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Report of the Auditor General on Health Sector Contracts – Phase 1

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Honourable Derek Bennett, MHA

PUBLIC ACCOUNTS COMMITTEE

Report of the Auditor General on Health Sector Contracts – Phase 1

Chair: Pleaman Forsey, MHA

Vice-Chair: Lucy Stoyles, MHA

Members: Joedy Wall, MHA
Perry Trimper, MHA

Clerk of the Committee: Bobbi Russell

Appearing:

Office of the Auditor General

Denise Hanrahan, Auditor General
Sandra Russell, Deputy Auditor General
Brad Brown, Assistant Auditor General

Newfoundland and Labrador Health Services

Dr. Pat Parfrey, Chief Executive Officer
Scott Bishop, Vice-President, Corporate Services
Debbie Molloy, Vice-President, Human Resources
Joanne Pelley, Chief Nursing Information Officer (acting) and Provincial Chief Nursing Officer

House of Assembly Service

Bobbi Russell, Principal Clerk of Committees
Evan Beazley, Committee Analyst

The Committee met at 1 p.m. in the House of Assembly Chamber.

CHAIR (Forsey): Okay, thank you.

First of all, I'd like to call the meeting to order. Welcome to the Public Accounts Committee public hearing respecting the Health Sector Contracts – Phase 1, Auditor General report.

The Committee wishes to thank the witnesses from Newfoundland and Labrador Health Services who are appearing here today, as well as the Auditor General, Denise Hanrahan, and officials from her team.

The Standing Committee on Public Accounts is dedicated to improving public administration in partnership with the Auditor General. The Committee examines the administration of government policy, not the merits of it, and strives to achieve consensus in its decisions whenever possible. Members take a non-partisan approach to the work on this Committee.

Before we start the review on matters of consideration, we will proceed with introductions of the Committee Members, followed by the Auditor General and her officials, then the witnesses appearing.

When called upon, please raise your hand. Your microphone will be activated. The tally light on the desk will turn red when it is turned on and identify yourself by saying your name.

I'll start first. I'm Pleaman Forsey, Member for Exploits, Chair of the Public Accounts Committee.

L. STOYLES: Thank you.

Lucy Stoyles, MHA for Mount Pearl and Vice-Chair of the Committee.

J. WALL: Joedy Wall, MHA, Cape St. Francis.

P. TRIMPER: Perry Trimper, MHA for Lake Melville.

D. HANRAHAN: Denise Hanrahan, Auditor General, Newfoundland and Labrador.

S. RUSSELL: Sandra Russell, Deputy Auditor General.

B. BROWN: Brad Brown, Assistant Auditor General.

P. PARFREY: Pat Parfrey, CEO, NLHS.

S. BISHOP: Scott Bishop, Vice-President, Corporate Services, NLHS.

D. MOLLOY: Debbie Molloy, Vice-President, Human Resources, NLHS.

J. PELLEY: Joanne Pelley, Vice President, Provincial Chief Nursing Officer and acting as Chief Operations Officer for Labrador-Grenfell zone.

CHAIR: Thank you.

I will now outline how the hearing will proceed, as well as remind some witnesses and Members.

Before I call the Clerk to swear affirm the witnesses, the hearing will proceed as follows. First, I'll invite the CEO of NLHS to make opening remarks, then the Committee Members will pose questions in turns of 10-minute periods. These rounds will continue until the Committee Members have exhausted all their questions.

Witnesses are reminded that this is a public meeting, and your testimony here today will be part of public record. Witnesses appearing before the Standing Committee of the House of Assembly are entitled to the same rights granted to Members respecting parliamentary privilege. Witnesses may speak freely, and what you say in this parliamentary proceeding may not be used against you in civil proceedings.

Live audio will be streamed on the House of Assembly website and social media channels, and an archived version will be available following the hearing. *Hansard* will also be available once finalized.

I now ask the Clerk to administer oaths or affirmations to witnesses.

Swearing of Witnesses

Dr. Pat Parfrey
Mr. Scott Bishop
Ms. Debbie Molloy
Ms. Joanne Pelley

CHAIR: Thank you.

I now call upon the CEO of NLHS to bring opening remarks.

P. PARFREY: Thank you, Mr. Chair.

I'd first like to start by recognizing the work that's gone into by the multiple people who have responded to the fires, and particularly around this area and the people who are from NL Health Services that have contributed enormously to the resolution, or the helping with those things that are currently afflicting us in our community. There's been a lot of really hard work done in this emergency.

I'd now like to address the timelines that are associated with the report that the Auditor General has made so that we are anchored in those timelines. COVID-19 started in March 2020. The great resignation peaked in 2022. These agency contracts came into effect in 2022 as a consequence of the great resignation and they were in a state of emergency because of hospital threats to be closed down, particularly Gander, Grand Falls and Stephenville.

In that emergency, contracts were entered into and administered in the legacy regional health authorities until the 1st of April came when NLHS came into effect. NLHS had to hire senior directors in the next four months and then, after hiring senior directors, had to sort out the directors and managers that existed across the province.

So there's a transition period from the regional legacy health authorities to NLHS having a role in being able to resolve the issues that occurred as a consequence of these contracts. I'm here today to try and

demonstrate that we are the solution for the problem created by the contracts and not the cause of the problems with the contracts.

Our timelines involved the creation of a central agency office for dealing with the invoices, et cetera, that occurred as a consequence of agency nurses that occurred by August of 2023. Then, subsequently, we went to a public tender with a request for proposals using standardized contract by August 2024, which was 16 months after the initiation of NL Health Services, and these more standardized contracts with appropriate methods of reconciliation were put into effect in 2025.

The recommendations arising from the Auditor General's report, we fully accept and will implement. Currently, we've got 12 of the 15 fully implemented, and the three that remain are as follows. One is concerning an audit for the agency A, a forensic audit. That audit has been put into the public arena for a request for proposals. Applicants have come forward and that contract will be provided by the end of this week, with the expectation that the forensic audit will be completed by the end of September. So it's partially implemented.

The second one revolves around the plans for casual nurses. A lot of stuff has been implemented that Debbie Molloy will report, and the expectation is that the plans around how casual nurses can be used more effectively will be by the end of September.

The third piece that's not fully implemented – it's not possible to be fully implemented – which is the evaluation of the current agency contracts. They were provided in February and they need six months of work, and the metrics against which they will be evaluated have been established and that will happen very soon. We have an action plan. We have an accountability plan that I can go into a lot more detail with you in terms of how it is rolling out and how accountability is maintained.

I'm going to table a number of pieces of information that bring us up to date where we stand for a number of things. They are where we stand about nursing vacancies by April 2025, where we stand about the progress against our plan for the predictions of agency nurses, the actual provision of agency nurses during the first three months of the year, and the actual costs for agency nurses during that period of time.

I'll also table where the agency nurses are by region, what services they are servicing and the need for those agency nurses to be able to maintain those particular services. I will table that and I will discuss that in evidence as we're going forward.

There are two other pieces of information. One is concerning the comparison of the CHMC rates for leasing as against the market rates that we actually obtained from the request for proposals. The final thing I'll table will be a copy of the letter that we received from the conflict of interest committee of the provincial government.

So those are available to be tabled for both the Members and the Auditor General.

I think maybe I'll just stop there, rather than using up the time for questions.

CHAIR: Okay, thank you.

I now call upon the Member for Mount Pearl North to proceed with questions.

L. STOYLES: Thank you, Chair.

First of all, I want to say thank you to the Auditor General and to her staff for this report. No doubt, when it was received by our Committee, it certainly was very disturbing and we knew then we were going to need to move forward fast in doing a lot of work to get some answers and have the department – and thank you to Dr. Parfrey and your staff today for coming. But, as we all know, today and the past number of days, our province has been in very uncertain time with the fires, especially the ones the past number of days out in Trinity -

Bay de Verde and the devastation that has happened out there.

I've a lot of family in that area; it's where I grew up. So I had actually said it's possibly the wrong time to be doing this, but it's so important and as part of the Committee and part of my job here in the House of Assembly, it's so important to get answers to all these questions because the public need answers and want to know where every dollar that we spend goes. I pride myself as a Member of the House of Assembly of trying to get to the bottom of this and finding out.

I know, Dr. Parfrey, you indicated that your department has done a lot of work already and you mentioned that you already implemented over half the report from the Auditor General. But obviously, we don't have all the answers that you have and your department has.

That's why we're here today, to try and get those answers. I just wanted to say that my heart goes out to all the people who are battling those fires, especially the firefighters themselves who are risking their lives today and every day to make sure we have a safe place to live.

Sometimes we take that for granted and we all know back a couple of years ago when we had the health scare all over the world with COVID and sometimes we tend to blame COVID for everything going forward. No doubt, people have been scared over things that have happened over the past number of years and especially over the past few days. So I'm looking forward to hearing from you and your staff.

Since the report was released, what steps have been taken to address those recommendations? Dr. Parfrey, you already mentioned that you have an action plan and I'd like to hear some more.

P. PARFREY: For sure, MHA Stoyles.

Of the 15 recommendations, a number of them are related to appropriate accounting procedures that would occur in a proper

functioning organization. I think that that piece of it is – I think that we are a proper functioning organization and, in fact, we've had an unqualified audit returned by the Auditor General for our spending of '24-'25 just recently, which would demonstrate that we can effectively function as a proper functioning organization.

Several of the other recommendations have been put into effect prior to the Auditor General's report, particularly around a central agency task force for the reconciliation of invoices and for the independent paying of those particular contracts. There's been action taken to be able to put into the public arena a request for proposals using standardized contracts, with a fairness advisor, and appropriate structures that would allow that to take place, particularly around the observation of whether conflicts of interest exist or not.

So those things have been – there were 47 applicants for the agency contracts, using centralized contracts and 17 of them were allocated and that occurred in February of 2025.

I think the other piece that we've put into effect revolves around have we created an action plan that would allow us to reduce the number of agency nurses and, at the same time, allow our health care delivery system to be able to deliver services appropriately to the public?

That plan has evolved and I think that if you open up the information that I tabled, if you go to slide three, which is the projections for agency nurses for '25-'26 that were established as a start of this financial year, you can see the blue bars which predict the fact that we expect it to go up during the summertime because we wanted to give summer relief to our nurses and, therefore, the only way we could provide summer relief was to increase agency nurses. Then, thereafter, the number of nurses steadily decreased by the end of the financial year. However, we were still dependent on agency nurses to deliver our services.

Then if you go to slide two, you can see there that the agency expenses from April of '24 to May of '25, that the monthly cost in April of '24 was approximately \$8 million per month. Then it went up, which you'd say is pretty strange. You've reduced the number of agency nurses by 42 per cent, but the cost went up. The reason for that was that the bills came in after the people worked, which makes common sense.

Then the reconciliation process that was undertaken in the central agency office was much stiffer and involved further follow-up and various invoices to ensure that they were adequately, appropriately billed. That occurred dominantly in the third quarter of 2024. So in that quarter, we've got bills coming in for work that was done a number of months prior to that. That interpretation or that reality is then demonstrated by the fact that in the last number of months, the costs have dropped substantially, such that in May of '25, the cost is less than \$6 million per month for agency nurses.

Let's go to Central zone there, where you've got the five zones in terms of their use of agency nurses, and I'll just explain to you how we put together the structure for getting better accountability for agency nurses, and the plan that we had to be able to reduce that demand and, at the same time, provide the services.

So in this one here, the left-hand diagram contains the blue bars of the projected number of agency nurses to maintain services in Central – and Central is the place that's actually most affected by vacancies, that has consistently had difficulty accessing health care providers. The blue bars demonstrate the expectation.

In the summertime, it was expected you'd have 120 agency nurses to be able to provide the services. In fact, we weren't able to get 120 agency nurses. It turns out that we got around 100. So there was a shortfall in the number predicted. Then the bottom left one shows you the hours that were predicted and the amount of overtime that was predicted.

Then, in the right box, you've got where these agency nurses were required. So they were acquired in general surgery in both the hospitals in Gander and Grand Falls for orthopedics, for perioperative services, and for emergency services in those two big hospitals. In fact, the reality is in those hospitals, as we get Newfoundland nurses to take those jobs, they're actually going to be oriented by agency nurses because of these massive vacancies.

I mentioned, also, you got ICU that has agency nurses. Dialysis has agency nurses. I'm not going to go through that in great detail anymore, but there are a very substantial number required to maintain services in that area. You can also see from the graph that the prediction is for Central, that the number of nurses will be around 76. I'm expecting that not only will we not be able to fill all those positions, but also I believe that we'll actually be able to reduce our need for those nurses as we go forward into the next financial year.

So now the question is – we have a projected plan, so how do we maintain an accountability? Are these nurses needed? If they're needed, are we using them for the minimum period of time that we need them, and have we got a plan to be able to try and replace them?

That accountability structure now involves me, as the CEO, involved with a committee that comprises Debbie Molloy and Scott Bishop from the provincial health authority, and every month, we engage with the leadership of each of the zones to discuss the need for agency nurses and how we can diminish that need. So I think we have an action plan, and I think we have an accountability structure, and I think our challenge is to balance the need to provide services at the coal face for everybody and, at the same time, limit the number of agency nurses.

In the coming year, it's anticipated that we will be able to include, and this year as well, internationally educated nurses who have become oriented and be able to go into some of those places, and we will have the

new batch of nurses that are going to qualify in 2026.

I'd like to say that in 2025, 244 nurses qualified and, of those, 93 per cent took full-time jobs in NLHS. We don't have enough nurses at the present moment to fill these positions this year, but we're optimistic that we will have enough nurses next year.

So maybe, MHA Stoyles, is that an adequate response, or do you want –?

L. STOYLES: No, that was great information, but my time is up now because I think what we're doing is each of us are having a 10-minute question and then pass it on to our colleagues. So I will have other questions for sure.

P. TRIMPER: You're on.

J. WALL: Oh, I am on. I'm on, Mr. Chair. My apologies. I was waiting for the Chair to recognize. Thank you, Perry.

Thank you everyone for being here today. I am glad that we are here today. My colleague just mentioned about the wildfires that are being battled, and we remember everyone that's involved in that. I have many people from my district involved with the fighting of those wildfires, including my own son. So it plays heavy on us all, but government is open, the building is open, all operations are as normal and I'm glad we are here today to do some very important work for the people of the province. So thank you all for coming out today and, of course, to the AG and her team for her guidance for our Public Accounts Committee.

Just for the benefit of those in the gallery and those listening at home via audio, I'm just wondering with respect to how these contracts came to be with the agency contracts, can you please update us as to what your positions were in 2022, the positions you held in 2022, just for context as we're looking back over the last number of years, looking at this in its entirety?

P. PARFREY: Well, my formal position was deputy minister for health transformation in the government, and I was also chair of the advisory committee to the Premier on COVID-19 decisions. So I know a lot about what happened in 2022 in relationship to the emergencies we had.

J. WALL: Thank you, Dr. Parfrey.

S. BISHOP: In 2022, I would have been placed in a similar role as I am today, as vice-president of Corporate Services, but with Eastern Regional Health Authority.

J. WALL: Thank you, Mr. Bishop.

D. MOLLOY: I'm the vice-president of Human Resources now. In 2022, I was not working in Newfoundland and Labrador.

J. WALL: Okay, thank you very much.

J. PELLEY: In 2022, I would have been in a similar role. I was the vice-president of integrated health, and the chief nursing executive for Central Health.

J. WALL: Thank you very much. I do appreciate that.

When I think back, Dr. Parfrey, to the nursing agency usage during that time in 2022, correct me if I'm wrong, it was virtually non-existent in 2022. It may not be entirely correct, but virtually non-existent, yet in June, I believe you made a statement about COVID being the key piece to this, and you alluded to that today in your speaking time. Nurses were needed immediately.

So with respect to the COVID pandemic officially being declared over by the World Health Organization in May of '23, yet we still can see the spending on nursing contracts significantly increasing since that time.

Now, I know you mentioned about COVID today and coming out of COVID, but in your opinion, do you still feel that COVID is the valid excuse for that, or the valid reason, and how can we still explain the continuous

increase in spending on travel nurses versus what they were in 2022? Please.

P. PARFREY: So I'll take you to the first slide of the tabled information, and I think this tells the story. In October of 2019, you can look at the grey line, which demonstrates there were approximately 250 vacancies in Central Health and Western Health, which demonstrates a system under an enormous amount of stress because those vacancies weren't filled.

You can see then, as COVID came in in April of '20, we're still below 300 registered nurse vacancies, but by April of '22, we now had 600 vacancies, and that's what they term the great resignation. It occurred in Newfoundland and Labrador. It occurred in all the provinces across Canada, and it occurred right across the world.

So the need for those people at that stage – the resignation was what created the problem. We're competing with all the other places in Canada to try and get nurses, and we had a system at risk. In my role as the chair of the advisory committee to the Premier, we had to deal with the fact that the hospitals in Grand Falls and Gander were losing nurses all the time, and in particular, they were losing nurses because of the isolation policies. So that if a nurse got COVID, it was catastrophic because that nurse went on leave for a week, but also her close colleagues were expected to go on leave for a week. As soon as that happened in a hospital, that hospital was now vulnerable. If those hospitals continued to be in their state of vulnerability, they would have gone into St. John's. If they went into St. John's, the system was blocked.

So from a medical perspective, this was an emergency, and I don't think there was any difference of opinion about whether or not we should be trying to get nurses. I think that the unions were calling for more nurses and for support because their members were getting destroyed.

In fact, the minister of Health worked 19 of 21 days during that period of time. This occurred right across the province. Then

you can see by that October of 2022, the number of vacancies was 695. This great resignation really put our health care system at risk. You can see that thereafter that's where the agency nurses came into effect to try and stabilize our health care system. I've demonstrated that they're in areas of profound need.

Subsequently, the number of nurse vacancies has diminished as we brought in more people into the system. On this graph, by April of 2025, we're now at less than 280 vacancies. I anticipate that as we get the intake from the internationally educated nurses and we get the intake from the nursing schools, we will be in good shape to be less dependent on agency nurses to deliver necessary services across the province.

My opinion is, when I was the chair of that advisory committee to the Premier, that we were in a medical emergency, trying to maintain services at that time, and that has not changed. I'll remind you that at that time people were – and I'm not blaming nurses for retiring. They had elderly parents. They were concerned about giving COVID to elderly parents and had a reason to resign. There was fear and people were dying. In particular, the older people in our community, they were the people who were at risk and who were dying.

That's my opinion and it hasn't changed.

J. WALL: Thank you, Dr. Parfrey.

Just to be clear in what you just said, in your opinion, we are still in a medical emergency?

P. PARFREY: No, as I've demonstrated, we've come out of that, because our vacancies for nurses has really dropped. But it's not dropped enough for us to be able to deliver our services without – and our use of agency nurses has dropped now by 45 per cent, and it's going to continue to drop. We haven't yet recovered those nurses who resigned, into our system.

Our system is still stressed, and without agency nurses delivering of those services that I demonstrated to you in Central Health, they wouldn't be possible. You'd end up having to close the medical units and dialysis and emergency rooms, et cetera.

The data that would confirm what I'm saying – I didn't provide it here – but the number of hours of diversions from emergency rooms in '22 and '23 was very high. Now we have very few diversions for two reasons. One is that we are staffing those emergency rooms with agency nurses and the second one is we're using virtual care to a much larger extent, that allows us to keep those emergency rooms open and we have a flat line.

In all honesty, I actually think that the capacity of our system to survive during COVID without these massive health care interventions like closing hospitals is a credit to the people who were working there and I think the fact that we're now out of this system of diversions is also a credit to how we're moving forward.

So I think the agency nurses helped us survive and now we're getting out of that situation and the anticipation is we will be out of that situation soon.

J. WALL: Quick question, Mr. Chair.

Dr. Parfrey, when I think back over the last number of months, you have been quite vocal within the media with respect to your concerns of the Newfoundland and Labrador Health Services being conflated with the legacy of the RHAs. At one point, I believe you called it unfair and unreasonable, in your words. So I'm just trying to wrap my head around it all with respect to the majority of your executive team is coming from those authorities, if I'm not mistaken.

So I'm trying to understand, with respect to the expenditure of taxpayers' dollars, when we're looking at the travel nurses, who is responsible? Who is responsible for the amount of taxpayer dollars that have been spent to get us where we are to today and

how we got to this point with the amount of money that's being spent? Who is responsible?

That's the question that I'm asked in the street when my constituents stop me and we're looking for that answer. I can't answer it.

P. PARFREY: Right, so the initiation of the contracts was the responsibility of the regional health authorities and the administration of the contracts was the responsibility of the regional health authorities. All of the regional health authorities engaged agency nurses in some way. The dominant areas were Central and Western. They had the most problems.

So, in effect, what I believe has happened in those legacy organizations that they were faced with a totally unanticipated situation, that COVID demonstrated a systemic issue with our capacity to be able to take on 200 nurses, deal with all the invoicing, deal with all the issues that were related to flights and accommodation, et cetera, and at the same time keep the hospitals open and the emergencies open and doing all that part of it. So there is little doubt that, at that period of time, the administration was not optimal.

So then you come to the initiation of NL Health Services, and NL Health Services has to recruit an executive committee that's going to be responsible for the entire province. So there was a formal objective process initiated by David Diamond, supported by various interviewers, who looked at their CVs, interviewed them, discussed their past and decided who was the best person to be able to take on a role at NL Health Services. That would have taken account of their previous experience. Those decisions were then made.

On top of that, I can't visualize how you can have an NL Health Services executive committee that did not have representation from across the province, that it would all be centred in Eastern Health. That would be ridiculous. So the need to be able to get representation from across the province is important.

I think there was a systemic failure, for sure, that occurred in our administration of these contracts. But I think that the decision to move forward with an executive committee that are representative from across the province was very reasonable and was made a judgment on the quality of the people that applied for those particular jobs.

I think the other piece that I'm keen to put forward is that as a provincial authority, we're propagating a just culture, and a just culture means that if you've got a complaint, you should be able to bring it forward and be able to have it developed by the institution in such a way that people feel as if they've been heard and they're being acted upon, et cetera.

So the idea then that we are in a systemic failure means that we've got to identify a few people who were responsible, I suppose. In some way, we were all incompetent. Then we were saying no, you're most incompetent so we're going to get rid of you. I don't really agree with that. I think that a just culture means that we've got to rectify the problems that we've had and to move on in a perspective manner in such a way that we're able to provide a better delivery of health services, and I think we're actually doing that. I've got a lot of confidence in the team that we've got, and I've got a lot of confidence that we will put into effect the recommendations made by the Auditor General to the benefit of our society.

Maybe I'll pass this on to Debbie Molloy who might like to add to my comments.

D. MOLLOY: I agree with everything that Dr. Parfrey did talk about. When we look at sort of what happened within both the contracts for agency nurses, around the contracts we entered into with leases, we do have to consider both the timing, which Dr. Parfrey talked about, it was during an emergency. These were contracts for services that there was no experience in the health authorities on entering into the contracts or how to administer the contracts.

It's very important to us that when we look at how we can improve services, which started right from really when NLHS came together, we recognized very early on that how we were looking at agency nurse administration was different across all of the province. Every regional health authority had it organized differently. We recognized that we needed to put together an agency office that was centralized, that had centralized processes, ensured that we were administering the different contracts in a consistent way.

That happened around August 2023 that the agency office came together. The agency office was together for a few months and they started to recognize that every one of these contracts had different terms and conditions. They were entered into at different times. They were different companies and they all had different terms. It was very difficult for a team of people to administer all of the different terms and conditions. So they recognized that we needed to have one standardized contract.

We also wanted to ensure that we had consistent rates within the contract, so we spent a lot of time putting together what a standardized contract should look like and then we went out to public tender for that. As Dr. Parfrey said, that public tender was awarded; we had 17 different agencies that came together.

But determining responsibility is really about determining, was there intent. When we look at what happened and we look at the history of it, we didn't see a lot of intent. We saw that people were doing the best that they could during a difficult time. There were systemic failures that we needed to review, that we needed to ensure that we put things in place so that they didn't happen in the future, and we've been working consistently towards that since that time.

J. WALL: Thank you, Chair.

P. TRIMPER: Thank you, Chair.

Thank you to everyone here. I don't need to repeat the comments, other than I offer my

own appreciation to everyone here. For those watching and those listening, may I say that, as the Chair said, the focus of this Public Accounts Committee is to get to the bottom of how government spends its money. Is it being spent as it is intended? We proceed in a very non-partisan way. It's really about getting to the bottom of it. It's been one of my – I would have to say, in my last 10 years, a very productive experience to be working here with my colleagues, and I thank the Auditor General and her team.

The way I'm going to phrase my remarks today, I want to organize it into two categories. The first one, I'm just describing it as the need for agency nurses, the overall rationale. I think we need to separate out this issue from – I think what I hear consistently, whether it be in this room today, whether it be in the media, whether it be in the reports that have come out this year, was on the administration of how those contracts were actually dealt with. Those are two separate issues.

I have a pretty good memory that I pride myself on, and I think back to those days in Happy Valley-Goose Bay with our Labrador Health Centre and with the outbreak of COVID. I can remember fly pass from Triple 4 Squadron, I can remember parades, all in honour, particularly of our nurses and doctors and others that were in those facilities. People were terrified. I can just remember what it was like as an elected official of responding to that fear. Yet, the tremendous appreciation for those who had to stand in harm's way on the front line and respond to a crisis.

I'm not sure of my order. I'll see how this goes as I proceed. But Minister Haggie, minister of Health at the time, he's often a man of interesting quotes. What he said at the time, as things were shutting down, and I remember there was a discussion – people were talking about how quickly and readily, thankfully, the world shut down. Not just our province, not just this country, but the world shut down. He said I fear for how it's going to be rebuilt.

He was the first one I heard talk about that, and it got me thinking way back in – I don't know, May, probably, of 2020, how challenging this would be. So, D. Parfrey, I appreciated your opening remarks. I'm here to get to the bottom of why we're here today, but I think it's important to think about that context.

So I have two questions I want to start with, my first bit of time. I can remember that pressure of the need to keep these operating facilities open. So could you talk about your role then, and frankly all of your roles at the time, and the lobbying pressure you were under – you've echoed some of that, but maybe just in this one perspective, whether it be from ourselves, provincial politicians, other elected officials, to do what you had to do to keep those operating.

I mean, I wonder if you might be able to comment on facilities that were frankly in great danger of shutting down.

P. PARFREY: Yes, I mean, I've alluded to the fact that Gander, Grand Falls and Stephenville were on the cusp of closing down at the start of 2023 as a result of the great resignation. I've alluded to the fact that we actually had substantial diversions from emergency rooms across the province as a consequence of not having enough providers to be able to keep those open, so we were in a state of crisis.

I think that the piece that we need to be reminded of is that, at that time, protective equipment was impossible to get. We were paying for masks and gowns and various things like that many times more than we had previously been doing. Masks were kind of in cents – C-E-N-T-S – before COVID and this period our masks were in dollars.

So there was a huge issue of supply and demand. The same thing was happening for human resources, and we were competing with the rest of Canada for human resources. They had to come in from away and we needed them to stay to be able to maintain our services, and bit by bit we've come off that necessity as we have a better

plan and more nurses coming into our system. By nurses, I mean both nurses and nurse practitioners and LPNs and personal care attendants coming back into our system. I probably shouldn't say back. I think I should probably say new people coming into our system.

I think everybody remembers but has probably forgotten what it was like in 2021 and '22, isolated in houses, worrying about whether we had enough ventilators, transferring people in from St. Anthony and Happy Valley-Goose Bay to the ventilator that's available in St. John's and to the issues that related to isolation policies. We remember that. At least, I remember it. The consequences of those isolation policies were putting anything to do with health care delivery into grave doubt.

So, at that period in time, whatever people would say we should plan for it, it was unprecedented, it was impossible to plan for it and it occurred quickly. In particular, that graph that shows you how the resignations mounted over the two years of COVID, that really was the thing that influenced what needed to happen.

I think that instead of – I'm talking for myself now; this is my own opinion. I actually think that Newfoundland and Labrador did really well to come out of this situation, both from the perspective of dealing with COVID without loss of care and dealing with the reorganization of NL Health Services massive reorganization that was added to this difficult environment, again without loss of care. So I think they deserve credit, actually.

P. TRIMPER: I'm thinking back to – and I'm going to keep us on topic, Chair – another area that we're dealing with, I think we have to recognize as a society – I feel it in Labrador – is aviation. We've run out of planes; we're run out of pilots. Just as another example, I still feel COVID every day, as we struggle to bring our society back to where we were.

I want to make a little comment about – I remember speaking with nurses who, at the

time, said if they didn't have those replacement contract nurses coming in, they wouldn't have had a break. I can tell you, and it's very personal for me, my wife, while she was battling cancer, she was often attended by somebody from British Columbia, Alberta and so on. Equally compassionate, equally professional and very, very necessary to keep our loved ones alive. It was very personal, very powerful.

I'm going to use this little phrase – it's just more or less to keep us focused on what I'm trying to say; I don't mean to make light of anything at all, but there's a line that I thought about at those days. I'm going to say it publicly here and it's in the Buddy Wasisname and the Other Fellers song, *Gotta Get Me Moose B'y*.

If you go through the versus and so on, he sings on about how I was off to their backyard and they was off to ours, to get their moose. I knew of nurses in Labrador who were travelling out West and, at the same time, I'm encountering nurses from out West in Labrador.

With that background – and again, not to make light of the matter, but I was aware and I just thought of this question this morning over lunch. I wonder if you, Dr. Parfrey, or somebody could update us on the national strategy, the national talks that go on at the FPT talks regarding agency nurses and their engagement across the country to try to stop the competition between provinces and where are we. I don't know if you're able – I'm putting you on the spot, but I thought of this at lunch time.

P. PARFREY: Well, I can't really answer your question. I don't know enough about that to be accurate, but there's little doubt that the agency contracts that were signed by us were such that agency nurses – that people from here couldn't be – sorry, I'll ask you to answer the question, but there was a proviso that agency nurses couldn't stay and take the jobs of Newfoundland nurses.

I'm not sure if I got that right. Go ahead, Debbie.

D. MOLLOY: So the contracts did have basically that an agency couldn't hire someone who had worked in our health system to put back in our health system. That was an attempt to ensure that, you know, we weren't having people who would move to an agency, get paid a higher rate and leave their position here.

P. TRIMPER: Okay, thank you.

I've got a few seconds left, but, Chair, I think I'll pass it on to yourself and I look forward to the next 10 minutes. But, again, I wanted to set that stage for the rationale and then we'll get into now the administrative issues.

Thank you.

CHAIR: Thank you.

I do appreciate, with COVID, we were into a pandemic. But this report is from 2022 to 2024, past COVID. So there are some questions in the report that we'd like to really get into.

Just alluding from the Member for Cape St. Francis with regard to the nurses, Dr. Parfrey, on July 2, you made a point to the media that the costs were down, citing millions paid out in the third quarter of 2024. That should have been applied in 2023.

The AG's report noted, even adjusting for an accounting error, agency nurse spending would have been down only by 9 per cent in the year ending March 31, 2025. Nowhere near the 42 per cent head count reduction that NLHS reported a month earlier. The 42 per cent reduction is not indicative of a proportional decrease in spending, correct?

P. PARFREY: Not particularly correct. The reason the table that I've provided, which is slide two, is trying to engage with that particular question. So the Auditor General commented at a media availability that I had, that I was misleading the public, and I kind of reject that. Let me explain what happens.

When I became chief executive officer, I agreed that I would go into the public arena

and take responsibility for operational issues and would accept any question that the media asked. So my responses to the questions are what's in my head, and the amount of information that's in my head is limited.

So the first question I got when I did my first media availability was about agency nurses. I knew they were down by 42 per cent, and I knew that the costs were strange, and I didn't really understand them and I certainly didn't remember the data.

So I was definitely not trying to mislead the public. I mean, that would be going against the reason that I've become the CEO. That's not the way it would be. I didn't have an adequate explanation to explain that graph.

We, bit by bit, got to the idea that that increase in costs in the third quarter of 2024, at a time when the number of agency nurses was dropping, was directly related to the fact that our bills were coming in after the work was done and the reconciliation process was taking longer than anticipated.

So we ended up paying bills that were six to 12 months – the work was incurred six to 12 months earlier. That's our explanation. That's what we believe has happened. What's happened, subsequently, in the first quarter of 2025 and April and May is you can see that the costs have dropped very substantially, as would have been predicted by that explanation. Our monthly cost in May was less than \$6 million.

That's the explanation for that particular thing occurring. I was definitely not misleading the public. In my own mind, I wasn't anyway because my job is to try and engender trust in NL Health Services and if I have misled them, that trust would be diminished.

P. FORSEY: Okay.

On page 29, the report mentions that the Central region did not seem aware that they even paid for electric vehicle charges. How can we be reassured that your

processing systems are complete and that the proposals that are being rejected are not ultimately being paid?

P. PARFREY: We have hired an external agency to audit those invoices from Agency A, an agency that will be finished by – we'll award the contract this week and we will have the results of the audit, hopefully, by the end of September. If that demonstrates that there has been fraudulent activity, we will definitely bring it to the appropriate places to resolve that.

The electric vehicle issue will be dealt with by that particular audit. Maybe I'll pass it over to Scott to make further comments about this.

S. BISHOP: Thank you, Dr. Parfrey.

I guess, just to elaborate a little bit on Dr. Parfrey's response, I think first and foremost it's important for us to highlight what the AG has referenced in the report in terms of the timeline which is associated with the audit review, the invoice section in particular, which stems from June of 2022 to June of 2024. Just for a perspective perspective, in context, that would be the final year of the legacy regional health authorities and technically the first year of NLHS. Ms. Molloy, earlier, talked about the development and the creation and establishment of what we refer to as a centralized agency office.

So I guess to your point, MHA Forsey, in terms of comfort to yourselves and the public in terms of what mechanisms are in place as control, that office actually provides a lot of rigour. In fact, it is likely the reason why we've seen that bump in our expense profile in that particular period from October '24 to January '25, particularly because the rigour of the invoice reviews that were occurring at that time, including some of the information that you've described around electric vehicles.

But, as Dr. Parfrey also included, there are certainly acknowledgements that there have been some system inconsistencies around how the past legacy RHAs had

administered the contracts. To get to the bottom of that appropriately, we have certainly sanctioned an RFP open call that was closed last week. We are actually in the process of reviewing those bidders and will likely award that contract, if not the end of this week, early next week, and from there we will take appropriate action as identified by the auditor around that particular issue.

CHAIR: Okay, thank you.

You mentioned Agency A. We know specifically the contract was with Agency A. How did the contract become with Agency A?

P. PARFREY: I think that they were the agency that had nurses available to us at the time we really needed them. Other agencies didn't have nurses available to us. Now, I wasn't in existence in any of those decisions around how Agency A was allocated a contract, but they were allocated a contract, in my understanding, that took account of the fact that we needed nurses immediately, and they were able to provide them. That contract, actually, has been stopped since early 2024.

Do you want to speak to that, Scott?

S. BISHOP: Yeah, just to sort of elaborate on the end of those contracts. As we became NLHS in April of 2023, there was an immediate requirement for us as an executive team and a board to understand the whole contract environment as it relates to agency. One of them was understanding what contracts were there from legacy boards. Part of that was understanding what the dates were and expirations of those particular contracts and, as Dr. Parfrey has highlighted, there were two particular contracts from Agency A that expired in February of 2024 and March of 2024, and those were dissolved at that time.

There were a number of other contracts that were signed by legacy regional health authorities that proceeded into the first year and beyond of NLHS, and that was done purposefully and by design in order to align end dates with the procurement mechanism

that we did and as described earlier that we've awarded 17 agencies of record, if you will, to provide that service with a very standardized rate and associated terms and conditions.

So the Agency A contract certainly expired as described and as soon as possible due to some inconsistencies and unstandardized terms and conditions that were problematic from an administrative perspective and those were allowed to dissolve and expire in February and March of 2024, respectively.

CHAIR: So who authorized the contract with Agency A?

P. PARFREY: Well, these contracts were authorized by the leadership of Central Health at that time.

CHAIR: Okay.

Can you comment on the role of the supply chain department on how they were able to not endorse the procurement process but yet participated in it?

P. PARFREY: I can't answer that. You answer that.

S. BISHOP: So again, I guess, in reference to the timeline associated with the audit, again in terms of the legacy regional health authorities and, at the same time, the legacy of the procurement and supply chain entity that governed the health authority at the time was not a provincial program within NLHS. That was, I would suspect, an arm's length, if I could say that, entity in relation to supply chain and procurement. But again, the contracts that were entered into by the legacy RHAs, as individual entities, were done so within the RHA and the confines of that.

Since becoming NLHS, supply chain and procurement has become a provincial program no different than corporate finance, budget, human resources, digital health. At that time and since that time, it's become a provincial program of a provincial authority, allowing for greater stakeholder

engagement and greater participation from the organization.

I would answer that, MHA Forsey, in saying that, by design, there may have been some inequities in terms of how supply chain interacted with the legacy RHAs in a time of emergency, which this is described as one, and the need for the individual RHAs at that time to engage supply chain for those procurement exercises appropriately.

CHAIR: Thank you.

The hon. the Member for Mount Pearl North.

L. STOYLES: Thank you.

I'm going to go back to the action plan, Dr. Parfrey, and your team. You stated about the plan that you're moving forward with. Were casual nurses offered those positions? My understanding of agency nurses would be in remote areas in the Province of Newfoundland and Labrador where we couldn't get a nurse or a casual nurse to do the job.

I'm just wondering, moving forward – and I know you've said you have a plan in place, I'm just make sure that if there was a casual nurse, that it was offered to them first. Is that the case?

P. PARFREY: I'll let Debbie Molloy answer that question.

But clearly, if we had a Newfoundland nurse who could do the job that we were interested in, we would definitely want a Newfoundland nurse more than any agency nurse. It bothers me to the extent that how would anybody think that NLHS would want to hire an agency nurse at \$360,000 a year to solve a delivery problem that a Newfoundland nurse could do. That just doesn't make common sense.

L. STOYLES: So the question is, though, did any Newfoundlanders and Labradorians work as agency nurses? That's more of a question than –

P. PARFREY: All right, okay. I'll ask Debbie to answer that.

But there is a degree of misunderstanding around casual nurses and layoffs. So we're told that nurses were laid off by NLHS and agency nurses were chosen. That's not what happened. There were nurses who were casual nurses that requested a record of employment so they could get EI. They requested it of NLHS and they were provided with it. They were not laid off.

But I'm going to get Debbie to answer the question around casual nurses.

D. MOLLOY: Thank you.

So we have different categories. I think it's important for me to provide a bit of context of employment. So some nurses work with us and they work with us full-time, and they would work a regular schedule that is with us. Some work part-time, and again, it's on a scheduled basis.

Then we have casual nurses who work with us when they're able and when we have shifts available. Casual nurses as well – and we're very thankful, first of all, that they are putting up their hand and working with us around their life schedule. So we offered and we've gone out consistently and offered all of those people full-time jobs. We would love to have folks come and work with us full-time, but not everyone can and we respect that. We still want to have them come and work any shifts with us that they can.

But a casual nurse who works in one area of our organization may not have an orientation or have the necessary skills to work in another area of the organization. As well, a casual nurse may live in St. John's, for example, and a shift is available in Happy Valley-Goose Bay. So we wouldn't expect that someone from St. John's would go to Happy Valley-Goose Bay.

We want to make sure that we're utilizing the casual nurses as much as we can, recognizing that they may not be available

to work with us on a regular schedule. So we will try to fit them in where we can.

Now, we do recognize that people have – again, as part of our plan going forward, that’s one of the recommendations that we’ve said is partially implemented, and the reason we said it was partially implemented was because we do want to re-engage with our casual workforce and ask them, as an example, are they willing to or would they like to have an orientation to a different unit that they currently have an orientation.

I guess, it would be perfectly natural for someone who perhaps only works casual with us in an operating room, if there was a period of time, and it may be two weeks, you know, that there wasn’t a shift available for them, and so there wouldn’t have been an opportunity for them to work within that two weeks, and for them to ask for a record of employment, of course we would give them a record of employment.

I am going to ask Joanne just to speak a little bit to the skills that are different depending on the different units within the organization.

J. PELLEY: As Debbie alluded to, a nurse is not just a nurse. They cannot really go between all units if they’re not trained or have the certifications for that area, and we want to make sure that we’re looking at skill mix. We’re assessing, is there a novice nurse? Do we need more seasoned nurses there to help support the team? And that really is what it is about. We’re looking at our core staffing gaps, but we’re also supporting the team that’s on the ground.

Some people, for example in many of our rural sites, they have to have emergency certification along with they may work in long-term care and acute care. So specialty courses that may not be, you know, for all casual nurses, they may not have it and may not be able to move freely between those areas.

L. STOYLES: Thank you.

My colleague mentioned about electric vehicles, and the rental of electric vehicles, and when they requested them, they were turned down. I’m just wondering, now, if we put a new policy in place regarding a standard so that if somebody was turned down, there would be a red flag, and it wouldn’t be paid, and the invoice would not be paid. Where those invoices were paid, I’m just wondering if we put something in place now so that would never happen again.

P. PARFREY: I’m pretty certain that what we’ve put in place is far better than what we had in Central Health at that particular time. I think that the professionalism of the reconciliation of invoices with the contracts that have been approved is far better. I think what happened at that time was a reflection of us having untrained people doing invoices and overwhelmed management is what happened. It was a systemic failure at that particular time. I believe that what we put in place is good and it is an accountability system that would allow that stuff to be more professionally dealt with.

My example, of course, was have we got the professionalism for the financial capacity is backed up by the fact that we’ve got an unqualified audit for 2024 by ’25 by the Auditor General, implying that we’ve actually got a pretty decent financial resource available within NLHS, but I’m going to pass it over to you, Scott, to just answer the question in a bit more detail.

S. BISHOP: Thank you, MHA Stoyles.

So I guess to elaborate a little bit on Dr. Parfrey’s response and to your question directly around control mechanisms in place and what’s changed since. From a contractual perspective we talked about how we’ve awarded agencies of record that was secured through open call, RFP. Those have been standardized across all the terms and conditions of the contractual arrangements, including standard rates of pay, depending on the position that’s been deployed from the agency provider. It also includes maximums for travel to and from the province. It also includes any related

travel costs that are in alignment with Treasury Board policy.

So all of those have been revamped to ensure that we are in alignment with government policy and they are all standardized. What that also helps us do is better manage our contracts administratively. We talked earlier about and referenced the centralized agency office that provides that rigour and that verification process for approvals prior to payment and it allows them to use standardized terms and conditions across 17 standardized contracts. We're not dealing with tens of invoices and contracts that have differing terms and conditions.

A couple of things around the control mechanisms – one is that we standardized the contracts, including all the terms and conditions and, secondly, in that we've infused and established a centralized agency office to manage those contracts with a standardized set of terms and conditions.

We do have comfort in terms of the verification and procedures that are associated with that at the moment.

L. STOYLES: Okay.

I just have one further question. Is the management and the board receiving regular reports back now from the agency nurses spending? I'm assuming you have everything in place. I'm just wondering if you're receiving regular reports if that's the case.

P. PARFREY: In those slides you've got, you have the predictions of the number of agency nurses that will be required to maintain services, you've got the monthly utilization of agency nurses and you've got the monthly cost for agency nurses. As I've said previously, the accountability stops in the CEO's office, such that every month, myself, Debbie Molloy and Scott Bishop meet with the leadership of each of the zones that comprise the chief operating officer and their senior directors to go over the predictions and re-evaluate the

predictions, and the contracts that are created for agency nurses are now 30-day contracts.

So there is a very strong accountability piece that leads to the head of the organization. These financial reports or these reports on agency nurses are also reported through Scott to the board. Again, I think that the accountability system is strong.

L. STOYLES: Is it because of the amalgamation of the system? I'm just wondering if that was part of the problem when the health care authority amalgamated their system. I'm wondering if that had an impact on any of this.

P. PARFREY: The NL Health Services was the solution to the problems, not the cause of the problems. The cause of the problems occurred in the legacy organizations where there was a systemic failure to be able to administer these contracts.

The fact that you now have a provincial health authority that was going to grapple with being able to have a more standardized approach to reconciliation and payments, and you have a provincial authority that had an agency reduction plan and an accountability system is a much stronger piece than we had with four regional health authorities.

So I think that the NLHS is part of the solution and was the solution to this, rather than the cause of anything.

L. STOYLES: I'll pass it on to my colleague.

J. WALL: Thank you.

Dr. Parfrey, I have so many questions, but I want to go back to your previous testimony that we shared when you said that you were the deputy minister for health transformation and advisor to the Premier. So I'm just wondering in that capacity at that time, did you have any conversations with the Premier of the day with respect to the health authorities and the signing of contracts for

Agency A? Were you involved in that particular conversation at that time?

P. PARFREY: So I was chair of the advisory committee to the Premier on COVID-19, not the advisor to the Premier. I had no conversations with the Premier about agencies.

J. WALL: Thank you for that clarification.

So in your role now, when did you first become aware of Agency A? Can you share that with us, please?

P. PARFREY: Well, as you know, I didn't become CEO until January of 2025 and I knew very little about the agency contracts that had occurred prior to me taking that job, but it was clear when I came into the job, that getting resolution to issues that related to the maintenance of agency nurses was priority for the government of the day and priority for the Department of Health and Community Services to the extent that there was no allocation of funding for agency nurses for this financial year.

J. WALL: Thank you, Dr. Parfrey.

I want to go back to the Auditor General's report and I want to see if either one of the four of you would speak to the actions to date and the plans to ensure the full implementation of Recommendation 2. For the benefit of those in the gallery and those listening online, Recommendation 2 is the "Newfoundland and Labrador Health Services should ensure emergency exemptions for procurement are pursued in accordance with provincial legislation and policy, including appropriate disclosures and pre-contract approvals."

So my question is: Can NLHS explain why exemption forms were signed by directors without delegating signing authority? How did that come down as what's reported in the AG's report?

S. BISHOP: Thank you, MHA Wall.

I guess, just to reiterate the timeline we're referring to here, between the AG's findings

and the formation of NLHS as a provincial authority, the contracts signed obviously pre-NLHS would have also existed at the time when supply chain and procurement as a functioning program was not embedded within a provincial system or a provincial RHA, provincial health authority. It was a standalone entity that was servicing the legacy separate RHAs as single entities.

So I can't speak a whole lot to what went on in terms of the exemptions that were filed but what I can say, in terms of since NLHS has formed, supply chain and procurement is a provincial program, not unlike any other that are provincial in nature and we do follow best practice when it comes to procurement legislation including the filing, every 15 days, to the public procurement officer, as per legislation requirements.

I'd also go a step further in terms of since NLHS has formed and procurement has become a provincial program of the entity, engagement has been occurring through regular town halls with stakeholders, making folks aware of what their obligations are around exemptions under the act, and that has been certainly solidified over the past couple of years and we'll continue doing that on a regular circuit to ensure folks across the organization, of almost 23,000 people, are aware of their obligations under the act, the Procurement Act. So ensuring that they are aware of their obligations is critical for us.

When it comes to delegation of authority, that's also another critical piece that we acknowledged early in the days of NLHS. In August of 2023, we issued an administrative policy, a delegation of authority policy that was released to the organization to ensure folks who were in a delegated position of authority to know their limits of what they could actually approve and what they could actually sign for.

That was distributed in August of '23. So that would have been around five months as a new organization, and a critical policy for us administratively and from a control perspective. That policy was subsequently reviewed by the Comptroller General's

Internal Audit Division, and we made further revisions to that policy in February of '25, and it was re-released at that time.

So that policy has certainly been in distribution and well aware of stakeholders across the organization since NLHS has formed, but again, not able to speak pre-NLHS as to what had occurred there.

J. WALL: Thank you, Mr. Bishop.

I am just trying to make sure that my questions are logistical as I'm trying to go along, I don't jump back and forth.

You mentioned earlier, or Dr. Parfrey, one or the other mentioned earlier about the standardized usage of detailed contracts going forward, because the report does point out a lack of consistency across the contracts that resulted in increased costs. So when did the standardized use begin and, going forward, how will NLHS prevent inappropriate payments being made to service providers so we don't have that – what catch mechanism do you have put in place going forward to ensure that taxpayers' dollars of the people of the province are not spent unnecessarily?

S. BISHOP: Thanks for the question.

I guess maybe just to highlight a response from earlier around a couple of mechanisms of control, MHA Wall. One would be, to answer your question around the effective dates, so April 1, 2025, all 17 new contracts that were secured through open call are effective, and the other legacy contracts had dissolved at that time. They are effective April 1, 2025, with standardized terms and conditions. Some of those standardized terms and conditions, which I think is part of our response to the Public Accounts Committee and its Members, includes the actual agreement template that's been standardized.

So in there, you can see that the rates have been standardized. There have been minimums influenced around travel to and from the province. There has been alignment with the Treasury Board policy

around travel to ensure there is alignment there from a government perspective.

In terms of what we've done to help establish control mechanisms – and again, not to sound repetitive, but I think the control mechanism for us that gives us great comfort is the establishment of that centralized agency office, that there is a group of verifiers that verify invoices as received from the service providers that are in alignment with the terms and conditions of those standardized contracts. From there, they go on for further approval in alignment with the delegation of authority policy that I just described in a previous response, and then they go on for payment.

So that full cycle, including delegation of authority and segregation of duties, gives us great comfort knowing that along with the standardized terms and conditions in the agreements, that we are in good stead when it comes from a control perspective, that those indications of inaccuracies in the past and inconsistencies from an administrative perspective doesn't occur again.

J. WALL: Okay, thank you.

Just for clarification because my mic wasn't working initially, the date that you gave was ...?

S. BISHOP: For the effective date of the contracts?

J. WALL: Yes.

S. BISHOP: April 1, 2025.

J. WALL: April 1, 2025. Thank you for that.

With respect to Recommendation 4 – I know you touched on it – “Newfoundland and Labrador Health Services should ensure that any future agency nurse contracts use standardized contract language I know it was spoke to before. I want to go back to it again with respect to clearly stating the expectations and standards going forward.

So that, if I'm correct in saying from my previous notes from Dr. Parfrey, is now standard for the whole province as of what date?

S. BISHOP: So the standardized terms and conditions are effective April 1, 2025, and that is provincial wide.

J. WALL: That is provincial wide.

S. BISHOP: Yes, it is.

J. WALL: Thank you for that. Again, trying to make sure we don't miss anything.

I want to go back – it was mentioned by one of my colleagues earlier – to when the health authority first became aware of Canadian Health Labs. I know, Dr. Parfrey, you touched on this, but with respect to any of the other three of you, when did you become aware of it and in what capacity?

P. PARFREY: Scott? I mean, I've answered that question.

S. BISHOP: So for me, I became aware of Agency A in my capacity as previous vice-president of Corporate Services for Eastern Regional Health Authority. At maybe the tail end of the final year of the health authority, we did have a small engagement with that particular agency.

D. MOLLOY: I started with the health authority in July of 2023 and I would have become aware of Agency A shortly after my arrival. So I would say August or September of that year.

J. WALL: Thank you.

J. PELLEY: I would have become aware of Agency A in the spring of 2022.

J. WALL: Thank you very much.

My time has expired, Chair; 10 minutes goes awfully fast.

Thank you.

P. TRIMPER: Thank you, Chair. Thank you to my colleague.

I'd like to pick up on another theme and maybe it's a bit of selfishness on my part but I'm very proud to live in Labrador. Labrador is a very proud region. I can tell you, through the Health Accord and the proposal to collapse the regional health authorities first came forward, it was quite a revolt.

However, it has proven to be very wise move and I'm not heaping great flattery on yourself and Sister Elizabeth, Dr. Parfrey, but frankly, I think I am because here's yet another example. I think the Royal Commission on Health was in 1965, actually initially proposed the idea of regionalizing our health authorities and if you get down to what we're dealing with here today, it's, again, the differences between each of these four entities and the lack of consistency and control that's come around. I think, and this is the third time – I'm looking over at the AG right now – that in the last year and a half, we dealt with a health matter where we've seen differences between these regional health authorities.

My colleague from the beautiful District of Cape St. Francis just was talking about RHAs and timelines. I was looking for the timeline, not for when they became effective, but when you saw the need to get in there and grab these contracts and create this central entity that you've alluded to, that now oversees the contracting of nurses.

P. PARFREY: I'll just give a general comment first of all, which is related to the purpose of the provincial health authority and the zones that function as a consequence of this reorganization. So the purpose of the health authority was that we would have provincial policies for all the programs we offer that try to ensure that there was equity of access to the citizens of that particular program, taking account of their geography and all other issues that might make them different from St. John's.

That kind of decision-making stuff on a provincial level is really the role of the

provincial health authority but also to deal with the back-office functions that could be undertaken by a province as exemplified by these agency contracts and the solution that would be necessary to ensure that we could effectively go forward with these contracts in the way that we're talking.

The other part of it is that it was felt that the regional delivery of care needed to have the influence of the people who are receiving the care, so that we wanted to keep with a regional delivery-of-care model, but we were complicating it by the fact that we were now going to be responsible for acute care, we were going to be responsible for community care and we're going to be responsible for long-term care. Then we added digital health to it.

So that is a really large change to take place in an organization, and to think that we can make it effective, that we can have the provincial approach effective in regions within two years is a massive ask. We're still in the process of trying to ensure that we have the capacity from a matrix structure and a dual-reporting and a collaborative-leadership model to try and ensure that this experiment works, which is an experiment of provincial approach to the delivery of programs, with a regional care delivery. That's still a challenge to us, and I think that we're doing a pretty good job going along that particular piece.

The tail end of your question, that – I forgot to answer it. So what was the tail end of your question, MHA Trimper?

P. TRIMPER: I was looking for, specifically, when these regional differences became apparent and when you were able to do something about it. I can recall sitting on this floor and speaking to this bill. I think that we passed it in 2023. I stand to be corrected. I think it was fall of 2023 when we collapsed those four regional health authorities. So I'm assuming it would have been some time after that you've been able to action the change or did you start something –

P. PARFREY: Well, if you just take the issues around agency nurses and the contract reconciliation and the payments and the standardized contracts, et cetera, the regional health authority entered into those discussions and those solutions very early, and the central agency office that was put together was put together by August of 2023, which was pretty quick in my mind.

Then the standardized contracts and the RFP and the planning that was required around that and the balancing out of ensuring that the agency contracts that had been entered into would all stop at the same time, that was also a pretty demanding endeavour. That was completed by the RFP that went out in August of 2024. So I thought that was pretty reasonable, as well, as an objective outsider. I'm now an objective insider.

At that time, I thought that was pretty good.

Do you want to comment on that, Scott?

S. BISHOP: Just to elaborate a little bit on Dr. Parfrey's response. I think to speak to when it was realized was almost day one, as we prepared for understanding what our physical environment looked like as a new provincial health authority and what the pressure points were from an expenditure perspective. One that had rose to the top at that time in conversations as an executive and a board were agency costs.

I think it was acknowledged early on that we needed to understand that landscape of agency. When I say early on, I would suspect within the first two months, hence the establishment of the centralized agency office in August of that year and subsequently, in that same month, the Delegation of Authority policy was created.

As Dr. Parfrey alluded to, from there, we started to design what a standardized contract could look like in early 2024. We also secured a fairness advisor in terms of objectively and transparently guiding that RFP process so that we were clear on what we were getting as an end result from that procurement exercise and that went on into

late 2024, at which point we signed contracts that were effective for April 1, 2025.

I think, to answer your question, MHA Trimper, it would have been the very early days of fiscal period '23-'24 that we would acknowledge that issue.

P. TRIMPER: Thank you.

My previous life before I got into provincial politics, I worked for 27 years as a consultant and we provided professional rates for my services and everything else. It was based on the administrative team around me, the cleaning services, the light, heat everything else and so on. We had the standard rate and when we were working for government or any other entity, you have those standard rates.

So I want to go down this line of just inquiry and discussion because when I see these big numbers associated with the engagement of an agency nurse, I think it's important to understand that probably not all that money went to that dedicated nurse for the work she did. It was somehow captured in the corporation that had the initial contract.

I just wondered, as you talk about standardizing them, I think it would be useful for us, going forward now – because, obviously, this is an option, albeit perhaps of last resort, but in the meantime, we still foresee the need to have agencies that provide nurses for positions or locations or both. I wonder if you could comment on those rates and the structure and how that will be standardized.

P. PARFREY: I mean, clearly, it's a non-economic model but it's undertaken because we have need. Because not only do we pay the rate for the nurse themselves, which is probably around the rate of twice the overtime of a Newfoundland nurse, now you add in the cost of the flights, the cost of the leasing of the house, the cost of their food and the profit margin for the agency. I think that the current standardized contract we've got is

much less attractive to the agencies than it was.

I would like to make a comment about the leases, because I tabled a table that provides us information on what the leasing costs would be. Here, respectfully, I do disagree with the comparator of the Canadian Mortgage Housing Company for our mortgage component as the base comparison price for leasing. Our leasing costs are probably on target with what the market is currently but they're pretty substantial. You're talking about for a two-bedroom house in St. John's that you need to pay a rate of \$2,200 a month. Or if you go to Grand Falls, where the number of agency nurses is far bigger, it's \$2,131 for a two-bedroom, fully furnished house and that's all factored into the agency rates that we end up paying for.

As I said earlier, there is not a single, intellectual argument you could make that we would want to maintain agency nurses instead of having Newfoundland and Labrador nurses.

However, I'll just pass over to Scott again for comment on that.

S. BISHOP: Just to elaborate again on Dr. Parfrey's, which has been tabled as a document for the Committee Members, is around a comparison of what's been highlighted as a significant premium on rates in comparison to the CMHC rates. I know it was noted by the AG that there may be some differences in the comparisons but, again, as this was flagged as such an enormous premium or suggested as an enormous premium, we wanted to understand that better ourselves as to was that indeed the case.

We actually reviewed the rates that we have secured through an open-call mechanism or an RFSQ, which is a request for supplier qualifications, to understand what the market was telling us on what one-, two- and three-bedroom apartments, fully furnished, all utilities included would cost us across all of the zones of NLHS dependent on the size of that unit.

We came up with slightly different numbers, of course, but what I'd like to highlight for the Committee is that they are in line with the rates that were paid during the audit period, which would suggest that the market premium is likely not as highlighted and likely somewhat different than that. In fact, the rates that the market sounding would tell us from an RFSQ perspective are in line with the rates that were paid during the audit period.

P. TRIMPER: Thank you.

My time has expired.

CHAIR: Okay, thank you.

I think we'll break now for probably 10 minutes or so. We'll return probably 2:45, and we'll continue. Is that good, or do you want a little bit longer? No?

All right, we'll say 2:45 just to get a glass of water and a stretch.

Recess

CHAIR: Okay, we'll continue with the questioning.

Dr. Parfrey, in July, you directly challenged the Auditor General's findings that the ROEs that had been issued were layoffs. Can you please elaborate, as the report has noted, all ROEs mentioned by the AG were issued as a result of a shortage of work? Would you like to clarify what you meant?

P. PARFREY: As I said previously, these were records of employment requested by the nurses or the people involved who wanted to use those records of employment for their purposes, and I'll pass on to Debbie to better explain what's going on here because they were not layoffs.

D. MOLLOY: Thank you, MHA Forsey.

The records of employment that were issues were to casual nurses who worked with us. As I explained before, we have different types of employment with nurses who work with us. Some of them work full-

time with us, some of them work part-time with us and some of them work casually with us, and what that means is on an intermittent basis. We follow their collective agreement in terms of when they work for us.

The easiest way to explain it is perhaps when they have availability and when we have shifts that are available. It's quite normal to end up with a break in employment, and it would be because of a shortage of work, and I'll use the example of someone who works casually with us in a specialty area.

So, perhaps, they work in an emergency department. They hold all the correct certifications, and they have the right education and training to work within that particular department, but they only work in that department. They don't work in other departments across the organization. So if we don't have someone who is off on a leave or there's extra workload that's required, if there's a period of time when that doesn't happen, then they have a natural break in their employment, and they can request a record of employment.

CHAIR: Okay, thank you.

The Auditor General notes 37 grievances have been filed in two years alleging that casual nurses had been overlooked while travel nurses were being offered shifts. Has NLHS completed their own follow-up on any of those grievances?

D. MOLLOY: Those grievances are still outstanding, so we're in a process around those particular issues that have been brought forward to us through the grievance process. I will tell you, when we bring in an agency nurse, we bring them in for a period of time. We don't bring them in on a shift-by-shift basis, and I think there would be agreement that that wouldn't be very cost effective, to bring someone in from another province and pay for their transportation, be paying for their accommodations, if we weren't bringing them in for a block of time.

So we're looking at, as I talked about earlier, one of the recommendations from the Auditor General that we've said is only partially completed. We are looking at whether or not there are ways in which we can use casual nurses more effectively. So for example, if we had an agency nurse who was on a particular unit, and a casual nurse said I can work one of those shifts in that two-week schedule, it works for my schedule, then is there a way for us to redeploy the agency nurse?

Currently, we don't do that. We bring the agency nurse in. We ask the casual nurses prior to booking that agency nurse, do they have availability? But we understand that availability might happen once someone is on the ground.

So we're working through that process and that's part of what we're doing and why we said that that particular recommendation has only been partially implemented, because we do want to determine whether there's a different way that we can redeploy our agency nurses so that if a casual nurse is able to work one shift or two shifts in a two-week schedule, that we can redeploy that agency nurse somewhere else in our organization.

CHAIR: The 37 total is as of December 2024. Have there been more grievances of this nature filed since then?

D. MOLLOY: I'm sorry, I don't have that information today. I can certainly get it for you.

CHAIR: Okay.

Getting back to the questioning that I was asking about earlier, in the press release, casual nurses employment records stated that 72 cases referred to in the Auditor General's report were not layoffs, but they were records of employment, like we said.

Can you explain what you meant, as the report states ROEs all stated reasons for issue of shortage of work. Are we to understand that there was no available work for registered nurses in those 72 instances?

D. MOLLOY: Thank you for the question.

As I've talked a little bit about, with casual employment, there is a particular area or a particular facility where a casual nurse has the necessary qualifications and skills to work, and where we have shifts that might be available or are using agency nurses.

So we have looked into the 72 different cases, and there were different reasons. They worked in different places. But, as I've explained, there are two things happening. One is, does the person have the necessary skills and specializations to work within that particular unit? Do they have a desire to work in more than one unit? Do they have the orientation to work in a different unit? So we have to look at that.

We also have to look at, where does someone say that they're able to work and where do we have a particular shift that's available? So it could be in a different community and if they live in St. John's, we could have a shift available in Carbonear and do they have the necessary skills and ability to do that?

CHAIR: Okay, thank you.

To follow up on a question that I asked earlier – and I'll ask this to Scott, I guess, or Mr. Parfrey. Who authorized the leadership of Central Health to sign the contract with Agency A?

P. PARFREY: With Agency A?

CHAIR: Yes.

P. PARFREY: I think that the Department of Health and the leadership of Central Health would agree to whether or not that should go forward. That would be the normal sequence of events. Just like if I had to authorize extra spending, I would do it with the Department of Health as the CEO of NL Health Services.

CHAIR: All right, thank you.

Forty-nine NLHS employees entered into 53 leases for the accommodations of health

professionals, including agency nurses in violation of conflict of interest legislation. In June, Dr. Parfrey, you said publicly that you didn't think there was badness done. We needed to get leased accommodations for these nurses coming into the province and we needed to get accommodations in various places.

Please explain how it is okay for staff to violate legislation.

P. PARFREY: I think that the current situation that we have, in terms of conflict of interest, is that we think that it's consistent with the legislation. We've tabled a document of advice from the conflict of interest group, the government committee, the Government of Newfoundland and Labrador. The piece that's the issue is the perception of a conflict of interest and how do you actually manage to do that when you need to get leases.

So what we've done is we are aware of who works for NLHS and they are a combination of nurses, front-line workers, managers, doctors who've got the capacity to be able to have another place that they can actually lease. We've decided that when this is in the public arena and we're aware that they are workers that they'd be the last person that we would give a lease to but if it fulfills our need, they'll get the lease.

That's our current policy and I think, Debbie, I'll ask you to comment on that as well.

D. MOLLOY: So when it came to our attention that there was a concern about a conflict of interest, we did conduct an internal audit to determine how many employees did have leases for us. Again, I'll take you back to the point when we were looking for people and leased accommodations, and we did a combination of things when we were doing that. Some of it was a public call.

For some of the RHAs, there was a testing of the markets. There might have been an ad that was put in a newspaper. We had a need in a lot of small communities for leased accommodations and we had,

actually, even went out in public town halls that we had with employees, in meetings that we had with employees and we asked people, do you have – we couldn't fulfill the need that we had. So we were out engaging and asking people to come forward.

When it came forward, we did ask our legal services team to kind of look at what was this, in fact, a violation of the Conflict of Interest Act and really, out of an abundance of caution, they suggested we should go out to all of those employees and ask them, did they feel like they fell under one of the exemptions which was in the act?

We wrote every employee that we had a lease with and we asked them, do you feel like you qualify for an exemption? The vast majority came back and said they did feel they qualified for an exemption, that it was an emergency under the act.

We, again, sought legal advice in that and said, does this qualify? There's no definition of emergency in the act and so, really, out of a lot of caution, we decided that we would end those leases and we would go out for a public call.

We do recognize that we do need to do more in the area of conflict of interest and we do need to make sure that everyone does have a very good understanding. For the RFSQ, as we've noted, someone has to say if they're an employee of ours if they do put in a proposal under the current, open RFSQ for a lease. Then, following the advice that we got from the conflict of interest committee, we do not enter into a lease until we have exhausted anyone else who is looking to lease to us.

We also recognize, though, that we perhaps need to do better in terms of the way that we're providing education around conflict of interest. So we're in the process of finalizing a policy for the NL Health Services, which is a combination of the previous health authority policies. We're going to ensure that it's part of the orientation for any new employee who's coming in. We did education sessions with our leadership team to ensure they understand, and

recently we also sent out a memo to all employees within the organization, so they understand their obligations under the Conflict of Interest Act.

P. PARFREY: I might just add that our policy around conflict of interest has been in development over a number of months, and we're optimistic that it will go to the board for confirmation by September. There has already been created an education model around conflict of interest that it will be the expectation that everybody in the organization will actually look at it.

L. STOYLES: Thank you.

My turn again, and I'll take my headpiece out; I'm hearing myself speak. First, I want to say that the fire is continuing in the area of Southlands and Galway, and I was on the standby for evacuation. So it's not good news again this afternoon for our province.

Dr. Parfrey, I want you to go back. In the beginning, you talked about the action plan, and I've asked a couple of questions. I don't think I've heard the answers that I wanted to hear about agency nurses. So are all agency nurses hired from outside this province?

P. PARFREY: Are they all what?

L. STOYLES: All agency nurses, every agency nurse that we hire under contract, are they all from outside of our province?

D. MOLLOY: So, MHA Stoyles, within our agency contracts, what we have is a proviso that says that a nurse cannot have worked with us within the last 12 months. So we can tell you that they weren't an employee of NLHS within the last 12 months, but we don't know, necessarily, where they live.

L. STOYLES: So they could have been in our province, working for private agencies or private companies or pharmacies and whatever? That's possible, right?

D. MOLLOY: That is certainly possible. We do have something that says they can't have worked with us in the last 12 months.

L. STOYLES: Okay.

We talked about moving forward and the policies and looking at the recommendations that have been put forward. I know Dr. Parfrey mentioned that they've come on the media right before the Auditor General's report was announced, talking about moving forward and what they were going to do. Of course, in the report we have before us today, we certainly have a great outline and that.

But I'm just wondering how much the public understands that. Sitting here today, it makes good sense moving forward and what you're doing. I just want to make sure that the public is aware of what the department is doing. I think when they hear horror stories about \$400,000, if you're a nurse working in this province and you're getting whatever, \$120,000 or \$130,000 or less probably, when you start your career and that, and of course it takes time to build up your experience and stuff like that in any profession.

I look at substitute teachers, they got the same thing. Sometimes we've got casual because they have family or whatever reasons, elderly parents, sick children. I know one mother that's a nurse, her parents as her nurse, and they stay home because they have a child with autism.

I'm just wondering if I can get more of an explanation about moving forward and all the good work that the department has done and planning on doing. I know you said it was four or five things that haven't been put in place yet, if you can expand on those, because the public needs to know.

P. PARFREY: Right, I agree totally with you.

The operational impact of removing agency nurses is present in those five slides that I gave you for each region, and it's clear that these are for front-line services that we can't do without. So the decision that NLHS has got to make is do we want to keep those services open or not, and in the short term, is it worth the type of money that we're

paying in the short term? The kind of decision we've made that in the short term, to keep those services open, we need to hire agency nurses.

So these documents that I've provided to you, we're going to put them on our website and we're going to provide the follow-up every month about where we stand on agency nurses and where we stand on nursing vacancies so the public can see what we're trying to do about these decisions.

I can affirm to you that we'd be kind of stupid if we felt that we wanted to hire agency nurses instead of Newfoundland and Labrador nurses, but the reality is that we're not able to fulfill those front-line demands because we do not have enough nurses in Newfoundland and Labrador to fulfill those demands.

That's taking account of the fact that we hired 93 per cent of the nurses that qualified this year and we still have vacancies.

L. STOYLES: So is agency nurses only in rural Newfoundland and was there or is there any agency nurses hired in this area, in Eastern –?

P. PARFREY: If you go through slide five, you can see that the projections for agency nurses for Eastern-Urban, at the current situation there are 25 agency nurses working in this region and you can see where they are. They are in the Health Sciences main OR. They're in four south B of the Health Sciences Centre. There's one in the cardiovascular operating room. There are some in the four west of the St. Clare's hospital, where we find difficult to recruitment. There are four in the Mental Health and Addictions Centre that's just opened and if we did not have those people, for instance, the one in the cardiovascular OR, we'd have to cut the number of surgeries that we're able to do. However, we have people in orientation at the present moment, so that particular person will no longer be hired by us in the next number of months.

Similarly in the Mental Health and Addictions, we have people in orientation, they will no longer be required for that particular program. You might see as well in that slide there that our prediction is that the number of nurses will go up towards the end of the year and that's directly related to the fact that we have over 100 per cent occupancy of our hospitals in St. Clare's and the Health Sciences that needs additional new beds for acute care and for transitional care and the capacity to staff those positions with nurses that exist in this region is considered to be removed until April and then, when they're oriented in April, we'll be able to decrease the number of human resources that are necessary there.

I think that this diagram demonstrates where they're working and what's the effect of removing those agency nurses in Eastern Health.

L. STOYLES: Okay, now

My colleague mentioned conflict of interest, and I'm just wondering now, when we hire an agency nurse, before they sign the contract, are they aware of the conflict of interest guidelines and all that? We have new policies put in place because certainly there's been a lot of discussion on conflict of interest and training, and I know your colleague mentioned training and all the stuff you've been doing with training on conflict of interest, especially in rural communities. I just wanted to get more of an answer on that.

P. PARFREY: The public procurement of these standardized contracts demands that they have to reveal that they are not in the health system, and therefore the people making assessment of the need for these leases determines which people they'll get. If they're the last person available, they can get it, but before that it's somewhere else it goes to.

I'll just let Debbie answer that.

D. MOLLOY: So yes, in terms of leasing, we have made sure that there's been a lot

of education to ensure that people know, and then if they do apply, to give us a lease in a small community as an example, they do have to indicate to us that they work for us, so we are aware during that process that it is an employee, and we would not enter into a lease with them, as Dr. Parfrey said, unless they were the last person who had accommodations available.

L. STOYLES: I'm going to pass to my colleague.

J. WALL: Thank you, MHA Stoyles.

Mr. Chair, I want to go back to a previous testimony from Ms. Pelley. Ms. Pelley, you said earlier that you became aware of Agency A in the spring of 2022. So I'm just wondering, again, while everyone is chatting and trying to get your thoughts around everything, I'm just thinking, how did you become aware of Agency A, and what conversations did you have? Were you a part of negotiations, or what was your role within all of that?

J. PELLEY: At the time, I was vice-president of Integrated Health and chief nursing executive with Central Health. We were having conversations as an executive team around the gaps we had with our nursing staff, and we had conversation around what agencies, potentially, could supply us the number of nurses that we needed.

At that time, we had about 65 nurses that we needed to support care, and as Dr. Parfrey mentioned, if we did not have these nursing staff in place, we would have a great operational risk and it's our responsibility as an organization to look at the delivery of health services, so safe, sustainable, quality services. That was a real risk from a clinical perspective.

So we became aware of Agency A. We had conversations, we connected with them around references and what they can provide, and they could provide us with the skill set that was required, particularly in our rural sites, we needed nurses that were

cross-trained for ER, for acute care, and they had the ability to do that for us.

J. WALL: Okay. Thank you, Ms. Pelley.

So with all of that, were you involved in the approval of Agency A?

J. PELLEY: I was involved in the approval of Agency A, yes.

J. WALL: Thank you very much for that.

I can't get away from the monetary portion of it because everyone that I spoke with over the last number of months was with respect to the taxpayers' dollars that were spent. So this report notes issues with invoice payment processing, with the causes seeming to range from the lack of training to a lack of documents to review.

So I'm just wondering, is this still an issue going forward? Are the same people in the same positions that made those mistakes then? Are they still involved in the process now currently?

P. PARFREY: No.

J. WALL: No?

Thank you.

P. PARFREY: Did you want to add to that?

S. BISHOP: Thanks, MHA Wall.

I guess just to elaborate a little bit, as identified by the AG, there had been, no doubt, systemic issues around capacity availability to rightfully administer the volume of invoices and supporting documentation.

As I described earlier, in the early days of NLHS, it was acknowledged that we needed to put more rigour around the control mechanisms to enhance that control element in the administration of these unstandardized contracts. To do that, we implemented, as I mentioned earlier, that centralized function.

These were a new group of folks who have now been trained on a very standardized contract with standardized terms and conditions. So I think, with that said, it provides good comfort in terms of how that's going forward, and they are not the same group of people.

J. WALL: Thank you for that information. I appreciate it. That is comforting.

Several places in this report mentions issues with documentation having insufficient evidence to support payments. I just want for you to explain to us how does NLHS ensure that only what should be paid is now getting paid. We've heard from the report, we've heard in the media, from e-vehicles to air fryers to flights and hotels, and again, it's all taxpayers' money that we are responsible for.

You said the different people are there currently working in those positions, but can you tell us specifically what is being done to ensure that only the proper invoices get paid going forward because of past history? I hope the question is clear. I'm just not rambling. I'm trying to express it.

P. PARFREY: Yeah, no problem.

I think I probably need to repeat what I believe to be true is that NLHS is the solution to the problems of the administration of contracts by the regional health authorities that occurred before we came into existence. What we put in place is substantially better than what we had.

Again, I'll ask Scott to add to that.

S. BISHOP: So I guess instead of, you know, repeating the whole idea of the centralized agency group that I referred to and the policies around that from a control mechanism perspective, maybe I'll touch a little bit about what had happened and what we're doing to understand that further and if there's actually further investigation required.

I think, in the earlier comments, Dr. Parfrey mentioned about a comprehensive audit. It

was one of the recommendations from the AG's office around understanding what had happened there. There was a small sample size reviewed by the AG's office in relation to supporting documentation. I think it was 84 in total, which is a small portion of total invoices, but nonetheless it warrants further investigation.

To help us with that from a capacity perspective and to be totally objective and transparent with that review we've sanctioned, as I mentioned earlier, an external audit to look into that further and to understand if there was indeed, one, any fraudulent activity, which we take quite seriously and, two, if there's actually any conversations and further dialogue we need to have with particular Agency A in understanding if there had been payments made in error and if there needs to be recoveries possible.

I think, from a retrospective perspective, the audit will be our safe harbour, if you will, in terms of understanding what can be done, if there needs to be recoveries made or conversations had. Going forward, our centralized agency function around that and policies and procedures around that gives us some comfort in terms of, going forward, what's rightfully paid is what should be paid.

J. WALL: Thank you, Mr. Bishop.

We're all very concerned with that. In the AG's report, she does not use the word "fraud" lightly. That is a very heavy, heavy word. So with respect to Agency A, who not only was involved in the nursing contract but, if I'm not mistaken and please correct me if I'm wrong, they had the electrical vehicle contract as well, have discussions began with respect to further investigation, from your words, an external audit – are any discussions started? Are they under way now with respect to the potential billing, if I'm not over speaking, but has that already started?

P. PARFREY: No, it hasn't started yet, MHA Wall, because the request for proposals for this forensic auditor was submitted a few weeks ago. It closed last week, and we'll be

able to name who the auditor is in the next few days or early next week. The intent will be that that auditor will report back to us at the end of September, and then a decision will be made concerning whether there was potentially fraudulent activity and how we would refer to the appropriate agencies.

J. WALL: Okay, thank you.

Ms. Pelley, I want to go back to you for a moment with respect to your answer you just provided shortly ago. I asked, how did you become aware, and you said we became aware. Can you please share with us who are the “we” in discussions with respect to Agency A contracts and as again, you were with Central Health, how did Central Health formally become aware?

J. PELLEY: At that time, we had conversations as an executive team. So the CEO was no longer there, our chief financial officer is no longer there because we’re a new entity. But we had conversations around the risk that we had with operations, and I guess the agencies that potentially we could use.

At that time, we were engaged with agency use somewhat with another agency. We became aware of CHL, of Agency A, and then we had conversations around what we would do.

J. WALL: On your executive team, who would be part of that team? You said there was no CEO at that time, because you were a new team. Is that the current team that’s in place now?

J. PELLEY: No, no. We would have had our previous CEO there when we were one entity.

J. WALL: Thank you for the clarification.

I’m going to pass it on to my colleague from Lake Melville. I only got 15 seconds, so I’ll pick it up on the next time.

P. TRIMPER: Thank you.

Just to bring everyone back to my final thought when I last spoke, I was talking about rates and some translation and understanding of how they are now determined and so on. I just throw it to the floor. Anyone listening that – and back to an earlier question when I talked about seeking some update on the status of the discussions nationally on each province and territory on how they will be going forward with procuring agency nurses, I see that as a very important element of agreement. Perhaps it’s the crux of it, is what is one province going to pay for the provision of these services that they need and location and, in particular, speciality.

I just throw that on the floor if anyone had any comment on that.

D. MOLLOY: So when we went out for our standardized terms and conditions of employment, we did connect with other health authorities and other operational facilities across the country to understand what were they procuring and how were they procuring.

We did test that, I guess, across the country to understand what we would put in our standard terms. I can tell you, when we went out for our standardized contract, we were in sort of the bottom quarter, bottom third in terms of what we said we would pay. As an operational organization, we have a national organization but the government, as well of course, has connections with other governments.

I know it is a live conversation among many other provinces to talk about, really, as a full system, we almost need to find a way to move away. I do understand a couple of provinces have exited out of the agency either altogether or they’ve set a date. There have been one or two others that have set a particular percentage or a number that they’re saying they won’t have more than a certain number.

To this point there is not, sort of, a common yet decision around, I guess, cost. But it is definitely a live conversation about how to do this together so that we can ensure that

we have a robust and healthy, publicly funded health system.

P. TRIMPER: Yes, I was thinking about that when you and your team were speaking earlier. I guess, in some ways, it's a contradiction or it's certainly opposing pressures as you work to now standardize these rates across our province, get those pays down so that, as you say, perhaps, it's less attractive for these agencies to come here but, on the other hand, we do need them. The last thing we need to get into is a bidding war across this country.

There was a point I wanted to make earlier, but I'm just going to throw it on the table about regional health authorities and the bizarreness that I have encountered in my own world of certain medical professionals from one entity having to go through some administrative burden if they were going to transfer to another. I know we dealt with that about two years ago when I brought it to a certain minister's attention but, wow, we've really developed a lot of disfunction, so the sooner this country can work together, the better.

I wanted to go over to – I heard you say, Dr. Parfrey, I think it was just a little subtle point and I'd like to go back to it for a second. I was going through some media reports. I mean, sometimes when you hear something, it's so outlandish that maybe it isn't true, as opposed to assuming that it is and that everyone in any position, whether elected or otherwise, is incompetent, and the fact that we wouldn't do everything we could to try to engage every single nurse that is graduating from our professional institutions in this province, I can't imagine why you wouldn't do that. I know you're doing it. I think the number you said was 93 per cent accepted. Is that what you said?

P. PARFREY: Yeah, 93 per cent of 244 nurses are in full-time employment in this province.

P. TRIMPER: Absolutely.

P. PARFREY: That means there's only 17 that didn't take full-time employment. We

need 280 to fill our vacancies. If we fill our vacancies, even if we got to have 100 vacancies, we wouldn't need agency nurses as long as they went to the places that we needed them.

P. TRIMPER: Then looking forward on assumptions around retirement, perhaps other reasons that someone may leave their post after so many years of service, that's where you're projecting into the future, where you're going to go.

P. PARFREY: Right.

This issue of attrition versus recruitment is a constant. We're optimistic for next year that we'll have more nurses in than out, because we've got that 244 qualifying again and we have a batch of internationally educated nurses that are finishing orientation who are capable of also of going in to these positions. But we're still left with the two places that have got the biggest problems, Central and Western, who traditionally have difficulty recruiting and our capacity to solve those issues, they're still there.

P. TRIMPER: Right on.

I wouldn't be a good MHA for Lake Melville if I didn't put a plug in for the Bachelor of Science and Nursing program at the Labrador campus and how tremendously successful that is and what a difference that's going to make for Labrador and across the province. Certainly a great ratio for students to teachers, if anyone is listening out there.

Two more points I have. One is there's a lot of text and talk in here around electric vehicles and contracts. I realize that within a week's time or so, we're going to have a third party actually do a forensic audit of what's gone on here. Could you, in your words, without compromising the work that's to come, what you see as some of the issues that arose around this rather obscure aspect of contracting nurses related to electric vehicles?

P. PARFREY: I don't really want to comment on electric vehicles. If there is

fraudulent activity, it'll be identified by the forensic audit and exactly how they came through and how they were approved is not really clear to me, if you want the truth.

The point I would continue to make is that COVID-19 identified those things in our society that were weak, and they fell apart under the pressure of COVID-19. Look at what happened with long-term care facilities across this country during COVID-19 and particularly the private ones, and also look at what's happened, our capacity to administer these agency contracts in areas that didn't have the resources to be able to manage all those new nurses coming into their community, 200, all those invoices that were – I think there were 8,000 invoices during the period of time that the Auditor General monitored – 8, 000 – to an organization that was not used to being able to deal with that and a managerial system that was under enormous pressure because they had to try and keep services open and never knew from day to day where they were going to get the human resources.

So I think that COVID identified a systemic weakness and a systemic administrative problem, and that NLHS, when they came into existence, was the solution to these problems.

P. TRIMPER: Thank you, Dr. Parfrey.

I mean, in terms of my thoughts in coming here today, this is somewhat how I wanted to wrap it up. This is the part that I believe angers the people of this province. I'm glad you're moving forward. I look forward to the outcome of this third party review.

I believe I may be finishing up, but we'll see when we come back down around, but I did have one question for you. In the working relationship that we enjoy with the Auditor General and her office, I wondered – and I looked at your action plan. We just had a chance to look at it today for the first time. Are there any aspects in here where you feel that you don't agree with the findings in terms of the recommendations? I mean, for the most part, I think all but three are implemented. You say those three are

partially implemented. Do we have points of debate, or it's just a matter of you're working forward to try to address them?

P. PARFREY: We have no points of difference with the Auditor General about any of the 15 recommendations and we are prepared to fully implement all 15.

P. TRIMPER: Thank you.

CHAIR: All right, thank you.

As per a question of who authorized the leadership of Central Health to sign the contract, Mr. Parfrey, you answered, the department. Who in the Department of Health? Was it the minister?

P. PARFREY: I have no idea. I'm just saying that the natural connection between spending the taxpayers' money comes from the government to the group who are operating the health system. So I'm assuming that there were discussions between the department and those regional health authorities when it came to spending money on agency nurses. It's an assumption. I know nothing about the details.

CHAIR: Ms. Pelley, you said you had conversations around CHL. Who authorized Canadian Health Labs? There must have been some conversation.

J. PELLEY: I would say that we had conversation around Agency A because they could provide us with the number of nurses that we needed. It was an executive conversation, and as we said earlier, as a health authority, we provide the operations when it comes to health care in our zones or in our regional health authorities. The department sets strategic priorities and provincial direction. We authorized as an entity that no longer exists.

CHAIR: So CHL had the nurses, you had the conversations, so who did actually make the authorization to approve CHL?

J. PELLEY: It was an executive group at Central Health that decided Agency A would

be the agency that could support the number of nursing staff that we needed.

CHAIR: Okay, thank you.

Through an ATIPP, we know now that there were 17 managers for leases. But have any of these been discovered leasing through family or a family company?

D. MOLLOY: So what we did do when it was brought forward that there was a concern about conflict of interest, we had a look at all of our leases through our procurement group, and then we sort of also did a listing of all our employees and determined where there was an overlap.

We also did look at if there was a company name and we did search through deeds to determine if there was an employee who had a company and we had a lease through a company, or if there was someone in their family that had a lease through a company.

We kind of used two ways to look to see if we were employing different leases.

CHAIR: Okay.

Eleven of these managers were identified in the Central zone. Why is there a higher prevalence of managers in conflict in that particular area?

D. MOLLOY: I don't believe it was zonally determined, to be honest. We went out in all of our zones asking for our employees and whether or not an employee had a leased accommodation that they could come forward with. Also, as a reminder, we have more leased accommodations in Central zone than in any other zone that we have. We have more agency nurses in that zone, so naturally there would be a higher percentage, I think, because we had a higher number of people in that zone.

CHAIR: You also said you needed accommodations for travel nurses. but those went three times the market value. Why would they go three times the market value?

D. MOLLOY: I'm going to pass that to Dr. Parfrey.

P. PARFREY: It didn't. The market value is presented in this table, and we do have a point of difference on the comparator with the Auditor General insofar as the assessment of the CHMC price was the one that was used by the Auditor General to compare what we actually paid for those leases.

We feel that the appropriate comparator is what the market would charge for those buildings. It could be a one-bedroom, a two-bedroom or a three-bedroom apartment, depending on what the decision was in terms of who'd go into what, and you can see there that there is little difference between the amount that was charged on the lease compared to what the market was bearing.

So we do disagree on the comparator and we do not feel there was a premium provided for those leases.

CHAIR: On pages 34 to 37 in the report: Employees who provided properties to NLHS charged well above market rates, with 98 per cent of those tested exceeding market rates. The rationale provided by NLHS was that these were places where it was nearly impossible to find accommodations. The report does not note that the accommodations were in bigger centres, so I'm wondering if alternative arrangement have been made now so you can get better price, and is it an emergency now?

P. PARFREY: Clearly, it's not an emergency as it was in 2022 when these contracts were put into place. So we're in the process of getting out of the marketplace for agency nurses, but we still have agency nurses that require accommodation.

In terms of the predicted lease prices that were based in those four urban areas that compared to what the market prices were, there's not much difference in what we think. We don't think there's a premium in

those areas. But that's our opinion, and we're respectfully disagreeing with the Auditor General.

In terms of what happens in rural areas, usually the people who have got the extra accommodation are people who are employed, and the health care system is a big employer of people in more isolated areas. If we needed accommodation there, we would really be dependent of those people offering to lease their houses.

But I think that Debbie can talk in more detail.

D. MOLLOY: We do feel like we have procured things correctly now. We went out to the market and the price that we're paying now for the leased accommodations is what the market would bear. So that is what was provided within the information.

We have moved away from an emergency and we have moved into where we do have a public process. So anyone who is leasing with us now has went through a public process and has declared if there's a conflict. So we feel very confident now that we have went through the correct process to ensure that we're getting the best value for money.

CHAIR: Okay.

Are staff still being asked to provide accommodations?

D. MOLLOY: We have went out through a public process now, and if in some communities, staff have accommodations that they can lease to us, they do have to go through this public process. So there are still some staff.

We're following the guidance which was provided to us by the conflict of interest committee of the province, which did indicate to us that it is not a conflict of interest. However, because of the perception of conflict, we should only be leasing from staff if we have leased from anyone else who has come forward. So that

is exactly the process that we're following now.

CHAIR: Okay, thank you.

Ms. Pelley, when you were asked about the confirmation of CHL, you said it was an executive group. Was all that executive group from Central Newfoundland or entire Health Services?

J. PELLEY: That would have been Central Health because we weren't formed as an entity as NLHS at that time.

CHAIR: Can you provide us with a list of that group?

J. PELLEY: We can do that, too.

CHAIR: Okay, thank you.

The Member for Mount Pearl North.

L. STOYLES: Thank you.

I have a couple of questions. I know my colleague in Exploits has talked about the contract and who actually signed the contract and you're going to give us a list of who served on that committee. When did we actually start agency nurses? My understanding is that agency nurses was started back a number of years ago on the West Coast by the minister of the day, the minister of Western Health. I'm just wondering when we started hiring agency nurses, was it somebody from outside the province, the agency, even back then?

I know other provinces in Canada, especially here in our Atlantic provinces, have hired and have used that same company. We talked about Agency A number of times in the report. Obviously, it wasn't Agency A when we started hiring agency nurses. I'm just wondering how it actually started and what year it actually started in.

D. MOLLOY: Thank you.

Prior to 2022, the only regional health authority that was using agency nurses was

the Labrador-Grenfell Health at that time. It was very difficult, sometimes, to attract employees to go into what's now Labrador-Grenfell zone. So there was a small number of agency nurses that had been working within there. I believe it was 2022.

I'm just looking for my colleague to confirm when Central Health, which was the first of the other regional health authorities to enter into a contract. So it would have been February of 2022 when Central Health, outside of Lab-Grenfell, that was first regional health authority to look to agency nurses to provide service.

L. STOYLES: The other question I have is when we talk about the 93 per cent of nurses accepting to stay here in Newfoundland and Labrador to work, I'm just wondering how many nurses are actually in the school system from outside the province and foreign students? I mean, I imagine there must be a high percentage of students here.

I'm just wondering, at the end of the day when we look at the numbers of foreign students, would there be almost 100 per cent compliance in the people who've accepted to stay in Newfoundland? Because I think the people need to know that.

D. MOLLOY: Thank you for the question.

I don't think we know necessarily where people are from who are within our nursing programs. So we're really pleased with that 93 per cent would determine – for sure, there are some people who are from other provinces. There are some people who may be from other countries who are attending nursing school in the province.

We don't distinguish between them as a health authority. We certainly go in and make job offers to every single student that is in our system.

L. STOYLES: I was just curious about that because I know a number of foreign students that are here and doing nursing

and I'm just wondering if that played an impact.

The other question I have is, retired nurses, people who retired – and I know when COVID hit all the people that were giving the needles, from what I heard, it was over 90 per cent of them that were retired nurses. I'm wondering if there was any consideration given because some nurses who retired give up their licence and I'm just wondering if any of them would have been grandfathered in to go to work in crisis situations like we've had?

I'm just wondering if can give us some information on that because you think someone would be.

D. MOLLOY: Yes, and we're very fortunate to have quite a number of nurses that retired from our system still are willing to provide some service to us. Many of them were casually with us. We're really, as I say, really thankful to anyone who puts up their hand and says they're willing to do shifts for us.

So we do tap into that group who have retired from us, and I'm really thankful for that. I'm also equally thankful for anyone who put up their hand during the COVID-19 pandemic and said they would be willing to come back to work. We were so thankful for anyone who did that and if they're willing to work with us again, we'd gladly welcome them back into the organization.

There is some assistance that is available to retired nurses. There has been, in the past, some assistance for licensure. I think that's what you were asking about, and there has been that in the past. We look at incentives all the time to determine what is the appropriate incentive that we can offer to have people to come and work with us.

I just did want to pick up really quickly, though, something Dr. Parfrey talked about, which is internationally educated nurses. We haven't actually talked very much about that today. But in addition to those graduating from the nursing schools, the campuses across Newfoundland and

Labrador now, we've been really fortunate to have had over 320 internationally educated nurses joining us, the majority from India, although some from other countries as well.

Many of them have very similar education systems to our system here in Newfoundland and Labrador, and I can tell you that even from India, some of them use the same textbooks. So they're educated in English and they're using the same textbooks that we have here in the province. That's why we determined that that was a really good country to go to, and they have additional trained nurses beyond what they need in their own country. So from an ethical standpoint in terms of recruiting, that was part of the reason that we went there.

Those nurses that are coming to work with us from India are going to work in every community within our province. We hear stories every day, success stories from people in St. Anthony, from people in Happy Valley-Goose Bay, on the Burin Peninsula, in Grand Bank, in St. Lawrence, in Central, in New-Wes-Valley, in Gander and in Grand Falls, as well as Corner Brook. So those who are coming to us who are internationally educated are helping us to ensure that our rural facilities are appropriately staffed.

Again, I can only say we're so pleased and happy with that initiative, and a lot of them are just finishing now their orientation program and going into full service with us.

L. STOYLES: One more question. I'm asking more or less for a rumour, or people have said to me that if you're a casual nurse, you can work as many hours as you want, and some are limited to one or two days a week. I'm just wondering, how many or what's the percentage of casual nurses that are making more than the average regular nurse would make on a regular shift?

I know some of the regular nurses work overtime and everything, too. I'm just wondering if nurses are not taking the permanent jobs because they can make

more money. People are asking that question and I'm asking for other people.

P. PARFREY: So if you go to figure one, you'll get the relevant proportion of those who are full-time and casual, and the total number. The orange line is the number who are casual, and you can see that the number of casual went up during the great resignation. Then you can see that there are very few casual vacancies at the present moment. Then the number of full-time vacancies is also dropping substantially, and that's in figure one.

L. STOYLES: Okay, I'm going to pass it back to my colleague.

J. WALL: Thank you very much.

I'm quite intrigued with the testimony that's coming out today and I want to go back with respect to Central Health. The question I have is: Did Central Health consult with or have any discussions with the Premier's office, with the minister regarding Canadian Health Labs in 2022? Was that discussion ever had? You mentioned who was part of the team, but how did it come to Central Health? Was the Premier or the minister of the day involved in any of the discussions?

J. PELLEY: To my knowledge, at my level, when we talked as an executive team, I was not aware of those conversations if any had happened. As I said earlier, as an organization, we are there to provide the operational care and service delivery, and the department sets strategic priorities. So we discussed as an executive team and that's how we made our decision.

J. WALL: Okay, thank you.

How did it get to the executive team?

J. PELLEY: We had conversations with our CEO, and I guess, you know –

J. WALL: Sorry, I apologize for interrupting. CEO at the time?

J. PELLEY: Yes.

J. WALL: Yes. Okay, thank you for that.

I guess I'll direct this to Dr. Parfrey. Are you aware if anyone in the department, the minister or the Premier requested the generation of a generic contract? At this particular time, are you aware of anything?

P. PARFREY: I'm not.

J. WALL: Thank you, Sir.

We have been told that the CEO of Central Health indicated her request for Canadian Health Labs for generic contract which involves the use of a personal email account. Now, given the fact with respect to what has happened with government, different departments, and being hacked, what have you, are you aware that these negotiations started with a personal, non-government-based email account, and is that something that's continuing today?

P. PARFREY: I am not aware.

J. WALL: Thank you, Sir.

I want to go back to my colleague from Exploits, and with respect to the accommodations and what's being done – sorry, not what's being done, what has transpired. I was given the information that a lady was renting a two-bedroom apartment in Central for \$850 a month. She's been there for quite some time and she was given a notice that she had to vacate the premises, and then someone come in under a travel nurse agency contract and it went to \$2,200 a month. From \$850 a month to \$2,200 a month with nothing done to the apartment only because it was a travel nurse that had to go in there.

So I understand, and I heard clearly what you said how you don't agree with respect to CMHC and the values, but that's real life. That happened. So what do we do, or how do we go forward with respect to that it doesn't happen again, and has there been any discipline done in cases where that did happen?

Like, I do know that there was a director involved with recruitment of nurses, and she was paid over \$50,000 through accommodation rental. So has any discipline been taken, any action taken on that? Just update us on it because, again, that's one of the egregious examples that real life is happening, and people have been faced with, and in today's age when housing is at a very minimum, we can't let this continue to happen. So has anything been done since that?

P. PARFREY: I don't know of the information of that particular individual, but I do know that the leasing rates that are part of the current contracts, using the standardized contracts, are what the market would bear, what the market is looking for. I mean, to get those fully furnished and with utilities, that those are the market prices.

The only point that I'm trying to make is that, in general, there's not a premium, and I don't know of any of these individual things that occurred with the regional health authorities.

However, I'll let Scott speak to that if you want to, Scott.

S. BISHOP: Just to elaborate a little bit on Dr. Parfrey's comments. What we've done in terms of solidifying in alignment with the Procurement Act from the legislation perspective is as per guidance and best practice in terms of an RFSQ, which is what I referenced before. Ms. Molloy also mentioned in terms of understanding what the market rates are and that's really what we need to go by.

In terms of individual circumstances, not aware of any of those, MHA Wall, in terms of what may have transpired in terms of lease expirations and new leases commencing but certainly happy to look into that if there are further details available.

The market rates that we've established in terms of what we've determined with our RFSQ process is what we're seeing. On average, it is in line with what rates were paid at the time of the Auditor General's

review. So, again, to that point the premium doesn't appear to be as extensive or at all to be present.

Again, if there's an individual circumstance that you referenced, we wouldn't be aware of that.

J. WALL: Just to ask the question again, has there been any discipline taken against staff or directors from that time where agency nurses were paid through accommodation rental that they were for the two travel nurses? Has anything been done since that time?

D. MOLLOY: As I talked about when it was brought to our attention that there was concern around conflict of interest, we went through a process of determining who, in terms of employees, were in leased accommodations with us. We also went, as I said, and checked whether there were companies that employees were involved in so that we could have a wholesome review of that.

Our determination when we consider a just culture is to look at, was there an intention here? Was there someone who was trying to do something that was underhanded or that they were trying to hide that they were employees with us? We did not find that. We did find that we had systemic issues. We hadn't always, in all cases, went out for a public call.

So we went through a process where we asked employees, did you feel like you were under one of the exemptions within the act? Employees came back and the vast majority told us they did feel that they had fell within an exemption within the act and they felt that there was an emergency.

We then went back to check and say, is there a definition of emergency within the Conflict of Interest Act? We didn't find a definition of emergency, so we went back to all of those people and we said, okay, we're going to need to go through a public process. We didn't do that. There was a systemic issue within the organization and we needed to do that, and so we gave them

notice that we would end the leases and then we told them they would need to look through the public process.

We didn't determine that anyone at the time was doing something that was discipline worthy. We did feel using a just-culture lens that we, as the system, had failed and we needed to look at how could we correct that as a system.

J. WALL: Understood, Ms. Molloy, thank you for that.

Due to my colleagues asking really good questions today, I'm just going to jump to the next one, because they've asked some questions that I had here, or similar questions.

I just want to ask this one quickly, if either one of you could speak to your actions to date with respect to ensuring the full implementation of Recommendation 8: "Newfoundland and Labrador Health Services should develop comprehensive nurse staffing plans, with regular reporting that enables management to perform effective evaluation."

Your submission mentions projections, but the recommendation is specific to a plan that could be used for operational management purposes. So can you just enlighten us how you're ensuring the full implementation of that, if you could, please?

P. PARFREY: At the start of this fiscal year, projections are made in each zone about what they believe were the needs for agency nurses to be able to maintain services, and those projections are on those tables in the blue boxes for each zone.

On top of that in those zones, you've got the actual number, they're actually higher to be able to provide those services and they're less than the projected numbers. We meet – we being me, Debbie and Scott, meet with the leaders of each of those zones monthly and we go through the actuals and the projected. We're in the process of repeating the projection for the next 12 months to see where we are.

So the projection in March said it would be 200 – well, it'll probably be a bit less than that because we're not able to get all the nurses. But we repeat the projection based on the accountability process and the fact that we're really focused on trying to ensure that we use less agency nurses and we'll see where we're going to end up for the start of this coming fiscal year. Then we'll factor in the number of nurses we think that we're going to get in the next fiscal year.

I think that we have a plan that's robust. We have the metrics to allow us to examine that plan. We add that to the monthly cost for agency nurses and we have an accountability structure that goes through the organization with the leader of the organization as the final common pathway.

J. WALL: Thank you, Dr. Parfrey.

Sorry, go ahead, Ms. Molloy.

D. MOLLOY: Thank you.

In addition to what Dr. Parfrey just talked about, we also do have a health human resources framework that we have worked with the Department of Health and Community Services to develop. Under that framework, we have identified six different areas within human resources that we need to do detailed planning on, and within NLHS, we have a health human resources plan which falls out of that framework.

We also, with the Department of Health and Community Services, have partnered with an external group to have a health planning tool which looks at a 10-year horizon. We can change the inputs and outputs of that particular tool, which will, in turn, tell us how many vacancies we might have up to 10 years in the future. We can check that every year as well then to see, okay, that was what we thought we would do. How did it actually end up working out?

So that's in addition to the detailed operational planning that we're doing around agency nursing. We are doing staffing plans that look out over that 10-year horizon.

J. WALL: I'm glad to hear that. Thank you. The forecasting is very important as you're moving forward to make sure that you have ample, and we don't rely on agency nurses going forward. Thank you both for that answer. I appreciate it.

Mr. Chair, that's it for me now. My time is up. I'll move it on.

P. TRIMPER: I want to respond to my colleague on a political point I believe he was making regarding the eight floor and the role of the premier. You know, I was thinking as you were asking that question, 12 years ago, I had two gentlemen walk into my consulting office and they wanted to engage our services to provide environmental assessment around the storage of nuclear waste on the North Coast of Labrador.

I said to those two gentlemen that wanted to engage our services, I said we're going to stop right here. We are not going to work for you until you seek permission from the Indigenous governments affected – end of story. That was the end of my discussion. I've been now 12 years finding my name and our company often raised in association with this issue.

I raise that for background because as the parliamentary assistant to this Premier and the one before, over the last several years, the particular inquiry, as far as I understood, because I did some background, this was an email that came in and got actioned. It was referred to the department for consideration. That was the end of it.

So I just wanted to shut that point down. It's like any other email that yourself or other colleagues would send to the eighth floor for action. It was sent to the department for consideration – end of story.

That's it for me, Chair.

CHAIR: Okay.

Throughout this report, it's the big amount of dollar value that was paid out. Why was an agency paid over three times as much

compared to local nurses? Why were they paid three times as much per year?

P. PARFREY: The nature of the agency is such that you're having to pay the premium for the nurse, you have to pay the margin for the agency itself, and you have to pay for all those things that relate to bringing in the nurse and feeding them and accommodating them.

At the time these contracts were put into effect, as I previously tried to demonstrate, is that there was a marketplace for these nurses all across Canada. So the fact that we felt that as an emergency we had to get these nurses as fast as possible meant they were able to negotiate a premium at that time. So that would have been at the time of the regional health authorities.

Now that we've got a centralized approach to it and now that we've created the terms and conditions of it and now that we've got control of our situation, that premium is far less. But, nonetheless, the amount of money we're paying for agency nurses is far more than what we would pay for Newfoundland and Labrador nurses, but we don't have enough Newfoundland and Labrador nurses to be able to provide or fulfill our obligations for care delivery.

We're anticipating that those obligations will be met next year by Newfoundland and Labrador nurses, but we still don't have them.

CHAIR: Thank you.

In the report it says: Newfoundland and Labrador's use of nursing agencies began to escalate in 2022. In April of 2022, the province's Central health authority signed a one-year contract with a nursing agency, hereafter referred to as Agency A – which I think now has been revealed as CHL – for up to \$28.2 million in one year.

Ms. Pelley, you said you had a conversation with the CEO, your group. So did the CEO approve this \$28.2 million?

J. PELLEY: We had conversation, as an executive team, the CEO would have been a part of that conversation. We would have agreed that we would approve a contract for agency nurses to supply what we needed on the ground at the time.

CHAIR: Mr. Parfrey, would a CEO authorize \$28.2 million without the approval of the department?

P. PARFREY: Well, the statutorily obligated agency for spending taxpayers' money is the Department of Health and community medicine.

CHAIR: Okay, thank you.

Anyway, we'll go with you if you have another question?

L. STOYLES: I do have another couple of questions.

When we talk about the agency nurses and we talk about the high cost, and the numbers come up almost \$400,000 per nurse, do you have the cost, the highest amount of money – after you take away the bones and, like Dr. Parfrey said, you've got to pay for their flight, you're going to pay for their meals while they're here.

I have a doctor friend that travelled, when she came here first, to Gander and St. Anthony. When she went, she had a rent-a-car. She stayed in a hotel. Her meals were all covered. She went to the emergency room and done her job for 10 or 12 hours and, at the end of the day, she got her salary. The salary is what I'm looking for. I'm just wondering, do we have the number for the highest paid travel nurses?

Taking away everything else out of the equation, for a better word, do we have those numbers because that's what the public is hearing and I don't think they get the number. I know we tell them that there's this and this and this and this, but can we get that number or do you have that number?

P. PARFREY: I think the rates that were paid – the Auditor General’s report reports that the rates that were paid by the agency nurses in this province were similar to the rates paid across the country.

L. STOYLES: Thank you.

Looking at the report, and I know when the Auditor General released the report, I’m just wondering – I know you just took over as CEO not too long ago and I know you’ve got a very good plan here in place and we look forward to the plan being implemented and all the Auditor General’s requests being looked at – is there anything you would change in that plan now?

I know it’s fresh and that but after hearing all the questions today and the concerns that the public have, not us as a Committee. We’re only here representing the public. We represent our own district but on this Committee we represent the whole province. I’m here because I’m representing my party of course, and I’m just wondering if there’s anything else you will look at and, after leaving today, will you go back and look at making further changes? I’m just wondering how far more we can go or if you feel this is sufficient?

P. PARFREY: I think that our job is to build trust in NLHS across the health care delivery areas that they’re responsible for: acute care, chronic care, community care and long-term care.

That necessity to get the trust of the public means that we’ve also got to deal with the issues that have arisen from this particular report. Where the conflation of our grouping the solution to these problems, the fact that we had contracts that were administered not optimally, is a concern for me. So it is really important that we are able to act on the agency nurses’ issues appropriately and that the public understands why we’re doing it. We believe that that action plan that we’ve got and the way that we’re having accountability for that action plan is actually pretty good.

However, if somebody has got other ideas that they think that we could do it better than that, we’re definitely open. People refer to me going into the media; the reason I go into the media is not because I really like it. I hate it. The reason I go in there is because people have got to think that I’m telling the truth and, as a consequence, they’ve got to trust me and if I give an explanation for what’s going on here, they actually believe it. For me going forward, I have to be able to believe that we’re doing the best we can on agency nurses and that we’re accountable for the way we roll out that plan.

It’s in the major objective of the organization, which is we’ve got to deliver – we’re the only organization that’s going to deliver health care to 540,000 people. We can’t disappear; we have to do it and we have to do it to the best of our abilities and the public have to trust us, right?

Clearly, if it said that I’m misleading the public, that’s diminishing trust and that’s what I get upset about. The reason that I’m going into the media every month and being open for any question that can be voiced by a reporter and try to answer it honestly is my effort to build trust with the public. The other thing that I end up doing is I have a staff meeting every month virtually, with over 1,000 people attend, and again, it’s to build trust with the employees of the organization.

We take it really seriously that we got to do the best we can in terms of delivering on all those responsibilities that we’ve got. So we will definitely follow the recommendations made by the Auditor General with no shadow of a doubt about it. Even if sometimes I disagree with her concerning details, her recommendations, we will totally follow and if we can find a better way of being able to execute in these recommendations we will, particularly around the action plan to reduce our dependency on agency nurses.

L. STOYLES: Thank you, Dr. Parfrey.

At the end of the day, it doesn’t matter which party is in power, we have to do

what's best for the people of this province. I know that's why I'm here and that's why my colleagues are here.

I thank you for that information. I'm going to pass it over now to my colleague.

J. WALL: Thank you, MHA Stoyles.

A couple of more questions, Mr. Chair.

First of all, I'd like to go back to Agency A and just wondering if Agency A had any contracts with travel nurses currently in place for the Province of Newfoundland and Labrador when they entered into the contract with Central Health? Were there any contracts in place prior to entering into the contract with Central Health?

P. PARFREY: I don't know the answer.

J. WALL: No one?

OFFICIAL: They don't know.

J. WALL: No? Okay.

Is there any way we can find that information?

P. PARFREY: It would have only had been with the regional health authorities, that's the only way. That's where it would have been. I'm –

J. WALL: Nothing was transferred from then to what's there now, is that correct?

P. PARFREY: Scott?

S. BISHOP: I guess just to clarify, MHA Wall, there was contracts in place at the time of the transition, legacy RHAs into NLHS. As I mentioned before, those contracts expired naturally based on expiration dates. A couple, for example with Agency A, expired in February '24 and there was another in March of '24. There were other contracts that were aligned in expiration dates for our new contract to take effect April 1, 2025.

But I guess to answer your original question of was the Central Health contract the first Agency A contract, I don't know the answer to that. It's something we can look into in terms of what contract was signed first and we can certainly provide the Committee with that information.

J. WALL: So we don't know if Agency A had any previous history or experience with the province before they entered into this particular contract. We don't know that. All right, thank you.

I want to go back to the AG's report with respect to some inappropriate billing. As my colleague from Mount Pearl North said, it is the people of the province, it's their money and we are responsible for it. So the AG noted that the CHL billed HST inappropriately for 81 per cent of their invoices they audited, and that's roughly \$35,000. Now, it's taxpayers' money and it's only a small sample that was taken.

So, to the best of my knowledge, this issue was identified beforehand in a random audit by NLHS, yet the authority did nothing at that time. There was no further audit triggered; there were no funds recovered. I'm just wondering why. If NLHS did their own audit and found that, why wasn't a further audit triggered and why weren't the funds recovered?

S. BISHOP: Thank you for the question.

So in terms of the reference to the audit, what was done was a preliminary review once we first formed as NLHS to understand where there was some exposure in terms of inconsistencies in the verification and approval process, and there were some issues highlighted.

What we've done subsequent to that, as I've outlined in the AG's report, is that we have indeed issued an RFP for a comprehensive audit of Agency A. If there are items in that audit that are identified as recoverable, we will certainly take action, or if there's fraud identified, we will certainly report it appropriately to the authorities.

I want to highlight one thing that you mentioned, MHA Wall, in terms of highlighted references in the AG's report in relation to the sample size. So the sample sizes of 84 invoices in approximately, I think, 8,000 during this audit period. What it doesn't highlight is the fact that there could have been – and this is where an audit comes into play here, a full audit which we've scoped with an RFP process, is to understand in subsequent periods, were there recoveries, were there credit notes issued, were there other adjustments on subsequent invoices where there were recoveries that did occur?

So what we've done to sanction that is, in agreement with the AG's recommendation, is sanction the audit, a comprehensive audit of Agency A. From that, we will find one of two things: Were there recoverable and ineligible expenses that we need to go back to Agency A to recover and have discussions and dialogue on; or alternatively, were there fraudulent billings that we also need to investigate further, likely with the appropriate authorities?

A couple of things will come from that, and those findings will become clearer in the next 30 to 45 days, and then we can have those audit findings discussed further.

J. WALL: Thank you for that. I'm glad to hear that.

Can you tell me when the random audit did take place on NLHS? Do you remember when it was done?

S. BISHOP: I think the review that was done, a very preliminary review of one particular agency, took place towards the end of calendar year of 2024. As we understood, there were some inconsistencies with how the administration of that one particular contract was being overseen.

So that's what triggered the review of that, to get an understanding of what exposure could have been there in that, in terms of understanding some of the oversight.

J. WALL: Was there anything else identified in that random audit? Was there anything else that stood out other than the inappropriate billing for HST?

S. BISHOP: Not that I can recall of anything of significance or material.

J. WALL: Okay. Thank you for that.

Who was made aware of the results of this random audit? Was it within the department? Was it in the health authority?

S. BISHOP: If I recall, I think it was discussed at the executive level and the board level.

J. WALL: Okay.

Just to be clear, it is not decided yet if you're going to seek for the return of these funds. That's going to come out in subsequent audit.

S. BISHOP: Correct.

J. WALL: Just wondering why it wasn't decided to do it at the time. Why was that decision made to not recover the funds at the moment, or is it because you're waiting on the full audit of its entirety?

S. BISHOP: Yes, I think, as I mentioned earlier, what we did was a small sample review to understand if there was exposure. To enable conversations with the agency, Agency A, it would have to be triggered by a full audit with details sufficient, information supporting documentations to enable those recovery dialogues.

That's what will come from this particular comprehensive audit review that will take place over the next 45 days.

J. WALL: Okay, and is that going to be done internally or is there going to be an outside contractor to come in to do that work?

S. BISHOP: So that will be done by an RFP. That will be an outside consultant.

J. WALL: Thank you.

S. BISHOP: So totally independent.

P. PARFREY: That has been done by an RFP.

J. WALL: Sorry?

P. PARFREY: That has been done by an RFP and the company that's going to do it will be announced in the next number of days.

J. WALL: Okay, thank you.

Thank you, Chair.

CHAIR: No questions?

I do have a couple of more questions that I was reviewing there.

The report notes that there were issues when the costs were realized since some invoices were missed in the '23-'24 so they are included in '24-'25 budget. Why were these invoices missed?

S. BISHOP: Thanks for the question, MHA Forsey.

Just to clarify, the invoices weren't missed. What has happened here, as Dr. Parfrey described earlier, is that once NLHS formed, the rigour that was required from a control perspective to understand the nuances within a magnitude of contracts that had non-standardized terms and conditions, we needed to enforce via the establishment of the centralized agency office. Due to the rigour that those folks put into reviewing those invoices, it created a backlog of review. That backlog of review led to invoices that needed to be adjusted, credit notes that needed to be issued and that was all pushed back to the agency for adjustment, for us to appropriately proceed with the payment to that agency.

Of course, as we pushed that back to the agencies for revisions of invoices, it took time. It took time for them; it took time for NLHS to process those. Knowing that we

were coming to an end of our fiscal quarter and our fiscal year as a health authority, we needed to get those invoices processed.

Once those invoices came in, along with the invoices that had been delivered to the organization for regular processing, those were processed within that period of October 2024 to January 2025 for services that were delivered in a previous year, but that was due to the rigour of that particular agency office that understood there needed to be adjustments made, there was insufficient supporting documentation that we needed to achieve and receive from that particular agency and once that was received, the bills were processed.

So the bills weren't missed, the bills were delayed in being processed through good control.

CHAIR: Can you confirm the same issue didn't happen again and will impact the 2025-26 costs that we are talking about now?

S. BISHOP: Just to clarify the 2024-2025 fiscal, as Dr. Parfrey alluded to earlier, we just closed off our financial statement audit, which is also been prepared by the Auditor General's office and we received an unqualified audit opinion, requiring no adjustments of material and statements for that particular fiscal period. So we feel that there have been no material errors in that reporting period, and we have issued those to our board of trustees.

Going forward, as I mentioned earlier, the centralized agency office that does the verification and approvals of those bills, in alignment with the new contracts, provides good comfort to us as an executive team and our board around the rigour, around the control. So I get some comfort in that particular piece of work from a control perspective, but also that the AG has just audited our financial statements of previous year and has not identified any particular issues, even in subsequent event testing, that led on past the fiscal period close that would drive any particular adjustments for the fiscal period '24-'25.

CHAIR: Okay, thank you.

In the report, it's also noted too, how could the department approve EVs that weren't in the province, air fryers and other items contained in this report? How did this get approved?

P. PARFREY: The department wasn't involved with those invoices.

CHAIR: Well, the health authority.

P. PARFREY: Health authority – do you want to answer, Joanne, or not? I can try and answer.

J. PELLEY: I think you've heard it from my colleague earlier that there is a process that needed to be followed in terms of standardization around invoice reconciliation and approval.

At the highest level of the organization, you would be aware of directional guidance and levels on the invoices, but not necessarily what would be approved at the lower level in terms of supply and whatnot. I think what he said, my colleague there, Mr. Bishop, that going forward there would be an invoice reconciliation process. There are strict controls on that.

I'll stop and I'll ask Scott to add.

P. PARFREY: I think that he's already said that the administration of those invoices in Central Health, and in Western Health in particular, the capacity of the organization to reconcile the invoices appropriately and administer contracts appropriately was not optimal.

We've moved in now to a situation where we believe we're able to do a far better job at that professional component of accounting, and that's been demonstrated by Scott revealing what we're doing and how we're going about it.

I do think that with the NLHS, we will have a far better way of being able to monitor the contracts that we're doing.

CHAIR: Okay. Thank you.

I'll move it down the line if there's any further questions.

L. STOYLES: I just have another question.

I just wanted you to repeat again, when you give us your report and how you've already implemented a lot of the report. I just wanted you to repeat again when you expect to have all the criteria done.

I know you have to wait for the audit to come in and all that so it won't be finished, I guess, for months down the road while you're waiting for the forensic audit to happen. I just wanted the public to know how long more this is going to take.

P. PARFREY: Sure.

We think that there are three recommendations that we say are not fully implemented: The first one is around the casual nurses, which Debbie already spoke to, and should be completed by how we have a better system to use casual nurses. We think that will be done by September of 2025.

The second area is around the forensic audit, which we believe will be finished – the audit that will be finished and the actions that occur as a result of the audit will be way beyond September, I'm assuming.

Then, the third one is the comparison of the metrics for contract fulfilment against what's actually happened is dependent on the contracts being in existence for six months. That's pretty close to happening, so everything will be done within the next number of months.

L. STOYLES: So going forward and any new contracts that are going to be renewed and signed, no contract will be signed without a formal assessment, is that correct?

P. PARFREY: That's been the case –

L. STOYLES: I'm assuming that's the plan that you're going to be moving forward to and I just wanted you to repeat that again, because I'm sure we've heard sometimes the same question in a different way, words maybe being repeated a number of times, but some of these questions and answers need to be repeated over and over again for the public to be assured that things are being done.

P. PARFREY: NLHS is committed to the procurement of standardized contracts with an appropriate accounting system to ensure that the payments that they have to pay are reconciled with the terms of the contract.

That's already in place and will continue to stay in place.

L. STOYLES: Thank you, that's it for me.

I'll pass it over to my colleague again.

J. WALL: Thank you, MHA Stoyles.

I'm just going to clue up; I just want to go back to what I spoke about last with respect to the billing. When we look at these large financial contracts for agency nurses, as the AG reported possible billing fraud and, at times, no oversight on payments of invoices, I'm just wondering, Dr. Parfrey, have you or anyone in the NLHS or the department had any communication with sending this to law enforcement with respect to an investigation because of the AG's report?

P. PARFREY: This is contingent on the report from the forensic audit. Depending on what that demonstrates, then we will make a decision about going forward with the law enforcement.

If there is an indication of fraud or potential fraud, we will do so.

J. WALL: Okay.

I think I'm good. Thank you very much for that.

Thank you, Chair.

CHAIR: Okay, thank you.

P. TRIMPER: We will we have a chance to summarize our thoughts (inaudible) or should I do that now?

CHAIR: If you want to use it for a question, go for it.

P. TRIMPER: All right. Well, perhaps I'll just do that now.

I sense, Chair, that we're wrapping up so I'm just going to take a moment to say I feel this has been an incredibly important exercise. While the province is definitely facing some other issues today, that we've all alluded to, it's been important to be here today and I'm glad it was. I feel that we've done a good job of separating out the need and rationale for agencies to provide nursing professionals where and when and how we need them. I see the plan going forward.

I will be watching on behalf of the PAC and from a retirement chair and looking forward to seeing the regular updates and making progress on the action plan and the updates on how we do. I wish everyone the best. I feel that we've got to the crux of the issue that's really frustrated, and that may be an understatement for the activities of this PAC, the AG and others who have been concerned with what they saw. I look forward to the results of this forensic audit.

Thank you all very much.

CHAIR: Anyone else with a comment?

J. WALL: I just thank you for this today. I learned a lot and I appreciate your time.

Thank you to the AG, of course, and to everyone involved. Thank you.

L. STOYLES: Again, Dr. Parfrey, and to all your staff and of course, the Auditor General and her team, for highlighting the issues that came about in Eastern Health. No doubt we will be moving forward and, again, thank you for all the efforts you have put into this.

Thank you.

CHAIR: Okay.

Given the results of this hearing, we have some understanding now of the answers but, for clarity of the full report, I think we may recall witnesses and others on a later date too for another hearing concerning this report.

With that we'll now conclude today's proceedings. Before I clue it up, I will extend on behalf of the Committee thanks again to the witnesses appearing here today, as well as the Auditor General and her team for their support and attendance today. I also extend my thanks to the Members of the Public Accounts Committee for your continued dedication and commitment in this important work.

With no further business, I'll now call for a motion for adjournment.

J. WALL: So moved.

L. STOYLES: Seconded.

CHAIR: Moved by the Member for Cape St. Francis.

All those in favour, 'aye.'

SOME HON. MEMBERS: Aye.

CHAIR: All those against, 'nay.'

Motion carried.

On motion, the Committee adjourned.