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.

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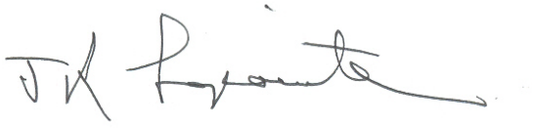
NOVA SCOTIA

Honourable Gordie Gosse
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 18(2) of the Auditor General Act, to be laid before the House in accordance with Section 18(4) of the Auditor General Act.

Respectfully submitted



JACQUES R. LAPOINTE, CA
Auditor General

Halifax, Nova Scotia
April 29, 2011

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Introduction

1 Message from the Auditor General

Introduction

1.1 I am pleased to present my May 2011 Report to the House of Assembly on work completed by my Office in the fall of 2010 and winter of 2011.

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 9, 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 Report to the Speaker on my forensic investigation with respect to the Members' expenses was issued on May 18, 2010.
- My Report to the House of Assembly on work completed in the fall of 2009 and winter of 2010, dated May 18, 2010, was tabled on June 2, 2010.
- My Business Plan for 2010-11 and my Report on Performance for 2009-10 were provided to the Public Accounts Committee on June 4, 2010 and July 13, 2010 respectively.
- My Report on the Province's March 31, 2010 consolidated financial statements, dated June 30, 2010, was tabled with the Public Accounts by the Minister of Finance on July 29, 2010.
- My Report to the House of Assembly on work completed in the spring and summer, dated October 29, 2010, was tabled on November 17, 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 House and the public, as well as the realities facing management, in providing sound, practical recommendations to improve the management of public sector programs.

1.4 My priorities 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 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 In December 2010, a new Auditor General Act came into effect. This Act provides my Office with a modern performance audit mandate to examine various aspects of programs including efficiency and effectiveness; performance monitoring and reporting; and appropriate use of public funds. It also clarifies which entities are subject to audit by this Office.

1.8 The Act establishes the Auditor General's mandate, responsibilities and powers. 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.

1.9 The Auditor General Act stipulates that the Auditor General shall provide an opinion on government's annual consolidated financial statements; provide an opinion on the revenue estimates in the government's annual budget address; and report to the House at least annually on the results of performance audits.

1.10 The Act provides my Office a mandate 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 funding recipients external to the provincial public sector.

1.11 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. We also seek guidance from other professional bodies and audit-related best practices in other jurisdictions.

Chapter Highlights

1.12 This Report presents the results of audits and reviews completed in the fall of 2010 and winter of 2011 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.

Follow-up

Chapter 2 – Follow-up of 2005, 2006, 2007 and 2008 Recommendations

1.13 Only 52% of our recommendations made between 2005 and 2008 have been implemented. This is not adequate and is not improving significantly. We are particularly concerned with the lack of progress by the Departments of Health and Wellness, and Education, in implementing our recommendations.

1.14 We have recommended that government's Audit Committee monitor the implementation status of our recommendations. We have further recommended that this Committee actively promote implementation of our recommendations.

Performance Audits

Chapter 3 – Financial Assistance to Businesses through NSBI and IEF

1.15 IEF has few processes, controls or documentation to support the review and evaluation of applications for loans or other assistance. A recently established advisory committee has no oversight role. Confidential Cabinet review and approval is the only significant control or oversight of this program. Additionally, few procedures exist to monitor compliance with loan conditions, repayments, or arrears. These inadequate policies, processes,

controls and documentation for IEF activities represent an inappropriate way to manage public funds.

1.16 NSBI's program management provides a sharp contrast to IEF. NSBI has adequate policies, processes, controls and documentation to support its assistance programs of loans, payroll rebates and venture capital investments.

Chapter 4 – Colchester Regional Hospital Replacement

1.17 The initial budget of $104 million to replace the Colchester Regional Hospital was not a realistic estimate and was not sufficient to complete construction. It was based on assumptions that were unreasonable or unsupported. It did not, for instance, consider inflation over the life of the project. The current budget of $184.6 million is still not complete; it excludes several items that should be part of the overall project budget.

1.18 While ineffective budgeting practices were significant contributors to apparent cost increases, oversight and project management weaknesses by both CEHHA and Health have contributed to project difficulties and cost overruns. Some significant decisions were made without sufficient consideration of the related costs.

Chapter 5 – Long Term Care – New and Replacement Facilities

1.19 The Department of Health and Wellness developed and followed a process to determine the number and location of new long term care facilities. However, the Department had no support to show it replaced facilities most in need of replacement. We do not know whether the facilities with the most serious deficiencies were replaced.

1.20 We also found the Department has not established agreements with existing long term care service providers, who represent the majority of long term care facilities. We recommended the Department address this issue in our June 2007 Report; however, none of our recommendations were implemented. We are concerned about the Department's willingness to implement the recommendations in Chapter 5 of this Report given its inaction in the past.

Chapter 6 – Office of the Fire Marshal

1.21 The Office of the Fire Marshal is not doing an adequate job of protecting the public from fire safety risks in buildings. Management is not performing appropriate oversight of operations; we believe this has contributed to a number of the deficiencies identified during our audit. The Office lacks fundamental information needed to effectively manage its operations.

Management does not know whether required fire safety inspections have been completed or whether significant deficiencies identified during inspections have been appropriately addressed.

1.22 We have previously completed audits in this area in 1987 and 2001. The results of the current audit make it apparent that the Department of Labour and Advanced Education has not made these important issues a priority. Over the years, the Office of the Fire Marshal has failed to exercise its responsibilities and has failed to take actions it has known to be necessary to protect the public.

Chapter 7 – Registry of Motor Vehicles

1.23 The Department of Service Nova Scotia and Municipal Relations' processes for identifying and taking action on high-risk drivers as well as monitoring motor vehicle inspection stations and testers are inadequate. We found backlogs of collision and medical reports, and significant time delays between the Department's review of drivers' records and intervention action taken.

1.24 We also found poor controls over the issue and return of motor vehicle inspection stickers and renewal of inspection station and tester licences. Additionally, there were weaknesses in inspection station audit selection and coverage across the province.

Chapter 8 – Registry of Motor Vehicles Information and Technology

1.25 The Department of Service Nova Scotia and Municipal Relations does not have adequate controls to ensure the confidentiality and integrity of the information in its Registry of Motor Vehicles (RMV) systems. The Department cannot be assured it provides licences, permits and identification cards only to those who are eligible to receive them. Stronger controls are needed to prevent such offences as credit card fraud, identity theft, and drivers having fraudulently-obtained licenses.

1.26 Processes to provide access to RMV systems are not documented. Some users of RMV systems have access to confidential information they do not need to perform their job.

1.27 Additionally, the Department does not have policies or procedures for sharing registry information with other provincial, municipal and federal government entities, as well as some private-sector and non-government organizations. It is at risk of providing this information in a manner that violates the laws and regulations protecting the privacy of information.

Follow-up

2 Follow-up of 2005, 2006, 2007 and 2008 Recommendations

Summary

During our audits, we may discover weaknesses in controls protecting government assets or in the efficiency and effectiveness of government systems and processes. Many of these controls, systems and processes help provide important services to Nova Scotians. We provide what we believe are practical and constructive recommendations to address the weaknesses we find. Failure to address these weaknesses in a timely manner increases the risks of financial loss or failure to effectively deliver services.

We have previously followed up on the implementation status of recommendations beginning two years after a report is issued. In June 2010, we also committed to extending our review of outstanding recommendations. This Chapter covers all recommendations made between 2005 and 2008.

Overall, the response from government in implementing recommendations from the four years under review is still not adequate and is not improving significantly. While there is considerable variation among departments and agencies, the overall implementation rate over four years is 52%. We are particularly concerned with the lack of progress by the Departments of Health and Wellness, and Education, in implementing our recommendations. The Department of Health and Wellness has implemented only 36% of our 2005 to 2008 recommendations. The Department of Education has implemented 14% and is essentially ignoring our recommendations. In contrast, the implementation rate for the Department Community Services is 75%.

We have recommended in this Chapter that government's Audit Committee monitor the implementation status of our recommendations and report the results of this monitoring process to the House of Assembly. We have further recommended that this Committee actively promote implementation of our recommendations, with a goal of achieving substantively full implementation within four years. We believe these recommendations promote greater responsibility for implementation results and will thereby increase the implementation rate of departments and agencies.

We performed a review of the self-assessments provided by management and can state that nothing has come to our attention to cause us to believe the representations made by government management are not complete, accurate and reliable. Details of all recommendations made from 2005 to 2008, along with their current status, can be found on our website at oag-ns.ca.

NOVA SCOTIA

2 Follow-up of 2005, 2006, 2007 and 2008 Recommendations

Background

FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.1 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 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 results of our audits are detailed in our Reports to the House of Assembly. Each Report contains recommendations which we believe provide practical, constructive advice to address issues raised by the audits.

2.2 Our reports have included formal recommendations since 2002. We 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. In our June 2010 Report, we informed the Legislature that we planned to assess the implementation status of outstanding recommendations in each year from 2005 forward, beginning in 2010. This Chapter reports how responsive departments and agencies have been in implementing the recommendations resulting from our 2008 audits, as well as outstanding recommendations from our 2005 to 2007 audits.

2.3 We requested that government management complete a self-assessment of their progress in implementing each 2008 recommendation as well as outstanding 2005 to 2007 recommendations in Treasury Board's Tracking Auditor General Recommendations (TAGR) system. We also asked management to provide supporting information. Our review process focused on whether self-assessments and information provided by management were accurate, reliable and complete.

Review Objective and Scope

2.4 The objective of this assignment was to provide moderate assurance on the implementation status of recommendations from the 2005 to 2008 Reports 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.

2.5 In early September 2010, we asked each auditee to document its self-assessment of progress on the implementation of the Office's recommendations recorded in the TAGR system. We asked each auditee to complete the self-assessment by October 15, 2010.

2.6 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 other than Audits of Financial Statements*.

2.7 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 were able to obtain sufficient support to satisfy our review objective for departments' self-assessments with the exception of one recommendation related to the Department of Health and Wellness. The response from government in implementing our recommendations is not adequate. 52% of the recommendations we made from 2005 to 2008 have been addressed and implemented to date. After two or more years, 41% of our recommendations are in various stages of implementation, and government will take no action on another 6%. Only 1% of our recommendations are no longer appropriate. Government needs to increase its commitment to implementing our recommendations. We have recommended that government's Audit Committee monitor the implementation status of our recommendations and report the results of this monitoring to the House. The Committee should also promote implementation of our recommendations.

2.8 *Review results* – We performed a review of the self-assessments and supporting documentation and provide moderate assurance to readers of this Chapter. Nothing came to our attention to cause us to believe that

the representations made by government are not complete, accurate, and reliable, except for the following.

December 2005 Chapter 8 – Sport & Recreation

Recommendation 8.9

We recommend the Sport and Recreation program area continue to implement the CIMS system for all grant programs.

FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.9 The Department of Health Promotion and Protection (now Health and Wellness) self-assessed the status of Recommendation 8.9 as *"Complete."* However, support provided by management indicated that they continue to use a spreadsheet program to track numerous smaller grants. Consequently, we cannot conclude that the status provided is plausible.

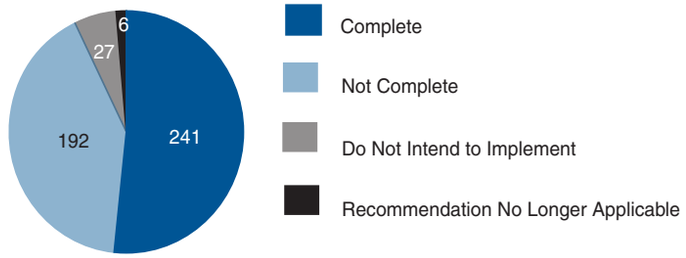
2.10 During the audit of the various grants provided under the Sport and Recreation program, we noted that a Community Investment Management System (CIMS) software application had been approved for use in tracking grant applications, payments, awards and other details. We understood all grant programs would eventually be included in the CIMS database and made the above recommendation in support of that action. Based on the information we received in conducting this review engagement, we continue to support the recommendation that all grant programs be entered in the CIMS to facilitate tracking and status of Sport and Recreation programs.

2.11 Our audits are meant to reflect our strategic priorities, including that we focus our audit efforts on areas of higher risk that impact the lives of Nova Scotians. Our follow-up activity reflects our desire to see improvements made to these areas. However, we emphasize that the work performed during our follow-up assignments is not an audit and therefore we provide only moderate assurance that these recommendations have been implemented. Only during a subsequent audit of the program area can we say with sufficiently high assurance that prior recommendations have been implemented.

2.12 *Implementation rate of recommendations* – We are disappointed with the implementation rate of our recommendations. The highest rate of the four years reviewed as part of this year's follow-up assignment was 60% in 2006; only 40% of the recommendations made in our 2007 Report were implemented. The combined implementation rate of the four reports issued during 2008 is 46%. The results of our previous follow-up activity on 2007 recommendations was 27% and therefore this is an improvement. Nevertheless, more than half of all recommendations remain incomplete. The following exhibits provide a summary of the implementation status in each of the four years and the overall status.

Implementation Status	2005 Reports	2006 Reports	2007 Reports	2008 Reports
Complete	57%	60%	40%	46%
Not Complete	33%	31%	58%	48%
Do Not Intend to Implement	9%	5%	2%	6%
Other	1%	4%	-	-
	100%	100%	100%	100%

Overall Results from 2005 - 2008



2.13 This response from government is not adequate. When we make recommendations as a result of our audits, we seek acknowledgment from departments and agencies that they agree with the recommendations, and whether they intend to implement them. Almost all published responses included in our Reports indicate both agreement and intention to implement. We therefore expect to see implementation rates far above those that have been shown to date and expect to see substantively full implementation within a reasonable period of time.

2.14 As time elapses and recommendations fail to be addressed, management is likely to lose track of important issues raised in our audits of programs and services, and changes encouraged by our recommendations may not occur. In addition to missed improvements in existing programs and services as a result of this inaction, government misses the opportunity to incorporate best practices in new or revised programs. Government's failure to correct the deficiencies pointed out in our Reports constitutes poor management practice and poor accountability to the House.

2.15 We are particularly concerned with the implementation rates in the Departments of Education, and Health and Wellness. These departments provide oversight of the education and health of Nova Scotians, and administer a combined $4.9 billion, or 62%, of total departmental expenditures (based on the April 5, 2011 forecast update). The Department of Education's implementation rate from 2005 to 2008 is 14%. The

Department of Health and Wellness's rate over the same period is 36%. We have made comments regarding the nature of the recommendations made to these departments, beginning in paragraph 2.21 below. In general, though, these implementation rates are deficient and need to be improved. The Department of Education is essentially ignoring our recommendations.

FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.16 In our December 2006 Report (Chapter 7 – Follow-up of 2003 Audit Recommendations) we noted that:

> *"Government needs to take a direct role and responsibility for coordinating response and actions on matters reported by the Auditor General. Government should regularly provide the House with its plans to deal with recommendations and other matters reported by the Auditor General."*

2.17 We were subsequently encouraged when government developed a system Tracking Auditor General Recommendations (TAGR) designed to track the implementation status of our recommendations (see further comments on TAGR in paragraph 2.19 below). Oversight of the TAGR system is provided by a steering committee which consists of senior management of the Department of Finance, Treasury Board and the Office of Priorities and Planning. TAGR results are also sometimes reviewed by the government's Audit Committee; a Committee consisting of deputy ministers from several departments and chaired by the Deputy Minister of Treasury Board.

2.18 The process for ensuring that the status of recommendations is entered in TAGR does not include responsibility for implementation. We believe this lack of responsibility has contributed to the poor implementation results. In the private sector, it is a best practice that entities' boards of directors ensure recommendations from their external auditors are implemented on a timely basis. We believe that government's Audit Committee should assume this responsibility. The implementation status of our recommendations should be a recurring item on the Committee's agenda, and results should be reported to the House of Assembly.

Recommendation 2.1
The Audit Committee should monitor the implementation status of Auditor General recommendations and report the results of this monitoring process to the House of Assembly.

Recommendation 2.2
The Audit Committee should actively promote implementation of Auditor General recommendations and target substantively full implementation within four years of their release.

2.19 This was the first year we extended our review of the implementation status of recommendations from those made two years previously to include those made from 2005 to 2008. This continuous monitoring of implementation status is consistent with our objective of holding government and the public service accountable. As a result of this year's assignment, we have decided that our follow-up work in future will continue to focus on recommendations made in audits conducted two years prior. In addition, we will also follow up on earlier outstanding recommendations. We will determine the time frame to capture in this additional follow-up work on an annual basis.

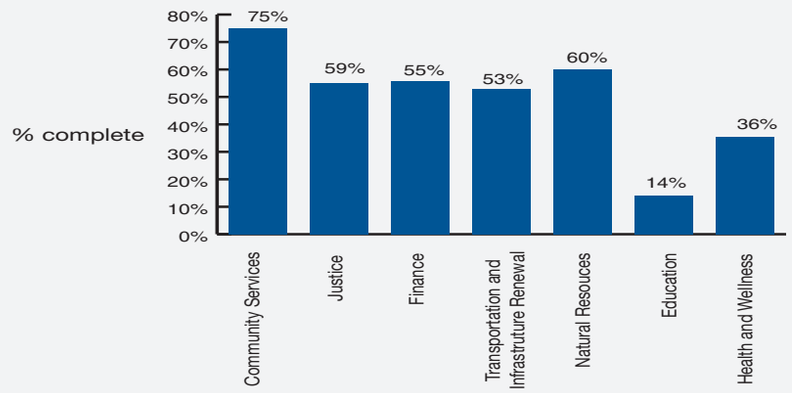
FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.20 We reported in our April 2009 and June 2010 reports that TAGR information was both incomplete and inaccurate. Not all recommendations were included in the system, and the status reported on several of the recommendations did not agree with the status as provided by certain departments and reported in our follow-up assignment results. We are aware that TAGR was updated recently in connection with our assignment, and not as part of ongoing monitoring. We suggest that if the Audit Committee intends to use TAGR as a tool in monitoring implementation, and as a means to implement recommendation 2.1 above, TAGR should be complete and accurate.

Recommendation 2.3
The Tracking Auditor General Recommendation system (TAGR) should be updated to ensure it is accurate and complete.

2.21 *Implementation results by department* – The departmental results provide an indication of which departments have made it a priority to address our recommendations. Of the departments in which we have conducted a significant number of audits, or to which we have made a significant number of recommendations to the department or their agencies, the Department of Community Services has the highest implementation rate at 75%, while the Department of Education has the lowest rate at 14%.

Completion Rate – Significant Departments 2005 to 2008



2.22 *Department of Health and Wellness* – As noted above, the Department of Health and Wellness has implemented only 36 (36%) of the 101 recommendations addressed to it or previous departments now combined with it between 2005 and 2008. Audits conducted at the Department of Health and Wellness during this period varied from assignments conducted at specific district health authorities to others related to programs delivered through the Department itself.

2.23 In December 2006, we conducted a review of the systems at both the Department and at the district health authorities to collect wait time information. Accurate and complete information on wait times is essential to managing the wait list. Only seven of the 13 recommendations have been implemented to date, with two recommendations no longer requiring action. This is an increase of only one completed recommendation from our first follow-up assignment on these recommendations, which we conducted in 2009. Wait time management and the resources allocated to this matter are significant issues in the health of Nova Scotians, particularly in light of our aging population.

2.24 Another significant program funded by the Department is long term care. We conducted an audit of aspects of this program in June 2007 and made several recommendations regarding accountability of service providers and placement decisions. While we understand from the results of our current audit (Chapter 5 – Long Term Care – New and Replacement Facilities) that some improvements have been incorporated into contracts with service providers for new facilities, none of the recommendations related to service providers in existing facilities has been fully implemented. In addition, the recommendations related to placement decisions have not been implemented. This response is insufficient for a program as significant as long term care.

2.25 *Department of Educatio*n – Recommendations included in our reports on Education are primarily applicable to the school boards. Only 21 of 78 recommendations made between 2005 and 2008 applied specifically to the Department of Education, with the remaining 57 applied to the school boards. The Department has implemented three recommendations while 13 are in progress; one recommendation is no longer applicable, and they do not intend to implement the remaining four. The Department's implementation rate of 14% is the lowest of all departments.

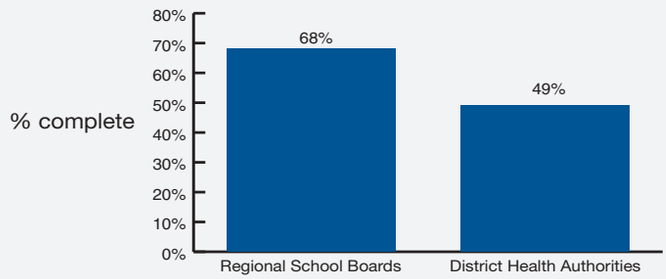
FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.26 The Department of Education has not made any further progress in addressing the recommendations from our June 2005 Chapter on Special Education since we first followed up in late 2007. Our recommendations focused on accountability and funding arrangements, including the need for the Department to provide additional guidance to school boards regarding accounting for special education costs. The recommendation was made to promote consistency among the boards related to these costs, which in turn provides the Department with a more accurate assessment of costs related to special education. During our first follow-up, we reported that two recommendations were in the planning stage, two were work in progress, and the Department did not intend to implement one recommendation. The implementation status of the remaining four recommendations has not changed in two years.

2.27 We provided our draft comments to senior management of the Department of Education. They noted several recommendations in our summary table beginning on page 20 are nearly fully implemented with only minor items to address. Department of Education senior management has also indicated they will make it a priority to address our recommendations.

2.28 *Implementation results by agencies* – District health authorities (DHAs) and regional school boards (which, for purposes of this Chapter, include the Conseil scolaire acadien provincial (CSAP) and the Atlantic Provinces Special Education Authority (APSEA)), deliver significant health and education programs in the province. Several of our audits of programs administered by the Departments of Health and Wellness, and Education, from 2005 to 2008 have included audits of aspects of program delivery at these DHAs and school boards, respectively. The implementation status of the recommendations made specifically to those entities is noted in the following exhibit.

Completion Rate – Agencies 2005 to 2008



2.29 *Regional school boards* – The implementation rate for recommendations applicable to the regional school boards is 68%. The rate is not reflective of recent results, and is mostly due to a lack of improvement in implementing recommendations made in 2006. In that year, we conducted an audit at the Atlantic Provinces Special Education Authority. To date, 62% of the recommendations have been implemented, an improvement of only 22% since our first follow-up conducted in 2008. Similarly, CSAP has only implemented 43% of the recommendations made from an audit conducted in 2006. These poor results offset the more robust implementation rates of the Strait Regional School Board (10 of 11 applicable recommendations have been implemented from our June 2006 audit) and more recently, 78% by the South Shore Regional School Board from our February 2008 audit. We are encouraged by the priority our recommendations have been given by these boards, and would like to see other boards address recommendations on a more timely basis.

2.30 *District health authorities* – The implementation rate of our recommendations to district health authorities from 2005 to 2008 is 49%. We conducted audits in 2006 at three DHAs and have noted a marginal improvement (from 40% to 55%) in the progress of implementing the recommendations from these audits from our first follow-up conducted in 2008. Similarly, there has been essentially no change in the implementation rate of the recommendations to two DHAs resulting from our June 2007 audit of the management of diagnostic imaging equipment.

2.31 *Department of Finance* – Nearly every Report includes at least one Chapter related to financial reporting or controls. Consequently, there are 60 recommendations made to the Department of Finance from 2005 to 2008, including 27 in 2008 alone.

2.32 The Department of Finance has improved its implementation rate since our last follow-up assignment, but improvement is still needed. When we first

followed up on 2005 recommendations in 2008, we noted that only 15% (five of 33) of our recommendations had been implemented. This has improved to an implementation rate of 57% (13 of 23) found in this year's follow-up work. Similarly, the implementation status of the recommendations made in 2006 has improved from 23% reported in 2009 to a current rate of 67%. In addition, one of our long outstanding recommendations, made in several reports and related to the need to document and assess internal controls, has progressed from the planning stage to work in progress as government moves forward with its project on internal controls over financial reporting.

FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.33 There is, however, one recommendation which has been made since 2006 which government has indicated it does not intend to implement. It was the sole recommendation made in 2007. Despite government's reported intention not to implement, we will continue to recommend that the Revenue Estimates be prepared on a gross basis and include the revenues of agencies in the consolidated entity. These revenues are included as part of the Budget Address and we provide an opinion as to their reasonableness. Because the actual results at March 31 each year are presented on a gross basis, generally accepted accounting principles require the budget to also be prepared on a gross basis. For this reason, our opinion on the Revenue Estimates is qualified each year. We do not consider it appropriate that an accountability document – the budget – includes a qualification. We will continue to recommend that government revise its presentation of the Revenue Estimates.

2.34 *Department of Justice* – Chapter 5 in our June 2010 Report noted our concerns with the lack of progress in implementing recommendations resulting from our 2007 audit of the Maintenance Enforcement Program. None of the 19 recommendations made had been fully implemented. During this year's assignment, we noted a significant improvement in the implementation rate of these recommendations; nine of the 19 recommendations have now been fully implemented. We urge the Department to complete the implementation of the remaining recommendations on a timely basis.

2.35 *Department of Community Services* – The implementation rate of recommendations made to the Department of Community Services is 75%, with an 80% rate in 2006. These implementation rates are the highest among departments to which a significant number of recommendations have been made. We encourage the Department to strive for a significant rate each year, and on a timely basis.

2.36 *Department of Environment* – In Chapter 3 of our February 2008 Report, we made seven recommendations to the Department of Environment regarding the Environmental Monitoring and Compliance Division. The Department has fully implemented five recommendations, while two

remain in progress. The Department retained the services of the Internal Audit Centre to review specific solutions they had implemented to five of the seven recommendations, and form an opinion as to whether the specific solutions were effective in helping to address our recommendations. We commend the Department for their initiative and interest in addressing our recommendations on a timely basis.

FOLLOW-UP OF 2005, 2006, 2007 AND 2008 RECOMMENDATIONS

2.37 *Other departments and agencies* – The overall implementation rate of departments and agencies is 52%. The majority (63%) of recommendations made to this remaining group relate to audits conducted in 2008; this is our first follow-up assignment on their status. In total, 19 of the 40 (48%) recommendations made in 2008 have been implemented. We are hopeful the remainder will be fully implemented by our next review.

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
Department of Health and Wellness						
June 2005						
Chapter 6: Nova Scotia Hospital Information System Project	DHW		1			1
December 2005						
Chapter 8: Sport and Recreation Program Area	DHW	9				9
June 2006						
Chapter 9: District Health Authorities	DHW		2			2
Chapter 10: Payments to Physicians	DHW	2	3	1		6
December 2006						
Chapter 4: Review of Systems to Collect Wait Time Information	DHW	7	4		*2	13
June 2007						
Chapter 2: Management of Diagnostic Imaging Equipment	DHW		5			5
Chapter 3: Emergency Health Services	DHW	4	6			10
Chapter 4: Long-term Care - Nursing Homes and Homes for the Aged	DHW		8			8
February 2008						
Chapter 4: Communicable Disease Prevention and Control	DHW	11	8			19

** includes 1 recommendation classified as "other" in our April 2009 Report*

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
November 2008						
Chapter 4: Home Care	DHW	3	25			28
Department of Health and Wellness Recommendations		**36**	**62**	**1**	**2**	**101**
		36%	**61%**	**1%**	**2%**	
District Health Authorities						
June 2006						
Chapter 9: District Health Authorities	CHA	4	2		1	7
Chapter 9: District Health Authorities	PCHA	3	4			7
Chapter 9: District Health Authorities	CEHHA	4	2			6
June 2007						
Chapter 2: Management of Diagnostic Imaging Equipment	CDHA	6	7			13
Chapter 2: Management of Diagnostic Imaging Equipment	CBDHA	5	7			12
District Health Authorities Recommendations		**22**	**22**		**1**	**45**
		49%	**49%**		**2%**	
Department of Education						
June 2005						
Chapter 4: Special Education	DOE		4	1		5
December 2005						
Chapter 7: Student Assistance	DOE	3	5	1		9
June 2006						
Chapter 6: Atlantic Provinces Special Education Authority	DOE		1		1	2
Chapter 7: Conseil Scolaire Acadien Provincial	DOE		1			1
Chapter 8: Strait Regional School Board	DOE		2	2		4
Department of Education Recommendations		**3**	**13**	**4**	**1**	**21**
		14%	**62%**	**19%**	**5%**	
Regional School Boards						
June 2005						
Chapter 4: Special Education	AVRSB	1	3			4
Chapter 4: Special Education	CCRSB	3		1		4

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
June 2006						
Chapter 6: Atlantic Provinces Special Education Authority	APSEA	8	5			13
Chapter 7: Conseil scolaire acadien provincial	CSAP	3	3		1	7
Chapter 8: Strait Regional School Board	SRSB	10	1			11
February 2008						
Chapter 2: South Shore Regional School Board	SSRSB	14	4			18
Regional School Boards Recommendations		**39**	**16**	**1**	**1**	**57**
		68%	**28%**	**2%**	**2%**	
Department of Natural Resources						
June 2005						
Chapter 8: Fleet Management	DNR	11	7	2		20
June 2006						
Chapter 11: Sustainable Timber Supply	DNR	7	3			10
Department of Natural Resources Recommendations		**18**	**10**	**2**		**30**
		60%	**33%**	**7%**		
Department of Transportation and Infrastructure Renewal						
June 2005						
Chapter 8: Fleet Management	TIR	7	6	1		14
December 2006						
Chapter 6: Planning and Management of Highway Projects	TIR	3	2			5
Department of Transportation and Infrastructure Renewal Recommendations		**10**	**8**	**1**		**19**
		53%	**42%**	**5%**		
Department of Finance						
June 2005						
Chapter 2: Government Financial Reporting	DOF	5		2		7
Chapter 3: Government Systems and Controls	DOF	1				1
December 2005						
Chapter 2: Government Financial Reporting	DOF	2	5	3		10
Chapter 3: Consulting Contracts and Service Arrangements	DOF	5				5

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
June 2006						
Chapter 2: Government Financial Reporting	DOF	1		1		2
Chapter 3: Government Systems and Controls	DOF	2	1	1		4
December 2006						
Chapter 2: Government Financial Reporting	DOF	3				3
June 2007						
Chapter 7: Government Financial Reporting	DOF			1		1
February 2008						
Chapter 6: Government Financial Reporting	DOF	3		1		4
November 2008						
Chapter 2: Payments to Vendors	DOF	8	3	2		13
Chapter 7: Government Financial Reporting	DOF	3	4	3		10
Department of Finance Recommendations		**33** **55%**	**13** **22%**	**14** **23%**		**60**
Department of Justice						
December 2005						
Chapter 4: Electronic Information Security and Privacy Protection	DOJ	5	3			8
December 2006						
Chapter 5: Correctional Services	DOJ	6	1			7
June 2007						
Chapter 5: Maintenance Enforcement Program	DOJ	9	9	1		19
Department of Justice Recommendations		**20** **59%**	**13** **38%**	**1** **3%**		**34**
Department of Community Services						
December 2005						
Chapter 6: Income Assistance and Child Care Centres	DCS	10	2			12
June 2006						
Chapter 4: Information Technology and Financial Controls	DCS	8	1	1		10

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
June 2007						
Chapter 6: Regional Housing Authorities	DCS	3	3			6
Chapter 6: Regional Housing Authorities	MRHA	3	1			4
Chapter 6: Regional Housing Authorities	CBIHA	3	1			4
Department of Community Services Recommendations		**27**	**8**	**1**		**36**
		75%	**22%**	**3%**		
Other Departments and Agencies						
Treasury Board						
December 2005						
Chapter 3: Consulting Contracts and Service Agreements		3				3
Internal Audit Centre						
November 2008						
Chapter 3: Internal Audit		4		1		5
Nova Scotia Community College						
November 2008						
Chapter 3: Internal Audit		3	1			4
Department of Environment						
February 2008						
Chapter 3: Environmental Monitoring and Compliance		5	2			7
Nova Scotia Liquor Corporation						
November 2008						
Chapter 3: Internal Audit		2	1			3
Nova Scotia Pension Agency						
June 2005						
Chapter 5: Pension Administration System (PenFax)		5	3		1	9
Economic and Rural Development and Tourism (formerly Office of Economic Development)						
June 2005						
Government Systems and Controls		1				1
December 2005						
Chapter 3: Consulting Contracts and Service Agreements		1	3			4
June 2006						
Chapter 5: Nova Scotia Research and Innovation Trust		3				3
Sub-total		5	3			8

Report and Chapter	Entity	Complete	Not Complete	Do Not Intend to Implement	No Longer Applicable	Total
Public Service Commission						
December 2005						
Chapter 3: Consulting Contracts and Service Agreements		1				1
December 2006						
Chapter 3: Audit of HR Application Controls in SAP R/3 System			1			1
Sub-total		1	1			2
Labour and Advanced Education						
November 2008						
Chapter 5: Pension Regulations		2	2	1		5
Chief Information Office						
February 2008						
Chapter 5: Governance of Information Technology Operations		2	5			7
Utility and Review Board						
November 2008						
Chapter 6: Public Passenger Vehicle Safety		1	6			7
Office of Immigration						
June 2008 Special						
Phase 1: Economic Stream of the Nova Scotia Nominee Program			1			1
October 2008 Special						
Phase 2: Economic Stream of the Nova Scotia Nominee Program			1			1
Sub-total			2			2
Communities, Culture and Heritage						
December 2005						
Chapter 3: Consulting Contracts and Service Agreements			1			1
Other Departments and Agencies Recommendations		**33** **52%**	**27** **44%**	**2** **3%**	**1** **1%**	**63**
Total Recommendations		**241** **52%**	**192** **41%**	**27** **6%**	**6** **1%**	**466**

Response: Executive Council

Recommendation 2.1
The Audit Committee should monitor the implementation status of Auditor General recommendations and report the results of this monitoring process to the House of Assembly.

Response: The Deputy Minister's Audit Committee serves an internal audit role, and these audits provide oversight to the Audit Committee and serve the management of departments in helping them assess and improve their operations. They also sometimes identify issues in one department that may have application in others and this information should be shared, or suggest a change to policy, and the Committee would facilitate this.

Although the Auditor General audits serve an entirely different purpose, they too will sometimes serve the same purpose as internal audits, and I therefore agree the Audit Committee should monitor the implementation status of Auditor General recommendations, and in fact they reviewed the update provided to the Auditor General for this report.

I do not agree that the Audit Committee should report to the House of Assembly. The Civil Service is accountable to Government, and Government to the House of Assembly. It is not appropriate for a DM Committee to report directly to the House. In addition, the House of Assembly currently receives this information from the Auditor General.

Recommendation 2.2
The Audit Committee should actively promote implementation of Auditor General recommendations and target substantively full implementation within four years of their release.

Response: The purpose of The Deputy Ministers' Audit Committee is to support Internal Audit as an independent and objective assurance and consulting function established by the Province of Nova Scotia to add value and improve operations. Certainly, the committee would promote any recommendations that improved operations. Commencing with the May 2011 meeting, the Audit Committee will be expanded to include all Deputies, so discussion of recommendations will also serve to promote recommendations.

I do not agree with a fixed timeline for full implementation. Recommendations have to be evaluated for the risks associated with the underlying issue and prioritized against other recommendations, and issues identified through other processes. In addition, we don't have, nor should we ever have, infinite resources. Resources to implement recommendations have to be balanced with the demand for resources for other priorities.

Recommendation 2.3
The Tracking Auditor General Recommendation system (TAGR) should be updated to ensure it is accurate and complete.

Response: Agree.

Performance Audits

3 Economic and Rural Development and Tourism: Financial Assistance to Businesses through NSBI and IEF

Summary

In late 2009 we began, but later withdrew from, an audit of the financial assistance programs at the Industrial Expansion Fund (IEF) and Nova Scotia Business Inc. (NSBI). In our June 2010 Report we denied an opinion on key controls due to refusals by both organizations to provide information required for the audit. Following the enactment of a new Auditor General Act in December 2010 which clarified our right of access, we returned to IEF and NSBI, received the information we required, and completed the audit.

IEF has few processes, controls or documentation to support the review and evaluation of applications for loans or other assistance. The only substantial documentation consists of confidential reports to Cabinet. This enhances the risk of inconsistent or inequitable treatment of applicants, inaccurate or incomplete analysis and recommendations, and poorly informed decisions. A recently established Advisory Committee has no oversight role. Confidential Cabinet review and approval is the only significant control or oversight of this program.

Similarly, following approval of assistance, IEF has inadequate processes, controls or documentation supporting ongoing management of loans. Few procedures exist to monitor compliance with loan conditions, repayments, or arrears.

These inadequate policies, processes, controls and documentation for IEF activities represent an inappropriate way to manage public funds.

NSBI has adequate policies, processes, controls and documentation to support its assistance programs of loans, payroll rebates and venture capital investments. Our tests of compliance with policies found few exceptions.

NSBI's program management provides a sharp contrast to IEF. As the administrator of the IEF, the Department of Economic and Rural Development and Tourism should determine whether it should set up a similar system of policies, processes and controls, or alternatively, employ NSBI to process IEF applications and monitor approved assistance.

3 Economic and Rural Development and Tourism: Financial Assistance to Businesses through NSBI and IEF

Background

3.1 We first attempted to audit the Industrial Expansion Fund (IEF) and Nova Scotia Business Inc. (NSBI) in 2009. We reported the results of our work in Chapter 2 of our June 2010 Report. At that time, we denied an opinion on certain aspects of our audit because both entities refused to provide the information we required to conclude on the adequacy of financial and program controls and compliance with legislation, regulations and policies related to financial assistance to businesses. In that Report, we made some recommendations based on the limited work we were able to complete.

3.2 A new Auditor General Act clarifying this Office's right of unrestricted access to all records of an audited entity came into effect on December 10, 2010. Subsequently, we revisited our original audit to complete our work as well as to test a sample of more recent transactions. This time we received all available information we needed to carry out our work.

3.3 In Nova Scotia, various departments and agencies are involved in business development through the provision of government financial assistance. IEF and NSBI are two organizations through which businesses can access financing and other assistance from the provincial government.

3.4 The Industrial Expansion Fund is administered through the Department of Economic and Rural Development and Tourism (Department). It helps businesses to get established or to expand in Nova Scotia by providing assistance through loan financing, loan guarantees and other development incentives. All IEF assistance is approved by Cabinet.

IEF-Approved Financing for the Past Five Years

	2006–07	2007–08	2008–09	2009–10	2010–11
Loans	$5,790,000	$19,000,000	$32,919,000	$168,400,000	$18,100,000
Development Incentives	$8,080,000	$29,125,950	$23,895,000	$14,510,500	$2,000,000
Equity	$0	$10,000,000	$1,000,000	$19,600,000	$4,000,000
Guarantees	$1,000,000	$1,500,000	$3,800,000	$19,200,000	$14,500,000
Total	**$14,870,000**	**$59,625,950**	**$61,614,000**	**$221,710,500**	**$38,600,000**

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

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

NSBI-Approved Financing for the Past Five Years

	2006–07	2007–08	2008–09	2009–10	2010–11
Loans	$19,172,500	$2,750,000	$3,060,000	$6,777,500	$29,190,000
Venture Capital	$4,000,000	$3,500,000	$4,530,000	$11,228,000	$5,750,000
Payroll Rebates	$36,908,540	$34,189,857	$15,191,120	$15,577,682	$8,479,185
Guarantees	$4,150,000	$0	$0	$1,000,000	$5,300,000
Total	**$64,231,040**	**$40,439,857**	**$22,781,120**	**$34,583,182**	**$48,719,185**

3.7 We have not audited the amounts included in the tables in this section.

3.8 Our audit covered the period from April 1, 2008 to November 30, 2010. Total financial assistance through IEF during this time totaled $282.5 million plus $27 million in loan guarantees. Total financial assistance and guarantees through NSBI during the same period was $82.6 million.

3.9 A 2010 report on the province's website titled *The Way Ahead for Nova Scotia* provides some advice to government on economic development in the province.

Audit Objectives and Scope

3.10 As noted earlier, in 2010 we denied an opinion on certain aspects of our audit of financial assistance to businesses through IEF and NSBI. In winter 2011, we completed work on our previous audit as well as updated our testing to include more recent transactions. The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

3.11 The objectives of the audit were to assess IEF's and NSBI's:

- financial and program controls over loans, payroll rebates, development incentives and venture capital investments to business entities; and

- compliance with legislation, regulations and internal policies and procedures in providing loans, payroll rebates, development incentives and venture capital investments.

3.12 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 of Economic and Rural Development and Tourism, and NSBI.

ECONOMIC AND RURAL DEVELOPMENT AND TOURISM: FINANCIAL ASSISTANCE TO BUSINESSES THROUGH NSBI AND IEF

3.13 Our audit approach included an examination of relevant legislation, files and documents as well as interviews with staff. We selected a sample of transactions from our previous audit, as well as a new sample of transactions from June 1, 2009 to November 30, 2010.

Significant Audit Observations

Industrial Expansion Fund

Conclusions and summary of observations

There are few program controls over loans and development incentives at IEF. There are no documented policies or consistent processes for loan and development incentive approval. There is no assurance that potential clients are consistently assessed. We found instances in which the information used to assess and approve loans and development incentives was inadequate. A recently established advisory committee has no oversight role. The Department needs to improve the manner in which funds approved from the Industrial Expansion Fund are handled. Government should consider whether adequate accountability for public funds can be achieved when the only oversight is through Cabinet. Additionally, IEF files are not complete. Much of the information we needed for testing was not in files; investment managers located some of the support we requested in individual email accounts and computers. There are inadequate policies, processes and documentation supporting the management of assistance subsequent to approval. The situation at IEF is in sharp contrast to what we found at NSBI. The Department should consider moving the administration of IEF to NSBI; this entity already has the appropriate governance structure, processes and controls to ensure investments are made in a fair and consistent manner. Alternatively, a similar system of governance, processes and controls, such as what already exists at NSBI, needs to be implemented for IEF.

Assessment and Approval

3.14 *No documented approval processes* – IEF has no documented policies or consistent processes for loan and development incentive approval. IEF investment managers assess potential recipients and prepare a report and recommendation and other supporting documentation for Cabinet who are ultimately responsible for approving all financial assistance through IEF.

3.15 Deficiencies in the approval process include the following, which we had also identified in our previous Report.

- There is no application system; companies either approach IEF management and discuss the potential for financial assistance or are referred to IEF from other departments.
- There are no standard checklists to ensure consistent information is collected from all potential loan or development incentive recipients.
- There is no risk assessment process to ensure all risk areas are considered when assessing loans and development incentives.

3.16 Although IEF provides funding to a range of different companies, a standard application process, such as the one used at NSBI, which obtains consistent information on all potential recipients and fully considers the risks involved is a basic program control and an important management tool. This would help ensure fair and consistent treatment for all recipients.

Recommendation 3.1
The Department of Economic and Rural Development and Tourism should document and implement processes for Industrial Expansion Fund loan and development incentive assessment and approval.

Recommendation 3.2
The Department of Economic and Rural Development and Tourism should develop and implement a risk assessment process to assess potential Industrial Expansion Fund loan and development incentive applicants.

3.17 *Little information in files* – Although a central filing system exists, there is very little information in many IEF files. During our testing, we often had to ask individual investment managers for additional information which was not on file. There were instances in which managers had to search through emails and individual computer files to provide support. For one file, it took a week for IEF management to locate the business plan that was used to assess the loan.

3.18 Keeping information used to assess loans and development incentives in individual email accounts and computers is risky. Information may not be consistently collected and considered for all applicants. In addition, if there is no evidence on file, it is difficult for senior management to complete any quality assurance processes on the investment managers' work.

3.19 The lack of file documentation combined with the lack of application and assessment processes could create problems when training new staff. It also makes it more difficult for investment managers to ensure they have fully assessed possible clients. NSBI uses checklists to ensure all required supporting documents are on file and IEF should institute a similar process.

ECONOMIC AND RURAL DEVELOPMENT AND TOURISM: FINANCIAL ASSISTANCE TO BUSINESSES THROUGH NSBI AND IEF

Recommendation 3.3
The Department of Economic and Rural Development and Tourism should improve the filing system used for the Industrial Expansion Fund. Files should contain all information used to assess potential applicants as well as all relevant correspondence between the Industrial Expansion Fund and the applicant.

Recommendation 3.4
The Department of Economic and Rural Development and Tourism should develop and use standard checklists to ensure consistent information is collected from potential Industrial Expansion Fund loan and development incentive applicants.

3.20 *Approval testing* – We selected a sample of 10 approved loans and four approved development incentives to determine if the informal processes as described by management were followed. Although there is no checklist of required information, we examined files to determine whether IEF investment managers obtained adequate information for the assessment.

3.21 Our sample included investments selected for testing during our previous audit, as well as investments approved between June 1, 2009 and November 30, 2010. We identified the following issues.

- In one instance, there was no support for the prospective company valuation.
- In one instance, verification of client-supplied working capital was inadequate because IEF staff based their recommendation for approval on unaudited financial statements.
- One development incentive which is based on employment levels and wages did not require the company to submit audited reports of employee numbers or payroll levels. Without any external assurance,

payments could be made for employment levels which do not meet the established target.

3.22 A great deal of the supporting information was missing from the 14 files we tested. IEF management were eventually able to locate some of this information in individual staff email accounts or computers. However different investment managers did not always collect a common core of information to assess potential recipients. These issues could be corrected with an improved filing system and the use of checklists.

Recommendation 3.5
The Department of Economic and Rural Development and Tourism should develop a process to ensure the assessment of loans and development incentives through the Industrial Expansion Fund is sufficiently supported. This should include guidelines detailing the appropriate level of assurance required for financial information submitted by the client.

3.23 *No rejected lists* – There is no list of rejected loan and development incentive applications. While IEF management makes recommendations for approval to Cabinet, potential clients may be rejected directly by management with no involvement of Cabinet. Without a list of rejected applicants and a rejection process, investment managers could reject possible recipients who should be recommended for approval. Failing to maintain a list of rejected applications means it is not possible to determine whether rejections were fair and reasonable.

Recommendation 3.6
The Department of Economic and Rural Development and Tourism should maintain a listing of rejected applications for the Industrial Expansion Fund along with documentation supporting the reasons for rejection. This information should be reviewed by senior management, at least on a test basis, to ensure rejections are appropriate.

3.24 As noted above, Cabinet is responsible for approving all financial assistance through IEF. When we tested the approved loans and development incentives, we also examined the confidential information prepared for Cabinet regarding each transaction. We found that this information provided some analysis of the proposed assistance and discussed potential risks associated with the assistance. However since there are no documented policies detailing what staff are to consider when assessing possible assistance, or how staff are to prepare this information for Cabinet, there is no assurance that transactions recommended to Cabinet have been subjected to a consistent and fair process.

3.25 *IEF Advisory Committee* – In May 2010, Cabinet created an external Advisory Committee to give advice to the Minister regarding some of the proposals for financial assistance through IEF. According to its terms of reference (available on the Department's website), the IEF Advisory Committee is to consist of up to five individuals appointed by Cabinet. The Committee is to provide advice and comments to the Minister regarding whether transactions are *"consistent with meeting the economic development objectives of the Province of Nova Scotia."* The terms of reference also provide seven high-level general principles regarding government's economic development policy, including areas such as sustainability, innovation and human resource development. There are no detailed criteria for committee members to review when considering transactions.

3.26 The Committee may be asked to provide advice on transactions over $500,000 or having a budgetary impact of more than $50,000. If the Minister considers a matter to be urgent he can chose to forego Committee advice and go directly to Cabinet. The Committee has no authority; it is an advisory body only. It does not provide external control or oversight such as a Board of Directors would offer.

3.27 The Department began consulting with the Committee on IEF transactions in September 2010. We reviewed one transaction which Advisory Committee members were asked to comment on. The information prepared for the Committee by Department management provided overall information on the company and its current situation. All Committee members expressed some concerns with the transaction; while some members noted there may be good reasons to provide assistance, they also expressed reservations and did not clearly indicate support. One member stated that if this transaction were to be approved, it would be hard to understand the circumstances in which a transaction would be rejected.

3.28 Additionally, the documentation prepared for Cabinet regarding this transaction understates these concerns. The information notes only that the Advisory Committee was reluctant to approve the request; it does not provide details of Committee members' concerns. This transaction was ultimately approved.

3.29 Consulting an external Advisory Committee does not provide any oversight of transactions. Effective oversight can help ensure a fair and consistent process is used to analyze assistance proposals; however, the only oversight of IEF transactions is by Cabinet. We believe government needs to consider whether this approach is appropriate and whether it achieves adequate accountability for public funds.

Monitoring and Management

3.30 *Monitoring and repayments* – We examined the processes used to monitor ongoing compliance with loan and development incentive terms and conditions, and loan repayments. Many of the concerns we identified were also reported in our June 2010 Report and are consistent with our findings in other areas.

- IEF has no written monitoring policies to ensure development incentive conditions are met and loan agreements are followed.
- There is no checklist to ensure clients submit all information required by letters of offer.
- IEF has no polices to ensure loan repayments are made on time, identify loans in arrears, and collect past due amounts owing.
- There is no written policy documenting standard processes for the annual review of each IEF loan account or guidelines regarding what information must be reviewed and documented. IEF management informed us that investment managers document the status of loans in an annual write-up. However there is no standard format to ensure consistent evaluation of loan account status. We noted that NSBI has appropriate policies documenting the annual review process and the methods used to ensure investment agreements are followed.

Recommendation 3.7
The Department of Economic and Rural Development and Tourism should develop processes to ensure Industrial Expansion Fund development incentive conditions are met and loan agreements are followed.

Recommendation 3.8
The Department of Economic and Rural Development and Tourism should implement a checklist to track the status of all information required in Industrial Expansion Fund letters of offer.

Recommendation 3.9
The Department of Economic and Rural Development and Tourism should develop processes to ensure that Industrial Expansion Fund loan repayments are on time.

Recommendation 3.10
The Department of Economic and Rural Development and Tourism should develop processes to identify and follow up Industrial Expansion Fund loans in arrears in a timely manner.

Recommendation 3.11
The Department of Economic and Rural Development and Tourism should determine the standard information which should be examined during Industrial Expansion Fund annual account reviews and develop a process to ensure this information is obtained and documented.

3.31 We selected a sample of five loans to determine if IEF was receiving the documentation required by the loan agreement. We found that required reports had not been received in a timely manner for two loans.

- In one instance, a business plan that was required by November 2010 had not been received as of February 2011. Additionally, the required quarterly financial statements had not been received for 2010.
- In another instance, required annual financial statements were not on file. IEF management informed us that the financial statements were reviewed online. However management has no evidence to support this.

3.32 Failure to ensure that required client reports are received in a timely manner could mean IEF management are unaware of client-related issues that may negatively impact loan repayment. As noted above, we have recommended that the Department establish a process to ensure information required by letters of offer is obtained and documented. In addition, management needs to follow up instances in which required information is not received and document steps taken in client files.

Recommendation 3.12
The Department of Economic and Rural Development and Tourism should document follow-up action in client files when information required by letters of offer is not received in a timely manner.

3.33 *Loans in arrears* – IEF has no documented policies to determine, assess and follow up loans in arrears. The arrears list is produced by manually entering information from the accounting system into a spreadsheet. Manual processes carry an increased risk of errors and there are no quality assurance processes in place to ensure the arrears report is accurate. In some instances, the report does not list the amount or date of the expected payment which could lead to an undetected late payment or underpayment. Additionally, IEF management has no evidence that this report is produced monthly.

3.34 In addition to the problems with the arrears report, there is no process to ensure loans in arrears are followed up in a timely manner.

3.35 We selected three loans identified as past due on IEF's arrears report. For two loans, there was no evidence on file to show whether investment managers had followed up with the recipient. This information was eventually provided to our staff from IEF management email accounts. The other loan did contain documentation of management's follow-up.

3.36 The lack of processes to ensure past due loans are followed up and funds collected means loans in arrears could go undetected. In recommendation 3.10 above, we have recommended that the Department address this situation.

Recommendation 3.13
The Department of Economic and Rural Development and Tourism should put processes in place to ensure an accurate monthly arrears report is prepared by Industrial Expansion Fund staff. This report should be signed off by senior management each month and historical copies should be retained in accordance with government records requirements.

3.37 *Loan/development incentive disbursements* – Once a loan or development incentive is approved, loan security and conditions are verified, either by IEF legal counsel or staff, before loans are disbursed. Disbursements must also be supported by a cheque requisition signed by the Minister, Deputy Minister and IEF management.

3.38 We tested seven loans which had been fully or partially disbursed. Loan security and conditions were verified prior to disbursement in all instances. All disbursements were supported by authorized cheque requisitions.

3.39 We also selected two development incentive disbursements and found payments were properly supported and authorized by cheque requisitions.

3.40 *Loan repayments* – NSBI staff are responsible for recording loan repayments received for IEF loans. We tested 10 IEF loan repayments and found that the payments were properly recorded.

3.41 *Legislative compliance* – IEF loans and investments are governed by the Industrial Development Act. The Act broadly defines the terms of financial assistance that IEF can offer; essentially financial assistance may be provided if the Minister deems it appropriate.

3.42 We tested 10 approved loans and four approved development incentives and found that all loans and development incentives tested complied with legislative requirements.

3.43 *Write-offs* – There is a process to recommend loans for write-off. On an annual basis, staff prepare information on loans which should be written

off. This report is signed by the Deputy Minister and the loans are part of a larger list of write-offs which are approved by Cabinet.

Overall Concerns

3.44 We are concerned by the systemic lack of documented policies, processes and basic program controls at IEF. The lack of a documented assessment process combined with the absence of readily available information to support investment recommendations means there is no assurance that IEF management recommends investments to Cabinet in a fair and consistent manner. As Cabinet relies on IEF to conduct necessary due diligence on prospective funding recipients, it is important for IEF to have stronger controls surrounding loan and development incentive assessment and approval. The only oversight of IEF transactions is by Cabinet. The question remains whether this provides adequate accountability for the management of public funds.

3.45 Additionally there are inadequate policies, processes and documentation supporting the management of assistance subsequent to approval. This includes monitoring and managing loan accounts, compliance with assistance conditions, and arrears.

3.46 Although NSBI and IEF are separate entities, both invest in businesses and assist with economic and business development in Nova Scotia. Unlike IEF, NSBI has well-established policies for lending and other activities. It also has a governance and oversight structure in place through its Board, which is responsible for reviewing and approving transactions over certain limits.

3.47 The Department of Economic and Rural Development and Tourism needs to significantly upgrade the administration of the Industrial Expansion Fund. An efficient way to accomplish this would be to transfer responsibility for the administration of the Industrial Expansion Fund to NSBI, since NSBI already has most required processes in place. Alternatively, IEF needs to implement a similar process to the one in place at NSBI. In order to achieve this, the Department needs to implement all of the recommendations in this Chapter.

Recommendation 3.14
The Department of Economic and Rural Development and Tourism should consider transferring the administration of the Industrial Expansion Fund to Nova Scotia Business Inc. to ensure appropriate governance, controls, and policies regarding transactions. Alternatively, the Department should implement a similar process with its own governance, controls and policies. This would be achieved by implementing all of the recommendations in this Chapter.

Nova Scotia Business Inc. (NSBI)

Conclusions and summary of observations

NSBI has adequate financial and program controls and appropriate documented policies and procedures for its lending, venture capital, and payroll rebate activities. These policies are adequate to ensure compliance with legislation and regulations. We found policies were followed in most instances. We did note one instance in which management could have provided more complete information to NSBI's Board regarding a policy issue for a loan approval. As we reported previously in our June 2010 Report, the accounting system is not producing a complete and accurate arrears listing. Manual processes are needed to correct the arrears report which increases the risk of errors.

3.48 *Loan approval* – NSBI has a documented system to receive, assess and approve loan applications. This system complies with legislation. Loans are approved at various levels of the organization based on the total amount of loans outstanding to the client. For example, loans valued up to $1.25 million are approved by the Investment Committee of the Board, between $1.25 million and $3 million must be approved by the Board, and loans in excess of $3 million are approved by the Governor-in-Council through an Order-in-Council.

3.49 We selected a sample of eight approved loans to test compliance with NSBI's policies and procedures; we noted one exception.

3.50 When assessing a potential loan, NSBI staff examine five risk elements. Current policy states that if one of these elements is assessed at maximum risk, the loan should not be approved. We found one instance in which a loan was approved despite one risk element rated at maximum. NSBI staff fully assessed the concerns related to this risk and determined that it was still appropriate to recommend to the Board that this loan be approved. The staff-prepared risk assessment, which identified all risks, was included in the proposal summary submitted to the Board; however the proposal did not specifically state that this loan did not comply with existing policy. Management should have ensured Board members were aware of this situation.

3.51 NSBI management informed us that they believe this policy should be updated to allow the Board to determine whether it might still be appropriate to provide a loan in certain situations where some risks are assessed as high. This change would make the loans policy consistent with NSBI's venture capital policies in this regard.

Recommendation 3.15
Nova Scotia Business Inc., in conjunction with its Board, should review and update loan policies and procedures as appropriate.

Recommendation 3.16
Nova Scotia Business Inc. should establish a process to ensure that any policy exceptions are separately identified to the approving authority (generally the Board or one of its Committees).

3.52 We tested five loan rejections and found all five loans were properly rejected according to policy.

3.53 *Legislative requirements* – NSBI's financial assistance is governed by the Nova Scotia Business Incorporated Act and the Nova Scotia Business Incorporated Financial Assistance Regulations. NSBI has detailed loan policies and procedures that are based on its statutory requirements.

3.54 We tested a sample of eight loans and found legislative requirements were followed in all instances.

3.55 *Loan repayments* – NSBI has appropriate, documented processes in place regarding the receipt and recording of loan payments. We tested 13 loan repayments and found the process was followed for all payments.

3.56 *Monitoring* – NSBI also has appropriate, documented processes in place to monitor the recipient's ongoing compliance with terms and conditions of loan agreements. At a minimum, there are annual reviews of financial statements and site visits. Although monthly arrears reports are also produced, as discussed below, there are concerns with the accuracy of these reports which may make them less useful from a monitoring prospective.

3.57 We selected 15 loan files to test for compliance with monitoring requirements. In one instance, the file did not contain the most recent audited financial statements. All remaining monitoring requirements were met for the sample tested.

3.58 *Arrears* – NSBI has an appropriate, documented process to identify loans in arrears and collect overdue amounts owing. We selected a sample of 10 loans in arrears and concluded that appropriate collection activities had been performed by NSBI staff.

3.59 As reported in Chapter 2 of our June 2010 Report, NSBI's accounting system does not produce a complete and accurate arrears listing. NSBI staff manually review arrears reports because the system doesn't include

loans with principal in arrears or loans which have only been partially disbursed. Manual processes carry a higher risk of error. Our previous Report identified instances in which these manual adjustments contained minor errors. To date, this situation has not been addressed and we have repeated our recommendation.

Recommendation 3.17
Nova Scotia Business Inc. should ensure the accounting system used for loans and other assistance can produce a complete and accurate listing of accounts in arrears.

3.60 *Venture capital approval* – NSBI has appropriate, documented processes for the receipt, assessment and approval of venture capital applications and purchase of equity investments that comply with legislation. Key controls include: review of opportunities with senior management; approval of investments up to $1.25 million by the Investment Committee of the Board; approval of investments between $1.25 million and $3 million by the Board; and approval of investments in excess of $3 million by the Governor-in-Council through Cabinet.

3.61 If an investment appears to be in accordance with NSBI's mandate, NSBI requests additional information from clients. Information requested is dependent upon the company and a list of requirements is tailored in each instance. Generally, NSBI reviews financial statements and technology and has discussions with staff, customers, and suppliers. Information is compiled to prepare the investment profile and evaluate against the equity investment criteria.

3.62 We tested a sample of two venture capital investments and noted that legislative requirements regarding purpose, eligibility, approval process, and terms and conditions were followed in both instances. We also tested two rejected venture capital applications and noted they were appropriately rejected as they did not meet eligibility requirements.

3.63 *Monitoring* – NSBI has appropriate, documented processes in place to monitor the recipient's ongoing compliance with terms and conditions of venture capital agreements. Generally, one member of NSBI management sits on the client's board for venture capital investments.

3.64 We tested five venture capital investments for compliance with the monitoring process and noted that all required monitoring activities had been performed.

3.65 *Payroll rebate approval* – NSBI has appropriate, documented processes in place for the receipt, assessment and approval of payroll rebate incentive applications, and to ensure compliance with legislation.

3.66 As previously reported, payroll rebate applications are processed by one of two divisions within NSBI depending on the type of assistance requested. In our June 2010 Report, we found that all practices for both types of rebates were not reflected in policy. We recommended that NSBI update its policies. NSBI now has two sets of policies in place that reflect both types of payroll rebates. Both systems are appropriate.

3.67 We tested 11 approved payroll rebate applications to ensure compliance with policies and procedures. We noted one instance in which projections and aged accounts receivable and payable listings were missing. In another instance, one file was missing a checklist.

ECONOMIC AND RURAL DEVELOPMENT AND TOURISM: FINANCIAL ASSISTANCE TO BUSINESSES THROUGH NSBI AND IEF

3.68 We selected four rejected business financing payroll rebate applications and noted they were appropriately rejected.

3.69 Investment attraction payroll rebates are used as an incentive to attract businesses to Nova Scotia. There is no application process; NSBI staff identify and negotiate with potential clients. If those negotiations are not successful, the rebate is not moved forward. We could not test unsuccessful investment attraction rebates because NSBI does not maintain a list of companies with whom negotiations were unsuccessful. It is important to maintain this information to track reasons for businesses not locating in Nova Scotia.

Recommendation 3.18
Nova Scotia Business Inc. should maintain a listing of investment attraction payroll rebates that did not move forward for approval.

3.70 *Payroll rebate payments* – NSBI has appropriate, documented processes in place to ensure compliance with terms and conditions of payroll rebate agreements before payroll rebate payments are made.

3.71 We tested a sample of 12 payroll rebate payments and found policies were followed in all instances.

APPENDIX I

June 2010 Report Recommendations

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.

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.

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.

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.

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.

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.

Response: Nova Scotia Business Inc.

Thank you for the opportunity to comment on the 2011 Auditor General's Report on Assistance to Business. Nova Scotia Business Inc. (NSBI) agrees with the report and its recommendations. NSBI is pleased that the report indicates that NSBI has adequate financial and program controls and appropriate documented policies and procedures. We strive to continue to improve our processes and would like to comment on the recommendations.

Recommendation 3.15
Nova Scotia Business Inc., in conjunction with its Board, should review and update loan policies and procedures as appropriate.

Response
NSBI agrees that the loan policies and procedures should be reviewed and updated as appropriate. All policies and procedures should be subject to a review based on changing circumstances and experience gained while the policies and procedures are in use. In the specific instance outlined in the report from the Auditor General NSBI believes its own policy was too rigid with respect to one risk component. The policy should continue to ensure that all relevant risks are assessed, but allow mitigating factors to also play a role in the assessment. In the specific case the policy did not allow for this consideration and the policy shall be updated accordingly.

Recommendation 3.16
Nova Scotia Business Inc. should establish a process to ensure that any policy exceptions are separately identified to the approving authority (generally the Board or one of its Committees).

Response
NSBI agrees with this recommendation. NSBI proposals generally outline any deviations from standard. There is also a compliance review. NSBI will take steps to ensure that exceptions are appropriately identified and not inadvertently missed.

Recommendation 3.17
Nova Scotia Business Inc. should ensure the accounting system used for loans and other assistance can produce a complete and accurate listing of accounts in arrears.

Response
NSBI agrees a system that does not require a manual review of arrears listings is the ideal solution. NSBI has commenced an assessment process and has explored some of the options available for loan portfolio systems. One consideration is that

NSBI has approximately 100 accounts, a relatively small number. The assessment must consider the appropriate use of public funds for this relatively small number of accounts.

While using the current system NSBI will continue with manual checks and balances. There is a monthly review by 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.

Recommendation 3.18
Nova Scotia Business Inc. should maintain a listing of investment attraction payroll rebates that did not move forward for approval.

Response
NSBI agrees with this recommendation. NSBI has always taken a proactive approach to its business development efforts and uses strong customer relationship processes with potential clients. While information related to the opportunities that did not lead to a company setting up operations in Nova Scotia exists there is no formal listing maintained. It will be relatively easy to track the few instances where NSBI may have lost business, but the difficulty will be in tracing business that may be lost before we are aware of the opportunity. NSBI does agree that maintaining such a list would provide benefit when assessing the effectiveness of the payroll rebate and the investment attraction process in general. NSBI will start maintaining this list.

Response: Department of Economic and Rural Development and Tourism

The Department of Economic and Rural Development and Tourism (ERDT) supports the recommendations made by the Office of the Auditor General (OAG) regarding management of the Industrial Expansion Fund (IEF).

While ERDT believes the compensatory controls and processes used to operate the IEF have been sufficient to manage the associated risks, and in particular with the addition of an independent advisory committee, ERDT will implement all OAG recommendations.

The OAG report notes that the IEF is compliant with the Industrial Development Act and that IEF approvals are consistent with legislative requirements.

The OAG acknowledges that an independent IEF Advisory Committee made up of prominent citizens has been established to provide confidential advice directly to the ERDT Minister, and through the Minister, to Cabinet.

Recommendations for IEF financial assistance are made to Cabinet through a Report and Recommendation (R&R) in substantially the same form as that provided to Cabinet by Nova Scotia Business Inc.

Since the OAG's June 2010 report:

1. IEF governance and oversight have been improved with the establishment of the independent IEF Advisory Committee made up Nova Scotians experienced in business and public policy.
2. A dedicated Financial Services Officer and administrative secretary were hired for the IEF in March, 2011.
3. An ERDT re-organization was announced in January, 2011; in part, this will result in a stronger Investment and Trade Branch, under a new Executive Director position.

Since June 2010, Investment staff have been working with the ERDT Measurement and Evaluation Team to develop a performance measurement framework for the IEF, to be piloted in Fiscal Year 2011-2012. The performance measurement framework is being undertaken in five steps:

1. Review of IEF goals.
2. Establish appropriate metrics. Measures are being developed in order to assess desired performance against the goals.
3. Understand performance. Assessment of desired performance with actual achievements.

4. Continuous improvement. Based on an understanding of performance, identify steps for further improvement.
5. Continue to review metrics and performance.

By design, the 2011 OAG review focuses on compliance accountability without a normative baseline. An average reader may incorrectly conclude that the IEF has not been a highly successful economic development tool for more than 50 years.

The IEF is not a standard loan entity and is designed to accommodate a large variety of economic development situations. The core staff of the IEF consists of five persons. One of the IEF's compensating controls is the daily engagement of IEF senior management in all IEF activities and functions.

The latest (2010) IEF annual report clearly outlines how decisions are made. The type of information collected is documented in the annual report under the "How decisions are made" section, and on the ERDT website (http://www.gov.ns.ca/econ/ief/decisions.asp).

Additionally:

- The IEF annual report includes audited financial statements; discloses write-offs and incentives earned; and provides the names of recipients and the purposes of the assistance provided.
    - An OIC, generally complemented by a news release, is published with each IEF transaction approved by Cabinet.
    - Over the past 25 years, the IEF has experienced a write-off rate of 2%, excellent results for an economic developmental portfolio.
    - An independent, external consultant was engaged to evaluate the effectiveness of both the IEF and NSBI. The 2008 report by Collins Management was positive.

The independent IEF Advisory Committee provides an impartial analysis of potential investments and provides advice directly to the ERDT Minister. Terms of reference for the committee have been developed and are available on the ERDT website, as is the current membership of the committee (http://www.gov.ns.ca/econ/ief/advisorycommittee/terms_of_reference.asp).

Members serve for a maximum three-year term. The committee meets with the Minister twice annually to provide general advice, as well as undertaking regularly scheduled conference calls to review potential IEF transactions. The committee reviews any transactions over $500,000 in value or any transaction that has an operating budget impact of more than $50,000.

RESPONSE: DEPARTMENT OF ECONOMIC AND RURAL DEVELOPMENT AND TOURISM

Proposed transactions are presented to the IEF Advisory Committee by ERDT's Investment staff. Staff presentations contain typical criteria by which to assess potential transactions:

- Company
- Nature of request
- Nature of business
- Purpose of request
- Relevant relationships (including nature of management, ownership, all current financial commitments to commercial, government, others)
- Proposed security
- Financial risk assessment
- Anticipated budget impacts to IEF
- Assessment of any other risk
- Summary of current situation for business

Investment staff respond to questions and observations from committee members, after which committee members provide their comments and assessment of the proposed transaction to staff and directly to the Minister through a confidential e-mail account. The information provided to the Advisory Committee is included as an appendix to the Report and Recommendation submitted to Cabinet.

Transaction risks are assessed by IEF staff and reviewed by the IEF Advisory Committee. The Cabinet is advised of the risks in the Report and Recommendation.

The IEF has been reviewed on many occasions. In his July 2010 report *"Invest More, Innovate More, Trade More, Learn More: The Way Ahead for Nova Scotia,"* Dr. Donald Savoie said:

> *"The differences between IEF and NSBI are sharp: IEF tends to focus on existing businesses in the province, relies on an assortment of instruments from cash incentives to loan guarantees, remains highly flexible to accommodate different circumstances, looks largely to the manufacturing sector, and continues to focus on both urban and rural Nova Scotia. In contrast, for the most part, NSBI looks to attract outside businesses to Nova Scotia, looks to payroll rebates as its key instrument, operates according to program guidelines, and looks mainly to the IT, financial, and aerospace sector. NSBI has a very low risk tolerance, while IEF is expected to respond quickly to emerging economic opportunities."*

Dr. Savoie went on to say:

> *"I can think of no better home for IEF than Economic and Rural Development (ERD). The goal is to build both ERD and NSBI's strengths. NSBI can never be the "only" economic development agency in Nova Scotia ... NSBI has a proven track record in marketing Nova Scotia and in pursuing and attracting business investments from outside the province. ERD, meanwhile, is connected to the business community in every community in the province through the province's political and public administration processes. It is no accident that when the government introduced the Manufacturing and Processing Investment Credit (now called the Productivity Investment Program), it was placed in ERD, not NSBI."*

He concludes: *"Managing the relationship between ERD and NSBI needs to rest on the recognition that both agencies have an important role to play in the economic development field..."*

ERDT will implement the recommendations from the Office of the Auditor General to further strengthen the position of the IEF within the economic development field in Nova Scotia.

4 Health and Wellness: Colchester Regional Hospital Replacement

Summary

The project to replace the Colchester Regional Hospital was approved in 2005 with a budget of $104 million. This budget was not a realistic estimate of the expected costs to build the new hospital and was not sufficient to complete construction. It was based on assumptions that were unreasonable or unsupported. It did not, for instance, consider inflation over the life of the project. The current budget of $184.6 million is still not complete; it excludes several items that should be part of the overall project budget.

The initial budget should have been considered to be only a preliminary spending approval. A schedule should have been put in place to revisit the budget regularly during construction to bring cost estimates up to date. It would then have been reasonable to expect those charged with oversight of the project to complete it within budget.

Supporting documentation prepared by the Department of Health and Wellness for Cabinet for the first budget and for two of the three subsequent budget approvals was incomplete and contained inaccuracies. The impact of this was to hinder effective decision making. While CEHHA were not involved in preparing the support, they agreed to the budgets submitted.

The new facility is over 100,000 square feet larger than the existing facility and is designed to offer more services to more people. However, there has been no analysis to determine whether additional funding will be required to operate the new facility at its intended capacity when it opens.

While ineffective budgeting practices were significant contributors to apparent cost increases, oversight and project management weaknesses by both CEHHA and Health have contributed to project difficulties and cost overruns. Some significant decisions were made without sufficient consideration of the related costs.

Since CEHHA had no experience with large construction projects, they hired a number of consultants to assist them. However, management and the Board should have more rigorously reviewed and challenged consultants' key estimates and decisions. Health had somewhat more experience but are also relying on an external consultant to manage the project for them. We have recommended responsibility for managing the construction of hospitals and other significant provincial buildings be assigned to a central government body with a high level of construction expertise.

4 Health and Wellness: Colchester Regional Hospital Replacement

Background

Project History

4.1 The existing Colchester Regional Hospital was built in 1965, while the annex building, which houses administration and mental health functions among others, was built in 1926. The facility is the oldest regional hospital in Nova Scotia. There were plans for a new inpatient tower and extensive renovations to the rest of the facility in 1985 but the project was canceled before significant work had been completed.

4.2 In 2001, government gave Colchester East Hants Health Authority (CEHHA) approval to complete a role study outlining the scope of services provided in the district and looking forward 10 to 15 years to identify future services. A role study considers district demographics and services offered in surrounding districts. It is the first step towards getting a significant capital project approved by the Department of Health and Wellness (Health).

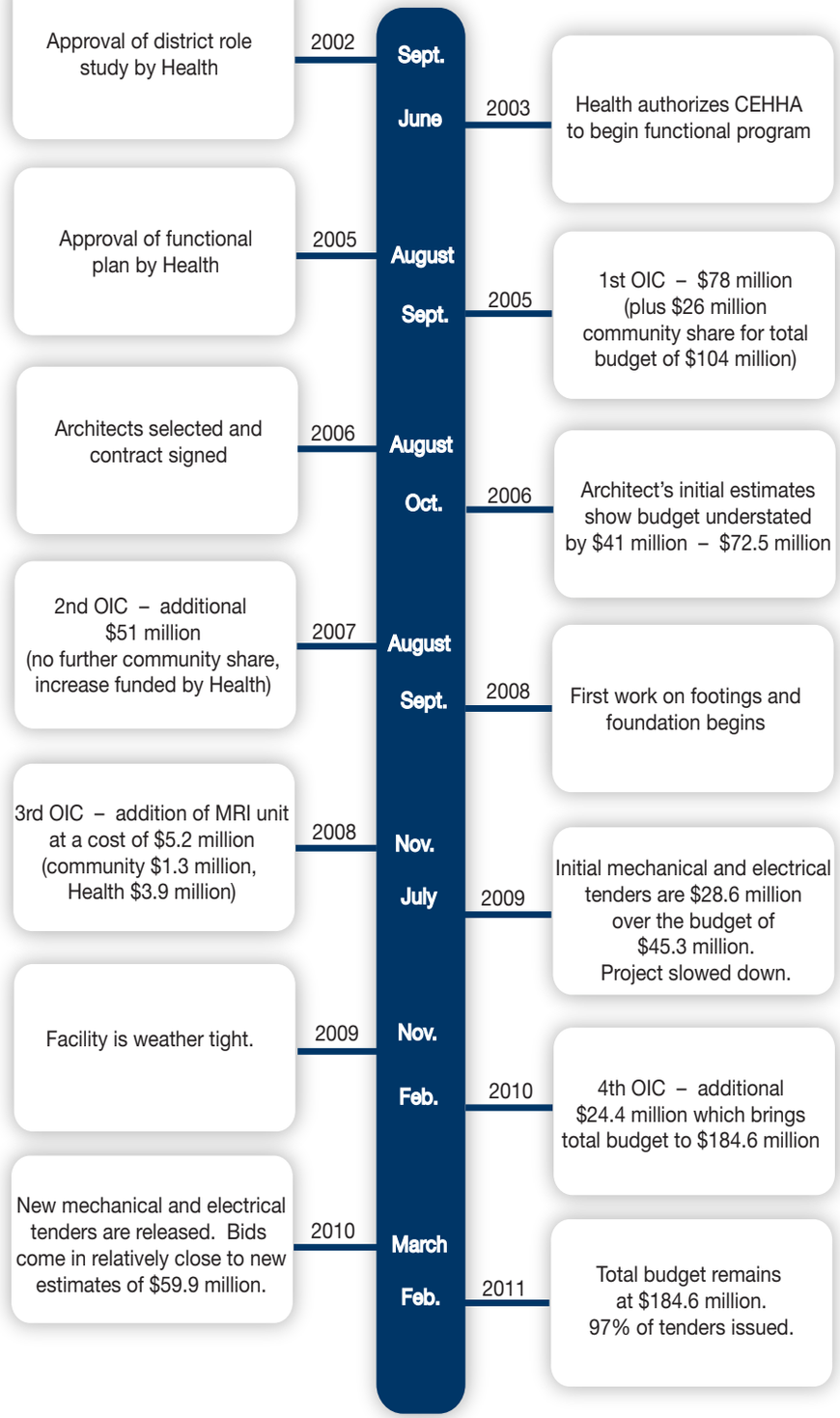
4.3 In September 2002, Health approved the role study. CEHHA started work on a master program and master plan outlining the programs and services to be offered in the new facility using narratives and basic drawings to describe the size, setup and location of departments within the building.

4.4 In June 2003, Health provided $1 million to allow CEHHA to proceed with a functional plan for the new facility as well as to start the site selection process and develop a schedule for project completion. A functional plan provides the details that will be required for an architect to design the building.

4.5 After various iterations of the functional plan, Health provided its final approval in August 2005. In September 2005, an Order-in-Council (OIC) approved $78 million in provincial money which, combined with the community commitment of $26 million, provided an initial project budget of $104 million.

4.6 CEHHA hired an internal project manager and a facilities planning director in early 2006. In August 2006, the lead architects were announced followed by the construction managers approximately one year later. In July 2007, the initial project manager resigned; an external project manager was hired in September. The official sod-turning was in October 2007.

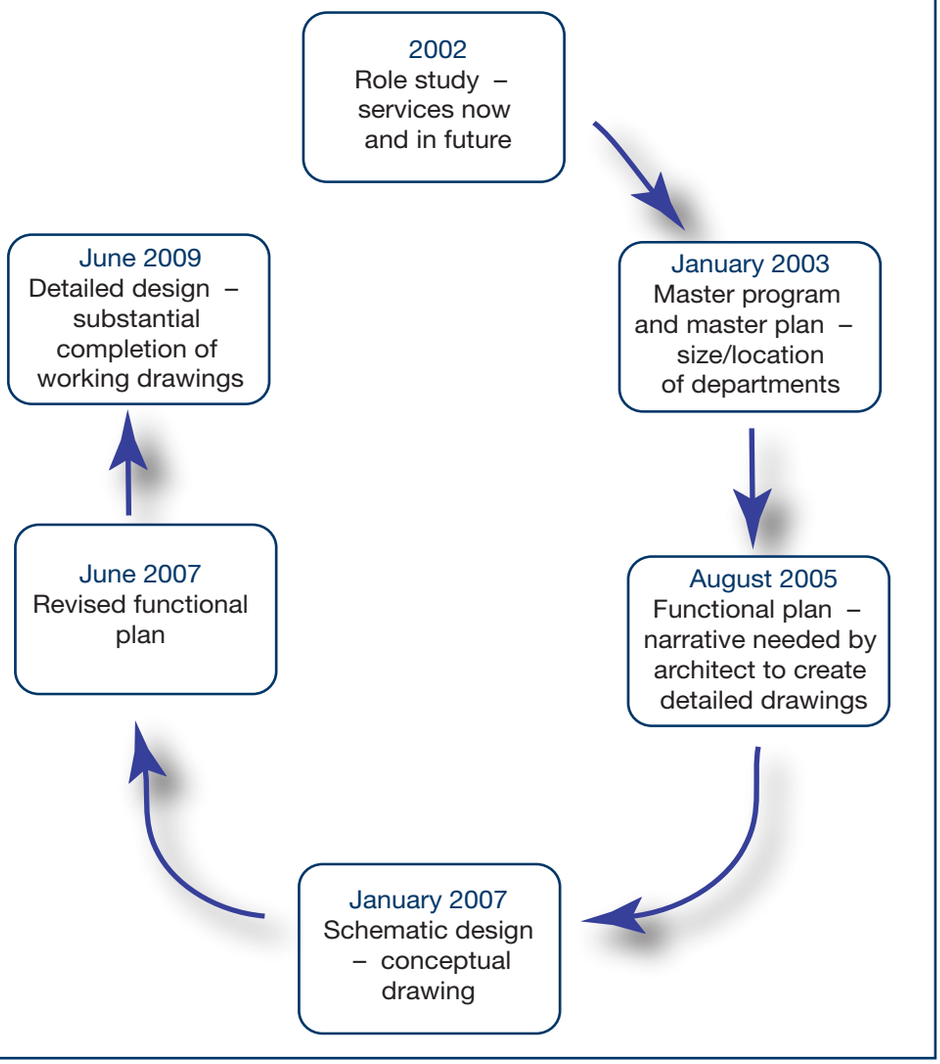
Colchester Regional Hospital Replacement Project Timeline



4.7 Once the design team began working with the functional plan, they soon identified that the existing project budget of $104 million would not be sufficient. The design team's initial estimates of the cost to construct the new hospital ranged from $145 million to $176.5 million. In March 2007, after ongoing negotiations, Health and CEHHA agreed to a budget of $163 million; this was further reduced to $155 million in June 2007. The $155 million budget was approved by Cabinet in August 2007. The province agreed to cover the entire $51 million increase in the project budget with no further funding required from the community.

4.8 The first approved design of the new facility was a schematic design (conceptual drawing) in January 2007. The detailed design development document was approved in April 2008. In September 2008, the first work on the footings and foundation began.

Key Design Stages



4.9 In November 2008, Cabinet approved the addition of an MRI to the new hospital. Original plans had included an MRI but it was removed prior to the second OIC. Since this was not part of the approved plan and work was underway, this addition required design changes. These changes plus the MRI equipment and installation added $5.2 million to the overall project cost.

4.10 In July 2009, when mechanical and electrical tenders closed, all the bids far exceeded the budgeted figures. The project slowed significantly until February 2010 when the most recent OIC was approved, adding another $24.4 million to the budget, bringing the current project budget to $184.6 million.

4.11 The new hospital was originally scheduled to open in 2010. At the time of our audit, 97% of construction tenders had been awarded; the hospital is scheduled to open its doors in the summer of 2012.

Audit Objectives and Scope

4.12 In March 2010, Treasury Board asked our Office to undertake an audit of the Colchester Regional Hospital replacement project. We started the audit in 2010 and finished in early 2011.

4.13 The audit was conducted in accordance with Sections 18, 21 and 22 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

4.14 The audit objectives were to assess:

- whether roles and responsibilities were clearly defined, documented and communicated at the start of the project;
- the adequacy of Health's oversight of the project;
- the adequacy of CEHHA's oversight of the project;
- the adequacy of processes used to determine and adjust budgets for the project;
- the adequacy of processes used to manage project costs;
- the adequacy of the project management framework used for the Colchester Regional Hospital replacement project;
- whether the project procurements were in compliance with the applicable Province of Nova Scotia Procurement Policy and CEHHA procurement policies;

- whether the overall procurement strategy was appropriate; and
- the adequacy of the process followed to prepare RFPs and award final tenders.

4.15 Certain of the audit criteria for this audit were obtained from the Project Management Body of Knowledge (PMBOK) while others were developed by our Office for this audit. While our office used PMBOK as a guide during our audit, CEHHA did not use PMBOK during the project, although CEHHA hired experienced project managers. The objectives and criteria were discussed with, and accepted as appropriate by, senior management at CEHHA and Health.

4.16 Our audit approach included examination of the project documentation and interviews. We met with management of CEHHA, their project managers, construction managers and the lead architects on the project. We also met extensively with Health staff and staff at CEHHA responsible for day-to-day operations of the project.

4.17 We wish to acknowledge the cooperation and efforts of staff at the Colchester East Hants Health Authority and at the Department of Health and Wellness, as well as their various consultants, for their help in completing this audit.

Significant Audit Observations

Budget Timing

Conclusions and summary of observations

The initial budget for the replacement hospital was prepared three years before detailed drawings of the facility were completed and several years before the planned opening date. At such an early stage, the total approved amount should be considered only an initial commitment to be finalized over time. Although it was clear this budget was not sufficient, it was used as the target to be achieved. Placing too much importance on this initial amount combined with incomplete and inadequate budgets as the project progressed created an unattainable target, thereby ensuring cost management processes could never be sufficient to keep the project on budget.

4.18 *Initial budget* – The initial $104 million budget was finalized in September 2005 when the expected completion date for the facility was 2009-10. At that point, CEHHA had an approved functional plan. A functional plan does not include any drawings. It provides narrative details for each room in the

new hospital and then adds a percentage to each room to determine the total departmental gross square feet. This total is multiplied by another grossing factor to determine the building gross square feet, which represents the full size of the facility. Finally, the building gross square feet is multiplied by the estimated cost per square foot to determine the total estimated cost of construction. Other amounts such as soft costs, including furniture and equipment and consultants fees, and contingencies are estimated as a percentage of the total construction budget.

4.19 The initial project budget was based on several estimates and rough concepts only with no drawings. These are standard practices in the construction industry and are used to establish preliminary project cost estimates. In this instance, the estimate was labeled as a project budget, but should not have been because the project was not far enough along. Starting from this point meant no cost control measures could ever be successful in keeping the project within the initial budget.

4.20 The documentation supporting the initial OIC request prepared for Cabinet did not adequately explain that these were merely preliminary estimates which would likely increase significantly over the life of the project. There were other deficiencies in the documents supporting the OICs which are discussed further in this Chapter.

4.21 Press releases from CEHHA following the approval and announcement of the funding included the following. "*The total project cost is about $104 million... After years of planning and consultation with our health-care team and communities, we finally have the commitment we need to bring this project to fruition*."

4.22 At this stage of planning a project, it should be made clear to Cabinet and to the general public that this is an initial commitment which will be reviewed in the future. There should be a schedule in place to revisit the overall budget to provide an opportunity to ensure planning is proceeding as intended and to update the project budget before construction begins. By updating the budget to ensure it is reasonable, management charged with oversight of the project can have a good understanding of the expected costs and can then be realistically expected to proceed within that budget.

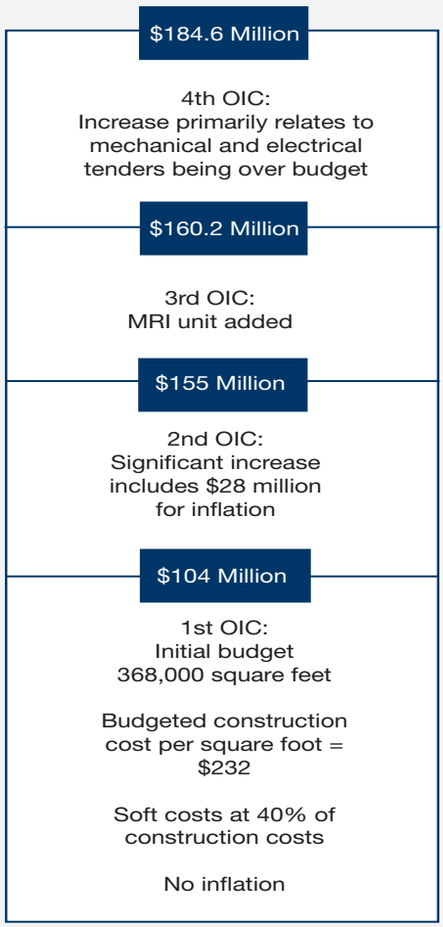
Recommendation 4.1
The Department of Health and Wellness should establish a schedule to review the preliminary budget and approve the final project totals for future capital projects.

Budget Inadequacies

Conclusions and summary of observations

The initial budget for the replacement hospital and subsequent increases which were approved by Cabinet over the life of the project were based on incomplete and inaccurate information. The initial budget lacked any estimates of potential inflation; it was never sufficient to build a new regional hospital. Subsequent budgets have been based on inaccurate information and commitments to reduce costs or facility size that have not always been carried forward to the actual construction. Ineffective budgeting practices have made it difficult to determine to what degree subsequent cost overruns may have been the result of management weaknesses, incomplete and inaccurate information, or unavoidable changes in the market or to building codes and standards. Further, there has been no assessment of the expected operating costs for the new facility. If CEHHA is unable to obtain increases in operating funding from Health, it may not be able to operate the new hospital at its intended capacity.

History of Cabinet Funding Approvals



First Order-in-Council

4.23 In September 2005, the first OIC request was approved providing funding for construction of a new regional hospital in CEHHA. This OIC committed government funding of $78 million, which represented 75% of the total project budget of $104 million. The remaining funding was to be provided by the community.

4.24 The $104 million budget was created through the functional planning process. The first draft of the functional plan included a budget of $126 million; both Health and CEHHA worked to reduce this amount before requesting Cabinet approval. A number of key items were taken out to move from $126 million to $104 million.

- Inflation ($8 million) – Construction cost estimates were presented in current-day dollars with no efforts to estimate construction inflation in the coming years.
- Physician offices ($2.5 million) – Costs to build onsite offices for physicians were removed. However, CEHHA still intended to include this space in the facility and asked Health to allow CEHHA to get an external loan to cover these costs.
- Physical plant ($4 million) – The cost of the physical plant for the new hospital was removed without a realistic alternative in place.
- Space contingencies ($2 million) – Health told CEHHA to remove all space contingencies from the budget, leaving no margin for error when designs were developed from preliminary drawings.

4.25 These decisions ultimately made the initial approved budget a meaningless number for planning purposes. Our concerns are discussed in more detail below.

4.26 *Construction inflation* – Health told CEHHA to remove inflation; this meant the project budget request to Cabinet was in current day dollars (2005). This appears to have resulted in a budget reduction of approximately $8 million, or 6.3%.

4.27 Inflation is likely to be a significant factor on a large construction project. The time frames involved are typically very long and costs increase over time. The original projected completion date was 2009-10, so this project was expected to take at least four years.

4.28 The final version of the functional plan approved by CEHHA and Health contains the following note.

> *"The Department of Health has recommended that the Health Authority submit the project budget using the cost of construction as of October 2005. Currently the project cost is estimated to the mid-point of the project (October, 2007). If the cost of construction as of October 2005 is used and no escalation is allowed for, the project budget would not be sufficient to complete the project. Additional information is required from the Department prior to proceeding with this."*

4.29 It is clear CEHHA and Health were both aware that removing inflation would mean the approved budget would not be sufficient to build a new hospital. However there were no plans as to how this issue would be handled in the future.

4.30 The information prepared for Cabinet supporting the OIC request clearly states inflation was not included. The document states that these costs are based on January 2005 dollars and may be impacted by future CPI and possible construction industry increases.

4.31 While this information is technically accurate, it is understating the situation to suggest that the costs may be impacted. Annual inflation in Nova Scotia had averaged just over 2% annually for the previous decade and had never been negative. It was clear that costs were going to increase. Additionally, Health was aware that the preliminary budget had included $8 million for inflation which was removed before asking Cabinet to approve the initial budget. Inflation represented a potentially significant increase to the approved budget and should have been estimated. Ultimately, the second OIC approved just two years later included $28 million for inflation.

4.32 *Physician offices* – The original plans for the new hospital included $2.5 million for office space that physicians currently renting space elsewhere could then rent from CEHHA. This was removed from the initial budget presented to Cabinet. At that time, CEHHA still intended to build space for physician offices. Management planned to ask Health to grant approval for CEHHA to obtain an external loan to cover the associated costs.

4.33 The documentation prepared for Cabinet did not indicate that the plans still included physician office space. There was no indication that CEHHA was seeking to have this space funded through an external loan. Ultimately the funding would still impact the overall cost of the facility and the province's financial statements but the documentation given to Cabinet did not contain this information. Subsequently, Health rejected CEHHA's request and the plan to include physician offices within the new facility was canceled.

4.34 *Physical plant* – CEHHA management hoped to find an external firm to build a physical plant and sell electricity to CEHHA for the new hospital as well as sell any excess to the power company. This would mean that the new hospital would not require its own physical plant. The $4 million cost of the plant was removed from the original budget before it was presented to Cabinet for approval. However at that time, there were no firm plans to achieve this, although CEHHA management informed us they had talked with one firm about pursuing this option. Ultimately, CEHHA was not able to find a company to agree to participate and although alternative options were explored, the physical plant funding was added back to the project in the second OIC. Cabinet should have been made aware that amounts had been removed from the initial budget without detailed plans to achieve the cost reduction.

4.35 *Space contingencies* – As part of the effort to reduce the initial estimate from $126 million to $104 million, Health asked CEHHA to remove all space contingencies from the budget. The first draft of the budget included $2 million to address any extra square footage required to cover unexpected changes to plans or requirements. At this stage of the process, there were no drawings of the facility, only the functional plan, which estimated the new facility at around 368,000 square feet. Buildings of that size should allow for possible changes during preliminary planning; space contingencies should not have been removed to achieve the desired budget amount. Doing so represented a significant risk to the project and the documents supporting the OIC should have identified this risk so that Cabinet would have a full understanding of the initial budget proposal.

4.36 *Impact of initial budgets* – By removing inflation estimates and space contingencies, as well as making further cost reductions with no concrete plans to achieve these goals, CEHHA and Health created an unrealistic budget which both parties should have known was not achievable. We do not know why they agreed to move forward with the project based on an understated budget of $104 million. This action did not demonstrate appropriate fiscal responsibility and accountability by either party.

Second Order-in-Council

4.37 Subsequent to the original OIC, a design team was selected in August 2006. That team prepared new budgets based on initial concepts for the new hospital. These budgets were presented to CEHHA in the fall of 2006. The revised estimated project cost was between $145 million and $176.5 million; making clear the inadequacy of the initial $104 million budget. Over the next year Health and CEHHA reviewed these estimates and negotiated in an attempt to reach a mutually agreed upon budget.

4.38 In March 2007, Health and CEHHA agreed to a budget of $163 million; however this option was never presented to Cabinet. Finally in August 2007, CEHHA and Health agreed on a budget of $155 million and a second OIC was approved. This OIC provided an additional $51 million in funding from the province. We also identified a number of issues with the supporting information presented to Cabinet with this budget.

4.39 *Hospital size* – The documentation prepared for Cabinet stated the new hospital would be reduced by 28,000 square feet. This would have resulted in a final facility size of around 340,000 square feet. The actual size is 384,000 square feet.

4.40 Subsequent to the OIC, Health approved a size increase to the facility of approximately 7,100 square feet to provide space for an MRI and to enclose certain areas with exterior walls. CEHHA management informed us that differences in how the facility is measured also represented an additional 8,500 square feet. However, together these changes only comprise around 16,000 square feet.

4.41 CEHHA provided evidence showing they identified a number of areas to reduce the size of the various departments in the new hospital in response to the commitment in the second OIC. Even with the increases in space and measurement differences discussed above, these changes should have resulted in a reduction to the total building size of over 19,000 square feet. The actual size is almost 384,000 square feet, 44,000 square feet larger than the size approved by Cabinet.

4.42 As discussed earlier, departmental gross square feet is multiplied by a grossing factor to allow items such as hallways, plumbing and electrical, to determine building gross square feet. The grossing factor used for the early estimates on this project proved to be too low. Over the life of the project to date, CEHHA has increased this grossing factor from 25% to 30%; the actual final figure is approximately 45%. While departmental useful space was reduced in response to the commitment in the second OIC, the grossing factor in use at that time was so inadequate that the overall size of the hospital actually increased. This is discussed further in the project management and oversight section later in this Chapter.

4.43 Using a grossing factor which was too low meant that the budget of $155 million was once again insufficient. Once an adequate grossing factor was used, a larger hospital had to be built than originally anticipated and this impacted the cost of the facility.

4.44 As discussed later in this Chapter, CEHHA did not analyze the grossing factor and was not monitoring its impact on the budget. This lack of oversight meant the attempt to achieve a significant reduction in space only

managed to reduce the usable space in the hospital while the total size, and overall costs, actually increased.

4.45 *Furniture and equipment* – When CEHHA agreed to the $155 million budget, management suggested that if they came in under budget, they would use the remaining budget funds to purchase furniture and equipment. An email from CEHHA to Health stated *"The concern with this would be the ability to equip and furnish the building with $15,300,000. This only represents 10% of the total project cost when most are between 15 and 20%."* Ultimately, the budget for furniture and equipment was approximately 12% of the total budget approved in the second OIC. Subsequent to approval of the second budget, Health have provided $3.3 million in funding for new equipment at the Colchester Regional Hospital. This new equipment will reduce the gap as it existed at the time of this OIC.

4.46 The current furniture and equipment budget is still approximately $4 million less than estimated requirements, even considering capital equipment purchases as noted in the previous paragraph. In order to help mitigate the gap in the equipment budget, CEHHA proposed a number of changes which would result in transferring some capital costs to future budgets by taking more furniture and equipment from the existing hospital when they move to the new facility. Management hopes to replace the older furniture and equipment over time through capital funding from Health or through CEHHA's Foundation. However there is no plan showing how this will be achieved or whether it is even possible.

4.47 *Information prepared for Cabinet* – The documentation prepared for Cabinet to support the second OIC request addressed why the budget needed to increase from $104 million to $155 million. The largest identified increase was $28 million as a result of inflation. This was excluded from the initial budget. Space contingencies had also been removed from the initial budget; these were still not reflected in this budget.

4.48 We identified two significant inaccuracies in the documentation supporting the second OIC request prepared for Cabinet by the Department of Health and Wellness.

- Site preparation costs – The documentation indicated part of the budget increase was to cover $10 million in additional costs for site preparation because the site had not been selected at the time of the original OIC. This statement was wrong; the site was selected and publicly announced in February 2005, more than six months before the first OIC was approved.

- Physical plant – The documentation also noted an additional $3.3 million was required because Truro had canceled plans to build a

heating plant. At the time of the original budget, CEHHA removed $4 million in hopes they could find a private company partner to build their physical plant. Subsequent to that decision, Truro considered its own plant but decided not to move forward with this project. It is not accurate to say that Truro's decision to cancel its plans caused an increase to the budget for the new hospital. The increase to the budget was required because CEHHA and Health agreed to remove the line item from the original budget without any formal plan or analysis to address how this cost reduction would be achieved.

Third Order-in-Council

4.49 In November 2008, Cabinet approved the addition of an MRI unit to the new hospital. An MRI had been in the original plans, but was removed prior to the second OIC. This increased the total hospital budget by $5.2 million. The approval was for an additional $3.9 million in government funding, with the remaining $1.3 million coming from community funding.

Fourth Order-in-Council

4.50 As part of the second budget, CEHHA had estimated total mechanical and electrical costs at $45.3 million. In July 2009, the mechanical and electrical tenders for the new hospital closed. The lowest bids totaled $73.9 million, $28.6 million more than CEHHA's estimate. Management concluded the tenders could not be awarded because there was such a significant difference between the bids and estimated costs. The project slowed down significantly for nine months while an extensive review of the tenders was completed and a variety of explanations were presented for cost overruns. These are discussed further below.

4.51 In February 2010, a fourth OIC was issued in which Cabinet approved an additional $24.4 million in funding, bringing the total project budget to $184.6 million. The $24.4 million increase resulted from mechanical and electrical tender overages offset by cost savings identified in other areas.

4.52 *Changes to design* – After the initial tender, a cost consulting firm was hired to provide an analysis of the changes between the plans included as part of the tender packages and those originally approved at the design development stage (conceptual drawings, no detailed drawings yet). They identified a significant increase in the size of the facility (discussed earlier in this Chapter) along with numerous items which had changed or which were added to the plans subsequent to the completion of the design development document. These changes often result from changes to code or standards, or may simply be due to a change in plans by the owner. In this instance, changes included items such as a significant increase in the

number of plumbing fixtures and doubling of feeders to electrical panels, and led to approximately $19 million or two-thirds of the $28.6 million in cost overruns.

4.53 Construction projects generally have cost estimates when final design documents are 30%, 60% and 90% complete. This allows project owners to identify significant items or cost changes which may not have been included in early design documents. CEHHA chose not to prepare cost estimates at the 30% or 60% completion stages of the project. Instead, estimates were prepared at the schematic design stage before any detailed drawings are completed. There were no further estimates until the pre-tender, or 90% complete stage when detailed drawings are near or at completion.

4.54 The changes identified by the cost consultants illustrate the need for regular estimates during the design process. While these changes may have been necessary, their impact should have been identified earlier in the design stage and should not have been a surprise to CEHHA when the tenders closed. Had these estimates been completed earlier, bid results might have been expected and it may not have been necessary to slow the project down for nine months in mid-construction; changes may have been identified early enough to avoid delays.

4.55 *Tender document completeness* – We have concerns regarding whether the original tender documentation provided to potential bidders was complete. 394 pages of addenda, with changes, were issued subsequent to the public release of the tenders. In a July 2008 status report, the project manager noted concerns regarding the timeliness of the architect's delivery of review documents related to tenders, and the possible impact this could have on the volume of addenda required for tenders and potential change orders once contracts were awarded. The volume of additions and changes may have meant uncertainty for the bidders, causing them to build some contingencies into their bids in case they had missed anything significant in all of the changes.

4.56 *Market conditions* – We realize the market was going through a period of high inflation and that this contributed to the cost increase. CEHHA management attributes much of the significant cost increase in mechanical and electrical tenders to changes in the construction market at the time. Management provided external support for the change in the market rates which showed growth in mechanical and electrical costs averaged around 8% from 2006 through 2009. This growth spiked to 28.5% in 2010, which would represent market costs around the time of the mechanical and electrical tenders. These changes are still not sufficient to explain the cost overruns experienced on the tenders.

4.57 It would be reasonable to assume the mechanical and electrical budgets considered the annual growth of 8%, leaving an unexpected increase of approximately 20.5% to impact the tenders. The original budget for the tenders was $45.3 million. An unexpected market fluctuation of 20.5% would result in an increase of just over $9 million. Even if the entire 28.5% market increase is considered, the impact would only be $13 million. The lowest bids from the tenders exceeded budget by $28 million. This leaves at least $15 million of unexplained budget overruns caused by other factors.

4.58 As discussed earlier, a post-tender review identified $19 million in increases to the project scope from the design development estimates, which were used to develop the budget. Management informed us they believe the pre-tender estimates identified all of the scope changes considered in the post-tender review and that the significant budget overruns on the mechanical and electrical tenders resulted from changes in market rates or inflation.

4.59 Before releasing the tender for bids, CEHHA had to get the Department of Health and Wellness to approve the pre-tender estimates. The documents CEHHA submitted for this approval identified $1.1 million in project scope changes; none of the significant items which comprised the $19 million identified in the post-tender review were noted. It appears that the pre-tender estimate failed to identify significant changes from the design development stage when there were no detailed drawings. As a result, the bids submitted were far over budget.

4.60 CEHHA management have acknowledged that there were some errors in the pre-tender estimates; however as previously stated, they informed us they believe the major impact on the mechanical and electrical tenders was due to inflation. The evidence which management provided during the audit shows there were significant other factors involved; at most inflation or market conditions contributed to approximately $13 million or 46% of the cost overruns.

4.61 C*osts of the delay* – The final OIC request included $3.9 million to cover costs associated with the project delay while tender results were evaluated and solutions sought. These costs include monthly costs to employ the various consultants on the project as well as claims for extra costs due to delays from consultants who were unable to proceed with their work during the delay.

4.62 *Additional items* – $1.8 million for previously unfunded items was also included in the fourth OIC. These items, such as the final fit out of the cafeteria, were either not identified previously or had been excluded in the hope of finding an alternative funding solution.

4.63 *Savings identified* – Documents supporting the final OIC also showed that CEHHA had identified a number of areas in which they could reduce costs. The total for these reductions was around $10 million, consisting of:

- $1.4 million through value engineering changes;
- $6.6 million through budget reallocations; and
- $2 million through reductions to furniture and equipment.

4.64 Our concerns with the value engineering process on this project and the current furniture and equipment budget are discussed elsewhere in this Chapter.

4.65 The $6.6 million reduction through budget reallocations is to be achieved by using existing contingencies to offset some of the budget overruns. Since most work has been tendered and construction is well underway, this is a reasonable approach.

Concerns with Current Budget

4.66 *Background* – The current budget is missing a number of items which will ultimately make it inadequate and will likely require more funding in the future. These issues are discussed further in the following paragraphs.

4.67 *Demolition costs* – $1 million to demolish the existing hospital was removed from the budget prior to the second OIC. CEHHA management informed us that they hope to sell the building but there has been no formal valuation of the building or surrounding land, and CEHHA management have not yet taken any action to start this process. They also acknowledged a building sale is not likely. If CEHHA is not able to sell the old hospital, management plan to use capital funding to cover demolition costs in the year the building is torn down. This may have an impact on the hospital's capital budget in that year.

4.68 *Furniture and equipment budget* – CEHHA management have lists of furniture and equipment requirements for the new hospital. The current furniture and equipment budget is approximately $4 million less than expected costs. The only mitigation plan in place at the time of our audit was to take much of the furniture from the existing hospital and to replace it as possible through annual capital budgets going forward. This will help ensure the equipment in the new facility meets estimated requirements and will only compromise on the furniture. CEHHA management have not prepared a detailed schedule showing which furniture can be reused, but there are detailed listings of the equipment required for the new facility.

4.69 *Operating costs* – Throughout the project, Health has reiterated that this is a replacement facility and there are to be no additional services or operating costs for the new hospital. The current budget includes $1.9 million to cover increased costs for the provision of environmental services and plant operations for a much larger building than the present facility. CEHHA has also received subsequent approval for some new programs, such as urology, which will be offered at the new hospital.

4.70 The supporting documentation for the first OIC request notes that the new facility is intended to offer some services which cannot be offered currently due to the size of the existing hospital. It also states that the new hospital should relieve some pressure from CEHHA residents seeking services in the Capital District Health Authority. When these comments are considered together, it is clear that CEHHA planned to offer more services to more people and cannot reasonably do so without any increase in operating costs.

4.71 Compounding this issue is the fact that there has been no analysis or review to determine what the operating costs of the new facility are likely to be. The existing hospital is 45 years old with some services being offered in an 85 year old annex. The total square footage of the current facility is approximately 260,000 square feet. The new facility is over 100,000 square feet larger and has a more spread-out design, yet no analysis has been done to determine whether the new facility can be operated at its intended capacity when it opens.

4.72 It is important for both Health and CEHHA to know the costs of operating the new facility. Health needs a plan to either provide the required funding or reduce services; CEHHA needs to know what funding is going to be available and prepare mitigation strategies as necessary.

Recommendation 4.2
The Department of Health and Wellness and Colchester East Hants Health Authority should prepare a comprehensive assessment of the funding required to operate the new facility at its intended capacity and agree on the level of funding to be provided.

4.73 Throughout this section, we have identified a number of instances in which information the Department of Health and Wellness prepared for Cabinet was inaccurate or incomplete. It is the Department's responsibility to provide Cabinet with complete and accurate information so that Cabinet has all the information it needs to make decisions.

Recommendation 4.3
The Department of Health and Wellness should put a process in place to ensure only complete and accurate information is presented to Cabinet.

Project Management and Oversight

Conclusions and summary of observations

We have identified significant weaknesses in the management and oversight of this project. Estimates included in the original budgets were not adequately supported. The cost per square foot used to prepare the initial budget was based on the costs of another facility but no assessment was done to ensure the two hospitals were comparable. The final design of the hospital is different from what was originally planned and is fairly complex, yet there was very little information to support this final design selection and costs of various design options were not considered. Monitoring and estimating during the design stage were not adequate. All of these issues led to changes to the intended scope without Health and CEHHA management realizing the full impact on the project.

4.74 *Background* – A large construction project such as the new hospital requires a strong project management framework and significant oversight efforts to identify risks, ensure costs and time budgets are managed, and to mitigate problems when they occur. Detailed roles and responsibilities for Health and CEHHA were not clearly defined and communicated at the start of this project. During the project, Health brought in a capital spending manual which defines high-level roles for capital projects. Although high-level roles and responsibilities were understood by both Health and CEHHA at the start of the project, we identified a number of issues which led us to conclude oversight by both parties was inadequate. Similarly, CEHHA has a project management framework which on the surface appears adequate; however, the significant issues identified throughout this Chapter indicate there were weaknesses in the management of this project. These matters are discussed further in the following paragraphs.

4.75 *Grossing factor* – Before detailed design documents are prepared, large construction projects need estimates of the total required square feet. This process starts by determining the space for each room and adding these together to help determine total requirements or departmental gross square feet. Space needed for common areas such as hallways and stairwells as well as mechanical and electrical items such as ducts and plumbing must also be estimated. This is accomplished by multiplying departmental gross square feet by a grossing factor to estimate the increased space needed and to determine the total estimated building size or building gross square feet.

4.76 The original budget for the new hospital was determined using a grossing factor of 25% of departmental gross square footage requirements. This was increased to 30% in the second approved budget; the actual is approximately 45%. It is clear that the original 25% was not a realistic estimate. The new hospital is 384,000 square feet, of which approximately 118,000 is for areas such as hallways, stairwells and space for mechanical and electrical requirements such as ducts and piping. This also suggests the possibility that the design of the new facility may not be the most efficient as this represents almost one-third of the hospital.

4.77 The grossing factors of 25% and 30% were both based on recommendations from CEHHA's consultants. Management did not request any support for these factors nor did management have a plan to review whether the grossing factor needed to be updated over the life of the project.

4.78 The shape of a building can have a significant impact on the grossing factor and resulting costs of construction. In this case the new hospital has been designed as a spread-out, low-storey building. This results in a large amount of wall and roof space which can cause the grossing factor to increase. The initial grossing factor was based on a plan for a relatively simple design, and was not reviewed or revised to reflect the design which was selected. Design decisions should be made in concert with a review of the grossing factor to ensure they do not have a significant negative impact on the project costs. CEHHA management informed us that their architects felt the design was cost efficient, but no evidence was provided to support this and no analysis was requested by management to substantiate this claim.

Recommendation 4.4
The Department of Health and Wellness should put a process in place to ensure management in charge of significant capital projects complete an adequate review and challenge of key estimates prepared by consultants.

Recommendation 4.5
The Department of Health and Wellness should put a process in place to require regular reviews of grossing factor estimates at significant stages of large construction projects.

4.79 *Soft cost contingencies* – Soft costs are those not directly attributable to constructing the building and are typically estimated early in the project based on a percentage of the expected construction costs. Soft costs would generally include design fees, scope contingencies and the cost of the various consultants required to manage the project. The original budget approval included a soft cost contingency of 40% or approximately $30 million. This figure was prepared by the consultant responsible for the

functional plan and CEHHA management did not request any support or assess it for reasonableness. Management should have tried to obtain an understanding of the rationale for such a significant project cost.

4.80 Currently, soft costs are running at approximately 40% of project costs, which indicates the consultants' estimate was reasonably accurate. However it is still important for parties responsible for oversight to have an adequate understanding of how soft costs were estimated.

4.81 *Cost per square foot* – A significant driver of early construction estimates is an overall cost per square foot. The initial budget for the new hospital was based on the cost per square foot of the new Amherst hospital which opened in 2002. While this was the most recent hospital construction project in Nova Scotia, three years had passed when the first budget for the Colchester Regional Hospital was prepared. The cost per square foot of the Amherst facility was increased by 1.9% per year to calculate the amount used in the initial budget. As discussed earlier, the initial approved budget did not include inflation over the construction period. The initial budget was based on a cost of $232 per square foot. The current cost per square foot for the actual construction is $358. This difference is the result of a number of factors, such as gross up to determine space requirements, design decisions and market inflation.

4.82 CEHHA management informed us they felt the Amherst facility had been a reasonable comparison due to the similarities between the two facilities. No formal analysis was prepared to compare the two hospitals to ensure the comparison was appropriate. The Amherst hospital is around 160,000 square feet while the Colchester replacement hospital is 384,000 square feet. Given the relative size of the two facilities and the differences in the size of the communities they serve, it would be appropriate to have a more thorough analysis showing the two are reasonable comparatives for construction costs. In this case, both CEHHA and Health failed in their respective oversight roles because they did not ensure the figure used was appropriate.

4.83 *Design changes* – Support for the initial OIC indicated the new hospital would be comprised of two buildings. One building was to house the health care facility, while the second would be for administrative functions. The information prepared for Cabinet noted that moving the administration functions into a separate building would reduce the construction costs of the administration building by approximately 60% compared to those for a health care facility due to reduced standards and requirements. At this stage, there were no drawings of the proposed facility.

4.84 In 2006, when the architects presented CEHHA with their suggested designs for the building, they recommended a single building approach with three

wings. The architects gave a presentation to project management outlining four options and recommending the three-wing approach that was selected. No mention was made of the two-building approach originally planned. Three of the four options were variations of the three-wing layout and the fourth option was a high-rise building. There was no analysis of how these approaches compared to the original intended design, nor was there an explanation for why the original plans were changed.

Aerial View of New Hospital – March 2010



Source: Colchester East Hants Health Authority

4.85 The architects' presentation provided pros and cons for each option. All of the options offered opportunities for future expansion. Most of the pros and cons listed appeared reasonable with one exception. The discussion of the high-rise option noted that necessary adjacencies, meaning keeping interdependent departments close together, could not be achieved. Intuitively the use of elevators would suggest that adjacencies would be possible to facilitate regardless of the shape of the building. Management informed us they were trying to minimize the risks of dependency on elevators.

4.86 The presentation did not discuss the potential costs of any of the alternatives. CEHHA management informed us they did not consider the impact on costs of the various design options. One specific impact of this decision was moving administrative functions back into the main hospital building. The second approved budget included an increase of $4.5 million related to this design change.

4.87 Both CEHHA and Health should have considered the impact on costs when approving the design for the new hospital. Failure to obtain any information regarding the cost of each option and failure to assess the change from the original approved approach represent a significant breakdown in the oversight function for this project.

4.88 Overall, there are certain aspects to the building design which cause concern. It is usually more expensive to build a spread-out facility with more wall and roof space than to build a simpler, square facility, meaning that the more elaborate design may have contributed to the increase in the grossing factor to 45% or almost one-third of the building.

4.89 The entry way and the three-storey, glass-walled cafeteria are also examples of design features which while esthetic, may be needlessly expensive. The cafeteria has been the subject of many discussions, and early value engineering processes suggested not completing this. In an explanation for rejecting one suggestion not to complete the cafeteria as designed, the architect is quoted as saying: "*Esthetic impact in that this space is the first space you see as you approach the facility – design intent was that it was to represent the gathering place (similar to a Maritime kitchen).*"

4.90 Decisions regarding overall design should have considered the costs of various alternatives.

Recommendation 4.6
The Department of Health and Wellness should put a process in place to ensure design decisions are made with due consideration of the impact on costs for future construction projects.

4.91 *Leadership in Energy and Environmental Design (LEED) certification* – LEED is an internationally recognized green building certification system. There are varying levels of certification, based on accumulating points for certain standards or approaches in constructing or operating a building. Silver certification was the original objective of the replacement hospital.

4.92 Specific funding for LEED was removed prior to the first budget but $3 million was added back to pursue LEED Silver according to the details behind the second budget. Shortly after the second OIC was approved, project management, which included CEHHA management and Board members along with Department of Health and Wellness management, decided they would not pursue LEED Silver, but instead would simply seek LEED certification. CEHHA management informed us that this decision included an agreement they would no longer spend any money pursuing LEED points. This effectively moved the $3 million in funding approved for LEED Silver certification to the rest of the project.

4.93 CEHHA management attempted to identify the potential costs of seeking LEED points near the start of the project; costs of LEED certification have not been tracked over the course of the project. Management informed us they cannot differentiate money spent on good building practices from costs to achieve LEED. Without any tracking, it is impossible to determine whether the commitment not to spend money on LEED certification has been met.

4.94 We are not suggesting that environmentally friendly buildings are not an appropriate goal. However, pursuing LEED certification without any consideration of the costs of doing so does not demonstrate responsible project oversight.

4.95 This is another example of a decision which was made without adequate consideration of the costs involved.

Recommendation 4.7
The Department of Health and Wellness should put a process in place to ensure decisions to seek LEED certification for construction projects are supported by an analysis of the costs. Costs should then be tracked over the life of the project.

4.96 *Value engineering* – Value engineering is a common process on construction projects to identify areas in which better value could be achieved without compromising construction quality or changing the intended use of the facility.

4.97 Although there was a value engineering process completed on the replacement hospital, we identified significant issues with this process. We examined the value engineering logs and found little support for the decisions reached. Many items did not have dollar values assigned to them. Without knowing how much a change will either cost or save the project, it is impossible to make appropriate decisions or to complete the degree of oversight that should be in place for a project of this size.

4.98 *Change management* – Change management is also a routine part of a large construction project. Changes occur for any number of valid reasons. Change order management is a key factor in controlling budgets, because while many changes are needed, not all suggestions are required and some may increase project costs unnecessarily.

4.99 We found CEHHA's change order policies and procedures were adequate. We tested 30 change orders, and found some minor deficiencies in which established processes were not followed.

4.100 The policy requires an estimate to be prepared by the construction manager prior to a change order being approved. This would help to identify the financial impact of any changes considered. We found five instances in the 30 change orders we tested in which these estimates were not done properly. Two of the estimates were not dated; and in three instances, there was no estimate prepared.

Recommendation 4.8
Colchester East Hants Health Authority should put a process in place to ensure all future change orders are compliant with their change order process.

4.101 *Measuring the size of the hospital* – The actual size of the hospital was not clearly understood by all parties. The architects informed us that the size of the facility was around 369,000 square feet but their cost consultants had calculated it at almost 386,000. We were informed this was likely due to different approaches to the calculation. Management indicated they were not concerned with these differences, as they were aware of the reasons behind them and the overall size of the building was no longer used for cost estimates.

4.102 In February 2011, CEHHA management asked the architects to review their calculations, this time using the Canadian Standards Association's standard for measuring a health care facility. The architect concluded that the actual size of the building is approximately 384,000 square feet. Management noted the actual size of the facility does not impact the costs at this point, as the structure has been built and any costs are based on the actual work done by contractors.

4.103 While we acknowledge the size of the finished building is not impacting specific costs now that estimates are no longer used, there are other possible impacts, both to past and future costs. Looking back, perhaps part of the explanation for the mechanical and electrical tender being so far over the pre-tender estimates is that the hospital was larger than expected. Looking to the future, the cost to maintain and operate the facility will be impacted by an increased floor area.

4.104 Regardless of any specific impacts of not knowing the size of the building, Health and CEHHA should have ensured all parties agreed at the start of the project on how the facility would be measured. Measurement should have been consistent with the Canadian Standards Association's standards for health care facilities.

Recommendation 4.9
The Department of Health and Wellness should put a process in place to ensure future construction projects have an agreement on how the size of the facility will be measured.

4.105 *Lack of estimates* – As discussed earlier, large construction projects are generally estimated at 30%, 60% and 90% of drawing completion. However CEHHA did not complete these estimates during the design process. The last estimate prior to the final design was completed based on schematic design documents which supported the second OIC request. Once that budget was approved and the architects began work on the detailed drawings, no estimates were prepared until tenders were ready to be issued. At that stage, pre-tender estimates were prepared to assess whether the response to the tender request was likely to fall within budget.

4.106 CEHHA management indicated they did not complete these estimates because their use of a fast track approach made it impossible. The fast track approach to designing and procuring the hospital means the project moves forward as each step is ready, rather than completing all plans and designs before construction starts. This meant CEHHA did not have fully complete drawings prior to starting construction. Instead, tenders were issued for various parts of the project as the drawings were ready. They believe following a 30%, 60%, 90% approach would have required them to complete too many estimates during the design process, as they would have to apply this to each tender package as it was prepared.

4.107 We do not accept this argument and feel at a minimum CEHHA should have identified the more significant tender packages, such as the mechanical and electrical package, and ensured appropriate estimates were prepared during the design stage. The budget for mechanical and electrical was originally $45.3 million; the lowest tenders were more than $73 million. Given the significant differences in the quality and quantity of information available at the schematic design stage (conceptual drawings only, no details) and the pre-tender stage, we feel it would have been appropriate for CEHHA to ensure they were actively monitoring the progress of the design to ensure it stayed within the approved budget.

4.108 A significant amount of work took place between the two estimates CEHHA completed. For example, a number of new plumbing and heating or ventilation requirements were identified between the two estimates. While management were aware of these changes, they were not included in the pre-tender estimate. Failure to identify mechanical and electrical changes contributed to project delays.

4.109 Management believes that more frequent estimates would not have made a difference because they believe the estimates would likely have had the same errors. While it is possible 30%, 60%, and 90% estimates may not have been any more accurate than the pre-tender estimates, it is reasonable to expect this would have increased the likelihood of these changes being identified earlier.

4.110 The extent to which this weak oversight contributed to the problems occurring on this project is impossible to say. It is clear, however, that this represents another instance of poor control and a lack of monitoring of the costs of the project.

Recommendation 4.10
The Department of Health and Wellness should require the completion of 30%, 60%, and 90% estimates during the design stage of future construction projects, including significant trade packages for fast track projects.

Other Concerns

Conclusions and summary of observations

The lack of construction expertise at CEHHA and Health has had a significant impact on the ability to manage and control this project. CEHHA management did not adequately review and challenge the work of various consultants whom they hired to assist with the project. Even without construction expertise, management should have tried to obtain a better understanding of the rationale for significant estimates proposed by consultants. Existing government expertise should be used to manage large construction projects in the future.

4.111 *Lack of construction expertise* – Management and staff at CEHHA are responsible for running the health district. Their expertise is almost exclusively health-care focused. While CEHHA did hire a staff member with extensive hospital construction experience to oversee this project, this position was relatively low in the organization's hierarchy. Those with ultimate decision-making authority, including Board members, did not have sufficient expertise in large construction projects to provide appropriate oversight. While the Departments of Transportation and Infrastructure Renewal, and Health and Wellness were represented on the planning committee, these representatives were non-voting members. The Department of Transportation and Infrastructure Renewal representative told us his role on this project was very limited.

4.112 While CEHHA hired numerous consultants and experts to work on their behalf, management's review and challenge of their consultant's work should have been more rigorous. They did not ask the questions needed to gain a better understanding of some very significant issues, such as the cost per square foot and grossing factor estimates used to estimate building size.

4.113 *Department of Health and Wellness* – Health management told us they had only one staff member responsible for capital construction projects when

this project was planned. Since that time Health has increased staffing within its capital infrastructure group to six engineers.

4.114 Due to this lack of expertise, in April 2007, Health hired an external firm to act as their project manager for this assignment. Health did not have a signed contract with this consultant at the time we completed fieldwork in early 2011. There was no formal reporting structure in place. Health management informed us they receive verbal or email updates on a bi-weekly basis or as required. They were able to provide examples of email correspondence from the consultant. However we would expect a more formal arrangement to ensure Health outlines the information they require and to clarify the consultant's role.

Recommendation 4.11
The Department of Health and Wellness should sign a contract including clear responsibilities and reporting requirements with its project manager for the Colchester Hospital replacement project.

4.115 Health management acknowledge that the role they expect their consultant to fill is one they now have staff perform internally. At the time the consultant was hired, they did not have adequate resources to fulfill this role from within the Department. Management currently feel that consistency on the project is of such significance that replacing their project manager with someone from inside Health is not an appropriate approach. Accordingly, the consultant continues to represent Health on the project.

4.116 In April 2007, Health hired a second external firm to review the detailed plans and identify areas of potential savings. The external firm provided an extensive report noting potential cost savings, as well as indicating where space was not sufficient. Health has not done any analysis to show whether these identified cost savings were achieved.

4.117 *Existing government expertise* – We interviewed a senior management member at the Department of Transportation and Infrastructure Renewal (TIR) to determine that Department's role in this project. He indicated TIR was involved on a limited basis. One member of TIR was part of the planning committee and was involved in the selection process for some of the key consultants on the assignment. Beyond that TIR was not asked for any detailed analysis and was never asked to review the facility designs.

4.118 In the past, TIR was responsible for constructing all public buildings, including hospitals, in Nova Scotia. The Department has not been involved in hospital construction for over 20 years. However, TIR are still involved in construction of schools, court houses and other buildings. We were informed that TIR would not have sufficient staffing at this time to take

on full responsibility for all projects, including health care facilities, but would have the construction expertise required to do so.

4.119 We believe a central government organization should be responsible for all large construction projects; the Department of Transportation and Infrastructure Renewal is one possibility. This could be accomplished using provincial government employees or by contracting with consultants. In either instance, staff at a central organization should have the appropriate expertise to either oversee projects themselves or to know what questions should be asked of external consultants.

4.120 While we acknowledge a central body may not have completely dealt with the challenges faced on this project, we believe internal expertise would make it much easier for government to work with the construction industry. Instead of health experts trying to negotiate with architects and engineers, the province should be represented by individuals with an extensive understanding of the construction market.

4.121 When projects are managed centrally, it is important that the needs of the project stakeholders still be considered. While a central body would have the necessary construction expertise, it would not have experts in all fields. Whether the end users for a project are in healthcare or any other field, input from stakeholders and ongoing involvement in projects will be necessary to ensure the right building is constructed to meet identified needs.

Recommendation 4.12
Treasury Board should assign responsibility for construction projects in Nova Scotia to a central organization with the necessary expertise to oversee all significant construction projects for all government departments in Nova Scotia.

Procurement

Conclusions and summary of observations

We found the overall procurement approach used by CEHHA to be appropriate and adequately supported, finding only minor deficiencies in the process followed. We also tested procurements at Health related to the project and identified minor improvements.

4.122 *CEHHA* – CEHHA issued and awarded RFPs and tenders appropriately; however we identified minor deficiencies in nine of 20 procurement files we tested. Certain files had more than one issue.

- Two files lacked a pre-tender estimate.
- Four files were not date stamped to show when they were received.
- Five files had issues with documentation not being complete, but overall evidence suggests process was followed.

4.123 *Department of Health and Wellness* – Health had two procurements related to this project. The consultant who was to act as the Department's project manager was hired from government's standing offer. While this is an acceptable approach, as reported earlier in this Chapter, Health failed to ensure there was a signed contract with this consultant.

4.124 An external firm with health care facility planning expertise was hired through an alternative procurement process. The process followed for this procurement was acceptable, although issues exist with the appropriateness of the support for some claims made by this consultant. Part of the contract with this firm allowed for reimbursement of reasonable expenses but claims for these expenses have not been consistently supported by adequate evidence.

Summary Comments

4.125 In this Chapter, we have identified certain problems with the process followed to build the new Colchester Regional Hospital. We have made recommendations to improve the process for future large construction projects.

4.126 Another important step on any large project involves examining the lessons learned after the project is complete. A lessons learned or post-occupancy exercise can provide useful information on what worked versus what should be done differently for future projects. It also provides an opportunity to assess how decisions made during construction impact the operation of the building. In this instance, a post-occupancy assessment should be conducted after the new hospital has opened.

4.127 Earlier in this Chapter, we noted the need for a central body to oversee large construction projects. This central body should ensure a post-occupancy assessment is completed for the new Colchester Regional Hospital as well as all future large construction projects.

Recommendation 4.13
Colchester East Hants Health Authority should conduct a post-occupancy assessment after the new hospital opens to identify lessons learned for future capital projects. The results of this assessment should be shared with the Department of Health and Wellness and central government so that the lessons learned can benefit future projects.

Recommendation 4.14
Following the establishment of a central body to oversee large construction projects, Treasury Board should assign responsibility for post-occupancy assessment of large construction projects to this group.

Response: Colchester East Hants Health Authority

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 the findings and conclusions identified by the Auditor General and his staff we wish to provide the following comments:

For 10 years our team has been devoted to building a new health centre to serve our communities. Since day one our goal has been to plan and deliver a facility that would allow us to offer safe quality care; a supportive workplace for our healthcare team and that would support health and healing. We believe that the facility that has been designed and is being constructed for our community will allow us to accomplish those objectives. Being diligent about our planning, oversight and spending was also equally important to us.

A complex project like ours was new territory for us all and so we began by seeking out the resources and supports available to assist us. We researched other health care construction projects, and at various stages of our initiative compared our projected costs with those projects as a means of informing us and supporting decisions. In addition, we became familiar with the Department of Health's own capital project manual and put structures and processes in place to guide our project based in part on their recommendations. Our role and responsibility for this project was understood and defined by our organization during the early stages of this initiative – we established a governance function to oversee the project scope, budget and timeline; contracts with project consultants were detailed with respect to roles and responsibilities; and position descriptions for project staff were clear with respect to roles and responsibilities.

We made sure those in government with experience and knowledge of capital projects were part of our planning committee and where we lacked experience and expertise, we relied on consultants with proven track records to advise us. With these resources in place we asked questions of what was presented to us by our consultants and sought evidence, options and details to support our decisions.

Despite all these preparations, measures and the countless hours our volunteers and staff have dedicated to the project, there have been many challenges to overcome, including rising costs related to construction supplies and labour. We welcomed the Auditor General's review of our project and any lessons that could be applied to our project or future initiatives, but are very discouraged by the findings that suggest a lack of diligence on our part. We wish to emphasize that budget adjustments on this project were requested as a result of two primary factors. First, the original budget did not include any adjustment for inflation and therefore was not adequate, from the beginning of the project, to build the

hospital. This was known by all parties involved. Second, the noted increase in the cost of construction for Mechanical and Electrical trade packages could not have been predicted and was too substantial to mitigate. It should also be noted that prior to proceeding to tender for Mechanical and Electrical work, the project was under budget. The Health Authority, at no time, proceeded with a contract award without agreement from the Province and without assurance that the project funds were adequate to complete the work. We believe that this demonstrates that we were concerned about the cost of the project and were making all efforts to manage those costs.

We will begin to address the issues identified within this report and ensure that we continue to effectively manage the project budget, as well as ensure that we deliver the facility that was committed to our community. We are proud of the fact that our new health centre will open next year and are fully committed to applying these findings to the ongoing management of our project as we work toward this important day for our communities and health care team.

With regard to recommendations directed toward the Districts:

Recommendation 4.2
The Department of Health and Wellness and Colchester East Hants Health Authority should prepare a comprehensive assessment of the funding required to operate the new facility at its intended capacity and agree on the level of funding to be provided.

4.2 Response
CEHHA agrees with this recommendation. With the decision now made on the mechanical/electrical systems being used in the facility, CEHHA is in the process of preparing an updated facility operating cost projection. In addition, CEHHA has initiated the process of developing program impact documents for consideration by the Department of Health and Wellness – for the program areas where growth/change is expected in the new facility. This is as per normal business planning process and is tied to the fiscal year in which the facility will be opened and operated.

Recommendation 4.8
Colchester East Hants Health Authority should put a process in place to ensure all future change orders are compliant with their change order process.

4.8 Response
CEHHA agrees with this recommendation. Currently, all change order documentation is reviewed by the construction manager, architect & project manager prior to issuance to CEHHA/DOH for their approval. A detailed review and approval does take place for all contract changes upon receipt of trade pricing

and prior to approval of change orders by CEHHA/DOH as noted above. This process will continue.

Construction Management estimates will continue to be completed for all discretionary changes to ensure there is appropriate benefit for the cost of the change.

CEHHA will all review and if necessary adjust its Change Order policy to ensure that it is appropriate for a project of this nature.

RESPONSE: COLCHESTER EAST HANTS HEALTH AUTHORITY

Recommendation 4.13
Colchester East Hants Health Authority should conduct a post-occupancy assessment after the new hospital opens to identify lessons learned for future capital projects. The results of this assessment should be shared with the Department of Health and Wellness and central government so that the lessons learned can benefit future projects.

4.13 Response
CEHHA recommended that this process be completed during our meeting with the Auditor General's staff as part of this review. CEHHA has established a process for completing a post occupancy evaluation and utilized the framework for two projects to date. It has always been CEHHA's intent to complete an evaluation of the project after occupying the new facility.

Response: Treasury Board

Recommendation 4.12
Treasury Board should assign responsibility for construction projects in Nova Scotia to a central organization with the necessary expertise to oversee all significant construction projects for all government departments in Nova Scotia.

The Treasury Board Office agrees that significant construction projects must have the appropriate level of central governance for oversight and must also have appropriate monitoring and reporting controls in place to enable the governance process. The Treasury Board Office has the following initiatives underway and processes in place to enable strong capital project governance throughout the project lifecycle:

The Tangible Capital Asset (TCA) Prioritization Committee

There is a committee in place, comprised of key representatives from across government, with a specific skill set, that evaluates and prioritizes proposed capital projects. Among others, the objectives of this committee, in evaluating proposed projects, are to ensure that the proposals:

- Include an appropriate level of detail with respect to planning and scope;
- Include cost estimates that are accurate and reasonable given the detailed planning

The role of the Committee has been evolving as the government continues to move toward a standardized and enhanced capital budgeting and management process. Treasury Board Office will look at further enhancing the work of the Committee to include the implementation of a benefits realization and post-project review process for larger capital projects. This process will evaluate whether the project has achieved its expected objectives. A post-project review process will not only help to determine project success and sustainable benefit, but will also provide the opportunity to identify, track and communicate project "lessons learned". This will provide valuable information to help ensure the success of future significant capital projects.

Consolidation of Building, Design, Construction Activities

The Treasury Board Office has begun a process to evaluate opportunities for shared services in Nova Scotia. These opportunities will include functional areas of government where standardization of processes and systems can occur and result in improved service, increased effectiveness and efficiencies.

RESPONSE:
TREASURY BOARD

Building design, construction, project management and asset management have been identified as having significant potential for standardization and consolidation which will provide greater control over the processes, policies and practices. This will help to ensure a consistent and effective approach in both large and small scale infrastructure planning, scoping, development, and ongoing maintenance. We are currently evaluating these areas and will further investigate the feasibility of consolidating design and construction responsibilities into a single organization to build both the capacity and knowledge within the public sector to better serve the province as a whole. This will also lead to the development of common standards for the procurement of design and project management services externally.

Contract Management Framework

In addition to the above initiatives, a new and comprehensive Contract Management Framework, which will direct and oversee the development and management of all future government contract initiatives, has been approved by Treasury Board and became effective April 1, 2011. The Framework employs best-practices for all stages of the contract management life-cycle and ensures a detailed review, by an expert advisory group, of all non-labour government contract initiatives with estimated annual costs of $1 million or more. This review will take place at various stages of a contract initiative's planning and development.

The Framework's best contract management practices and contract initiative review process are intended to result in the better management of contract risk, the reduced likelihood of contract failure and the improvement of contract quality.

Recommendation 4.14
Following the establishment of a central body to oversee large construction projects, Treasury Board should assign responsibility for post-occupancy assessment of large construction projects to this group.

The Treasury Board Office also recognizes the importance of a post-project review whereby lessons learned can be identified and recorded, and, most importantly leveraged for future projects. This responsibility has been included in the stated objectives of the TCA Prioritization Committee.

Please see the response under 4.12 which refers to the TCA Prioritization Committee and its responsibility for post-project review.

Response: Department of Health and Wellness

Recommendation 4.1
The Department of Health and Wellness should establish a schedule to review the preliminary budget and approve the final project totals for future capital projects.

Agreed. The Department of Health and Wellness will work within government to develop the process.

Recommendation 4.2
Department of Health and Wellness and Colchester East Hants Health Authority should prepare a comprehensive assessment of the funding required to operate the new facility at its intended capacity and agree on the level of funding to be provided.

Agreed. The new hospital is designed as a replacement facility. As a result the reuse of existing furniture and equipment from the current hospital, to the extent possible, is good fiscal management. In addition $1.6 million dollars were included in the operations budget to cover the increased plant footprint. Demolition costs were not considered part of the overall project costs and will be considered once the future of the existing facility is decided.

Recommendation 4.3
Department of Health and Wellness should put a process in place to ensure only complete and accurate information is presented to Cabinet.

Agreed. Submissions to Cabinet are managed through the Policy and Planning Division. Many levels of review take place from the originator of the document to the Chief Financial Officer, the Deputy Minister and the Minister. Financial staff are an integral part of the document development and review to ensure complete and accurate financial information is presented.

Recommendation 4.4
The Department of Health and Wellness should put a process in place to ensure management in charge of significant capital projects complete an adequate review and challenge of key estimates prepared by consultants.

Agreed. The Department now has a robust Infrastructure Management group comprised of six engineers. During the start of the Colchester project there was one engineer.

RESPONSE: DEPARTMENT OF HEALTH AND WELLNESS

Recommendation 4.5
The Department of Health and Wellness should put a process in place to require regular reviews of grossing factor estimates at significant stages of large construction projects.

Agreed: The Department of Health & Wellness will require regular reviews of grossing factors of all large construction projects.

Recommendation 4.6
The Department of Health and Wellness should put a process in place to ensure design decisions are made with due consideration of the impact on costs for future construction projects.

Agreed. The Department now has a robust Infrastructure Management group comprised of six engineers. During the start of the Colchester project there was one engineer. There is also a financial advisor dedicated to the capital budget.

Recommendation 4.7
The Department of Health and Wellness should put a process in place to ensure decisions to seek LEED certification for construction projects are supported by analysis of the costs. Costs should then be tracked over the life of the project.

This project was approved and designed before the requirement for LEED certification. LEED compliant facilities are now the practice for new construction within all Government Departments.

Recommendation 4.8
Colchester East Hants Health Authority should put a process in place to ensure all future change orders are compliant with their change order process.

Agreed

Recomendation 4.9
The Department of Health and Wellness should put a process in place to ensure future construction projects have an agreement on how the size of the facility will be measured.

Agreed. This is currently in place.

Recommendation 4.10
The Department of Health and Wellness should require the completion of 30%, 60% and 90% estimates during the design stage of future construction projects, including significant trade packages for fast track projects.

Agreed. While the practice of 30, 60, and 90% estimates is restricted to lump sum contracts which are seldom currently used on the construction of large facilities The Department of Health and Wellness agree that an increased frequency of estimates by multiple sources will be used on future construction management projects of significant size.

Recommendation 4.11
The Department of Health and Wellness should sign a contract including clear responsibilities and reporting requirements with its project manager for the Colchester Hospital replacement project.

RESPONSE: DEPARTMENT OF HEALTH AND WELLNESS

Agreed. Legal is currently drafting the contract.

Recommendation 4.12
Treasury Board should assign responsibility for construction projects in Nova Scotia to a central organization with the necessary expertise to oversee all significant construction projects for all government departments in Nova Scotia.

This recommendation is for Treasury Board, however, an MOU between the Department of Health and Wellness and the Department of Transportation and Infrastructure Renewal is in the final review stage.

Recommendation 4.13
Colchester East Hants Health Authority should conduct a post-occupancy assessment after the new hospital opens to identify lessons learned for future capital projects. The results of this assessment should be shared with the Department of Health and Wellness and central government so that the lessons learned can benefit future projects.

Agreed

Recommendation 4.14
Following the establishment of a central body to oversee large construction projects, Treasury Board should assign responsibility for post-occupancy assessment of large construction projects to this group.

Again, this is a recommendation for Treasury Board to provide comments, however, an MOU between the Department of Health and Wellness and the Department of Transportation and Infrastructure Renewal is in the final review stage.

5 Health and Wellness: Long Term Care – New and Replacement Facilities

Summary

The Department of Health and Wellness (Department) engaged in a detailed needs analysis to determine the number and location of new long term care facilities to be constructed under its Continuing Care Strategy. We found the Department had an appropriate process to develop the request for proposals, and evaluate the bids received. We concluded the Department complied with the provincial procurement policy and appropriately awarded successful proposals. The estimated commitment to construct and operate these new and replacement facilities during the 25-year contracts with the service providers is approximately $4.5 billion.

The Department had no support to show it replaced those facilities which were most in need. We do not know whether the facilities with the most serious deficiencies were replaced. We recommended the Department take appropriate steps to ensure decisions to replace long term care facilities are based on a fair and consistent process and are adequately supported and documented.

The Department developed and followed an adequate process for the development, construction, commissioning and initial licensing of new and replacement facilities. The Department also signed standard development agreements covering facility construction, and long term care service agreements with facility operators.

The Department has not established agreements with existing long term care service providers, who represent the majority of long term care facilities. Since there were no agreements and therefore no clear termination provisions, Department management believed they had to negotiate with existing service providers for replacement facilities rather than going through a competitive bid process. Although this process was in compliance with the Provincial procurement policy, we do not accept the reasonableness of this explanation. It is a poor management practice to spend large amounts of public funds without contractual agreements.

None of the eight recommendations made in our June 2007 Report have been implemented. We recommended that the Homes for Special Care Act and Regulations be updated as far back as 1998; however, no action has been taken. We are concerned about the Department's willingness to implement the recommendations in this Chapter given its inaction in implementing our 2007 recommendations.

5 Health and Wellness: Long Term Care – New and Replacement Facilities

Background

5.1 The Department of Health and Wellness, through the Continuing Care Branch, is responsible for administration of the Continuing Care program, which includes home care and long term care. Long term care is provided through third party for-profit or not-for-profit service providers who operate nursing homes, residential care facilities, and community based options across the Province. There were 6,772 nursing home beds, 832 residential care beds and 90 small option or community residence beds in 146 facilities as of December 2010.

5.2 In May 2006, the Department released the *"Continuing Care Strategy for Nova Scotia: Shaping the Future of Continuing Care"* (Strategy). This is a ten-year action plan to improve and expand the province's continuing care system.

5.3 The Strategy called for 1,320 new long term care beds to be added across the province. New beds were to be allocated based on *"geographic disparity, population projections, community needs, and current pressures on acute care services."* The Department issued two requests for proposals (RFPs) for new stand-alone facilities or attachments to existing long term care facilities in April 2007 and June 2009. The Department also reviewed existing long term care facilities to identify facilities in need of replacement.

5.4 Most of the Department's new and replacement beds constructed in recent years fell under the Strategy; a small number had already been announced before May 2006.

5.5 The Department is adding almost 800 new beds. Most of these beds were constructed following an RFP; a small number of beds were added to existing facilities. In addition, the Department is also replacing over 800 beds in a number of facilities.

5.6 The estimated commitment to construct and operate these new and replacement facilities during the 25-year contracts signed with the service providers is approximately $1 billion in capital costs, and $3.5 billion in operating costs for a total of $4.5 billion.

5.7 As of December 31, 2010, approximately 600 beds had been opened in 16 facilities while another 200 beds were either planned or under construction. Two replacement facilities were open; the majority of those facilities were still under construction.

5.8 In 2006-07 when the Continuing Care Strategy was implemented, the average number of clients waiting for long term care beds was 1,079. The Department believed adding new long term care beds would reduce the wait list.

5.9 Six long term care service providers operate 180 temporary beds in areas such as Halifax Regional Municipality, Berwick, and Glace Bay. These temporary beds were implemented between 2004 and 2008 to relieve pressures identified on the wait list for nursing homes. The temporary beds are an interim measure, and are to be evaluated at a later date to determine if these beds are still required.

5.10 Long term care service providers are funded through a per diem based on the number of beds in a facility. Each year, facility operating budgets are established by the Department. Service providers receive annual funding under two funding envelopes: protected funding and unprotected funding.

5.11 Protected funding covers costs related to direct patient care and food costs. These are established by the Department to ensure patient care, staffing levels, and food quality meet Department standards. Any unused protected funding at year-end must be returned to the Department. Unprotected funding covers accommodation costs such as housekeeping and food preparation, as well as administrative and maintenance costs. The service provider can allocate costs within categories; however, the Department must approve changes to staffing levels. Any unprotected funding remaining at year-end is retained by the service provider.

5.12 Operational costs are indexed based on the Consumer Price Index, while unionized wages are adjusted based on negotiated collective agreements.

5.13 Capital funding is included in the unprotected envelope. A portion of the capital funding relates to the cost to build and finance the facilities over the 25-year term of the mortgage. This capital cost is a fixed sum which does not change from year to year. Mortgage financing is offered to service providers by the Nova Scotia Housing Development Corporation over a 25-year term. Service providers submit a monthly progress claim, certified by an architect, outlining the work completed to date and the amount claimed. Information on the monthly claim is used by Department staff to monitor construction progress and the amount claimed and advanced by the Housing Corporation.

Audit Objectives and Scope

5.14 In the winter of 2011, we completed a performance audit of the long term care program at the Department of Health and Wellness. The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and audit standards established by the Canadian Institute of Chartered Accountants.

5.15 The audit objectives were to determine whether:

- the Department has adequate processes to analyze current and future long term care bed requirements and to identify the number and location of long term care beds to be constructed or replaced;
- the Department has an adequate process to develop facility standards for the design, operation, staffing and funding of long term care facilities;
- the Department had an adequate process to develop the requirements for the request for proposals for new long term care facilities;
- the process to award new long term care facilities was in compliance with the provincial Procurement Policy and the related request for proposals requirements;
- the Department and successful bidders complied with the facility development approval process;
- the development and service agreements between the Department and facility operators were adequate;
- the Department is providing adequate oversight during the development, construction, commissioning and initial licensing of long term care facilities; and
- the Department has adequately monitored the impact of opening new long term care facilities on the wait list for long term care placement.

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

5.17 Our audit approach included examining requests for proposals, bid submissions, documents and reports, interviews with management and staff, and testing of compliance with policies and processes. Our testing covered May 2006 to December 2010.

Significant Audit Observations

Long Term Care Facility Needs

Conclusions and summary of observations

An analysis was performed to determine the location and type of new beds to be constructed under the Continuing Care Strategy. The Department also developed new space, design, program and funding standards. However the Department does not have evidence that those facilities most in need were selected for replacement. We recommended the Department take appropriate steps to ensure decisions to replace long term care facilities are based on a fair and consistent process and are adequately supported and documented.

5.18 *Background* – In May 2006, the Department released the Continuing Care Strategy (Strategy). The Strategy noted that the province needed more long term care facilities to meet its needs; 1,320 new beds were to be added over a 10-year period. In February 2007, the Department released the *"Long Term Care Renewal & Replacement Update"*. This document described the process to determine where new facilities were to be constructed throughout the Province and considerations when determining which existing facilities should be replaced.

5.19 *New and replacement facility locations* – An analysis was completed to determine the location and type of new beds to be constructed. Consideration was given to county population projections, demand patterns and wait list data for long term care beds, and the location and number of beds of existing long term facilities. In April 2007, the Department issued a request for proposals (RFP) to build new stand-alone long term care facilities or attachments to existing facilities.

5.20 The Department is also replacing more than 800 existing beds. These facilities are currently under construction or have been completed and occupied.

5.21 The Department does not have any evidence to support that the facilities most in need were selected for replacement. It is possible that facilities which required significant improvements are still open while facilities which had fewer needs were replaced.

5.22 For example, initially the Department did not select Villa Saint-Joseph du Lac (Villa) for replacement. However in March 2007, the Department received notification from the Office of the Fire Marshal that the facility had 38 fire and life safety issues, including corridors and door widths which did not meet minimum nursing home requirements. There were resident

rooms that needed to be vacated as they were located outside fire doors and would not provide adequate protection in the event of a fire. The fire alarm system did not meet current standards; water supply pressure was low; and new sprinkler heads were required. Subsequently, the Department decided to replace the Villa.

5.23 Given the significant dollar amounts involved, the Department should have documented the rationale for determining which facilities to replace. The lack of analysis does not promote either transparency or accountability in the decision-making process. The absence of documentation increases the risk that facilities most in need of being replaced were incorrectly assessed, or significant information was not considered in the assessment.

Recommendation 5.1
The Department of Health and Wellness should take appropriate steps to ensure decisions to replace long term care facilities are based on a transparent, consistent process and are adequately supported and documented.

5.24 *Building, program and staffing standards* – The Department developed new space and design standards for long term care facilities, as well as new program standards. These standards were developed based on a review of current practices, visits to certain long term care facilities, and recommendations from a consultant's study. Significant changes resulting from the new standards include an alternative staffing model, having 12 to 13 resident beds per household, private bathrooms and bedrooms, and single-level households. These standards were incorporated in the April 2007 and June 2009 requests for proposals.

5.25 Existing facilities were not required to conform to these new standards since significant changes to facility layout would have been required.

5.26 *Funding standards* – We found the Department had an appropriate process to determine the estimated capital cost of constructing long term care facilities. The Department used externally-prepared construction costs to estimate the cost of building a 52-bed facility in the Metro Halifax area in May 2007. Since construction of the new long term care facilities was expected to start in 2008, the Department included estimated inflation in their calculation. Costs were also adjusted based on geographic location across the province to reflect different labour and construction rates. The Department also developed operating cost standards based on costs incurred by existing service providers.

5.27 *Status of facilities*– There are more than 500 new beds identified under the Continuing Care Strategy which have not been constructed. We were informed no additional facilities will be tendered until a review of the Strategy is completed.

Recommendation 5.2
The Department of Health and Wellness should proceed with the review of the Continuing Care Strategy as soon as possible.

Selection of Service Providers

Conclusions and summary of observations

Service providers for new long term care facilities were selected through a request for proposals process. We found the bidders with the highest evaluation scores were selected in each geographical area tendered. Service providers for all newly-constructed facilities were required to sign standard facility development agreements and long term service provision agreements. We found these agreements covered significant areas. Despite previous recommendations by this Office, the Department does not have agreements with existing long term care service providers which represent the majority of long term care facilities. Funding service providers on a long term basis without agreements is poor management of public funds and could result in increased future service costs. Department management believed they had to negotiate with existing service providers for replacement facilities. Although this complies with the Provincial procurement policy, we do not accept the reasonableness of this explanation.

5.28 *Background* – The Department issued a request for proposals in April 2007 for new stand-alone long term care facilities or attachments to existing facilities totaling 804 new beds.

5.29 Fourteen service providers were selected to construct 24 facilities with over 700 new beds. There are approximately 100 beds in nine locations for which there were either no bids under the RFP or the bids were not accepted. A second RFP in June 2009 for 44 of these beds also did not lead to any successful proposals.

5.30 *New facilities* – The Department developed a request for proposals and tendered new facilities. The RFP was comprehensive and covered areas such as facility space and design; program requirements; and agreements for the construction and operation of long term care facilities. The process followed for replacement facilities is discussed later in this Chapter.

5.31 *Evaluation of proposals* – The Department had an appropriate process for the evaluation of the proposals submitted under the April 2007 and June 2009 RFPs. Bids had to address certain mandatory items or the proposal was considered noncompliant and would not be evaluated. The evaluations were consistent with the RFP requirements and included presentations from

the two highest scoring proponents for each location. The Department used a procurement consultant to facilitate the RFP development and to assist with proposal evaluation and debriefing the proponents.

5.32 *Testing results* – We found the April 2007 and June 2009 RFPs were in compliance with the Provincial procurement policy. We selected a sample of seven successful service providers and reviewed their April 2007 RFP submissions for compliance with requirements. The evaluation of these successful bidders was consistent with the evaluation criteria. Bids received were evaluated on their long term care culture, service delivery, proposed facility, and financial plan. For each geographic area tendered, the proponent with the highest evaluation score was appropriately selected.

5.33 We also reviewed the submissions of four unsuccessful proponents from the April 2007 RFP and three unsuccessful proponents from the June 2009 RFP. We determined these submissions had been appropriately evaluated and rejected by the Department.

5.34 *Replacement facilities* – The Department is also replacing more than 800 beds in a number of facilities. As of December 31, 2010, ten facilities are under construction and two facilities are open. Replacement facilities were awarded in accordance with the provincial procurement policy based on an existing relationship with the service providers. This issue is discussed further below.

5.35 *Development and service agreements* – Service providers were required to sign facility development and long term service agreements for all new stand-alone or attached facilities as well as replacement facilities. These agreements outline the roles and responsibilities of both the service provider and the Department for facility construction and operation, including service standards and initial per diems. For those instances in which an attachment was added to an existing facility, the service agreement with the operator only covers the new beds; there are still no service agreements for the existing beds.

5.36 When all of the new and replacement facilities have been opened, 39 of 150 facilities (26%) will have agreements covering some or all of their beds.

5.37 We examined signed development and service agreements for seven new and six replacement facilities and concluded standard agreements were signed in all instances. These agreements covered the areas we expected including: legislative requirements, RFP requirements, provisions for delays and termination, establishing annual funding, future funding changes, and audit by the Department.

5.38 *Lack of agreements with existing facilities* – There are no signed service agreements between the Department and existing long term care facility service providers whose facility is not being replaced. In our June 2007 Report (Chapter 4 – Long-term Care – Nursing Homes and Homes for the Aged), we recommended the Department establish service agreements with all nursing homes which include performance expectations and reporting requirements. In the four years since we made this recommendation, Department management informed us they have been unable to negotiate an agreement which existing long term care facility service providers are willing to sign. We do not accept the reasonableness of this explanation for the Department's lack of action.

5.39 Because they lacked signed agreements, Department management told us they believed they had to negotiate with existing service providers for replacement facilities rather than going through a competitive bid process. Management was not certain how much notice would be required for these service providers in order to tender replacement facilities. Tendering could mean ending a long term service relationship between the provider and the Department if another party were to win the RFP. We do not accept the validity of this explanation. Management needs to decide the notice required to break the arrangement, and take action to safeguard the public interest.

5.40 Additionally, this lack of agreements and subsequent negotiation directly with service providers may not have resulted in the most cost effective solutions for replacement long term care facilities. The funding commitment for replacement facilities totals $2.3 billion over the 25-year agreements ($619 million in capital construction, and $1.7 billion in operating costs). It is possible that government will pay more for future services than if these arrangements had been subject to a competitive bid process. We were not able to compare per diems between new and replacement facilities because the per diems vary due to facility size, staff models selected, and other factors. Service providers were required to publicly tender for construction services and materials as part of the development process for replacement facilities.

5.41 The absence of service agreements may result in inconsistent service delivery standards and expectations, or may result in inconsistent or unclear reporting requirements.

5.42 Department management informed us that they are working on an accountability framework with the district health authorities (DHAs) which would include the delivery of continuing care services, including long term care. We were told the Department will require DHAs to have signed agreements with their service providers. Since the Department has not been successful in signing agreements with service providers over the past four

years, it is difficult to see how simply requiring DHAs to put agreements in place will address this issue. The Department needs to immediately develop a plan to move all service providers to signed agreements. This issue cannot be left to each individual health district to resolve on their own. It is a poor management practice to spend large amounts of public funds without contractual agreements. We repeat our recommendation below and urge the Department to address this issue within a year.

Recommendation 5.3
The Department of Health and Wellness should sign agreements with all long term care service providers within a year.

Funding

Conclusions and summary of observations

Funding for new long term care facilities was based on the proposals submitted by the service providers, while funding for replacement facilities was negotiated individually with existing service providers. Funding policies are included in the development and service agreements. Once approved by the Department, both new and replacement facility construction costs were fixed.

5.43 *Background* – The Department provides funding to long term care service providers through an approved per diem rate which is paid based on the number of beds in the facility. Overall per diem rates for new stand-alone or attached facilities range from $158.30 to $306.55. Rates for replacement facilities range from $275.27 to $320.03.

5.44 Funding for both new and replacement facilities is broken into two main components: protected and unprotected funding. This funding is described in policies and forms part of the development and service agreements.

5.45 *New facilities* – The RFPs included minimum and maximum per diem rates for each facility tendered. These per diems were established based on the construction and operating cost standards developed, and based on one of two approved staffing models. Inclusion of a maximum per diem in the RFPs may have resulted in providers offering per diems higher than they would have otherwise. Department staff indicated they included the per diem in the RFPs to ensure rates proposed were within the Department's acceptable range and to aid in situations where there may not have been sufficient competition for facilities in some areas.

5.46 *Replacement facilities* – Replacement facilities funding was based on a negotiated per diem with the existing service provider. The Department

used the per diems established in the requests for proposals as a starting point in their negotiations.

5.47 *Testing results* – All facility construction costs were to be fixed once approved by the Department. Facility per diems include a fixed amount to cover this capital component over the 25-year service agreement. Service providers were responsible for construction costs exceeding the approved budget. The Department did not change the approved capital budget for service providers who completed the facilities for less than the approved capital budget, providing an incentive for service providers to complete projects at or under the approved budget. We tested the files of seven new and six replacement facilities and noted the mortgage amount advanced was less than or equal to the approved budgets for all 13 facilities tested.

Design and Construction of Long Term Care Facilities

Conclusions and summary of observations

The Department developed and followed an adequate process for the development, construction, commissioning and initial licensing of new and replacement facilities. The development process includes a series of steps to be completed by the service providers. The Department reviewed the service providers' documentation and approved the submissions before service providers could advance to the next step in the development process. We tested the facility development approval process and initial licensing process, and noted only minor instances of noncompliance.

5.48 *Facility development approval process* – The Department developed and followed an adequate process for the development, construction, commissioning and initial licensing of new and replacement long term care facilities. The development process for new facilities includes significant steps such as site selection, budget submission, facility design, commissioning and pre-licensing. The same process was used for replacement facilities with minor differences.

5.49 Service providers were required to submit information to the Department at the end of each step of the facility development process. The Department was responsible for reviewing and approving the required documents before the service providers could move to the next step.

5.50 *Testing* – We tested a sample of seven new facilities and six replacement facilities, all of which were at various stages of the facility development approval process. We found only minor instances of noncompliance.

5.51 Commissioning is undertaken to test the building and related components to ensure everything functions as designed. This can be carried out by

the service provider or a third party. We tested the files for three new and two replacement facilities and did not note any deficiencies. At the time of our audit, the remaining facilities we selected for testing were still under construction and were not yet ready for commissioning.

5.52 Finally, service providers were required to submit a pre-licensing checklist, including copies of key reports such as inspections to the Department. We tested the files for three new and two replacement facilities and did not note any issues. The remaining facilities selected for testing had not completed the pre-licensing checklist submission at the time of our testing.

5.53 *Licensing* – Long term care facilities are licensed by the Department's monitoring and compliance division. For new facilities, a pre-occupancy licensing inspection is completed. This focuses primarily on the physical structure. A pre-occupancy inspection report is provided to the service provider, who is required to respond in writing indicating how each issue will be addressed and providing a time frame for resolution. Once issues have been resolved to the Department's satisfaction, a short-term license is issued to the service provider.

5.54 A second licensing inspection is completed three months after occupancy. This inspection is more focused on the residents and other issues which could exist once a facility is occupied. The service provider receives a written inspection report. The provider must respond to the inspection and indicate the time frame for resolution of identified issues. Once the Department is satisfied that issues have been dealt with, another short-term license is issued for the remainder of the year. Following these initial inspections, facilities are inspected annually.

5.55 *Pre-occupancy licensing testing* – We tested five facilities with completed pre-occupancy licensing inspections. We examined Departmental inspection records, as well as documentation submitted by the service provider during the inspection. We also reviewed the inspection report to ensure all documented deficiencies were addressed by the service provider. We did not note any deficiencies in the pre-occupancy inspection process.

5.56 *Three month licensing testing* – We also reviewed the three month inspection after the pre-occupancy inspection to ensure requirements had been followed. Four of the five facilities we selected for testing had the second inspection completed at the time of our testing. We noted all four facilities were in compliance with the Department's licensing process and all identified deficiencies were addressed by the service providers.

Departmental Oversight

Conclusions and summary of observations

The Department is providing adequate oversight during the development, construction, commissioning and initial licensing of long term care facilities. However, the Department did not perform an overall risk assessment at the start of this project, and should develop a risk assessment process for subsequent projects. The Department has documented processes for monitoring individual project risks, and the Department has ensured significant risks have been included in the request for proposals requirements and signed agreements. Our testing indicated service providers are submitting monthly status reports as required. Regular reports concerning the long term care project are prepared and reviewed by department staff and committees.

5.57 *Roles and responsibilities* – Roles and responsibilities for the development, construction, commissioning and initial licensing of new and replacement facilities are clearly documented in the facility development approval process. Roles and responsibilities are further defined in the development and service agreements signed with the service providers.

5.58 *Project risks* – The Department did not perform a risk assessment at the start of this project. The Department identified certain risks prior to the issuance of a pre-strategy RFP and incorporated provisions to address these risks in the April 2007 and June 2009 RFPs. Ongoing project risks are documented in service providers' monthly status reports submitted to the Department, and addressed in consultation with Department staff. Due to the significance of the project, the Department should have developed a process to identify, monitor and address risks.

Recommendation 5.4
The Department of Health and Wellness should develop a risk assessment process for subsequent projects.

5.59 *Status reporting* – Service providers are required to submit monthly status reports during the development and construction phases. Status reports contain information on the status of project milestones, project pressures, expected occupancy date and budget information. There is no requirement that Department staff respond to the service providers regarding the status reports; however, there is regular and ongoing verbal and written communication with the service providers. Department staff also performed site visits which are documented in site inspection reports. Any significant issues identified are escalated to the continuing care leadership team for their review.

5.60 We selected two months to determine whether status reports were submitted and submission date requirements met by 13 long term care service providers. All the reports were submitted, and all reports included required information.

5.61 *Internal reporting* – Regular reports on the long term care project are prepared and reviewed by Department staff and committees, usually on a monthly basis. Key reports include occupancy forecast reports, mortgage reports, and status reports.

5.62 We selected seven internal reports to determine if they were prepared for the two months we tested. We found the reports were prepared on a regular basis.

5.63 The long term care project team and the continuing care leadership team meet weekly to discuss the status of new and replacement long term care facilities, and in particular, issues and challenges encountered by service providers.

Wait Lists

Conclusions and summary of observations

We found the Department has adequately monitored the impact of opening new long term care facilities on the wait list for long term care placement. The addition of new long term care beds has not decreased the wait list for long term care placement. We were informed the Department is examining various options, such as expansion of the home care program, and changes to policies, procedures and processes, to reduce wait times for admission to long term care facilities. Wait list information concerning long term care placement should be publicly available on the Department's website.

5.64 Wait lists are a key indicator of whether the Department is able to provide placement in long term care facilities in a timely manner. The long term care wait list is managed using SEAscape; the Department's computerized assessment system. There are a number of weekly and ad-hoc wait list reports which can be generated from SEAscape. These reports provide information on the numbers of clients who are waiting for long term care, the numbers of clients who have been placed, as well as trending information. We did not perform any audit work on these reports.

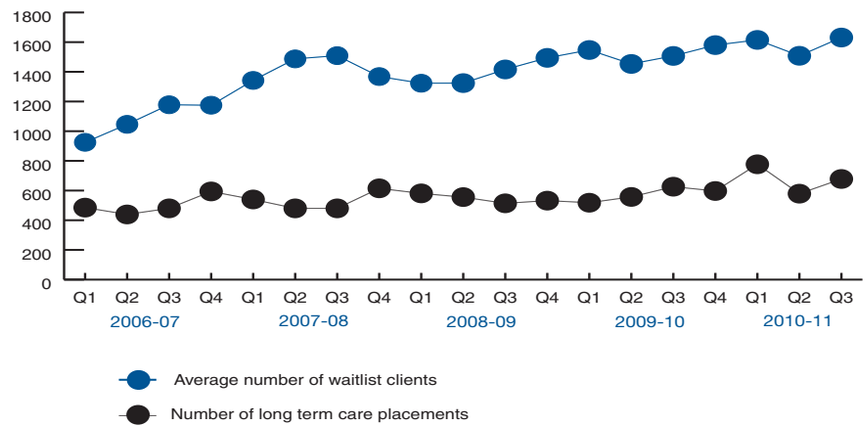
5.65 Wait list information concerning long term care placement is not publicly available on the Department's website. We believe this is useful information which should be available.

Recommendation 5.5
The Department of Health and Wellness should include wait list information concerning long term care placement on its website.

5.66 One of the goals of the Department is to increase the number of long term care facilities and to reduce wait times for admission to these facilities. A 2010 draft report titled *"Removing Barriers in Accessing Long Term Care"* noted the following.

- The wait list for long term care grew by 38% since 2007.
- The number of hospital clients on the wait list remained relatively stable with between 200 and 250 clients at any time.
- The number of clients waiting to access long term care from the community continues to grow, increasing from approximately 1,280 people in April 2007 to approximately 1,740 people in April 2010, representing a 35.5% increase.
- Bed capacity has increased 13% between April 2007 and April 2010.

Long Term Care Wait List and Placements



Source: SEAscape; Continuing Care Branch, Department of Health and Wellness

Unaudited

5.67 There are many factors that impact the demand for long term care services. Not all individuals who are eligible for long term care services may apply for admission. The draft report identified a number of factors which could influence demand for long term care services resulting in increases to the wait list despite the added capacity. Factors such as the desirability of the

new facilities and barriers in accessing home care or other community-based services may impact the demand. In addition, public perception of access issues may lead to clients beginning the process prior to being prepared to move to a long term care facility, in an attempt to get on the wait list and ensure a bed is available when they need it.

5.68 We were informed the Department is examining various options, such as expansion of the home care program, and changes to policies, procedures and processes, to reduce wait times for admission to long term care facilities.

Other Audit Observations

Conclusions and summary of observations

We followed up the status of the eight recommendations we made in our June 2007 Report related to the long term care program and found that none of our recommendations were implemented. We recommended Health immediately implement all recommendations from our 2007 Report. As far back as 1998, we recommended that the Homes for Special Care Act and Regulations be updated but the Department has taken no action to implement this recommendation. Finally, we identified instances in which long term care facilities were licensed without approval from the Office of the Fire Marshal.

5.69 *Background* – Our most recent audit of the long term care program was reported our June 2007 Report (Chapter 4). We follow up the status of the eight recommendations made in that audit in Chapter 2 of this Report. None of the recommendations have been implemented. We are concerned with the Department's inaction in implementing these recommendations and its willingness to implement the recommendations in this Chapter.

Recommendation 5.6
The Department of Health and Wellness should immediately implement all recommendations made in Chapter 4 of the June 2007 Report of the Auditor General.

5.70 *Homes for Special Care Act* – One of the recommendations made in our June 2007 Report concerned the Homes for Special Care Act and Regulations. The Act and Regulations are administered by the Departments of Health and Wellness, and Community Services. The Homes for Special Care Act was introduced in 1989. There were minor amendments to the Act in 1994-95 and 2007. Regulations were introduced in October 1977, with minor amendments up to February 2010.

5.71 The Regulations include standards which must be met by long term care service providers. The new and replacement service agreements exceed the standards specified in the existing Regulations. As far back as 1998, we recommended that the Act and Regulations be updated. Since the Department has taken no action to implement the recommendation, we have repeated it here.

Recommendation 5.7
The Departments of Health and Wellness and Community Services should update the Homes for Special Care Act and Regulations to ensure current service delivery standards are included.

5.72 *Annual licensing* – This audit did not focus on the annual licensing process; however, in conjunction with our audit at the Office of the Fire Marshal, we performed additional testing to determine whether long term care facilities are licensed only after approval by the Office of the Fire Marshal. The Homes for Special Care Act Regulations require long term care facility operators to request that the Fire Marshal inspect each facility at least yearly. The Department requires either an inspection or approval from the Fire Marshal to license a facility. We selected a sample of 15 long term care facilities and found three instances in which the facility was licensed even though there was no approval or inspection from the Office of the Fire Marshal. We suggest Department staff meet with Office of the Fire Marshal staff to develop a process to ensure this legislative requirement is met.

Response: Department of Health and Wellness

Thank you for this opportunity to respond to the recommendations in Chapter 5 of the Report of the Auditor General for May 2011, on the area of Health and Wellness: Long Term Care – New and Replacement Facilities. The Department also appreciates the learning opportunities afforded our staff through the auditing process. Following are the Department's responses to each of the recommendations identified as a result of the recent audit.

Recommendation 5.1
The Department of Health and Wellness should take appropriate steps to ensure decisions to replace long term care facilities are based on a transparent, consistent process and are adequately supported and documented.

The Department of Health and Wellness concurs with the recommendation to ensure decisions to replace long term care facilities are based on a transparent, consistent process and are adequately supported and documented. Although the Department is confident that the facilities currently being replaced were appropriately selected, we recognize that clear and concise documentation for all steps of the selection process would have provided transparency and improved accountability. Using lessons learned from the previous analysis and incorporating the recommendations of this audit, the Department will develop a process map with documentation requirements to be followed when considering future facilities for replacement.

Recommendation 5.2
The Department of Health and Wellness should proceed with the review of the Continuing Care Strategy as soon as possible.

The Department of Health and Wellness accepts recommendation 5.2 to proceed with the review of the Continuing Care Strategy prior to the tendering of additional long term care facilities. Work has already begun on validating the previously identified future requirements for new beds. In addition, we are collaborating with research partners to evaluate the effectiveness of the environment and models of care delivery on the clients, families and staff.

Recommendation 5.3
The Department of Health and Wellness should sign agreements with all long term care service providers within a year.

Department of Health and Wellness supports the recommendation to have signed agreements with all long term care service providers within a year. The Department has been collaborating with the District Health Authorities and the LTC providers for more than a year to develop these, and the Service level Agreements are now in the final stages of approval. As the long term care facilities are being integrated

with the District Health Authorities, the signing authorities on the agreement will be the individual long term care facility and its respective District Health Authority.

Recommendation 5.4
The Department of Health and Wellness should develop a risk assessment process for subsequent projects.

The Department of Health and Wellness supports the recommendation to develop a risk assessment process and will ensure this process is followed and documented for subsequent projects in all project charters. The Department will continue to include the requirement for risk assessments to be performed and documented by the successful proponents of all RFPs as well as continuing to require it as part of the formal facility development approval process carried out by the Department.

Recommendation 5.5
The Department of Health and Wellness should include wait list information concerning long term care placement on its website.

The Department of Health and Wellness recognizes that the wait list information concerning long term care placement has potential value for clients and other stakeholders and will make a business case for long term care wait list information to be included within the larger wait list strategy for the Department.

Recommendation 5.6
The Department of Health and Wellness should immediately implement all recommendations made in Chapter 4 of the June 2007 Report of the Auditor General.

The Department of Health and Wellness will review all previous recommendations in Chapter 4 of the June 2007 Report of the Auditor General for current state. Activity has begun on the identified recommendations, however, it is recognized that most have not yet been fully implemented. The Department will review each recommendation to determine what action, if any, is now required to fully implement these recommendations and proceed accordingly.

Recommendation 5.7
The Departments of Health and Wellness and Community Services should update the Homes for Special Care Act and Regulations to ensure current service delivery standards are included.

The Department of Health and Wellness recognizes the need to update the Homes for Special Care Act and Regulations and accepts the recommendation to ensure current service delivery standards are included in the regulations. The Department of Health and Wellness, in consultation with the Department of Community

Services, will explore the most effective way to incorporate the new standards in the Regulations and follow through on the process to enable this to occur.

RESPONSE: DEPARTMENT OF HEALTH AND WELLNESS

6 Labour and Advanced Education: Office of the Fire Marshal

Summary

The Office of the Fire Marshal is not doing an adequate job of protecting the public from fire safety risks in buildings. Management is not performing appropriate oversight of operations, which we believe has contributed to a number of the deficiencies noted throughout this Chapter.

The Office lacks fundamental information needed to effectively manage its operations. For example, there is no inventory of buildings which require fire safety inspections. Management does not know whether required fire safety inspections have been completed or whether significant deficiencies identified during inspections have been appropriately addressed.

The Office of the Fire Marshal is not meeting minimum fire safety inspection frequencies specified in legislation and policies for buildings under its inspection responsibility. In our sample, 47% of required inspections were not completed. There is also no evidence that significant fire safety deficiencies discovered during inspections were corrected.

The Office of the Fire Marshal's monitoring of municipalities is also inadequate. Many buildings for which municipalities have fire safety inspection responsibilities are not being inspected as required. Since 2003, only five of 56 municipalities have been reviewed for compliance with the Fire Safety Act. None of the five municipalities reviewed completed all required inspections; one did not complete any inspections. Additionally, the two largest municipalities have not been reviewed. The Office of the Fire Marshal does not have a plan to address its oversight responsibilities and has not taken appropriate action to address findings in the few reviews it has completed.

We are concerned with the lack of progress made by the Department of Labour and Advanced Education in addressing our previous audit findings from 1987 and 2001. For example, inadequate monitoring of municipalities, an inadequate management information system, and not completing inspections in accordance with the required frequency are all issues which were previously reported. The results of this audit make it apparent that the Department has not made these important issues a priority. Over the years, the Office of the Fire Marshal has failed to exercise its responsibilities and has failed to take actions it has known to be necessary to protect the public.

We have made 25 recommendations to address the weaknesses noted in this Chapter such as the need for a comprehensive assessment of operations which identifies and assesses fire safety risks.

6 Labour and Advanced Education: Office of the Fire Marshal

Background

6.1 The Office of the Fire Marshal (OFM), an operational unit within the Department of Labour and Advanced Education, is responsible for the administration of the Nova Scotia Fire Safety Act (Act). The Act details the authority and responsibilities of the OFM and municipalities related to fire safety in the province. The primary responsibility of the OFM is fire prevention and investigation; fire fighting is performed by the municipalities. The OFM has established three major program areas to address its responsibilities under the Act: education; enforcement; and engineering.

6.2 Through its education program the OFM provides training to industry, institutions, government, and fire services including fire safety training to staff within correctional facilities and nursing homes. Information on fire safety is also provided to the general public. The OFM's engineering program includes the review of new construction and renovation plans for certain types of buildings to identify contraventions of the Act and regulations, and the National Fire Code of Canada (fire code), prior to construction.

6.3 The enforcement program objective is to assess whether building owners and operators are complying with the Act, regulations and the fire code, and to take action where noncompliance is identified. To accomplish this, the OFM conducts fire safety inspections on certain building types as mandated in legislation or determined by management. The Act also requires municipal inspectors to complete fire safety inspections on a large number of building types as listed in the regulations. These include assembly buildings like theatres and restaurants and residential buildings such as apartment buildings and hotels. The OFM also follows up on complaints received and conducts fire investigations as required.

6.4 Eight Deputy Fire Marshals (DFMs) are responsible for performing fire safety inspections for the OFM, completing fire investigations as required, and monitoring the inspection activities of municipal inspectors. One of these DFMs is responsible for the education program. A Fire Protection Engineer is responsible for the review of construction plans.

Audit Objective and Scope

6.5 In the fall of 2010 we completed a performance audit of the Office of the Fire Marshal. The audit was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

6.6 The purpose of this audit was to determine whether fire safety risks in buildings are being adequately managed to protect the public.

6.7 The audit objective was to determine whether fire safety inspection, enforcement and education systems and processes at the Office of the Fire Marshal are adequately designed and implemented to manage identified risks to the public. The scope of the audit did not include an examination of fire safety operations at the municipalities, although certain municipal management were interviewed during the audit.

6.8 Generally accepted criteria consistent with the objective 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.

6.9 Our audit approach included interviews with OFM management and staff; documentation of systems and processes; testing of inspection and compliance processes and procedures; and examination of legislation, policies and results of municipal reviews. Our testing period for inspections covered fiscal years 2007-08, 2008-09 and 2009-10.

Significant Audit Observations

Management Information

Conclusions and summary of observations

Management is not performing appropriate oversight of operations, which we believe has contributed to a number of the deficiencies noted throughout this report. The Office lacks fundamental information needed to effectively manage its operations. The OFM does not have adequate systems and processes in place to know whether education, inspection, enforcement and engineering systems are operating as designed and are effective in managing identified risks. As an example, there is no inventory of buildings which require fire safety inspections by the OFM and management does not know whether required fire safety inspections have been completed. Management does not know whether significant deficiencies

identified during fire safety inspections have been appropriately addressed. We recommended that management conduct a comprehensive assessment of OFM operations, including the identification and assessment of risks.

6.10 *Operational assessment* – Management has not conducted a comprehensive assessment of OFM operations. An assessment would consider the basic requirements of an effective inspection and investigation program, including an identification and assessment of risks. This would help management identify areas of concern and actions required to address them. Such an assessment would also help determine whether the resources currently available to the OFM are sufficient to fulfill their responsibilities, and whether those resources are allocated to the highest priority areas. For example, certain buildings, such as provincially-owned or leased buildings, need to be assessed to determine the appropriate inspection frequency. In addition, the OFM needs to determine staff resource requirements including the number of DFMs needed to perform required fire safety inspections, investigations, and other OFM responsibilities.

6.11 Based on the findings of our audit, we believe there is a need for a comprehensive evaluation of OFM operations, including human and other resource needs, as well as operational policies and procedures. The recommendations in this Chapter should be considered in this evaluation and any resulting action plan to redesign operations.

Recommendation 6.1
The Office of the Fire Marshal should conduct a comprehensive assessment of its operations, including an identification and assessment of fire safety risks and resources needed to address those risks. Subsequent to the assessment, a plan should be developed and implemented to change operations as required. Both the assessment and resulting plan should be completed immediately.

6.12 *Fire department management system* – The OFM has a central database available for use by staff and management – the fire department management system (FDM). This system can capture important information on fire inspection and fire investigation activities. The FDM does not include an inventory of all buildings requiring inspections by the OFM nor are all completed inspections and investigations recorded in this database. Of the 70 inspection files we tested, 76 % (53 files) were not recorded in FDM. Because the information in FDM is not complete, required information is not available for management to adequately monitor inspection, compliance, and enforcement activities. The following are examples of information that was not included in the database which we expected would be available to management and staff.

- A complete inventory of all buildings requiring inspection.

- The date each building was last inspected.
- The date when the next inspection is due.
- The results of the inspections completed, including inspection date, report date, method of reporting, deficiencies identified, date by which compliance is required and achieved, if reinspection was completed, and enforcement action taken.
- Causes, origin and circumstances of fires.

6.13 Management indicated that there are frequent technical problems and resource issues which have contributed to the lack of use of the FDM system.

Recommendation 6.2
The Office of the Fire Marshal should evaluate its operational information needs and its management information systems to ensure that all necessary information is being collected and is available for use by staff and management.

Recommendation 6.3
The Office of the Fire Marshal should ensure that at a minimum, a complete inventory of all buildings requiring inspections by that Office, and all inspection and investigation activities, are entered into the system in a timely manner.

6.14 *Activity reports* – The DFMs are required to complete monthly activity reports. These reports break down which activities are completed each day and the number of hours used to conduct inspections and other activities. Only three of the eight DFMs submitted these activity reports in 2009-10 and one of them only submitted the information for five months.

6.15 If completed, these reports could provide valuable information for monitoring the activities and performance of the DFMs as well as provide data to aid in the development of performance standards. The reports could also help determine the level of resources needed to fulfill responsibilities.

Recommendation 6.4
The Office of the Fire Marshal should ensure all Deputy Fire Marshals submit activity reports as required.

6.16 *Performance standards* – There are no performance standards or targets established for DFMs. Possible standards which could help evaluate DFM performance include: time required to complete various types of inspections; length of time from inspection to ensuring the deficiencies are addressed; and the number of inspections which should be completed

monthly or annually. Such standards would also assist with scheduling inspection activities and determining the resources required to address the responsibilities of the OFM.

Recommendation 6.5
The Office of the Fire Marshal should implement performance standards for Deputy Fire Marshals' activities.

6.17 *Monitoring staff performance* – Staff performance evaluations are not being done on a regular basis. None were completed during 2009-10. Four staff were last evaluated nine years ago, one staff eight years ago, and two staff two years ago. Performance evaluations are necessary to ensure that staff are meeting desired performance expectations including recognition of good performance as well as identifying and addressing areas in which staff require development. The OFM needs to develop a process for the ongoing monitoring and evaluation of staff performance. Such a process should include establishment of performance expectations and targets; regular monitoring by management; and annual performance assessments.

Recommendation 6.6
The Office of the Fire Marshal should implement a system to regularly monitor and assess staff performance.

6.18 *Quality assurance process* – Management does not have a quality assurance process in place such as the regular review of a sample of inspection files. A quality assurance process is a set of planned and systematic actions to provide confidence that a system is performing as required. At the OFM, a quality assurance process should include inspections and follow up of complaints. This would provide management with some assurance that policies and procedures are followed, that activities are carried out consistently between DFMs, and that activities completed are properly documented. Additionally, DFMs use professional judgment regarding which compliance activities they complete and the timing of those activities. A quality assurance process would allow management to determine if appropriate judgment is being used.

Recommendation 6.7
The Office of the Fire Marshal should implement a quality assurance process which includes key operational activities.

6.19 The fact that management does not have critical information available to determine whether the OFM is fulfilling its important public safety responsibilities is concerning. Management is not performing an appropriate level of oversight of OFM operations. This audit notes several

significant deficiencies which support the lack of management oversight. To ensure that the deficiencies identified in our report are addressed and do not continue to occur, management must be more effective in its oversight responsibilities.

Monitoring of Municipalities

Conclusions and summary of observations

The Office of the Fire Marshal's monitoring of municipalities is inadequate. Many buildings for which municipalities have fire safety inspection responsibilities are not being inspected as required. Since 2003, only five of 56 municipalities have been reviewed for compliance with the Act; the two largest municipalities were not reviewed. Based on the results of the Office of the Fire Marshal's reviews, none of the five municipalities have been completing all required inspections, with one completing no inspections at all. The OFM does not have a plan on how to address its oversight responsibilities for all municipalities in the province and has not taken appropriate action to address findings in the few reviews it has completed to date. Due to the lack of clarity in the Fire Safety Act, buildings with similar conditions may be inspected with varying frequency throughout the province. The Fire Safety Act needs to be amended to clarify the acceptable inspection frequency for non-assembly buildings. As the legislation exists, municipalities can conduct inspections at any frequency and still comply with the Act.

6.20 *Legislative responsibilities* – The Fire Safety Act came into force in 2002 and the regulations in February 2003. The regulations require municipalities to inspect assembly buildings every three years; for non-assembly buildings, Section 19(1) of the Act requires them to "*establish a system of fire safety inspections of land and premises situated within its jurisdiction, as required by regulations, to provide for compliance with this Act, the regulations and the Fire Code*". The non-assembly building types are residential, business and personal services, mercantile, and industrial. Assembly buildings have a gathering of persons within the buildings such as theatres and restaurants.

6.21 Section 19(1) of the Act lacks clarity. It does not define what a system of fire safety inspections is. There is no requirement for time frames to be established. The system could be based solely on complaints; in other words no inspection would be conducted unless a complaint was received. Management indicated that one municipality is using this as its system of inspections. If municipalities decided to implement time frames for inspections, they would be able to set any time frame they like, even if it is potentially unsafe, and still be in compliance with the Act. There is a need to set reasonable parameters within the legislation so municipalities have

some discretion in determining the system of inspections while ensuring that any decision made by municipalities will result in adequate public safety.

Recommendation 6.8
The Office of the Fire Marshal should define minimum standards to be used in determining an appropriate system of inspections for municipalities and update legislation as required.

LABOUR AND ADVANCED EDUCATION: OFFICE OF THE FIRE MARSHAL

6.22 *Review of municipalities* – Although the Fire Safety Act came into force in 2002 and the regulations in February 2003, there has been no monitoring of the municipalities by the OFM until 2009-10. In 2009-10, in order to begin some monitoring, eight of 56 municipalities were judgmentally selected for review. Five of those eight selected were completed at the time of our audit with four being done in 2009-10. The results from the five reviews completed by the OFM indicated that:

- one municipality had not completed any inspections in the past three years;
- one municipality had completed 12 inspections in the past three years;
- four municipalities had not inspected any non-assembly buildings;
- five municipalities had not inspected all assembly buildings every three years; and
- two municipalities did not know how many assembly buildings they were responsible for.

6.23 The Act requires the OFM to perform inspections where the municipalities have not. For the five municipalities reviewed, the OFM did not conduct its own inspections and has not assessed the risks for those buildings where systems of inspections have not been established. In these cases both the OFM and the municipalities are in contravention of the Fire Safety Act.

Recommendation 6.9
The Office of the Fire Marshal should perform fire safety inspections when municipalities fail to complete inspections as required by the Fire Safety Act.

6.24 *Follow up on order to take action* – The Fire Safety Act allows the OFM to issue an order to take action when it is believed there is a contravention of the Act, regulations or fire code. In all five municipalities, it was found that none were complying with the Act and regulations. However, an order to take action was only issued to one of the municipalities.

6.25 For the one order to take action issued, there was not adequate follow up to ensure the municipality complied with the order to take action. According to

the DFM involved, the municipality provided a list of inspections completed but the DFM did not verify whether the inspections were completed.

Recommendation 6.10
The Office of the Fire Marshal should implement policies and procedures to follow up deficiencies identified during its reviews of municipalities.

6.26 *Ongoing monitoring of municipalities* – The objective of the initial OFM reviews was to find out if municipalities were doing inspections as required and how they were being conducted. According to OFM management, more detailed reviews are to be completed on all municipalities but no plans have been developed addressing what information will be covered, how it will be obtained, when these will be done and what monitoring will be done after these detailed reviews are completed. The Fire Safety Act places considerable responsibility for fire safety inspection of buildings with the municipalities; therefore appropriate OFM oversight is important.

6.27 The reviews conducted by the OFM did not include the Halifax Regional Municipality (HRM) or the Cape Breton Regional Municipality (CBRM) but as part of our audit we interviewed management from these municipalities. We were told that neither the HRM nor the CBRM have met all their fire safety inspection requirements under the Fire Safety Act.

Recommendation 6.11
The Office of the Fire Marshal should develop and implement a plan to determine whether municipalities are currently complying with their legislative responsibilities and to ensure that they continue to comply.

6.28 Management at the HRM and the CBRM described their systems for conducting fire safety inspections. Although these systems were not audited by us, they indicated the use of checklists, enforcement guidelines, building inventories, and other processes which we believe may be of interest to the OFM. When conducting the operational assessment discussed in paragraph 6.10, consideration should be given to the inspection processes used by others, including the HRM and CBRM, in determining the best process for the OFM.

6.29 We are concerned that there are buildings for which municipalities have fire safety inspection responsibilities that are not being inspected as required. For these buildings possible fire safety risks are not being identified and addressed; this compromises public safety. Also, where the frequency of inspections is not established clearly in the Act, similar buildings with similar conditions may be inspected with varying frequency throughout the province.

Inspection, Compliance and Enforcement

Conclusions and summary of observations

The fire safety inspection program of the OFM is inadequate to protect the occupants and users of buildings under its inspection responsibility from undue fire safety risk. We determined fire safety inspections are not taking place as required by legislation or policy. We found very limited procedural guidance exists to assist the DFMs in conducting and reporting inspection and compliance activities and in handling complaints; as a result, we found inconsistencies in some of these practices. We also found untimely reporting of serious deficiencies and no evidence of follow up on serious deficiencies.

LABOUR AND ADVANCED EDUCATION: OFFICE OF THE FIRE MARSHAL

6.30 *Inspection frequency* – Fire safety inspections are required either by legislation or OFM policy to be conducted at specified intervals of between once a year to every three years, depending on the type of building. Legislation provides specific inspection frequencies for some buildings but not all. For example, the frequency of inspections for non-assembly buildings owned by the province are not specified. For testing purposes, we requested 144 inspection files for certain buildings for the 2007-08, 2008-09, and 2009-10 fiscal years.

6.31 Our testing of fire safety inspections found that 47% (67 of 144) of requested inspection files could not be provided by the OFM. We have concluded that these inspections were not completed based on the fact that no evidence exists at the OFM supporting they were completed, and management indicated they were not done. Failure to complete the inspections as required may expose occupants and users of these buildings to undue fire safety risk. The table below summarizes the results of our testing by building type.

Buildings	Inspection Frequency	No Inspection Done	Expected Inspections
University Buildings (non-residential)	every 3 years	12	12
Community Colleges (non-residential)	every 3 years	2	2
Correctional Facilities	Annual	13	21
Hospitals	every 3 years	3	9
Nursing Homes	Annual	6	39
Daycares (over/under 40 occupants)	Annual/every two years	15*	34
Developmental residences	Annual	8	12
Group Homes	Annual	3	6
Residential Care Facilities	Annual	5	9
Total		67	144

**This is the minimum number missing. We cannot determine with certainty the number missing, because we do not know the due date of some inspections.*

Recommendation 6.12
The Office of the Fire Marshal should meet their inspection responsibilities as required by legislation and Office of the Fire Marshal policy.

6.32 Legislation requires that public schools be inspected by municipalities every three years. However, according to OFM management, the municipalities have not been conducting these inspections as they feel they are owned by the province and are not within their mandate. According to management, prior to 2010-11, the OFM did not inspect many public schools. This means the Office would not have met legislative requirements. OFM management indicated that as of 2009-10, there is an informal agreement with the Department of Education to complete an inspection of all non-HRM schools over the next five years, beginning in 2010-11. After five years, the intention is for the municipalities to take responsibility for compliance with the legislation. The Office of the Fire Marshal also has a memorandum of understanding with HRM which states that municipal inspectors are to inspect schools at the frequency required by legislation. However even under these agreements, the OFM has no mechanism by which it can monitor whether inspections are carried out as required.

Recommendation 6.13
The Office of the Fire Marshal should ensure that public schools are inspected at the frequency required by the Fire Safety Act.

6.33 *Lack of OFM operational policies and procedures* – The OFM has not developed policies and procedures supporting many key operational activities. Policies and procedures are important to ensure staff are aware of what is required and to ensure there is a consistent approach. The following paragraphs describe several of the areas in which policy and procedure development is required.

6.34 *Serious fire safety deficiencies* – There are no documented criteria for determining the seriousness of fire safety issues. Based on discussion with management and the DFMs, we determined what fire safety deficiencies are considered serious in nature due to the immediate impact on occupant safety. These include deficiencies related to clear access to leave the building, fire separation, fire alarm systems, sprinkler systems, and smoke detectors. The seriousness of deficiencies should be an important consideration when staff decide the reporting method, follow-up and enforcement action to be taken.

Recommendation 6.14
The Office of the Fire Marshal should define what constitutes a serious fire safety deficiency identified during inspections.

6.35 *Inspection reporting method* – Inspections are reported using either a letter or an order to take action. The letter makes recommendations to address deficiencies while the order to take action is legally enforceable. There are no defined criteria for when to use an order to take action versus a letter. Based on interviews with DFMs, an order to take action would most likely be used for serious matters.

6.36 In our testing of inspection files we found that DFMs were inconsistent in the reporting method used. Of the 70 files we examined, 59 files identified deficiencies; 23 orders to take action were issued and letters were issued for the remaining 36 files. Of the 36 files with letters issued, there were 104 serious deficiencies identified in 26 files. Three of eight DFMs issued the orders to take action, with two DFMs accounting for 21 of the 23.

Recommendation 6.15
The Office of the Fire Marshal should implement policies and procedures regarding the inspection reporting method to be used by Deputy Fire Marshals when deficiencies are found.

6.37 *Inspection reporting time frames* – There are no defined time frames, based on the seriousness of deficiencies, regarding when a report must be issued following an inspection. In the 63 files for which we were able to determine the inspection date, 12 reports were issued more than 30 days from the inspection date, including two which were over 90 days. Of these 12 reports, 11 identified deficiencies with ten including 49 serious deficiencies. The two reports which were issued more than 90 days after the inspection date identified three deficiencies with one being serious. We believe that issuing a report with serious deficiencies more than 30 days after the inspection date is bad practice and is not timely. One action which could be considered to help address the timeliness of when reports are issued is providing DFMs with computers which would allow them to document the inspection results and provide a report to the clients at the time of the inspection.

Recommendation 6.16
The Office of the Fire Marshal should implement policies and procedures regarding the time frames required to report deficiencies identified during inspections.

6.38 *Time frame to address inspection deficiencies* – There are no defined time frames for compliance with orders to take action or letters of recommendation based on the seriousness of deficiencies. When deficiencies are reported, a deadline to address is typically provided; however this is not a requirement other than for an order to take action. A required

compliance date would motivate owners to correct deficiencies in a timely manner, especially if deficiencies are serious.

6.39 We examined 59 files in which deficiencies were reported and found the following.

- 11 reports had no compliance date (19%); nine of these included 39 serious deficiencies.
- 21 reports had compliance dates of 30 days or less (36%).
- 24 reports had compliance dates between 31 and 60 days (41%).
- The remaining three files had compliance dates of 61 days, 74 days and 146 days and included 25 serious deficiencies.

Recommendation 6.17
The Office of the Fire Marshal should implement policies and procedures regarding required time frames for building owners to address deficiencies noted in inspection reports.

6.40 *Follow up and enforcement of inspection deficiencies* – Ensuring deficiencies identified are appropriately addressed is critical to the effectiveness of the fire safety inspection process. A compliance letter, which highlights whether building owners have addressed (or plan to address) each deficiency reported, may be requested but this is not a consistent practice among DFMs. The DFM can also reinspect to confirm that deficiencies have been adequately addressed rather than asking for a compliance letter. We believe a compliance letter is not sufficient evidence of compliance for serious deficiencies.

6.41 Based on our analysis of 68 inspection files in which there was an inspection report on file, we are concerned that the OFM is not following up on serious fire safety deficiencies to ensure they have been appropriately addressed. We noted a consistent lack of evidence to support follow up of deficiencies and no evidence to support compliance with existing policies. The following is a summary of the key findings from our detailed testing of inspection files.

- Deficiencies were reported in 59 files while nine had clean reports.
- Of the 59 files, 23 orders to take action were issued, including 22 files which identified 134 serious deficiencies.
  - 15 of the 22 files with serious deficiencies had no evidence of reinspection by a DFM as required by policy.
  - In eight of the 15 files, the building owner provided a compliance letter.

- The remaining seven files included 46 serious deficiencies and had no evidence of compliance.

- Of the 59 files in which deficiencies were reported, 36 letters were issued with 26 including 104 serious deficiencies.
  - There was no evidence of reinspection in the 36 files for which letters were issued.
  - Compliance letters were received for 17 of the 36 files.
  - The remaining 19 files had no evidence of compliance and 11 of those files included 48 serious deficiencies.

- For five inspection files which noted a compliance date, clients responded some time later. There was no evidence that the DFM followed up when no response was received by the deadline. A number of days passed between the compliance date and when a letter was received – 131, 112, 74, 62, 45 days. These files included 18 serious deficiencies.

- 17 deficiencies were noted in six licensed facility inspection files. This would include nursing homes and daycares. Four of these files had eight serious deficiencies. The OFM made a licensing recommendation for all six facilities before each facility provided a compliance letter to confirm the deficiencies were addressed.

6.42 Enforcing compliance with the Fire Safety Act and regulations can involve the use of an order to take action, summary offense ticket, and prosecution. There are no established enforcement guidelines which outline appropriate responses and enforcement options when violations are detected. This is left to the discretion of the Deputy Fire Marshals. Other than the issuance of an order to take action, no other enforcement actions were noted in the inspection files. In six files, we noted repeat deficiencies from a prior inspection report. In one of these files, there was a serious deficiency and no order to take action was issued. When there are repeat serious deficiencies, we would expect an order to take action would be issued.

Recommendation 6.18
The Office of the Fire Marshal should implement policies and procedures for adequate follow-up and enforcement of inspection deficiencies.

6.43 *Completeness of inspections* – As indicated in paragraph 6.44, there is no documentation supporting the areas examined as part of each inspection. We interviewed six DFMs to determine their approaches to conducting inspections and found they appear to be consistent regarding what is examined. However, we did note differences in inspection coverage among the DFMs. Some DFMs perform 100% inspection of certain items such as resident rooms and fire extinguishers while others pick a sample based on

perceived risks. The OFM should provide inspection coverage guidance to promote consistency among inspectors. The lack of clarity in this area could result in inadequate inspection coverage by some DFMs. Offsetting this, we found that the nature of fire safety deficiencies identified in the inspection files we tested were broadly dispersed across inspections and covered a number of areas within the fire code. This provides at least some support that all code areas are being examined.

Recommendation 6.19
The Office of Fire Marshal should implement inspection guidelines regarding inspection coverage.

6.44 *Inspection checklists* – There is no documentation supporting the extent or completeness of the inspection conducted, such as an inspection checklist. The use of a checklist would reduce the risk of items being missed, help ensure consistency among DFMs and provide some evidence that the inspection was adequate. A checklist could also provide a basis for management to review inspection activity. This is discussed in paragraph 6.18. Currently, the only documentation supporting what was examined during the inspection is the final report which would include deficiencies identified if applicable.

Recommendation 6.20
The Office of the Fire Marshal should implement an inspection checklist which should be signed by the Deputy Fire Marshal.

6.45 *Complaints* – The OFM does not have policies and procedures to respond to fire safety complaints. Policies and procedures should address required documentation, investigation and resolution steps, and a mechanism to track complaints to resolution. Without an established process, serious fire safety related complaints may not be appropriately investigated.

Recommendation 6.21
The Office of the Fire Marshal should implement policies and procedures related to the documentation and investigation of fire safety related complaints.

6.46 *Staff orientation training* – Deputy Fire Marshals meet the OFM's qualification requirements. However, there is a need for an orientation training policy to help ensure new Deputy Fire Marshals receive appropriate training. DFMs receive orientation training through a mentor when they are first hired. However, there is no policy which specifies what this orientation training should cover. We realize that certain individuals may have different training needs but an overall training plan should be developed which can be customized as required. For example, an

individual may have a lot of experience in investigating fires already so he or she may not need mentoring in this area. A policy would establish the minimum requirements which need to be considered when creating individual training programs.

Recommendation 6.22
The Office of the Fire Marshal should implement an orientation training policy.

6.47 *Review of construction plans* – According to the Fire Safety Act, before construction starts or before alterations or repairs for certain building types, an owner must submit the plans to the OFM for review. The OFM will advise the owner if there are any apparent contraventions of the Act, regulations or the fire code. Staff review the plans which are submitted and note deficiencies in a report to the client. Staff will also request a compliance letter from the client indicating that the deficiencies reported were addressed. However, there is no follow up to ensure a compliance letter is received or to verify that the deficiencies have been appropriately addressed. Municipal building officials are involved with buildings which require a building permit but OFM staff do not provide a copy of the OFM review report to the applicable building inspectors unless they ask for it. We examined a sample of ten files in which plans were reviewed and found one file in which two of the deficiencies identified in the plan review still existed when the building was inspected by a DFM post-construction.

Recommendation 6.23
The Office of the Fire Marshal should follow up on fire safety deficiencies noted during the review of construction plans to ensure these deficiencies have been appropriately addressed.

6.48 *Results from prior audits* – We are concerned with the lack of progress made by the Department in addressing our previous audit findings from 1987 and 2001. For example, inadequate monitoring of municipalities, an inadequate management information system, and not completing inspections in accordance with the required frequency are all issues which were reported previously. The results of this audit make it apparent that the Department has not made these important issues a priority. The Office of the Fire Marshal has, over the years, failed to exercise its responsibilities and has failed to take actions it has known to be necessary to protect the public.

Recommendation 6.24
The Department of Labour and Advanced Education should make it a priority to address all recommendations in this Chapter.

Fire Safety Education

Conclusions and summary of observations

The Office of the Fire Marshal's education systems and processes are not adequately designed and implemented to manage risks to the public. An education plan has not been developed based on an assessment of related risks.

6.49 *Education plan* – The OFM does not have an education plan. Generally, training is provided by request. Training programs are offered for staff of correctional facilities and nursing homes. OFM staff indicated that the material for these courses is revisited periodically to ensure the content is relevant and that lessons learned informally from inspections and investigations are incorporated. Management feels there are education opportunities involving the general public and government agencies which are not currently addressed. In addition, the Fire Safety Act requires public schools, private schools, universities, community colleges, and a "*person who owns, operates, manages or controls a plant or equipment used primarily for the production, transmission, delivery or furnishing of electric power or energy for sale*" to implement a system of inspections for their buildings, plant or equipment to ensure compliance with the Fire Safety Act, regulations and the fire code. The OFM helped the Department of Education develop a fire safety program for school boards to help address this legislative requirement. Program training was also provided. The need for education programs at private schools, universities, community colleges and for the plant and equipment related to electric power or energy for sale has not been assessed. There is a need to perform a risk assessment regarding all fire safety education requirements in order to rank and prioritize training needs according to risk. This assessment will help in developing an education plan.

Recommendation 6.25
The Office of the Fire Marshal should implement a fire safety education plan based on an assessment of risks. The plan should be monitored and periodically updated where applicable.

Response: Department of Labour and Advanced Education

The Department of Labour and Advanced Education (LAE) has prepared this response to the Auditor General's Audit Report of the Office of the Fire Marshal (the "OFM"). The OFM undertakes significant activities to protect the public from fire safety risks. We concur with the observations and recommendations of this audit

RESPONSE: DEPARTMENT OF LABOUR AND ADVANCED EDUCATION

Addressing all of the recommendations contained in the Audit Report is a priority for LAE. As a result, we have assigned a Project Director to oversee the development and implementation of an action plan to address the issues and recommendations and to ensure that timelines are met as noted below. LAE recognizes that this is an opportunity to improve our overall processes and practices related to fire prevention and investigation in the province.

Management Information

Recommendation 6.1
The Office of the Fire Marshal, should conduct a comprehensive assessment of its operations, including an identification and assessment of fire safety risks and resources needed to address those risks. Subsequent to the assessment, a plan should be developed and implemented to change operations as required. Both the assessment and resulting plan should be completed immediately.

As noted above, LAE has assigned a Project Director to conduct an analysis of operations including inspection/ investigation activities and an identification and assessment of risks. A draft working plan has been developed which incorporates activities related to implementing each of the recommendations noted below. This will also include a determination of appropriate staffing levels to fulfill our responsibilities and to ensure that resources are allocated to the highest priority areas. The objective is to ensure that the timelines noted in each recommendation are met.

Recommendation 6.2
The Office of the Fire Marshal should evaluate its operational information needs and its management information systems to ensure that all necessary information is being collected and is available for use by staff and management.

The OFM will immediately begin an assessment of its information needs so that management information systems can be evaluated that meet operational requirements, policy/legal considerations, and our stakeholders' needs. An interim process will be established to ensure that information needs for operational management are met over the next eight months. In the meantime, a more comprehensive review will be undertaken to establish a long term solution over the next eighteen months. This will include a review of existing information

management systems within LAE with consideration to the business requirements for the OFM.

Recommendation 6.3
The Office of the Fire Marshal should ensure that at a minimum, a complete inventory of all buildings requiring inspections by that Office, and all inspection and investigation activities, are entered into the system in a timely manner.

The OFM has acquired a listing of provincial buildings from Transportation and Infrastructure Renewal. The OFM is also in the process of obtaining listings for other buildings for which the OFM is responsible (e.g. Department of Health and Wellness – nursing homes).

A complete inventory will be compiled no later than June 1, 2011. Once a management information system is in place, all activities will be entered into the system in a timely manner (see Recommendation 6.2).

Recommendation 6.4
The Office of the Fire Marshal should ensure all Deputy Fire Marshals submit activity reports as required.

The OFM has already implemented daily/monthly activity reporting utilizing a software program. As we move forward, we will review processes and systems to ensure that any necessary adjustments are made.

Recommendation 6.5
The Office of the Fire Marshal should implement performance standards for the Deputy Fire Marshals' activities.

The OFM has updated the position description for the Deputy Fire Marshals (DFM). Once approved, the OFM will work in collaboration with other regulatory agencies to develop and implement performance standards reflective of the roles and responsibilities of this position. This work will be completed over the next six months.

Recommendation 6.6
The Office of the Fire Marshal should implement a system to regularly monitor and assess staff performance.

The Province of Nova Scotia has an annual performance management process for bargaining unit employees. The OFM will ensure that an annual performance planning process is implemented for 2011-12.

RESPONSE: DEPARTMENT OF LABOUR AND ADVANCED EDUCATION

Recommendation 6.7
The Office of the Fire Marshal should implement a quality assurance process which includes key operational activities.

The OFM will develop and implement a quality assurance process to ensure that policies and procedures are consistently applied. This process will be based on best practices and similar programs in place within LAE. This work will support the overall operating policy development as noted below in Recommendation 6.15.

Monitoring of Municipalities

Recommendation 6.8
The Office of the Fire Marshal should define minimum standards to be used in determining an appropriate system of inspections for municipalities and update legislation as required.

The OFM recognizes the importance of providing support and direction to municipalities to enable them to successfully carry out their responsibilities under the Act. The OFM has begun work in collaboration with the Fire Inspection Association to develop a standard for assessing "a system of fire-safety inspections" which will allow municipalities to develop their own inspection programs to make sure that public safety is a priority. This work will be completed over the next nine months.

Recommendation 6.9
The Office of the Fire Marshal should perform fire safety inspections when municipalities fail to complete inspections as required by the Fire Safety Act.

The OFM will develop and implement a plan to support municipalities to ensure that legislative requirements are met – this will include a review of inspection practices. The OFM will conduct inspections and ensure that activities are tracked when municipalities fail to do so. This plan is part of our broader agenda to ensure that our mandate and legislative requirements are met and as a result, will be completed over the next twelve months.

Recommendation 6.10
The Office of the Fire Marshal should implement policies and procedures to follow up deficiencies identified during its reviews of municipalities.

Once the "system" is defined as noted in recommendation 6.8, the OFM will develop and implement procedures to ensure that identified deficiencies are corrected. This work will be completed over the next nine months.

Recommendation 6.11
The Office of the Fire Marshal should develop and implement a plan to determine whether municipalities are currently complying with their legislative responsibilities and to ensure that they continue to comply.

See Recommendation 6.9 – The plan will include an assessment of inspection, compliance, and enforcement activities performed by municipalities to ensure legislative responsibilities are met.

Inspection, Compliance and Enforcement

RESPONSE: DEPARTMENT OF LABOUR AND ADVANCED EDUCATION

Recommendation 6.12
The Office of the Fire Marshal should meet their inspection responsibilities as required by legislation and Office of Fire Marshal Policy.

The OFM recognizes the importance of meeting our legislative responsibilities. The OFM will review its mandate and operational inspection activities to ensure that legislative responsibilities are carried out. This will include a comprehensive review of our current structure, allocated resources, and management information systems. This will be part of our broader agenda to ensure that our mandate and legislative requirements are met. This will be completed over the twelve months.

Recommendation 6.13
The Office of the Fire Marshal should ensure that public schools are inspected at the frequency required by the Fire Safety Act.

See Recommendation 6.12 – This will include a review of our legislative responsibilities related to "public schools" under the Act (See Also Recommendation 6.9).

Recommendation 6.14
The Office of the Fire Marshal should define what constitutes a serious fire safety deficiency identified during inspections.

See Recommendation 6.15 – In addition, the OFM will develop procedures to provide support for key operational activities and to ensure consistency in approach. This will include the definition of a "serious fire safety deficiency" so that consideration can be given to the appropriate reporting method, follow-up, and enforcement action when applicable.

Recommendation 6.15
The Office of the Fire Marshal should implement policies and procedures regarding the inspection reporting method to be used by the Deputy Fire Marshals when deficiencies are found.

RESPONSE: DEPARTMENT OF LABOUR AND ADVANCED EDUCATION

The OFM will develop and implement overall operating policies to ensure that inspection, compliance, and enforcement activities are carried out as required by the Act. This will include specific inspection processes and procedures to ensure compliance. This is part of our broader policy agenda for the OFM which will be completed over the next twelve months.

Recommendation 6.16
The Office of the Fire Marshal should implement policies and procedures regarding the time frames required to report deficiencies identified during inspections.

See Recommendation 6.15 – This will also include the establishment of time frames to report identified deficiencies.

Recommendation 6.17
The Office of the Fire Marshal should implement policies and procedures regarding time frames for building owners to address deficiencies noted in inspection reports.

See Recommendation 6.15 – This will also include the establishment of time frames for building owners to address deficiencies as noted in inspection reports.

Recommendation 6.18
The Office of the Fire Marshal should implement policies and procedures for adequate follow-up and enforcement of inspection deficiencies.

See Recommendation 6.15 – This will include specific inspection processes and procedures to ensure there is adequate follow-up and enforcement of inspection deficiencies.

Recommendation 6.19
The Office of the Fire Marshal should implement inspection guidelines regarding inspection coverage.

Inspection guidelines will be developed and implemented by the fall of 2011. This will provide guidance regarding inspection coverage expectations and ensure that there is consistency in approach among DFM.

Recommendation 6.20
The Office of the Fire Marshal should implement an inspection checklist which should be signed by the Deputy Fire Marshal.

The OFM is developing an inspection checklist that will be implemented by the fall of 2011.

Recommendation 6.21
The Office of the Fire Marshal should implement policies and procedures related to the documentation and investigation of fire safety related complaints.

See Recommendation 6.15 – This will also include processes and procedures to ensure there is appropriate documentation regarding the investigation of fire safety complaints.

Recommendation 6.22
The Office of the Fire Marshal should implement an orientation training policy.

The OFM will develop and implement an orientation training policy based on best practices and existing programs within LAE. The policy/program will incorporate the Department's generic orientation program and include specific training components so that customized plans can be developed. This policy will be implemented by the winter of 2011/12.

Recommendation 6.23
The Office of the Fire Marshal should follow up on fire safety deficiencies noted during the review of construction plans to ensure these deficiencies have been appropriately addressed.

See Recommendation 6.15 – This will also include follow up on fire safety deficiencies as noted during a review of construction plans

Recommendation 6.24
The Department of Labour and Advanced Education should make it a priority to address all recommendations in this Chapter.

Addressing all of the recommendations contained in the Audit Report is a priority for LAE (see preamble and Recommendation 6.1). In addition, the Project Director will issue progress reports for each time line to the senior officials within LAE (i.e. fall 2011, winter 2011/12, spring 2012) to ensure that all recommendations are implemented as soon as possible.

Fire Safety Education

Recommendation 6.25
The Office of the Fire Marshal should implement a fire safety education plan based on assessment of risks. The plan should be monitored and periodically updated where applicable.

The OFM will conduct a risk assessment of fire safety education requirements to prioritize needs and develop an appropriate education plan. This work will be completed over the next twenty-four months.

7 Service Nova Scotia and Municipal Relations: Registry of Motor Vehicles

Summary

The Department of Service Nova Scotia and Municipal Relations' (Department) processes for identifying and taking action on high-risk drivers as well as monitoring motor vehicle inspection stations and testers are inadequate. Although it is impossible to prevent all accidents and injuries on Nova Scotia roadways, ensuring that only competent and safe drivers are licensed and the vehicles which they operate are mechanically fit are important aspects of accident prevention. Unsafe vehicles and drivers compromise the safety of our roadways. We have made 21 recommendations to address the weaknesses identified during the audit.

Our audit identified a ten-month backlog of collision reports and a three-month backlog of medical reports. These reports are key documents needed to identify and assess drivers who pose a safety risk to the public. We also found significant time delays between the Department's review of drivers' records and intervention action taken.

The Department is not enforcing deadlines for drivers to provide required medical assessments. This means drivers with medical conditions that could impact their ability to safely operate a motor vehicle may continue to drive. Additionally, the Department does not consistently review drivers' records when high-risk driving behaviour is identified. We did note however, that driver's licences were issued in accordance with legislative requirements and Departmental policies for the cases we examined.

We found poor controls over the issue and return of motor vehicle inspection stickers and renewal of inspection station and tester licences. We also identified areas in which policies and procedures should be established. Safety inspection investigation procedures and management oversight processes were unclear or not followed. Additionally, there were weaknesses in inspection station audit selection and coverage across the province. We recommended the Department establish investigation procedures and management oversight processes, as well as improve the audit selection process.

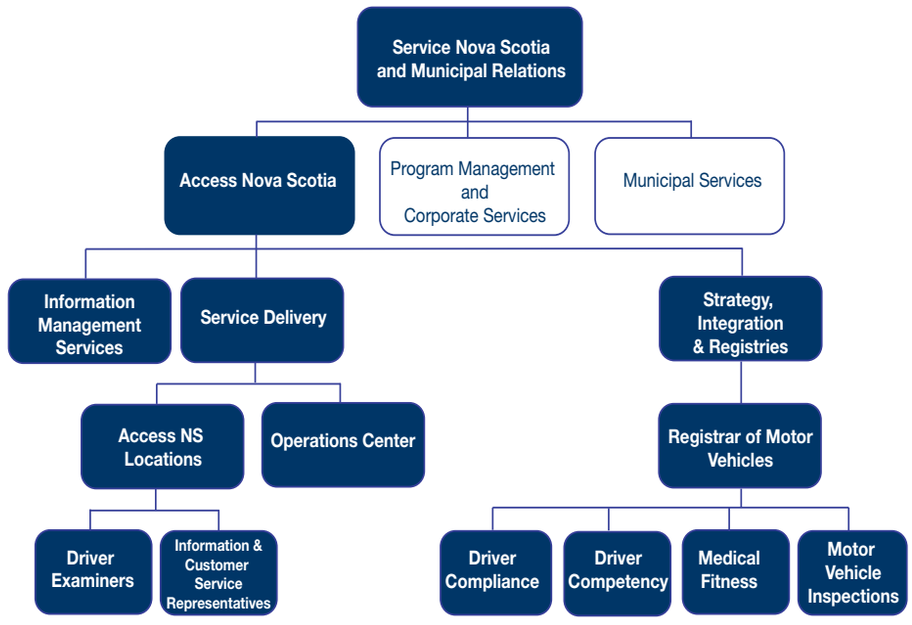
7 Service Nova Scotia and Municipal Relations: Registry of Motor Vehicles

Background

7.1 Registry of Motor Vehicles (RMV) operations are carried out within two divisions of the Department of Service Nova Scotia and Municipal Relations (Department) – the Service Delivery division and the Strategy, Integration and Registries division. The Service Delivery division operates 30 Access Nova Scotia and RMV offices and driver testing locations. Over 450 employees handle approximately 5.4 million customer transactions (RMV and other) annually. The Strategy, Integration and Registries division's responsibilities include:

- monitoring driver compliance and maintaining driver records;
- managing the motor vehicle inspection program;
- licensing and inspecting driver training schools; and
- overseeing the commercial carrier safety fitness rating and audit program (examined in our April 2009 Report).

Service Nova Scotia and Municipal Relations
RMV Structure Overview



Source: OAG

Shaded boxes = RMV responsibilities

7.2 The Department maintains a database and registry application (RMV system) to collect information to support RMV operations. Service Delivery customer service representatives initiate the licensing process and issue, renew or replace driver's licences. Driver examiners administer road tests when required.

7.3 Nova Scotia has a demerit point system for drivers. If a driver is convicted of certain offences under the Motor Vehicle Act, demerit points are added to the driver's record. The Department initiates remedial action if a driver accumulates a certain number of demerit points and revokes a driver's licence upon conviction of certain motor vehicle offences. The Department may suspend a licence if it determines mental or physical disabilities impair an individual's driving ability.

7.4 The Department requires motor vehicles to be safety inspected periodically at one of the 1,200 licensed inspection stations in the province. The Department issues inspection station licences under the Motor Vehicle Act and regulations.

7.5 We also completed an audit of the management of the information technology supporting the RMV systems, which is reported in Chapter 8 of this Report.

Audit Objectives and Scope

7.6 In the fall of 2010, we completed a performance audit of the Registry of Motor Vehicles' operations at the Department of Service Nova Scotia and Municipal Relations. The engagement was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

7.7 The purpose of our audit was to determine whether the Registry of Motor Vehicles (RMV) has appropriate processes to ensure only properly qualified, competent and safe drivers are licensed to operate a motor vehicle, and only roadworthy motor vehicles are safety approved.

7.8 Our audit objectives were to determine whether:

- RMV has adequate processes to ensure only properly qualified drivers are licensed to drive in the province;
- RMV has adequate processes to help ensure only those drivers who demonstrate safe driving competency are approved to drive in the province; and

- RMV has adequate monitoring processes to know that only roadworthy vehicles receive an approved safety inspection sticker.

7.9 We developed criteria specifically for this engagement. The objectives and criteria were discussed with, and accepted as appropriate by, senior management of the Department.

7.10 Our audit examined RMV processes and transactions for the period from April 1, 2009 to August 31, 2010. Our approach consisted of interviews with management and staff at the Department; documentation of systems, policies and procedures; and testing and analysis of transactions and records.

Significant Audit Observations

Driver Testing

Conclusions and summary of observations

Driver's licences were issued in accordance with legislative requirements and Departmental policies for the driver testing cases we reviewed. Driver examiners who administer road tests have received required training. However, the Department does not verify important driver examiner employment criteria, such as having a valid driver's licence and safe driving record. Additionally, the Department's processes for licensing and monitoring of driving schools need to be improved.

7.11 *Driver testing* – Nova Scotians wishing to obtain a learner's licence must successfully complete a vision test and written road signs and rules tests. Customer service representatives administer these tests at 30 testing locations throughout the province. A driver must successfully complete a safe driving practices (road) test to advance from the learner's licence stage to the newly licensed (Class 5N) stage or, in certain cases, for a regular (Class 5) licence. Driver examiners evaluate drivers through the duration of the road tests.

7.12 We selected a sample of 20 individuals who attempted the written road signs and rules tests. 18 passed and received their licence; two were not successful and were not granted a licence. We also examined the records of 14 individuals who obtained their driver's licence (Class 5 or Class 5N) and found that they all successfully passed the required road test.

7.13 *Issuing a driver's licence* – We examined driver's licence transactions processed by the Department. Our results are reported in the transaction controls section of Chapter 8 of this Report.

7.14 *Driver examiner training* – There are 21 driver examiners who conduct road tests. Examiners are required to undergo a ten-week, in-house training period before assuming responsibility for administering road tests. We examined documentation for a sample of nine staff and found they received the required training to carry out their road testing responsibilities.

7.15 *Driver examiner qualifications* – The Department requires a driver examiner to hold a valid driver's licence and have a safe driving record. At the time of our audit, the Department did not have a process to ensure the examiners meet and continue to meet these requirements.

Recommendation 7.1
Service Nova Scotia and Municipal Relations should implement a process to verify that driver examiners meet and continue to meet the position requirements for a valid driver's licence and safe driving record.

7.16 *Driving schools and instructors* – In Nova Scotia, driving schools provide training programs for beginner drivers as well as those who already hold a driver's licence. A new driver must have a minimum of six hours of instruction from a driving school before obtaining a regular (Class 5) licence. It is important that the Department appropriately monitor driving schools to ensure that students are receiving driver training as approved by the Department.

7.17 Driving schools must meet certain criteria to receive a licence which includes having appropriate curriculum, facilities, vehicles and insurance. Both schools and instructors must be licensed. Instructor licensing requirements include completion of a driver instructor course as well as criminal and driving record checks.

7.18 We examined one instructor and nine school applications to determine if they met the requirements for obtaining or renewing their licence. We found five instances in which school licences were issued without required support such as a list of instructors or vehicles, facility layout, evidence of proper vehicle signage, and evidence of dual control brakes. These requirements are necessary to help ensure driving instruction is provided in a safe and effective manner.

Recommendation 7.2
Service Nova Scotia and Municipal Relations should only issue licences to driving schools and instructors when all licensing requirements have been met and documented.

7.19 *Monitoring of driving schools* – In December 2009, the Department initiated an on-site monitoring process to ensure driving schools are offering instruction and maintaining their facilities and vehicles within the guidelines set out in regulations. Staff may also visit a school to investigate a complaint.

7.20 We examined the files for the eight reviews and three complaint investigations carried out during our audit period. In two of the reviews, staff instructed the driving schools to take certain actions or make changes to correct deficiencies. We found no evidence the schools had carried out the instructions or that staff followed up to ensure the corrections were made. Timely follow-up by staff regarding instructions to driving schools is important to ensure deficiencies are addressed and corrected. For two of the complaints, other than a notation in the complaint log, there was no evidence in the files that staff took appropriate action to address the complaint.

Recommendation 7.3
Service Nova Scotia and Municipal Relations should implement a process to follow up complaints and action items resulting from the review of driving schools. The process should include appropriate file documentation standards and timelines for completion.

Driver Monitoring

Conclusions and summary of observations

The Department's processes for identifying and taking action on high-risk drivers are not adequate. The Department does not consistently review drivers' records once high-risk driving behaviour is identified. We found the Department's review of documentation and recording in the RMV system is not timely and a significant backlog of documents for processing exists. We also found the Department is not enforcing deadlines for drivers to provide medical assessments. We recommended a quality assurance process be implemented to ensure drivers are notified of enforcement actions in a timely manner and to ensure accurate recording in the drivers' records.

7.21 *Background* – Under the Motor Vehicle Act, the Registrar of Motor Vehicles can suspend the licence or the privilege of obtaining a licence of any driver deemed medically unfit or potentially dangerous. There are three main groups within the Registry of Motor Vehicles that share responsibility for monitoring driver records.

- The Driver Compliance group is responsible for updating driver records for collisions and convictions reported under the Motor Vehicle Act and the Criminal Code of Canada.
- The Medical Fitness group identifies drivers with medical conditions that could potentially impact their ability to safely operate a motor vehicle.
- The Driver Competency group is responsible for administering intervention and enforcement action against drivers who have exhibited high-risk driving behaviour.

7.22 *Collisions* – For certain motor vehicle accidents, a police officer completes a collision report and submits it to Driver Compliance to update the driver's record. Certain collisions trigger the suspension of a driver's licence, such as driving without insurance; others may warrant a review by Driver Competency, such as any collision involving a motor vehicle and a pedestrian.

7.23 We examined 27 collision reports received and processed by Driver Compliance during our audit period to determine if the collisions were correctly recorded in the RMV system and whether required action was taken. Our results are noted below.

- The 27 reports were correctly recorded in the system.
- Seven of the collisions involved a driver who was not insured. In all seven instances the appropriate suspension was recorded in the driver's record.
- Staff took from two to 288 days to record the information in the system.
- In 16 instances, staff took more than 100 days to record the information in the system.

7.24 Staff are not recording collisions in the RMV system in a timely manner. There was a ten-month backlog of collision reports which had not been processed at the time of our audit. We acknowledge staff review the reports when received to identify and process priority collisions. However, all priority collisions may not be identified and patterns of high-risk driving behaviour could go undetected. Without current information, dangerous

drivers may not be promptly identified and referred to Driver Competency for review and intervention action.

Recommendation 7.4
Service Nova Scotia and Municipal Relations should eliminate the backlog of collision reports for processing.

Recommendation 7.5
Service Nova Scotia and Municipal Relations should implement a process for timely recording of collision reports in the Registry of Motor Vehicles system.

7.25 *24-hour and 90-day suspensions* – Under the Motor Vehicle Act, police can issue drivers a 24-hour or 90-day licence suspension for certain alcohol-related offences. When the police issue a suspension, they forward the suspension form to Driver Compliance for recording in the RMV system. Driver Compliance may refer the driver's record to Driver Competency for review and further action.

7.26 Driver Compliance does not manage the receipt, recording and referral of 24-hour and 90-day suspension forms. Staff do not track the number of forms received from the police, nor those suspensions referred to Driver Competency for review. Similarly, Driver Competency does not track the suspension forms received from Driver Compliance. When suspension reports received are not tracked, Driver Compliance could fail to record certain suspensions in the system and these omissions would go undetected. This could allow a driver with a suspended licence to continue to drive without any means for the police to know the licence was suspended.

Recommendation 7.6
Service Nova Scotia and Municipal Relations should develop a tracking system to record all 24-hour and 90-day suspension reports and to document those reports referred to Driver Competency for further review. The tracking log should be reconciled periodically to ensure all suspensions have been recorded and the required reviews completed.

7.27 *JEIN* – Nova Scotia uses a demerit point rating system to identify drivers who have been convicted of Motor Vehicle Act (MVA) infractions. The Registry of Motor Vehicles system is updated for MVA and Criminal Code convictions through an automated interface with the Department of Justice's Enterprise Information Network (JEIN) system. Action by Driver Compliance, such as warning letters, re-examinations and suspensions, is triggered when a certain number of demerit points have accumulated in a driver's record. A Criminal Code conviction can result in revocation of a licence.

7.28 We examined 30 records which were received through JEIN and recorded in the RMV system. For 29 of the 30 sample items, Driver Compliance took the appropriate action based on the number of demerit points accumulated. In one instance, staff sent a driver with eight demerit points a warning letter rather than a letter requesting an interview. When we reported the error, staff made the correction and sent the appropriate letter. A driver with six to nine demerit points is interviewed as a stronger intervention to change and improve the driver's behaviour.

7.29 *Medical Fitness group* – The Medical Fitness group relies on information from medical professionals, the police and the public to assist in identifying drivers with medical conditions that could impact their ability to safely operate a motor vehicle. Drivers with medical conditions may be required to provide assessments from qualified medical practitioners. The Registrar may suspend a driver's licence until the information is provided if a driver refuses or fails to provide the documentation requested.

7.30 The Medical Fitness group has a process for receiving and reviewing documentation from medical professionals and responding to complaints against drivers. We found staff are not reviewing documentation received in a timely manner. At the time of our audit, staff had not yet reviewed medical documents received in July 2010 (three-month backlog). We were informed staff make an effort, as mail is received, to identify priority documents. However, items may still be missed.

7.31 Evaluation of medical and other related information should be a high priority for the Department. Medically unfit drivers operating motor vehicles pose a risk to public safety. No standards have been established for how long it should take staff to process important medical information. As an example, we reviewed a letter from a doctor indicating a driver was not capable of safely operating a motor vehicle due to a medical condition. It took staff 27 days to review the documentation, record the licence suspension and notify the driver. The driver was still licensed to operate a vehicle for almost a month after being deemed medically unfit to drive.

Recommendation 7.7
Service Nova Scotia and Municipal Relations should eliminate the backlog of medical documentation awaiting review.

Recommendation7.8
Service Nova Scotia and Municipal Relations should implement and monitor standards for appropriate time frames to review and process medical documents received.

7.32 The Medical Fitness group does not enforce medical assessment deadlines for drivers. Drivers are normally given 60 days to comply with a medical assessment request. If the required documentation is not provided when requested, the Department can suspend the driver's licence. The results of our audit testing in this area are noted below.

- There were approximately 290 drivers who had not complied with a request to provide a medical assessment.
- 29 of the outstanding requests were from 2009.
- Following our audit, review by Medical Fitness staff of the 29 outstanding requests resulted in 14 licence suspensions.
- Seven suspensions were eventually rescinded when the requested reports were submitted.
- Staff indicated they reduced the total number of outstanding requests for documentation from 290 to 34.

7.33 Staff noted they do not actively manage deadlines as there is a possibility some drivers provided the documents but they were not reviewed due to the processing backlog. Drivers may also submit the information to an Access Nova Scotia office and it may not get forwarded to the Medical Fitness group. If deadlines are not enforced, the incentive for drivers to provide important medical information is reduced, and drivers who are not medically fit to safely operate a vehicle may continue to drive.

Recommendation 7.9
Service Nova Scotia and Municipal Relations should monitor and enforce deadlines for drivers to provide medical assessments within the required time frame.

7.34 *Driver Competency group* – The Driver Competency group identifies potentially dangerous drivers by reviewing collision reports, vehicle seizure forms, and 24-hour or 90-day suspension forms, along with other correspondence received from the public and police. Based on the review, the Registrar may suspend a driver's licence for an indefinite period. In addition to suspensions, Driver Competency has other options for intervention and enforcement, including warning letters, defensive driving courses, re-examinations or addiction services assessments.

7.35 Driver Competency reviews records of drivers involved in collisions that meet certain criteria. Our sample of 27 collision reports discussed in paragraph 7.23 of this Chapter, included ten that met Driver Competency's criteria for review. Of the ten that should have been reviewed, there was no evidence of this review in two cases. We analyzed collision transactions

from April 2009 to August 2010 and found six instances in which drivers were involved in four or more collisions. In five of the six cases, the driver's record was referred to Driver Competency for review. Staff indicated the sixth driver's record should also have been referred to Driver Competency but was missed in error.

7.36 Driver Competency's process to identify high-risk driver behaviour and take intervention action is not being carried out in a timely manner. In six of ten files we tested, it took between 39 and 106 days for Driver Competency to review reports and notify the driver of the enforcement action. To help ensure public safety, prompt action by the Department is necessary to identify and intervene with individuals who exhibit potentially dangerous driving behaviour.

Recommendation 7.10
Service Nova Scotia and Municipal Relations should implement standards that set out an appropriate time frame for review of, and action on, high-risk drivers' records. These standards should be monitored for compliance.

7.37 *Quality assurance* – The Driver Competency group does not have a quality assurance process to help ensure timely and accurate updating of high-risk drivers' records. Errors and delays in recording information to the RMV system may be identified if a driver's record is referred to Driver Competency for a second time. However, this is not a timely or reliable method to ensure suspensions and other decisions are properly recorded. A systematic review process is a more effective means to ensure high-risk drivers' records are accurately updated.

Recommendation 7.11
Service Nova Scotia and Municipal Relations should implement a quality assurance process to ensure suspensions and other decisions are accurately recorded in the Registry of Motor Vehicles system and drivers are promptly notified.

7.38 *Criteria for review* – In examining the work of Driver Compliance and Driver Competency, we noted inconsistencies in the criteria used by each group to determine whether a driver's record should be reviewed by Driver Competency. For example, six items in our sample of 24-hour or 90-day suspensions met Driver Competency's criteria for review but three were not forwarded by the Driver Compliance group. Staff indicated the records were not referred to Driver Competency because the drivers were already subject to suspension or revocation of their licence as a result of previous driving infractions. However, Driver Competency could determine that an additional suspension or other intervention is warranted and such files should be reviewed to ensure appropriate action is taken.

Recommendation 7.12
Service Nova Scotia and Municipal Relations should implement one set of criteria to identify high-risk drivers' records which require additional review and intervention action.

Motor Vehicle Inspection Monitoring

Conclusions and summary of observations

The Department's processes for monitoring motor vehicle inspection stations and testers are not adequate. We identified weaknesses in several areas. There are poor controls over inspection stickers and renewal of inspection station and tester licences. As well, there is limited audit coverage of stations in some areas of the province, and policies and procedures do not exist or are outdated.

7.39 *Qualifications for station and tester licensing* – The Motor Vehicle Act and regulations set out the requirements for obtaining a motor vehicle inspection (MVI) station or tester licence. Department inspectors verify the suitability of the station facility and equipment to carry out vehicle safety inspections. Inspectors also examine the certification and employment status of the mechanics, who must also be licensed. Upon successful completion of the application and verification process, the Department issues a licence and inspection stickers to the station. A station may employ more than one licensed tester to carry out the inspections.

7.40 *New applications* – Once MVI inspectors have completed their examinations, customer service representatives (CSRs) process new applications for licences. We tested 16 inspection station applications to determine if licensing requirements were met and found 10 instances in which the application form was not correctly completed or required documents were not on file to support the issuance of the licence.

7.41 *Renewals* – Station and tester licences expire on December 31 and must be renewed each year. Generally, station owners renew station and testers' licences at the same time. We examined 12 renewal transactions and found one instance in which the tester's licence was not renewed when the station licence was renewed, nor was it renewed at a later date. The station should not be issued a station licence if there is no licensed tester to carry out the vehicle safety inspections.

Recommendation 7.13
Service Nova Scotia and Municipal Relations should issue motor vehicle inspection licences only when licence requirements are met and documented.

7.42 *Late renewals* – We analyzed licence renewal transactions during our audit period and found 281 station licences (24%) were not renewed until after the expiry date of the previous licences. The majority of the late renewals occurred in January (65%) and February (11%). In both 2009 and 2010, over 15 renewals were more than three months late, with at least two renewals occurring more than six months after the licence had expired. There is no penalty or financial repercussion if a station is late in renewing its licence. Without a valid licence, a station is not legally authorized to carry out vehicle safety inspections.

7.43 CSRs in the Service Delivery division process licence renewals and issue new licences but are not responsible for monitoring the stations and testers and ensuring they renew their licences on time. MVI inspectors, in a separate division within the Department, monitor the stations and testers. However, the inspectors are not part of the licence renewal process and do not have ready access to information from the RMV system regarding which stations have not renewed their licences by the expiry date. Without the necessary information and processes, MVI staff's ability to appropriately monitor licence renewals is compromised.

Recommendation 7.14
Service Nova Scotia and Municipal Relations should implement a process to monitor and ensure stations and testers renew their licences prior to expiry.

7.44 *Inspection stickers* – Licensed stations purchase safety inspection stickers and certificates in books of 25. When sticker books are purchased, CSRs complete a form that lists the range of sticker numbers the station purchased and enter the information in the RMV system. The reverse side of the form states *"Owners must return completed sticker books to receive new sticker books. This will be on a replacement basis only."* When stations return completed books, CSRs are to review the books to ensure all stickers are properly accounted for and complete the sticker book reconciliation process in the RMV system.

7.45 We examined the sticker book purchasing history of nine stations and found five did not return their completed books when new books were purchased. In two of the four cases where the stations returned their completed books, CSRs had not reconciled most or all of the completed books. We also looked at the reconciliation history of six stations for which the sticker book return date could be determined, and noted CSRs took from 0 to 217 days to reconcile the sticker books.

7.46 We analyzed sticker book transactions and found there were over 67,000 sticker books issued from January 2008 to the end of our audit period – August 31, 2010. We noted that over 12,000 of the books issued in 2008

and 2009 had not yet been returned and reconciled. There were 24 stations with more than 100 outstanding books; two of those stations had over 200 outstanding books.

7.47 Control and monitoring of safety inspection stickers are important. Lost or unaccounted for inspection stickers can potentially be misused and sold for cash by station owners and testers, and attached to vehicles without a proper safety inspection. Vehicles that have not been properly inspected may pose a safety risk to the driving public. If staff do not monitor sticker book purchases, ensure stations return completed books, and promptly reconcile returned books, misuse of inspection stickers may go undetected with no intervention action taken.

Recommendation 7.15
Service Nova Scotia and Municipal Relations should implement policies and procedures to ensure inspection stations return completed sticker books, returned sticker books are promptly reconciled, and discrepancies investigated.

Recommendation 7.16
Service Nova Scotia and Municipal Relations should obtain all outstanding completed sticker books.

7.48 We also analyzed and compared late renewal of station licences with sticker book purchases and found the following.

- 84 stations purchased sticker books in December without renewing their licence.
- 11 of the stations purchased books on December 29 or 30.
  - Seven of the 11 stations purchased a single book.
  - Four of the 11 stations purchased from two to five books.
- The station that purchased five books renewed its licence over one month late.
- The station that purchased four books renewed its licence five months late.

7.49 If stations can purchase an unlimited number of sticker books at the end of the year, it reduces the incentive for them to renew their licence in a timely manner. These stations may also be conducting vehicle safety inspections when they are not licensed to do so.

Recommendation 7.17
Service Nova Scotia and Municipal Relations should establish a cut-off date in December and cease issuing sticker books to stations that have not renewed their licence by that date.

7.50 *Station monitoring* – MVI inspectors monitor stations and testers through a variety of means such as audits, investigations, and station checks. The Department currently has five MVI inspectors (a sixth inspector position is currently vacant) and a coordinator to monitor approximately 1,200 stations and 3,000 testers. Each inspector is responsible for monitoring from 122 to 407 inspection stations spread over large geographical areas. For example, one inspector's area of responsibility covers Antigonish, Colchester, Cumberland, East Hants, and Pictou counties.

7.51 *Station audits* – MVI inspectors conduct periodic audits at licensed stations. An audit includes examining a station's sticker books for proper completion and secure storage as well as verifying proper equipment is on hand to perform inspections. The Department does not have a systematic risk-based process for selecting stations for audit. Inspectors select stations for audit based on factors such as complaints or proximity to other work they are doing in an area.

7.52 During our audit period (17 months), inspectors conducted 294 station audits. Each inspector audited from four to 191 stations. Four of the inspectors conducted less than 15 audits during the period. We found audit coverage across the province was not uniform, with stations in some areas more likely to be audited than in others. If the possibility of an audit is high, station owners are more likely to ensure they remain in compliance with the MVI regulations. The effectiveness of the audit process as a deterrent to noncompliance will be weaker in those areas where few audits are conducted.

Recommendation 7.18
Service Nova Scotia and Municipal Relations should implement a risk-based process for inspection station audit selection, set audit targets, and ensure uniform audit coverage across the province.

7.53 *Complaints and investigations* – The Department may receive complaints from the public concerning vehicle safety inspections. Complaints are marked for investigation if the complaint was made within three months of the date of the vehicle inspection or if the vehicle was driven less than 3,000 km after the inspection. MVI administrative staff manually log complaints received. If a complaint meets the criteria, an inspector is assigned to investigate. Inspectors document their follow up of complaints

and other types of investigations on an occurrence report, which they enter into their computer system (CAPS). Administrative staff update the log for completion of the complaint investigation when notified by the inspector.

7.54 We examined nine complaints and occurrence reports and found one instance in which the report recommendation was for a written warning letter to the station for a poor-quality vehicle safety inspection. There was no record a warning letter was issued. In a second case, the report recommendation was for the tester's licence to be suspended. There was no record that this was done. Management informed us that the process for completing occurrence reports changed during our audit period. Previously, inspectors noted their recommendations on the report and signed it off as complete in the CAPS system. Management's subsequent review of the report may have changed the recommendation. Under the revised process, reports are reviewed by management and a recommendation determined before the report is signed off as complete in the system.

7.55 We examined the 55 occurrence reports prepared by inspectors during our audit period and found the following.

- 21 of the reports were not complete.
- 17 of the 21 incomplete reports were outstanding from 2009.
- 13 of the 21 reports were initiated from a complaint.
- Eight of the 13 complaints were not listed in the complaints log.

7.56 Our review of the complaints log found 18 complaints and investigations were still outstanding; 11 of these were outstanding since 2009. Management informed us that previously, if an inspector was contacted directly concerning a complaint, it might not have been recorded in the complaints log. A new process has recently been established whereby all complaints are to be directed to administrative staff for logging and monitoring. We were also informed the log is now being monitored and outstanding complaints followed up with the assigned inspector.

Recommendation 7.19
Service Nova Scotia and Municipal Relations should implement investigation procedures and management oversight processes for motor vehicle safety inspections.

7.57 *Enforcement* – MVI inspectors use a number of tools to help ensure stations and testers stay in compliance with MVI regulations. These include warning letters, licence suspensions and summary offence tickets. Inspectors use their discretion in determining an appropriate response to violations, based on their assessment of the situation and the severity of the violation.

7.58 When we examined the number of tickets issued during our audit period we found 129 tickets were issued but noted a significant variation among inspectors. Individual inspectors issued from two to 69 tickets; two inspectors issued less than five tickets each. While each situation an inspector encounters will have its own unique circumstances, a consistent approach to enforcement is important to help ensure program compliance and fair treatment to all.

Recommendation 7.20
Service Nova Scotia and Municipal Relations should provide written guidance for inspectors on enforcement strategies to assist them in determining appropriate action when they encounter vehicle safety inspection violations.

7.59 *Inspector's manual* – The MVI inspector's manual, which outlines the inspectors' responsibilities and procedures for monitoring stations and testers, has not been updated since 1992, when the inspectors were part of the Department of Transportation. Management indicated they are in the process of updating the manual and documenting their work procedures.

Recommendation 7.21
Service Nova Scotia and Municipal Relations should update its inspector's manual and policies to provide clear and appropriate guidance to motor vehicle safety inspectors.

Response: Service Nova Scotia and Municipal Relations

Service Nova Scotia and Municipal Relations (SNSMR) is pleased to provide a response to the Auditor General's review of Registry of Motor Vehicles.

We appreciate the extensive work done by the Auditor General's staff to identify areas that can be improved in the management of the delivery of this program. This review has provided SNSMR with a number of recommendations that, when implemented, will improve our operations.

SNSMR recognizes the importance of ensuring that:

- only qualified drivers are licensed;
- only drivers who demonstrate safe driving competency are approved to drive; and
- vehicles are monitored to ensure that only roadworthy vehicles receive an approved safety inspection sticker.

The Auditor General's recommendations for SNSMR are accepted in principle and work has begun to implement many of these recommendations. We are also undertaking comprehensive review of motor vehicle compliance operations.

We are confident that the planned review, and the implementation of these recommendations, will strengthen business processes for the Registry of Motor Vehicles.

Recommendation 7.1
Service Nova Scotia and Municipal Relations should implement a process to verify that driver examiners meet and continue to meet the position requirements for a valid driver's licence and safe driving record.

SNSMR agrees with, and has implemented, this recommendation. While SNSMR has always verified that Driver Enhancement Officers have a valid driver's licence and clean driving record at the time of hire, SNSMR did not have a documented policy or process for monitoring on-going compliance. The process was documented in a policy on March 17, 2011 to ensure that this information continues to be validated prior to hire, and annually thereafter. Employer driver abstracts were obtained for all staff currently conducting road examinations. The results indicate that all staff had a valid driver's licence and safe driving record over the last 5 years.

Recommendation 7.2
Service Nova Scotia and Municipal Relations should only issue licences to driving schools and instructors when all licensing requirements have been met and documented.

SNSMR agrees with the recommendation. A check list will be developed, within the next six months, to ensure that all necessary documents have been included with the application.

Recommendation 7.3
Service Nova Scotia and Municipal Relations should implement a process to follow up complaints and action items resulting from the review of driving schools. The process should include appropriate file documentation standards and timelines for completion.

SNSMR agrees with this recommendation. SNSMR will develop and implement a formal process to follow up complaints and action items resulting from the review of driving schools.

Recommendation 7.4
Service Nova Scotia and Municipal Relations should eliminate the backlog of collision reports for processing.

SNSMR agrees that the backlog should be significantly reduced, but it is not practical to eliminate the backlog given the current resources and process employed. SNSMR uses a triage process, so those collisions of highest criticality (injury, death) are processed first. SNSMR has been able to reduce the backlog from ten to eight months, since the end of the field work by Auditor General staff. SNSMR will consider resourcing options to further reduce the backlog. Longer term solutions are being considered and are discussed under Recommendation 7.5.

Recommendation 7.5
Service Nova Scotia and Municipal Relations should implement a process for timely recording of collision reports in the Registry of Motor Vehicles system.

SNSMR agrees with this recommendation. With a significant investment, the most efficient solution would be to have the data entered by police. This option continues to be considered and SNSMR has had preliminary discussions with police agencies around the province to consider options for this automated data entry.

Recommendation 7.6
Service Nova Scotia and Municipal Relations should develop a tracking system to record all 24-hour and 90-day suspension reports and to document those reports referred to Driver Competency for further review. The tracking log should be reconciled periodically to ensure all suspensions have been recorded and the required reviews completed.

RESPONSE: SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS

SNSMR agrees with this recommendation. SNSMR will develop a process to track the receipt and forwarding of reports to the Driver Competency. Further consideration will be given to automation which would provide a more efficient process. SNSMR will also undertake discussions with the Policing Services Division of the Department of Justice to determine if a means can be developed to track the issuance of suspensions by police.

Recommendation 7.7
Service Nova Scotia and Municipal Relations should eliminate the backlog of medical documentation awaiting review.

SNSMR agrees with this recommendation. As of April 1, 2011 the backlog has been cleared and a staff vacancy in this area has been filled.

Recommendation 7.8
Service Nova Scotia and Municipal Relations should implement and monitor standards for appropriate time frames to review and process medical documents received.

SNSMR agrees with this recommendation. SNSMR has adopted a 3-5 day turnaround time, which is currently being met.

Recommendation 7.9
Service Nova Scotia and Municipal Relations should monitor and enforce deadlines for drivers to provide medical assessments within the required time frame.

SNSMR agrees with this recommendation. Standards for submission are being enforced. SNSMR will continue to monitor compliance.

Recommendation 7.10
Service Nova Scotia and Municipal Relations should implement standards that set out an appropriate time frame for review of and action on high-risk drivers' records. These standards should be monitored for compliance.

SNSMR agrees with this recommendation. SNSMR will develop standards, compliance procedures, and an implementation plan over the next 18 months.

Recommendation 7.11
Service Nova Scotia and Municipal Relations should implement a quality assurance process to ensure suspensions and other decisions are accurately recorded in the Registry of Motor Vehicles system and drivers are properly notified.

SNSMR agrees with this recommendation. SNSMR will develop a quality assurance/transaction review process over the next 18 months.

Recommendation 7.12
Service Nova Scotia and Municipal Relations should implement one set of criteria to identify high-risk drivers' records which require additional review and intervention action.

SNSMR agrees with this recommendation. Considering the work of other jurisdictions, SNSMR will develop a common set of criteria for use in assessing high-risk driver records.

Recommendation 7.13
Service Nova Scotia and Municipal Relations should issue motor vehicle inspection licences only when licence requirements are met and documented.

SNSMR agrees with this recommendation. SNSMR will consider control and process improvements that can be made for inspection station and tester licence issuance and renewal.

Recommendation 7.14
Service Nova Scotia and Municipal Relations should implement a process to monitor and ensure stations and testers renew their licenses prior to expiry.

SNSMR agrees with this recommendation. SNSMR will explore process improvements that will streamline this process for stations and testers.

Recommendation 7.15
Service Nova Scotia and Municipal Relations should implement policies and procedures to ensure inspection stations return completed sticker books, returned sticker books are promptly reconciled, and discrepancies investigated.

SNSMR agrees with this recommendation. While it is SNSMR policy to return and reconcile sticker books, there is currently no automated process to facilitate this. Consideration will be given to system, process, and policy enhancements that will mitigate the issue raised.

Recommendation 7.16
Service Nova Scotia and Municipal Relations should obtain all outstanding completed sticker books.

SNSMR agrees with this recommendation. As noted in 7.15, a process will be undertaken to review this policy and our current practices, consider any gaps, and work to resolve any issues.

Recommendation 7.17
Service Nova Scotia and Municipal Relations should establish a cut-off date

in December and cease issuing sticker books to stations that have not renewed their licence by that date.

SNSMR agrees with this recommendation. As noted in recommendations 7.14, 7.15, and 7.16, SNSMR will initiate a review of this process.

Recommendation 7.18
Service Nova Scotia and Municipal Relations should implement a risk-based process for inspection station audit selection, set audit targets, and ensure uniform audit coverage across the province.

RESPONSE: SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS

SNSMR agrees with this recommendation. SNSMR will develop a risk based audit process to ensure uniform coverage across the Province.

Recommendation 7.19
Service Nova Scotia and Municipal Relations should implement investigation procedures and management oversight processes for motor vehicle safety inspections.

SNSMR agrees with this recommendation. SNSMR will implement more robust investigation procedures and management oversight processes for motor vehicle safety inspections. SNSMR will undertake a comprehensive review of motor vehicle compliance operations beginning in May of 2011.

Recommendation 7.20
Service Nova Scotia and Municipal Relations should provide written guidance for inspectors on enforcement strategies to assist them in determining the appropriate action when they encounter vehicle safety inspection violations.

SNSMR agrees with this recommendation. The Department will develop appropriate guidelines.

Recommendation 7.21
Service Nova Scotia and Municipal Relations should update its inspector's manual and policies to provide clear and appropriate guidance to motor vehicle safety inspectors.

SNSMR agree with this recommendation. SNSMR will update it's inspector's manual and policies to provide clear and appropriate guidance to motor vehicle safety inspectors.

8 Service Nova Scotia and Municipal Relations: Registry of Motor Vehicles Information and Technology

Summary

The Department of Service Nova Scotia and Municipal Relations does not have adequate controls to ensure the confidentiality and integrity of the information in its Registry of Motor Vehicles (RMV) systems. Nova Scotians who operate or own a motor vehicle are required to provide personal, sensitive information to the Department and strong controls are needed to protect the privacy and safety of these individuals. Stronger controls are needed to prevent such offences as credit card fraud, identity theft, and drivers having fraudulently-obtained licenses.

Processes to provide access to RMV systems are not documented and the removal of access privileges is deficient. Some users of RMV systems have access to confidential information they do not need to perform their job, and their access privileges are not always removed when they change job responsibilities or leave the Department.

The Department cannot be assured it provides licences, permits and identification cards only to those who are eligible to receive them. Potentially, certificates and cards could be issued based on fraudulent misrepresentations by customers or inappropriate actions of employees.

Privacy policies are not always followed. When processing transactions, some employees make photocopies of sensitive identity documents as part of the process to verify the customer's identity. Department policy states that such information is not to be retained. Further, any credit card information retained in this manner is against rules established by credit card companies when they authorize the use of their cards for receipt of payments. This is further complicated by the fact that the Department is unable to determine if its employees view this information, as well as other sensitive registry information, for their own personal knowledge or gain.

The Department provides RMV systems access to many other provincial, municipal and federal government entities, as well as some private-sector and non-government organizations. The Department does not have policies or procedures for sharing registry information in the course of business and it is at risk of providing this information in a manner that violates the laws and regulations protecting the privacy of information. Some sharing arrangements are not supported by a signed information sharing agreement, and some arrangements that are supported by agreements are outdated and do not reflect all current standards and legislation.

8 Service Nova Scotia and Municipal Relations: Registry of Motor Vehicles Information and Technology

Background

SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS: REGISTRY OF MOTOR VEHICLES INFORMATION AND TECHNOLOGY

8.1 The Department of Service Nova Scotia and Municipal Relations (SNSMR) operates the Registry of Motor Vehicles (RMV). RMV collects significant amounts of information in a database to support its processing of transactions relating to the operation and ownership of motor vehicles. This information includes names, birth dates, residential addresses, driving histories, vehicle ownership, licence plates, and motor vehicle fines and suspensions, which are used by RMV in its issuance and management of photo identification cards, licence plates, driver's licences, vehicle ownership documents and vehicle permits.

8.2 RMV systems are supported by other systems within the provincial government.

- Judgments and fines under the Motor Vehicle Act are processed through the Department of Justice and are connected to RMV through the Justice Enterprise Information Network.
- The summarized health information stored in RMV systems is supported by information in a separate database, the Road Safety Medical System. SNSMR is also responsible for this database. It contains detailed health information of certain drivers.
- Filenet is an electronic document repository at SNSMR that contains all scanned documents used to support RMV transactions. This includes application forms, statements of insurance, and vehicle purchases and sales certificates.

8.3 Customer service representatives at SNSMR use RMV systems to process transactions and to look up information for customers. Numerous other entities have access to RMV information, such as other provincial government departments (e.g., Community Services); the federal government (e.g., Canada Revenue Agency, Statistics Canada, Elections Canada); municipal governments (e.g., police agencies); and certain private-sector and non-government organizations.

8.4 Much of the information maintained in these systems is personal and sensitive. Proper management of the information technology supporting RMV operations is critical to ensuring the confidentiality and integrity

of such information. As well, strong controls are essential to protect the public from negative experiences such as fraud and identity theft.

8.5 In addition, RMV needs strong controls to ensure only properly qualified, competent and safe drivers are licensed to operate a motor vehicle, and only roadworthy motor vehicles are safety approved. Audit work was conducted to address these issues and is reported in Chapter 7 of this Report.

Audit Objectives and Scope

8.6 Early in 2011 we completed an audit of the use of information and technology by the Registry of Motor Vehicles. The engagement was conducted in accordance with Sections 18 and 21 of the Auditor General Act and auditing standards established by the Canadian Institute of Chartered Accountants.

8.7 The purpose of our audit was to determine if there are sufficient controls in place to ensure the protection and accuracy of information collected and stored in RMV systems. Audit fieldwork was conducted between September 2010 and January 2011, which included testing of transactions dated between April 1, 2009 and August 31, 2010.

8.8 Our audit objectives were to assess the adequacy of:

- controls to ensure completeness, accuracy and availability of information collected, produced and reported;
- fraud prevention practices, policies and procedures;
- systems and processes to protect the privacy of information collected and stored; and
- control over information shared with other government entities.

8.9 The majority of the criteria used to audit RMV IT processes and controls were obtained from the IT Governance Institute's framework, *Control Objectives for Information and related Technology (COBIT 4.1)*, which is a widely-accepted international source of best practices for the governance, control, management and audit of IT operations. Other audit criteria were developed specifically for this engagement.

8.10 These objectives and criteria were discussed with, and accepted as appropriate by, senior management of the Department.

Transaction Controls

Conclusions and summary of observations

SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS: REGISTRY OF MOTOR VEHICLES INFORMATION AND TECHNOLOGY

The Department of Service Nova Scotia and Municipal Relations has policies and procedures to guide the processing of transactions within RMV systems, but compliance can be improved. We found that processed transactions are reviewed to monitor whether SNSMR policies and procedures are followed, however the timing and nature of these reviews are not consistent across the province. As a result, there is risk that transactions are being processed for customers with invalid identification, thereby providing permits and licenses to ineligible individuals.

8.11 *Collection of information* – Customer service representatives of SNSMR's Service Delivery division collect, assess and input motor vehicle and driver information into RMV systems. They are responsible for ensuring that appropriate forms for each transaction are completed in accordance with departmental policies. Depending on the type of transaction, there are different requirements for the retention of supporting documentation.

8.12 We selected a sample of 90 transactions dated between April 1, 2009 and August 31, 2010 to test whether department policies and procedures were followed. We selected:

- 30 vehicle-related transactions;
- 15 photo identifications and licence renewals; and
- 45 licence testing transactions.

8.13 *Vehicle transactions* – We found that appropriate documentation is retained for transactions related to vehicle registrations, permits and plates.

8.14 *Photo identification cards* – Two photo identification transactions did not have sufficient documentation to indicate that the identity of the applicant was appropriately verified before a card was issued.

8.15 *Driver's licence transactions* – Our testing of driver's licensing transactions included learner's licences (Class 7), upgrading to a newly licensed driver's licence (Class 5N), exiting the graduated driving licensing program (Class 5), and obtaining a new licence through exchange of an existing licence. Our findings were as follows.

- All 12 of the learner drivers in our sample were at least 16 years of age, as required. Of nine instances in which parental consent was required, there was no evidence of consent in one file.

- One of the nine records that required evidence of completion of a driver's education course did not contain sufficient information to identify the driving school.
- There were five transactions that did not record the correct transaction type or previous driver's licence held.
- For one transaction there was no application form on file to document required signatures and the types of identification reviewed.
- All eight newly licensed drivers in our sample completed the proper waiting period before obtaining their Class 5N licence.
- All four drivers in our sample who exited the graduated driver licensing program met the requirements of the program.
- An Interprovincial Records Exchange network check was completed for the 11 licence exchanges in which it was necessary.
- Many licensing transactions require the creation of a new master number. This is the unique identifier for each customer in the registry. Customers must present certain verification documents for these transactions. The type of identification presented and reviewed is to be noted on the application form. The creation of a new master number was required for 27 of the 45 licensing transactions we tested. There was one transaction in which there was no indication on the application form that any of the required identification was presented.

8.16 Employees have their transactions reviewed on a periodic basis to determine if they are following the Department's policies and procedures. These reviews attempt to identify and correct processing errors. While we saw evidence that reviews were being completed, management informed us that the timing and nature of the reviews are not consistent between Service Delivery and Non-service Delivery staff. Therefore, there is risk that errors are not being detected and corrected.

Recommendation 8.1
Service Nova Scotia and Municipal Relations should implement and adhere to a transaction review process for all staff members who enter transactions into the Registry of Motor Vehicles systems.

Access Management Controls

Conclusions and summary of observations

There are deficiencies in the management of access to Registry of Motor Vehicles systems. Some system users have more access than required to perform their jobs. There is no process to identify and remove dormant user accounts. Improper access management increases the risk of unauthorized viewing or use of confidential information.

8.17 *Background* – Access management is the process of providing authorized individuals with computer accounts, setting and changing their ability to access different types of information, and removing those accounts when access is no longer needed. To ensure the security of confidential information in RMV systems, individuals should only be able to access the specific information needed to perform their tasks. When access is no longer required due to job changes or termination of employment, an account should be immediately deactivated. Individuals terminated could retaliate by disclosing, modifying or deleting sensitive information if prompt deactivation of their user accounts does not occur.

8.18 *Access management process* – There are no policies or procedures describing the process that system administrators are to follow to manage access to RMV systems. Requests for access and changes to current access privileges are submitted via email or paper memos. There are no standardized forms with unique identification numbers to control the authorization, tracking and management of access requests.

8.19 There are currently two separate processes to manage access. One process manages access of employees who provide services to customers (Service Delivery). Another process manages access for all other users, whether internal or external to the Provincial government (Non-service Delivery). A separate system administrator manages access for each group. We observed that each system administrator retains different supporting documentation and uses different methods to file that documentation. Multiple processes increase the risk that access is not granted and terminated appropriately.

8.20 We tested samples of newly hired, newly assigned, transferred, and terminated system users to determine if there was adequate management of their access privileges. We found the following areas of concern.

- Non-service Delivery access requests are filed together, but are not catalogued for easy retrieval and review. We found access requests for all of our sample items, but there was no documentation to support the level of access provided to two individuals.

- The time taken to remove system access for Service Delivery employees leaving the Department ranged from three to 425 days. Five accounts had been set as inactive, but there was no record indicating when these accounts were disabled.

- There is no periodic review of user accounts to minimize the existence of dormant accounts. Dormant accounts are active accounts that are not being used by their registered owner. They can become targets for malicious individuals to gain access to a computer system. There is also risk that a terminated employee can provide an existing employee with their username and password, thus providing the existing employee with elevated access to the system.

- Our review of registry user accounts identified that 155 of the 680 accounts are considered dormant.

8.21 We also found poor control over the level of access assigned to some users.

- Employees at the Department of Community Services require inquiry-only access to the registry for specific information. However, they have been assigned more access than needed, which may impact customer privacy.

- We tested ten user accounts with the ability to back out transactions posted to the registry. One of those ten also had the ability to post transactions. No one should have the ability to perform both of these functions because it represents poor segregation of duties and increases the risk of abuse. It was also determined that this individual had changed positions in the Department and should not have retained the ability to back out transactions.

- We tested 59 user accounts with the ability to authorize transactions as supervisors. Four of those individuals no longer required that level of access due to changes in their job responsibilities.

- We identified 14 instances in which access privileges were not updated for changes in personnel. This could lead to individuals who have changed jobs but are still employed by the government accessing information they do not require for their current jobs.

8.22 Without appropriate and consistent processes, managing and controlling access to RMV systems is more difficult. Individuals may gain or retain inappropriate levels of access which can negatively impact the confidentiality, integrity and availability of information in the system.

Recommendation 8.2
Service Nova Scotia and Municipal Relations should improve its management of access to Registry of Motor Vehicles systems, including:

- the use of consistent processes;
- better documentation and tracking of the granting and changing of access privileges;
- provision of access to only the information needed by a system user;
- avoidance of segregation of duties problems;
- more timely deletion of access privileges when they are no longer needed; and
- removal of dormant user accounts.

Fraud Controls

Conclusions and summary of observations

Compliance with fraud prevention policies and procedures is monitored. However, the Department does not have adequate controls to prevent fraudulent transactions by customers or employees. Deficiencies were also found in fraud prevention training. Strong controls over day-to-day processing of registry transactions are critical to preventing fraudulent activity and maintaining the completeness and accuracy of RMV systems information.

8.23 *Monitoring* – The Department has an internal audit group which consists of four individuals who are independent of the customer service representatives. The primary purposes of the group are to monitor exception reports and perform reconciliations of inventory and financial transactions. Inventory consists primarily of licence plates and stickers, blank registration and permit certificates, and blank driver's licences and photo identification cards.

8.24 We found there are regular reports to enable management and internal auditors to watch for unusual transactions and trends. There are also regular reports to reconcile inventories and monitor financial transactions. The internal audit group is responsible for investigating any discrepancies or anomalies identified. We saw documented evidence of the internal audit group's investigations.

8.25 Supervisors are responsible for monitoring inventory, including regular spot-checks of sequentially-numbered documents. We also saw evidence of this process.

8.26 *Prevention of fraudulent transactions* – The Department is at risk of issuing certificates and cards based on fraudulent misrepresentations by customers or inappropriate actions of employees. These weaknesses are not mitigated by the monitoring procedures noted above.

- Customers are required to complete a statement of insurance for some RMV transactions, but staff members do not validate the accuracy of the information submitted.
- Customers who have lost their licence or photo identification are able to send a fax authorizing another individual to pick up their replacement card. There are no procedures to validate the identity of the person sending the fax or the person picking up the new card.
- Learner's licences, medical assessments and accessible parking permits require applicants to obtain specific signatures before the transaction can proceed (e.g., parents, doctors). There is no verification that these signatures are legitimate.

Recommendation 8.3
Service Nova Scotia and Municipal Relations should develop processes for verifying information received from customers, at least on a test basis subsequent to the transaction.

8.27 *Fraud training* – Driver's licences and photo identification cards issued by the government of Nova Scotia are meant to be very secure forms of identification. The documents used to authenticate a customer and validate information they provide need to be assessed to ensure they are authentic. We found that customer service representatives are provided with some guidance and visual aids for assessing the validity of identification documents. However, comprehensive training has only been provided to one member of management.

Recommendation 8.4
Service Nova Scotia and Municipal Relations should provide fraud training to all staff responsible for assessing the authenticity of identification documents.

Privacy Controls

Conclusions and summary of observations

There are documented policies and procedures to protect the privacy of sensitive information maintained by SNSMR. However, there are deficiencies with respect to the collection and retention of unneeded personal information that could subject

customers to fraud or identity theft, and could impact on the Province's ability to conduct business using credit cards. There are also deficiencies with respect to the monitoring of access to registry information. Due to the sensitive nature of some of the information collected, it is imperative that registry information be protected from inappropriate exposure.

8.28 *Privacy policies* – The Department has policies regarding the protection of confidential information in accordance with privacy legislation. In addition, all system users are required to sign a confidentiality agreement to document their acknowledgement and understanding of those policies. We found that this requirement is not being enforced for all system users. Without signed agreements, the Department cannot be assured that all system users are knowledgeable of their responsibilities to protect private information.

Recommendation 8.5
Service Nova Scotia and Municipal Relations should enforce the requirement that all system users read and sign a confidentiality agreement before being granted access to Registry of Motor Vehicles systems.

8.29 *Monitoring of information retained* – Department policies and procedures identify documents that customer service representatives are to copy and retain for specific transactions. However, there is no monitoring of information collected.

8.30 When new customers apply for a photo identification card or a driver's license, they must provide multiple pieces of identification. These include one primary piece of identification, such as a birth certificate or passport, and two other pieces of identification that contain a signature. The specific types of identification provided are to be recorded by customer service representatives on the forms that support the transaction. However, there is no requirement to copy and retain such documents.

8.31 During our testing of RMV transactions we noted that photocopies of identification documents are sometimes included in registry files. We believe that retaining copies of identification documents would help control the risk of employees issuing fraudulent cards, and the Department should have a policy to retain such photocopies. However, the photocopies we found included customer's social insurance numbers, credit card numbers, card bearer names, expiry dates and the three-digit security numbers located on the back of credit cards. All documentation used to support such transactions, including the photocopied identification documents, is electronically scanned, backed up to electronic media, and uploaded to an electronic file repository. During this process, no sensitive private information is redacted or encrypted. Accordingly, this sensitive

information can be viewed by individuals who have access to the electronic file repository, as well as by those who scan and destroy the paper copies. This places customers at increased risk of identity theft and fraudulent use of their credit cards.

8.32 All entities receiving payment by way of credit cards must follow the payment card industry's data security standard. This standard prohibits the retention of credit card numbers unless they are encrypted. Further, the standard does not allow the retention of the three-digit security number in any format. In the event credit card information is used fraudulently due to the Department's poor data retention practices and noncompliance with credit card industry standards, the government could be fined, or even lose its ability to accept credit card payments.

Recommendation 8.6
Service Nova Scotia and Municipal Relations should create and enforce policies to prevent the retention of personal information that is not required to complete a transaction.

8.33 *Monitoring access to information* – The various users of RMV systems require different levels of access to information to perform their assigned duties. This includes the ability to view private information of thousands of individuals, such as names, birth dates, residential addresses, driving histories, vehicle ownership, licence plates, and motor vehicle fines and suspensions.

8.34 System users can view such sensitive information for personal use, gain or knowledge because no one is monitoring users' access to such information. Reports can be generated from system access logs to allow monitoring, but this is not happening. In addition, RMV's logs of users' actions contain only 14 days of data, so they cannot be used to investigate suspicious events that have occurred before that time span.

Recommendation 8.7
Service Nova Scotia and Municipal Relations should develop access log reports and use them to monitor for inappropriate access to Registry of Motor Vehicles' customer records.

Sharing of Information

Conclusions and summary of observations

SNSMR is currently misinforming some customers by indicating that their information is not being shared. Additionally, the Department does not have a policy for its sharing of registry information to fulfill business obligations. Some sharing arrangements are not supported by a written agreement, and some arrangements that are supported by agreements are outdated and do not reflect all current standards and legislation. As a result, SNSMR is at risk of providing information that is in violation of laws and regulations protecting the privacy of information.

8.35 *Privacy statement* – The Department is restricted by the Freedom of Information and Protection of Privacy (FOIPOP) Act from disclosing personal information obtained from Nova Scotians to persons or entities outside of the provincial government, unless certain criteria are met. However, Section 5(3) of the Act permits the Registry to disclose personal information if an information sharing arrangement was in place before the FOIPOP Act was proclaimed in 1993.

8.36 A privacy statement provided to customers conducting online transactions states *"We do not disclose your personal information to other organizations or individuals, except as required to fulfill the purpose(s) of the transaction or only to the extent required by law."* This is not an accurate statement. Every year, the Department prepares a report containing the names, addresses and master numbers of Nova Scotia drivers in its motor vehicle registry and provides it to The War Amps to support its key tag service. Whereas this sharing of information is permitted by the Freedom of Information and Protection of Privacy Act, the Department's privacy statement is inconsistent with the practice. Further, there is no need to provide The War Amps with master numbers.

Recommendation 8.8
Service Nova Scotia and Municipal Relations should have a process to ensure privacy statements provided to customers are accurate.

Recommendation 8.9
Service Nova Scotia and Municipal Relations should have a process to ensure only necessary information is shared with external organizations.

8.37 *Policies for sharing information* – SNSMR shares information from RMV systems with other provincial government departments (e.g., Community Services); the federal government (e.g., Canada Revenue Agency, Statistics

Canada, Elections Canada); municipal governments (e.g., police agencies); and certain private-sector and non-government organizations.

8.38 These sharing arrangements should be carefully administered in accordance with the FOIPOP Act, which states:

> *"24 (1) Personal information should not be collected by or for a public body unless:*
>
> *(a) the collection of that information is expressly authorized by or pursuant to an act,*
>
> *(b) that information is collected for the purpose of law enforcement; or*
>
> *(c) that information relates directly to and is necessary for an operating program or activity of the public body."*

8.39 Section 26 (a) of the FOIPOP Act also calls for the monitoring of information sharing arrangements to determine if information provided is being used *"for the purpose for which that information was obtained or compiled, or for a use compatible with that purpose."* Section 24(3) states *"The head of a public body shall protect personal information by making reasonable security arrangements against such risks as unauthorized access, collection, use, disclosure or disposal."*

8.40 We believe signed information sharing agreements are needed to ensure compliance with provincial legislation, as well as to secure the use of such sensitive information. We found that most of the Department's information sharing arrangements are supported by memoranda of understanding or other forms of agreement, and they generally address the maintaining of data security and confidentiality.

8.41 However, some of the information sharing agreements were outdated and did not reflect current standards or legislation. If the level of care over shared information is not defined, disclosure of personal information could occur, and such disclosure could result in legal proceedings against the government. An outdated agreement indicates that it may not reflect current business needs, standards, laws and regulations. This increases the risk of misuse or poor control of information that is shared.

8.42 We did find some cases in which information was being shared without a signed agreement. When agreements do not exist, applicable regulatory or privacy requirements are not defined and agreed upon. This increases the risk of inappropriate use or disclosure of such information.

8.43 The Department does not have a policy to guide its administration of information sharing arrangements. This makes it more difficult for the Department to ensure that registry information is being shared for valid business purposes and that all applicable legislation is being followed.

Recommendation 8.10
Service Nova Scotia and Municipal Relations should develop and follow a comprehensive policy with respect to the sharing of Registry of Motor Vehicles' customer information. The policy should indicate all external parties receiving information from and providing information to the Registry of Motor Vehicles, and set out requirements to administer information sharing agreements on a continual basis.

IT Security Controls

Conclusions and summary of observations

Personal information is not secure in the test environment or the training environment of RMV systems. A related database, the Road Safety Medical System, has weaknesses in the security of its data. These deficiencies expose sensitive personal information to inappropriate use by persons who can access registry systems.

8.44 *Training environment and test environment* – The Department regularly makes copies of the data in its registry system (the live environment) to maintain two other separate computer environments. One is used to train employees and the other to test software changes. This allows training and testing activities to occur without slowing down registry systems and delaying service to customers.

8.45 We observed that the training environment does not require a unique username or password to access it, allowing unauthorized government employees to have full access to the personal information in the database. This includes names, birth dates, residential addresses, driving histories, vehicle ownership, licence plates, as well as motor vehicle fines and suspensions.

8.46 The test environment normally requires a username and password for access. However, during our audit, the Department disabled user authentication in the test environment for two days to test a change to its registry system. For these two days the information in the system was exposed to potential unauthorized access.

Recommendation 8.11
Service Nova Scotia and Municipal Relations should control access to the Registry of Motor Vehicles' training environment and test environment with the same level of rigor used for its live environment. Alternatively, it should not use data from its live systems in its training and test environments.

8.47 *Road Safety Medical System* – SNSMR obtains medical information for some licensed drivers as part of its mandate to preserve the safety of the driving public. The Road Safety Medical System (RSMS), isolated from other Department systems, is used to retain this sensitive personal information. Any updates to the registry for this information are performed manually and are summary in nature. Accordingly, details of medical information are recorded only in the RSMS.

8.48 Access to RSMS should be limited to specific employees who process medical records. We reviewed RSMS user accounts and found that seven of the 21 accounts pertain to individuals who no longer require access to the system. Their access privileges should have been removed.

8.49 Given the sensitive nature of the information contained within RSMS, and the ability of all government employees to access the login screen for the application, the use of strong passwords is critical. Our review of configuration settings for RSMS identified that it does not force users to create strong passwords. This increases the risk of someone cracking a password and inappropriately accessing sensitive personal information.

Recommendation 8.12
Service Nova Scotia and Municipal Relations should increase the security around the data in its Road Safety Medical System by regularly reviewing user accounts to ensure all accounts are still required, and by changing the configuration settings of the system to require stronger passwords.

8.50 *Oracle database* – The Oracle database supporting RMV systems is shared with the vital statistics registry. We reported in our November 2010 Report, based on our audit of the vital statistics registry, that the Oracle database had not been patched since 2008. We reviewed the current status of the database and determined that it has still not been patched. Patches are software changes issued by software vendors, many of which are intended to correct identified security vulnerabilities. They should be implemented as soon as they are tested in order to provide adequate security against hackers and malicious users.

Recommendation 8.13
The Chief Information Office should test and implement security patches for its Oracle database in a timely manner.

Response: Service Nova Scotia and Municipal Relations

Service Nova Scotia and Municipal Relations (SNSMR) is pleased to provide a response to the Auditor General's review of Registry of Motor Vehicles Information and Technology.

We appreciate the extensive work done by the Auditor General's staff to identify areas that can be improved in the management of the delivery of this program. This review has provided SNSMR with a number of recommendations that, when implemented, will improve our operations.

SNSMR recognizes the importance of minimizing the risk of unauthorized access to the Registry of Motor Vehicles, ensuring that licenses, permits, and identification cards are only provided to eligible recipients, and that privacy policies and practices are defined, are current, and are followed.

The Auditor General's recommendations for SNSMR are accepted in principle and work has begun to implement many of these recommendations. We are confident that the implementation of these recommendations will strengthen both the business process and information technology for the Registry of Motor Vehicles.

Recommendation 8.1
Service Nova Scotia and Municipal Relations should implement and adhere to a transaction review process for all staff members who enter transactions into the Registry of Motor Vehicles systems.

SNSMR agrees with this recommendation. SNSMR has a transaction review process for Service Delivery staff, which represents 95% of users. This will be expanded to include all departmental staff in the next 18 months.

Recommendation 8.2
Service Nova Scotia and Municipal Relations should improve its management of access to Registry of Motor Vehicles systems, including:

- ***the use of consistent processes;***
- ***better documentation and tracking of the granting and changing of access privileges;***
- ***provision of access to only the information needed by a system user;***
- ***avoidance of segregation of duties problems;***
- ***more timely deletion of access privileges when they are no longer needed; and***
- ***removal of dormant user accounts.***

SNSMR agrees with this recommendation. SNSMR will continue to improve the current user account lifecycle management processes to ensure that all network,

application, operating system and database accounts are current and assigned the appropriate privileges.

Recommendation 8.3
Service Nova Scotia and Municipal Relations should develop processes for verifying information received from customers, at least on a test basis subsequent to the transaction.

SNSMR agrees with this recommendation and has processes in place to verify information based on the associated risk. For example, an accessible parking permit tag is not considered a high risk transaction. In cases where there is reason to suspect wrong doing, which the Auditor General notes that SNSMR regularly runs reports to watch for unusual transactions or trends (8.24), SNSMR does make contact with customers and authorizing agents.

Recommendation 8.4
Service Nova Scotia and Municipal Relations should provide fraud training to all staff responsible for assessing the authenticity of identification documents.

SNSMR agrees with the recommendation. SNSMR recently invited the Internal Audit staff from the Department of Finance to develop and deliver fraud awareness materials and training to several front line staff. This has been well received and we will continue to seek, develop, and deliver training programs that enhance our operations and reduce our risk of fraud.

Recommendation 8.5
Service Nova Scotia and Municipal Relations should enforce the requirement that all system users read and sign a confidentiality agreement before being granted access to Registry of Motor Vehicles systems.

SNSMR agrees with this recommendation. An employee responsibility package containing a number of policies and protocols, including a confidentiality agreement, is signed by all Service Delivery front line employees each year. Over the next 18 months, this will be rolled out to all employees who have access to the RMV system.

Recommendation 8.6
Service Nova Scotia and Municipal Relations should create and enforce policies to prevent the retention of personal information that is not required to complete a transaction.

SNSMR agrees with this recommendation. Service Delivery has provided a reminder to front line staff that secondary identification may not be copied or retained. In addition, a process has been established to identify situations where staff do not adhere to this process prior to the sensitive information being

scanned. The incidents will also be reported to ensure the matter is addressed with the appropriate staff.

Recommendation 8.7
Service Nova Scotia and Municipal Relations should develop access log reports and use them to monitor for inappropriate access to Registry of Motor Vehicles' customer records.

RESPONSE: SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS

SNSMR agrees with this recommendation. Access logs exist but are not consistently used for monitoring purposes. Over the next 12 months, SNSMR will initiate an analysis to determine the most efficient approach to meet this recommendation.

Recommendation 8.8
Service Nova Scotia and Municipal Relations should have a process to ensure privacy statements provided to customers are accurate.

SNSMR agrees with this recommendation. SNSMR will revise our privacy statements within 3 months.

Recommendation 8.9
Service Nova Scotia and Municipal Relations should have a process to ensure only necessary information is shared with external organizations.

SNSMR agrees with this recommendation. SNSMR will review where information is shared with external organizations and ensure that only necessary information is provided.

Recommendation 8.10
Service Nova Scotia and Municipal Relations should develop and follow a comprehensive policy with respect to the sharing of Registry of Motor Vehicles' customer information. The policy should indicate all external parties receiving information from and providing information to the Registry of Motor Vehicles, and set out requirements to administer information sharing agreements on a continual basis.

SNSMR agrees with this recommendation. SNSMR has initiated work to establish a comprehensive policy and to review all existing information sharing arrangements. It is expected that this review will be completed within 12 months.

Recommendation 8.11
Service Nova Scotia and Municipal Relations should control access to the Registry of Motor Vehicles' training environment and test environment with the same level of rigor used for its live environment. Alternatively, it should not use data from its live systems in its training and test environments.

SNSMR agrees with this recommendation. SNSMR is evaluating data masking technologies that will replace sensitive information with realistic but not real data. We expect this recommendation to be implemented within 18 months.

Recommendation 8.12
Service Nova Scotia and Municipal Relations should increase the security around the data in its Road Safety Medical System by regularly reviewing user accounts to ensure all accounts are still required, and by changing the configuration settings of the system to require stronger passwords.

RESPONSE: SERVICE NOVA SCOTIA AND MUNICIPAL RELATIONS

SNSMR agrees with this recommendation. This will be included in the comprehensive practice and protocols established in support of recommendation 8.2.

Recommendation 8.13
The Chief Information Office should test and implement security patches for its Oracle database in a timely manner.

SNSMR has forwarded this recommendation to colleagues at the Chief Information Office for consideration.

Response: Chief Information Office

The Chief Information Office would like to thank the staff of the Auditor General for their courtesy and professionalism while conducting this audit. One of the responsibilities of the Office is to supply infrastructure support services to departments including Service Nova Scotia and Municipal Relations. We are committed to providing quality secure services to our client departments.

RESPONSE: CHIEF INFORMATION OFFICE

The Chief Information Office has recently taken on the support responsibilities from the Corporate Service Units and from Corporate IT Operations for a good deal of government's infrastructure. Much of the efforts to date have been in rationalizing infrastructure and services, simplifying our technical environment and continuously working to evolve and advance our security measures as technology changes. We are focused on adopting best practices for the processes that support the infrastructure environment.

The Auditor General's recommendation related to the Chief Information Office is accepted in principle. Work began last fiscal year to address this recommendation and will continue until completed.