December 2018

# Report of the Auditor General to the Nova Scotia House of Assembly


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December 11, 2018

Honourable Kevin Murphy
Speaker
House of Assembly
Province of Nova Scotia

Dear Sir:

I have the honour to submit herewith my Report to the House of Assembly under Section 18(2) of the Auditor General Act, to be laid before the House in accordance with Section 18(4) of the Auditor General Act.

Respectfully,

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# Chapter 1
# Health and Wellness; Internal Services; IWK Health Centre; and Nova Scotia Health Authority: Management and Oversight of Health Sector Information Technology

**Overall Conclusions**

- **The Department of Health and Wellness does not provide effective leadership and direction on information technology (IT) in the health sector**
- **The four government organizations responsible for IT in the health sector (Department of Health and Wellness; Department of Internal Services; IWK Health Centre; Nova Scotia Health Authority)**
  - **have not formalized roles and accountabilities**
  - **do not adequately manage IT risks**

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## Accountability for Information Technology in the Health Sector

The four entities have not finalized key agreements for centralized health sector IT services

- A roles and accountabilities exercise started in 2017 is ongoing as of fall 2018
- An Executive Committee proposed to provide strategic oversight has not met

The health sector does not adequately monitor IT service levels

- Health sector does not ensure that required service levels are met by providers
- Contracts, with one dating back to 1996, have not been reviewed or updated

## Managing Information Technology Risks in the Health Sector

The four entities do not have adequate risk management frameworks

- Health and Wellness and Internal Services do not have risk management frameworks
- IWK and Health Authority frameworks have risk identification and mitigation weaknesses

Internal Services and the Health Authority do not have policies requiring IT controls to be monitored

The four entities do not ensure that collective risk to the health sector is adequately managed

## Recommendations at a Glance

Recommendation 1.1
The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should finalize agreements related to information technology services in the health sector, including the roles and accountabilities of each entity.

Recommendation 1.2
The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should evaluate the transition to centralized information technology services, and identify lessons learned which can be applied to future collaborative health sector initiatives.

Recommendation 1.3
The Department of Health and Wellness, IWK Health Centre, and Nova Scotia Health Authority should develop and implement policies for the management of IT service levels, including periodic review of agreements and monitoring of service levels.

Recommendation 1.4
The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should develop and implement comprehensive risk management frameworks which include risk management policies, risk registers, a defined risk tolerance, and risk mitigation strategies.

Recommendation 1.5
The Department of Internal Services and Nova Scotia Health Authority should ensure policies are in place to require that IT controls are monitored, results are reported, and deficiencies are managed.

Recommendation 1.6
The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should establish a process to assess if IT risks are collectively identified, assessed, and mitigated.

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# 1 Health and Wellness; Internal Services; IWK Health Centre; and Nova Scotia Health Authority: Management and Oversight of Health Sector Information Technology

## Accountability for Health Sector IT

1.1 Information technology (IT) provides clinicians and support staff in the health sector with the tools and information needed to effectively and efficiently manage and provide care to Nova Scotians. A broad range of information systems are used in healthcare facilities; registration and scheduling systems, lab diagnostic systems, electronic health records, and other clinical applications allow health care facilities to organize patient flow, analyze and store lab results, and keep detailed medical histories.

1.2 Ensuring effective and efficient health care requires that information technology systems and personal health information remain secure and available. Failure to do so can have significant impacts. Potential consequences include unauthorized disclosure of personal health information, increased wait times for services, increased costs to the health care system, and overall negative impacts on the health and well-being of Nova Scotians.

### Department of Health and Wellness is not effectively leading IT in the health sector

1.3 The Department of Health and Wellness has not provided the level of leadership and direction required to effectively transition the health sector to centralized information technology services. There are no signed agreements for the delivery of IT services in the health sector, roles and accountabilities are not clear, key service levels are not monitored and reported, and IT risk management is inadequate. These issues leave the Province with a greater risk of significant IT-related deficiencies not being identified or adequately managed. We discuss each issue in more detail throughout this chapter.

1.4 The provincial health sector consists of the Department of Health and Wellness, the IWK Health Centre (IWK) and the Nova Scotia Health Authority. Subsequent to the introduction of the Shared Services Act, the mandate of the Department of Internal Services expanded in 2016 to include the network and systems supporting the applications used and managed by the health sector. These four organizations can only meet the IT needs of the health sector if they work together with effective leadership from Health and Wellness.

1.5 Health and Wellness is accountable for the performance of the health system and needs to ensure that the Health Authority and the IWK fulfill their responsibilities. Internal Services is a service provider to the health sector, therefore Health and Wellness is also ultimately responsible for both the overall operation of the health system and to ensure the services required from Internal Services are clearly established and performance is monitored.

1.6 The recommendations throughout this chapter are directed at the entities responsible to act; however, Health and Wellness must provide more leadership and direction to ensure IT services and IT risks in the health sector are appropriately governed and managed. The completion of the following recommendations will support enhanced leadership.

### Government entities do not have signed agreements for centralized health sector IT services

1.7 There are no signed agreements for IT services provided by Internal Services or the Health Authority to support the entities in the health sector. While the four entities work together to ensure IT aligns with the needs of the health sector, agreements are critical when obtaining IT services from another organization to ensure that services required are received. Agreements should define roles and accountabilities, what services are contracted, and the level to which they are to be provided. Not having agreements in place increases the risk of misunderstandings regarding expectations and gaps in services, and limits the ability to hold providers accountable.

1.8 A draft agreement exists between the Health Authority and the IWK for the management of the IWK's clinical applications. Health Authority and IWK management indicated this draft agreement was verbally agreed to, although not formalized. There is however no agreement between the Health Authority and Health and Wellness for IT services provided to support the Department's clinical applications.

1.9 Three draft agreements exist between Internal Services and the health sector for the delivery of central IT services. Questions surrounding roles and accountabilities have resulted in these contracts remaining unsigned and in ongoing negotiations.

### Health sector has not formally agreed upon roles and accountabilities, including clinical applications

1.10 A roles and accountabilities exercise involving all four organizations was initiated in fall 2017; the results are yet to be determined as of fall 2018. One issue in clarifying roles and accountabilities and finalizing the agreements is obtaining consensus on responsibilities for clinical applications.

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1.11 The health sector has responsibility for clinical applications, and as part of the transition to centralized IT services there was significant discussion around the Health Authority taking responsibility for all clinical applications. No formal decision was made on the roles and accountabilities for clinical applications.

1.12 Currently, Health and Wellness manages several significant health applications such as Panorama, Drug Information System, and Personal Health Records. Health and Wellness management defines these as digital health applications supporting provincial health programs that extend beyond the responsibility of the Health Authority. However, Health Authority management considers these applications clinical and feel they should be within their mandate.

1.13 Documents from 2014 prepared by an internal working group which included Health and Wellness, and a consultant's report outlining a model for the management of clinical applications, clearly classify the applications as clinical. In fall 2015, a decision request was prepared to approve these documents which include the definition of a clinical application and listings classifying clinical and non-clinical applications.

1.14 This is an example of the issues that occur when leadership and direction are not effective in resolving key issues. A decision which was considered at length remains an ongoing issue, more than three years after the creation of the Health Authority. The health sector did not formalize and agree upon roles and accountabilities before the implementation of a significant transition and change in operations. There is an increased risk that roles and accountabilities are not fulfilled as required to best support the health sector due to lack of clarity and agreement.

### Proposed Executive Committee is not meeting to provide strategic oversight

1.15 The draft agreements between the entities propose three new committees – an Executive, a Health Information Management and Technology Governance, and a Management Committee. While the governance and management committees are meeting, the Executive Committee is not.

1.16 The purpose of the Executive Committee is to ensure IT services meet the needs of the health sector. This Committee is critical, as the proposed responsibilities include providing strategic oversight, monitoring the delivery of services, and resolving disputes between the organizations. The issues addressed in this chapter indicate there is a need for this Committee, or alternative governance structure, to be formalized to provide this high-level oversight.

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**Recommendation 1.1**

The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should finalize agreements related to information technology services in the health sector, including the roles and accountabilities of each entity.

*Joint Response: The Departments, IWK and NSHA agree with this recommendation and are in the process of signing the referenced agreements. At the September 13, 2017 Governance meeting, and under the commitment to continuous improvement, the four organizations identified the need to define clearer roles and accountabilities and began a RACI (responsible, accountable, consulted and informed) exercise as a foundation to building stronger health IT governance. This work continues and is a priority. The RACI will complement the existing agreements and will align with the COBIT framework.*

## Health sector should apply lessons learned from the transition to future large initiatives

1.17 While the health sector has not finalized roles and accountabilities for centralized IT services, the organizations are currently planning another significant Health and Wellness IT strategic initiative.

1.18 "*One Person, One Record*" (OPOR) is a partnership of the four organizations and will replace hundreds of aging clinical applications with a single centralized health information system for the Health Authority and the IWK. The IT strategies of the Health Authority and the IWK are in line with this major initiative. Internal Service's IT strategic plan to deliver effective IT services supports it as well.

1.19 Clearly-defined roles and accountabilities are key to the effective implementation of any large strategic initiative and will be very important in the successful introduction of a centralized health information system in Nova Scotia. This project will have a direct impact on the delivery of health services, and therefore the health and well-being of Nova Scotians. The entities must ensure they identify the key issues which impacted the collaborative relationship throughout the transition to centralized information technology services and ensure they do not continue to impact future initiatives.

**Recommendation 1.2**

The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should evaluate the transition to centralized information technology services, and identify lessons learned which can be applied to future collaborative health sector initiatives.

*Joint Response: The Departments, IWK and NSHA agree with this recommendation and will document lessons learned in a summary document. This work has begun and will inform current and future collaborative health sector initiatives. The RACI referenced in 1.1 will clarify roles and accountabilities.*

## Health sector is not monitoring service levels

1.20 The health sector is not ensuring service providers deliver IT services at the required levels. As an example, a service level requirement may define the acceptable amount of time a system can be down before the service provider is required to respond. A lack of, or improper response by a service provider, can increase the amount of time a system is not effectively supporting the delivery of health care and could directly impact patients.

1.21 It is the responsibility of Health and Wellness, the Health Authority and the IWK to ensure their IT service providers do what they are contractually required to do. This includes obtaining and reviewing reports on key performance metrics to ensure agreed-upon levels are met.

1.22 Internal Services does not report service levels to the health sector for the delivery of IT services. The draft master agreement between the four organizations requires Internal Services to submit quarterly and annual reports to the Executive Committee; however, as noted, this Committee is not meeting and these reports are not submitted elsewhere to the health sector organizations.

1.23 The Health Authority is reporting on service levels to the IWK for its management of clinical applications. The Health Authority is not reporting on service levels to Health and Wellness, as there is no agreement with the Department, as previously addressed in this chapter.

1.24 The Health Authority does not receive service level reports for clinical applications from various external vendors. In addition to effectively monitoring ongoing operations, this is a concern for overall contract management. Health Authority management stated that review of IT contracts is based on need and risk; however, the vendor contracts relating to two of the Health Authority's significant clinical applications were not reviewed or updated upon the creation of the Health Authority. These contracts, dating as far back as 1996, may no longer reflect the service levels required.

**Recommendation 1.3**

The Department of Health and Wellness, IWK Health Centre, and Nova Scotia Health Authority should develop and implement policies for the management of IT service levels, including periodic review of agreements and monitoring of service levels.

*Joint Response: DHW, IWK and NSHA agree with this recommendation and DHW will lead the development of a joint policy on the management of IT service levels within the health sector. The key clinical applications that underpin the current health IT system have undergone a preliminary assessment to identify those agreements that will be subsumed by OPOR (for example the 1996 agreement referenced in the audit), those that will no longer be required when OPOR is in place and those that will continue separate from OPOR. The policy will identify requirements for periodic review of service agreements and the management and monitoring of service levels. This work has already commenced, and the policy will align with the COBIT framework.*

## IT Risk Management

### The four organizations do not have adequate risk management frameworks

1.25 The four organizations have weaknesses in IT risk management, varying from a complete lack of a risk management framework to significant gaps in the requirements for a robust framework. An effective enterprise risk management framework requires an entity to identify, assess, respond to, and appropriately control risks which may have an undesired impact on the organization.

1.26 We assessed whether each entity had in place the key components of an established risk management framework, including a:

- high-level risk management policy;
- risk register which clearly states risks identified;
- defined risk tolerance; and,
- risk mitigation strategies to reduce risk to the acceptable level.

| IT Risk Management Framework | DHW | ISD | IWK | NSHA |
|---|---|---|---|---|
| Risk management policy | No | No | Yes | Yes |
| Risk register | No | Partial | Partial | Partial |
| Defined risk tolerance | No | No | Yes | No |
| Risk mitigation strategies | No | Partial | No | Partial |

1.27 The Departments of Health and Wellness and Internal Services do not have enterprise risk management frameworks in place; however, Internal Services developed a risk register to identify and mitigate cybersecurity risks.

1.28 The IWK implemented an enterprise risk management framework to identify and assess risks to the organization. Although it recognized the risks to the entity, it did not establish mitigation strategies to address and control them.

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1.29 The Health Authority also implemented an enterprise risk management framework; however, management at the Health Authority has not defined and communicated the level of risk it is willing to accept. By not defining a risk tolerance, the Health Authority may not properly address a risk with a potential impact greater than it is willing to accept, or may over allocate resources to a risk that would not significantly impact the entity or its stakeholders.

1.30 We also identified some areas where the risk registers maintained by the Health Authority and the IWK failed to consider some IT security risks that could impact their organizations. Examples include the risk of unauthorized access to personal health information by employees or vendors, and the risks associated with outsourcing for and providing information technology services. These are key risks to consider in protecting the security of the Province's information technology and may indicate the Health Authority and the IWK require a more thorough assessment of IT risks.

**Recommendation 1.4**

The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should develop and implement comprehensive risk management frameworks which include risk management policies, risk registers, a defined risk tolerance, and risk mitigation strategies.

*Joint Response: The Departments, IWK and NSHA agree with this recommendation as it applies to health IT service delivery. Risk management practices including risk registers, risk tolerance assessment and risk mitigation strategies will align with the COBIT framework and will include continuous processes that support new initiatives and ongoing operations.*

## Internal Services and Health Authority do not have policies for monitoring control effectiveness

1.31 We enquired with senior management at Internal Services and the Health Authority, as the two entities provide IT services, and determined that neither has policies requiring IT controls to be monitored or deficiencies to be addressed in a timely manner and reported to management. The lack of policies does not support an adequate level of direction and oversight.

1.32 The risk of IT controls not being adequately monitored in the health sector is increased without direction and oversight from those charged with governance. IT controls must be monitored, to ensure the protection of health information and systems supporting the delivery of health care services.

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**Recommendation 1.5**

The Department of Internal Services and Nova Scotia Health Authority should ensure policies are in place to require that IT controls are monitored, results are reported, and deficiencies are managed.

*Joint Response: The Department of Internal Services and the NSHA agree with this recommendation and will be developing a joint policy. The policy will identify the agreed upon IT controls that will be monitored and reported, to be approved and overseen by DHW.*

## The four organizations are not collectively managing health sector IT risks

1.33 IT risks that could impact the entire health sector are not effectively managed. The failure of one organization to effectively secure its systems against unauthorized access or cybersecurity attacks could have a negative impact on all organizations within the health sector.

1.34 The draft service level agreement between Internal Services and the health sector allows Internal Services to hire an independent organization to assess the IT controls at the IWK and the Health Authority. However, Health and Wellness, the IWK, and the Health Authority do not have the authority to obtain an independent assessment of Internal Service's IT controls. Risks related to information technology can impact both service providers and receivers, therefore these organizations may be exposed to control deficiencies and risks from the Department of Internal Services, without the ability to assess and mitigate those risks.

1.35 The draft agreement for management of the IWK's clinical applications by the Health Authority does not include an independent assessment to verify the effectiveness of the IT controls in place to protect the IWK's information. Health and Wellness does not have an agreement with the Health Authority and does not require an independent assurance report on IT controls.

1.36 The IT security of the health sector is dependent on several organizations effectively managing IT risks. Each organization needs to ensure the others have effectively managed risks and implemented the necessary IT controls through collaboration, self-reporting, or independent assurance reports.

**Recommendation 1.6**

The Department of Health and Wellness, Department of Internal Services, IWK Health Centre, and Nova Scotia Health Authority should establish a process to assess if IT risks are collectively identified, assessed, and mitigated.

*Joint Response: The Departments, IWK and NSHA agree with this recommendation and the process will be put in place as part of the response to recommendation 1.4. The framework will provide the foundation to establish a process to assess IT risks collectively, ensuring they are identified, assessed and mitigated.*

## Additional Comments from Health and Wellness; Internal Services; IWK Health Centre; and Nova Scotia Health Authority

*Providing high quality health care is dependent in part on modernized and integrated health information systems. Nova Scotia's goal is the creation of a single integrated health record for every Nova Scotian. One Person One Record (OPOR) will support and enable clinical transformation and improved health care delivery in Nova Scotia, creating a high functioning, data driven, agile, digital system. This goal guides our work in health sector IT, including steps to have greater coordination and integration of existing systems as we work toward OPOR.*

*While this work was not in scope for the OAG audit, it informs our response to the findings in this audit. The recommendations from this audit will be aligned with the OPOR Governance structure, clarifying accountability for IT in the health sector. Recommendations 1.2 through to 1.6, will be completed through the lens of OPOR and the lessons learned from transition. Work has been underway:*

- *In October, the Health Information Management/Information Technology Governance Committee updated their Terms of Reference to support the operational and strategic work underway in health sector IT. The Committee adopted COBIT as the Business Framework for the Governance and Management of Health Sector IT. COBIT is a generally accepted source of best practices, enabling IT to be governed and managed in a holistic manner, by maintaining a balance between realizing benefits and optimizing risk level and resource use. DHW will lead the development of a plan to implement COBIT. The plan will outline the work required and the timelines for completing the supporting policies, templates and procedures.*
- *In November, the Health System IMIT Executive Sponsors Committee approved changes to the OPOR Governance structure to confirm clear accountability and oversight exists for all health sector IT. Updated Terms of Reference have been approved for both the Governance Committee and the Executive Committee.*
- *Work has begun to obtain an independent assessment of our current state and to provide guidance on the development of a COBIT implementation roadmap and plan for any improvements identified.*
- *To summarize, the Departments, IWK and NSHA intend to implement all recommendations related to the Management and Oversight of Health Sector IT.*

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Appendix I

## Reasonable Assurance Engagement Description and Conclusions

In fall 2018, we completed an independent assurance report of the management and oversight of health sector IT of the Department of Health and Wellness; Department of Internal Services, IWK Health Centre and Nova Scotia Health Authority. The purpose of this performance audit was to determine whether there is appropriate IT governance in place for the health care sector.

It is our role to independently express a conclusion about whether the Departments of Health and Wellness and Internal Services, IWK Health Centre, and Nova Scotia Health Authority comply in all significant respects with the applicable criteria. Management at the Departments of Health and Wellness and Internal Services, IWK Health Centre, and Nova Scotia Health Authority acknowledged their responsibility for IT governance in the health care sector.

This audit was performed to a reasonable level of assurance in accordance with the Canadian Standard for Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada; and Sections 18 and 21 of the Auditor General Act.

We applied the Canadian Standard on Quality Control 1 and, accordingly, maintained a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we complied with the independence and other ethical requirements of the Code of Professional Conduct of Chartered Professional Accountants of Nova Scotia, as well as those outlined in Nova Scotia's Code of Conduct for public servants.

The objectives and criteria used in the audit are below:

Objective:
To determine whether the Health Authority, IWK, and the Departments of Internal Services and Health and Wellness have appropriate IT governance in place for the health care sector.

Criteria:

1. The selected entities should establish an IT governance framework to provide accountability and oversight.
2. The selected entities should have implemented IT risk management frameworks.
3. The selected entities should have processes in place to align IT with the needs of the business.
4. The selected entities should ensure agreed-upon service levels have been met.
5. The selected entities should monitor controls to ensure they are designed and operating effectively.
6. The selected entities should evaluate and assess independent assurance reports.

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Criteria for the audit are from the IT Governance Institute's framework, COBIT 4.1, which is generally accepted as an international authoritative source of best practices for the governance, control, management, and audit of IT operations. The criteria were accepted as appropriate by senior management at the entities audited.

Our audit approach consisted of interviewing management and other key personnel and reviewing documentation to determine whether management and those charged with oversight responsibilities established an IT governance framework; considered the Province's health care goals in IT strategies; implemented processes to determine, evaluate, and manage IT risks; and monitored key IT controls, service level agreements, and independent assurance reports. Our audit covered the period April 1, 2015 to March 31, 2018. We examined documentation outside of that period as necessary.

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 14, 2018, in Halifax, Nova Scotia.

Based on the reasonable assurance procedures performed and evidence obtained, we have formed the following conclusions:

- The Department of Health and Wellness is not providing effective leadership and direction on IT in the health sector.
- The Departments of Health and Wellness and Internal Services, IWK Health Centre, and Nova Scotia Health Authority do not have not formalized roles and responsibilities for IT in the health care sector and are not adequately managing IT risks.

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# Chapter 2
# IWK Health Centre: Financial Management Controls and Governance

**Overall Conclusions**

- **The Board of Directors and management of the IWK Health Centre did not effectively govern and oversee the development and performance of financial controls**
- **Financial controls were not effective**

## Financial Management Controls

**(Audit Period – April 1, 2017 to March 31, 2018)**

Significant financial and other internal controls were not effectively designed and implemented

- Controls over the seven business processes we examined were not effective

Significant transactions were not appropriate, adequately supported, or properly authorized

- Almost half (86) of the 199 samples requiring approval were not appropriately approved

- Internal controls were not documented and many policies lacked clear guidance
  - No policies covering fraud, hospitality, and internal meeting expenses

- Procurement controls were not effective, allowing individuals to make unapproved purchases or override the process
  - 8 of 10 procurement contracts could not be found
  - No evidence of quotes

- Payment controls were not effective and could result in IWK Health Centre paying for items not received
  - 16 of 25 transactions were not signed or stamped to show goods or services were received before payment was made
  - 78 percent (59) of 76 Board and executive travel and other expenses paid did not comply with policies, including 32 not appropriately approved (12 of 14 Board expenses were approved by management and not the Board Chair as required) and 9 expenses with no receipts

- Senior management did not promote compliance with policies
  - Former Chief Financial Officer approved expense claims with no receipts more than a year after the expenses had supposedly been incurred
  - Contrary to policy, the former Chief Financial Officer submitted a personal expense claim 173 days after the expenses had been incurred

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## Governance

**(Audit Period – January 1, 2014 to December 31, 2017)**

Although the IWK Health Centre Board has many good governance practices, based on the pervasive financial internal control weaknesses, the Board did not effectively govern the IWK Health Centre

- The Board and management did not have a comprehensive risk framework
  - Financial risks were identified in 2012, but only five lower risk areas were addressed; most higher risk areas had no plan to manage

- The Board did not set the tone at the top for internal controls and did not adequately challenge management
  - Board committees did not question management's rationale for assessing the control environment as mature
  - Board committees did not obtain evidence to support legislative compliance or follow up on management's promise to deliver information

- The Board did not update the finance committee terms of reference in 2014 for best practices
  - No assurance that Board and senior management expenses comply with expense policies
  - No mention of the Committee's role to establish tone at the top related to internal controls

- The Board did not document the performance evaluation of the former Chief Executive Officer

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## Recommendations at a Glance

Recommendation 2.1
The IWK Health Centre should create and update policies to provide clear expectations to staff. These policies should address fraud, travel and hospitality, internal meeting expenses, staff social events, gifts of appreciation, signing authority, and procurement.

Recommendation 2.2
The IWK Health Centre should complete a risk-based evaluation of its internal controls. Management should design, document, and implement appropriate internal controls and monitor to ensure the controls are operating effectively on a regular basis.

Recommendation 2.3
The IWK Health Centre Board of Directors should oversee the development and implementation of internal controls and receive regular reporting on the effectiveness of internal controls.

Recommendation 2.4
The IWK Health Centre should implement a comprehensive risk management framework. This framework should identify both operational and strategic risks and identify how the IWK Health Centre is responding to the risks. The Board and management should regularly monitor the effectiveness of the IWK Health Centre's response to the risks.

Recommendation 2.5
The IWK Health Centre should re-evaluate whether it has appropriately assessed and ranked its financial risks, using the issues identified in this report as a guide.

Recommendation 2.6
The IWK Health Centre Board of Directors should update its governance policy to set a clear expectation of the significant transactions requiring Board approval. The Board should verify that management presented all changes to the Board for approval as required.

Recommendation 2.7
The IWK Health Centre should identify and put appropriate controls in place to verify the accuracy of reporting to the Board of Directors.

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## Recommendations at a Glance (continued)

Recommendation 2.8
The IWK Health Centre Board of Directors should review the Finance, Audit and Risk Committee terms of reference. The Board should make necessary updates to the terms of reference to improve management accountability for financial management controls.

Recommendation 2.9
The IWK Health Centre Board of Directors should regularly review the performance of the Chief Executive Officer and maintain sufficient documentation to support the results of the evaluation.

Recommendation 2.10
The IWK Health Centre Board of Directors should hold the Chief Executive Officer accountable to complete annual performance evaluations of executives as required.

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# 2 IWK Health Centre: Financial Management Controls and Governance

2.1 The IWK Health Centre Board of Directors and management did not provide effective oversight and governance in the development and performance of financial management internal controls nor did they adequately hold management accountable for the financial internal controls. The lack of oversight created a culture that did not promote accountability for the functioning of the controls. Throughout this report we note financial internal control deficiencies that resulted from management not effectively monitoring the control environment.

2.2 We did not design or intend our audit to be a forensic audit. The former Chief Executive Officer's travel and other expenses referred by the IWK Health Centre to law enforcement were not part of the scope of our engagement. We looked at the broader IWK Health Centre financial management controls and governance by the Board to better understand how the systems and practices at the IWK Health Centre allowed this situation to occur.

2.3 To reflect the IWK Health Centre's financial reporting cycle, we examined financial management internal controls in place between April 1, 2017 to March 31, 2018. We conducted walkthroughs of the financial management internal controls at a point in time to determine if the controls were appropriately designed and implemented, and tested the controls to determine if they were operating effectively for the 2017-18 fiscal year. For the rest of our audit work, we examined information between January 1, 2014 to December 31, 2017. We did not evaluate or assess the actions taken by current management to respond to the former Chief Executive Officer's expenses, nor did we evaluate changes management told us they made after the end of our audit period to identify and respond to internal control deficiencies.

## Financial Management Controls

### The Board and management did not effectively oversee internal controls

2.4 The Board and management did not effectively oversee internal controls. Internal controls are the processes designed, implemented, and maintained by the Board, management, and staff to ensure reliable and accurate financial reporting, efficient and effective operations, and compliance with laws and regulations. The Board, through the Chief Executive Officer, is responsible to create a culture of awareness of internal controls.

2.5 The lack of adequate oversight by the Board and management significantly increases the risk of fraud, theft, unauthorized transactions, inefficient spending, and wasted money which the IWK Health Centre could have used

for other organizational priorities. Once implemented, the recommendations made throughout this report will help create a culture of awareness of internal controls and support the Board in holding management accountable.

## Management did not document the internal control environment or provide clear guidance

2.6 Management had very little documentation to support the processes, procedures, and internal controls for the business processes we examined. We examined transactions in significant financial processes – procurement, payables, revenue, cash and treasury, financial reporting, human resources, and payroll.

2.7 Many policies were outdated and in many areas management did not develop appropriate policy guidance. For example, management had not updated the corporate signing authority policy since 2012 and there were no policies to guide staff on hospitality expenses, internal meeting expenses, staff social events, or gifts of appreciation. Management did not develop clear procurement policies; they allowed staff to follow a wide variety of approaches to both complete and document purchase transactions.

2.8 The Board and management did not create an expectation to report and investigate fraud and did not have a fraud policy in place. Although management did establish a whistleblower process in May 2018 and completed a fraud risk assessment in June 2018, these measures were not in place during our audit period. Whistleblower processes are a best practice to create an expectation that staff report known or suspected issues. Having a clear fraud policy would further strengthen Board and management expectations and provide staff with guidance on what to do if they suspect fraud.

2.9 Without policies that provide clear guidance and create clear expectations, there is an increased risk the IWK Health Centre will use public funds inefficiently or inappropriately, or staff will not appropriately safeguard assets.

**Recommendation 2.1**

The IWK Health Centre should create and update policies to provide clear expectations to staff. These policies should address fraud, travel and hospitality, internal meeting expenses, staff social events, gifts of appreciation, signing authority, and procurement.

*IWK Health Centre Response: The IWK agrees with the recommendation and this aligns with the significant work currently underway to update administrative policies. The IWK Board of Directors approved a Procurement Policy and an Internal Audit Policy in September 2018 and implementation is underway. A Policy on Wrong Doing which includes a fraud hotline was approved in February 2018*

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*and has since been implemented. Policies relating to fraud, travel, hospitality, internal meeting expense, recognition events and activities, signing authority, investments and corporate credit cards were reviewed by the IWK Finance, Audit and Risk Management Committee in November 2018 and will be brought forward for approval by the Board at its December meeting.*

## Management did not put appropriate procurement controls in place

2.10 Management did not design appropriate controls over procurement, thereby increasing the risk of inappropriate or unauthorized purchases. Staff had access to make purchases without approval, change existing purchase orders without approval, and the ability to override the approval process entirely. These weaknesses give staff access to make unapproved, inappropriate, or unnecessary purchases, either intentionally or in error, and could lead to poor decisions or missed opportunities and cost the organization money which could be better spent on other organizational priorities.

2.11 Management did not implement a process to store basic procurement documents. Staff were not able to provide us with 8 of 10 procurement contracts we selected for testing. Failure to store contracts makes it impossible for the IWK Health Centre to know when those contracts expire and it significantly increases risks should a vendor dispute the contract terms or requirements. Staff also were not able to provide documentation showing they obtained the three quotes required to demonstrate purchases were cost effective. If purchases are not cost effective, the IWK Health Centre could be spending more for purchases than necessary.

2.12 In early 2018, management at the IWK Health Centre shared the findings of an internal review of its procurement process from the beginning action of requesting a purchase through to the final payment. In total, they identified 242 gaps throughout the process and said they were working to address the issues they identified. Some of the issues they noted are listed below.

- Nineteen near misses in the supply chain for 2017-18. Management said that a near miss has the potential to negatively impact patient care.
- Approximately 40 percent of contracts had not used a potentially more cost-effective purchasing option available to the IWK Health Centre. Management estimated they saved approximately $300,000 between June 2016 and early 2018 using this option, which suggested they could realize additional savings to support hospital priorities.
- Half of the items physically counted during a mid-year inventory count were different from the values in the inventory system. Management said these differences could be the result of theft, error, or due to how staff received inventory. Staff received inventory based on the shipping documents, rather than observing and recording the

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inventory actually received. This practice resulted in the electronic system showing inventory was available when it had not actually been received. Significant differences between what is physically on hand and what is in the inventory system could mean the hospital does not have the supplies and inventory they need to properly provide care to its patients.

### Payments, including travel expenses, were not in compliance with policies

2.13 Management did not make sure controls related to vendor payments were effective. Through our testing, we found staff did not sign or stamp 16 of 25 sample items to show they received the goods or services before other staff made the payment. This creates a risk that the IWK Health Centre might pay for items that are not received.

2.14 Management did not make sure internal controls over travel claims were effective. We found 4 of the 25 items sampled had errors in mileage rates or were missing information on the distance driven. An additional 5 samples were not appropriately approved. We found staff paid these claims without correcting the errors or obtaining the required approvals.

2.15 We found similar weaknesses in our detailed testing of Board and executive travel and other expenses. In total, 59 of the 76 (78%) expenses we tested did not comply with IWK Health Centre policies. The 59 samples included 32 that did not have appropriate approval, 9 that did not have receipts to support the expense, and 20 that did not have enough detail for us to determine why the expense was incurred or if it was for IWK Health Centre business purposes. Staff paid these claims without correcting these errors or obtaining the necessary approvals.

2.16 Overall, in the various business processes, we found issues with the approval of transactions. Almost half (86) of the 199 samples requiring approval had not been appropriately approved. The lack of appropriate review and approval increases the risk of inappropriate or incorrect transactions being processed.

2.17 Senior officials at the IWK Health Centre did not demonstrate or promote a culture of compliance with policies or the importance of internal controls. The former Chief Financial Officer submitted an $11,500 travel claim that included expenses outside the sixty-day timeframe required by IWK Health Centre policy; one of the expenses had been incurred 173 days before the claim was submitted. Submitting expenses late for reimbursement makes it harder to hold staff accountable for purchases and increases the likelihood there will not be adequate support for, or appropriate review of, the expenses.

2.18 In January 2016, the former Chief Financial Officer submitted and inappropriately authorized two expense claims from 2014 for another member

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of the executive team. Staff processed the two payments totaling $2,000, with neither claim having receipts to confirm or support the expenses.

2.19 The current and former Board Chairs did not properly approve Board-related expenses. Despite the fact that IWK Health Centre policy requires the Board Chair to approve Board-related expenses, a member of the Executive Team approved 12 of the 14 Board expenses we tested. The Executive Leadership Team, through the Chief Executive Officer, is accountable to the Board. It is inappropriate for an individual to review and approve the expenses of the person they report to.

2.20 A Board and management set the tone for an organization and lead by example to create an environment that supports well-functioning internal controls. It is important that the IWK Health Centre Board and management be aware of internal controls and monitor the effectiveness of the controls used to safeguard the organization's assets.

## Controls over the seven business processes we audited were not effective

2.21 Controls over the seven business processes we audited were not effective between April 1, 2017 and March 31, 2018. We found issues with procurement, payables, revenue, cash and treasury, financial reporting, human resources, and payroll. In addition to the procurement and payment weaknesses described in the previous paragraphs, there were also control weaknesses in other business processes.

2.22 In the financial reporting process, we found management did not review manual journal entries and the attached support prior to posting, thereby increasing the risk of unapproved or inappropriate adjustments of financial records. In revenue, staff did not compare the billings they submitted for reimbursement to the revenue received, potentially resulting in lost revenue to the Health Centre. In payroll, staff could alter staff information without adequate review by management, and could result in unapproved or inaccurate changes to staff pay rates, annual pay increases, or staff bank account numbers.

2.23 These examples highlight the weaknesses resulting from management not properly designing and implementing controls and from the Board not holding management accountable for monitoring the effectiveness of controls. An ineffective internal control environment increases an organization's exposure to risk, increases the risk of fraud or error, and decreases management and staff accountability.

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**Recommendation 2.2**

The IWK Health Centre should complete a risk-based evaluation of its internal controls. Management should design, document, and implement appropriate internal controls and monitor to ensure the controls are operating effectively on a regular basis.

*IWK Health Centre Response: The IWK agrees with this recommendation. A comprehensive risk based review of IWK's internal controls has been partially completed, incorporating observations from both external and internal sources. The internal project team is tasked with understanding the current control strengths and deficiencies, creating priorities and defining resource requirements. While improvements to internal controls continue to be made this fiscal year, the objective is to commence fiscal 2019-20 with enhanced internal controls in place for all areas under review.*

**Recommendation 2.3**

The IWK Health Centre Board of Directors should oversee the development and implementation of internal controls and receive regular reporting on the effectiveness of internal controls.

*IWK Health Centre Response: The IWK agrees with this recommendation. The Finance, Audit and Risk Management Committee has overseen the internal controls project since the project's inception in November of 2017. Regular progress reports have been reviewed by the committee and the report recommendations with a tracking tool for progress and completion has been endorsed. While improvements to internal controls continue to be made this fiscal year, the objective is to commence fiscal 2019-20 with enhanced internal controls in place and mechanisms to evaluate their effectiveness.*

2.24 Management told us it has been working hard to address the internal control deficiencies we identified, as well as the issues management and staff identified from their own internal control assessment as discussed earlier.

## Enterprise Risk Management

### The Board and management did not have a comprehensive risk management framework

2.25 The Board and management did not have a comprehensive risk management framework that identified risks to the IWK Health Centre and defined how the Health Centre will respond to those risks. As a result, the Board and management cannot demonstrate that the IWK Health Centre is effectively responding to the risks.

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2.26 In 2012, management completed a financial risk management plan and identified 13 financial risks, but only developed a response plan for 5. Two of the risks with response plans had both the lowest potential impact and the lowest likelihood of occurring, and were the two least riskiest of the original 13 risks. Procurement was one of the higher risk areas not selected, and as discussed earlier, we found significant issues with controls relating to procurement. Management presented updates to the Finance, Audit and Risk Committee on the five risks into April 2014; however, we saw no evidence that management addressed the other high-risk areas at any time since they were identified in 2012.

2.27 Management engaged consultants to complete reviews of specific financial business processes and reported to the Board that these projects were part of a risk-based plan. However, there was no evidence of a risk-based plan or evidence the Board asked management how it selected the projects or how the topics aligned with the IWK Health Centre's strategic objectives.

2.28 In 2016, management started to update its enterprise risk management approach to include strategic risks and incorporate board oversight. Management presented the framework, including risk registers, to the Board in the fall of 2017 and again in 2018. None of these frameworks included the required mitigation plans for the risks identified or identified the actions management will take to address the risks.

2.29 The Board did not hold management accountable to develop a comprehensive risk management framework. Once developed and implemented, the Board should use the risk framework as a tool to hold management accountable. The Board should review and identify the risks which could impact on the IWK Health Centre achieving its strategic objectives. The Board should also have a clear expectation of how management is mitigating and responding to the risks and use this expectation to hold management accountable for the effective operation of internal controls to manage risk.

**Recommendation 2.4**

The IWK Health Centre should implement a comprehensive risk management framework. This framework should identify both operational and strategic risks and identify how the IWK Health Centre is responding to the risks. The Board and management should regularly monitor the effectiveness of the IWK Health Centre's response to the risks.

*IWK Health Centre Response: The IWK agrees with this recommendation and has adopted a comprehensive enterprise risk management framework which identifies both operational and strategic risks. The risk response, owner and reporting mechanism have been designated for the strategic risks. Highest ranked operational risks have been designated to owners and action plans are under development.*

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*Processes to assign, manage and report on the remainder of the identified risks at a team and program level are underway.*

*Processes to update the organization's Risk Registry, response and governance to reflect changes to the entity's operation and environment continue to be evolved and strengthened, including regular (quarterly) report to the Finance, Audit and Risk Management Committee of the Board.*

2.30 The 2018 risk framework did not identify financial-related risks among the top risks selected for mitigation. The Board and management are accountable for all aspects of the IWK Health Centre, including patient care and efficient financial operations to support patient care. Given the pervasive internal control weaknesses discussed earlier, the Board and management should reassess whether they have appropriately evaluated the risks related to their financial processes.

2.31 In the Governance section of this report we discuss how vulnerabilities with the procurement process led to external preventative maintenance on the emergency generators lapsing for a year without staff noticing. Financial processes, such as procurement, allow the IWK Health Centre to have the inventory, supplies, and services needed to allow staff to meet its obligation of providing care. It is important the IWK Health Centre consider the impact of financial processes on patients when evaluating risk.

**Recommendation 2.5**

The IWK Health Centre should re-evaluate whether it has appropriately assessed and ranked its financial risks, using the issues identified in this report as a guide.

*IWK Health Centre Response: The IWK agrees with this recommendation. As part of the risk management project, the framework was presented to the Finance, Audit and Risk Management Committee in February 2018. In June 2018, the entire Risk Registry was discussed by the Committee. The finance and procurement Risk Registry was reviewed and evaluated in November 2018 at the Finance, Audit and Risk Management Committee and will be brought forward for approval at December 2018 Board meeting.*

## Governance

The Board did not adequately challenge and follow up when management failed to provide requested information

2.32 The IWK Health Centre did not have an internal audit function. Internal audits provide independent information to a Board to make Board members aware of new risks or verify the accuracy of management reporting. In the absence of internal audit, a board needs to be more critical of the information

received from management, so they can hold management accountable for the processes, practices, and controls of the organization.

2.33 As discussed in the following paragraphs, the IWK Health Centre Board did not adequately question or challenge the information management presented to it. The Board also did not follow up when management failed to provide the information requested by the Board.

2.34 The Board, through the Building and Infrastructure Committee, did not hold the former Chief Financial Officer accountable to respond to 47 recommendations in a March 2016 external consultant report on maintenance and asset management. The recommendations addressed several areas of hospital operations, including a vulnerability in the procurement process that resulted in staff not reissuing a contract for external preventative maintenance on its emergency generators. Although the report said staff continued its regular testing, it also said the lapse went unnoticed for a year before staff accidently discovered it. As discussed previously, staff did not keep contracts on file and this likely contributed to staff being unaware the contract had expired.

2.35 There was nothing documented to show the Committee requested management's plans to address the consultant's recommendations. Although the former Chief Financial Officer gave the same summary update to the Committee from September 2016 to March 2017, the Committee did not request or receive a detailed response plan. The former Chief Financial Officer told the Committee he would provide a detailed update in May 2017, but this never happened, and again the Committee did not bring it up or address it further.

2.36 The Board and management should have been very concerned by the issues that allowed preventative maintenance on the emergency generators to lapse. The Board should have been very active to ensure management took appropriate actions to address the issue. Failure of the Board to take any proactive measures to ensure management addressed these issues is very concerning and highlights the fact that the Board was in the habit of accepting the information provided by management rather than directing management to take the actions the Board deemed necessary.

2.37 Members of the Board and the Building and Infrastructure Committee did not discuss how reductions to the inventory and supply area could impact patient care at the IWK Health Centre. Between December 2016 and May 2017, management presented the Board and the Committee with information on management's plan to rearrange space on the lower levels of the IWK Health Centre. The project allowed management to move offsite administrative services into the recovered space to save on external lease expenses.

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2.38 Current management told us these changes reduced the space available for inventory storage and resulted in the IWK Health Centre holding less inventory onsite than it did previously. Management also told us the IWK Health Centre needed to make more frequent purchases because they had less space for onsite storage. Holding less inventory could also increase the risk to operations from potential supply disruptions. Combined with the concerns noted earlier around procurement, these changes increased the risk to the hospital.

2.39 The Board did not ask, and the former Chief Financial Officer did not fully explain the impact of the project, including the associated risks. A Board is responsible for setting expectations for management and holding management accountable, especially in areas where operational changes may impact an organization's strategic risks. Current management at the IWK Health Centre told us it has since disclosed this matter to the Finance, Audit and Risk Committee and the Board.

2.40 The Finance, Audit and Risk Committee did not adequately question the former Chief Financial Officer's June 2017 assessment that the internal control environment at the IWK Health Centre was mature. The assessment cited policies that management had just put forward for approval to the Board at the same meeting, therefore the controls and polices were not yet in place, but no one asked how that could result in a mature control environment. In addition, the assessment cited an internal audit function which the IWK did not have. Nothing was documented in the meeting minutes to show the Committee had questioned the rationale for the assessment or asked management what work it did to reach its conclusions on the control environment.

2.41 The policies put forward by management for approval had minimal involvement from staff. The updated signing authority policy listed a member of the management team as the policy sponsor, yet this individual told us they saw the policy for the first time the day before the former Chief Financial Officer presented it to the Committee for approval, and they had not been involved in its development. Current management has identified signing authorities granted within the policies as inappropriate and other areas of the policies that conflict with provincial procurement policies. Current management told us in October 2018 it has not implemented these policies, pending further review.

2.42 The Finance, Audit and Risk Committee did not hold the former Chief Financial Officer accountable to explain how management complied with legislative requirements. The former Chief Financial Officer was responsible to provide the Committee with a quarterly compliance statement outlining the legislation management must comply with. In January 2016, the Committee asked how management satisfied itself that the IWK Health Centre complies with the legislation. The former Chief Financial Officer said he would bring

a full description of the process to the Committee at a future meeting. The former Chief Financial Officer did not provide this information, and neither the Committee nor the full Board followed up on the original request.

2.43 The Finance, Audit and Risk Committee also did not question changes the former Chief Financial Officer made to the compliance statement. The former Chief Financial Officer reviewed the statement and presented an updated version to the Committee in June 2017. There was no documentation of any discussion about the change from a quarterly statement, as required by the Committee's terms of reference, to an annual statement, nor was there any discussion about the matter of management omitting one piece of legislation from the updated statement.

2.44 Without an adequate understanding of management's process, the Finance, Audit and Risk Committee would not know if it could rely on the compliance statements provided by management. It would also not know whether it needed to ask for more information to hold management accountable to comply with the legislation. This shows a continued pattern of the Board and its committees taking the word of management at face value and not completing the due diligence expected of them.

### The Board did not set clear expectations for management

2.45 In its governance policy, for expenses that change from the Board-approved budget, the Board did not set a threshold for significant expenses that require Board approval. Without a clear expectation from the Board of what a significant expense is, it would be difficult to hold management accountable if it did not bring these changes to the Board for approval. Additionally, the lack of internal audit meant the Board would have had to rely on the information from management without any independent verification of it.

2.46 Current management told us the former Chief Financial Officer changed the IWK Health Centre's policy related to preferred accommodation billing and it resulted in losing potentially significant revenue. Based on our review of the Board and committee minutes, previous management did not inform the Board of this change. Current management at the IWK Health Centre told us it has since disclosed this matter to the Finance, Audit and Risk Committee and the Board.

**Recommendation 2.6**

The IWK Health Centre Board of Directors should update its governance policy to set a clear expectation of the significant transactions requiring Board approval. The Board should verify that management presented all changes to the Board for approval as required.

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*IWK Health Centre Response: The IWK agrees with this recommendation. The regularly scheduled annual review by General Counsel of the Corporate Bylaws and Governance Policy begun in March 2018 resulted in a number of recommendations for updates to the existing policy. These included guidelines regarding significant transactions requiring Board approval. The updated Governance Policy was reviewed at the Governance and Nominating Committee meeting in November 2018 and is being recommended for approval at the December Board meeting. This annual review process, a best governance practice, has been in place at the IWK since 2016.*

*A mechanism to enable the Board to verify that on an annual basis management has presented all changes as required will be designed and implemented effective the date of Board approval.*

### Management did not put controls in place to verify the accuracy of financial reporting to the Board

2.47 The Board regularly reviewed and approved key accountability reports. It received quarterly information from management on management's progress toward meeting Board-approved quality improvement plans. The reporting included the current year performance against established targets and management's planned initiatives and action plans. The reporting and performance measures linked to the IWK five-year strategic plan objectives. Management also regularly reported financial and other information to the Board.

2.48 Board members we interviewed said they felt free to question management and to request additional information. However, based on our review of Board and committee minutes, and based on the examples discussed earlier, we saw little evidence of regular questioning or requesting additional information from management.

2.49 The Board did not hold management accountable to put controls in place over the accuracy of financial reporting presented to the Board. Staff could make manual adjustments to information taken from the financial system and the information presented to the Board was not signed off by management to give the Board assurance that someone other than the preparer had reviewed the information. This lack of controls over reporting could result in the Board receiving inaccurate or incomplete information.

**Recommendation 2.7**
The IWK Health Centre should identify and put appropriate controls in place to verify the accuracy of reporting to the Board of Directors.

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*IWK Health Centre Response: The IWK agrees with this recommendation. As a feature of the IWK Accountability Agreement with the Department of Health & Wellness, continuity of single source financial information to the Board and its committees has been in place since July 2018. With leadership from the Department of Health & Wellness, this exact financial information is provided to government on a monthly basis, effecting a 3-way shared quality verification of financial results and forecasts. This verification process will be supported by the provision of dated source documents from SAP.*

2.50 The Board needs to make sure they hold management accountable for operations at the IWK Health Centre. As discussed earlier, a fully developed and implemented enterprise risk management framework would help to define the Board's expectations of management with regard to risk and responding to risk. The framework would also allow the Board to take a strategic view to identify the areas it wants more assurance on and to hold management accountable for the effectiveness of controls and the organization's response to the risks.

### The finance committee terms of reference do not meet best practices

2.51 The Finance, Audit and Risk Committee last updated its terms of reference in 2013. The Committee did not update the terms of reference to include areas of best practice identified by an externally-hired consultant in 2014. Some of the areas are significant and would have helped improve management accountability. Some examples are:

- there was no mention of the Committee's role to establish appropriate tone at the top of the organization related to internal controls;
- there was no reference to responsibility for fraud policies or anti-fraud programs;
- there was no assurance obtained from internal or external auditors on Board or management's compliance with expense policies; and
- there was no mention of the Committee's role in hiring key individuals, like the Chief Financial Officer.

**Recommendation 2.8**

The IWK Health Centre Board of Directors should review the Finance, Audit and Risk Committee terms of reference. The Board should make necessary updates to the terms of reference to improve management accountability for financial management controls.

*IWK Health Centre Response: The IWK agrees with this recommendation. The terms of reference for all Board Committees has been reviewed and updated. The enhancements for the Finance, Audit and Risk Management Committee include*

*the delineation of the responsibility for each of its three functions with specific reporting requirements. This proposed terms of reference was reviewed at the May 2018 meeting and forwarded to Governance and Nominating Committee at their September 2018 meeting. Accompanied by the annual committee work plan, they will be brought forward for approval at the December 2018 Board meeting.*

### The Board did not document the performance evaluation of the former Chief Executive Officer

2.52 Although Board members told us the former Board Chair reviewed the performance of the former Chief Executive Officer, the former Board Chair did not keep copies of the evaluation. As a result, we were unable to determine if the former Chief Executive Officer met performance expectations, whether the expectations were reasonable, whether there were any areas requiring follow up, or whether the Board completed the evaluation in a timely manner. Board members told us the former Board Chair presented the results during an in-camera session, therefore the discussion was not documented in the meeting minutes.

2.53 A Board is responsible for holding its Chief Executive Officer accountable for their performance and the operations of the organization. Completing and documenting performance evaluations is a basic and critical way for a Board to show it is fulfilling its responsibility to hold the Chief Executive Officer accountable.

**Recommendation 2.9**

The IWK Health Centre Board of Directors should regularly review the performance of the Chief Executive Officer and maintain sufficient documentation to support the results of the evaluation.

*IWK Health Centre Response: The IWK agrees with this recommendation. Building on established Human Resources principles, an updated process for the annual performance evaluation of the new CEO was developed in September/ October 2018 and was discussed at the November 2018 Executive Committee meeting. Recommendations include revisions of the Governance Policy to outline expectations, responsibilities, and documented results.*

### The former Chief Executive Officer did not hold staff accountable for performance evaluations

2.54 Of the eight executive team members we selected for testing, three did not have fiscal 2016-17 annual evaluations completed as required. One executive did not have a documented performance evaluation for the preceding three years and two had no documented performance evaluations during their employment with the IWK.

2.55 Only one of the five completed executive team evaluations had been signed by the executive team member and their supervisor to indicate the supervisor had discussed the evaluation with the team member. Completing regular performance evaluations creates a culture in which management holds staff accountable for their performance from the prior year and sets the expectations for the upcoming year.

**Recommendation 2.10**

The IWK Health Centre Board of Directors should hold the Chief Executive Officer accountable to complete annual performance evaluations of executives as required.

*IWK Health Centre Response: The IWK agrees with this recommendation and this process now follows the established Human Resources procedures of the Health Centre. The 2017-2018 reviews of executive team members were undertaken by the Interim CEO in April/May 2018 and reported at the Executive Committee in June 2018.*

## The Board had experienced Board members and followed many good practices

2.56 The IWK Health Centre Board is comprised of 19 Board members, most of whom are volunteers. Board members have varied experience and backgrounds which include private industry, legal, accounting, construction, medical, academic, and government. Many of the current and former Board members we interviewed said they had prior experience on other boards.

2.57 The Board followed many good board governance practices, such as having:

- annual board, as well as individual evaluations;
- an orientation process for new members on their roles and responsibilities;
- documented governance practices; and
- a skills matrix to evaluate existing and prospective Board members skills, allowing the Board to address identified skill gaps.

2.58 Although having a skills matrix is a good governance practice, the matrix used did not explicitly include knowledge and understanding of internal controls. Given the issues discussed in this report, the Board should consider adding other skills they feel would help them effectively govern the IWK Health Centre.

## Additional Comments from IWK Health Centre

*At the IWK, responsible stewardship is a key enabler to consistently deliver on our mandate of improving the health of women, children, and families.*

*In June 2017, the IWK Board of Directors appointed Grant Thornton to review its former CEO's expenses. Following the receipt of this report in August 2017, the Board requested the Auditor General conduct a performance audit. At initial meetings in September 2017 the Board identified its areas of concern.*

*The IWK is committed to addressing the recommendations in this report. Significant progress has been made on evolving the control environment at the IWK over the past sixteen months. The IWK is pleased that these audit recommendations complement the existing work plan and future focus areas.*

*The IWK Board is confident that new executive leadership will continue to drive momentum and results around this important work, including broadened reporting and disclosure to the Board on a regular basis.*

*The IWK fully embraces continuous improvement in all areas. These audit recommendations align to that philosophy and to the work delivered each day by talented and dedicated teams. The care, safety and well-being of patients and families always has, and continues to be, the IWK's central focus.*

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Appendix I

## Reasonable Assurance Engagement Description and Conclusions

In fall 2018, we completed an independent assurance report of the governance and financial management controls at the IWK Health Centre. The purpose of this performance audit was to determine whether the Izzak Walton Killiam Health Centre's Board of Directors and management are providing effective governance and oversight, including appropriate financial management.

It is our role to independently express a conclusion about whether the governance and financial management controls comply in all significant respects with the applicable criteria. The Board and management at the IWK Health Centre acknowledged their responsibility for organizational governance and financial management controls.

This audit was performed to a reasonable level of assurance in accordance with the Canadian Standard for Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada; and Sections 18 and 21 of the Auditor General Act.

We applied the Canadian Standard on Quality Control 1 and, accordingly, maintained a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we complied with the independence and other ethical requirements of the Code of Professional Conduct of Chartered Professional Accountants of Nova Scotia, as well as those outlined in Nova Scotia's Code of Conduct for public servants.

The objectives and criteria used in the audit are below:

Objective:
To determine whether the IWK Board is effectively governing the IWK Health Centre.

Criteria:

1. Roles and responsibilities of the IWK Board and its relevant committees should be clearly defined and communicated.

2. The Board should ensure that performance expectations for the CEO and the Board are clearly defined, performance is evaluated, and actions are taken based on the results of the evaluation.

3. The Board and its committees should be comprised of individuals with appropriate skills and expertise.

4. There should be processes in place for the Board and its committees to regularly request financial, performance, and other relevant information from IWK management to fulfill the Board's oversight responsibilities.

5. The IWK Board and its committees should regularly review and approve key accountability reports.

6. The IWK Board and its committees should be aware of key risks facing the IWK and respond appropriately.

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Objective:

1. To determine whether significant financial and other internal controls have been effectively designed and implemented.

2. To determine whether significant financial and other transactions are appropriate, adequately supported, properly authorized, and in accordance with legislation and policies.

Criteria:

1. There should be effective risk management processes in place to identify, assess, prioritize, mitigate, and report on financial and other risks.

2. Policies and guidelines for the IWK's significant internal controls should be clearly documented and communicated.

3. Appropriate controls should be in place for significant financial reporting and other transactions at the IWK.

4. Significant financial reporting and other transactions should be consistent with legislation and policies, and reasonable under the circumstances.

5. There should be a process to monitor performance and compliance with significant financial reporting and other internal controls to ensure they are effectively designed and implemented.

Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed specifically for this engagement. Criteria were accepted as appropriate by the Board and senior management of the IWK Health Centre.

Our audit approach consisted of interviews with Board members, management, and staff of the IWK Health Centre, reviewing policy, examining processes for governance and financial management related controls, and detailed file review. We conducted walkthroughs of the financial management internal controls to determine whether the controls were appropriately designed and implemented at a point in time, and tested the controls to determine whether they were operating effectively between April 1, 2017 and March 31, 2018. We examined relevant processes, plans, reports, and other supporting documentation between January 1, 2014 and December 31, 2017. We examined documentation outside of that period as necessary.

We obtained sufficient and appropriate audit evidence on which to base our conclusions on November 28, 2018, in Halifax, Nova Scotia.

Based on the reasonable assurance procedures performed and evidence obtained, we have formed the following conclusions:

- The IWK Health Centre Board did not effectively govern the IWK Health Centre related to financial management internal controls.
- Significant financial and other internal controls were not effectively designed or implemented.
- Significant financial and other transactions were not appropriate, adequately supported, properly authorized, or in accordance with legislation and policies.

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# Chapter 3
# Workers' Compensation Board: Governance and Long-term Sustainability

**Overall Conclusions**

- **The Board of Directors has governance structures and processes to provide oversight and accountability in support of the achievement of the Workers' Compensation Board's goals and objectives**
- **The Workers' Compensation Board has a plan to become fully funded and has made continued progress in reducing the unfunded liability**

## Governance, Oversight, and Accountability

The Board of Directors is carrying out its established roles and responsibilities

- The Board and committees meet regularly, including in camera
- An established agenda of reporting and meeting topics guides processes
- Performance evaluations of the CEO and Board of Directors occur annually

The governance manual is not up to date with some current practices

## Long-term Sustainability

Many steps have been taken to achieve sustainability

- The Workers' Compensation Board publicly shares its plan to become fully funded. The plan is to become fully funded between 2020 and 2024
- The rate-setting process is in line with the funding strategy, clearly communicated to employers, and followed
- The annual average assessment rate target has been $2.65 per $100 of assessable payroll since 2005. The rate is set above annual funding requirements in order to reduce the unfunded liability, while maintaining stability for employers
- The Board of Director's Investment Committee monitors and evaluates the investment strategy which is managed externally by a third party

## Recommendations at a Glance

Recommendation 3.1
The Board of Directors of the Workers' Compensation Board should examine the process for reviewing the Corporate Governance Manual to ensure it is adequate to identify any changes or updates required.

Recommendation 3.2
The Board of Directors of the Workers' Compensation Board should review annual performance evaluation processes for the Board of Directors and the CEO to address weaknesses and ensure processes are efficient and effective.

Recommendation 3.3
The Worker's Compensation Board should evaluate and define the process for assessing, documenting, and reviewing changes to employer industry classifications.

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# 3 Workers' Compensation Board: Governance and Long-term Sustainability

## Governance, Oversight, and Accountability

### Governance roles and responsibilities support the mandate, mission, and vision

3.1 The mandate, mission, and vision of the Workers' Compensation Board (WCB) are consistent with meeting the needs of stakeholders and are aligned with governance roles and responsibilities. They have been clearly documented and communicated to stakeholders.

3.2 The primary stakeholders of the WCB are workers, employers, government, partner agencies, and advocacy groups. The needs of stakeholders are managed through a stakeholder representative Board of Directors, as well as through the WCB's annual engagement strategy.

3.3 The Board of Directors of the Workers' Compensation Board consists of 10 members – 4 employer and 4 worker representatives, a Chair, and a Deputy Chair. Through interviews with members of the Board, we found that:

- directors understand their roles and responsibilities, including who their stakeholders are, the information they need, and the types of decisions they are responsible to make;
- directors are comfortable challenging or debating other members or senior executives and describe the Board as open, collegial, and effective; and
- regular opportunities exist to discuss topics in camera without management present.

3.4 The WCB's Corporate Governance Manual defines the governance roles and responsibilities of the Board of Directors and the CEO. It also includes the:

- annual agenda,
- decision-making process,
- terms of reference for each committee of the Board of Directors,
- communications and stakeholder relations policy, and
- Board evaluation processes.

## Workers' Compensation Board's Corporate Governance Manual is not up to date

3.5 The Board of Directors conducts an annual review of the Corporate Governance Manual each December. Despite this review, we noted several instances where the manual is not updated to reflect current practices; it uses outdated terms of reference and meeting requirements.

3.6 The Board provided sufficient evidence to support that current practices were appropriate and in line with Board decisions. However, it is important that the manual be updated to reflect current practices as it is a means for stakeholders to hold the Board accountable. In addition, keeping the manual up to date will ensure governance roles and responsibilities remain clear and are executed appropriately.

**Recommendation 3.1**
The Board of Directors of the Workers' Compensation Board should examine the process for reviewing the Corporate Governance Manual to ensure it is adequate to identify any changes or updates required.

*Workers' Compensation Board Response: Agree with this recommendation. This process will be reviewed in early 2019.*

## The Board of Directors is fulfilling its governance responsibilities

3.7 For 2016 and 2017, the Board of Directors and its committees fulfilled their established roles and responsibilities in a timely manner by holding regular meetings, preparing meeting minutes, and resolving all recorded action items. The Board of Directors has committees for:

- Governance and Policy;
- Finance, Audit and Risk;
- Investment, and;
- a subcommittee to oversee a current business transformation project.

3.8 The Board is responsible for setting the strategic direction of the WCB through the development and approval of strategic plans. The current strategic plan covers 2016-20 and includes five strategic goals. The Board is also responsible for the annual review and approval of the operational plan.

3.9 Quarterly, the Board monitors progress of the strategic goals through a balanced scorecard. The scorecard contains financial and non-financial performance measures for the organization in four categories: service, operations, employee, and financial. An example of the balanced scorecard from the WCB's 2017 Annual Report is shown in Appendix III.

3.10 The Board of Directors and its committees regularly review and approve requested performance reporting submitted by management. In addition to the balanced scorecard measures, the Board monitors quarterly performance through review of results of injured worker and employer satisfaction surveys, reports from the Client Relations Officer, and legal updates. It poses relevant questions to management and requests further education and reporting on items as deemed necessary. Questions and concerns raised by Board members were addressed fully by management and in a timely manner.

3.11 The Board does not receive any operations level reporting at the claims, benefits, or appeals administration level, such as the average time between a claim filing and issuance of a written decision. It asserts that the performance metrics included in the balanced scorecard are sufficient for the appropriate level of oversight required to identify significant or systemic issues.

3.12 Claims and benefits administration, appeals, return-to-work programs, and contract management are to be examined and reported in our Office's spring 2019 report.

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### The Workers' Compensation Board Executive Team is completing its accountabilities to the Board of Directors

3.13 For 2016 and 2017, the Executive Team fulfilled its accountabilities in a timely manner to the Board of Directors. Committees of the Executive Team executed their roles and responsibilities by holding regular meetings, maintaining meeting minutes, and discussing matters relevant to their terms of reference.

3.14 The Executive Team has five members with the Chief Executive Officer (CEO), the Vice President Corporate Services and Chief Financial Officer, the Vice President Prevention and Service Delivery, the Vice President of People and Change, and the Executive Corporate Secretary. They each have extensive experience at the WCB and understand their governance role and responsibilities as defined in legislation and policy manuals. In interviews, members of the Executive Team indicated that Board reporting requirements have been clearly communicated to them, with sufficient time to prepare the information that is requested.

### Evaluations of CEO and Board of Directors occur annually, with some weaknesses identified

3.15 CEO performance evaluations were conducted in accordance with the established internal process for 2016 and 2017.

3.16 The Chair and Deputy Chair of the Board of Directors are primarily responsible for conducting the annual performance evaluations of the CEO.

They seek input from all members of the Board through the completion of individual evaluation forms which include scoring on several attributes. The Chair compiles feedback from the evaluations into a memo that is provided to the CEO and reported back to the Board.

3.17 The Chair stated that the evaluation forms are destroyed following the review. The memo that is provided to the CEO does not contain the aggregate scoring results on each of the attributes and is kept at a high-level overview. As a result, we were unable to determine if the memo accurately reflected the scoring and opinions of directors or to determine the level of change in each attribute year over year.

3.18 The Board of Directors also conducted annual evaluations of its overall performance for 2016 and 2017 in accordance with its established process.

3.19 As with the CEO evaluations, the Chair is responsible for compiling feedback from the individual Board evaluation surveys into a consolidated summary for discussion at the Board meeting. Supporting data is maintained for these evaluations and we found it to be consistent with the summary prepared. The results were discussed in a timely manner amongst Board members with appropriate action taken based on comments made.

3.20 The response rate for the Board evaluation survey was 100 percent in 2016 and 80 percent in 2017. We did note that a large number of questions were skipped by those who participated. For example, several questions that were relevant to all Board members had only 50-60 percent participation. This is concerning as the performance evaluation results may not be an accurate representation of the opinions of all members. The Board should consider why questions are skipped and whether they are asking the number and mix of questions needed to meet the objective of the evaluation process.

**Recommendation 3.2**

The Board of Directors of the Workers' Compensation Board should review annual performance evaluation processes for the Board of Directors and the CEO to address weaknesses and ensure processes are efficient and effective.

*Workers' Compensation Board Response: Agree with this recommendation. These processes will be reviewed during their next evaluation cycles in 2019.*

### Appointments and re-appointments to the Board of Directors were appropriate

3.21 All seven appointments and re-appointments to the Board of Directors made between January 1, 2016 and July 31, 2018 followed the established appointment process, with the successful applicants deemed qualified by the required selection committee or screening panel and recommended by the Minister for appointment by the Governor in Council.

3.22 All directors stated in interviews that they received adequate and timely orientation and training upon appointment.

3.23 One of three re-appointments examined was for a board member to serve a fourth term. The Statement of Principles and Objectives of the Workplace Safety and Insurance System and the Corporate Governance Manual indicates directors may serve up to a full third term. Legislation does not indicate a re-appointment limit. In this case, it was determined that circumstances required re-appointment beyond three terms and justification for the decision was documented. A reduced term of two years was granted instead of the usual four years.

3.24 Currently, there are two Board members who are serving their fourth terms. It is important to consider limits to the number of terms for which a Board member may serve to ensure appropriate rejuvenation on the Board. New Board members can encourage new ideas and ensure fresh perspectives are provided to strategic planning.

### Board of Director positions were not filled before the term expired

3.25 Members of the Board of Directors raised concerns related to the timeliness of filling Board vacancies. None of the seven appointments we examined were determined before the previous term expired. Reasonable explanations for the delays were provided for the two appointments that took longer than nine months to fill. Of the remaining five appointments, four were made between two and three months post-expiry and one was made just under five months post-expiry.

3.26 Executive Council Office conducts appointment campaigns in the spring and fall, each covering a 12-month period for existing and anticipated vacancies. However, formal timelines for filling vacancies do not exist and the process typically is expected to take between three to six months.

3.27 Director appointments are four years; therefore, expirations are known immediately when a new director is appointed, except for instances of early vacancies. There is sufficient time for planning of the next appointment, and not filling positions before the incumbent term expires does not allow for a smooth transition process.

3.28 Members of the Board of Directors also raised concerns regarding the diversity of the Board. There are many dimensions to creating a diverse Board of Directors with one dimension being gender. The current gender composition of the Board is shown in the following table.

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| Board of Directors | Representatives | |
|---|---|---|
| | Male | Female |
| Chair | 1 | |
| Deputy Chair | 1 | |
| Employer Representatives | 4 | |
| Worker Representatives | 2 | 2 |

3.29 Following the screening process, the Minister is responsible for selecting which qualified candidate to recommend for appointment. A communications plan is prepared for the recommended appointee. The plan includes the impact on the composition of the Board and confirms that affirmative action and gender equity policies of the government are met.

3.30 Our Office's October 2017 report on financial audit work included a review of board vacancies and noted 33 percent of government organizations surveyed at the time had vacancies, and that on average, these positions had been vacant for more than 13 months. We recommended that Executive Council Office address the weaknesses related to filling board vacancies.

3.31 When following up on the recommendation in our October 2018 report, we found that Executive Council Office indicated they had taken action to address board vacancies and diversity. These actions included:

- launching an online application process where applicants are encouraged to self-identify;
- expanding recruitment and outreach methods;
- engaging with advocacy groups to improve diversity on boards, and;
- enhancing tracking of board vacancies.

3.32 It is important that Executive Council Office continue their work to address board vacancies and fill positions in a timely manner.

## Long-term Sustainability

### The Workers' Compensation Board has a strategy to become fully funded

3.33 As of December 31, 2017, the WCB reported a funded ratio of 89 percent, with an unfunded liability of $217 million. The funded ratio is a key measure of the organization's ability to fulfill all obligations, including payment of future benefits to injured workers, with existing assets in the Accident Fund. With a funded ratio of 89 percent, the WCB does not have sufficient assets

to pay all future obligations, and this is a risk to Nova Scotians who rely on receiving the benefits they are owed.

3.34 The WCB has a funding strategy to support the goal of becoming financially stable and sustainable; it is outlined in the organization's five-year strategic plan. The strategy defines the WCB's financial needs and outlines actions to achieve the goal of becoming fully funded.

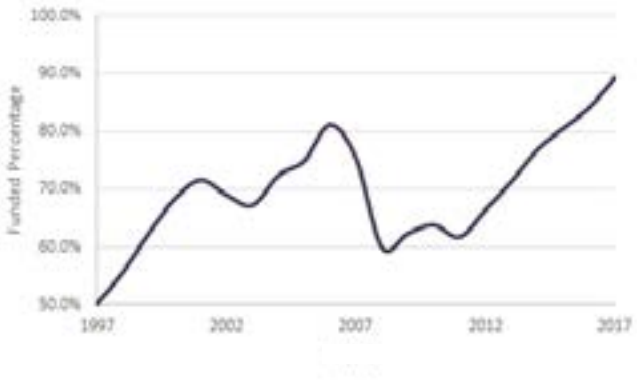
3.35 Controls are in place to address the risks related to the funding strategy, including monitoring by management, reporting to the Board of Directors, and semi-annual actuarial reviews of data and assumptions used.

3.36 Historically, the existence of an unfunded liability has been an area of ongoing concern for the WCB. In 1995, the WCB was only 41 percent funded, which at the time meant the Fund was short $368 million. Legislation was enacted in 1995 that required the Accident Fund to be fully funded and included a provision for time to address the existing unfunded liability.

3.37 The Accident Fund is currently at its strongest financial position since the strategy began. The most recent update to the funding strategy, published in summer 2018, states the WCB has a target of reaching full funding between 2020 and 2024. The funding strategy established in 1995 targeted the Accident Fund to be fully funded by 2039.

3.38 Since the initial funding strategy, there have been challenges, such as the financial market crash in 2008 which saw significant investment losses, and the legislation of various extended benefits; however, the funded ratio has consistently improved over the long-term. The WCB's ability to improve its funded ratio and decrease the total unfunded liability are key metrics of the success of the funding strategy.

Funded Ratio – 20 Year Trend

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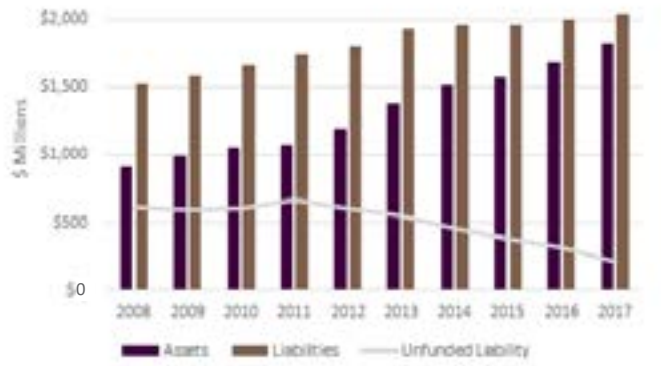
Financial Information – 10 Years




3.39 Since the beginning of the funding strategy in 1995, a primary component has been to ensure the WCB is collecting sufficient funds to cover the current and future expenses associated with claims for the year, plus an additional amount to contribute to the unfunded liability. The Board of Directors sets the target average assessment rate annually based on achieving this objective.

3.40 Rates charged to employers in Nova Scotia are set above current year requirements and the average rate has remained stable at $2.65 per $100 of assessable payroll since 2005. Although the contribution to the unfunded liability varies by year, this rate stability provides consistency for employers while the liability is addressed. For the past five years, 2013-17, the average contribution to the unfunded liability has been 15 percent of employer contributions.

Rate-setting process is communicated to employers and is in line with the funding strategy

3.41 We examined the application of the rate-setting process for 30 employers from various industries and found it was applied consistently for all employers.

3.42 The rate-setting process is outlined in policy and communicated to stakeholders. The rate model uses the target average assessment rate set by the Board of Directors to create the revenue target. The rate model then allocates base assessment rates by industry and rate group, based on claims experience.

3.43 Industries experiencing lower than average costs pay lower than average premiums and industries experiencing higher than average costs pay higher than average premiums. Additional factors like merit, demerit, surcharge, and association levies are also applied. A detailed breakdown of the various factors impacting individual employer premiums is available to employers on request.

## The Workers' Compensation Board does not have adequate processes for employer classification changes

3.44 There is no clear or defined process on the approach to assessing and documenting a rate change based on a change in the industry classification of an employer. Employers are categorized based on the Standard Industrial Classification system. When there is a significant change to the type of product or service a business produces or performs, it may result in an employer being reclassified, which may have a direct impact on the rate it is assessed.

3.45 Although documentation was inconsistent in location and format, some form of support for the change was identified in 9 of the 10 rate changes we examined. A monthly review is performed on industry classification changes as a quality assurance process. However, there is no clear documentation to support what the review process includes.

3.46 During 2016 and 2017, 5054 new employers were classified, and 242 classifications were changed. The 30 initial industry classifications we examined were well documented.

3.47 There should be a consistent approach for documenting the rationale and support for a change in industry classification and adequate review processes to ensure improper changes are not made. Without adequate processes, an employer may be assigned to the wrong industry, which may result in the employer paying the wrong rate.

**Recommendation 3.3**

The Worker's Compensation Board should evaluate and define the process for assessing, documenting, and reviewing changes to employer industry classifications.

*Workers' Compensation Board Response: Agree with this recommendation. This process will be documented in 2019 when a new Guidewire assessment system is in place.*

## The Investment Committee monitors performance of the investment strategy

3.48 In 2017, the WCB achieved a one-year return on investment of 10.3 percent, with a five-year average return on investment of 9.6 percent. Investment assets at December 31, 2017 totalled $1.8 billion. Achieving a target return on investments is a key aspect of the funding strategy.

3.49 Since 2015, the WCB manages its investment strategy through an Outsourced Chief Investment Officer model, with governance and oversight provided by the Investment Committee of the Board of Directors.

3.50 The Investment Committee monitors performance of the investment strategy and reports to the Board of Directors quarterly and annually, based on quarterly reporting provided by an external service provider and summary information prepared by the Workers' Compensation Board staff. Committee members examine such information as compliance with risk tolerance and approved asset mix, fund returns, comparison to benchmarks, and overall effectiveness of the strategy.

3.51 The Investment Committee also completes an annual evaluation of the external service providers, and in June 2017 completed a detailed evaluation, reviewing the first two years of the outsourcing model. The evaluation of the Outsourced Chief Investment Officer found that contractual obligations were met and included a qualitative review of service and advice to staff, a quantitative review of performance and risk tolerance, and a qualitative review of the relationship with the Investment Committee.

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Appendix I

## Reasonable Assurance Engagement Description and Conclusions

In fall 2018, we completed an independent assurance report of governance practices and plans for the long-term sustainability of the Workers' Compensation Board. The purpose of this performance audit was to determine whether the Workers' Compensation Board has established governance practices to support the long-term sustainability of the Workplace Injury Insurance program and the meeting of its objectives. This audit is the first of a two-phase audit at the Workers' Compensation Board.

It is our role to independently express a conclusion about whether governance and long-term sustainability complies in all significant respects with the applicable criteria. Management at the Workers' Compensation Board acknowledged their responsibility for governance and long-term sustainability.

This audit was performed to a reasonable level of assurance in accordance with the Canadian Standard for Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada; and Sections 18 and 21 of the Auditor General Act.

We applied the Canadian Standard on Quality Control 1 and, accordingly, maintained a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

In conducting the audit work, we complied with the independence and other ethical requirements of the Code of Professional Conduct of Chartered Professional Accountants of Nova Scotia, as well as those outlined in Nova Scotia's Code of Conduct for public servants.

The objectives and criteria used in the audit are below:

Objective:

1. To determine whether governance structures and processes are in place and are working to provide oversight and accountability in support of the achievement of the Workers' Compensation Board's goals and objectives.

Criteria:

1. The mandate, mission, and vision of the Workers' Compensation Board should be clearly defined and communicated, and consistent with addressing the needs of stakeholders.

2. Roles and responsibilities of the Board of Directors and its Committees, the CEO, and management should be clearly defined, and consistent with the mandate, mission, and vision.

3. The Board of Directors and its Committees, the CEO, and senior management should complete required actions to fulfil their established roles and responsibilities.

4. The Workers' Compensation Board should have specific and measurable goals and objectives to evaluate performance.

5. The Workers' Compensation Board should have a process in place to monitor whether the program is achieving its goals and objectives.

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Objective:

1. To determine if the Workers' Compensation Board has a plan for long-term sustainability of the Workplace Injury Insurance program.

2. To determine if the Workers' Compensation Board follows a process for setting rates charged to employers which supports sustainability of the Workplace Injury Insurance program.

Criteria:

1. The Workers' Compensation Board should have a plan for long-term financial sustainability, which includes a completed risk assessment for the Workplace Injury Insurance program.

2. The Workers' Compensation Board should have a long-term investment plan and strategy that is monitored and evaluated regularly.

3. The Workers' Compensation Board should have a defined process for setting insurance rates to meet the financial needs of the program.

4. The process for setting rates should be clearly communicated to employers.

5. Rates should be calculated and charged to employers based on the process.

Generally accepted criteria consistent with the objectives of the audit did not exist. Audit criteria were developed specifically for this engagement. Criteria were accepted as appropriate by senior management at the Workers' Compensation Board.

Our audit approach consisted of interviews with members of the Board of Directors, management and staff of the Workers' Compensation Board, reviewing policy, examining processes for governance and long-term sustainability, and detailed file review. We examined relevant processes, plans, reports, and other supporting documentation. Our audit period covered January 1, 2016 to December 31, 2017. We examined documentation outside of that period as necessary.

We obtained sufficient and appropriate audit evidence on which to base our conclusions on October 29, 2018, in Halifax, Nova Scotia.

Based on the reasonable assurance procedures performed and evidence obtained, we have formed the following conclusions:

- Overall, the Workers' Compensation Board has governance structures and processes in place to provide oversight and accountability in support of the achievement of its goals and objectives.

- The Workers' Compensation Board has a plan for the long-term sustainability of the Workplace Injury Insurance program. It has a formal process for setting rates charged to employers, which is followed, and supports the sustainability of the program.

Appendix II

## Background Information on the Workers' Compensation Board

1. Workers' insurance systems in Canada are based on the Meredith Principles, which include a historic trade-off between workers and employers. In the event of a work-related injury, workers surrender their right to pursue legal action in exchange for benefits defined in legislation. Employers are responsible for funding the cost of the system in exchange for immunity when work-related injuries occur.

2. The Workers' Compensation Act established by government provides the framework for the administration of workplace insurance in Nova Scotia, including injuries covered and benefit levels.

3. The Workers' Compensation Board is responsible for administering workers' compensation in line with the Act and operates at arm's length from government. The WCB provides regular reporting to the Department of Labour and Advanced Education and collaborates by providing input in areas of mutual interest, such as legislative changes ultimately decided by government.

4. Employers are required to register for coverage if they are conducting business in a mandatory industry and have three or more workers at one time. Compensation is paid to injured workers out of the Accident Fund which is funded by annual assessments collected from employers.

| | 2017 | 2016 |
|---|---|---|
| Number of Covered Employers | 19,500 | 19,100 |
| Labour Force Covered | 75% | 75% |
| Number of Claims Registered | 23,952 | 24,311 |

*Source: WCB 2017 Annual Report*

5. The WCB must balance providing benefits and services in an efficient manner, while also delivering programming and considering the impact of raising premiums. This challenging reality emphasizes the importance of a high functioning board of directors.

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Appendix III

## Workers' Compensation Board: Balanced Scorecard (unaudited)

| | Actual 2016 | Actual 2017 | Target 2017 | Target 2018 | Target 2022 |
|---|---|---|---|---|---|
| **Service** | | | | | |
| Worker Satisfaction Index | 74% | 76% | 70% | 70% | 70% |
| Employer Satisfaction Index | 79% | 78% | 70% | 70% | 70% |
| **Operations** | | | | | |
| Time-Loss Injuries per 100 Covered Workers | 1.74 | 1.76 | 1.72 | 1.76 | 1.62 |
| Composite Duration Index (in days) | 110 | 117 | 110 | 117 | 114 |
| Time-Loss Days Paid per 100 Covered Employees | 232 | 241 | 229 | 241 | 220 |
| Cost of New EERBs ($ millions) | $59.2 | $67.8 | $59.6 | $57.7 | $63.2 |
| Return to Employability | 95.2% | 94.4% | 95.4% | 95.4% | 95.3% |
| **Employee** | | | | | |
| WCB Employee Satisfaction Index | 71% | 70% | 70% | 70% | 70% |
| **Financial** | | | | | |
| Claims Payments for the past 3 years per $100 of Assessable Payroll | $0.664 | $0.667 | $0.673 | $0.665 | $0.654 |
| Administration costs per $100 of assessable payroll (excluding prevention costs) | $0.40 | $0.41 | $0.45 | $0.48 | $0.37 |
| Five-year Rate of Return on Investment (as measured by the Benchmark Portfolio Return)<br>Five-Year Return<br>Five-Year Target | <br>9.8%<br>9.3% | <br>9.6%<br>9.3% | Exceed Benchmark Portfolio Return | Exceed Benchmark Portfolio Return | Exceed Benchmark Portfolio Return |

*Source: WCB 2017 Annual Report*

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