AUDITOR GENERAL
of Newfoundland and Labrador

Report to the House of Assembly

On Reviews of Departments and Crown Agencies

January 2014

Office of the Auditor General
Newfoundland and Labrador

The Auditor General reports to the House of Assembly on significant matters which result from the examinations of Government, its departments and agencies of the Crown. The Auditor General is also the independent auditor of the Province's financial statements and the financial statements of many agencies of the Crown and, as such, expresses an opinion as to the fair presentation of their financial statements.

VISION

The Office of the Auditor General is a highly valued legislative audit office recognized for assisting Members of the House of Assembly in holding Government accountable for the prudent use and management of public resources.

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AUDITOR GENERAL
of Newfoundland and Labrador

January 2014

The Honourable Ross Wiseman, M.H.A.
Speaker
House of Assembly

Dear Sir:

In compliance with the *Auditor General Act*, I have the honour to submit, for transmission to the House of Assembly, my Report on Reviews of Departments and Crown Agencies for 2013.

Respectfully submitted,

TERRY PADDON, CA
Auditor General

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CHAPTER
1
COMMENTS OF THE
AUDITOR GENERAL

Comments of the Auditor General

This is my second report, as Auditor General, on Reviews of Departments and Crown Agencies. This report reflects the work of the Office of the Auditor General over the past year focusing on specific programs within Government departments and agencies. A separate report is issued related to the Consolidated Summary Financial Statements for the year ended March 31, 2013.

The *Auditor General Act* requires that I report, at least annually, to the House of Assembly on the work of the Office. This report, and the report on the Consolidated Summary Financial Statement of the Province, fulfill the requirements of the *Auditor General Act*.

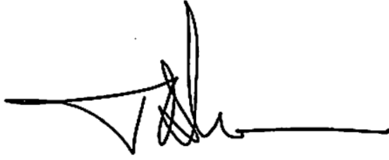
We plan our work based on a risk assessment of various programs administered by Government departments or through crown agencies. We also receive information and requests from individuals outside our office which we evaluate to determine whether we will undertake work in a particular area. This report provides recommendations resulting from our review of the following 8 different programs and crown agencies:

- Eastern Regional Health Authority
- Fee-for-Service Physicians: Audit Process
- Fines Administration
- Waste Management Strategy
- Cranberry Industry Support
- Oil Royalty Monitoring
- Bridge Inspection and Monitoring
- Contracted and Chartered Air Services

The information is provided to Members of the House of Assembly for their consideration. Recommendations contained in this report are intended to strengthen the overall level of accountability within Government and help ensure a greater level of stewardship of public money. I look forward to continued collaboration with the Public Accounts Committee as they consider the recommendations contained in this Report.

Comments of the Auditor General

I wish to acknowledge the cooperation and assistance that my Office has received from Government departments and agencies during the conduct of our reviews. I also wish to thank the staff of the Office of the Auditor General for their support, dedication and professionalism throughout the year.



TERRY PADDON, CA
Auditor General

CHAPTER
2
OUR OFFICE

Our Office

The Office of the Auditor General operates from two locations - Mount Pearl and Corner Brook. The staff of the Office contribute, as a team, in the preparation of the January 2014 Report on Reviews of Departments and Crown Agencies.

The following is the staff of the Office of the Auditor General as of December 31, 2013:

Nicole Abbott
Marc Blake
Paul Burggraaf, CAPM
Greg Butler
Keith Butt, CA
John Casey, CMA
Jeff Cook
Gertrude Critch
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Lindy Stanley, CA
Brad Sullivan, CA
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CHAPTER
3
REVIEWS OF DEPARTMENTS AND CROWN AGENCIES

PART 3.1

DEPARTMENT OF
HEALTH AND COMMUNITY SERVICES

EASTERN REGIONAL HEALTH AUTHORITY

Summary of Findings

Introduction

The Eastern Regional Health Authority (the Authority) is a Crown agency reporting to the Department of Health and Community Services (the Department).

The Authority is responsible for the delivery and administration of health services and community services in its health region and provincially as designated by the Minister.

Our review was completed in December 2013 and covered the period April 1, 2011 to March 31, 2013.

The objectives of our review were to determine whether:

1. absenteeism was properly monitored and effectively managed and leave and overtime were properly monitored and recorded;

2. compensation and recruitment practices were in accordance with Government and Authority policy;

3. purchases complied with the *Public Tender Act* and *Regulations*;

4. the Authority was adequately monitoring its financial position and operations; and

5. capital assets were monitored and controlled.

Findings

Monitoring of Financial Position

1. The Authority required $74.9 million in additional funding by the Province and incurred an $8.3 million budget deficit, despite the approved budget increasing 22% during the past five years.

2. Position approval processes are not consistent with Government policy, despite the Minister's direction to align them.

3. The creation of a new position does not require the Authority to ensure that funding is available for the new position.

Compensation and Recruitment

4. Non-physician job competition files did not contain evidence of Director/Site Administrator approval to recruit an employee and were missing screening documentation and applicant assessments resulting from the interview process and were, therefore, not in accordance with Authority policy, Government policy, and best practices.

5. During 2012, there were 132 individuals in receipt of both a Provincial Government pension and a salary from the Authority. In fact, two of these individuals held two positions with the Authority while in receipt of a Provincial Government pension. Where individuals were employed by the Authority while receiving a pension, we found instances where no documentation was available to show that preference had been given to hiring persons other than those in receipt of a pension, as directed by Cabinet.

6. The Authority provided signing bonuses that were beyond that allowed in the *Department's Salaried Physician Quick Reference Guidelines (2006)* and the *Physician's Services Memorandum of Agreement (2009-2013)*. In addition, the Authority provided a signing bonus to a physician beyond the date at which they were told to discontinue the practice by the Department of Health and Community Services.

7. No return-in-service agreements are in place for physicians who received reimbursement of relocation costs. Therefore, the costs would not be recoverable if the physician were to leave before the end of their two year term.

8. The relocation policy is not being followed for both physicians and non-physicians. Therefore, individuals are being reimbursed for amounts higher than to which they are entitled.

9. The classification of some management positions subsequent to the amalgamation of the health boards in the eastern region in 2005 did not occur until 2013. The significant delay resulted in 123 employees being paid at higher than necessary amounts for more than six years after they were placed in management positions with the Authority at the end of 2006, at a cost in the range of $3.6 million to $4.7 million. Because red circling was delayed, other compensation benefits such as pensions and severance will also be higher.

10. Additional workload benefits are compensation payments provided to physicians for additional workload due to vacancies. One physician received $1,473,528 in additional workload payments over a period of approximately 11 years relating to a vacant position that the Authority had never advertised and does not intend to fill. Authority officials indicated that the physician had the same workload as other physicians, in this specialty, employed by the Authority.

11. Educational differentials were being paid to executive and management employees although the education requirements were part of the position requirements and, therefore, would already have been included in the pay scales. This is inconsistent with Government policy.

12. An employee received reimbursement for personal vehicle usage related to travel to and from work, resulting in reimbursement of $2,364 for the year ended March 31, 2013. This is not in compliance with Authority policy.

13. An employee received reimbursement for personal vehicle usage without approval.

14. The Authority was not always declaring positions redundant on a timely basis.

Leave and Overtime

15. There is a lack of effective oversight to ensure that employees annual and paid leave is properly approved and documented. Without this oversight, there is a risk that the leave balance is overstated and will cost the Authority more than which the employees would have otherwise been entitled.

16. Annual and paid leave are not being adequately monitored to ensure required leave is taken, carry forward and usage complies with policy and collective agreements, and the leave accruals database is accurate. The Authority has recorded approximately $8.5 million in unused leave to be carried forward and used or paid in subsequent years, which is inconsistent with collective agreements.

17. At March 31, 2013, 712 employees have taken annual or paid leave beyond which they are entitled with a total cost of $192,541.

18. There is a lack of effective oversight to ensure that employee sick leave is properly approved and documented.

19. Sick leave expense of the Authority is approximately 20% higher than that of Government on a relative basis.

20. There is a lack of effective oversight to ensure that overtime is properly approved and documented such as to decrease the risk of unauthorized overtime worked and the risk that employees are being compensated for overtime hours beyond those worked.

21. Callback overtime is when employees are called back to work outside their regular shift hours. Employees receive a minimum of three hours overtime pay at the prescribed overtime rate. Callback unworked is the portion of a callback shift that is unworked. Callback unworked was 48% of the total callback overtime. This resulted in an expense of $1.7 million (2012 - $1.6 million) for overtime hours that were not actually worked.

22. Of 229 callback shifts we reviewed, there were 106 shifts (46%) in which employees had, for example, multiple callback shifts within 90 minutes. In one instance, for example, an employee whose annual salary was $61,831 received overtime pay of $51,887 that was unworked overtime.

23. The management overtime policy is not consistent with Government policy, despite the Minister's direction to align policy with that of Government policy. The Authority incurred a $0.9 million expense related to leave in lieu provided to management. This was not in accordance with Government policy.

24. The education leave policy of the Authority is not consistent with Government policy.

Internal Controls

25. Current Authority controls are not adequate to prevent or detect fraud or error in areas of purchasing. For example:

    - inadequate authorization and review of purchase orders;
    - lack of monitoring of final tender costs compared to awarded costs;
    - lack of controls over user access to purchase orders;
    - no dollar limits on spending authorization for employees; and
    - an overall lack of oversight of the purchasing process by the Materials Support Department

26. The purchasing function was being performed by individuals outside of the Material Support Department. There were 243 users that are able to create purchase orders, however, there were only 140 employees in the Materials Support Department

27. Internal controls over cheque processing are inadequate. As a result of improper segregation of duties and authorization requirements, there is an increased risk of fraud and error occurring.

28. There was no functioning Internal Audit Department during the period of our review. An effective internal audit function can help ensure that preventative and detective controls are implemented and functioning properly.

Tendering of Goods and Services

29. We found instances where purchases made were not in compliance with the *Public Tender Act* (*PTA)* and where there was insufficient support in tender files. As a result, the Authority could not demonstrate that bids were reviewed for compliance with tender specifications. We also found instances where the purchasing policy of the Authority was not being followed.

30. Form Bs, which document exceptions to the *PTA*, are not always being submitted on a timely basis. As a result, the Authority is not in compliance with the *PTA* and is impacting the timeliness and relevancy of the information being reported to the House of Assembly. Some pressing emergency exceptions and sole source exceptions may not be appropriate. As a result, the Authority may not be getting the most economical price in these instances.

31. We found instances where contract change orders did not comply with the *PTA*.

32. We found instances where the Authority was not in compliance with the *Consultant Guidelines* pertaining to the hiring of external consultants.

Monitoring of Capital Assets

33. During the period covered by our review, there was no policy to conduct annual capital asset inventory counts. This increased the Authority's risk of not detecting lost or stolen capital assets. Also, there is no policy to conduct asset listing reconciliations to the general ledger. This would help ensure the accuracy of both systems by highlighting differences in asset information.

34. The system, which ranks biomedical capital assets for priority replacement, has inaccurate priority rankings. These rankings are a key factor in determining which biomedical assets need to be replaced.

35. The Authority was not monitoring maintenance expenses to provide information pertaining to the efficiency of the biomedical capital assets to assist in decisions regarding the replacement of existing equipment.

36. There was no segregation of duties between asset removal and record keeping and there are no authorization requirements on the biomedical database. Therefore, there was an increased risk that the database contains inaccurate information and assets are not protected against misappropriation.

Background

Overview

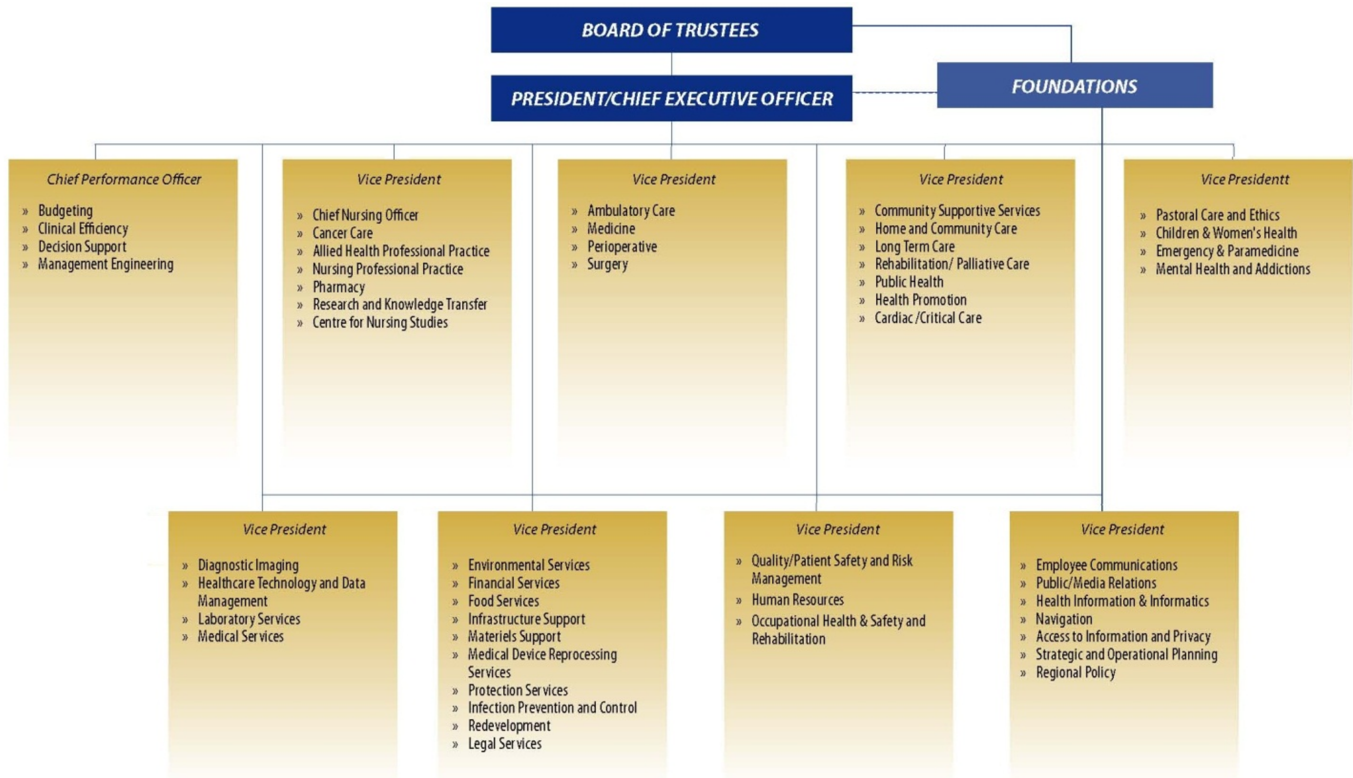
The Eastern Regional Health Authority (the Authority) is a Crown agency reporting to the Department of Health and Community Services (the Department). The Authority was established on April 1, 2005, when the Authority assumed the operations of the former Health Care Corporation of St. John's, Health and Community Services St. John's, St. John's Nursing Home Board, Newfoundland Cancer Treatment and Research Foundation, Health and Community Services Eastern, Avalon Health Care Institutions Board and the Peninsulas Health Care Corporation. The Authority is governed by the *Regional Health Authorities Act* (the *Act*).

The Authority is responsible to the Minister of Health and Community Services (the Minister) through its Board of Trustees (the Board), members of which are appointed by the Minister.

Figure 1 shows the organizational structure of the Authority as at March 31, 2013.

Figure 1

Eastern Regional Health Authority
Organizational Structure



Source: Eastern Regional Health Authority

Mandate

The Authority is responsible for the delivery and administration of health services and community services in its health region and provincially as designated by the Minister.

As shown in Figure 2, the Authority's geographical boundaries include the island portion of the Province east of, and including, Port Blandford. Within this geographical region, the Authority serves approximately 306,000 residents.

Figure 2

Eastern Regional Health Authority
Geographical Boundary

Source: Eastern Regional Health Authority

Financial Position

As at March 31, 2013, the Authority reported a net debt of $449.1 million. Table 1 shows the financial position of the Authority at March 31, 2012 and March 31, 2013.

Table 1

Eastern Regional Health Authority
Financial Position
As at March 31
($000's)

	2012	2013
Financial Assets		
Cash	$ 6,406	$ 13,288
Accounts Receivable	22,684	31,924
Due from government/other government entities	67,924	62,135
Advance to General Hospital Hostel Association	1,374	1,248
Sinking fund investment	12,063	13,506
Total assets	110,451	122,101
Liabilities		
Accounts payable and accrued liabilities	107,917	106,076
Due to government/other government entities	24,617	23,087
Accrued vacation pay	48,132	47,454
Employee future benefits		
Accrued sick leave	61,508	63,288
Accrued severance pay	107,068	113,908
Deferred revenue		
Deferred capital grants	50,597	65,984
Deferred operating revenue	7,750	12,910
Long-term debt	141,001	138,473
Total liabilities	548,590	571,180
Net Debt	**(438,139)**	**(449,079)**
Non-financial assets		
Tangible capital assets	354,867	353,264
Supplies inventory	14,505	15,397
Prepaid expenses	6,271	4,053
Total Non-financial assets	375,643	372,714
Accumulated deficit	**$ (62,496)**	**$ (76,365)**

Source: Eastern Regional Health Authority Audited Financial Statements

Increasing accumulated deficit

As at March 31, 2013, the Authority reported an accumulated operating deficit of $76.4 million, an increase of $13.9 million (22%) from the accumulated deficit of $62.5 million as at March 31, 2012.

The Authority's accumulated operating deficit will be affected by the results of future operations and the level of funding by Government. If the Authority has annual operating surpluses in the future, these surpluses could be used to reduce the accumulated operating deficit. However, if the Authority has annual operating deficits, these deficits, along with the accumulated deficit, will have to be funded by taxpayers.

Operating Results

The Provincial Government provided operating grants of $1.20 billion and $1.15 billion for the fiscal years ended March 31, 2012 and March 31, 2013, respectively.

Table 2 provides a breakdown of the revenues and expenditures of the Authority for the years ended March 31, 2012 and March 31, 2013.

Table 2

Eastern Regional Health Authority
Revenue and Expenditures
For the Years Ended March 31
($000's)

	2012		2013	
	Amount	**Percent**	**Amount**	**Percent**
Revenue				
Provincial plan	$ 1,202,911	85.6%	$ 1,149,258	86.2%
Provincial plan capital grant	44,800	3.2%	23,497	1.8%
Other capital contributions	5,083	0.4%	6,713	0.5%
MCP	73,302	5.2%	74,483	5.6%
Inpatient	10,260	0.7%	10,779	0.8%
Resident	18,005	1.3%	18,560	1.4%
Outpatient	8,015	0.6%	9,091	0.7%
Other	42,569	3.0%	39,951	3.0%
Total Revenue	1,404,945	100%	1,332,332	100%
Expenditures				
Patient and resident services	365,589	26.2%	362,744	27.0%
Client services	258,235	18.5%	210,918	15.7%
Diagnostic and therapeutic	175,989	12.6%	179,020	13.3%
Support	150,964	10.8%	164,273	12.2%
Ambulatory care	128,924	9.2%	142,729	10.6%
Administration	113,574	8.1%	113,861	8.5%
Medical services	105,373	7.5%	98,875	7.3%
Amortization of tangible capital assets	31,605	2.3%	31,813	2.4%
Research and education	18,227	1.3%	16,526	1.2%
Interest on long-term debt	9,594	0.7%	9,469	0.7%
Other	24,567	1.8%	8,031	0.6%
Employee future benefits				
Accrued severance pay	10,125	0.7%	6,840	0.5%
Accrued sick leave	2,831	0.2%	1,780	0.1%
Accrued vacation pay	979	0.1%	(678)	(0.1%)
Total Expenditures	**1,396,576**	**100%**	**1,346,201**	**100%**
Annual Surplus (Deficit)	**$ 8,369**		**$ (13,869)**	

Source: Eastern Regional Health Authority Audited Financial Statements

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

- absenteeism was properly monitored and effectively managed and leave and overtime were properly monitored and recorded;
- compensation and recruitment practices were in accordance with Government and Authority policy;
- purchases complied with the *Public Tender Act* and *Regulations*;
- the Authority was adequately monitoring its financial position and operations; and
- capital assets were monitored and controlled.

Scope

Our review was completed in December 2013 and covered the period April 1, 2011 to March 31, 2013. Our review included an examination of the Authority's policies and procedures, Board and committee minutes, financial information and file documentation, and interviews with Authority officials.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Monitoring of Financial Position
2. Compensation and Recruitment
3. Leave and Overtime
4. Internal Controls
5. Tendering of Goods and Services
6. Monitoring of Capital Assets

1. Monitoring of Financial Position

Overview

Our review included an analysis of the Authority's budget, and its effect on the Authority's financial position and operations.

In reviewing the Authority's financial position we identified issues in the following areas:

A. Budget Deficit
B. Position Administration

1A. Budget Deficit

Introduction

The budget process for any particular fiscal year usually begins in the fall of the preceding year with the Department requiring the Authority to provide a budget submission, including any proposals for new initiatives or funding changes. The Department, through its Acute Services Division and Financial Services Division, reviews and assesses the budget information. Once the Provincial budget is approved by the House of Assembly, the Authority is provided with a draft Provincial Plan Revenue (PPR) schedule, outlining its funding, for review and comment. Once the PPR is finalized, the Department requests that the Authority submit a revised budget. The budget process concludes with the receipt and approval of this budget.

For the fiscal years ending March 31, 2012 and March 31, 2013, the Authority approved a balanced budget.

Section 21 of the *Act* states that *"except with the prior approval of the minister, an authority shall not make, or contract to become liable for, an expenditure or indebtedness beyond or in excess of the estimated amount of expenditure set out in its budget and approved by the minister under this section."*

Minister concerned

On May 13, 2011, the Minister wrote the Chair of the Board concerning budget management and fiscal controls. The Minister informed the Chair of a concern with "*the pattern of fiscal expenditures (and resulting deficits) being incurred annually by Eastern Health resulting in the requirement for stabilization funding to be provided by the department.*"

The Authority was advised by the Minister, in the letter, that "*Section 16 of the* Regional Health Authority Act *requires that an authority (RHA) manages and allocates resources… and complies with directions that the minister may give...*"

The Chair was informed that the Minister did not want or intend to get involved in the day-to-day operational management and decision making processes of a RHA. However, the Minister noted "*issues and comments [that] should be considered as directives from [the Minister] to [the Authority] for implementation as it relates to fiscal controls and budgetary management for 2011/12 and onward.*" The Minister also noted "*Fiscal management and an organization's budgetary performance are seen as being an integral part in the roles and responsibilities of a Chief Executive Officer (CEO). To meet this challenge and recognizing that the CEO is only one person, it is incumbent on everyone, including the Board of Trustees, to ensure that a culture of fiscal responsibility is created and sustained in the organization… However, as I have repeatedly stated, these efficiencies should not be achieved through staff layoffs and/or service delivery reductions...*"

The Minister directed that "*All current practices that are discretionary in nature and have a significant fiscal liability associated with them should be scrutinized and wherever possible curtailed, if not discontinued.…All policies must be reviewed to ensure consistency with comparable Government (Treasury Board) policies. For those policies determined to be in keeping with Government policy and are appropriate to remain in place, your organization must have controls in place to minimize their fiscal impact.*"

The letter went on to discuss those areas in particular, in which the Minister had concerns and/or suggestions. These areas included:

- educational differential for management personnel;
- management overtime policy; and
- management of positions.

On June 28, 2011 the Chair acknowledged receipt of this letter, and informed the Minister that "*A detailed response to your letter dated May 13, 2011 on budget management and fiscal controls will be provided under separate cover*."

A formal response to the Minister was not issued.

$83.2 million in budget overruns within past 5 years

Table 3 shows the budget of the Authority for fiscal years ended March 31, 2009 through to March 31, 2013.

Table 3

Eastern Regional Health Authority
Budget
For the Years Ended March 31
($000's)

Year	Approved Budget (Note 1)	Budget Overruns		Final Budget (Note 2)
		Funded by Province	Deficit Incurred	
2009	$ 943,594	$ 17,700	$ -	$ 961,294
2010	1,062,568	22,000	-	1,084,568
2011	1,152,549	22,700	-	1,175,249
2012	1,190,103	12,500	-	1,202,603
2013	1,149,258	-	8,295	1,149,258
Totals		**$ 74,900**	**$ 8,295**	

Source: Eastern Regional Health Authority Budgeting and Decision Support Division
Note 1: Includes net change in deferred revenue and budget adjustments during the year.
Note 2: Deficit incurred not included in Final Budget numbers.

As shown in Table 3, over the past five years, the Authority has received $74.9 million in funding from the Province to cover budget overruns, and has incurred an $8.3 million deficit, for a total of $83.2 million in spending in excess of budgeted amounts during the past five years.

On June 1, 2011, the Minister informed the Chair that "*Budget 2011 provides increases in funding to your Authority to sustain existing programs, address program growth, and expand services in a manner consistent with the Department's strategic directions. It is my expectation that Eastern Health plan for and achieve a balanced budget in keeping with the spirit of the* Transparency and Accountability Act*. As well, please refer to my letter dated May 13, 2011, on Budget Management and Fiscal controls. Unless approved in writing by me, no deficit should be incurred.*"

In the fiscal year ended March 31, 2012, the Authority required funding of $12.5 million from the Province in order to cover its budget shortfall. On March 28, 2012, Treasury Board approved stabilization funding of $10.7 million for the Authority. On April 26, 2012, Treasury Board then approved another $1.8 million in stabilization funding, bringing the total to $12.5 million.

In the fiscal year ended March 31, 2013 the Authority did not obtain funding from the Province to cover its budget shortfall. Instead, it reported a deficit of $8.3 million. On March 28, 2013, Treasury Board authorized the Minister to allow the Authority to incur expenditures in excess of the estimated amount set out in Eastern Health's budget in 2012-13. The Minister granted approval to the Authority on April 16, 2013.

The funding by the Province to cover budget overruns in the fiscal years 2009 to 2012, and a reported deficit in 2013, were despite continued increases in the approved budget. The approved budget grew from $943.6 million in 2009 to $1.15 billion in 2013, a 22% increase.

Finding

1. The Authority required $74.9 million in additional funding by the Province and incurred an $8.3 million budget deficit, despite the approved budget increasing 22% during the past five years.

1B. Position Administration

Introduction

For the fiscal year ended March 31, 2013, the Authority spent $812.5 million (2012 - $823.3 million) on salaries and employee benefits while employing approximately 12,810 employees (2012 - 12,989 employees) on a full or part-time basis.

The Budgeting Department of the Authority maintains an Authorized Position system. The system maintains approved Authorized Position Numbers (Authorized Position Number is a combination of department and job code) through a budget transaction process which logs the Budget Letter reference number that initiates a change in approved authorized positions. Any other change requires the approval of a Vice President or a Chief Operating Officer.

Ministerial Direction

In a letter to the Chair from the Minister dated May 13, 2011 the Minister stated that *"Choosing to implement positions without formally approved funding is a significant decision for a RHA to take. Within your global budgets, it is recognized that your organization has the authority to redirect the salary funding for a position to other critical positions or existing unfunded positions as you manage risk. As 70% of a RHA's budget is associated with human resource costs, all RHAs should have processes established to assess the need to refill a position when it is vacated, relative to other HR pressures in your organization, and that the decision to refill a position is appropriately approved at the senior executive level in the RHA. In Government, the decision to fill any position requires the approval of the Minister. Your organization is expected to review your current processes for the creation and/or filling of positions (funded and non-funded) to ensure appropriate need assessments and approval processes are in place and more closely aligned with Government's processes... During the Budget 2011 process, several requests were received from RHAs for the funding of "new" (but already filled) positions that had been requested in previous budget submissions and not approved. Please note that such action is not appropriate and will not result in future budget adjustments."*

Authority policy inconsistent with Government despite Minister's Direction

Government policy requires the approval of the Minister for filling vacancies and the approval of Treasury Board for the creation of new positions.

Authority policy requires the approval by a Director or Site Administrator for filling vacancies and the approval by a Vice-President or a Chief Operating Officer for the creation of new positions.

As a result, the Authority's policy was inconsistent with Government.

Recruitment process does not require budget analysis

The Authority's recruitment authorization policy does not require approval from the Authority's Budgeting Department to ensure that funding is available for positions prior to the recruitment process.

Given the significant salary costs, we would expect to see controls in place related to the number of employee positions within the Authority and the related salary expenditures and the assurance that funding is available for newly created positions prior to the recruitment process.

Findings

2. Position approval processes are not consistent with Government policy, despite the Minister's direction to align them.

3. The creation of a new position does not require the Authority to ensure that funding is available for the new position.

Recommendations

The Authority should:

- revise the Recruitment Authorization policy to require that appropriate funding is available for a position prior to initiating a recruitment action; and

- comply with Ministerial directives.

2. Compensation and Recruitment

Overview

During the year ended March 31, 2013, the Authority employed approximately 12,810 employees (2012 - 12,989 employees) on a full or part-time basis with expenditures of $812.5 million (2012 - $823.3 million) in salaries and employee benefits.

Direction from Treasury Board on consistency of market adjustment policy

In a letter dated January 3, 2012, the Authority was advised by the Deputy Minister of Health and Community Services (the Deputy Minister) that "*The Market Adjustment Policy of Government states that 'departments, agencies, boards and commissions are prohibited from paying employees any other form of market adjustment outside the terms of this policy. Additional forms of remuneration, unrelated to market conditions, may be permitted, subject to Treasury Board approval.'*"

The letter went on to reference an attached listing of market adjustments that had been compiled during 2011. The letter requested the Authority to: "*Please review the attached report and indicate by January 31, 2012: 1) Accuracy and completeness to ensure any items that can be considered a market adjustment have been included. 2) The date, within 2012, by which your RHA will submit market adjustment proposals for approval of the items listed. 3) The date by which your RHA will discontinue these adjustments.*"

In a letter dated February 17, 2012 the Authority provided the requested information regarding market adjustments and advised the Deputy Minister in the response letter that "*We are progressing to align our practices with Government's Market Adjust Policy and will be submitting further submissions in 2012 as noted.*"

On June 4, 2012, the Authority was advised by the Deputy Minister of recent decisions by Treasury Board in relation to market adjustments: "*Any market adjustment items in place in your organization that are currently not approved by Treasury Board and which you wish to continue, must be reviewed by the Department of Health and Community Services. Those items that the department supports must then be submitted to Treasury Board by the Department for approval by November 1, 2012. Any market adjustments that are not supported by the Department of Health and Community Services must cease payment by November 1, 2012. In order that the department has adequate time to analyze any proposals to retain these benefits, we ask that your proposals be submitted to the Health Workforce Planning Division not later than September 1, 2012.*"

The Authority submitted a 'Proposal for Market Adjustment for Managers' to the Department on August 24, 2012 and on October 24, 2012, sent a revised 'Proposal for Market Adjustment for Managers'.

We were informed by the Authority that they had not received a formal response from the Department. As a result, they continue to provide market adjustments that are not approved by Treasury Board. These market adjustments include such items as: education differentials, paid education leave, management leave in lieu of overtime, membership fees, and professional fees. This is despite the fact that the Market Adjustment policy of Government has been in effect since February 26, 2010 and the Minister first directed the Authority to ensure consistency with comparable Government policies in May of 2011.

In reviewing the Authority's compensation and recruitment practices we identified issues in the following areas:

A. Job Competitions
B. Individuals Employed by Authority while Receiving a Pension
C. Physician Signing Bonuses
D. Relocation
E. Classification of Positions
F. Additional Workload
G. Educational Differentials
H. Reimbursement for Personal Vehicle Usage
I. Redundancy

2A. Job Competitions

Introduction

The Human Resources Client Services Division of the Authority manages recruitment from internal and external sources, including both temporary and full-time positions.

The Public Service Commission is responsible for the protection of the merit principle in appointment and promotion to permanent positions within the public service. While the Authority does not fall under the jurisdiction of the Public Service Commission, it would be expected that policies and procedures followed by the Human Resources Client Services Division of the Authority would be consistent with Government policies and procedures since the Authority uses public money to compensate employees.

The Public Service Commission recommends a competition file contain documentation such as screening criteria and details of why applicants were screened out, and applicant assessment details outlining the suitability assessment of each applicant interviewed.

The Authority held more than 7,000 job competitions from April 1, 2011 to March 31, 2013. We reviewed a sample of 44 non-physician job competition files to determine if files were complete and to determine whether hiring practices were in compliance with Government policy. Our review identified the following:

Non - physician job competition files incomplete

Our review of the 44 job competition files, of which 39 were for union positions and 5 were for management positions, identified issues with the completeness of the documentation to support the competition process. We identified:

- 3 of 39 (8%) union position job competitions reviewed had no Director/Site Administrator approval to recruit an employee; and
- that in all 5 management position job competition files reviewed:
  - screening assessments were not documented in any of the files. As a result, the Authority could not demonstrate that the most suitable candidates were interviewed; and
  - applicant assessments resulting from the interview process were not documented in any of the files. As a result, the Authority could not demonstrate that the most suitable applicant interviewed was selected.

Finding

4. Non-physician job competition files did not contain evidence of Director/Site Administrator approval to recruit an employee and were missing screening documentation and applicant assessments resulting from the interview process and were, therefore, not in accordance with Authority policy, Government policy, and best practices.

2B. Individuals Employed by Authority while Receiving a Pension

Introduction

Cabinet directed that, *"as a matter of policy applicable to government departments, and all government agencies and Crown corporations, a preference be given in hiring to persons other than those in receipt of a pension under the Public Service Pension Plan, the Uniformed Services Pension Plan, the Teachers' Pension Plan, and the Members of the House of Assembly Pension Plan, unless there are no other persons qualified to fill the position, with exceptions to this policy to be subject to Cabinet approval."*

Double and Triple Dipping

During the 12 months ended December 31, 2012, there were 132 individuals in receipt of both a Provincial Government pension and a salary from the Authority. Two of these individuals held two positions at the same time with the Authority while in receipt of a Provincial Government pension. Approximately 57% of these pensioners were members of the Newfoundland and Labrador Nurses Union (the NLNU).

Our review of 10 of these pensioners identified that there was no documentation available to show that a job competition had occurred for any of these positions. Authority officials advised that 6 of the 10 were for the rehiring of nurses, and that these nurses were rehired during a nursing shortage. Authority officials advised that 4 of 10 were for the rehiring of Management employees and that these employees were rehired for their expertise.

Preference had not been given to hiring persons other than those in receipt of a pension. Cabinet approval was not obtained to authorize the hiring of these pensioners.

Finding

5. During 2012, there were 132 individuals in receipt of both a Provincial Government pension and a salary from the Authority. In fact, two of these individuals held two positions with the Authority while in receipt of a Provincial Government pension. Where individuals were employed by the Authority while receiving a pension, we found instances where no documentation was available to show that preference had been given to hiring persons other than those in receipt of a pension, as directed by Cabinet.

2C. Physician Signing Bonuses

Introduction

The Authority provided benefits to some physicians above what was required under the *Department's Salaried Physician Guidelines (2006)* (the *Guidelines*) and the *Physician's Services Memorandum of Agreement (2009-2013) (*the *MOA).*

In a memo to the Authority from the Department dated July 18, 2011, the Authority was informed that "*with the advent and expansion of the Provincial Bursary Program, the significant improvement in physician remuneration and the enhancement of the provincially negotiated retention bonuses it has been decided that all four RHAs must conform to provincial standards regarding all physician compensation. Therefore all RHA based physician recruitment bursaries and sign-on bonuses must stop effective immediately*."

Each RHA was requested to forward a list of physicians to the Department where an RHA based sign-on bonus or bursary had been committed in writing or verbally. The Department informed the Authority that they would permit the RHAs to honor commitments made.

Physician benefits beyond guidelines and MOA

During our review, we found that signing bonuses were provided which were not in accordance with the *Guidelines* and the *MOA*, as follows:

- 10 salaried physicians were provided signing bonuses that were beyond that allowed in the *Guidelines* and *MOA*;

  - 7 of the signing bonuses were included on the list of commitments that were sent to the Department in July 2011 and therefore, were in compliance with Department direction;

  - 2 of the signing bonuses were not included on the list of commitments that was sent to the Department in July 2011. These signing bonuses had been committed to prior to July 2011. A portion of the committed signing bonuses had been previously paid to each of the two physicians. However, an amount of $20,000 remained owing to each physician as of July 2011. These amounts were paid in September 2011; and

- the remaining physician was provided with a $20,000 signing bonus in February 2013. This bonus was not on the list of commitments that was sent to the Department in July 2011. Therefore, this bonus was not in compliance with Department direction to cease signing bonuses immediately.

Finding

6. The Authority provided signing bonuses that were beyond that allowed in the *Department's Salaried Physician Quick Reference Guidelines (2006)* and the *Physician's Services Memorandum of Agreement (2009-2013)*. In addition, the Authority provided a signing bonus to a physician beyond the date at which they were told to discontinue the practice by the Department of Health and Community Services.

2D. Relocation

Introduction

Government's relocation policy requires a relocated employee to enter into a two year return-in-service agreement with the employer in return for being reimbursed relocation expenses. The Authority reimburses physicians based on this policy and reimburses non-physicians based on an Authority policy that also has a two year return-in-service agreement.

Our review identified that:

No return-in-service agreements for physicians

The Authority had not entered into return-in-service agreements with any of the physicians who received reimbursement of relocation costs. Therefore, if the physicians leave before their two year terms, these costs will not be recoverable.

Application of the relocation policy inconsistent with Government policy for physicians

We reviewed a sample of 5 relocation expense claims for physicians to determine if they were in compliance with policy. Our review identified that:

- One physician was reimbursed for 33 nights' accommodations for temporary living, although policy only allows for 14 nights' accommodations for temporary living, resulting in an overpayment of $4,012.

- One physician was reimbursed for one month's accommodations for temporary living, although policy only allows for 14 nights' accommodations for temporary living, resulting in an overpayment of $1,253.

- One physician was reimbursed $22,413 relating to the purchase of a principal residence, although they had not sold, nor were they in the process of selling (e.g. listed with real estate company or broker) the principal residence at the former location, which was required by Government policy.

- Two physicians were directly reimbursed more than $10,000 for the transportation of furniture and household effects, despite Government policy stating that "*The selection of movers will be processed in accordance with the established purchasing procedures as outlined by the Government Purchasing Agency*," and therefore, were required to be tendered.

Issues with the application of the relocation policy of the Authority for non-physicians

We reviewed a sample of 5 relocation expense claims for non–physicians to determine if they were in compliance with policy. Our review identified that:

- Two non-physicians were reimbursed for the transportation and storage of motor vehicles in the amounts of $6,978 and $7,100. Authority policy only allows $3,000 for these costs, resulting in an overpayment to the two totaling $8,078;

- Four non-physicians were reimbursed for the transportation of furniture and household effects ranging between $19,092 and $26,949. Authority policy only allows $15,000 for these costs, resulting in an overpayment to the four totaling $34,709.

- One non-physician did not enter into a return-in-service agreement with the Authority, therefore, if they leave before their two year term, these relocation costs may not be recoverable;

- Three non-physicians entered into return-in-service agreements after they received reimbursement from the Authority, therefore, if they left before they signed the agreement, these relocation costs may not have been recoverable; and

- Within the Authority policy regarding non-physician relocation, transportation of furniture and household effects can be reimbursed up to $15,000. Authority policy also states that "*The selection of movers will be processed in accordance with the established purchasing procedures as outlined by the Government Purchasing Agency*". These purchasing procedures require tendering. Four non-physicians were reimbursed more than $10,000 for the transportation of furniture and household effects, without going through a tendering process.

Findings

7. No return-in-service agreements are in place for physicians who received reimbursement of relocation costs. Therefore, the costs would not be recoverable if the physician were to leave before the end of their two year term.

8. The relocation policy is not being followed for both physicians and non-physicians. Therefore, individuals are being reimbursed for amounts higher than to which they are entitled.

2E. Classification of Positions

Introduction

The Authority was established on April 1, 2005. Starting in 2005 the Authority began filling their management level positions, with the majority (over 98%) of positions being filled by the end of 2006. These positions were filled by employees that had been working in the former Health Care Corporation of St. John's, Health and Community Services St. John's, St. John's Nursing Home Board, Newfoundland Cancer Treatment and Research Foundation, Health and Community Services Eastern, Avalon Health Care Institutions Board and the Peninsulas Health Care Corporation.

There were some changes in the duties of positions that resulted in a classification action, with some employees receiving the same pay, some employees getting paid more, and some employees getting paid less.

In an executive management meeting on May 2, 2007, the executive indicated that "*Recognizing that the organization has been delayed with the formal classification process, a decision has been made to delay implementation of the salary decreases until the formal rating process is carried out. The appropriate adjustments as per policy will be implemented at that time.*"

Government policy states that "*An involuntary demotion is an employer initiated action, beyond the employee's control, resulting in the movement of the employee from an existing position to a position assigned a lower maximum hourly rate of pay. Situations would include:*

(i) changes in the duties of the employee's position results in classification action; or

(ii) a position has been re-assessed and determined to be incorrectly classified.

When an employee is involuntarily demoted:

(i) the employee shall be given written notification stating the reasons for demotion;

(ii) the rate of pay shall be established at a rate in the new pay range equivalent to the existing rate, except that:

- *Wherever the rate of pay prior to demotion is above the maximum of the pay range established for the position to which the employee is being demoted, the existing rate of pay shall be retained, but for purposes of awarding future salary increases, the "Red Circle" policy shall apply.*

- *Wherever the rate of pay prior to demotion falls between two steps within the pay range established for the position to which the employee is demoted, it shall be adjusted to the higher step.*"

Management employees were responsible for the completion of their own position description evaluation summaries, and the Human Resources Client Services Department of the Authority was responsible for forwarding them to the Human Resource Secretariat (HRS) of Government for formal evaluation and classification.

Figure 3 shows the timeline associated with the formal classification of the Authority's positions.

Figure 3

Eastern Regional Health Authority
Management Classification Timeline

Source: Eastern Regional Health Authority Human Resources Client Services Division

Managers continued to be paid at higher rate for more than six years

There were 519 management positions that required classification as a result of the formation of the Authority in April 2005. The majority (more than 98%) of management positions were filled by the end of 2006. However, formal classification of 519 management positions did not occur until November 2012, with implementation of the new pay scale classification beginning on April 25, 2013. The results of the classification resulted in 185 positions being classified upwards; 211 positions remaining at the same pay level; and 123 positions being classified downward. The delay in the classification process resulted in 123 employees who continued to be paid at the higher rate for more than six years, from the time they were placed into positions within the Authority in 2006.

Table 4 provides examples of the results of the management classification review that occurred in November 2012. Table 4 shows, in particular, those management positions within the Authority that had the most significant downward scale classification as a result of the Human Resource Secretariat's classification of those positions. Had the reclassification process occurred on a more timely basis, these individuals would have been paid at a lower rate or red circled earlier.

Table 4

Eastern Regional Health Authority
Management Classification
November 2012

# of Employees	Salary Scales		Pay at Step 1			Pay at Step 25		
	Before	After	Before	After	Diff.	Before	After	Diff.
2	HL-24	HL-20	$73,166	$59,774	$13,392	$95,116	$77,706	$17,410
1	HL-25	HL-21	74,546	62,619	11,927	96,910	81,405	15,505
2	HL-24	HL-21	73,166	62,619	10,547	95,116	81,405	13,711
1	HL-23	HL-20	69,316	59,774	9,542	90,111	77,706	12,405
5	HL-22	HL-19	65,967	56,927	9,040	85,757	74,005	11,752
8	HL-25	HL-22	74,546	65,967	8,579	96,910	85,757	11,153
3	HL-20	HL-17	59,774	51,906	7,868	77,706	67,477	10,229

Source: Eastern Regional Health Authority Human Resources Client Services Division

Employees paid $3.6M to $4.7M more than if classification process was more timely

In total, at the time of the implementation of the new pay scale classification in 2013, positions that were classified downwards were being paid in the range of $631,373 to $820,806 more annually than what was ultimately paid once the positions were classified.

The process took approximately six years to complete and resulted in employees being paid more than if the classification process was more timely.

The Authority's decision not to demote any managers whose salary was negatively affected through management restructuring until their new positions were formally classified resulted in these employees being paid in the range of $3.6 million to $4.7 million more from the end of 2006, when the majority of management positions had been filled, until the implementation in 2013.

Employees continue to benefit from delay in classification

The delay in the classification process resulted in 123 employees being paid more than necessary for more than six years. Additionally, as a result of the delay in the classification process, the red-circling of the positions was also delayed. A job is red-circled when the results of a job evaluation exercise reveal that it has been over-graded, resulting in a higher rate of pay. As a result of pay raises in years subsequent to 2006, the position pay ranges had become higher than they were in 2006 and, therefore, the salaries of the individuals were red-circled at an amount significantly higher than it would have been had the classification occurred earlier. An individual's position pay shall remain red-circled until such time as their existing regular salary is equal to or lesser than the top step of the position they occupy. At such time employees cease to be red-circled and are placed on a step on the approved pay range.

We were able to determine that if the Authority had classified these positions downward in 2007, all of those employees affected would currently be paid in accordance with their pay scale (ie. no red circling), as the Government's salary increases that had occurred between 2007 and current would have brought their new pay scale in line with their rate of pay.

It is possible that the salaries of many of the 123 demoted employees will continue to be above the rate of pay for their pay scale, and will, therefore, continue to be red-circled.

Higher pay also results in higher pension, severance, and accrued paid leave payouts on retirement or termination of positions.

Finding

9. The classification of some management positions subsequent to the amalgamation of the health boards in the eastern region in 2005 did not occur until 2013. The significant delay resulted in 123 employees being paid at higher than necessary amounts for more than six years after they were placed in management positions with the Authority at the end of 2006, at a cost in the range of $3.6 million to $4.7 million. Because red circling was delayed, other compensation benefits such as pensions and severance will also be higher.

2F. Additional Workload Benefits

Introduction

The Authority provides additional workload benefits to some physicians under the *Guidelines*. The *Guidelines* provide physicians compensation for additional workload due to vacancies. One half of the salary at step 2 of the appropriate scale is available to be distributed to salaried physicians who take on the responsibility of additional work in a salaried position(s) not filled by locums. The daily rate is 50% of the applicable salary scale divided by 240.

Physician getting additional pay for similar workload

Our review identified that a physician had been receiving additional workload payments since December 14, 2001 despite the fact that the Authority did not have a job posting for a vacant position. We were informed by Authority officials that the Authority has no intentions of filling the vacant position. The Authority has also acknowledged that this physician's workload was consistent with that of other physicians in the physician's specialty within the Authority. As at March 31, 2013, the physician had received $1,473,528 in additional workload payments since December 14, 2001.

Finding

10. Additional workload benefits are compensation payments provided to physicians for additional workload due to vacancies. One physician received $1,473,528 in additional workload payments over a period of approximately 11 years relating to a vacant position that the Authority had never advertised and does not intend to fill. Authority officials indicated that the physician had the same workload as other physicians, in this specialty, employed by the Authority.

2G. Educational Differentials

Introduction

The Authority pays educational differentials to qualifying nurses in accordance with the Nurses' collective agreement. In addition, the Authority pays other employees educational differentials that are not provided under collective agreements.

For the year ended March 31, 2013, the Authority spent $2.0 million (2012 - $2.0 million) on educational differentials.

Payments not consistent with Government policy

Education differentials are also being paid to executive and management employees although the education requirements were part of the position requirements and, therefore, would have already been included in the pay scales for the particular position under the HAY rating system which was implemented in the late 1980s. For the 2013 fiscal year, the Authority paid differentials totaling $356,204 (2012 - $343,818) to these executive and management employees.

These education differentials were inconsistent with Government policy.

Finding

11. Educational differentials were being paid to executive and management employees although the education requirements were part of the position requirements and, therefore, would already have been included in the pay scales. This is inconsistent with Government policy.

2H. Reimbursement for Personal Vehicle Usage

Introduction

For the year ended March 31, 2013, the Authority spent approximately $1.7 million (2012 - $2.2 million) on personal mileage claims. Authority policy states "*Employees who travel to their office to begin their work day or who travel from their office at the end of their work day shall not receive kilometer reimbursement for such travel.*"

Employee claiming mileage to and from work

Our review of the personal mileage claims for six employees with the highest annual personal mileage reimbursement identified that one employee was being reimbursed for travel from home to their office to begin their work day and from their office to home at the end of their work day. For the fiscal year ended March 31, 2013, this employee received a total of $2,364 (2012 - $8,096).

These reimbursements were not in compliance with Authority policy.

Personnel mileage claims being paid without approval

Our review of the personal mileage claims for six employees with the highest annual personal mileage reimbursement identified that one employee was reimbursed monthly without any approval of the mileage claims. For the fiscal year ended March 31, 2013, this employee received a total of $7,017 (2012 - $8,452) in mileage claim reimbursements.

Findings

12. An employee received reimbursement for personal vehicle usage related to travel to and from work, resulting in reimbursement of $2,364 for the year ended March 31, 2013. This is not in compliance with Authority policy.

13. An employee received reimbursement for personal vehicle usage without approval.

2I. Redundancy

Introduction

The Authority's policy allows for employees to be provided with an appropriate notice or pay in lieu of notice upon elimination of a position. The period of notice shall depend upon the employee's age and complete years of continuous service. Where an earlier effective date is required, employees shall receive pay in lieu of notice.

Position redundancy not being declared on a timely basis

We reviewed the files of four former employees whose jobs were deemed redundant and who were, therefore, terminated.

In one instance, a terminated physician's redundancy letter stated that the "*position of Vice-President of Medical Services, [of a] Legacy Board with Eastern Health, has been declared redundant, effective January 14, 2011. This decision has been necessitated because of organizational restructuring.*"

The above-noted Legacy Board was assumed into the operations of the Authority on April 1, 2005. Furthermore, the physician had maintained the salary of his former Vice-President position, yet performed the duties of a lower paying position up until the time of his redundancy. The ultimate declaration of the position redundancy coincided with the retirement date of the physician. He had not held the title of the position for more than five years.

As a result of the declaration of the position redundancy, the retiring physician received $287,552 for 57 weeks pay in lieu of notice and 20 weeks of severance pay at the time of retirement. A few months later, the retired physician received an additional $119,737 in retroactive pay on his termination package to account for the new *MOA*.

Finding

14. The Authority was not always declaring positions redundant on a timely basis.

Recommendations

The Authority should:

- ensure compensation and recruitment practices are in accordance with Authority and Government policy;
- maintain adequate documentation in competition files;
- calculate employee compensation accurately;
- comply with Government's relocation policy for all employees and ensure that return-in-service agreements are signed and approved; and
- ensure compliance with its mileage reimbursement policy.

3. Leave and Overtime

Overview

As at March 31, 2013, the Authority reported $110.7 million (2012 - $109.6 million) in accrued sick leave and accrued vacation leave (annual leave and paid leave) owing to its employees.

Authority policy requires use of a Leave Request form to document the request and approval of employee leave. Approved leave forms are held and filed at the Department/site. Leave hours of employees are recorded in bi-weekly payroll reports or schedules and are forwarded to the Authority's Payroll Division for payroll and attendance processing.

The Authority recorded overtime expense of $25.2 million for the 2012 fiscal year and $23.9 million for the 2013 fiscal year. Overtime represents the hours worked by an employee in the performance of a specific task or designated project that requires the employee to work in excess of his or her regularly scheduled or normal hours of work, and hours of work performed on designated paid holidays.

In reviewing the leave and overtime practices of the Authority, we identified issues in the following areas:

A. Annual and Paid Leave
B. Sick Leave
C. Overtime
D. Management Overtime Policy
E. Education Leave

3A. Annual and Paid Leave

Introduction

Authority policy states that *"All unionized employees, with the exception of casual employees ([Newfoundland and Labrador Nurses' Union] (NLNU) and [Association of Allied Health Professionals] (AAHP) collective agreements), accrue annual leave in accordance with the respective collective agreement. Part-time and temporary employees accrue annual leave benefits on a pro-rated basis based on hours worked. Casual employees (NLNU and AAHP collective agreements) are paid a percentage of their salary in lieu of such benefits."*

Management and management support (non-management/non-bargaining) employees accrue paid leave benefits based on years of service, as per the Authority's human resources policy.

Employees are eligible to receive payment for their remaining unused accumulated annual leave and/or paid leave when they terminate employment with the Authority (resign, retire, are laid off or upon death). Annual leave payouts are paid at the base salary of the position the employee occupies immediately prior to termination of employment.

Leave not always approved or documented

Authority policy states that for pre-planned absences, a Leave Request form must be completed and approval obtained prior to the commencement of leave.

We sampled the files of 52 employees who had taken annual or paid leave during the period of our review. Our review identified that, of those 52 employees, 27 did not have the required Leave Request form on file. Without Leave Request forms on file, the Authority does not have the documentation required by policy and does not have a record that proper supervisor/manager approval was granted for the employee's leave.

Without adequate documentation, the Authority may not be accurately tracking the amount of annual or paid leave employees have taken, as well as the employees' remaining annual or paid leave balance. This creates a risk that an employee may take more leave than to which they are entitled.

Leave usage not adequately monitored

Authority policy states that management/management support staff must use a minimum of three weeks paid leave during the year, while unionized employees are encouraged to take a minimum of two weeks annual leave each year.

During our review, we determined that the Authority's human resources information system did not have the ability to generate flags to indicate when employees did not take the required or encouraged amount of paid or annual leave during the year. This inability to flag employees who were not meeting the minimum required paid or annual leave usage reduces the ability of the Authority to adequately monitor leave activity.

Inadequate monitoring of leave used during a period allows employees to carry over more leave each year than to which they are entitled. According to Authority policy, unused leave balances are paid out upon termination of employment, at the base salary of the position held at the time of the leave payout. An annual or paid leave carry forward balance that is overstated has a real cost to the Authority upon termination of the employee and the resultant payout of the balance at the employee's current salary.

Non - compliance with leave carry forward provision in collective agreements

All collective agreements currently in place between the Authority and the unions allow unionized employees to carry forward any proportion of annual leave not taken until the employee has accumulated a maximum of:

- twenty (20) days annual leave if the employee is eligible for twenty (20) days in any year;
- twenty five (25) days annual leave if the employee is eligible for twenty five (25) days in any year;
- thirty (30) days annual leave if the employee is eligible for thirty (30) days in any year.

Table 5 shows the number of employees that, according to the collective agreements, are over their allowable leave carry forward limit as at March 31, 2013. It also outlines the resulting overstated payable balance.

Table 5

Eastern Regional Health Authority
Leave Carry Forward
As at March 31, 2013

Allowable Leave Carry Forward	Number of Employees Above Limit	Overstated Payable Balance
20 days	686	$ 2,007,000
25 days	626	2,856,000
30 days	483	3,598,000
Total	**1,795**	**$ 8,461,000**

Source: Eastern Regional Health Authority Payroll Division

Authority policy does not state any limitations on the number of annual leave days allowed to be accumulated. Rather, it states that "*Annual leave not taken will remain in the employee's annual leave bank.*" Authority policy is inconsistent with collective agreements.

As a result of leave records that appear to follow Authority policy rather than that noted in the collective agreements, our review identified 1,795 employees covered by the collective agreements, who have accrued annual leave balances greater than the maximum allowed in their collective agreements. As a result, the Authority has recorded a liability that is approximately $8.5 million beyond what is otherwise required by the collective agreements.

Authority policy states "*Annual leave will be paid out only upon termination, layoff or change to casual employment*." The Authority practice of not enforcing leave carry-forward provisions outlined in the collective agreements allows employees to accrue significantly more leave days which can be paid out in the future at a higher salary.

Employees with overdrawn annual or paid leave balances

Authority policy states: "*Employees are responsible for…ensuring benefits are available prior to requesting time off and refrain from taking leave for which they are not entitled.*" Authority policy also states: "*Managers/Supervisors are responsible for… ensuring employees are eligible and that balances are available prior to approving leave…*" Our review identified that as at March 31, 2013, there were 712 employees who had overdrawn annual or paid leave balances with a total cost of $192,541.

Employees accruing two types of leave

Employees in unionized positions accrue annual leave, while those in management/management support positions accrue paid leave. In instances where employees move from a unionized position to a management/ management support position, their annual leave bank is transferred into a paid leave bank. Our review identified 20 employees whose annual leave bank was transferred into a paid leave bank during the period of our review. However, the annual leave bank was not deactivated and the employees continued to accrue annual leave. As at March 31, 2013, these employees were simultaneously accruing both annual leave and paid leave.

Findings

15. There is a lack of effective oversight to ensure that employees annual and paid leave is properly approved and documented. Without this oversight, there is a risk that the leave balance is overstated and will cost the Authority more than which the employees would have otherwise been entitled.

16. Annual and paid leave are not being adequately monitored to ensure required leave is taken, carry forward and usage complies with policy and collective agreements, and the leave accruals database is accurate. The Authority has recorded approximately $8.5 million in unused leave to be carried forward and used or paid in subsequent years, which is inconsistent with collective agreements.

17. At March 31, 2013, 712 employees have taken annual or paid leave beyond which they are entitled with a total cost of $192,541.

3B. Sick Leave

Introduction

During the fiscal year ended March 31, 2013, the Authority paid $50.3 million (2012 - $48.9 million) in salaries associated with employees being away from work on sick leave. Table 6 shows salary costs resulting from sick leave taken during the fiscal years ended March 31, 2012, and March 31, 2013.

Table 6

Eastern Regional Health Authority
Sick Leave
Fiscal Years Ended March 31
($000's)

Sick Leave Category	2012	2013
Sick Leave Regular	$ 29,384	$ 29,474
Sick Leave < ½ Day	751	803
Sick Leave Relief	14,386	15,004
Overtime Sick Leave Relief	4,367	5,057
Total	**$ 48,888**	**$ 50,338**

Source: Eastern Regional Health Authority Payroll Division

Sick Leave Regular is the salary cost associated with an employee being away from work without loss in pay due to the employee being sick. Sick Leave < ½ day is the salary cost associated with an employee being away from work for less than half a day without loss in pay due to the employee being sick for less than half a day. In the case of sick leave < ½ day, there is no reduction in an employee's sick leave entitlement.

Sick Leave Relief and Overtime Sick Leave Relief are the salary costs associated with replacing another employee who is availing of sick leave. The salary costs incurred in the Sick Leave Relief category represent salary relief costs that were incurred at straight time, while the Overtime Sick Leave Relief salary costs are salary costs that were incurred at overtime premium rates.

As shown in Table 6, the Sick Leave Regular category amounted to $29.5 million in the fiscal year ended March 31, 2013 (2012 – $29.4 million). Sick leave relief (regular and overtime) totaled $20.1 million for the year ended March 31, 2013 (2012 - $18.8 million), which is 68% (2012 - 64%) of regular sick leave.

We reviewed a sample of 63 instances of sick leave usage during the period of our review and identified the following issues:

Sick Leave not always approved or documented

Authority policy requires that for unplanned absences, employees must notify their supervisor or manager on the first shift/day back to work or as soon as possible thereafter and a Leave Request form must be submitted before the end of the pay period in which the leave was taken.

Of the 63 instances of sick leave usage we reviewed, 39 did not have the required Leave Request form on file. Without Leave Request forms, the Authority does not have the documentation required by policy and does not have a record that proper supervisor/manager approval was granted for the sick leave used by the employee.

Without adequate documentation, the Authority may not be accurately tracking the amount of sick leave employees have taken, as well as the employees' remaining sick leave balance. This creates a risk that an employee may take more sick leave than they are entitled.

Rate of sick leave higher than that of Government

We were informed by the Human Resources Secretariat that Government has 8,737 employees and incurred a total sick leave expense for fiscal 2013 of $17.2 million. The Authority has 12,810 employees with a total sick leave expense for fiscal 2013 of $30.3 million. When we compare the Authority's expense to that of Government, on a prorated basis across the number of Authority employees, the Authority's sick leave is $5 million, or 20%, higher than Government's sick leave.

Findings

18. There is a lack of effective oversight to ensure that employee sick leave is properly approved and documented.

19. Sick leave expense of the Authority is approximately 20% higher than that of Government on a relative basis.

3C. Overtime

Introduction

Given the significant cost associated with overtime, we would expect the Authority to have systems and procedures to budget, authorize, record, monitor and control these costs. Such systems and procedures would include a requirement to consider alternate work arrangements in order to minimize overtime costs.

Authority policy requires that prior to overtime costs being incurred there must be approval by the employee's manager. Proper approval should indicate the necessity for overtime in order to meet the operational requirements of the applicable department.

Overtime is often compensated at a premium rate such as time and one-half or double time. This compensation is determined in accordance with various policies and collective agreements. Table 7 shows the overtime expenses relating to the various overtime rate categories for the fiscal years ending March 31, 2012 and 2013.

Table 7

Eastern Regional Health Authority
Overtime Rates
Fiscal Years Ended March 31
(000's)

Overtime Rates	2012	2013
1 times regular pay	$ 1,908	$ 1,749
1.5 times regular pay	13,497	12,152
2 times regular pay	8,883	9,048
Statutory holiday premium	883	994
Total	**$ 25,171**	**$ 23,943**

Source: Eastern Regional Health Authority Payroll Division

Table 8 shows the cost of overtime payments to employees, grouped according to union contracts.

Table 8

Eastern Regional Health Authority
Overtime by General Occupation Category
Fiscal Years Ended March 31
($000's)

General Occupation Category	2012	2013
Newfoundland and Labrador Nurses' Union	$10,743	$11,017
NAPE - Hospital Support	5,717	5,785
NAPE - Lab/X-ray	3,384	3,560
NAPE - Hospital Support LPN	1,843	1,734
Association of Allied Health Professionals	1,257	1,197
NAPE - Health Professionals Social Workers (Note 1)	1,460	40
Management	426	401
NAPE - Health Professionals	173	51
Non Union Non Management	145	121
CUPE - Hospital Support	12	20
Professional Association of Interns and Residents	11	17
Total	**$25,171**	**$23,943**

Source: Eastern Regional Health Authority Payroll Division
Note 1: Effective October 31, 2011, social workers were transferred to the Department of Child, Youth and Family Services Department.

Overtime not always approved and documented

Authority policy requires that managers are responsible to review and approve all overtime worked by their employees through the use of overtime forms.

During our review, we sampled the files of 97 employees where policy required documentation for overtime. Our review identified that for 31 employees, or 32%, the required overtime documentation was not on file. Without approved overtime forms on file, the Authority does not have the documentation required by policy and does not have a record that proper supervisor/manager approval was granted for the overtime worked.

Inadequate documentation and approval records increase the risk of unauthorized overtime worked and the risk that employees are being compensated for overtime hours beyond those worked.

Overtime required to cover leave

Authority policy states that both employees and managers are responsible for ensuring that leave does not unduly interfere with operational requirements. Table 9 shows the overtime expense related to different overtime types.

Table 9

Eastern Regional Health Authority
Overtime Classification
Fiscal Years Ended March 31
($000's)

Overtime Type	2012	2013
Operational requirements	$ 10,186	$ 8,117
Sick Leave Relief	4,367	5,057
Callback Worked	1,912	1,874
Callback Unworked	1,598	1,729
Extra Workload	1,473	1,737
Meal Time Coverage	1,234	1,300
Other Relief	1,215	1,160
Constant Care	1,194	639
Stat Holiday Premium	883	994
Vacation Leave Relief	663	815
Patient Escort	245	284
Meetings	201	237
Total	**$ 25,171**	**$ 23,943**

Source: Eastern Regional Health Authority Payroll Division

During our review, we identified that a significant portion, approximately 29%, of the overtime expense for 2013 relates to relief work. Sick leave relief is the largest portion of relief work and during the year ended March 31, 2013, accounts for approximately $5.1 million, or 21%, of the overall overtime expense.

Overtime pay earned in excess of $10,000

Table 10 shows the number of employees whose overtime pay earned was in excess of $10,000.

Table 10

Eastern Regional Health Authority
Overtime Pay Earned in Excess of $10,000
Fiscal Years Ended March 31

	Number of Employees	
Overtime Pay Earned	**2012**	**2013**
$10,000 - $19,999	396	352
20,000 - 29,999	89	81
30,000 - 39,999	32	36
40,000 - 49,999	10	6
50,000 - 59,999	3	5
60,000 - 69,999	2	4
70,000 +	1	-
Total	**533**	**484**

Source: Eastern Regional Health Authority Payroll Division

During our review, we noted that 8,219 individuals earned overtime during the year ended March 31, 2013. Of these, 484 individuals earned overtime in excess of $10,000 for the year ended March 31, 2013 (2012 - 533). 51 individuals earned overtime pay in excess of $30,000 during the year ended March 31, 2013 (2012 - 48).

Overtime pay earned greater than salary

Table 11 shows the 15 employees with the highest overtime pay earned during the year ended March 31, 2013. The table details the annual salary and overtime pay of the 15 employees. Table 11 also shows the individuals' callback unworked pay received and the percentage of overtime pay that was comprised of callback unworked pay.

Table 11

Eastern Regional Health Authority
Employees with Highest Overtime Pay Earned
Fiscal Year Ended March 31, 2013

Union Contract	Position	Annual Salary	Overtime Pay			
			Overtime Pay Total	Overtime as a Percentage of Annual Salary	Callback Unworked Pay	Callback Unworked as a Percentage of Overtime Pay
NLNU	Psychiatric Nurse I	$ 69,411	$ 66,271	95%	$ -	-
NAPE LX	Laboratory And X-Ray Technologist	61,831	62,842	102%	51,887	83%
NLNU	Nurse I	71,098	61,878	87%	-	-
NLNU	Psychiatric Nurse II	79,155	60,579	77%	-	-
NLNU	Nurse I Permanent Relief	71,098	59,458	84%	-	-
NLNU	Nurse I	74,283	58,622	79%	-	-
NAPE LX	Laboratory Technologist I	59,902	55,504	93%	41,508	75%
NLNU	Nurse I	71,098	55,229	78%	-	
NAPE LX	Diagnostic Imaging Technologist III	68,662	51,949	76%	35,929	69%
NAPE LX	Diagnostic Imaging Technologist III	68,662	47,841	70%	31,973	67%
NAPE LX	Diagnostic Imaging Technologist III	68,662	47,280	69%	33,130	70%
NAPE LX	Diagnostic Imaging Technologist III	68,662	43,571	63%	33,267	76%
NLNU	Psychiatric Nurse II	79,155	41,983	53%	-	-
NAPE LX	Laboratory Technologist II	65,118	41,885	64%	25,454	61%
NAPE LX	Diagnostic Imaging Technologist III	68,662	40,767	59%	26,561	65%

Source: Eastern Regional Health Authority Payroll Division

As shown in Table 11, for some employees detailed, overtime pay is almost equal to the employees' annual salary. For the 15 employees with the highest overtime pay, their overtime pay for the year ended March 31, 2013 ranged from 53% to 102% of their annual salaries. For example, overtime pay of $62,841 earned by the Laboratory and X-Ray Technologist was 102% of their annual salary of $61,831. Table 11 shows that the Authority may not have an adequate complement of staff to meet operational requirements.

Table 11 also shows the amount of callback unworked overtime included within total overtime pay. The table shows that, for employees who receive callback overtime, the portion relating to callback unworked is comprised of at least 61% of the total overtime, with the highest percentage reaching 83% of total overtime. This results in a significant expense relating to overtime payment for hours that are not worked.

Overtime Callback

For employees who are called back to work outside their regular shift hours, the various collective agreements state that the employee is to receive a minimum of three hours overtime pay at the prescribed overtime rate.

Our review identified that the total callback expense at March 31, 2013 was $3.6 million (2012 - $3.5 million). Of the total overtime callback expense, 48% (2012 - 46%) related to callback overtime unworked. Some hospitals had a high percentage of callback unworked as a percentage of total callback overtime pay received. Specifically:

- Bonavista Home and Health Centre 82%;
- Placentia Health Center 79%; and
- Newhook Clinic 77%.

During our review, we obtained details of 229 overtime callback shifts. There were 106 overtime callback shifts in which employees had multiple callback shifts within a 90 minute time period. The majority of these 106 overtime callback shifts were compensated at a rate of 1.5 times regular pay. A breakdown of these instances is detailed in Table 12.

Table 12

Eastern Regional Health Authority
Overtime Call Back
Two Fiscal Years ended March 31, 2013

Time Out Between Shifts	Number of Instances
<15 minutes	19
15-30 minutes	24
30-45 minutes	23
45-60 minutes	21
60-90 minutes	19

Source: Eastern Regional Health Authority Payroll Division

Pyramiding results when employees are called back to work, work less than three hours, but earn the three hour pay minimum, and are then called back multiple times during the same three hour period, earning three hours of overtime pay for each of the callbacks.

Pyramiding is not allowed under some collective agreements, but not addressed in others.

Specific examples of those instances within Table 12 include:

- Three instances where an employee received three overtime shifts within a 1.5 hour time period. This resulted in employees being paid for 9 hours of overtime in 1.5 hours.

- Two instances where employees received three overtime shifts within a 2 hour time period. This resulted in employees being paid for 9 hours of overtime in 2 hours.

- One instance where an employee received five overtime shifts within a 3.5 hour time period. This resulted in an employee being paid for 15 hours of overtime in 3.5 hours.

- One instance where an employee received six overtime shifts within a 4 hour time period. This resulted in an employee being paid for 18 hours of overtime in 4 hours.

- One instance where an employee received five overtime shifts within a 5 hour time period. This resulted in an employee being paid for 15 hours of overtime in 5 hours.

- One instance where an employee received six overtime shifts within a 7 hour time period. This resulted in an employee being paid for 18 hours of overtime in 7 hours.

Our review also identified nine instances where there were two employees of the same position working overtime callback in the same Authority department at the same time.

We also identified two employees who received callback overtime for working overtime immediately following their regular shift. This overtime should have been compensated as regular overtime, not callback overtime. One of the employees received callback overtime immediately following their regular shift in four instances within our samples. We also identified an instance where this employee received callback overtime for showing up for work 15 minutes before the start of a regular shift.

Findings

20. There is a lack of effective oversight to ensure that overtime is properly approved and documented such as to decrease the risk of unauthorized overtime worked and the risk that employees are being compensated for overtime hours beyond those worked.

21. Callback overtime is when employees are called back to work outside their regular shift hours. Employees receive a minimum of three hours overtime pay at the prescribed overtime rate. Callback unworked is the portion of a callback shift that is unworked. Callback unworked was 48% of the total callback overtime. This resulted in an expense of $1.7 million (2012 - $1.6 million) for overtime hours that were not actually worked.

22. Of 229 callback shifts we reviewed, there were 106 shifts (46%) in which employees had, for example, multiple callback shifts within 90 minutes. In one instance, for example, an employee whose annual salary was $61,831 received overtime pay of $51,887 that was unworked overtime.

3D. Management Overtime Policy

Introduction

Authority policy provides managers one week (35 hours) of leave in lieu of general day-to-day overtime and travel time. In addition, in instances when managers are required to perform work that results in significant overtime, Authority policy provides that, *"they will be compensated at the rate of time and one-half (1 ½) at the manager's rate of pay, for the time spent working."*

Authority policy inconsistent with Government policy

During the period of our review, up to and including August 31, 2012, Government policy permitted the payment of overtime for management if they accrue more than 35 hours of overtime in an 8 week period. Effective September 1, 2012, Government policy permits management employees to be compensated at straight time for each hour of overtime worked in excess of two and one half (2½) hours per week, based on the employee's current salary. The Authority's policy is inconsistent with Government policy.

Minister direction not followed regarding management overtime policy

In a letter to the Chair from the Minister dated May 13, 2011, the Minister stated that "*The fiscal impact of this policy has been roughly estimated to cost $1 million annually in unproductive, non-worked hours. This does not include the payment of any approved overtime that relates to their performance of their job responsibilities….Unless such a policy has been authorized by Treasury Board and appropriately funded, they should be discontinued immediately*."

Subsequent to May 13, 2011, the date of the letter to the Chair from the Minister, and throughout the period of our review, Authority policy and practice did not change and, therefore, was not in accordance with the direction provided by the Minister.

Our review of management overtime identified the following issues:

- Leave in lieu expense for management was $0.9 million for fiscal 2013 (2012 - $0.9 million).
- Management overtime expense was $0.4 million for fiscal 2013 (2012 - $0.4 million).
- 625 employees were provided with 35 hours of leave in lieu in 2013 (2012 - 664 employees).

Finding

23. The management overtime policy is not consistent with Government policy, despite the Minister's direction to align policy with that of Government policy. The Authority incurred a $0.9 million expense related to leave in lieu provided to management. This was not in accordance with Government policy.

3E. Education Leave

Introduction

Authority policy allows managers to enroll in post-secondary programs. The policy states, "*one semester may be approved where 50% of the study weeks will be funded education leave and 50% of the study weeks will be taken by the manager as either earned paid leave or approved unpaid leave*". In addition, Authority policy also states, "*Eastern Health will provide up to five days per year paid education leave for those enrolled in post-secondary academic programs to assist in preparation of academic papers, study or exams*."

Education leave not consistent with Government policy

Government does not have a policy that allows management to enroll in post-secondary programs and receive paid education leave.

Our review of education leave identified education leave expense of $191,668 for the year ended March 31, 2013 (2012 - $324,676) and that education leave was used by 162 employees in the year ended March 31, 2013 (2012 - 226 employees).

Finding

24. The education leave policy of the Authority is not consistent with Government policy.

Recommendations

The Authority should:

- amend policies to ensure consistency of Authority policies as compared to Government policies and collective agreements;
- monitor and record employee leave and overtime in accordance with Government and Authority policy, and collective agreements; and
- review policies and practices to identify ways in which to cut associated costs.

4. Internal Controls

Overview

Internal control is comprised of the control environment, accounting systems and control policies and procedures established and maintained by management to assist in achieving the orderly and efficient conduct of the affairs of an organization. It is essential that there be adequate controls to ensure proper stewardship over public money.

The primary objectives of internal control systems are to ensure:

- the reliability and integrity of information;
- compliance with procedures, policies, plans and legislation;
- the economical and efficient use of resources;
- the safeguarding of assets; and
- the accomplishment of established objectives and goals.

General computer control systems affect various areas of applications and are intended to establish a framework of overall control over information systems processing activities. Controls should be considered in computerized information systems design and operations. They should be in place to provide reasonable assurance that systems are efficient and function in a manner consistent with organizational objectives. Many preventative controls are built into computer systems (eg. edits, security access restrictions, authorization requirements, etc.).

It is the responsibility of management to ensure that the following basic general controls, amongst others, are part of the internal control processes of an organization:

- authorization of transactions - each organizational process must have authorization requirements for transactions within the process; and

- segregation of duties - each organizational process must have an appropriate distribution of incompatible tasks amongst multiple individuals within the process. The primary objective of the segregation of duties is the prevention of fraud and error. Examples include: the separation of vendor creation and the initiation of purchase orders and the separation of the initiation and approval of purchase orders.

We would expect to see effective internal controls at the Authority to ensure safeguarding of assets, and proper stewardship over public money.

In reviewing the Authority's purchasing processes, we identified issues in the following areas:

A. Internal Controls over Purchasing
B. Internal Controls over Payments
C. Internal Audit Function

4A. Internal Controls over Purchasing

Introduction

The Materials Support Department has the exclusive authority to commit the Authority to legal contracts for the acquisition of goods and services. Authority policy states: "*The Materials Support Department, acting on behalf of the President and CEO, has the authority to commit Eastern Health to legal contracts for the acquisition of goods and services. Other staff are not permitted to commit Eastern Health to contracts, either verbally or in writing.*"

According to Authority policy, the Materials Support Department is responsible for all aspects of the purchasing process.

Authority policy requires a properly authorized purchase requisition for the acquisition of goods and services. The requisition must be approved by a director or delegate before being sent to the Materials Support Department. Authority policy also requires that the Materials Support Department issue a properly authorized purchase order.

Our review identified the following:

Purchasing function performed outside of Materials Support Department

During our review, we noted that the purchasing function is being performed by individuals outside of the Materials Support Department. This is in contravention of Authority policy. Authority officials within the Materials Support Department advised that they do not have systematic internal control audit processes or reviews that would detect unauthorized purchasing or prevent it from occurring. We obtained a listing of user accesses for the purchasing system. These reports contained 243 names of users that, as of November 22, 2013, had access to perform certain functions, such as creation of a purchase order, within the system. As of the same date, there were only 140 employees in the Materials Support Department. Materials Support Department officials were not aware that there were a significant number of employees with system accesses that were not in compliance with Authority policy.

Inadequate authorization and review processes

Authority policy requires a properly completed and approved purchase order prior to initiation of the purchasing process. The purchase order is also required as support of the purchase prior to payment processing by the Accounts Payable Division of the Authority. Although payment processing was completed by the Accounts Payable Division, Department officials advised it was most often performed by an official without seeing the original documentation. Purchase order authorization is a manual process within the Authority's processes and is evidenced by an authorizing signature on the purchase order.

During our review, we identified instances in which the initiator of the purchase order was also the approver of the purchase order. This is not proper authorization of the transaction. These are incompatible functions and should be segregated.

We also noted instances in which the Accounts Payable Division was processing payments without purchase orders. This increases the risk that purchases are being made without the approval of the Materials Support Department. Since only the Materials Support Department has the authority to commit the Authority to legal contracts for the acquisition of goods and services, purchases made without their approval are in contravention of policy. The Materials Support Department cannot ensure Authority policy, the *Public Tender Act (PTA)* and Government's *Guidelines for the Hiring of External Consultants (Consultant Guidelines)* are being followed for the purchase of goods and services when they are not aware of the purchases. For example, during our review, we noted an instance where a consultant was hired for $210,000 to manage an infrastructure project. This hire was made without a purchase order, the Materials Support Department was not involved in the transaction, and the *Consultant Guidelines* were not followed.

The Materials Support Department was not monitoring purchasing activity to prevent these unauthorized transactions from occurring.

Inadequate segregation of duties

During our review of user access listings for the purchasing system and associated manual processes, we identified 143 individuals on the listing that had current access that allowed them to:

- set up a new vendor;
- initiate a purchase order; and
- receive goods on the system.

These processes are incompatible, as they provide an individual with access to the purchasing process from beginning to end, without any systems authorization required. The access to these incompatible functions increases the risk of fraud or error occurring without detection. Purchase order approval is a manual process outside of these system accesses.

Lack of monitoring of final tender costs

During our review of the tendering processes, we would have expected to see evidence of monitoring, by the Materials Support Department, of the final costs of tendered work as compared to the awarded costs to ensure proper fiscal management and internal control.

The Materials Support Department was unable to provide us with a complete listing of tenders, and also could not provide any analysis of the final costs of the tendered work as compared to the awarded costs.

Lack of controls over changing purchase orders

During our review of the purchase order process, we would have expected to see controls in place to ensure the proper approval of any purchase order changes.

Purchase orders can be changed by anyone with access to the purchasing module. Therefore, a purchase order that was created and approved can be subsequently modified by the creator of the purchase order, the approver of the purchase order, or any other employee with access to the purchasing module. The access to these incompatible functions increases the risk of fraud or error occurring without detection.

In addition, we determined that purchase orders are being changed without the necessary approval required. For example, the Materials Support Department does not require a copy of a signed change order relating to a tender, prior to changing the amount of a purchase order. As a result, it is possible that change orders may occur without the approval of the head of the Government Funded Body, or the Board.

No review of computer access

System access to the purchasing system was not being adequately monitored during the period of our review. We identified the following concerns:

- system access logs were not being reviewed;
- employees outside the Materials Support Department had access to the purchasing module; and
- terminated employees' accounts were not being removed.

Without adequate monitoring and maintenance, there is an increased risk of improper transactions occurring, as a result of either fraud or error.

Lack of automated controls in purchasing module

Automated controls within a system allow certain preventative measures without significant manual intervention. Automated controls have not been integrated into the purchasing system to reduce the risk of fraud or error from occurring. We identified that the system does not:

- require a purchase requisition number to be entered;
- restrict purchasing authority limits for employees;
- require purchase orders to be approved on the system, by an individual other than the creator of the purchase order;
- require a Tender or Form B number when purchases are greater than $10,000; and
- restrict the delivery locations of goods.

Lack of these automated controls increase the risk of fraud or error, as a system user has access to create and approve a purchase order of any dollar amount and also has access to set the delivery of goods or services to any location of their choosing.

No dollar limits on spending

Government policy regarding delegated purchase authority requires limits on spending authority.

Authority Policy does not require limits on spending authorizations. Authority practice does not have spending limitations in place for the purchasing function.

This does not allow for proper fiscal management.

Lack of oversight by Materials Support Department

Government policy surrounding delegated purchasing authority includes:

- placing limits on spending authority;
- ensuring that financial authorities are clearly assigned, properly approved, and that delegation instruments are regularly updated;
- ensuring that appropriate officers are delegated authority that enables them to effectively administer programs within their budget responsibility; and
- ensuring that an appropriate financial control framework is maintained which permits a balance of risks, costs and efficiencies.

The Materials Support Department has not ensured that the appropriate internal controls around the purchasing processes are in place at the Authority.

This has been demonstrated by the lack of:

- segregation of duties;
- review of computer accesses;
- automated controls in the purchasing system; and
- overall monitoring regarding the purchase of goods and services.

Without properly working internal controls surrounding the purchase of goods and services, the Authority cannot ensure compliance with policies and procedures, the economical and efficient use of resources and the adequate safeguarding of assets.

Findings

25. Current Authority controls are not adequate to prevent or detect fraud or error in areas of purchasing. For example:

    - inadequate authorization and review of purchase orders;
    - lack of monitoring of final tender costs compared to awarded costs;
    - lack of controls over user access to purchase orders;
    - no dollar limits on spending authorization for employees; and
    - an overall lack of oversight of the purchasing process by the Materials Support Department.

26. The purchasing function was being performed by individuals outside of the Material Support Department. There were 243 users that are able to create purchase orders, however, there were only 140 employees in the Materials Support Department.

4B. Internal Controls over Payments

Employees have the ability to prepare, approve, and print cheques without requiring supervisory approval

During our review of the purchasing processes, we would have expected adequate segregation of duties around cheque processing. During our review, we identified that there are 26 individuals within the Financial Services, Budgeting, and the Healthcare Technology and Data Management (HTDM) Departments that have system access to prepare, approve, and print cheques, all without any level of supervisory approval.

Without the proper segregation of duties and authorization requirements, there is an increased risk of fraud or error occurring.

Finding

27. Internal controls over cheque processing are inadequate. As a result of improper segregation of duties and authorization requirements, there is an increased risk of fraud and error occurring.

4C. Internal Audit

No internal audit function

An internal audit function is an integral part of an effective internal control system, particularly for an organization the size of the Authority. Without such a system, including the presence of an internal audit function, instances of the following may go undetected:

- public money not being appropriately collected and disbursed;
- non-compliance with legislation and/or Government policies;
- lack of safeguarding and accounting for the Authority's assets; and
- accounting and management control weaknesses.

We would expect the Authority to have an Internal Audit Department which would have an independent, functional responsibility to the Finance and Audit Committee of the Board of Trustees for the adequacy and effectiveness of internal controls.

There was no functioning Internal Audit Department during the period of our review.

An effective internal audit function can help ensure that preventative and detective controls are implemented and functioning properly.

Finding

28. There was no functioning Internal Audit Department during the period of our review. An effective internal audit function can help ensure that preventative and detective controls are implemented and functioning properly.

Recommendations

The Authority should:

- strengthen internal controls relating to purchasing and payments;
- complete regular reviews of internal controls to ensure they are operating effectively;
- create a delegation of authority policy that is consistent with Government;
- consider the need for an Internal Audit Department; and
- consider the need for an overall review of purchasing.

5. Tendering of Goods and Services

Overview

The Authority spent approximately $357.1 million during the year ended March 31, 2013 (2012 - $356.1 million) on goods and services. The Materials Support Department of the Authority is responsible for the procurement of goods and services, related to both operating expenses and acquiring capital assets. To acquire goods and services, the Authority must comply with the requirements of the *Public Tender Act (PTA)* and the *Public Tender Regulations, 1998* (the *Regulations*).

In reviewing the Authority's tendering of goods and services practices we identified issues in the following areas:

A. Tendering and Purchasing Policies
B. Tender Exceptions - Form Bs
C. Infrastructure Projects

5A. Tendering and Purchasing Policies

Introduction

Table 13 summarizes certain requirements of the *PTA* based on the cost thresholds of the goods and services.

Table 13

Eastern Regional Health Authority
***Public Tender Act* Requirements**

When goods and services cost …	Or a public work costs …	Then the Authority must …
More than $10,000	More than $20,000	Invite tenders
$10,000 and less	$20,000 and less	• Obtain quotations from at least 3 legitimate suppliers, or • Establish for the circumstances a fair and reasonable price.

Purchases not in compliance with *PTA* and Authority policy

Our review included a sample of 20 purchases for the period April 1, 2011 to March 31, 2013 to assess the Authority's compliance with the *PTA* and the *Regulations*.

Our review identified the following:

- 2 purchases totaling $3,875 did not have the 3 required quotations; and
- 3 purchases totaling $17,040 did not contain any support to indicate a fair and reasonable price.

Insufficient support in Tender files

Our review of 9 tender files identified issues with the completeness of the documentation to support the tender awarding process. Specifically, bid checklists were not completed by the Materials Support Department in 8 of the 9 files. As a result, the Authority could not demonstrate that bids were reviewed for compliance with tender specifications. This creates a risk that tender requirements are not consistently applied to each tender bid.

Purchasing policy not being followed

The purchasing policy of the Authority for acquisition of professional services states that for professional services valued at $10,000 or greater, approval must come from a Vice-President, or Chief Operating Officer. Our review identified that senior management other than the Vice-President or Chief Operating Officer are approving professional service contracts valued at $10,000 or greater.

Finding

29. We found instances where purchases made were not in compliance with the *Public Tender Act* (*PTA)* and where there was insufficient support in tender files. As a result, the Authority could not demonstrate that bids were reviewed for compliance with tender specifications. We also found instances where the purchasing policy of the Authority was not being followed.

5B. Tender Exceptions – Form Bs

Introduction

Section 3(1) of the *PTA* states that: "*Where a public work is to be executed under the direction of a government funded body or goods or services are to be acquired by a government funded body, the government funded body shall invite tenders for the execution or acquisition.*" Although the *PTA* makes public tendering a requirement when acquiring goods or services, it does specify instances in which tenders are not required. These instances are commonly referred to as "tender exceptions". All tender exceptions require a "Form B" to be completed and tabled in the House of Assembly.

Our review included a sample of 33 Form Bs for the period April 1, 2011 to March 31, 2013 to assess compliance by the Authority with the *PTA* and *Regulations*.

Our review of Form Bs identified issues in the following areas:

Form Bs not submitted to the Agency on time

Of the 33 Form Bs sampled, we noted 10 instances where the Form Bs were not submitted within the required timeframe. The extent to which the form B submissions were overdue ranged from 5 to 255 days.

By not submitting Form Bs on time, the Authority is not in compliance with the *PTA* and is impacting the timeliness and relevancy of the information being reported to the House of Assembly.

Inappropriate pressing emergency exceptions

Our review of Form Bs indicated that the Authority did not always apply section 3(2)(d) of the *PTA*, the *pressing emergency exception*, appropriately. Of the 33 Form Bs reviewed, 12 were categorized as a pressing emergency. In 2 of the 12 instances, we question the appropriateness of the rationale:

- Rental of two suites ($23,922): the Authority indicated on the Form B, "Emergency Purchase - This was needed ASAP - no time to tender". However, documentation about the rental indicated that the Materials Support Department was contacted on January 24, 2013 to book the rental of the two suites for March 1, 2013. In our view, the Authority had enough time to tender the contract.

- Central laundry equipment ($38,409): the Authority was unable to provide documentation to support the pressing emergency claim.

As a result, the Authority may not be getting the most economical price in these instances in which a pressing emergency exception may not have been required.

Inappropriate sole source exceptions

Our review indicated the Authority did not always apply section 3(2)(e) of the *PTA*, the *sole source exception*, correctly. Of the 33 Form Bs reviewed, we found 21 instances where the sole source exception was reported.

In 8 of these 21 instances, we question the appropriateness of the rationale. As a result, the Authority may not be getting the most economical price in these instances in which a sole source exception may not have been required.

Finding

30. Form Bs, which document exceptions to the *PTA*, are not always being submitted on a timely basis. As a result, the Authority is not in compliance with the *PTA* and is impacting the timeliness and relevancy of the information being reported to the House of Assembly. Some pressing emergency exceptions and sole source exceptions may not be appropriate. As a result, the Authority may not be getting the most economical price in these instances.

5C. Infrastructure Projects

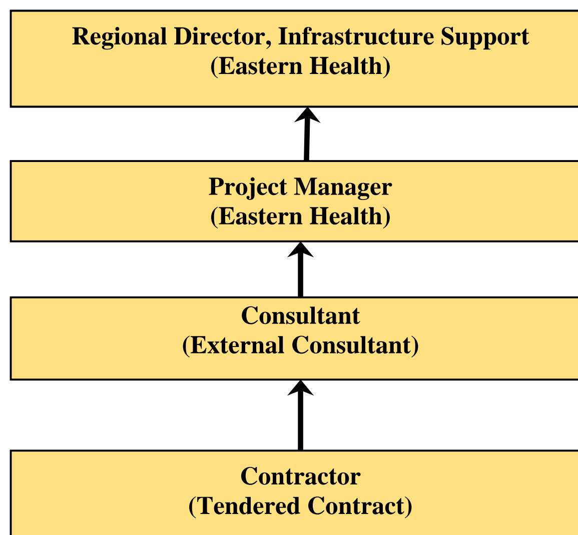
Introduction

The Infrastructure Department of the Authority is responsible for the development and monitoring of capital infrastructure projects.

Each capital infrastructure project has a reporting structure as shown in Figure 4.

Figure 4

Eastern Regional Health Authority
Infrastruture Department
Project Reporting Structure



Source: Eastern Regional Health Authority

Under the terms of the *PTA,* subject to the prior approval of the head of the government funded body, *"A government funded body may authorize change orders within the requirements of a contract or authorize extensions of the contracts."*

The *PTA* provides for extensions or change orders within the scope of the original contract up to: $15,000 for contracts under $100,000; $15,000 or 10%, of the contract price, whichever is greater, for contacts over $100,000 and less than $500,000; or $50,000 or 5% of the contract price, whichever is greater, for contracts over $500,000.

These extensions or change orders require prior approval of the head of the government funded body, which in the Authority, is the CEO. Extensions or change orders above these limits must have the prior approval of the Board of Trustees.

We reviewed a sample of 10 infrastructure projects in which change orders were issued. Our review identified the following:

- A tender for $1,397,327 for a lab development received 48 change orders totaling an additional cost of $928,465. According to the *PTA*, the change orders required CEO and Board approval. However, the change orders were completed without prior approval by the Board.

- A tender for $98,750 for the replacement of 56 windows was increased by $154,974 for an extra 70 windows. According to the *PTA*, the change order required CEO and Board approval. However, the change order was completed without prior approval of the CEO or the Board. Furthermore, the change order pertained to replacing windows that were not within the scope of the original contract.

- A tender for $211,250 for an Electric Arc Flash Study was increased by $42,250 to add another hospital. According to the *PTA*, the change order required CEO and Board approval. However, the change order was completed without prior approval of the CEO or the Board.

- A tender for $640,000 for Cardiac Catherization Lab Re-Development was increased by $11,907 at the request of the Authority. Additional enclosures were requested by Authority officials, which were outside the scope of the original tender.

CEO approval of change orders within legislative thresholds, and CEO and Board approval of change orders in excess of the legislated thresholds is required by the *PTA*, and contributes to effective budget monitoring. Our review indicated instances of a lack of compliance with the *PTA*. Issuing change orders outside the scope of the original tender is not in compliance with the *PTA* and is ineffective in terms of fiscal controls and budgetary management.

Noncompliance with Guidelines for hiring external consultants

Authority Policy states that they are required to follow Treasury Board guidelines when acquiring professional services. The *Consultant Guidelines* provides the requirements for proposals, approvals, selections, and expenditures. The Guidelines require that when engaging consultants for the express purpose of design or project management of the construction or major renovation of a government facility, water and sewer project, or public road that:

- Departments may use their discretion and not request limited or public proposals when fees and expenses are not estimated to exceed $100,000.

- Departments may suspend the requirement to request public proposals but must request limited proposals when total consultant fees and expenses are estimated to be in range of $100,000 - $150,000.

- Departments must prepare and advertise a public "Request for Proposals" when total consulting fees and expenses are estimated to exceed $150,000.

- If a department deems it impractical to request either type of request for proposal for those projects in excess of $100,000, it must receive specific Treasury Board approval to suspend the request for proposals.

- In situations of multi-phased projects where it is in Government's best interest, a department has discretionary authority to retain the same consultant on all phases without a need to invite proposals for each phase.

We reviewed the listing of consultants used on capital infrastructure projects from April 2011 to March 2013 to assess whether the Authority was adhering to the *Consultant Guidelines*.

Our review identified the following:

- A consultant was hired to manage an infrastructure project at a cost of $135,000. Authority officials indicated there was only one consultant suitable to provide the service, and therefore did not issue any requests for proposal. However, the Authority did not receive Treasury Board approval as required by the *Consultant Guidelines*.

- A consultant was hired and paid $210,000 to manage an infrastructure project. The consultant was not selected through a request for proposal process as required by the *Consultant Guidelines*. Furthermore, there was no formal contract signed between the Authority and the consultant. The project was not authorized by the Materials Support Department, as required by Authority policy.

The Authority was not in compliance with the *Consultant Guidelines* for these contracts.

Findings

31. We found instances where contract change orders did not comply with the *PTA*.

32. We found instances where the Authority was not in compliance with the *Guidelines* pertaining to the hiring of external consultants.

Recommendations

The Authority should:

- comply with the *Public Tender Act* and *Regulations*; and

- comply with Authority policy, which requires following Government's *Consultant Guidelines for the Hiring of External Consultants*.

6. Monitoring of Capital Assets

Overview

As at March 31, 2013, the Authority reported capital assets with a cost of $889.4 million (2012 - $859.3 million). Table 14 provides a summary of the capital assets of the Authority.

Table 14

Eastern Regional Health Authority
Capital Assets (original cost)
As at March 31
($000's)

	2012	2013
Land and improvements	$ 2,810	$ 2,810
Buildings	351,727	362,377
Equipment	441,116	459,470
Equipment under capital lease	15,445	15,445
Construction in progress	48,221	49,317
Total Capital Assets	**$859,319**	**$889,419**

Source: Eastern Regional Health Authority Audited Financial Statements

The HTDM Department is responsible for the monitoring of biomedical assets. The Infrastructure Support (IFS) Department is responsible for the monitoring of infrastructure assets.

In reviewing the Authority's monitoring of capital assets we identified issues in the following areas:

A. Policies and Procedures
B. Priority Rankings for Equipment Replacement
C. Monitoring for Efficiency
D. Database Management

6A. Policies and Procedures

Introduction

To ensure adequate control and monitoring of capital assets, the Authority must ensure that policies and procedures are documented and communicated to employees, and that assets are identified and recorded when purchased, periodically inventoried and reconciled to financial records.

We would expect to see well defined policies and procedures within the Authority to ensure proper monitoring of capital assets. Our review of policies and procedures identified issues in the following areas:

No policy to conduct annual capital asset inventory counts

During the period covered by our review, the Authority did not have a policy to conduct regular capital asset inventory counts. By not having this policy, the Authority was at an increased risk of not detecting lost or stolen capital assets. Subsequent to the period covered by our review, Authority officials approved a policy to conduct annual capital asset inventory counts.

No policy to conduct asset listing reconcilations to the General Ledger

The Authority does have a policy on the disposal of capital assets, which addresses the removal of the items from the asset listings upon disposal. However, the policy does not require a procedure to reconcile capital assets to the general ledger. Regular reconciliations done between the information systems and the general ledger would help ensure the accuracy of both systems by highlighting differences in asset information.

Finding

33. During the period covered by our review, there was no policy to conduct annual capital asset inventory counts. This increased the Authority's risk of not detecting lost or stolen capital assets. Also, there is no policy to conduct asset listing reconciliations to the general ledger. This would help ensure the accuracy of both systems by highlighting differences in asset information.

6B. Priority Rankings for Equipment Replacement

HTDM - Inaccurate priority rankings

The HTDM Department assigns a priority ranking to each biomedical capital asset in the database. The priority ranking is meant to indicate the urgency for replacement. For example, a ranking of 5 indicates the biomedical capital asset is in excellent condition, whereas a ranking of 1, indicates a more urgent need for replacement.

Based on our review of 24 items with staff of the HTDM Department, 8 items had inaccurate ratings. According to Authority officials, ratings should have been adjusted down to reflect the deteriorating condition of the equipment, but this had not been done.

As priority ratings are a key factor in determining which biomedical capital assets need replacement, it is necessary to have accurate priority ratings in the database.

Finding

34. The system, which ranks biomedical capital assets for priority replacement, has inaccurate priority rankings. These rankings are a key factor in determining which biomedical assets need to be replaced.

6C. Monitoring for Efficiency

HTDM - Not monitored for efficiency

We would expect the HTDM Department to monitor biomedical capital assets for efficiency; that is, review the ongoing maintenance cost of equipment as compared to the equipment replacement cost. This could be done by tracking the maintenance expense incurred on each piece of equipment and comparing this information to equipment replacement cost.

Our review indicated the HTDM Department tracks the number of work orders associated with each biomedical asset. However, Authority officials were unable to provide a listing of maintenance expenses for the biomedical capital assets. Monitoring biomedical capital asset maintenance expenses would give the Authority better information pertaining to the efficiency of the equipment, and better equip the Authority to make decisions regarding the cost/benefit to replacing existing biomedical capital assets.

Finding

35. The Authority was not monitoring maintenance expenses to provide information pertaining to the efficiency of the biomedical capital assets to assist in decisions regarding the replacement of existing equipment.

6D. Database Management

HTDM - No segregation of duties on assets removed from database

We would expect to see preventative controls built into the HTDM database, such as: segregation of duties between custody of assets, record keeping, and authorization requirements for decommissioning biomedical capital assets. This would help ensure the database is accurate, and help safeguard biomedical assets against loss and theft.

Our review indicated there was no segregation of duties between officials that physically remove biomedical assets, and officials that have access to edit the database.

Furthermore, we found that the biomedical equipment database did not have any authorization requirements to decommission equipment. For example, an official could remove an item from the database without management approval.

Given that there are no segregation of duties between asset removal and record keeping, and there are no authorization requirements on the database, there was an increased risk that the biomedical database contains inaccurate information and assets are not protected against misappropriation.

Finding

36. There was no segregation of duties between asset removal and record keeping and there are no authorization requirements on the biomedical database. Therefore, there was an increased risk that the database contains inaccurate information and assets are not protected against misappropriation.

Recommendations

The Authority should:

- develop and implement policies and procedures for the identification, recording, controlling and monitoring of capital assets; and
- ensure asset purchases and disposals are recorded in a capital asset ledger, and assets are periodically inventoried and reconciled to the financial records.

Authority's Response

Eastern Health was formed on April 1, 2005, bringing together seven previous health and community services boards serving the eastern region of Newfoundland and Labrador. Eastern Health offers the full continuum of health and community services – from prenatal to end-of-life care. With an annual budget of over $1.3 billion, Eastern Health is the largest, integrated health authority in the province serving a regional population of over 300,000 people. In addition to its regional role, Eastern Health is responsible for provincial tertiary level health services, such as paediatrics, and provincial programs, such as cancer care.

Eastern Health welcomes the review by the Auditor General and is actively working to implement changes in accordance with recommendations where appropriate.

In many cases Eastern Health has already changed its practices, policies and oversight. In other cases, more work remains to be done by Eastern Health and in a very few cases more investigation is required.

Eastern Health has provided responses to the Office of the Auditor General's recommendations as outlined in the sections of its report:

1. *Monitoring of Financial Position*
2. *Compensation and Recruitment*
3. *Leave and Overtime*
4. *Internal Controls*
5. *Tendering of Goods and Services*
6. *Monitoring of Capital Assets*

1. Monitoring of Financial Position

Recommendations

The Authority should:

1i) Revise the Recruitment Authorization policy to require that appropriate funding is available for a position prior to initiating a recruitment action; and

1ii) Comply with Ministerial directives.

Eastern Health's Response

1i) Eastern Health is embedding position control within its Human Resources Information System (HRIS) that will validate there is funding available for a position prior to a recruitment action beginning. This has been in a pilot phase for the past four months and will be fully implemented in 2014-15.

Since 2010-11 Eastern Health is working to eliminate unfunded positions or to secure permanent funding for those positions. This work continues with our Operational Improvement Plan. Currently, there are 144 unfunded full-time equivalent (FTE) positions within Eastern Health, down from 630 in 2010-11.

1ii) Eastern Health will continue to comply with Ministerial directives.

2. Compensation and Recruitment

Recommendations

The Authority should:

2i) Ensure compensation and recruitment practices are in accordance with Authority and Government policy;

2ii) Maintain adequate documentation in competition files;

2iii) Calculate employee compensation accurately;

2iv) Comply with Government's relocation policy for all employees and ensure that return-in-service agreements are signed and approved; and

2v) Ensure compliance with its mileage reimbursement policy.

Eastern Health's Response

2i) Eastern Health will ensure its compensation and recruitment processes and policies are comparable to those of the Provincial Government and the Public Service Commission, where appropriate.

2ii) Eastern Health will ensure that appropriate documentation is maintained in competition files.

Of note, Eastern Health recruits for approximately 3,000 positions annually.

2iii) Eastern Health will ensure that it calculates compensation accurately.

Eastern Heath implemented process changes in 2013 to ensure timely classification occurs. Eastern Health acknowledges that it took a significant amount of time for the classification process to conclude. Management positions were benchmarked within the Authority as positions were created. The Authority did not anticipate the changes that occurred when positions were formally classified. In fact, the majority of the 519 positions classified either remained at the same level or were higher than what was proposed by Eastern Health.

2iv) Eastern Health implemented a new relocation policy in September 2012 to align more closely with Provincial Government policy. Eastern Health processes have been tightened to ensure that any return-in-service agreements are signed prior to the individual starting work.

2v) Eastern Health will strive to ensure compliance with its mileage reimbursement policy.

For one of the instances referenced by the Auditor General, the employee is a retired employee who was hired to provide relief for the only permanent employee in this classification at a rural facility. Part of the agreement for the employee to return to work was that Eastern Health covered travel expenses for the employee to and from work. Failure to agree would have jeopardized continued provision of emergency medical services to the community. Recruitment efforts will continue to allow Eastern Health to comply with its mileage reimbursement policy.

3. Leave and Overtime

Recommendations

The Authority should:

3i) Amend policies to ensure consistency of Authority policies as compared to Government policies and collective agreements;

3ii) Monitor and record employee leave and overtime in accordance with Government and Authority policy, and collective agreements; and

3iii) Review policies and practices to identify ways in which to cut associated costs.

Eastern Health's Response

3i) Eastern Health will ensure there is consistency with its policies as compared to Government policies and collective agreements.

As of January 13, 2014, Eastern Health received direction from the Department of Health and Community Services to eliminate management education differentials for all managers with the exception of nurse managers; eliminate the management education leave policy; and change the management overtime policy to mirror that of the Provincial Government. That will be implemented in 90 days.

3ii) and 3iii)

Eastern Health will work to improve its monitoring and recording of employee leave and overtime.

Eastern Health has recognized for some time the use of sick leave and overtime at Eastern Health has exceeded our counterparts in parts of Newfoundland and Labrador and across Canada. As part of its Operational Improvement Initiatives Eastern Health has tightened controls on the use and approval of these benefits in an effort to reduce costs.

The Human Resources department of Eastern Health conducts both regular and ad-hoc audits of compensation and benefits items. Eastern Health will continue and expand the audits as necessary to ensure employees accrue benefits correctly and supporting documentation is in place.

In addition to leave request forms, both Managers and Directors review and approve an "Attendance Data Hours Check Report" after each pay period. This report breaks down how each employee was paid during each two week period i.e. regular hours, annual leave hours, paid leave hours etc. so management is aware of all leave that was taken during each pay period.

Eastern Health has an Attendance Management Program which was developed to help assist employees to return to work as quickly as possible after a period of sick leave. The Authority will be undergoing a review of the program given the sick leave usage and also pilot new programming in areas experiencing higher than average levels of sick leave.

Oversight for overtime is a responsibility for all managers. Given the 24/7 nature of most units/departments at Eastern Health, overtime will occasionally occur when a manager is not available to preauthorize. Eastern Health will ensure managers follow-up with their employees to verify and validate the use of overtime when it occurs without prior approval.

4. <u>Internal Controls</u>

Recommendations

The Authority should:

4i) Strengthen internal controls relating to purchasing and payments;

4ii) Complete regular reviews of internal controls to ensure they are operating effectively;

4iii) Create a delegation of authority policy that is consistent with Government;

4iv) Consider the need for an Internal Audit Department; and

4v) Consider the need for an overall review of purchasing.

Eastern Health's Response

Eastern Health will review all recommendations made in this section of the report with its Board Finance Committee and with its auditors. Recommended changes, as appropriate, will be achieved within the next 12-18 months.

Eastern Health's Board has initiated an organization wide process to assess Enterprise Risk Management. Internal Audit has been identified as a component of that assessment and will be addressed during the process.

5. <u>Tendering of Goods and Services</u>

Recommendations

The Authority should:

5i) Comply with the Public Tender Act *and* Regulations*; and*

5ii) Comply with Authority policy, which requires following Government's Guidelines for the Hiring of External Consultants.

Eastern Health's Response

Eastern Health is committed to following all policies and procedures, best practices and legislation in relation to tendering for Goods and Services. Where Eastern Health has been found to be lacking, Eastern Health will take immediate remedial measures.

6. Monitoring of Capital Assets

Recommendations

The Authority should:

6i) Develop and implement policies and procedures for the identification, recording, controlling and monitoring of capital assets; and

6i) Ensure asset purchases and disposals are recorded in a capital asset ledger, and assets are periodically inventoried and reconciled to the financial records.

Eastern Health's Response

Eastern Health is in the process of establishing policies and procedures related to the monitoring of capital assets. Many have been implemented and Eastern Health continues to strengthen this area of control within Eastern Health.

In October 2013, Eastern Health implemented an equipment inventory policy requiring that a current medical equipment inventory for each site be kept on file in Eastern Health's Computerized Maintenance Management System and that inventory be reviewed annually.

PART 3.2

DEPARTMENT OF HEALTH AND COMMUNITY SERVICES

FEE-FOR-SERVICE PHYSICIANS: AUDIT PROCESS

Summary of Findings

Introduction

The Newfoundland and Labrador Medical Care Plan (MCP) is a comprehensive plan of medical care insurance designed to cover the cost of physician services for bona fide residents of the Province.

Physicians are paid in one of three different ways:

1. Fee-For-Service (FFS) - Payments are made for each service performed by the physician;

2. Salary - Physicians are considered employees of the Regional Health Authorities and are paid a salary set through the Memorandum of Agreement between Government and the Newfoundland and Labrador Medical Association; and

3. Alternate Payment Plan (APP) - The amount in payments the physician receives is supported by individual contracts which are based on block funding arrangements. This payment method contains elements of the FFS and salary payment methods.

Payments to physicians represent a significant cost to the Province. In 2013, total payments made to physicians totalled $443.1 million. Of that amount, $310.9 million (70%) were payments made to physicians under the FFS and the APP payment structures.

The Audit Services Division (the Division) is responsible for auditing FFS payments made to physicians.

The objectives of our review were to determine whether the policies and procedures governing the MCP audit function are effective in identifying overpayments made to physicians and to determine whether the overpayments identified are being recovered in a timely manner.

Findings

Audit Selection

1. The Division does not use available reports to the fullest extent as a means of identifying audits. As a result, the Division may be missing opportunities to identify appropriate physician claims to audit.

2. Only 11% of FFS physicians who earned salaries above the average of FFS physicians in their category were selected for audit during the 6½ year period of our review. As a result, the Division may be missing opportunities to identify appropriate claims to audit that may result in increased recoveries.

3. There are no safeguards in place to prevent double billing of services to MCP and the Workplace Health, Safety and Compensation Commission of Newfoundland and Labrador. As a result, physicians could be paid twice for the same service.

Audits of Claims

4. During the 6½ year period of our review only 87 audits were started by the Division. In comparison to the FFS physician expenditures, the number of audits started is small. As a result, the Division may be missing opportunities to fulfill their mandate of ensuring that only legitimate and accurate claims are paid which may prevent future incorrect billings.

5. FFS physician audits are taking a long time to complete. As a result, the Division is increasing the risk of not collecting the full amount of the recovery identified and missing opportunities for corrective action.

6. The Division does not consistently pursue audits when high error rates are detected. This is inconsistent with Division policy. As a result, the Division maybe missing opportunities to maximize recoveries.

7. Recoveries of overpayments are not always pursued. As a result, the Division is missing opportunities to maximize recoveries.

8. The Medical Consultants' Committee is not meeting on a regular basis. This results in delays in issuing assessments and also delays in recoveries which increases the risk of not collecting the full amount of the assessments.

9. The Alternate Dispute Resolution process, which is intended to be completed within 90 days, is taking considerably longer to conclude. As a result, identified recoveries are taking longer to recover which increases the risk of not collecting the full amount.

10. There was no Audit Review Board in place for a period of three years even though its existence is required by legislation. As a result, physicians could not avail of this function as part of the audit process and consequently were denied due process.

11. The Division is not consistently applying the criteria for placement into the Physician Claims Intervention Program. Therefore, not all physicians who meet the criteria for placement are entered in the program. As a result, incorrect billings could go undetected and potential overpayments may not be identified.

Audit Recoveries

12. The Department is not collecting recoveries in a timely manner. As a result, they are increasing the risk of not collecting the full amount identified.

Audit File Documentation

13. The Division does not have formalized policies that outline documentation requirements for audit files. As a result, the audit files include findings and conclusions without adequate support and documentation which may impede the Division in ensuring that only legitimate claims are paid

Performance Measurement and Reporting

14. The Division does not have an operational plan in place. As a result, they have no plan to guide their work or to encourage the achievement of their mandate.

15. The Division has not established performance measures or reporting requirements specific to the MCP FFS audit function. As a result, the Division has no goals or targets against which to measure the amount and quality of work completed.

Background

Overview

The Newfoundland and Labrador Medical Care Plan (MCP) was introduced on April 1, 1969. It is a comprehensive plan of medical care insurance designed to cover the cost of physician services for bona fide residents of the Province. Prior to April 1, 2000, MCP was administered by the Newfoundland Medical Care Commission. On April 1, 2000, Government dissolved the Newfoundland Medical Care Commission and merged its activities with the Department of Health and Community Services (the Department). In July 2001 the claims assessing and processing section was transferred to Grand Falls-Windsor. MCP Headquarters, including the Audit Services Division (the Division), remained in St. John's.

Physicians are paid in one of three different ways:

1. Fee-For-Service (FFS) - Payments are made for each service performed by the physician. The physician submits a claim to the MCP processing division. The claim is processed and paid in accordance with approved FFS rates that are set out in the MCP payment schedule;

2. Salary - Physicians are considered employees of the Regional Health Authorities. Payments are made bi-weekly in accordance with the salaries set through the Memorandum of Agreement between Government and the Newfoundland and Labrador Medical Association (NLMA); and

3. Alternate Payment Plan (APP) - This payment method contains elements of both the FFS and the salary payment arrangements. The payment a physician receives is supported by individual contracts with each physician and are based on block funding arrangements administered by the Department. The existence of such arrangements is necessary to recruit and retain physicians whose specialties are rare, and for whom the market is competitive.

The Division has five employees involved in conducting FFS physician audits:

- Medical Auditor I (2 positions);
- Medical Auditor II (2 positions); and
- Manager of Audit Services.

The function of this staff is to review physician payment documentation and investigate potential over-billings by FFS physicians. The audit manager has other responsibilities within the Division. The Division is part of the Audit and Claims Integrity Division which reports to the Assistant Deputy Minister of Corporate Services at the Department.

Table 1 shows the number of physicians, by payment type, that received payments in each of the years covered by our review.

Table 1

Fee-For-Service Physicians: Audit Process
Number of Physicians by Payment Type
For the Years Ended March 31

Physician Payment Type	2008		2009		2010		2011		2012		2013	
	#	%	#	%	#	%	#	%	#	%	#	%
FFS	640	65	653	63	656	61	672	61	698	63	729	63
Salaried	320	32	347	33	381	35	384	35	374	33	378	33
APP	29	3	37	4	38	4	40	4	43	4	48	4
Total Physicians	**989**	**100**	**1,037**	**100**	**1,075**	**100**	**1,096**	**100**	**1,115**	**100**	**1,155**	**100**

Source: MCP

As indicated by Table 1, the majority of physicians are paid through the FFS payment structure. FFS physicians represent in excess of 60% of the total number of physicians practicing in the Province.

Payments made to physicians through the MCP are governed by:

- the *Medical Care Insurance Act, 1999* and *Regulations;*

- the Memorandum of Agreement between the Government and the NLMA. This most recent agreement expired September 30, 2013. To date, a new agreement has not been reached; and

- the MCP rate schedule which provides the allowable rates at which physicians can be reimbursed by MCP for each type of service provided, as well as, guidance on how to claim for a service.

MCP payment to physician expenditures

Payments to physicians represent a significant expenditure of the Province. Table 2 shows the total expenditures pertaining to physician services paid through MCP compared to the total expenditures of the Department for the six years covered by our review.

Table 2

Fee-For-Service Physicians: Audit Process
MCP Expenditures vs Department Expenditures
For the Years Ended March 31
$ Millions

Expenditures	2008	2009	2010	2011	2012	2013
FFS and APP	$ 212.3	$ 226.9	$ 238.6	$ 298.0	$ 294.4	$ 310.9
Out of Province Services	8.1	8.3	9.1	8.5	9.3	9.7
Grants and Subsidies (salaries)	77.8	85.0	91.3	116.3	129.1	122.5
Total Physician Services	**$ 298.2**	**$ 320.2**	**$ 339.0**	**$ 422.8**	**$ 432.8**	**$ 443.1**
Total Department	**$ 2,079.7**	**$ 2,316.1**	**$ 2,527.0**	**$ 2,651.5**	**$ 2,874.4**	**$ 2,915.3**
Physician Services as a % of total Department	**14%**	**14%**	**13%**	**16%**	**15%**	**15%**

Source: Financial Management System

As Table 2 indicates, payments to physicians have increased by $144.9 million (49%) over the past six years from $298.2 million for the year ended March 31, 2008 to $443.1 million for the year ended March 31, 2013. Payments to FFS and APP physicians have increased by $98.6 million over the same period, accounting for approximately 68% of the overall increase in payments to physicians. Furthermore, payments to physicians represent approximately 15% of the total expenditures of the Department.

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

- the policies and procedures governing the MCP audit function are effective in identifying overpayments made to physicians; and
- overpayments identified are being recovered in a timely manner.

Scope

Our review of the MCP audit function covered the period from April 2007 to October 2013. It included discussions with Division officials, a review of documentation pertaining to the audit function, an assessment of the policies and procedures governing the audit function and a detailed review of the audits started in the timeframe of our review. Our review was completed in November 2013.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Audit Selection
2. Audit of Claims
3. Audit Recoveries
4. Audit File Documentation
5. Performance Measurement and Reporting

1. Audit Selection

Overview

The Division has a variety of resources available to identify which claims to select for audit. Audits can be selected based on the following:

Physician Practice Profiles

Statistical information for all physicians is tracked and compiled by the MCP claims processing system to present a comparative picture of service patterns of physicians to those of his or her peers. Whenever service volume significantly exceeds area or provincial averages or when practice patterns are otherwise irregular, such cases may be investigated and could result in the commencement of a physician audit.

Targeted Fee Codes

Targeted fee code audits are initiated when certain services appear to be subject to widespread misinterpretation or incorrect billing. The MCP Payment Schedule assigns a fee code to each service a physician provides to a patient. The physician must reference these fee codes when submitting claims for the services provided. The MCP claims processing system generates statistical reports which can be used to determine if certain fee codes appear to be used incorrectly. These reports identify physicians who may be misinterpreting the fee code or billing it incorrectly and may result in an audit of the claims of those physicians.

Complaints/Voluntary Information

Occasionally, the Audit Services Division receives complaints/information regarding the billings or pattern of practice of a particular physician. These tips may be either internal or external. The Division has a responsibility to ensure that any concerns regarding potential abuse of the program are addressed and corrected. As a result, this information can result in audits of physician claims.

Beneficiary Verification Audits

The Division regularly asks patients to verify that the services which were paid on their behalf were actually provided. The service to be verified is randomly selected from all claims processed in the pay period. The confirmation letter contains various questions specific to the service which has been billed by the physician. While the primary purpose is to verify that a service was actually provided, it also ensures that the service was billed using the correct fee code and paid at the correct rate. If discrepancies appear in information that the patient provides, this could result in an audit of a physician's claim.

Claims Monitoring System

The Claims Monitoring System (CMS) was introduced in October 2006 and is a program designed to monitor the integrity of claims billed through MCP. Every physician that bills MCP has a minimum of one record selected for review, once every two months. Service documentation is examined and compared to the MCP Payment Schedule. If errors are found, the number of records reviewed increases. If a significant number of errors are found, this can result in the commencement of an audit.

Our review indicated the following:

Available reports not used to fullest extent

There are many ways in which a claim can be identified for audit. To ensure that the Division selects appropriate claims to audit we would expect that there would be a systematic process to guide audit selection.

Of the 87 audit files that were started during the 6½ year period of our review we noted that:

- 76 (88%) of them were selected as a result of Physician Practice Profiles or targeted fee codes;
- 2 (2%) of them were selected as a result of complaints or voluntary information;
- 0 of them were selected as a result of patient verifications; and
- 9 (10%) of them were selected as a result of the CMS.

The Division uses the selection methods available to them, however, there is no methodology or guidance relating to how these selection methods should be used. Audit selection is at the discretion of the Manager of the Division.

There are a variety of reports that can be generated by the MCP claims processing system. Physician Practice Profile reports and fee code reports are examples of reports that are generated and used to identify claims for audit. However, there is no set process in place for how often these reports are to be printed or reviewed by the Division. Officials of the Division have indicated that these reports are not printed or reviewed on a regular basis.

Finding

1. The Division does not use available reports to the fullest extent as a means of identifying audits. As a result, the Division may be missing opportunities to identify appropriate physician claims to audit.

Not all FFS above average earners are audited

Department officials provided information to indicate that the average earnings for FFS General Practitioners and FFS Specialists for the year ended March 31, 2012 were approximately $180,000 and $250,000 respectively. We would expect that physicians receiving payments in excess of the averages for their category would be closely monitored and would be selected for audit more frequently. Division officials have indicated that they do not regularly compile or review reports that would indicate which General Practitioners or Specialists receive payments from MCP that are above the average.

Table 3 shows FFS payments to physicians by range. It indicates the number and the percentage of FFS physicians that received payments within each range and the total amount of payments made to those physicians for the year ended March 31, 2012.

Table 3

Fee-For-Service Physicians: Audit Process
MCP FFS Payments to Physicians
For the Year Ended March 31, 2012

FFS Payment Range	Number of Physicians	Percentage of Physicians	Total FFS Payments
Greater than $1,000,000	8	1%	$ 8,931,911
$500,001 to 1,000,000	142	11%	91,848,369
$400,001 to 500,000	89	7%	40,138,929
$300,001 to 400,000	142	11%	49,175,202
$200,001 to 300,000	161	13%	39,795,432
$100,000 to 200,000	155	12%	23,583,166
Less than $100,000	560	45%	16,249,556
	1,257	**100%**	**$ 269,722,565**

Source: MCP

As indicated by Table 3, 542 physicians received payments in excess of $200,000. Of those, 524 received payments in excess of the averages provided by the Department, 267 of them were General Practitioners and 257 were Specialists. We cross-referenced the list of physicians audited by the Division since 2008 with the list of physicians earning higher than average salaries and found that only 59 physicians, 38 General Practitioners and 21 Specialists, had been audited over the 6½ year period of our review.

Finding

2. Only 11% of FFS physicians who earned salaries above the average of FFS physicians in their category were selected for audit during the 6½ year period of our review. As a result, the Division may be missing opportunities to identify appropriate claims to audit that may result in increased recoveries.

No safeguards in place to prevent double billings of services

FFS physicians submit claims to MCP for services rendered to patients. Physicians also submit claims to the Workplace Health, Safety and Compensation Commission of Newfoundland and Labrador (WHSCC) for services provided to patients for work-related issues.

Division officials have indicated that there are no mechanisms in place to compare MCP claims with WHSCC claims to ensure that physicians are not billing both entities for the same service. In prior years, electronic claims data was provided to the Division by the WHSCC so that the data could be compared to MCP claims to ensure that there were no instances of double billing. This data has not been provided to the Division since the mid-90s and no comparisons of claims have been performed since that time.

Finding

3. There are no safeguards in place to prevent double billing of services to MCP and the Workplace Health, Safety and Compensation Commission of Newfoundland and Labrador. As a result, physicians could be paid twice for the same service.

Recommendations

The Department should:

- make sufficient use of available reports to ensure that potential issues are investigated for audit identification;
- monitor physicians that receive payments in excess of the average in order to identify appropriate claims to audit; and
- work with the WHSCC to implement a mechanism that would prevent and detect the double billing of services.

2. Audit of Claims

Overview

Physicians are entitled to payment for services which are rendered. The purpose of auditing a physician's billing is to verify that services were paid in accordance with the rates and regulations specified in the MCP Payment Schedule.

The steps in the MCP FFS audit process are outlined in Figure 1:

Figure 1

Fee-For-Service Physicians: Audit Process
Audit Process Steps

Step	Procedure	Detail
1	Audit initiation	Physician audits may be initiated based upon information from: • beneficiary utilization audits; • complaints or voluntary information; • Physician Practice Profiles; • targeted fee code audits; and • CMS
2	Preliminary audit stage	Involves a review of a small sample of claims and if these claims are satisfactory the audit is closed, if not, the review proceeds to the comprehensive audit stage.
3	Comprehensive audit stage	As a result of any one of the occurrences noted in Step 1 or Step 2, a comprehensive audit is initiated that: • uses a larger sample of physician claims; • involves a two year audit period; • is closed if the number of over-billings is small; • is moved to the notification phase if the over-billings are significant which is determined by the Manager of the Division; and • is moved to the negotiation and appeal phase after notification, at the discretion of the physician being audited.

Step	Procedure	Detail
4	Medical Consultants' Committee (MCC)	A professional, peer dominated, review committee comprised of: • three physicians nominated by the NLMA; • the Department's Medical Director; • the Department's Assistant Medical Director; • the Department's Dental Director; and • a private industry Chartered Accountant. The mandate of the MCC is to assess and make recommendations with regard to cases of physician and beneficiary over-utilization, inappropriate billing and/or abuse. Only used for certain audits at the discretion of the Manager of the Division.
5	Alternate Dispute Resolution (ADR) process	A 90 day negotiation process between Department officials and the physician to arrive at a settlement as to the amount to be recovered. The process involves legal counsel for both parties. Only used at the request of physician.
6	Audit Review Board	The Board consists of three members including, one member appointed by the Minister, one member appointed by the physician under audit and a third member who is appointed jointly by the Minister and the physician. Only used at the request of the physician.
7	Ministerial Order	After considering the results of the previous audit, negotiation and appeal phases the Minister makes a decision on the case that may include an order for the physician to repay the estimated overpayment and any penalties.
8	Appeal to Supreme Court Trial Division	The physician can appeal the Minister's decisions to the Supreme Court Trial Division and ultimately to the Supreme Court of Canada.

Our review of audit files and discussions with officials identified issues in the following areas:

A. Audit Statistics
B. Medical Consultants' Committee
C. Alternate Dispute Resolution Process
D. Audit Review Board
E. Physician Claims Intervention Program (PCIP)

2A. Audit Statistics

Overview

The audit of FFS physician claims is based primarily on the documentation contained in the physician's record of service. In cases where specific elements of record or documentation requirements are specified in the Payment Schedule but do not appear in the patient's record of service, that element of service is deemed not to have been rendered and the fee component represented by that element is not payable. In addition to the record of service, the Division will also consider several other audit factors which include medical necessity, patterns of servicing and information supplied by beneficiaries as well as other individuals.

Our review indicated the following:

Inadequate number of audits being completed

At any given point in time audits are in various stages of completion. An audit is considered assessed when the audit process is complete and the physician under audit has been notified of any amount owing. It is considered closed when all monies outstanding have been collected. Table 4 shows the number of audits started on an annual basis over the period of our review. For the 87 files that were started during the period, it shows the number of audits assessed and closed. There were 17 audit files that had been started prior to April 1, 2007 that are not incorporated into the table as they were not included in the audit files that we reviewed.

Table 4

Fee-For-Service Physicians: Audit Process
Number of Audits Started, Assessed and Closed
For the Period April 1, 2007 to October 4, 2013

	2008	2009	2010	2011	2012	2013	2014 YTD	Total
Started	3	26	15	3	10	16	14	**87**
Assessed	-	13	11	9	9	22	6	**70**
Closed	-	11	10	9	9	14	10	**63**

Source: MCP

As indicated by Table 4, the number of audits started, assessed and closed varies from year to year. Payments to FFS physicians totaled approximately $1.6 billion for the six years covered by our review, however, only 73 audits (this excludes the 14 audits started after March 31, 2013) were started, an average of 12 per year. Of the 87 files that were started over the period of our review, 70 were assessed and, of those, 63 were closed. Given the magnitude of FFS payments to physicians, we would have expected to see more work undertaken by the Division.

Furthermore, audit recoveries assessed and collected were low in comparison to the total MCP FFS and APP payments made to physicians. Table 5 presents actual audit recoveries assessed and collected from 2008 to 2013 and compares them to the total FFS and APP payments.

Table 5

Fee-For-Service Physicians: Audit Process
MCP Expenditures vs Audit Recoveries Assessed and Collected
For the Years Ended March 31
$ Millions

	2008	2009	2010	2011	2012	2013	Total
FFS and APP Payments	$212.3	$226.9	$238.6	$298.0	$294.4	$310.9	$1,581.1
Audit Recoveries Assessed	$0.215	$0.829	$0.836	$0.109	$0.141	$0.425	$2.555
%	0.1%	0.4%	0.4%	0.04%	0.05%	0.1%	0.2%
Audit Recoveries Collected	$0.146	$0.750	$0.348	$0.161	$0.148	$0.041	$1.594
%	0.07%	0.3%	0.1%	0.05%	0.05%	0.01%	0.1%

Source: Government's Financial Management System and the Department of Health and Community Services

As indicated by Table 5, the amount of audit recoveries assessed and collected varies from year to year even though FFS and APP payments have increased steadily over the period of our review. Division officials indicated that approximately 90% of FFS and APP payments relate to payments made to FFS physicians. In addition, audit recoveries assessed and collected represent less than one half of one percent of the total FSS and APP payments made to physicians in each of the years covered by our review. Division officials indicated that they have experienced significant amounts of staff turnover and vacancies during the period of our review which has impacted the amount of work completed by the Division.

Finding

4. During the 6½ year period of our review only 87 audits were started by the Division. In comparison to the FFS physician expenditures, the number of audits started is small. As a result, the Division may be missing opportunities to fulfill their mandate of ensuring that only legitimate and accurate claims are paid which may prevent future incorrect billings.

Long time taken to complete audits

We would expect audits to be completed in a timely manner. The length of time that passes from the audit initiation stage to the closing stage could have a negative impact on the timeliness and eventual collection of the FFS recoveries identified. Table 6 shows the length of time taken to assess the 70 audits that had reached the assessment stage. It also shows the length of time the files still waiting to be assessed have been in progress.

Table 6

Fee-For-Service Physicians: Audit Process
Payments to Physicians
Audit Timeframes

Time Frame	Number of Audits Assessed	Number of Audits in Process of being Assessed
>4 years	0	1
>3 years	4	0
>2 years	4	2
>1 years	11	3
<1year	51	11
Total	**70**	**17**

Source: MCP

As shown in Table 6, of the 70 audit files that had reached the audit assessment stage, 19 (27%) took longer than one year to be assessed. The average time taken to complete an assessment was 292 days.

Furthermore, we found that a number of audits currently in the process of being assessed are following a similar trend. Of these 17 audit files, 6 have been in the process of being assessed for longer than one year. Of those, one had been in the process of being assessed for longer than four years.

Finding

5. FFS physician audits are taking a long time to complete. As a result, the Division is increasing the risk of not collecting the full amount of the recovery identified and missing opportunities for corrective action.

High error rates not always pursued

Division policy states that if an error rate of 20% or higher is noted in a Preliminary Audit, a Comprehensive Audit may be pursued. If the Division does not follow the policies and procedures governing the MCP FFS audit function, they cannot ensure that all overpayments are being detected. This could compromise the overall mandate of ensuring that only accurate and legitimate claims are paid. Our review indicated that this policy was not applied consistently to all audit files.

Of the 87 audit files that were started during the period, we found five instances where error rates noted in Preliminary Audits exceeded 20%, in fact in all five instances the error rates exceeded 80%. None of these audits progressed to the Comprehensive stage.

Finding

6. The Division does not consistently pursue audits when high error rates are detected. This is inconsistent with Division policy. As a result, the Division maybe missing opportunities to maximize recoveries.

Recoveries not always pursued

In order for the audit function to be effective, the Division must ensure that its efforts to identify and collect overpayments made to physicians are maximized. Of the 87 audit files that were started during the period, we found one instance where overpayments were identified through audit procedures but the Division did not attempt to recover these amounts.

The audit covered the period from March 2006 to March 2008. The Division was aware that the physician continued to incorrectly bill a fee code subsequent to the end date of the audit period. An additional $17,000 in overpayments occurred during this time period, however, the Division elected not to pursue efforts to assess and recover this amount.

Finding

7. Recoveries of overpayments are not always pursued. As a result, the Division is missing opportunities to maximize recoveries.

2B. Medical Consultants' Committee

Overview

The Medical Consultants' Committee (MCC) is responsible for reviewing selected audit files where medical expertise is needed to support the audit assessment. The MCC is used by the Division when officials feel that the input of this professional peer group would be beneficial. This usually occurs when there are new, complex or contentious billing issues.

The Committee consists of seven members, as follows:

- three physicians appointed by the Department from a list submitted by the Newfoundland Labrador Medical Association;
- a Chartered Accountant appointed by the Minister; and
- the Department's Medical Director, Assistant Medical Director and Dental Director who are ex-officio members.

The Committee is established pursuant to Sections 14 and 15 of the *Medical Care Insurance Physicians and Fee Regulations*.

Our review indicated the following:

MCC not meeting on a regular basis

The MCC's meeting activity for the period covered by our review is summarized in Table 7.

Table 7

Fee-For-Service Physicians: Audit Process
MCC Meetings
For the Period April 1, 2007 to November 30, 2013

	2008	2009	2010	2011	2012	2013	2014 YTD	Total
Number of MCC Meetings Held	4	2	1	1	3	1	-	**12**
Number of Audits Reviewed	8	5	2	3	7	3	**-**	**28**

Source: MCC Meeting Minutes

Of the 87 files started during the period, 15 of them were referred to the MCC. However, the MCC's review was not always completed in a timely manner. In particular, we found the following:

- for one audit the decision was made to use the MCC in December 2010. As of November 2013, the file still had not been reviewed by the MCC. The potential recovery associated with this file is approximately $25,000;

- for two audits the decision was made to use the MCC in December 2009. They were not reviewed until June 2012. The recoveries associated with these files were $16,303 and $31,517 respectively. It should be noted that the $16,303 is still outstanding and the physician associated with the $31,517 recovery has filed for bankruptcy and thus recovery is not expected;

- for one audit the decision was made to use the MCC in December 2009 and was reviewed in April 2011. The recovery associated with this file was $27,480; and

- two audits commenced in July 2012 are pending MCC review. The potential recovery associated with both of these files are estimated to be in the $60,000-$65,000 range.

The longer it takes the MCC to meet, the longer it takes to assess an amount for recovery and the less assurance the Division has over the eventual collection of the amount. For example, a physician may leave the Province in the time taken to complete the process.

Subsequent to the completion of our review, the MCC met on December 8, 2013.

Finding

8. The Medical Consultants' Committee is not meeting on a regular basis. This results in delays in issuing assessments and also delays in recoveries which increases the risk of not collecting the full amount of the assessments.

2C. Alternate Dispute Resolution Process

Overview

Alternate Dispute Resolution (ADR) is a mechanism for resolving issues between the Division and the physician.

The intent of the ADR is to:

- encourage a cooperative climate;
- achieve fair and appropriate settlements; and
- to avoid the excessive financial, psychological and procedural costs associated with formal court proceedings.

An ADR must be requested by the physician within 30 days from the date of the audit assessment letter. The process has a maximum 90 day time limit from the date of assessment and involves Division officials, the physician under audit, and legal counsel for both parties.

In the event that an agreement is reached, any necessary adjustments to the recovery amount will be made accordingly. The audit will then proceed to the recovery stage as part of the ADR agreement, and the physician will waive the right to appeal the audit findings to the Audit Review Board.

If a mutually acceptable agreement is not reached within the 90 day time limit, the conclusions and recovery amount stand and the audit will proceed to either recovery or a hearing before the Audit Review Board.

Our review indicated the following:

90 day limit not enforced

Of the 87 audit files that were started during the period, we found that 14 of them availed of the ADR process. Of those, five took longer than 90 days to complete the ADR process, averaging 205 days. In addition, three audit files had started, but not completed the ADR process. As of November 30, 2013, the length of time these audit files had been involved in the process were 576 days, 491 days and 442 days.

Finding

9. The Alternate Dispute Resolution process, which is intended to be completed within 90 days, is taking considerably longer to conclude. As a result, identified recoveries are taking longer to recover which increases the risk of not collecting the full amount.

2D. Audit Review Board

Overview

Once the ADR process concludes, the physician under audit has the option to make a written representation of their position and request a hearing before the Audit Review Board. The Audit Review Board is appointed from a review panel consisting of up to 15 members who are appointed by the Lieutenant-Governor in Council. The review panel members are appointed for a three year term, and are eligible for re-appointment. A three person review board is selected from the panel, with one member being selected by the Minister, one member by the physician under audit, and a third member is selected jointly by the Minster and the physician under audit.

Our review indicated the following:

Audit Review Board inactive for three year period

The Audit Review Board is a requirement of *The Medical Insurance Act (1999)*. A three year period elapsed between the dissolution of the previous Audit Review Board on July 13, 2009 and the appointment of the current Audit Review Board on July 26, 2012. During this period, there was no Audit Review Board in place for a physician to make an appeal after the ADR process had concluded.

From our review of the 87 audit files started during the period, we found 6 instances where physicians had expressed interest in using the Audit Review Board but since it was not in place they could not avail of this process.

Finding

10. There was no Audit Review Board in place for a period of three years even though its existence is required by legislation. As a result, physicians could not avail of this function as part of the audit process and consequently were denied due process.

2E. Physician Claims Intervention Program

Overview

The Physician Claims Intervention Program (PCIP) is a monitoring mechanism for physicians who have been identified as having submitted claims which are not properly supported. If a physician is entered into the PCIP, they must provide adequate support for all of their claims in order to get paid. The decision to enter a physician into PCIP for a particular fee code is guided by defined criteria, however, the decision ultimately lies with the Manager of the Division. The criteria used are as follows:

- All physicians from whom an audit recovery is made.
- Physicians whose audits have entered the comprehensive stage of the audit process.
- Physicians whose documentation requirements are inconsistent with the MCP Medical Payment Schedule may at any time be entered into the PCIP.

The PCIP is designed to be a short term measure to ensure billings are in compliance with the requirements of the MCP Medical Payment Schedule. Physicians remain in PCIP until it is determined that their billings for two successive pay periods are in keeping with these requirements.

Our review indicated the following:

PCIP criteria not consistently applied

Of the 87 audit files started during the period, we found that 47 had recoveries but only 8 were referred to PCIP. If the criteria had been consistently applied, all of these physicians would have been referred to the PCIP.

Finding

11. The Division is not consistently applying the criteria for placement into the Physician Claims Intervention Program. Therefore, not all physicians who meet the criteria for placement are entered in the program. As a result, incorrect billings could go undetected and potential overpayments may not be identified.

Recommendations

The Department should:

- ensure that a sufficient number of audits are commenced on an annual basis;
- ensure that audits are completed in a timely manner;
- follow the policies and procedures governing the MCP Fee-For-Services audit function; and
- work with the Medical Consultants' Committee to ensure that committee meetings are held on a regular basis.

3. Audit Recoveries

Overview

Once an audit is completed, the physician is notified of the results and the amount, if any, required to be repaid. The Division is not responsible for the actual collection of the audit recoveries. Staff of the Corporate Services Division from the Department perform this function.

Our review indicated the following:

Not all assessed amounts are being collected on a timely basis

Once the physician is notified of the recovery amount, we would expect that recoveries would be collected on a timely basis. The longer it takes to recover an overpayment, the less assurance there is of eventual collection as a physician may leave the Province or declare bankruptcy.

Of the 87 audit files that were started during the period, 47 had identified recoveries that totaled $974,624. Of that amount $565,295, representing 40 audit files, has been collected. The average collection period was 188 days. Table 8 presents these collection periods and the amount of the associated audit recovery for those 40 files.

Table 8

Fee-For-Service Physicians: Audit Process
Collection Periods for Recovered Amounts

Collection Period	Number of Closed Audits	Total Recoveries
> 2 years	4	$211,532
> 1 year	4	16,857
< 1 year	32	336,906
Total	**40**	**$565,295**

Source: MCP

As of the date of our review, we noted that assessments totaling $409,329, representing 7 audit files, had been outstanding for a considerable amount of time. Table 9 presents the amounts relating to each of these audits and the length of time the amount has been outstanding.

Table 9

Fee-For-Service Physicians: Audit Process
Current Recoveries Outstanding
As of November 2013

Assessment Date	Recovery Amount	Time Outstanding
November 2011	$83,909	2 years, 0 months
April 2012	16,803	1 year, 7 months
May 2012	166,111	1 year, 6 months
June 2012	31,517	1 year, 5 months
July 2012	41,896	1 year, 4 months
July 2012	22,080	1 year, 4 months
August 2012	47,013	1 year, 3 months
Total	**$409,329**	

Source: MCP

The average time outstanding for these recoveries, as of November 2013, was approximately one year and six months.

Furthermore, while automatic deduction of assessed amounts is one of the payment options offered to physicians when the audit assessment letter is sent, legislation currently does not give the Department the authority to deduct audit assessments against future claims submitted by the physician. Payments continue to be made to the physician for services claimed even though an audit assessment is outstanding.

Finding

12. The Department is not collecting recoveries in a timely manner. As a result, they are increasing the risk of not collecting the full amount identified.

Recommendation

The Department should implement policies that would result in the more timely collection of identified recoveries, thus mitigating the risk of uncollectible assessments.

4. Audit File Documentation

Overview

The main objective of the Division, with regard to payments to FFS physicians, is to investigate potential over-billings by FFS physicians. Its overall mandate is to ensure that only legitimate and accurate claims are paid. Given the complexity surrounding MCP claims processing and the magnitude of the payments made to FFS physicians each year, we would expect the work of the Division to be guided by established policies and procedures.

Our review indicated the following:

Lack of policies regarding audit file documentation

The Division does not have formalized policies that outline audit file documentation requirements. In October 2011, the Division implemented an audit checklist which is to be completed by the auditor and placed at the front of the audit file. The purpose of the checklist is to ensure that appropriate documentation is included in all audit files. Prior to October 2011, the Division had no checklist in place to serve this function.

Our review of the audit files indicated that this checklist was not being completed on a consistent basis. There were 32 audit files started after October 2011. Of those, 17 were closed and 9 had no checklist in the file.

The audit checklist indicates that each audit file should have an Initial Audit Analysis document which explains why the audit was selected. Of the 87 audit files that were started during the period, 35 did not have an Initial Audit Analysis in the file.

The audit checklist indicates that each closed audit file should include an Auditor's Findings Report. This details the results of audit procedures and makes a conclusion on whether the claims as submitted are acceptable or not. Of the 63 closed audit files, 12 did not contain an Auditor's Findings Report.

Furthermore, documentation contained in audit files was not always clear. There was one instance where the Auditor's Findings Report did not support the findings noted in the audit assessment letter that was sent to the physician. Per the Auditor's Findings Report, 74 of 82 records tested were found to be unacceptable. However, the audit assessment letter noted that 20 of 82 records were found to be unacceptable. We discussed this discrepancy with the Manager of the Division who indicated that additional details on the records tested was obtained which changed the Auditor's assessment of the records tested. However, the Auditor's Findings Report was never updated and the change in the assessment was not documented anywhere in the file.

Finding

13. The Division does not have formalized policies that outline documentation requirements for audit files. As a result, the audit files include findings and conclusions without adequate support and documentation which may impede the Division in ensuring that only legitimate claims are paid.

Recommendation

The Department should develop formalized policies that outline documentation requirements for audit files.

5. Performance Measurement and Reporting

Overview

Performance measures would be included as part of the goals and objectives of the Division and form part of an operational plan. An operational plan would contain information specific to the Division, such as measures and indicators specific to the goals and objectives of the Division along with reporting requirements for those goals and objectives.

Our review indicated the following:

Division does not have an operational plan

We would have expected there to be an operational plan in place to guide the work of the Division. Proper planning is crucial to achieving the Division's mandate of ensuring that only legitimate and accurate physician claims are paid. An operational plan would assist the Division in focusing their activities toward achieving their identified goals and objectives, promote accountability and encourage staff to be more results-oriented.

Finding

14. The Division does not have an operational plan in place. As a result, they have no plan to guide their work or to encourage the achievement of their mandate.

No established performance measures or reporting requirements

We would have expected there to be established performance measures and reporting requirements specific to the MCP FFS audit function, however, Division officials indicated that there were none. They indicated that they meet with the Director on a monthly basis to review results and/or issues, however, there are no meeting minutes or other documentation to support this.

Finding

15. The Division has not established performance measures or reporting requirements specific to the MCP FFS audit function. As a result, the Division has no goals or targets against which to measure the amount and quality of work completed.

Recommendation

The Department should develop an operational plan, performance measures and reporting requirements to guide their work.

Department's Response

1. Audit Selection

Recommendation 1:
The Department should make sufficient use of available reports to ensure that potential issues are investigated for audit identification.

Department's Response
The Department has a variety of reports that are generated from the MCP claims processing system which are available and utilized by staff of the Department to identify providers to audit. The Department will review the reports on a regular basis to determine which reports will be most beneficial in determining issues to be investigated for audit identification.

Recommendation 2:
The Department should monitor physicians that receive payments in excess of the average in order to identify appropriate claims to audit.

Department's Response
Physicians' earnings are a product of the provider's specialty, the demographics of the physician's patient population, and the hours the physician works, therefore, high earnings are not necessarily indicative of a potential for overbilling. The Department does routinely assess high earners and high earning physicians will be selected for audit if the assessment concludes that there is a perceived risk of overbilling. The Department will review the methodology used for the selection of audits and will ensure that the percentage of fee-for-service physicians selected for audit who earn salaries above the average increases over the next 2-4 years.

Recommendation 3:
The Department should work with the WHSCC to implement a mechanism that would prevent and detect the double billing of services.

Department's Response
The Department will work with WHSCC to determine and implement a mechanism that will prevent and detect the double billing of services.

2. *Audit of Claims*

Recommendation 1 and 2:
The Department should ensure that a sufficient number of audits are commenced on an annual basis.

The Department should ensure that audits are completed in a timely manner.

Department's Response:
While the number of audits commenced on an annual basis is low for the period of audit, the Department reviewed billing patterns of more than 225 individual providers since 2007. These reviews represent a detailed analysis of providers' billing activity that was initiated as a result of regular evaluation of the various statistical reports available to audit staff. The analysis considers provider billing activity from various aspects such as high earnings levels, high usage of certain fee codes and abnormal billing patterns in general.

The Department is currently in the process of developing and implementing operational work plans in the Department for each division. As well, the Department will be providing training to staff on how to use and monitor these plans in an effort to monitor and measure performance. The operational plan for the Audit Services Division will include targets that will maximize resources and establish timelines that will ensure a sufficient number of audits are commenced on an annual basis and are completed in a timely manner.

Recommendation 3:
The Department should follow the policies and procedures governing the MCP Fee-For-Services audit function.

Department's Response:
This section of the report highlights several different areas where the Department should follow the policies and procedures governing the MCP fee-for-service audit function. The following is the Department's response to each of these areas:

- *It was noted in the report that there were five (5) instances where the error rates noted in a Preliminary Audit exceeded 20% and the audit did not progress to the Comprehensive stage. The policy for the MCP fee-for-service audit function states that if an error rate of 20% or higher is noted in a Preliminary Audit, a Comprehensive Audit may be pursued. The five (5) instances noted were audits of new physicians with a short claim period and/or with low recoveries, therefore, the Department made a judgment, in accordance with the implied discretion of its policy, that a Comprehensive Audit was not required.*
- *It was noted in the report that the Alternate Dispute Resolution (ADR) process, which is stated in policy to have a ninety (90) day time limit from the date of the first ADR meeting, is taking longer to conclude. The Department acknowledges there are process improvements that can be made to ensure the timely conclusion of the ADR process, but notes there are provider dynamics that also contribute to delays. The Department will ensure that the division establishes an operational plan with targets and timelines that will enable the ADR process to conclude within the ninety (90) day limit as set out in policy. In addition, the Department will work with providers and their representatives to ensure a mutual understanding of the ninety (90) day requirement for ADR conclusion.*
- *The report highlighted that there was no Audit Review Board in place for a period of three years and as a result physicians were denied due process. The Audit Review Board is a requirement of The Medical Insurance Act (1999). The Audit Review Board has not been required or used since 1998. All issues, since 1998, have been resolved using the Alternate Dispute Resolution (ADR) process between the Audit Services division and the physician. The report notes six (6) instances where physicians expressed interest in using the Audit Review Board during the three year period when there was no Audit Review Board in place. These six (6) physicians were not denied due process as their issues were resolved through ADR. If these issues were not resolved through ADR and the Audit Review Board was required, the Department would have ensured an Audit Review Board was in place to provide due process for the physicians. The Department currently has an Audit Review Board in place for future audits, if required.*

- *The report noted that the division is not consistently applying the criteria for placement into the Physician Claims Intervention Program (PCIP). The MCP fee-for-service policy states "if potential problems with a particular physician's billings have been identified, the physician may be entered into the PCIP". The current policy allows for professional judgment to be used by the Audit Services Division in determining when PCIP is utilized. The Department will continue to utilize PCIP in accordance with the policy and focus on areas of potential problems in order to augment other audit functions.*

Recommendation 4:
The Department should work with the Medical Consultants' Committee to ensure that committee meetings are held on a regular basis.

Department's Response:
The Department will ensure committee meetings are held on a regular basis in the future.

3. Audit Recoveries

Recommendation:
The Department should implement policies that would result in the more timely collection of identified recoveries, thus mitigating the risk of uncollectible assessments.

Department's Response
The Department is in the process of implementing operational plans throughout the divisions in the Department. The operational plan for the Audit Services division will ensure appropriate targets and timelines are in place to enable the division to collect identified recoveries in a timely manner.

4. Audit File Documentation

Recommendation:
The Department should develop formalized policies that outline documentation requirements for audit files.

Department's Response:
The Department will revise the policies for the MCP fee-for-service audit function to ensure there are documented formal policies and procedures that outline the documentation requirements for audit files.

5. Performance Measurement and Reporting

Recommendation:
The Department should develop an operational plan, performance measures and reporting requirements to guide their work.

Department's Response:
As mentioned previously, the Department is currently in the process of developing and implementing operational work plans in the Department. As well, the Department will be providing training to staff on how to use and monitor these work plans. As part of this process, the Audit Services Division will be implementing operational plans. These plans will include targets that will maximize resources and establish timelines that will ensure a sufficient number of audits are commenced on an annual basis and are completed in a timely manner. In addition, the targets and timelines established in this operational plan will be used to guide the work of the division and monitor the performance of the division on a go forward basis. The Department will also ensure that reporting requirements are established for the MCP fee-for-services audit function.

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PART 3.3

DEPARTMENT OF JUSTICE

FINES ADMINISTRATION

Summary of Findings

Introduction

The Fines Administration Division (the Division) of the Strategic and Corporate Services Branch within the Department of Justice (the Department) is the Provincial processing, billing and collection centre for court imposed fines, for fines imposed through a ticket and for the related penalties and surcharges.

There are 81,771 identifiable accounts totaling $33.1 million of Provincially owed tickets, court fines, and penalties and surcharges as at March 31, 2013.

The Division is responsible for the effective and efficient functioning of the ticket processing system in the Province, including ensuring that a proper control system is implemented, maintained and monitored.

The objectives of our review were to:

- determine the growth, composition and age of fines receivable held by the Department;
- assess if collection efforts have improved the overall collection rates of fines receivable since the previous review completed in 2008; and
- assess Departmental efforts to collect or dispose of fines receivable.

Findings

Planning, Performance Measurement and Monitoring

1. There was no operational plan in place for the Division nor were there any performance measures or reporting requirements established. As a result, an effective planning and reporting process is not in place for the administration of fines receivable.

Fines Receivable

2. The fines owed to the Province have grown by $5.6 million in the five years since 2008 to $37.3 million, an increase of 17.7%. Approximately 75% of the outstanding fines receivable are considered uncollectible by the Department.

3. In 2013, 142 accounts had balances owing greater than $20,000, an increase of 106% since 2008. In fact, 46% of the accounts receivable are owed by 2% of the accounts.

4. A total of 54,400 transactions, totaling $1.5 million, are unidentifiable or have incomplete information. As a result, these receivables are difficult or impossible to collect.

5. The age of Provincial fines receivable has deteriorated significantly since 2008. At March 31, 2013 approximately 72% of Provincial fines receivable had remained uncollected in excess of three years.

6. Provincial fines receivable are increasing while receivable collection rates remain relatively constant at less than 30%. Collection efforts are not keeping pace with the volume of fines being imposed.

Collections

7. There is no evidence to suggest that the current level of penalties is an effective inducement to ensure early payment.

8. At March 31, 2013, there were 8,640 accounts totaling $26.8 million registered with the Judgment Enforcement Registry being actively collected by eight collections officers, approximately 1,100 accounts per collections officer. As of April 24, 2013, the Division lost two collections officers due to Government budgetary restraint. Collection activity will be negatively impacted by the reduction in staff.

9. Renewals of hunting licenses, requests for birth certificates, MCP re-registration, and registry of companies and deeds are not utilized as collection instruments. As a result, the Province is not using the option of refusing to issue licenses and permits, in an effort to collect fines receivable, to its fullest extent.

10. Although legislative authority exists, a Fines Option Program (credit in exchange for work) has not been established and there has not been a proposal to the Lieutenant-Governor in Council for the introduction of a Fines Option Program. As a result, this option is not being used to reduce fines receivable.

11. The Judgment Enforcement Registry, payment arrangements and the Canada Revenue Agency collection options are not being used to their fullest extent because these options are only used for accounts with balances greater than or equal to $400. As a result, there are 73,131 identifiable accounts with a balance less than $400, totaling $6.3 million, that are not being actively pursued for collection.

Background

Overview

The Fines Administration Division (the Division) of the Strategic and Corporate Services Branch within the Department of Justice (the Department) is the Provincial processing, billing and collection centre for court imposed fines, for fines imposed through a ticket and for any related penalties and surcharges.

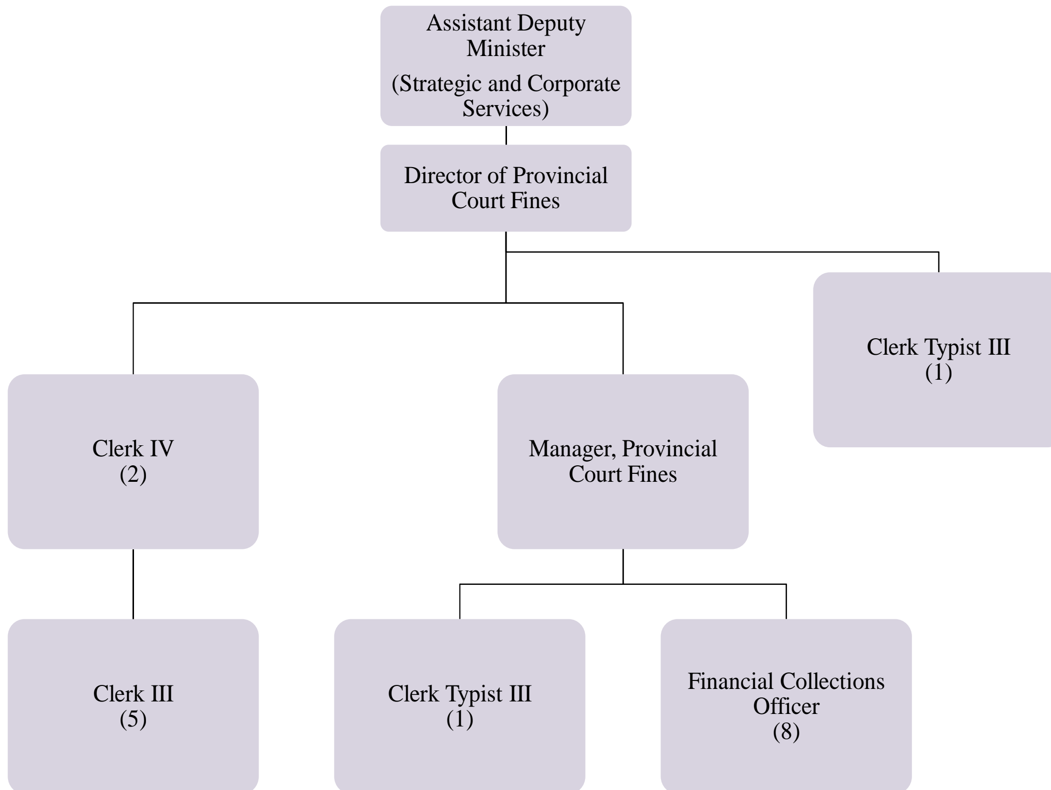
Fines receivable are maintained by the Division using the Ticket Management System (TMS) database. All tickets or fines issued are entered into the TMS database. Fines imposed by the Court are entered when the time granted by a judge to pay the fine has expired. The TMS allows officials at the Division to track fines by individual and offence, to notify offenders of convictions and fines, and to process payments received on behalf of the Province.

The Division is responsible for the effective and efficient functioning of the ticket processing system in the Province, including ensuring that a proper control system is implemented, maintained and monitored.

As at March 31, 2013, the Division had a total of 19 staff, including 8 collections officers. Figure 1 shows the organizational structure of the Division.

Figure 1

Department of Justice
Fines Administration Division
Organizational Chart
March 31 2013



Total expenditures for the Division for the year ended March 31, 2013 was $1.2 million.

In 2008, we performed a review of fines receivable covering the period 2004 - 08. Our prior report on fines owed to the Province was included in our 2008 Annual Report.

Objectives and Scope

Objectives

The objectives of our review were to:

- determine the growth, composition and age of fines receivable held by the Department;
- assess if collection efforts have improved the overall collection rates of fines receivable since the previous review completed in 2008; and
- assess Departmental efforts to collect or dispose of fines receivable.

Scope

Our review of fines administration was completed in November 2013 and covered the period April 1, 2008 to March 31, 2013. Our examination included interviews with Department officials, a review of legislation, policies and procedures, analysis of the Ticket Management System database and a review of other documentation within the Department.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Planning, Performance Measurement and Monitoring
2. Fines Receivable
3. Collections

1. Planning, Performance Measurement and Monitoring

Overview

An operational plan would assist the Division in meeting its objectives of managing and controlling collection activities in order to maximize revenue collection for the Province. A plan would help ensure revenue collection is maximized through effective policies, procedures, guidelines and monitoring systems.

We would expect to find well defined performance measures relating to fines administration within the Division to help ensure that a proper control system, with an appropriate focus on outcomes, is implemented, maintained and monitored. These measures should form part of the divisional work plan. For example, performance measures may include expected collection rates, overall and by collections officer, desired cash flow outcomes and expected collection dates for various fines receivable.

We would also expect to find established reporting requirements, within the Division, to enable effective monitoring which would outline such things as:

- responsibility for reporting;
- nature and content of reports;
- frequency of reporting;
- deadlines for report preparation and submission; and
- distribution and review of reports.

Finding

1. There was no operational plan in place for the Division nor were there any performance measures or reporting requirements established. As a result, an effective planning and reporting process is not in place for the administration of fines receivable.

Recommendation

The Department should ensure an operational plan is in place for the Fines Administration Division with appropriate performance measures and reporting requirements established for all areas of fines administration.

2. Fines Receivable

Overview

Provincial fines receivable are comprised of:

- Ticket fines - tickets issued for violations of the *Highway Traffic Act* and other Provincial statutes;
- Court fines - fines imposed by a Provincial Court; and
- Penalties and surcharges on third party fines.

While there were no performance reports available, we were able to analyze the TMS database to determine if the Division was collecting fines receivable on a timely basis. To achieve this, we examined the following:

- growth of fines receivable;
- the composition of significant balances;
- the age of the fines receivable; and
- collection rates of receivables.

Where applicable, we also compared our results to a similar analysis we performed in 2008.

In reviewing court fines receivable, we made observations in the following areas:

A. Growth of Fines Receivable
B. Composition of Provincial Fines Receivable
C. Account Aging
D. Collection Rates of Provincial Fines Receivable

2A. Growth of Fines Receivable

As at March 31, 2013, the Province was owed $37.3 million in fines issued for offences under a variety of statutes. In addition, $27.8 million (74.5%) of these fines were considered uncollectible by Government. Table 1 shows the details of the fines receivable owed to the Province over the past six years.

Table 1

Department of Justice
Fines Receivable
Years Ended March 31
(000's)

	2008	2009	2010	2011	2012	2013
Provincial Fines Receivable	$29,270	$30,323	$31,734	$34,136	$34,144	$34,630
Other Fines and Amounts	2,416	3,297	4,034	3,428	2,884	2,693
Total Fines Receivable	**$31,686**	**$33,620**	**$35,768**	**$37,564**	**$37,028**	**$37,323**
Less: Amounts considered to be Uncollectible	$25,130	$25,298	$26,122	$27,583	$27,812	$27,793
Fines Receivable considered collectible	**$ 6,556**	**$8,322**	**$9,646**	**$9,981**	**$9,216**	**$9,530**
Percentage of Fines receivable considered uncollectible	**79.3%**	**75.2%**	**73.0%**	**73.4%**	**75.1%**	**74.5%**

Source: Department of Justice

Finding

2. The fines owed to the Province have grown by $5.6 million in the five years since 2008 to $37.3 million, an increase of 17.7%. Approximately 75% of the outstanding fines receivable are considered uncollectible by the Department.

2B. Composition of Provincial Fines Receivable

Introduction

To determine the distribution of Provincial fines receivable by amount owed, the TMS database was summarized by account and stratified based on the account balance. Each account in the TMS represents an individual or company for which a ticket had been issued or a fine imposed**.**

Table 2 provides details of the Provincial fines receivable, stratified by amount, along with a comparison to a similar analysis done in 2008.

Table 2

Department of Justice
Provincial Fines Receivable
Stratification of Receivable Balance
As at March 31, 2013

Balances	Number of Accounts		Amount (000's)	
	2008	2013	2008	2013
$20,000 or greater	69	142	$ 2,167	$ 5,056
$5,000-$19,999	892	1,191	7,669	10,863
Sub-Total	**961**	**1,333**	**$ 9,836**	**$ 15,919**
$1,000-$4,999	5,005	3,852	10,380	8,802
$500-$999	3,859	2,512	2,651	1,708
$100-$499	22,571	25,047	4,621	5,150
Less than $100	51,510	49,027	1,624	1,513
Sub-Total	**83,906**	**81,771**	**$ 29,112**	**$ 33,092**
Unidentified Transactions	**Note 1**		158	1,538
Total	**83,906**	**81,771**	**$ 29,270**	**$ 34,630**

Source: Ticket Management System Database

Note 1: There were 55,460 and 54,400 of unidentifiable transactions for 2008 and 2013, respectively. These transactions are not readily identifiable and are excluded from the final number of total accounts.

Number of accounts with significant balances continue to grow

As Table 2 shows, there are a large number of accounts with significant balances which have grown over the past five years. For example:

- In 2013, 1,333 accounts had amounts owing in excess of $5,000, a 39% increase since 2008. These accounts totaled $15.9 million;
- In addition, $5.9 million of this amount (37%) has been outstanding for more than five years;
- 46% of Provincial fines receivable are owed by less than 2% of the accounts;
- In 2013, 142 accounts had balances owing greater than $20,000, an increase of 106% since 2008; and
- In 2013, there were 54,400 unidentified transactions with insufficient information to allow for the collection of these amounts that totaled $1.5 million. This included 13,099 accounts totaling $1.3 million that had an incomplete account (master) number making it difficult to pursue collections. In addition, there were 41,301 unidentified tickets totaling $262,605 where collection efforts were not possible to pursue because of insufficient information such as incomplete or inaccurate vehicle plate numbers.

Findings

3. In 2013, 142 accounts had balances owing greater than $20,000, an increase of 106% since 2008. In fact, 46% of the accounts receivable are owed by 2% of the accounts.

4. A total of 54,400 transactions, totaling $1.5 million, are unidentifiable or have incomplete information. As a result, these receivables are difficult or impossible to collect.

2C. Account Aging

Table 3 provides details of our analysis of Provincial fines receivable including the amount owed and the age of each major category of fines.

Table 3

Department of Justice
Provincial Fines Receivable
Aged Analysis
(000's)

Type of Receivable	Total	Age			
		≤ 1 year	1-2 Years	2-3 Years	> 3 years
Ticket Fines	$29,986	$2,363	$3,838	$2,915	$20,870
Court Imposed Fines	811	1	17	213	580
Penalties and Surcharges on Third Party Fines	3,833	13	86	112	3,622
Provincial Fines Receivable at March 31, 2013	$34,630	$2,377	$3,941	$3,240	$25,072
Percentage of Total Provincial Fines Receivable	**100.0%**	**6.9%**	**11.4%**	**9.3%**	**72.4%**
Provincial Fines Receivable as at March 31, 2008	$29,270	$4,650	$3,953	$3,340	$17,327
Percentage of Total Provincial Receivable	**100.0%**	**15.9%**	**13.5%**	**11.4%**	**59.2%**
Increase (Decrease) in Receivable	$5,360	($2,273)	($12)	($100)	$7,745
Percentage Increase (Decrease) in Receivable	**18.3%**	**-48.9%**	**-0.3%**	**3.0%**	**44.7%**

Source: Ticket Management System Database

Age of Provincial fines receivable has deteriorated since 2008

As Table 3 indicates, the age of Provincial fines receivable has deteriorated since 2008. The Department is not collecting amounts owed in a timely manner and balances are getting older. In 2008, 59.2% ($17.3 million) of Provincial fines receivable had been outstanding for more than three years. By 2013, in excess of 72.4% ($25.1 million) of Provincial fines receivable were over three years old.

Finding

5. The age of Provincial fines receivable has deteriorated significantly since 2008. At March 31, 2013 approximately 72% of Provincial fines receivable had remained uncollected for in excess of three years.

2D. Collection Rates of Provincial Fines Receivable

Introduction

Effective policy and procedures for collections should result in the timely collection of fines receivable. Timely collection is crucial since the older the receivable becomes, the more difficult it is to collect.

As indicated earlier, we would expect to find established reporting requirements to enable effective monitoring. For example, these reporting requirements would require the monitoring of collection rates in total and by individual collections officer.

Although there were no well defined performance requirements in place to properly monitor collections, in Table 4 we compared total fines receivable to total receipts collected to determine overall collection rates for the last six years.

Table 4

Department of Justice
Provincial Fines Receivable
Collection Rates
As at March 31

Year	Provincial Fines Receivable	Provincial Fines Collected	Percentage of Fines Collected to Fines Receivable
2008	$ 29,327,308	$ 6,834,688	**23.3%**
2009	$ 30,323,714	$ 8,256,443	**27.2%**
2010	$ 31,733,737	$ 9,443,209	**29.8%**
2011	$ 34,136,339	$ 9,884,345	**28.9%**
2012	$ 34,143,652	$ 10,153,545	**29.7%**
2013	$ 34,630,789	$ 9,731,028	**28.1%**

Source: Department of Justice

Finding

6. Provincial fines receivable are increasing while receivable collection rates remain relatively constant at less than 30%. Collection efforts are not keeping pace with the volume of fines being imposed.

Recommendations

The Department should:

- set performance targets and measure the collection effort by staff to help ensure that fines receivable are collected on a timely basis; and
- take steps to follow up on the disposition of the 54,400 unidentified tickets and accounts with incomplete information and put procedures in place to ensure that all fines imposed can be identified and collected.

3. Collections

Introduction

The Division has a number of collection tools available to assist collections officers with collecting funds owed to the Province:

- Late payment penalty;
- Application of *Judgment Enforcement Act*;
- Crown may refuse to renew instruments;
- Fines Option Program;
- Payment arrangements; and
- CRA Agreement.

Our review of these options indicated the following:

Late Payment Penalty

Late payment penalties are financial penalties imposed on offenders that have not paid a fine within the required timeframe. These penalties are as follows:

- where the fine is $50 or less, the penalty is $6;
- where the fine is more than $50 but not more than $100, the penalty is $12; and
- where the fine is more than $100, the penalty is $12 for each increment of $100 to a maximum penalty of $120.

These penalties are automatically generated by the TMS. The late payment penalty is a one-time charge applied to fines and no interest or escalation of this amount is permitted.

According to Department officials, the late payment penalty, which is used as an incentive for early payments, is automatically assessed by the TMS if not paid in a specified period.

Finding

7. There is no evidence to suggest that the current level of penalties is an effective inducement to ensure early payment.

Application of the *Judgment Enforcement Act*

Under the provisions of the *Judgment Enforcement Act (*the *Act),* an unpaid fine can be entered as a judgment in the Supreme Court Trial Division by the Attorney General or a person authorized by the Attorney General. The Division registers its judgments with the Judgment Enforcement Registry (the Registry), allowing it to be enforceable against the debtor in the same manner as if it were a judgment rendered in a civil court proceeding. Our review indicated that the Division registers Provincial fines and accounts with balances greater than or equal to $400.

The Registry is maintained by the Office of the High Sheriff (the Sheriff). Once a debtor has been registered under the *Act*, upon instructions from the Fines Administration Division, the Sheriff can collect monies from the debtor, seize and sell assets of the debtor or garnish wages of the debtor. In 2013, the use of the Registry resulted in collections of $2.9 million, 29.9% of the total amount collected of $9.7 million.

The Division is required to provide information to the Sheriff, including instructions in writing, a current statement of status and the information respecting the nature and location of the property to be seized.

Our review indicated that there were 81,771 ($33.1 million) identifiable accounts in the TMS. As at March 31, 2013 there were eight collections officers in the Division. This amounts to approximately 10,200 accounts per collections officer.

The registration of an account in the Judgment Enforcement database is the beginning of collection activities against the account. Our review identified 8,640 registered accounts with balances greater than or equal to $400, totaling $26.8 million. These accounts require collection activity by the eight collections officers, an average of approximately 1,100 accounts per collections officer.

Officials indicated that effective April 24, 2013 the Division had lost two collections officers due to recent government budgetary restraint. This reduction in staff results in an increase in accounts assigned to each collections officer who now have, on average, in excess of 1,400 accounts each.

Our review also indicated that at March 31, 2013 there were 73,131 accounts totaling $6.3 million which had balances less than $400 that had not been registered under the *Act*. Of this $6.3 million, 53.6% were outstanding for more than four years. There is no active collection of these accounts by collections officers.

Finding

8. At March 31, 2013, there were 8,640 accounts totaling $26.8 million registered with the Judgment Enforcement Registry being actively collected by eight collections officers, approximately 1,100 accounts per collections officer. As of April 24, 2013, the Division lost two collections officers due to Government budgetary restraint. Collection activity will be negatively impacted by the reduction in staff.

Refusal to Renew Instruments

Although there are many licenses and permits that Government issues and which could be refused to debtors, the only action taken in this regard relates to either driver license renewals once every five years or the annual vehicle registration. Therefore, amounts owing could go uncollected for up to five years in the case of driver license renewals for individuals if this was the only collection tool used.

There has been no change in the application of this collection option since our 2008 review. Officials indicated that the Department cannot further utilize this option without significant system modifications and cost. However, there has been no cost benefit analysis performed to determine if costs would be greater than the value of outstanding fines.

Finding

9. Renewals of hunting licenses, requests for birth certificates, MCP re-registration, and registry of companies and deeds are not utilized as collection instruments. As a result, the Province is not using the option of refusing to issue licenses and permits, in an effort to collect fines receivable, to its fullest extent.

Fines Option Program

In our 2008 report, Division officials indicated that the Lieutenant-Governor in Council, under provisions in the *Provincial Offences Act*, may make regulations establishing a program to permit payment of fines by means of credit for work performed. Although such a program would not increase collections, it would reduce the fines and penalties owed to the Province since the debtor would be released from the debt in exchange for work performed.

Such a program had still not been established.

Finding

10. Although legislative authority exists, a Fines Option Program (credit in exchange for work) has not been established and there has not been a proposal to the Lieutenant-Governor in Council for the introduction of a Fines Option Program. As a result, this option is not being used to reduce fines receivable.

Payment Arrangements

The Division has collections officers who make contact with debtors to make payment arrangements. Payment arrangements can include a payment schedule. This option is not being used for accounts, totaling $6.3 million, with account balances less than $400.

CRA Agreement

Under an arrangement with the Canada Revenue Agency (CRA) which commenced in November of 2008, the Fines Administration Division can register accounts for collection with the CRA taxation collection system. The agreement allows that, the Goods and Services Tax rebate and Income Tax refunds can be intercepted from the individual and remitted to the Province for payment of fines outstanding. In 2013, $1.1 million of the total collected through the Judgment Enforcement Registry was collected through the CRA Agreement.

This option is not being used for accounts, totaling $6.3 million, with account balances less than $400.

According to Division officials, a judgment account (those registered in the Registry) is sent to CRA after the financial collections officer has worked the file without success. Department officials indicated that CRA is a collection tool of last resort, used only after all other avenues have been unsuccessful.

Finding

11. The Judgment Enforcement Registry, payment arrangements and the Canada Revenue Agency collection options are not being used to their fullest extent because these options are only used for accounts with balances greater than or equal to $400. As a result, there are 73,131 identifiable accounts with a balance less than $400, totaling $6.3 million, that are not being actively pursued for collection.

Recommendations

The Department should ensure that all delinquent accounts are assigned to collection staff for follow up. To improve collections, the Department should consider:

- registering Provincial fines and accounts below $400 with the Judgment Enforcement Registry to allow collection efforts by the collections officers including payment arrangements and registering accounts with the CRA; and

- attaching fine balances to all possible Government permits and Licenses.

The Department should consider increasing the late payment penalty rates to encourage payment of the required fine within the required timeframe.

The Department should also consider whether the introduction of a Fines Option Program, as outlined in the *Provincial Offences Act,* to allow debtors of the Province to discharge their fines by a means other than monetary compensation is feasible.

Department's Response

Recommendation:
The Department should ensure an operational plan is in place for the Fines Administration Division with appropriate performance measures and reporting requirements established for all areas of fines administration.

Department's Response:
The Department agrees that it is important to have appropriate performance measures and reporting procedures in place to ensure optimization of resources and effective fulfillment of the Division's mandate. Consequently, significant management resources are deployed on a continual and daily basis to ensure both of these key areas are addressed. While no formal operational plan is presently in place for the Division, performance is measured through actual outcomes, direct observation and ongoing management review of work prepared and completed. All work is reviewed daily by management personnel, and feedback to staff is immediate. From a reporting perspective, Divisional financial and statistical reports are submitted to the Executive, and for Public Accounts reporting purposes as

required, on a monthly, quarterly and annual basis. In accordance with this recommendation, consideration will be given to documenting this process, potentially in the form of a more formalized operational plan, which will be communicated and shared with divisional staff.

Recommendations:
The Department should

- *set performance targets and measure the collection effort by staff to help ensure that fines receivable are collected on a timely basis; and*
- *take steps to follow up on the disposition of the 54,400 unidentified tickets and accounts with incomplete information and put procedures in place to ensure that all fines imposed can be identified and collected.*

Department's Response:
The Division is very operations-oriented with a focus on ticket processing and fines collections. Efforts continue to ensure that fines receivable are collected on a timely basis. Performance management processes are in place and outcomes are monitored daily. While the potential to establish specific performance targets will be taken under consideration, it is noted that there are numerous factors impacting collection outcomes which remain beyond the Division's control. As such, it is anticipated that introduction of performance targets may not lead to the desired increase in revenue generation or a significant reduction in fines receivable as predicted.

Based on a review of fines receivable, it appears that the 54,400 unnamed accounts are likely parking fines attached to out-of-province vehicles. As such, the ability and authority to determine vehicle ownership extends beyond the Fines Administration Division. As many of the parking fines processed by the Division are payable to third parties, it is further noted that successful identification of vehicle ownership may not effectively enhance collection of Provincial fines.

Recommendations:
The Department should ensure that all delinquent accounts are assigned to collection staff for follow up.
To improve collections, the Department should consider:

- *registering Provincial fines and accounts below $400 with the Judgment Enforcement Registry to allow collection efforts by the collections officers including payment arrangements and registering accounts with the CRA; and*
- *attaching fine balances to all possible Government permits and Licenses.*

The Department should consider increasing the late payment penalty rates to encourage payment of the required fine within the required timeframe.

The Department should also consider whether the introduction of a Fines Option Program, as outlined in the Provincial Offences Act, to allow debtors of the Province to discharge their fines by a means other than monetary compensation is feasible.

Department's Response:
The Department has been reviewing and assessing numerous options for enhancing collections and reducing fines receivable, including several options outlined in this report.

The Division has been actively exploring the possibility of decreasing the $400 threshold for registering Provincial fine accounts with the Judgment Enforcement Registry. Further review is necessary to determine an appropriate balance given that the majority of these accounts are less than $200 and have an average value of under $150. It should be noted that CRA offers the Federal set-off program as a tool of last resort; collection action must be taken, documented and exhausted before accounts will be accepted by the CRA for collection. The Department is of the opinion that it is neither efficient nor cost effective to register all these accounts, as collection efforts may be more appropriately focused on higher dollar balances.

The Department has explored the possibility of attaching fines balances to Government permits and licenses other than those at Motor Registration Division (MRD). MRD intercepts are an extremely valuable tool due to the province-wide usage of that system, and the cost-effectiveness created by the volume of transactions. Feedback from other Departments indicates, however, that such intercepts would likely be a manual process that would place an unreasonable administrative burden on staff. Automation of such processes to alleviate the burden would involve significant changes to systems, legislative amendments, and undetermined costs that do not appear to support the business case for introducing such a program.

The Department has considered an increase in the late payment penalty as an option to improve fine collection, but does not believe this would be an effective inducement to ensure early payment or significantly reduce fines receivable. As noted, 46% of the accounts receivable are owed by only 2% of the accounts so increasing the late payment penalty would likely only increase the balance owing.

As indicated, the Provincial Offences Act (s.38) does have provision for the establishment of a Fines Option program, which has been considered by the Department. We will further consider such options but our preliminary concern is that implementation of such a program would require an investment of additional administrative and human resources which would likely militate against the economic feasibility of such initiatives and possibly compromise other departmental initiatives vying for limited resources.

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PART 3.4

DEPARTMENT OF
MUNICIPAL AND INTERGOVERNMENTAL AFFAIRS

WASTE MANAGEMENT STRATEGY

Summary of Findings

Introduction

In 2002 the Government of Newfoundland and Labrador released, through the Department of Environment and Conservation, the *Newfoundland and Labrador Waste Management Strategy* (the Strategy). Estimated at a capital cost of $200 million, it was designed to result in long-term solutions for modern waste management in the Province. The implementation of the Strategy stalled, mainly due to a lack of funding. The Strategy was re-released in 2007. The estimated cost remained unchanged from the 2002 Strategy at $200 million.

The goals set out in the Strategy are to:

- divert 50% of materials currently going to disposal by 2015;
- eliminate open burning at disposal sites by 2012;
- phase out the use of incinerators by 2008;
- reduce the number of disposal sites by 80% by 2020;
- phase out the use of unlined landfill sites by 2020; and
- have full Province-wide modern waste management by 2020.

The entities responsible for overseeing the Strategy are the Department of Environment and Conservation, the Department of Municipal and Intergovernmental Affairs, Service NL and the Multi-Materials Stewardship Board.

The objectives of our review were to determine the progress made towards implementing and achieving the goals and objectives of the Strategy and to determine whether there are systems in place to monitor and report on waste management activities.

Findings

Goals of the Strategy

1. The Strategy goal of 50% diversion of materials being disposed by 2015 will likely not be met.

2. The goal of eliminating open burning by 2012 has not been achieved.

3. The goal of phasing out the use of incinerators was achieved by 2013.

4. It is expected that the goal of reducing the number of waste disposal sites by 80% by 2020 will be met with an anticipated reduction of 94% of disposal sites.

5. It is expected that the goal of phasing out the use of existing unlined landfills by 2020 will likely be met.

6. Consideration is being given to construct an unlined landfill in Labrador that is not in accordance with existing environmental standards.

7. Specific waste management standards for Labrador have not been developed since the directive to do so in 2007.

8. The Province expects to achieve its goal of full Province-wide modern waste management by 2020, however, considerable work is required over the next seven years which may challenge the timing of achieving this objective.

Cost of the Strategy

9. There was no proper cost estimate prepared at the beginning of the Strategy, therefore, there is no appropriate measure against which to compare actual expenditures and thus monitor whether costs are on budget.

10. The original estimated cost of $200 million to complete the Strategy is now expected to be $315.8 million - an overrun of 58%.

11. Support for the projected cost of the Strategy, relating to composting, is currently being developed and remains uncertain. As a result, the Department cannot ensure that the projected cost is reasonable which may lead to an increase in the overall cost of the Strategy.

Oversight of the Strategy

12. The interdepartmental Steering Committee has been inactive for a period of approximately two years. As a result, the implementation of the Strategy as a whole may not be effectively monitored.

13. There is a lack of reporting completed for the Strategy as a whole. Not having a proper reporting function in place does not allow the entities to determine the progress made towards the implementation of the Strategy.

Background

Overview

In 2002 the Government of Newfoundland and Labrador, through the Department of Environment and Conservation, released the *Newfoundland and Labrador Waste Management Strategy* (the Strategy). Estimated at a capital cost of $200 million, it was designed to result in long-term solutions for modern waste management in the Province.

The implementation of the Strategy stalled mainly due to a lack of funding. Other factors that impeded the implementation of the Strategy included resistance by some communities to close waste sites, the absence of firm standards and the lack of an implementation plan.

The Strategy was re-released in 2007. The estimated cost remained unchanged from the 2002 Strategy at $200 million. Revisions to the 2002 Strategy included a change to provide that liner systems would not be required for existing sites where geological features on the site provide effective protection to the environment.

The goals of the Strategy remained the same, however, the target dates for their completion were extended. Table 1 compares the original target dates with the new target dates for each goal.

Table 1

Waste Management Strategy
Comparison of Strategy Target Dates by Goal

Goal	Target Date	
	2002 Strategy	2007 Strategy
Diversion of 50% of waste materials going to disposal	2010	2015
Eliminate open burning	2005	2012
Phase out the use of incinerators	2008	2008
Reduce number of disposal sites by 80%	2010	2020
Phase out use of unlined landfills	2010	2020
Full Province-wide modern waste management	2010	2020

Sources: 2002 Waste Management Strategy and 2007 re-release of the Strategy

A steering committee, made up of Assistant Deputy Ministers from the Department of Environment and Conservation, the Department of Municipal and Intergovernmental Affairs (the Department) and Service NL and the Chief Executive Officer of the Multi-Materials Stewardship Board (the MMSB), oversees the implementation of the Strategy.

The entities involved in overseeing the Strategy are assigned duties and are responsible for taking the lead on the implementation, monitoring and reporting in specific areas as follows:

- Environment and Conservation - the development of environmental policies and procedures;
- Municipal and Intergovernmental Affairs - the provision of funding, resources and direction to municipalities and regional waste management committees;
- Service NL - the inspection of facilities and the determination of compliance with established standards; and
- Multi-Materials Stewardship Board - the implementation of waste management initiatives, including recycling, public awareness and funding programs.

Funding

Capital funding for the implementation of the Strategy is being provided through allocations from the Federal Gas Tax Program and by the Province through the Municipal Capital Works (MCW) Program administered by the Department. Table 2 shows the expenditures of the Strategy along with the funding, by source, on an annual basis.

Table 2

Waste Management Strategy
Expenditures and Sources of Funding
For the Years Ended March 31
($000's)

Year	Expenditures	Funding Source	
		MCW	Gas Tax
2003 - 2007	$1,205	$1,205	-
2008	1,005	-	1,005
2009	25,737	3,243	22,494
2010	38,206	11,398	26,808
2011	36,787	24,598	12,189
2012	41,768	41,768	-
2013	1,695	1,695	-
Total	**$146,403**	**83,907**	**62,496**

Sources: Department of Municipal and Intergovernmental Affairs and Government's Financial Management System

The funding committed under the current Federal Gas Tax Agreement which ends in 2014, allocated a total of $62.5 million towards the implementation of the Strategy. While the Province is expecting to receive funding for the Strategy from the Gas Tax Agreement, which is now a permanent program, the 2014-19 agreement is still in the process of being finalized and therefore the amount of future funding from this source is unknown.

Objectives and Scope

Objectives

The objectives of our review were to determine:

- the progress made towards implementing and achieving the goals and objectives of the Strategy; and
- whether there are systems in place to monitor and report on waste management activities.

Scope

Our review was completed in November 2013 and covered the fiscal years ending March 31, 2008 through to March 31, 2013. Our review included interviews with officials and an examination of database information and other documentation provided by the Departments of Municipal and Intergovernmental Affairs and Environment and Conservation and the MMSB.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Goals of the Strategy
2. Cost of the Strategy
3. Oversight of the Strategy

1. Goals of the Strategy

Overview

The goals set out in the Strategy are to:

- divert 50% of materials currently going to disposal by 2015 - led by the MMSB;
- eliminate open burning at disposal sites by 2012 - led by the Department of Environment and Conservation;
- phase out the use of incinerators by 2008 - led by the Department of Environment and Conservation;
- reduce the number of disposal sites by 80% by 2020 - led by the Department of Municipal and Intergovernmental Affairs;
- phase out the use of unlined landfill sites by 2020 - led by the Department of Municipal and Intergovernmental Affairs; and
- have full Province-wide modern waste management by 2020 - collective effort of all entities involved.

The Strategy states that, given the geographic make-up of Newfoundland and Labrador, it is not possible for all communities to participate in a regional approach to waste management. For isolated/remote areas, community disposal sites will remain in operation, however, emphasis will be on improving existing disposal sites and enhancing opportunities for diversion. Waste disposal alternatives for isolated/remote communities are determined on a community by community basis in order to address immediate, local environmental conditions and considerations. While the goal is to eliminate incineration as a means of disposal, it is recognized that incineration may remain in use in isolated communities as a last resort following waste diversion.

In addition, although not explicitly mentioned in the Strategy, it has been communicated that the Strategy is not prescriptive to Labrador. Labrador presents a unique set of challenges that need be addressed separately.

The goals of the Strategy are to be achieved through five primary actions:

- increase waste diversion;
- establish waste management regions;
- develop modern standards and technology;
- maximize economic and employment opportunities associated with waste management; and
- public education.

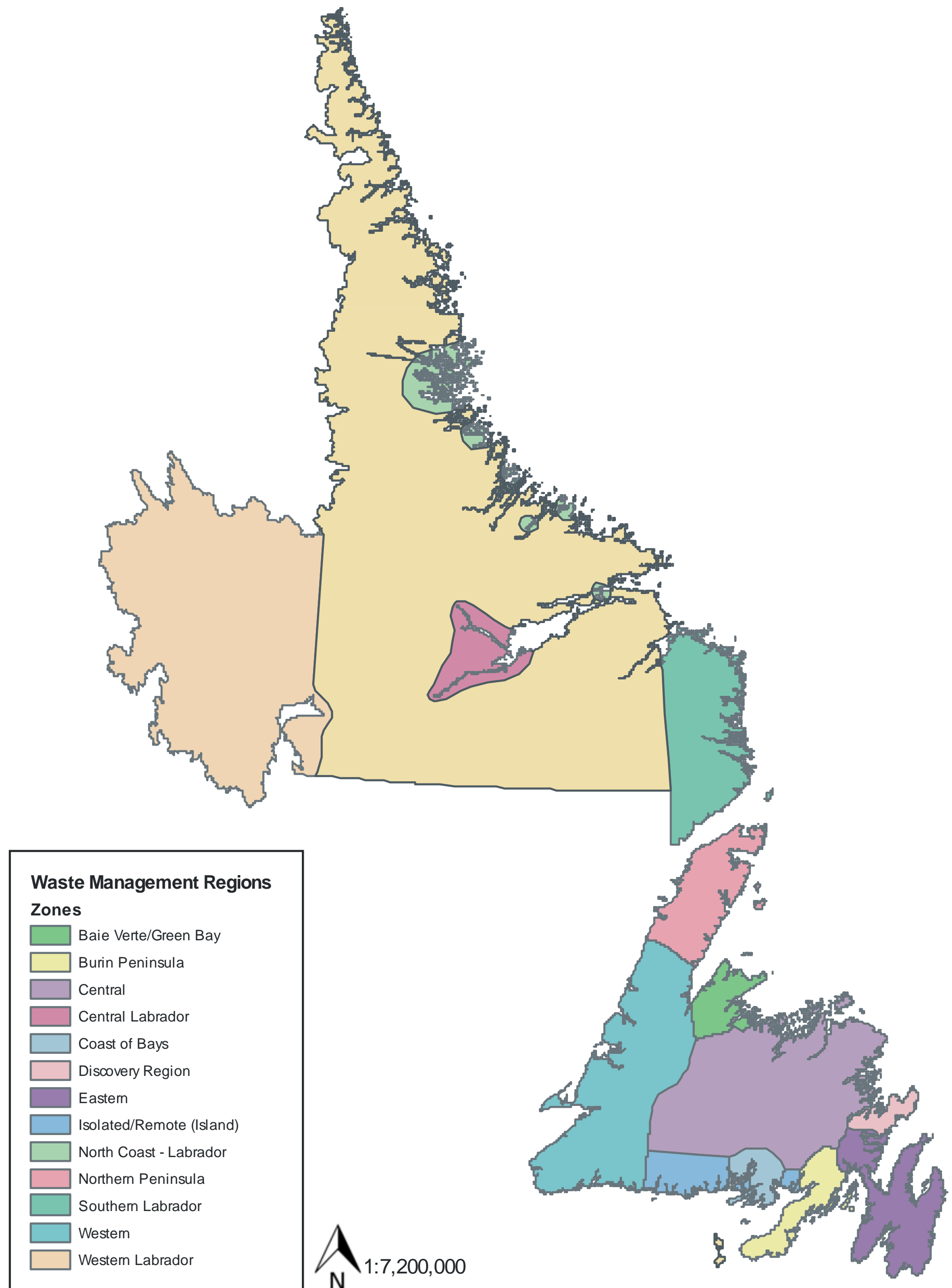
Waste management regions

Newfoundland and Labrador is comprised of 12 waste management regions. The island portion of the Province is made up of two host regions (Eastern and Central) and six non-host regions, while Labrador is comprised of four regions. Host regions will have full service waste management facilities that will include compost facilities, material recovery facilities and lined landfills for final waste disposal. Non-host regions will have both waste diversion and waste handling facilities, services and operations. Any residual waste from these regions will be transported via a transfer station for final disposal at one of the full service waste management facilities. It should be noted that isolated/remote areas exist in addition to these regions.

Waste management regions are located throughout the Province as indicated in Figure 1.

Figure 1

Waste Management Strategy
Waste Management Regions



Source: Department of Municipal and Intergovernmental Affairs

We reviewed the progress made toward each goal within the following sections:

A. Diversion of 50% of the Materials Going to Disposal by 2015
B. Eliminate Open Burning at Disposal Sites by 2012 and Phase Out the Use of Incinerators by 2008
C. Reduce the Number of Disposal Sites by 80% by 2020
D. Phase Out the Use of Unlined Landfill Sites by 2020
E. Full Province-Wide Modern Waste Management by 2020.

1A. Diversion of 50% of the Materials Going to Disposal by 2015

Overview

In the release of the Strategy in April 2002, the Province indicated that it planned to divert 50% of waste materials with the target date of 2010. In the 2007 re-release of the Strategy, the target date was extended to 2015.

Our review indicated the following:

Goal of 50% diversion of material will likely not be met

The MMSB takes the lead in advancing the Provincial goal of increasing waste diversion rates through the implementation of various waste diversion programs. Table 3 shows waste generation by metric tonne (MT) and diversion rates for 1992 and 2012.

Table 3

Waste Management Strategy
Newfoundland and Labrador Waste Generation, Disposal and Diversion

	1992 Provincial Waste		2012 Provincial Waste	
Population	580,109		514,536	
Measure	**MT/Year**	**% Total**	**MT/Year**	**% Total**
Generation	507,400	100%	493,595	100%
Disposal	474,000	93%	356,469	72%
Diversion	33,400	7%	137,126	28%

Source: Multi-Materials Stewardship Board

As indicated in Table 3, 28% of the waste generated in the Province in 2012 was diverted, up from the 7% diversion rate in 1992. The Provincial goal is to divert 50% of waste by 2015. If waste generation remains approximately the same, this will require the Province to divert an additional 109,672 MT of waste over the next 3 years. This is an 80% increase over the amount that is currently being diverted within the Province.

Officials of the MMSB have indicated that in order to meet the goal, all province-wide infrastructure, including compost facilities, would need to be in place. Thus, they are working towards a goal of 50% waste diversion by 2020.

Finding

1. The Strategy goal of 50% diversion of materials being disposed by 2015 will likely not be met.

1B. Eliminate Open Burning at Disposal Sites by 2012 and Phase Out the Use of Incinerators by 2008

Overview

Open burning and incinerators produce many pollutants including dioxins and furans. Exposure to these pollutants has been linked to liver problems, immune system issues and certain types of cancer. The 2002 Strategy set the goal of eliminating open burning at disposal sites by 2005 and to phase out the use of incinerators by 2008. In the 2007 re-release of the Strategy, the timeline for the goal of eliminating open burning was extended to 2012, however the timeline related to the phase out of the use of incinerators remained the same.

Our review indicated the following:

Open burning not eliminated by 2012

In order to advance the Strategy with regards to open burning, the 2007 re-release set target dates for its elimination for the Avalon, Central and Western regions of the Province. These target dates are provided in Table 4.

Table 4

Waste Management Strategy
Schedule for the Elimination of Open Burning

Region	Target Date for Completion
Avalon	2007
Central	2010
Western	2011

Source: 2007 re-release of the Waste Management Strategy

Information provided by the Department of Environment and Conservation indicated that as of November 1, 2013 open burning was still taking place at 32 disposal sites within the Province, 20 in Labrador and 12 on the island portion of the Province as shown in Table 5.

Table 5

Waste Management Strategy
Open Burning Sites by Region as of November 2013

Region	Number of Open Burning Sites	Isolated/Remote Area or Labrador
Burin Peninsula	6	No
Discovery Region	5	No
Western Newfoundland	1	No
North Coast - Labrador	6	Yes
Southern Labrador	12	Yes
Western Labrador	2	Yes
Total	**32**	

Source: Department of Environment and Conservation

Department of Environment and Conservation officials explained that bans on open burning are not imposed by region but in approvals for individual waste disposal sites. They indicated that when there are valid reasons to continue open burning beyond the target cessation date, it can be approved on a case by case basis. However, this information is not provided as part of the Strategy.

Finding

2. The goal of eliminating open burning by 2012 has not been achieved.

Incinerator use phased out by 2013

In 2002 there were 53 incinerators operating within the Province. At the end of 2008, 24 incinerators were still in use as follows:

- there were 22 incinerators operating on the island portion of the Province, 16 incinerators were in designated waste management regions while 6 were in remote/isolated areas; and
- there were 2 incinerators operating in Labrador.

As of November 2013, there were 6 incinerators still operating in the Province, 5 of them were in isolated remote areas on the island and 1 was in Labrador.

Finding

3. The goal of phasing out the use of incinerators was achieved by 2013.

1C. Reduce the Number of Disposal Sites by 80% by 2020

Overview

The 2002 Strategy included a goal to reduce the 235 disposal sites by 80% by 2010. In the 2007 re-release of the Strategy, the timeline for the goal was extended to 2020.

Our review indicated the following:

Reducing the number of disposal sites by 80% expected by 2020

Significant progress has been made in reducing the number of landfills in the Province. In 2002 there were 235 landfills in the Province, while as of October 31, 2013, there were 88 landfills in operation. The closure of 147 landfills since 2002 has reduced the number of landfills in operation within the Province by 63%. Of the 147 landfills that have been operationally closed, 93 have been remediated in accordance with the *Guidelines for the Closure of Non-Containment Municipal Solid Waste Landfill Sites*. In addition, 73 landfills are expected to close by 2020.

Finding

4. It is expected that the goal of reducing the number of waste disposal sites by 80% by 2020 will be met with an anticipated reduction of 94% of disposal sites.

1D. Phase Out the Use of Unlined Landfill Sites by 2020

Overview

The use of a liner in a landfill site controls the escape of leachate. The contained leachate can then be recovered and treated in order to further minimize potential environmental consequences. The 2002 Strategy set the goal of phasing out the use of unlined landfills by 2010. In the 2007 re-release of the Strategy, the timeline for the goal was extended to 2020. It also amended the requirement regarding liner systems to state that they were no longer required for existing sites where geological features on the site provide effective protection to the environment.

Our review indicated the following:

Phase out of unlined landfills expected by 2020

In reducing the number of waste disposal sites within the Province, significant progress has been made in phasing out the use of unlined landfill sites as well. To date, 147 of 235 landfill sites have been closed, all of which were unlined. In addition, 73 landfills are expected to close by 2020 which would leave only 15 in operation. Of the 15 landfills that will remain in operation two of these will be lined; Robin Hood Bay is naturally lined due to geological features of the site and Norris Arm North is artificially lined. The other 13 unlined landfills which will remain open are all located in Labrador.

Finding

5. It is expected that the goal of phasing out the use of existing unlined landfills by 2020 will likely be met.

Planned construction of unlined landfill

The 2002 Strategy stated that unlined landfill sites would not be an acceptable means of disposal except in those isolated areas where no alternatives exist. The 2007 re-release of the Strategy amended the requirement regarding liner systems to state that they were no longer required for existing sites where geological features on the site provide effective protection to the environment. Therefore, we concluded that any new landfills that are constructed are required to be lined, either artificially or naturally. This is reiterated through the fact that the standards developed and released by the Department of Environment and Conservation, *Environmental Standards for Municipal Solid Waste Landfill Sites,* relating to the construction and operation of new landfills only speak to contained (lined) sites.

In 2007, Cabinet directed the Department of Environment and Conservation to finalize waste disposal standards and regulations, develop standards for closing landfill sites and research new technologies that may be of a particular benefit in meeting provincial goals in Labrador zones and isolated areas. At the time of our review, standards for Labrador had not been developed.

Departmental officials of Municipal and Intergovernmental Affairs and Environment and Conservation indicated that there is currently a consultant recommendation to construct a new unlined landfill in southern Labrador. This proposal is currently being reviewed to determine if there are any significant environmental or technical issues. Once a final approach is determined, including a specific location, a formal submission for environmental assessment may be required under the *Environmental Protection Act*. This will provide the opportunity for potential environmental effects to be identified and addressed and if there are significant issues with the proposed site other alternatives will be considered including the redevelopment of existing landfill sites in the area.

Findings

6. Consideration is being given to construct an unlined landfill in Labrador that is not in accordance with existing environmental standards.

7. Specific waste management standards for Labrador have not been developed since the directive to do so in 2007.

1E. Full Province-Wide Modern Waste Management by 2020

Overview

The 2002 Strategy set the goal of full Province-wide modern waste management by 2010. In the 2007 re-release of the Strategy, the timeline for the goal was extended to 2020.

Our review indicated the following:

Modern waste management is comprised of optimized waste diversion, regional waste management systems and modern standards and technology. The host regions, Eastern and Central will have full service waste management facilities including composting facilities, material recovery facilities and lined landfills for final waste disposal. Material recovery facilities accept, process and market dry recyclable materials.

The Robin Hood Bay site is complete with the exception of a composting facility. With the exception of a composting facility and materials recovery facility, the Norris Arm North site is also nearing completion. Non-host regions on the island portion of the Province will ultimately transfer their residual waste to one of the host regions for final disposal, but will take advantage of local opportunities to divert waste, such as composting and thus reduce the quantity of waste to be transported to host regional facilities. Regional waste management systems will have both waste diversion and waste handling facilities.

Significant work is required to be completed throughout the Province to ensure that the goal is met. This includes:

- the construction of a waste recovery facility and a transfer station in the Eastern region;
- the construction of transfer stations and waste recovery facilities in the six non-host regions of the island; and
- the completion of a study and resultant infrastructure required for the Province's composting initiative.

In addition, the development of the standards and plans for waste management in Labrador are still being finalized. The following initiatives currently in progress are as follows:

- the design and construction of a landfill in Southern Labrador;
- the completion of a study and resultant infrastructure required for Central Labrador; and
- the completion of a study and resultant infrastructure required for the Northern Coast of Labrador.

Finding

8. The Province expects to achieve its goal of full Province-wide modern waste management by 2020, however, considerable work is required over the next seven years which may challenge the timing of achieving this objective.

Recommendation

The Department of Municipal and Intergovernmental Affairs, the Department of Environment and Conservation and the Multi-Materials Stewardship Board should ensure that they have the proper plans and mechanisms in place to meet the goals stipulated in the Strategy by the targeted 2020 completion date.

2. Cost of the Strategy

Overview

Upon its initial release in 2002 by the Department of Environment and Conservation, the Strategy was estimated to have a capital cost of approximately $200 million.

Five years later in 2007, the Strategy was re-released. Very little had been spent and there had been modest advancement in the Strategy to that point. However, the estimated cost remained the same as the initial $200 million identified in the 2002 Strategy.

Total expenditures relating to the Strategy as of March 31, 2013 were $146.4 million. This was spent throughout the various regions of the Province as indicated in Table 6.

Table 6

Waste Management Strategy
Strategy Expenditures
For the Years Ended March 31
($000's)

Region	2003 - 2007	2008	2009	2010	2011	2012	2013	Total
Eastern	$39	$782	$23,084	$23,331	$3,778	$7,581	$367	$58,962
Central	97	203	2,105	11,751	30,298	27,626	19	72,099
Baie Verte/ Green Bay	-	-	-	188	206	18	270	682
Burin Peninsula	-	-	-	136	167	297	218	818
Coast of Bays	16	-	-	9	52	1	-	78
Discovery Region	-	-	-	53	8	331	290	682
Northern Peninsula	406	20	300	302	360	374	48	1,810
Western	413	-	175	680	1,013	1,175	447	3,903
Labrador	20	-	73	1,714	867	3,261	36	5,971
Provincial	214	-	-	42	38	1,104	-	1,398
Total	**$1,205**	**$1,005**	**$25,737**	**$38,206**	**$36,787**	**$41,768**	**$1,695**	**$146,403**

Source: Department of Municipal and Intergovernmental Affairs

Table 7 presents the total expenditures by type for each region up to March 31, 2013.

Table 7

Waste Management Strategy
Strategy Expenditures by Type
As at March 31, 2013
($000's)

Region	Studies/ Interim Disposal Site Consolidations	Site Closures	Regional Infrastructure	Total Expenditures
Eastern	$ 8,078	$ 2,207	$ 48,677	$ 58,962
Central	1,150	3,800	67,149	72,099
Baie Verte/ Green Bay	394	288	-	682
Burin Peninsula	818	-	-	818
Coast of Bays	78	-	-	78
Discovery Region	682	-	-	682
Northern Peninsula	1,707	103	-	1,810
Western	3,728	175	-	3,903
Labrador	232	-	5,739	5,971
Provincial	1,398	-	-	1,398
Total	**$ 18,265**	**$ 6,573**	**$ 121,565**	**$ 146,403**

Source: Department of Municipal and Intergovernmental Affairs

Our review indicated the following issues with the costs of the Strategy:

Initial cost of Strategy not adequately defined

We would have expected there to be documentation to support the original planned expenditures of the Strategy, however, none was provided. Officials of the Department of Municipal and Intergovernmental Affairs (the Department) indicated that the estimated $200 million cost of the original Strategy had not been well defined and when the Strategy was re-released in 2007 the $200 million cost estimate was just carried forward.

Department officials have also indicated that that the $200 million estimate did not include an amount for inflation. They believe that if a 5% construction cost index was applied annually this would more accurately reflect the cost of the Strategy by increasing it to approximately $460 million by the 2020 implementation date.

Finding

9. There was no proper cost estimate prepared at the beginning of the Strategy, therefore, there is no appropriate measure against which to compare actual expenditures and thus monitor whether costs are on budget.

Projected cost of the strategy will exceed budgeted cost

As of March 31, 2013, capital expenditures of $146.4 million had been incurred related to the Strategy. Projected costs to complete the Strategy are $169.4 million. This would result in total capital costs of approximately $315.8 million. The projected $169.4 million remaining to complete the Strategy is shown by the years remaining for each region in Table 8.

Table 8

Waste Management Strategy
Expected Costs to Complete the Strategy
For the Years Ending March 31
($000's)

	2014	2015	2016	2017	2018	2019	2020	Total
Eastern	$ 256	$ 4,917	$10,775	$10,000	$ -	$ 275	$ -	$ 26,223
Central	-	10,300	10,000	-	-	-	-	20,300
Baie Verte/ Green Bay	-	3,000	2,000	2,500	600	600	500	9,200
Burin Peninsula	571	6,300	3,000	-	-	-	-	9,871
Coast of Bays	26	5,000	3,000	500	-	-	-	8,526
Discovery Region	18	3,000	625	625	-	-	-	4,268
Northern Peninsula	171	5,000	2,500	500	-	-	-	8,171
Western	1,890	11,200	12,000	12,000	20,625	10,625	100	68,440
Labrador	-	600	2,100	2,375	275	-	900	6,250
Provincial	175	3,600	1,750	1,100	500	500	500	8,125
Total	**$3,107**	**$52,917**	**$47,750**	**$29,600**	**$22,000**	**$12,000**	**$2,000**	**$169,374**

Source: Department of Municipal and Intergovernmental Affairs

Table 9 presents the total projected expenditures by type for each region.

Table 9

Waste Management Strategy
Expected Costs to Complete the Strategy by Type
($000's)

Region	Studies/ Interim Disposal Site Consolidations	Site Closures	Regional Infrastructure	Total
Eastern	$500	$ 1,650	$24,073	$26,223
Central	-	300	20,000	20,300
Baie Verte/ Green Bay	-	1,700	7,500	9,200
Burin Peninsula	457	2,414	7,000	9,871
Coast of Bays	26	1,000	7,500	8,526
Discovery Region	18	1,250	3,000	4,268
Northern Peninsula	171	500	7,500	8,171
Western	700	12,740	55,000	68,440
Labrador	-	2,250	4,000	6,250
Provincial	6,625	1,500	-	8,125
Total	**$8,497**	**$25,304**	**$135,573**	**$169,374**

Source: Department of Municipal and Intergovernmental Affairs

Not only have projected costs exceeded what was initially budged, the scope of the work that had been planned in order to implement the Strategy has been reduced. The 2007 re-release of the Strategy indicated that there would be three full service regional waste disposal facilities (super sites) developed in the Avalon, Central and Western regions of the island portion of the Province. However, it has been communicated that a regional waste disposal facility, estimated to cost a further $80 million to $100 million, will not be constructed on the Western portion of the island.

Finding

10. The original estimated cost of $200 million to complete the Strategy is now expected to be $315.8 million - an overrun of 58%.

Projected cost for composting not adequately supported

We would have expected there to be documentation detailing how the Department arrived at the projected expenditures of the Strategy. Officials of the Department of Municipal and Intergovernmental Affairs indicated that the majority of the projected expenditures have been developed based on work they have already completed with regard to the Strategy. For example, 93 disposal sites have already been closed and remediated so the projected cost for the remaining site closures are based on that experience. They have also applied the same rationale in the development of the projected expenditures relating to the remaining infrastructure to be built.

Included in the infrastructure estimate of $136 million is approximately $75 million for the implementation of the Province's composting initiative, with which the Department has no past experience. There was no supporting documentation outlining how the estimate for the composting initiatives was arrived at. Department officials indicated that these estimates were developed in 2011 based on information collected from surveying the state of composting processes and facilities across North America and discussions with operators. They have also indicated that the Department is a member of the Solid Waste Management Association of North America and has regularly attended technical conferences to gain a better understanding of potential infrastructure solutions including composting. Furthermore, a consultant is currently performing a study which is expected to be completed by early 2014. Department officials indicated that they expect to revise the composting estimates after receiving the consultant's final report.

Finding

11. Support for the projected cost of the Strategy, relating to composting, is currently being developed and remains uncertain. As a result, the Department cannot ensure that the projected cost is reasonable which may lead to an increase in the overall cost of the Strategy.

Recommendations

The Department of Environment and Conversation should ensure that proper budgets are developed for future work plans.

The Department of Municipal and Intergovernmental Affairs should ensure that proper support documentation is developed for all projected costs.

3. Oversight of the Strategy

Overview

The implementation of the Strategy is overseen by an interdepartmental Steering Committee made up of Assistant Deputy Ministers from the Department of Environment and Conservation, the Department of Municipal and Intergovernmental Affairs and Service NL and the Chief Executive Officer of the MMSB. Therefore, we would have expected there to be appropriate oversight to ensure that the goals and the overall mandate of the Strategy are on track.

Our review indicated the following issues with the oversight of the Strategy:

Inactive Steering Committee

We would expect the Steering Committee to meet regularly to discuss the status of the Strategy and monitor the progress towards the achievement of the overall goals of the Strategy. We requested the minutes for any Steering Committee meeting meetings held during the period of our review, March 31, 2008 to March 31, 2013, but none were provided. The last record of a Steering Committee meeting held, that we were provided with, was the agenda from a meeting held in October 2011.

Finding

12. The interdepartmental Steering Committee has been inactive for a period of approximately two years. As a result, the implementation of the Strategy as a whole may not be effectively monitored.

Lack of overall reporting on the Strategy

We would have expected the Departments and the MMSB to have a process in place to monitor progress made toward the goals where that entity takes the lead. This would enable the entities to report on the progress made towards the implementation of the Strategy as a whole. Officials of the Department of Municipal and Intergovernmental Affairs, Environment and Conservation and the MMSB provided information to indicate that they track the pertinent information related to the goals where that entity takes the lead. However, none of them could provide documentation to support that reporting was completed for the Strategy as a whole. Officials of the Department of Municipal and Intergovernmental Affairs indicated that a performance report template was created in 2011 and the first report for the Strategy was completed for the year ended March 31, 2013, however, this report has not been publically released.

Finding

13. There is a lack of reporting completed for the Strategy as a whole. Not having a proper reporting function in place does not allow the entities to determine the progress made towards the implementation of the Strategy.

Recommendations

The Departments of Municipal and Intergovernmental Affairs, Environment and Conservation and Service NL and the Multi-Materials Stewardship Board should work together to ensure that the Steering Committee meets on a regular basis to promote effective oversight of the implementation of the Strategy.

The Departments of Municipal and Intergovernmental Affairs, Environment and Conservation and the Multi-Materials Stewardship Board should ensure that proper reporting is in place for the remainder of the Strategy.

Joint Response from:
Department of Environment and Conservation
Department of Municipal and Intergovernmental Affairs
Multi-Materials Stewardship Board
Service NL

Recommendation

The Department of Municipal and Intergovernmental Affairs, the Department of Environment and Conservation and the Multi-Materials Stewardship Board should ensure that they have the proper plans and mechanisms in place to meet the goals stipulated in the Strategy by the targeted 2020 completion date.

General Response:

It is acknowledged that a detailed implementation plan was not included in the initial strategy release in 2002 and in 2007; however, since 2007 the strategy partners have worked diligently with municipal stakeholders to develop a detailed implementation plan that includes the establishment of environmental policy and regulation, use of appropriate technologies, best practices and infrastructure to support meeting the goals and objectives of the strategy. The detailed implementation plan was developed with an initial focus on the elimination of open burning, the closure of tee-pee incinerators, consolidation of community curbside collection and waste disposal sites, and the establishment of lined (or equivalent to lined) landfills at the host regions (Eastern and Central). Secondary implementation included construction of recycling and composting facilities. Since 2007, there has been significant progress made in implementing the Strategy, as recognized in several of the findings in the report.

The Waste Management Strategy is now entering its thirteenth year. Environmental policies and best practices will change over time as new information arises and new technology becomes available. The implementation process needs to be flexible and responsive to such changes. A good example of this is the change from three to two lined landfills on the island, and improved transfer station technologies that have made this a viable and more economical option for the Province. Further refinement of the Strategy may be required as we work towards the goal of province-wide modern waste management by 2020.

It is also acknowledged, however, that there is significant work remaining. We will continue to monitor and amend the implementation plan to ensure the goals stipulated in the strategy are met by 2020.

With specific reference to Finding # 1, it is acknowledged that the 50% diversion target set in 2007 will not likely be met by 2015. However, significant progress has been made in increasing diversion rates from 7% to 28% as of March 31, 2013. This increase has resulted from a number of initiatives brought about through the ongoing implementation of the strategy, including:

- *Greater regional cooperation, planning and pooling of resources as waste management regions are formed, waste management plans completed, waste management services consolidated and waste management plans executed.*

- *The establishment and improvement of waste management infrastructure in NL.*

- *The continued improvement and expansion of province-wide recycling programs for products such as beverage containers, tires, waste paint and electronics.*

- *Increased business sector participation in recycling and diversion activities.*

- *Increased public awareness of the need to reduce the amount of waste that goes to curb.*

The opening of a recycling facility in 2014 in Norris Arm that is currently under construction is expected to further increase diversion rates by 2015 and work nearing completion by a compost consultant will assist in developing a detailed province-wide composting plan that will enable the Province to achieve its 50% diversion target.

With specific reference to Finding #2, it is acknowledged that all open burning was not eliminated by 2012, however, tremendous progress has been made with the elimination of open burning at 127 sites, representing 72% of all dumpsites. Sites that continue to burn are approved on an interim case by case basis due to site condition. Open burning at these sites will cease as these sites are closed.

With specific reference to Findings #6 and #7, it is acknowledged that consideration is being given to constructing an interim unlined landfill in Labrador.

The 2002 Waste Management Strategy states that "unlined landfill sites will not be (an) acceptable means of disposal, except in those isolated areas where no alternative exists". The public consultation, "A Call to Action on Environmental Protection", on which the Strategy was based states "There are some areas of the province where a regional approach is not appropriate due to geographic separation and type of transportation links." Hence, absolute compliance with the goals of the Strategy in Labrador was not a requirement but a target. Should the construction of an unlined landfill be pursued, it could significantly improve waste management in southern Labrador and will meet the goals of the Strategy in Labrador.

Now that a new landfill is under consideration for Labrador, the Department of Environment and Conservation will prepare a guidance document for final landfill disposal in Labrador and other remote sites that improves waste management practices to the extent practical. This will be done in 2014.

Recommendations

The Department of Environment and Conversation should ensure that proper budgets are developed for future work plans.

The Department of Municipal and Intergovernmental Affairs should ensure that proper support documentation is developed for all projected costs.

Response:

It is acknowledged that the strategy, upon its re-release in 2007, did not contain a detailed budget for implementation of the strategy. The $200 million cost estimate would have been a preliminary estimate based on the level of detail available at the time the strategy was released. As detailed planning work was completed in regions and sub-regions, detailed cost estimates and cost projections were developed and continue to be updated regularly. In completing a detailed implementation plan and associated cost projections, numerous reports were completed to support implementation and costing. The Department of Municipal and Intergovernmental Affairs acknowledges that early cost projections related to composting facilities were based on high level information gathered from other jurisdictions; however, these projects have recently been validated by a comprehensive compost study that is nearing completion.

The Department of Municipal and Intergovernmental Affairs, its strategy partners and over 600 stakeholder communities have worked aggressively to keep capital and operational costs to a minimum while respecting the goals of the strategy. A prime example of that was the decision not to construct a lined landfill facility in the Western region as initially proposed resulting in a projected cost saving of approximately $80 to $100 million in Capital expenditure and $1.8 million annually in operation and maintenance cost to householders.

Recommendations

The Departments of Municipal and Intergovernmental Affairs, Environment and Conservation and Service NL and the Multi-Materials Stewardship Board should work together to ensure that the Steering Committee meets on a regular basis to promote effective oversight of the implementation of the Strategy.

The Departments of Municipal and Intergovernmental Affairs, Environment and Conservation and the Multi-Materials Stewardship Board should ensure that proper reporting is in place for the remainder of the Strategy.

Response

It is acknowledged that the Steering Committee has not had formal meetings in the past two years as it had done regularly during the initial implementation phase and the development of the detailed implementation plan. However, there is still frequent communication between the various partners to discuss issues and make decisions as required. The Committee did meet recently and will meet quarterly to ensure that all internal stakeholders are aware of the progress being made.

In order to ensure a proper reporting mechanism was in place to report on progress of the Strategy, in 2011, the Department of Municipal and Intergovernmental Affairs developed a Performance Measures Accountability Framework Report to measure outcomes against the five strategic goals outlined in the strategy with the first report being completed on March 31, 2013. The intention is to update the report on an annual basis under the oversight of the Steering Committee until the strategy is fully implemented in 2020. While the focus of reporting to date has been internal, individual partners for the strategy have communicated publicly on various aspects of the strategy when certain milestones occurred. The Steering Committee has recently discussed the need for consideration to be given to a public reporting approach, and further dialogue will occur in that regard in the coming months.

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PART 3.5

DEPARTMENT OF NATURAL RESOURCES

CRANBERRY INDUSTRY SUPPORT

Summary of Findings

Introduction

The Production and Market Development Division (the Division) of the Department of Natural Resources (the Department) is responsible for supporting the development of the cranberry industry. The Cranberry Industry Development Program (CIDP) was a 5-year program established in 2008 to facilitate cranberry site development. The CIDP was expected to contribute $12.2 million to the cranberry industry from 2009 to its completion in 2013. In addition to providing grants under the CIDP, the Department also operated the Wooddale Provincial Tree Nursery (the Nursery) for growing cranberry plants for producers and operated a research site at Deadman's Bay.

The objectives of our review were to determine whether the Department:

- administered the Cranberry Industry Development Program (CIDP) in accordance with established guidelines; and

- adequately recorded, monitored and reported on the revenues and expenditures for other Department activities related to the cranberry industry in the Province.

Findings

Program Assessment and Approval

1. The Department did not always obtain information that was required by the CIDP guidelines from an applicant before funding was approved or ensure that all the required checks and assessments were completed before approval of funding. We found the following instances where guidelines were not always followed:

    - business plans received after funding provided;
    - incomplete financial information provided;
    - good standing checks not completed;
    - other funding sources not confirmed;
    - arrears checks not completed;
    - no documentation that environmental farm scans completed;
    - internal applicant assessments not completed; and
    - CIDP Committee meetings not adequately documented.

Program Payments

2. Payments were made to applicants when inspection certificates, which were intended to ensure that the applicant had developed the property in accordance with program guidelines, were not on file or when the inspection certificate indicated that the minimum requirements for acreage development were not met.

3. We found instances where minimum program requirements were not being met. Documentation was not always in the minutes of the CIDP Committee, which approved the applications, to indicate whether these issues were discussed or if they were addressed.

4. Project claims forms were not on file for 4 payments totaling $200,800.

Program Monitoring

5. The Department did not adequately monitor and document producer activities or development costs to evaluate the success of the CIDP, to determine whether its objectives were being met, or to determine whether changes were needed to the CIDP policies to ensure its success.

6. The Department only disbursed $727,000 of the $5.2 million (or 14%) in approved funding during the five years of the CIDP. Given the significant shortfall in funding provided under the CIDP, it would be difficult for the Department to meet the objectives of the program.

7. The Department did not comply with Cabinet directives related to the CIDP. The Department did not recover 50% of the estimated plant cost from the producers nor did the Department prepare an annual program evaluation as directed by Cabinet.

Wooddale Provincial Tree Nursery

8. The Department maintained production and inventory levels, throughout the five year program, based on a budgeted amount established in 2008 instead of the annual demand of the producers. As a result, excess inventory levels were being maintained at the Nursery and the level of production throughout the five year program was not required to meet the demand of the producers.

Industry Goals

9. The Province's investment in the cranberry industry was segmented and was not coordinated. Funding was provided to programs that were distributed and monitored differently than the CIDP which may have affected the ability of the Department to attract investment.

10. Although the Province spent $5.6 million during the past five years on the cranberry industry, the Department did not reach its short-term goal of developing 500 acres.

11. Funding under the CIDP ceased on March 31, 2013. It was not known if future cranberry assistance programs will be approved by Government, however, as at November 2013, there were producer acreages yet to be developed which received initial funding under the CIDP and there was a large inventory of plugs and vines still being maintained at the Nursery.

Background

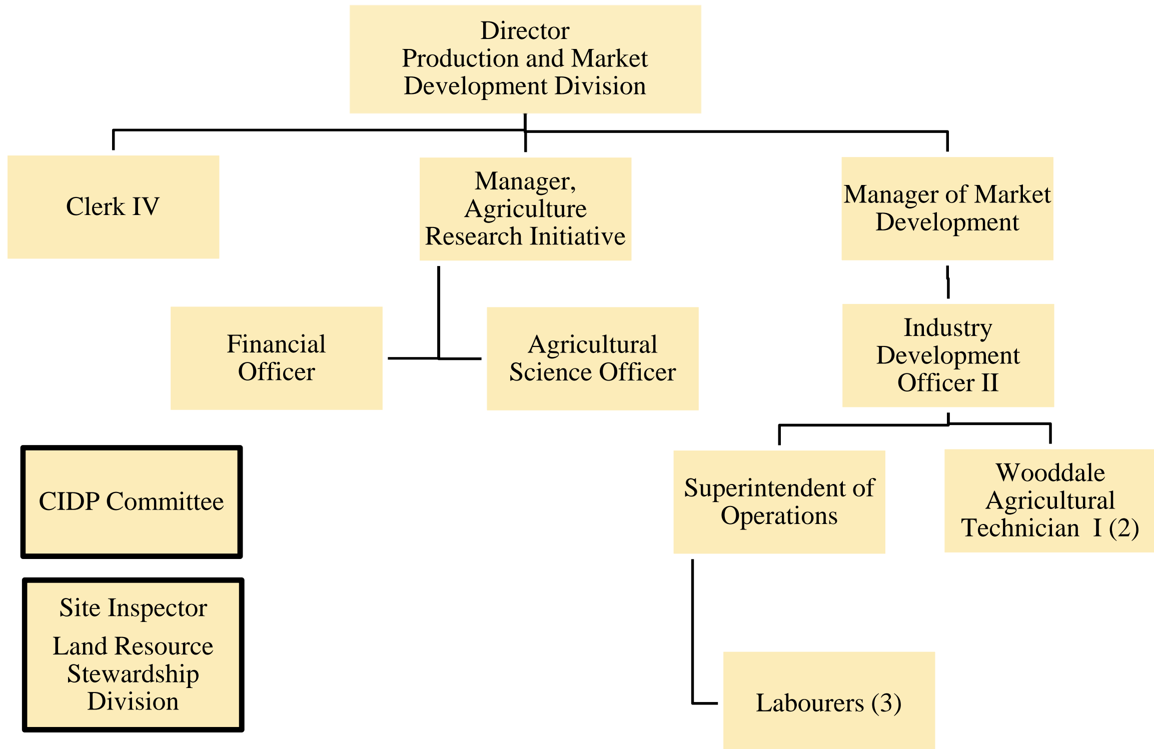
Overview

The Department of Natural Resources (the Department) has been supporting the development of the cranberry industry since 1996 through the establishment of five pilot sites across the Province – two in the Stephenville area, one in Terra Nova, one in Fortune Bay and one in Bonavista Bay. These sites were developed though the Agrifoods Development Branch (the Branch) of the Forestry and Agrifoods Agency (the Agency). The Branch is responsible for promoting the development, expansion and diversification of agriculture and agrifoods businesses in the Province.

The Production and Market Development Division (the Division) of the Branch is responsible for supporting the development of the cranberry industry. Figure 1 shows an organizational chart of the Division.

Figure 1

Department of Natural Resources
Review of the Cranberry Industry
The Production and Market Development Division
Organizational Chart



Source: Department of Natural Resources

Programs

The five pilot sites established throughout the Province included four commercial sites managed by private sector entities and one managed by the Province as a research site. The most recent program undertaken by the Department to develop and expand the industry was the Cranberry Industry Development Program (CIDP). The CIDP was a 5-year program established in 2008 to facilitate cranberry site development. The CIDP was expected to contribute $12.2 million to the cranberry industry from 2009 to its completion in 2013. As part of the CIDP 5-year commitment, the Division was to provide financial assistance grants totaling $1.5 million annually to cranberry producers.

In addition to the CIDP, the Province participated in other funding programs to develop and sustain the cranberry industry. The Province provided funding under the Town of Grand Falls-Windsor Cranberry Project and the Pre-Commercialization Program carried out by the Newfoundland and Labrador Federation of Agriculture.

The objectives of the CIDP were to facilitate the development of the industry by providing financial assistance to applicants who were presently cranberry farming or who were entering the industry. The CIDP facilitated the continued development of the cranberry industry from the research and development phase to the commercialization phase and provided financial assistance for cranberry site development.

The Department also operated a cranberry research site at Deadman's Bay in Bonavista Bay. The Department also produced cranberry plugs at the Wooddale Provincial Tree Nursery (the Nursery) for the CIDP and the other two cranberry industry development programs.

As at March 31, 2013 there were 14 producers with cranberry farms in the Province with approximately 200 acres in total.

Figure 2

Department of Natural Resources
Review of the Cranberry Industry
Cranberry Plants

Source: Department of Natural Resources

Program budgets

Table 1 shows the budgeted expenditures for the years ended March 31, 2009-2013 for the CIDP, the Nursery and the research site located at Deadman's Bay. For the year ended March 31, 2013, budgeted expenditures totaled $1.7 million.

Table 1

Department of Natural Resources
Review of the Cranberry Industry
Budgeted Expenditures for Cranberry-related Activities
Years Ended March 31
($ 000's)

Program Activity	2009	2010	2011	2012	2013	Total
CIDP grants to producers	$1,500	$1,500	$1,500	$1,500	$1,200	$ 7,200
CIDP equipment	650	-	-	-	-	650
CIDP plugs (Nursery)	800	800	800	800	800	4,000
CIDP revenue from plugs	(400)	(400)	(400)	(400)	(400)	(2,000)
Research site	330	274	459	396	125	1,584
Budgeted Expenditures	**$2,880**	**$2,174**	**$2,359**	**$2,296**	**$1,725**	**$11,434**

Source: Department of Natural Resources

CIDP grants description

The CIDP provided financial assistance to eligible applicants involved in developing cranberry sites in the Province. The development of cranberry production sites was estimated to cost in the range of $30,000 to $35,000 per acre of land and take from three to five years to reach a level of harvestable yields. Each applicant would be eligible for $15,000 per acre up to a maximum of $150,000 per year. Based upon the estimated producers' cost to develop an acre of land, the Division's CIDP funding represented approximately 50% of total costs. Applications were to be submitted annually and were reviewed by the Cranberry Industry Development Program Committee (the Committee) which was comprised of Agency officials. The CIDP required applicants to provide a business plan that demonstrated a sustainable and viable cranberry operation.

Objectives and Scope

Objectives

The objectives of our review were to determine whether the Department:

- administered the Cranberry Industry Development Program (CIDP) in accordance with established guidelines. Specifically, whether the Department:
    - assessed and approved project applications in accordance with CIDP criteria,
    - made payments which were within the maximum funding limits, were supported by the required documentation and were properly approved, and
    - monitored approved projects to determine if funds were spent as intended and CIDP objectives were achieved; and
- adequately recorded, monitored and reported on the revenues and expenditures for other Department activities related to the cranberry industry in the Province.

Scope

Our review was completed in November 2013. We reviewed the CIDP from its establishment in 2008 through to 2013. We also examined other Department expenditures and revenues related to the cranberry industry including the operations of the Nursery and the Deadman's Bay research site. Our review included an examination of policies and procedures, Committee minutes, client files, Department proposals and reports; and included interviews with staff.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. CIDP Grants
2. Other Department Initiatives

1. CIDP Grants

Overview

During the five years that the CIDP operated, 15 producers applied for funding with 9 eventually receiving funding. Table 2 shows the number of applications received, the number of applications approved and paid, and the amount of funding provided for each of the five years that the CIDP operated.

Table 2

Department of Natural Resources
Review of the Cranberry Industry
Grants to Producers
Years Ended March 31

	2009	2010	2011	2012	2013	Total
Applications received	3	6	12	12	10	43
Applications approved and paid	-	2	2	8	5	17
Funding provided (Note 1)	-	$49,450	$126,350	$322,110	$229,450	$727,360

Source: Department of Natural Resources and the Government's Financial Management System.
Note 1: No payments were made in the year ended March 31, 2009 as the CIDP started in November 2008 after the construction season ended.

We reviewed a sample of 6 producer files, that included 14 applications, which were approved for funding under the CIDP, with payments totaling $589,150. Our review identified issues in the following areas:

1A. Program Assessment and Approval
1B. Program Payments
1C. Program Monitoring

1A. Program Assessment and Approval

Introduction

Guidelines for the CIDP along with an application form were provided on the Department website. These guidelines provided requirements for the program such as eligible activities, eligible applicants, and required documentation.

Producers were required to submit applications annually for funding under the CIDP. Applications and supporting documentation were submitted to the Program Manager. The Program Manager reviewed the application and requested separate recommendations from a Departmental Agricultural Representative and a Farm Management Specialist. After these recommendations were received, the Program Manager presented the application to the Committee.

The Committee was responsible for approving all projects for funding. After approval, the Program Manager prepared a contribution agreement which stated the amount and the conditions of funding. The contribution agreement was signed by the Minister of Natural Resources and then forwarded to the applicant for signing.

Our review of the 14 applications identified the following:

Business plans not always provided prior to funding

The CIDP guidelines required business plans to be submitted with the application. Business plans were required to include a business overview, marketing plan, human resources plan, production plan, financial plan, goals and supporting documentation.

Two applications were approved and funding of $49,450 was provided during the year ended March 31, 2010, however, business plans were not submitted until the producers applied for funding in subsequent years.

Financial information not always provided or adequate

The CIDP guidelines required applicants to submit financial statements for the previous three years of operation. For the years ended March 31, 2009 - 2012, the guidelines required applicants to submit financial statements prepared by a licensed accountant on a review engagement basis. For the year ended March 31, 2013, the guidelines were changed and no requirement regarding the type of engagement was included.

Three applications included financial information for only two years as opposed to the three years required by the guidelines. Prior to the year ended March 31, 2013, 9 applications were accepted by the Department which contained financial information that was not prepared on a review engagement basis.

Good standing status not always checked

The CIDP guidelines required that eligible applicants must be in good standing with the Province of Newfoundland and Labrador. This requirement was to be met by staff checking the status of the applicant with the Registry of Companies and Deeds. Four applications did not have a check on the status of the applicant with the Province's Registry of Companies and Deeds.

Other sources of funding not confirmed

The application form required the applicant to indicate all sources of funding for the project. The Department did not confirm the other sources of funding for 4 applications. Without confirmation of this funding the applicant may not have had sufficient funds to complete the project.

Arrears checks incomplete

As part of the assessment process, Departmental staff were required to confirm that the applicant and its related parties were not in arrears with three Government entities/divisions: the Business Investment Corporation; the Expenditure Control and Compliance Division of the Department of Finance; and the Debt Management Division of the Department of Finance.

Applications did not always have the required arrears checks completed with Government entities/divisions. Specifically:

- 2 applications did not have required arrears checks completed with any of the Government entities/divisions;
- 4 applications only had checks completed with the Expenditure Control and Compliance Division; and
- 8 applications that required an arrears check for the applicants' related parties did not have this check completed.

Environmental farm scans not always completed

The contribution agreements under the CIDP required that an environmental farm scan be completed prior to disbursement of funding. An environmental farm scan is a quick overview carried out by the Land Resource Stewardship Division of the Department of environmental practices on farms.

There was no documentation on file for 9 applications from 4 producers to indicate that Departmental staff had checked that environmental farm scans had been completed before funding was provided. Without documentation on file, we could not determine if these checks were conducted by the Division.

For these 9 applications, we requested whether scans were completed by the Land Resource Stewardship Division. We found that 2 producers were provided initial funding totaling $67,000 before a scan was conducted. We do note that both producers did have a scan completed before final payments were made.

Incomplete assessments by staff

As part of the assessment process, recommendations were requested from a Departmental Agricultural Representative and a Farm Management Specialist. These officials provided an assessment as to whether the applicant met the program requirements and had the resources required to complete the project. They also provided their concerns and their recommendation whether to fund the project.

Required assessments, as to whether applicants met program requirements, were not completed for 4 applications that were approved and for which funding totaling $165,010 was provided. As a result, the Committee approved applications without all assessments being performed.

Minutes not adequately documented

A review of all Committee minutes identified the following:

- 12 of 25 minutes had not been signed and dated. Also, of the 13 minutes that were signed, 10 were signed on the same date resulting in minutes being signed from 25 days to over one year from the date of the meeting.

  The review and approval of minutes of the previous meeting was not documented in 7 of the 25 meeting minutes. Of the minutes that included documentation of the review and approval, the time delay was significant. For example, one set of minutes documented the review and approval of minutes from the last four meetings with the earliest occurring 6 months prior. Also, 11 minutes indicated that changes were required.

- The Committee minutes did not always include documentation on administrative issues such as discussions or approval of the original CIDP guidelines or changes to the guidelines such as revising the requirements for sand specifications, or the removal of the requirement for review engagement financial statements.

- 2 of the 4 positions on the Committee were vacant since February 2012 due to the retirement of two staff.

The timely review, approval and signing of minutes is important to ensure the accuracy of the records. In addition, if decisions of the Committee are not properly documented and approved, it could result in a lack of accountability within the program.

Finding

1. The Department did not always obtain information that was required by the CIDP guidelines from an applicant before funding was approved or ensure that all the required checks and assessments were completed before approval of funding. We found the following instances where guidelines were not always followed:

   - business plans received after funding provided;
   - incomplete financial information provided;
   - good standing checks not completed;
   - other funding sources not confirmed;
   - arrears checks not completed;
   - no documentation that environmental farm scans completed;
   - internal applicant assessments not completed; and
   - CIDP Committee meetings not adequately documented.

1B. Program Payments

Introduction

Under the CIDP, payments of $15,000 per acre were disbursed in 2 payments – an initial payment of $5,000 per acre was made for bed construction which included access roads, dykes, and water reservoir construction, and a final payment of $10,000 per acre was made for the completion of site construction which included irrigation, ditches, drainage, and approved plant material. Payments for the full $15,000 per acre would also be disbursed if the acreage was fully completed and an initial payment was not provided. Applicants were required to submit a separate project claim form for each payment. On-site inspections were required to be conducted in advance of funding to ensure work was completed in accordance with the CIDP guidelines and the contribution agreement.

Upon receipt of inspection documentation and a claim form from the producer, a payment form was prepared by the Financial Officer and forwarded to the Program Manager and the Director of Production and Market Development for signing. The signed form was returned to the Financial Officer who prepared a copy for the client file and forwarded the original for processing.

We reviewed 12 payments totaling $589,150 for 5 producers. Our review identified the following:

Inspection process issues

The inspection process required an Agricultural Representative to visit the site and assess whether the site development met the minimum requirements for bed construction. The Agricultural Representative took digital photos of the site and completed an inspection certificate. The inspection certificate identified the requirements for the size of the bed, the size of the dykes, volume of water required in the reservoir, irrigation and drainage requirements, and sand and plant requirements. The Agricultural Representative was to indicate whether each requirement was met by the producer.

Our review of the inspection process identified the following issues:

- For 2 payments totaling $85,250, there were no inspection documents on file to verify that an inspection was carried out before funding was provided.

- We reviewed 24 inspection certificates related to 10 payments totaling $503,900 and identified 42 instances for 9 of the payments where the minimum requirements were not met. Specifically, the inspection certificates indicated:

  - 8 instances where the bed was over the maximum width allowed;

  - 2 instances where the depth of the ditch was less than the minimum of 60cm;

  - 6 instances where the field was not leveled to a minimum grade of 30cm;

  - 4 instances where the dyke width was less than the minimum of five metres;

- 14 instances where the dyke height was less than the minimum of one metre;
- 4 instances where irrigation requirements were not met; and
- 4 instances where the sand was not screened to ¾ inch.

4 of the 9 payments were for final payments and therefore, the acreage should have been developed in accordance with minimum requirements before payment was provided to the producer.

Finding

2. Payments were made to applicants when inspection certificates, which were intended to ensure that the applicant had developed the property in accordance with program guidelines, were not on file or when the inspection certificate indicated that the minimum requirements for acreage development were not met.

Inspection issues not documented in Committee minutes

We would expect that the issues with minimum requirements identified through the inspection process would have been documented in the minutes of the Committee. However, there were only 2 instances in our payment sample where there was documentation in the Committee minutes that these minimum requirements were not met by the producer. In both instances the Committee agreed to fund the initial payment but indicated that the acreage must be fully compliant with the minimum requirements before final payment. However, the inspection certificate for the final payment for one of these producers indicated the minimum requirement was still not met. There was no documentation to indicate that this non-compliance was again brought to the attention of the Committee.

Finding

3. We found instances where minimum program requirements were not being met. Documentation was not always in the minutes of the CIDP Committee, which approved the applications, to indicate whether these issues were discussed or if they were addressed.

Project claim forms not on file

Applicants were required to submit a project claim form signed by the applicant for each payment requested. The claim form indicated whether permits were acquired, the development at the site, the type of payment and the number of acres requested.

Finding

4. Project claims forms were not on file for 4 payments totaling $200,800.

1C. Program Monitoring

Introduction

The CIDP guidelines included the right of the Department to inspect any sites to ensure that the acreage was being developed in accordance with best management practices for cranberry production. Therefore, the Department could continue to monitor the sites throughout the term of the CIDP to ensure compliance with CIDP requirements and that developed acreage was being effectively managed to become viable cranberry production sites. The guidelines also required that the applicants participate in cranberry production courses and other training as required by the Department.

The contribution agreement required the repayment of funding received if the acreage was converted to a use that was incompatible with the intent of the project or sold or disposed of within three years.

In addition, in 2008, Cabinet directed the Department to develop evaluation criteria and submit to Cabinet an annual program evaluation of the CIDP.

Producer follow-up not performed

Our review of the Department’s monitoring and documentation of producer activities and development costs identified the following:

- There was no documentation that best management practices such as weeding, fertilizing, pest management, etc. were being followed by the producers. While the Department indicated that staff regularly visited farms and were aware of activities, there was no documented evidence as to how often visits occurred or the observations of staff. In addition, even though most farms were still being developed, there was no plan to monitor the future harvests, yields, profits, land use etc. of those producers receiving CIDP grants.

- The Department had not been collecting data on the actual cost of the development of land and whether it was still meeting its objective of funding 50% of the total costs. Producers estimated costs in their application and verbal feedback was received but there was no data collected or invoices submitted to verify actual development costs.

  Departmental staff indicated that as of 2013, the estimated cost to develop acreage was $40,000 to $45,000 per acre compared to the $30,000 to $35,000 estimated when the CIDP was established in 2008.

Finding

5. The Department did not adequately monitor and document producer activities or development costs to evaluate the success of the CIDP, to determine whether its objectives were being met, or to determine whether changes were needed to the CIDP policies to ensure its success.

CIDP funding not utilized

The majority of funding allocated for grant disbursements to producers under the CIDP over the five years was not utilized. Table 3 shows a comparison of the budget to actual grants for each year of the CIDP.

Table 3

Department of Natural Resources
Review of the Cranberry Industry
Grants to Producers
Budget to Actual
Years Ended March 31
($ 000's)

	2009	2010	2011	2012	2013	Total
Budgeted grants	$1,500	$1,500	$1,500	$1,500	$1,200	$7,200
Less budgeted revenue	(400)	(400)	(400)	(400)	(400)	(2,000)
Net	$1,100	$1,100	$1,100	$1,100	$ 800	$5,200
Actual grants	-	49	126	322	230	727
Funding not used	$1,100	$1,051	$ 974	$ 778	$ 570	$4,473
% of funding used	**0%**	**4%**	**11%**	**29%**	**29%**	**14%**

Source: Department of Natural Resources' financial reports

Departmental staff indicated funding was under-utilized because of a number of factors including:

- it was a new program;
- a considerable amount of time and construction was required before producers could access CIDP funding;
- the slow process to acquire land; and
- the availability of funding under the Town of Grand Falls-Windsor Cranberry Project and the Pre-commercialization Program was more attractive since only 10% producer contribution was required under these programs versus 50% under CIDP.

Finding

6. The Department only disbursed $727,000 of the $5.2 million (or 14%) in approved funding during the five years of the CIDP. Given the significant shortfall in funding provided under the CIDP, it would be difficult for the Department to meet the objectives of the program.

Revenue not collected

In 2008 as part of the Department's approval process for the CIDP, Cabinet required a 50% cost recovery for plant propagation. The Department planned to sell the cranberry plugs produced at the Nursery for 8 cents per plug (based on a cost of 16 cents per plug) to producers that received funding under the CIDP. The annual revenue budget of $400,000 was based on selling 5 million plugs per year to producers, however, producers were never charged for plugs during any of the five years. Departmental staff indicated that based upon the acreage planted by the farmers during the five years of the CIDP, approximately $152,400 in revenues were not collected by the Department.

Departmental staff indicated that plugs were provided free of charge under the Pre-commercialization Program and the Town of Grand Falls-Windsor Cranberry Project and it would have been unfair to charge the producers under the CIDP. Departmental officials indicated that a request was prepared and forwarded to Departmental Executive to repeal Cabinet's decision but due to staff turnover it was not known if the request was ever filed.

Program evaluation not completed

Cabinet also directed that the Department develop evaluation criteria and prepare an annual evaluation. The Department prepared briefing notes for the years ended March 31, 2012 and 2013 that included background information, grants disbursed, and reasons for the underutilization of funds, however, it did not report on evaluation criteria. The Department prepared a draft performance template that included some indicators and targets, however, the draft was never finalized and a performance report was not submitted during any of the five years.

Finding

7. The Department did not comply with Cabinet directives related to the CIDP. The Department did not recover 50% of the estimated plant cost from the producers nor did the Department prepare an annual program evaluation as directed by Cabinet.

Figure 3

Department of Natural Resources
Review of the Cranberry Industry
Cranberry Harvest

Source: Department of Natural Resources - 2010-2011 Annual Report

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Recommendations

If similar programs are to be provided in the future, the Department should:

- obtain all required information from applicants and complete all checks and assessments as required by program guidelines;
- document the discussions and approvals of program guidelines in Committee minutes and approve and sign all minutes of meetings in a timely manner;
- ensure the minimum requirements as per guidelines are met before payment is disbursed;
- establish a process to determine that best farm management practices are being followed;
- collect and monitor data on the actual cost of acreage development, producer yields and returns; and
- finalize a program evaluation and complete evaluations annually.

2. Other Department Initiatives

Overview

In addition to providing grants to producers, the Department was involved in other activities related to the cranberry industry. The Nursery produced the plant material for all cranberry farms in the Province. This restriction on the production of plant material was to ensure high-producing, genetically-pure cranberry fields to enhance berry quality and to prevent the introduction of diseases and pests. As well as the plugs being provided to farmers receiving grants under the CIDP, plugs were also provided to farmers for the Town of Grand Falls-Windsor Cranberry Project and the Pre-commercialization Program carried out by the Newfoundland and Labrador Federation of Agriculture.

Since 1999, the Department also operated a research site at Deadman’s Bay located in Bonavista Bay where the Department conducted research on plant varieties and best practices for cranberry production. During the year ending March 31, 2014 the site was closed and employee positions were terminated. In May 2013, the Department advertised a request for proposals for an operator for the site, however, as of December 2013 an operator had not been found as there were no qualified respondents to the request.

We reviewed expenditures, proposals and reports related to these other Departmental initiatives and identified issues in the following areas:

2A. Wooddale Provincial Tree Nursery
2B. Industry Goals

2A. Wooddale Provincial Tree Nursery

Introduction

The Nursery is located between Grand Falls -Windsor and Bishop's Falls and opened in 1974 to produce tree seedlings to meet reforestation needs in the Province. In 2008, it was decided to use 3 of the 36 greenhouses at the Nursery for cranberry production. Vines were grown in the three greenhouses and cuttings were taken from these vines to produce cranberry plugs. Plug production generally took place in the fall and plugs were usually distributed in late spring or early summer to cranberry producers for planting in their fields.

Figure 4

Department of Natural Resources
Review of the Cranberry Industry
Cranberry Plants at Wooddale Tree Nursery

Source: Department of Natural Resources

Excess inventory levels

The budget allocated to the Nursery for plug production was $800,000 annually, which was based on producing 5 million plugs at an estimated cost of 16 cents per plug. Departmental staff indicated that production levels were maintained to ensure that 5 million plugs were ready and available annually. However, over the five years of the CIDP, the average production was only 3.2 million plugs while on average, shipments to producers were only 1.7 million plugs, about 53% of the average produced. The development of a cranberry field generally took two years as the bed was constructed in the fall of the first year and planting was done in the summer of the following year. Therefore, plug production could have been based on the acres of beds constructed and ready for planting the following summer rather than the 5 million plugs budgeted.

In addition, the decision to utilize three greenhouses was based on sustaining an inventory level of 5 million plugs. The vine inventory in the three greenhouses had the capacity to produce 9 to 12 million cuttings annually. The success rate of these cuttings was approximately 60% to 70%, therefore maximum capacity would produce 5.4 to 8.4 million plugs.

The maximum capacity was utilized only in 2011 when 6.5 million plugs were produced. Departmental staff indicated that an inventory of 9 to 12 million vines was not maintained every year and in a low year there may have only been 6 million, however, the Department could not provide any data regarding the actual vine inventory maintained over the five years.

As a result of sustaining the budgeted number of plugs, an inventory of approximately 6.2 million plugs remained at the end of the CIDP in March 2013. Nursery staff indicated that a cranberry seedling would ideally be shipped within one year of production and that retaining plugs in inventory resulted in additional maintenance costs, exposure to weeds and overwintering losses. In addition, older plugs required more effort on the part of the producer as planting equipment would have to handle longer vines which resulted in problems with separating the vines and culling the weeds. The Department indicated they were hopeful that the remaining plugs would be utilized by producers as they moved forward with development, however, as of November 2013, only 1 million plugs of the 6.2 million in inventory had been distributed to producers since March 2013.

Finding

8. The Department maintained production and inventory levels, throughout the five year program, based on a budgeted amount established in 2008 instead of the annual demand of the producers. As a result, excess inventory levels were being maintained at the Nursery and the level of production throughout the five year program was not required to meet the demand of the producers.

2B. Industry Goals

Introduction

In 2008, when the CIDP was established, the program was expected to contribute $12.2 million over five years to the cranberry industry. The Department's short-term goal was to reach a minimum of 500 acres within five years to sustain a viable industry. The long-term goal of the industry was the development of 600 to 800 acres within ten years to justify the establishment of a processing facility for cranberries. Departmental officials indicated that the vision for the industry was to develop 2,500 acres for cranberry production.

Program expenditures

The Department did not have a centralized process for compiling expenditures related to the cranberry industry. In addition to the programs included in our review, funds were also provided to cranberry producers under other Department programs such as the Growing Forward program and the Agrifoods Assistance Program.

In addition to the Department's contributions, another department provided $1.1 million to the Town of Grand Falls-Windsor Cranberry Project and approximately $185,000 to the Pre-commercialization Program.

Based upon the financial and operational information reviewed, Table 4 summarizes the Province's investment in the cranberry industry from 2009 to 2013.

Table 4

Department of Natural Resources
Review of the Cranberry Industry
Cranberry Program Expenditures
Years ended March 31
($000's)

Cranberry Programs	2009	2010	2011	2012	2013	Total
Department of Natural Resources programs						
CIDP grants	$ -	$ 49	$ 126	$322	$230	$ 727
Wooddale Tree Nursery	312	778	906	359	356	2,711
Research site (Note 1)	168	223	241	90	105	827
Total	$480	$1,050	$1,273	$771	$691	$4,265
Other Department programs						
Pre-commercialization Program						185
The Town of Grand Falls-Windsor Cranberry Project						1,125
Total						**$5,575**

Source: Department of Natural Resources' financial reports
Note 1: Expenditures were based upon a 95% allocation of total expenditures related to cranberry operations.

Differing program criteria

The funds provided under the Town of Grand Falls-Windsor Cranberry Project and the Pre-commercialization Program were distributed to producers through not-for-profit organizations and not directly from the Provincial government. The terms and conditions of funding under these two programs varied from the CIDP. For example,

- CIDP required approximately 50% contribution from the producer, however, the Town of Grand Falls-Windsor Cranberry Project and the Pre-commercialization Program only required a 10% contribution.

- The agreements for the CIDP required the producers to repay all funding received if the acreage was sold or changed from cranberry production within three years, however, there was no similar requirement under the other programs.

- Under CIDP, funding was not provided until the acreage was developed and inspected for each producer. However, under the other programs, funding was distributed to the not-for-profit organizations for all producers before development was complete. We note that for one program there was still acreage remaining to be constructed and planted by the farmers but the funding has already been provided to the not-for-profit organization.

  Furthermore, final reports from the not-for-profit organizations were required to be submitted before the final payments were provided, however, these have not yet been submitted even though all funds have been disbursed.

Finding

9. The Province's investment in the cranberry industry was segmented and was not coordinated. Funding was provided to programs that were distributed and monitored differently than the CIDP which may have affected the ability of the Department to attract investment.

Department goals not reached

In 2008 there were four pilot sites in the industry with cranberry beds totaling approximately 23 acres. Over the next five years, approximately 189 acres were planted. As of November 2013, there were 14 producers with approximately 212 acres completed and the Province spent approximately $5.6 million over the last five years.

Finding

10. Although the Province spent $5.6 million during the past five years on the cranberry industry, the Department did not reach its short-term goal of developing 500 acres.

Future Provincial funding unknown

Our review of the status of the CIDP identified the following:

- As at March 31, 2013 five producers had been provided initial funding of $155,850 towards bed construction under CIDP but had not planted plugs for 31.17 acres. As at November 2013, only one of the five producers had planted plugs and completed an additional 6.5 acres. Departmental staff indicated that producers had anticipated a new program and had waited before proceeding with additional development. If the four producers do not complete their acreage, the initial grants provided by the Department may have no value to the industry.

- The Nursery had over 5 million plugs as at November 2013 as well as the vine inventory with the capacity to produce an additional 4 million plugs annually. If these plugs and vine inventory are not used in the future, the Department's investment in these resources will have provided no value to the industry.

- The price producers received for cranberries has dropped from 85 cents per pound in 2009 to 12 cents per pound in 2013. Given this decline in pricing, it is uncertain whether the future development of the industry can continue without financial and technical assistance from the Province.

Finding

11. Funding under the CIDP ceased on March 31, 2013. It was not known if future cranberry assistance programs will be approved by Government, however, as at November 2013, there were producer acreages yet to be developed which received initial funding under the CIDP and there was a large inventory of plugs and vines still being maintained at the Nursery.

Recommendations

If similar programs are to be provided in future, the Department should:

- vary the budget annually for changes in targets and objectives and establish production targets based on program demand; and
- ensure that all Government initiatives for the industry are consistent and coordinated amongst the various programs with regards to program criteria, producer contributions, terms of funding and monitoring activities.

Department's Response

The Forestry and Agrifoods Agency acknowledges the findings and recommendations identified in the Auditor General's report on its review of the Cranberry Industry and will take the appropriate action to address the recommendations.

The specific actions the Forestry and Agrifoods Agency will take regarding your recommendations are as follows:

1. Cranberry Industry Development Program Grants:

Recommendations:

If similar programs are to be provided in the future, the Department should:

- *Obtain all required information from applicants and complete all checks and assessments as required by program guidelines.*

  Action:

  The Department will ensure appropriate procedures are in place for future programs to ensure all required information from applicants is received and all checks and assessments are completed as required by program guidelines.

- *Document the discussions and approvals of program guidelines in Committee minutes and approve and sign all minutes of meetings in a timely manner.*

Action:

The Department will ensure that for future programs, procedures are in place to ensure the documentation of discussions and approvals are in Committee minutes and are signed off in a timely manner.

- *Ensure the minimum requirements as per guidelines are met before payment is disbursed.*

  Action:

  The Department will develop procedures for future programs to ensure the minimum requirements of the guidelines are met before payments are disbursed.

- *Establish a process to determine that best farm management practices are being followed.*

  Action:

  The Department will establish a process for future programs to ensure that best farm management practices are followed.

- *Collect and monitor data on the actual cost of acreage development, production yields and returns.*

  Action:

  The Department will establish procedures for future programs that will collect and monitor data as required for the specific program involved.

- *Finalize a program evaluation and complete evaluation annually.*

  Action:

  The Department will establish procedures for future programs that ensure program evaluations are completed annually and on program completion.

2. Other Department Initiatives

Recommendations

If similar programs are to be provided in future, the Department should:

- *Vary the budget annually for changes in targets and objectives and establish production targets based on program demand.*

  Action:

  The Department will establish procedures for similar programs in the future that the annual budget and production targets will be reviewed and modified where possible based on change in targets, objectives, demands, etc.

- *Ensure that all Government initiatives for the industry are consistent and coordinated amongst the various programs with regards to program criteria, producer contributions, terms of funding and monitoring activities.*

  Action:

  The Department will establish procedures in similar programs in the future to ensure the consistency and coordination of all Government initiatives amongst the various programs.

PART 3.6

DEPARTMENT OF NATURAL RESOURCES

OIL ROYALTY MONITORING

Summary of Findings

Introduction

Oil royalty revenues are a significant source of revenue for the Province. In addition, the royalty and cost audits of these royalties also result in significant adjustments to royalty revenues. The Department of Natural Resources (the Department) is responsible for administering and monitoring petroleum projects and related oil royalties paid to the Province through the Royalties Division (the Division).

The objective of our review was to determine whether the Department had systems and practices for monitoring the completeness and accuracy of oil royalties received from the project owners.

Findings

Our review concluded that the Division needs to improve the timeliness of auditing oil royalties and project costs submitted by the various project owners and operators of the Province's five producing oil projects. Specifically:

Completion of Audits

1. The Division is not starting audits until late in the audit period. If audits are not started until late in the audit period, this could result in audits not being completed by the Division if unforeseen circumstances arise (i.e. staff vacancies). If audits are not issued within the required timeframe as a result of Division delays, royalties for that period would not be subject to audit reassessment resulting in possible lost revenues to the Province.

2. As the amount of time between the royalty year and the year an audit commences increases, the sufficiency and quality of audit evidence gathered or available may be impacted.

3. The Division has 159 audits yet to be completed by 2018. Of the 143 annual royalty and eligible cost audits, 23 were in progress at December 2013 and 120 had yet to be started. In addition, the Division also had 16 various development and transportation cost audits yet to be completed. Although the Division has established a schedule for the completion of these audits, the expected completion dates for these audits are either in the last year or second last year of the audit period resulting in limited audit time if unforeseen circumstances arise.

Monitoring of Audit Time

4. Although the Division prepared overall staffing requirements and determined expected budgeted hours for different types of audits (i.e. royalty or cost) during the Department's annual budget process, it did not establish and document specific time budgets for each audit to be conducted.

5. The Division did not have a time management system in place to record the time auditors spent on each audit. As a result, the Division could not provide specific details of how many hours were worked on each audit or a breakdown of these hours by staff. Without the monitoring of actual time spent on each audit, it is difficult for the Division to determine if variances between budgeted and actual time exist or whether future budgeted time will be impacted.

Use of Consulting Services

6. Given the vacancies in the Division's staff complement, competing working assignments and the amount of time required to complete the remaining royalty and cost audits, it is unlikely that the Division has sufficient resources to avoid using the services of external consultants, a more costly option to the Department.

Background

Overview

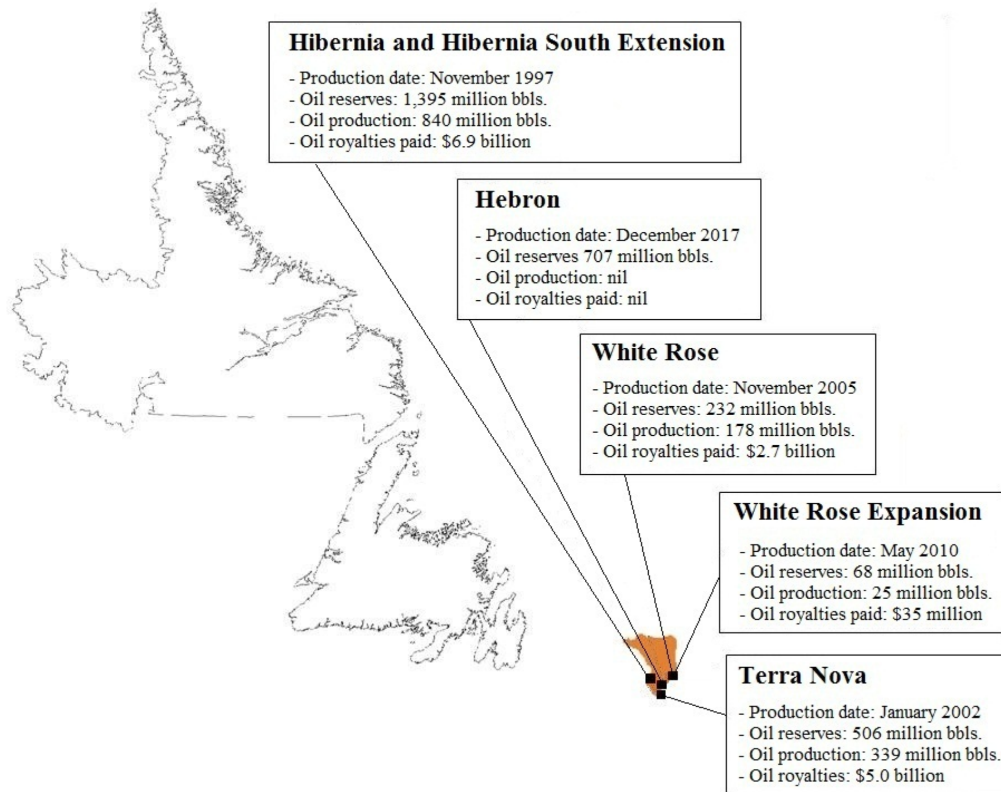
The Department of Natural Resources (the Department) is responsible for administering and monitoring petroleum projects and related oil royalties paid to the Province.

As at March 31, 2013, there were five producing offshore projects – Hibernia, Hibernia South Extension, Terra Nova, White Rose and White Rose Expansion; and one non-producing offshore project – Hebron. The five producing projects have project owners as follows: Hibernia (6), Hibernia South Extension (7) Terra Nova (7), White Rose (2) and White Rose Expansion (3). Each of the projects has a designated project operator.

The six projects are located in the Jeanne d'Arc Basin, approximately 350 kilometres east-southeast of St. John's. Figure 1 shows information on the six projects.

Figure 1

Department on Natural Resources
Oil Royalties
Petroleum Oil Projects
As at March 31, 2013



Royalties Division

The Department monitors the petroleum projects and the royalties paid to the Province through its Energy Branch. The Royalties Division (the Division) is responsible for the administration and audit of oil royalties paid to the Province.

Project Monitoring and Administration Section

The Division's Project Monitoring and Administration Section (the Accounting Section) is responsible for the verification and assessment of the monthly reports and annual reconciliations submitted by the project owners. The Accounting Section refers to this as a "desk review" which consists of the recalculation, reconciliation, analysis and assessing reasonableness of royalty information submitted by the project owners.

The Accounting Section also reviews and analyzes the annual external auditor reports on project costs submitted by each of the project operators. In addition, the Accounting Section performs an annual reconciliation of royalty receipts reported by the Central Cash Division of the Department of Finance to information submitted to the Department of Natural Resources by the project owners.

Petroleum Audits and Assessments Section

The Division's Petroleum Audits and Assessments Section (the Auditing Section) is responsible for auditing all oil projects within the Province and offshore. There are two main types of audits:

- **Royalty audits** - These audits are to determine whether the royalties paid by each project owner are accurate. These audits are conducted for every project owner.

- **Cost audits** - These audits are to determine whether pre-development costs, development costs and project costs are eligible in accordance with established guidelines. These audits are conducted for every project operator.

The Division is required to complete royalty and cost audits within an approved audit period.

Division management information system

The Division maintains a Petroleum Revenue Monitoring and Administration Management System which records information from:

- monthly reports submitted by the project owners which include items such as oil sales, exchange rates, pricing, sales, inventories, costs, and royalties;

- annual cost reports submitted by the five project operators which are audited by external auditors; and

- oil production reports received from the Canada-Newfoundland and Labrador Offshore Petroleum Board.

The Division uses the system to recalculate royalties each month, for internal information purposes and to assist staff in conducting audits.

Funding

Table 1 outlines the Division's expenditures for the last five years.

Table 1

Department of Natural Resources
Oil Royalties
Royalties Division Expenditures
For the Years Ending March 31

Expenditure	2009	2010	2011	2012	2013
Salaries	$ 673,222	$ 854,444	$ 916,323	$1,097,436	$1,150,197
Employee benefits	6,510	6,795	7,745	8,796	4,166
Transportation and communications	43,270	26,670	14,903	22,596	4,044
Supplies	17,797	3,009	8,243	19,638	8,885
Professional services	555,608	556,664	226,731	218,639	288,695
Purchased services	7,185	1,400	2,578	3,297	1,370
Property, furnishings and equipment	11,599	8,637	3,235	2,586	2,007
Total	**$1,315,191**	**$1,457,619**	**$1,179,758**	**$1,372,988**	**$1,459,364**

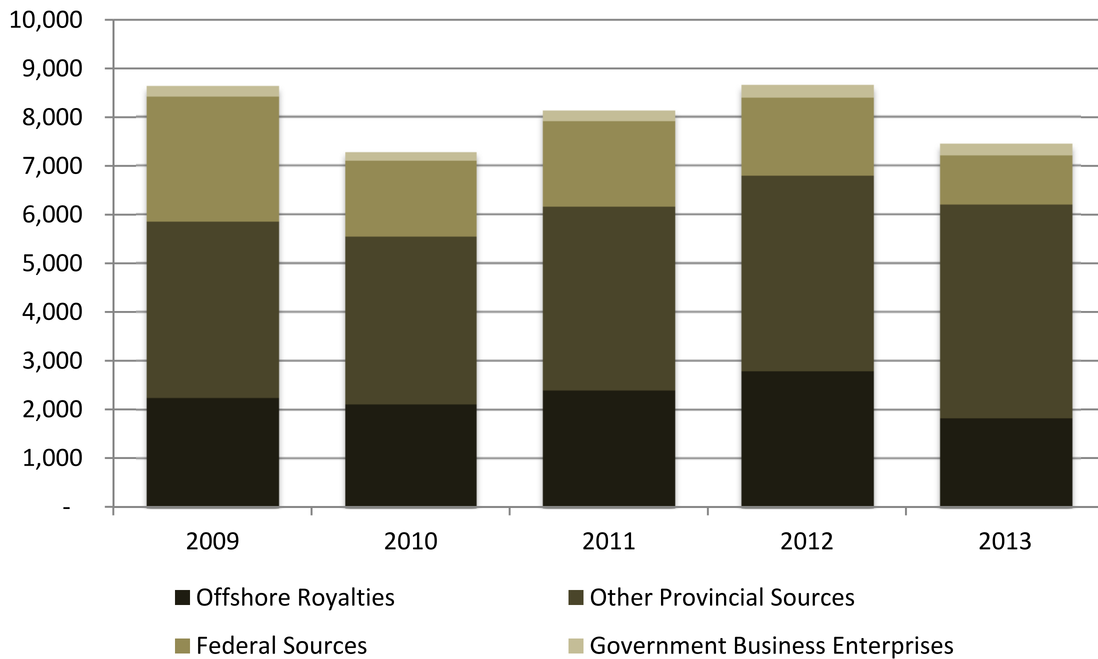
Source: Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

Oil royalty revenue

Oil royalty revenues represent a significant portion of the Province's total revenues. Oil royalties of $1.83 billion accounted for 25% of the Province's revenue for the year ended March 31, 2013 (2012 - $2.79 billion or 32%). Figure 2 provides an overview of oil royalty revenue compared to other sources of revenue for the Province. As the figure shows, offshore royalties have become a significant source of revenue for the Province over the past five years.

Figure 2

Department of Natural Resources
Oil Royalties
Oil Royalty Revenues
For the Years Ending March 31
($ Millions)



Source: Consolidated Summary Financial Statements

Increasing revenues

Each of the project owners pay oil royalties to the Province monthly through a self-assessment process. The oil royalties are determined and submitted based on established agreements, legislation, formulas and remittance forms. Table 2 shows all oil royalties reported up to March 31, 2013. The Province's reliance on offshore royalties to fund its programs and services has grown significantly in recent years. In 2003, offshore royalties were $82 million, while in 2013 offshore royalties were $1.8 billion.

Table 2

Department of Natural Resources
Oil Royalties
For the Years Ending March 31
($ Millions)

Year	Hibernia	Hibernia South Extension	Terra Nova	White Rose	White Rose Expansion	Total
1998	$ 0.7	$ -	$ -	$ -	$ -	$ 0.7
1999	3.9	-	-	-	-	3.9
2000	23.4	-	-	-	-	23.4
2001	39.8	-	-	-	-	39.8
2002	28.8	-	1.9	-	-	30.7
2003	65.6	-	16.7	-	-	82.3
2004	80.6	-	46.3	-	-	126.9
2005	164.6	-	99.5	-	-	264.1
2006	231.5	-	299.4	5.1	-	536.0
2007	208.6	-	188.0	26.4	-	423.0
2008	209.1	-	1,004.4	536.5	-	1,750.0
2009	229.5	-	1,142.6	866.5	-	2,238.6
2010	983.6	-	788.3	349.4	-	2,121.3
2011	1,398.4	-	672.6	323.0	5.4	2,399.4
2012	1,744.2	3.9	562.1	468.9	15.5	2,794.6
2013	1,465.2	4.2	174.9	170.0	13.9	1,828.2
Total	**$ 6,877.5**	**$ 8.1**	**$ 4,996.7**	**$ 2,745.8**	**$ 34.8**	**$ 14,662.9**

Source: Department of Natural Resources and the Public Accounts of the Province

2008 review highlights

Our Office performed a review of the Division's administering and monitoring of oil royalties in 2008. Our review identified issues with the timeliness and scheduling of annual audits conducted by the Division, limited access to certain information from the Hibernia project operator, Hibernia's and Terra Nova's transportation costs, inadequate assessment of annual reconciliations, outdated audit manual, limited desk review procedures, and contract fees paid in excess of approved rates.

Our Office followed up on our 2008 recommendations in 2010, 2011 and 2012. Although the Division had taken action on our 2008 recommendations, the timeliness of annual royalty and cost audits remained a concern.

Objective and Scope

Objective

The objective of our review was to determine whether the Department had systems and practices for monitoring the completeness and accuracy of oil royalties received from the project owners.

Scope

We completed our review in December 2013. Our review covered the period April 1, 2011 to March 31, 2013 and included oil royalties from the Hibernia, Hibernia South Extension, Terra Nova, White Rose and White Rose Expansion projects. Our review examined the Division's financial and statistical information, reports submitted by each project operator and owner, the Division's audit processes, and project cost and royalty audit reports.

Detailed Observations

This report provides detailed findings and recommendations on the status of audits.

Status of Audits

Overview

The Department is required to complete its audits of oil royalties within an approved audit period for each of the five producing projects.

In accordance with the *Hibernia Royalty Agreement* and the *EL1093/PL1005 Royalty Agreement*, audits for Hibernia and Hibernia South Extension are to be conducted within six calendar years following the calendar year in which royalties were payable or an eligible cost was paid. In addition, the Department is required to issue its audit findings to each project owner before the end of the calendar year following the end of the audit period. For example, 2012 royalties and costs are required to be audited by December 31, 2018 and findings issued by December 31, 2019.

Oil Royalty Monitoring

In accordance with the *Royalty Regulations, 2003*, audits for Terra Nova, White Rose and White Rose Expansion are to be conducted within five years following the calendar in which the royalty or an eligible cost was reported. In addition, the Department is required to issue its audit findings to each project owner within 120 days following the end of the audit period. For example, given that 2012 royalties and costs are to be reported by April 30, 2013, royalty and costs are required to be audited by December 31, 2018 and findings issued by April 30, 2019.

In reviewing the Division's administration and monitoring of oil royalties we identified issues in the following areas:

A. Completion of Audits
B. Monitoring of Audit Time
C. Use of Consulting Services

Details are as follows:

A. Completion of Audits

Introduction

The Division performs audits on oil royalties to ensure revenues remitted are accurate, complete and in accordance with agreements and legislation. Benefits of timely audits include:

- audit work can be more efficiently and effectively performed if conducted closer to the reporting period, e.g. improved quality/quantity of audit evidence available (i.e. less likely to have missing documentation), availability of company staff that were present during the royalty audit year and more opportunity to manage Division staff vacancies if they arise during the audit period;

- audit issues and royalty adjustments can be dealt with in a timely manner;

- additional royalties can be collected promptly; and

- future royalty calculations can take advantage of audit recommendations and rulings.

Efforts to have more timely audits

The Division has made reducing the inventory of audits and decreasing the audit turnaround period a priority. Since our 2008 review, the Division indicated that a number of factors have negatively affected their progress in reducing the number of audits to be completed.

- In 2010, the Division reported that there had been additional staff turnover and assignment of resources to negotiations and dispute resolution.
- In 2011, the Division reported that audit staff were involved with other work, in addition to cost and royalty audits, which was important to the integrity of royalty administration.

We note that in the 2013-14 budget, appropriations were approved for the Division for the creation of 4 permanent audit positions to help more efficiently and effectively resource the audit function within the Division. As a result, the Division's approved audit staff complement for the year ended March 31, 2014 was 12 employees – 2 managers, 6 senior auditors and 4 auditors. A Division official indicated that as of November 2013, 1 auditor was on leave with the position vacant and 2 employees (one manager and one senior auditor) had been reassigned to other non-audit duties, resulting in a staffed complement of 9 audit employees active on annual audit activities.

Importance of the audit process

The Division determines the reassessments (referred to as re-determinations in the case of Hibernia) that are required to the amount of royalties paid by the project owners. The project owners must pay any amounts due to the Province or the Province must pay amounts due to project owners, as a result of the reassessment, in the month following the month of final notification. A project owner may object to a final reassessment and, if not resolved, the project owner can submit the issue to arbitration for a ruling.

The annual Hibernia royalty and cost audits for the years 1997 to 2005 resulted in additional royalties totaling $2.9 million payable to the Province. The annual Terra Nova royalty and cost audits for the years 2002 to 2005 resulted in additional royalties totaling $45.4 million payable to the Province. The magnitude of these audit results indicates the importance of these annual audits and why these audits should be performed on a timely basis.

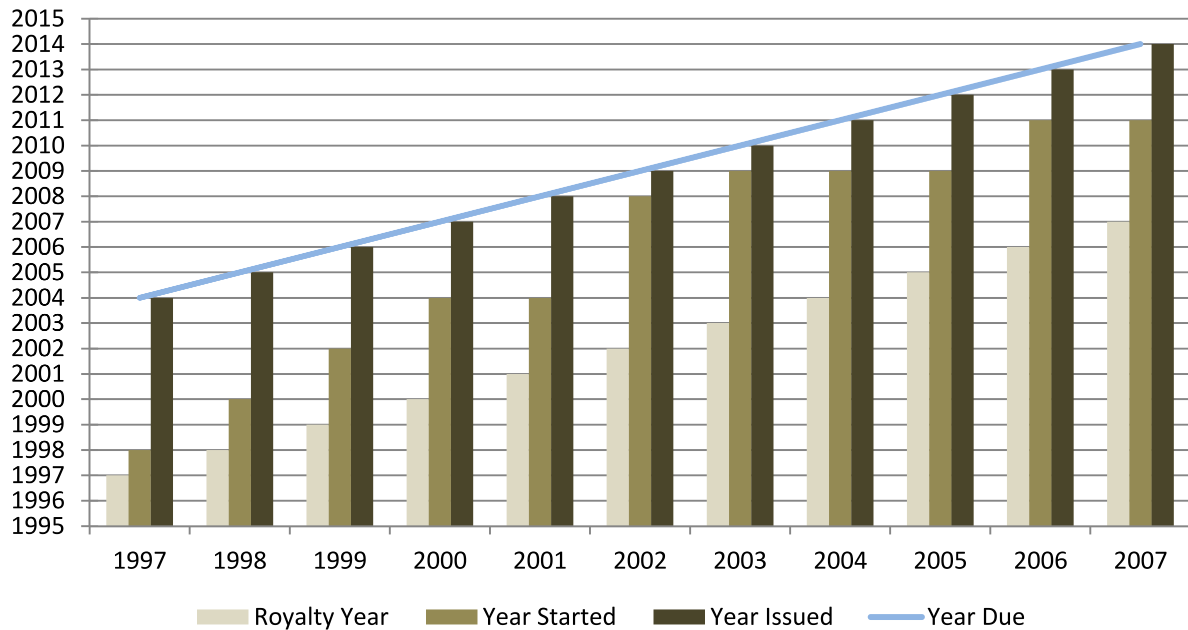
Audit status

Figure 3 provides an overview of the start dates compared to the issue dates of the audits for the Hibernia and Terra Nova projects.

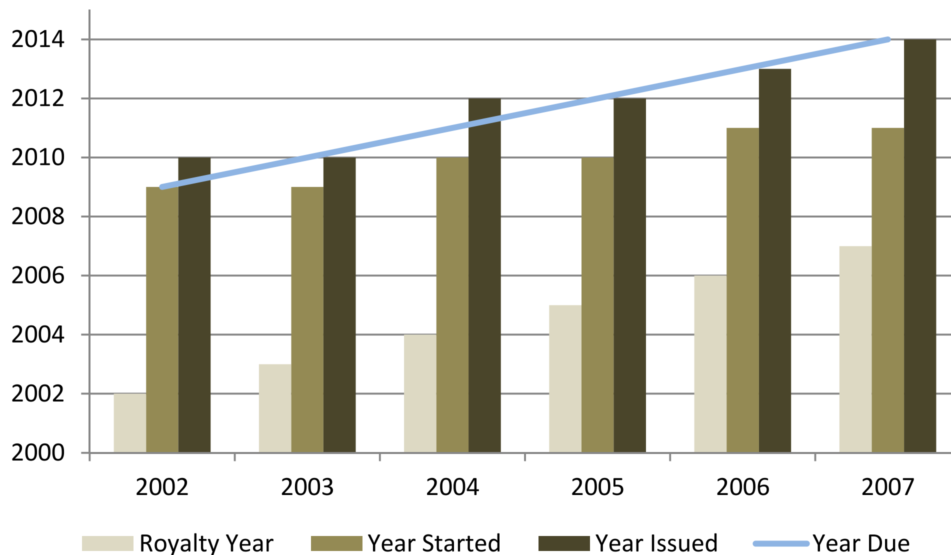
Figure 3

Department of Natural Resources
Oil Royalties
Hibernia and Terra Nova Completed Audits
For the Royalty Years Ending December 31

Hibernia Audits



Terra Nova Audits



Audits not being started and completed in timely manner

As Figure 3 illustrates audits are not being started and completed in a timely manner. For example, the Terra Nova annual royalty and cost audits for 2002 through to 2005 were not started until 2009 and 2010, the fifth and sixth year of the respective audit periods, leaving only one to two years to complete the audits.

Although the Division is completing audits within the required timeframes, the Division has issued all of its audits in the last year of the required timeframe for the issuance of audits. In some cases the audit period had been extended (i.e. Terra Nova – 2002 and 2004 audit period), however, it was as a result of regulatory issues or client delay issues.

Findings

1. The Division is not starting audits until late in the audit period. If audits are not started until late in the audit period, this could result in audits not being completed by the Division if unforeseen circumstances arise (i.e. staff vacancies). If audits are not issued within the required timeframe as a result of Division delays, royalties for that period would not be subject to audit reassessment resulting in possible lost revenues to the Province.

2. As the amount of time between the royalty year and the year an audit commences increases, the sufficiency and quality of audit evidence gathered or available may be impacted.

Table 3 shows the breakdown of the audits by project that remain uncompleted by the Department as of December 2013.

Table 3

Department of Natural Resources
Oil Royalties
Audits Not Completed as of December 2013

Audits Not Completed	Hibernia	Terra Nova	White Rose	White Rose Expansion	Hibernia South Extension	Hebron	Total
Annual audits							
Cost	7	6	6	3	2	-	24
Royalty	42	42	12	9	14	-	119
Total annual audits	**49**	**48**	**18**	**12**	**16**	**-**	**143**
Other audits							
Pre-development and/or development cost	-	-	-	2	1	1	4
Annual tanker cost	4	4	4	-	-	-	12
Total other audits	**4**	**4**	**4**	**2**	**1**	**1**	**16**
Total audits to be completed	**53**	**52**	**22**	**14**	**17**	**1**	**159**

Source: Division Audit Status Report

Schedule of audits to be completed

Table 4 lists the expected completion dates for the audits in progress and yet to be started.

Table 4

Department of Natural Resources
Oil Royalties
Audit Schedule
For the Years Ending December 31

Year	Hibernia (6 royalty audits & 1 cost audit)	Terra Nova (7 royalty audits & 1 cost audit)	White Rose (2 royalty audits & 1 cost audit)	White Rose Expansion (3 royalty audits & 1 cost audit)	Hibernia South Extension (7 royalty audits & 1 cost audit)
2006	December 2013				
2007	March 2014	March 2014	March 2014		
2008	March 2015	March 2015	March 2015		
2009	March 2015	March 2015	March 2015		
2010	March 2016	March 2016	March 2016	March 2016	
2011	March 2017	March 2017	March 2017	March 2017	March 2017
2012	Not scheduled	Not scheduled	Not scheduled	Not scheduled	Not scheduled

Source: Department of Natural Resources

The Division also has the following 16 cost audits scheduled to be completed:

- the 12 tanker cost audits for 2009 through to 2011 have an expected completion date of March 2015, March 2016 and March 2017;
- the White Rose Expansion pre-development cost audit has an expected completion date of March 2014 while the White Rose Expansion development cost audit has an expected completion date of March 2016;
- the Hebron pre-development cost audit has an expected completion date of March 2015; and
- the Hibernia South Extension development cost audit has an expected completion date of March 2016.

Finding

3. The Division has 159 audits yet to be completed by 2018. Of the 143 annual royalty and eligible cost audits, 23 were in progress at December 2013 and 120 had yet to be started. In addition, the Division also had 16 various development and transportation cost audits yet to be completed. Although the Division has established a schedule for the completion of these audits, the expected completion dates for these audits are either in the last year or second last year of the audit period resulting in limited audit time if unforeseen circumstances arise.

B. Monitoring of Audit Time

Introduction

The Audit Manual for petroleum audits states that management should provide to their audit staff, an estimate of the time expectations and deadlines for each audit. This estimate should be realistic based on past audits and the experience and qualifications of the staff involved. The purpose of estimating time requirements for the completion of the audits is so that the Division can anticipate any resource constraints in achieving their audit objectives for the period. Our review identified the following issues:

Inadequate budget and time management system

During the year ended March 31, 2013, the Division had 8 positions in the Audit Section. The Division estimates that an annual royalty audit will take 175 hours to 300 hours to complete depending upon the project. An annual cost audit is expected to take 500 hours to 750 hours to complete depending upon the project. Although the Division prepared overall staffing requirements and determined expected budgeted hours for different types of audits (i.e. royalty or cost) during the Department's annual budget process, it did not establish and document specific time budgets for each audit to be conducted. Because the petroleum audits are subject to different project owner percentages and annual sales, production levels and operating and cost variations, we would expect the time to complete each audit would vary depending upon the project owners and year audited.

In addition, the Division did not have a time management system in place to record the time auditors spent on each audit. As a result, the Division could not provide specific details of how many hours were worked on each audit or a breakdown of these hours by staff.

Findings

4. Although the Division prepared overall staffing requirements and determined expected budgeted hours for different types of audits (i.e. royalty or cost) during the Department's annual budget process, it did not establish and document specific time budgets for each audit to be conducted.

5. The Division did not have a time management system in place to record the time auditors spent on each audit. As a result, the Division could not provide specific details of how many hours were worked on each audit or a breakdown of these hours by staff. Without the monitoring of actual time spent on each audit, it is difficult for the Division to determine if variances between budgeted and actual time exist or whether future budgeted time will be impacted.

C. Use of Consulting Services

Overview

The Division uses the services of an external consultant to conduct various audit-related services. In August 2011, the Department entered into a 3-year contract with the external consultant for the provision of audit support and advisory services for the period July 1, 2011 to March 31, 2014 at a maximum cost of $1.3 million ($400,000 in 2011-12, $450,000 in 2012-13 and $450,000 in 2013-14). During the period covered by our review, the Department used this external consultant for the completion of various cost audits and to review notices of objections received from project owners. For the period April 1, 2011 to March 31, 2013, the Department paid the consultant $507,334.

Increased cost of contracted services

Division officials indicated that the use of contracted services over the past number of years was required to assist with its audit-related services. Division officials stated that because of staff vacancies, as a result of staff turnover and transfers, Divisional audit staffing levels were not always sufficient to ensure that audits would be completed within the required audit periods.

Division officials were aware that the use of contracted services was a more expensive alternative to that of using internal Divisional audit resources. A review of the consultant's contract identified an approved time rate schedule with fees ranging from $85 per hour for secretarial duties to $340 per hour for senior audit staff. The Division indicated that the hourly rates (adjusted for Government's cost of employee benefits) for Divisional audit staff ranged from approximately $40 to $64. Although these consultant services were deemed necessary to ensure audits were completed within the required deadlines, the cost associated with these services suggests that the Department should review the adequacy of its internal structure and resources.

Demand for contracted services

In its 2013-14 budget, the Department had increased the Division's audit staffing complement to 12 permanent audit staff which was expected to result in a reduced requirement for contracted services, and a lower professional services budget allocation. However, Division staff indicated that as of November 2013, one audit position was vacant and two audit staff had been assigned to other duties not associated with the annual audits.

Also, the Division has scheduled the 2008 and 2009 annual royalty and cost audits for Hibernia, Terra Nova and White Rose, the 2009 tanker cost audits, and the Hebron Pre-development cost audit to be completed and issued by March 2015. Based upon the estimated audit hours for each of these audits to be completed, the Division will need approximately 16,250 audit hours. Our review identified that, based upon a full complement of 12 audit staff and the Division's allocated audit hours per staff, the Division has approximately 16,053 available audit hours from December 2013 to March 2015.

Therefore, based upon a full complement and being able to start work on the scheduled audits in December 2013, the Division would be able to meet its March 2015 schedule for these audits. However, as of November 2013, the Division did not have a full staff complement and audits scheduled to be completed for March 2014 were still in progress and would also require the use of some of the 16,053 available audit hours. Therefore, in order for the Division to meet its March 2015 schedule, the Division would either have to avail of consultant services, re-assess its internal resources and audit processes or extend the schedule.

Finding

6. Given the vacancies in the Division's staff complement, competing working assignments and the amount of time required to complete the remaining royalty and cost audits, it is unlikely that the Division has sufficient resources to avoid using the services of external consultants, a more costly option to the Department.

Recommendations

The Department should:

- ensure audits commence earlier in the audit cycle to ensure timely completion;
- develop a budget and time keeping system to track and monitor time spent on audits for the purpose of audit planning; and
- continue efforts to maintain a Divisional staff complement that would reduce the need for consulting services.

Department's Response

Recommendation 1:

The Department should ensure audits commence earlier in the audit cycle to ensure timely completion.

Department's response:

As noted in the report the Department has added additional audit resources this past 2013/2014 budget and has developed an audit schedule to reduce the audit turnaround period. Key to this schedule is maintaining these audit resources.

The Department continues to monitor the audit turnaround closely to ensure that no audit deadlines are missed. In reducing this inventory, the Department continues to strike a balance to ensure that the quality and scope of the audits are not impacted by focusing solely on reduction of audit numbers.

Recommendation 2:

The Department should develop a budget and time keeping system to track and monitor time spent on audits for the purpose of audit planning.

Department's response:

The Department currently maintains an annual audit time budget however it is not matched to a time tracking system. The Department acknowledges the value of a time keeping system for budget tracking and planning purposes and has undertaken to identify system solutions to implement this recommendation.

Recommendation 3:

The Department should continue efforts to maintain a Divisional staff complement that would reduce the need for consulting services.

Department's response:

As noted in the report the Province has added an additional four (4) audit positions and reduced its Professional Services budget this past 2013/2014 budget. The Department currently has a position complement necessary for the annual audit cycle.

Issues such as staff turnover and the reallocation of staff to other priority projects as they arise (such as negotiation support) may result in future short term needs. The Department will continue to evaluate staffing requirements and may need to avail of external auditing services to supplement such staff shortages in future should they arise.

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PART 3.7

DEPARTMENT OF TRANSPORTATION AND WORKS

BRIDGE INSPECTION AND MONITORING

Summary of Findings

Introduction

The Province's bridges are aging and their related condition is deteriorating. This situation highlights the need for an adequate system of bridge inspection and planning for future bridge rehabilitation and replacement. This would include identifying the funding for future anticipated work.

The objectives of our review were to identify information on the age and condition of bridges in the Province and to determine whether the Department of Transportation and Works (the Department) has ensured that:

- project costs and related funding are adequately monitored;
- there are adequate plans in place for rehabilitation and replacement of bridges based upon information gathered from bridge inspections;
- bridge inspections and related repair, rehabilitation and replacement work are properly managed;
- there is an adequate bridge information system in place; and
- the program is administered in accordance with legislation, policy and objective standards.

Findings

Age and Condition of Provincial Bridges

1. The Province's bridges are aging and, as a result, there are a significant number of bridges that are approaching the age where they will have to be considered for replacement. In excess of half of Provincial bridges are over 40 years old. This will represent a significant cost to the Province in the near to medium term.

2. The condition of Provincial bridges has deteriorated since our last review in 2003. The number of bridges rated in poor overall condition has increased by 93% since 2003.

3. Information on the condition of over 400 larger culvert structures was not reflected in the bridge inspection system. Therefore, information required for decision making on large culverts was not contained in the bridge management system.

Planning and Monitoring

4. The Department only completed 58% of the planned 234 bridge projects that were contained in the 2004-11 eight year plan.

5. The actual cost of bridge work was 62% higher than the original cost estimates included in the 2004-11 eight year plan.

6. The Department performed rehabilitation and replacement work on an additional 143 bridges which was not contemplated in the 2004-11 eight year plan.

7. The 2004-11 eight year plan did not rank bridge rehabilitation and replacement projects in order of priority.

8. Much of the decision making related to bridge rehabilitation and replacement is based upon known safety issues and judgment. Life-cycle costing and other analytical tools are not used to assist in determining an optimal plan for bridge rehabilitation and replacement.

9. 126 (82%) of the 154 bridges which have a poor overall rating, are not included in the current five year plan (2014-18) for rehabilitation and replacement.

10. The cost of replacing bridges, 40 years old or greater, could be in excess of $800 million. This required investment by the Province, in the near to medium term, is 8 times greater than the Department's planned level of funding in the next five years.

11. Planned projects included in the current five year plan (2014-18) are not ranked in order of priority and are selected on a judgmental basis.

12. There is no overall formal inspection plan or schedule in place for Provincial bridge inspection work. Also, the Department had not established adequate performance measures and reporting requirements for bridge inspections. As a result, there is no formal process in place to monitor and assess Departmental performance as it relates to bridge inspections.

13. Based upon our review of available information on bridges belonging to other jurisdictions but forming part of the Provincial roadway system, we found that the Department is not aware of the condition of bridges in municipal and other jurisdictions. As a result, the condition of bridges integral to the Provincial roadway system may not be adequately monitored.

Bridge Inspection Process

14. The frequency of bridge inspections was not risk-based as Departmental policy requires and, as a result, Provincial bridges are not always selected for inspection in compliance with best practices.

15. The two year minimum bridge inspection standards were not always complied with and, as a result, the Provincial bridges are not always inspected within the maximum interval that is best practice as required by Departmental policy. We found 235 instances where there were gaps of more than three years between bridge inspections and, in fact, there were 69 instances where there were gaps of more than five years between bridge inspections.

16. Well-defined documented guidelines and standards were not in place to assist staff in the performance of bridge inspections and as a result, the Department cannot ensure the objectivity and consistency in the inspection process, findings, and resulting bridge condition ratings and follow-up.

Information Management

17. The Department does not have an integrated project management system for bridge construction projects. The compilation of information for analysis of actual costs for bridge rehabilitation and replacement relies largely on manual, time consuming processes and, therefore, is not readily available.

18. Historical construction and rehabilitation costs for bridges are not adequately tracked. Such information would assist in future replacement and rehabilitation decisions. As a result, the Department does not have ready access to information that it needs in order to plan, monitor and perform bridge rehabilitation and replacement work.

Background

Overview

The Department of Transportation and Works (the Department) is responsible for the inspection of bridges within Provincial jurisdiction as well as their repair, maintenance and replacement. In 2003, we performed a review of bridge inspections at the Department.

At March 31, 2013, the Department had 1,865 permanent, temporary and seasonal employees operating from seven regional offices with 67 depots/units located throughout the Province.

The Department is responsible for the construction and maintenance of the Province's road system. The system consists of approximately 9,800 kilometers of primary and secondary highways and community access roads. Bridge construction and maintenance are the responsibility of the Transportation Branch. Divisions directly involved in bridge inspections include the Highway Design and Construction Division and the five Regional Offices.

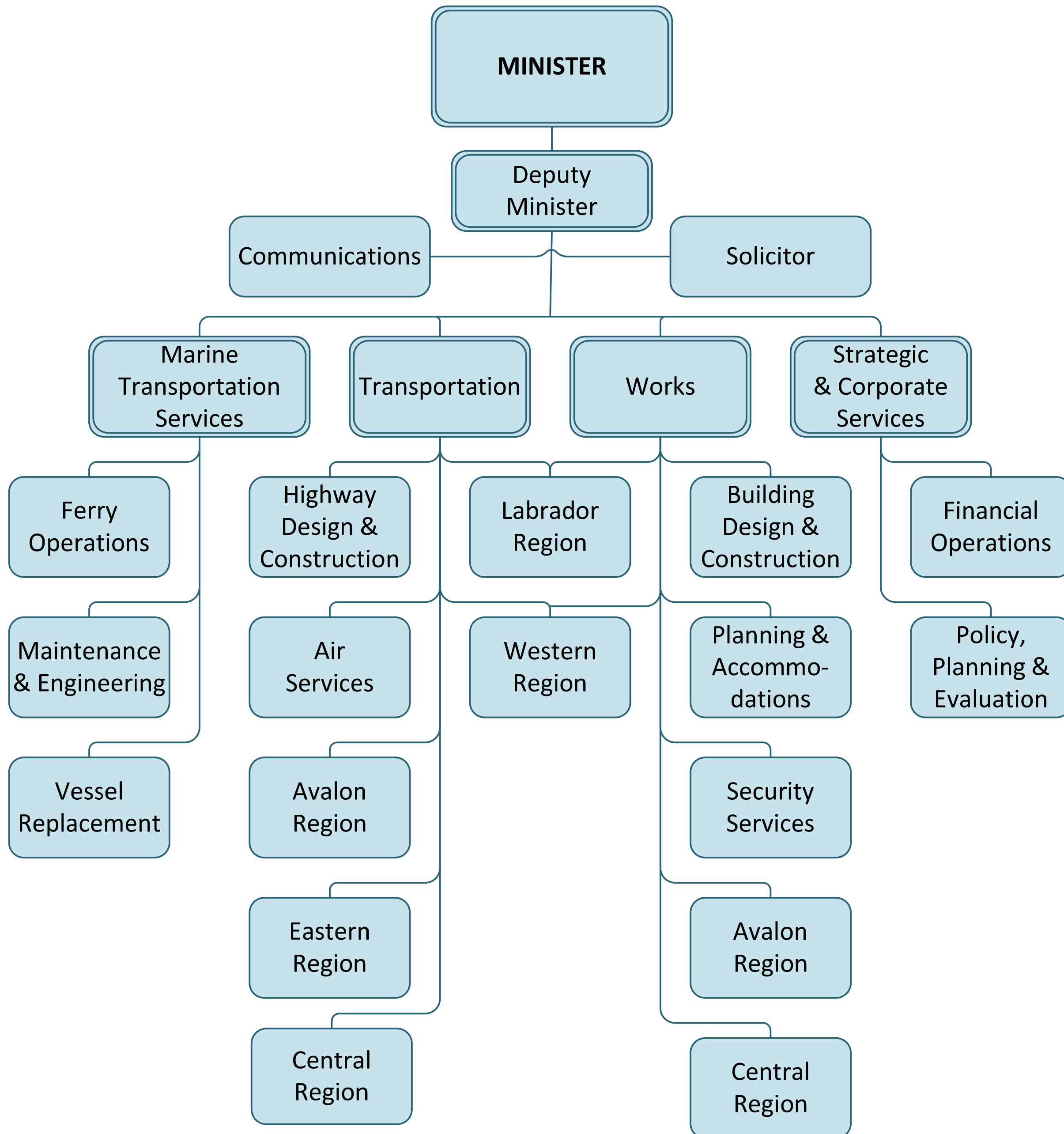
The Highway Design and Construction Division is responsible for:

- designing transportation infrastructure including bridges and highways;
- managing and inspecting bridge and highway construction and rehabilitation projects in conjunction with the Regional Offices;
- quality assurance of construction materials;
- investigating soil conditions; and
- managing related Federal/Provincial cost-shared agreements.

The Regional Offices, in conjunction with the Highway Design and Construction Division, are responsible for bridge and highway construction, rehabilitation and maintenance in their designated regions. An organizational chart for the Department is shown in Figure 1.

Figure 1

**Department of Transportation and Works
Organizational Chart
March 31, 2013**



Source: Department of Transportation and Works

During the year ended March 31, 2013, there was bridge repair and rehabilitation, bridge replacement and new construction work performed on 42 bridges amounting to $29.2 million in expenditures for the year. A breakdown is included in Table 1.

Table 1

Department of Transportation and Works
Bridge Expenditures by Category
Fiscal year 2012-13

Project Category	Number of Bridges	Expenditures
Bridge repair and rehabilitation	27	$4,921,103
Bridge replacement	11	18,059,121
New bridge construction	4	6,182,446
Total	**42**	**$29,162,670**

Source: Department of Transportation and Works

Objectives and Scope

Objectives

The objectives of our review were to identify information on the age and condition of bridges in the Province and to determine whether the Department has ensured that:

- project costs and related funding are adequately monitored;
- there are adequate plans in place for rehabilitation and replacement of bridges based upon information gathered from bridge inspections;
- bridge inspections and related repair, rehabilitation and replacement work are properly managed;
- there is an adequate bridge information system in place; and
- the program is administered in accordance with legislation, policy and objective standards.

Scope

Our review was completed in October 2013 and, primarily covered the year ended March 31, 2013. Our review included interviews with Departmental officials and an examination of relevant legislation, policies and procedures, database information and other documentation within the Department.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Age and Condition of Provincial Bridges
2. Planning and Monitoring
3. Bridge Inspection Process
4. Information Management

1. Age and Condition of Provincial Bridges

Overview

The Department is responsible for the inspection, maintenance and rehabilitation, and construction of bridges within the Provincial road system. Bridges with a span of 3 metres or greater are subject to official bridge inspections (structural) and are included in the bridge inspection database. Smaller bridges are subject to review by highways maintenance staff.

In March 2013, we were provided with a bridge inspection database which contained information on 801 structures that had Departmental inspections performed. The structures were noted by responsible jurisdiction as follows:

- 768 Provincial;
- 27 Municipal;
- 4 Federal; and
- 2 with no jurisdiction indicated.

In reviewing information on bridges provided by the Department, we made observations in the following areas:

A. Age of Provincial Bridges
B. Condition of Provincial Bridges

1A. Age of Provincial Bridges

Introduction

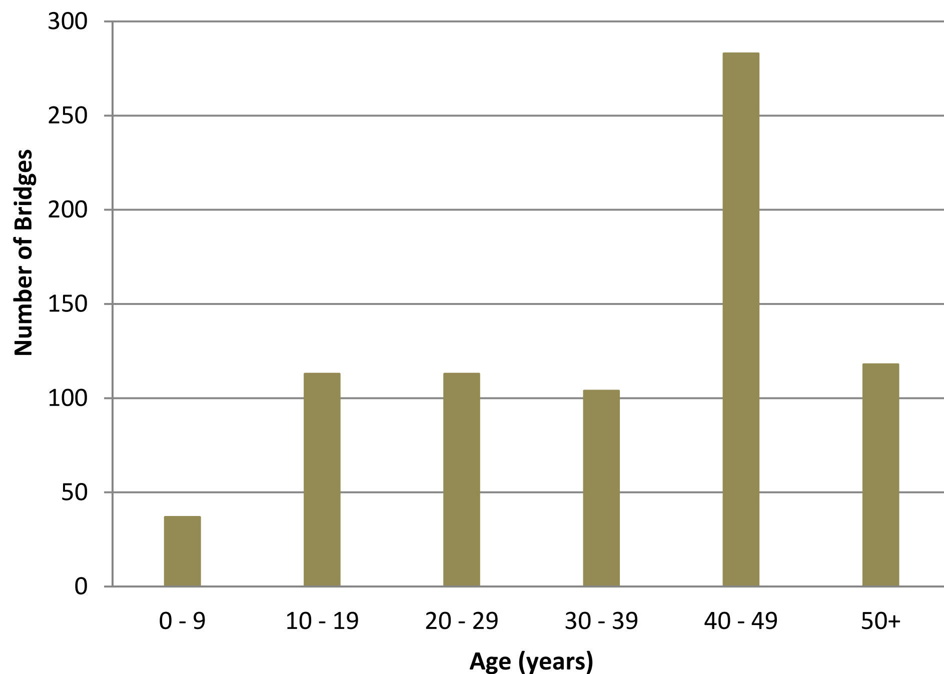
Age of bridges can serve as a primary benchmark to determine whether rehabilitation and replacement work is necessary. In general terms, as bridges become older, inspection reports tend to indicate an increasing number of issues with conditions that require rehabilitation work or bridge replacement.

Analysis

We stratified the 768 Provincial bridges in the system by age as indicated in Chart 1.

Chart 1

Department of Transportation and Works
Bridge Age
March 31, 2013



Source: Department of Transportation and Works

Chart 1 indicates that:

Significant number of bridges over 50 years old

- There are 118 bridges 50 years old or greater. Officials indicated that 50 years is used as a benchmark for considering a bridge for replacement;

Significant number of bridges approaching 50 year benchmark

- There are 283 bridges in the 40 to 49 year old range. This means that there are a significant number of bridges that are approaching the age where they will have to be considered for replacement. In excess of half of Provincial bridges are over 40 years old.

As well, from a review of information on the 768 Provincial bridges in the system, we determined that:

- Bridges in the system ranged in year built from 1925 (87 years old) to 2012;
- The average bridge age is approximately 36 years old; and
- The most common construction completion years for bridges in the database were:

Significant number of older bridges are the same age

  - 67 bridges completed in 1970 (42 years old);
  - 55 bridges completed in 1965 (47 years old); and
  - 38 bridges completed in 1960 (52 years old).

Finding

1. The Province's bridges are aging and, as a result, there are a significant number of bridges that are approaching the age where they will have to be considered for replacement. In excess of half of Provincial bridges are over 40 years old. This will represent a significant cost to the Province in the near to medium term.

1B. Condition of the Provincial Bridges

Introduction

The bridge inspection database contains information related to 5,809 inspections that were performed from 1982 to 2013. The inspections were identified by jurisdiction as follows:

- 5,718 Provincial;
- 75 Municipal; and
- 16 Federal.

Comparison of condition of bridges to prior review

Since our 2003 report on bridge inspections, the Department has changed its bridge inspection form to allow greater flexibility to inspectors for assigning condition ratings. The condition codes of good, fair, poor, and unsafe that existed in 2003 were expanded to show a required action such as inspection within a given period. For the 768 Provincial bridges in the bridge inspection system, a summary of data on overall bridge condition ratings for the latest inspection is contained in Table 2.

Table 2

Department of Transportation and Works
Provincial Bridge Overall Condition Rating
March 31, 2013

Latest overall condition rating	2013	2003	Change
Good (Inspection within 2 years)	134	349	(215)
Fair (Inspection within 2 years)	350		
Fair (Inspection within 1 year)	93		
Total Fair	443	226	217
Poor (Repair within 3 years)	62		
Poor (Repair within 1 year)	68		
Poor (Immediate Repair)	24		
Total Poor	154	80	74
Unsafe (Closed to Public)	2	6	(4)
Not rated/inapplicable/other	35	54	(19)
Total	**768**	**715**	**53**

Source: Department of Transportation and Works Database

Condition of bridges deteriorating

We compared the latest available ratings to those reported in our 2003 report on bridge inspections. Table 2 indicates that:

- the number of bridges rated in poor overall condition increased by 74 (93%);
- the number of bridges rated in fair overall condition increased by 217 (96%); and
- the number of bridges rated in good overall condition declined by 215 (62%).

These findings suggest that the overall condition of bridges has deteriorated since our last review. There are fewer bridges with a good overall condition rating and more bridges rated in the poor overall category. This would be consistent with the aging of the Provincial bridge infrastructure.

Finding

2. The condition of Provincial bridges has deteriorated since our last review in 2003. The number of bridges rated in poor overall condition has increased by 93% since 2003.

Condition of Large Culverts

Our review indicated that the bridge inspection system maintained by the Department did not contain information on the condition of larger culvert structures. Officials indicated that the Department had recently identified in excess of 400 larger culverts that should be inspected.

Finding

3. Information on the condition of over 400 larger culvert structures was not reflected in the bridge inspection system. Therefore, information required for decision making on large culverts was not contained in the bridge management system.

Recommendation

The Department should ensure that inspection information in the bridge management system is complete and accurate to facilitate the Department's ability to effectively monitor all Provincial bridge structures and culverts.

2. Planning and Monitoring

Overview

Provincial bridges are aging and their condition, based upon Departmental inspection ratings at March 31, 2013, is deteriorating. This highlights the need for an adequate system of bridge inspection and planning for future bridge rehabilitation and replacement. This would include an estimate of the funding required for future anticipated work.

In reviewing the planning processes in place at the Department, we identified issues relating to the following areas:

A. Long-term Planning
B. Measuring Performance
C. Municipal/Other Bridge Infrastructure

2A. Long-term Planning

Introduction

In our 2006 Report on Monitoring Recommendations, the Department indicated that it had developed an eight-year plan (2004-11) to address issues related to aging bridge infrastructure. The plan identified bridges by region and indicated the replacement or rehabilitation work required along with the estimated cost. In 2006, we were informed that updates to the plan were made as bridgework was completed including the costs incurred and the year of completion. The Department originally estimated funding requirements of $78.2 million over the eight year period 2004-11.

We requested information from the Department on the most recent long-term plan as at March 31, 2013 to address issues with aging bridge infrastructure. We were provided with an update to the eight year (2004-11) plan. As well, in October 2013, officials provided us with a current five year plan for bridge rehabilitation and replacement for years ending March 31, 2014-18.

Information on the current status of 234 projects contained in the original eight year (2004-11) plan for bridge replacement and rehabilitation was provided by the Department. Based upon our review of the plan, we found that there were significant differences in actual work performed and the original plan. In particular, we noted the following:

135 of the planned 234 projects completed

- 135 bridge projects (58%) of the 234 projects contained in the 2004-11 plan had been completed at an actual cost of $81.9 million as of March 31, 2013. 99 bridge projects contained in the plan had not been completed as of March 31, 2013;

Plan cost estimates varied widely from actual

- The 135 completed projects in the plan were originally estimated at $50.4 million but actually cost approximately $81.9 million, an increase of $31.5 million (62%) based upon project tender values.

Additional work not in original plan

- Additional required rehabilitation and replacement work not included in the original eight year plan was performed during the same planning period on 143 bridges for a total tendered cost estimate of $35.7 million. This consisted of:

  - Additional rehabilitation work on 95 bridges with a total tendered cost of $14.2 million; and

  - Additional construction work on 48 bridges with a total tendered cost of $21.5 million.

- Repair work on 21 bridges with a total tendered amount of $2.0 million related to necessary work for damage caused by Hurricane Igor.

Findings

4. The Department only completed 58% of the planned 234 bridge projects that were contained in the 2004-11 eight year plan.

5. The actual cost of bridge work was 62% higher than the original cost estimates included in the 2004-11 eight year plan.

6. The Department performed rehabilitation and replacement work on an additional 143 bridges which was not contemplated in the 2004-11 eight year plan.

Projects not ranked

We also observed that projects in the eight year plan were listed by anticipated construction year, however, Departmental officials indicated that neither the eight year plan nor the list of projects submitted as part of the annual budget process contained any project ranking in terms of priority. Adjustments to the annual project list were made judgmentally after being advised of the funding level for bridge work.

Finding

7. The 2004-11 eight year plan did not rank bridge rehabilitation and replacement projects in order of priority.

Judgmental selection process

Departmental officials indicated that decisions on bridge rehabilitation and replacement were made largely on a judgmental basis, taking into account known factors including safety issues. Life-cycle costing or other similar techniques were not being used to assist in identifying optimal intervention points for bridge rehabilitation or replacement.

Finding

8. Much of the decision making related to bridge rehabilitation and replacement is based upon known safety issues and judgment. Life-cycle costing and other analytical tools are not used to assist in determining an optimal plan for bridge rehabilitation and replacement.

Current five year plan

In October 2013, the Department provided us with their current five year plan for $109.4 million in bridge rehabilitation and replacement work for years ending March 31, 2014-18. The plan included a list of 39 bridges planned for replacement with cost estimates totaling $94.5 million and 9 bridges with cost estimates totaling $3.7 million identified for rehabilitation work. As well, $11.2 million was allocated for annual bridge maintenance work under the rehabilitation category. A summary of the five year plan is included in Table 3.

Table 3

Department of Transportation and Works
Five Year Bridge Plan
for Fiscal Years Ended 2014 to 2018
($000s)

Project Category	No. of Bridges	Cost Estimates					
		2014	2015	2016	2017	2018	Total
Bridge rehabilitation	9	2,900	775	-	-	-	3,675
Bridge annual maintenance	N/A	-	2,225	3,000	3,000	3,000	11,225
Total rehabilitation	**9**	**2,900**	**3,000**	**3,000**	**3,000**	**3,000**	**14,900**
Bridge replacement	39	18,950	12,750	19,200	18,500	25,100	94,500
Total	**48**	**21,850**	**15,750**	**22,200**	**21,500**	**28,100**	**109,400**

Source: Department of Transportation and Works
N/A – bridges are not identified in annual maintenance component

82% of bridges rated poor are not included in the current five year plan

We reviewed a listing of bridge rehabilitation and replacement work for 2012-13 as well as the Department's latest five year plan for bridge rehabilitation and replacement for the years ending March 31, 2014-18. Based upon our review, we observed that 126 (82%) of 154 bridges which had a poor overall rating are not included in the 2012-13 work listing or in the bridge plan for the subsequent five years.

Finding

9. 126 (82%) of the 154 bridges which have a poor overall rating, are not included in the current five year plan (2014-18) for rehabilitation and replacement.

Significant future replacement cost

Table 3 indicates that the estimated replacement cost of 39 bridges planned in the next 5 years is $94.5 million or an average of $2.4 million per bridge. There are a large number of bridges at a similar age which will present planning challenges in terms of construction and funding as they come closer to their replacement age. The replacement cost of a bridge varies depending upon size and type of structure. An estimate of the replacement cost of Provincial bridges was not readily available. Officials indicated that it would take a significant amount of resources and time to prepare a reasonable estimate.

However, if the 401 bridges that are 40 years old or greater were to be replaced at an average cost of $2 million, it would cost the Province in excess of $800 million.

Finding

10. The cost of replacing bridges, 40 years old or greater, could be in excess of $800 million. This required investment by the Province, in the near to medium term, is 8 times greater than the Department's planned level of funding in the next five years.

Projects not ranked

Our review of the information provided by officials determined that the planned work did not include any project ranking in terms of priority. A ranking would assist in decision making, especially in those instances where available funding may not be adequate to complete all planned projects.

Judgmental selection process

There are no rehabilitation projects identified beyond 2015 in the plan. Officials indicated that the document changes from year to year with priorities being adjusted due to the results of bridge inspection work.

Finding

11. Planned projects included in the current five year plan (2014-18) are not ranked in order of priority and are selected on a judgmental basis.

2B. Measuring Performance

Introduction

Performance measurement and monitoring are important in evaluating the effectiveness of programs including taking corrective action when necessary. We expected that the Transportation Branch would have well defined performance measures relating to bridge inspection activities and a system to monitor those activities and report on their effectiveness.

Officials indicated that the selection of bridges to be inspected and their timing has primarily been the responsibility of the five Regional Engineers and their staff located at the Regional offices.

No inspection plan

Our review indicated that there is no overall formal inspection plan or schedule in place for Provincial bridge inspection work. Officials indicated that much of the inspection work was done by Regional engineering staff between major road and bridge construction projects, as time permitted. There was no staff dedicated primarily to bridge inspections.

Officials indicated that commencing in April 2013, the Department has assigned a two person inspection team operating from headquarters to lead and perform much of the inspection work.

An overall schedule would serve as a basis for measuring performance.

No performance measures and reporting requirements

Our review indicated that the Department had not established adequate performance measures and reporting requirements for bridge inspections. Upon enquiry, Departmental officials could not provide any performance reports for the bridge inspections.

Finding

12. There is no overall formal inspection plan or schedule in place for Provincial bridge inspection work. Also, the Department had not established adequate performance measures and reporting requirements for bridge inspections. As a result, there is no formal process in place to monitor and assess Departmental performance as it relates to bridge inspections.

2C. Municipal/Other Bridge Infrastructure

Introduction

Each municipality and the Federal government are responsible for bridges within their own jurisdiction. The condition of bridges in municipal and other jurisdictions should be adequately monitored.

Limited information on bridge infrastructure for municipal and other jurisdictions

The Department was not aware and did not have access to information that would allow for the assessment of the condition of municipal and other bridge infrastructure which is beyond its jurisdiction. These bridges form part of the Provincial road network and as a result their condition should still be monitored. Officials indicated that there was no database available containing information on the number and condition of bridges outside of Provincial jurisdiction.

We were informed that it is only in rare cases where the assistance of the Department has been requested with respect to bridge inspections, that such information has been captured in the bridge inspection database. Based upon our review, there were 75 inspections in the database noted as being performed on municipal structures.

The Department does not have information on the number, type and condition of bridges under municipal and other ownership. There could be instances where a municipality may not have the resources to inspect and maintain bridges to an acceptable standard. As well, the Province could be asked for funding assistance in instances where there are significant safety and rehabilitation and/or replacement matters.

Finding

13. Based upon our review of available information on bridges belonging to other jurisdictions but forming part of the Provincial roadway system, we found that the Department is not aware of the condition of bridges in municipal and other jurisdictions. As a result, the condition of bridges integral to the Provincial roadway system may not be adequately monitored.

Recommendations

The Department should:

- examine life-cycle costing and other analytical tools to assist in determining an optimal plan for bridge rehabilitation and replacement;
- rank potential bridge rehabilitation and replacement projects contained in long-range plans in order of priority and include realistic costing;
- ensure performance measures and reporting requirements are established related to bridge inspections;

- develop and monitor progress against a schedule for the inspection of Provincial bridges; and

- work with municipalities and other jurisdictions to ensure that the condition of bridges in municipal and other jurisdictions is adequately monitored and that issues are addressed.

3. Bridge Inspection Process

Introduction

A policy for bridge inspections that was developed in 2004, and in place at the time of our review, stated that all bridges having a span equal to or greater than 3 metres, under the jurisdiction of the Department, shall receive routine inspections. Official inspections, based upon a standard form, were required. The Departmental policy for bridge inspections requires the frequency of inspections to be risk-based and to follow generally accepted good engineering practices. The interval between inspections must not exceed two years. Risk was defined as the combination of a probability of failure and consequences (fatalities and property damage).

Frequency of inspection not Risk-based

However, we were informed that inspectors perform most inspections by geographic area, for practical reasons. Exceptions would be made for specific requests for bridge inspections identified as having safety issues. As a result, the frequency of bridge inspections was not risk-based.

Finding

14. The frequency of bridge inspections was not risk-based as Departmental policy requires and, as a result, Provincial bridges are not always selected for inspection in compliance with best practices.

We performed a review of bridge inspection information contained in the database. Based upon our review, we determined that there were numerous instances of non-compliance with the minimum two year interval standard. In particular, we found 235 instances where there were gaps of more than three years between bridge inspections. These included:

Minimum inspection standard not complied with

- 142 instances of three years between inspections;
- 24 instances where there were gaps of more than four years between bridge inspections; and
- 69 instances where there were gaps of more than five years between bridge inspections.

As a result, the Department was not always complying with the minimum interval of inspection standard.

Finding

15. The two year minimum bridge inspection standards were not always complied with and as a result, the Provincial bridges are not always inspected within the maximum interval that best practices require by Departmental policy. We found 235 instances where there were gaps of more than three years between bridge inspections and, in fact, there were 69 instances where there were gaps of more than five years between bridge inspections.

Limited guidance available

We would expect to find well defined documented guidelines and standards in place to assist staff in the performance of bridge inspections. This would increase the objectivity and consistency in the inspection process, findings, and resulting bridge condition ratings and follow-up.

There was only limited documentation available to provide guidance for bridge inspections. As previously indicated, a general inspection policy for bridges dealt with frequency of official inspections and other types of inspections. As well, there is the actual bridge inspection form. Copies of in-house presentations from past training sessions were provided that covered common bridge problems.

However, there was no available documented guidance on the inspection process such as the required procedures to follow, or how to assess bridge conditions using the required ratings for individual bridge elements or overall bridge condition. Without such guidance, it is difficult to ensure consistency in inspections and the related required documentation.

Officials indicated that there was detailed information provided on a new Ontario methodology to be adopted by the Department for inspections commencing in April 2013 including a condensed guidebook, policy manual, and a training session manual.

Finding

16. Well-defined documented guidelines and standards were not in place to assist staff in the performance of bridge inspections and as a result, the Department cannot ensure the objectivity and consistency in the inspection process, findings, and resulting bridge condition ratings and follow-up.

Recommendations

The Department should:

- comply with its bridge inspection policy; and
- ensure there are well defined guidelines for the bridge inspection process.

4. Information Management

Introduction

As previously indicated, the Department spent approximately $29.2 million on 42 bridges for rehabilitation and construction projects during 2012-13. To ensure that funds are expended in an optimal manner, it is important to have an adequate information management system. This system should include complete and accurate information on Provincial bridges and their individual elements.

No integrated project management system in place

The Department does not have an integrated project management system that could assist in planning and monitoring costs and related revenues. Actual costs that are tracked in manual progress billing files would have to be compiled and are therefore not readily available on a current or historic basis for each bridge.

Stand-alone systems and manual compilation processes in effect

The Department relies on a number of stand-alone systems and manual compilation processes including:

- manually prepared spreadsheets to monitor Federal funding received and expenses incurred;
- progress billing files for construction projects;
- payment information from Government's Financial Management System; and
- a computerized project planning system that includes cost estimates using tender estimates as opposed to actual costs.

Finding

17. The Department does not have an integrated project management system for bridge construction projects. The compilation of information for analysis of actual costs for bridge rehabilitation and replacement relies largely on manual, time consuming processes and, therefore, is not readily available.

Historical costs not tracked

Our request for information on actual costs on bridge projects for the 2012-13 fiscal year resulted in information being compiled manually by staff from manual bridge project billing files retained at Headquarters. Historical costs, related to a bridge since its original construction, were not readily available.

Finding

18. Historical construction and rehabilitation costs for bridges are not adequately tracked. Such information would assist in future replacement and rehabilitation decisions. As a result, the Department does not have ready access to information that it needs in order to plan, monitor and perform bridge rehabilitation and replacement work.

Bridge Inspection and Monitoring

Recommendations

The Department should:

- consider the implementation of an integrated project management system for bridge construction projects; and
- track costs by structure to facilitate related planning, monitoring and bridge rehabilitation and replacement planning.

Department's Response

1. Age and Condition of Provincial Bridges

Recommendation

The Department should ensure that inspection information in the bridge management system is complete and accurate to facilitate the Department's ability to effectively monitor all Provincial bridge structures and culverts.

Response

The department will continue to ensure that the inspection information contained in the bridge inspection record management system is accurate.

In 2012 the department hired two staff who are dedicated to bridge inspection and bridge management. These staff are currently conducting a review of the inventory data to ensure that all information contained is accurate and to add all culvert type structures with span greater than 3 meters.

With an aging bridge inventory the needs are great. We continue each year to rehabilitate and replace bridges as required with expenditures during the time period from 2004 to 2012 of $111.5 million. This work has included the rehabilitation or repair of 166 bridges and the replacement of 88 bridges.

2. Planning and Monitoring

Recommendations

The Department should:

- *examine life-cycle costing and other analytical tools to assist in determining an optimal plan for bridge rehabilitation and replacement;*
- *rank potential bridge rehabilitation and replacement projects contained in long-range plans in order of priority and include realistic costing;*
- *ensure performance measures and reporting requirements are established related to bridge inspections;*
- *develop and monitor progress against a schedule for the inspection of Provincial bridges; and*
- *work with municipalities and other jurisdictions to ensure that the condition of bridges in municipal and other jurisdictions is adequately monitored and that issues are addressed.*

Response

In 2011 the department purchased new Bridge Management Software. This software has far greater capabilities then the existing database which stores only bridge inspection records. It has the ability to produce work recommendations on a network level based upon life cycle cost analysis, benefit-cost analysis and risk analysis basis. A system such as this however does require a large amount of quantified condition data. In 2012, the department began the implementation of this system and is currently working on preparing this data for the bridge inventory.

The ranking of the projects in the current five year plan is reflected by the year in which the projects have been recommended. If funding is not available to complete each project then the input of the department's engineering staff most familiar with the inventory will be called upon to establish the projects with the highest priority. The estimates prepared are felt to be realistic preliminary estimates for each project but will require further detailed study prior to budget submission.

The new bridge management software now being implemented does allow for the production of reports with respect to inspection scheduling based upon risk. The department will put in place reporting requirements to ensure that bridge inspections are carried out in accordance with the department's bridge inspection policy and that the frequency of inspection for each structure does not exceed two years.

The department will give consideration to the implementation of a system to audit bridge inspections for quality and consistency.

The new Bridge Management Software will be a valuable tool in planning and prioritizing bridge rehabilitation and replacement projects. In addition to this software the department will continue to rely upon the recommendations and judgment of the professional engineers of the department to ensure that work priorities are established and modified as required with consideration to safety, bridge condition, engineering and contractor resource availability, opportunities for funding arrangements and extreme event response.

With regards to the bridges in municipalities and other jurisdictions, given that these structures fall outside the department's mandate, it is the department's view that they would remain the responsibility of those municipalities and jurisdictions; however, the department is available to assist these municipalities and other jurisdictions if required.

3. Bridge Inspection Process

Recommendations

The Department should:

- *comply with its bridge inspection policy; and*
- *ensure there are well defined guidelines for the bridge inspection process.*

Response

The department will put in place reporting requirements to ensure that bridge inspections are carried out in accordance with the department's bridge inspection policy and that the frequency of inspection for each structure does not exceed two years. Geography and availability of resources will continue to play a role in scheduling of bridge inspections.

Corresponding with the purchase of new bridge management software in 2011 the department began the implementation of a new bridge inspection method utilizing the Ontario Structure Inspection Manual (OSIM). This is a much more detailed level of inspection quantifying the condition of all bridge elements. This is the methodology now employed by many provincial jurisdictions across the country. In the fall of 2012 the department provided a two week training course to staff involved with bridge inspection and management in the use of this methodology. This training provided all those involved with bridge inspection course notes, an inspection manual and field guide to help ensure that inspections are carried out correctly and consistently.

4. Information Management

Recommendations

The Department should:

- *consider the implementation of an integrated project management system for bridge construction projects; and*
- *track costs by structure to facilitate related planning, monitoring and bridge rehabilitation and replacement planning.*

Response

The department will consider the implementation of an integrated project management system. The aim of such a system is that it could be utilized for all projects related to transportation infrastructure and not only bridge construction projects. Until such time as such a system is implemented the department will continue to rely upon the standalone systems in place to effectively manage all construction projects including bridges.

The new bridge management software does allow for the tracking of work history on a structure basis. On a go forward basis the department will track estimated tendered bridge construction and rehabilitation costs using this system.

PART 3.8

DEPARTMENT OF TRANSPORTATION AND WORKS

CONTRACTED AND CHARTERED AIR SERVICES

Summary of Findings

Introduction

The Department of Transportation and Works (the Department), through its Air Services Division (the Division), is responsible for:

- managing Provincial Air Services;
- operating and maintaining the Government forest fire protection service (water bombing operation);
- administering contract and charter aircraft for the Government; and
- operating and maintaining the Government air ambulance service.

Government-owned aircraft are used in forest fire protection and air ambulance services. Third-party carriers are utilized by the Division for air services beyond air ambulance and forest fire protection services. Also, in instances where Government-owned aircraft cannot meet the demands of air ambulance or forest fire protection services, third-party carriers are utilized for these services.

The objectives of our review were to determine whether:

- the use of contracted and chartered aircraft services by Government is in accordance with legislation and Division policies and procedures;
- infrastructure requirements are being properly assessed; and
- adequate systems and procedures are in place to manage aircraft costs.

Findings

Departmental Contracts and Charters

1. Inconsistencies between procedures described in the Air Services Procedures Manual (the Manual) and practice has led to ambiguity as to what is required when requesting a contract or charter flight for Government departmental use. As a result, some practices are inconsistent with the required authorization processes. Furthermore, it is possible for a Government department to book a flight and receive a dispatch number without a valid authorization.

2. Information, such as purpose of trip and passenger names, was missing from flight authorization documents. This undermines the authority of the approval and ultimately results in a service being received and payments being made with incomplete and/or incorrect information.

3. Authorization documents for Government departmental flights are not always approved and/or dated, making it impossible to ensure the flight authorization was approved by a designated signing officer before the flight. These instances are not in accordance with required procedures and undermine the approval process.

4. In some instances, Government departments do not have an Aircraft Flight Report (AFR), which provides details of the flight, to compare to the authorization or the invoice. This increases the risk that a payment is made to a carrier that is not consistent with services received.

5. There were a number of instances in which information was missing from the AFRs. Without a fully completed AFR, the Government department does not have a complete record of the details of the flight and may not have all information necessary to be verified during invoice review and processing procedures.

6. In instances in which not all required signatures are present on an AFR, there is no evidence that information details of the flight have been verified by all required parties. Invoice processing without this verification increases the risk that a payment is made to a carrier that is not consistent with services received.

7. In certain instances, details on the AFR, such as flight route and flight date, did not agree to that detailed on the flight authorization document, without explanation. For example, the flight authorization approved four stops, while the AFR indicated six stops. Therefore, the flight that took place was not as was approved by the Government department.

8. Our review indicated instances of inadequate review and verification of invoices and supporting documentation. This increases the risk that a payment is made to a carrier that is not consistent with services received.

9. The Division has outdated procedures manuals governing its processes. Also, not all employees of the Division and not all Government departments are aware of the existence of the Manual or they have just excerpts of the Manual. As a result, the procedures to be followed within the Division and by Government departments when booking a flight are not clear, as they have not been updated in 10 years and processes may not be operating efficiently and effectively.

10. Inaccuracies in the dispatch log book result in flight records that are not an accurate representation of the flight activity. As a result, the Division does not have appropriate records of its flights for reference.

Air Services Facilities

11. Leased Government space is being used for personal benefit of employees of the Division, in contravention of the *Conflict of Interest Act, 1995*.

12. There was a lack of planning for storage of the new waterbombers. This led to the risk of damage to one of the new waterbombers, as it was stored in unheated hangar space until additional heated hangar space was acquired.

Management of Aircraft Costs

13. The Division is not utilizing its WinAir Maintenance and Inventory System to track aircraft costs in an effective manner.

14. The Division has not reviewed its hourly charge-out rate for out-of-province air ambulance transport since 2005. Therefore, Government may not be recovering the full cost of those air ambulance transports.

Background

Overview

The Department of Transportation and Works (the Department), through its Air Services Division (the Division), is responsible for:

- managing Provincial Air Services;
- operating and maintaining the Government forest fire protection service (water bombing operation);

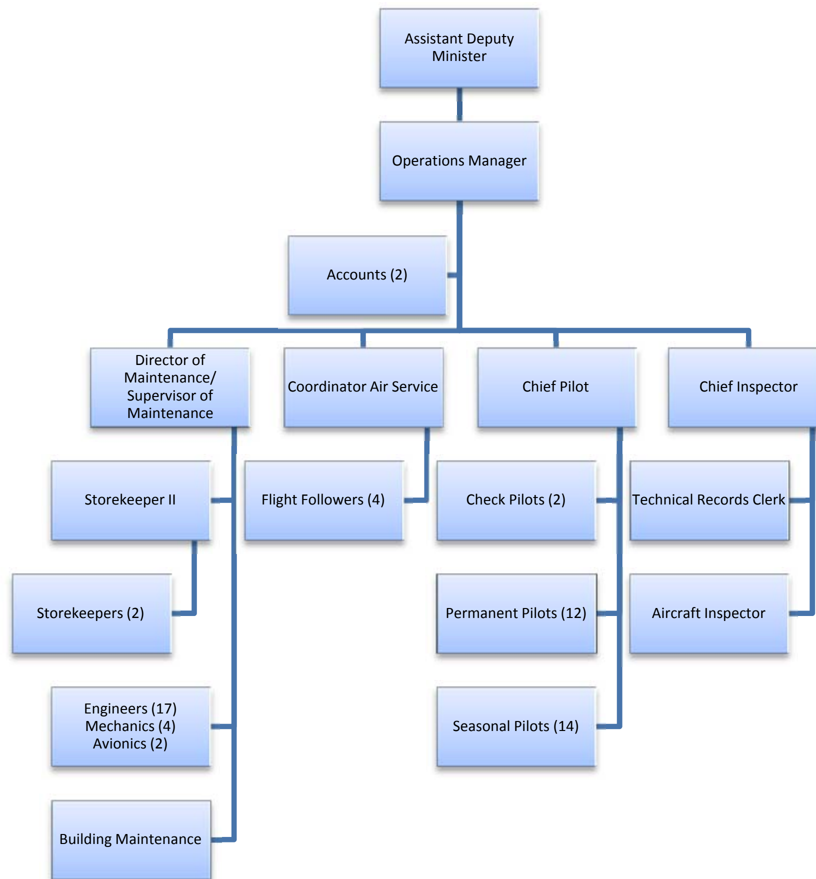
- administering contract and charter aircraft for the Government; and
- operating and maintaining the Government air ambulance service.

Air Services Division

The administrative offices for the Division are located in Gander. The Division utilizes hangar space and storage facilities in Gander, St. John's, Deer Lake, Happy Valley-Goose Bay and Wabush for storage, maintenance and operation of aircraft. The Division has 68 positions. Figure 1 shows the organizational structure of the Division.

Figure 1

Transportation and Works
Air Services Division
Organizational Structure



Source: Department of Transportation and Works

Aircraft owned by the Province

Government-owned aircraft are used in forest fire protection and air ambulance services. The Division is responsible for both the operation and maintenance of these aircraft. These services are provided to the Forestry and Agrifoods Agency of the Department of Natural Resources and the Department of Health and Community Services.

As at March 31, 2013, the Province owned 10 aircraft used in forest fire protection and air ambulance services, all of which are fixed-wing. Table 1 outlines the aircraft type and number of each, function and location of the Government-owned aircraft.

Table 1

Transportation and Works
Government-owned Aircraft
As at March 31, 2013

Aircraft Type	# of Aircraft	Function	Designated Location
Forest Fire Protection Services			
Bombardier CL-415	4	Waterbomber	Gander/ St. John's/ Deer Lake/ Happy Valley-Goose Bay/ Wabush
Canadair CL-215	2		
Cessna 337	1	Fire Spotter	Gander
Air Ambulance Services			
Beechcraft King Air 350	3	Air Ambulance	St. John's/ Happy Valley-Goose Bay

Source: Department of Transportation and Works

As shown in Table 1, aircraft used in air ambulance services are located in Happy Valley-Goose Bay and St. John's. The aircraft required for forest fire protection services are located at designated locations throughout Newfoundland and Labrador. The waterbomber aircraft locations are the locations used during fire season, which is between April and September. During the period October to March they are all stored in Gander.

Aircraft contract and charter services

Third-party carriers are utilized by the Division for air services beyond air ambulance and forest fire protection services. Also, in instances where Government-owned aircraft cannot meet the demands of air ambulance or forest fire protection services, third-party carriers are utilized for these services. The Division has a helicopter service contract with a third-party carrier and also charters helicopters through standing offers with four third-party carriers. If the existing contract or standing offers in place do not meet the needs of a Government department, they may receive quotes from carriers that are able to provide the required service.

The Division is responsible for advising Government departments regarding the availability and suitability of aircraft contract and charter services to meet the needs of a Government department. The Division is also responsible for the coordination of flights. Each individual Government department is responsible for the authorization processes pertaining to these services and is also responsible for the processing of invoices for payment which should be supported by the required documentation for invoice processing.

Expenditures and Revenue of the Division

Table 2 summarizes the expenditures and revenues for the Division for the years ended March 31, 2012 and 2013.

Table 2

Transportation and Works
Air Services Division
Expenditures and Related Revenue
For the Years Ended March 31

	2012	2013
Expenditures		
Government - operated Aircraft (Capital)	$33,439,409	$1,473,230
Government - operated Aircraft (Current)	11,756,966	12,034,932
Administration Hangar Facilities	1,226,331	1,532,828
Total expenditures	**46,422,706**	**15,040,990**
Revenues		
Revenue - Provincial (Current)	1,018,566	553,246
Revenue-Provincial (Capital)	1,005,900	1,046,010
Revenue – Federal (Current)	-	300,000
Total revenues	**2,024,466**	**1,899,256**
Net expenditures over revenues	**$44,398,240**	**$13,141,734**

Source: Report on the Program Expenditures and Revenues of the Consolidated Revenue Fund

As shown in Table 2, net expenditures over revenues of the Division were $44.4 million in 2012 and $13.1 million in 2013. These amounts represent the net costs to acquire and operate Government-owned aircraft, as all coordinated contract and charter services are expenses of the recipient Government departments. The delivery of two new waterbombers in the fiscal year ended March 31, 2012 increased expenditures in that year.

Provincial revenues consist of billings for air ambulance services to the Department of Health and Community Services and billings for waterbomber services beyond that used by the Forestry and Agrifoods Agency of the Department of Natural Resources. Federal revenue of $300,000 in 2013 represents a Federal grant for the operation of the air ambulance service.

Objectives and Scope

Objectives

The objectives of our review were to determine whether:

- the use of contracted and chartered aircraft services by Government is in accordance with legislation and Division policies and procedures;
- infrastructure requirements are being properly assessed; and
- adequate systems and procedures are in place to manage aircraft costs.

Scope

Our review was completed in November 2013 and covered the period April 2011 to March 2013. It included interviews with Division officials, an examination of Division procedures, and testing of Division and Government department documents and processes to ensure compliance with Division procedures.

Detailed Observations

This report provides detailed findings and recommendations in the following sections:

1. Departmental Contracts and Charters
2. Air Services Facilities
3. Management of Aircraft Costs

1. Departmental Contracts and Charters

Overview

Departmental contracts and charters represent flights taken by Government departments using a helicopter or fixed-wing aircraft. A contract flight signifies a flight taken using an existing contract with a third-party carrier. Charter flights are flights taken using one of the standing offers currently in place between the Division and helicopter service providers. Charter flights also include other helicopter and fixed-wing aircraft available from various carriers for hire when aircraft under the contract and standing offers are not available or appropriate.

The existing contract with a third-party carrier provides for exclusive use of six helicopters for the period of April 20, 2012 to April 19, 2014. The four standing offers currently in place are with various third-party carriers.

The contract arrangement offers the lowest per hour flight rate and commits the Department to a guaranteed minimum number of hours of flying time per aircraft type over the term of the contract. The standing offers charge a higher per flying hour rate and have a minimum flying hours requirement per trip. Therefore, in order to ensure the most economical flight is taken, the Division should always consider use of the contract carrier before considering using aircraft available under the standing offers.

Table 3 shows the total payments made by Government departments for contract and charter flights during the years ended March 31, 2011 to 2013.

Table 3

Payments for Contract and Charter Flights (Note 1)
For the years ended March 31

Department	2011	2012	2013
Natural Resources	$3,241,318	$2,152,548	$4,569,045
Environment and Conservation	2,889,738	3,143,043	2,902,716
Transportation and Works	180,017	170,035	824,237
Justice	180,099	84,299	161,818
Fire and Emergency Services - NL (Note 2)	401,521	98,141	73,333
Legislature	8,776	132,796	16,626
Service NL	28,368	27,720	14,756
Fisheries and Aquaculture	5,149	11,557	2,084
Executive Council	17,004	58,995	1,042
Education	4,246	3,289	-
Tourism, Culture and Recreation	5,531	6,068	-
Advanced, Education and Skills	-	3,998	-
Innovation, Business, and Rural Development	4,673	-	-
Total	**$6,966,440**	**$5,892,489**	**$8,565,657**

Source: Financial Management System of the Government of Newfoundland and Labrador
Note 1: These figures do not include contract and charter costs associated with air ambulance services utilized by the Department of Health and Community Services.
Note 2: Included in the amount of $401,521 for the year ended March 31, 2011 are costs totaling $277,958 related to Hurricane Igor that are expected to be recovered from the Federal Government under the Disaster Financial Assistance Arrangements program.

The total cost of $8.6 million for the year ended March 31, 2013, represents 248 flights coordinated by the Division for nine Government departments.

During our review, we identified issues in the following areas related to departmental contracts and charters:

A. Flight Authorization
B. Flight Reports
C. Invoice Processing
D. Procedures

1A. Flight Authorization

Introduction

When a contract or charter aircraft is requested by a Government department, the Division requires coordination of the flight in accordance with Division procedures. According to the Air Services Procedures Manual (the Manual), an Aircraft Flight Authorization form (AFA) must be completed and approved by the Deputy Minister or designate of the requesting department, in order to utilize a contract or charter aircraft. According to the Manual, *"The [AFA] is necessary to document the users' authority to engage aircraft service."*

The Manual requires that the Division supply pre-numbered AFAs to Government departments. The Government department is responsible for completing the AFA based on the procedures outlined in the Manual. The form requires department-specific information such as:

- the purpose of the trip;
- intended destination;
- the dates of travel; and
- the names of all passengers.

When a request is received by the Division, all pertinent information is placed on a reservation card. The Division is required to determine the least expensive trip option based on the rates and information on existing contracts and standing offers. Once the least expensive travel option has been determined, the Division will contact the carrier to ensure that they can comply with the request. The Division then provides the Government department with all additional information to complete an AFA form, such as carrier, estimated cost, and aircraft type to be utilized.

Upon completion of the AFA by the Government department, the approved AFA number is required to be provided to the Division. The AFA number is inserted in the dispatch log book alongside the next consecutive dispatch number, which is then provided to the Government department for completion of the AFA.

We reviewed a sample of 39 chartered and contracted flights for the period April 1, 2011 to December 31, 2012 and identified the following issues with the authorization process:

Practices inconsistent with required authorization processes

The Manual states that an AFA must be completed and a copy provided to the Division in order for a Government department to engage aircraft service. Division officials advised that they do not require Government departments to provide a copy of the AFA. Rather, they accept just the authorization number, which is then documented in the log book.

In 18 of the 39 samples we reviewed, an AFA number was used to book the flight. In the remaining 21 items we reviewed, a Purchase Order (PO) number was used, instead of an AFA, to book a contract or charter flight which is inconsistent with the required procedures.

In the 21 instances in which a PO number was used to book a flight, there were 7 instances in which an AFA did not exist. A fully completed AFA form contains all information requirements outlined in the Manual. The standard PO form is not tailored to the information requirements needed for aircraft contract or charter services and, therefore, there is a risk of missing required information.

In the remaining 14 of 21 instances in which a PO number was used to book the flight, the Government department also had an AFA form completed for the flight. In these instances, the AFA number should have been provided to the Division as an authorization number, rather than the PO number.

In another instance, we discovered that a flight was booked with a PO number that was unrelated to a contract or charter flight. Since the Division relies on the Government department to provide an authorization number, any number that has not been previously provided to the Division will be accepted to book a flight. This issue is further exacerbated by the fact that the Division was unaware that this flight had been booked with an invalid authorization number until we requested additional information on this flight. Therefore, it is possible for the Government department to book a flight and receive a dispatch number without a valid authorization.

Finding

1. Inconsistencies between procedures described in the Air Services Procedures Manual (the Manual) and practice has led to ambiguity as to what is required when requesting a contract or charter flight for Government departmental use. As a result, some practices are inconsistent with the required authorization processes. Furthermore, it is possible for a Government department to book a flight and receive a dispatch number without a valid authorization.

Authorization document not properly completed

A fully completed AFA ensures that the flight has been approved by an appropriate official of the Government department and is a required document as part of the service provision of the Division and Government department invoice processing. The Manual states: "*Aircraft owners/operators have been advised that no flights will be undertaken unless a properly completed flight authorization is presented prior to flight…and a dispatch number is received from dispatch.*"

Table 4 outlines the number of instances of missing information from the required fields contained in the flight authorization documents, detailed by Government department, for the 39 samples we examined.

Table 4

Transportation and Works
Missing Information from Flight Authorizations
For the period April 1, 2011 to December 31, 2012

Missing Information	Environment and Conservation	Natural Resources	Executive Council	Legislature	Fire and Emergency Services - NL	Total	% of Total Samples
Total samples	12	9	1	13	4	39	
Purpose of trip	-	3	1	-	-	4	10%
Passenger names	1	2	1	4	4	12	31%
Dispatch number	3	2	-	-	4	9	23%
Contract or standing offer	5	1	1	4	4	15	38%

Further details regarding the missing information from flight authorizations in Table 4 are as follows:

- The purpose of the trip is to be documented on the AFA as required by Cabinet Directive. In 4 of the 39 flight authorization documents (10%) that we reviewed, the purpose of the trip was not documented. As a result, the Government department did not know why the contract or charter was used.

- Passenger names are required, by Cabinet Directive, to be listed on the AFA. In instances where it is planned that non-Government employees are going to be on the flight, additional documentation is required. In 12 of the 39 items (31%) we reviewed, the passengers names were not listed on the flight authorization. As a result, the Government departments did not document who they were authorizing to travel at taxpayers' expense.

- The Manual requires that a dispatch number be assigned for each flight. An issued dispatch number is intended to ensure that all processes have been followed and the lowest-cost flight has been booked. In 9 of the 39 samples (23%) we reviewed, the AFA was missing a dispatch number. Without a dispatch number, it is not clear whether the appropriate processes had been followed or if the lowest-cost flight was booked.

- The Division is to inform Government departments if a contract or standing offer agreement is to be used in the requested flight, which is then required to be documented on the AFA by Government departments. This ensures that the department is aware of the cost of the flight. In the 39 flight authorization documents we analyzed, 15 (38%) did not indicate whether the flight was using a contract or standing offer. As a result, the department would not have had information with which to validate the invoiced rate when billed by the aircraft carrier.

- Other items missing from the flight authorization documents sampled included: aircraft type, aircraft registration, and account to be charged. These items are all required as per the Manual.

While not covered in the Manual, current department practice allows flight bookings using either an AFA or a PO. A PO is not tailored to the information requirements for aircraft contract and charter services, which increases the risk of missing required information. For those issues outlined in Table 4 related to missing information on AFAs and POs, in a significant number of cases the required information was missing due to the fact that a PO was used as opposed to an AFA. In the 7 instances where only a PO existed, we found all were missing passenger names and 2 of 7 were missing trip purpose details.

Finding

2. Information, such as purpose of trip and passenger names, was missing from flight authorization documents. This undermines the authority of the approval and ultimately results in a service being received and payments being made with incomplete and/or incorrect information.

Approval process of authorization documents not complete and not timely

The Manual indicates that an AFA must be completed and authorized through signature of a designated signing officer. When the AFA is approved by the Government department, the Division can proceed to book the flight. We identified the following issues:

In 1 of the 39 samples reviewed, the flight authorization documents were never approved.

In the 38 samples with approval, 3 approved documents were not dated. In another 6 instances, the flight authorization documents were approved after the flight date. The Manual does acknowledge that there are exceptions pertaining to medical emergencies, forest fires and emergency measures initiated flights whereby an AFA may be completed and approved after the flight date. The Manual states that: *"In the event of exceptional cases, the Department involved must complete the flight authorization as soon as possible after completion of the flight and ensure that the copies are provided to the appropriate recipients."* In the 6 instances where the flight authorization was approved after the flight date, 5 of the flights were for exceptional circumstances. The remaining 1 flight was not for exceptional circumstances as allowed for in the Manual. As a result, the flight was booked without proper Government department approval.

Finding

3. Authorization documents for Government departmental flights are not always approved and/or dated, making it impossible to ensure the flight authorization was approved by a designated signing officer before the flight. These instances are not in accordance with required procedures and undermine the approval process.

1B. Flight Reports

Introduction

The Division provides carriers who have a contract or standing offer with Government with a series of pre-numbered Aircraft Flight Report (AFR) forms. These AFR forms are to be completed at the end of a flight by the carrier. The purpose of the AFR forms, according to the Manual, is *"to provide the details of each flight in a uniform manner."* According to the Manual: *"The Carriers are responsible to have these forms available and to ensure that they are properly completed with a legitimate signature affixed in the "Signed for Department" before passenger(s) deplane. The Carriers are also advised that invoice processing will not occur without the properly completed Aircraft Flight Authorization and Flight Report Form."*

Information requirements in an AFR include such things as:

- the carrier name;
- the AFA number;
- flight date;
- dispatch number;
- the name of the Government department requesting the flight;
- name of all passengers traveling on flight;
- total flying time;
- total distance traveled;
- pilot/captain signature; and
- signature from a Government department official.

Our review of 39 samples for the period April 1, 2011 to December 31, 2012 identified issues as follows:

Missing AFRs

The Manual indicates that an AFR must be completed by the carrier at the end of a contract or charter flight and provided to, and signed by, a Government department representative on the flight. The AFR serves as the basis for invoice processing. It provides information such as flying time or distance traveled which form the basis for the cost of the flight. The Manual required that these details, amongst others, must be compared to the invoice before it is processed. The AFR also ensures the flight plan agrees to the original plan in the AFA.

In our review, 8 of the 39 samples reviewed were missing an AFR. As a result, we were unable to validate any of the invoiced details of these flights. In 1 instance, the Government department was unable to locate the AFR. In the other 7 instances, the Division was unable to clarify for us whether or not the third-party carrier had copies of AFRs for use. A missing AFR also indicates that the Government departments did not follow the validation procedures required between the invoice and the AFR prior to payment of the invoice.

Finding

4. In some instances, Government departments do not have an Aircraft Flight Report (AFR), which provides details of the flight, to compare to the authorization or the invoice. This increases the risk that a payment is made to a carrier that is not consistent with services received.

AFR not properly completed

A properly completed AFR is the basis for invoice processing. Table 5 identifies the missing information from the sampled AFRs, by Government department, for the period April 1, 2011 to December 31, 2012.

Table 5

Transportation and Works
Missing Information from AFR
For the period April 1, 2011 to December 31, 2012

Missing Information	Environment and Conservation	Natural Resources	Executive Council	Legislature	Fire and Emergency Services - NL	Total	% of Total Samples
Total samples	11	7	0	9	4	31	
Passenger names	5	4	-	2	3	14	45%
Authorization number	-	2	-	-	-	2	6%

Further details regarding the missing information from AFRs in Table 5 are as follows:

- Passenger names are required to be listed on the AFR, as per Cabinet Directive, in order to provide adequate control over the system. In 14 of the 31 items (45%) we reviewed, passenger names were not listed. As a result, the Government department does not have a record of who flew at taxpayer expense.

- The Manual indicates that a "*properly completed Flight Authorization is presented prior to the flight.*" Therefore, an authorization number should be available for the AFR. In 2 of the 31 samples reviewed (6%) the authorization number was missing. As a result, the Government department cannot compare the AFA to an AFR, which is a required procedure when reviewing the invoice for payment.

Finding

5. There were a number of instances in which information was missing from the AFRs. Without a fully completed AFR, the Government department does not have a complete record of the details of the flight and may not have all information necessary to be verified during invoice review and processing procedures.

AFR is not signed

The carriers are responsible to have the AFRs available and ensure that they are properly completed before the passengers deplane. Carriers are advised in the Manual, of which they have a copy, that no invoice processing will take place without a properly completed AFR. A completed AFR must include a signature from the pilot/captain and a signature from the Government department representative who holds the AFA.

In 5 of the 31 samples we reviewed, not all required signatures were provided. Therefore, it is not clear who is accountable if there are any discrepancies between the AFA or invoice and the AFR. In 2 of the 5 instances, the carrier's signature was missing. In 3 of the 5 instances, the Government department representative signature was missing. Therefore, there is no evidence that a Government department representative verified the information provided by the carrier on the AFR. In these instances invoice processing still took place without a properly signed AFR.

Finding

6. In instances in which not all required signatures are present on an AFR, there is no evidence that information details of the flight have been verified by all required parties. Invoice processing without this verification increases the risk that a payment is made to a carrier that is not consistent with services received.

Details of AFR does not agree to AFA

The AFA is required to be approved before the flight departure and the AFR is required to be completed after the flight but before the passengers deplane. Information on these documents should agree to one another. Any deviations from the original AFA should be documented with explanations for the changes prior to invoice processing.

The Manual states that the *"…route indicated on the [AFA] must agree to the [AFR and any] discrepancies should be checked out before processing for payment."*

In 11 of the 31 samples, the flight plan on the AFR did not agree to the approved AFA. In some instances, the flight made additional stops beyond those indicated in the flight plan approved by the Government department without explanation. For example, the flight authorization approved four stops, while the flight report indicated six stops.

In 6 of the 31 items reviewed, the date of the flight did not agree to the date approved on the AFA. No explanation was provided to explain the difference.

Finding

7. In certain instances, details on the AFR, such as flight route and flight date, did not agree to that detailed on the flight authorization document, without explanation. For example, the flight authorization approved four stops, while the AFR indicated six stops. Therefore, the flight that took place was not as was approved by the Government department.

1C. Invoice Processing

Introduction

Invoice processing is the responsibility of the Government department that utilized the contract or charter flight. The Manual outlines that for invoice processing, the Government department must have a copy of the AFA, a copy of the AFR, and a copy of the invoice. The Manual provides procedures to adhere to when certifying invoices for payment such as:

- route indicated on AFA and AFR must agree;
- total flying time is calculated correctly;
- examine variations between the AFA and AFR;
- agree the rate to contract or standing offers; and
- crew expenses should be checked.

Inadequate review and verification of invoices and supporting documentation

During our review we discovered that the procedures outlined in the Manual for certifying payments were not being followed by Government departments and there was inadequate verification taking place. Such instances include:

- In 1 of the 39 samples we reviewed, two invoices for the same flight were paid resulting in an overpayment of $6,763. As a result, the Government department does not have adequate review and verification processes for aircraft contract or charter invoices. Officials of the Government department provided evidence that a credit note had been subsequently received.

- In 8 of the samples, the AFR was not available. As a result, invoices were certified for payment by the Government department without supporting documentation such as total flying time, rate, and route.

- In 15 of the 39 samples reviewed, the flight authorization did not indicate if a contract or standing offer was utilized. As a result, when invoice processing takes place the rate charged cannot be checked to the flight authorization, contract or standing offer as per the Manual.

Finding

8. Our review indicated instances of inadequate review and verification of invoices and supporting documentation. This increases the risk that a payment is made to a carrier that is not consistent with services received.

1D. Procedures

Introduction

A procedure is a series of steps to be followed as a consistent and repetitive approach to accomplish an end result. We expected to see procedures in place to guide the processes of the Division around the use of contracted and chartered aircraft.

Procedures are a useful training tool for new employees and a good reference tool for existing staff. Without procedures, the processes of the Division may be inconsistent or incomplete. Also, within the processes of the Division regarding the coordination of contract and charter services, there are significant responsibilities designated to the carriers and the Government departments requesting the flights. It is critical that procedures are fully documented and up to date at all times to ensure that all parties involved are aware of the processes around the services and their responsibilities within it.

Procedure manuals outdated

The Division has two procedures manuals currently in place: *The Air Services Procedure Manual* (the Manual) and *Dispatch Procedures*.

The Manual was created by the Division and has been distributed to Government departments and third-party carriers. Its purpose is to assist Government departments, carriers and the Division *"in ensuring the proper procedures are followed to control the use of Government Owned, Contracted and Chartered Aircraft."*

Dispatch Procedures is an internally used document provided to those employees involved in arranging and dispatching contracted and chartered aircraft. *Dispatch Procedures* is designed to assist dispatch employees in complying with the Manual.

The Manual was last updated in August 2001 and *Dispatch Procedures* was last updated in January 2002. These procedures manuals have not been updated in more than 10 years, and there are areas of the operations in which these procedures manuals do not represent the current practices used by the Division and Government departments.

During our review, we noted the following observations, some of which have already been detailed in other sections of this report:

- The Manual states that an AFA is required in order to engage aircraft services. However, according to Division officials, most flights are now booked using a PO number instead of an AFA despite the gap in information required on each document. This is inconsistent with required procedures as outlined in the Manual.

- Our review indicated that not all employees in the Division are aware of the existence of the procedure manuals. For example, we inquired with a dispatcher about the Manual and the employee advised that he was not aware the Manual existed.

- Our review indicated that not all Government departments are aware of the existence of the Manual. Also, officials from two Government department advised that they only have excerpts from the Manual.

The procedures documents currently in place are intended to cover procedures pertaining only to use of aircraft (both Government-owned and contract and charter). The Division does not have a procedures document to cover the management of aircraft costs.

Finding

9. The Division has outdated procedures manuals governing its processes. Also, not all employees of the Division and not all Government departments are aware of the existence of the Manual or they have just excerpts of the Manual. As a result, the procedures to be followed within the Division and by Government departments when booking a flight are not clear, as they have not been updated in 10 years and processes may not be operating efficiently and effectively.

Dispatch log book inaccurate

The dispatch log book is used to assign the next consecutive dispatch number, which is then provided to the Government department for completion of the AFA. The dispatch log book is completed and maintained by the Division and serves as a listing of all flights booked by the Division.

During our review, we encountered a number of instances where inaccuracies were found in the dispatch log book. Examples of these inaccuracies include: flights booked with the wrong Government department name, flight time not being completed, authorization numbers not filled in, and illegible entries.

Finding

10. Inaccuracies in the dispatch log book result in flight records that are not an accurate representation of the flight activity. As a result, the Division does not have appropriate records of its flights for reference.

Recommendations

The Department should:

- develop and communicate well defined procedures for the administration of air services as it relates to flight authorization, flight reports, invoice processing, and all other areas within the air services administration;
- ensure valid approved flight authorizations are provided by Government departments to the Division; and
- ensure more care is taken to ensure the dispatch log book is accurate and legible.

Government departments should comply with procedures as directed by the Division around the use of contracted and chartered aircraft.

2. Air Services Facilities

Overview

The administrative offices of the Division are located in Gander. The Division has hangar space and storage facilities in Gander, St. John’s, Deer Lake, Happy Valley-Goose Bay, and Wabush for storage, maintenance and operation of aircraft.

Personal items stored in Government facilities

The *Conflict of Interest Act, 1995* states that *"…A public office holder shall not engage in an activity…in which he or she may acquire an advantage derived from employment as a public office holder."*

During our review, we noted that there was personal property being stored in a leased hangar in Gander which is intended for storage of Government-owned aircraft. These personal items included automobiles, campers, motorcycles, boats, golf carts, all-terrain vehicles, and snowmobiles. The storage of these personal property items in the hangar contravenes the *Conflict of Interest Act, 1995*. This also increases the risk of damage to Government-owned aircraft stored in the hangar in instances such as fire, fuel leaks and movement of items.

Finding

11. Leased Government space is being used for personal benefit of employees of the Division, in contravention of the *Conflict of Interest Act, 1995*.

Additional lease space required for waterbombers

In October 2009 the Department signed a purchase agreement for four new Bombardier CL-415 waterbombers. Delivery of the new waterbombers took place between 2011 and 2013. As the new waterbombers were delivered, older waterbombers were disposed of.

Table 6 outlines the number of Government-owned waterbombers, by aircraft type, for the years ended March 31, 2010 through to 2013.

Table 6

Transportation and Works
Government-owned Waterbombers
For the years ended March 31

	# of Waterbombers	
	Canadair CL-215	**Bombardier CL-415**
2010	6	-
2011	4	2
2012	2	4
2013	2	4

Source: Department of Transportation and Works

Since 2001, the Division has leased two hangar spaces in Gander, Hangar 21 and Hangar 22, for the storage and maintenance of aircraft used in waterbomber operations.

Hangar 21 is primarily used in the summer months, as the hangar is not heated. In the winter, it is used for the storage of the Canadair CL-215 waterbombers, as the space is not heated to accommodate the electronic instrumentation of the new Bombardier CL-415 waterbombers. Hangar 22 is used for administrative offices, and the maintenance and storage of aircraft. Hangar 22 is heated hangar space and therefore can accommodate the new Bombardier CL-415 waterbomber for storage in the winter months.

Table 7 outlines the waterbomber storage capacity and lease cost of each hangar for the years ended March 31, 2010 to 2013.

Table 7

Transportation and Works
Capacity by Hangar and Annual Lease Cost
For the years ended March 31

	Hangar 21		Hangar 22		Total Capacity	Total Lease Cost
	Storage Capacity	Lease Cost	Storage Capacity	Lease Cost		
2010	4	$8,778	2	$628,753	6	$637,531
2011	4	35,114	2	643,891	6	679,005
2012	4	35,114	4	1,146,682	8	1,181,796
2013	4	39,224	4	1,541,222	8	1,580,446

Source: Financial Management System of the Government of Newfoundland and Labrador
Department of Transportation and Works

The Department was aware of the requirement for heated hangar space. Upon the delivery of the third new waterbomber, in August 2011, there was insufficient heated hangar space available. Therefore, the new waterbomber had to spend two months in the unheated hangar space, Hangar 21. The Department risked causing significant damage to the new waterbomber by not having acquired the required heating space. In October 2011, additional hangar space in Hangar 22 was leased to accommodate the third and eventually the fourth waterbomber, in order to ensure no damage was caused to the electronic instruments.

Finding

12. There was a lack of planning for storage of the new waterbombers. This led to the risk of damage to one of the new waterbombers, as it was stored in unheated hangar space until additional heated hangar space was acquired.

Recommendations

The Department should ensure that:

- Division employees comply with the *Conflict of Interest Act, 1995*; and
- planning for hangar space is complete before purchasing additional waterbombers.

3. Management of Aircraft Costs

Introduction

Table 9 below summarizes air service costs by aircraft type for the fiscal years ending March 31, 2012 and March 31, 2013.

Table 9

Transportation and Works
Air Service Costs
For the years ended March 31

Cost Category	# of Aircraft	Approximate Age	Operating Costs	
			2012	2013
Forest Fire Protection Services				
Bombardier CL-415	4	1-3	$961,072	$522,923
Canadair CL-215	2	44	1,289,972	1,214,417
Cessna 337	1	38	64,916	139,154
Air Ambulance Services				
Island- Beechcraft King Air 350	2	2, 23	2,460,019	3,306,029
Labrador- Beechcraft King Air 350	1	5	983,673	898,301
Total			**$5,759,652**	**$6,080,824**

Source: Financial Management System of the Government of Newfoundland and Labrador
Department of Transportation and Works

Inadequate monitoring of aircraft costs

To determine if there was adequate management of aircraft costs, we examined the processes used by the Division for the monitoring of these costs.

The Division uses a WinAir Maintenance and Inventory System (the System) to track costs by aircraft type. The Division does not track costs by individual aircraft. As a result, the Division is not able to compare and analyze individual aircraft costs using criteria such as: types of aircraft, hours flown, industry standards or time.

According to Division officials, staff responsible for tracking aircraft costs have never received training on how to use the System. While the System is capable of tracking maintenance and labour costs associated with individual aircraft, the System is not being utilized in that manner.

Tracking costs for individual aircraft would help the Division monitor operating and maintenance costs, particularly for those aircraft types that have a broad range of ages within them. For example, the ages of the Island Air Ambulances are 2 and 23 years.

According to a Division official, one of the Island Air Ambulances will need major upgrades in the near future. If costs were to be tracked by aircraft, the Division would more easily be able to analyze total costs associated with the aircraft to date to assist in the determination of whether the cost to upgrade is reasonable, or whether the purchase of a new aircraft should be considered.

Finding

13. The Division is not utilizing its WinAir Maintenance and Inventory System to track aircraft costs in an effective manner.

Hourly charge-out rates not current

Cost information is used by the Division to determine the hourly rate to be charged to out-of-province users of the air ambulance transport. Amounts collected are provincial revenue for the Province. Division officials indicated that the hourly rates used for 2013 are the same as those used in 2005, even though more recent data is available. Therefore, the Province may not be recovering its costs associated with the usage of the King Air as prescribed in its policy.

Finding

14. The Division has not reviewed its hourly charge-out rate for out-of-province air ambulance transport since 2005. Therefore, Government may not be recovering the full cost of those air ambulance transports.

Recommendations

The Department should:

- monitor operating and maintenance costs by individual aircraft and should ensure Division staff are properly trained in the use of the system.
- review its hourly charge-out rates for air ambulance in order to recover costs associated with its use.

Department of Transportation and Works' Response

1. Departmental Contracts and Charters

Recommendations

The Department should:

- *develop and communicate well defined procedures for the administration of air services as it relates to flight authorization, flight reports, invoice processing, and all other areas within the air services administration;*
- *ensure valid approved flight authorizations are provided by Government departments to the Division; and*
- *ensure more care is taken to ensure the dispatch log book is accurate and legible.*

Response

The department will undertake a review of the Air Services Procedures Manual, and will prepare a written procedure based on the manual to be distributed to line departments that clearly outlines the requirements and responsibilities of other government departments when requesting Government Air Services (GAS) to book a charter or contract aircraft. The department feels that the written procedure would be a more clear, concise document, and would be more specific to the procedures departments need to follow, as compared to the more detailed Air Services Procedures Manual. The written procedure will clearly specify the requirement for the department using the aircraft to obtain the fully completed Aircraft Flight Report (AFR) at the end of the flight and prior to leaving the service providers' premises/aircraft.

Departments and/or Agencies will be required to provide a list of persons/positions authorized to approve Aircraft Flight Authorization forms. Except for those instances identified in the Air Services Procedures Manual as exceptional circumstances, GAS will not complete a booking or provide a dispatch number until all required information is provided. Instances that are deemed "exceptional circumstances" will be identified in the written procedure noted above. In instances where flight plans have changed, detailed explanations of the variances will be required. As part of its review, GAS will consider the review of all supporting documentation including the aircraft booking and the AFR to ensure that all information is correct before payment is issued to the carrier.

As part of its review of the Air Services Procedures Manual, GAS will consider the review and modification of its dispatch log for each aircraft charter to ensure that all information is accurate and the staff is fully aware that it must be completed to ensure accuracy before the payment of invoices can be completed.

2. Air Services Facilities

Recommendations

The Department should ensure that:

- *Division employees comply with the Conflict of Interest Act, 1995; and*
- *planning for hangar space is complete before purchasing additional waterbombers.*

Response

The department has directed all Air Services Division employees to have all personal property not required for the performance of duties removed from Government property, both leased and owned. In addition, the department will clearly communicate the Conflict of Interest Act, 1995 to our employees.

The department agrees that heated hangar space is required over the long term to ensure no damage to electronic instruments. However, the two month delay that occurred in August and September did not subject the waterbomber to cold temperatures or damage. The department is planning on constructing a new hangar to negate the need for leased space in Gander. That project is currently approved in principal, and is progressing through Government's 4-Stage Infrastructure Approval Process.

3. Management of Aircraft Costs

Recommendations

The Department should:

- *monitor operating and maintenance costs by individual aircraft and should ensure Division staff are properly trained in the use of the system; and*
- *review its hourly charge-out rates for air ambulance in order to recover costs associated with its use.*

Response

Training on the use of WinAir will be sourced and provided to those employees requiring such training in order to track aircraft costs in an effective manner.

The department will review the charge-out rates for air ambulance and may be revised to reflect actual costs of providing the service.

Department of Environment and Conservation's Response

The Department of Environment and Conservation's response to the recommendation that "Government departments should comply with procedures as directed by the Division around the use of contracted and chartered aircraft" is as follows:

The Department of Environment and Conservation will comply with procedures as directed by the Division around the use of contracted and chartered aircrafts.

Department of Natural Resources' Response (Forestry and Agrifoods Agency)

Departmental Contracts and Charters

The Department of Natural Resources (DNR), Forestry Services Branch (FSB) routinely uses contracted and chartered aircraft services in accordance with legislation and Division policies and procedures. The department always considers use of a contract carrier before considering the use of aircraft on standing offers.

We concur with the Auditor General's recommendations that a number of improvements need to occur to address deficiencies reported under Departmental Contracts and Charters:

1. *We will ensure Aircraft Flight Authorizations (AFA's) are completed before flight departures. For example, there may be instances involving aircraft requirements for forest fires (emergency situation) where the AFA's are not available prior to the flight departure, however these AFA's in future will be completed as soon as possible. Staff that is directly involved in arranging aircraft requests will be reminded of this requirement and provided copies of the air services procedures manual.*

2. *We will ensure Aircraft Flight Reports (AFR's) are finalized before passengers depart the aircraft. Our staff will be reminded of this requirement and provided copies of the air services procedures manual.*

3. *Before any invoices are processed and approved for payment, information on the AFA's/AFR's and corresponding invoices will be reviewed to ensure the information provided is complete and consistent on all documents.*

4. *All FSB staff directly involved in arranging aircraft requests will be provided copies of the air services procedures manual and training to ensure we follow a consistent approach when arranging aircraft.*

Air Services Facilities

1. *The Forestry Services Branch can confirm that a portion of the items stored in a leased hangar in Gander were personal property. A review of inventory is underway and corrective action is being taken to remove any personal items in leased government space and to ensure this doesn't occur again.*

Department of Natural Resources' Response (Mines and Energy Branches)

The report provided findings pertaining to nine Department of Natural Resources' flights. One of these flights related to the Mines and Energy Branches with the remainder falling under the responsibility of the Forestry and Agrifoods Agency. My response below addresses the findings related to the Mines and Energy flight only.

My officials have investigated this matter and have taken corrective measures to ensure that these and similar discrepancies are not repeated. The staff members involved in the flight noted above have been fully informed of the correct procedures and their responsibilities. These procedures will be monitored closely by supervisory staff on an ongoing basis to ensure correct information is supplied and procedures followed.

In closing, I would like to confirm that the Department of Natural Resources, Mines and Energy Branches, concurs with the recommendations of the Auditor General on this matter.

Executive Council's Response

*Under **Section 1: Departmental Contracts and Charters**, it is recommended that "Government departments should comply with procedures as directed by the Division around the use of contracted and chartered aircraft."*

Please be advised that Executive Council will ensure that its departments and offices comply with the required procedures as provided by the Department of Transportation and Works. We will take steps to ensure staff who are responsible for booking and utilizing aircraft charters are reminded of the requirement for Aircraft Flight Authorization forms and Aircraft Flight Reports. In addition we will review our invoicing processes to ensure all related documents are reconciled before payments are issued.

Legislature's Response

The last recommendation in your report, Section 1 - Departmental Contracts and Charters, states that:

> *"Government departments should comply with procedures as directed by the Division around the use of contracted and chartered aircraft."*

The Legislature has been provided with a complete copy of the Air Services Procedures Manual and will comply with procedures, where possible, as directed by Air Services Division around the use of contracted and chartered aircraft.

Fire and Emergency Services - NL's Response

The Recommendation states, "Government departments should comply with procedures as directed by the Division around the use of contracted and chartered aircraft."

Agency Response:

Fire and Emergency Services - NL (FES-NL) will continue to strive to comply with procedures set out by Air Services Division for the use of contracted and chartered aircraft, as may be updated or amended from time to time, on the understanding there may be exceptional circumstances regarding urgent air support for Ground Search and Rescue upon the request of the Royal Canadian Mounted Police or the Royal Newfoundland Constabulary. In such circumstances, the following procedures will be utilized:

- *The operational requirements to provide emergency air support services will generate the necessary Aircraft Flight Authorization (AFA) number and Dispatch number. The subsequent administrative requirements will be completed to ensure that a Purchase Order (PO) number is generated to process payment of any invoices related to the provision of emergency air support services.*

- *The Agency will initially record the name of the law enforcement officer requesting emergency air support services, and will obtain the names of personnel on the flight as soon as possible after the operation has concluded.*

- *The duration of air support required may be unknown at the time of the request. Agency policy provides for the initial approval of two hours of search time and amendments to the amount of flying time required are made as necessary upon the request of the lead police force conducting the Ground Search and Rescue operations. Search time refers to the point in time when the air support asset reaches the officer in charge and begins to provide air support for the Ground Search and Rescue operations. FES-NL will (depending on the location of the ground search) also incur the flying time expense for the transit of the air support asset from its base of operation to the search area and return.*