparation is needed. Wait times may also include women requiring MRI for gynecological examinations.

Adult MRIs scheduled through Capital Health and done at the IWK Health Centre are included in Capital Health's data.

How do we measure wait times for MRI (Magnetic Resonance Imaging)?

Wait times for MRIs are measured by counting the number of calendar days from the day the request arrives in the diagnostic imaging department to the next available day with three open appointments.

Source: Department of Health Website:
http://www.gov.ns.ca/health/waittimes/wt_treatment_service/diagnostic/mri.htm

Exhibit 2.5

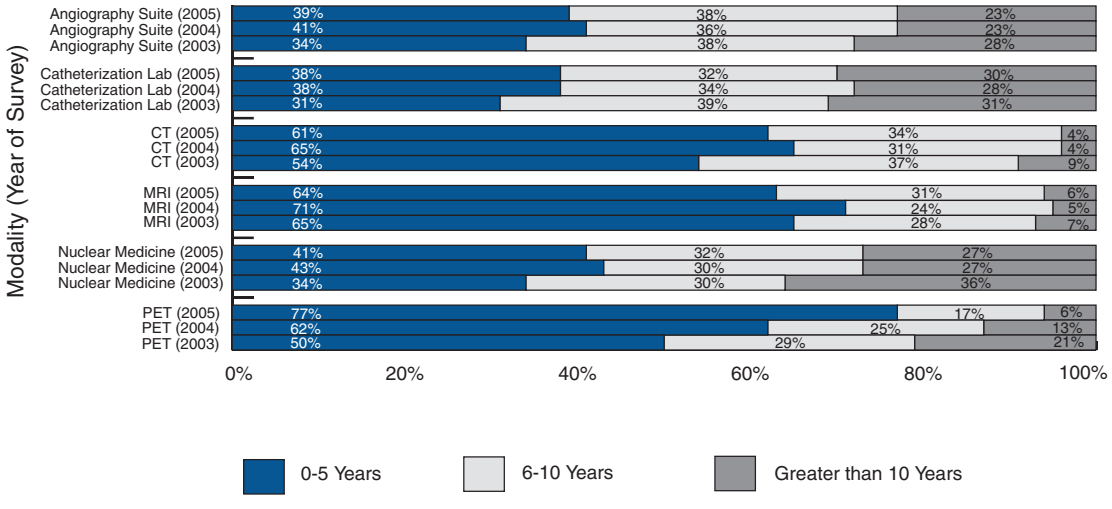
CDHA and CBDHA – Age of CT Scanners as at January 1, 2006

DHA	Site	Age (years)	Type
CDHA	Dartmouth General Hospital	1	Multi-slice
CDHA	Cobequid Community Centre	1	Multi-slice
CDHA	QEII - Halifax Infirmary	2	Multi-slice
CDHA	QEII - Halifax Infirmary	10	Single-slice
CDHA	QEII - Victoria General	4	Multi-slice
CDHA	QEII - Victoria General	12	Single-slice
CBDHA	Cape Breton Regional Hospital	7	Multi-slice
CBDHA	Cape Breton Regional Hospital	11	Single-slice

Source: National Survey of Selected Medical Equipment (2006), Canadian Institute for Health Information.

Exhibit 2.6

Age of Selected Medical Imaging Equipment in Canada



Source: Medical Imaging in Canada 2005, Canadian Institute for Health Information, Page 60.

Sources of Capital Funding - CDHA and CBDHA for the year ended March 31, 2006 ($ millions)

Exhibit 2.7

	District Health Authority			
	Capital		Cape Breton	
Funding Source				
Federal Government	$4.1	12%	$0.6	11%
Nova Scotia Department of Health	17.6	53%	3.7	68%
Hospital Foundation	8.3	25%	0.9	17%
Other	3.4	10%	0.2	4%
Total	**$33.4**	**100%**	**$5.4**	**100%**
Capital Expenditures				
Equipment	17.8	53%	3.3	61%
Building	-	-	2.1	39%
Leasehold Improvements	12.9	39%	-	0%
Information Technology	2.7	8%	-	0%
Total	**$33.4**	**100%**	**$5.4**	**100%**

Source: CDHA - March 31, 2006 audited financial statements
CBDHA - Capital Equipment Plan, September 2006 and March 31, 2006 audited financial statements

DEPARTMENT OF HEALTH'S RESPONSE

Recommendation 2.1 - The Department of Health (DoH) concurs with this recommendation. The DoH is making reasonable efforts to establish appropriate technical positions to lead, develop and evaluate/maintain a provincial planning process. Presently such planning is done within the DoH/DHA/IWK Business Planning Process. The establishment of such a process is well recognized and will be a priority of the DoH.

Recommendation 2.2 - The DoH will provide an internal and an external directive to ensure that these considerations form a part of all future RFP processes at the DoH and the DHAs. This information will be shared with present DoH Action Committees which are composed of Department & DHA staff.

Recommendation 2.4 - Although we believe that such a system already exists, the DoH will direct correspondence to the CBDHA instructing them of the need to comply. This will also be reviewed by our internal quality committee.

Recommendation 2.6 - This requirement is one of the goals and objectives of the MRI reveiw committee established as an activity to follow the last MRI diffusion.

Recommendation 2.9 - As per the response to recommendation 2.4, the necessity to comply with this recommendation will be included in our correspondence to all DHAs.

Recommendation 2.10 - Refer to above response. We will also communicate this requirement internally to the information system management group for their information and future action.

Recommendation 2.11 - Again, although we believe that such a system already exists, the DoH will direct correspondence to the CBDHA and the CDHA instructing them of the need to comply.

Recommendation 2.12 - The DoH will so direct all DHAs to comply.

Recommendation 2.13 - These activities are also being addressed within processes of the MRI review committee.

Recommendation 2.14 - The DoH will review this requirement with Department Legal Staff for advice on compliance.

Recommendation 4.4 throuth 4.11 inclusive - These recommendations will be reviewed by Department staff responsible for all wait time activities and those responsible for the production and maintenance of the DoH website.

CAPE BRETON DISTRICT HEALTH AUTHORITY'S RESPONSE

Recommendation 2.1
We recommend that DOH, in conjunction with the DHAs, develop a Provincial long-term medical equipment capital plan including criteria for assessing competing DHA needs on a Province-wide basis.

We have a departmental 5-year plan which equipment planning is a part. To date this has not been started, and the plan is to begin a 5-year equipment plan this fall - 2007.

Recommendation 2.2
We recommend the procurement processes at DOH and DHAs be improved to include:
- **identification of all needs prior to issuing the RFP;**
- **inclusion of the present value of lifecycle costs in the quantitative analysis; and**
- **documentation of the entire procurement process including a detailed comparison of bids received according to criteria in the RFP document.**

Diagnostic Imaging has consulted with Materiels Management to improve procurement process to include recommendations on future purchases. Materiels Management has agreed.

Recommendation 2.3
We recommend that CDHA and CBDHA actively monitor manufacturers' equipment up-time guarantees.

Materiels Management has purchased AIMS software which will enable CBDHA to monitor manufacturers equipment uptime guarantees. To date resources are not in place to support however a business case is being put forth.

Recommendation 2.4
We recommend that CBDHA establish a process to track and monitor required maintenance and repairs to its MRI and CT scanners.

AIMS software will enable us to do this.

Recommendation 2.5
We recommend that CDHA and CBDHA implement formal capital asset ledgers to control all medical equipment.

CBDHA is currently recording all capital assets on procurement and working toward a complete ledger system.

Recommendation 2.6
We recommend that the Department of Health, in conjunction with radiologists, establish and implement clinical practice guidelines for use of MRIs and CT scans in the Province.

CBDHA radiologists recommend that this be carried out with the Nova Scotia Association of Radiologists.

Recommendation 2.7
We recommend that CDHA implement centralized booking for all of the CDHA's CT scanners.

Referenced CDHA only.

Recommendation 2.8
We recommend that CDHA and CBDHA establish utilization standards for each MRI and CT scanner and monitor performance in achieving the standard.

There is presently a provincial committee being established to look at MRI protocols.

Recommendation 2.9
We recommend that CBDHA set standard times for reporting of diagnostic imaging examination results and monitor progress in achieving the standard. CBDHA and CDHA should take action to ensure standard turnaround times are achieved.

As of May 2005 we have set a standard for turnaround time of reports at 24 hours. We have begun to monitor this monthly to assess and subsequently take action.

Recommendation 2.10
We recommend that CDHA and CBDHA examine the computerized diagnostic imaging systems in use to determine whether they can produce additional statistical information, such as wait times and utilization indicators, which are currently manually produced. We also recommend that requirements for statistical reports be included in future information system procurements.

CBDHA will do.

Recommendation 2.11
We recommend that CDHA and CBDHA document policies and procedures relating to the quality assurance processes, including patient safety, for diagnostic imaging equipment and related testing of MRIs and CT scanners.

Provincially there is a QA process/program being established for MRI. CBDHA Diagnostic Imaging also put forth a business case for a Quality Assurance Technologist.

Recommendation 2.12
We recommend that CDHA ensure patient safety questionnaires are completed for all MRI patients and retained in the patient's files.

Referenced CDHA only.

Recommendation 2.13
We recommend that the Department of Health and the DHAs establish and implement a quality assurance program for all MRIs and CT scanners in the Province.

Provincially there is a QA process/program being set up for MRI.

Recommendation 2.14
We recommend that CDHA and DOH establish conflict of interest guidelines for medical staff including policies on relationships with private facilities.

Referenced CDHA & DOH only.

3 EMERGENCY HEALTH SERVICES

BACKGROUND

3.1 The Emergency Health Services Act was proclaimed effective September 30, 2005. It gives the Minister of Health responsibility for the provision of emergency health services in the Province.

3.2 Emergency Health Services Nova Scotia (EHS) is a division of the Department of Health (DOH). EHS' mission indicates that it "*assures best practices in prehospital emergency services and emergency preparedness to the communities* [it serves] *through regulation, prevention, education and research.*" EHS fulfills its mission by:

- "*setting the system's strategic direction through planning, policy development and standard setting*
- *funding*
- *monitoring, evaluating and reporting on performance and outcomes*
- *ensuring the provision of quality care*" (EHS website: http://www.gov.ns.ca/health/ehs/Homepage/strategy.htm)

3.3 EHS is responsible for a number of programs including ground ambulance services, Lifeflight (air ambulance), the Nova Scotia Trauma Program, the Atlantic Health Training and Simulation Center, and the EHS Medical First Response Program.

3.4 The 2006-07 Estimates for the Department of Health include $75.1 million for Emergency Health Services. This is comprised of gross costs of $86.5 million less fees and recoveries of $11.4 million. $65.7 million of the net costs (88%) are related to the operation of the ground ambulance system including communications and dispatch.

3.5 EHS is not a direct service provider of emergency health services. The Act gives the Minister the authority to contract with service providers. The day-to-day operation of emergency health services programs is contracted to various service providers. Operation of the ground ambulance system including communications and dispatch is contracted to EMC Emergency Medical Care Inc. (EMC). Exhibit 3.2 provides details of the respective responsibilities of EHS and EMC with respect to the provision of ambulance services.

3.6 The ambulances are leased by the Province from another contractor and provided to EMC for use in the program. EMC is responsible for maintenance of the vehicles according to standards.

3.7 EMC is a wholly-owned subsidiary of Medavie Blue Cross which has been administering the Medical Services Insurance (MSI) program for the Province since April 1968. EMC is the first Canadian ambulance service to be accredited by the

international Commission on Accreditation of Ambulance Services. It employs more than 900 professional paramedics and support staff and responds to all ground ambulance emergency calls across the Province.

3.8 The Province's agreement with EMC became effective April 1, 1999 and originally covered an eight-year period to March 31, 2007. On December 31, 2002 the agreement term was extended to March 31, 2009 as provided for by the agreement. The Province awarded the initial contract to EMC on a sole-sourced basis. The Province received an "expression of interest" dated April 1997 which was approved by Executive Council.

3.9 The contract between the Province and EMC is *performance-based*. It includes performance targets such as response times and qualifications for paramedics which must be met, and penalties for failure to meet these targets. Contract payments to EMC are made in accordance with a base budget that is fixed for the term of the contract based on defined service levels. However, the contract permits adjustments for price increases in certain costs including wages, fuel and facility rentals and for service volume increases above threshold levels specified in the contract. The contract also includes incentives in certain areas such as achievement of cost savings. For example, 60% of cost savings remain with EMC and 40% are returned to the Province. The initial base budget was $29.75 million in 1999. The contract does not include specific provisions regulating how EMC can spend the funds it receives from the Province. The contract emphasizes performance and holds EMC accountable for achieving specified results in the area of service delivery. For 2006-07, payments to EMC totaled $82.1 million (2005-06 - $81.9 million).

3.10 EMC provides annual audited financial statements to the Department of Health. The auditors provided an unqualified opinion on EMC's March 31, 2006 financial statements. The financial statements show that EMC received 99% of its total revenue for that year from the Province and is economically dependent on the Province. Although Medavie Blue Cross is a not-for-profit corporation which is not subject to corporate income tax provisions, EMC is a taxable entity.

3.11 In 2001, EHS engaged a consultant to complete a performance evaluation of emergency health services in N.S. The consultant concluded as follows:

> *"The Nova Scotia EHS system has made dramatic improvements over the last few years. As performance continues to improve, both EHS and EMC can work on some of the remaining issues to insure that the citizens of Nova Scotia can receive the highest level of emergency health services possible within the resources available. A pertinent question to be asked is: Are the taxpayers of Nova Scotia receiving good value for the money spent on its emergency health services? The answer is an unequivocal-yes."* (*Performance Evaluation of Nova Scotia Emergency Health Services*, Fitch & Associates, LLC, November 2001, page 5. Full report is available at http://www.gov.ns.ca/health/downloads/Nova_Scotia_Final_Report.pdf)

3.12 We performed our audit of certain aspects of the ground ambulance program in early 2007. We last audited emergency health services in 2000 and the results of that audit were reported in Chapter 8 of the 2000 Report of the Auditor General.

RESULTS IN BRIEF

3.13 The following are the principal observations from our audit.

- The ground ambulance contract gives DOH the right to audit EMC's financial records. DOH has not exercised these rights since 2000. DOH receives performance information from EMC. However, we recommend that DOH exercise its audit rights under the contract to enhance its monitoring of EMC's performance and expenditure of public funds.

- The contract between the Province and EMC does not provide audit rights for the Auditor General. We believe that any significant service delivery contracts should include audit access for the Auditor General to ensure the House of Assembly receives assurance that public funds are appropriately controlled and expended with due regard for economy and efficiency.

- Most of the financial risk related to the provision of ambulance services remains with the government although an outside company has been contracted to provide the service. We recommend that the issue of risk transfer be reexamined when future contracts are awarded to ensure that contracts are cost-effective.

- EHS should improve its monitoring practices related to user fees collected by EMC. In addition, EHS does not account for user fee revenues and receivables in accordance with generally accepted accounting principles.

- Optimal deployment of ambulances to communities in the Province is essential for achievement of value for money. In 2001, a report by an emergency services consulting firm identified certain communities where unit hours could possibly be reduced without impacting contractual response times. We recommend that government follow up on the recommendations of this report prior to the next ground ambulance contract to ensure ambulance deployment optimizes service levels and costs.

- We examined issues with respect to significant delays in ambulance turnaround times at certain emergency departments and concluded there is risk of a negative impact on response times although EMC has processes in place to mitigate the risk. We note a working group comprised of representatives of EMC, EHS and Capital Health has been formed to review the issue of ambulance delays in emergency departments and encourage the group to proceed with its work to resolve this issue.

- We reviewed EMC's policies governing certain administrative expenses to determine whether they reflect adequate control and due regard for economy

and efficiency. We concluded that policies exist and that they are generally complied with but we recommend improvements in some aspects.

- We found that EMC had paid bonuses to six senior managers which, although included in the company's financial statements, were not appropriately classified as salaries. EHS had not identified the amount of the bonuses or the fact that the bonuses had been partially funded by DOH as operating expenses of the company. We acknowledge that EMC is not a government organization and that the agreement does not govern the level or type of compensation payments which EMC can make. The payments do not violate the company's agreement with the Province.

AUDIT SCOPE

3.14 The objectives of our audit of EHS were to assess adequacy of EHS' processes to:

- ensure the ground ambulance service provider complies with contract terms and achieves due regard for economy and efficiency;

- establish user fees for ambulance trips and ensure collection of all user fees to which the Province is entitled; and

- ensure timely completion of maintenance on leased ambulances and minimize penalties at lease end.

3.15 In addition, we also performed audit work on-site at EMC. This was our first audit of financial aspects of EMC's operations although we had audited certain non-financial areas in 2000. We met with EMC management and requested the right to audit certain aspects of the company's operations. The contract between EMC and the Province does not specifically address the right of the Office of the Auditor General to audit EMC's operations. The Auditor General Act also does not clearly address this specific situation where the Province procures services from contractors. However, we believe that the Office of the Auditor General should have audit rights in this case because EMC receives virtually all of its revenue from the Province and operates a significant government program. EMC management agreed to our request to perform the audit.

3.16 The objectives of our audit work at EMC were to:

- analyze certain aspects of EMC's financial transactions for 2005-06 and test selected transactions for compliance with EMC's policies;

- review and assess the impact of EMC's plans for expansion to other provinces on the delivery of emergency health services in Nova Scotia;

- review and assess the processes for deployment of ambulances to determine compliance with policies and contracts and due regard for economy and efficiency; and

- examine issues associated with reported delays in discharging ambulance patients at certain hospitals.

3.17 Our audit criteria were taken from sources including the agreement between the Province and EMC relating to ground ambulance services, and standards of the Canadian Council on Health Services Accreditation. We discussed our audit plan and criteria with management of the Department of Health and EMC. Our audit approach included interviews with staff of EHS and EMC, and detailed examination of contracts, files, reports and other documentation. During the course of our audit, EMC provided statistical information on ambulance deployment and response times. We did not audit the underlying data used to create this informaton. We selected certain accounts from EMC's general ledger and were provided information with respect to the transaction detail. We then selected certain transactions for detailed testing. In addition, we reviewed the working paper files of the public accounting firm which performs the financial statement audit of EMC.

PRINCIPAL FINDINGS

3.18 Our findings are reported below under two major headings. First we report our audit findings relating to EHS' responsibilities and then the findings from our audit work at EMC.

EMERGENCY HEALTH SERVICES

Monitoring Performance under the Ground Ambulance Contract

3.19 Summary of observations - Our objectives were to assess adequacy of EHS's processes to ensure the ground ambulance service provider complies with contract terms; and achieves due regard for economy and efficiency. We concluded that while EHS has processes for monitoring key performance aspects of the contract, financial monitoring could be improved. We recommended that EHS exercise its audit rights under the contract. We also recommended that future contracts provide audit access rights for the Office of the Auditor General and improve financial information provided to EHS by the contractor. While certain operational and financial risks were transferred to the contractor, we noted that the majority of financial risks were retained by the Province. We recommended that the issue of risk transfer be reviewed when developing future contracts to ensure that contracts are cost-effective.

3.20 Non-financial performance - The ground ambulance contract includes provisions that specify response times for various types of calls based on call location - urban versus rural - and urgency of situation. EMC report detailed response times to EHS on a daily basis. The information for the response time reports comes from EMC systems. We were informed that the system automatically stamps the time when a call comes in and dispatchers enter information as the ambulance is dispatched and arrives at the call location. At this time, EHS does not verify the accuracy of

the data used by EMC to create monthly response time reports. However, EHS management informed us they are considering purchasing a software program called First Watch. This program allows live monitoring and analysis of data. EHS indicated this will allow them to better monitor system performance in real-time and minimize their reliance on other parties for information.

3.21 Response time reports are received shortly after month end and EHS management are satisfied with the timeliness of the reports. We reviewed a sample response time report, but did not audit the underlying data. We concluded that the report provided good information to monitor EMC's compliance with performance aspects of the contract. We also noted evidence of regular review of these reports by EHS, including discussions by a contract management committee comprised of senior EHS staff. Based on the information included in the reports and evidence of regular monitoring, we concluded there is good accountability for performance aspects of the ground ambulance contract.

3.22 Financial performance - Monitoring of financial results is another aspect of accountability. We were interested in determining whether contract administration and monitoring were adequate to ensure due regard for economy and efficiency. To complete our work in this regard we assessed EHS' review of financial information provided by EMC and recommended EHS include requirements for accountability information, including detailed financial reporting, in future contracts.

3.23 The ground ambulance contract provided for regular performance reporting but did not provide for regular reporting of financial information. EHS does not receive such detailed information from EMC on a regular basis. EHS staff informed us that they periodically request and are provided forecast information from EMC. However the contract did not provide for the provision of forecast information.

3.24 EHS monitor financial costs of the ground ambulance contract through monthly review of year-to-date contract costs. Although this level of monitoring provides information regarding whether payments will be within the established budget, it does not provide an indication of whether EMC's expenditures were made with due regard for economy and efficiency.

3.25 Section 9.10 of the contract states *"EHS may require annual audited financial statements by chartered accountants of the Contractor's operations."* EHS management and staff informed us that the audited statements are reviewed with EMC's chief financial officer. If EHS has questions regarding certain line items on the statements, they will ask EMC for explanations and support if necessary.

Recommendation 3.1

We recommend requirements for accountability information, including requirements for submission of detailed financial information at specified intervals, be included in contracts to ensure information required for appropriate monitoring is received on a regular basis.

3.26 Audit access to EMC - Although the contract is performance-based as discussed in paragraph 3.9, it includes a provision that any cost efficiencies implemented by EMC will be shared; 60% of the savings remain with EMC and 40% are returned to EHS. Once EMC's budget for a fiscal year is approved by EHS, any excess of budget over actual expenditures is considered to be cost savings. The amount payable to EHS under the cost savings provision is a separate line item on EMC's audited financial statements. However, EHS does not have any assurance that expenditures were made with due regard for economy and efficiency.

3.27 The ground ambulance contract provides DOH with audit rights "*…Contractor shall make available to EHS for its examination any and all business records including financial records…EHS may audit and inspect any and all Contractor's records and documents as may be necessary for EHS to fulfill its oversight role.*" (Section 9.10, ground ambulance contract) Since 2000, DOH has not audited EMC. We note that EHS could use this provision to gain assurance that EMC expends funds with due regard for economy and efficiency.

Recommendation 3.2

We recommend that DOH exercise its right to audit financial records under the ground ambulance contract to monitor EMC's performance and gain assurance that EMC's expenditures were incurred with due regard for economy and efficiency.

3.28 Audit access by Auditor General - The contract with EMC does not provide any audit rights for the Office of the Auditor General. As described in paragraph 3.7, EMC is a subsidiary of Medavie Blue Cross. We note that Medavie's most recent contract with the Province of Nova Scotia provides full audit rights for this Office. We believe that any significant service delivery contracts with non-government operators should include audit access for the Office of the Auditor General to ensure there is a mechanism in place to provide assurance to the House of Assembly that public funds are controlled and expended with due regard for economy and efficiency. We acknowledge that EMC voluntarily provided access to the Office of the Auditor General in this case, but there is no contractual or legal requirement for the company to do this.

Recommendation 3.3

We recommend that any new contracts negotiated for provision of ground ambulance services or any other significant contracts between government and service providers include provision for audits by the Office of the Auditor General.

3.29 Risk sharing between government and contractor - EHS contracts with EMC for provision of ground ambulance services. See Exhibit 3.6 for a summary of key contract provisions. In exchange for providing services, EMC receives an annual management fee. If EMC is able to deliver ambulance services for less than the

budgeted costs, these cost savings are shared between EMC and EHS on a 60%/40% basis. In each year of the contract, if the management fee plus EMC's share of the cost savings does not exceed a specified minimum amount, EMC is guaranteed to receive that minimum. EMC has always made a profit on this contract due to the management fee and cost savings.

3.30 The ground ambulance contract is not a level-of-effort contract. EMC is required to provide services within specified response times for various areas and types of calls. The company is paid a lump sum to cover the cost of providing those services. If services cost less than the budgeted amount, the contract does not provide for reductions to budget in subsequent years. However, cost savings are shared between EMC and EHS.

3.31 We reviewed various sections of the ground ambulance contract that deal with risk. Risks transferred to EMC include responsibility for equipment damaged by negligent use and paying license fees for ambulances. Among the risks retained by EHS are various cost increases such as increases in the consumer price index, fuel, and wages. The original ground ambulance contract had a budget of $29.7 million; with a communications centre addendum signed shortly after at a cost of $1.7 million. By fiscal 2006-07, the total budget for the contract was $73.2 million, an increase of 238%. Of the $43.5 million increase, $33.0 (76%) is due to labour cost increases and $3.1 million (7%) relates to adding new territories (providing services to areas previously not covered by EMC). The remaining $7.3 million increase relates to various areas which are contractual in nature (e.g., fuel increases). The current contract has resulted in large cost increases for DOH because most of the program's financial risk remains with the Province, while EMC records a profit on the contract as a result of earning the management fee specified in the contract and sharing in cost savings when actual expenditures are less than the budget. DOH should reexamine the issue of risk sharing in future contracts to ensure cost-effectiveness.

Recommendation 3.4

We recommend that EHS review risk sharing when negotiating contracts to ensure there is an appropriate balance between risks transferred to the contractor, risks retained by the Province and cost of the contract.

User Fees

3.32 Summary of observations - We assessed whether there is clear responsibility and accountability for assessment and collection of ambulance user fees, and whether the fee structure is clearly defined, appropriately approved and well documented. We also assessed whether EHS has a system in place to ensure the completeness of user fee revenues collected and submitted by the contractor. We concluded that improvements could be made to EHS' monitoring processes and recommended that EHS verify the completeness and accuracy of user fee revenue submitted

by EMC. User fee revenues and receivables are not accounted for by EHS in accordance with generally accepted accounting principles and we recommended that EHS modify its accounting practices for these revenues.

3.33 User fee rate structure - Ambulance Fee Regulations made under Section 17A of the Health Services and Insurance Act enable EHS to collect ambulance user fees based on rates approved by Executive Council. The rate structure dates back to before 1998. At that time, it was determined that 20% of average operating costs relate to transportation while 80% represents essential medical services which are covered under the Canada Health Act. Fees were set based on this allocation. However, we noted there was no documentation on file to substantiate the split between transportation and medical costs. The basic fee for ambulance transports in 2006-07 was $120 for residents of Nova Scotia, with higher rates for work-related and motor vehicle accidents and non-residents. A summary of rate history is shown in Exhibit 3.3. Based on 2005-06 financial data, the current ambulance rate for residents of Nova Scotia represents 14.3% of ambulance costs.

3.34 Billing and collection of user fees - In accordance with the ground ambulance contract, EMC is responsible for all aspects of billing and collection of ambulance fees. EHS is responsible for establishing ambulance fee regulations and policies as well as monitoring EMC's collection efforts under the contract. Our audit indicated that EHS has not reviewed the billing and collections system used by EMC or attempted to verify EMC's user fee reports.

3.35 EMC uses patient care reports completed by on-duty paramedics as supporting documents for ambulance fee billing. During our review of the ambulance fee billing process, we noted appropriate reconciliations were not completed. We were informed by EMC management that they are considering implementation of a monthly reconciliation process to ensure accuracy of billings.

Recommendation 3.5

We recommend that EHS verify the completeness and accuracy of user fee revenues submitted by EMC.

3.36 The ground ambulance contract requires EMC to meet a minimum collection target of 75% of amounts billed. Collections in excess of this amount are shared equally between EMC and EHS to provide EMC with an incentive for collection. EMC has consistently exceeded the collection target established in the contract and has collected more than 80% of user fees since 2002-03 as shown in Exhibit 3.4. In 2005-06, EMC billed $9.8 million in user fees and collected $8.2 million (84%); of which $0.8 million was shared equally between EMC and EHS.

3.37 There are no write-off policies for ambulance user fees and no amounts have been written off. Standard practice in most organizations is to review accounts receivable each year to determine whether any amounts are deemed uncollectible,

and to write off uncollectible amounts. EHS and EMC are unclear as to who is responsible for developing such policies and reviewing outstanding accounts receivable. As of March 31, 2006, there were $13.3 million in outstanding ambulance user fees. Of this total, 44% or $5.9 million, were more than five years old.

Recommendation 3.6

We recommend that EHS establish write-off policies for ambulance user fee accounts receivable and review receivables annually to identify and write off uncollectible amounts.

3.38 Accounting for user fees - EMC has been contracted to collect ambulance user fees on EHS' behalf. The related user fee accounts receivable are not included on EMC's audited financial statements because EMC does not have ownership of the receivables. EHS accounts for ambulance fee receivables based on the net amounts submitted by EMC. As a result, outstanding ambulance fee receivables for amounts yet to be collected are not recorded on the books of the Province and are not included in the Province's consolidated financial statements in accordance with generally accepted accounting principles (GAAP). The impact of including these receivables on the government's financial statements would not be material since a significant portion of the user fees would likely be uncollectible. However, we note that recording user fee receivables and related revenues would provide EHS with better financial information and improve control over receivables.

Recommendation 3.7

We recommend that EHS record ambulance user fee revenues and receivables to provide better control over uncollected amounts and ensure compliance with generally accepted accounting principles.

Fleet Maintenance

3.39 In the 2000 Report of the Auditor General, we reported that minor and major preventative maintenance was not always performed on leased ambulances resulting in lost return rebates of $562,000 because of disputes over the condition of ambulances returned at lease end. In 2000, we also recommended that EHS establish more rigorous monitoring of EMC compliance with maintenance standards. In our current audit, we assessed whether Emergency Health Services had dealt with this issue by establishing an adequate system to ensure maintenance is completed on leased ambulances on a timely basis and whether the maintenance program had successfully eliminated financial penalties at lease end.

3.40 EMC is required to maintain the leased ambulances in sufficient condition to pass Provincial motor vehicle inspection requirements as well as more stringent

inspection requirements set forth in the EHS Fleet Inspection Manual. The Fleet Inspector performs random and annual inspections on the ambulance fleet and reports his findings to EHS and EMC. We examined fifteen inspection reports prepared by the Fleet Inspector and noted only minor deficiencies found during inspections. We also examined documentation for ten lease returns and determined that penalties have not been incurred since our 2000 Report. Accordingly, we concluded that adequate maintenance is completed on leased ambulances on a timely basis, therefore eliminating penalties at lease end.

EMERGENCY MEDICAL CARE INC. (EMC)

Ambulance Deployment

3.41 Summary of observations - Our objectives were to assess whether EHS has procedures in place to ensure that EMC's ambulance deployment system is in accordance with the terms of the contract, and considers due regard for economy and efficiency. We concluded that EHS is aware of the deployment plan used by EMC and a reporting system is in place to ensure EMC is in compliance with the terms of agreement. We recommended that EHS and EMC review available ambulance resources and deployment to communities prior to the next ground ambulance contract.

3.42 We also examined issues with respect to ambulance turnaround times at certain emergency departments and whether EMC has processes to minimize the risk associated with ambulance redeployment and emergency department delays. We noted a working group has been formed to review the issue of ambulance delays in emergency departments. We encourage the group to continue its work to resolve the delays on a timely basis.

3.43 System status plan - EMC uses a centralized dispatch and communication system for receiving and processing emergency and non-emergency requests for ambulance services throughout Nova Scotia. EMC employs a System Status Plan (SSP) that posts ambulances at strategic locations to provide coverage to multiple communities, while ensuring clinical standards and required response times are met. The location of ambulance posts and fleet centres is shown in Exhibit 3.1.

3.44 Achievement of performance standards - EMC is responsible for developing deployment methods to meet ground ambulance performance standards detailed in the Community Categorization and Response Times agreements which are supplementary to the ground ambulance contract. We noted that EHS receives information on ambulance deployment. EHS also receives information from EMC that indicates EMC is meeting the required performance standards.

3.45 We examined statistical data prepared by EMC which indicated that contractual standards for response times have been met in all community categories. The contract provides an incentive for EMC to achieve a high level of efficiency since EMC retains 60% of cost savings. See paragraph 3.26 for further discussion of cost savings.

3.46 Follow up of consultant's report on ambulance deployment - Optimal deployment of ambulances to communities around the Province is essential for achievement of due regard for economy and efficiency. There is a risk that certain communities which presently have ambulances may not meet deployment criteria due to low call volume or available ambulance resources in the adjacent communities. Fitch & Associates, LLC, an emergency services consulting firm, was commissioned to assess the ground ambulance program in 2001. The Fitch Report identified several communities where unit hours could be reduced while still achieving contractual response times. A unit hour represents one ambulance staffed with two paramedics. We compared data provided by EMC for 2001 and 2006 and noted call volumes remained fairly constant over this time period.

3.47 EMC informed us there have been changes in the delivery of health services in the Province since the 2001 Fitch Report which must be considered.

- The scope of pre-hospital care has evolved. Paramedics are now performing treatments that were performed by nurses or emergency physicians. EMC staff indicated this is often due to the lack of on-duty emergency physicians or health care services in rural communities.

- Ambulance redeployment to Halifax draws from some of the communities identified in the Fitch Report when there are significant delays in Halifax emergency departments.

- Response times for communities in categories three, four and five had not been finalized at the time of the 2001 Report. Target response times have since been developed and these could possibly impact on the communities identified in the Fitch Report.

3.48 We note that the frequency of redeployment among communities might be reduced if emergency department delays, discussed in paragraph 3.50 below, are resolved.

3.49 EHS management indicated the extent to which the Fitch recommendations will be implemented is beyond the control of EHS and depends on government policy decisions about ambulance deployment in rural communities.

Recommendation 3.8

We recommend government follow up the Fitch Report and review deployment of all ground ambulance resources prior to the next ground ambulance contract to ensure optimal deployment of ambulances and due regard for economy and efficiency.

3.50 Delays at emergency departments - Ambulance turnaround time is the time required for paramedics to discharge a patient at an emergency department. EMC has a Provincial target turnaround time of 20 minutes or less, 90% of the time.

Management reports indicate this target is met by most hospitals in Nova Scotia. However these reports identify three hospitals where the target is not met. Cape Breton Regional Hospital meets the target approximately 88% of the time. Reports indicate turnaround times at the Halifax Infirmary (HI) and Dartmouth General Hospital (DGH) are often considerably longer than the target. Average turnaround has exceeded 160 minutes at the HI and 100 minutes at the DGH. Based on the data provided by EMC, these hospitals were meeting the 20 minute target 85% of the time in 2004. This has decreased to less than 10% in 2006. The amount of time lost by paramedics due to delays at hospitals has increased 254% since 2004.

3.51 EMC redeploys ambulances from adjacent communities to Halifax to cover ambulances delayed in emergency departments. This approach creates a ripple effect by redeploying ambulances from rural communities which could result in certain communities having no local ambulance coverage. During those times, the communities would be covered by ambulances in adjacent communities. This redeployment can also result in increased overtime and other operating costs.

3.52 We reviewed an example of the impact of redeployment of ambulances due to emergency department delays based on information provided by EMC. In this instance, we noted that ambulance redeployment due to delays in Halifax emergency departments affected communities as far as Bridgewater, Oxford, and Yarmouth. We concluded that EHS is subject to an increased risk of not being able to respond effectively to emergency situations due to unavailability of ambulances during these time periods.

3.53 The Department of Health (DOH) established a Turnaround Time Working Group in 2004 comprised of members from DOH, Capital Health (CDHA), EHS, and EMC. The final report from this group was tabled on March 8, 2007. Two decisions were made:

- EHS will deploy three additional ambulances to the metro region for a trial period of three months; and

- CDHA will assemble a working group to address emergency overcrowding issues.

3.54 We understand that CDHA has established a working group to oversee the expansion of the emergency department at the HI site. The committee includes representatives from EMC and EHS.

Recommendation 3.9

We encourage EHS, EMC and Capital Health to continue to work together to resolve ambulance turnaround delays on a timely basis.

Due Regard for Economy and Efficiency

3.55 Summary of observations - Because EMC expends public money, we reviewed certain of the company's policies to determine whether they adequately consider due regard for economy and efficiency. We assessed EMC's compliance with its internal policies for a sample of meals, travel, and executive expense transactions. We concluded that there is general compliance with internal expense policies, however, we made recommendations to strengthen certain policies. We also found that EMC had paid bonuses to six senior managers which, although included in the company's financial statements, were not appropriately classified as salaries. EHS did not have sufficient information to allow it to identify the amount of the bonuses or the fact that the bonuses had been partially funded by DOH as operating expenses of the company. We acknowledge that the agreement does not govern the level or type of compensation payments which EMC can make and that the payments do not violate the agreement.

3.56 EMC's administrative policies - EMC has formal policies for meals, travel and purchases made using corporate procurement cards. These policies provide guidelines for expenses incurred by employees on behalf of EMC. We found the following areas where the policies require clarification in order to better achieve due regard for economy and efficiency.

- EMC's current policy requires all meal claims be reasonable and supported by receipts but does not set per diems or a dollar guideline. This leaves the policy open to interpretation. Controls over meal expenses could be enhanced by setting reasonable per diem rates as a guideline.

- The policy states that alcohol will not normally be reimbursed but does not detail the circumstances under which alcohol may be eligible for reimbursement. The policy should include specific instances where alcohol may be reimbursed.

- We noted from discussions with EMC management that detailed invoices are no longer required for meal amounts less than $50 purchased using corporate procurement cards. While EMC still requires the credit card receipt to support these purchases, detailed receipts should be required to ensure all amounts claimed fall within EMC's policies and are appropriate.

3.57 Compliance with EMC's policies - Our audit of compliance with policies included examination of 34 management and employee expense claims for meals and travel. We identified one or more instances of non-compliance in four of the expense claims related to management expense transactions.

3.58 We noted the following deficiencies with management expense claims.

- One expense claim had three instances of meals expensed with inadequate descriptions on the receipt. Examples of missing information include names of the attendees or purpose of the meals.

- Three expense claims had six instances of meals reimbursed without detailed receipts.
- Two expense claims had three instances of expenses reimbursed without receipts.
- When reviewing CEOs' expense claims, we noted there is no requirement for those expenses to be reviewed or approved prior to reimbursement.

Recommendation 3.10

We recommend that EMC clarify and strengthen meal and travel policies by:

- **requiring submission of original supporting invoices rather than signed credit card vouchers;**
- **providing more detail regarding acceptable dollar guidelines for meals and specifying circumstances under which alcohol is claimable;**
- **requiring the people for whom meals are claimed to be identified;**
- **requiring documentation of the purpose of meetings or events for which meals are claimed; and**
- **requiring review and approval of the CEO's travel expenses by the Chair of the Board.**

3.59 Retention bonuses - When reviewing EMC's accounting records, we noted entries had been made to accrue and pay retention bonuses to six senior managers. In 2005, EMC's CEO retired and a new CEO was appointed. The company wished to ensure the senior managers remained with EMC over a 20-month period surrounding the change in CEO. The bonus amounts were 30% of the annual salaries of the individuals involved. All bonuses were approved by the CEO of Medavie Blue Cross and the former CEO of EMC. Although the bonuses are not something typically seen in the public sector environment, there is nothing in the contract that specifically prohibits this type of expenditure. The bonuses were paid to eligible individuals in January 2007.

3.60 When we reviewed the documentation surrounding the bonuses we noted that the expenditures, although included in the company's financial statements, were not appropriately classified as salaries. The amounts had not been charged to salary accounts and were not included in the payroll registers but the statutory payroll deductions were remitted. Rather the bonuses were included in the "*other operating expenses*" line on the financial statements which meant that the increase in management salaries was not obvious to readers of the audited financial statements. DOH management were aware that bonuses had been paid but did not know the amount of the bonuses or the fact that the bonuses had been partially funded by DOH as operating expenses of EMC. Given the impact of the cost savings calculation, DOH effectively paid 40% of the total bonuses. We acknowledge that the agreement does not govern the level or type of compensation payments which EMC can make and that the payments do not violate the agreement. However, such

bonuses are not paid in the Nova Scotia public sector and our concern is that EHS did not have sufficient information to allow it to identify the bonuses as an issue that potentially could have a negative impact on achievement of due regard for economy and efficiency in the delivery of ground ambulance services.

3.61 EMC management has indicated that this practice may be common in the private sector and EMC felt that ensuring the continuity of senior management through this transition period would benefit the EHS system. EMC has subsequently offered to repay the Province's 40% share in recognition of the fact that the accounting treatment of these payments was not explicitly discussed with EHS prior to charging it in the company's records.

EMC Expansion

3.62 We were informed by the Department of Health that EMC and/or its sister companies had recently been selected by the governments of Prince Edward Island and New Brunswick to provide ground ambulance services in those provinces. Our objectives were to assess the impact of EMC's plans for expansion into other provinces on the delivery of emergency health services in Nova Scotia, utilization of Province of Nova Scotia assets and due regard for economy and efficiency. EMC informed us that the company is not directly providing services to other provinces but that sister companies were formed for this purpose. Assets owned by the Nova Scotia government are not being used in the other provinces. Accordingly, we concluded that Nova Scotia assets are protected and that expansion has not resulted in a negative impact on due regard for economy and efficiency.

3.63 Two subsidiaries of Medavie (sister companies to EMC) were created to provide ambulance services in New Brunswick and Prince Edward Island. (See Exhibit 3.5.) Certain members of EMC's executive team provide management services to the sister companies. We were informed by EMC that the other companies will be compensating EMC and, therefore, EHS for time spent working with the sister companies in 2006-07. For 2007-08, EMC has reduced its budget request to EHS by an amount to compensate for anticipated time required for sister companies. We have not audited the accuracy of EMC's estimates of time spent on sister company activities.

CONCLUDING REMARKS

3.64 Government contracts the delivery of many significant services to non-government contractors who are paid from public funds. In all cases where government contracts services, we believe that the establishment of appropriate accountability is essential to ensure control of public monies and due regard for economy and efficiency.

3.65 EHS has adequate processes to ensure EMC complies with the performance standards established in the ground ambulance contract. Accountability could be improved if DOH opted to exercise its audit rights under the contract on a regular

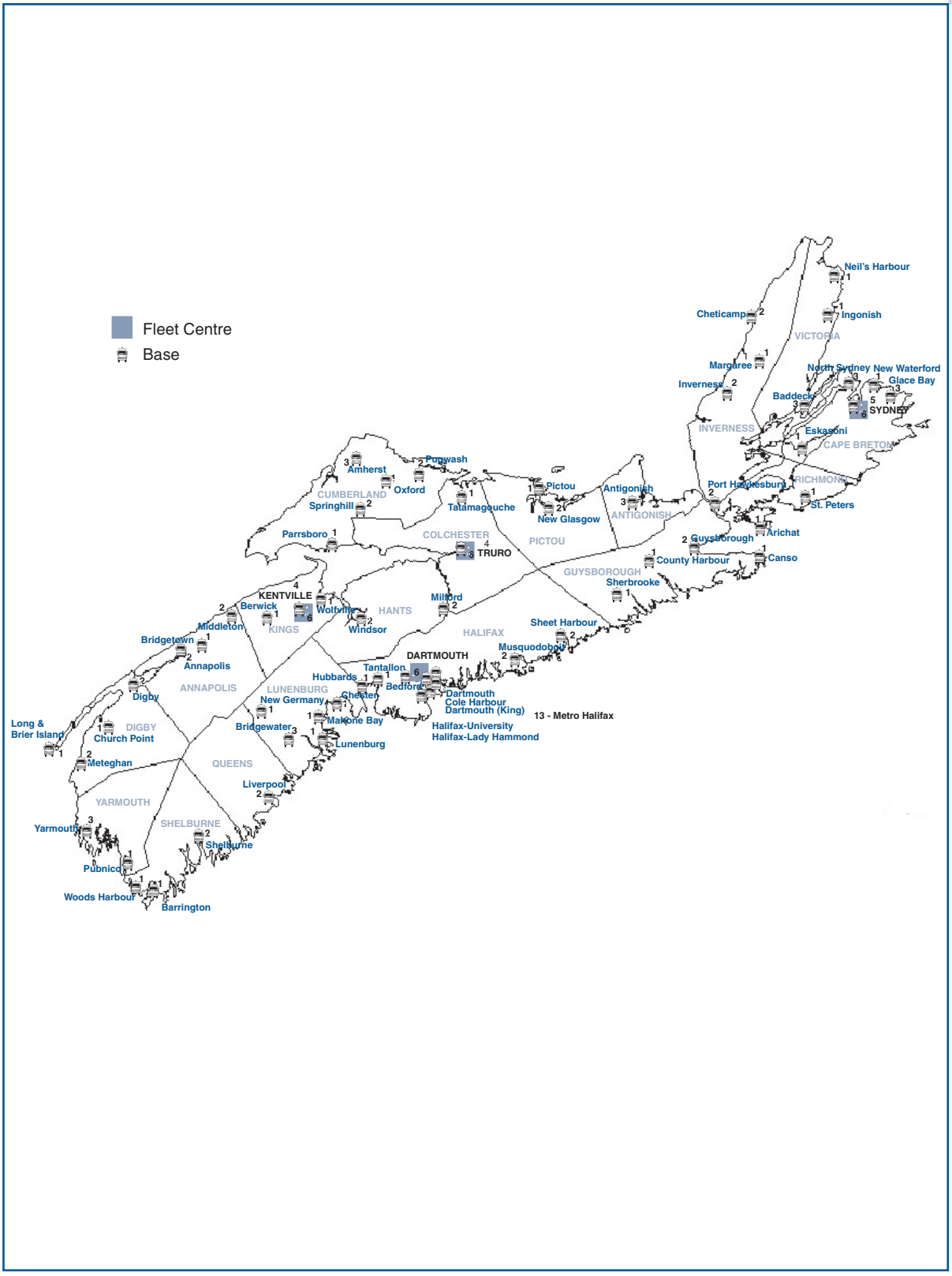
basis. Requirements for regular receipt of detailed financial information by EHS should be included in future contracts. Significant contracts should also include full audit access for the Office of the Auditor General to provide assurance to the House of Assembly that public funds directed towards service provision have been expended with due regard for economy and efficiency.

3.66 The optimal deployment of ambulances to communities across the Province is essential to achievement of value for money. EMC uses sophisticated techniques to deploy ambulances and meet response times. However, there are two issues which should be examined by government. Delays at emergency rooms pose a risk that response times may not be achieved and there is a risk that some ambulances may be deployed to communities which do not meet deployment criteria.

3.67 User fees for ambulances generate a significant amount of revenue for the Province. We believe that there is a need for EHS to improve its accounting controls and financial statement disclosure relating to these fees.

Emergency Health Services - Fleet Centres and Bases

Exhibit 3.1



Source: EMC

Exhibit 3.2

Ground Ambulance Services - Responsibilities of Emergency Health Services (EHS) and EMC Emergency Medical Care Inc. (EMC)

EHS, as the Ambulance System Authority, has the following functions:

- System ownership. EHS either owns or has unimpeded access through the contract with EMC to all elements of production, such as the communications system, ambulances, bases, equipment, and supplies.
- Approves paramedic training and registration to practice within three levels of competency.
- Approves the regulations and medical protocols that provide the medical framework for the service.
- Provides the medical authority and medical oversight of the system.
- Provides the communications systems, vehicles and equipment used in the service.
- Contracts out the management of the service throughout the province by private contractor(s) and provides the performance expectations for the services.
- Monitors and evaluates the service provided by the private contractor(s).
- Provides for public accountability for the system.
- EHS, as the system authority, ensures the provision of the ambulance and related services to Nova Scotians.

EMC, as primary contractor, has the following functions:

- Manage the ambulance service delivery system with the responsibility to achieve provincial performance requirements relating primarily to response time reliability and medical quality.
- Hires and manages registered paramedics and other staff to operate the system.
- Develops and delivers post employment training programs for paramedics.
- Creates a province-wide ambulance management system to match available ambulances to the changing patterns of demand for those ambulances at specific hours of the day and days of the week.
- Builds/leases/manages the bases and physical infrastructure for the system.
- Manages the Communications Centre that receives calls from the public for emergency and non-emergency health resources and dispatches ambulances to people in need.
- Maintains the communications system, bases, vehicles and equipment to Authority established standards.
- Purchases the supplies and services for the system.
- Reports on the performance expectations required by the Authority.

Source: *Department of Health's website*
http://www.gov.ns.ca/health/ehs/ground_ambulance/ehsemc_roles.htm

Ambulance Fee Rate History

Exhibit 3.3

Type of Transport	Effective Date			
	May 1, 2000	April 1, 2002	April 1, 2004	April 1, 2007
Nova Scotia resident (ground and air)	$ 85	$ 105	$ 120	$ 128
Non-resident other province	500	600	600	640
Non-resident other country	750	750	900	961
Work related (WCB)	500	600	600	640
Motor vehicle accidents	500	600	600	640
Mobility challenged	125	150	150	160
Private pay	500	600	600	640
Inter-facility transfer	No fee	No fee	No fee	No fee

Source: EHS report and Ambulance Fee Regulations

Summary of Ambulance Transports and Ambulance Fees

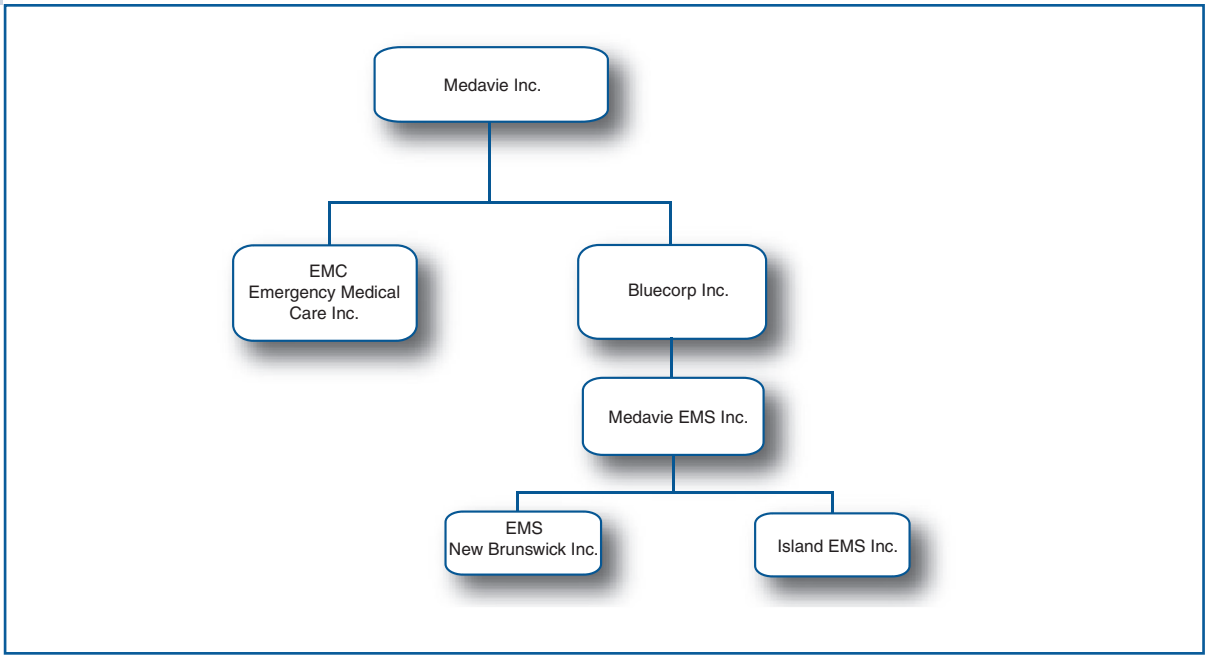
Exhibit 3.4

Type of Transport	2002-03		2003-04		2004-05		2005-06	
	Total Transports (#)	Amount Billed ($)	Total Transports (#)	Amount Billed ($)	Total Transports (#)	Amount Billed ($)	Total Transports (#)	Amount Billed ($)
Inter-Facility	24,809	Nil	26,779	Nil	27,311	Nil	29,319	Nil
Resident	53,789	5,520,375	54,306	5,702,130	53,904	6,544,326	54,831	6,580,140
Motor Vehicle Accident	3,181	1,920,600	2,981	1,788,600	2,939	1,764,600	2,798	1,678,860
Work Related Injury	599	355,800	500	303,000	466	279,600	441	264,600
Non-Resident	1,625	1,038,450	1,659	1,101,900	1,685	1,126,500	1,662	1,110,620
Mobility Challenged	58	7,800	155	23,550	91	13,650	177	26,550
Private Pay	225	135,00	289	173,400	309	185,400	254	152,400
Total	**84,286**	**8,978,025**	**86,669**	**9,092,580**	**86,705**	**9,914,076**	**89,482**	**9,813,170**
% of Fee Collected		81.3%		80.1%		84.8%		84.0%

Source: EHS trend report

Exhibit 3.5

Medavie Inc. Group of Companies



Note: Includes only those companies that are involved in the delivery of emergency medical services.

Summary of Principal Terms and Conditions - Ground Ambulance Contract

Exhibit 3.6

Scope	Terms
Contractor	Emergency Medical Care Inc., wholly owned subsidiary company of Medavie Blue Cross
Contract term	Effective April 1, 1999 - March 31, 2009
Termination	Either party may terminate the contract with at least 90 days advance notice or EHS may terminate in the event of major breach of the agreement.
Initial base budget	Initial base budget (April 1999): $29,750,000 plus management fee of $975,000 less applicable savings incentive shared 60% contractor and 40% EHS.
General scope of services	• Ground ambulance transportation • Ambulance personnel training • Communication and dispatch • Management of ambulance fleet • Collection of user fees on behalf of EHS
Response time performance compliance	Response time standard, at least 90% of the time: Population — Urgent code, 1, 11 — Non-urgent code 2, 22 >15,000 — < 9 minutes — <15 minutes 2,500 to 14,999 — <15 minutes — <20 minutes <2,500 — <30 minutes — <40 minutes
Ambulance personnel certification	Ambulance personnel requiring registration and licensure are appropriately certified. Progression to Advanced Life Support certification.
Equipment and facilities provisions	EMC is responsible for maintaining ambulances in accordance with vehicle lease requirements.
Incentives	- User fees collected in excess of 75% are shared equally with EHS - Cost savings incentive: actual costs less than budgeted shared 60% EMC and 40% EHS. - EMC may obtain outside work for-profit - Exclusive market right to provide ground ambulance services subject to conditions detailed in the agreement
Penalties	Penalties may be imposed if EMC fails to meet the following: - Required response times - EHS policy and report requirements - Equipment maintenance as required per lease agreements
Call volume	Call volume range from 65,000 to 85,000 covered by the contract. EHS will absorb incremental costs for calls received beyond 85,000 and deduct costs if call volume falls below 65,000.

DEPARTMENT OF HEALTH'S RESPONSE

Thank you for the comprehensive auditor's report on the Ground Ambulance System of EHS, and the operator EMC. The objectives of the audit were well understood, and the report clearly provides valuable information on opportunities for continuous improvement in processes associated with this high value, high performance system.

We have welcomed the opportunity to inform the Auditor General's office about this system of care and to discuss recommendations in the spirit of full accountability to the people of Nova Scotia.

The following seven recommendations were made in regard to the EHS portion of the report:

Recommendation 3.1

We recommend that requirements for accountability information, including requirements for submission of detailed financial information at specified intervals, be included in contracts to ensure information required for appropriate monitoring is received on a regular basis.

Recommendation 3.2

We recommend that DOH exercise its right to audit financial records under the ground ambulance contract to monitor EMC's performance and gain assurance that EMC's expenditures were incurred with due regard for economy and efficiency.

Recommendation 3.3

We recommend that any new contracts negotiated for provision of ground ambulance services or any other significant contracts between government and service providers include provision for audits by the Office of the Auditor General.

Recommendaiton 3.4

We recommend that EHS review risk sharing when negotiating contracts to ensure there is an appropriate balance between risks transferred to the contractor, risks retained by the Province and cost of the contract.

Recommendation 3.5

We recommend that EHS verify the completeness and accuracy of user fee revenues submitted by EMC.

Recommendation 3.6

We recommend that EHS establish write-off policies for ambulance user fee accounts receivable and review receivables annually to identify and write off uncollectible amounts.

Recommendation 3.7

We recommend that EHS record ambulance user fee revenues and receivables to provide better control over uncollected amounts and ensure compliance with generally accepted accounting principles.

EHS and the Department of Health agree that these are helpful recommendations to ensure continued effective and efficient governance of the system.

EMERGENCY MEDICAL CARE INC.'S (EMC) RESPONSE

As part of our ongoing review of policies within EMC, we are reviewing our Meal and Travel policies to ensure consistent application throughout the company. The implementation of the recommended financial policies and controls should not be the only standard against which due regard to economy and efficiency should be measured. Our experience has shown that there can be more cost effective internal controls, including the ones that presently exist at EMC, than the ones that are being recommended to accomplish the same objectives.

While there was no specific recommendation with respect to retention bonuses, it is important to address the comment in the report with respect to the accounting treatment of this transaction. There are no specific general accounting principles that state these types of payments must be allocated to a salary line item. Given the fact that this was a non-recurring item and that the expense was immaterial in amount, we chose to account for this item in a separate account and allocate it to a line item where other expenditures associated with CEO transaction had been accumulated. It has been consistent accounting practice for EMC to allocate non-recurring expenses in other years to this same expense line and this accounting practice has been validated with our external auditors.

4 LONG-TERM CARE - NURSING HOMES AND HOMES FOR THE AGED

BACKGROUND

4.1 The Continuing Care Branch of the Department of Health (DOH) provides access to:

- Adult Protection Services
- Home Care
- Long-term Care

4.2 The 2006-07 budget of the Continuing Care Branch was $478.8 million. Of that amount, $326.9 million (68.7%) related to Long-term Care. The long-term care program provides a range of services to individuals who can no longer live independently. These individuals, many of whom are seniors, receive accommodation, supervisory care, personal care and nursing services as required. Although there are three types of homes which fall under the long-term care umbrella - nursing homes, residential care facilities and community-based options - in 2006-07 88% ($286 million) of the long-term care budget was allocated directly to nursing homes or homes for the aged (nursing homes).

4.3 Nova Scotia, like other provinces in Canada, has an aging population. In 2006, 14.1% of the Province's population was sixty-five or older. This percentage is expected to continue to grow and nearly double by 2026. Nova Scotia currently has the oldest population in Atlantic Canada and the third oldest in Canada. The growing population of seniors is expected to continue to strain the Province's health care resources. Ensuring seniors' health care requirements are met in the most economical way possible is a significant challenge facing the Province.

4.4 Individuals who meet certain admission requirements are eligible for placement to long-term care facilities including nursing homes and homes for the aged. These clients have needs for personal care, supervision, and nursing care which exceed the services offered by the Home Care program. In 2006-07 there were 76 licensed nursing homes in the Province. For-profit operators owned 20 while the remaining 56 were owned by not-for-profit organizations including municipalities (see Exhibit 4.1 for breakdown of Provincial beds between profit and not-for-profit operators). In the same year, there were 5,778 licensed nursing home beds in the Province (see Exhibit 4.2 for breakdown of beds by DHA).

4.5 Nursing homes are governed by the requirements of the Homes for Special Care Act and Regulations and detailed policies. The Continuing Care Branch has established offices in each health district in the Province. District staff are responsible for the intake, assessment and placement of clients in nursing homes while head office staff conduct mandatory annual inspections and license homes. The financial administration of the long-term care program is the responsibility of the Financial Services Branch of DOH.

4.6 Access to all licensed nursing homes in the Province is controlled by DOH through a Single Entry Access (SEA) system initiated in 2002. Under SEA, eligible clients are placed on a wait list based on the date a decision was made regarding the necessary level of care. The wait lists for all homes are maintained by DOH and clients can only gain entry to nursing homes through the SEA system. Once assessed and deemed eligible for placement in a nursing home, clients request to be placed on the wait list for their preferred homes as well as any others they would accept as alternatives. Clients are also prioritized based on specific criteria. The majority of clients are priority 3. Priorities 1 and 2 are placed ahead of 3 and relate to cases such as adult protection clients, peritoneal dialysis and spousal placements. Management has indicated that priority levels 1 and 2 combined total 11% of all clients.

4.7 In 2006-07, there were approximately 7,400 new assessments. When we completed our audit testing, there were 1,750 clients in the Province waiting for placement to a facility. Exhibit 4.3 provides a breakdown of the wait times experienced by clients who received initial placement to a facility between March 1, 2006 and February 28, 2007. The average wait time was 142 days from the date the care level classification decision was made to placement.

4.8 In January 2005, DOH implemented the new Cost of Care Initiative which significantly changed the way nursing homes are funded and how the required financial contribution from clients is determined. Prior to 2005, clients with the required financial resources contributed to all costs associated with their care in a nursing home. Since 2005, health-care costs for residents of nursing homes are borne by the Province but clients are still required to contribute to accommodation charges and personal expenses based on ability to pay.

4.9 DOH sets one standard accommodation charge each year based on the average operating costs of all homes. The maximum standard charge to be paid by clients for 2006-07 is $75.50 per day. The financial contribution required from each client is based on an initial financial assessment using criteria established by DOH. DOH pays the portion of the accommodation charges in excess of the client's financial resources. Clients able to pay the full standard accommodation charge are permitted to retain all remaining income and assets. A budget for each home is approved by the Department of Health and paid bi-weekly. Accommodation costs and health care costs account for 26% and 74%, respectively, of the total costs of long-term care facilities.

4.10 In May 2006, the Minister of Health announced the *Continuing Care Strategy for Nova Scotia Shaping the Future of Continuing Care*. The strategy includes several initiatives to expand and improve the continuing care system in the Province. The action plans related to the strategy are expected to take ten years to complete; initiatives planned for the first four years are estimated to cost $122 million. The strategy document is available on the DOH website at http://www.gov.ns.ca/health/ccs/Continuing_Care_Strategy06.pdf.

4.11 In February 2007, the Minister of Health announced 832 new long-term care beds for the Province, 721 replacement beds in nine aging facilities and the fast tracking

of 77 beds to help ease immediate pressures on the system. The new beds are to be distributed among the Province's health districts and contracts for development and operation of long-term care facilities are expected to be awarded through a request-for-proposal process starting in April 2007.

4.12 Our most recent audit of the long-term care program was reported in the 2003 Report of the Auditor General (Chapter 9). We followed up on implementation of our recommendations from that audit in the December 2006 Report of the Auditor General (Chapter 7).

RESULTS IN BRIEF

4.13 The following are our principal observations from this audit.

- The Homes for Special Care Act and Regulations are outdated and should be amended to reflect current standards and program changes such as the new Cost of Care Initiative and Single Entry Access.

- We believe that DOH should continue its efforts and implement a funding formula for nursing homes to improve the efficiency and consistency of the funding process. The recent announcement of new bed construction increases the need for a fair, transparent funding formula as new service providers will likely be entering the system.

- The accountability framework for nursing homes should be improved by establishing service agreements to more clearly set out performance expectations and reporting requirements for the nursing homes.

- We examined documentation relating to the annual inspection and licensing process for homes. We noted several deficiencies and concluded that significant improvements are required to ensure that the process is effective in ensuring clients' care needs and legislative requirements are met.

- Our testing of the accuracy of information in the SEAscape system found instances where the information was inaccurate. Since this information has the potential to affect decisions on placement, wait list position and level of care, we believe that DOH should develop and implement an effective quality assurance process for this information.

- We tested placement decisions for a small sample of clients and identified four situations where clients appear to have been placed in nursing homes in a manner that was not consistent with DOH placement policies. We acknowledge that circumstances may exist in specific situations which would warrant exceptions to the placement policy but, in these cases, there was no supporting documentation to explain the rationale for placement of these clients before others on the wait list. We recommend that all exceptions to placement policies be specifically approved by DOH management.

AUDIT SCOPE

4.14 The objectives of this audit were to review and assess:

- processes to assess, prioritize, and place clients in nursing homes;
- compliance with policies and procedures for placement of nursing home residents;
- completeness and accuracy of wait list reports;
- DOH's process for setting out performance expectations for nursing homes;
- compliance with accountability reporting requirements for nursing homes;
- systems for funding nursing homes;
- processes for the annual licensing and monitoring of nursing homes; and
- compliance with licensing requirements.

4.15 Our audit criteria were obtained from recognized sources including internal policies and procedures and legislation and were discussed with DOH management.

4.16 Our audit approach included interviews with DOH management, and examination of relevant policies, procedures, legislation and other documents as deemed necessary. Our audit procedures included detailed testing of the licensing, budgeting and payment processes for nursing homes. We also conducted testing for compliance with the nursing home application, wait list, and placement processes.

4.17 The scope of our audit did not include the home care program and we did not visit any nursing homes in the Province to review operations. We plan to audit other aspects of Continuing Care, such as the Home Care program and awarding of contracts for the new long-term care beds (see paragraph 4.11), later in 2007 and early 2008.

PRINCIPAL FINDINGS

Accountability and Performance Reporting

4.18 Summary observations - We assessed DOH's accountability framework for nursing homes. We concluded that service agreements should be established to more clearly set out performance expectations for all nursing homes, and that DOH should ensure nursing homes submit required information on a timely basis.

4.19 Performance expectations for nursing homes - Although the Homes for Special Care Act and Regulations include a number of provisions related to nursing homes (see paragraph 4.35), DOH has not yet established formal performance expectations for nursing homes. Management has indicated that, informally, nursing homes are expected to operate within the financial resources provided and to comply with appropriate legislation. Management has recognized the need to develop service-level agreements and are currently drafting an agreement which new facilities will be required to sign. Management indicated this new agreement will include formal performance expectations and reporting requirements and that there are plans to require all nursing homes in the Province to have similar agreements in the future. We believe such agreements will enhance the nursing homes' accountability to DOH and should be required for all nursing homes in the Province.

Recommendation 4.1

We recommend that DOH establish service agreements with all nursing homes which include performance expectations and reporting requirements.

4.20 Nursing home reporting requirements - DOH's annual budget letter to nursing homes (see paragraph 4.25) includes a requirement to submit audited financial statements each year. Management indicated they use this information to analyze and compare operating results, cost pressures and other issues on an equitable and consistent basis across the sector. These statements are to be submitted to DOH by July 31 and there are specific requirements relating to financial statement presentation and disclosure. To supplement the information provided by the financial statements, nursing homes are also required to provide an annual accountability report which provides further detail relating to the expenditures in the financial statements. Management indicated that they do not require nursing homes to submit copies of the external auditors' management letters. These annual letters include details of any control weaknesses and other findings during the financial statement audit. We believe these letters could provide important information to DOH with respect to financial management of the nursing homes and we recommend that DOH require nursing homes to submit these letters to DOH annually.

4.21 We tested documentation relating to 30 nursing homes to determine whether DOH reporting requirements were met. As a result of our testing, we noted the following:

- In 15 cases, the date the financial statements were received had not been documented.
- In 7 cases, nursing homes had submitted financial statements after the July 31 deadline.

- In 8 cases, specific reporting requirements were not met by the nursing homes.
- In 5 cases, auditors had issued qualified auditors' reports related to depreciation policy, completeness of donation revenue, and accounting for accrued vacation pay.
- In 6 cases, the basis of accounting used to prepare the financial statements was not Generally Accepted Accounting Principles.
- In 5 cases, nursing homes had not submitted accountability reports.

4.22 In order for information to be useful to DOH management in analyzing and comparing operating results, and making decisions, it must be timely, complete and prepared on a comparable basis. Our testing indicates improvements are needed to ensure information submitted by nursing homes possesses these attributes. We also noted some nursing homes have March 31 year ends which makes providing audited financial statements by July 31 more difficult than for those with December 31 year ends.

Recommendation 4.2

We recommend DOH ensure reporting requirements for all nursing homes are practical, and establish a process to ensure requirements are met and appropriate action taken if inconsistencies are identified. DOH should also require nursing homes to submit auditors' management letters for review.

Funding Nursing Homes

4.23 Summary observations - We reviewed the systems for setting budgets and providing payments to nursing homes. We determined that DOH had established processes in place but that improvements were required in certain areas. There is no funding formula for nursing homes and we recommend that DOH continue its efforts to implement one to reduce the inconsistencies in funding that currently exist.

4.24 Annual budget process - DOH determines a budget for each eligible facility on an annual basis. The budget process is detailed and includes spring and fall consultation sessions with representatives of the nursing homes. In December, each nursing home submits a business plan to DOH which includes funding requests for the upcoming year and capital requirements. This information is used by DOH to prepare its Estimates for the next fiscal year.

4.25 DOH maintains spreadsheets which detail the approved budget for each nursing home. The spreadsheet includes details of funding related to staff complement and salaries, operations, mortgages, capital requirements, profit margin where applicable, and recoveries. The spreadsheet is updated for cost pressures approved

as part of the DOH budget. Once the final budgets have been approved by DOH, nursing homes are notified by letter of funding including explanations for variances from the previous year. The funding letter does not specifically indicate that approved staffing levels must be maintained, but DOH management indicated during the audit that the expectation is that nursing homes maintain the approved staffing levels for resident care. However, some portability of funding among areas which do not impact resident care (e.g., administrative costs) is acceptable.

4.26 Salaries and benefits comprise approximately 75% of each nursing home's annual budget. Salaries related directly to resident care, such as Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Continuing Care Assistants (CCAs), represent a significant portion of total funded salaries at about 65%. The rates used for all salaries are approved by DOH and are consistent for all nursing homes. DOH has also established guidelines for resident care staffing ratios, including RNs, LPNs and CCAs.

4.27 DOH has not established a formula or guidelines with respect to specific operational funding provided to nursing homes in areas such as maintenance staff. Each year, DOH reviews the previous year's funding for operations and compares nursing homes, based on average funding per approved bed, to identify any funding gaps between nursing homes. If new operational funding is approved as part of the DOH budget, this amount is allocated to the nursing homes with the largest identified gaps when compared to the average.

4.28 We examined the supporting documentation for the calculation of the 2005-06 annual budget for 30 nursing homes. Our objective was to assess whether the budgeting process and DOH guidelines were followed. We concluded that the process and guidelines were generally followed although we did note instances where there were inconsistencies in the funded staffing ratios for certain nursing homes.

4.29 Funding formula - The 2003 Report of the Auditor General (page 146) included the following recommendation "*We recommend that the DOH continue with its efforts to develop an overall funding formula for the Long-term Care program.*" The budgeting process continues to be complex and time consuming. Management indicated they would like to move to a funding formula and have been gathering and analyzing information with a goal of implementing a formula but an expected completion date has not been established. A new funding formula would include such factors as the acuity level of residents, square footage, age of facilities, and capital requirements. We believe that a funding formula would provide a more consistent and efficient method of determining funding for nursing homes especially in the areas of operational and capital funding and urge DOH to proceed with implementation in the near future. The recent announcement of new bed construction (see paragraph 4.11) increases the need for a fair, transparent funding formula as new service providers will likely be entering the system.

Recommendation 4.3

We recommend DOH continue its efforts to implement a funding formula for the long-term care program.

4.30 Payments to nursing homes - The nursing home's approved budget (see paragraph 4.24) is reduced by DOH's estimate of residents' required contributions toward accommodation costs for the year (see paragraph 4.9). The net amount is forwarded to nursing homes through bi-weekly payments throughout the year. The nursing homes also receive monthly reimbursement for payments made on behalf of residents for special needs, such as hearing aids, as defined in DOH policies. The nursing homes are required to submit monthly claims supporting special needs payments for approval by district staff prior to DOH reimbursement.

4.31 Quarterly reconciliations - Bi-weekly payments to nursing homes are based on DOH's approved budget for nursing homes less DOH estimates of residents' accommodation contributions. To ensure payments made are appropriate, DOH requires nursing homes to report actual resident movement information and residents' contributions monthly. This information is reconciled every three months to the estimates used to determine the nursing home's bi-weekly payment amount. Any differences between actual results and estimated amounts are either paid to or reimbursed by the nursing home. The results of the reconciliations are communicated to the nursing homes by a letter from DOH. The impact of the accommodation cost payment and reconciliation process is that DOH effectively guarantees the nursing homes they will receive all accommodation costs to which they are entitled.

4.32 We reviewed the detailed support for a 2005-06 quarterly reconciliation for 30 nursing homes. Although we found no errors in the reconciliations examined, we noted six nursing homes did not have up-to-date reconciliations. In three cases, the monthly reports required by the nursing homes had not been submitted. DOH management indicated they are aware of the delays and have been completing four to five quarters at a time in an attempt to eliminate the backlog.

4.33 We also noted that three nursing homes owed a balance to DOH as a result of the reconciliation process ($92,000, $169,000 and $194,000, respectively). These amounts had been identified in January or February 2007 but, as of late March, DOH had not yet made arrangements with the nursing homes for repayment. Management indicated that they planned to call the nursing homes and request repayment, either by lump-sum cheque or reductions in bi-weekly funding.

Recommendation 4.4

We recommend that DOH perform quarterly reconciliations and collect funding overpayments in a timely manner.

Licensing and Inspections

4.34 Summary observations - We assessed the annual licensing and inspection process for nursing homes and determined significant improvements are required to ensure the process is effective in ensuring residents' care needs and legislative requirements are met.

4.35 Legislation - The Homes for Special Care Act and Regulations include requirements for annual licensing and semi-annual inspections or visits of nursing homes. The Regulations include many specific requirements which must be met by nursing homes. DOH management informed us that many of the requirements in the Act and Regulations need to be updated as they do not reflect current standards. In addition, significant new DOH policies such as the Cost of Care Initiative and Single Entry Access are not reflected in the current legislation. Management has indicated they recognize the need to update the current legislation. However, DOH's focus on other significant initiatives in process has meant that updating legislation is not currently a priority for DOH. We emphasize the need to update legislation is urgent in this case as there have been significant changes in the program which are not in compliance with current legislation.

Recommendation 4.5

We recommend that DOH work towards having the House of Assembly update the Homes for Special Care Act and Regulations to ensure the legislative framework reflects current long-term care operations and standards.

4.36 Annual licensing process - As indicated in paragraph 4.35, all nursing homes are required to be licensed by DOH annually. The inspection and licensing process is key to ensuring residents receive quality care. We selected a sample of 30 nursing homes to determine if they were operating with a current license. All 30 files we examined indicated that the nursing homes were issued a one-year license and all licenses were current.

4.37 DOH can cancel, suspend, refuse to issue or re-issue a license to operate a nursing home. There have been no recent license cancellations or suspensions for any nursing homes. We noted that DOH has not established policies and procedures to govern the licensing function, and in particular, to set out conditions when licenses should not be granted to a nursing home or when a license should be issued for a period of less than a year. We understand that management plans to address this issue starting in 2007. At the time of our audit, the Fire Marshal had informed DOH he would be recommending one nursing home not be issued a license due to fire and safety deficiencies. DOH staff have been working with the Fire Marshal and the nursing home to address deficiencies contained in the Fire Marshal's report.

4.38 Inspections of nursing homes - DOH monitoring and evaluation staff are required to inspect nursing homes to ensure compliance with the Homes for Special Care

Act and Regulations, and to prepare and submit reports and recommendations for licensing of nursing homes. The inspections do not include a review of financial management, internal control, staffing or accreditation status of the nursing homes.

4.39 The timing of inspections is based on the expiry date of the nursing home's license. Visits to the nursing homes are generally unannounced. A detailed licensing questionnaire is completed by administration of the nursing home in advance of the inspection visit. Nursing homes are required to submit a number of documents with the licensing questionnaire. A licensing letter is written to the administrator of the nursing home at the conclusion of the inspection outlining areas of commendation as well as areas for improvement. The administrator is required to respond to DOH within 30 days outlining steps taken or planned to address the licensing letter's recommendations.

4.40 We examined DOH's inspection files related to 30 nursing homes to determine whether requirements under the regulations and DOH policies had been met. In all 30 cases, we concluded that an inspection had been performed within the last year but we observed several areas where the inspection process should be improved.

- Legislation requires an annual inspection supported by a second visit. In only one case was there evidence that a second visit had been completed during the year as required by legislation.

- There are no policies and procedures relating to specific inspection procedures to be performed, the extent of the review to be conducted, required documentation of inspection files, or required monitoring of recommendations.

- Many of the requirements detailed in the regulations, such as sufficient staffing levels, do not appear to be addressed as part of the inspection process.

- Numerous documents required from nursing homes as part of the licensing questionnaire were not always submitted. Examples of documents not submitted include the Fire Marshall's annual inspection report, evidence of testing of emergency plans, and proof of liability insurance.

- There is no documentation of which residents' files were examined and the criteria used to assess the contents of the files.

- There is no review and analysis of actual resident care staffing levels in comparison to the numbers of staff funded.

- Some nursing homes are accredited and inspected by the Canadian Council on Health Services Accreditation. These accreditation reports are not reviewed as part of the inspection process although they would include information relevant to this process.

4.41 The existence of a strong licensing and inspection process, which is functioning properly, is a key control to ensure that nursing homes are providing an appropriate level of care to residents and all DOH requirements are met, including important patient safety related processes. Our review of the licensing and inspection process revealed several deficiencies and we concluded significant improvements are required to ensure residents' care needs and DOH requirements are met. We understand that a two-year review of the standards and licensing process is scheduled to begin in spring 2007 as part of implementing the Continuing Care Strategy; this review may address the identified weaknesses.

Recommendation 4.6

We recommend that DOH review and improve the licensing and inspection process to address deficiencies noted in paragraph 4.40 above.

4.42 Complaints process - The authority to investigate complaints against nursing homes and staff falls under the general provisions of the Homes for Special Care Act and Regulations and is the responsibility of inspection staff. Complaints received are included in a file for follow-up by inspection staff. Although DOH does not have formal policies and procedures with respect to documentation and investigation of complaints, an informal process does exist. We examined 11 complaints made and noted that in all cases documentation in the files indicated DOH had investigated. We noted there were differences in how the results of the 11 complaint investigations were reported to complainants. In 6 of the 11 cases, a letter was sent to the complainant. We understand DOH is in the process of developing policies and procedures related to this process as part of implementing the Continuing Care Strategy.

Single Entry Access and Wait Lists for Nursing Homes

4.43 Summary observations - We examined the adequacy of DOH's processes for placement of clients in nursing homes. The Department of Health assesses all applicants and maintains a wait list of eligible applicants for all licensed nursing homes in the Province using a computerized system known as SEAscape. We performed detailed testing of a sample of cases and found inaccuracies in some of the SEAscape data. This increases the risk that some individuals may not be placed in nursing homes in accordance with DOH placement policies. We tested 28 data fields in SEAscape. Data fields related to medical assessment information were excluded from testing. We also found a small number of cases where placement of residents did not appear to have followed DOH policies, although we acknowledge there may have been extenuating circumstances which had not been documented in the files. We have made recommendations for increased quality assurance in the SEAscape placement process.

4.44 Intake process - Clients requesting placement in a Provincial nursing home are required to go through the Single Entry Access system implemented by DOH in

2002. Clients, or their representatives, call a 1-800 number that is routed to one of four Intake Offices around the Province. To be eligible to receive services, each individual must have a valid Nova Scotia Provincial Health Card and agree to a functional assessment. Financial assessments are only done where the client does not wish to pay the maximum daily charge (see paragraph 4.9).

4.45 Due to the large volume of requests for functional assessments received by DOH (see paragraph 4.7), intake officers complete a Prioritization Assessment Tool (PAT). This provides a consistent method to determine the time frame in which the client should be assessed by the allocated care coordinator. For example, if the client is assessed as high priority, DOH policy requires the functional assessment be completed within 5 days.

4.46 Client assessment process - Assessments are usually completed in a face-to-face meeting where the client resides. The care coordinator completes the assessment using a tool, known as the MDS-HC. This is a minimum set of data which provides case workers with the information needed to make decisions on the level of care the client requires and whether placement in a nursing home is needed or whether home care or respite services may be more appropriate. The tool is endorsed by the Canadian Institute for Health Information.

4.47 Assessments which result in a requirement for long-term care placement are reviewed by Classification Officers. The date on which the care level decision is made determines the client's place on the wait list for a facility in conjunction with the individual's priority level assigned according to DOH guidelines. With the assistance of the care coordinator, clients choose a preferred facility as well as any alternates they will accept while waiting for placement in the preferred facility. They are placed on the wait lists for each facility chosen in chronological order with other clients at the same priority level.

4.48 The majority of clients are assessed at priority level 3. Only clients who are placed under Adult Protection (see paragraph 4.6) are assigned as priority 1 (urgent). Priority 2 classification is reserved for special placement cases, for example, when spouses request placement together.

4.49 We observed there are very specific, documented policies and procedures for the various stages of the intake and assessment processes. These include timelines for assessment and documentation and definitions for priority levels. This information is entered into a computer application called SEAscape which is the primary information system used to manage the intake, assessment and placement process. As noted below, during testing we found instances where some information was not posted to SEAscape.

4.50 We selected a random sample of 30 clients who had been assessed during the one-year period between February 1, 2006 and February 1, 2007. Our objective was to test whether DOH guidelines throughout the intake and assessment process were followed and whether information in SEAscape was accurate and complete. We tested 28 fields in SEAscape but did not examine the accuracy of the results of the functional assessment. Our findings are summarized below.

- The specific PAT (assessment tool) required by DOH policy was not used in three cases.
- In 13 cases, the PAT results were not included in the client's file so we could not assess whether SEAscape information was correct.
- In one case, the priority rating for assessment per the PAT was incorrectly recorded in SEAscape as low when it should have been medium.
- There were seven clients who were not assessed within the established timelines.
- In five cases, placement coordinators had not been assigned to the client as required by policy.
- In two cases, information to support the care level decision was not included in the client's file so we could not assess whether SEAscape information was correct.
- In one case, the level of care required per the client's assessment (NH1) was incorrectly recorded in SEAscape (NH2).
- In two cases, the client's gender was incorrectly recorded in SEAscape.

4.51 If DOH policies and procedures are not followed and information in the SEAscape system is inaccurate, there is a risk that improper decisions on placement, wait list position and care level may be made. While we recognize management uses some of the canned reports provided by SEAscape for monitoring, we believe that DOH should develop a formal internal quality assurance process to ensure compliance with policies and accuracy of management information in SEAscape.

Recommendation 4.7

We recommend DOH develop and implement a quality assurance process to help ensure compliance with policies and accuracy of SEAscape information.

4.52 The intake process also includes clients requesting home care services and not placement in nursing homes. We tested a sample of 15 clients who were assessed in the past 12 months but not included on our placed listing or on the wait list. All of those sample clients were assessed for home care only and correctly identified as such in SEAscape.

4.53 Nursing home placement and wait list management - Wait lists for all licensed facilities are monitored and managed by DOH. When a bed becomes available, the facility contacts the placement coordinator for the area who determines which client is next on the wait list and fits the criteria for the bed. Criteria include

gender, care level, security requirements, etc. The facilities cannot fill the available beds without contacting DOH but they can transfer their clients internally from one bed to another.

4.54 To ensure fair and consistent treatment of wait-listed clients, DOH has developed policies and guidelines to assist in managing the wait lists. Clients are to remain on the wait list for their preferred facility until they are placed or voluntarily withdraw their request. Clients who are offered placement in one of their chosen facilities but refuse the offer are removed from all wait lists and are required to reapply. They will then be placed on the wait list at the new application date.

4.55 When a client accepts the offer in a preferred facility, acceptance is recorded in the SEAscape application. This automatically removes the client from all other wait lists. If the client accepts an offer from a facility on the alternates list, the client will remain on the preferred facility's wait list but be removed from the accepted facility's wait list. We tested this process and found that all of our test cases were appropriately removed from the wait lists based on the offer accepted.

4.56 Clients in hospital who are assessed as needing long-term care placement are usually considered to be priority 3 clients; however, they are required to accept the conditions of the *First Available Bed Provision*. This provision allows the client to be placed in the next available bed within any suitable facility that is within 100 kilometers of the preferred community. Should the client decide to remain in hospital while waiting for placement and not agree to the Provision; the District Health Authorities may charge the client a per-diem.

4.57 The District Health Authorities also have the ability to apply to DOH for a variance. The variance policy states that if a hospital is experiencing a shortage of beds and cannot meet standard service levels, the patients waiting at that hospital for long-term placement can be moved to the top of the placement wait list for their priority level.

4.58 Clients who require immediate or urgent assistance have two formal options for placement. Clients who meet strict criteria can be placed under the Adult Protection Act and clients who are in hospital but medically discharged are subject to the First Available Bed Provision (see paragraph 4.56). DOH is currently developing a formal *Urgent Exception to Placement Policy* to assist clients who are in crisis but do not require placement under the Adult Protection Act.

4.59 Of the 30 clients we selected for testing (see paragraph 4.50), 15 had been placed in nursing homes and 15 were still on the wait list. For those 15 clients who had been placed, our objective was to assess whether DOH placement policies were followed. We attempted to determine whether they had been at the top of the wait list for that particular bed at the time of placement. For example, because the majority of rooms are occupied by two residents, the next available bed may only be appropriate for a male or female depending on the gender of the current occupant. As a result, the client who meets the gender criteria and is the highest on the wait list should be offered the bed according to DOH policies.

4.60 Although historical wait list information is not readily available through the SEAscape system, we were able to obtain the raw data needed to recreate the wait lists at the time of placement for these 15 clients. We wished to determine whether these clients had been placed in accordance with DOH policies according to date of eligibility and priority levels in SEAscape. We found the following instances where placement policies did not appear to have been followed:

- In two cases, clients were placed before others who were next on the wait list and no explanation was documented in SEAscape, or subsequently provided to us.

- There was one client who was placed in a nursing home bed even though assessed as requiring a bed in a residential care facility.

- In one case, a client was placed in a dementia bed although the client had not been assessed as requiring that type of bed.

4.61 Our testing indicated that DOH nursing home placement policies may not have been complied with in all cases. We acknowledge that extenuating circumstances may have existed at the time of placement which might have warranted exceptions to policy but there was no documentation supporting the decisions and no explanations were provided by DOH staff. We believe that policies should be followed and, if exceptions are warranted, the rationale should be clearly documented and approved by appropriate DOH management.

Recommendation 4.8

We recommend DOH establish a process to review placement decisions made by staff. Management should specifically approve all cases where exceptions are made to the policy and clearly document the rationale for the action taken.

4.62 We noted that DOH management does not formally monitor the client wait list for placement in nursing homes and no aged report is prepared. We believe this is important management information and should be more closely monitored. Management has stated that, starting June 1, 2007, DOH will publicly report average wait times for placement in long-term care facilities including specific wait times by facility.

4.63 Information technology controls related to SEAscape system - As indicated in paragraph 4.49, all information related to the intake, assessment and placement of clients in nursing homes is entered into SEAscape. Management indicated that reports from SEAscape are used to help ensure compliance with Departmental policies and to monitor and report on Branch operations including wait list management. We reviewed certain aspects of the general information technology control environment related to the SEAscape system. We did not perform a complete review of the information technology control environment. We found

the Department of Health does not have a formal business continuity plan related to the SEAscape system, and has not analyzed the associated risks. DOH management indicated they are in the process of developing a business continuity plan which will incorporate an assessment of risks.

CONCLUDING REMARKS

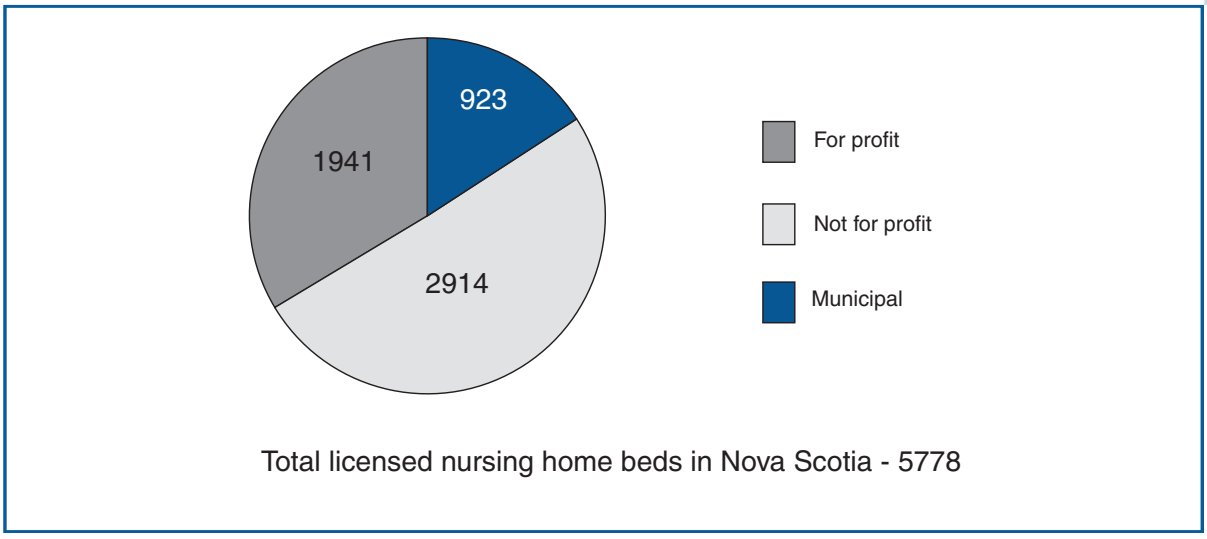
4.64 In 2003 we recommended that DOH improve processes related to funding and accountability of nursing homes. These recommendations have not yet been addressed and we encourage DOH to implement the necessary improvements. We acknowledge that there have been significant changes within the long-term care program since our last audit. Major initiatives such as Cost of Care, Single Entry Access, the Continuing Care Strategy and plans for additional beds have been DOH's primary focus.

4.65 DOH's annual licensing and inspection process is the primary control over quality of care in nursing homes and compliance with requirements of legislation and policies. We identified several weaknesses in the current process that need to be addressed to ensure it is effective in meeting its objectives.

4.66 This was our first audit of the Single Entry Access process for nursing homes. The information in the database must be accurate to ensure the process is transparent and effective in placing clients according to DOH policies. Our testing of the information related to a small sample of clients processed through the system identified a number of errors in the database and some cases where it appeared clients were not placed according to policies. Explanations of the reasons for policy exceptions had not been documented. We believe there is an immediate need to establish a quality control process over the data in the system and to document management approval of exceptions to policy.

Nursing Home Beds in Nova Scotia, Profit and Not-for-Profit

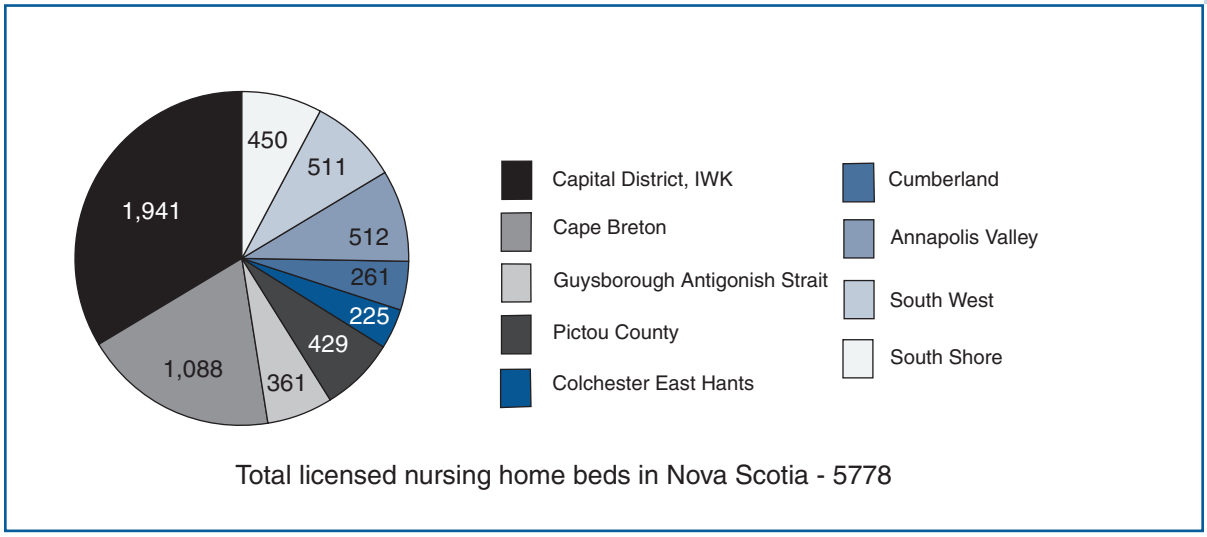
Exhibit 4.1



Source: Department of Health

Nursing Home Beds, by District Health Authority

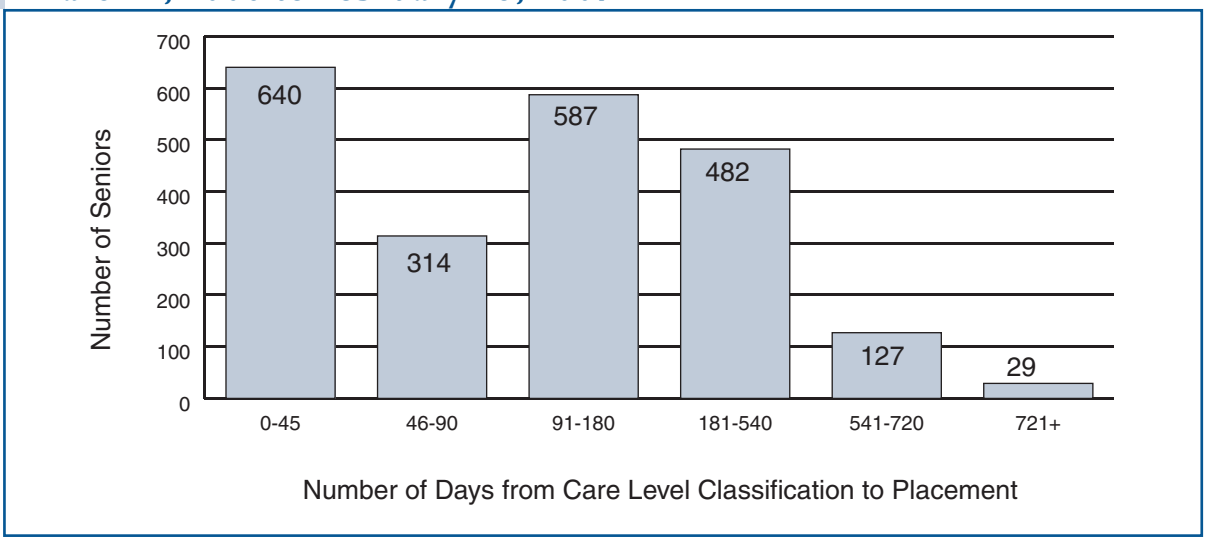
Exhibit 4.2



Source: Department of Health

Exhibit 4.3

Wait Time Statistics for Seniors placed in Nursing Homes March 1, 2006 to February 28, 2007



Source: *Created by Office of the Auditor General using a database provided by Department of Health. We did not audit the completeness of the database.*

Note: *This data relates to clients who received their initial placement to a nursing home between March 1, 2006 and February 28, 2007.*

DEPARTMENT OF HEALTH'S RESPONSE

Recommendation 4.1
We recommend that DOH establish service agreements with all nursing homes which include performance expectations and reporting requirements.

Response #1 - DOH is in the process of developing service agreement for use with future owner/ operators of new and replacement long term care beds. These agreements will be implemented with the awarding of the LTC beds in the current Request for Proposal closing summer 2007. Additionally, plans are being develop for future implementation to existing providers.

Recommendation 4.2
We recommend DOH ensure reporting requirements for all nursing homes are practical, and establish a process to ensure requirements are met and appropriate action taken if inconsistencies are identified. DOH should also require homes to submit auditors' management letters for review.

Response #2 - DOH is currently preparing a process to ensure reporting requirements are identified for LTC facilities and to ensure they are submitted regularly. We plan to implement this process over the next two years as we prepare for the licensing of the new LTC facilities. It will be connected to the licensing requirements for both the new and existing facilities.

Recommendation 4.3
We recommend DOH continue its efforts to implement a funding formula for the Long-term Care program.

Response #3 - DOH supports this recommendation and is currently working on the development of a funding formula for the Long-term Care program.

Recommendation 4.4
We recommend that DOH perform quarterly reconciliations and collect funding overpayments in a timely manner.

Response #4 - DOH concurs with this recommendation The process for reconciliation has been established, and we intend to implement quarterly reconciliation and collection funding in 2007-2008.

Recommendation 4.5
We recommend that DOH work towards having the House of Assembly update the Homes for

Special Care Act and Regulations to ensure the legislative framework reflects current long-term care operations and standards.

Response #5 - DOH agrees with this recommendation. DOH recognizes the importance of updating the Homes for Special Care Act and Regulations. Work on new legislation for long term care is scheduled to begin in 2008-09.

Recommendation 4.6
We recommend that DOH review and improve the licensing and inspection process to address the deficiencies noted in paragraph 4.40 above.

Response #6 - DOH agrees with the above recommendations. The Monitoring and Evaluation team, responsible for licensing, is taking formalized training in the regulatory processes throughout May, 2007. Following this training a new licensing process will be developed which will include requirements to address the items identified in paragraph 4.40, including analysis of resident care staffing and a mechanism to record and audit all required reports. It is anticipated that this new process will be implemented in 2008-09.

Recommendation 4.7
We recommend DOH develop and implement a quality assurance process to help ensure compliance with policies and accuracy of SEAscape information.

Response #7 - DOH agrees with this recommendation. A quality assurance process has been developed which will be implemented in 2007-08

Recommendation 4.8
We recommend DOH establish a process to review placement decisions made by staff. Management should specifically approve all cases where exceptions are made to the policy and clearly document the rationale for the action taken.

Response #8 - DOH agrees with this recommendation and recognizes the need to review both the placement process, and placement decisions made by staff which appear to deviate form the placement process. Documentation standards have just been completed and are to be implemented in 2007 and will include requirements for documenting exceptions.

5 MAINTENANCE ENFORCEMENT PROGRAM

BACKGROUND

5.1 In 1996, under the authority of the Maintenance Enforcement Act, the Province assumed responsibility for the administration and enforcement of maintenance orders issued by the courts. Maintenance orders require an individual to make spousal or child support payments. Prior to 1996, enforcement of maintenance orders was a function of the court.

5.2 The Maintenance Enforcement Program was created in the Department of Justice to administer the collection and disbursement of funds in accordance with the terms and conditions of maintenance orders. The Program's mission is defined as "*to ensure that people who have maintenance orders enrolled in our program receive payments in full, on time, and in an efficient manner in accordance with the Maintenance Enforcement Act and Regulations.*" The enforcement of a maintenance order entails the use of authorized powers, as defined by the Act, to ensure collection of amounts due. In addition to enforcing maintenance orders issued by Nova Scotia courts, the Program also administers and enforces maintenance orders of other jurisdictions in accordance with reciprocal enforcement agreements.

5.3 The Maintenance Enforcement Act assigns responsibility for the administration of the Act to the Director of Maintenance Enforcement. All powers of the Act are vested in the Director. When an order is issued by a Nova Scotia court, it is forwarded to the Program's enrollment unit for automatic enrollment in the Program. At any time, individuals can request to have their case removed from the Program, subject to certain conditions and approvals. Cases can also be withdrawn for administrative reasons, such as when both the payer and the recipient leave the Province.

5.4 To facilitate administration and enforcement processes, each maintenance order is assigned a unique case number. Amounts received from payers are categorized as either '*flow-through*' or '*pay-to.*' Flow-through payments are received in the form of cheques or money-orders made out to the maintenance recipient, recorded by the Program, and subsequently forwarded to the recipient for deposit. The funds are not deposited to the Program's trust account. Pay-to payments are received, recorded, deposited to the trust account and subsequently disbursed from the trust account to the recipient.

5.5 There are seven maintenance enforcement offices located throughout the Province in Amherst, Dartmouth, Kentville, New Glasgow, Truro, Sydney and Yarmouth. The Maintenance Enforcement Program also has a central enrollment unit and a payment processing unit located in the Dartmouth office. A reciprocal enforcement unit has been established in the Sydney office to administer orders of other jurisdictions and monitor orders administered on behalf of Nova Scotia.

5.6. The Program also operates an automated information line to facilitate communication between individuals and Program staff. The automated system allows individuals to provide and receive information on their cases.

5.7 As at March 31, 2007, there were 19,552 maintenance orders enrolled in the Program, including 3,273 orders pertaining to other jurisdictions. During 2006-07, the Program processed approximately $57.4 million in payments, consisting of $36.1 million in flow-through and $21.3 million in pay-to payments.

5.8 The Maintenance Enforcement Program employed 48 people as of March 31, 2007. Thirty-six were engaged in enforcement activities and 12 were responsible for management, enrollment and payment processing functions. For the year ended March 31, 2007, the Program generated $316,000 in fee revenue and incurred operating costs of $2.6 million. Fees are charged to payers for various reasons such as payments in default.

RESULTS IN BRIEF

5.9 The following are our principal observations from this audit.

- Performance information is inadequate to assess the efficiency and effectiveness of the Maintenance Enforcement Program. There is an absence of sufficient information to enable an assessment of how well the Province has administered the Maintenance Enforcement Act. The only performance information prepared and reported by management is a collection rate and we found this statistic to be unreliable and inadequate.

- The Province collects money from payers and then disburses these funds to recipients. These payments are deposited to a trust account. By acting as administrator of the trust account, the Province has established a fiduciary responsibility to ensure money collected is safeguarded and paid to the appropriate recipients. We found trust account assets were not adequately safeguarded because of deficiencies in internal control and the Province does not prepare annual audited financial statements or other information to demonstrate how it has discharged its fiduciary responsibility for the trust account.

- There are inadequate collection processes to ensure the full and timely collection and payment of maintenance orders. We identified significant deficiencies such as a failure to adequately comply with policies and procedures, deficient management reports, and unreliable system data. Program systems contained 11,845 arrears cases in which case records indicated employment information was not confirmed. Management informed us that employment information is not always up-to-date and they do not always record employment confirmations in their system. As a result of this and inadequate documentation of key decisions by enforcement officers, we were unable to determine if garnishment of wages would have been

appropriate for 24 of our 60 sample items. Management identified 6,081 arrears cases for which the Program did not have a notice of federal intercept in place which would allow payments from the federal government such as income tax refunds to be applied against arrears. We were informed one of the reasons for not placing a federal intercept order is due to the lack of information required by the federal government to process orders, such as social insurance numbers. As discussed in this Chapter, we also found we could not rely on the Program's systems for accurately reporting the number of cases in arrears.

- There are significant internal control weaknesses over receipts and disbursements. These weaknesses appear to have been a significant contributing factor to the financial loss which occurred as a result of an alleged fraud within the Program. Prior to our audit, we were informed the alleged fraud was identified when internal audit advised management of a planned audit of the Program. Subsequent to the announcement of the audit, an employee of the Program told management she had made several unauthorized payments. Management terminated the employee and contracted an accounting firm to complete a forensic review. The firm provided management with a preliminary estimate of the loss resulting from the unauthorized payments. The loss was estimated to be approximately $268,000, of which $67,000 was related to trust fund assets and $201,000 to Program fees. Several internal control deficiencies that appear to have contributed to the unauthorized payments had not been addressed as of the completion of our audit.

- The Program has complex financial and operating systems through which a large amount of money flows. The Director of Maintenance Enforcement is responsible for the administration of the Program and also has other responsibilities related to the operation of the Court Services Division. We noted that no professional accounting staff have been engaged to manage and control the financial operations of the Program. Based on the deficiencies identified during our audit, we believe there is a need to apply additional resources and expertise to the management and control of the Maintenance Enforcement Program.

AUDIT SCOPE

5.10 In March 2007, we completed a performance audit of the Maintenance Enforcement Program of the Department of Justice. The audit was conducted in accordance with Section 8 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants (CICA) and accordingly included such tests and procedures as we considered necessary in the circumstances.

5.11 Our audit of internal controls focused on significant computer and financial management controls over receipts and disbursements. We did not assess all

controls, and thus our conclusion and comments address only those systems and controls examined.

5.12 The objectives of the audit were to assess the adequacy of:

- performance information prepared and reported;
- systems and processes to administer and enforce maintenance orders on a timely basis; and
- internal controls to ensure receipts and disbursements are completely and accurately recorded and properly authorized.

5.13 Audit criteria were used to assist in the planning and performance of the audit. For the audit of performance information, criteria were obtained from the CCAF-FCVI Inc. publication *Public Performance Reporting - Reporting Principles*. Criteria for the audit of collection processes were developed based on past audits completed by this Office and other legislative audit offices. Criteria used in our audit of internal controls over receipts and disbursements were developed from *Internal Control Evaluation Questionnaires* and *Information Technology Control Guidelines* of the CICA, supplemented by information from other audit organizations including the Information Systems Audit and Control Association.

5.14 All criteria were discussed with and accepted as appropriate by senior management of the Maintenance Enforcement Program.

PRINCIPAL FINDINGS

Performance Information

5.15 Conclusion and summary of observations - Our objective was to assess the adequacy of performance information prepared and reported by the Maintenance Enforcement Program. We concluded performance information prepared and reported by management is very limited and does not provide sufficient, relevant and appropriate information to enable an assessment of the efficiency and effectiveness of the Program in meeting its stated mission. We determined the only performance information prepared and reported by management was the collection rate and we found this statistic to be inadequate and unreliable. We also noted information included in Statistics Canada's annual survey titled *Child and Spousal Support: Maintenance Enforcement Survey Statistics* indicated the Program was less effective than other jurisdictions.

5.16 Performance information and reporting - The Program's only significant performance indicator is its current collection rate. Statistics provided to us indicated a collection rate of 78% ($53.4 million) for the period April 1, 2005 to March 31, 2006. This statistic includes active flow-through and pay-to payments. Our examination of the collection rate identified data integrity concerns. As a

result, we concluded the collection rate is unreliable (see paragraph 5.37) and does not provide an appropriate indication of collections. Further, a collection rate, by itself, is insufficient to measure Program performance.

5.17 Another indicator of collection performance is the change in amounts owing (arrears). As at March 31, 2007, management determined total arrears to be $106.1 million, excluding arrears on withdrawn files which were estimated to be $57.2 million. A portion of the total arrears relate to cases which entered the Program in arrears in 1996, but the amount was not available. As a result, we were unable to determine the growth in arrears since the implementation of the Program. We noted management does not track or report on the change in arrears, nor do they provide comments to explain the change in the arrears balance. We believe changes in arrears, along with explanations, are an indicator of performance which should be measured and reported.

5.18 Although we concluded performance information is inadequate, our audit identified information currently being maintained by the Program which could be used to make improvements in reporting. We noted monthly call statistics are tracked and complete case histories are maintained.

5.19 We also noted the Program provides information from its databases to support Statistics Canada's annual survey titled *Child and Spousal Support: Maintenance Enforcement Survey Statistics*. Our review of the report identified several indicators and measures of performance which could be used by management for internal and external reporting purposes.

Recommendation 5.1

We recommend the Maintenance Enforcement Program develop and report performance measures and targets for all key aspects of its operations to enable assessment of the efficiency and effectiveness of the Program.

5.20 We examined position descriptions for management and staff and found roles and responsibilities were generally well defined, assigned and communicated. However, roles and responsibilities for preparing and reporting performance information are not formally defined or assigned.

Recommendation 5.2

We recommend the Maintenance Enforcement Program clearly define, assign and communicate staff roles and responsibilities for performance information and reporting.

5.21 Trust account - The Maintenance Enforcement Program acts on behalf of parties to a maintenance agreement to facilitate the flow of court-ordered payments from

payers to recipients. By acting on behalf of these individuals, the Province has established a fiduciary responsibility. Our audit identified an absence of external reporting on how the Program has discharged this responsibility. The Department of Justice does not prepare annual financial statements for the associated trust account, does not have a financial statement audit performed, and does not prepare an accountability or annual report for the account. We believe an appropriate level of external reporting is essential to the accountability process. We strongly encourage the Department of Justice to implement such reporting for the trust account.

Recommendation 5.3

We recommend the Department of Justice prepare annual financial statements for the Maintenance Enforcement trust account. We further recommend that the financial statements be audited and publicly reported.

Collection Processes

5.22 Conclusion and summary of observations - Our objective was to assess the adequacy of systems and processes used to administer and enforce maintenance orders on a timely basis. We concluded the systems and processes are inadequate to ensure the timely collection and disbursement of support payments. We identified significant weaknesses such as unreliable system data, deficient reports and processes, and failure to adequately comply with policies and procedures.

5.23 Efficient and effective collection processes are essential to ensuring recipients receive support payments on a timely basis. Payers are obligated to make payments to the recipient. The Program is responsible to ensure payments are collected and disbursed. A failure to collect and disburse support payments can lead to financial hardship for recipients or make it difficult for them to collect amounts owed.

5.24 Policies and procedures - Well crafted and communicated policies and procedures are needed by the Maintenance Enforcement Program to guide its staff in the timely collection of maintenance payments. Policies and procedures also help ensure operational consistency throughout the Province. Our audit of the Program included assessing the adequacy of policies and procedures, as well as compliance. We also assessed the adequacy of the documentation maintained to support key decisions on cases.

5.25 We examined the Program's policies and procedures and concluded they are inadequate and do not provide staff with sufficient guidance. The following is a list of our concerns.

- The policy manual identifies policies which have not yet been drafted and contains several policies in draft form. We also noted the policy manual has not been subject to a complete review and update.

- There are inconsistencies between policies and there is a need to clarify the application of certain policies.

- There is significant discretion in the use of enforcement actions. However, the manual does not contain adequate guidance on which enforcement actions to use, and when to use them.

- Collection efforts are often affected by the employment status of the payer, but there is no requirement to confirm this information.

- There are no formal policies and procedures for the ongoing review of data entry, case work or enforcement actions.

5.26 We examined 60 cases for compliance with stated policies and procedures. We determined 75% (45 of 60) of these cases contained one or more instances of non-compliance. The following are the significant discrepancies.

- 37% of cases had an incorrect case status recorded (e.g., active, inactive, withdrawn).

- 17% of the inactive files were not reviewed by an enforcement officer as required by policy.

- 48% of the files were in arrears, but had no evidence of enforcement efforts within the past year.

5.27 In addition to the testing results noted above, our analysis of case data identified 162 withdrawn cases with fees still owing to the Program. The withdrawal of cases with outstanding fees is not permitted by current policy.

Recommendation 5.4

We recommend the Maintenance Enforcement Program develop and implement processes to improve upon compliance with its policies and procedures. We further recommend a review and update of the policies and procedures manual to ensure staff is provided with appropriate guidance to adequately administer and enforce maintenance orders.

5.28 Our examination of the 60 cases also identified 33 cases (55%) which did not contain adequate documentation to support key decisions made (e.g., decision to not employ specific collection procedures). We noted there are formal documentation standards. However, these standards do not address the documentation of key decisions for case files. We believe documentation of key decisions is a critical component of the case management and collection process and should be required.

Recommendation 5.5

We recommend the Maintenance Enforcement Program update formal case documentation standards to ensure support for key decisions is adequately documented.

5.29 Case management - The Maintenance Enforcement Act provides the Program with significant powers to facilitate the timely collection of support payments and fees. These powers include, but are not limited to, suspension of driver's licenses, seizure of property and other assets, collapse of pension funds, and garnishment of wages.

5.30 Decisions on the application of enforcement powers depend on various factors including a payer's employment situation. For example, a wage garnishment is only applied when there are amounts owing from a payer and it is confirmed that he or she has employment. We analyzed Program data and identified 15,088 arrears cases containing information on employment. However, based on case records, employment information was not indicated as confirmed for 11,845 (78%) of these cases. Management informed us employment information is not always up-to-date and the employment information confirmation indicator in the system is not consistently used. Since case records indicated employment information as not confirmed and key decisions were not adequately documented as discussed in paragraph 5.28, we were unable to determine if a wage garnishment would have been appropriate for 24 of our 60 sample items. We believe employment information is critical to the effective enforcement of cases in arrears and should, therefore, be kept current and accurate through communication with payers and confirmation with employers.

5.31 During our interviews, Program staff expressed concerns regarding difficulty in confirming employment income, identifying and confirming assets, locating individuals, as well as other administrative and enforcement challenges. Maintenance orders do not include information such as social insurance numbers, date of birth, employment information, business ownership, personal financial information (e.g., net worth) and other information which could assist in the administration and enforcement of a maintenance order. We believe inclusion of such information could facilitate the timely collection of payments and improve the efficiency of Program operations. For example, management advised us of 6,081 arrears cases which did not have a notice of federal intercept in place as of March 31, 2007. A notice of federal intercept order allows the Program to collect money from the federal government which would otherwise be disbursed to a payer, such as income tax refunds. We were informed one of the reasons for not placing a federal intercept order is the absence of information required by the federal government to process such orders.

Recommendation 5.6

We recommend the Maintenance Enforcement Program identify information which could help facilitate the effective administration and enforcement of maintenance orders, and initiate discussions with the courts to have such information incorporated into future maintenance orders.

5.32 Review and approval - Maintenance orders are recorded by enrollment staff prior to being assigned to an enforcement officer. As noted in paragraph 5.25, policies and procedures do not require a quality assurance review of data entry, case work or enforcement actions. Enforcement officers informed us they review the accuracy of data entered into the system by enrollment staff. Management advised us that there are some reviews of case files, however they are not formally required or conducted on a regular basis.

5.33 Review and approval processes are important for ensuring accurate data and consistent compliance with Program policies and procedures. We believe review and approval processes should be clearly defined and there should be a formal requirement to document reviews performed. Informal policies and procedures increase the risk of processes not occurring.

Recommendation 5.7

We recommend the Maintenance Enforcement Program develop, document and implement formal review and approval procedures for all significant processes. We further recommend a formal requirement to adequately document reviews and approvals.

5.34 Computer systems - All information related to the administration and enforcement of a maintenance order is recorded in the maintenance enforcement computer system. We examined the system and found it capable of recording and tracking maintenance orders. We did, however, identify some areas for improvement.

5.35 Our concerns over the system related primarily to internal controls and how information in the system was used. Our observations relating to internal controls are discussed later in this Report. Our concerns over information usage relate primarily to the lack of meaningful reporting to assist enforcement officers and management in their duties.

5.36 Management and enforcement officers informed us of concerns over the adequacy and usefulness of current system reports. Enforcement officers described types of reports they would find helpful but have difficulty obtaining. We also noted the current system does not provide management with a general ledger for the maintenance enforcement trust account, and information on trust activities is limited and not timely. Our analysis of system data determined more meaningful and useful reports could be produced if changes were made to the system or other software was used.

Recommendation 5.8

We recommend the Maintenance Enforcement Program review staff information needs and update system reporting capabilities to ensure timely and relevant information is available to assist staff in administration and enforcement activities.

5.37 Data integrity - Data integrity is critical to the effective decision making processes of any organization or program. We obtained an extract of all case records and transactions from the maintenance enforcement computer system and performed several analyses on the data. Our analysis and subsequent examination of case files identified significant problems with the integrity of the data. As a result, and due to noted weakness in controls over system data, we were unable to rely on the completeness or accuracy of the data in the performance of our audit.

5.38 Our analyses and testing identified errors in the recording of maintenance orders and reporting of arrears. For example, we noted amounts accruing on accounts which are no longer being enforced by the Program because payments are being made directly to recipients by payers. Management informed us many of the employment records referred to in paragraph 5.30 were old and inaccurate. Inaccurate case data make management and other reports unreliable and therefore inadequate for use in decision making. We believe reliable data is essential to the efficient and effective operation of the Program and our concerns in this area should be addressed in a timely basis.

Recommendation 5.9

We recommend the Maintenance Enforcement Program implement processes to correct inaccurate information in its computer system and ensure ongoing data integrity.

5.39 Complaint process - Our testing of the Program's complaint process noted complaints are documented and addressed within established time limits. However, we believe the communication of the complaint process to Program clients could be improved.

5.40 Interdepartmental coordination -The Department of Service Nova Scotia and Municipal Relations (SNSMR) serves as the primary collection agency for the Province and is responsible for the collection of amounts owed to the Province under various programs. We met with the manager of collections at SNSMR and identified similarities and differences between the collection processes used by the Department and those used by the Maintenance Enforcement Program. We noted SNSMR has access to information and resources which are unavailable to the Maintenance Enforcement Program, while the Program has enforcement powers which are not available to the Department. We also noted information on collection techniques and experiences is not shared between SNSMR and the Program. We believe there are opportunities for cooperation in areas such as

training and sharing of best practices. We also believe the potential costs and benefits of further cooperation should be investigated.

Recommendation 5.10

We recommend the Departments of Justice and Service Nova Scotia and Municipal Relations investigate the potential to share collection training and best practices, and examine the potential costs and benefits of further cooperation.

Internal Controls - Receipts and Disbursements

5.41 Conclusion and summary of observations - Our objective was to assess the adequacy of internal controls used to ensure Program receipts and disbursements are completely and accurately recorded and properly authorized. Our audit focused on the significant computer and financial management controls which would impact our objective and, as a result, did not examine all controls. Therefore, our conclusion and comments are limited to those internal controls which impact receipt and disbursement processes. Based on our examination, we concluded control over receipts and disbursements are inadequate. We identified significant deficiencies such as inadequate policies and procedures, staff with incompatible duties, computer access control deficiencies, as well as inadequate reconciliation, review and approval processes. The deficiencies identified represent a significant risk of financial loss or other negative consequences to the Program.

5.42 Policies and procedures - The Maintenance Enforcement Program has documented polices and procedures to guide staff. In addition to weaknesses previously discussed in paragraph 5.25, our audit identified policy and procedure deficiencies specifically related to internal controls. There is an absence of formal policies and procedures in areas such as electronic funds transfers, reconciliation processes and changes to computer access rights. Management informed us the Department of Justice has established a committee to develop a common format for manuals, prioritize the updating of manuals and develop an on-line manuals management system. However, the development and updating of Program policies and procedures remains the responsibility of maintenance enforcement staff. We believe internal control policy and procedure deficiencies should be addressed in a timely manner. See recommendation 5.4.

5.43 Segregation of duties - We identified a number of serious weaknesses related to inadequate segregation of incompatible duties. Staff who receive and disburse funds also have responsibility for recording these transactions. Certain of these individuals are also responsible for reconciliation processes. We determined certain staff could complete a disbursement, either by way of cheque or electronic funds transfer, without the involvement of another staff member. The ability to initiate and account for payments is inappropriate because it provides the opportunity to both initiate and conceal an unauthorized transaction. We did not identify adequate compensating controls to mitigate the risks associated with these incompatible duties.

Recommendation 5.11

We recommend the Maintenance Enforcement Program review its current staff roles and re-assign responsibilities or implement adequate compensating controls to address the segregation of duties weaknesses.

5.44 Access controls - In order to maintain effective internal controls, it is necessary to control access to an organization's information systems. Access rights need to be limited to those necessary for staff to effectively fulfill position responsibilities. Unrestricted or inappropriate access to systems and data can increase the risk of unauthorized transactions or system changes leading to financial loss and other negative consequences.

5.45 We examined access controls for the Maintenance Enforcement Program. Facilities where computers are located are adequately secured and computer access is protected by passwords. However, we identified a number of weaknesses in this area. The following is a list of our concerns.

- Seven individuals had more than one user profile, including an information technology support staff member who had two user profiles.
- Staff had access to fields in the system not required to fulfill position responsibilities. This could result in unauthorized changes to system information.
- One staff member had the electronic funds transfer user ID automatically entered when accessing the system.
- There are no control logs or reports of changes to access rights.
- There are no regular reviews or tests of access rights.

5.46 Control over computer access rights is a critical component of an internal control framework. We concluded there are inadequate controls to ensure all access rights are properly authorized and appropriate for each user. We were advised by management that action has been taken to address some of the concerns noted above, but we believe additional action is required.

Recommendation 5.12

We recommend the Maintenance Enforcement Program review all computer access rights and ensure staff members only have access rights necessary to fulfill position responsibilities. We further recommend regular monitoring of access rights and review and approval of changes.

5.47 Program change controls - The process to initiate a change to the maintenance enforcement computer program is not formalized. Authorized staff e-mail

requests to information technology staff who document requested changes. Only one information technology staff member is required to implement a program change. We were informed program changes are completed in a development (test) environment and tested by Program staff. Once accepted, the change is implemented in the production (live) environment. We noted program code changes are not independently reviewed or approved prior to implementation. We also noted program changes are not independently monitored. We concluded there are inadequate controls to ensure all program changes are authorized and properly performed. Without adequate control, unauthorized changes may occur either intentionally or in error, which could have negative consequences for the Program.

5.48 During our audit, we identified a computer program function which was not operating as intended. This error allowed information such as payee name, mailing address or direct deposit information to be changed by unauthorized staff. The issue was immediately addressed by management.

Recommendation 5.13

We recommend the Maintenance Enforcement Program formally document computer software program change procedures. We further recommend independent review and approval of program changes prior to implementation and monitoring of program change logs to ensure all changes are authorized and properly completed.

5.49 Control over master data - Good control over case master data is necessary to protect data integrity and confidentiality, and to ensure only authorized payments are made. We found unauthorized changes to case master data could occur and not be detected. We also noted changes to case master data are not independently monitored or reviewed.

Recommendation 5.14

We recommend the Maintenance Enforcement Program formally define critical case master data and ensure the ability to change such data is limited to appropriate, authorized staff. We further recommend logs of master data changes be maintained and independently monitored to ensure all changes are authorized and appropriate.

5.50 Output controls - Control over system outputs such as electronic funds transfer (EFT) files is essential to safeguarding the Program's financial assets. Failure to adequately safeguard these items can pose a significant risk of financial loss. We identified serious weaknesses in controls over EFT files. We found unauthorized EFT files could be created and unauthorized file changes could occur prior to the transfer of the file to the bank. We also noted an EFT could be completed from any computer at any location provided there was a valid user ID and password, though

Program management thought special software had to be installed on a computer to do so.

5.51 In addition, we noted access to blank cheques and the signature stamp was not logged or monitored. Accordingly, there is a risk of unauthorized disbursements. We concluded there are inadequate compensating controls to mitigate these risks.

Recommendation 5.15

We recommend the Maintenance Enforcement Program develop and implement adequate control over electronic funds transfer files and blank cheques.

5.52 Computer edit controls - Maintenance enforcement system application controls require a payer receipt be recorded before a payment to a recipient can be processed. This control is ineffective in preventing unauthorized payments because staff members with responsibility for recording receipts are also responsible for initiating disbursements. We concluded there are inadequate controls to ensure amounts recorded as received were actually received and deposited to the bank prior to the related disbursement.

5.53 There are no computerized edit checks to identify unusual balances, duplicate payments, or multiple payments to the same account. There are also no pre-programmed dollar limits for individual cheques or EFTs. Management advised us EFT amounts were limited to a maximum daily amount of $300,000. We were unable to verify this due to a lack of documentation (see paragraph 5.64).

5.54 EFT risks are further increased because there is no payment processing delay to allow time to reconcile the payment file received by the bank to the Program's records. EFT payments are immediately processed by the bank once received. We believe the absence of both a programmed dollar limit on individual payments and a timely bank file reconciliation process significantly increase the risk of financial loss due to unauthorized payments.

Recommendation 5.16

We recommend the Maintenance Enforcement Program implement programmed dollar limits for individual cheques and electronic funds transfers. We further recommend bank processing of electronic funds transfers be delayed to allow for timely reconciliation processes to be completed.

5.55 Bank reconciliations - Bank reconciliations are essential for effective control over receipts and disbursements. Our examination of the Maintenance Enforcement Program bank reconciliation process identified the following serious deficiencies.

- Reconciliations for the trust account were not completed for several years. However, Program staff subsequently completed these reconciliations.

- There are no policies or procedures to ensure reconciliations are completed on a timely basis.

- Trust account reconciliations contain unreconciled differences and old outstanding cheques. Procedures have recently been developed to address old outstanding cheques. However, there are no processes to ensure unreconciled differences are investigated and resolved in a timely manner.

- Reconciliations are not signed or dated by the preparer.

- Reconciliations are not independently reviewed or approved.

- Reconciliations have not been completed for the Program's revenue and special bank accounts. Subsequent to the completion of our audit, management advised us the special account has been closed.

Recommendation 5.17

We recommend the Maintenance Enforcement Program complete reconciliations for each of its bank accounts on a timely basis. Unreconciled differences should be investigated and resolved, and reconciliations should be independently reviewed and approved.

5.56 As noted in recommendations 5.4 and 5.7, we believe reconciliation processes should be formalized to help ensure they are properly performed and approved. We strongly encourage management to immediately address the reconciliation deficiencies noted above.

5.57 Review and approval - Effective control systems include independent review and approval processes. In addition to the inadequate review and approval processes noted above, we identified weaknesses in management oversight processes relating to:

- electronic funds transfer reports;

- disbursement variance reports;

- Program revenues transferred;

- bank deposits;

- receipt of goods and services acquired using purchase cards to ensure intended goods and services have been received;

- IT support staff activities; and

- fee adjustments.

5.58 We previously recommended development of formal review and approval procedures for all significant processes. See recommendation 5.7

Other Observations

5.59 We made a number of additional observations during our audit which we believe should be addressed. These observations are discussed in the following paragraphs.

5.60 Program management - The Maintenance Enforcement Act assigns responsibility for the administration of the Act to the Director of Maintenance Enforcement. However, the Department of Justice has also assigned other responsibilities related to the operation of its Court Services Division to the Director of Maintenance Enforcement. Despite the complexity of the Program's financial operations and systems, and the large amount of money involved, there has been no professional accounting staff engaged to manage and control the financial operations of the Program. Based on the deficiencies identified during our audit, we believe there is a need to apply additional resources and expertise to the management of the Maintenance Enforcement Program.

Recommendation 5.18

We recommend the Department of Justice review and assess the managerial needs of the Maintenance Enforcement Program and apply sufficient resources and expertise to effectively manage the Program and adequately fulfill its fiduciary responsibility.

5.61 General computer environment controls - Control over an organization's general computer environment is critical to its overall control. Although we did not complete an audit of all general computer environment controls, we conducted several interviews and reviewed selected documentation related to general computer environment controls. We noted the computer systems of the Maintenance Enforcement Program are maintained and supported by the Department of Justice's Information Management Division. We found the Division has:

- a formal business continuity plan;

- policies and procedures to support the establishment, approval, communication and monitoring of IT objectives and plans;

- formal policies to address end-user computer applications, computer monitoring, virus protection and illegal software; and

- indicators and measures to track IT performance.

5.62 We also noted areas where improvements could be made. The Department should prepare a formal IT strategic plan and complete a formal IT risk assessment and management strategy. We believe the Department should also formally document all significant computer standards and operating procedures.

5.63 Accounting - Prior to our audit, we were informed an alleged fraud was identified when internal audit advised management of a planned audit of the Program. Subsequent to the announcement of the internal audit, an employee of the Program advised management she had made several unauthorized payments. Management terminated her employment and contracted an accounting firm to complete a forensic review. The firm provided management with a preliminary estimate of the loss resulting from the unauthorized payments. The loss was estimated to be approximately $268,000, of which $67,000 was related to trust fund assets and $201,000 related to Program fees. The Province recorded a liability to the trust account for the estimated loss of trust funds, but did not record the receipt and loss of the Program fees. We advised that the receipt and loss of Program fees be recorded as required by generally accepted accounting principles.

5.64 Banking agreements - We requested a copy of the Program's agreement with the bank. Management was unable to locate a copy of the agreement and advised us the agreement was in excess of twelve years old, and preceded the Program's electronic funds transfer process. We advised management to update the current banking agreement and ensure it addresses all current banking activities, including electronic funds transfers. We further advised management to ensure the banking agreement addresses the controls the bank is expected to apply to ensure data security and confidentiality. Subsequent to the completion of the audit, management informed us they have received a copy of the banking agreement and are reviewing it.

5.65 Payment options - Currently, individuals can make support payments to the Maintenance Enforcement Program by cash, cheque or money order. The Program does not permit electronic payment. Service Nova Scotia and Municipal Relations staff informed us that they use electronic funds transfers in their collection efforts. We believe electronic payment options could improve the operational efficiency and effectiveness of the Maintenance Enforcement Program by reducing staff workloads. We suggested management further investigate this option.

CONCLUDING REMARKS

5.66 Performance information is inadequate to assess the efficiency and effectiveness of the Maintenance Enforcement Program. The Department of Justice should develop, implement and report adequate performance measures and targets for the Program. We also believe the Department should prepare annual audited financial statements for the trust account. The preparation and reporting of both financial and non-financial information are essential to the accountability process. Without this information, it is difficult to assess how the Department of Justice has managed the

Maintenance Enforcement Act and discharged its fiduciary responsibility related to the Program's trust account.

5.67 In this chapter we raise several significant concerns regarding internal controls and the administration and enforcement of maintenance orders. The deficiencies negatively impact Program operations and pose a significant risk to the Program.

5.68 The Maintenance Enforcement Program requires a substantial effort to address the deficiencies noted in our Report. We strongly encourage management to immediately prioritize and address these serious deficiencies.

DEPARTMENT OF JUSTICE'S RESPONSE

During late 2006 and early 2007, a performance audit of the Maintenance Enforcement Program was conducted by the Office of the Auditor General. This is the first comprehensive audit in the ten year history of the program. The report of the Auditor General underscores the complexity and enormity of the Maintenance Enforcement Program and has identified three main areas for improvement. The Department appreciates this opportunity to provide a preliminary response identifying steps that have been taken thus far to address deficiencies. The Department acknowledges the considerable work that remains to be done to ensure the continued effectiveness of the Program and is in the initial stages of developing an implementation plan for the remainder of the recommendations.

Key Findings

1. Performance Information

"Performance information" refers to the data which is collected and shared that demonstrates that MEP is doing its job properly. It was found that performance information in relation to MEP is limited and does not speak fully enough to the efficiency or effectiveness of the program. There is an identified need to:

- move beyond "collection rate" as a primary indicator and identify and report upon other performance indicators such as "change in arrears"
- develop processes to increase data integrity
- clarify responsibility for reporting performance information
- have prepared and report the results of independent, annual audits

Government Response

The following action has been taken to address recommendations regarding performance information:

- the Maintenance Enforcement computer system is in the process of being upgraded. The upgrade has included a intensive program review which has identified deficiencies, the correction of which will improve data integrity
- the Program is examining statistics currently collected and reported to identify which of those are appropriate performance indicators
- a MEP Logic Model outlining performance indicators and responsibilities of reporting has been adopted
- MEP Directors across Canada are working to identify national performance measures

- NS Court Services has created a Justice Indicators project to address performance management within the Division

2. Collection Processes

The "collection process" refers to how support payments are collected and disbursed. It has been determined that collection systems and processes could be improved. There is an identified need to:

- further develop and disseminate policy and procedure
- ensure compliance with policy and procedure
- increase sources of information to assist with collection
- develop processes for the review and approval of data entry
- enhance the MEP database to allow for more informative reporting
- develop processes to increase data integrity
- consult with partners to share information sources and best practices

Government Response

The following action has been taken to address recommendations regarding the collection process:

- The Department is currently reviewing system enhancements which will improve the reporting process
- a senior Program Officer has been assigned a Manual Renewals project and will be addressing the Maintenance Enforcement Program manual
- priority has been given to reviewing and updating policy and procedure
- enrollment information is being reviewed and verified for accuracy during the file intake process at the enforcement offices
- the *Maintenance Enforcement Act* was amended in 2006 to increase enforcement powers
- a "field officer" pilot project was successful in identifying additional collection information sources that continue to be used
- implementation of file review has successfully reduced the overall caseload and the arrears amounts

3. Internal Controls – Receipts and Disbursements

"Internal controls - receipts and disbursements" refers to technological and financial management. There is a need to increase management control over these areas by:

- developing policy and procedure to increase internal checks and balances
- segregating duties in relation to these controls
- increasing internal control over computer access and master data
- increasing internal control over electronic fund transfers and banking procedures

Government Response

The following actions have been taken to address the recommendations respecting internal control:

- there has been a segregation of banking duties and immediate steps are being taken to segregate other duties where appropriate
- computer access security has been increased
- internal controls have been developed in relation to the use of receipt books
- internal controls have been developed in relation to the use of trust cheques
- banking resolutions and signing officers have been updated and banking agreements are being reviewed
- internal controls have been developed in relation to the receipt of front counter payments
- internal controls have been developed in relation to access to the revenue account.

COMMUNITY SERVICES

6 REGIONAL HOUSING AUTHORITIES

BACKGROUND

6.1 In August 2000, the Department of Community Services was assigned responsibility for government housing programs upon the dissolution of the Department of Housing and Municipal Affairs. The Department of Community Services provides a range of housing services through a number of programs. The Department, through the Nova Scotia Housing Development Corporation and the Housing Authorities, also provides and maintains approximately 12,000 public housing units.

6.2 The Nova Scotia Housing Development Corporation owns the public housing properties on behalf of the Province. Staff of the Department of Community Services performs the management and administrative functions of the Housing Development Corporation. Seven Housing Authorities (see Exhibit 6.1) are responsible for the administration, operation and maintenance of the public housing properties on behalf of the Corporation. Staff of the Housing Authorities are not employees of the Corporation or the Department. The financial results of the seven Housing Authorities are included in the financial statements of the Housing Development Corporation, which are consolidated into the financial statements of the Province.

6.3 Housing Authorities are established under the Housing Act. The Act gives the Minister of Community Services "*general management, supervision and authority over*" the Housing Authorities. There have been as many as 46 Housing Authorities in the Province. The Authorities were merged in 1991 to form 19, and were further amalgamated in 1997 to the current seven. Each of these seven Housing Authorities was established by an Order in Council and a formal management agreement between the Minister and the Housing Authority's Board.

6.4 The Housing Authorities manage the day-to-day operations of the public housing stock. Their responsibilities include administering tenant applications and placements, collecting rent, resolving tenant issues, and maintaining and repairing of the properties. The Department, through the Housing Development Corporation, provides funding to the Authorities to carry out their responsibilities. Net losses of the Housing Authorities are cost-shared. For the year ended March 31, 2006, the Province was responsible for approximately 88% ($48.9 million) of the losses, and the respective municipalities for approximately 12% ($6.7 million) (see Exhibit 6.2).

6.5 The two largest Housing Authorities in Nova Scotia are the Metropolitan Regional Housing Authority (MRHA) and the Cape Breton Island Housing Authority (CBIHA). MRHA, with 165 staff, oversees 3,965 public housing units, 520 rent supplement units and approximately 7,300 tenants. MRHA's budgeted

expenditures for 2006-07 were $35.7 million (see Exhibit 6.3). CBIHA has 177 staff and manages 3,264 public/non-profit housing units, 71 rent supplement units and approximately 5,400 tenants. CBIHA's budgeted expenditures for 2006-07 were $30.7 million (see Exhibit 6.4).

RESULTS IN BRIEF

6.6 The following are the principal observations from our audit of the Metropolitan Regional Housing Authority and the Cape Breton Island Housing Authority.

- The Housing Authorities receive direction and guidance from the Department of Community Services and function similarly to a division of the Department. Roles and responsibilities are understood at the Housing Authorities and they comply with the reporting requirements established by the Department. Non-financial outcomes, measures and targets should be developed and reported upon by the Authorities to enable a more complete assessment of performance.

- There are weaknesses in access controls over the Housing Authorities' computer system. Access logs and access rights should be reviewed on a regular basis.

- System controls over the receipt, recording and depositing of revenues are adequate at MRHA and CBIHA. However, we identified instances of the use of inaccurate information in the calculation of rental charges. Adjustments to rental charges should be fully supported and reviewed for accuracy and appropriateness.

- We noted control weaknesses and instances of failure of control procedures relating to the processing of expenditures at MRHA and CBIHA. Proper support and authorization should be obtained prior to processing payments, and review procedures should be improved and better documented. In addition, we identified assignment of incompatible responsibilities to staff at CBIHA which should be addressed.

- MRHA and CBIHA have processes in place for open and fair procurement that provides value for money. The Public Housing Operations Manual should be reviewed and updated to ensure it is consistent with the Government Procurement Policy.

AUDIT SCOPE

6.7 In February 2007, we completed a performance audit at the Metropolitan Regional Housing Authority and the Cape Breton Island Housing Authority. The audit was conducted in accordance with Section 8 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants, and included such tests and procedures we considered necessary in the circumstances.

6.8 The objectives for this assignment were to assess:

- the governance function and accountability framework for the Housing Authorities;
- the adequacy of control over revenues and expenditures at the Authorities; and
- the adequacy of procurement processes in place to provide for value for money.

6.9 Our audit included two of the Province's seven Housing Authorities. Accordingly, while some policies, practices and other matters mentioned in this chapter may be applicable to all of the Housing Authorities, our comments are restricted to the two we audited.

6.10 Audit criteria were derived from recognized sources, including the *Canadian Institute of Chartered Accountants (CICA) Standards and Guidance Collection - Guidance on Control*, *CICA Professional Engagement Manual*, *CICA InformationTechnology Control Guidelines*, as well as the Government Procurement Policy and the Department of Community Services Public Housing Operations Manual. Criteria used in this audit were discussed with senior management of the two Housing Authorities and the Department and were accepted as appropriate.

6.11 We visited both Housing Authorities in early 2007 and conducted audit work on-site. We interviewed members of management and staff; examined policies, files and other documentation deemed to be relevant; reviewed systems and processes; and tested certain processes and key controls.

PRINCIPAL FINDINGS

Governance and Accountability

6.12 Conclusions and summary of observations - Governance relates to how a governing body leads and oversees an organization. Accountability is the requirement to answer for the discharge of responsibilities that have been assigned. We examined the governance function and the accountability framework for both Metropolitan Regional Housing Authority (MRHA) and Cape Breton Island Housing Authority (CBIHA). We concluded the Housing Authorities receive direction and guidance from the Department and function similar to a division of the Department. In addition, we concluded the Housing Authorities are in compliance with the reporting requirements established by the Department.

6.13 Governance and accountability - Under a traditional governance structure, a governing body or board provides leadership and oversight for an organization. For the Housing Authorities, the Boards are not responsible for providing strategic direction, oversight and control. They are primarily responsible for tenant issues, such as approval of applicants for public housing, tenant transfers, renewal or non-

renewal of leases, and responding to complaints or inquiries from tenants. The management agreements signed between the Minister of Community Services and the Boards indicate that the Minister is responsible for direction and supervision of the property management activities carried out by staff of the Authorities. The Minister assumes this role by having Housing Authority administrators report to management of the Department (See Exhibit 6.5).

6.14 Management at the Authorities indicated that they receive direction and guidance on their mission and objectives from the Department through the Department's Business Plan and communication with Department staff. As well, MRHA prepared an internal document that outlined goals and objectives for the organization for 2006-07. We reviewed the Department's 2006-07 Business Plan and noted that it addresses various housing programs, but Housing Authorities are not specifically mentioned within that document. The Nova Scotia Housing Development Corporation's 2006-07 Business Plan refers to the Housing Authorities as direct service providers of tenant and property management. We noted the responsibilities of the Housing Authorities align with the Corporation's mission and strategic goals. We also noted the Housing Authorities were included in a 2004 Departmental strategic planning exercise for government housing programs.

6.15 Roles and responsibilities are set out in the management agreements and Housing Authority job descriptions, and are understood at the Authorities. Documented policies and guidelines, as well as regular communication with the Department, provide direction and guidance, especially with regard to budgeting and financial reporting. Annual budgets and capital repair plans are submitted to the Department for approval. MRHA and CBIHA report financial results monthly, as well as statistics on public housing unit vacancies and the number of applicants on waiting lists

6.16 The Department and the Corporation have established performance outcomes, as well as measures and targets to determine progress on achievement, which are documented in their respective business plans. Housing Authorities report on their financial performance to the Department, but there are no requirements to establish and report non-financial performance measures, targets and results. The performance measures and targets for the Department and the Corporation are not sufficiently specific to be useful for determining the performance of MRHA and CBIHA. In our view, performance measures and targets that link to those of the Department and Corporation should be established to enable a more complete assessment of the performance of the Housing Authorities in discharging their responsibilities and contributing toward the achievement of the Department's goals.

Recommendation 6.1

We recommend that performance outcomes, measures and targets be developed for the Housing Authorities and that performance against these targets be assessed on a regular and timely basis.

Controls over Revenues and Expenditures

6.17 Conclusion and summary of observations - We assessed whether the two Housing Authorities have adequate control over revenues and expenditures. Our examination of controls included those related to receipt and recording of revenues, collection of receivables, recording and payment of expenditures, as well as general and application controls for financial information systems. We found areas where control is adequate, but also identified control weaknesses and instances where controls did not operate as intended.

6.18 Organizational controls - Financial results at MRHA and CBIHA are reviewed monthly and compared to budgets. Variances between budgeted and actual results are investigated. We noted that the Housing Authorities carry out regular reconciliations of payables, receivables and bank accounts.

6.19 Many of the Housing Authorities' policies and procedures are documented in the Public Housing Operations Manual provided by the Department of Community Services. We observed that a number of chapters or sections in the manual are outdated and do not reflect current practices. For example, the arrears collection procedures need to be updated and the financial management chapter outlines procedures for a manual accounting system, rather than the computerized financial information system used by the Housing Authorities. We noted there are training manuals for the computer system, but they also require updating. Some areas in the training manuals are still incomplete, such as procedures for pre-approved rent payments.

6.20 We found that staff members are clear on their roles and responsibilities, as well as the policies and procedures to be followed. Staff members are informed of their job requirements when they are hired and through on-going training. Changes to policies are communicated through e-mail, staff meetings and management direction. We noted that some job descriptions at the Authorities have not been updated for many years.

Recommendation 6.2

We recommend that job descriptions, and policy and procedures manuals, including financial and system training manuals, be reviewed and updated in a timely manner.

6.21 General computer controls - The Housing Authorities use a web-based property management application called Yardi Voyager (Yardi) for property management and financial operations. Yardi is owned and maintained by a private sector company, and made available for use by various public and private property management operators on a fee-for-service basis. It is available to the Housing Authorities through a service agreement signed in 2002.

6.22 Payroll transactions are processed through the Nova Scotia government's corporate financial management system (SAP HR module). The Housing Authorities have

a service agreement with the government for use of this system. The Housing Authorities also have a service agreement with the Department of Community Services for support of their own information technology infrastructures.

6.23 We examined controls around the general computer environment at MRHA and CBIHA to determine if the integrity, confidentiality and availability of computer processing, as well as access to the information system functions and data are adequately protected. We noted the following control weaknesses.

6.24 Access to Yardi is controlled by a user ID and password. We examined access procedures and made suggestions to management for improvement relating to the setting of passwords and limiting of log-on attempts. We were informed that changing the password security setup would require customization of the Yardi system. This would require the agreement and services of the system owner, possibly at significant cost.

6.25 Access to Yardi is through the Internet, with the use of a standard browser. In addition to a user ID and password, a computer and an active internet connection is all that is required to access the system. The Department issued a directive to the Housing Authorities that indicated access to Yardi must be through computers properly configured by the Department's information technology specialists. System access logs which identify the address of computers that have accessed Yardi are available to the IT specialists. We were informed they do not review the access logs to ensure that only authorized and properly-configured computers are accessing Yardi. As a result, if unauthorized access to the system from outside the Authorities occurred, it could go undetected.

6.26 There are no documented policies and procedures for setting up users on the Yardi system, although staff is aware of the processes to be followed. The system can provide information on employees which have access to various system functions, but this has not been reviewed since the system was implemented. Access rights should be reviewed periodically to ensure they are appropriately assigned and incompatible responsibilities are separated.

Recommendation 6.3

We recommend that financial system access logs and access rights be reviewed on a regular basis to ensure that only authorized users are accessing the system and that access rights assigned are appropriate for assigned responsibilities and functions.

6.27 As noted in paragraph 6.21, a private sector company operates and supports the financial information system used by the Housing Authorities, and the Nova Scotia government provides payroll services to the Authorities. The Housing Authorities should seek assurance regarding the adequacy of controls surrounding these systems since they are beyond the oversight of the Authorities. Assurance on the adequacy of controls can be obtained through an independent audit of the computer operations of these external service providers.

Recommendation 6.4

We recommend that the Housing Authorities and the Department of Community Services consider options available to obtain assurance on the adequacy of controls surrounding the information systems which the Authorities use.

6.28 Control over revenues - We examined the processes and controls in place at MRHA and CBIHA and tested certain key controls to determine if revenues received were completely and accurately recorded and deposited in a timely manner. At each Housing Authority we also recalculated rental charges for 30 sample items, and examined collection activities for 10 accounts with arrears balances.

6.29 Based on our tests, we concluded that system controls over the receipt, recording and depositing of revenues were adequate at both MRHA and CBIHA. However, we identified the use of inaccurate information in the calculation of rental charges. At MRHA, we noted instances where documentation of income was not in the tenant file or was inadequate to support the rent calculation, and we were unable to verify property manager review of rent calculation documents for several sample items. At CBIHA, we found instances where inaccurate amounts were entered in the tenant records or were used in determining income for the rent calculation. We were also unable to verify property manager review of rent calculation documents for certain sample items. Although the noted errors were small, we provided details of our test results to management to indicate where control procedures had not operated as intended.

6.30 Tenants may have rent reduced during a lease term as a result of lower household income. At CBIHA, we were informed that rent reductions prepared by income review clerks subsequent to yearly lease renewals are not reviewed by the property managers. The documents are filed in tenant files and available for yearly lease review by property managers. This increases the risk that an inappropriate rent reduction will be processed. At MRHA, rent reductions, as well as lease renewal documents, are reviewed by the property manager.

Recommendation 6.5

We recommend that all changes to rental charges be fully supported and reviewed for accuracy and appropriateness by the property managers. Completion of the review should be documented.

6.31 Both Housing Authorities have collection policies and procedures including measures such as phone calls, personal visits, verbal and written agreements for repayment, reminder letters, and orders for termination of tenancy. Property managers are responsible for monitoring tenants' arrears balances, and are responsible for sending reminder letters, making personal visits and following up on tenant commitments for payment. MRHA and CBIHA also have collections

officers on staff to aid in collections activities. All Housing Authorities must abide by the regulations of the Nova Scotia Residential Tenancies Board, including those which dictate the process for addressing nonpayment of rents. We found that CBIHA made adequate collection efforts for the ten accounts we tested that were in arrears at December 31, 2006. We concluded that collection efforts could have been improved for three of the ten accounts in arrears we examined at MRHA.

6.32 Control over expenditures - We examined the processes and controls in place at MRHA and CBIHA and tested certain key controls to determine if expenditures are properly supported, approved and completely and accurately recorded. We selected 30 non-payroll and 9 payroll items at each of the Housing Authorities for testing. We provided details of our testing results to management.

6.33 We found certain controls over expenditures at MRHA were functioning appropriately, but also noted control weaknesses. Certain review procedures are carried out by the accounts payable clerks and the senior accounting clerk before payments are processed. This review is not documented (i.e., no signature or initials), so we were unable to determine if the appropriate reviews had taken place for all 30 of our sample items. We also found instances where control procedures had failed to operate as intended, including approval for payment by a person without the appropriate spending authorization; issue of purchase orders after the goods or services were obtained; no indication that labour rate charges were verified to the contract rate; and a timesheet not approved and signed by the employee's supervisor.

6.34 We found certain controls over expenditures at CBIHA were functioning appropriately, but also noted cases where control procedures had failed to operate as intended. For example, we found instances of approval for payment by a person who did not have the appropriate spending authorization; amounts or rates charged on invoices which did not match tender amounts; and no documentation that a review of invoices and supporting documents had taken place.

6.35 From our review of work performed in 2005 by the auditors of the Housing Development Corporation's financial statements which included auditing at the Authorities, we noted incompatible duties were identified among the accounts payable positions at CBIHA. Certain accounts payable staff have the ability to record payments in the accounting system, as well as prepare and sign cheques. This creates the potential for inappropriate payments to be processed and not detected. At the time of our audit, this situation remained unchanged.

Recommendation 6.6

We recommend that the Housing Authorities review their internal control procedures to ensure proper support and authorization are obtained prior to making payments and to ensure review procedures are properly carried out and documented. In addition, Cape Breton Island Housing Authority should ensure incompatible responsibilities are not assigned to its accounts payable staff.

Procurement

6.36 The Housing Authorities are required to conduct operations in compliance with policies and guidelines in the Public Housing Operations Manual, as stated in the management agreements. Chapter 46 of the manual outlines procurement policies. The chapter also notes that Housing Authorities are subject to the Nova Scotia Government Procurement Policy and the Atlantic Procurement Agreement. We examined the procurement policies and practices at MRHA and CBIHA and concluded that the Authorities have processes in place for open and fair procurement that provide value for money. However, we identified weaknesses that resulted in non-compliance with some policies.

6.37 The Public Housing Operations Manual states that, should there be a conflict between the manual and other applicable policy documents, the manual shall prevail. It is not clear that authority to override the Nova Scotia Government Procurement Policy has been granted by government. We reviewed the two policies to determine if there were any areas of conflict and noted the following.

- The Public Housing Operations Manual requires contracts be awarded to the lowest bidder and a contract should only be awarded to other than the lowest bidder in unusual circumstances. The Government Procurement Policy allows bids to be evaluated on other criteria such as quality, delivery, servicing, and capacity to meet requirements, in addition to price. The bid request documents must clearly identify the criteria and assigned weights to be used in bid evaluations.

- The Public Housing Operations Manual has no provision for procurement in emergency or other situations where following the required procedures is not feasible or practical. The Government Procurement Policy outlines circumstances where alternative procurement methods may be used (e.g., purchasing without a competition) and the required documentation to support those decisions.

6.38 We tested 30 procurement transactions at each of the two Housing Authorities to determine if policies and procedures were followed. We found four procurement transactions at MRHA and nine at CBIHA where alternative procurement methods were used (primarily sole-sourcing). Documentation of the reasons for alternative methods was not consistent. While there may be valid reasons for using alternative procurement methods, the Public Housing Operations Manual does not address such situations. Government Procurement Policy requirements were not followed in these instances and we are unclear on whether the Authorities were aware of these requirements. Without clear guidelines to address emergency or other special circumstances, there is a risk that alternative procurement methods will be used inappropriately.

Recommendation 6.7

We recommend that the Public Housing Operations Manual be reviewed and updated to ensure it is consistent with the Government Procurement Policy and to provide clear guidance on using alternative procurement methods.

6.39 We also noted that MRHA has a conflict of interest policy which provides guidance to staff in relation to procurement. CBIHA does not have a similar policy and we suggested that they prepare one.

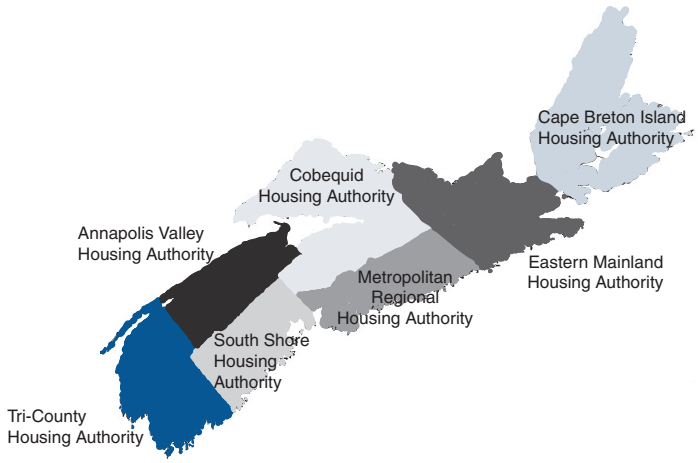
CONCLUDING REMARKS

6.40 We found that the Metropolitan Regional Housing Authority and the Cape Breton Island Housing Authority receive direction and guidance from the Department of Community Services and the Authorities report to the Department on their operations, as required. We believe non-financial performance information should be developed to enable a more complete assessment of the Authorities' progress in achieving the housing objectives and outcomes of the Department.

6.41 While certain controls over revenues, expenditures and the general computer environment are adequate, we identified a number of control weaknesses that increase the risk of financial loss either through error or fraudulent actions. We encourage the Housing Authorities to take more care in performing internal control procedures and address the concerns we identified.

Exhibit 6.1

Housing Authorities



Source: Department of Community Services

Exhibit 6.2

Housing Authority - Revenues and Expenditures

For the year ended March 31, 2006
($ thousands)

	Annapolis Valley	Cape Breton Island	Cobequid	Eastern Mainland	Metro Regional	South Shore	Tri-County	Total
Revenue	$4,038	$12,552	$4,282	$4,462	$14,740	$1,621	$3,328	$45,023
Expenditures	7,699	30,298	8,958	9,135	33,713	3,247	7,548	100,598
Net operating loss	($3,661)	($17,746)	($4,676)	($4,673)	($18,973)	($1,626)	$4,220)	($55,575)
Provincial distribution	($3,173)	($15,773)	($4,071)	($4,056)	($16,694)	($1,433)	$3,692)	($48,892)
Municipal distribution	(488)	(1,973)	(605)	(617)	(2,279)	(193)	(528)	(6,683)
Net operating loss	($3,661)	($17,746)	($4,676)	($4,673)	($18,973)	($1,626)	($4,220)	($55,575)

Source: Department of Community Services

Metropolitan Regional Housing Authority
2005-06 actual financial results and 2006-07 budget

Exhibit 6.3

	Actual 2005-06 ($ thousands)	Budget 2006-07 ($ thousands)
Revenue	$14,740	$14,869
Expenditures		
Utilities/other	8,532	9,632
Maintenance	5,479	5,273
Capital improvements	2,278	2,763
Administration	3,321	3,905
Non-operating	14,103	14,175
	33,713	35,748
Net operating loss	($18,973)	($20,879)

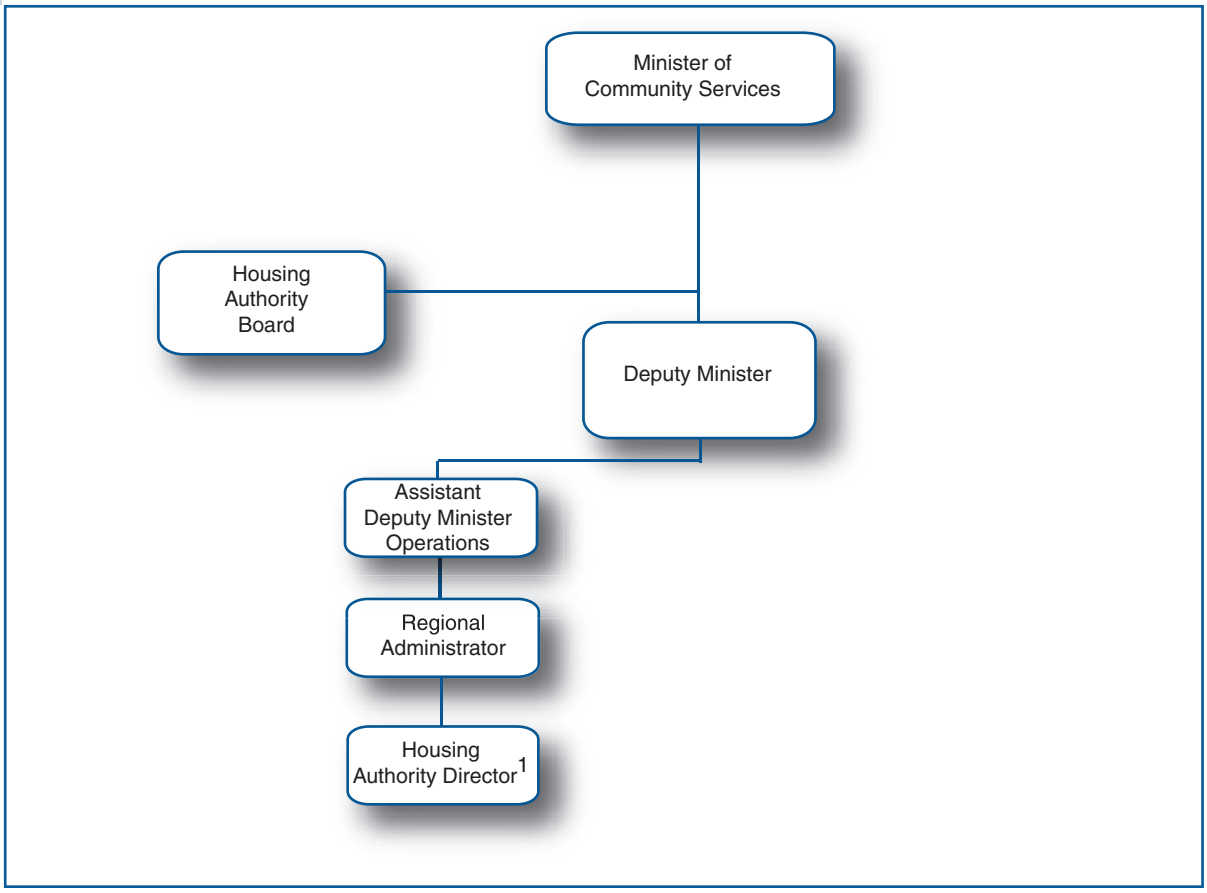
Cape Breton Island Housing Authority
2005-06 actual financial results and 2006-07 budget

Exhibit 6.4

	Actual 2005-06 ($ thousands)	Budget 2006-07 ($ thousands)
Revenue	$12,552	$12,575
Expenditures		
Utilities/other	6,518	7,422
Maintenance	6,013	5,417
Capital improvements	2,416	1,939
Administration	2,892	3,105
Non-operating	12,459	12,778
	30,298	30,661
Net operating loss	($17,746)	($18,086)

Exhibit 6.5

Housing Authorities – Reporting Structure



Note 1 – The Department is in the process of creating a new position – Executive Director, Housing Authorities – reporting to the Deputy Minister. Directors of the Housing Authorities will report to this new position.

Source: Department of Community Services

DEPARTMENT OF COMMUNITY SERVICES' RESPONSE

The Department welcomes the many positive comments noted in the Principal Findings Sections in the body of the report. There are always opportunities for improvements identified in these types of engagements which the Department also welcomes as part of its on-going initiative to improve housing services provided to Nova Scotians. One recent significant step in that regard from a governance perspective is the creation of a new position within head office, the Executive Director, Housing Services. The Directors of the Housing Authorities will report to this position. Once hired, this person will have as one objective the assessment of all of the recommendations with a view to implementing all of them as soon as is practicable. It should also be noted that some in whole or in part have already been implemented.

Financial Audits

7 GOVERNMENT FINANCIAL REPORTING

BACKGROUND

7.1 Members of the Legislative Assembly need adequate information on the Province's financial plans, performance and condition to hold government accountable for its use and control of public funds and resources.

7.2 The Minister and Deputy Minister of Finance are assigned various authorities and responsibilities related to the role of a chief financial officer for the Province under the provisions of the Provincial Finance Act. Certain of these assignments include the need for Executive Council approval or ratification of planned actions.

7.3 The Provincial Finance Act defines a number of financial reporting requirements for the Minister or Deputy Minister of Finance to meet on behalf of government. Further, Section 73 of the Provincial Finance Act requires that crown corporations' business plans, audited financial statements and proposed public financing be tabled in the House of Assembly each year.

7.4 As a foreign registrant of the Securities and Exchange Commission in the United States, or its equivalent in other countries, government must file required documents in order to be able to access financing or financial markets.

7.5 In addition to required financial reporting, government periodically releases other financial information or reports publicly.

7.6 For the Province's financial reporting, oversight responsibility rests, to a significant extent, with the Executive Council. In addition, the House of Assembly, including its Public Accounts Committee, has an important role in the oversight and public accountability processes for the Province's financial reports issued by government.

CHAPTER OBJECTIVES

7.7 The Auditor General Act provides a broad mandate for the Office to examine and report on the use and control of public resources by government, its controlled entities, and recipients of financial assistance. Further, Sections 9 and 9B of that Act provide for specific annual reporting by the Auditor General on the Province's consolidated financial statements (an audit - high assurance) and government's revenue estimates (a review - moderate assurance).

7.8 The annual financial statements of various crown entities and trusts, depending on statutory or other arrangements, are audited and reported upon by either the Auditor General or a public accounting firm. We consider the results of those financial statement audits, as well as other government financial reporting, during the conduct of the Office's discretionary performance audits.

7.9 The purpose of this chapter is to provide summary comments and observations on the government's financial reporting, including:

- information on the results of our review of the government's 2007-08 revenue estimates included in the March 23, 2007 budget documents; and

- our planning for the audit of the Province's March 31, 2007 consolidated financial statements.

RESULTS IN BRIEF

7.10 The following summarizes our principal observations in this chapter.

- Significant steps have been taken towards preparing and presenting the government's revenue estimates in full accordance with generally accepted accounting principles (GAAP). Department of Finance and other staff are to be commended for the progress they have made in improving government's financial reporting. We encourage the government to take further steps towards achieving full GAAP compliance.

- The Auditor General's opinion on the 2007-08 revenue estimates, required under Section 9B of the Auditor General Act, was tabled in the House of Assembly on March 23, 2007 along with the government's budget documents. The opinion was qualified because the revenue estimates were not presented on the same consolidated basis as the Province's consolidated financial statements. As well, the Department of Finance was not able to provide support for third-party revenues of certain consolidated government units because the budget was not completed on a consolidated basis. As a result, the Auditor General was unable to form an opinion on the reasonableness of these revenues or the support for their underlying assumptions.

- A management letter detailing observations from our examination of the government's 2007-08 revenue estimates was provided to the Department of Finance in May 2007.

- The Department of Finance is planning to release the Province's March 31, 2007 consolidated financial statements before the end of August. This is earlier than the legislated date of September 30, 2007. We commend and support the Department of Finance in its efforts to improve the timeliness of the Province's consolidated financial statements.

- Our audit of the Province's March 31, 2007 consolidated financial statements will be completed between May and July 2007. We plan to provide our opinion on the Province's March 31, 2007 consolidated financial statements by August 2, 2007. The scheduled date assumes government will meet year-end accounting and audit-readiness requirements on a timely basis and that our access to required information will be unrestricted.

- We are pleased to acknowledge that progress has been made on eliminating access to information problems reported in the December 2006 Report of the Auditor General. We look forward to working further with government's senior management to fully resolve this issue. Nevertheless, we caution that any restrictions placed on our access to information during the course of our audit of the Province's March 31, 2007 consolidated financial statements could affect our ability to conduct the audit and could impact our opinion.

- Additional appropriations of $120.2 million for 2006-07 expenses were approved on March 30, 2007 by Order in Council 2007-189. The amount of additional appropriations required for March 31, 2007 could change as a result of finalizing figures in the March 31, 2007 audited financial statements of the Province. No special warrants have been approved since our last Report.

PRINCIPAL FINDINGS

Results of Review of Government's Estimates of Revenue

7.11 The Auditor General's Report on the 2007-08 Revenue Estimates, required under Section 9B of the Auditor General Act, was tabled in the House of Assembly on March 23, 2007 along with supporting information for the 2007-08 Nova Scotia budget (see Exhibit 7.1). It contained a reservation of opinion related to a scope limitation and non-compliance with generally accepted accounting principles (GAAP).

7.12 In May 2007, we sent a management letter to the Department of Finance including detailed observations from our examination of the government's 2007-08 revenue estimates.

7.13 We are pleased to acknowledge the Department of Finance has taken significant steps to move towards preparing and presenting the revenue estimates included in the budget in full accordance with GAAP. The review opinions of both 2006-07 revenue estimates included a number of qualifications, as noted in Chapter 2 of the December 2006 Report of the Auditor General. Many of these qualifications were not required in the opinion provided on the 2007-08 revenue estimates; although there was still a reservation of opinion for this review based on two qualifications discussed below. However, staff of the Department of Finance and other relevant departments should be commended for the steps they have taken to move towards preparing and presenting the revenue estimates in full accordance with GAAP and in providing all information required by my Office to conduct our review.

7.14 A reservation of opinion was issued this year as a result of our review of the 2007-08 revenue estimates. There was a qualification because the revenue estimates were not presented on the same consolidated basis as the Province's consolidated financial statements. As well, because the budget was not completed on a consolidated basis, the Department of Finance was not able to provide support for third party revenues for certain government units. As a result, the Auditor General

was unable to form an opinion on the reasonableness of these revenues or the support for their underlying assumptions.

7.15 We acknowledge that addressing the above qualifications would be a major undertaking which would require significant changes to the existing budget process in order to move to consolidated budgeting. We understand that a number of challenges would have to be addressed and that this issue cannot be dealt with in a short time period. However, it is a significant issue which needs to be addressed.

Recommendation 7.1

We recommend further steps be taken to move towards preparing and presenting the revenue estimates included in the budget in full accordance with generally accepted accounting principles.

Planning for the Audit of the Province's Consolidated Financial Statements

7.16 Under Section 9 of the Auditor General Act, the Auditor General is mandated to examine and report on the government's annual consolidated financial statements.

7.17 The Department of Finance is planning to release the Province's March 31, 2007 consolidated financial statements before the end of August. This is earlier than the legislated date of September 30, 2007. We commend and support Department of Finance staff in their efforts to improve the timelines of the Province's consolidated financial statements.

7.18 The majority of our audit work on the Province's March 31, 2007 consolidated financial statements will be completed between May and July 2007. We plan to provide our opinion on the Province's March 31, 2007 consolidated financial statements by August 2, 2007. The scheduled date assumes government will meet year-end accounting and audit-readiness requirements on a timely basis and that our access to required information will be unrestricted.

7.19 The following are some of the key control issues we will consider when finalizing our strategy and approach to the 2006-07 financial statement audit.

- Deficiencies identified in the service auditors' report on general environmental controls for the centralized SAP infrastructure (see June 2006 Report of the Auditor General, Chapter 3, paragraph 3.14 to 3.26). An update of this report is expected in May 2007 related to the March 31, 2007 fiscal year.

- Deficiencies identified in the SAP application controls audit completed under contract for this Office (see June 2006 Report of the Auditor General, Chapter 3, paragraph 3.8 to 3.13).

- Deficiencies identified in the SAP HR application controls audit completed under contract for the Department of Finance, the Public Service Commission, and this Office (see December 2006 Report of the Auditor General, Chapter 3, paragraph 3.9 to 3.15).

- Denial of opinion and deficiencies identified in the audit of the governance and control framework of the operations of the Investment, Liability Management and Treasury Services and Capital Markets Administration Divisions completed by a private sector firm during 2004 (see December 2004 Report of the Auditor General, Chapter 3, paragraphs 3.18 to 3.21). The Department of Finance 2006-07 Business Plan has a target date of March 31, 2007 for completion of an audit assessment regarding implementation status of the original recommendations. It was to be completed by the Internal Audit and Risk Management Centre of the Department of Finance or outsourced. We were informed that some planning steps have been taken to address this issue but the audit assessment has not yet been completed.

7.20 Accounting standards and pronouncements comprising GAAP continue to evolve. New developments could require changes to government's financial reporting. For the March 31, 2007 consolidated financial statements, revisions to the tangible capital asset standards of the Public Sector Accounting Board (PSAB) now require tangible capital assets to be recorded at gross values as opposed to net values. During our audit, we will examine the effects of these revisions on the consolidated financial statements to ensure they are appropriately reflected.

7.21 The financial statements of various crown corporations and agencies of government are audited by other auditors. As appropriate under generally accepted auditing standards, we will rely on the work and reporting of these other auditors.

7.22 The December 2006 Report of the Auditor General noted that significant steps have been taken to address certain areas in which the Province's consolidated financial statements were not yet fully in compliance with GAAP. Certain areas were identified where further actions were required in order to achieve full compliance with GAAP. (see December 2006 Report of the Auditor General, Chapter 2, paragraph 2.21) During our audit of the March 31, 2007 financial statements, we will follow up on the following areas.

- Budget information should be included on the Statement of Change in Net Direct Debt.

- All revenues which are netted directly against expense accounts should be included in gross revenues.

- We will consider the proper accounting treatment of Canadian Blood Services.

- Tangible capital asset balances of entities included in the consolidated financial statements should be adjusted to comply with the government's relevant accounting policy requirements for thresholds and amortization.

- Further research and review of the Province's tangible capital assets threshold limits should have been completed by the Department of Finance to ensure the thresholds allow for the fair and consistent presentation of the balance on the consolidated financial statements.

7.23 The Auditor General will express an opinion as to whether the Province's consolidated financial statements present fairly, in all material respects, the financial position, results of operations and cash flows of the Province of Nova Scotia in accordance with generally accepted accounting principles for the public sector. Our audit will be carried out in accordance with generally accepted auditing standards.

OTHER MATTERS

Access to Information

7.24 In the December 2006 Report of the Auditor General we discussed the issue of restrictions on the Auditor General's access to information. We recommended that Treasury and Policy Board and the Department of Finance work with the Office of the Auditor General to clarify boundaries regarding access to information provided under the Auditor General Act. We are pleased to acknowledge that progress has been made in identifying and eliminating access problems. For example, the Auditor General's opinion on both of the 2006-07 Revenue Estimates tabled in the House included a scope limitation due to a number of restrictions in access to information. In the 2007-08 review of the revenue estimates, a scope limitation exists for a single restriction in access to information but central government did not possess this information and could not make it available to us. Access to Treasury and Policy Board and Executive Council minute letters was partially restricted last year. During our work on the 2007-08 revenue estimates review, we had full access to information requested relating to these minute letters.

7.25 A number of meetings have been held with senior management of Treasury and Policy Board, the Department of Justice, the Department of Finance and the Office of the Auditor General in order to move towards clarifying the boundaries of the access to information allowed under the Auditor General Act. We look forward to working with these parties further to fully resolve this issue. Nevertheless, we caution that any restrictions placed on our access to information during the course of our audit of the government's March 31, 2007 consolidated financial statements could affect our ability to conduct the audit and impact our opinion.

Additional Appropriations and Special Warrants

7.26 Section 9A of the Auditor General Act requires, among other things, that we call attention to every case observed in which any appropriation is exceeded or a special warrant is authorized. Our last reporting under that section was in the December 2006 Report of the Auditor General, Chapter 2. We provide the following updated comments.

7.27 Under the provisions of Section 28 of the Provincial Finance Act, on March 30, 2007 Executive Council approved Order in Council 2007-189 approving additional appropriations for 2006-07 of $48,692,000 for program expenses and $71,500,000 for capital purchase requirements. The amount of additional appropriations required for March 31, 2007 could change as a result of finalizing figures in the March 31, 2007 financial statements of the Province.

7.28 We note that since our last Report, there have been no special warrants approved by Executive Council under Section 29 of the Provincial Finance Act.

CONCLUDING REMARKS

7.29 Significant steps have been taken to move towards preparing and presenting government's revenue estimates in full accordance with generally accepted accounting principles. In order to achieve full compliance, the budget would need to be completed on a fully consolidated basis. We encourage government to take further steps towards achieving this result.

7.30 The Department of Finance is planning on releasing the consolidated financial statements of the Province for March 31, 2007 at least one month earlier than the legislated deadline. We encourage and support the Department in this endeavor as it will contribute to the quality of the consolidated financial statements through improved timeliness of financial reporting.

Report of the Auditor General to the House of Assembly on the Estimates of Revenue for the fiscal year ending March 31, 2008 used in the preparation of the March 22, 2007 Budget Address

Exhibit 7.1

I am required by section 9B of the Auditor General Act to provide an opinion on the reasonableness of the estimates of revenue used in the preparation of the annual budget address of the Minister of Finance to the House of Assembly.

The estimates of revenue for the fiscal year ending March 31, 2008 are the responsibility of the Department of Finance and have been prepared by departmental management using assumptions with an effective date of March 22, 2007 or earlier. I have examined the support provided by departmental management for the assumptions and the preparation and presentation of the revenue estimates in the amount of $8,017,687,000 as described in the financial forecast of Revenues By Source, (Schedule 13 of the Nova Scotia Budget Assumptions and Schedules) (the 2007-08 revenue estimates). My examination did not include, and my opinion does not cover, the budget speech, the 2006-07 forecast, the 2007-08 expense estimates or the actual figures in Schedule 13 for the fiscal years ended March 31, 2003-2004, 2004-2005 and 2005-2006. Except as explained in the following paragraph, my examination was made in accordance with the applicable Assurance and Related Services Guideline issued by the Canadian Institute of Chartered Accountants. I have no responsibility to update this report for events and circumstances occurring after the date of my report.

Third party revenues of certain government units are excluded from the 2007-2008 revenue estimates. These revenues are included elsewhere in the budget as offsets against expenditures of the respective government units rather than as part of the revenue estimates. As a result, the revenue estimates are not presented on a basis consistent with the consolidated financial statements, a requirement of generally accepted accounting principles in such circumstances. To the extent of these exclusions, the 2007-08 revenue estimates are not presented in accordance with generally accepted accounting principles. In addition, management was unable to provide support for these third party revenues and therefore I was unable to complete my review of them or determine the amount of these revenues.

In my opinion, except that certain third party revenues have been excluded from the revenue estimates as noted in the preceding paragraph:

- as at the date of this report, the assumptions used by departmental management are suitably supported and consistent with the plans of the government, as described to us by department management, and provide a reasonable basis for the 2007-08 revenue estimates; and
- the 2007-08 revenue estimates as presented reflect fairly such assumptions; and
- the 2007-08 revenue estimates comply with presentation and disclosure standards established by the Canadian Institute of Chartered Accountants.

Since the 2007-08 revenue estimates are based on assumptions regarding future events, actual results will vary from the information presented and the variance may be material. Accordingly I express no opinion as to whether the revenue estimates will be achieved.

Jacques R. Lapointe, CA•CIA
Auditor General

Halifax, Nova Scotia
March 22, 2007

DEPARTMENT OF FINANCE'S RESPONSE

The Department of Finance is pleased to be able to provide a management response to Chapter 7, Government Finance Financial Reporting of the Report of the Office of the Auditor General. Significant steps have been taken toward the reporting of revenue estimates in the provincial budget.

While these steps have not entirely removed the qualification of the revenue review, staff should be commended for their efforts. The final requirement for an unqualified revenue review would be a move to consolidated budgeting. I am pleased that the Auditor General has acknowledged that such a move would be a major undertaking, one which I do not anticipate in the foreseeable future. The Department looks forward to the pending audit of the 2006/07 Public Accounts. With the cooperation and assistance of the Office of the Auditor General as well as staff at central and line departments, the expedited release of our financial statements will prove beneficial to the readers of the Public Accounts. I am also confident there will be continued clarity with the Auditor General on what entities should be included in our consolidated statements. As well, the audit of the Public Accounts will show improvements of key control issues that were identified in previous Auditor General reports.

Appendix

I AUDITOR GENERAL ACT - SECTIONS 8, 9, 15, 17

AUDITOR GENERAL ACT

Section 8

The Auditor General shall examine in such manner and to the extent he considers necessary such of the accounts of public money received or expended by or on behalf of the Province, and such of the accounts of money received or expended by the Province in trust for or on account of any government or person or for any special purposes or otherwise, including, unless the Governor in Council otherwise directs, any accounts of public or other money received or expended by any agency of government appointed to manage any department, service, property or business of the Province, and shall ascertain whether in his opinion

(a) accounts have been faithfully and properly kept;

(b) all public money has been fully accounted for, and the rules and procedures applied are sufficient to secure an effective check on the assessment, collection and proper allocation of the capital and revenue receipts;

(c) money which is authorized to be expended by the Legislature has been expended without due regard to economy or efficiency;

(d) money has been expended for the purposes for which it was appropriated by the Legislature and the expenditures have been made as authorized; and

(e) essential records are maintained and the rules and procedures applied are sufficient to safeguard and control public property.

Section 9

(1) The Auditor General shall report annually to the House of Assembly on the financial statements of the Government that are included in the public accounts required under Sections 9 and 10 of the *Provincial Finance Act*, respecting the fiscal year then ended.

(2) The report forms part of the public accounts and shall state

(a) whether the Auditor General has received all of the information and explanations required by the Auditor General; and

(b) whether in the opinion of the Auditor General, the financial statements present fairly the financial position, results of operations and changes in financial position of the Government in accordance with the stated accounting policies of the Government and as to whether they are on a basis consistent with that of the preceding year.

(3) Where the opinion of the Auditor General required by this Section is qualified, the Auditor General shall state the reasons for the qualified opinion.

Section 9A

(1) The Auditor General shall report annually to the House of Assembly and may make, in addition to any special report made pursuant to this Act, not more than two additional reports in any year to the House of Assembly on the work of the Auditor General's office and shall call attention to every case in which the Auditor General has observed that

(a) any officer or employee has wilfully or negligently omitted to collect or receive any public money belonging to the Province;

(b) any public money was not duly accounted for and paid into the Consolidated Fund of the Province;

(c) any appropriation was exceeded or was applied to a purpose or in a manner not authorized by the Legislature;

(d) an expenditure was not authorized or was not properly vouched or certified;

(e) there has been a deficiency or loss through fraud, default or mistake of any person;

(f) a special warrant, made pursuant to the provision of the *Provincial Finance Act*, authorized the payment of money; or

(g) money that is authorized to be expended by the Legislature has not been expended with due regard to economy and efficiency.

(2) The annual report of the Auditor General shall be laid before the House of Assembly on or before December 31st of the calendar year in which the fiscal year to which the report relates ends or, if the House is not sitting, it shall be filed with the Clerk of the House.

(3) Where the Auditor General proposes to make an additional report, the Auditor General shall send written notice to the Speaker of the House of Assembly thirty days in advance of its tabling or filing pursuant to subsection (2).

(4) Whenever a case of the type described in clause (1)(a), (b) or (e) comes to the attention of the Auditor General, the Auditor General shall forthwith report the circumstances of the case to the Minister.

(5) The Auditor General shall, as soon as practical, advise the appropriate officers or employees of an agency of Government of any significant matter discovered in an audit.

(6) Notwithstanding subsection (1), the Auditor General is not required to report to the House of Assembly on any matter that the Auditor General considers immaterial or insignificant.

Section 9B

(1) The Auditor General shall annually review the estimates of revenue used in the preparation of the annual budget address of the Minister of Finance to the House of Assembly and provide the House of Assembly with an opinion on the reasonableness of the revenue estimates.

(2) The opinion of the Auditor General shall be tabled with the budget address.

Section 15

Notwithstanding any provision of this Act, the Auditor General may, and where directed by the Governor in Council or the Management Board shall, make an examination and audit of

(a) the accounts of an agency of government; or

(b) the accounts in respect of financial assistance from the government or an agency of the government of a person or institution in any way receiving financial assistance from the government or an agency of government,

where

(c) the Auditor General has been provided with the funding the Auditor General considers necessary to undertake the examination and audit; and

(d) in the opinion of the Auditor General, the examination and audit will not unduly interfere with the other duties of the Office of the Auditor General pursuant to this Act,

and the Auditor General shall perform the examination and audit and report thereon.

Section 17

(1) Where the Governor in Council pursuant to this Act or any other Act has directed that the accounts of public money received or expended by any agency of government shall be examined by a chartered accountant or accountants other than the Auditor General, the chartered accountant or accountants shall

(a) deliver to the Auditor General immediately after the completion of the audit a copy of the report of findings and recommendations to management and a copy of the audited financial statements relating to the agency of government; and

(b) make available to the Auditor General, upon request, and upon reasonable notice, all working papers, schedules and other documentation relating to the audit or audits of the agency accounts.

(2) Notwithstanding that a chartered accountant or accountants other than the Auditor General have been directed to examine the accounts of an agency of government, the Auditor General may conduct such additional examination and investigation of the records and operations of the agency of government as he deems necessary.