Office of the Auditor General

Our Vision

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

Our Mission

To make a significant contribution to enhanced accountability and performance in the provincial public sector.

1888 Brunswick Street
Suite 302
Halifax, NS B3J 3J8
Telephone: (902) 424-5907
Fax: (902) 424-4350
E-mail: oaginfo@gov.ns.ca
Website: http://www.oag-ns.ca

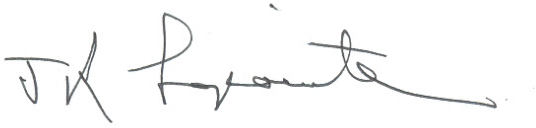
NOVA SCOTIA

Honourable Charlie Parker
Speaker
House of Assembly
Province of Nova Scotia

Dear Sir:

I have the honour to submit herewith my 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(3) of the Auditor General Act.

Respectfully submitted



JACQUES R. LAPOINTE, CA
Auditor General

Halifax, Nova Scotia
May 18, 2010

Table of Contents

Introduction

1 Message from the Auditor General

Introduction

1.1 I am pleased to present my June 2010 Report to the House of Assembly on work completed by my Office in the fall of 2009 and winter of 2010.

1.2 During 2010, I submitted the following reports.

- My Report to the House of Assembly on work completed in the summer and fall of 2009, dated January 19, 2010, was tabled on February 3, 2010.
- My Report on the Estimates of Revenue for the fiscal year ending March 31, 2011, dated April 3, 2010, was included with the budget address delivered by the Minister of Finance on April 6, 2010. My findings related to my work on the Estimates of Revenue will be included in my Fall 2010 Report.
- My Report to the Speaker on my forensic investigation with respect to the Members' expenses was tabled May 18, 2010.

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, nonpartisan 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 the 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 conduct and report audits that provide information to the House of Assembly to assist it in holding government accountable; to focus audit efforts on areas of higher risk that impact on the lives of Nova Scotians; to contribute to a better performing public service for Nova Scotia; and to encourage continual improvement to financial reporting by government; 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 board members and staff in 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 needed in the performance of his or her duties. Additionally, public servants must provide free access to all information which the Auditor General 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.

Chapter Highlights

1.11 This Report presents the results of audits and reviews completed in the fall of 2009 and winter of 2010 at a number of departments and agencies. Where appropriate, we make recommendations for improvements to government operations, processes and controls. Department or agency responses have been included in the appropriate chapter. We will follow up on the implementation of our recommendations in two years, with the expectation that significant progress will be made.

Performance Audits

Chapter 2 – Financial Assistance to Businesses Through NSBI and IEF

1.12 Management of Nova Scotia Business Inc. and the Industrial Expansion Fund refused to provide the information we required to complete our audit. Consequently, we have denied an audit opinion on both organizations' financial and program controls, compliance with legislation, regulations and policies related to loans, payroll rebates, and other financial assistance to business. Files requested by audit staff were withheld until documents which management or Department of Justice solicitors considered to be subject to Cabinet confidentiality or solicitor-client privilege were removed. This practice contravenes the Auditor General Act and we recommended that Cabinet instruct departments and agencies to comply with the Act.

Chapter 3 – Management of Contaminated Sites

1.13 The risks associated with contaminated sites in Nova Scotia are not being adequately managed to protect the public interest. The Department needs to improve its monitoring of contaminated sites to ensure risks to third parties, human health and the environment are being appropriately addressed. The Department is aware of known and possible contaminated sites where the landowner or responsible person was not required to assess and address applicable risks to the public and the environment. We are concerned that there may be sites in the province in which unacceptable risks have not been properly mitigated. We also found there is no process in place to ensure higher-risk sites are given priority when the Department monitors cleanup processes.

Chapter 4 – Mental Health Services

1.14 There is inadequate oversight of the mental health system and no effective monitoring of compliance with mental health standards by the Department of Health. The Department is not fulfilling its legislative requirements under the Health Authorities Act to monitor and evaluate the quality of mental health services. Although Nova Scotia adopted mental health standards in 2003, no formal plan was developed to move the mental health system to compliance with standards. We tested compliance with selected mental health standards and found only 14% of 358 files tested met all selected standards. While certain standards were met most of the time in some districts, the overall lack of compliance is concerning and could negatively impact mental health patient care.

Follow-up

Chapter 5 – Follow-up of 2007 Recommendations

1.15 Only 22 of 82 (27%) of the recommendations made in the June 2007 Report of the Auditor General have been implemented. This is the lowest rate found in any year since we began to track implementation status. Our audit recommendations provide constructive advice to correct weaknesses. We strive to ensure our recommendations are practical and implementable. It is evident from the results of our follow-up of 2007 recommendations that these have not been given priority. We noted that neither the Department of Health's Long-Term Care program nor the Department of Justice's Maintenance Enforcement program have completed any of our 2007 recommendations. We plan to assess the implementation status of outstanding recommendations in each year from 2005 forward, beginning in 2010.

Performance Audits

2 Financial Assistance to Businesses Through NSBI and IEF

Summary

Management of Nova Scotia Business Inc. (NSBI) and the Industrial Expansion Fund (IEF) have refused to provide the information we required to complete our audit of financial assistance to businesses through these organizations. We therefore have denied audit opinions on both NSBI's and IEF's financial and program controls and compliance with legislation, regulations and policies, related to loans, payroll rebates and other financial assistance to businesses.

Denial of an audit opinion is the most severe audit sanction available to us. Withholding information relevant to an audit of public expenditures constitutes disregard for public accountability. In doing so, both NSBI and IEF acted in contravention of the Auditor General Act.

Management informed us that staff at Executive Council Office instructed them to withhold Cabinet submissions and Cabinet-related information. NSBI management and IEF's Department of Justice solicitor also withheld solicitor-client communications.

Ultimately the authority and responsibility for these decisions rests with Cabinet. The Auditor General Act requires that all documents, whether confidential or not, be provided to the Auditor General and does not contain any exemption for Cabinet submissions or solicitor-client communications. We have therefore recommended that Cabinet instruct departments and agencies to comply with the Auditor General Act.

All files requested by audit staff at both NSBI and IEF were withheld until they could be reviewed and documents removed or sections redacted which either NSBI management, IEF management, or Department of Justice solicitors considered to be subject to Cabinet confidentiality or solicitor-client privilege. We have no way of knowing whether all documents removed or sections redacted were, in fact, Cabinet or solicitor-client documents.

NSBI management removed 173 documents from 21 files and redacted information in 32 documents. At IEF, 108 documents were removed from 24 files. In April 2010, IEF's Department of Justice solicitors reconsidered their decision and provided 10 documents for which they had previously claimed solicitor-client privilege. This action calls into question the basis on which these decisions are being made.

There is ample and recent precedent for releasing this type of information to the Auditor General. A previous audit of NSBI in 2004 included full and complete

access to documents submitted to Cabinet as well as communications between NSBI and its lawyer. In June 2008, the Executive Council Office provided the Auditor General with access to the cabinet and solicitor-client documents related to the Nova Scotia Nominee Program, although not before the Public Accounts Committee issued subpoenas.

For the limited work we were ultimately able to complete, we made recommendations for improvements at both NSBI and IEF which are detailed in this Chapter.

2 Financial Assistance to Businesses Through NSBI and IEF

Background

2.1 In Nova Scotia, various departments and agencies are involved in business development through the provision of government financial assistance. Nova Scotia Business Inc. (NSBI) and the Industrial Expansion Fund (IEF) are two organizations from which businesses can access financing and other assistance from the provincial government.

2.2 NSBI is a crown corporation, owned by the Province of Nova Scotia and governed by an independent Board of Directors. NSBI is Nova Scotia's business development agency with a primary goal of expanding business in the province.

2.3 NSBI assists business development through various means including payroll rebates, loans and venture capital investments. Payroll rebates provide companies with a rebate for a portion of their gross payroll provided they meet certain conditions.

2.4 The Industrial Expansion Fund (IEF) is administered through the Department of Economic and Rural Development. IEF helps businesses to get established or expand in Nova Scotia.

2.5 IEF provides assistance to businesses through loan financing, loan guarantees and other development incentives. All assistance through IEF is approved by Order-In-Council.

2.6 Although IEF is a fund rather than a separate organization, we will refer to it as an organization for purposes of this report.

2.7 Total financial assistance and guarantees through IEF in 2009-10 was $221.7 million (2008-09 – $61.6 million). Total assistance through NSBI in 2009-10 was $33.8 million (2008-09 – $22.8 million). The following tables list assistance totalling $2 million or greater through both entities in 2008-09 and 2009-10.

FINANCIAL ASSISTANCE TO BUSINESSES THROUGH NSBI AND IEF

IEF Financial Assistance, Loans and Guarantees $2 million or Greater			
OIC #	Company	Amount	Type of Assistance
2009-10			
2010-152	Scanwood Canada Limited	4,750,000	Loan
2010-103	DSME Trenton Ltd.	59,360,500	Loan ($36.160 M) Shares ($19.6 M) Forgiveable Loan ($3.6 M)
2010-90	Northern Timber Nova Scotia Corporation	75,000,000	Loan
2010-87	Irving Shipbuilding Inc.	20,000,000	Loan
2010-1	Irving Shipbuilding Inc.	8,800,000	Incentive ($6.6 M) Loan ($2.2 M)
2009-490	D.B. Kenney Fisheries Limited	2,500,000	Guarantee
2009-478	NewPage Port Hawkesbury Corp.	5,000,000	Loan
2009-475	Ligni Bel Ltd.	3,000,000	Guarantee
2009-360	Irving Shipbuilding Inc.	12,200,000	Guarantee
2009-282	Maritime Steel and Foundries Limited	2,000,000	Loan
2009-280	Ka'Le Bay Seafoods Ltd.	3,500,000	Loan
2009-277	Clearwater Seafoods Limited Partnership	15,000,000	Loan
2009-212	G.N. Plastics Company	2,000,000	Loan
2008-09			
2009-136	Northern Pulp Nova Scotia Corporation	15,000,000	Loan
2009-44	Bay Ferries Limited	2,000,000	Contribution
2009-28	Bay Ferries Limited	12,000,000	Contribution
2009-20	Yarmouth International Airport Corporation	2,000,000	Loan
2008-655	Investing in Nova Scotia Enterprises Co-operative Ltd. (Immigrant Small Business Financing)	2,000,000	Loan Guarantee
2008-521	Scotian Gold Co-operative Limited	2,000,000	Loan
2008-490	ACA Co-operative Limited	3,500,000	Loan
2008-370	Bay Ferries Limited	4,400,000	Contribution
2008-351	Composite Sea to Sky Limited	4,545,000	Loan ($2.9 M) Incentive ($1.645 M)

NSBI Payroll Rebates, Loans, Guarantees and Venture Capital $2 million or Greater			
OIC #	Company	Amount	Type of Assistance
2009-10			
2010-132	RSA Canada (ROINS Holding Limited)	2,699,274	Payroll Rebate
2010-102	Tech Link International Entertainment Limited	2,500,000	Venture Capital
2009-376	LED Roadway Lighting Ltd.	6,000,000	Venture Capital
2009-218	Aecon Construction Group (Aecon-Fabco)	2,255,057	Payroll Rebate
2009-217	Unique Solutions Design Ltd.	2,000,000	Venture Capital
N/A	Enlinga Canada	2,420,000	Loan
2008-09			
2008-425	Admiral Insurance Services	2,836,500	Payroll Rebate
N/A	Origin BioMed	2,000,000	Venture Capital

Audit Objectives and Scope

2.8 In fall 2009, we conducted a performance audit of financial assistance to business through Nova Scotia Business Inc. and the Industrial Expansion Fund. 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. NSBI and IEF were also informed that Section 14 of the Auditor General Act applied to this audit.

2.9 The objectives for this assignment were to:

- assess IEF's and NSBI's financial and program controls over loans, payroll rebates, development incentives and venture capital investments and compliance with legislation, regulations, and internal policies and procedures in providing these programs; and
- determine whether IEF and NSBI have adequate processes in place to measure and report on the effectiveness of the assistance to business programs which they each administer.

2.10 Generally accepted criteria consistent with the objectives of this audit do not exist. Audit criteria were specifically developed for this assignment. These criteria were discussed with and accepted as appropriate by senior management of the Department and NSBI.

2.11 Our planned audit approach included examining documents and reports, interviews with management and staff, and testing certain processes and

procedures. We intended to audit the period from April 1, 2008 to September 30, 2009. However, we encountered a scope limitation when completing our work on the financial and program controls over the assistance to business programs selected for audit. Both NSBI and IEF management reviewed their respective files and removed documents they considered to be privileged and confidential before allowing us to see the files. Department of Justice solicitors also reviewed certain IEF files before those files were provided to us. We denied an opinion on the program and financial controls for both entities as we could not form an audit conclusion.

Significant Audit Observations

Information Denied During the Audit

Conclusions and summary of observations

Both NSBI and IEF management withheld their files from our staff until they could be reviewed to remove Cabinet submissions and other Cabinet-related documents. They informed us Executive Council Office staff told them Cabinet submissions are confidential and instructed them not to provide these submissions to our Office. NSBI management told us they removed 30 Cabinet submissions from 12 files and redacted Cabinet-related information in three documents from these same 12 files before providing these to our staff. IEF management told us they removed 76 Cabinet submissions from 24 files before giving the files to our staff. NSBI management also removed 143 documents from 16 files and redacted sections in 29 documents because they deemed the information subject to solicitor-client privilege. IEF's Department of Justice solicitor also removed 32 documents from 11 files related to IEF. IEF management were not aware this occurred. Subsequently, in April 2010, the Justice solicitor provided 10 of those documents to our Office indicating they were not actually subject to solicitor-client privilege. Reviewing files and other documents prior to providing information to the Auditor General represents unwarranted interference with the audit process and contravenes the Auditor General Act. The Auditor General, not the auditee, has the right and responsibility to determine what information is necessary to express an opinion and conclusion on the audit objectives. We do not know what information was withheld, what impact it might have had on our work, or whether all documents were, in fact, Cabinet submissions or related to solicitor-client communications. In the case of IEF, the Department of Justice solicitor initially deemed documents were solicitor-client privileged and later decided certain of these documents were not subject to privilege. Since we were not given the information we needed to conduct the audit, we were required to deny an audit opinion on NSBI's and IEF's financial and program controls, and their compliance with legislation, regulations and policies, related to payroll rebates, loans and other financial assistance.

2.12 *Files withheld and documents removed* – All files were withheld from our staff until they could be reviewed to remove Cabinet submissions and other Cabinet-related documents. We were informed that Executive Council Office staff told NSBI and IEF management that the documents were confidential and should not be provided to our staff. NSBI management also reviewed files and removed documents which they deemed to be subject to solicitor-client privilege. Additionally NSBI management withheld all staff reports until they could be reviewed and information removed which referred to documents which they believed to be privileged. IEF's Department of Justice solicitor also reviewed files and removed solicitor-client communications before giving our staff the files.

2.13 We asked both entities to provide a list of documents removed from the files or documents with sections deleted.

2.14 Initially IEF management informed us they deleted 76 Cabinet submissions from 24 files before giving our staff these files. We confirmed with IEF management that no solicitor-client communications had been removed from the files. Subsequently, our staff found information in one of the files which suggested solicitor-client communications had been removed. In following up this matter, we discovered that IEF's Department of Justice solicitors had custody of IEF's legal files. The solicitors reviewed all these files and removed solicitor-client communications before providing the files to our staff. IEF management were not aware this had occurred. We asked the solicitors to provide a list of documents which were removed. The solicitors informed us 32 documents were initially removed from 11 files. However 10 of those documents were subsequently provided to our Office in April 2010 because the solicitors reconsidered their decision, noting *"on reflection, it is our view that some documents are not subject to solicitor-client privilege."* This action puts in question the basis on which these decisions are being made.

2.15 NSBI management told us that they removed 30 Cabinet submissions from 12 files and redacted information in three documents from the same 12 files because they related to Cabinet submissions. NSBI management also told us that they removed 143 documents and redacted sections from 29 documents in 16 files because they considered the information subject to solicitor-client privilege.

2.16 We cannot be certain these lists are complete. We do not know what information was withheld, for what reasons, what impact it might have had on our work, or whether all documents were, in fact, related to Cabinet submissions or solicitor-client communications. This practice constitutes an unwarranted interference with the audit process. It represents poor accountability to the House of Assembly.

2.17 Management informed us of the restrictions on the information the entities were prepared to provide at the start of this audit and referred us to Executive Council. The Auditor General wrote to the Premier on October 30, 2009 to request that our staff be provided with the documents we required to complete our work at IEF and NSBI.

2.18 Senior management at the Executive Council Office then told us they intended to discuss a means to provide us with the information we needed. We proceeded with the audit, anticipating a timely resolution of the issues. Subsequently, the Deputy to the Premier/Clerk of Executive Council Office wrote the Auditor General and stated we would not be allowed to see the documents we requested.

FINANCIAL ASSISTANCE TO BUSINESSES THROUGH NSBI AND IEF

2.19 Initially, NSBI management indicated a willingness to discuss our access to solicitor-client documents. However, NSBI management eventually informed us they were not willing to provide us with solicitor-client communications which they considered subject to solicitor-client privilege.

2.20 We were not informed that access to solicitor-client communications for IEF files might be restricted until late in the audit process, when OAG staff discovered this to be an issue.

2.21 Once we concluded that restrictions on Cabinet-related documents and submissions, and solicitor-client communications would not be resolved during the audit, we limited the scope of our remaining audit procedures and then concluded the audit. If a similar situation occurs during a future audit we will immediately withdraw from the audit and report the restrictions to the House.

2.22 *Documents submitted to cabinet* – In government, when recommendations are forwarded to Cabinet for a decision, all related information is generally included in a Cabinet submission called a Report and Recommendation (R&R). R&Rs generally include background information and analysis of the issue, a list of alternatives and staff recommendations, and a communications plan.

2.23 NSBI and IEF management informed us that senior management staff at the Executive Council Office told them all documents submitted to Cabinet are confidential. Further, Executive Council Office staff told NSBI and IEF management that they were not permitted to provide Cabinet submissions or other Cabinet-related documents to our Office even though these documents contained information significant to our audit. NSBI and IEF followed these instructions.

2.24 *Solicitor-client documents* – Certain, but not all, communications and documents between a solicitor and his or her client may be privileged.

This means the solicitor cannot be compelled to release those documents. However the client can choose to release the documents. In certain instances, releasing the documents would mean the client had waived the privilege associated with those documents – meaning that the documents are no longer confidential. However, providing documents subject to solicitor-client privilege to the Auditor General does not constitute a waiver of privilege. The Auditor General has the right to examine documents to determine whether they are subject to solicitor-client privilege. If the documents are determined to be privileged, we would maintain their confidentiality and not disclose the contents.

2.25 NSBI management claimed our Office does not have the right to examine what they believe to be solicitor-client privileged documents. They informed us they withheld certain documents sent to or from their Department of Justice lawyer as well as certain information in reports related to actual or potential legal matters.

2.26 IEF uses the same government lawyer as NSBI. As noted above, IEF management initially informed us no solicitor-client communications had been removed from the files we examined. Subsequently, we found IEF's Department of Justice solicitor had removed solicitor-client communications without management's knowledge before we were permitted to see the files.

2.27 *Why we have the right to examine all documents* – The Auditor General Act requires that all documents, whether confidential or not, be provided to the Auditor General and does not contain any exemption for Cabinet submissions or solicitor-client privileged documents. Section 10(1) of the Auditor General Act states: *"Notwithstanding the provisions of any other Act, every officer, clerk or employee of an agency of government shall provide the Auditor General with such information and explanation as the Auditor General requires..."* Further, section 14 notes *"The Auditor General shall have, in the performance of his duties, the same powers, privileges and immunities as a Commissioner appointed under the Public Inquiries Act."* These sections together give the Auditor General the authority to compel production of information.

2.28 *Why we need this information* – When making conclusions, auditors draw audit evidence from a variety of sources including examination of documents, testing transactions and assessment of key controls. We require sufficient, appropriate audit evidence to form an audit conclusion.

2.29 Initially, all NSBI assistance requests are reviewed at the Board's Investment Committee. This Committee can approve loans provided the total owed by the applicant as a result of the loan will not exceed $1.25 million. The Board of Directors approves loans where the total owed by the applicant

will be between $1.25 million and $3 million. NSBI regulations require OIC approval for any loans or venture capital where the total amount of the assistance will exceed $3 million. The Provincial Finance Act requires Minister of Finance approval, or at the Minister's discretion, OIC approval, for any payroll rebate financial obligation. Therefore documents on all these assistance requests are forwarded to Cabinet in the form of an R&R prepared by NSBI. These R&Rs are supposed to include information on the applicant, analysis of alternatives, and the terms and conditions of the proposed assistance, and are a key program control. The R&R is reviewed by Cabinet which determines whether or not to grant the assistance. If Cabinet approves the R&R, an OIC is issued approving the terms and conditions attached to the R&R.

2.30 IEF uses a similar process. However in the case of IEF, all assistance is approved by Cabinet. There is no prior approval by any other group. Approval of the R&Rs is the primary internal control for IEF assistance.

2.31 *What it means when information is not provided* – When an auditor cannot obtain the information he or she planned to collect, the auditor must determine whether alternative procedures can be applied and, if this is not possible, what impact the lack of information has on the audit opinion or conclusion.

2.32 At NSBI, we were able to examine some of the information provided to the Investment Committee of the Board as well as certain supporting documentation in assistance files. However because R&Rs were removed before we were allowed to examine the files, we have no way to know whether the information which went to Cabinet accurately reflected all information gathered on the company, the results of risk analysis and other information. Without this, we cannot know whether Cabinet was provided everything necessary to make a decision. There were no alternative procedures to allow us to gather the audit evidence needed to conclude on this matter.

2.33 At IEF, there is no file documentation to support the loan analysis and recommendation. Although files may contain some information received from the business requesting the loan, there was no evidence of IEF management's review and analysis of this information. Similarly, there was no risk analysis indicating whether IEF should proceed with the financial assistance. IEF management informed us this is included in the R&R to Cabinet. Since we were not permitted to examine any of this information, we cannot conclude whether IEF management completed a thorough analysis of companies requesting assistance or whether Cabinet was given everything it needed to make an informed decision. As with NSBI, there were no alternative audit procedures which we could carry out that would give us the audit evidence necessary to conclude on the appropriateness

or effectiveness of controls or compliance with legislation, regulations, policies and procedures.

2.34 *Who determines what information is required for an audit* – The Auditor General, not the auditee, has the right and the responsibility to determine what information is needed to express an opinion on the audit objectives. At the end of an audit, the Auditor General should be confident that he has reviewed all relevant documentation. When documents are removed from files and the Auditor General is denied information, this is not possible.

2.35 When the Auditor General cannot obtain all the information needed during an audit and alternative procedures are not possible, he must decide the impact on the audit. This could involve qualifying an opinion – a situation in which an auditor expresses an opinion on most aspects of an audit but cannot conclude in certain areas. However, when auditors are not provided significant information required to conclude, the only alternative is to deny an audit opinion – the most severe option available to the auditor.

2.36 We do not know what impact, if any, the information that was removed from the files would have had on our audit opinion had it been provided. As a result, we must deny an audit opinion on the appropriateness and effectiveness of NSBI's and IEF's financial and program controls and their compliance with legislation, regulations and policies related to loans, payroll rebates, venture capital investments and other financial assistance to businesses.

2.37 The failure to provide information that this Office requires contravenes the Auditor General Act, constitutes an undue interference with the Auditor General's mandate and his responsibility to report to the House of Assembly, and represents poor public accountability.

2.38 *Responsibility for denial of information* – In the December 2004 Report of the Auditor General, we reported the results of a performance audit of the payroll rebate program at NSBI. Our work on that audit included file testing. We were given full access to NSBI's files. Management did not review the files before OAG staff examined them. We had full access to all file documents and staff reports, regardless of whether these included communications between NSBI and its Department of Justice solicitor. Since all payroll rebates are approved by Cabinet, files routinely included Cabinet submissions which OAG staff reviewed as part of our fieldwork.

2.39 Problems with denial of information are also noted in Chapter Four (Mental Health Services) of this Report. Similar issues were reported in the June 2008 Special Report of the Auditor General – Office of Immigration Economic Stream of the Nova Scotia Nominee Program. After the release of the June 2008 Special Report, the Public Accounts Committee of the

House subpoenaed the Premier and several Cabinet Ministers requiring them to produce all documents which this Office had been refused. Shortly afterwards, we were contacted by Executive Council Office and were allowed to view the documents which had been previously denied based on claims they were confidential Cabinet documents or subject to solicitor-client privilege.

2.40 Both NSBI and IEF management claimed during the current audit that senior management at Executive Council Office instructed them to withhold information related to Cabinet submissions. As well, NSBI management decided not to provide our staff with certain communications with their solicitor. They told us they believed this would waive solicitor-client privilege. As discussed earlier in this Chapter, IEF management were not aware their Department of Justice solicitor had reviewed files and removed solicitor-client communications prior to providing these files to OAG staff.

2.41 We have been informed that the decision to withhold Cabinet submissions and other Cabinet-related documents was made at Executive Council Office by the Deputy to the Premier/Clerk to the Executive Council.

2.42 In the absence of direction from Cabinet regarding Cabinet documents, it is within the authority of the Deputy Minister, CEO and Board of Directors to provide those documents. Executive Council Office staff do not have the authority to tell NSBI or IEF whether or not they can provide information to the Auditor General. It is also within the authority of the Deputy Minister, CEO and Board of Directors to provide solicitor-client communications as the privilege belongs to the client, not the solicitor. Accordingly, the responsibility for interference with the audit rests with the Deputy Minister, CEO and Board of Directors. Cabinet, however, has the authority to direct management to provide the information to this Office.

Recommendation 2.1
We recommend that Cabinet instruct all departments and agencies of government to comply with all terms of the Auditor General Act and the Public Inquiries Act, cooperate fully with the Office of the Auditor General, and provide the Auditor General with timely and unrestricted access to all information in their possession.

Areas In Need Of Improvement Identified

Conclusions and summary of observations

Although we were unable to express an opinion on NSBI's and IEF's financial and program controls, we did identify areas in need of improvement. NSBI needs to

update policies and procedures to include all processes related to payroll rebates. IEF should prepare written policies and procedures and certain processes need to be strengthened. For instance, IEF and NSBI cannot produce a complete and accurate list of loans in arrears.

2.43 Although we were unable to express an opinion on NSBI's and IEF's program and financial controls, and compliance with legislation, regulations and policies related to payroll rebates, loans and other financial assistance through these entities we did find areas where improvements are required.

2.44 *NSBI* – Payroll rebate applications are processed by one of two divisions within NSBI depending upon the type of assistance requested. One of the divisions does not always require applicants to submit all required documentation. Management informed us there are some instances when they believe certain information is not required. If this is the case, policies and procedures should reflect which documents must always be obtained versus those which are optional.

Recommendation 2.2
Nova Scotia Business Inc. should ensure that all practices for both types of payroll rebates are accurately reflected in documented policies and procedures. Policies and procedures should be followed in the review of information and awarding of payroll rebates.

2.45 *IEF* – We identified a number of deficiencies in IEF's processes to review and approve financial assistance.

- There are no written policies and procedures regarding the receipt, assessment, approval and payment of loans and development assistance.
- Standard loan application forms are not used to obtain information on applicants.
- There is no listing of documents that applicants are required to submit
- Although we were informed a risk assessment is performed, we were unable to determine the adequacy of the analysis because the assessment is not formally documented outside the R&R to Cabinet, which we were not permitted to see.

2.46 IEF may provide assistance to applicants who cannot obtain financing elsewhere. This strengthens the need for documented policies and procedures, formal risk analysis and other steps. Under the current system, applicants may not be evaluated consistently, decisions may be made based upon incomplete information, or assistance could be given to applicants who should be denied assistance.

Recommendation 2.3
The Department of Economic and Rural Development should formally document its policies and procedures for the Industrial Expansion Fund. These should include establishing standard application forms, developing a checklist of documents which should be considered and performing a formal risk assessment.

2.47 We also reviewed the systems and processes used to monitor the status of loans. While we were unable to express an audit opinion, we did identify areas for improvement.

- IEF has no written policies and procedures for processing loan repayments and monitoring the recipient's ongoing compliance with the terms and conditions contained in the loan agreements.
- IEF has no formal processes to ensure loan repayments are made on time, identify loans in arrears and collect overdue amounts owing.
- We were informed there is an annual review of each IEF loan account. There is no standard format for documenting the results of the annual review and there are no guidelines concerning what information should be documented.

2.48 We are concerned that collection activities may not begin on a timely basis. Year-end reviews may be based upon incomplete information or may not be consistently performed.

Recommendation 2.4
The Department of Economic and Rural Development should develop formally documented policies and procedures to process loan repayments and for ongoing monitoring of recipients for the Industrial Expansion Fund.

2.49 NSBI and IEF use a common accounting system to record loans and other assistance. This system does not produce a complete and accurate arrears listing. NSBI has to manually review its arrears because the system doesn't include loans with principal in arrears or loans which have only been partially disbursed. Whenever there are manual processes, the risk of errors is increased. We identified minor errors in the manual adjustments to the arrears listing. IEF can only produce an arrears listing if staff consider each file and develop the list manually. At the time we completed our audit, there was no current arrears listing for IEF.

Recommendation 2.5
The Department of Economic and Rural Development and Nova Scotia Business Inc. should ensure the accounting system used for loans and other assistance at the Industrial Expansion Fund and Nova Scotia Business Inc. can produce a complete and accurate listing of accounts in arrears and an aged accounts receivable listing.

Measuring and Reporting On Performance

Conclusions and summary of observations

NSBI has systems in place to measure and report on the performance of its financial assistance programs. NSBI developed performance indicators, including annual targets, and includes this information in its annual report. Additionally, NSBI had a consultant review the impact of its programs over the past several years. While the Department of Economic and Rural Development also had a consultant review the impact of the Industrial Expansion Fund, in order to truly measure program effectiveness, the Department must establish targets for IEF's performance indicators and report progress annually.

2.50 *Background* – In order to assess the effectiveness of a program, an entity must establish goals and objectives and assess whether these are being met. Typically, goals, objectives and related performance targets are documented in a strategic plan and annual business plans. Corrective action should be taken when performance targets are not met.

2.51 *Information required for this section of the audit* – We were provided with all information we requested to complete this section of the audit. As a result, we were able to form a conclusion.

2.52 *IEF* – There is no strategic plan or business plan for the Industrial Expansion Fund. The Department of Economic and Rural Development, which has administrative responsibility for IEF, leads the cross-government implementation of Opportunities for Sustainable Prosperity – government's long-term economic growth strategy. IEF provides funding for certain initiatives outlined in the strategy. Although Opportunities for Sustainable Prosperity refers to using IEF to make capital available to businesses, it does not provide specific plans or targets detailing how IEF is to be used.

2.53 The Department of Economic and Rural Development contracted with a consulting firm to prepare an economic impact analysis of IEF and its clients over a six-year period ended March 31, 2007 as well as the expected impact by 2012. The report showed a positive return to government from money

invested through IEF – $5 return to government for every $1 invested. We did not audit these statistics and express no opinion on their accuracy.

2.54 Although the consultant's report is positive, to truly measure program effectiveness, we believe that the Department of Economic and Rural Development should establish annual targets for IEF and report whether the Fund achieves these targets. While IEF has performance indicators – jobs created or maintained, new annual salary and wages, and annual tax revenue from new jobs – no targets have been established. Similarly, IEF produces an annual report but there is no reporting against targets. Without targets, it is difficult to assess whether the Fund is meeting its goals and objectives.

Recommendation 2.6
The Department of Economic and Rural Development should establish annual targets which will help assess the effectiveness of financial assistance through the Industrial Expansion Fund. Once established, results against targets should be reported annually.

2.55 *NSBI* – NSBI has a strategic plan covering the period from 2007 to 2012. NSBI has established strategic goals and objectives and performance indicators. The overall performance indicator is total new and retained payroll. All performance indicators have yearly targets and results are published in NSBI's annual report.

2.56 NSBI also contracted with a consulting firm to prepare an economic impact analysis of the impact of NSBI and its clients on Nova Scotia's economy. The report considered impacts from NSBI's inception in 2001 to 2007 and included projections through to 2012. The consultant concluded NSBI achieved its short term goal of 18,000 private sector jobs created or retained over the five year period covered by the strategic plan. The consultant also concluded NSBI will be able to achieve its long term goal of returning $2 to government for every $1 invested over a ten year period. We did not audit the information in the consultant report and express no opinion on its accuracy.

Response: Executive Council Office

The Executive Council Office appreciates the opportunity to respond to the 2010 Auditor General's Report on Financial Assistance to Businesses Through NSBI and IEF (the Audits).

The Province continues to take the position that it is not a contravention of the Auditor General Act to protect privileged documents by not disclosing them to the Auditor General.

With respect to solicitor-client privileged documents, the Auditor General's power to compel the production of documents is not absolute and is subject to the Province's right to protect solicitor-client privileged information. This protection from disclosure is based on preservation of the solicitor-client relationship which is fundamental to the proper functioning of the legal system.

With respect to Cabinet privileged documents, when the staff of the Auditor General made requests in the Audits for documents that had been submitted to the Executive Council (Cabinet), they were properly referred to the Clerk/Secretary of the Executive Council/Executive Council Office as the holder of these documents. As in the past, the decision in regard to what Cabinet privileged documents would be released to the Auditor General was based on long-standing parliamentary traditions in protecting the confidentiality of Cabinet deliberations and was communicated in writing by the Clerk/Secretary of the Executive Council to the Auditor General. Executive Council Office provided the Auditor General with records of decisions (Orders in Council) and any schedules referred to therein, outlining the terms and conditions of the financial assistance that were the subject of the Audits.

Unlike several other Canadian jurisdictions, there is no provision in the current Auditor General Act to allow for a limited waiver of privileged documents to the Auditor General. A limited waiver means that privileged documents provided to the Auditor General are still considered privileged and cannot be disclosed to third parties. Since there is no limited waiver provision in the Nova Scotia Auditor General Act, disclosure to the Auditor General may be considered a full waiver of privilege and could, therefore, result in the loss of protection against disclosure to third-parties.

There have been ongoing discussions between the Auditor General and government staff regarding the Auditor General's authority to access privileged documents and whether amendments to the Auditor General Act would assist in striking a balance between preservation of solicitor-client and Cabinet privilege and access to documents by the Auditor General for audit purposes. We anticipate that these discussions will continue.

RESPONSE: DEPARTMENT OF ECONOMIC AND RURAL DEVELOPMENT

Response: Department of Economic and Rural Development for Industrial Expansion Fund

Recommendation 2.3
The Department of Economic and Rural Development should formally document its policies and procedures for the Industrial Expansion Fund. These should include establishing standard application forms, developing a checklist of documents which should be considered and performing a formal risk assessment.

The government is committed to improving the accountability and the transparency of the Industrial Expansion Fund. In this regard, an improved governance mechanism is being put in place which will be communicated in the near future.

The policies and procedures of the operations of the Industrial Expansion Fund will be formally documented.

Recommendation 2.4
The Department of Economic and Rural Development should develop formally documented policies and procedures to process loan repayments and for ongoing monitoring of recipients for the Industrial Expansion Fund.

The policies and procedures to process loan repayment and for ongoing monitoring of recipients will be formally documented.

Recommendation 2.5
The Department of Economic and Rural Development and Nova Scotia Business Inc. should ensure the accounting system used for loans and other assistance at the Industrial Expansion Fund and Nova Scotia Business Inc. can produce a complete and accurate listing of accounts in arrears and an aged accounts receivable listing.

Most transactions within the IEF contain business specific terms and conditions for the financial assistance provided. In many cases, the terms and conditions are not standard compared with a residential mortgage, for example. The accounting system currently used is derived from a system designed to account for residential mortgages. Consequently, the system does not produce accurate arrears reports.

A manual system, and good compensating controls, will be formally instituted to compensate for this deficiency in the computer system.

Recommendation 2.6
The Department of Economic and Rural Development should establish annual targets which will help assess the effectiveness of financial assistance through the Industrial Expansion Fund. Once established, results against targets should be reported annually.

Responsibility for the establishment of annual goals and targets rests within the framework of government.

RESPONSE: DEPARTMENT OF ECONOMIC AND RURAL DEVELOPMENT

Response: Nova Scotia Business Inc.

Thank you for the opportunity to comment on the 2010 Auditor General's Report on Assistance to Business.

Nova Scotia Business Inc. (NSBI) would first like to acknowledge the role and responsibility of the Auditor General, the Office of the Auditor General and the Auditor General Act. It is NSBI's position, as supported by the response of the Executive Council Office, that its actions did comply with the Auditor General Act.

With respect to solicitor-client privileged documents NSBI agrees with the Auditor General that it is within NSBI's authority to provide such documents. NSBI also agrees with the Auditor General that for solicitor-client privileged documents the privilege belongs to NSBI, as the client. NSBI's position, after careful consideration, including the consideration of input from legal counsel, is that solicitor-client privilege may not be maintained if documents are provided to the Auditor General. As a result NSBI has taken the position to not waive privilege by providing such documents.

NSBI referred all requests for Cabinet documents to the Executive Council Office. Cabinet document privilege belongs to Cabinet, not NSBI. NSBI must defer to Executive Council/Executive Council Office on such matters.

Recommendation 2.2
Nova Scotia Business Inc. should ensure that all practices for both types of payroll rebates are accurately reflected in documented policies and procedures. Policies and procedures should be followed in the review of information and awarding of payroll rebates.

NSBI agrees that the policies and procedures should accurately reflect the practices being followed. The type of assistance and the nature of the project being undertaken impacts the type and nature of the documents required to do a proper analysis. NSBI shall undertake to review the documented policies and procedures.

Recommendation 2.5
The Department of Economic and Rural Development and Nova Scotia Business Inc. should ensure the accounting system used for loans and other assistance at the Industrial Expansion Fund and Nova Scotia Business Inc. can produce a complete and accurate listing of accounts in arrears and an aged accounts receivable listing.

NSBI agrees a system that does not require a manual review of arrears listings is the ideal solution. NSBI is in the initial stages of assessing options. This assessment

must address the reality that most automated systems are built for traditional banking portfolios. The NSBI portfolio and loan characteristics do not match this. NSBI also has approximately 100 accounts, a relatively small number. Since the requirements will be relatively complex and portfolio is small, the assessment must also consider the appropriate use of public funds.

While using the current system NSBI will continue with manual checks and balances. There is a monthly review by administrative and account management staff. Reports are provided to management, the Investment Committee, the Audit Committee and the full Board of Directors. The arrears listing is an important aspect of the detailed portfolio valuation process. This process ensures an accurate financial representation in the financial statements and is subject to yearly audit by the financial statement auditor. We remain confident that the public funds used to finance the portfolio are appropriately managed and being subjected to detailed scrutiny throughout the process.

RESPONSE:
NOVA SCOTIA
BUSINESS INC.

3 Environment: Management of Contaminated Sites

Summary

The risks associated with contaminated sites in Nova Scotia are not being adequately managed to protect the public interest. The Department needs to improve its monitoring of contaminated sites to ensure risks to third parties, human health and the environment are being appropriately addressed. The existence of contaminated sites which are not cleaned up may also negatively impact the competitiveness of our economy.

The Department is aware of known and possible contaminated sites where the landowner or responsible person was not required to assess and address applicable risks to the public and the environment. Management indicated that there are also sites where risks have been assessed to be unacceptable which have not been cleaned up or a risk assessment has not been completed because the person responsible does not have the funds to pay. We are concerned that there may be sites in the province for which unacceptable risks have not been properly mitigated.

Timely monitoring of sites is required to help ensure cleanups are completed and risks are addressed appropriately. For those sites where the cleanup is in progress and being monitored by the Department, there is no process in place to ensure sites with higher risks are given priority. We identified sites where we believe monitoring activities did not take place in a timely manner. We also found weaknesses in the systems established to ensure qualified site professionals are performing the cleanup and we found inspectors are not verifying the accuracy of important information reported by these professionals.

Overall we found the inspectors are conducting inspections for complaints and notifications of possible contaminated sites in an appropriate and timely manner.

Although we identified instances in which Departmental policies and procedures were not being complied with or needed improvements, we are encouraged by new operational initiatives and an information system which should address some of the weaknesses noted in this report.

3 Environment: Management of Contaminated Sites

Background

3.1 Soil, water and air can become contaminated as a result of a chemical spill or release. A contaminated site is a site with concentrations of chemicals that exceed acceptable standards for the particular land use and that has caused, is causing, or may cause, an adverse effect. According to the Environment Act, an adverse effect means *"an effect that impairs or damages the environment including an adverse effect respecting the health of humans or the reasonable enjoyment of life or property."*

3.2 Contaminated sites can negatively affect human health, the natural environment and the competitiveness of our economy. Under the Environment Act, the Department of Environment has a responsibility *"to support and promote the protection, enhancement and prudent use of the environment"* of Nova Scotia. Within the Department, the Environmental Science and Program Management Division (ESPM) is responsible for coordinating a contaminated sites program including the development and implementation of plans, standards, guidelines, policies and regulations related to the program. They also provide technical assistance to inspectors of the Environmental Monitoring and Compliance Division (EMC) of the Department. EMC is responsible for the delivery of the program in the field. The main responsibilities of EMC staff are to conduct inspections for compliance and respond to complaints and notifications received regarding potential contamination to ensure responsible parties comply with provincial legislation, standards and policies.

3.3 According to legislation, remediate means *"to clean up land which is impacted by the release of a contaminant to a level required by the Minister."* For purposes of this Chapter, we will use cleanup when referring to the remediation of a site.

3.4 For operational purposes, the province is divided into four regions. A network of regional and district offices provides environmental compliance coverage to all areas of the province. The EMC Division employs approximately 70 inspectors with 31 of those inspectors having responsibility for the contaminated sites program along with responsibilities under other Department programs. Inspectors are supported by EMC and ESPM resource staff such as engineers and compliance and inspection coordinators.

3.5 In 2008-09, actual expenditures for the EMC Division were $11.4 million. For 2009-10, the budget for EMC was $12.0 million from a total departmental budget of $44.3 million. Management indicated $19.5 million of the total departmental budget related to grant funding leaving $24.8 million available for operations.

3.6 Section 4(2)(m) of the Environmental Goals and Sustainable Prosperity Act of 2007 commits the Province to develop regulatory tools to *"stimulate redevelopment of contaminated land and contribute to economic development while protecting the environment"* by the year 2010. Management has indicated they have taken actions to achieve this goal.

Audit Objectives and Scope

3.7 In the winter of 2010 we completed a performance audit of the Department of Environment's management of its contaminated sites program. 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.

3.8 The purpose of our audit was to determine if the risks associated with contaminated sites in Nova Scotia are being managed adequately to protect the public interest.

3.9 The objectives of our audit were to determine if the Department of Environment:

- is adequately monitoring and enforcing compliance with applicable legislation, policies and guidelines related to its responsibilities for contaminated sites;
- has adequate processes to respond to complaints or notifications received concerning possible contaminated sites; and
- has adequate management information and processes to ensure it is effectively managing its responsibilities for contaminated sites.

3.10 Generally accepted criteria consistent with the objectives of this audit did not exist. Audit criteria were developed specifically for the engagement using both internal and external sources. Criteria were accepted as appropriate by senior management of the Department.

3.11 Our audit approach included interviews with ESPM and EMC Division management and staff; documentation of systems and processes; and examination of legislation, policies, guidelines and other documentation.

We also performed detailed testing of compliance with certain processes and procedures including complaints, monitoring, and enforcement. Compliance testing for monitoring and enforcement covered the period from April 2008 to January 2010. Compliance testing for complaints covered the period October 2009 to January 2010. We conducted audit work at the Department of Environment head office and the four regional offices.

Significant Audit Observations

Monitoring and Enforcement

Conclusions and summary of observations

The Department is not adequately monitoring contaminated sites to ensure risks to third parties, human health and the environment are being adequately addressed to protect the public interest. The Department is aware of some known and possible contaminated sites where no action has been taken to assess and address possible risks to the public and the environment. There are also sites where risks have been assessed as unacceptable but the sites have not been cleaned up, or an assessment of risks has not been done, because the person responsible does not have the funds to pay, Public Prosecution Services will not prosecute, and the Department does not have the funds to have the work done. For those sites where cleanup is ongoing and the Department is monitoring, there is no process in place to ensure sites with higher risks are given priority after dealing with immediate threats. Additionally we identified sites for which monitoring activities did not take place in a timely manner. Inspectors rely on site professionals to assess and manage the cleanup of contaminated sites. However, we found weaknesses in the systems established to ensure qualified individuals are hired and we found there is no process in place for inspectors to identify and verify, on a sample basis, the accuracy of key information reported by site professionals on cleanup processes conducted and final results.

3.12 *Roles and responsibilities* – The Environment Act places responsibility for the cleanup of contaminated sites with the landowner or other persons responsible as defined in legislation. Generally the landowner or person responsible will hire a site professional or certified cleanup contractor to assess whether the land is contaminated and, where required, manage the cleanup. For purposes of this chapter we will refer to those who manage the cleanup as site professionals. Site professionals determine how the site will be cleaned up and the timing and frequency of any testing and monitoring that may be required.

3.13 EMC inspectors review and evaluate site professionals' reports of site assessments, cleanup plans and cleanup results to ensure compliance with provincial legislation, standards, policies and guidelines where applicable. Inspectors are responsible for taking necessary monitoring and follow-up actions, including enforcement actions in cases of noncompliance with legislation.

3.14 *Known or likely contaminated sites* – Department management indicated they are aware of known or likely contaminated sites owned by a municipality, the province, or other landowners or persons responsible. These are not sites for which the Department received complaints or were notified of a spill.

3.15 The Department has not required the municipality, the province, or other landowners or persons responsible to complete site assessments to determine whether there is an unacceptable risk to human health and the environment resulting from contamination which may exist at these locations. The Department does not track or otherwise monitor these sites. Any site which the Department knows is contaminated or believes is likely contaminated should be assessed and all necessary actions within its mandate taken to ensure any unacceptable risks which may exist are adequately addressed.

Recommendation 3.1
The Department of Environment should ensure sites which are known to be or likely to be contaminated are appropriately assessed and any unacceptable risks to human health and the environment are addressed by the responsible party.

3.16 *Lack of funds* – Costs associated with the cleanup of a contaminated site are the responsibility of the landowner or other persons responsible. According to management, in a case where the landowner does not have the money to clean up a site, EMC staff may take action to contain the contamination if required and may issue a ministerial order to clean up the site. However, management noted that Public Prosecution Services may not prosecute a landowner or other persons responsible if they do not have the ability to pay. This is outside the control of the Department. If this is the case, the site will not be cleaned up by the Department.

3.17 The Department indicated that as regulators they are not responsible, nor do they have the funding, to clean up sites where landowners or persons responsible cannot pay. The Department also noted that there are contaminated sites in the province where third party impacts have not been adequately addressed. As well, we identified a site during our testing where emergency cleanup activities were completed and a ministerial order was issued to assess remaining contamination risks. However Department staff informed us this assessment was not completed because Public Prosecution

Services did not prosecute to enforce the ministrial order. We are concerned that third party impacts and risks to human health and the environment with respect to these sites are not being adequately addressed.

Recommendation 3.2
The Department of Environment should report to Cabinet those contaminated sites where unacceptable risks have not been adequately addressed to ensure Cabinet has appropriate information for policy decisions.

3.18 *Initial site assessments* – Potential contaminated sites typically come to the attention of EMC inspectors through complaints or notifications. Inspectors usually perform a site visit to determine if there is any direct and immediate threat to human health or the environment. Where an immediate threat exists, the risks associated with those sites must be dealt with immediately by the person responsible. For sites where there is no immediate threat but contamination is likely present, the person responsible will be notified that a site assessment or other activities are required and a contaminated site file is opened by EMC inspectors for monitoring purposes.

3.19 According to staff, in the six month period ending March 31, 2010, there were 39 contaminated site files opened for monitoring purposes throughout the province.

3.20 *EMC monitoring activities* – Site professionals, involved in the cleanup of a contaminated site and acting for landowners or other persons responsible, may be required to provide EMC with various reports including site assessments, cleanup plans and final cleanup reports. As part of EMC monitoring, inspectors follow up with the site professionals to ensure these reports are received. Once received, EMC inspectors review these reports and note any deficiencies or additional information which the site professionals need to address to support compliance. Monitoring may include ensuring required action has been taken as a result of enforcement activities.

3.21 *Defined timeframes* – There are no defined timeframes established for EMC monitoring activities, including follow-up to ensure reports are received and subsequent review of reports. The timeframes involved could vary depending on the risk levels of sites and the complexity of site conditions. Establishing timeframes would help management assess whether EMC monitoring activities are conducted in a timely manner. Management informed us that timeframes to follow up required reports have since been established.

3.22 *EMC follow-up of site professional reports* – To help ensure that cleanup is done in a timely manner and risks have been adequately addressed, it is

important that EMC staff actively monitor whether required information is received and deficiencies have been addressed. We examined 36 open files for contaminated sites and found four in which EMC monitoring activities to obtain required reports did not take place within a reasonable timeframe. The timeframe ranged from eight to 15 months.

Recommendation 3.3
The Department of Environment should implement timeframes to follow up receipt of site professional reports and ensure timeframes are being followed.

3.23 *Timelines for review of reports* – One of the key reports received from site professionals is the remediation report. This report describes how a site has been cleaned up and concludes whether it has been cleaned to provincial standards. As part of our testing of files we found instances in which remediation reports were not reviewed in a timely manner. We found two files for which the reports were reviewed approximately one year and 11 weeks after receipt. There was also one report which, at the time of our audit, had been received 6 weeks earlier and had not yet been reviewed. As well, we identified an environmental site assessment report which was reviewed approximately five months after receipt.

3.24 One of the four regions places all cleanup reports received in a queue to be reviewed when time permits. They remain in the queue until an inspector reviews the report for deficiencies. As of February 22, 2010, there were 32 reports in the queue. Of the 32 reports, eight had been received more than six months ago (the oldest was nine months), 22 had been received between one and six months ago, and the remaining two were in the queue for less than a month. We were unable to determine similar information for the other three regions as reports are not tracked in this manner. Staff at one other region indicated that the timely review of reports is an issue.

3.25 Until important information such as a remediation report is reviewed and accepted by an inspector, the Department has little knowledge about whether a site has been properly cleaned up and risks have been appropriately addressed.

Recommendation 3.4
The Department of Environment should ensure that site professional reports and other information are reviewed in a timely manner based on timeframes established.

3.26 *Prioritization* – EMC staff address immediate threats to human health and the environment from contaminated sites. However, a site may still need to be cleaned up to address remaining risks. EMC staff do not have a formal prioritization process to ensure higher-risk contaminated sites are the first

priority for monitoring by inspectors after dealing with immediate threats. Certain sites potentially pose a higher human health risk than others, such as spills which could potentially contaminate a nearby water supply. At present higher-risk sites are not specifically identified and more closely monitored. With limited resources available, it is important that EMC inspector activity is targeted to the sites which pose the highest risk.

Recommendation 3.5
The Department of Environment should develop a formal prioritization process to identify higher-risk contaminated sites. Inspector monitoring activities should ensure priority is given to higher-risk sites.

3.27 *Inspector site visits* – EMC inspectors do not typically perform site visits during the cleanup process to verify the accuracy of information reported by site professionals. EMC staff rely heavily on this information to assess whether the contaminated site has been appropriately cleaned up. Without a process which allows for the verification of certain information reported to the inspectors, there is a risk that inaccurate information is reported and a site which EMC thought was properly cleaned up may not be. We understand that verification of all information would not be practical but a process could be implemented, on a sample basis, which takes into account the level of risk associated with a particular site.

Recommendation 3.6
The Department of Environment should conduct periodic site visits on certain sites, taking into consideration the level of risk involved, to verify key information reported by site professionals.

3.28 *Site professionals* – Inspectors rely on site professionals throughout the contaminated sites cleanup process. Qualified site professionals are an important component of the Department's contaminated sites program. Under the Department's Domestic Fuel Oil Spill Policy, site professionals must apply to be on a list of registered individuals who are eligible to complete cleanup work. This list is available to landowners or persons responsible for choosing a site professional to manage necessary cleanup work for them on a site. To be eligible for the Department's site professional list, applicants must either have a bachelor's degree in an appropriate discipline, a minimum of five years practical experience in all phases of site cleanup, and adequate insurance coverage; or take a two-day course, pass an exam, and submit references demonstrating experience with site cleanup. There are different qualification requirements under the Guidelines for the Management of Contaminated Sites. Site professionals are required to be professional engineers or professional geoscientists.

3.29 The Department does not verify the professional credentials or the education and work experience requirements of site professionals involved in the cleanup of contaminated sites. There is a risk that unqualified individuals may be responsible for managing important cleanup work on contaminated sites. Individuals who are not qualified could potentially delay or fail in the proper cleanup of the site, which could negatively impact addressing related risks in a timely manner.

Recommendation 3.7
The Department of Environment should complete background checks to ensure site professionals have the education and work experience required under Departmental guidelines.

3.30 *Site professionals reporting requirements* – There are no standard cleanup submission requirements or report format for site professionals. As a result, the work done and remediation reports submitted are different depending on the site professional. EMC management informed us this can negatively impact inspector effectiveness in processing such reports and increases the risk that important information may be missing and go undetected.

3.31 Related to these issues is the fact that there are no required timeframes for landowners or persons responsible for completing the various stages of cleanup. Management believes such regulation would help achieve timely cleanup of sites. Management informed us they are considering establishing timeframes for the various stages of cleanup through the revised regulations being developed. Management indicated that they are currently developing standardized cleanup and report structure requirements to update current guidelines. However, this project has been pending since 2006.

Recommendation 3.8
The Department of Environment should develop standardized cleanup submission requirements as well as standard report formats.

3.32 *Closed files* – Contaminated site files can be closed by inspectors once a site has been cleaned up to Department standards. We examined 19 closed files and found all files contained required reports supporting proper file closure.

3.33 *Enforcement* – Enforcing compliance with the Environment Act and regulations can involve non-punitive measures, such as persuasion and education, and punitive measures such as warnings, summary offense tickets, and ministerial orders. Inspectors determine and carry out enforcement activities, guided by the Department's compliance model and consultation with compliance and investigation coordinators or the district manager.

3.34 During file testing, we reviewed seven files which had a total of ten enforcement actions. We determined that enforcement actions taken were consistent with the Department's enforcement framework, with the exception of two actions in which we saw no evidence that the Compliance and Inspection Coordinator was consulted and neither he nor the district manager were informed prior to an enforcement action being taken.

Recommendation 3.9
The Department of Environment should ensure consultation with the Compliance and Inspection Coordinator and notification to the coordinator and district manager occurs prior to enforcement action being taken.

Complaints and Notifications

Conclusions and summary of observations

Overall the Department has an adequate process to respond to complaints and notifications of possible contaminated sites. We found the assessment and inspection of complaints and notifications is carried out in a timely and appropriate manner but improvements could be made in how complaints and notifications are tracked. We also found management does not review closed complaint files to ensure closure is supported although this is required by department procedures. Additionally there is no requirement that closed notification files be reviewed by management.

3.35 According to staff, in the six-month period ending March 31, 2010, there were 128 complaints and notifications of potential contaminated sites received throughout the province.

3.36 *Timeliness and appropriateness of assessment* – In 28 of 29 complaint and notification files tested, inspections were carried out in a timely and appropriate manner. In one file, a complaint was received in July 2009 but, as of the time of our audit, there was no evidence in the file that the owner of the property where the contamination originated had been contacted.

3.37 *Management review of closed complaint and notification files* – If it is decided that a site is not contaminated and no further action is required, the complaint or notification file is closed. Otherwise, it is changed to an open contaminated site file to be monitored. Three regions follow a complaint tracking protocol which requires management review of all closed complaint files to ensure the decision to close the file is supported. However, there is no evidence of this review in the files. For these regions in which the complaint tracking protocol is followed, management in two districts indicated all closed files are not reviewed due to the volume. These

three regions also have no requirement for management to review closed notification files. The fourth region has been following a pilot departmental operating procedure. This procedure requires the district managers to review a sample of closed complaint and notification files. However, this review process has not been completed since January 2009. Management indicated that a new departmental procedure has now been approved which requires the review of a sample of closed complaint and notification files in all regions. Management review of closed complaint and notification files reduces the risk that closure may be premature and possible contaminated sites are not being appropriately addressed.

Recommendation 3.10
The Department of Environment should ensure closed complaint and notification files are reviewed by management as required. Evidence of review, including the date, should be documented in the file.

3.38 *Performance standards* – The Department does not have any documented standards that outline when an inspector should begin the inspection of a complaint or notification for those files which do not require an inspector's immediate attention. As well, there are no standards for the timing of the District Managers' review of closed files. Timely assessment of complaints and notifications and the review of closed files are important controls to ensure possible contaminated sites are properly assessed and managed.

Recommendation 3.11
The Department of Environment should implement time standards for the inspection of a complaint or notification by inspectors and for district manager review of closed files.

3.39 *Accuracy of information in the activity tracking system (ATS)* – ATS is a province-wide system used by management to monitor and track complaints and notifications. It enables management to see which inspector has been assigned to a file as well as the status, such as when a file was opened, actions taken and when it was closed.

3.40 We tested the accuracy of information in ATS for 10 complaint and notification files in two regions and found the following.

- In three cases the assessment completed by the inspector was documented in the paper file but not in ATS.
- In five files the date of the complaint or notification entered into ATS was between three and 18 days later than the actual date received by the Department.

- In one file ATS indicated the file was still open when it had actually been closed.
- In one file the assessment was not documented in ATS until 23 days after it was completed.

3.41 We realize the ATS system is new, having been implemented as of October 2009, and there is a learning curve involved, however, without accurate information in ATS complaints and notifications may not be assessed in a timely manner and important operational information needed by management may not be available.

Recommendation 3.12
All information related to a complaint and notification file should be accurately reflected in the activity tracking system.

Management Information

Conclusions and summary of observations

The Department has not, to date, had adequate management information and processes to ensure it is effectively managing its responsibilities for contaminated sites. However, action has been taken to make improvements. Prior to October 2009 and the implementation of a new province-wide activity tracking system, we found the systems used by the regions did not provide appropriate information to manage the program. However, we are encouraged by the implementation of the new activity tracking system which has the capability to provide more appropriate information. This new system is in the process of being fully operationalized. The Department does not have an established process to review contaminated site files on a regular basis to ensure inspectors in all regions are complying with operational and administrative responsibilities. Although management indicated they have a training program, based on interviews with staff, improvements to the program are required to ensure staff receive the training they need.

3.42 *Management communications* – Management indicated that regional managers communicate and meet regularly with district managers to obtain information on district issues, provide direction and outline priorities. District managers are responsible for the daily management of inspection staff and have regular discussions, communication and meetings with inspectors to keep up-to-date on work activities. District managers also communicate with Compliance and Inspection Coordinators and meet individually with inspectors to discuss enforcement activities.

3.43 *District tracking systems* – During our audit period up to October 2009, each of the four regions used spreadsheets or word processing software

to track activity on contaminated site files. Across the four regions three different tracking systems were used. The tracking systems contain records on contaminated sites that are recently or currently being worked on by inspectors.

3.44 These tracking systems did not provide management with summarized reporting for management purposes such as identifying files opened or closed during the reporting period; files with enforcement action; files with no recent activity; and high priority files. These systems did not provide alerts of key dates such as expected due dates for reports from contractors or a more informative status of the file (e.g., received remediation plan, cleanup completed, awaiting remediation report, report received but not yet reviewed) to give an indication of inspector workload and backlogs.

3.45 *Activity tracking system (ATS)* – As discussed in paragraph 3.39, ATS is an activity tracking system implemented across all four regions as of October 2009. It is used for all program areas including contaminated sites. Having one system province-wide should promote consistency of information across the province. We have not tested the ATS data to determine if the information is complete or accurate other than for some complaint and notification testing (see paragraph 3.40). This new system is in the process of being fully operationalized. According to management the information available is continuously improving. New operational procedures have been approved which will help to ensure the potential benefits of ATS are achieved.

3.46 One of the key benefits of ATS is the ability of inspectors to enter due dates into the system for such things as when follow-up activities should be done or when reports are expected. The system will notify the inspector when a due date is reached. It will also notify the district manager if an inspector has not met a due date. This benefit will help inspectors complete timely monitoring activities and provide management with information as to whether there are issues with inspectors completing timely follow-up activities.

3.47 ATS has reporting capabilities that did not exist with the previous tracking systems. Although some reports are currently produced, management is still assessing their reporting needs. We suggest management complete their assessment of information needs so they can receive the full benefits of the activity tracking system.

3.48 *Management review* – Management is not required to routinely review contaminated site files opened or closed by inspectors. Inspectors use their professional judgment as to the monitoring activities they complete and the timing of those activities and to determine whether to close a file once they are satisfied cleanup has taken place.

3.49 Although there is no policy requirement, all district managers indicated they have a process to review certain files to ensure proper policies and procedures are followed. However, there are inconsistencies among district managers regarding which files are reviewed. For example, some managers only review files of new staff while others only review closed files. The files tested during our audit did not include evidence of management review.

3.50 In Chapter 3 of the February 2008 Report of the Auditor General (paragraph 3.15), we discussed the Department's Quality Assurance Program. Its purpose is to determine the degree of compliance with operational and administrative responsibilities. At that time, the program was a pilot project which we recommended the Division implement across all its compliance programs as soon as possible. The Division is continuing with the program but the contaminated sites program has not yet been evaluated.

3.51 Management indicated that a new departmental procedure has now been approved which requires a quality assurance review of a sample of contaminated site files each year.

Recommendation 3.13
The Department of Environment should implement the quality assurance program for contaminated site files.

3.52 *Inspector training and development* – We assessed the inspector training processes in place related to the contaminated sites program. We determined training was largely ad hoc and inconsistent among inspection staff. Some inspectors interviewed felt the training they had received was not adequate. For example they identified the need to provide training on evaluating the risk level for a site and internal file management processes. A number of inspectors felt regular refresher courses would be beneficial.

3.53 From interviews with management and staff, mentoring was considered an important training tool for new staff working on contaminated site files given the inherent complexities of the files. During our testing, we identified one file which was monitored by a new inspector. The site was assessed and cleaned up under the Domestic Fuel Oil Spill Policy although it was not considered a domestic fuel oil spill. This resulted in a certified cleanup contractor being responsible for the remediation as opposed to the required site professional. In this case, according to management, the site was properly cleaned up to Departmental standards. If mentoring of new staff is not effective, there is a risk that they may not be receiving appropriate training and a contaminated site may not be cleaned up properly. During our fieldwork, management was finalizing a Development Accountability Model for inspection staff, which defines the development path for inspectors based on their needs. This model will link training

and development expectations to the performance cycle of inspection staff. Since we completed fieldwork, management indicated that the model was finalized and released for use but training had not been completed when this Chapter was written.

Recommendation 3.14
Management should closely supervise all new inspectors to ensure they are receiving appropriate training and sites assigned to them are properly monitored.

Recommendation 3.15
Training on the use of the Development Accountability Model should be completed as soon as possible.

3.54 *Program objectives, outcome measures, inventory of sites* – There are no defined objectives and related measurable outcomes in place for the contaminated sites program. Well-defined objectives help reduce the risk of confusion over what is expected of the program and clearly demonstrate the benefits of its existence. The Environment Act does identify a number of goals for the Department. Program objectives should be linked to those goals. Defined measurable outcomes help to demonstrate whether the program objectives are achieved. Related to this issue, there is no inventory of known contaminated sites in the province including information such as the stage of clean-up for each site and the level of risk involved. Such inventory information would help to demonstrate the value of the program and would help with the development and monitoring of outcome measures.

Recommendation 3.16
The Department of Environment should clearly define and communicate the objectives of the contaminated site program as well as establish outcome measures including reporting on program performance.

Recommendation 3.17
An inventory of known contaminated sites should be established and maintained for management purposes. This should include information on the stage of cleanup and risks involved for each site.

3.55 *Law Reform Commission* – Section 4(2)(m) of the Environmental Goals and Sustainable Prosperity Act of 2007 commits the Province to develop regulatory tools to *"stimulate redevelopment of contaminated land and contribute to economic development while protecting the environment"*, by the year 2010. To help meet this goal, in January 2008, the Attorney

General of Nova Scotia requested that the Law Reform Commission examine a number of issues pertaining to contaminated sites in Nova Scotia. The Commission's report was released in December 2009 and includes a number of recommendations for *"the improvement of the current legislative regime, to promote the cleanup of contaminated sites while at the same time protecting human health and the environment."*

ENVIRONMENT: MANAGEMENT OF CONTAMINATED SITES

3.56 The Department will be considering the recommendations made by the Law Reform Commission when contaminated site management regulations are drafted. The Department issued a discussion paper on May 7, 2010, for public comment, concerning ideas proposed for a contaminated sites regulatory program. Responses are to be received by July 6, 2010. The public responses will be considered when drafting regulations. The Department plans to have final regulations by the end of 2010. Management has indicated that some of the recommendations made in this Chapter may be addressed through the new regulations.

Response: Department of Environment

Nova Scotia Environment recognizes that the report from the Office of the Auditor General refers to a very important issue. The department takes the issue very seriously and would like to thank the Auditor General for providing recommendations to improve the management of contaminated sites in Nova Scotia. We are pleased to provide this general response.

Our department has been working diligently to address the issues of contaminated sites in Nova Scotia. This is reflected in legislation that calls for new tools to be put in place by 2010, in stakeholder consultation and research over the past two years, and in the department's request for the Law Reform Commission to undertake research and provide recommendations in this area. The department recently issued a discussion paper to Nova Scotians to support the development of new regulatory tools as committed to in legislation.

The information management recommendations raised in the Auditor General's Report refer to similar recommendations made in 2008. The department is well along in addressing these items with the development of an Activity Tracking System which was implemented in the fall of 2009.

There is no indication from either the audit or from the department's experience that these deficiencies have resulted in unacceptable risks to public health or the environment. While the department agrees that improvements are needed, this work is underway.

Limited time precludes responding in depth to all the recommendations in time for publication of the report. The department will carefully consider them as part of our current review of contaminated site management.

The department has already implemented many changes that address recommendations 9 to 15. A new Activities Tracking System and a Quality Assurance/Quality Control program have been implemented, divisional operation procedures have been improved, and an inspectors training model has been developed. These changes are already improving the collection and management of information, and the way inspectors' carry out their day to day duties.

The department will consider recommendations 1 to 8 and 16 and 17 as it continues to develop regulatory management tool in accordance with the direction provided in the Environmental Goals and Sustainable Prosperity Act. Public consultation is currently underway, and the department will incorporate this feedback into development of an integrated package of regulatory and non-regulatory tools in late 2010.

RESPONSE: DEPARTMENT OF ENVIRONMENT

It is reassuring to note that the audit found that, overall, departmental inspectors are conducting inspections for complaints and notifications of possible contaminated sites in an appropriate and timely manner. The department also welcomes the support provided to our current initiatives such as the Activity Tracking System and Quality Assurance procedures.

Nova Scotia Environment appreciates the recommendations provided in the Auditor General's report. These findings will contribute to the development of an effective management framework for contaminated sites in Nova Scotia. There is widespread agreement that Nova Scotia needs a better system to manage contaminated sites, to ensure Nova Scotians and our environment are protected, and to encourage these lands to be cleaned up and returned to productive use.

4 Health: Mental Health Services

Summary

There is inadequate oversight of the mental health system and no effective monitoring of compliance with mental health standards by the Department of Health. The Department is not fulfilling its legislative requirements under the Health Authorities Act to monitor and evaluate the quality of mental health services.

Nova Scotia implemented mental health standards in 2003. DOH management informed us they were aware at the time that additional funding was needed to move the system towards compliance with standards. However no formal plan was developed to address areas of noncompliance with standards and funding concerns.

We carried out detailed audit work at Annapolis Valley District Health Authority (AVDHA), Capital District Health Authority (CDHA), Colchester East Hants Health Authority (CEHHA) and the IWK Health Centre. We tested compliance with selected mental health standards and found only 14% of 358 files tested met all selected standards. While certain standards were met most of the time in some districts, the overall lack of compliance is concerning and could negatively impact mental health patient care.

Historically there has been no province-wide wait time information for mental health services. While certain DHAs and the IWK had wait time information for their services, the data has not always been reliable. There is a new initiative called community-wide scheduling which is intended to provide province-wide wait time information. However CDHA, the province's largest DHA, will not be able to use this system as it is not compatible with their current system. DOH management informed us they will combine information from the community-wide scheduling system with CDHA's data to produce province-wide wait times. Manually compiling data from two systems is inefficient and increases the risk of errors. Additionally, only outpatient wait times will be reported initially which will limit the usefulness of the information.

Department of Health senior management refused to provide information related to DOH budget requests and plans to improve DHA/IWK accountability. Management informed us that Executive Council Office staff told DOH that they were not permitted to provide us with information that went to Executive Council as this is considered confidential. This denial of information represents interference with the work of the Auditor General and limits our ability to provide the House with complete information about the entities we audit.

4 Health: Mental Health Services

Background

4.1 The Department of Health (DOH) is responsible for the coordination and governance of the entire healthcare system while the Mental Health Services Branch at DOH has overall responsibility for mental health services in Nova Scotia. Mental health services are delivered by the District Health Authorities (DHAs) and the IWK Health Centre (IWK). The responsibilities of DOH, the DHAs and the IWK are defined in the Health Authorities Act and the Izaak Walton Killam Health Centre Act. DOH is also responsible for administering the Involuntary Psychiatric Treatment Act.

4.2 Each DHA and the IWK has a Director of Mental Health Services. The directors and DOH Mental Health Services Branch management meet monthly to discuss mental health issues.

4.3 Mental health services provided by the DHAs and the IWK include acute inpatient admissions; community-based intensive support for individuals with severe and persistent mental illness; and outpatient appointments such as occupational therapy, medication monitoring or psychiatric assessments. The IWK is responsible for providing acute inpatient services to children and youth across the province. The DHAs and the IWK share in providing outpatient and community support services for youth and adults. Specialty services such as eating disorder or autism are provided predominantly through the IWK and Capital District Health Authority; however, to some extent, all DHAs share in the provision of these services at their local levels.

4.4 According to the Canadian Mental Health Association, *"Mental illness is estimated to impact the lives of 20% of all Canadians in their life-times. Mental illnesses affect people of all ages, educational and income levels, and cultures."* The Institute of Health Economics argued mental health is underfunded in its September 2008 report titled *"How Much Should We Spend on Mental Health?"* The Report stated mental illness accounts for more than 15% of the disease burden in developed countries like Canada but only 5.4% of total health expenditures. In Nova Scotia, according to provincial estimates documents, expenditures on mental health represented 3.4% of total health expenditures in 2008-09 and 3.3% in 2007-08. These figures do not include costs for psychiatrists which are funded through MSI. None of these figures have been audited.

4.5 In 2003, the document titled *"Standards for Mental Health Services in Nova Scotia"* was released. The standards were developed based on professional

best practices and expert consensus, and were intended to allow DOH to plan and evaluate mental health services in Nova Scotia. Nova Scotia continues to be the only jurisdiction in Canada with mental health standards. A large number and variety of organizations were included in the development process, including the Department of Community Services, DHAs/IWK, Canadian Mental Health Association, the Schizophrenia Society of Nova Scotia, psychiatrists, researchers, mental health consumers and family members.

4.6 Portions of the mental health standards were updated between 2007 and 2009 through involvement of the Directors of Mental Health and various staff across the province.

4.7 The standards are divided into 5 core areas.

- Mental Health Promotion, Advocacy, Prevention, and Education
- Inpatient Program
- Outpatient and Outreach Mental Health Program
- Community Mental Health Supports
- Specialty Services

4.8 DOH management informed us that they recognized when the standards were released in 2003 that there was a funding shortfall of approximately $20 million which would need to be addressed to enable the DHAs and the IWK to meet all of the standards.

4.9 We wish to acknowledge the work of the staff at the Department of Health (DOH) and thank them for their cooperation over the course of our audit. We also wish to thank the staff at Annapolis Valley District Health Authority (AVDHA), Capital District Health Authority (CDHA), Colchester East Hants Health Authority (CEHHA), and the IWK Health Centre (IWK) where we completed audit work. During audit planning we surveyed the Mental Health Directors at all District Health Authorities across the province and we wish to thank them for sharing their perspectives and concerns with us.

Audit Objectives and Scope

4.10 In early 2010 we completed a performance audit of mental health services. We wanted to determine if Nova Scotians have timely access to comparable mental health services regardless of where they live.

4.11 This audit was conducted in accordance with Section 8 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

4.12 The objectives of the audit were to assess whether:

- there is timely access to mental health services across Nova Scotia;
- adequate mental health information is readily available to the public;
- mental health services' wait time information is consistently and accurately prepared across the province;
- the provision of mental health services is in compliance with the *Standards for Mental Health Services in Nova Scotia*;
- DOH adequately monitors compliance with *Standards for Mental Health Services in Nova Scotia*; and
- there is adequate governance of the mental health system by, and accountability to, the Department of Health.

4.13 We completed detailed audit work at the Department of Health, three District Health Authorities – Annapolis Valley District Health Authority, Colchester East Hants Health Authority and Capital District Health Authority – and the IWK. This allowed us to examine mental health services for children, youth and adults in various areas of Nova Scotia. We also surveyed nine DHAs and the IWK to get basic information on the level of services available across Nova Scotia. We excluded specialty services from the scope of our audit.

4.14 Audit criteria for this engagement were derived from the Department of Health's *Standards for Mental Health Services in Nova Scotia* and Accreditation Canada Standards, as well as some criteria which we developed for this audit. These criteria were discussed with, and accepted as appropriate by, senior management of the Department of Health and senior management of the IWK, AVDHA, CEHHA, and CDHA – the entities in which we completed detailed audit work.

4.15 Our audit approach included an examination of the *Standards for Mental Health Services in Nova Scotia* (mental health standards), legislation, mental health patient records, and other relevant documents. We completed testing of compliance with selected mental health standards and conducted interviews with management and staff. Our testing covered files with activity from April 1, 2007 to late 2009. We also examined mental health standards which were released in 2003.

Information Denied During Audit

Conclusions and summary of observations

Department of Health senior management refused to provide information we required to complete our audit related to DOH budget requests and possible plans to improve DHA/IWK accountability to DOH. DOH management informed us that Executive Council Office staff told DOH that Cabinet submissions are confidential. Further we were informed Executive Council Office staff directed DOH management not to provide Cabinet submissions to our Office. As a result, we could not determine whether DOH requested sufficient funds to allow DHAs/IWK to comply with mental health standards. We were also unable to determine whether DOH has begun to take steps to improve DHA/IWK accountability. The Auditor General Act gives this Office access to any information we require to complete our work. This denial of information represents interference with the work of the Auditor General and limits our ability to provide the House with complete information about the entities we audit.

4.16 *Budget submissions* – When the mental health standards were developed, we were informed DOH and the Directors of Mental Health across the province estimated the total cost to comply with the standards was approximately $20 million. Neither the Department nor the entities in which we completed fieldwork were able to provide a detailed analysis supporting this amount, although all entities provided the same figure.

4.17 As part of their self-assessments in 2007-08, DHAs/IWK estimated the amount needed to comply with mental health standards had risen to $23.5 million.

4.18 We requested budget support from DOH to determine whether the Department asked Treasury Board for additional mental health funding in order to comply with standards. DOH senior management refused to provide this information. They informed us that Executive Council Office staff told DOH management they were not permitted to release any information related to budget submissions as these ultimately go before Executive Council and are considered confidential. Accordingly, we were unable to determine whether DOH requested sufficient funding to allow DHAs/IWK to meet existing mental health standards.

4.19 *Possible changes to DHA/IWK accountability to DOH* – Near the end of our audit, DOH senior management alluded to a new initiative addressing accountability within the health care system. However when we asked

DOH for details of this initiative, we were informed that the project is before Executive Council and DOH are not permitted to share information submitted to Executive Council with our Office. We were unable to assess whether this project might impact the issues we identified with DOH's oversight of DHAs which are discussed in the *Departmental Oversight* section below.

4.20 The Auditor General Act gives our office access to any documentation we require to complete our work. This denial of information represents interference with the work of the Auditor General and limits our ability to provide the House with complete information about the entities we audit.

4.21 Similar issues have been encountered on two other recent audits by this Office: Chapter 2 – Financial Assistance to Businesses Through NSBI and IEF of this Report and the June 2008 Special Report of the Auditor General – Office of Immigration – Economic Stream of the Nova Scotia Nominee Program.

Departmental Oversight

Conclusions and summary of observations

There is inadequate oversight of the mental health system and no effective monitoring of compliance with mental health standards by the Department of Health. The Department is not fulfilling its legislative requirements under the Health Authorities Act to monitor and evaluate the quality of mental health services. DOH's review of DHA/IWK annual self-assessments against mental health standards is not formally documented, nor does DOH develop formal recommendations to improve standards compliance. Although DOH was aware DHAs/IWK would not be able to fully comply with mental health standards at the time they were implemented, no formal plan was developed to move the system towards compliance with standards and address funding concerns. The lack of effective oversight significantly increases the risk of creating a disjointed system that fails the people who need it most.

4.22 *Background* – In 2000, the Health Authorities Act established the District Health Authorities. Each DHA/IWK has the responsibility to plan, manage and deliver certain health services (acute, primary, mental health and addictions) within its district.

4.23 Section 60 of the Act requires the Minister of Health to:

> *(a) "be responsible for the strategic direction of the health-care system including the development, and implementation and evaluation of Provincial health policy;"*

(b) "develop or ensure the development of standards for the delivery of health services;"

(c) "monitor, measure and evaluate the quality, accessibility and comprehensiveness of health services;"

(d) "conduct financial and human-resource planning;"

(e) "administer the allocation of available resources for the provision of health services; and"

(f) "establish requirements for information systems used in the health-care system."

4.24 The Department approves DHA/IWK business plans but day-to-day management of operations is the responsibility of District/IWK management and Boards of Directors. DOH collaborates with DHAs/IWK and tries to achieve consensus throughout the province.

4.25 As part of our audit of mental health services, we examined whether there is adequate governance of the mental health system by DOH and whether the accountability of the DHAs/IWK to the Department of Health is adequate.

4.26 We found DOH has interpreted its governance responsibilities regarding DHAs/IWK very broadly. Although District Health Authorities are separate legal entities, each governed by a Board of Directors, we believe the Department of Health also has an important role in providing oversight of the health care system. Significant provincial funds are expended for delivery of health care services through DHAs/IWK. In 2009-10, the Department of Health's budget was $3.4 billion, 42% of the Province's total program expenses budget of $8.1 billion. Of the $3.4 billion, $2.1 billion was allocated to DHAs.

4.27 *DOH monitoring of mental health standards* – As discussed earlier in this Chapter, *Standards for Mental Health Services in Nova Scotia* was released in 2003. DHAs/IWK are asked to prepare an annual self-assessment against these standards and submit this to DOH. Management in the Mental Health Services Branch at the Department of Health identified these self-assessments as a significant tool which DOH uses to monitor the provision of mental health services by DHAs/IWK.

4.28 We expected DOH would have a well-established process to review the self-assessments against mental health standards and make formal recommendations for improvement where required.

4.29 DOH staff in the Mental Health Services Branch collects the annual self-assessments and compiles a summary. This summary does not include any detailed analysis of the self-assessments. The Department does not require DHAs/IWK to provide support for their self-assessments nor are the assessments formally evaluated for accuracy.

4.30 We were informed the summary and self-assessments are discussed at district mental health director meetings. However we were unable to assess the depth of discussion as there are no detailed minutes for these meetings. DOH was not able to provide any evidence of a thorough discussion of the issues.

4.31 We noted DOH does not make formal recommendations for improvement where self-assessments identify deficiencies in meeting the standards. We believe a formal summary of deficiencies and recommendations for improvement would provide a useful tool for DOH to hold DHAs/IWK accountable for the provision of mental health services.

Recommendation 4.1
The Department of Health should formally document its evaluation of the District Health Authority and IWK Health Centre self-assessments. The Department should also document areas in which improvements are required, make recommendations to increase compliance with standards in the future, and follow up to ensure changes have been implemented.

4.32 DOH Mental Health Services Branch management informed us they expect deficiencies in meeting these standards as they knew improvements and additional funding were required before the standards could be fully met. The mental health standards have been in place for seven years. If DOH management were aware the standards could not be met as introduced, a detailed plan should have been developed to address the standards over the upcoming years. Such a long-range plan should have included specific plans to move DHAs/IWK toward fully meeting standards as well as identifying any funding requirements.

Recommendation 4.2
The Department of Health should prepare a long-range plan documenting steps needed to ensure all District Health Authorities and the IWK Health Centre can fully meet the *Standards for Mental Health Services in Nova Scotia*. This plan should include a timeframe for implementation and should identify funding requirements to fully implement the standards.

4.33 *Lack of formal documentation to support self-assessments* – We asked the entities in which we completed detailed audit work whether their self-assessments are prepared based on specific evidence illustrating whether

standards are complied with. AVDHA, CEHHA and the IWK informed us they gather the relevant staff to discuss the standards and determine the appropriate response for the entity. Only CDHA had data which supported their assessment against the standards.

4.34 While some standards may be more generic and it may be difficult for entities to support their assessment beyond discussion among senior mental health staff, there are standards which are quantifiable. For example, certain standards address time frames in which specific procedures must be completed. If these standards represent best practices in mental health care, compliance with standards suggests an entity is doing a good job with its mental health services. It is concerning that compliance with standards is being assessed without concrete evidence. As the provincial oversight body for DHAs and the IWK, we believe DOH should have ensured entities used a more robust process to assess standards compliance.

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

Recommendation 4.4
The Department of Health should ensure each District Health Authority and the IWK Health Centre have a robust, evidence-based process to assess compliance with mental health standards.

4.35 *Concerns identified with self-assessments* – We examined the self-assessments for all nine District Health Authorities and the IWK for 2007-08 and 2008-09. We noted standards which a number of entities assessed as either not met or not applicable/ needs updating. We asked DOH what had been done to follow up these areas. The Department was not able to answer our detailed questions or to provide any evidence that DOH staff contacted the DHAs or the IWK to follow up these concerns. We were informed these issues were discussed at monthly mental health director meetings but, as noted earlier in this Chapter, there are no detailed minutes for these meetings.

4.36 Since certain specialty services are only provided in some DHAs and the IWK, there are standards which should be not applicable to most districts. However we noted instances in which other districts assessed these standards as either not met or requiring updates. DOH management informed us they

believe these districts were assessing their experience with these standards at a provincial level. However the issues were not formally followed up to ensure this understanding was correct.

4.37 We believe the Department should have reviewed the standards at a more detailed level, followed up with DHAs/IWK where concerns were noted and formally documented the issues and responses for future follow-up to ensure concerns are addressed going forward. Recommendations 4.1 and 4.4 address this issue.

4.38 *Concurrent disorder standards* – Certain mental health standards relate to concurrent disorders for those who have difficulties with addictions as well as mental health concerns. DOH management informed us Addictions Services field staff did not support the proposed concurrent disorder standards in 2003. As a result, the Department has been unable to implement those standards and DHAs and the IWK have not been held accountable for the concurrent disorder standards for mental health.

4.39 This further demonstrates our concerns related to the Department of Health's oversight of the mental health system. Under the Health Authorities Act, the Department is responsible for setting policy. While we appreciate the desire to achieve consensus, these standards were developed seven years ago and the Department has not made significant progress towards full implementation. DOH needs to take a stronger role in ensuring DHAs and the IWK cannot simply continue to disagree with the Department's plans to move forward.

Recommendation 4.5
The Department of Health should review the concurrent disorder standards to determine if these are still valid and if so, should require District Health Authorities and the IWK Health Centre to comply with the standards.

Mental Health Standards Testing

Conclusions and summary of observations

Only 14% of 358 files tested at AVDHA, CEHHA, CDHA and the IWK met all of the applicable mental health standards we selected for testing. While our testing did not assess whether clinical decisions were appropriate, we did test whether clinical services were delivered within required timeframes and whether clinician assessments were completed as required by standards. None of the standards we tested were met in all four entities. Additionally we found some standards are poorly worded making it difficult for staff to determine what

the standard intended. In other cases, vague wording means certain standards would always be met. Failure to comply with mental health standards negatively impacts mental health patient care across the province and increases the risk of poor patient outcomes.

4.40 *Testing approach* – We reviewed all mental health standards and selected certain standards for file testing in three of the five core program areas: outpatient and outreach services; inpatient services; and community supports. Although outpatient and community supports are categories in the mental health standards, we found DHAs and the IWK all have slightly different interpretations of which services are included in community supports versus outpatient. We worked with the DHAs and the IWK to identify and test the programs to which each set of standards applied. However we cannot be certain our testing covered all relevant programs due to the uncertainty around how and where the standards apply. We concentrated on those standards which would have the broadest applicability in the mental health system for both youth and adults. We did not test standards related to specialty services such as eating disorders or autism. We also excluded certain standards which were not clearly written and therefore we were unable to test. We addressed mental health promotion at a system-wide level but did not test detailed standards related to this area.

4.41 We visited four entities – AVDHA, CDHA, CEHHA and the IWK. We assessed whether those entities met the selected standards for mental health services in Nova Scotia. Our testing was divided into two sections, those related directly to individual patient care and those at a system-wide level. We excluded standards that would require assessing whether a clinical decision was appropriate. However standards such as ensuring the clinician documented a treatment plan or completed tasks within the prescribed timeframe were included in our scope.

4.42 We selected 30 patient files (a combination of youth and adult) from each of the three core areas (90 files per entity) at three of the four entities we visited. One exception was AVDHA where we selected 30 adult and 5 youth files in each core area. This was the first DHA we visited and we decided to group the youth and adult file testing for CEHHA. All youth services for CDHA are provided through the IWK.

4.43 After completing our audit, we determined there were errors in the file information provided to us by CDHA management. We needed to identify community supports patient files for testing. However the information we were given by CDHA included some community supports patients as well as patients in a specialty program. As noted in the *Audit Objectives and Scope* section of this Chapter, we excluded specialty services from the audit. By the time this issue was identified, we had completed our audit. As a result of these errors, 12 of the 30 community supports patient files we

selected should not have been included in our population. We did not select additional sample items due to timing. As a result, we tested 18 community supports files at CDHA.

4.44 We selected files with activity between April 1, 2007 and late 2009 when we began our audit fieldwork. We examined the files for evidence specific mental health standards had been followed.

4.45 *Older versions of standards still in use* – During audit planning we obtained a copy of the 2004 *Standards for Mental Health Services in Nova Scotia* from DOH. These standards were also on the Department's website. We discussed the standards with Department management and completed our AVDHA audit testing which included discussing various standards with AVDHA staff. During our audit work at CEHHA, District staff informed us we were working with outdated standards. The mental health standards had been updated between March 2007 and January 2009. This caused delays in our audit as we had to review the revised standards, determine the impact on our audit testing and revisit the patient file testing at AVDHA.

4.46 In October 2009, we informed DOH the standards on the Department's website were outdated. As of December 2009, the Department still had not updated the website. This website is the Department's main communication tool for the public to obtain information. Patients and families accessing the standards on the website from March 2007 until December 2009 would not have been aware they were using outdated standards.

4.47 We are concerned that neither the Department of Health nor AVDHA informed us the 2004 standards had been updated.

Recommendation 4.6
The Department of Health should ensure that the most current version of the mental health standards is available on its website and distributed to District Health Authorities and the IWK Health Centre.

4.48 *Overall standards testing results* – Only 14% of 358 files reviewed met all the standards we selected for testing. The results for each entity in which we completed detailed file testing follow.

- 26% of IWK files met all standards tested.
- 18% of CEHHA files met all standards tested.
- 11% of AVDHA files met all standards tested.
- CDHA only had 1 file (1%) which met all standards tested.

4.49 The table below summarizes our detailed testing results for certain of the standards we selected for testing.

Summary – Mental Health Standards Testing

Standards	AVDHA	%	CDHA	%	CEHHA	%	IWK	%	Totals	%
Outpatient										
Eligibility criteria	35/35	100	23/30	77	26/30	87	26/30	87	110/125	88
Initial assessment and diagnosis	35/35	100	21/29	72	19/28	68	19/30	63	94/122	77
Triage of referrals and assessment/ appointment within required timeframes	2/35	6	21/30	70	22/30	73	10/30	33	65/125	52
Referrals reviewed within 1 working day to determine eligibility	5/35	14	0/30	0	16/30	53	20/30	67	41/125	33
Inpatient										
Admission criteria	30/30	100	27/29	93	30/30	100	30/30	100	117/119	98
Care plans	15/30	50	7/29	24	16/30	53	29/30	97	67/119	56
Risk assessments	1/1	100	11/11	100	5/7	71	9/9	100	26/28	93
Recommendations for admission	30/30	100	26/29	90	30/30	100	30/30	100	116/119	97
Advance notice of patient discharge sent to community care provider	0/26	0	15/27	56	3/26	12	19/27	70	37/106	35
Discharge plans prepared with input from community care provider	10/21	48	6/27	22	4/22	18	12/30	40	32/100	32
Objectives of admission to inpatient unit documented	30/30	100	29/29	100	30/30	100	30/30	100	119/119	100
Community Supports										
Eligibility criteria	34/35	97	17/18	94	30/30	100	30/30	100	111/113	98
Community supports plans	12/35	34	9/18	50	27/30	90	27/30	90	75/113	66
Annual reviews (adult)	4/30	13	2/18	11	15/18	83	N/A	N/A	21/66	32
Intake assessment initiated within 10 working days	2/10	20	0/2	0	3/14	21	1/28	4	6/54	11
Progress reviews (youth)	5/5	100	N/A	N/A	5/5	100	21/30	70	31/40	78

4.50 The results of our detailed testing are concerning. There were significant deficiencies in many of the standards tested and few patient files met all the standards we selected for testing.

4.51 CDHA, CEHHA and the IWK all had several files in which the initial outpatient assessment and diagnosis was either not done or was not completed within the timeframe required under the standards.

4.52 We found deficiencies in files for community supports patients at all four entities. Individuals who have been identified as having severe and persistent mental illness often access services through community supports programs. Standards require documented plans for all community supports clients and annual reviews for all adult clients. As illustrated in the table above, none of the entities had documented community supports plans for all files tested. Additionally, at AVDHA and CDHA, more than 85% of the files we selected for testing did not have the required annual reviews. These reviews would not only ensure the services accessed are helping the patient, but would also help identify changes in the patient's mental health status which could require different services going forward.

4.53 The standards for youth community supports clients do not require an annual review. Rather regular progress reviews are required, although the standard does not suggest a time period. In order to assess compliance with this standard, we simply looked for evidence of at least one review in each patient file tested. 30% of the files tested at the IWK did not meet this standard.

4.54 We also identified instances where an individual's wait time to access community supports programming was excessive. Three community supports clients at the IWK waited more than eight months to have an intake assessment and one youth outpatient client at AVDHA waited approximately one year from the time of referral until they were first seen. There was no documentation in the client files that provided any explanation for why these individuals waited so long for services.

4.55 Community supports clients have severe and persistent mental illness and are expected to require long-term treatment and ongoing interaction with the mental health system. Significant delays in assessment and starting treatment carry a high risk to the individual's mental health. These clients could experience additional symptoms and have their mental health deteriorate further while waiting for service. This could lead to the need for more intensive service going forward.

4.56 When a patient first contacts mental health services, the individual should be triaged to determine urgency. The level and timing of future services are determined based on this classification. We found AVDHA does not track triage categories for adult outpatients. We were informed patients are triaged but the results are not recorded in the patient file. Without a record of the triage category, there is no way to review files later to ensure standards were met and individuals received services in a timely manner.

Recommendation 4.7
Annapolis Valley District Health Authority should record the triage category for all mental health patients.

4.57 *Standards as best practices* – Staff at the Department of Health and all four entities where we completed detailed file testing informed us that the mental health standards were intended as best practices for the mental health system in Nova Scotia. The standards were adopted in 2003 and we were told staff working in mental health knew that additional work and funding were needed to meet the standards. The introduction in the standards document indicates that it will take five to ten years for full implementation. After seven years, we found there is still a general lack of compliance with the standards we selected for testing. Only 14% of 358 files tested met all selected standards. The issue of how to achieve full compliance with standards is discussed earlier in this Chapter and we recommended that the Department of Health prepare a long-range plan, including funding requirements, to address how mental health standards will be met in the future.

4.58 *System-wide standard testing* – In addition to patient file standards, we also tested standards related to the mental health system. The standards addressed a number of areas including policies and procedures in place at the DHAs and the IWK related to issues such as access to services, crisis or emergency response services, education, training, and supervision of staff. We identified 28 system standards which did not require testing client files. Two of these standards relate to the Department of Health as they deal with provincial access policies and the development of provincial prevention strategies for mental health. Neither of these standards were met. We assessed the remaining 26 standards at each of the three District Health Authorities and the IWK.

- AVDHA met 20 of 26 system standards.
- CDHA met 20 of 26 system standards.
- CEHHA met 21 of 26 system standards.
- IWK met 22 of 26 system standards.

4.59 *Concerns with standards* – During our testing we noted some standards which are unclear, lack definitions necessary to evaluate compliance, or lack any requirements. As discussed earlier, we excluded certain standards from our testing because they were difficult to understand and assess. DHA management and staff were sometimes unclear what a given standard meant and often asked OAG staff how we interpreted the standards. When staff are confused by standards, it is difficult for DHAs and the IWK to accurately

assess their compliance with standards. The following paragraphs provide two examples of poorly-worded standards.

4.60 Standard E7.14 states *"The range of services for children and youth with neurodevelopmental disorders may include inpatient, day treatment, residential, etc."* A standard which includes *may* essentially has no requirements. Each DHA/IWK can choose if they want to offer the services listed or not. While it is useful to provide guidance, this is not appropriate as a standard. We noted nine of the 20 DHA and IWK self-assessments we reviewed from 2007-08 and 2008-09 indicated this standard was not met. Careful reading and interpretation of standards is imperative to an accurate assessment.

4.61 Standard B3.8 states *"Urgent referrals are offered an appointment to carry out a mental health assessment to occur within seven (7) calendar days of the date of referral."* It is unclear what is meant by offered in this context. Can patients expect to have their assessment within seven days? Will patients be called within seven days and offered an appointment at a future date? For our testing we assumed this standard meant the assessment should be completed within seven days, but ambiguous wording such as this can lead to confusion. We noted other standards with similar wording concerns.

Recommendation 4.8
The Department of Health should review the mental health standards to ensure each standard is measurable, specific and can be evaluated.

Access to Services Across Nova Scotia

Conclusions and summary of observations

Mental health standards requiring formal access policies to ensure services are available to all Nova Scotians are not met. Certain services are not available in all districts and there are no formally documented arrangements to share services. Additionally, youth transitioning to adult services are not treated consistently throughout the province, with some districts requiring youth to be reassessed and placed on adult service waitlists. We were also concerned with outdated information on the Department of Health's website and the lack of detailed information regarding service availability and location on some DHA/IWK websites.

4.62 *Access to core programs* – There are two mental health standards which require that core programs be accessible to all Nova Scotians and clear provincial access protocols be established. We found these standards were not met because there are no formal agreements between DHAs/IWK and no documented provincial access policies.

4.63 *Shared services* – It is not possible for all services to be available in all areas of every District Health Authority. In some instances, DHAs/IWK may have informal arrangements to share services with another DHA/IWK.

- Cumberland Health Authority (CHA) patients requiring inpatient treatment are sent to Colchester East Hants Health Authority because CHA does not have an acute inpatient mental health unit.
- Pictou County Health Authority (PCHA) patients requiring admission to an inpatient unit designated under the Involuntary Psychiatric Treatment Act are sent to CEHHA.
- CDHA provides many specialty services for the whole province.
- The IWK provides inpatient services for youth and most specialty services for youth for the whole province.

4.64 There are currently no written agreements between DHAs/IWK to provide services for other districts. CEHHA management indicated they are having discussions with CHA and PCHA to develop agreements for inpatient admissions. Department of Health management explained the lack of formal agreements between the DHAs/IWK as being consistent with the approach in other areas of health care. Without written agreements, there is a risk DHAs/IWK will not accept patients living outside the DHA/IWK boundaries.

4.65 The Health Authorities Act designates the IWK Health Centre and Queen Elizabeth II Health Sciences Centre (part of CDHA) as provincial health care centres providing certain specialty services to the whole province. However this does not cover all arrangements between DHAs/IWK. More formal arrangements would be beneficial for all DHAs and the IWK, would clarify the conditions under which districts provide shared services, and ensure compliance with provincial mental health standards.

Recommendation 4.9
Colchester East Hants Health Authority, Cumberland Health Authority and Pictou County Health Authority should develop formal, written agreements for inpatient care.

Recommendation 4.10
The Department of Health should ensure future shared services arrangements for mental health services between District Health Authorities or the IWK Health Centre are formally documented.

4.66 *Short-term service requirements* – There may also be instances when a district is experiencing a bed shortage and needs to send patients to another DHA. For example, CDHA management informed us their acute care mental health patients may be sent to AVDHA or CEHHA when there are shortages of available beds at CDHA. AVDHA management informed us they may have CDHA or CEHHA patients when those two DHAs are at capacity.

4.67 We noted one situation in which the lack of formal written agreements between DHAs has resulted in a potentially detrimental policy being developed. CDHA's Bed Management Policy indicates CDHA Mental Health will only accept out-of-district inpatient admissions if there are four empty acute or short-stay beds within CDHA for local admissions. The lack of clear, province-wide access protocols or agreements as required by the mental health standards has resulted in a policy which only considers the best interests of one DHA's patients, not the interests of all mental health patients in the province.

Recommendation 4.11
The Department of Health should ensure District Health Authorities and the IWK Health Centre are not restricting access to services to local patients only and excluding or limiting services to patients from other District Health Authorities.

4.68 *Service transition from youth to adult programs* – We noted there is no provincial policy for transition from youth mental health services to adult. Each district deals with this in its own manner, leading to potentially inconsistent treatment for patients from different areas of the province. CEHHA's process for patients transitioning from youth to adult services uses an internal referral which allows youth to move to an adult program without the need to be reassessed and placed on a waitlist. CDHA and AVDHA require youth to be reassessed in the adult programs as any new referral would be. This means patients may be placed on a waitlist for services as an adult. IWK management indicated that outpatient clients typically get referred to enter the adult system, while inpatients are usually transferred directly to another inpatient unit if it is deemed clinically necessary.

4.69 Management at the IWK, AVDHA and CEHHA all indicated that youth who could not be seen immediately within the adult system may continue receiving care through the youth system. However there may also be instances in which youth are placed on a waitlist for adult services and do not continue to receive further mental health services until a space becomes available. The lack of a formal policy dealing with youth transitioning to adult care leads to the risk that all youth may not be treated consistently as they move to adulthood.

Recommendation 4.12
The Department of Health should develop a formal policy to ensure youth transferring to adult services are treated in a consistent manner in all areas of the province. This policy should ensure patients have continued access to services either in the youth or adult system.

4.70 *Communication to public regarding where to access services* – Communication to the public regarding mental health services is important. Information on services available should be easy to access for mental health patients and their families. Mental health standards also require communication of mental health information to the public and potential referral sources such as general practitioners.

4.71 *Types of communications* – We identified various methods of communication to the public including DHA/IWK and DOH websites and brochures in clinics and physician offices. We reviewed information available to determine if someone seeking mental health services could find information easily.

4.72 *Inadequate information* – We identified instances at DOH and the entities we visited where we believe information could have been more readily available.

4.73 As noted earlier in this Chapter, in the fall of 2009, we found DOH's website had outdated mental health standards which had been updated from 2007 to January 2009.

4.74 CEHHA's website and brochures were not up-to-date. In late 2009, the DHA's website only had a single paragraph and a contact number, with no listing or description of services available. CEHHA management informed us they were aware of the website issues but stated there was currently no funding available to fix them. AVDHA has not updated its communication tools to reflect the most recent changes to the standards. CDHA offers a wide variety of services through community team locations. However, there are no clear communications to the public regarding where to obtain services.

4.75 *Communication with doctors* – We also found service and program information was not always communicated to local physicians by all DHAs and the IWK. This could result in physicians not being aware what services are available for their patients.

Recommendation 4.13
All services available through mental health should be clearly identifiable on District Health Authority, IWK Health Centre and Department of Health websites and in printed formats at clinics and physician offices.

Recommendation 4.14
District Health Authorities and the IWK Health Centre should formalize communication with physicians in their districts and provide regular updates on the services available.

Information Systems

Conclusions and summary of observations

We identified concerns with the adequacy and consistency of information available from IT systems in some of the entities we visited. We found there is no central system in place at DOH. Without a central system, adequate monitoring and oversight of the provincial mental health system is made more difficult. In order to have comparable data, systems must collect information in a consistent manner. Even when the same systems are used, we noted differences in the quality of data collected through patient records.

4.76 *Availability and consistency of data* – With the exception of CDHA, all DHAs are using the Meditech system to gather patient information. Additionally, Meditech's community-wide scheduling module is being used to gather and report wait time data and schedule patients at all DHAs and the IWK except CDHA and South West Health. CDHA uses two programs – one for wait times and scheduling, and another to scan paper patient records and store them electronically. We do not have further information on what other systems South West Health may utilize as this district was not included in our audit scope.

4.77 Using different information systems across DHAs/IWK can pose challenges. Entities need reliable data in order to make informed decisions regarding services. In order to have comparable data, systems must collect information in a consistent manner. Although most districts are using the community-wide scheduling module, they are not necessarily collecting the same data in a consistent manner. We found differences in the quality of data collected through patient records. Additionally, IWK and CEHHA management both noted their concern that Meditech does not track patient outcomes. Management felt this was a significant shortcoming as they are unable to determine how well specific mental health services are addressing patient needs.

4.78 Lack of comparable data and concerns with information available can limit the ability to benchmark performance and to obtain best practice information to help improve performance of the system.

4.79 *Department of Health* – The Department lacks a central system to allow it to easily collect and analyze data from DHAs and the IWK. Without a central system adequate monitoring and oversight of the provincial mental health system is made more difficult. While the Department has a wait time initiative using the community-wide scheduling module of Meditech, this system is not available to CDHA as that district does not use the Meditech system. This issue is discussed further in the *Wait Times* section below.

4.80 *AVDHA* – When we completed fieldwork at AVDHA, the DHA was transitioning to the Meditech system for mental health patients. Our work required us to audit the records in the old system. We found AVDHA was failing to use its IT system to track triage information required by the mental health standards. In AVDHA's old system, outpatients could be classified using six codes. While the descriptions of these codes were not consistent with mental health standards, AVDHA could have matched the standard triage categories with one of the existing codes. By not taking this simple step, AVDHA failed to capture important information. Since the District implemented the Meditech system this will no longer be an issue. However it illustrates the need to consider alternative ways to capture information and potentially improve data collection.

4.81 *CDHA scheduling and wait times system* – CDHA's system for scheduling and wait times cannot capture information on attendance at group therapy offered through outpatient clinics. This lack of information prevents clinic management from determining the number of attendees, frequency of patient visits to groups, and usefulness of various groups. Such information is required to assess accurately which groups are providing the best treatment options to clients.

4.82 *CDHA patient records* – CDHA's patient file system relies on scanning documents to create an electronic image of the record. It allows health care providers from across CDHA to view a patient's file at any time. We identified instances in which documents were scanned out of order, making it more difficult to determine the most recent events in the patient file. This could lead to a clinician using older medication or treatment records to make decisions regarding patient care. CDHA management informed us that the system allows documents to be rearranged once scanned, but resourcing issues mean this seldom occurs.

Recommendation 4.15
The Department of Health should oversee a review of mental health data systems throughout the province. This review should identify Department, and District Health Authority and IWK Health Centre information requirements and ensure the information systems in place are adequate for these purposes.

Recommendation 4.16
The Department of Health should ensure all District Health Authorities and the IWK Health Centre produce consistent and comparable information.

Wait Times

Conclusions and summary of observations

At the time of our audit the Department of Health did not collect or report wait time information for mental health services. Since there was no province-wide wait time information, we could not conclude whether patients could access timely mental health services. Of the entities we visited for fieldwork, only CDHA and the IWK prepared detailed wait time information and we found errors in CDHA's calculations. The IWK had comprehensive wait time information. AVDHA and CEHHA had no formal wait time information. Although DOH has had overall patient wait time strategies for several years, no meaningful results have come from this for mental health services. Recently, the community-wide scheduling initiative has provided DOH with wait time information from most DHAs and the IWK. However improvements are needed in patient file information if this initiative is to produce meaningful data. Additionally, this project is initially intended to report on outpatient wait times only which will limit the usefulness of the information.

4.83 *Provincial wait time strategy* – The Department of Health has a provincial strategy to improve wait times over a three year period (*Timely Access to Healthcare in Nova Scotia: Improving Wait Times 2007-2010 N.S. Strategy*), as recommended by the provincial Wait Times Advisory Committee. Similarly, in 2004, a DOH report discussed the three year strategy for managing patient wait times (*Working together toward better care: Ministers' Report to Nova Scotian's 2004-2005*). Despite this, there was no meaningful province-wide information on mental health services wait times at the time of our audit.

4.84 *Mental Health Wait Times Steering/Advisory Committee* – The Mental Health Wait Times Steering/Advisory Committee was created in 2009 to develop a standardized provincial approach to reporting wait time information for mental health services. The Committee has agreed only

outpatient wait times will be reported initially. This limits the usefulness of the information.

4.85 Outpatient wait times does not include the community supports program area accessed by patients who have been identified as having severe and persistent mental illness and who are likely to require long-term treatment. We are concerned that there are no plans to report province-wide wait time information for these patients. Knowing how long those with long-term mental illness are waiting for their initial community supports services is valuable information. During our standards testing, we identified four community supports patients who waited an excessive time to begin receiving services. Significant delays in treatment increases the risk these individuals will see their condition worsen and potentially require more intensive treatment.

Recommendation 4.17
The Department of Health should assess whether province-wide wait time information is needed for other mental health treatment areas in addition to outpatient.

4.86 *Current situation* – At the time of our audit, DOH did not collect wait time information from DHAs and the IWK. When we began our work, DOH's most recent information on mental health services wait times was from 2007. After we completed audit fieldwork, Department management provided updated information they obtained from most DHAs and the IWK. We were also informed an Advisory Committee created in 2009 will help address deficiencies in wait time information.

4.87 Of the four entities we visited, only CDHA and the IWK are collecting wait time information. The IWK has the most comprehensive wait list information, policies regarding wait lists, and an established process for reviewing wait lists. Its information is not available publicly. CDHA wait times are available to the public through its website. However it does not have documented policies for reviewing wait lists and we found errors in wait time calculations which are discussed below. CDHA has been collecting wait time information for a few years, and management indicated they are working to improve the quality of the data recorded and reported.

4.88 While AVDHA knows how many children are waiting for service, it has no information on how long these patients have been waiting. As well it has no wait time information for adult mental health services.

4.89 CEHHA have lists of patients waiting for appointments. While these lists include how long the patient has been waiting, as soon as a patient is given an appointment they are removed from the list. The District is only able to

print these lists, they are not able to work with the data to determine any system-wide information. This is not adequate wait time information.

4.90 Given the lack of province-wide wait time information, we could not conclude whether Nova Scotians have timely access to mental health services. Since DOH does not have current wait time information, the Department is not able to assess this either.

4.91 *Community-wide scheduling* – The Department of Health is leading an initiative to implement the community-wide scheduling (CWS) module of the Meditech system. When this report was written, CDHA and South West Health did not use CWS. South West Health does use the Meditech System and we understand it plans to implement CWS during 2010. CDHA management informed us they already have a system and management stated it would not be cost effective to replace this with Meditech. As a result, CDHA will not be able to implement Meditech's community-wide scheduling module. CDHA and DOH have been working together to ensure the data prepared by CDHA is comparable with the data from CWS. DOH will manually compile the information from CDHA and the community-wide scheduling module. Such processes are inefficient and increase the risk of errors.

4.92 CWS is intended to provide the districts and the Department of Health with the ability to measure and monitor wait times. During our audit we identified concerns with the information in existing systems which are detailed elsewhere in this Chapter, for example triage codes not recorded and instances of files with insufficient information to demonstrate how provincial mental health standards were met. In order for the CWS initiative to be a success, all DHAs and the IWK must ensure they capture necessary information and complete meaningful assessments of the results.

Recommendation 4.18
The Department of Health should take the lead in establishing consistent wait time measurements for District Health Authorities and the IWK Health Centre. Resulting wait time data should be verified to ensure it is accurate.

4.93 *Wait time testing* – We tested wait time information at CDHA and the IWK. As noted above, AVDHA and CEHHA have no wait time information.

4.94 *CDHA results* – CDHA collects and reports wait time information related to outpatients only. It uses an extensive, manual process to calculate wait times. We found three errors in the one month of data which we tested.

Recommendation 4.19
Capital District Health Authority should review its system to calculate wait time information, identify areas in which improvements are required and take steps to implement necessary changes. As part of this review, the District should also develop and implement regular processes to ensure its wait time information is accurate.

4.95 *IWK results* – The process to calculate wait times for mental health services at the IWK relied on fewer manual processes and we did not find any errors in the wait time information we tested.

RESPONSE: ANNAPOLIS VALLEY DISTRICT HEALTH AUTHORITY

Response: Annapolis Valley District Health Authority (AVDHA)

AVDHA is appreciative of the time and effort the Auditor General's staff took in their thorough review of the implementation of Mental Health Standards in Nova Scotia.

AVDHA acknowledges the findings and has begun implementing improvements within our health district. Further, we concur with the Auditor General's recommendation that Provincial Mental Health Standards need to be specific and measurable.

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

AVDHA accepts this recommendation and will work with the Department of Health and the DHAs/IWK to develop the necessary tools and performance indicators to appropriately assess compliance to Nova Scotia's Mental Health Standards.

Recommendation 4.7
Annapolis Valley District Health Authority should record the triage category for all mental health patients.

AVDHA accepts this recommendation and is now recording the triage category for all mental health patients.

Recommendation 4.13
All services available through mental health should be clearly identifiable on District Health Authority, IWK Health Centre and Department of Health websites and in printed formats at clinics and physician offices.

AVDHA accepts this recommendation and is updating our website and printed material to clearly identify the range of services available and the means to access those services.

Recommendation 4.14
District Health Authorities and the IWK Health Centre should formalize communication with physicians in their districts and provide regular updates on the services available.

AVDHA accepts this recommendation and will develop and implement strategies to communicate with local physicians on a regular basis to ensure awareness of available services and access to those services.

RESPONSE:
ANNAPOLIS
VALLEY
DISTRICT
HEALTH
AUTHORITY

RESPONSE: COLCHESTER EAST HANTS HEALTH AUTHORITY

Response: Colchester East Hants Health Authority (CEHHA)

We thank the Auditor General and his staff for their work on this audit and appreciate the respectful manner with which his staff conducted the audit in this District.

With regard to recommendations directed toward the Districts:

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

CEHHA agrees with this recommendation. Implementation of the Health Records module through Meditech (underway) will allow CEHHA to provide reports that support the self assessment on standards that can be assessed through a file audit. It will also track deficiencies electronically and enable immediate action.

CEHHA are reviewing the systems and processes related to the documentation of standards to ensure documentation expectations are clear to staff and that there are clearly identified locations for documentation related to timelines.

Recommendation 4.9
Colchester East Hants Health Authority, Cumberland Health Authority and Pictou County Health Authority should develop formal, written agreements for inpatient care.

CEHHA agrees with this recommendation. Discussions with CHA and PCHA regarding inpatient care and the benefits of a formal written agreement have already begun and CEHHA will facilitate the timely development of an agreement.

Recommendation 4.13
All services available through mental health should be clearly identifiable on District Health Authority, IWK Health Centre and Department of Health websites and in printed formats at clinics and physician offices.

CEHHA agrees with this recommendation. The web site and printed material were under revision at the time of the audit and will be complete by the time this report is released.

Recommendation 4.14
District Health Authorities and the IWK Health Centre should formalize communication with physicians in their districts and provide regular updates on the services available.

CEHHA strongly agrees with the need for formal communication with physicians and will continue to provide regular updates on the services available and explore ways to enhance communication about services.

RESPONSE:
COLCHESTER
EAST HANTS
HEALTH
AUTHORITY

RESPONSE: CAPITAL DISTRICT HEALTH AUTHORITY

Response: Capital District Health Authority

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

- We accept this recommendation and note that we are the only District which actually provided evidence in support of the Standards.
- We will continue to improve our data systems and our audit procedures, as we have over the past three years, so as to provide improved evidence of compliance.
- The Standards are written in a manner which leaves them open to interpretation and which makes establishing measurable indicators difficult.
- In going forward, we support rewriting the Standards in collaboration with DOH to further ensure measurability and from this better alignment of care with the Standards. (Recommendation 4.8, above)
- We suggest that the Standards also be aligned with those of Accreditation Canada.

Recommendation 4.10
The Department of Health should ensure future shared service arrangements for mental health services between District Health Authorities or the IWK Health Centre are formally documented.

- We agree with this recommendation and we will work with DOH and other mental health programs in the province on this item.
- In addition to shared service arrangements for acute, general outpatient and community support services, shared service arrangements for tertiary, quaternary and specialty services, most of which are provided by CDHA to the rest of the Province, would also be most useful.

Recommendation 4.11
The Department of Health should ensure District Health Authorities and the IWK Health Centre are not restricting access to services to local patients only and excluding or limiting services to patients from other District Health Authorities.

- We accept this recommendation.
- It would be useful to have clear DOH directives which support this, both for inpatient and outpatient services.

Response: Department of Health

The Department of Health wishes to thank the Office of the Auditor General for their interest in mental health services in Nova Scotia. This audit will provide the department with an opportunity to enhance and build on services and processes already in place. This document will be of value for current service enhancements and as we move forward in the development of a Mental Health Strategy for Nova Scotia. We accept this report and we agree with all 19 recommendations.

Recommendation 4.1
The Department of Health should formally document its evaluation of the District Health Authority and IWK Health Centre self-assessments. The Department should also document areas in which improvements are required, make recommendations to increase compliance with standards in the future, and follow up to ensure changes have been completed.

In the fiscal year 2010-2011 a new process will be introduced to comply with this recommendation and the evaluation report will be formally documented and sent to the Deputy Minister.

Recommendation 4.2
The Department of Health should prepare a long-range plan documenting steps needed to ensure all District Health Authorities and the IWK Health Centre can fully meet the Standards for Mental Health Services in Nova Scotia. This plan should include a timeframe for implementation and should identify funding requirements to fully implement the standards.

A mental health strategy will be developed beginning in the Fall 2010. This strategy will be accompanied by a business plan which will address the mental health standards.

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

A letter will be sent by the Deputy Minister to the CEOs of the DHAs/IWK directing them that the Department of Health will require evidence of the assessment compliance ratings. It will be the responsibility of the DHAs/IWK to ensure they have sufficient information to do the assessments. After an analysis of the full assessment by DHAs/IWK the results will be reviewed with the DHAs/IWK.

RESPONSE: DEPARTMENT OF HEALTH

Recommendation 4.4
The Department of Health should ensure each District Health Authority and the IWK Health Centre have a robust, evidence-based process to assess compliance with mental health standards.

Nova Scotia is the first Canadian province to develop mental health standards. The department follows a process similar to Accreditation Canada and like most other existing processes, it is qualitative. We will continue to refine evidence-based measurements.

Recommendation 4.5
The Department of Health should review the concurrent disorder standards to determine if these standards are still valid and if so, should require District Health Authorities and the IWK Health Centre to comply with the standards.

Activities to address this recommendation are underway. Experts in mental health and addictions have been working together to develop recommendations for addressing concurrent disorders. Standards will be a component of this work. Recommendations will be made to government by the summer of 2010.

Recommendation 4.6
The Department of Health should ensure that the most current version of mental health standards is available on its website and distributed to the District Health Authorities and the IWK Health Centre.

The web site was updated February2010 with the most recent standards. They will be kept current.

Recommendation 4.7
Annapolis Valley District Health Authority should record the triage category for all mental health patients.

A letter will be sent by the Deputy Minister to AVDHA CEO advising of the Auditor General's findings directing them to record the triage category for all mental health patients.

Recommendation 4.8
The Department of Health should review the mental health standards to ensure each standard is measurable, specific and can be evaluated.

All standards will be reviewed with the DHAs/IWK to ensure each standard is measurable, specific and can be evaluated. Standards will be redrafted where necessary.

Recommendation 4.9
Colchester East Hants Health Authority, Cumberland Health Authority and Pictou County Healthy Authority should develop formal, written agreements for inpatient care.

A letter will be sent by the Deputy Minister to the CEOs of the three DHAs advising them of the Auditor General's findings and directing that a formal written agreement for inpatient care be developed. A copy of the agreement, in the form of a Memorandum of Understanding, will be documented and the agreement monitored by DOH. All future service arrangements among DHAs/IWK will have a Memorandum of Understanding developed, documented and monitored by DOH.

Recommendation 4.10
The Department of Health should ensure future shared services arrangements for mental health services between District Health Authorities or the IWK Health Centre are formally documented.

All future service arrangements between DHAs/IWK will be formally documented and monitored by DOH.

Recommendation 4.11
The Department of Health should ensure District Health Authorities and the IWK Health Centre are not restricting access to services to local patients only and excluding or limiting services to patients from other District Health Authorities.

The Deputy Minister will issue a written directive to CEOs of all DHAs/IWK that access to services must not be restricted. This directive will ensure that individuals who are assessed and deemed by a psychiatrist and/or admitting physician to require inpatient admission have access to a bed and are admitted.

A protocol has been established by the Chiefs of Psychiatry for out of district admissions or transfers. This protocol will be formally documented and monitored by DOH.

Recommendation 4.12
The Department of Health should develop a formal policy to ensure youth transferring to adult services are treated in a consistent manner in all areas of the province. This policy should ensure patients have continued access to services either in the youth or adult system.

The DOH will direct the DHAs/IWK to establish a formal policy for a process for youth to adult service transfer without service interruption. The policy will be documented and monitored by DOH.

RESPONSE: DEPARTMENT OF HEALTH

Recommendation 4.13
All services available through mental health should be clearly identifiable on District Health Authority, IWK Health Centre and Department of Health websites and in printed formats at clinics and physician offices.

A letter will be sent by the Deputy Minister to the CEOs advising them of the Auditor General's findings and direct this be done, subject to budgetary approval of print materials.

Recommendation 4.14
District Health Authorities and the IWK Health Centre should formalize communication with physicians in their districts and provide regular updates on the services available.

A letter will be sent by the Deputy Minister to the CEOs advising them of the Auditor Generals findings and directing them to develop a process of formal communication with physicians within their catchment area. Copies of correspondence will be documented and the process monitored by DOH.

Recommendation 4.15
The Department of Health should oversee a review of mental health data systems throughout the province. This review should identify Department, District Health Authority and IWK Health Centre information requirements and ensure the information systems in place are adequate for these purposes.

The mental health data systems and data requirements will be reviewed.

Recommendation 4.16
The Department of Health should ensure all District Health Authorities and the IWK Health Centre produce consistent and comparable information.

DOH will work with the DHAs /IWK to assess the quality of the data that is readily available to be collected. Standards will be set and DHAs/IWK will be expected to meet these data/information standards. The first phase will be to work with the existing systems and their functionality to ensure that data is being captured in a consistent and comparable manner. For the data that cannot be collected due to current system parameters – the data requirements and standards will be designed into new systems.

Recommendation 4.17
The Department of Health should assess whether province–wide wait time information is needed for other mental health treatment areas in addition to outpatient.

All admissions to mental health inpatient units are emergencies. Anyone who is clinically assessed to be in need of admission, will be admitted.

The outpatient wait time project referred to in recommendation 4.15 is in progress and will be completed in June 2010 in all DHAs/IWK. The wait time project will be expanding its scope to include other mental health treatment areas once the process for collecting quality data for the community mental health clinics has been established.

Recommendation 4.18
The Department of Health should take the lead in establishing consistent wait time measurements for District Health Authorities and the IWK Health Centre. Resulting wait time data should be verified to ensure it is accurate.

The DOH and HITS Nova Scotia are the leads on the wait time project with the resources from the Wait Time Project Office. All data collected is being verified and an audit report has been developed to identify data elements that are missing or inaccurate. This is a phased in project and the timing of implementation is anticipated to be completed by June, 2010.

Recommendation 4.19
Capital District Health Authority should review its system to calculate wait time information, identify areas in which improvements are required and take steps to implement necessary changes. As part of this review, the District should also develop and implement regular processes to ensure its wait time information is accurate.

CDHA will be required to review its wait times information for accuracy and to identify areas where improvements are required. The wait time committee does have a process in place to ensure the appropriate data elements are being collected and to improve and to ensure data quality.

Response: IWK Health Centre

The IWK Health Centre agrees with the findings of the report. This letter is to indicate our response to recommendations 4.3, 4.13, and 4.14.

Recommendation 4.3
Each District Health Authority and the IWK Health Centre should ensure there is adequate support for its assessment of compliance with mental health standards. Any areas in which there is insufficient information to assess compliance should be reviewed and the District Health Authority or IWK Health Centre should determine how it can obtain the information necessary for the assessments.

The IWK has and will continue to work on a systemic approach including all staff/physicians input to review standards. We have developed a Standards Coordinator role across the Mental Health and Addictions Program. This role will work with all teams and other departments of the IWK on standards. We have/will continue to identify resources required to meet the standards recognizing that this would require additional resources.

Recommendation 4.13
All services available through mental health should be clearly identifiable on District Health Authority, IWK Health Centre and Department of Health websites and in printed formats at clinics and physician offices.

We are in the process of working closely with our Public Relations department to update our printed material and websites. The IWK Mental Health and Addictions Program has an advisory committee including clients and families who provide guidance and feedback into the development, content and process for access to this information.

Recommendation 4.14
District Health Authorities and the IWK Health Centre should formalize communication with physicians in their districts and provide regular updates on the services available.

We have been working closely with our Family Physician colleagues on the need for improved communication and access to services. Recognizing that this relationship is important, we have identified a Primary Mental Health role and one of the priorities is to link with physicians and determine next steps including ongoing service updates. We will continue to work with Dr. Carolyn Thomson, Chief, Family Medicine on our relationship with family physicians.

The IWK will work closely with all government departments, stakeholders and partners to implement the recommendations. We recognize that some of these recommendations will require additional resources to implement.

Follow-up

5 Follow-up of 2007 Recommendations

Summary

Only 22 of 82 (27%) of the recommendations made in the June 2007 Report of the Auditor General have been implemented. This is the lowest rate found in any year since we began to track implementation.

We noted that neither the Department of Health's Long-Term Care program nor the Department of Justice's Maintenance Enforcement program have completed any of our 2007 recommendations.

Our audit recommendations provide constructive advice to correct weaknesses in systems and controls; they may also address deficiencies in the efficiency or effectiveness in the delivery of government programs and services to Nova Scotians. We strive to ensure our recommendations are practical and implementable. It is evident from the results of our follow-up of 2007 recommendations that these have not been given priority.

During 2008, government decided to take a more direct role in monitoring actions taken on matters reported by the Auditor General. Treasury and Policy Board (now Treasury Board Office) and the Department of Finance developed the Tracking Auditor General Recommendations (TAGR) system to monitor progress on implementing our recommendations. In the fall of 2009 we found that the data in the TAGR system was inaccurate and incomplete. We do not believe that government can rely on the system to provide accurate results to track the status of recommendations made in our Reports. We have recommended government develop a process to monitor the implementation status of our recommendations, including ensuring TAGR is complete and accurate.

All other legislative audit offices in Canada perform follow-up work. We noted the status of implementing recommendations was monitored until it was determined they were fully implemented in 40% of the other jurisdictions. We plan to assess the implementation status of outstanding recommendations in each year from 2005 forward, beginning in 2010.

5 Follow-up of 2007 Recommendations

Introduction

5.1 Our Office's strategic priorities include serving the House of Assembly, considering the public interest and improving government performance. We work toward these priorities by providing legislators with the information they need to hold government and the public service accountable. We obtain this information primarily by conducting audits which, over time, will cover major activities of government. The result of each audit is detailed in a Report of the Auditor General. Each report chapter contains recommendations which we believe provide practical constructive advice to address issues raised by the audit.

5.2 Our Reports have included formal recommendations since 2002. Our established practice is to follow up on the implementation status of these recommendations after two years. We believe two years is sufficient time for auditees to address our recommendations. This Chapter reports how responsive departments and agencies have been in implementing the recommendations resulting from our 2007 audits.

5.3 We requested that government management complete a self-assessment of their progress in implementing each 2007 recommendation, and document the results in the Tracking Auditor General Recommendations (TAGR) system. This system was developed in 2008 as a joint project between the Department of Finance and Treasury and Policy Board (now Treasury Board). We also requested management provide supporting information. Our review process focused on whether self-assessments and supporting information provided by management were accurate, reliable and complete.

Review Objective and Scope

5.4 The objective of this assignment was to provide review level or moderate assurance on the implementation status of recommendations from our June 2007 Report of the Auditor General. This level of assurance is less than for an audit because of the type of work performed. An audit would have enabled us to provide high assurance but would have required a significant increase in the resources devoted by the Office of the Auditor General to this follow-up assignment.

5.5 In early October 2009 we asked each auditee to document their self-assessment of progress on the implementation of the Office's

recommendations recorded in the TAGR system. We requested each auditee complete the self-assessment by October 31, 2009.

5.6 Our review was based on representations by government management which we substantiated through interviews and examination of documentation. Moderate assurance, in the context of this assignment, means performing sufficient work to satisfy us that the implementation status as described by government is plausible in the circumstances. Further information on the difference between high and moderate assurance is available in the *Canadian Institute of Chartered Accountants (CICA) Handbook, Section 5025 – Standards for Assurance Engagements*.

5.7 Our criteria were based on qualitative characteristics of information as described in the CICA Handbook. Management representations on implementation status were assessed against three criteria.

- Accurate and neither overstate nor understate progress
- Reliable and verifiable
- Complete and adequately disclose progress to date

Significant Observations

Conclusions and summary of observations

We concluded only 27% of our 2007 recommendations have been addressed and implemented to date. After two or more years, 69% of our recommendations are in various stages of implementation, and government will take no action on another 4%. We continue to be concerned with the timeliness of actions taken to address the recommendations in our Reports. We are not aware of any situations in which the recommendations from our 2007 audits are no longer appropriate. Consequently, we have to conclude the outstanding recommendations have not been given priority.

5.8 *Results of review procedures* – The June 2007 Report of the Auditor General includes 82 recommendations (2006 – 146 recommendations in two reports) to government. Government, including management of agencies, departments and service providers, completed a self-assessment of the implementation status of these recommendations. We performed a review of the self-assessments and supporting documentation and provide moderate assurance to readers of this Chapter. Nothing has come to our attention to cause us to believe that the representations made by government management are not complete, accurate and reliable.

5.9 The summary results indicate 27% (22) of these recommendations have been implemented; 69% (57) have not been fully implemented; and government does not intend to implement 4% (3) of these recommendations.

FOLLOW-UP OF 2007 RECOMMENDATIONS

5.10 Recommendations made as a result of our 2007 audits were intended to improve operations in the programs we examined. They were intended to ensure increased compliance with program legislation, or to strengthen systems and controls so that the programs could be delivered more efficiently and effectively. We noted none of the recommendations made in two audits were implemented, increasing the risk the programs are not operating as intended.

5.11 During the audit of the Department of Health's (DOH) Long-Term Care Program, we recommended that nursing home reporting requirements for financial and management information be improved. Financial information submitted by nursing homes was not always comparable and management letters issued by nursing home auditors were not required by DOH. In order for information to be useful to DOH management for analysing and comparing nursing home operating results the information must be timely, complete and comparable. The nursing home external auditors' management letter would detail control weaknesses and other information respecting improvements required in the management of the nursing home. We also recommended improvements be made to ensure the integrity of nursing home placement decisions.

5.12 In 2007 we raised several significant concerns regarding internal controls and the administration and enforcement of court orders under the Maintenance Enforcement Program at the Department of Justice. Although Program management indicated significant progress had been made toward the implementation of several recommendations, none of the recommendations have been fully implemented. For example, we recommended that segregation of incompatible duties regarding receipt and handling of funds needed to be improved, and that weaknesses in computer access rights needed to be restricted to only the functions necessary for staff to do their job. Inappropriate access to funds and systems could lead to financial loss or other negative consequences. Management noted duties have been segregated according to job functions and access rights restricted. Management have also noted they are in the process of developing a compliance structure to ensure regular monitoring and have indicated the final processes to ensure full implementation of all recommendations will occur in 2010.

5.13 *Implementation results reported since 2002* – A summary of implementation status from our follow-up work on chapters reported from 2002 to 2007 follows.

Implementation Status	3rd Year Follow-up			2nd Year Follow-up		
	2002 Follow-up December 2005	2003 Follow-up December 2006	2004 Follow-up February 2008	2005 Follow-up February 2008	2006 Follow-up March 2009	2007 Follow-up May 2010
Complete	35%	48%	49%	28%	39%	27%
Not Complete	56%	42%	47%	63%	56%	69%
Do Not Intend to Implement	5%	7%	4%	8%	4%	4%
Other	4%	3%	-	1%	1%	-
	100%	100%	100%	100%	100%	100%

5.14 Our follow-up work to date has focussed on the implementation status at a point in time. Consequently, we have not reviewed the progress of the recommendations since the year in which the initial review was conducted.

5.15 During this year's assignment, we obtained information on the scope of the follow-up work performed in other legislative audit offices. We note that all offices conduct follow-up engagements. Of these 40% (4) continue to review their government's progress in implementing recommendations until they have been fully implemented, and most of the other offices perform follow-up on recommendations for more than one year.

5.16 This continuous monitoring of implementation status is consistent with our objective of holding government and the public service accountable. Accordingly, the scope of our follow-up work will increase in 2010. We will extend our review to include the status of recommendations which were reported from 2005 to date as not having been implemented.

5.17 *Tracking Auditor General Recommendations system* – The Department of Finance, and Treasury and Policy Board (now Treasury Board Office) assumed responsibility for developing a system to monitor recommendations made by the Auditor General – the Tracking Auditor General Recommendations (TAGR) system. Development of the tracking system began in spring 2008, and in June 2008 testing of the system was completed. Additional improvements were made over the summer and the system was available for use in October 2008. Information sessions on use of the system were held with personnel from all departments.

5.18 In the fall of 2009 we initially relied on the TAGR system to conduct our follow-up work on the recommendations included in the June 2007 Report of the Auditor General. When we were ready to begin our review work on November 2, 2009 the TAGR system did not contain the current status for many recommendations made in 2007. In addition, the recommendations for each entity were not clearly distinguished, and for 23 (28%) of 82

recommendations the status recorded in TAGR was incorrect based on our review procedures.

5.19 During our review work we also found the information in the TAGR system was neither complete nor correct for some recommendations made in prior years. We found that:

- 2002 and 2003 recommendations were not in the TAGR system;
- 2004 and 2005 recommendations were in the TAGR system, but there was no indication of status for most recommendations; and
- 2006 recommendations were in the TAGR system, but 40 recommendations to the Department of Education and five recommendations to Transportation and Infrastructure Renewal did not indicate a status and seven recorded statuses of other departments were incorrect.

FOLLOW-UP OF 2007 RECOMMENDATIONS

5.20 Since many recommendations had no status reported in the TAGR system, and due to the high error rate in the recorded status of recommendations reviewed, we determined we cannot rely on the TAGR system during our follow-up assignment. It is also evident from the above errors that government cannot rely on the system to provide accurate results to track the status of prior recommendations made by the Auditor General. Government needs to fully develop the TAGR system to monitor the implementation of our recommendations, and take responsibility for its use and maintenance.

Recommendation 5.1
Government should ensure that the Tracking Auditor General Recommendations (TAGR) database is both accurate for the status level of each recommendation, and complete for all published recommendations.

5.21 *Responses to information requests* – We sent a request to each department or entity in early October 2009 asking that a self-assessment of the implementation status be completed in TAGR by October 31, 2009. We encountered significant delays in obtaining the self-assessments, particularly from the Financial Services division of the Department of Health regarding the Long-Term Care report. Our enquiries to Health continued into January 2010. The staff resources required by our Office to follow up the tardy responses would have been better used elsewhere.

5.22 *Implementation status* – Exhibit 5.1 at the end of this chapter details the 82 recommendations from our June 2007 Report of the Auditor General along with management's assessment of implementation status.

5.23 The following table summarizes departmental or entity progress. Some departments or entities have made more progress in addressing our recommendations than others. Overall progress in implementing our audit recommendations has been slow.

Status of Recommendations

June 2007 Report of the Auditor General	Complete	Not Complete	Do not intend to implement	Total Recommendations
Community Services				
Chapter 6 – Regional Housing Authorities				
Community Services	3	3		6
Cape Breton Island Housing Authority	3	1		4
Metropolitan Regional Housing Authority	3	1		4
Subtotal	9 64%	5 36%		14 100%
Finance				
Chapter 7 – Government Financial Reporting			1 100%	1 100%
Health				
Chapter 2 – Management of Diagnostic Imaging Equipment				
Health		5		5
Cape Breton District Health Authority	4	8		12
Capital District Health Authority	6	7		13
Chapter 3 – Emergency Health Services	3	6	1	10
Chapter 4 – Long-Term Care – Nursing Homes and Homes for the Aged		8		8
Subtotal	13 27%	34 71%	1 2%	48 100%
Justice				
Chapter 5 – Maintenance Enforcement Program		18 95%	1 5%	19 100%
Total 2007 Recommendations	**22 27%**	**57 69%**	**3 4%**	**82 100%**

Exhibit 6.1 – Implementation Status of June 2007 Recommendations

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

2.1 We recommend that DOH, in conjunction with the District Health Authorities, develop a long-term Provincial medical equipment capital plan including criteria for assessing competing DHA needs on a Province-wide basis.
Status – Department of Health – Planning stage
Status – Cape Breton District Health Authority – Work in progress
Status – Capital District Health Authority – Complete

2.2 We recommend the procurement processes at DOH and the DHAs be improved to include:
- identification of all needs prior to issuing the Request for Proposals;
- 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.

Status – Department of Health – Work in progress
Status – Cape Breton District Health Authority – Work in progress
Status – Capital District Health Authority – Complete

2.3 We recommend that CDHA and CBDHA actively monitor manufactors' equipment up-time guarantees.
Status – Cape Breton District Health Authority – Work in progress
Status – Capital District Health Authority – Complete

2.4 We recommend that CBDHA establish a process to track and monitor required maintenance and repairs to its MRI and CT scanners.
Status – Cape Breton District Health Authority – Complete

2.5 We recommend that CDHA and CBDHA implement formal capital asset ledgers to control all medical equipment.
Status – Cape Breton District Health Authority – Complete
Status – Capital District Health Authority – Work in progress

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.
Status – Department of Health – Work in progress

2.7 We recommend that CDHA implement centralized booking for all CDHA's CT scanners.
Status – Capital District Health Authority – Work in progress

2.8 We recommend that CDHA and CBDHA establish utilization standards for each MRI and CT scanner and monitor performance in achieving the standard.
Status – Cape Breton District Health Authority – Planning stage
Status – Capital District Health Authority – Work in progress

2.9.1 We recommend that CBDHA set standard times for reporting of diagnostic imaging examination results and monitor progress in achieving the standard.
Status – Cape Breton District Health Authority – Complete

2.9.2 CBDHA and CDHA should take action to ensure standard turnaround times are achieved.
Status – Cape Breton District Health Authority – Planning stage
Status – Capital District Health Authority – Complete

2.10.1 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.
Status – Cape Breton District Health Authority – Complete
Status – Capital District Health Authority – Work in progress

2.10.2 We also recommend that requirements for statistical reports be included in future information system procurements.
Status – Cape Breton District Health Authority – No progress to date but plan to take action
Status – Capital District Health Authority – Work in progress

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.
Status – Cape Breton District Health Authority – Planning stage
Status – Capital District Health Authority– Complete

2.12 We recommend that CDHA ensure patient safety questionnaires are completed for all MRI patients and retained in the patients' files.
Status – Capital District Health Authority – Complete

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.
Status – Department of Health – Planning stage
Status – Cape Breton District Health Authority – Planning stage
Status – Capital District Health Authority – Work in progress

2.14 We recommend that CDHA and DOH establish conflict of interest guidelines for medical staff including policies on relationships with private facilities.
Status – Department of Health – No progress to date but plan to take action
Status – Capital District Health Authority – Work in progress

Chapter 3 – Emergency Health Services

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.
Status – Complete

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.
Status – No progress to date but plan to take action

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.
Status – Complete

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.
Status – Complete

3.5 We recommend that EHS verify the completeness and accuracy of user fee revenues submitted by EMC.
Status – No progress to date but plan to take action

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.
Status – No progress to date but plan to take action

3.7 We recommend that EHS record ambulance user fee revenue and receivables to provide better control over uncollected amounts and ensure compliance with generally accepted accounting principles.
Status – No progress to date but plan to take action

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.
Status – No progress to date but plan to take action

3.9 We encourage EHS, EMC and Capital Health to continue to work together to resolve ambulance turnaround delays on a timely basis.
Status – Work in progress

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.

Status – Do not intend to implement

Chapter 4 – Long-Term Care – Nursing Homes and Homes for the Aged

4.1 We recommend that DOH establish service agreements with all nursing homes which include performance expectations and reporting requirements.
Status – Work in progress

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.
Status – Work in progress

4.3 We recommend DOH continue its efforts to implement a funding formula for the long-term care program.
Status – Work in progress

4.4 We recommend that DOH perform quarterly reconciliations and collect funding overpayments in a timely manner.
Status – Work in progress

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.
Status – Planning stage

4.6 We recommend that DOH review and improve the licensing and inspection process to address deficiencies noted in paragraph 4.40.
Status – Work in progress

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

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.
Status – Work in progress

Chapter 5 – Maintenance Enforcement Program

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.
Status – Work in progress

5.2 We recommend the Maintenance Enforcement Program clearly define, assign and communicate staff roles and responsibilities for performance information and reporting.
Status – Work in progress

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.
Status – Planning stage

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.
Status – Work in progress

5.5 We recommend the Maintenance Enforcement Program update formal case documentation standards to ensure support for key decisions is adequately documented.
Status – Work in progress

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.
Status – Work in progress

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.
Status – Work in progress

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.
Status – Work in progress

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

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.
Status – Work in progress

5.11 We recommend the Maintenance Enforcement Program review its current staff roles and reassign responsibilities or implement adequate compensating controls to address the segregation of duties weaknesses.
Status – Work in progress

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.
Status – Work in progress

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.
Status – Work in progress

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.
Status – Work in progress

5.15 We recommend the Maintenance Enforcement Program develop and implement adequate control over electronic funds transfer files and blank cheques.
Status – Work in progress

5.16.1 We recommend the Maintenance Enforcement Program implement programmed dollar limits for individual cheques and electronic funds transfers.
Status – Work in progress

5.16.2 We further recommend bank processing of electronic funds transfers be delayed to allow for timely reconciliation processes to be completed.
Status – Do not intend to implement 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.
Status – Work in progress

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.
Status – Work in progress

Chapter 6 – Regional Housing Authorities

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.
Status – Department of Community Services – Work in progress

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.
Status – Department of Community Services – Work in progress
Status – Cape Breton Island Housing Authority – Work in progress
Status – Metro Regional Housing Authority – Work in progress

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.
Status – Department of Community Services – Complete

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.
Status – Department of Community Services – Complete

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.
Status – Cape Breton Island Housing Authority – Complete
Status – Metro Regional Housing Authority – Complete

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.
Status – Cape Breton Island Housing Authority – Complete
Status – Metro Regional Housing Authority – Complete

6.7.1 We recommend that the Public Housing Operations Manual be reviewed and updated to ensure it is consistent with the Government Procurement Policy
Status – Department of Community Services – Work in progress

6.7.2 and to provide clear guidance on using alternative procurement methods.
Status – Department of Community Services – Complete
Status – Cape Breton Island Housing Authority – Complete
Status – Metro Regional Housing Authority – Complete

Chapter 7 – Government Financial Reporting

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.
Status – Do not intend to implement recommendation

Response: TAGR Steering Committee

Recommendation 5.1
Government should ensure that the Tracking Auditor General Recommendations (TAGR) database is both accurate for the status level of each recommendation, and complete for all published recommendations.

November 2009 was the first time departments were required to respond to the Auditor General Recommendations using only the TAGR system. Overall most of the departments responded appropriately and within the allotted timelines.

The Committee feels there is no value added as a management tool to track older recommendations when the recommendations are either complete, or there are no plans to implement. Management is focusing on more current recommendations that will provide positive operational benefits. Management agrees the responses to the recommendations should be accurate in the system and will instruct departments to review and update prior year recommendations in the near future.

To facilitate a timely review of the recommendations the TAGR system went through system enhancements in Spring 2010 and training sessions for users is planned in the near future. The processes and business practices are also currently being reviewed by the Committee and any further enhancements to this new system and its new business practices will be addressed.

Appendix

An Act Respecting the Office of Auditor General

Short title

1 This Act may be cited as the Auditor General Act. *R.S., c. 28, s. 1.*

Interpretation

2 (1) In this Act,

(a) "agency of government" means any department, board, commission, foundation, agency, association or other body of persons, whether incorporated or unincorporated, all the members of which, or all the members of the board of management or board of directors of which,

(i) are appointed by an Act of the Legislature or by order of the Governor in Council, or

(ii) if not so appointed, in the discharge of their duties are public officers or servants of the Crown, or for the proper discharge of their duties are, directly or indirectly, responsible to the Crown;

(b) "Auditor General" means a person appointed pursuant to this Act and includes any person appointed in his place and stead;

(c) "Minister" means the Minister of Finance;

(d) "public property" means property immovable or movable, real or personal, belonging to Her Majesty in right of the Province and includes property belonging to an agency of Her Majesty in said right.

(2) Unless otherwise provided in this Act, the words and expressions used herein have the same meaning as in the Provincial Finance Act. *R.S., c. 28, s. 2.*

Auditor General and Deputy Auditor General

3 (1) Subject to the approval of the House of Assembly by majority vote, the Governor in Council shall appoint a person to be the Auditor General.

(1A) Subject to subsection (1B), the Auditor General holds office for a term of ten years and may not be re-appointed.

(1B) The Governor in Council shall remove the Auditor General on the passing by the House of Assembly of a resolution carried by a vote of two thirds of the members of the House of Assembly voting thereon requiring the Governor in Council to remove the Auditor General from office.

(2) The Auditor General shall be paid out of the Consolidated Fund of the Province such salary as the Governor in Council determines.

(3) Notwithstanding subsection (2) hereof, the salary of the Auditor General shall not be reduced by the Governor in Council except on the passing by the House of Assembly of a resolution carried by a vote of two thirds of the members of the House of Assembly voting thereon requiring the Governor in Council so to do.

(4) Upon written advice of the President of the Executive Council and the Leader of the Official Opposition, the Governor in Council may, at any time the Legislature is not in session, suspend the Auditor General for cause, but the suspension shall not continue in force beyond the end of the next ensuing session of the Legislature.

(5) The Governor in Council may appoint a person to be Deputy Auditor General who shall hold office during pleasure and shall be paid such salary as the Governor in Council determines and shall perform such duties as are assigned to him by the Auditor General and who shall during any vacancy in the office of the Auditor General or during the illness or absence of the Auditor General have and exercise all the powers of the Auditor General.

(6) Such officers and employees as are necessary to enable the Auditor General to perform his duties shall be appointed in accordance with the Civil Service Act.

(7) The Auditor General and the Deputy Auditor general shall be qualified auditors. *R.S., c.28, s.3; 2005, c.13, s.1.*

Experts

4 (1) The Auditor General may engage the services of such counsel, accountants and other experts to advise him in respect of matters as he deems necessary for the efficient carrying our of this duties and functions under this Act.

(2) The compensation paid to those persons mentioned in subsection (1) hereof shall be determined by the Auditor General within the total dollar limitations established for the Office of the Auditor General in The Appropriations Act for the year in which the compensation is paid and shall be paid out of the Consolidated Fund of the Province. *R.S., c.28, s.4.*

Oath

5 (1) The Auditor General and every officer, agent and other person employed in the execution of any duty under this Act or under any regulations made hereunder, before entering upon his duties, shall take and subscribe to the following oath:

> I, ...solemnly and sincerely swear that I will faithfully and honestly fulfil the duties that devolve upon me by reason of my employment in the Office of the Auditor General and that I will not, without due authority in that behalf, disclose or make known any matter that comes to my knowledge by reason of such employment. So help me God.

(2) This oath shall be taken before such person, and returned and recorded in such manner, as the Governor in Council perscribes. *R.S., c.28, s.5.*

Public Service Superannuation Act

6 The Auditor General and all officers and employees of the Auditor General are employees within the meaning of the Public Service Superannuation Act and are entitled to all benefits therein set forth. *R.S., c.28, s.6.*

Powers and duties

7 (1) The Auditor General shall supervise and be responsible for all matters relating to the conduct of his office and of persons employed by him and shall have all the powers and perform all the duties conferred and imposed upon him by this Act, any other Act and the Governor in Council.

(2) The Auditor General may delegate to any person employed by him any duty, act or function that by this Act he is required to do other than reporting to the House of Assembly or to the Governor in Council. *R.S., c.28, s.7.*

Examination of account

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. *R.S., c.28, s.8.*

Annual report

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. *1998, c.5, s.1.*

Other reports

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 willfully 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 provisions 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. *1998, c.5, s.1.*

Review and opinion of revenue estimates

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. *1998, c.5, s.1.*

Access to information

10 (1) Notwithstanding the provisions of any other Act, every officer, clerk or employee of an agency of government shall provide the Auditor General with such information and explanation as the Auditor General requires and the Auditor General shall have free access, at all times, to the files, records, books of account and other documents, in whatever form, relating to the accounts of any agency of government.

(2) The Auditor General, if he deems it expedient, may station one or more of his officers in any agency of government to enable him more effectively to carry out his duties under this Act, and the agency of government shall provide necessary office accommodation for such officer or officers. *R.S., c.28, s.10.*

Audit before payment

11 (1) The Auditor General, if directed by the Governor in Council, shall audit the accounts of any agency of government before payment.

(2) Where the Auditor General is directed to audit, before payment, certain accounts or classes of accounts, no payment of such accounts may be made until the Auditor General has certified them to be correct or the Minister directs. *R.S., c.28, s.11.*

Examination of security

12 The Auditor General may examine in such manner and to the extent he considers necessary such of the securities representing any debt of the Province which have been redeemed and cancelled. *R.S., c.28, s.12.*

Security required

13 The Auditor General shall require every person employed by him who examines the accounts of an agency of government to comply with any security requirements applicable to officers and employees of that agency of government. *R.S., c.28, s.13.*

Powers, privileges, immunities

14 The Auditor General shall have, in the performance of his duties, the same powers, privileges and immunities as a Commissioner appointed under the Public Inquiries Act. *R.S., c.28, s.14.*

Special audit and report

15 Notwithstanding any provision of this Act, the Auditor General may, and where directed by the Governor in Council or the Treasury and Policy 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. *R.S., c.28, s.15; 2005, c.13, s.2.*

Payment for statutory audit

16 (1) Where under this Act or any other Act of the Legislature, the Auditor General is, or may be, required to examine and audit or inquire into the accounts of any agency of government, the Governor in Council may direct that the cost of the examination and audit or inquiry be paid by that person, institution or agency of government, and upon such direction such payment shall be made.

(2) The Auditor General may charge fees for the examination and audit or inquiry, or such other professional services rendered by the Office of the Auditor General, on the basis approved by the Treasury and Policy Board. *R.S., c.28, s.16; 2005, c.13, s.3.*

Examination by chartered accountant

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. *R.S., c.28, s.17; revision corrected 1999.*

Where other auditor designated

18 Nothing in this Act shall be construed to require the Auditor General to audit or report upon the accounts of any agency of government if the Governor in Council, in pursuance of statutory authority in that behalf, has designated another auditor to examine and report upon the accounts of the agency of the government. *R.S., c.28, s.18.*

Powers and authorities

19 The Auditor General shall have all the powers and authorities exercisable by a deputy head under the Civil Service Act. *R.S., c.28, s.19.*

Regulations

20 The Governor in Council may make such regulations as are deemed expedient for the better carrying out of this Act. *R.S., c.28, s.20.*

Annual estimate

21 The Auditor General shall prepare annually an estimate of the sums required to be provided by the Legislature for the carrying out of this Act during the fiscal year, which estimate shall be transmitted to the Treasury and Policy Board for its approval, and shall be laid before the Legislature with the other estimates for the year. *R.S., c.28, s.21; 2005, c.13, s.4.*

Expenses

22 The expenses to be incurred under this Act shall be paid out of the Consolidated Fund of the Province. *R.S., c.28, s.22.*

Regulations Act

23 Regulations made by the Governor in Council pursuant to Section 20 shall be regulations within the meaning of the Regulations Act. *R.S., c.28, s.23.*

APPENDIX I