STANDING COMMITTEE ON PUBLIC ACCOUNTS

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STANDING COMMITTEE ON PUBLIC ACCOUNTS

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Mr. Warren Michelson
Moose Jaw North

Mr. Rob Norris
Saskatoon Greystone

Mr. Randy Weekes
Biggar

Mr. Trent Wotherspoon
Regina Rosemont

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[The committee met at 13:31.]

The Chair: — Good afternoon everyone. Welcome to Public Accounts and a review of the Provincial Auditor's reports. I'd like to start by introducing members. I'm Danielle Chartier, the Chair of PAC [Public Accounts Committee]. We have Larry Doke, Warren Michelson, Randy Weekes, Rob Norris, Paul Merriman, and Trent Wotherspoon.

We have a few documents to table today before we get on to the rest of the business of the day. I'd like to table PAC document 35/27, Ministry of Health: status report of outstanding audit issues in the health system, dated June 27, 2014; PAC 36/27, Ministry of Finance: reporting of public losses for the period from April 1, 2014 to June 30, 2014, dated August 1, 2014; PAC 37/27, Ministry of Health: reporting of public losses for the period from January 1, 2014 to March 31, 2014, dated May 2, 2014; and PAC 38/27, Ministry of Health: reporting of public losses for the period from April 1, 2014 to June 30, 2014, dated August 1, 2014.

I'd like to advise the committee that pursuant to rule 142(2) the following documents were deemed referred to the committee on June 26th, 2014: Provincial Auditor of Saskatchewan, *Annual Report on Operations for the Year Ended March 31st, 2014* and Public Accounts 2013-14 volume 1 summary financial statements, and copies have been distributed to members.

First of all again I'll welcome everybody here this afternoon. I'd like to introduce the officials from the Provincial Comptroller's Office. We've got Terry Paton who is the Provincial Comptroller — good to see you here — and Chris Bayda who is the executive director of the financial management branch. I'd like to introduce our Acting Provincial Auditor, Judy Ferguson, and she will introduce her officials when they have an opportunity to speak. And I'd like to get down to the first agenda item here, if Mr. Hendricks, the deputy minister, if you'd like to introduce your officials.

Health

Mr. Hendricks: — Thank you, Ms. Chairperson. My name is Max Hendricks. I'm the deputy minister of Health, and to my immediate left is Mark Wyatt, the assistant deputy minister; and to my right is Cindy Fedak, the director of financial services branch. Immediately behind me is Shelley Reddekopp, the executive director of financial services branch; and to her right is Val Hunko who is vice-president of integrated services with the Regina Qu'Appelle Health Region. Right next to her is Sue Fairburn who is with our primary health services branch; and to her right is Tracey Smith, an assistant deputy minister with the Ministry of Health. We have other officials, but I will have them introduce themselves when they come forward.

The Chair: — Thank you, Mr. Hendricks. And now I will ask the Provincial Auditor to make her presentation. I think we're starting with the 2012 report volume 2, chapter 10 and the 2013 report volume 2, chapter 11. So I will pass it off to Ms. Ferguson to give her remarks.

Ms. Ferguson: — Thank you, Madam Chair. Good afternoon, Madam Chair, Deputy Chair, committee members and officials. This afternoon I've got with me Mr. Mobashar Ahmad. Bashar actually leads the work on the Health division. Behind him is Regan Sommerfeld. Regan's a principal with our office; again is leading some of the work that's presented this afternoon. And Kim Lowe who likes to do double duty; Kim's been involved in some of the audits that are being presented this afternoon in addition to being a liaison to this committee.

As the Chair indicated, we are focusing on Health first here. Before, on your agenda, there's three chapters. We're going to present those three chapters in two parts. The first part is going to focus on chapter 10 of our 2012 report volume 2 and chapter 11 of our 2012 report volume 2. These two chapters report the results of our integrated audits for the year ending March 31st, 2012 and 2013.

The second part will focus on chapter 32 of our 2012 report volume 2. That chapter reports the results of the audit of the ministry related to prevention of diabetes-related complications. I'm going to turn it over to Mr. Ahmad to present part one here.

Mr. Ahmad: — Thank you, Ms. Ferguson, and good afternoon everybody. I'm going to present both chapters, that's chapter 10 of 2012 report volume 2 and chapter 11 of 2013 report volume 2, together. These chapters contain five recommendations for the committee's consideration. As stated earlier, these chapters report the result of our annual integrated audits of the Ministry of Health and various health-related agencies for the years ended March 31, 2012 and 2013.

Section 2.2 of each chapter provides a listing of health-related agencies included in these chapters. We reported a financial statement of the listed health-related agencies for the year ended 2012 and '13 were reliable and those agencies had effective rules and procedures to safeguard public resources and complied with authorities governing their activities other than the matters we report in these chapters.

I will focus on chapter 11 of the 2013 report volume 2 as it provides the most recent results. Chapter 11 begins on page 93. In this chapter we make three new recommendations and provide status of the two new recommendations that we made in chapter 10 of our 2012 report volume 2 and four other past recommendations.

First the new recommendations. On page 96 we recommend the ministry follow its processes to remove unneeded user access to its system and data promptly. We made this recommendation because the ministry did not promptly remove user access for three of its employees who had left this employment. Lack of prompt removal of unneeded user access increases the risk of inappropriate access to the ministry's systems and data.

On page 97 we recommend the ministry follow Canadian generally accepted accounting principles, that is GAAP, for the public sector when accounting for assets constructed under shared ownership agreements. This is the same recommendation that we made at the Ministry of Education and discussed with your committee on June 17th, 2014. It is also similar to the issue discussed with your committee on March 26th, 2014 of our regional health authorities in discussion of chapter 19 of our 2013 report volume 2.

We made this recommendation because in our view the ministry incorrectly included health care facilities as capital assets of its assets constructed under those agreements. As previously discussed with your committee, our office had the appointed auditors of each auditee involved in holding . . . in each auditee's audit hold the view that these auditees continue to have substantively the risk and benefit associated with assets constructed or acquired under those agreements. We understand the government is reviewing this matter.

On page 98 we recommend the ministry follow GAAP of public sector when accounting for assets constructed under shared ownership agreements and for recording funds provided to RHAs [regional health authority] for repayment of principal and interest and the related liabilities.

Canadian GAAP for the public sector requires transactions to be accounted for based on their substance and that loans expected to be repaid through future funding be accounted for as liability as an expense in the year that the expectation or promise is made.

We made this recommendation because the ministry did not record its obligations, that is a liability, resulting from its established practice of providing regional health authorities with funding to repay the principal and interest due on loans for certain capital projects. This is a similar situation as the Ministry of Advanced Education discussed with your committee in May of 2014 and the Ministry of Education discussed with your committee in June 2014.

Also on page 98 we provide an update of the two new recommendations that we made in chapter 10 of our 2012 report volume 2, that is on pages 104 and 105. We reported that at March 2013 the ministry had not implemented these recommendations. On page 98 we recommend the ministry comply with the financial administration manual when entering into contracts for services exceeding the limits prescribed in the manual.

We made this recommendation because in 2012 we found that in about 30 per cent of its contracts for services, the ministry did not advertise its need for a contract on SaskTenders or document why it did not follow the formal process. The manual requires all ministries to do so. Doing so would help ensure that a ministry acquires services in the fairest and most equitable manner.

Also on page 98 we recommend the ministry document its due diligence and consideration of alternatives when awarding contracts. During 2012 the ministry had signed a multi-year contract for helicopter ambulance services with the Shock Trauma Air Rescue Society, that is commonly known as STARS. Although the signed contract with STARS includes all the necessary elements of good supervision and accountability, the ministry could not provide us any evidence of requests for proposal or written bids for air ambulance services, evidence of due diligence, and consideration of alternative proposals before signing the contract. That is, the ministry did not document its rationale for sole sourcing this contract.

Although the ministry did not sign any new service contracts during 2012-13, it did renew contracts with CBOs [community-based organization], exceeding the limits prescribed in the manual. Lack of documented due diligence and consideration of alternatives increases the risk that decision makers may not have all the relevant information about other innovative and competitive proposals.

In the remainder of this chapter, we report that while the ministry had made some progress, it had not yet implemented our past recommendations relating to verification of medical services to patients, developing a capital asset plan, and completing a business continuity plan. We report that the ministry has implemented the recommendation regarding updating risk assessment for health . . . [inaudible] . . . agencies and partially implemented the recommendation for a business continuity plan. It continues to work on the remaining recommendation. That concludes my presentation.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to make some comments?

Mr. Hendricks: — Yes, thank you. I think what I'll do is I'll actually just start going through the recommendations and providing our responses.

So on page 96 with respect to "We recommend that the Ministry of Health follow its processes to remove unneeded user access to IT systems and data promptly," the ministry has addressed this recommendation by ensuring all administrative staff are aware that all terminations and sick leaves are to be communicated to the financial services branch as soon as staffing changes occur. The financial services branch also receives monthly termination reports from the Public Service Commission to confirm that the information regarding terminations and sick leaves is up to date. So we believe we have implemented an action to address that recommendation.

With respect to the recommendation on page 97, "We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector when accounting for assets constructed under shared ownership agreements," as I said last time we appeared before this committee, the government has moved to budgeting on a summary financial basis and this accounting treatment has no impact on the summary financial statements.

Health does have legal agreements in place regarding the shared ownership arrangements with health regions. It is a model that was announced and a policy decision taken by government. It is accounted for based on the legal obligations that have been established and contracts that are in place. It is an appropriate application with the guidelines established through the generally accepted accounting principles in our opinion.

With respect to the recommendation on page 98, "We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector to record, in its financial records, funding provided to regional health authorities for the repayment of principal and interest due on loans and their related liabilities," the government has moved again budgeting on a summary financial basis, so this has no impact on treatment on the statements. Many regional health authorities do have revenue other than government from a variety of sources. The ministry does provide global funding

to regional health authorities, and they determine how these funds are allocated. The ministry does not provide any guarantee of repayment of the debt.

With respect to the recommendation also on page 98, "We recommended that the Ministry of Health comply with the *Financial Administration Manual* when entering into contracts . . . exceeding the limits prescribed in the *Financial Administration Manual*," and the subsequent recommendation, "We recommended that the Ministry . . . document its due diligence and consideration of alternatives when awarding contracts," we have addressed these two audit recommendations by communicating to ministry staff that the financial administration manual requires that services over $75,000 are to be posted on SaskTenders website. The ministry's contract review sheets have also been revised with a section to document the rationale for sole-source decisions. These types of decisions are now documented and maintained in an applicable branch. So we believe that we have implemented this recommendation.

[13:45]

With regards to verifying medical services for patients provided by physicians, we also believe that we are in compliance with this recommendation. We have introduced a claims verification system where, on a quarterly basis, we do send out verification statements to patients.

With respect to the recommendation on page 99, "We recommended that the Ministry of Health update its risk assessments for agencies delivering healthcare services to help monitor their performance," I believe that the auditor has noted that we are in compliance with this. Also on page 99, "We recommended that the Ministry of Health develop a capital asset plan to help ensure that it can carry out its strategic plan," the ministry is currently in the process of developing a high-level, multi-year capital asset plan for new projects and maintenance of existing facilities. This plan will include an assessment of the current challenges with capital planning in the province and an analysis of the work needed to address these challenges. Our expectation is that this plan will be completed by June of 2016. So we were in progress on that one.

In terms of business continuity planning on page 100, "We recommended that the Ministry of Health prepare a complete business continuity plan," the ministry has finalized and completed its testing of the business continuity plan. The business continuity information technology priorities have been approved and were provided to eHealth. eHealth Saskatchewan is developing a business continuity management plan that would respond to IT requirements set out by the ministry.

I believe that completes the recommendations.

The Chair: — Thank you, Mr. Hendricks. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — So just going back . . . Thanks for speaking specifically to each of the items. It's helpful to focus our attention and to note some of the progress on them as well. With the changes made then around removing unneeded user access, have those changes, from your perspective, implemented or is compliance the circumstance now for the auditor's concern that was raised?

Mr. Hendricks: — We believe that we are in compliance. I guess I would look to my colleagues in the Provincial Auditor's office to see if they concur.

Mr. Wotherspoon: — Thank you. Yes, as far as recommendation no. 2, you know, we've been through this discussion a couple of times with different ministries and with this ministry. It's one that's frustrating from I think many people's perspective that it's not simply resolved.

With the shift to summary, it's noted that the implication of the accounting treatment that Health has chosen on this front doesn't have an impact on this from the reporting on a summary perspective, and that may be the case, but what's the problem with shifting to a position that would allow the confidence of Saskatchewan people to know that Canadian GAAP is being used by the health authorities in relation to the ministry through these arrangements?

Mr. Hendricks: — I think a couple of things. First of all, as I said, we do believe that, based on the advice that we have received, that we are in compliance with GAAP. You will note that obviously, when the ministry enters into capital arrangements with health regions, there's considerable due diligence on the part of the ministry in the management of those contracts — the execution, the monitoring, all of that. Local regions raise 20 per cent of their total capital costs for a facility; generally government provides 80 per cent. So we believe that in health situation, we are in compliance with GAAP.

Mr. Wotherspoon: — Okay. So you say, you know . . . Government says that, and I don't want to get into a debate with yourself because I appreciate the role you fulfill to Health, but you know, I certainly do have a big issue with government, with cabinet, in continuing to push forward with this policy because the problem is that all the independent authorities within the accounting community, our audit office and then the accounting community and the various firms across the province, share the position of the auditor. So it's not like there's just two different opinions here.

Last time there was a detail that highlighted which health authorities had a concern noted by their independent auditor or an adverse opinion because of this. Could you speak to which health regions have I guess been flagged by the independent audit community because of this issue?

Mr. Hendricks: — It's my understanding that seven of the eight health regions did receive qualified statements from their auditors, some of whom would have been the Provincial Auditor, obviously, in certain cases. Oftentimes when we get into public sector accounting, there are differing opinions. We have eight co-ownership agreements for capital facilities. We've not undertaken any new ones. I think that, you know, with respect to your point, we look to government and the accountants that we have working for us to provide us with guidance. So based on that advice, we proceeded with this policy.

Mr. Wotherspoon: — And I recognize you're in a tricky spot here as well, so thanks for the answer. The qualified statements

that were provided, could you just state the accounting firms that have placed those qualified opinions?

Mr. Hendricks: — If I recall, we provided them last time. We don't have them with us this time but we would gladly provide them to the committee. I don't know, unless the Provincial Auditor has them.

Ms. Ferguson: — So for Cypress Regional Health Authority, it's Stark & Marsh. For Prince Albert Parkland it is Meyers Norris Penny. For Five Hills it's Virtus Group. For Prairie North it's — oh I apologize this if I enunciate this incorrectly — Menssa Baert Cameron Odishaw. Sun Country Regional Health Authority is Virtus Group. Heartland is KPMG. Kelsey Trail is NeuPath Group PC Inc.

Mr. Wotherspoon: — So that's a pretty wide swath of the independent accounting community having a shared position of concern that the auditor has here. Outside of the opinion of government, are there independent firms, either national firms or Saskatchewan firms that you could speak to that support government's opinion on this?

Mr. Hendricks: — Again I would have to check on that.

Mr. Wotherspoon: — I don't think we . . . I don't know how far we're going to get here today. This is an area that frustrates me to no end and I've expressed that. But I know at the end of the day it's ministers and a cabinet and a Premier that are setting a policy, in this case a policy that's choosing not to follow proper accounting standards. And it's a big concern to myself. I know it's, I'm sure it's a shared concern by other members of this committee and certainly it's a concern to many others across the province.

And as one example, I mean we just came from a luncheon, a dialogue with the Saskatchewan Chamber of Commerce. We were joined by many, many, many businesses, fine businesses from across our province. And not a single one of them get to choose their own accounting policy; they comply with accounting standards. That's what ensures some integrity of public reporting and proper accountability.

But I'm cognizant that you're not, as deputy minister, making this choice and that my debate is with a Minister of Finance, a Minister of Health, and a Premier who have chosen to not properly account for our finances and report to the public in a proper fashion.

Mr. Michelson: — Point of order.

Mr. Wotherspoon: — Certainly we urge action and change there, so I'll put that onto . . .

Mr. Michelson: — There's a point of order.

Mr. Wotherspoon: — Onto the record. So there's another member that looks, that wants to say something.

Mr. Michelson: — Point of order, Madam Chairman. The individual has referred to this twice as not a proper accounting system. I think it's a proper accounting system. I don't think it's the integrity of the system. I think the . . . The question is whether it's generally accepted accounting principles. And I think there's a difference there because it can still be a proper accounting system.

Mr. Wotherspoon: — I'd ask the member to explain.

Mr. Michelson: — Well to say it's not a proper accounting system seems that there is something not right going on.

Mr. Wotherspoon: — That's what the auditor has stated and that's what the accounting firms have stated.

Mr. Michelson: — No. The auditor has stated that it's not accepted, generally accepted.

The Chair: — Mr. Michelson, could you put your comments through the Chair, please. Just to note, that is not a point of order. This is a point of debate. But, Mr. Michelson, if you'd like to make your comments, and please through the Chair.

Mr. Michelson: — Okay. Madam Chair, as I said, the member has said it's not a proper accounting process. That I would say is not correct. What the auditor is saying, it's not Canadian generally accepted accounting principles. And I think there's a difference there. They can still be a proper accounting system, but it may not be accepted as the general accepted accounting principles.

The Chair: — Thank you for your comments, Mr. Michelson. Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I'm wondering if I could get the Provincial Comptroller to discuss their side of it, and we'd like to be able to hear their side of the opinion. We've heard the auditor's side of the opinion. We'd like to be able to hear your side, if you could please. Thank you.

Mr. Paton: — Madam Chair, if I could just make a few comments. First of all, in regards to whether or not this is a proper accounting system, I think both the auditor and ourselves believe that this is generally accepted accounting principles, and when you apply those principles you use judgment.

In the auditor's case, they have come down with an opinion that they don't believe that we're following those principles. We in turn believe we are following them, and the deputy minister I think has done a great job of explaining exactly what has happened here in terms of legal agreements being in place, ensuring that the proper ownership, the proper transfer of risks and responsibilities has taken place. So we've come to the conclusion that those procedures and documents are indeed appropriate and that we've accounted for them appropriately.

The Chair: — Thank you. Mr. Wotherspoon. Sorry.

Mr. Wotherspoon: — Sure. Thank you for the response. Is that position supported by any of the independent accounting community that there was a fairly wide scan that was highlighted by the auditor of those that had weighed in on the various health authorities? Are there independent accounting community nationally or provincially that support that position?

Mr. Paton: — Madam Chair, we did not solicit information

from any of the national or local accounting firms in this regard.

The Chair: — Thank you.

Mr. Wotherspoon: — So as I say, I think we could get into a long debate on here that I'm not sure that we get to where we want to be here today. It's a significant concern to many within the province, I know many within the business community, certainly to the opposition, I suspect members on the other side as well.

But it's important to maintain trust with Saskatchewan people as it relates to your accounting. And I find that the fact that the government has chosen its own accounting system — one that's been highlighted by the auditor — and that is of concern and in part contributed to an adverse opinion that was offered to the province of Saskatchewan as a concern and that concern seems to be shared by a broad swath, if not all, of the Saskatchewan independent accounting community. So we continue to call for accountability on this front, proper reporting. And certainly we would like to see this matter addressed and would like to see public sector accounting and that of health regions, that of the Ministry of Health, to be consistent with Canadian GAAP.

The Chair: — Thank you, Mr. Wotherspoon. Are there further questions for these two chapters? Seeing no further . . . oh, Mr. Wotherspoon.

Mr. Wotherspoon: — Well there's other recommendations, so just if we're looking here, I think those were focused more around the liabilities and the accounting pieces. There were a few other pieces. I think there was mention, there was concern that was highlighted around entering into contracts and the due diligence when considering awarding contracts and processes around that. From what I heard from them, the deputy minister, there seemed to be progress on this front. And if anything, I think I heard that the recommendation, that a couple are now . . . Those recommendations have been implemented. Could the deputy minister speak to those?

[14:00]

Mr. Hendricks: — Yes. So on any contract that we do issue over $75,000, we will post that to SaskTenders. Occasionally there will be a situation where you want to do an advanced contract award notice where you don't think that you have a competitor in that field. And that allows an opportunity for other people to say, no, we would like to bid on this, in which case we'd go through a tender process. So we believe we've implemented the necessary measures to make sure this doesn't happen.

Mr. Wotherspoon: — And of course not having a system like that puts potentially the public or public resources at risk. Is there any specific example that that risk occurred, or I guess that the risk was present? Was there a challenge identified where there might have been waste or excess dollars or some cost that taxpayers paid because of a system that wasn't quite as strong as it should be?

Mr. Hendricks: — I'll give you an example of where this was done. You know the Provincial Auditor has noted that the Saskatchewan Prevention Institute AIDS [acquired immune deficiency syndrome] program in south Saskatchewan, AIDS Saskatoon Incorporated, they were awarded contracts over $75,000 without a tender. In the judgment of the ministry, those were kind of the only agencies in the community that were capable of providing that service, that had set up an infrastructure, that sort of thing. So I guess now as we go forward we would tender those agreements and see if there are other interested parties. But I think where you'd most commonly see it is with CBOs where we have long-standing arrangements.

Mr. Wotherspoon: — There was a concern identified with the relationship or the contract that was entered into initially with STARS, or the process around that. That being said, has there been any concerns since then? Or have further contracts that have been entered into, have those been consistent with policies that are supported by the auditor and that protect the public?

Mr. Hendricks: — Yes. I'm not aware of any contracts. You know I think that we try and exercise a fair amount of scrutiny and diligence over contracts that we enter into and those are reported.

Mr. Wotherspoon: — Good.

The Chair: — Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. So my understanding is there was 30 per cent of the contracts that were going to . . . not going through SaskTenders, and now that we are at 100 per cent, other than the single-source ones such as STARS or the CBO of Aids Saskatoon, those are the only ones that are single-source supplier. Other than that everything is going through SaskTenders?

Mr. Hendricks: — No. They would go through SaskTenders when they do come due for renewal now. So we've changed our process. So if any company were to or any CBO were to say that they were interested in competing with Aids Saskatoon, we would take that into account. Highly unlikely, but . . .

Mr. Merriman: — So 100 per cent of them are done now through SaskTenders. So that's complete compliance with the auditor's recommendations.

Mr. Hendricks: — Yes. But we do have multi-year arrangements with STARS, that sort of thing. As well, you know, there are physician contracts that we do have for specialized services where we do know there to be . . . like for example, my chief medical officer was through a selection process versus an actual tender award, and that's because I would like some discretion in who my chief medical officer is.

Mr. Merriman: — Thank you.

Mr. Wotherspoon: — So touching on this point about verification of medical services, and there's a statement that patients receive . . . And that process would then address this concern that's raised by the auditor. Is that correct?

Mr. Hendricks: — Yes. I think we've always and still remain of a . . . We've implemented it, but we do have a difference of opinion as to whether it's an effective audit mechanism. We

have a joint medical professional review committee that we use that uses, actually, computer programs, and we have a professional review unit. So we do quite a wide swath when looking at physician payments, and that committee regularly recovers in the order of half a million to three-quarters of a million dollars from physicians. The actual verifications that we sent out — and we used to do this process a long time ago — don't do much in terms of actually catching bad actors.

Mr. Wotherspoon: — So is there, there's a difference of opinion on this front or there's more that could be done, is that the thought?

Mr. Hendricks: — Yes, based on the auditor's recommendation we're in compliance. So just a difference of opinion as to how effective it is.

Mr. Wotherspoon: — Does the auditor have a statement on that?

Ms. Ferguson: — We're still actually working on our current year audit. So once we get through that, we'll render our final views on it.

The Chair: — Are there any further questions on these two chapters?

Mr. Wotherspoon: — The only other one I'd like to touch on — and you noted, it sounded like, a fair amount of progress on the front — it's an important piece. That's the capital asset plan. You talked about the timeline to June 2016, and that is a big project because you're dealing with a lot of assets, a lot of infrastructure, and many partners.

Can you speak to, I guess, the complexity? Because I think some people would look to that timeline and say, well this is something that we should have sooner than later. But it's something you want to have that's reflective of your needs and that is all-encompassing as well. So I recognize some complexity to this file. But it should allow the dollars that are being provided by the Ministry of Health to be of optimal value to the province as a whole. So maybe just speak to why that's a fairly protracted process.

Mr. Hendricks: — It is very complicated for several reasons. One is that we have $6 billion of health facility capital out there — hospitals, long-term care homes, health centres. And you know, over the years and over the decades, the maintenance of those have become an issue. And so what we have to do is we have to balance the need for new facilities, where it makes sense to replace facilities, with our maintenance requirements.

I think that we also have to be cognizant in doing that, you don't design capital just in isolation. You have to look at your health service delivery needs. And so being mindful of where populations are growing and, you know, the future care delivery models that we have for certain types of care might affect your capital plan. So it is a highly complex model.

Entering into that is more recently the Ministry of Health has introduced lean planning into facility design, which we've done with Swift Current and at SHNB [Saskatchewan Hospital North Battleford] and children's hospital. And that's kind of changing the landscape in terms of how we design facilities and how we integrate services. So it is probably one of the more complicated areas of government capital, I would say.

Mr. Wotherspoon: — Thank you for the answer.

The Chair: — Are there any further questions on these two chapters? No? So seeing none, we will move on to what is the wish of the committee. We'll start with the 2012 report volume 2, chapter 10. We have two recommendations there. I'm wondering what the wishes of the committee are on that first recommendation: "We recommend that the Ministry of Health comply with the *Financial Administration Manual* when entering into contracts for services exceeding the limits prescribed in the *Financial Administration Manual*." Mr. Merriman.

Mr. Merriman: — I would recommend that we concur with the recommendation and note compliance.

The Chair: — Mr. Merriman has moved that this committee concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Agreed. Carried. Recommendation no. 2: "We recommend that the Ministry of Health document its due diligence and consideration of alternatives when awarding contracts." What are the committee's wishes with respect to this recommendation? Mr. Merriman.

Mr. Merriman: — My recommendation is that we concur with the recommendation and note progress towards compliance.

Mr. Wotherspoon: — Which one is this one? Sorry.

Mr. Merriman: — No. 2.

The Chair: — I'm sorry. So you move that we concur and note progress to compliance.

Mr. Merriman: — No, sorry. Note compliance. Sorry, my mistake.

The Chair: — Note compliance. So Mr. Merriman has moved that for recommendation 2 of the 2012 report volume 2, chapter 10 that we concur with the recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Moving on to the 2013 report volume 2, chapter 11, there are three recommendations with which we need to deal. What are the committee's wishes on the first recommendation? The auditor's recommendation is that "We recommend the Ministry of Health follow its processes to remove unneeded user access to its IT systems and data promptly." What are the committee's wishes? Mr. Merriman.

Mr. Merriman: — I recommend that we concur with the recommendation and note compliance.

The Chair: — Mr. Merriman has moved that this committee concur with this recommendation and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Recommendation no. 2. The auditor has recommended that "The Ministry of Health follow Canadian generally accepted accounting principles for the public sector when accounting for assets constructed under shared ownership agreements." Do I have a motion? What are the committee's wishes? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I concur with the recommendation and note progress towards compliance.

The Chair: — Mr. Wotherspoon.

Mr. Wotherspoon: — I concur as well and appreciate the concurrence. I'm not sure that there is any progress towards compliance right now. It seems to me that there's some difference of opinion expressed by the government itself, and it doesn't seem that there's necessarily any actions right now to resolve the matter. I would be more comfortable just supporting that this committee concur with this recommendation.

The Chair: — Are there any other thoughts? Mr. Merriman.

Mr. Merriman: — Well in principle, I think we have agreed that we are doing this process and it's just a difference of opinion on the implementation of it. I think we've heard the Provincial Comptroller say that there is . . . this is open to interpretation. I would like to hear what the auditor's thought is on this.

The Chair: — Ms. Ferguson.

Ms. Ferguson: — Thank you very much. I guess where we're at, you know, we feel that, as expressed earlier, is that in our view the government isn't following generally accepted accounting principles in this regard.

As indicated, the auditors of the regional health authorities and the school divisions had the same view as us in that really, when we look at the substance of the transactions, you know, looking through the legal form of the shared ownership agreements, we feel that substantively the risks of ownership still reside within the users of those facilities, which is the regional health authorities or, if you're talking about the education sector, the school divisions. So it is quite correct that there is a difference of view in this regard.

In our view, currently the government is not following generally accepted accounting principles for accounting for the assets under shared ownership agreements and that, you know, those assets are more appropriately accounted for in the books and records of the school divisions or the regional health authorities. And you'll find that the concern is we don't want them to be double counted. It's the same asset.

The Chair: — So we can as a committee simply concur with the recommendation. We don't have to note compliance. And as there seems to be . . . We can just concur with the recommendation if that is the committee's wishes.

Mr. Hendricks: — Madam Chair?

The Chair: — Mr. Hendricks.

Mr. Hendricks: — Just in response to the Provincial Auditor's point. I think the other element of this and the reason that the Ministry of Health does not support this recommendation, on the advice of our accountants, is that when we actually talk about who bears risk in the facility, regional health authorities, if there's a catastrophic failure in infrastructure, just like we were talking about, regional health authorities usually come looking to government to pay for those costs. So where the risk really lies is a question here.

The Chair: — I think, Mr. Hendricks, we had this with Education and the exact same question came to that deputy minister. So I think you've said, your advice has been not to support this recommendation, so it's hard to note compliance when in fact the ministry doesn't support this recommendation and isn't moving to compliance. Is that a fair comment? Yes.

[14:15]

Mr. Paton: — Madam Chair, I think we have to be careful here if we just vote compliance. From my office's opinion, we are following generally accepted accounting principles. From the Provincial Auditor's, they believe we aren't. I believe if you concur with this recommendation the way it stands, you're indirectly implying that the auditor's office is correct and that changes should be made. So I'm not saying the committee should or shouldn't say that, but I think you have to be clear that complying with it means that you're supporting the position of the Provincial Auditor.

The Chair: — Mr. Hendricks, do you believe that you're in compliance with this recommendation?

Mr. Hendricks: — We believe that we're in compliance with generally accepted accounting principles based on the advice of the provincial comptrollers and the accountants with the government.

The Chair: — It's hard . . . In my role as the Chair, I do have some latitude to ask questions, but I'll see if there are other any further questions or comments. Mr. Wotherspoon?

Mr. Wotherspoon: — It's pretty cut and dried. We've been through this discussion with others. We've engaged the independent accounting community on it. The auditor is the independent officer to the people of the province whose position is supported by the independent accounting community or the vast majority of that. Government's position isn't supported by anyone, at least stated here today, within the independent accounting community.

We're not talking about small little operations. And not that they wouldn't be able to do the same important work, but we're talking about Meyers Norris Penny. We're talking about KPMG who share the position of the auditor of Saskatchewan that this isn't consistent with GAAP. And from my perspective it's straightforward and simple that it should be. So it needs to be, it

needs to be resolved, and I urge that we concur with this recommendation. And we've dealt with this same recommendation in Education as well.

The Chair: — So in terms of the wishes of the committee, where do we stand? Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I'm still of the opinion that we are concurring with the principles of what the comptroller has said, that this is an interpretation of the generally accepted accounting principles. Obviously there is a difference of opinion of that interpretation of the generally accepted accounting principles and again I would make the recommendation that we concur with the recommendation and note progress towards compliance.

The Chair: — Is there any further discussion? Mr. Wotherspoon.

Mr. Wotherspoon: — Well I would vote against the piece around the progress because there's two very different opinions here. On one side you're saying that you concur with the recommendation that says that they're not complying, whereas their position of government is that they feel they are following those standards.

The concern from my perspective and I think many in the province, and I believe that of the auditor and the independent accounting community, is that their assessment of this is that the government has chosen to record this in a way that's not consistent with GAAP.

And as I say, it's of course a position that I suspect is, or I know is not arrived at in a light fashion by the auditor's office, and it's an office I certainly I trust in. And then when it comes to KPMG, Meyers Norris Penny, and these folks, I trust in the work they do within our province as well.

So I simply concur with the recommendation, and I'm hopeful that in fact this is of course an important piece to be addressed moving forward. And I've stated my frustration earlier so I'll leave that for now.

The Chair: — Thank you, Mr. Wotherspoon. Mr. Merriman.

Mr. Merriman: — Thank you very much. And I'm just wondering, we obviously have a difference of opinion and you've, Mr. Wotherspoon, you've cited many different things. Is there something that you could table before this committee from Meyers Norris Penny, such organizations, that says that . . .

Mr. Wotherspoon: — Sure. So I think I don't have a whole bunch of details. Certainly we could request that, and that might be something we could request as a committee here. But what I do know we have is the documented record of who the independent auditors are for each of those health authorities, which ones have been audited, and then which ones have been provided a qualified opinion and from whatever respective independent accounting firms. So I think that the auditor supplied some of that information here today, but you know, this is a good comment as well.

Mr. Merriman: — Well yes. The question will be, has the auditor's office or yourself received from independents saying that this is not generally accepted accounting principles? And I'm assuming that the comptroller, their version, their interpretation of that is different. I'm just trying to get the verification on the one side. We have verification, I think, on this side saying that this is their interpretation of the generally accepted accounting principles. We are in compliance with that. And on the other side, I'm just, I think . . .

Mr. Wotherspoon: — You know I would . . . [inaudible interjection] . . . I would defer it to the auditor, but I think they've received qualified opinions for this reason and I'm sure that would be public, but I think I'll defer to the auditor to speak to that.

The Chair: — And Ms. Ferguson could provide you with some information here.

Ms. Ferguson: — Certainly, Madam Chair. In response to the question, what you'll find is actually the public and the legislative committee of the Legislative Assembly has actually received that information through the audited financial statements of the regional health authorities, in that the audit report on the audited financial statements rendered by each of those firms is a qualified audit report for this particular matter. So what they're saying in their audit reports is these financial statements present fairly, other than how they've recorded the capital assets with respect to these particular arrangements.

And then what you'll find on . . . Because what has happened is that these regional health authorities did not include the portion of the assets recorded by the government in their books and records and in their financial statements, and their auditors felt that they should have.

The school divisions that were funded in the same manner under the same type of agreements did record them in their financial statements and the auditors of those school divisions provided unqualified opinions in that they agreed with the school divisions and their management and board that they appropriately included 100 per cent of those assets.

Mr. Merriman: — In saying that, just from what I understand, the government has invested for 80/20 split on the provincial, so how would we be able to account for 100 per cent of it when 100 per cent of it isn't ours?

Ms. Ferguson: — Well it's really no different than the other. The government has funded capital at school divisions, at regional health authorities, for absolutely years and it continues to do so. Even currently it's got some funding arrangements under the shared ownership agreements and some that are not. And I think that's the really the nub of the issue, is that the legal agreement surrounding the shared ownership agreement doesn't really change the accounting for those assets. So you know, if you want to argue that the shared ownership agreement changes the accounting, then if there's no agreement, you know, and in substance the same thing's happening to the assets, those other assets that are also funded by the government. So in one case, you know, in our view the existence of the agreement doesn't change the accounting, you know, for assets that are funded by the government.

Mr. Merriman: — Would it change the percentage of the value of it? Because if it's a shared agreement and let's say it's a 50/50 split, then technically it's 50/50 on the assets and the liabilities.

Ms. Ferguson: — You are funding other assets, other capital assets at regional health authorities . . .

Mr. Merriman: — Yes.

Ms. Ferguson: — And at school divisions. And in a number of cases, you're not doing 100 per cent of the funding or there's various percentages used. So in part like that's where we're at, is that the agreements don't change the funding. When we look at the substance of the transactions, you know, the government continues to fund assets just like it funds other assets that are built and on the books of the regional health authorities and on the school divisions, you know, in the same manner.

There's a lot . . . We do acknowledge that those shared ownership agreements, they do provide rigour to the process in terms of how assets are maintained. You know, there's a lot of good attributes to those agreements to making sure that things are done. We're just saying it doesn't change the accounting.

Mr. Merriman: — Okay. And any other comments from the comptroller's office on this?

Mr. Paton: — No, Madam Chair, there's nothing further that we can offer.

The Chair: — Thank you, Mr. Paton. Do you have any other thoughts over here? Another option . . . Do you need more information, Mr. Merriman? Would you be interested in further information around the qualified audits?

Mr. Merriman: — Thank you, Madam Chair. I'm not sure if I . . . I just wanted to make sure we were hearing all sides of this. And from my perspective, and again I leave this up to the committee to decide, but from my perspective we are in compliance with this and it's a difference of opinion. And I understand Mr. Wotherspoon's position that this a bigger picture. But I think in this side, we have noted compliance on this. And I think it's a difference of opinion and a difference of interpretation. So I stand by that and I guess we could put it to the committee.

The Chair: — So your motion was actually to concur with the recommendation and note progress to compliance.

Mr. Merriman: — Progress towards compliance, yes, thank you.

The Chair: — Okay.

Mr. Merriman: — Thank you for the correction.

The Chair: — So Mr. Merriman has moved that this committee concur with the recommendation and note progress to compliance. Okay. And we don't need a seconder, but thank you, Mr. Weekes.

Mr. Wotherspoon: — I'm not sure how . . . [inaudible] . . . So I don't support the motion that was put forward. I concur with the recommendation, and I was hopeful that that was the simple, straightforward message we were able to send. So I guess I will vote against this motion based on the point around progress when I think it's been noted even by officials at the table that there's not progress towards addressing this matter. So I strongly feel we should be concurring in. It's an important statement to the public at large. So I'll be voting against. And are you able to record a division, as Chair, as a committee?

The Chair: — Yes, we can have a recorded division.

Mr. Wotherspoon: — I just wanted to give the justification for my vote dissenting.

The Chair: — Yes.

Mr. Wotherspoon: — I suspect there's probably others too.

The Chair: — Thank you, Mr. Wotherspoon. Just one clarification.

Thank you for your patience here. As to the motion before us again, is that this committee concur with the recommendation and note progress to compliance. And this is the 2013 report volume 2, chapter 11, recommendation no. 2. Is that agreed? May I have a show of hands — my apologies — show of hands in agreement? Five in agreement. Are there any opposed? Mr. Wotherspoon is opposed. That is carried. Thank you.

Moving on to recommendation no. 3:

> We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector to record in its financial records funding provided to regional health authorities for the repayment of principal and interest due on loans and the related liabilities.

And what are the wishes of the committee with respect to this?

Mr. Wotherspoon: — I move that we concur with this recommendation.

The Chair: — We have a motion before us that this committee concur with this recommendation. Is that agreed?

An Hon. Member: — Agreed.

Mr. Michelson: — Madam Chair, is this different from the one we just . . .

The Chair: — This is recommendation no. 3, yes.

Mr. Michelson: — I know. But the principle of it is really the same.

The Chair: — That is for you to . . . It is a different recommendation. If you want to look at page 98 of your report, no. 3.

Mr. Michelson: — I guess the principle is saying the same thing really. So I think if we noted progress on the last one, we

should be noting progress on this one as well.

The Chair: — We have a motion before us, and you can defeat the motion if you wish and make another motion. Sorry. I'm still learning this whole chairing or getting a better handle on it so . . .

Mr. Michelson: — Can we amend that motion, then?

The Chair: — We have a motion on the floor. So we vote on the motion and then can have another motion following that if it's defeated.

So Mr. Wotherspoon has moved that for the 2013 report volume 2, chapter 11, recommendation no. 3:

> We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector to record, in its financial records, funding provided to regional health authorities for the repayment of principal and interest due on loans and the related liabilities.

Is that agreed? Can I have a show of hands in favour? So that motion is defeated. Again, what are the wishes of the committee with respect to this recommendation? Mr. Weekes.

[14:30]

Mr. Weekes: — I would just like to ask the comptroller for his view on that issue, whether it is different from the previous item.

The Chair: — Mr. Paton.

Mr. Paton: — Madam Chair, I think you're entering into the same debate that we just left . . .

The Chair: — Yes. Yes, I know.

Mr. Paton: — Where in both cases we've got two different bodies disagreeing with the application of generally accepted accounting principles. So again the auditor believes that we should follow one process. We are following a different process. So even though we both believe we are in compliance, we have different results here.

The Chair: — Mr. Hendricks.

Mr. Hendricks: — So both recommendations are actually confusing to me because on the last one, if we note in progress, well in fact we are saying we disagree with the recommendation in the sense that we believe we are following Canadian generally accepted accounting principles for both of these recommendations. The way that it was worded last time was that we would continue to review our position on this, but we took no position whether it was in progress or compliance or anything. So it's really a decision. We have a professional difference here on both of these.

The Chair: — Thank you, Mr. Hendricks. Mr. Paton.

Mr. Paton: — If I could just further the deputy's comments. When you talk about progress towards compliance, I'd be in the same position as the deputy in terms of what further steps are required because in both cases we believe that compliance is the procedures that we're currently following. So when I hear that it's progress towards compliance, it means to me that something further or something different should be happening. And I don't believe that's the case here, from our position.

The Chair: — Thank you for that, Mr. Paton. We can't revisit the previous . . . I think we had this . . . Do you have further . . .

Mr. Paton: — Well, Madam Chair, if I could, I just got a . . . Mr. Bayda just passed something onto me about a motion that was concurred to from a past Public Accounts Committee from January 13th of 2014. And the recommendation was that:

> Recognizing the difference of the professionals' interpretations, the Standing Committee on Public Accounts recommends that the Minister of Finance have his officials continue to examine the issue and discuss it further with the Provincial Auditor.

So this was, I believe, the same issue that we're talking about here, when the Ministry of Finance was before the committee.

The Chair: — Thank you for that. And also, I have to note, when Education was here, that's why they were very blunt when Education was here, in that there was no compliance to note. It was just, we are in complete disagreement with this recommendation. And so I think that that's how the committee dealt with that in the spring. So one moment please.

Can I suggest a five-minute recess or make it a 10-minute recess to further discuss this? Okay, agreed. Thank you. So we'll come back in 10 minutes.

[The committee recessed for a period of time.]

The Chair: — Welcome back everyone. Thanks for that short recess. We still have, I think, some discussion on the 2013 report volume 2, chapter 11. Mr. Merriman?

Mr. Merriman: — Madam Chair, I'd like to take leave to propose a motion for 11.3 and, due to the recent information that we just received about January 2014, rescind the motion of 11.2.

The Chair: — Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Can you repeat that, Mr. Merriman?

Mr. Merriman: — Absolutely. Madam Chair, I'd like to ask leave to propose a motion for 11.3.

The Chair: — Okay. Okay. So your motion for the 2013 report volume 2, chapter 11, what is your motion?

Mr. Merriman: — Thank you very much, Madam Chair. And I want to thank the Provincial Comptroller for reading this into the record. I will read into the record what was said on January 2013. My motion would be:

> Recognizing the difference of the professionals' interpretations, the Standing Committee on Public Accounts recommends that the Minister of Finance have his officials continue to examine this issue and discuss it further with the Provincial Auditor.

The Chair: — We have your motion, Mr. Merriman. Thank you. So for the 2013 report volume 2, chapter 11, recommendation no. 3:

> We recommend that the Ministry of Health follow Canadian generally accepted accounting principles for the public sector to record, in its financial records, funding provided to regional health authorities for the repayment of principal and interest due on loans and the related liabilities.

Is there any . . . This is a motion before us. Is that agreed? No. Okay. Sorry, sorry. So my apologies here one more time. Thank you for your patience everybody. The motion that Mr. Merriman has before us is, I move the following motion:

> Recognizing the difference of the professionals' interpretations, the Standing Committee on Public Accounts recommends that the Minister of Finance have his officials continue to examine this issue and discuss it with the Provincial Auditor.

Is there any discussion on this motion? Mr. Wotherspoon.

Mr. Wotherspoon: — I mean, this is a tad outrageous. The motion that was put forward noting progress — one that I didn't support — was argued for by members that are opposite. And now they are changing that . . . I mean, government members here today are, you know, displaying more positions here today than the evening class at Yoga Mala. I mean, this is rather ridiculous on an area that's been debated for some time within this Assembly.

As far as professional differences of opinion and then trying to get in and pull back a position that members just debated for a few minutes ago, it's just I don't quite understand the purpose of where members are going. And I believe that the handling and treatment by government members was different yet with the Ministry of Education not too long ago. So government's positions, as I say, are all over the map on this one.

Whose positions aren't all over the map are that of the auditor, the independent accounting community — KPMG, Meyers Norris Penny, and many others. And I think we should just be dealing with this in a matter-of-fact way and concurring with the recommendations that are before us that call for a very important piece of accountability but a simple piece, and that's that the Government of Saskatchewan follow Canadian GAAP. So that's my position.

The Chair: — Thank you, Mr. Wotherspoon. Mr. Merriman.

Mr. Merriman: — Thank you, Madam Chair. I think it's always extremely good practice for the comptroller's office to be continuing to discuss things with the Provincial Auditor and exploring their own interpretations of what the general accepted accounting principles are. I don't think that conversation should ever stop, in my opinion. And we should make sure that these two offices, through the Minister of Finance, discuss what is generally accepted accounting principles and how our ministries are working with those generally accepted accounting principles and our interpretation of those generally accepted accounting principles. So I think that that conversation is healthy and I think it should continue. Thank you, Madam Chair.

The Chair: — Thank you, Mr. Merriman. Are there any other questions or comments before we vote? Mr. Norris.

Mr. Norris: — Thanks very much, Madam Chair. I think an important part of the context here relates to the government's shift to the summary of financial statements that have occurred. And that's where I think, as the Chair has noted, I think this would be a fruitful position for the committee to consider. And certainly we're doing our best to ensure greater accountability. There's a difference and I think it's important, as the Chair has said, to really look at what that difference will be, and that's through dialogue. And so just to reinforce, I think this is a helpful opportunity for us on this one — us being all committee members — it's about really encouraging that dialogue.

The Chair: — Thank you, Mr. Norris. Mr. Wotherspoon.

Mr. Wotherspoon: — Just in quick response, the shift of summary is separate and apart from this, and it doesn't make the concerns raised by the auditor null and void. Those are still the valid concerns, and it still is causing qualified opinions to be placed on health regions across the province and will still be a statement that's provided by the auditor's office.

So as far as ongoing dialogue, it's important for everyone at home to realize that before these reports are published, there is an incredibly long working relationship on these files between government, the auditor, and the independent audit community. And for the auditor's office — and she'd be best to speak to this — or the independent auditing community to place qualified opinions or to state specific concerns or to place adverse opinions, before they do that, there is significant dialogue back and forth. And I think it's a shame for us and a regressive step for us to do anything less than concur with the position of the Provincial Auditor that the province of Saskatchewan follow Canadian GAAP as supported by the independent audit community in this province.

The Chair: — Thank you, Mr. Wotherspoon. Any further questions or comments? No? We have a motion in front of us here. Mr. Merriman has moved that:

> Recognizing the difference of the professionals' interpretations, the Standing Committee on Public Accounts recommends that the Minister of Finance have his officials continue to examine this issue and discuss it with the Provincial Auditor.

Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. All right. Moving on to the 2012 report volume 2, chapter 32, I will hand it over to the Provincial Auditor to make her comments.

Ms. Ferguson: — Thank you very much, Madam Chair, Deputy Chair, officials, and members. I'm just going to actually just keeping moving down the table and turn it over to Mr. Ahmad to present chapter 32 that deals with an audit related to the prevention of diabetes-related health complications.

Mr. Ahmad: — Thank you, Ms. Ferguson. Chapter 32 of our 2012 report volume 2 begins on page 256. The chapter relates to prevention of diabetes-related health complications. The Ministry of Health is ultimately responsible for ensuring that people with chronic diseases such as diabetes receive appropriate care. Diabetes is a chronic condition where the body does not produce enough insulin or cannot effectively use insulin to regulate blood glucose levels. In 2011 the Canadian Diabetes Association estimated that the economic burden of diabetes in Saskatchewan was 257 million in 2000, 419 million in 2010, and will increase to 532 million by the year 2020.

Diabetes-related health complications account for over 80 per cent of the diabetes cost. People with diabetes are three times more likely than people without diabetes to be hospitalized at least once a year and remain hospitalized for five times as many days as people without diabetes.

[15:00]

We audited the ministry's strategies for preventing diabetes-related health complications in the province. We also examined how well Saskatoon Regional Health Authority and Kelsey Trail Regional Health Authority translated the ministry's strategies into programs for services. We did not examine the ministry's efforts to prevent people from developing chronic diseases like diabetes. However we focused on the ministry's efforts to help people with diabetes reduce or delay development of serious complications that often result from diabetes.

We concluded that at March 31, 2012, the Ministry of Health did not have effective strategies for preventing diabetes-related health complications. The two RHAs deliver programs for people with diabetes, but these programs were at times ad hoc because the RHA did not have strategic direction from the ministry about the provincial goals and objectives and did not have enough information to know if the programs were effective.

We made 12 recommendations for the ministry to help make its strategies effective. On page 264 we recommend the ministry to implement an actionable work plan relating to chronic disease management, including diabetes and prevention of diabetes-related complications, and provide guidance to RHAs. We made this recommendation because, while the ministry had a broad strategy and various plans under way for diabetes management, it did not have a sustainable, actionable plan and related guidance for RHAs. Without such a plan and guidance, the ministry and RHA may spend money on diabetes initiatives that may not result in coordinated and effective programs and services.

On page 265 we recommend the ministry set goals and objectives, performance indicators, and targets to manage diabetes and prevent diabetes-related health complications. We made this recommendation because the ministry had a broad strategy to promote better health and broad performance indicators and targets related to chronic diseases, but did not have goals, objectives, performance indicators, or targets relating to diabetes and diabetes-related complications.

On page 265 we recommend that the ministry establish processes to monitor that people with diabetes receive appropriate services to reduce their risk to developing diabetes-related complications and they have access to appropriate services in the province. We made these recommendations because the ministry did not have information to know whether people with diabetes are monitored and necessary interventions are taking place to reduce the risk of developing complications. Although physicians must ensure that patients receive appropriate care and monitoring, the ministry's standard work should require regular clinical checks.

On page 267 we recommend that the ministry implement processes to accumulate, analyze, and monitor provincial spending information on people with diabetes and on the programs for prevention of diabetes-related complications to assess the reasonableness of its resource allocations. We made this recommendation because the ministry could not tell us the total cost of treating diabetes or diabetes-related complications in the province's acute care facilities. Knowing how much is spent on treating diabetes would help determine if its diabetes-related programs work and would assist in making funding decisions.

On page 267 we recommend the ministry work with the Saskatchewan Medical Association to establish a method for assessing physician activities in monitoring people with diabetes. Since 2011 the ministry has agreed to increase annual funding to improve and increase services physicians provide for chronic disease treatment and management. This includes diabetes services. We made this recommendation because the ministry had no mechanism to know if physicians are monitoring people with diabetes effectively and consistently.

Also on page 267 we recommend the ministry work with RHAs to ensure resources on a regional basis are effectively deployed to manage diabetes and diabetes-related complications. We made this recommendation because the ministry had not provided guidelines to RHAs to help decide how much of the global funding they should spend on chronic diseases or more specifically diabetes management and diabetes-related complications.

On page 268 we recommend the ministry review RHAs' primary health care plans and programs to ensure they contain appropriate actions and align with the ministry's strategies relating to chronic disease management, including diabetes. We made this recommendation because the ministry could not provide evidence of such reviews and the RHAs' plans that we examined had few actions related to chronic disease management and did not specifically address management of diabetes.

On page 269 we recommend the ministry to implement processes to gather sufficient information relating to people with diabetes and diabetes-related complications to ensure they're receiving care consistent with provincial standards. We made this recommendation because the ministry did not know if

the people with diabetes in the province received the same level of service and monitoring by care providers. People with diabetes without appropriate monitoring and intervention have increased risk of developing complications which in turn increases the nature and extent of health services needed.

On pages 269 and 270 we recommend that the ministry collect and analyze information to assess whether care providers deliver needed services effectively and assess the RHAs' program to manage diabetes respectively. We made these recommendations because the ministry did not collect this data. Without such data, the ministry cannot assess the effectiveness of services to people with diabetes or effectiveness of the RHAs' program to improve ability of people with diabetes to self-manage their disease and prevention of diabetes-related complications.

Finally, on page 271 we recommend that the ministry report publicly its progress in implementing its strategies to manage chronic diseases, separately identifying diabetes and prevention of diabetes-related health complications. We made this recommendation because the ministry report contains statistical information that was not as useful in assessing whether the strategies are effective in achieving the desired goals and objectives.

And that concludes my overview.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, would you like to walk through the recommendations.

Mr. Hendricks: — Actually my assistant deputy minister, Mark Wyatt, is going to step through the responses.

Mr. Wyatt: — Thank you very much. I will. I guess a number of our responses to the recommendations are actually very similar and speak to some of the activity that's taken place since 2012. And so I guess rather than going through a detailed response individually to each recommendation, what I was going to suggest is I can provide some broad description of what has been introduced in recent, in the past couple of years that I think directly respond, and then I guess I could come back to whether we believe we have in fact implemented the recommendation or in any instances where we would say we've made progress as opposed to having achieved that. So if that's acceptable, I can proceed.

The Chair: — Yes, I think that that would be very helpful.

Mr. Wyatt: — Okay, thank you. So I think just to start by stating the obvious, which is clearly diabetes is a significant problem in Saskatchewan and I think the impacts both on patients and individuals, their families, as well as the impacts that are described too in terms of health service delivery, the impact on emergency rooms, hospitalizations, clearly all of that is recognized by the ministry and the health system broadly.

Over the past several years there have been a number of initiatives that have been targeted towards diabetes. And I think the one change that has occurred in the last few years is moving away from focused strategies that are targeted towards individual chronic diseases and looking at chronic disease on a broader perspective, looking at the importance of primary care and preventative programs, recognizing that a lot of the underlying risk factors are very similar whether you're talking about diabetes, whether you're talking about heart disease, lung, or COPD [chronic obstructive pulmonary disease]. I mean many of the chronic diseases that we're familiar with have those same conditions related to whether it's smoking, obesity, or risk factors such as high blood pressure or cholesterol or those kinds of things.

So I guess rather than introducing a specific diabetes strategy, what we've been moving towards is a broader focus around chronic disease management. And I think that would be consistent with the approach that's taken across the country to get away from dissecting the patient into a series of body parts and looking at the individual as a whole, and how many of the chronic disease and conditions have a common approach that is required.

So with that by way of background, the one I think significant change that's been introduced in the last couple of years is the chronic disease management — quality improvement program. The goals of the CDM-QIP [chronic disease management quality improvement program], which is the acronym that we use are to improve the continuity and quality of care for people living with chronic conditions, to encourage and support physicians and other health care providers to implement best practices with such things as flow sheets and clinical practice guidelines, and to leverage Saskatchewan's health information system to better meet the needs of residents and providers through technology such as electronic medical records and EMRs.

The partners that are involved in the chronic disease management quality improvement program include the Ministry of Health, different branches — our primary services branch, our medical services branch among them, also the SMA [Saskatchewan Medical Association]. This involves individual physicians, and through the SMA we've worked with the SMA around the funding that is provided to physicians who are participating in the program and also had physician involvement in the development of the program and some of the tools. eHealth Saskatchewan has been another partner. Because of the use of electronic medical records as the means by which some of this information is tracked and captured, eHealth has been an important partner as well in this program.

Just to briefly touch on the process, what it would involve is a patient who is seeing their family physician typically, or primary care provider, there would be a flow sheet that captures a number of examinations, laboratory tests, and basically all of the elements of best practice for a particular chronic disease.

And I should mention that the two chronic diseases that were introduced at the beginning of the CDM-QIP were diabetes and congestive heart failure. So diabetes was one of the first to I guess come out from this process where we've identified two others that are . . . I guess in the process of implementing two others and two more have been selected.

So the physician would then use their electronic medical record or they can use a paper process for identifying and going through I guess a checklist of sorts to make sure that the elements that are considered to be the standard of care, that

follow the clinical practice guideline, are in fact employed. Again they would enter that into their EMR, or electronic medical record, if they are using an EMR or on paper, follow these flow sheets. Through the electronic aspect of it, you would have links and the ability to then quickly refer to best practice and clinical practice guidelines. It also triggers patient recalls so that if you have a particular test or a particular part of the guideline that needs to be monitored on a six-month or an annual basis, that there are functions that allow you to then make sure that you are bringing those patients back for the required care.

So the physician is inputting data and also has access to that data so that they can look at not just individual patients but look at their practice broadly to ensure the compliance with best practice. And there are payments that have been negotiated with the SMA related to the physicians' full compliance. They have to meet all of the elements of this flow sheet in order to receive their funding.

So that has been, I think, the significant strategy that's been undertaken through again the ministry with a number of partners, targeting chronic disease broadly. But within that, certainly diabetes has been one of the lead-out areas that has been addressed.

Just to touch on a couple of the other areas related to diabetes programming, certainly the . . . Oh, I should say that so far there have been 545 physicians in the province who have been trained around the use of the chronic disease management QI [quality improvement] program. And so the program is still in its early days; they're beginning to enter data and we will begin to see some of the data being uploaded and then beginning to see more of the payments going out in response.

With respect to one of the advantages that we won't see today but is certainly available to us is, as we move through a privacy review, we'll have the ability then to look at rolled-up data and have that secondary use of the data that's being generated in physicians' offices to be able to answer questions around the number of people who have diabetes, who are being treated for diabetes because, as mentioned, it's not an area where we have strong timely data. We do have data around the number of people with diabetes, but it typically lags by a couple of years by the time it's gone through the province to national agencies and back, as often is the case with data that moves through those national reporting processes.

[15:15]

Some of the other areas that I would touch on, the Saskatchewan insulin pump program was originally introduced in 2007 for children age 17 and younger that require a pump to adequately stabilize blood sugar levels and meet program criteria. The insulin pump program was expanded in January 2012 to include eligible patients 25 and under, and that program pays 100 per cent of the cost of the insulin pump and assists families with the costs of insulin pump supplies.

As well, the Saskatchewan formulary lists a number of products to manage diabetes. These products include a variety of insulin formulations; oral diabetes medications; blood glucose testing strips; diabetes supplies such as needles, syringes, lancets, and swabs.

A couple of other things that I can touch on include work that's being done around practice pathways, work around appropriateness that we're doing on lower leg vascular disease and ischemia, which is certainly one of the complications that results from unmanaged diabetes. And so there are a number of areas that are also supporting within, I guess, within the system and within the ministry that we're working on that either do directly address patients with diabetes or broadly chronic disease. The primary care work that we're doing itself is certainly not targeted exclusively towards patients with diabetes but does certainly meet some of the needs of patients, of individuals with diabetes along with other chronic disease concerns.

Finally the goals that have been established through the ministry's strategy and performance plan have been introduced around primary care broadly and the CDM-QIP program. Those have been introduced into our performance plan and are part of the targets and goals that have been established and again, I think, would probably be subsequent to the 2012 time frame that this report addresses. I think that covers, I guess broadly, some of the developments over the last 18 months, two years.

Just with respect to the recommendations, based on the response that I've provided, we would report that we have implemented recommendation no. 1. This is the recommendation on chapter 32, page 264. I hope the numbering coincides with your numbering here. With recommendation no. 2, we would also say the ministry has addressed the recommendation, as the ministry's strategic plan identifies objectives for the reduction in hospitalizations for persons living with a chronic disease, including diabetes, as well speaking to the chronic disease QI program as being part of that response.

Recommendation no. 3, again we would submit that we have addressed that recommendation with the implementation of the QI program as well as performance indicator data related to best practices. With respect to recommendation no. 4, the ministry has addressed this recommendation, as processes are in place to track both access to and appropriateness of care related to diabetes.

Recommendation no. 5, our submission is that we are making progress on this recommendation. We currently collect information on direct care costs such as drugs and insulin pump program spending. Other costs can be estimated, such as hospitalization, the renal program, and those incurred by regional health authorities. We would submit that we are making progress in this area.

Recommendation no. 6, the ministry has addressed this recommendation primarily through the QI program. Under this program, performance indicator data related to diabetes and its related complications are collected and have the potential to be, well, certainly can now be used by the physicians and have the potential to be used more broadly in terms of the broader population.

Recommendation no. 7, that we have made progress on this recommendation. The ministry has established objectives and

targets related to chronic disease management, including diabetes, and through the CDM-QIP performance indicator, data is being collected. In addition, we're working with regions to identify and address gaps in care for patients with chronic disease.

Recommendation no. 8. We have implemented this recommendation. All regions provided primary health care plans for 2014-15, outlining actions to increase access to collaborative, team-based care.

Recommendation no. 9, page 269. The ministry has implemented this recommendation, as the chronic disease management QI program collects performance indicator data on individual physician's care to patients.

And recommendation no. 10. The ministry has implemented this program under the CDM-QIP. Data related to diabetes and its complications are collected through the electronic medical record and the electronic record viewer and will enable the ministry to assess whether services provided in relation to managing diabetes are effective.

Recommendation no. 11. The ministry has implemented this recommendation, again under the CDM-QIP. Data related to diabetes and its complications are collected and will enable us to assess over time how services and programs provided to residents are impacting outcomes.

Recommendation no. 12, page 271. The ministry has addressed this recommendation as Health reports on progress towards strengthening primary health care, as well as chronic disease management through the annual health system plan.

That certainly concludes my overview, and I certainly welcome any questions you may have.

The Chair: — Thank you, Mr. Wyatt. Having both the overview and walking us through the recommendations, I think is very helpful for the committee. So thank you very much for that.

I'd like to open up the floor for questions. You know what? I would like to . . . Seeing none at this exact moment — I'm sure someone will come up with some others — I'm wondering a little bit more about the CDM-QI in terms of you said it was in its early days. When did you first implement the program?

Mr. Wyatt: — The program was implemented in 2013. And I'm just trying to see if I've got . . . So the EHR [electronic health record] viewer data screen was completed by March 23rd, 2013, and that's for diabetes and coronary artery disease. Some of the early-adopter-payment-provider-based reports were implemented in July of '13, paper flow sheets implemented September of '13. There's a number of stages related to the EMR vendors. So basically through 2013, it was being the different stages of implementation, and the training with respect to physicians has also been ongoing through '13 and '14.

The Chair: — Thank you. And you said there's so far 545 doctors participating or are trained?

Mr. Wyatt: — That's correct; 545 have completed the training as of the end of August.

The Chair: — Is there, in terms of goals for the number of docs trained over a length of time, have you set some goals or targets for doctor participation?

Mr. Wyatt: — The original target that was set was for 35 per cent of family physicians and, with approximately 1,000 family physicians in the province, that would be 350. We've exceeded that target now that we've moved up to 545. Ultimately our goal would be for all family physicians to be part of this program. We don't at the moment have a, I guess, a next-tier target.

The Chair: — Yes. Thank you for that. So you've got diabetes and congestive heart failure under that program right now, but you're bringing a couple other chronic illnesses on stream? Is that correct?

Mr. Wyatt: — Yes. I'm going to correct myself just on the second one that was in that phase 1. So it was another heart-related . . . It's coronary artery disease and diabetes, so that's my mistake. Congestive heart failure and COPD were part of phase 2. And two others have been identified: asthma and depression are the other two chronic diseases, and their implementation is scheduled for 2015.

The Chair: — What are those other two?

Mr. Wyatt: — Asthma and depression.

The Chair: — In terms of the training for the docs, so the partnership with the SMA, you're providing funding to the SMA to . . . Okay. Can you tell us a little bit about that?

Mr. Wyatt: — Sure. I'll just be one moment here.

The Chair: — Yes.

Mr. Wyatt: — So physicians who are participating would be eligible for two payments under the CDM-QIP. They are in addition to payments that are already part of the physician payment schedule.

The eligible population are residents who are at least 17, patient population would be residents at least 17 years of age at the time of their first visit in which observations are submitted. The payments, there was one payment that was targeted to bring early adopters on board. Physicians would receive a one-time payment for each patient with a chronic disease for which they submit chronic disease indicators. To support continuity of care, payments will be made after the second submission of indicators and will be made on a biweekly basis over the term of the payment period, and observation data must be submitted within a six-month time period of a chronic condition.

The other thing that's important to recognize is that in order to receive the payment, you have to have entered and have compliance with all of the designated elements of the flow sheet. It's not sufficient to say for a diabetic patient that we are monitoring your A1c but we haven't tracked your cholesterol or had a discussion around eye exams or smoking or other behaviours that may result in complications for diabetes.

So the second payment is the ongoing payment for the submission of all chronic disease indicators over a 12-month period. Physicians are paid $75 per patient per year for each chronic condition in which all of the relevant indicator data has been submitted.

The Chair: — Can I ask how you . . . Sort of following that second payment then, the goal is to sort of create that culture of reporting chronic illnesses. So following that, completion of that second payment, the goal is that those habits or that culture of reporting will be entrenched. Is that what you anticipate?

Mr. Wyatt: — Right. And so I think the answer is yes. It's a combination of following the clinical practice guideline and I think . . . I guess broadly there are a lot of clinical practice guidelines. There's a world of information in clinical practice guidelines out there for any condition, whether it's a chronic disease or an acute condition, and the challenge is getting clinicians to both follow it and then, between the clinician and the patients, to actually follow it routinely. And so I think part of that is making sure that the recalls are occurring, when patients need to come back and have the different elements reviewed.

And so there are flow sheets — I've got an example of the one here for diabetes and coronary artery disease — and so the flow sheets will take you through some of the patient history and then there's a series of check boxes related to lifestyle, glycemic control, cardiac history, medications that patients would be on. So it basically requires the physician to move through the flow sheet and make sure that they're addressing all areas of the best practice for diabetes management.

[15:30]

The Chair: — And am I understanding correctly then that the payment process will continue throughout the . . . beyond the second payment?

Mr. Wyatt: — Yes.

The Chair: — Yes, like it's part of the fee schedule going forward.

Mr. Wyatt: — It's built into the existing agreement with the SMA and we're right now in the process of negotiating a new agreement with the SMA. So I guess, depending on the outcome of that negotiation, it may well continue.

The Chair: — Thank you for that. Mr. Norris.

Mr. Norris: — Great. Thanks very much, Madam Chair. Thanks very much for this overview. I'd just like, if I could, just a little bit more detail on the RHAs, the regional health authorities and their efforts to work on chronic disease management and what that looks like — maybe just a couple of snapshots from your perspective as the reporting structure is now coming along, especially as it pertains to diabetes.

Mr. Wyatt: — I think it's fair to say that the approach to chronic disease management is embedded within the overall primary care strategy that is moving forward through the province. And with the introduction of primary care sites within the regions, they're clearly emphasizing the proper management of chronic disease in those sites as they're establishing the teams with the team members.

Typically, primary care has been the patient-physician relationship and I think as you start to take a more team-based approach, look at some of the alternate allied providers who can be either direct members of that team or can have a relationship with those teams, the involvement of dieticians, the involvement of educators can take on a far greater emphasis when you're looking at how you are addressing any chronic disease. If you not only receive care through those 10-, 15-minute encounters with a physician but have access either through direct or group counselling and follow-up appointments with other members of the team, I think it just expands the overall team-based approach. Pharmacists would be another one in terms of medication management.

And so I think the . . . I guess to speak to your question broadly, it would be starting to take more of the team, the primary care team in order to work with patients in managing their care rather than leaving it exclusively to that physician visit.

Mr. Norris: — That's great. Thanks very much.

The Chair: — Thank you. Are there more questions? Seeing none, we have 12 recommendations with which we need to deal. I'm wondering, we . . . Just noting that there are 10 that the ministry has implemented and two where they've noted progress. So I might suggest we want to handle some of them in a more bulk fashion or whatever the wishes . . .

Mr. Merriman: — Thank you very much, Madam Chair. As far as if . . . We can group them if that's okay with the committee. Certainly recommendation no. 1, recommendation no. 2, recommendation no. 3, recommendation no. 4, recommendation no. 6, recommendation no. 8, recommendation no. 9, 10, and recommendation no. 11 and 12, I would concur with the recommendation and note compliance on all of those, inclusive.

The Chair: — I just want to make sure that I have these. Okay. Mr. Merriman has moved that the committee concur and note compliance . . . Sorry, just one moment, please. Which chapter are we on here? So for the 2012 Provincial Auditor report volume 2, chapter 32, Mr. Merriman has moved that we concur and note compliance for recommendations no. 1, 2, 3, 4, 6, 8, 9, 10, 11, and 12. Any further discussion on this? No? Is this agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. And with outstanding recommendations no. 5 and 7, what are the wishes of the committee?

Mr. Merriman: — Madam Chair, I would concur with the recommendation and note progress towards compliance on no. 5 and no. 7.

The Chair: — For the 2012 Provincial Auditor report volume 2, chapter 32, Mr. Merriman has moved this committee concur with recommendation no. 5 and 7 and note progress to compliance. Any further discussion?

Mr. Wotherspoon: — You know, I would want to say I think that I found this a really interesting audit and area of analysis certainly important to the province of Saskatchewan. I appreciated hearing lots of the actions that are being taken on by the Ministry of Health and look forward to tracking the progress on this file. It's an important one.

The Chair: — So with respect to the recommendation no. 5 and 7, that this committee concur with those recommendations and note progress to compliance, is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. Okay. I would ask if we have a five-minute, very brief adjournment . . . or recess, pardon me. A five-minute recess. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay. Thank you.

[The committee recessed for a period of time.]

[15:45]

Regina Qu'Appelle Regional Health Authority

The Chair: — Welcome back, everyone. We are now on the 2013 report volume 1, chapter 20 of the Provincial Auditor's reports, and I will pass it off to the Acting Provincial Auditor for her remarks.

Ms. Ferguson: — Thank you very much. And I'm actually going to continue to move down the table, but just to mention that this report is focused on Regina Qu'Appelle Regional Health Authority and on surgical facilities there.

Mr. Ahmad: — Thank you, Judy. Chapter 20 begins on page 253 of the 2013 report volume 2, relating to efficient use of Regina Qu'Appelle Health Authority's surgical facilities. Madam Chair, members, effective and efficient use of surgical facilities is vital for providing timely surgical services to patients and help reduce wait times.

The utilization of surgical facilities depends on the availability of surgeons, health staff, anesthesiologists, specialized surgical equipment, and in-patient beds. Determining the capacity available, planning for the effective use of that capacity, and appropriate scheduling are crucial to effectively utilizing the resources and address longer-than-targeted wait times.

Monitoring and analyzing the actual usage compared to planned usage of surgical facilities can help identify and address reasons that may inhibit the efficient use of existing facilities and where and when more resources may be needed.

We examined the effectiveness of the authority's processes to support the efficient use of surgical facilities for the period from March 1st, 2012 to February 28, 2013. We concluded that the authority did not have effective processes to do so. We made nine recommendations for the authority.

On page 263 we recommend the authority to establish and approve standards for the use of surgical facilities. We made this recommendation because the authority did not have a comprehensive and approved set of standards to manage the efficient use of surgical facilities. Such standards will help staff work consistently and provide a foundation for policies and procedures on providing surgeries and safe patient care.

On page 265 we recommend the authority to develop and approve clear policies and guidance for allocation of time and surgical facilities to physicians who provide surgical services and for scheduling time for individual patients. At the time of our audit, the authority used what it called business rules. We made these recommendations because although these rules provide some guidance, they did not provide comprehensive guidance for the use of surgical facilities. For example, they did not provide guidance to staff on optimum time usage, tracking required equipment, moving equipment in and out of the facility, coordination of surgical staff, communication with post-operative and housekeeping departments, or composing the daily slate. Also it did not have policy that set the rules, responsibilities, and composition of groups that allocate surgeries. Without clear policies and guidance, staff may not apply consistent criteria in allocating time and facilities for our surgeons.

On page 265 we recommend the authority to establish efficiency-focused performance measures and targets for assessing the use of surgical facilities. We made this recommendation because the authority had not determined the efficiency-based performance information it must collect. We provide examples of efficiency-based measures on top of page 266. Use of efficiency-focused measures would help it identify factors that need addressing for efficient use of facilities.

On page 267 we recommend the authority to work with surgeons to develop a standard surgical request form that surgeons must use. At the time of our audit, the authority used more than 10 different surgical, surgery request forms based on the preference of individual surgeons. Having one standardized form would improve the efficiency of the scheduling processes.

On page 269 we recommend the authority to establish formal processes for the composition, review, and approval of scheduling daily surgeries. We made this recommendation because this would help ensure desired coordination between all participating departments like pre-operative, surgical, post-operative, and housekeeping.

On page 270 we recommend the authority to implement a system to collect all needed information relating to the efficient use of surgical facilities and monitor their efficiency-focused information about the use of surgical facilities. We made this recommendation because, although the authority used the system for collection of information such as the length of surgery, start time, and delays . . . [inaudible] . . . it did not collect information on when and why surgery was cancelled. Collecting such information and analyzing and monitoring would be valuable in addressing the efficient use of surgical facilities.

Finally, on page 271 we recommend the authority to take timely action to address issues that negatively impact the efficient use of surgical facilities. We made this recommendation because, at

the time, the authority identified the actions needed to address issues but it did not properly implement the required action.

Now that concludes my overview. Thank you.

The Chair: — Thank you, Mr. Ahmad. Mr. Hendricks, do you have some comments?

Mr. Hendricks: — Yes. Just to begin with, Val Hunko, the vice-president of integrated health services, has joined me at the front from Regina Qu'Appelle. I also should introduce Brent Kitchens who is the director of the kaizen or surgical kaizen operations office. What I would start out by saying is when we undertook the surgical initiative, there were three pillars — sooner, safer, and smarter. And one of the things that our regions have been very successful at doing is looking at how surgical patients flow through the system. So I must commend Val and Brent and the entire region on the progress that they've made in achieving what have been some very challenging targets in surgical, or very close to achieving.

I would also just point out that what I am going to reference in terms of some of the improvements have been improvements using lean-based methodologies, including the introduction of standard work in certain processes. So it has helped us to address many of the issues that the auditor has raised.

So with respect to audit recommendation on page 263, that "We recommend that [the] . . . Regional Health Authority establish and improve standards for the use of surgical facilities," Regina Qu'Appelle has made considerable progress on this recommendation by implementing standard work in regards to operating room business rules and booking processes. Standard work has been implemented in the areas of operating room scheduling, ophthalmology, and plastic surgery, and additional work will be implemented over 2014-15. So we believe that we are well under progress on this particular recommendation.

With respect to the recommendation on page 265, "We recommend that the Regina Qu'Appelle Regional Health Authority develop and approve clear policies and guidance for allocation of time and surgical facilities to physicians who provide surgical services," again progress has been made. The region has contracted with a third party to perform a review of the operating room allocation process and assist with the development of a new process. We expect that this will be ready for implementation by January of 2015.

With respect to the third recommendation on page 265, "We recommend that Regina Qu'Appelle Regional Health Authority develop and approve clear policies and guidance for scheduling [of surgical] time and surgical facilities for individual patients receiving surgical services," the region believes that they have implemented this recommendation by developing operating room scheduling, business rules, and procedures.

Four surgical program policies were developed: operation requirements for surgical bookings, notice for unfilled O.R. [operating room] time, deferral and cancellation of surgical patients, and reprioritization of surgical patients. Business rules were sent to all surgeons and their office personnel on June 2nd, 2014 and were effective on June 23rd, 2014.

The fourth auditor's recommendation on page 266, "We recommend that Regina Qu'Appelle Regional Health Authority establish efficiency-focused performance measures and targets for assessing the use of surgical facilities," again we believe this has been implemented. The region has implemented this recommendation by establishing annual, monthly, weekly, and daily targets to ensure surgical volume demands are being met. These targets are reviewed on a weekly basis at the surgical service line weekly wall walk held every Tuesday. So every Tuesday they actually visually are able to look at where they're tracking against this.

A value stream map has been developed for the surgical program to assist in understanding the flow of patients, materials, and information into a system of identifying opportunities for improvement.

The auditor's recommendation on page 267, no. 5, "We recommend that Regina Qu'Appelle Regional Health Authority work with surgeons to develop a standard surgical request form that surgeons must use," again this has been implemented. A standard form has been introduced in the region.

No. 6, "We recommend that Regina Qu'Appelle Regional Health Authority establish formal processes for the composition, review, and approval of scheduling daily surgeries," we believe this is implemented. The region has implemented this recommendation by developing and implementing standard work in the areas of operating room scheduling and, as I mentioned, ophthalmology and plastic surgery. Standard work has also been implemented in areas such as first in, first out scheduling, addressing multiple bookings, workstation organization, wait-list monitoring, and filing and maintenance of operating room forms and documents.

The seventh auditor's recommendation on page 270, "We recommend that Regina Qu'Appelle Regional Health Authority implement a system to collect all needed information relating to the efficient use of surgical . . . [services]," this one is still in progress. Regina Qu'Appelle is currently updating and improving its business processes in the ancillary services that provide daily support to the functioning of operating rooms. Improved integration and flow of information and supplies from ancillary services such as sterile processing and materials management must be and are being addressed before deployment of the surgical information system, before that will move forward. So we believe that's still in progress.

On page 270, auditor's recommendation no. 8, "We recommend that Regina Qu'Appelle Regional Health Authority monitor efficiency-focused information about the use of surgical facilities," the region has implemented this recommendation by the development of a spreadsheet to capture efficiency-focused information and has also developed a narrative as to the rationale. A narrative provides an explanation regarding the reasons for surgical cancellations.

On page 271, recommendation no. 9, "We recommend that Regina Qu'Appelle Regional Health Authority take timely action to address issues that negatively impact the efficient use of surgical facilities," the region is making progress on this one. A work placement assessment was performed by a third party and the region has implemented the recommendations. The

third party will do a follow-up on the work done in the fall and provide information on the improvements. So we should have something fairly quickly as to whether that has actually been achieved. And that concludes our review of the remarks.

The Chair: — Thank you, Mr. Hendricks. I'd like to open up the floor for questions. Mr. Wotherspoon.

Mr. Wotherspoon: — Thanks for the presentation and the comments and a lot of the work that's gone on in this very important area. Looking at recommendation no. 8, the recommendation around monitoring and analyzing the efficiency-focused information and the benefit that's been stated in doing so, could the deputy minister or officials speak to examples of what sort of information that is, or some examples of that sort of efficiency-focused information?

Ms. Hunko: — What we do at our weekly wall walk, and which we've started to do is starting to look at the reasons why we have cancellations is one clear . . . And we brought our stuff that we would have been talking about today, but I'm not there, and neither is Brent. So I did bring it along just to give some information.

So every week we meet at our wall and we follow a quality — a QCDSM, it's called. It's quality, cost, delivery, safety, and morale. So under those headings is where we have different strategies and targets that we're working towards. And we report on those on a weekly basis. And so as we're getting closer to our targets, to the three-month target, we start to look at the utilization and the efficiency of all operating rooms, and whether or not we have a lot of downtime, which we can have for certain reasons and we need to know why.

So for the week of September 1st to the 7th, we ran our data and we looked at the cancel reasons from both sites. And these are the two acute care sites that I'm talking about — so for the General and the Pasqua. And it could be a physician decision that the patient was cancelled. So something perhaps came up as part of the review they do prior to going into the operating room that they may have decided that the patient won't be having surgery. A patient decision: we do have patients who come and then decide at the very last minute that they aren't going to go through with the surgery.

We have rooms that run late, and oftentimes rooms run late for a variety of reasons and those . . . We track those reasons. So was it a late start or did a case go particularly long? So oftentimes you may have a surgery that was targeted for an hour and a half or two hours and ends up going longer because there was something happening through the surgery that perhaps the surgeon found and the patient needs to be in longer.

The patient is ill or unfit and oftentimes something happens again too. They may be waiting on the unit and so that cancellation could happen because they maybe aren't feeling well or their blood work is not right or something else has come up.

We also run out of time. So we may end up cancelling patients if we run out of time which very much relates to running late. But also again, we do have emergency categories of surgery. So we may have to bump a patient because something has come in through a trauma that needs to get into the operating room right away.

[16:00]

And then we also have equipment. Equipment is a fairly interesting piece of reason why we wouldn't . . . We have a lot of high-tech equipment that oftentimes, if we don't have it, we move things back and forth, or we may have used it and it's not available. That doesn't happen very often, but it's a good place for us to take a look at why our operating rooms would not be running at fully efficient services on a regular basis. So that's one of them.

We also track on a regular basis where we are at a target. So if we're not meeting our targets related to what we said we were going to be doing in terms of elective, which are in-patient and outpatient — we break our procedures down by that — we also see whether or not we've met that target. And for example, this week we were 20 patients over our in-patient target and 38 over in our . . . I'm sorry, 18 over in our outpatient. But we were also under in one of our third party sites. So we track all of that and look at the reasons why we perhaps aren't meeting those targets. Because we do, in order for us to meet the goals related to the provincial initiative, we need to understand what our daily work is supposed to be and on a weekly basis.

Mr. Wotherspoon: — Thanks for that information.

The Chair: — Do you have any questions right now, Mr. Wotherspoon?

Mr. Wotherspoon: — If others don't, yes, I have a couple others I wouldn't mind. Just when you're talking about the utilization of the surgical facilities, and obviously you're aiming to optimize those facilities, you've highlighted I guess some of these challenges here. Maybe these are the same. But what are the most significant factors that challenge optimal use of the surgical facilities?

Ms. Hunko: — It's the booking and making sure we get our bookings and our pre-bookings done and that we've done all . . . making sure that the patients who are ready to come in are available and fit to come in, that they've had their pre-teaching and all of those activities. Surgeon availability and making sure that we have got them all lined up and all of their equipment lined up. So part of the business rules that we've put in place is that we do like to get our information out to them as to the days of the week that they are working so that we can fill their time with particular patients.

Also making sure we have enough staff. One of the challenges that the region had a couple of years ago was not enough operating room staff. So even though we had large lists that we needed to get done, we weren't able to run all of our operating rooms. So we have 11 operating rooms at the General and we have eight fully functioning operating rooms at the Pasqua. And so making sure that we have the staff available to run those rooms and that our capacity in the rest of the region is not challenging those particular efficiencies, if you will, because if we don't have beds for our patients to go to, then we have to make sure that we're managing that.

So it's the flow through the system, on-time starts and all of those things and making sure we've got our anesthetists lined up, and if we do need another surgeon in the room. Some of these surgeries require up to two or three surgeons and so trying to organize that with their schedule and their practices is a challenge too. But our scheduling office has really developed some good working relationships with the different sections and so we have targeted those operating room schedulers to work with certain groups, if you will. So whether it's the plastic section or the general surgery or the orthopedics and making sure that we have a really good understanding of their availability and when they're going to be coming in as well too, or away because they do go away.

Mr. Wotherspoon: — Thanks for a bit of the broader perspective there. You mentioned the operating room staff and some challenges of a couple of years ago. Does that continue to be a challenge to some extent? And maybe just characterize that.

Ms. Hunko: — I think it's one of those things we have to monitor. We did lose a lot of staff out of our operating room for a variety of reasons and that was why we did the workplace assessment. Working in an operating room is a team effort so you need to have a really well-functioning team, so whether it's your surgeons with your nurses working together cohesively. And I think we've worked through a lot of that.

And having the visibility of the leadership out on the floor and finding out what the problems and the challenges are, particularly when you are trying to ramp up your surgeries. We've done more surgeries than we ever have done in the health region, and that puts additional pressure on a system and on the staff.

So part of the work that we need to do with recruiting is we did stabilize, through some of the training that we got through SIAST [Saskatchewan Institute of Applied Science and Technology], so we had certain spots held so that we could train operating room nurses. We did a lot of advertising, if you will, and going out and talking about what the opportunities were. But we have to monitor it because no sooner had we got our operating room, the actual operating room staff up and going, then our recovery room started to have challenges.

Now we've got a mixed population of nurses. We have the older nurses, which I might fall into that category if you will, who have worked for 25, 30, 35 years, so who are looking to transition out, and then a younger population coming in who are having children. And so it's maintaining that balance and making sure we have a good recruitment strategy and making sure we understand what the attrition is and how things are going to look in the next couple of years.

So we used a different . . . We worked with our union partners, particularly with SUN [Saskatchewan Union of Nurses] and also with CUPE [Canadian Union of Public Employees], and we put some strategies in place which we continue to use on a regular basis where we bring in nurses from . . . They're travel nurses. So they're Canadian nurses who come into our region who have experience working in the operating room or recovery rooms, and they can come in and within a week be up and working in that environment. So we have really benefited from that. And it's also been a good opportunity as well for other people to see that when you talk to these travel nurses, they bring a good perspective from across the country. And sometimes things aren't always as bad as they seem to be when you build that collegial relationship. So some really good positive work that's happened in there because of those strategies.

Mr. Wotherspoon: — Thank you.

Ms. Hunko: — Okay.

The Chair: — I'm curious — thank you for that — St. Paul's Hospital in the Saskatoon Health Region was experiencing some challenges this spring, and I know the health region has tried to rectify that. And that was around a shortage of O.R. nurses, and they've accelerated some O.R. nurse training positions. Have you done similar things here or are you covering off, it sounds like, with travel nurses?

Ms. Hunko: — We did, we put a program in. Now for recovery room, we were looking at an accelerated program, one that we could maybe go down in terms of saying you need to have three months of experience and training. So we worked with our department head of anesthesiology, and we talked about what the criteria was because usually if you're going to work in recovery room, you need some background in critical care or emergency, and so what were the key skills that we wanted too. So we worked on those things.

The operating room course that we have here in the city has met our needs in terms of making sure we have those nurses coming through on a regular basis. So that has met our needs with the operating room. So we may have one or two travel nurses in at a time, but it's when you run into a pinch — all of a sudden you have an exit of people for a variety of reasons — that the travel nurses would come. So some of the travel nurses actually worked in the O.R. and then moved over to the recovery room when we ran into that.

So I think there are lots of opportunities to work collaboratively, particularly with SIAST for example, with the program to look at ways that we can, you know, maybe not draw out some of the programming or get those people in a little bit sooner.

The Chair: — Mr. Wyatt.

Mr. Wyatt: — If I can just speak to that from a provincial perspective, when we set out on the surgical initiative back in 2009, SIAST was training and had funding from Advanced Ed to train 18 perioperative nurses each year. And that was clearly not going to be sufficient both to meet the growing volumes of surgery and also in situations like Regina where you had an existing shortage. And so we had dollars through the initiative that we used to double the number, bring that up to 36. I think we may have edged it up even further from that point. When an individual region has a particular challenge over and above what was available through even the doubled numbers, they'll sometimes broker training and work with SIAST directly to get additional numbers.

The one thing that we were quite happy, as we were winding

down the surgical initiative, was that those additional 18 seats that we had funded through Health, and were to double the number now, my understanding has been assumed by Advanced Ed. So it's become part of the standard SIAST program and funding level. And so we've been able to sustain that at a much higher level and it puts us in a much better position to respond to the turnover that occurs, as Val mentioned, through just kind of natural attrition. But also if you have a particular region that's in a problem spot, you can allocate seats to that region and help kind of meet their needs in a much better way than we could previously.

The Chair: — Thank you. With respect to the . . . Obviously the surgical initiative has been wound down, but with respect to the targets that had been set, I know RQHR had some challenges. I'm just wondering where you're at in September 2014 with respect to meeting some of those targets.

Ms. Hunko: — We're on goal to meet the target by March 31st, 2015, and we are well on our way to that target. I believe at this point in time we're about 300 cases above where we think we should be. But again it's the ongoing monitoring. And when you have issues that, you know, happen that you might not have any insight into, we had our SPD [sterile processing department], our central processing department went down because we had a flood. So you have to, you know, monitor that. That's why the weekly monitoring for us is a really good tool to make sure that we are meeting those targets, and if we aren't, we have to figure out a different strategy. So we are, we have said that we will meet our target by the end of March 31st.

The Chair: — Thank you for that.

Ms. Hunko: — Okay.

The Chair: — Are there further questions on any of these nine recommendations? Everyone is good. Well seeing no more questions, we do need to deal with nine recommendations, so I'm wondering what the wishes of the committee are. Again we have several that have been implemented and several that are in progress. So what are the wishes of the committee?

Mr. Merriman: — Madam Chair, if it's okay with the committee, I will just group the ones that have been implemented and then the ones that are in process.

So starting with, we'll do the recommendation and note progress towards compliance on recommendation no. 1, no. 2, and no. 7, no. 8, no. 9 . . . [inaudible interjection] . . . Oh sorry, I removed that from . . . so 7 and 9.

The Chair: — So, Mr. Merriman, your motion then.

Mr. Merriman: — Concur with the recommendation and note compliance for . . .

The Chair: — Or progress.

Mr. Merriman: — Sorry, note progress towards compliance.

The Chair: — Mr. Merriman has moved that for the 2013 report volume 1, chapter 20, recommendations no. 1, 2, 7, and 9, that this committee concur with the recommendations and note progress. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried.

Mr. Merriman: — Thank you, Madam Chair. And I will concur with the recommendations and note compliance on recommendation 5, 6, and 7.

The Chair: — No, 3, 4, 5, 6 and 8.

Mr. Merriman: — And 8, sorry. Got them confused or got them backwards: 3, 4, 5, 6, and 8.

The Chair: — Mr. Merriman, has moved that this committee, for the 2013 report volume 1, chapter 20, Mr. Merriman has moved that this committee concur with recommendation 3, 4, 5, 6, and 8 and note compliance. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Great. Carried. All right. Well I think that that's it for the officials from Health today. Thank you so much for your time; we appreciate that. And it's good to hear from you in terms of what's going on with the recommendations. So enjoy the rest of your day.

Mr. Hendricks: — Thank you.

[16:15]

Standing Committee on Public Accounts

The Chair: — Moving on to the 2012 report volume 2, chapter 55 and the 2013 report volume 2, chapter 52 for which there are no recommendations, but I will pass it over to the Acting Provincial Auditor for her comments.

Ms. Ferguson: — Thank you, Madam Chair, Deputy Chair, committee members and, I guess in this case, the only government officials are comptroller's office there.

So this afternoon I'm joined by Kim. As I indicated earlier, Kim's the office liaison for this committee here, and Kim's going to actually provide us with the overview of the two chapters that are before us. So I'm just going to turn it over to Kim.

Ms. Lowe: — All right. Thanks, Judy. The chapters before you this afternoon do not contain any recommendations. Rather, they provide your committee with an overview of your accomplishments and the status of the implementation of your committee's recommendations.

Your committee is very important. In our view, it's the audit committee for the Legislative Assembly. It plays a critical role in fostering an open, accountable, and transparent government and better management of government operations. Your work contributes to the government's implementation of a significant number of recommendations.

In your review of our work and recommendations, your

committee makes recommendations. Your committee includes its recommendations in its report to the Assembly. The committee's last report was the third report to the 26th legislature, which was tabled on September 6, 2011. That report included over 230 recommendations, including those where PAC concurred with our recommendations.

Your committee has asked our office to assess the government's compliance with its recommendations and to report on their status. We make this assessment as part of our examinations. We report the results of these assessments in either specific chapters or, where there's not a specific chapter for the related entity, in a table in the Public Accounts chapter, such as the table on page 365 of chapter 52 of our 2013 report volume 2.

Each year in the Public Accounts Committee chapter we provide you with the summary of these assessments. As set out in chapter 52 of our 2013 report volume 2, as of October 2013 the government has implemented 78 per cent or 421 of the 539 recommendations included in committee reports. As well, by this date the government has partially implemented another 18 per cent. That's 97 recommendations. These are recommendations up to and including the committee's last report to the Assembly. These percentages do not include recommendations that the committee has considered but not yet reported to the Assembly.

And that concludes my overview, and I'd be happy to answer any questions.

The Chair: — Thank you very much, Ms. Lowe. Are there questions from the committee members? Seeing no further discussion is needed, I would like to suggest that we conclude consideration of these chapters. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Okay. So consider 2012 report volume 2, chapter 55 and the 2013 report volume 2, chapter 52 that considerations are concluded. So with that, I need a motion to adjourn. Mr. Norris. All right. Adjourned. Are we in agreement?

Some Hon. Members: — Agreed.

The Chair: — Agreed. Okay, thank you. Adjourned.

[The committee adjourned at 16:18.]