PROVINCIAL AUDITOR
of Saskatchewan

2022 Report – Volume 1

Report of the Provincial Auditor to the Legislative Assembly of Saskatchewan

PROVINCIAL AUDITOR
of Saskatchewan

Vision:
A valued legislative audit office, advancing excellence and inspiring confidence in the public sector.

Mission:
Preserving independence, we promote accountability and better management of public resources.

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PROVINCIAL AUDITOR
of Saskatchewan

June 2022

The Honourable R. Weekes
Speaker of the Legislative Assembly
of Saskatchewan
Room 129, Legislative Building
Regina, SK S4S 0B3

Dear Honourable R. Weekes:

I have the honour of submitting my *2022 Report – Volume 1*, to be laid before the Legislative Assembly in accordance with the provisions of section 14.1 of *The Provincial Auditor Act*.

Respectfully yours,

T. Clemett

Tara Clemett, CPA, CA, CISA
Provincial Auditor

/mr

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The Provincial Auditor's Overview

1.0 PREAMBLE

The Office of the Provincial Auditor is the external, independent auditor of the Government. *The Provincial Auditor Act* makes us responsible for auditing the Government of Saskatchewan and approximately 260 agencies. **Appendix 1** lists each agency along with its year-end date, whether matters are reported, and, if so, in which Report.

Our Office's mission to promote accountability and better management of public resources, while preserving our independence, provides legislators and the public with an independent assessment of the Government's use of public resources. We do this through our audit work and publicly reported results, along with our mutual involvement with legislative committees charged with reviewing our Reports.

This *2022 Report – Volume 1* provides legislators and the public critical information on whether the Government issued reliable financial statements, used effective processes to administer programs and services, and complied with governing authorities. It includes the results of examinations of different agencies completed by May 4, 2022 with details on annual integrated and performance audits, as well as our follow-up work on previously issued recommendations by our Office and by the Standing Committees on Public Accounts and Crown and Central Agencies.

Section 2 of this Overview defines annual integrated, performance and follow-up audits, and highlights key findings of each section.

2.0 HIGHLIGHTS OF EACH SECTION

2.1 Annual Integrated Audits

Integrated audits are annual audits of agencies that examine:

- The effectiveness of their financial-related controls (e.g., processes to plan, evaluate, and coordinate financial activities) to safeguard public resources with which they are entrusted
- Their compliance with authorities governing their activities related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing
- The reliability of the financial statements (where applicable)

Since our *2021 Report – Volume 2*, our Office, along with appointed auditors (if in place), completed annual integrated audits of 58 different agencies with fiscal year-ends between July and December 2021.[1] These include integrated audits of 3 Crown corporations and agencies, 27 school divisions, and 18 pension and employee benefit plans.

This Section includes only new concerns with IT controls at certain school divisions. Prairie South School Division No. 210 and Northern Lights School Division No. 113 need to

[1] **Appendix 2** lists agencies using an appointed auditor. **Appendix** 1 outlines all agencies we examined with fiscal year-ends in 2021.

appropriately restrict user access to their financial systems. Appropriately restricting privileged user access reduces the risk of staff either obtaining inappropriate access or making improper transactions.

Also, 13 school divisions use a key financial IT system—managed by a third-party service provider—with identified system vulnerabilities that exposes them to increased cybersecurity risks. An opportunity exists for the Ministry of Education to work with the impacted school divisions not only to improve the monitoring of the IT system and the service provider, but also to mitigate identified risks and reduce cyber threats.

2.2 Performance Audits

Performance audits take a more in-depth look at processes related to the management of public resources or compliance with legislative authorities. Performance audits span various topics and government sectors. In selecting which areas to audit, we attempt to identify topics with the greatest financial, social, health, or environmental impact on Saskatchewan.

This Section of the Report includes the results of six non-financial, performance audits completed since our last Report (*2021 Report – Volume 2*).

Chapter 3: 3sHealth—Managing Disability Claims

What our Office examined:

3sHealth's management of disability claims for certain healthcare employees. At October 2021, there were about 40,000 healthcare employees from various healthcare organizations among the four disability income plans.

- **Disability claims increasing**: More than 3,600 disability claims between January and October 2021 compared to over 3,200 in 2020
- **Majority of claims accepted**: 128 claims (4%) denied between January and October 2021
- **Appeals on denied claims declining**: 22.7% appealed in 2021 compared to 49.3% appealed in 2019
- 68 appeals on denied claims in 2020, with 35 claim decisions overturned after appeal
- Claim decisions made within eight business days—over 80% of the time
- **80% of appeal decisions made later** than the expected 30 days

Why our Office examined this area:

A serious injury or illness can mean loss of income and future security, as well as emotional difficulties for an injured employee. The longer employees stay away from work with a disability, the less likely they are to return to employment.

3sHealth having effective processes to manage disability claims can help minimize delays in injured employees receiving appropriate financial support and treatment to improve their mental and physical health, and to return to work. 3sHealth receives about 250 disability benefit applications monthly.

What our Office found: Overall, 3sHealth has effective processes to manage disability claims, but needs to improve in a few areas.

3sHealth needs to:

- Submit claim applications to adjudicators in a timely manner (delays ranged from 4–11 days)
- Follow established timelines to complete appeal reviews (i.e., within 30 days) or document reasons for delays
- Centrally track and analyze complaints from disability plan members
- Enhance written reports to senior management and to the Board about disability claim management processes (e.g., reasons 8-day claim decision target missed, whether appeals reviewed within 30 days and if not, why not)

Chapter 7: Saskatchewan Workers' Compensation Board—Administering Psychological Injury Claims

What our Office examined: Workers' Compensation Board's processes to administer compensation claims for psychological injury.

Why our Office examined this area: Psychological or mental health issues are the number one cause of disability in Canada. Psychological injuries are often complex, and, as a claim, generally more difficult to administer and frequently require more judgment than some other injuries.

WCB revised its compensation processes for psychological injuries in 2016 due to changes in its Act that defines rules regarding psychological injury. The number of psychological claims and their costs continue to increase. The duration of psychological injury claims are often longer than for other types of injuries.

- A **traumatic event** is a single or series of events that arose out of or in the course of employment that may result in psychological injury
- **578 psychological injury claims** received and 238 accepted (41%) in 2021; corrections workers and paramedics have highest amount of accepted claims
- **Claim decisions not always made within 14 business days**
- About 50 appeals for psychological claims in 2021, with six claim decisions overturned after the appeal
- Appeal decisions made within 30 days 80% of the time

What our Office found: WCB communicates requirements necessary to apply for psychological injury compensation benefits and to submit appeals. WCB maintains clear policies and procedures to guide the adjudication of psychological injury claims, except it needs to enhance its guidance in certain areas, and follow its procedures in other areas.

Workers' Compensation Board needs to:

- Regularly (every three weeks) communicate with psychological injury claimants
- Make timely (i.e., within 14 business days) psychological injury claim decisions—57% of the claims we tested did not meet the 14-day target
- Complete ongoing quality reviews for psychological injury claim and appeal files

- Set formal guidance on what key information is needed for appeals; what to communicate for appeal outcomes; and what claim information to release to employers for appeals

Effective processes to administer psychological injury claims minimizes delays in injured workers receiving appropriate support to improve their mental health, and return to work.

Chapter 5: Saskatchewan Health Authority—Buying Goods and Services

What our Office examined:

The Saskatchewan Health Authority's direct purchasing of goods and services over $5,000.

Why our Office examined this area:

Ineffective purchasing processes increase the risk of the Authority not selecting the most suitable supplier or receiving the best value. In addition, unfair, non-transparent, or biased purchases, whether perceived or real, could damage the Authority's reputation.

- Purchases over $75,000 go through a central purchasing department and get posted on the SaskTenders website
- **75% of public tenders did not have award details posted** on SaskTenders as required
- **34 out of 38 sole or single source purchases tested not justified**
- Delegation for signing authority not always followed (e.g., contracts, purchase orders)

What our Office found: The Authority needs a more centralized approach to purchasing goods and services to allow for appropriate storing of purchasing documents and to support better monitoring of staff's compliance with its purchasing policy. We found a number of areas where staff did not follow purchasing policies or the Authority could not provide purchasing support documentation.

The Saskatchewan Health Authority needs to:

- Follow its policies when purchasing goods or services over $5,000 through single or sole source purchasing methods, including when using credit cards.
- When tendering, consistently evaluate suppliers, obtain conflict of interest declarations from staff involved, and properly communicate supplier award decisions.
- Properly authorize the initiation of purchases and the resulting contracts with suppliers.
- Establish a process to assess and track supplier performance.

Chapter 6: Saskatchewan Liquor and Gaming Authority—Regulating Locally Manufactured Craft Alcohol

What our Office examined: Saskatchewan Liquor and Gaming Authority's regulation of the production and sale of locally manufactured craft alcohol.

Why our Office examined this area: Consumers are purchasing craft alcohol products more often with craft alcohol sales nearly doubling in 2020–21 compared to 2017–18. At November 2021, SLGA permitted 64 different craft alcohol producers in the province.

Effective regulation of craft alcohol production reduces the risk of the public consuming unsafe alcohol and alcohol inconsistent with labelling. As the regulator of beverage alcohol, SLGA must also treat craft alcohol producers consistently and fairly while ensuring it receives all and accurate production levy revenue.

- Producer permits expire after three years; four craft alcohol producers **operated without a valid permit**
- SLGA completed 10 inspections and 24 pre-permit inspections in 12 months (compared to 64 craft alcohol producers in total)
- Lab test results for each alcohol product line required every two years
- At November 2021, at least **43 craft alcohol product lines required lab test results** (some nine months late)

What our Office found: SLGA needs to increase its regulatory oversight of craft alcohol producers. SLGA needs to:

- Obtain craft alcohol quality assurance results (lab tests) every two years as expected
- Use a risk-based approach to inspect craft alcohol producers and high-risk manufacturing areas, and to determine inspection frequency; SLGA had not inspected one producer in the past three years
- Renew craft alcohol permits prior to expiry
- Perform reasonability assessments of craft alcohol producers' monthly sales and production information to confirm permit compliance and accurate production levies

Chapter 8: Sun West School Division No. 207— Supporting Students' Completion of Grades 10–12 Distance Education

What our Office examined:

Sun West School Division No. 207's processes to support students to complete Grades 10–12 distance education courses through its Distance Learning Centre. For the 2020–21 school year, the Centre taught over 3,900 courses to more than 2,100 Grades 10–12 students.

Why our Office examined this area:

Provincially, distance-education course registrations substantially increased in 2020–21 due to COVID-19. There were 13,000 Grades 10–12 students on average registered in distance education courses, which doubled (i.e., over 26,000) in 2021.

Sun West has the highest proportion of Grades 10–12 distance-education course registrations compared to the other individual distance education schools in the province. It is an entirely rural school division with no cities within its boundaries located in west central Saskatchewan with 42 schools including 18 Hutterite colony schools, and 24 others located in 19 different communities (e.g., Kindersley, Biggar).

Not having effective processes to support distance education students increases the likelihood of them not completing courses, which in turn may adversely affect graduation rates.

What our Office found: Sun West utilizes supports (e.g., orientation, course expectations, ongoing communication) to help students successfully complete distance education courses, but has a few areas to improve.

- Sun West has **2,100 students** in Grades 10–12 distance education courses
- **61% course completion rate** for all Sun West distance education students
- **31 staff** directly involved in online teaching
- Nine students tested did not receive phasing notification emails from teachers for inactivity, and did not complete their online course
- 60% of Sun West distance education students took only online courses (**no course completion target**); 23% took in-person and online (**90% course completion target compared to 76% actual course completion rate**)

Sun West needs to:

- Improve its IT system to help monitor the timeliness of grading coursework to identify those teachers who are critically behind in grading
- Follow its student inactivity phasing process to engage students who are behind in coursework, and to help increase successful course completion
- Implement a course development policy that includes frequency of course reviews and updates
- Establish a course completion-rate target for students learning solely online
- Analyze key information related to distance learning to identify trends, issues and improvements, and provide regular written reports to its Board
- Assess the need for ongoing, focused professional development for teachers educating students in a distance education environment

Chapter 4: Public Service Commission—Advancing Workplace Diversity and Inclusion in Ministries

What our Office examined:

The Public Service Commission's processes to advance workplace diversity and inclusion in ministries.

Why our Office examined this area:

The Public Service Commission is the central human resource agency for 17 government ministries—over 11,000 employees work across these ministries. In 2020–21, the Commission had 300 full-time equivalent positions and spent $33.2 million.

The Commission works closely with all ministries to support workplace diversity and inclusion, which can lead to greater innovation, employee retention and productivity, and ability to meet client needs.

- **Workplace diversity and inclusion** means taking steps to try to represent all people at all levels in the workforce
- Percentage of ministry **employees who report as disabled, Indigenous, or racialized are below the Commission's benchmarks**
- About 3.5% of ministry employees self-reported as disabled persons and 9.3% as Indigenous (Commission benchmarks are 22.2% and 14.0% respectively)

A 2018 report showed many Canadians continue to experience labour force participation far below other nations, and the gaps show no sign of closing. For example, Indigenous people, disabled people, and racialized people face significant challenges. Leaders who address workplace diversity and inclusion recognize inequities and bias, as well as disrespect and marginalization in the workplace, and strive to eliminate related barriers to both employment and great client service.

What our Office found: The Commission set up a framework for collaborating with ministries to develop and maintain diversity and inclusion policies, goals, and strategies. However, the Commission needs to improve its measuring and tracking of whether ministries meet their established diversity and inclusion goals and, if not meeting, support them in devising strategies and plans to advance diverse and inclusive workplaces.

The Commission needs to:

- Modernize its policies and guidance for ministry managers to include all key diversity and inclusion concepts; its Employment Equity Policy was last revised in August 2000.
- Monitor ministries' inclusion plans and progress reports. The Commission did not require, and therefore did not receive, 13 of 17 ministry diversity and inclusion plans for 2021-22 (nine ministries did not have finalized plans).
- Establish clear indicators, measure and analyze relevant data, and then report progress toward achieving cross-ministerial diversity and inclusion goals.

2.3 Follow-Up Audits

Follow-up audits assess the sufficiency of actions taken to address recommendations made in our past performance audits, and those made by the Standing Committees on Public Accounts and on Crown and Central Agencies from their review of our Reports.

Our Office systematically assesses the status of outstanding recommendations to determine whether agencies made recommended improvements. We do our first follow-up either two or three years after the initial audit, and every two or three years thereafter until the agency either implements the recommendations or we identify them as no longer relevant.

This Section of the Report includes the results of 19 follow-up audits.

Overall, agencies implemented less recommendations on an overall basis (42%) than our recent Report (*2021 Report – Volume 2*: 55%). The percentage of recommendations not implemented (at 18%) is similar to our past Report (*2021 Report – Volume 2*: 18%). The extent to which agencies implement recommendations demonstrates whether the recommendations reflect areas that are important to improve public sector management, and whether agencies act on them quick enough.

As evident from the table below, some agencies were successful in making substantive improvements in a relatively short period.

SGI implemented all four recommendations made in 2019 related to monitoring automated speed enforcement fines. SaskEnergy also implemented all three recommendations made

in 2020 around keeping existing transmission pipelines operating safely. We were also pleased to see SaskPower fully implemented five of the seven recommendations we first made in 2018 in regards to maintaining above-ground assets used to distribute electricity. SaskPower implemented a broader strategy for managing its distribution assets. Adopting this strategy is changing how employees complete maintenance work and how senior management makes key maintenance decisions.

There are some agencies that have further work to do.

Stemming from our original 2017 audit of MRI services in Regina, the Saskatchewan Health Authority has not yet formally assessed the quality of MRI services that radiologists provide, but is in the process of developing a peer-review program to do so. Such a process will help confirm whether a patient receives an appropriate diagnosis.

Workers' Compensation Board is also undertaking a significant claims transformation process initiative that it expects will result in better coordination of injured workers' return to work. The initiative anticipates increased standardization, communication, and monitoring and should be complete by December 2025.

The following table summarizes the results of the 19 follow-up audits. It sets out the status of recommendations by agency, grouped by initial and subsequent follow-ups.

Chapter Name	Related Report[A,B]	Status of Recommendations				
		Recommendations	Implemented	Partially Implemented	Not Implemented	No Longer Relevant
Initial Follow-Ups						
Energy and Resources—Auditing Producer Returns for Non-Renewable Resources	2019 V1	**5**	0	3	2	0
Financial and Consumer Affairs Authority—Regulating Motor Vehicle Dealers to Protect Consumers	2020 V1	**4**	2	1	1	0
Horizon School Division No. 205—Maintaining Facilities	2020 V1	**5**	1	4	0	0
Northern Lights School Division No. 113—Purchasing Goods and Services	2021 V1	**14**	0	8	6	0
SaskPower—Maintaining Above-Ground Assets Used to Distribute Electricity	2018 V2	**7**	5	2	0	0
Saskatchewan Government Insurance—Monitoring Automated Speed Enforcement Fines	2019 V1	**4**	4	0	0	0
Saskatchewan Health Authority—Preventing and Controlling Hospital-Acquired Infections in the Regina General and Pasqua Hospitals	2018 V2	**4**	0	2	2	0
Saskatoon School Division No. 13—Supporting Students with Intensive Needs	2018 V1	**11**	6	5	0	0
SaskEnergy—Keeping Existing Transmission Pipelines Operating Safely	2020 V1	**3**	3	0	0	0
Social Services—Monitoring Foster Families	2020 V1	**6**	2	4	0	0

Chapter Name	Related Report[A,B]	Status of Recommendations: Recommendations	Implemented	Partially Implemented	Not Implemented	No Longer Relevant
St. Paul's Roman Catholic Separate School Division No. 20—Adapting Technology for Learning in Elementary Schools	2019 V2	**6**	5	1	0	0
Initial Follow-Ups Subtotal		**69**	**28**	**30**	**11**	**0**
% of Initial Follow-Ups Subtotal			**41%**	**43%**	**16%**	**0%**
Subsequent Follow-Up Audits[C]						
Environment—Regulating Landfills	2013 V2 2015 V2 2018 V1 2020 V1	**2**	2	0	0	0
Health—Detecting Inappropriate Physician Payments	2017 V1 2020 V1	**2**	0	2	0	0
Modernizing Government Budgeting and Financial Reporting	2013—Special Report 2016 V1 2019 V1	**3**	1	0	2	0
Saskatchewan Government Insurance—Confirming Only Qualified Drivers Remain Licensed	2016 V1 2018 V1 2020 V1	**1**	1	0	0	0
Saskatchewan Health Authority—Delivering Accessible and Responsive Ground Ambulance Services in Southwest Saskatchewan	2016 V2 2019 V2	**6**	5	0	1	0
Saskatchewan Health Authority—Efficient Use of MRIs in Regina	2017 V1 2020 V1	**4**	1	3	0	0
Saskatchewan Health Authority—Medication Management in Long-Term Care Facilities in Kindersley and Surrounding Area	2014 V2 2017 V2 2020 V1	**2**	2	0	0	0
Saskatchewan Workers' Compensation Board—Coordinating Injured Workers' Return to Work	2016 V2 2019 V2	**6**	0	3	3	0
Subsequent Follow-Ups Subtotal		**26**	**12**	**8**	**6**	**0**
% of Subsequent Follow-Ups Subtotal			**46%**	**31%**	**23%**	**0%**
Overall Total		**95**	**40**	**38**	**17**	**0**
% of Overall Total			**42%**	**40%**	**18%**	**0%**

Source: Compiled by the Provincial Auditor of Saskatchewan.
[A] V—means Volume.
[B] The related Report reflects the report in which the Office first made the recommendation(s) (for initial follow-ups) and subsequent reports (for subsequent follow-ups).
[C] For subsequent follow-ups, the number of recommendations is the number of outstanding recommendations that remained not implemented after the previous follow-up audit.

3.0 ACKNOWLEDGEMENTS

Our Office always appreciates the cooperation from the staff and management of government agencies, along with their appointed auditors, in the completion of the work included in this Report. An extended thanks also to the various experts who shared their knowledge and advice.

We also appreciate the ongoing support of the all-party Standing Committees on Public Accounts and on Crown and Central Agencies, and acknowledge their dedication in helping to hold the Government to account. Our Office remains focused on serving the Legislative Assembly and the people of Saskatchewan.

As Provincial Auditor, I am honoured to lead the Office, and our team of professionals. I am truly proud of their diligence and commitment to quality work. Their unwavering professionalism helps us fulfill our mission—to promote accountability and better management by providing legislators and Saskatchewan residents with an independent assessment of the Government's use of public resources.

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4.0 About the Office of the Provincial Auditor

The Office of the Provincial Auditor is the external, independent auditor of the Government. *The Provincial Auditor Act* makes us responsible for auditing the Government of Saskatchewan and over 262 agencies.

Our Office promotes accountability and better management through our audit work and public reports along with our involvement with legislative committees charged with reviewing our Reports. We routinely examine the Government's administration of its programs and services.

Through *The Provincial Auditor Act*, the Provincial Auditor, the Office, and staff are independent from the Government.

Our Office uses Canadian professional auditing standards published by CPA Canada to conduct our audits. As required by the Act, the Provincial Auditor reports directly to the Legislative Assembly on the results of all examinations, and highlights matters that require the attention of legislators.

Our Office strives to complete audits of value to legislators and the public. This means selecting audit topics of importance and with higher risk, and sharing the results (whether positive or negative) within a reasonable time. We aim to complete larger and more complex audits within a year of their initiation.

In addition to our Reports on our audit work results, we give legislators two key accountability reports each year—a business and financial plan, and an annual report on operations. These describe the Office, including our purpose, accountability mechanisms, staffing, and key systems and practices. These reports are publicly available on our website, as well as further details about the Office of the Provincial Auditor at auditor.sk.ca.

Annual Integrated Audits

Chapter 1
School Divisions

1.0 Main Points

This chapter summarizes the results of the 2020–21 annual audits of the 27 school divisions. The 2020–21 financial statements of each school division are reliable, and each complied with authorities governing its activities related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.

School divisions had effective rules and procedures to safeguard public resources other than the following. We found 13 school divisions across the province use an IT system with identified system vulnerabilities, exposing them to increased cybersecurity risks. The Ministry of Education needs to work with the impacted school divisions to improve the school divisions' monitoring of the IT system and its service provider.

We also found Northern Lights and Prairie South need to appropriately restrict user access to their financial systems, and Prairie South needs to formally approve new user access to its financial system. In addition, Sun West requires an updated and tested IT disaster recovery plan. In 2020–21, Regina Public improved its financial-related controls by following its purchasing policy.

2.0 Introduction

Over 186,000 students attend more than 770 provincially funded schools each day.[1] *The Education Act, 1995,* and related regulations set out the roles and responsibilities of the Ministry of Education and Saskatchewan's 27 school divisions.

Elected Boards of Education (school boards), including the Conseil des Écoles Fransaskoises No. 310 (French language schools), are responsible for administering and managing provincially funded schools (i.e., public, separate, or French language). **Figure 1** provides the combined financial results of the 27 school divisions for 2019–20 and 2020–21.

Figure 1—School Divisions' Combined Financial Results

	2020–21	2019–20
	(in billions)	
Net Financial Assets[A]	$ 0.3	$ 0.3
Non-financial Assets[B]	2.3	2.3
Grants from the Ministry of Education	1.9	1.9
Other Revenue (e.g., property taxes, school generated funds)	0.5	0.3
Total Revenue	2.4	2.2
Total Expense	2.3	2.2
Annual Surplus (Deficit)	$ 0.1	$ 0.0

Source: Audited school division financial statements years ending August 31.
[A] Net financial assets are financial assets (e.g., cash, receivables) less liabilities (e.g., accounts payable, debt).
[B] Non-financial assets includes capital assets such as schools and busses.

[1] www.publications.saskatchewan.ca/#/products/103519 (25 January 2022); provincially funded schools do not include schools under the responsibility of First Nations or private schools.

3.0 AUDIT CONCLUSIONS

Our Office worked with appointed auditors to carry out the annual integrated audits of the school divisions. We followed the framework in the *Report of the Task Force on Roles, Responsibilities and Duties of Auditors*. See **Appendix 2** in this Report for the name of each school division and its appointed auditor.

In our opinion, for the year ended August 31, 2021, we found, in all material respects:

- **Each school division had effective rules and procedures to safeguard public resources except for the matters reported in Section 4.0**

- **Each school division complied with the following authorities governing its activities related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing:**

The Education Act, 1995
The Education Regulations, 2019
The School Division Administration Regulations
The Government Service Organizations (Provincial Sales Tax) Remission Regulations
The Education Property Tax Act
The Financial Administration Act, 1993 (section 38)
The Pension Benefits Act, 1992 (section 44)
The Pension Benefits Regulations, 1993 (section 38)
Pension Benefit Standards Regulations, 1985 (Canada) (sections 9[1], 11[1])

- **The financial statements of each school division are reliable**

We used standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (including CSAE 3001 and 3531) to conduct our audit. We used the control framework included in COSO's *Internal Control—Integrated Framework* to make our judgments about the effectiveness of each school division's controls. The control framework defines control as comprising elements of an organization that, taken together, support people in the achievement of an organization's objectives.

As school divisions' expenses consist primarily of payroll and other goods and services, each audit included examining processes for preparing and processing payroll, and ordering, paying for, and receiving goods and services. Also, as each school division uses IT systems to operate, audits included examining school divisions' processes to safeguard financial-related IT systems and data.

4.0 KEY FINDINGS AND RECOMMENDATIONS BY AGENCY

4.1 Improved Monitoring of IT Service Provider Needed

School divisions are not adequately monitoring a key financial IT system and the related service provider. Thirteen school divisions across the province use a key financial IT system with identified system vulnerabilities, exposing them to increased cybersecurity risks.[2]

[2] Cybersecurity risks include risk of loss or theft of confidential information or damage/failure of an IT system. Common threats include ransomware, viruses, worms, spyware, and phishing attacks.

Audit testing performed at several school divisions identified a key IT system with outdated software. Outdated software increases the presence of security vulnerabilities, which makes agencies more susceptible to cyberattacks (e.g., theft of confidential information, ransomware attacks).[3] We found 13 school divisions across the province use this outdated software at August 2021.

A third-party service provider manages the IT system. School divisions remain responsible for managing risks associated with their IT systems and data. Better monitoring of the IT system and the service provider could help school divisions to identify risks (e.g., security vulnerabilities) and know when to work with the service provider to mitigate identified risks.

As almost half of the province's school divisions use this IT system and service provider, there is an opportunity for the Ministry of Education to work with the impacted school divisions to improve the monitoring of the IT system and the service provider (e.g., require standard security monitoring reports from the service provider). Obtaining the necessary information (e.g., end-of-support dates) from the service provider could help the Ministry and each school division to assess the risks to make effective decisions.

1. **We recommend the Ministry of Education work with impacted school divisions to establish a process to monitor the key financial IT system and the IT service provider.**

4.2 Northern Lights School Division No. 113—User Access Not Appropriately Restricted

Northern Lights School Division No. 113 has not appropriately restricted users' access to its financial system.

Audit testing found that some business users have privileged access (e.g., ability to grant user access and change their own user access) to the financial system. Good practice would assign the responsibility to change business user access to someone independent of financial processes.

Not appropriately restricting privileged access to the financial system increases the risk of staff obtaining inappropriate access (e.g., incompatible purchasing duties) to the financial system and making inappropriate transactions within the financial system.[4]

2. **We recommend Northern Lights School Division No. 113 appropriately restrict user access to its financial system.**

4.3 Prairie South School Division No. 210—User Access Not Appropriately Restricted or Approved

Prairie South School Division No. 210 has not appropriately restricted users' access to its financial system. Prairie South also does not have a process for approving and granting new user access to its financial system.

[3] Security vulnerabilities provide hackers the ability to exploit known data bugs or weaknesses to adversely affect programs, data, computers or a network.
[4] Incompatible purchasing duties include initiating purchases, receiving goods or services, approving invoices for payment, and adding suppliers to a financial system.

Audit testing found that some business users have privileged access (e.g., ability to grant user access and change their own user access) to the financial system. Good practice would assign the responsibility to change business user access to someone independent of financial processes.

Not appropriately restricting privileged access to the financial system increases the risk of staff obtaining inappropriate access and making inappropriate transactions.

3. **We recommend Prairie South School Division No. 210 appropriately restrict user access to its financial system.**

Prairie South does not formally document requests and approval for granting new user access to its financial system. Not maintaining documentation to support granting of user access could result in users having inappropriate access to the financial system.

4. **We recommend Prairie South School Division No. 210 document approval for granting new user access to its financial system.**

4.4 Sun West School Division No. 207—Disaster Recovery Plan Requires Updating

We recommended Sun West School Division No. 207 formally document its IT disaster recovery plan. (*2017 Report – Volume 1*, p. 22, Recommendation 2; Public Accounts Committee agreement June 12, 2018)

Status—Partially Implemented

In January 2019, Sun West School Division No. 207 finalized and approved a disaster recovery plan. However, as of August 2021, Sun West was in the process of significantly changing its IT infrastructure and services, and will need to update and test its disaster recovery plan.

Without an up-to-date and tested disaster recovery plan, Sun West does not know whether it could continue to deliver its programs and services if disruption or damage occurred to its key IT systems (e.g., accounting system, student data system). Regular testing of its disaster recovery plan would confirm the plan's effectiveness, relevance, and identify necessary updates.

5.0 Implemented Recommendation by School Division

Figure 2 sets out, by school division, each past recommendation and key actions taken during 2020–21 to implement it.

Figure 2—Implemented Recommendation by School Division

Past Recommendation (Initial PAS Report, Date of PAC Agreement)[A]	Key Actions Taken During 2020–21 to Implement Recommendations
Regina School Division No. 4	
We recommended Regina School Division No. 4 follow its purchasing policy for its Facilities Department contracts. (*2021 Report – Volume* 1, p. 43, Recommendation 1; Public Accounts Committee agreement January 12, 2022)	During 2020–21, Regina School Division publicly tendered purchases as required by its policy, and properly approved the resulting contracts.

[A] PAS: Provincial Auditor Saskatchewan PAC: Standing Committee on Public Accounts

Chapter 2
Summary of Implemented Recommendations

1.0 Main Points

This chapter lists agencies that implemented recommendations from previous annual integrated audits or IT audit work with no other significant findings included as a chapter in this Report.

2.0 Summary of Implemented Recommendation

The table below sets out, by agency, the recommendation as well as highlights key actions taken by the agency to implement its recommendation.

Past Recommendation (Initial PAS Report, Date of Agreement of PAC)[A]	Key Actions Taken During 2021–22 to Implement Recommendation
Saskatchewan Workers' Compensation Board	
We recommended the Saskatchewan Workers' Compensation Board follow its documented procedures for managing user access to its IT systems and data. (*2020 Report – Volume 1*, p. 40, Recommendation 1; Public Accounts Committee has not yet considered this recommendation as of May 4, 2022)	During 2021, for the sample of terminated users tested, WCB removed IT access on a timely basis and it performed periodic IT user access reviews to verify only legitimate users have appropriate IT access.

[A] PAS: Provincial Auditor of Saskatchewan
PAC: Standing Committee on Public Accounts

Performance Audits

Chapter 3
3sHealth—Managing Disability Claims

1.0 Main Points

Health Shared Services Saskatchewan (3sHealth) is responsible for administering four disability income plans for certain healthcare employees (e.g., working in hospitals or long-term care facilities) in Saskatchewan. 3sHealth staff assess and adjudicate disability claims, and may obtain advice from medical advisors to help guide adjudication decisions or from physicians to help interpret medical information and the appropriateness of treatment.

At October 31, 2021, our audit found 3sHealth had generally effective processes to manage disability claims for certain healthcare employees, but needs to improve its processes to address delays experienced by members.

3sHealth does not always process incoming disability benefit applications in a timely manner, which delays claims adjudication and resulting benefit payments. For about one-third of the applications we tested, staff submitted completed applications to adjudicators between four to 11 business days after the application completion date. Such delays place more stress on members waiting for decisions on their disability claims and impacts subsequent payment of benefits.

In addition, 3sHealth does not always make appeal decisions in a timely manner. Collective bargaining agreements provide members with the ability to appeal disability claim decisions. As set out in collective bargaining agreements, 3sHealth expects staff to review and make a decision regarding an appeal within 30 business days of receipt. Our data analysis found, during 2020 and 2021, 3sHealth made over 80% of its appeal decisions later than the expected 30 days.

Furthermore, 3sHealth needs to:

- Enhance its reports to senior management and the Board of Trustees to include all key performance information, analysis of results, and action plans to address issues
- Centrally track and analyze plan member complaints regarding disability benefit claims

Effective processes to manage disability claims can contribute to timely recovery of injured or ill employees. It helps minimize delays in employees receiving the appropriate support and treatment needed to improve their mental and physical health, and return to work.

2.0 Introduction

This chapter outlines results from our audit of Health Shared Services Saskatchewan's (3sHealth) processes to manage disability claims for certain healthcare employees for the 12-month period ending October 31, 2021. This audit did not question medical decisions of healthcare providers for the disability claims.

2.1 Managing Disability Claims

Through its service agreement with the Employee Benefit Plans' Board of Trustees, 3sHealth is responsible for administering four disability benefit plans for certain healthcare employees (i.e., plan members) in Saskatchewan.[1,2] For example, plan members include healthcare workers in hospitals, emergency services, and long-term care facilities across the province. At October 2021, there were 40,144 healthcare employees from various healthcare organizations among the four disability income plans (**See Figure 1**).

Figure 1—Number of Healthcare Employees in Each Disability Plan (October 2021)

	CUPE	SEIU–West	SUN	General	Total
Employee Members	11,789	10,605	9,745	8,005	**40,144**

Source: Adapted from information provided by 3sHealth.

The disability plans provide protection for members against loss of income due to injury or illness. Each plan is self-insured. Both employers and employees contribute to the plan in accordance with the respective collective bargaining agreements. The contributions and resulting investments fund the plan (see **Figure 2** for 2020 contributions).[3] The Employee Benefit Plans' Board of Trustees set the contribution rate annually for each plan.

Figure 2—Contributions and Surplus Position (in millions) by Disability Plan for 2020

	CUPE	SEIU–West	SUN	General	Total
Employee Contributions	$5.3	$4.3	$4.1	$3.2	**$16.9**
Employer Contributions	$5.3	$4.3	$4.8	$3.2	**$17.6**
Total Contributions	**$10.6**	**$8.6**	**$8.9**	**$6.4**	**$34.5**
Surplus	$49.4	$29.3	$40.0	$25.0	**$143.7**

Source: Adapted from 3sHealth Disability Income Plan Audited Financial Statements.

As shown in **Figure 3**, the number of disability claims for each plan has increased over the last four years. Claims for the first 10 months of 2021 already exceeded the total number of claims in 2020 with 34 and 23 diagnosed COVID-19 claims in 2021 and 2020 respectively.

Figure 3—Number of Disability Claims by Plan

Year	CUPE	SEIU–West	SUN	General	Total
2018	1,204	986	312	252	**2,754**
2019	1,438	1,096	340	238	**3,112**
2020	1,447	1,168	373	275	**3,263**
2021 (January–October)	1,348	1,640	371	292	**3,651**

Source: Adapted from information provided by 3sHealth.

With increasing claims, 3sHealth has also seen an increase in payments made to members (see **Figure 4**).

[1] 3sHealth's Board of Directors signed a formal trust agreement with the Employee Benefit Plans' Board of Trustees in January 2015 effectively making it the governing authority for the four disability plans.
[2] Disability benefit plans include Canadian Union of Public Employees (CUPE), Service Employees International Union–West (SEIU–West), the General Plan, and the Saskatchewan Union of Nurses (SUN).
[3] *Long-term Disability Plan Commentary*, p. 4 (CUPE, SEIU–West, SUN, General).

Figure 4—Disability Claim Payments from 2018 to 2021

	2018	2019	2020	2021 (January–October)
	(in millions)			
Disability Claim Payments	$36.6	$40.9	$47.9	$42.0

Source: Adapted from information provided by 3sHealth.

Depending upon the nature of the plan members' health, they may be able to return to work with modifications (e.g., return to work part-time or return full-time with different duties). For members needing modifications, 3sHealth along with the employee, employer, and health professionals work together to customize a suitable return to work program based on members' abilities.

In spring 2019, 3sHealth began work on a disability claims management redesign project called "Path to Health." The focus of this three-year project was to improve members' experiences through the disability claim lifecycle, align disability management processes with good practice, select a rehabilitation service provider, and look for options to replace the current claims management IT systems.

2.2 Importance of Effectively Managing Disability Claims

According to the Canadian Society of Professionals in Disability Management, at any given time, 8% to 12% of the workforce in Canada is off work due to injury, and receiving workers' compensation, long-term disability, or weekly compensation benefits. A serious injury or illness can mean loss of income and future security, which can create emotional, personal, and financial difficulties for the injured employee.[4]

The long-term effects of the COVID-19 pandemic on Canada's health workforce, including mental health, remain to be fully seen. Healthcare workers continue to provide care for patients despite exhaustion, personal risk of infection, fear of transmission to others, and the loss of patients and colleagues.[5]

Moreover, the longer individuals stay away from work with a disability, the less likely they are to return to employment. After one year of absence, only 20% of employees return to work.[6]

Effective processes to manage disability claims can contribute to timely recovery of injured or ill employees. It helps minimize delays in those employees receiving the appropriate support and treatment needed to improve their mental and physical health, and to return to work.

[4] The Canadian Society of Professionals in Disability Management is part of the International Association of Professionals in Disability Management, an organization overseeing the global certification process of two professional designations: Certified Return to Work Coordinators and Certified Disability Management Professionals. www.cspdm.ca/dm-in-context/impact-of-disability/ (21 September 2021).
[5] www.cihi.ca/en/health-workforce-in-canada-highlights-of-the-impact-of-covid-19/overview-impacts-of-covid-19-on (12 October 2021).
[6] The Canadian Society of Professionals in Disability Management, *Impact of Disability,* www.cspdm.ca/dm-in-context/impact-of-disability/ (21 September 2021).

3.0 AUDIT CONCLUSION

We concluded that, for the 12-month period ended October 31, 2021, Health Shared Services Saskatchewan (3sHealth) had, other than in the following areas, effective processes to manage disability claims for certain healthcare employees.

3sHealth needs to:

- **Provide complete disability benefit claim applications to adjudicators in a timely manner**
- **Follow its established timelines to complete disability claim appeal reviews and document reasons for significant delays**
- **Enhance its reports to senior management and the Board of Trustees to include all key performance information, analysis of results, and action plans to address issues**
- **Centrally track and analyze complaints regarding plan member disability benefit claims**

Figure 5—Audit Objective, Criteria, and Approach

Audit Objective:

The objective of this audit was to assess whether 3sHealth had effective processes to manage disability claims for certain healthcare employees for the 12-month period ending October 31, 2021.

Audit Criteria:

Processes to:

1. **Adjudicate disability claims and appeals**
   - Set policies and procedures for adjudicating disability claims and appeals, aligning with good practice
   - Communicate clear requirements for submitting disability claims and making appeals
   - Assess disability claims (e.g., use qualified, independent staff to assess eligibility)
   - Issue timely decisions (e.g., claims, benefits, with rationale)
   - Reassess disability claim decisions when requested by members (i.e., appeals)
2. **Administer disability claims**
   - Facilitate creation of members' recovery plans in collaboration with key partners (e.g., medical practitioners, employers)
   - Actively manage implementation of recovery plans (e.g., member check-ins, referrals to rehabilitative supports, gradual return to work)
   - Periodically reassess members' disability claims and benefits
3. **Monitor and report on claims managed**
   - Maintain quality assurance processes (e.g., claim file reviews, detecting fraudulent claims/inaccurate data, member surveys)
   - Analyze key information about disability claims management (e.g., timeliness of decisions, number of members returning to work, duration of claims, number of appeals)
   - Periodically report key information to senior management and Board of Trustees

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate 3sHealth's processes, we used the above criteria based on our related work, review of literature including reports of other auditors, and consultations with management. 3sHealth's management agreed with the above criteria.

We examined 3sHealth's policies and procedures relating to managing disability claims. We interviewed key staff responsible for adjudicating and managing disability claims. We tested a sample of declined and approved disability claims, including appeals, to assess whether staff followed 3sHealth's established processes for managing disability claims. We also conducted data analytics on the data in 3sHealth's IT system. In addition, we used an independent consultant with subject matter expertise in the area to help us identify good practice and assess 3sHealth's processes.

4.0 KEY FINDINGS AND RECOMMENDATIONS

4.1 Requirements for Disability Claims and Appeals Clearly Communicated

3sHealth makes plan members and employers aware of the requirements for submitting disability claims and making appeals through its website, booklets and welcome packages for members, and through newsletters.[7]

3sHealth uses its website to provide members with an overview of disability benefits (e.g., how to apply, what forms to complete), to answer frequently asked questions, and to direct members to booklets on each of the four disability income plans. We found the website easy to navigate in providing members with clear and sufficient information about applying for benefits and filing appeals if their application is denied or benefits are terminated (see more on appeals in **Section 4.7**).

The collective bargaining agreements between the unions and employers for each plan outline member eligibility for disability benefits. 3sHealth maintains members' booklets for each disability income plan and makes them publicly available on its website. We found the members' booklets provide clear and sufficient detail on each plan, for example:

- Plan details and eligibility for benefits (e.g., a member must be unable to perform their job duties due to illness or injury)
- How to apply for disability benefits, the forms to be submitted to 3sHealth (e.g., employee application, employer application, attending physician statement), and other supporting documents required (e.g., void cheque, medical test results)
- The adjudication process, noting that a 3sHealth adjudicator will review an application once the application is complete (i.e., all forms and supporting documentation have been received) and make a decision within eight business days
- Disability coverage and benefit information[8]
- How to request a review for a denied or terminated claim (i.e., the appeal process)

[7] www.3shealth.ca/employee-benefit-plans (7 February 2022).
[8] Members of CUPE and SEIU–West are eligible for short-term benefits that equals 66.66% of pre-disability regular weekly earnings to cover the first 119 days from the date of disability if members' sick leave does not cover that period. After the 119 days, CUPE and SEIU–West members receive long-term benefits equalling 60% of pre-disability regular monthly earnings. SUN and General members do not have short-term disability benefits. Members receive 75% of pre-disability regular monthly earnings after 119 days from the date of disability.

In addition, 3sHealth clearly requires members to apply to other disability programs, such as Workers' Compensation Board (for a workplace injury) and Saskatchewan Government Insurance (for a motor vehicle accident injury) prior to applying for benefits through 3sHealth.

3sHealth also provides (via mail) a welcome package to all new members. It includes such information as disability income plan eligibility, reference to 3sHealth's website for members' booklets, how to contact 3sHealth (e.g., email, phone numbers), and a brief overview of the various disability income benefits. We found the welcome package provides members with the necessary information to apply for disability benefits.

In addition, 3sHealth sends out an *Employee Benefit Plans* newsletter to its members twice a year. We found some newsletter topics related to processing disability claims (e.g., the goal to make a claim decision within eight business days of receiving a complete application) or success stories of members on disability benefits.

We also found that if changes to disability benefits terms (e.g., changes to the contribution rates for disability plans) or to 3sHealth's processes occur, 3sHealth provides an update to employers through ad hoc bulletins. In addition, it meets with employers monthly to discuss any questions or issues regarding disability benefits.

Providing all parties with clear, accessible, and understandable information about disability benefits, including how to apply, helps them know what to expect during the disability claim process.

4.2 Well-Defined Procedures to Adjudicate and Manage Claims

3sHealth maintains up-to-date, clear, and understandable standard procedures about adjudicating and managing disability claims.

3sHealth provides its staff with standard procedures for processing incoming applications, setting up members' information in the claims management IT systems, adjudicating claims, establishing a plan to manage a claim (e.g., routinely contact members, refer members to rehabilitation services such as psychology, physiotherapy), and handling appeals.

We found all procedures current (i.e., updated within the last two years), easy to understand, and accessible to staff (i.e., located on an the intranet). All work standards clearly outline staff roles and responsibilities, and provide clear decision-making structures.

We also found that procedures not only align with good practice, but also with terms set out in the collective bargaining agreements (e.g., necessary claim information, timelines for appeal decisions).

Having clearly written and up-to-date procedures helps 3sHealth communicate expected processes to staff responsible for adjudicating and managing disability claims.

4.3 Delays in Processing Incoming Applications

3sHealth does not always process incoming disability benefit applications on time, which delays the adjudication of claims.

A claim application for disability benefits is complete when 3sHealth receives both employee and employer applications, and an attending physician statement. See **Figure 6** for the information 3sHealth requires from each party to complete these forms.[9] 3sHealth makes these forms available on its website.[10]

Figure 6—Information Required to Complete a Disability Claim Application

Employee Initial Application	Employer Initial Application	Attending Physician Statement
• Plan member information (e.g., name, address) • Claim information (e.g., medical condition preventing member from working, nature of medical condition, expected date of return to work) • Other income received (including other benefits from SGI or WCB) during absence from work • Direct deposit information	• Plan member information • Payroll information (e.g., member's position, date member last worked, number of hours in a regular work week) • Additional information (e.g., return to work plan) • Employer information (e.g., payroll, attendance, and accommodations contacts) • Job description	• Plan member information • Diagnosis (e.g., primary diagnosis and its date, whether work-related) • Treatment/care plan (e.g., medication taken, hospitalization date(s), future plans) • Functional abilities (e.g., member's restrictions and limitations, expected return to work date or timeframe)

Source: Based on information provided by 3sHealth.

When 3sHealth receives a completed application, its benefit service officers set up a member profile in the claims management IT systems. The benefit service officers are required to contact members (via phone, letter, and/or email) the same day advising their application is complete and then submit it to an adjudicator to assess members' eligibility and coverage.

3sHealth receives about 250 disability benefit applications monthly. At October 2021, 3sHealth had 15 benefit service officer positions (including five temporary officers, one vacant position, and one officer on leave) to process applications, as well as other duties such as processing member enrolment forms and retirement requests.

For the 30 applications tested, we found the benefit service officers called and sent emails to members advising their application was complete. However, officers did not always make timely application submissions to the adjudicator, which caused delays in decision-making. For example, for 12 out of 30 applications tested, we found the delays in submitting completed applications to adjudicators ranged from four to 11 business days after application completion date (i.e., the day the last piece of the application was submitted). As a result, some members did not receive a claim decision up to 30 days later.

3sHealth management noted that such delays are due to the increased number of claims 3sHealth received in the last two years. As described in **Figure 3**, 3sHealth already received more disability claims in the first 10 months of 2021 (3,651 claims) compared to all claims in 2020 (3,263 claims) and 2019 (3,112 claims). Management indicated this is due to the ongoing impact of the COVID-19 pandemic on front-line healthcare workers (e.g., work-related demands on their physical and mental health).

[9] Forms can be submitted by email, mail, fax, or in person.
[10] Forms available at www.3shealth.ca/applying-for-disability-benefits (7 January 2022).

Delays in processing incoming applications cause further delays in adjudicating, which places more stress on members waiting for decisions on their disability claims and subsequent payment of benefits.

1. **We recommend Health Shared Services Saskatchewan send completed disability benefit claim applications to adjudicators on time.**

4.4 Qualified and Objective Personnel Adjudicate Disability Claims

3sHealth hires qualified personnel to assess and adjudicate disability claims, and it requires its staff to declare conflicts of interest.

The Employee Benefits Division at 3sHealth is responsible for managing disability claims and appeals. At October 2021, Claims Services had 19 positions: one claims manager, two claims services specialists, 12 adjudicators (two positions vacant and one adjudicator on leave), two rehabilitation advisors, and two mental health advisors (one position vacant).

Adjudicators use medical advisors (i.e., mental health advisors, rehabilitation advisors) as a source of advice for understanding medical conditions (e.g., multiple sclerosis' impact on a member's ability to perform their job) and helping to guide adjudication decisions. 3sHealth also uses physicians to help understand and interpret medical information, as well as to advise whether a plan member's treatment is appropriate.

3sHealth appropriately uses job descriptions to set out expected educational and experience requirements for its staff involved in adjudicating claims. It expects adjudicators to have at least five years of experience in disability claims adjudication. In addition, it expects the claims services specialists and manager to have three to six years of experience in benefit plan administration, insurance, or claims management.

We found the two adjudicators, two specialists, and the manager we tested had significantly more applicable experience than required. Further, we found all three medical advisors 3sHealth used for consultation had appropriate education and certification for their positions (e.g., mental health advisor is a psychiatric nurse), along with experience in rehabilitation.

3sHealth also contracts two physicians to provide consultations for adjudication and appeals. Both contracted physicians were licensed by the College of Physicians and Surgeons of Saskatchewan and in good standing as of November 2021.

Upon hiring, 3sHealth provides adjudicators with on-the-job training specific to their responsibilities (e.g., how to use 3sHealth's claims management IT systems). Medical advisors provide ad hoc training to adjudicators on topics of interest (e.g., rehabilitation after stroke) to deepen adjudicators' knowledge about different medical conditions and recovery expectations.

Between June 2020 and April 2021, 3sHealth offered its adjudicators in-house courses on nine different areas as set out in **Figure 7**. It expected adjudicators to take at least two courses. We found all adjudicators employed with 3sHealth at April 2021 took two or more of the offered courses. Throughout the remainder of the year, adjudicators received ad hoc training (e.g., stroke rehabilitation, functional capacity evaluations) from medical advisors.

Figure 7—3sHealth's In-House Courses Offered to Adjudicators

• Documentation • Communication skills for client-centred service • Time management and prioritization • Cultural sensitivity • Addictions	• Business writing skills • Supporting grief and loss • Different types of grief and loss • Self-care, wellness, and resilience

Source: Adapted from information provided by 3sHealth.

In addition, 3sHealth has a process for its staff to declare any conflicts of interest to ensure they remain objective when adjudicating claims. Each year, it requires staff to sign an annual code of conduct with a conflict of interest declaration. For two adjudicators and two medical advisors tested, we found each signed the code of conduct declaration, noting no conflicts of interest.

For claims where the assigned adjudicator or advisors know the plan member, they are to inform the claims specialists and remove themselves from the claim. In our testing of 30 disability claims, we found one instance where the medical advisor declared a conflict of interest and appropriately removed themselves from providing consultation on the claim.

Having qualified and trained staff to adjudicate claims helps ensure plan members receive a fair assessment of their eligibility and coverage for disability benefits. Moreover, objective staff reviewing and making decisions on claims reduces the risk of bias, either real or perceived, in making claim decisions.

4.5 Advice Sought and Rationale Documented for Disability Claim Decisions

3sHealth adjudicators seek input from medical advisors when needed and document claim decisions in members' files.

Using the forms submitted by both employees and employers, adjudicators make decisions about whether members are eligible and have coverage (e.g., a casual employee must have worked at least 390 hours in the first 26 weeks of employment).

Adjudicators primarily make a claim decision—whether to approve or deny an application—based on provided medical information (e.g., initial physician statement along with test results, reports) about the member's medical condition and its impact on the member's ability to perform their job duties. To be eligible for disability benefits, provided medical information must show that a member is unable to perform their job duties due to illness or injury (e.g., a care aide cannot perform their duties due to knee replacement surgery).

3sHealth received about 250 claims each month from November 2020 to October 2021. This means each adjudicator has to make a decision on about 28 new claims a month, as well as manage existing claims and appeals. As noted in **Section 4.4**, 3sHealth has three adjudicator vacancies as of October 2021.

Adjudicators may seek advice from claim specialists (e.g., if an adjudicator is unsure about a member's eligibility for disability benefits) or medical advisors, including contracted physicians. Such advice is necessary when adjudicators need more clarification

concerning a member's medical condition and/or recovery (e.g., plan member has a diagnosis like a rare blood disorder).

In our testing of 30 claims, we found adjudicators appropriately sought medical advice for eight applications; a rehabilitation advisor was consulted for two applications, a mental health advisor was consulted for four applications, but could not consult on one application because of a conflict of interest, and a contracted physician was consulted for one application. Medical consultations include discussions about prolonged recovery, treatment plans and specific medical conditions.[11]

3sHealth reported that the top four medical diagnosis for disability benefits claims in the last 2.5 years were:

- Musculoskeletal injuries (e.g., carpal tunnel syndrome)
- Mental or nervous disorders
- Neurological conditions
- Cancer

In addition, we noted the number of diagnosed COVID-19 claims in 2020 and 2021 was 23 and 34 claims respectively (about 1% of all claims in those years).

During our testing of 30 claims, we found adjudicators appropriately documented each decision—to approve or deny a claim—in members' files with rationale (e.g., evidence of adjudicator review of medical information and input from medical advisors). For the 30 claims tested, we found adjudicators approved 28 claims and denied two.

For both denied claims, adjudicators provided rationale for their decision in the file, sent a denial letter to each member outlining reasons for denial, as well as phoned each member to explain details of the claim denial (e.g., one claim denied due to the medical condition not being work-related).

For the 28 approved claims, we found:

- Adjudicators called members the same day they made their decision.
- All members received appropriate information (e.g., letter, paystub) outlining the decision, along with the duration and benefit amount the member will receive.
- All members had their benefits correctly calculated. For three members receiving benefits from another disability program (e.g., CPP, SGI), 3sHealth appropriately adjusted their benefits.

Seeking advice and documenting rationale for claim decisions helps ensure members' claims are consistently assessed and properly supported.

[11] We found on average, for the period November 2020 to October 2021, 3sHealth engaged two rehabilitation advisors in a review of medical information for about 35 claims each month. These advisors also provided consultation (e.g., answered adjudicators' questions) for about 20 claims each month. For the same period, 3sHealth used a mental health advisor for a review and consultation of about 15 claims each month. Adjudicators sought contracted physicians' advice for 47 claims in total for the same period.

4.6 Claims Decisions Monitored for Timeliness

3sHealth makes disability claim decisions within eight business days of receiving a completed application and monitors claim decisions taking longer than four business days (i.e., 3sHealth's internal target).

3sHealth, through various means (e.g., website, members' booklets, emails), makes members aware that adjudicators will make a decision on their claim within eight business days of receiving a complete application. Management indicated they communicate an eight-day timeframe to members, and adjudicators strive to make a decision within four business days of receiving a complete application. This is consistent with good practice.

As shown in **Figure 8**, for the 30 claims we tested, we found 3sHealth made a decision on 26 applications (87%) within eight business days.

Figure 8—Timelines for 30 Claim Decisions Tested

Number of Business Days to Decision From Complete Application	Number of Applications	Percentage of Claim Decisions Made on Complete Applications
Within 4 days	5	17%
Within 8 days[A]	26	87%
> 8 days	4	13%

Source: Based on our testing of plan member files.
[A] Applications decided within eight days also encompasses those applications decided within four days.

When adjudicators do not make a decision within eight business days, the delay is typically a result of waiting for additional medical information or needing to consult with a medical advisor. However, in one case, management indicated a misplaced manual application resulted in 3sHealth having no contact with the member for 52 days nor did the member contact 3sHealth about the delay. Once the file was found, the adjudicator requested additional medical information (which took 69 days to receive). The adjudicator did not make a decision until 144 days after receiving the complete application.

3sHealth is not meeting its internal target of providing a claim decision within four business days as it only made a claim decision on five applications tested (17%) within that timeframe. Management indicated delays are due to having three vacant adjudicator positions, along with 3sHealth receiving more disability claim applications than in past years (see **Figure 3**).

In addition, adjudicators are not always receiving completed applications in a timely manner, which caused delays in decision making (see **Section 4.3**).

At October 2021, our data analysis showed the caseload per adjudicator averaging, at that point in time, between 135 and 160 claims (i.e., processing new claims and managing existing claims). Management stated its goal is 120 claims per adjudicator which is marginally above good practice of 100 claims.

Each day, claims services specialists monitor the number of overdue claim decisions (i.e., exceeding four days). For example, on November 2, 2021, there were 10 overdue claim decisions. The claims services specialists noted they are responsible for managing adjudicator caseloads and discussing overdue claim decisions as needed.

We encourage 3sHealth to continue toward meeting its four-day target for making claim decisions once adjudicators receive completed applications. This will help ensure members do not wait extended periods of time, which causes undue stress while waiting for decisions and benefits.

4.7 Appropriate Appeal Process in Place

3sHealth has an adequate appeal process available to members who are dissatisfied with their disability claim decision.

3sHealth may deny a disability claim or terminate benefits for two main reasons:

- **Medical**: the disability plan does not support the member's disability as outlined in their medical information
- **Administrative**: pre-existing condition (i.e., health condition that a member had or received treatment for six months prior to joining the plan), late application, or no coverage (e.g., temporary employee who does not qualify for disability coverage)

A member dissatisfied with the adjudicator's decision has a right to request a review if they believe information is missing from the application, or if they believe the adjudicator incorrectly applied the plan's terms to their claim. As set out in the collective bargaining agreements, members can appeal 3sHealth's disability claim decisions.[12] Members have 60 days after the initial decision or termination of benefits to make an appeal. They can email or mail their request for appeal and provide additional information to 3sHealth (e.g., additional medical information such as exams and lab results).

There are three levels of appeal reviews available to members (see **Figure 9**).

Figure 9—Levels of Review for Appeals

Review Level	Performed By	Review Considers
First Level	3sHealth adjudicator and one claims specialist with a medical consultant available	Medical information and administrative terms such as late application or eligibility for plan membership
Second Level	3sHealth claims services manager with a medical consultant available	Medical information and administrative terms such as late application or eligibility for plan membership
Third Level (Final Adjudication)	External adjudicator (i.e., physician)	Medical information only

Source: Adapted from information provided by 3sHealth.

To complete its first and second appeal reviews, 3sHealth uses standard forms (i.e., one for medical appeals and another for administrative appeals) that document information such as claim details, appeal information, and recommendation (i.e., agree or disagree with the initial or termination decision). Claims specialists, medical advisors, and the claims service manager (if required) will review the forms and sign off on the decision. Once the decision is made, 3sHealth provides the member, as well as the employer, with the written appeal decision.

[12] 3sHealth does not receive appeals from employers as the main basis for appeals is medical information, and employers do not, and should not, have access to such information.

Once the two-stage, internal appeal process is complete, and 3sHealth denied or terminated the claim on medical grounds, a member can chose to proceed to an external, independent adjudication. The external adjudicator is a physician chosen by an External Appeal Committee, comprised of employers' and unions' representatives. External adjudicators sign a contract with 3sHealth outlining roles and responsibilities for completing appeals. For the period of November 2020 to October 2021, 3sHealth used three physicians to complete external adjudications.[13] We found all three external adjudicators were licensed physicians in good standing.

We found 3sHealth's appeal process and forms used for appeals align with good practice.

We tested six appeals and found:

- Members submitted five appeals within 60 days, as required. For one third-level appeal, the member did not submit the appeal until 282 days after the decision was made. However, 3sHealth granted multiple extensions on the appeal due to COVID-19 restrictions and the member's inability to see a medical specialist.
- Staff used the appropriate appeal form to document the member's medical information, appeal summary and recommendation, and the medical advisor's agreement with the decision for all first and second level appeals.
- 3sHealth staff engaged medical advisors when needed and appropriately forwarded the third-level appeal to an external adjudicator (i.e., physician).

As shown in **Figure 10**, our data analysis found a small number of claims are denied, and the number of first-level appeals (on denied claims) has been declining (22.7% appealed in 2021 compared to 49.3% appealed in 2019).

Figure 10—Number of Appeals Compared to Total Number of Claims

Year	Number of Claims	Denied Claims	First-Level Appeals	Percentage of First-Level Appeals on Denied Claims	Second-Level Appeals	Third-Level Appeals
2019	3,112	150	74	49.3%	24	9
2020	3,263	146	50	34.2%	8	10
2021 (January–October)	3,651	128	29	22.7%	0	2

Source: Adapted from information provided by 3sHealth.

We also found 3sHealth overturned (i.e., approved claim) about half of the first-level appeals in 2019 and 2020 (see **Figure 11**). In addition, we found 3sHealth overturned the majority of decisions during appeal review, mainly due to members providing new medical information (more than 98% for both first and second appeal levels).

[13] One contract expired in July 2021 and was not renewed.

Figure 11—Number of Overturned Claims Decisions

Year	First-Level Appeals Overturned	Percentage of First-Level Appeals Overturned	Second-Level Appeals Overturned	Percentage of Second-Level Appeals Overturned	Third-Level Appeals Overturned	Percentage of Third-Level Appeals Overturned
2019	36	49%	10	42%	4	44%
2020	29	58%	3	38%	3	30%
2021 (January–October)	5	17%	0	0%	1	50%

Source: Adapted from information provided by 3sHealth.

Having an appropriate appeal process increases members' confidence they will be treated fairly and that any errors in decisions will be rectified.

4.8 Appeals Not Always Decided in a Timely Manner

3sHealth does not always make appeal decisions in a timely manner; nor does it document rationale for not meeting expected timelines.

As set out in the collective bargaining agreements, 3sHealth expects staff to review and make a decision on all appeals within 30 business days of their receipt. It tracks all appeals in a spreadsheet, noting receipt dates, review completion dates, number of business days to assess appeals, and the appeal outcome.

As shown in **Figure 12**, our data analysis found 3sHealth does not make timely appeal decisions. For example, we found the average time to complete first and second level appeal reviews (i.e., to make a decision) in 2020 was 59 days and 49 days in 2021 (up to October) with over 80% of all appeal decisions made later than the expected 30 days.

Figure 12—Timeliness of First and Second Level Appeals

Year	First-Level Appeals	Second-Level Appeals	Number of Appeals Reviewed Longer Than 30 Days	Percentage of Appeals Reviewed Longer Than 30 Days	Average Time to Review Appeals (Days)	Maximum Number of Days to Review Appeals
2019	74	24	49	50%	31	86
2020	50	8	47	81%	59	164
2021[A]	29	0	25	86%	49	93
2021[B]	10	1	9	82%	60	121

Source: The Office of the Provincial Auditor based on 3sHealth records.
[A] Appeals completed between April and October 2021.
[B] Appeals not completed as of October 2021.

For third-level appeals completed by external adjudicators, it took 48 days on average to make appeal decisions in 2020 (for 10 appeals), while it took 23 days on average (for two appeals) in 2021.

Our testing of six appeals showed similar results. We found three appeals tested took longer than 30 days:

- 3sHealth completed two first-level appeals 51 and 56 business days after receipt of the appeal. 3sHealth did not document reasons for delays.

- An external adjudicator completed one third-level appeal 35 business days after receipt of the appeal and included rationale for the delay (i.e., waiting on specific information from the member).

Management indicated increased workload in processing more claims in 2020 and 2021, as well as adjudicator vacancies, as reasons for delays in reviewing first and second level appeals.

Without timely appeal review and decisions, members may not be receiving benefits on time, which may place undue stress on plan members. Without knowing why appeal decisions take longer than expected, management cannot address root causes of delays.

2. We recommend Health Shared Services Saskatchewan follow its established timelines to complete appeal reviews on disability claims and document reasons for significant delays.

In addition, we found 3sHealth reports the number of appeals received to senior management and the Board of Trustees, but it does not report on meeting its target to review appeals within 30 business days of receipt. Without reporting on the status of appeal decisions, senior management and the Board of Trustees may be unaware of potential issues with the appeal process and therefore may not take timely action to address issues. See **Recommendation 4** about enhancing reporting to senior management and the Board of Trustees.

4.9 Complaints Not Centrally Tracked or Analyzed

3sHealth does not centrally track the number, or specific nature, of complaints related to plan member disability benefit claims and subsequent resolution. This limits 3sHealth's ability to analyze complaints and adjust processes as necessary.

3sHealth does not have documented procedures on how to handle complaints (e.g., how quickly to respond). However, if a member has a complaint or inquiry, the member can contact 3sHealth (via phone or email). 3sHealth expects adjudicators to escalate complaints or inquiries through the IT systems to management (e.g., a claims specialist) who will contact the member to resolve the issue. Escalations can also include other internal matters (e.g., determining whether an application was late) where an adjudicator may need advice from the claims specialist.

3sHealth tracks all escalations to claims specialists in its IT system. However, it does not specify whether the escalation was a complaint, inquiry, or other internal matter. Between November 2020 and October 2021, 3sHealth escalated 49 items to claims specialists.

3sHealth does not centrally track the number, or specific nature, of complaints received. Rather, 3sHealth records the complaint, and the resolution, in members' files. As a result, 3sHealth could not provide us with the total number of complaints received in our audit period. We tested three complaints (identified by management in its IT system) and found that all three were appropriately resolved within three to eight business days. For example, a member complained about their adjudicator and requested a new one because of issues in reaching the assigned adjudicator. The claims specialist contacted the member to provide an update on the claim and determined the best way for the adjudicator to contact

the member (i.e., via email rather than phone). The complaint was resolved within three business days.

Without centrally tracking complaints, 3sHealth does not know the number and nature of complaints it receives. As such, it is unable to analyze complaint information to improve its disability claims management processes.

3. **We recommend Health Shared Services Saskatchewan centrally track and analyze complaints from plan members regarding disability benefit claims.**

4.10 Quality Assurance Processes in Place

3sHealth maintains quality assurance processes for administering and managing disability claims.

3sHealth has a quality assurance process to ensure all required information for a disability claim is maintained in a member's file. 3sHealth claims services specialists complete a claims management checklist on each claim file. Each area (i.e., administrative, benefit service officer, adjudicators, claims payment officer) is required to complete and sign off on the checklist when each step of managing a claim is complete. For example, the benefit service officer verifies all required documents (i.e., employee application, employer application, attending physician statement) are complete and recorded in the file. For the 30 claim files we tested, we found each file had a completed checklist signed by appropriate individuals.

In addition, 3sHealth's claims services specialists conduct monthly quality audits of claims (one claim per adjudicator per month—about 100 audits each year) based on pre-determined criteria (e.g., claims opened for more than 12 months). These audits help 3sHealth assess whether staff properly administer and manage claims. The claims services specialists discuss the audit results with adjudicators. The audits examine three areas:

- Technical: completion of adjudication procedure (e.g., decision call to member completed, member check-ins scheduled)
- Initial claim decision: accuracy of the initial adjudicatory decision (e.g., enough information in member file to approve a claim, potential barriers such as workplace issues, transportation, childcare identified and considered in the decision)
- Ongoing management: effective use of advisors or consultants, and appropriate review and update of ongoing claims (e.g., advisors engaged appropriately, external rehabilitation referrals process followed—see **Section 4.11**)

We tested four quality audits and found the claims services specialist appropriately completed the audit form and provided comments to adjudicators about areas for improvement.

3sHealth also tracks defects (e.g., an error impacting a plan member—such as an overpayment or privacy breach) found through quality assurance checklists and audits.

Staff will follow up on defects until resolved. 3sHealth tracks various information about defects such as member name, specific issue, impact (e.g., late payment), action taken to mitigate the defect, and the date resolved. Between January and October 2021, we determined 3sHealth had approximately 2.7 defects per month, with the majority being either a late payment under $1,000 or an overpayment. We found 3sHealth appropriately resolved the defects (e.g., EFT for late payment).

Effective processes to assess the quality of administering and managing claims brings confidence to 3sHealth management that its processes to properly manage claims in a timely manner are working as intended.

4.11 3sHealth Supports Development of Return to Work Plans

3sHealth has a supporting role in members' return to work plans. It maintains regular communication with plan members and their employers regarding return to work, refers members to its external rehabilitation partner if recovery is not progressing as planned, and adjusts members' disability benefits when a member is on a gradual return to work plan.

Typically, the employer (e.g., Saskatchewan Health Authority) works with a plan member to develop a return to work plan considering the member's limitations and restrictions, if any. Return to work plans are based on members' abilities to perform their job duties. Employers provide return to work plans to 3sHealth for inclusion in members' files. In cases when other agencies are involved (e.g., Workers' Compensation Board), 3sHealth only receives updates on return to work plans and progress.

Regular Communication with Plan Members

3sHealth has regular check-ins with a member based on their expected recovery plan. For example, 3sHealth will schedule a call with a member a few weeks after surgery to enquire whether recovery is as expected. If recovery takes longer than expected, 3sHealth requests medical information (e.g., doctor's note) indicating current treatment (e.g., physiotherapy) and expected length of recovery. Based on medical information provided, 3sHealth may extend benefits until the date noted in the medical support documents.

For the 28 approved claims we tested, we found 15 claims where 3sHealth extended the benefits beyond the initially approved timeframe. We found each of these 15 claims had appropriate and sufficient medical support for extending benefits. We also found documented support in members' files of 3sHealth staff regularly communicating (e.g., phone calls, emails) with members and their employers on their recovery and return to work progress.

For the other 13 out of 28 claims, we found limited communication with employers and members, as those claims were issued short-term and members were either already back to work or were participating in a return to work program (e.g., a member was off work for four weeks post-surgery and returned to full duties). We assessed this limited communication as reasonable in those instances.

In addition to regular contact with members, 3sHealth schedules 12- and 18-month check-ins with members on long-term disability to evaluate whether they continue to be eligible

for benefits (i.e., whether a member's medical condition continues to limit their job duties).[14] Of 28 approved claims we tested, 10 claims were long-term disability claims. We found 3sHealth followed its processes to have 12- and 18-month check-ins with its members for these 10 claims and modify return to work plans, if necessary.

As shown in **Figure 13**, the number of long-term claims paid each year is increasing.

Figure 13—Average Number of Long-Term Claims Paid Per Month by Disability Plan

Year	CUPE	SEIU–West	SUN	General	Total
2018	424	116	214	181	**935**
2019	484	132	232	185	**1,033**
2020	580	143	272	212	**1,207**
2021 (January–September)	655	257	281	222	**1,415**

Source: Adapted from information provided by 3sHealth.

3sHealth also tracks the duration of long-term disability claims. Claims with long-term disability duration impose a considerable burden on injured or ill workers and are costly to disability insurance coverage plans and employers. As shown in **Figure 14**, the average duration of long-term disability claims decreased from 2019 to 2020.

Figure 14—Average Duration of Long-Term Disability Claims (in months)

Year	CUPE	SEIU–West	SUN	General
2019	56.3	56.7	65.1	81.1
2020	53.1	53.9	64.3	75.6

Source: Adapted from information provided by 3sHealth.

External Rehabilitation Referrals

When a plan member's recovery is not progressing as expected, 3sHealth may refer the member to its external rehabilitation partner for functional assessment.[15] The external rehabilitation partner will provide a recommended treatment plan for 3sHealth's consideration, including specific assessments, treatment and/or therapies recommended, cost, and expected impact to the member.

If 3sHealth agrees with the recommended treatment plan, it contacts the member to discuss the plan. It will also notify the employer of the treatment plan and expected return to work.

In our testing of 28 approved claims, we found 3sHealth referred one claim to its external rehabilitation partner for further member assessment and treatment. We found evidence of 3sHealth discussing the treatment plan with the member. We also found evidence of 3sHealth contacting the employer to update them on the member's recovery and to enquire about whether they could provide any accommodations for the member (e.g., reduced or part-time duties to facilitate a gradual return to work).

[14] A member receives long-term disability benefits after 119 days of total disability.
[15] 3sHealth's contract with its external rehabilitation partner expires June 30, 2022.

Disability Benefits Adjusted Based on Earnings

A member may return to full or modified duties based on their abilities (e.g., part-time or gradual basis, modified duties). When a member is on a gradual return to work plan, the member may receive earnings from the employer for the hours worked. 3sHealth receives statements noting the hours worked and their pay. 3sHealth adjusts the member's disability benefits by the amount of earnings received from the employer.

Out of the 28 approved claims we tested, eight members participated in a gradual return to work program. We found 3sHealth correctly calculated and adjusted the disability benefits based on the additional earnings.

By providing a supportive role in return to work plans, 3sHealth helps support members recover from injury or illness and minimize delays in returning to work.

4.12 Most Key Performance Information Monitored, But More Analysis Needed

3Health reports most of its key performance information to senior management and the Board of Trustees, but could include more. The reports do not include written analysis.

3sHealth has two key performance measures related to disability claims that it reports monthly to senior management and quarterly to the Board of Trustees:

- Delivery: total number of disability claim applications processed within eight days with a 90% target. For the period of April 2020 to August 2021, 3sHealth reported it met its goal for 11 out of 17 months, results ranging from 84% to 95%.

- Quality: rate of disability claims' quality based on audits performed with a 97% target.[16] For the period of April 2020 to August 2021, 3sHealth reported that it met its target for 16 out of 17 months, results ranging from 95% to 100%.

In addition to key performance information reported, the Board also receives the following information at its quarterly meetings:

- Results of member surveys relating to the disability claims process (e.g., members' satisfaction regarding contact with 3sHealth, information received, overall satisfaction with process). From June 2019 to October 2021, there were 372 responses (out of approximately 40,000 members). Since starting the surveys in 2019, client satisfaction has remained consistent, with about 92% of clients satisfied with the disability claims process.

- Reports outlining emerging issues, service metrics (e.g., initial disability claims processed), and updates on the claims management redesign project (see **Section 4.13**).

- A claims activity report including information such as the total claim dollars paid quarterly and annually (per plan), total overpayments on a monthly basis for all

[16] Quality audits assess whether adjudicators assess and manage disability claims as expected (e.g., required information, file checklists).

disability plans combined, and overpayments by type (e.g., CPP, WCB). This report also provides details about the percentage of new claims denied on an annual basis along with the reasons for denial (e.g., ineligible medical condition, late application), and appeals in progress on a monthly basis.

- Reports of any suspicious activity by a member (e.g., earning additional income and not reporting to 3sHealth) as reported to 3sHealth by other members, employers, or other parties. We found there were no suspicious activities reported to the Board during the audit period.

However, as noted in **Section 4.8**, neither senior management nor the Board receive information on 3sHealth's performance target for appeals (i.e., making a decision within 30 business days of receiving the appeal). Good practice recommends reporting and analyzing such information.

3sHealth could further improve its reports to senior management and the Board by including written analysis of the results. For example, if 3sHealth is not meeting its delivery or quality targets, reports could explain why and any action required to address issues.

Having more information and analysis on its disability claims management process would allow senior management and the Board of Trustees to know whether the claims management process is working as intended, and adjust as needed.

4. **We recommend Health Shared Services Saskatchewan enhance its written reports to senior management and the Board of Trustees about its disability claims management processes.**

4.13 Disability Claims Management Redesign Project Underway

Following a review of its processes in 2018, 3sHealth began work in spring 2019 on a disability claims management redesign project called "Path to Health." The focus of this three-year project is to improve members' experience through the disability claim lifecycle, align disability management processes with good practice, select a rehabilitation service provider, and look for options to replace the current claims management IT systems.

As a result of this redesign project, 3sHealth hired medical advisors and increased communication with members (e.g., phone calls to discuss claim applications once applications are complete and outline expectations of the claims process). It also worked on developing standard procedures (e.g., claims case management checklist). 3sHealth is currently in the process of updating its IT systems, with implementation expected by March 31, 2022.

3sHealth reports to senior management and the Board of Trustees every two months and annually about its progress on the Path to Health project. This report includes performance metrics such as plan member satisfaction measured through member surveys, adjudicator quality scores measured through quality case audits, and time to decision. It also includes other statistical information such as adjudicator caseload, long-term disability recovery by diagnosis, and budget.

Having a plan to redesign its disability claims management processes helps 3sHealth ensure its processes reflect good practice to support members submitting disability claims.

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Chapter 4
Public Service Commission—Advancing Workplace Diversity and Inclusion in Ministries

1.0 Main Points

Workplace diversity and inclusion can lead to greater innovation, employee retention and productivity, and ability to meet client needs. Diversity recognizes each person is different and unique, which fosters a variety of skills, ideas, and experiences to help organizations meet their objectives. Inclusion is creating a workplace where every employee feels valued and a sense of belonging.

The Public Service Commission is responsible to coordinate the development and implementation of employment equity policies and programs in ministries, and develop a public service representative of Saskatchewan's diversity. We found the Commission had effective processes to advance workplace diversity and inclusion in ministries, except it needs to:

- Modernize the Employment Equity Policy and expand its inclusion toolkit (i.e., guidance for managers) to include all key diversity and inclusion concepts.
- Monitor ministries' inclusion plans and progress reports. This will allow the Commission to identify where to assist individual ministries with implementing effective actions for increasing diversity and inclusion in their workplaces, and determine changes needed to cross-ministerial inclusion strategies.
- Establish clear indicators (e.g., employment satisfaction scores by different demographic groups) to measure, and then report progress toward achieving cross-ministerial diversity and inclusion goals. This will promote transparency, show commitment, and help legislators and the public hold the Commission and ministries accountable for results.
- Conduct sufficient analysis of diversity and inclusion data to better assess progress toward cross-ministerial goals and plan further actions for building diverse and inclusive workplaces. As of September 2021, the percentage of employees in ministries who report as disabled, Indigenous, or racialized (e.g., someone who is non-Caucasian) are below the Commission's benchmarks.

One of the best ways to know if diversity and inclusion in ministries is improving is to measure and track it. Effective processes for advancing workplace diversity and inclusion can help ministries to better innovate, problem solve, and provide services to the public.

2.0 INTRODUCTION

The Public Service Commission is the central human resources agency for the Government of Saskatchewan. The Commission operates under the authority of *The Public Service Act, 1998*. As of January 2022, it provides human resources leadership and policy direction to 17 government ministries.[1] The Commission works with ministries on workforce management by supporting the delivery of foundational services such as payroll, staffing and classification, as well as strategic support including labour relations and organizational development.[2]

In 2020–21, the Commission had 300 full-time equivalent positions in offices in Regina, Saskatoon, and Prince Albert. For 2021–22, the Public Service Commission had a total budget of $34 million (2020–21 actual: $33.2 million).[3,4]

We audited the Commission's processes to advance workplace diversity and inclusion in ministries.

Diversity refers to all the ways each person is different and unique. These differences can include factors such as race, ethnicity, gender, and/or having a disability. Inclusion is how a person feels they belong. An inclusive workplace creates an environment where employees of every demographic feel safe, welcomed, and supported to succeed.[5]

Workplace diversity and inclusion means taking steps to try to represent all people at all levels in the workforce. It is designed to eliminate barriers faced by designated groups who are not employed in the same proportions in which they are available in the working age population (i.e., ages 15–74).[6] Designated groups include:

- Individuals reporting an Indigenous identity
- Members of a visible minority (e.g., racialized) group
- Individuals reporting a disability
- Women in underrepresented occupations (e.g., heavy equipment operator)

2.1 Public Service Commission's Role in Advancing Workplace Diversity and Inclusion

By law, the Public Service Commission is responsible for representing the public interest in human resource management in the public service, including in ministries. It is responsible for developing, establishing, and maintaining classification plans; conducting research on compensation and working conditions within the public service, including at

[1] Ministries include Advanced Education; Agriculture; Corrections, Policing and Public Safety; Education; Energy and Resources; Environment; Finance; Government Relations; Health; Highways; Immigration and Career Training; Justice and Attorney General; Labour Relations and Workplace Safety; Parks, Culture and Sport; SaskBuilds and Procurement; Social Services; and Trade and Export Development.
[2] *Public Service Commission Plan for 2021–22*, p. 3.
[3] *Public Service Commission Annual Report for 2020–21*, pp. 4 and 18.
[4] *Public Service Commission Plan for 2021–22*, p. 8.
[5] Public Service Commission, taskroom.sp.saskatchewan.ca/how-do-i/access-employee-information/workplace-diversity (22 February 2022).
[6] saskatchewanhumanrights.ca/2019-employment-equity-targets/ (28 February 2022).

ministries; and coordinating the development and implementation of employment equity policies and programs as described in *The Public Service Act, 1998*.[7] The Commission also strives to develop a public service representative of Saskatchewan's diversity.

The Commission's Talent Branch within the Centres of Excellence Division leads its work on advancing workplace diversity and inclusion. At January 2022, the Branch had about 25 employees, and is responsible for supporting the acquisition, engagement, and development of the public service, including in ministries, through strategic workforce planning, succession planning, as well as supporting sourcing, recruiting, selecting, and developing talent.[8]

The Commission works closely with ministries to support workplace diversity and inclusion. While the ministries are responsible for hiring and managing employees in ways that will achieve cross-ministerial diversity and inclusion goals, the Commission provides the policies and guidance to lead and support that work.

2.2 Importance of Diversity and Inclusion in Saskatchewan

A 2018 report showed many Canadians continue to experience labour force outcomes that are far below other nations, and the gaps show no sign of closing. For example, Indigenous peoples, disabled people, and racialized people face significant challenges. The report showed the workforce participation rate for Indigenous people was approximately 10% below that of non-Indigenous people.[9]

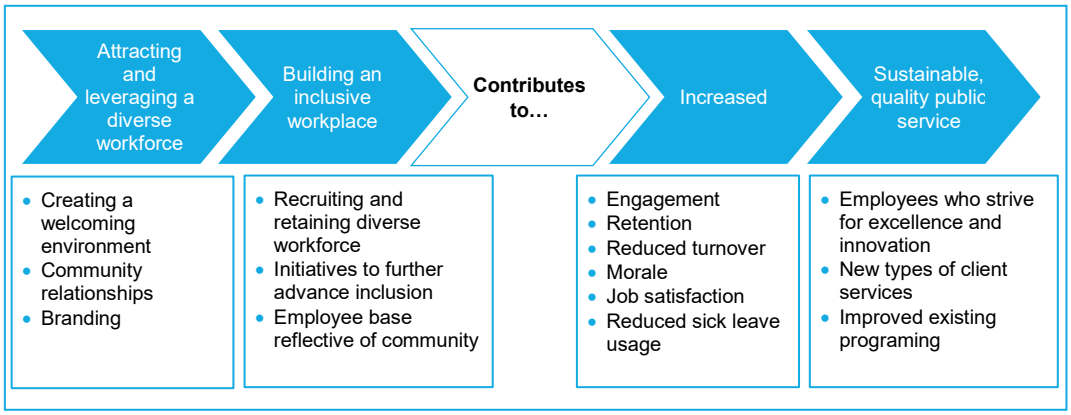
The report also showed disabled people face lower workforce participation rates. Only 48% of disabled individuals were employed compared to nearly 74% without disabilities. Many disabled people with jobs were uncomfortable disclosing information about their disability, with 27% of those interviewed indicating their employer was not aware of their work limitations.[10]

In addition, across Canada, vulnerable populations disproportionately felt the impact of the COVID-19 pandemic. These vulnerable populations include individuals from marginalized communities (e.g., racialized people, those with lower incomes).[11]

A diverse workforce provides a larger pool of skills, ideas, and experience enabling an organization to become more innovative in planning, problem solving, and in providing better services to clients. Organizations that value diversity and maintain an inclusive workplace culture may improve retention of workers with diverse backgrounds and enhance their loyalty. In turn, this may reduce costs associated with employee turnover, recoup training investments, and sustain institutional memory.[12] **Figure 1** shows how inclusion benefits ministries.

[7] *The Public Service Act, 1998*, s. 3(d), 11 (1) and (2).
[8] *Public Service Commission Annual Report for 2020–21*, p. 4.
[9] Deloitte. (2018). *Report on Outcomes over Optics—Building Inclusive Organizations*, p. 20. www2.deloitte.com/content/dam/Deloitte/ca/Documents/audit/ca-audit-abm-scotia-inclusion-outcomes-over-optics.pdf (28 February 2022).
[10] Ibid., p. 20.
[11] Vosburgh, Elizabeth (2021). *Developing an Equity, Diversity and Inclusion Program*, p. 1.
[12] International Labour Organization (2016). *Promoting Diversity and Inclusion through Workplace Adjustments – A Practical Guide*, p. 22.

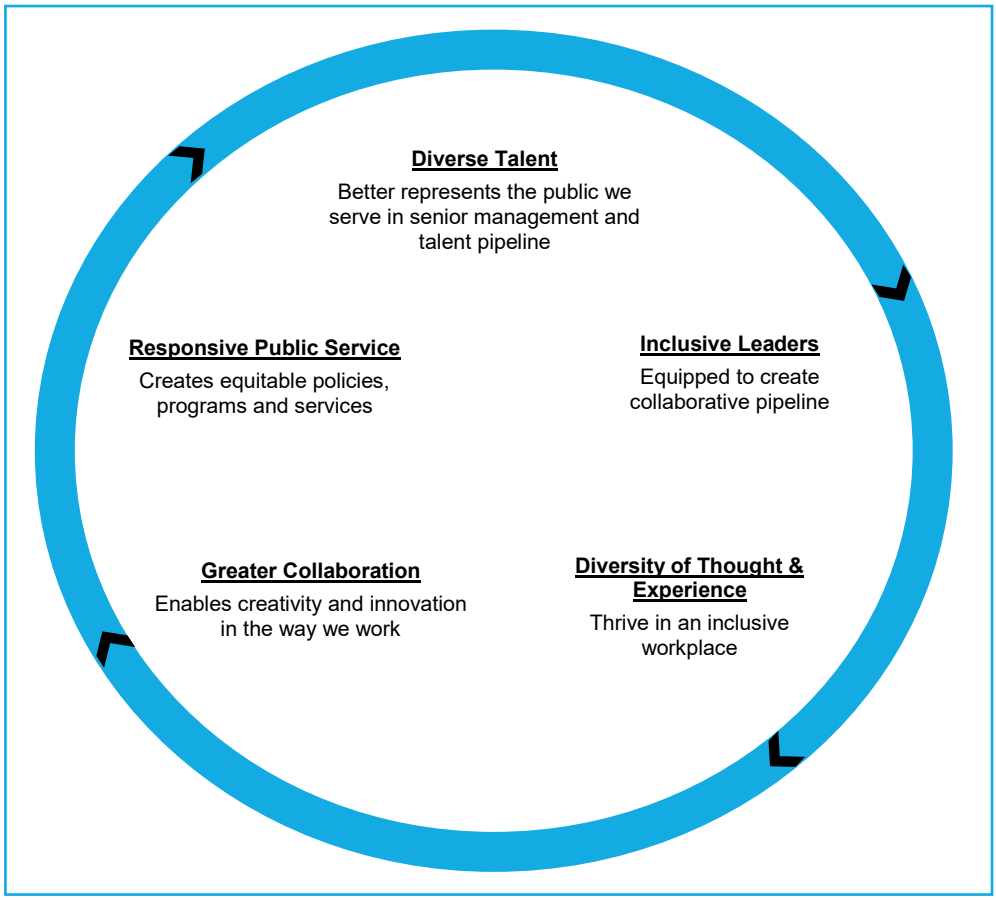
Figure 1—How Inclusion Benefits Ministries



Source: *Government of Saskatchewan Inclusion Strategy* (9 March 2022).

Leaders who engage in addressing workplace diversity and inclusion recognize inequities and bias, as well as disrespect and marginalization in the workplace. By addressing these issues through education, performance management, and formal programs, leaders will help foster the creation of a safe and accountable workplace culture that eliminates barriers to both employment and customer service. **Figure 2** shows how inclusion and diversity works.

Figure 2—How Inclusion and Diversity Works



Source: *Ontario Public Service – Inclusion and Diversity Blueprint.* www.ontario.ca/page/ops-inclusion-diversity-blueprint (9 March 2022).

Diversity brings creative and innovative thought, makes the workplace more dynamic, and leads to successful business results, as well as an engaged and productive workforce. Leveraging diversity and inclusion creates and supports more ideas, as well as meaningful relationships and partnerships with community groups, and builds value for the people the ministries serve.[13] As a large employer group of over 11,000 people, ministries require strong policy direction and guidance from the Commission to help them attract and retain a diverse workforce.

Without effective processes for advancing workplace diversity and inclusion in ministries, the Commission may not adequately support ministries' abilities to innovate, problem solve, and provide services to the public.[14] Further, this may also negatively affect certain individuals' ability to fully participate in the economy and may increase their reliance on publicly-funded social programs.

3.0 AUDIT CONCLUSION

We concluded, for the 12-month period ending January 31, 2022, the Public Service Commission had effective processes, except in the following areas, to advance workplace diversity and inclusion in ministries. The Public Service Commission needs to:

- **Modernize the Employment Equity Policy and expand its inclusion toolkit to consistently embed key diversity and inclusion concepts**
- **Establish clear indicators to measure and then report progress toward achieving cross-ministerial diversity and inclusion goals**
- **Monitor ministries' inclusion plans and progress reports to support ministries with implementing effective actions that increase diversity and inclusion in their workplaces**
- **Conduct sufficient analysis of diversity and inclusion data to assess progress, and plan further actions for building diverse and inclusive workplaces**

Figure 3—Audit Objective, Criteria, and Approach

Audit Objective: Assess the effectiveness of the Public Service Commission's processes, for the 12-month period ending January 31, 2022, to advance workplace diversity and inclusion in ministries.

Audit Criteria:

Processes to:

1. **Set a framework for workplace diversity and inclusion**
   - Set clear policies that support workplace diversity and inclusion (e.g., workforce planning, recruitment, education and awareness)
   - Establish cross-ministerial goals and strategies to advance workplace diversity and inclusion in collaboration with key partners (e.g., ministries, unions, community organizations)

[13] Public Service Commission (2021). *Government of Saskatchewan Inclusion Strategy*, p. 1.
[14] International Labour Organization (2016). *Promoting Diversity and Inclusion through Workplace Adjustments – A Practical Guide*, p. 22.

2. **Support strategies to advance diversity and inclusion**
   - Provide appropriate guidance and tools to support ministries (e.g., procedures, templates, training, working groups)
   - Oversee implementation of cross-ministerial diversity and inclusion strategies (e.g., timely monitoring, reviews, feedback, follow-up)
   - Address implementation issues (e.g., identified during oversight processes, complaints analysis)

3. **Monitor diversity and inclusion results achieved**
   - Periodically collect data related to workplace diversity and inclusion (e.g., labour force participation, employment recruitment and turnover, employee surveys, complaints, industry benchmarks)
   - Analyze data to assess progress toward goals and strategies (e.g., compare success of candidates to labour market representation, compare results to targets, identify root causes for shortfalls)
   - Adjust policies and strategies to address shortfalls
   - Communicate results to Commission senior management, ministries, and the public (e.g., actuals compared to targets, plans to address shortfalls)

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Public Service Commission's processes, we used the above criteria based on related work, reviews of literature, and consultations with Commission management and our audit consultant. The Commission's management agreed with the above criteria.

We examined the Commission's policies, procedures, research, and reports relating to advancing workplace diversity and inclusion in ministries. We also assessed training, inclusion work-plans, and meeting minutes. We interviewed key Commission staff responsible for workplace diversity and inclusion. We hired an external equity, diversity, and inclusion consultant to aid in the assessment of the Commission's policies, strategy, and guidance related to advancing workplace diversity and inclusion.

4.0 Key Findings and Recommendations

4.1 Sufficient Collaboration with Key Partners

The Public Service Commission collaborates, shares resources, and communicates effectively with ministries, diversity networks, post-secondary institutions, community-based organizations, and its counterparts in other Canadian jurisdictions about workplace diversity and inclusion.[15]

The Commission established cross-ministerial goals and strategies to advance workplace diversity and inclusion in the *Government of Saskatchewan Inclusion Strategy* and *2021–22 Government of Saskatchewan Inclusion Action Plan* (see **Figure 5** for further details). Key partners help the Commission to establish and maintain this Inclusion Strategy.

Within Saskatchewan, the Corporate Inclusion Community of Practice (ICoP) is a forum comprised of the Commission, ministry, and government agency members.[16] It meets bi-monthly for sharing, learning, and determining actions to support the work of embedding and creating an inclusive workplace culture within ministries. The forum also gives members the opportunity to provide input into key diversity and inclusion documents such as the Inclusion Strategy and annual Inclusion Action Plan.

[15] Diversity networks assist all employees with learning more about the workplace, growing their careers, and building connections to enable success. These networks include the Aboriginal Employees' Government Network, the Disability Support Network, the Pride Alliance Network, Engaging and Developing Government Employees network, and Saskatchewan Visible Minorities Employees' Association taskroom.sp.saskatchewan.ca/how-do-i/access-employee-programs/employee-networks (9 March 2022).

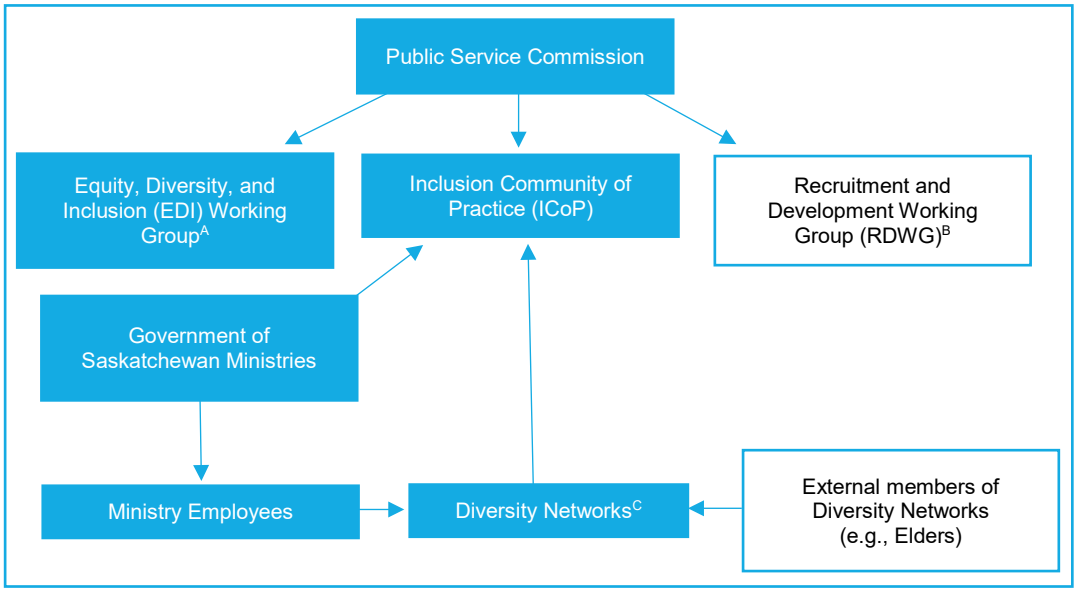
[16] The ICoP comprises the Commission, all 17 government ministries, Saskatchewan Public Safety Agency, Status of Women Office, and four diversity networks (Aboriginal Employees' Government Network, Disability Support Network, Pride Alliance Network, and Saskatchewan Visible Minorities Employees' Association).

Collaboration with post-secondary institutions and community-based organizations (e.g., open-door societies) during the year allows the Commission to identify further practices to support diversity and inclusion in ministries. For example, practices identified include educational programs that increase employment entry and advancement opportunities for underrepresented groups.

Furthermore, the Commission collaborates with other Canadian jurisdictions through monthly meetings of the Recruitment and Development Working Group (RDWG). The RDWG's purpose is to share information on strategies, practices, programs, and services for public sector recruitment, retention, and employee learning and development. It seeks to identify and facilitate access to information across jurisdictions and identify the common needs and opportunities for collaboration. These activities include developing common models, frameworks, and approaches. The Commission also participates in a number of RDWG sub-groups on specific diversity and inclusion topics, such as the Equity and Diversity and Inclusion in Talent Acquisition Working Group and the Inclusive Leadership Working Group.

Figure 4 shows the key working groups the Commission and ministries use to support the Inclusion Strategy. Across the working groups, the Commission included representation from all ministries, persons from all four designated groups, and external organizations or persons who are instrumental in developing and implementing the Inclusion Strategy.[17]

Figure 4—Key Working Groups Supporting Diversity and Inclusion in Ministries



Source: Adapted by the Provincial Auditor of Saskatchewan from the Commission's records.
* Blue shaded boxes indicate parties internal to the Government of Saskatchewan.
[A] The Equity, Diversity, and Inclusion (EDI) Working Group is the Public Service Commission's internal group that supports implementation of its Inclusion Strategy, and meets weekly.
[B] The Recruitment and Development Working Group (RDWG) includes representatives of the Government of Canada, provinces, and territories.
[C] Diversity networks assist all employees with learning more about the workplace, growing their careers, and building connections to enable success. The networks are made up of Commission and ministry employees and invited external representatives. ICoP includes representatives of the Aboriginal Employees' Government Network, the Disability Support Network, the Pride Alliance Network, and Saskatchewan Visible Minorities Employees' Association.

[17] The four designated groups include individuals who report an: Indigenous identity, racialized group identity, disability, and/or female gender who are in an underrepresented occupation.

The Commission uses insights from these different partners, leveraging their valuable knowledge and experience to obtain meaningful feedback on key diversity and inclusion strategies. The Commission uses the knowledge gained from these partners to inform its diversity and inclusion guidance for ministries.

Effective collaboration among key partners supports the Commission in developing and maintaining appropriate workplace diversity and inclusion policies, goals, and strategies for all ministries.

4.2 Employment Equity Policy Needs to be Modernized

The Employment Equity Policy developed by the Public Service Commission for use by ministries is outdated and does not contain sufficient and appropriate direction to support achievement of cross-ministerial diversity and inclusion goals set out by the Commission.

Under *The Public Service Act, 1998*, the Commission is responsible for setting policies relating to workplace diversity and inclusion for ministries. We found the Commission established an Employment Equity Policy and made it publicly available (including for all ministry employees) via its website. The Employment Equity Policy states its purpose is to improve representation of Aboriginal people, people with physical/mental disabilities, members of visible minority groups, and women in management and non-traditional occupations in the public service.[18]

The Commission last updated the Employment Equity Policy in August 2000. As a result, the policy does not sufficiently reflect content and language consistent with good practice.

We found the policy:

- Does not define workplace inclusion.
- Uses outdated definitions or terminology for designated groups (e.g., Aboriginal instead of Indigenous, visible minority groups instead of racialized groups, people with disabilities instead of disabled people, women in management and non-traditional occupations instead of women in underrepresented occupations, working age population defined as ages 15–65 instead of 15–74).[19]
- Does not define roles and responsibilities to set out clear expectations of the Commission or ministry management and employees for leading and demonstrating behaviours to create a diverse and inclusive workplace. For example, the policy states ministries are committed to an employment system that provides equality of opportunity and which leads to equality of results for individuals from the designated groups. However, the policy does not indicate any expectations of their management or employees to make this a reality.

[18] Public Service Commission, *Human Resource Manual: Section 1000—Employment Equity* taskroom.sp.saskatchewan.ca/how-do-i/access-the-human-resource-manual/section-1000-employment-equity#1001 (15 March 2022).
[19] Underrepresented occupations include management, skilled trades, and technical positions such as engineers or transport and heavy equipment operators.

We found certain other Canadian jurisdictions (e.g., Nova Scotia, Alberta, British Columbia) generally included these aspects in their policies. Commission management indicated it plans to update this policy in 2022–23.

Our review of other policies (e.g., Employment Accommodation Policy) in the Human Resource Manual maintained by the Commission found it considered diversity and inclusion aspects. However, these policies could be strengthened in certain evolving areas (e.g., protecting privacy of self-declared diversity information). In addition, once the Employment Equity Policy is modernized, these policies, along with the Inclusion Toolkit provided to managers in ministries (see **Section 4.5** for further details), should be reviewed for consistency and to further embed key diversity and inclusion concepts.

The absence of an up-to-date policy for diversity and inclusion increases the risk ministry managers and employees do not have clear direction and understanding of expectations to support an inclusive and diverse workplace culture, and outline equitable treatment for all ministry employees. This may result in individuals from underrepresented groups (e.g., disabled persons, racialized groups) receiving unequal access to, or even exclusion from, employment in ministries, as well as a lack of clear understanding around what accountability employees from underrepresented groups can expect from their managers and leaders.

1. **We recommend the Public Service Commission modernize the Employment Equity Policy to align with good practice.**

4.3 Appropriate Cross-Ministerial Goals and Strategies Established

The Public Service Commission collaborated with its key partners to establish appropriate cross-ministerial goals and strategies to advance workplace diversity and inclusion in ministries.

The Commission created the *Government of Saskatchewan Inclusion Strategy* in 2017 in collaboration with its key partners (e.g., ministries), and updated it in 2021. The Inclusion Strategy sets goals, themes, objectives, programs, and actions for workplace diversity and inclusion. The overall goals of the Inclusion Strategy are to create an inclusive workplace culture and to develop and implement a sustainable inclusion strategy which creates inclusive programs and services, served by a diverse workforce that meets the needs of ministries' growing and changing demographics.

The Commission worked with key partners through the Inclusion Community of Practice to leverage their knowledge and experience, and to gain support for the draft Inclusion Strategy before its finalization. The Inclusion Strategy included sufficient supporting details for key partner understanding (e.g., context around the need to be more diverse and inclusive to respond to Saskatchewan's growing diversity as indicated by changes in its demographic statistics for designated groups).

The Inclusion Strategy included the roles and responsibilities for ministry senior executives, management, all employee levels, and the Commission in delivering the Inclusion Strategy. For example, the Commission is responsible to ensure human resources policies, practices, and programs support an inclusive workplace, address barriers in employment

systems, build awareness training programs, incorporate current hiring trends and best practices on diversity and inclusion, and report on successes from the annual Inclusion Action Plan. Whereas senior executives of ministries are responsible for ensuring the integration of the Inclusion Strategy into ministry business plans and initiatives, as well as to identify inclusion targets for ministry reporting. All ministry employees are responsible for maintaining an inclusive, welcoming work environment, supporting employees who may be subject to disrespectful or discriminating behaviour, and sharing innovative solutions to address barriers to an inclusive workplace.

The Commission also works with its key partners to develop annual action plans (i.e., *2021–22 Government of Saskatchewan Inclusion Action Plan*) built around the four themes defined in the Inclusion Strategy (see **Figure 5**).

Figure 5—Ministry Inclusion Themes and 2021–22 Planned Actions

Themes	2021–22 Actions for Ministries	Performance Reporting by the Commission	Potential Performance Indicators Identified by PAS
Inspire accountability at all levels, starting at the top	Continue to embed and continuously improve the Inclusion Toolkit across the Government, with ministry collaboration and participation by including activities from the Toolkit within their individual plans[A]	Overall employment representation (%) by designated group – we found the Commission did not clearly set this out as an indicator; needs improvement	Employment satisfaction scores by designated group (e.g., overall satisfaction score via employee culture survey)
	Identify, analyze and understand from a corporate perspective current diversity and inclusion measures available within the Government		
Improve intercultural competence through awareness, education, and training	Consultation, approval, and launch of the Transgender Transition Guidelines	Completion of diversity and inclusion training – we found the Commission did not clearly set this out as an indicator; needs improvement	Increase in knowledge following training (e.g., increase in training survey scores before and after training)
	Review of Respect in the Workplace and Aboriginal Awareness training		
Enhance talent acquisition processes and tools	Execute on 2020–21 strategy for hiring students experiencing disability—Summer Student Program.	Number of disabled students hired compared to 2022–23 target	Number of self-declarations compared to those received in applications, and in prior years Hiring rates for designated diversity groups including students who become full-time hires after graduation Ministry satisfaction with processes and tools (e.g., survey) Time to advance into senior positions for designated groups compared to all employees
	Improvements to self-declaration definitions		
Create an inclusive and supportive workplace for all employees	Support Saskatchewan Accessibility Legislation and impacts (consultation in 2021–22)	Overall employment representation (%) by designated group – we found the Commission did not clearly set this out as an indicator; needs improvement	Employment inclusion related scores by designated group (e.g., scores via employee culture survey) Employment retention rates for designated groups Number of separations attributed to a non-inclusive or non-supportive workplace per exit interviews/surveys Complaints by designated groups (e.g., number received, % founded)

Source: Adapted by the Provincial Auditor of Saskatchewan (PAS) from *2021–22 Government of Saskatchewan Inclusion Action Plan* taskroom.sp.saskatchewan.ca /how-do-i/access-employee-information /workplace-diversity (14 December 2021).

[A] The Inclusion Toolkit provides tools, resources, best practices, and ideas to support ministry managers to build a diverse and inclusive workplace culture.

We found the 2021–22 Inclusion Action Plan included seven reasonable and appropriate, cross-ministerial planned actions (e.g., consultation, approval, and launch of the Gender Transition Guidelines). These actions aligned with the four themes outlined in the overall Inclusion Strategy. The Commission identified deadlines for expected completion of each planned action and determined who would lead the actions (e.g., the Commission or ministries). See **Recommendation 2** regarding the need for clear indicators for measuring progress.

We found Commission senior management appropriately approved both the Inclusion Strategy and annual Action Plan.

Active involvement of appropriate key partners in establishing cross-ministerial goals and strategies relating to diversity and inclusion fosters deeper trust and more commitment from employees.

4.4 Inclusion Strategy Needs Clear Indicators and Timeframe for Measuring Progress

The current Inclusion Strategy used by the Public Service Commission did not set out how the Commission planned to measure success of the Inclusion Strategy, or over what timeframe.

The Inclusion Strategy and annual Action Plan did not formally set out clear indicators and related targets for what success would look like relating to diversity and inclusion themes and actions (see **Figure 5**). While the Commission used the 2019 Saskatchewan Human Rights Commission (SHRC) targets as long-term benchmarks in internal briefing memos to the Commission senior management, it does not consider these as its own targets, nor has it set other long-term indicators and targets. We note several other Canadian jurisdictions, such as Canada, Ontario, and Nova Scotia, use labour force rates as indicators in their reports to the public.

The Commission and ministries' management set one short-term measure and target related to the cross-ministerial action around hiring disabled summer students (i.e., to identify 40 specific opportunities/positions for 2022–23). **Figure 6** shows the actual number of disabled summer students hired in 2021–22 was higher than the previous two years, and a target to increase this further has been set for 2022–23.

Figure 6—Disabled Summer Students Hired

	2022–23 Target	2021–22 Actual	2020–21 Actual	2019–20 Actual
Disabled summer students hired	40	21	7	18

Source: Public Service Commission human resources records.

The Commission had no other targets. For example, the Commission considers employment participation rates for designated groups compared to SHRC targets, but does not set these out in its plans as indicators of success. It also measures employees who take equity and inclusion awareness training, but does not formally set targets to determine whether it trained the optimum number of employees or whether employees learned anything.

The Commission could also consider other performance indicators as noted in **Figure 5**, such as comparing retention rates for the designated groups to the overall retention rate of all employees, the number of inclusion complaints that are founded compared to previous years, or results of its bi-annual employee surveys to look for improving trends in satisfaction of designated groups. The 2022–23 Inclusion Action Plan includes plans to develop performance indicators for diversity and inclusion.

Furthermore, the Inclusion Strategy did not set out a timeframe for completion (e.g., five years) to support periodic review of the Inclusion Strategy. Our discussions with Commission management confirmed that the Inclusion Strategy has a long-term time horizon, but no specific timeframe (e.g., end date) set.

The absence of clear indicators and timeframe for measuring progress of key diversity and inclusion strategies makes it difficult to hold the Commission and ministries accountable for results, and increases the risk the strategies may become outdated or unfulfilled. Clear indicators and timeframes also show ministry commitment to accelerate progress in workplace diversity and inclusion, and create more transparency.

2. **We recommend the Public Service Commission set clear indicators for measuring progress and a timeframe for its inclusion strategy.**

4.5 Expanded Inclusion Toolkit Needed to Support Inclusive Ministry Workplaces

During 2019, the Public Service Commission finalized and shared an Inclusion Toolkit with all ministries. The Toolkit provides tools, resources, good practices, and ideas to create a common understanding of diversity and inclusion to aid in building an inclusive culture in ministries' workplaces, although it requires further expansion to align with good practice.

The Commission developed a Toolkit to support ministry managers with embedding diversity and inclusion in their workplaces, and shared it with them in 2019 through its website. The Toolkit has four primary purposes:

- **Getting Started**: Build knowledge on diversity and inclusion
- **Acquire**: Build an inclusive workplace by attracting diverse, talented employees
- **Engage**: Connecting employees to teams, work and organization
- **Grow**: Support employees to innovate and grow in their careers

The Commission reviews and updates the Toolkit quarterly based on feedback from key partners, and shares updates with ministries. We found the Commission shared updates to the Toolkit with ministries in October 2021.

We found the content of the Toolkit contained some relevant and helpful information (e.g., certain key definitions, purpose, focus areas, educational and reference materials). For example, the Toolkit included tools such as videos, self-assessment worksheets, questions to support group discussions, and exercises on topics such as helping managers to be

equitable in processes to hire (e.g., post jobs, screen applicants, interview candidates) and retain (e.g., accommodate, plan work, evaluate performance) diverse employees.

The Toolkit also provides certain information to help managers understand their role in contributing to an inclusive environment by creating a discrimination and harassment-free environment, as well as to reframe their biases and understand the importance of self-declaration.

However, the Commission did not set a formal process to periodically (e.g., every two or three years) research good practice to identify more fulsome changes to the Toolkit. We found the Toolkit had insufficient content to reflect certain current issues and language related to diversity and inclusion. For example, the Toolkit lacked:

- A sufficiently detailed list of key terms and their definitions, such as for workplace equity, intersectionality, decolonization, anti-racism, anti-discrimination, and gender fluidity[20]
- Further case studies on bias to make the definitions more meaningful and memorable, and help employees find ways to disrupt bias
- Relevant content about accessibility and neurodiversity in the workplace to support accommodation practices[21]
- Further explicit Indigenous content and links to other high–quality, Indigenous-sourced materials
- Further content to support diverse hiring (e.g., examples of plain and accessible language in job descriptions, case studies to help identify biases when reviewing samples of Canadian-born and internationally-trained candidate resumes)
- Expanded content about how to create a safe and facilitated space (e.g., external facilitator) to practice and learn the skills and ideas in the toolkit (e.g., how to talk about current events such as uncovering of children's graves at residential schools or the ongoing impact of the COVID-19 pandemic)
- Content for building inclusive cultures in remote-work environments, and for when recruiting or working virtually

An expanded Toolkit reflecting evolving good practice can help the Commission provide managers and employees with adequate understanding and support to achieve cross-ministerial inclusion and diversity goals. Without sufficient content in the Inclusion Toolkit, ministries may be less inclusive and diverse than expected.

3. We recommend the Public Service Commission expand its inclusion toolkit to embed diversity and inclusion concepts consistent with good practice.

[20] Intersectionality is where multiple factors of advantage and disadvantage (e.g., gender, race, disability, sexuality, religion) combine to create discrimination or privilege.
[21] Neurodiversity refers to the range of differences in individual brain function and behavioural traits regarded as part of normal human variation, including attention deficit hyperactivity disorder (ADHD), autism spectrum disorder, and dyslexia.

4.6 Diversity and Inclusion Training Provided to Ministry Employees

The Public Service Commission provides cross-ministerial mandatory training courses relating to diversity and inclusion to ministry employees.

The Commission provided two cross-ministerial mandatory training courses relating to diversity and inclusion topics during 2021. 'Aboriginal Awareness' and 'Respect in the Workplace' are mandatory training courses for all ministry employees to attend at least once during their employment. The Aboriginal Awareness training includes terminology, demographic and socioeconomic issues, history including treaty negotiations, Indigenous rights and law, and Truth and Reconciliation. Respect in the Workplace training includes bullying, abuse, harassment, and discrimination.

The Commission selects qualified service providers to develop and deliver content for these two training courses.[22] To help it select the provider, it compares training content from multiple potential service providers against predefined objectives and expected coverage areas. It also considers past experience with potential service providers when renewing future contracts.

The Commission also offered additional optional training courses and resources to all ministry employees. These include courses such as:

- Inclusion and You
- Reframing Our Bias
- Disability Awareness
- Accommodating Employees

Commission employees develop and make these courses available to all ministry employees either as ongoing digital (e-learn) courses or periodically throughout the year for instructor-led courses. Employees can use the Commission's Learning Catalogue to find available times and to sign up for courses. Ministries may also help with instructor-led delivery in some cases.

We found the content of both the optional and mandatory training courses offered by the Commission was reasonable and provided appropriate educational opportunities for ministry employees on key diversity and inclusion topics.

Ministries track attendance at these courses within the Commission's human resources IT system. The Commission and individual ministries can run reports of employees who have taken the training and those who still need to be enrolled to monitor training completion. We found the number of employees taking the mandatory training for the period tested was reasonable compared to the number of employees hired in that period given most employees take this training within the year they are hired. Overall, between June and December 2021, about 700 employees took the in-person/virtual two-day Aboriginal Awareness training and nearly 1,800 employees took the 90-minute Respect in the Workplace webinar training.

[22] *Respect in the Workplace* training module is delivered virtually through a website on demand (i.e., webinar).

The Commission uses participant surveys taken before and after the course to evaluate the impact of each course. For example, surveys may ask employees to rate their awareness of key areas such as treaty negotiations, myths versus realities of Indigenous people's taxation, or ask whether they have seen or experienced harassment or discrimination in their workplaces. Increased positive responses after the training indicate the employees were better able to understand these areas, or recognize these situations after the training. Increased awareness and recognition increases the chance the employees will respond in inclusive ways in the future. This provides the Commission with information about whether overall employee awareness and knowledge increased as a result of the training.

Providing sufficient training tools to ministries that support diversity and inclusion helps employ these practices consistently across ministries. Training also helps increase the knowledge of ministry employees and build a workforce that supports and understands the importance of diversity and inclusion.

4.7 Inclusion Community of Practice Forum: A Valuable Resource to Share Inclusion and Diversity Ideas

The Public Service Commission used a forum called the Inclusion Community of Practice (ICoP) to effectively share, learn, and support the work of embedding and creating an inclusive workplace culture within ministries.

ICoP provides a community for all ministries and other key partners (e.g., recognized diversity networks) to learn and share tools, practices, ideas and resources. ICoP's terms of reference set out its objectives, meeting frequency, and members' roles and responsibilities. ICoP developed four primary goals (see **Figure 7**) and meets on a bi-monthly basis to discuss emerging and important inclusion and diversity topics.

Figure 7—Goals of the Inclusion Community of Practice

1. To be an education and sharing forum where members learn and share best practices, ideas, experiences and resources related to inclusion
2. To act as a liaison between ministry diversity and inclusion committees, and leverage each other's knowledge and resources
3. To identify the tools and resources that will help to create an inclusive workplace culture across the Government of Saskatchewan
4. To build the knowledge and capacity of ICoP members in inclusion development

Source: Inclusion Community of Practice Terms of Reference.

ICoP develops an annual Corporate Diversity and Inclusion Communications Plan to support ministry diversity and inclusion activities. The objectives of the 2021–22 Communications Plan were to:

- Support ICoP by providing content to distribute to its ministries (e.g., newsletter articles on inclusion topics or to highlight resources in the Inclusion Toolkit)
- Promote important inclusion awareness days (e.g., posters and promotional materials or links for Orange Shirt Day and Regina Pride Parade)

- Promote inclusion and diversity in the workplace by sharing stories from ministry employees (e.g., written or video interviews with employees)

- Support the employee diversity networks by sharing their content (e.g., article or resource links ministries could include in internal newsletters)

We found ICoP met every two months as expected. It shared sufficient materials on ICoP's dedicated internal website for all ICoP members to access. At each meeting, over 60 members discussed key diversity and inclusion topics and events. We noted ICoP gave all members the opportunity to collaborate and contribute during a roundtable discussion that took place at each meeting. The Commission used attendance at ICoP to know about ministry diversity and inclusion activities at a high-level.

Frequent, open, and transparent communication between the Commission and its key partners in ICoP provides a platform for meaningful discussion and educational opportunities for members. It also allows the Commission to informally follow some of the inclusion and diversity initiatives taking place across ministries to help the Commission assess progress toward cross-ministerial diversity and inclusion goals.

4.8 Ministry Inclusion Plans and Progress Reports Not Monitored by the Commission

The Public Service Commission does not require ministries to submit annual diversity and inclusion plans, or related progress reports. Also, the Commission does not provide regular feedback to support progress by individual ministries toward the cross-ministerial diversity and inclusion goals.

During 2021–22, the Commission did not require ministries to submit diversity and inclusion plans for its review. Furthermore, the Commission did not provide ministries with guidance such as templates to assist ministries with preparing such plans. Ministry diversity and inclusion plans set out actions each ministry plans to use during the year to contribute to the cross-ministerial annual Inclusion Action Plan and to develop a diverse and inclusive workplace. Given ministries hire their employees and create the environment where they work, these plans will help determine the success of the Inclusion Strategy.

We found the Commission received four plans from ministries during the year. We found an additional four ministries prepared a plan for the year, although they chose not to submit it to the Commission. The remaining nine ministries did not have finalized diversity and inclusion plans for 2021–22.

We found the four ministry plans we reviewed were a good start. For example, the plans included that ministries may hold lunch-and-learn days, share articles, or have a speaker present about topics such as treaty awareness or accommodating disabilities. All four plans could be improved by including content such as:

- Indicators or targets to define success (e.g., employment rate for designated groups, satisfaction and engagement rates by diversity group based on surveys)

- Risk mitigation strategies (e.g., additional training in ministries with low representation of certain designated groups to ensure an inclusive culture supporting retention)

- Critical success factors (e.g., sufficient ministry executive management support, appropriate and well-attended awareness training)

- Actions focused on the most underrepresented designated groups specific to the ministry (e.g., plans to work with universities and community-based organizations if insufficient candidates apply for positions [such as women in engineering])

Ministries also did not submit progress reports on actions taken during the year. Our review of ICoP minutes found the Commission was kept aware of ministry activities at a high-level through verbal roundtable updates, but these updates were insufficient in providing adequate support to ministries, or to enable monitoring of progress across ministries.

Without requiring, obtaining, and analyzing ministry diversity and inclusion plans and progress reports directly, the Commission may have inadequate information to monitor the overall strategic direction related to diversity and inclusion. As a result, the Commission cannot reliably monitor the effectiveness of diversity and inclusion initiatives across ministries and may not identify or offer additional support to ministries where challenges appear to exist. In addition, the Commission may not identify changes to the cross-ministerial Inclusion Strategy to help achieve the ministries' diversity and inclusion goals.

4. **We recommend the Public Service Commission monitor ministry diversity and inclusion plans and progress reports to help ministries increase diversity and inclusion in their workplaces.**

4.9 Data Collected About Persons in Designated Groups

The Public Service Commission collects data about employees who identify as one of the designated groups and summarizes workforce statistics about these various groups on a quarterly basis.

The Commission collects and summarizes data about four designated groups—individuals reporting an Indigenous identity, persons of a racialized group, individuals reporting a disability, and women in underrepresented occupations (e.g., senior management).

The Commission collects data about these designated groups based on ministry employees voluntarily self-declaring as an individual of one of these groups in the Commission's IT system when they are hired, or as updated during their employment. While the Commission did not formally document the risk associated with using self-declared information voluntarily submitted by ministry employees (e.g., someone belonging to a designated group chooses not to self-declare), it was apparent in our discussions that Commission management understood and accepted this risk.

The Commission prepares quarterly reports on key workforce diversity statistics based on the data in its IT system (e.g., percentage of women in senior management, percentage of Indigenous persons). The Commission independently verifies the accuracy of the reported statistics. We found the data was reasonably accurate and complete.

The Commission uses, as its benchmarks, the targets for working age population for designated groups set by the Saskatchewan Human Rights Commission (SHRC) in 2019 for comparison to actual workforce statistics. **Figure 8** provides a comparison of ministries' progress toward the SHRC targets set for the four designated groups. As shown, the percentage of women in management positions is meeting SHRC's targets, but the percentage of employees who report as disabled, Indigenous, or racialized are below the SHRC targets.

Figure 8—SHRC 2019 Targets Compared to Saskatchewan Ministry Results for 2019–20 to 2021–2022

Key Statistics Related to Diversity and Inclusion	SHRC 2019 Target [A]	Mid-year 2021–22 (September)[B]	2020–21 (March)[B]	2019–20 (March)[B]
Number of Employees [C]	n/a	11,373	11,051	10,651
% Indigenous persons	14.0	9.3	9.5	9.6
% Disabled persons	22.2	3.5	3.5	3.4
% Racialized persons	10.6	7.2	6.6	5.7
% Women in senior management	47.0	45.9	47.4	47.0
% Women in mid-management	47.0	56.4	56.1	55.2

Source: Public Service Commission human resource records.
[A] saskatchewanhumanrights.ca/2019-employment-equity-targets/ (2 March 2022).
[B] Public Service Commission records (9 November 2021).
[C] Number of employees represents the total of all ministries' permanent full time and part-time, labour service, and non-permanent employees.

The Commission also periodically (e.g., every two years) conducts ministry employee engagement and culture surveys. The survey asks a variety of specific questions, many of which have a particular diversity and inclusion component (e.g., diversity is valued in my ministry). The Commission summarizes the survey results by question and also groups them (e.g., by Indigenous, racialized, disabled, gender) to identify where answers from a specific diversity group may be below that of the ministries' averages as a whole.

We found results of the last culture survey conducted in December 2021 broken down into specific diversity groups for further analysis, as expected. We noted that generally results for some groups (e.g., disabled and non-binary persons) were notably lower than the ministries' overall averages.[23] Survey results may also help to explain lower employment participation rates for disabled persons shown in **Figure 8**. The Commission had not yet completed its analysis of the diversity and inclusion related survey results and planned focus group discussions as of January 2022 given employees completed the survey in December 2021.

Collecting reliable data allows the Commission to better understand the current workforce diversity and inclusion in ministries. Comparing results to SHRC benchmarks and previous results helps the Commission assess progress in ministries, including where they can make improvements. However, the Commission insufficiently analyzes the data to identify and address potential implementation issues (see **Section 4.10**).

[23] The Commission has not included non-binary persons as a designated group, but does consult with the Pride Alliance diversity network through ICoP to gain input from this community on the Inclusion Strategy. Non-binary relates to or being a person who identifies with or expresses a gender identity that is neither entirely male nor entirely female.

4.10 Insufficient Analysis to Identify Implementation Issues and Support Corrective Action

The Public Service Commission does not have routine processes, such as review of ministry inclusion plans and progress reports or robust data analytics, to identify and track system-wide issues relating to implementing diversity and inclusion initiatives. As a result, the Commission cannot adequately monitor whether ministries are addressing issues in a meaningful and productive manner.

The Commission uses an internal Equity, Diversity, and Inclusion (EDI) working group to discuss information learned at other working groups (e.g., ICoP, RDWG). We found the EDI working group met weekly as expected.

However, we found the meetings of this group and other working groups (e.g., ICoP) did not discuss or capture overall systemic gaps or system-wide implementation issues (i.e., consider all ministries). Commission management advised us each ministry is responsible for its own performance and the Commission does not actively oversee results from a cross-ministry perspective. As described in **Section 4.8**, the Commission does not review ministry inclusion plans and progress reports to sufficiently support and monitor achievement of cross-ministerial goals for diversity and inclusion.

The Commission also does not routinely analyze data that may indicate negative implementation trends. For example, the Commission did not analyze the reasons ministries are not achieving the Saskatchewan Human Rights Commission targets or reasons for trends (e.g., past three or five years) to determine whether the Inclusion Strategy and annual Inclusion Action Plan adequately address these issues.

In addition, the Commission advised us it has a process to handle complaints at an entity-wide level (i.e., all complaints and not just those specific to EDI issues). However, it does not analyze these complaints (e.g., trends in the number or severity of complaints) to help identify potential implementation issues. Nor does it routinely analyze hiring or retention rates of designated groups compared to overall cross-ministry rates or complete exit interviews to gather additional information that may indicate issues. Identifying potential hiring issues can lead to more analysis around language in job postings and in interview questions, processes to screen applicants, and processes to reduce biases in interviews and deciding to whom to offer jobs. Identifying potential retention issues along with information from exit interviews can be used to further determine additional training to develop appropriate inclusive attitudes in relevant ministry branches.

The Commission is in the process of replacing the ministries' main HR system, so it is critical the Commission identify key process and data needs, and use this opportunity to build these into the new system to support future analysis and reporting.

Without formal processes to analyze diversity and inclusion data, the Commission may not identify and address implementation risks that could prevent ministries from achieving cross-ministerial goals in a timely manner. As a result, the Commission may not effectively coordinate ministry actions for supporting diversity and inclusion goals.

5. **We recommend the Public Service Commission sufficiently analyze diversity and inclusion data to identify and address risks that may prevent ministries from achieving cross-ministerial diversity and inclusion goals.**

4.11 Public Reporting Needed to Show Accountability and Commitment

The Public Service Commission did not receive adequate reporting on diversity and inclusion results, nor did it sufficiently report to the public about such results.

The Commission had not documented what reports it requires, by when, and what type of analysis the reports should include. It also has not documented reporting it expects to provide to the public to demonstrate accountability for creating a diverse and inclusive workplace to best serve all the people of Saskatchewan.

As noted in **Section 4.9**, the Commission currently receives key diversity and inclusion statistics compared to Saskatchewan Human Rights Commission (SHRC) targets quarterly, but these reports do not explain differences between current results and the SHRC targets or changes from prior years (i.e., trends). The Commission shared these statistics with ministries via the Commission's Human Resource Business Partners.[24]

The Commission prepared bi-annual briefing notes communicating further information on the quarterly statistics for its senior management. In the reports, the Commission began to identify potential gaps and basic root causes for certain shortcomings, but neither analyzed the data to its fullest extent, nor conducted this gap analysis consistently across reports. We found that while the quality of analysis varied across these reports, the reports still provided some useful information to Commission senior management and were consistently prepared during 2021.

For example, the Commission prepared a report on summer student diversity hiring looking at positions posted and filled by persons who identified as one or more of the designated groups. The report identified root causes such as lack of connection with disabled students (i.e., need to bring jobs to students to help with awareness) and inadequately prepared workplaces to support and engage disabled students throughout their placements. The Commission used the analysis in this report to set a short-term target (40 disabled summer students) for 2022–23.

Furthermore, while the Commission reported internally against the 2019 SHRC targets, it did not consider these as its targets, nor has it set other long-term indicators and targets. In addition, the Commission had not set clear, meaningful, and actionable short and mid-range targets to help determine progress toward all of the cross-ministerial diversity and inclusion goals—see **Recommendation 2**.

Currently, the Commission does not report publicly (e.g., in its annual report) on the diversity and inclusion statistics. For example, it does not publicly report on the percentage of employees who self-declared for each designated group compared to the SHRC targets.

[24] Human Resource Business Partners are Commission employees assigned to support specific ministries with human resources functions.

The Commission reports publicly on the percentage of employees completing training and total percentage of employees who self-declared as an individual of a designated group.

Good practice suggests the Commission should publicly report additional meaningful indicators, such as progress toward SHRC targets, and trends in retention and survey satisfaction results of employees belonging to designated groups compared to all employees. Public reporting demonstrates commitment and transparency. For example, the governments of Canada, Ontario, and Nova Scotia report on their employment participation rates for designated groups (e.g., Indigenous, disabled persons) compared to labour force rates for their respective jurisdictions.

Without formal reporting policies (e.g., setting out what information is required to be reported to who and when), the Commission may insufficiently report to its senior management and ministries, hindering these stakeholders' ability to monitor and take action to support progress toward the cross-ministerial diversity and inclusion goals. Consistent reporting would also allow the Commission to work with ministries to address shortfalls identified in a timely and consistent matter, and publicly demonstrate their commitment to building diverse and inclusive workplaces. A consistent and robust reporting process helps all relevant parties receive appropriate information in a timely and consistent manner.

6. **We recommend the Public Service Commission implement a written policy for reporting diversity and inclusion results to its senior management and to the public to demonstrate accountability and commitment for workplace diversity and inclusion.**

5.0 GLOSSARY

Decolonization – the process by which colonies become independent of the colonizing country. In Canada, it often refers to cultural, psychological, and economic freedom for Indigenous people with the goal of achieving Indigenous sovereignty—the right and ability of Indigenous people to practice self-determination over their land, cultures, and political and economic systems.

Designated Groups – Individuals reporting an Indigenous identity, members of a visible minority (e.g., racialized) group, individuals reporting a disability, and women in underrepresented occupations.

Diversity – All the ways in which each person is different and unique. These differences can include factors such as race, ethnicity, gender, and/or having a disability.

Equity – To provide fair opportunities for all employees in a workplace based on their individual needs.

Gender-fluidity – Relates to a person who does not identify themselves as having a fixed gender.

Inclusion – How a person feels they belong, such as being appreciated, respected and valued for what they bring to the table.

Inclusive Workplace – An environment where employees feel safe, supported, respected, welcomed and are able to succeed.

Intersectionality – Multiple factors of advantage and disadvantage (e.g., gender, race, disability, sexuality, religion) that combine to create discrimination or privilege.

Marginalize – To treat a person or group of people as insignificant or peripheral.

Non-binary – Relating to or being a person who identifies with or expresses a gender identity that is neither entirely male nor entirely female.

Neurodiversity – The range of differences in individual brain function and behavioral traits regarded as part of normal human variation, including attention deficit hyperactivity disorder (ADHD), autism spectrum disorder, and dyslexia.

Racialized People – People categorized or marginalized according to their race. Racialized people are defined as individuals who are non-Caucasian. As opposed to racism, which is a belief that racial differences produce an inherent superiority of a particular race, leading to prejudice or discrimination directed against people based on their race or ethnic group.

Unconscious Bias – A learned stereotype that is automatic, unintentional, deeply engrained, universal, and able to influence one's behaviour.

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Chapter 5
Saskatchewan Health Authority—Purchasing Goods and Services

1.0 Main Points

The Saskatchewan Health Authority purchases capital assets (e.g., hospital beds, diagnostic machines, buildings), goods (e.g., medical supplies, food, prosthetics), and services (e.g., repairs and maintenance, professional fees) to support the delivery of health services each year. The Authority purchased approximately $483 million in goods and services directly, which included about $170 million in capital asset additions.

At February 2022, the Authority had, other than in the following areas, effective processes to purchase goods and services over $5,000. It needs to:

- Consistently follow its established policies when purchasing goods or services using single or sole source purchasing methods, including when buying with credit cards. Not following policies increases the risk of not treating suppliers fairly and equitably. It also increases the risk of staff making inappropriate purchases, and not obtaining best value.

- Consistently evaluate suppliers when tendering to ensure it awards contracts based on best value. The Authority also needs to ensure staff involved in tender evaluations formally declare any real or perceived conflicts of interest, as well as properly communicate supplier award decisions. Doing so will help the Authority mitigate possible financial, legal, and reputational risks.

- Properly authorize the initiation of purchases and the resulting contracts with suppliers. Appropriate approvals helps ensure the Authority commits to purchases that meet its needs. It also helps to reduce risks in contract disputes.

- Formally assess and track supplier performance. Having a formal supplier evaluation process reduces the risk of using unqualified or inappropriate suppliers.

In addition, we found the Authority needs a more centralized approach for purchasing goods and services over $5,000 as it could not always provide support (e.g., purchase orders, invoices, tender evaluations) for purchases made. The Authority expects to implement the new Administrative Information Management System (AIMS) in 2022–23. Having a centralized system will enable the Authority to better monitor staff compliance with policies and provide a centralized location to maintain required documentation.

Ineffective purchasing processes increase the risk of the Authority not selecting the most suitable supplier or receiving the best value, and obtaining goods or services that inadequately serve the Authority's needs. In addition, unfair, non-transparent, or biased purchases, could damage the Authority's reputation.

2.0 INTRODUCTION

The Provincial Health Authority Act makes the Saskatchewan Health Authority responsible for planning, organizing, delivering, and evaluating health services within the province. Its mission is to improve Saskatchewan residents' health and well-being, every day, for everyone.[1]

To help fulfill its mandate, the Authority purchases goods and services related to the delivery of health services. It purchases capital assets (e.g., hospital beds, diagnostic machines, buildings), goods (e.g., medical supplies, food, prosthetics), and services (e.g., repairs and maintenance, professional fees) to support the delivery of health services each year.

At December 1, 2021, the Authority had 615 contracts with suppliers for goods and services. From April 1, 2020 to February 3, 2022, the Authority publicly tendered 171 new contracts through the SaskTenders website.[2] The Authority directly established and managed these contracts.

The audit did not include purchases made by the Authority under contracts established by 3sHealth.[3] 3sHealth manages contracts with more than 200 suppliers for goods and services. The Authority purchases goods and services under these contracts to ensure it receives best value; however, these contracts are not subject to the Authority's purchasing processes.

As set out in **Figure 1**, in 2020–21, the Authority purchased approximately $483 million in goods and services directly, which included about $170 million in capital asset additions. It also included purchases of $15.1 million in response to the need for new COVID-19 related goods and services (e.g., hand sanitizer, COVID-19 test kits).

Figure 1—The Authority's Purchases of Goods and Services

	2020–21	2019–20
	(in millions)	
Capital asset additions	$170.3	$217.1
Contracted out services (e.g., laundry services)	106.9	97.2
Medical and surgical supplies	168.3	150.9
Operations, maintenance, and administration	474.6	456.4
Total purchases of goods and services	**$920.1**	**$921.6**
Less: Purchases made on 3sHealth contracts[A]	(437.5)	(371.1)
Total purchases subject to audit	**$482.6**	**$550.5**

Source: Saskatchewan Health Authority, *Annual Report to the Legislature 2020–2021*, pp. 40 and 63.
[A] Adapted from information provided by the Saskatchewan Health Authority on contracts established by 3sHealth and the *Annual Report to the Legislature 2020–2021*, amounts paid to suppliers, pp.186–208. The audit did not include purchases made by the Authority under contracts established by 3sHealth.

[1] Saskatchewan Health Authority, *Annual Report to the Legislature 2020–2021*, p. 5.
[2] SaskTenders is the website that hosts public sector tender notices for Saskatchewan. www.sasktenders.ca/content/public/Search.aspx (16 November 2021).
[3] The Authority and 3sHealth have a Supply Chain Partnership Agreement that facilitates the purchase of goods and services for the Authority by negotiating provincial and national group purchasing contracts to obtain the best rates, terms, and conditions when buying goods and services. In 2015, our Office completed a purchasing audit at 3sHealth and made 13 recommendations. See our *2015 Report – Volume 2*, Chapter 34, for the original audit and *2020 Report – Volume 1*, Chapter 14 for our most recent follow up showing all implemented recommendations.

The Authority has a centralized purchasing department responsible for purchasing goods and services over $75,000 (over $200,000 for construction). Supply chain personnel in various locations are responsible for purchases less than $75,000.

At the beginning of the COVID-19 pandemic, the Authority acted quickly to purchase various goods, including personal protective equipment and medical devices. Having to purchase goods quickly increased the risk of the Authority not following its purchasing policies; however, having these goods readily available and purchased using its best-value approach remained important for the Authority to consistently deliver health services during the pandemic.

Ineffective purchasing processes increase the risk of the Authority not selecting the most suitable supplier or receiving the best value, and obtaining goods or services that inadequately serve the Authority's needs or specifications. In addition, unfair, non-transparent, or biased purchases, whether perceived or real, could damage the Authority's reputation.

3.0 AUDIT CONCLUSION

We concluded, for the period ended February 28, 2022, the Saskatchewan Health Authority had, other than in the following areas, effective processes to purchase goods and services over $5,000. The Saskatchewan Health Authority needs to:

- **Follow its policies when purchasing goods or services using single or sole source purchasing methods, including when purchasing with credit cards**
- **When tendering, consistently evaluate suppliers, obtain conflict of interest declarations from staff involved, and properly communicate supplier award decisions**
- **Properly authorize the initiation of purchases and the resulting contracts with suppliers**
- **Establish a process to assess and track supplier performance**

Figure 2—Audit Objective, Criteria, and Approach

Audit Objective:

To assess whether the Saskatchewan Health Authority had effective processes, for the period ending February 28, 2022, to purchase goods and services over $5,000.

The scope of the audit did not include payments for salaries and benefits to Authority employees, medical remuneration and benefits, and grants to ambulance, healthcare organizations, and affiliates.[A] Although these purchases are a key component of the Authority's operations, grants, salaries and benefits are exempt from its purchasing policies.

Audit Criteria:

Processes to:

1. **Set policies for purchasing goods and services**
   - Maintain approved and clear policies for purchasing goods and services
   - Align policies with externally-imposed requirements (e.g., *New West Partnership Trade Agreement, Canadian Free Trade Agreement*, legislation)
   - Keep staff and suppliers informed of purchasing policies

2. **Define the need and specifications for required goods and services**
   - Define the need, in sufficient detail, for suppliers' and agency's understanding
   - Define specifications to encourage open and effective competition
   - Specify other requirements (e.g., warranty, delivery, packaging, performance guarantees)
   - Use specifications that align with relevant authorities (e.g., legislation, policies, agreements)
3. **Treat potential suppliers equitably and fairly**
   - Identify feasible sources of supply (e.g., sole source, invited bid)
   - Document basis of sourcing decision (e.g., rationale for purchasing method)
   - Obtain appropriate authorization to initiate purchase (e.g., approval to tender)
   - Obtain quotes fairly (e.g., provide consistent information to suppliers at the same time)
4. **Select suppliers for required goods and services**
   - Evaluate potential suppliers for best value
   - Document decision for supplier selection
   - Obtain appropriate approval to buy goods and services
   - Inform bidders of competitive purchasing decisions
   - Formulate written contractual agreements
5. **Manage suppliers**
   - Validate suppliers (e.g., new suppliers, changed information for existing suppliers)
   - Pay suppliers in accordance with written contracts
   - Track performance of key suppliers
   - Report performance problems to suppliers
   - Address supplier performance problems promptly

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's processes, we used the above criteria based on our related work, reviews of literature including reports of other auditors, and consultations with management. The Authority's management agreed with the above criteria.

We examined the Authority's criteria, policies, and procedures relating to purchasing goods and services. We interviewed staff responsible for the purchase of goods and services, including senior management. We assessed the Authority's purchasing processes by examining purchasing documentation (e.g., policies, tender documents, purchase orders, contracts, invoices). In addition, we tested samples of purchases (tenders, quotes, single and sole source, purchase cards, invoices) and supplier change forms.

[A] In 2020–21, the Authority paid $2.8 billion for salaries and benefits, $529.5 million for medical remuneration and benefits, and $362.9 million in grants to ambulance services, healthcare organizations, and affiliates.

4.0 Key Findings and Recommendations

4.1 More Centralized Approach to Purchasing Goods and Services Coming

The Saskatchewan Health Authority needs a more centralized approach for purchasing goods and services, which the Authority expects to implement with the new Administrative Information Management System (AIMS). The Authority plans to implement AIMS in 2022–23.

The Authority has a centralized purchasing department responsible for purchasing goods and services over $75,000 (over $200,000 for construction). However, supply chain personnel in various locations are responsible for purchases less than $75,000.

As a result, we found the purchasing department does not know whether staff across the Authority are following the procurement policy (e.g., obtaining three quotes) and maintaining the proper support (e.g., invoices).

We also found the Authority has not developed a standard purchase order template for use across the organization. Various locations use their own purchase order templates. We reviewed three purchase order templates and found templates to be missing terms and conditions that align with good practice (e.g., delivery, liability, or authorization of changes to terms and conditions). We encourage the Authority to develop a standard purchase order template aligned with good practice.

In addition, we found the purchasing department could not always provide support (e.g., tender evaluations, conflict of interest declarations) for public tenders. Authority management indicated this was due to staff inconsistently retaining relevant documentation in the expected centralized location (i.e., shared drive). Rather, staff may save documents in locations (e.g., laptop local drive) the purchasing department cannot access.

In 2022–23, the Authority plans to implement the new Administrative Information Management System (AIMS) to replace the current 11 separate financial systems in various locations across the province used to support purchasing. It expects this new system to address a number of the issues identified in this chapter (e.g., maintaining required information in a centralized location, standardized purchase orders). Having a centralized and easily accessible IT system can save an organization money while storing purchasing documents safely. Automation (e.g., three-way matching, automated invoicing) can also minimize repetitive operational purchasing processes.[4]

Having a more centralized system for purchasing goods and services will also enable the Authority to better monitor staff compliance with its procurement policy.

4.2 Comprehensive Procurement Policy Exists

The Saskatchewan Health Authority maintains a comprehensive procurement policy with supplemental procedures for purchasing, competitive bidding, and sole sourcing.

In October 2019, the Authority implemented its Procurement and Competitive Bidding Policy and procedures. The Authority makes these policies and procedures available to staff on its intranet, and uses e-mails to advise staff of changes to them. We found these documents clear, concise, and easy to follow.

In addition, our review of these procurement-related policies and procedures found their content consistent with good practice for purchasing goods and services. For example, the Authority's policies and procedures:

- Outline key principles when making purchasing decisions (e.g., achieve best value, conduct purchasing in a fair and equitable manner)
- Set out available purchasing methods (e.g., competitive requests for quotes and public tenders, non-competitive purchasing methods such as single or sole source purchases)

[4] Three-way matching is a process that matches the vendor's invoice to the organization's purchase order to the goods received to help avoid paying an incorrect or fraudulent invoice.

- Set out guidance for evaluating potential suppliers when staff use competitive purchasing methods (e.g., quotes, public tender)

- Outline signing authorities for specific positions and types of purchases (e.g., Chief Financial Officer can approve purchases of goods and services up to $5 million, and capital purchases up to $15 million)

As shown in **Figure 3**, the procurement policy also sets reasonable dollar-value thresholds to guide staff on which purchasing method to use. Given the Authority's competitive purchasing expectations begin for purchases over $5,000, our audit focused on purchases greater than that threshold.

Figure 3—Thresholds for Purchasing Methods

Threshold	Purchasing Method
Value less than $5,000 for products, materials and services (Value less than $20,000 for construction)	For requisitions and contracts under $5,000 per commitment for products, materials and services (under $20,000 for construction per commitment), the person with signing authority responsible for budget may approve the purchases without competitive quotes, if sufficient budget is available. Competitive quotes are encouraged.
Value between $5,000–$75,000 for products, materials and services (Value between $20,000–$200,000 for construction)	For requisitions and contracts ranging from $5,000–$75,000 for products, materials and services ($20,000–$200,000 for construction) per commitment, a minimum of three (3) competitive quotes are required where possible.
Value greater than $75,000 for products, materials and services (Value greater than $200,000 for construction)	For requisitions and contracts greater than $75,000 for products, materials and services ($200,000 for construction) per commitment, all applicable rules of the *Canadian Free Trade Agreement* and the *New West Partnership Trade Agreement* are to be adhered to.[A,B] A formal, public competitive bid document must be issued.
Value greater than $365,700 for products, materials and services (Value greater than $9,100,000 for construction)	For requisitions and contracts greater than $365,700 for products, materials and services ($9,100,000 for construction) all applicable rules of the *Canada-European Union Comprehensive Economic and Trade Agreement* are to be adhered to.[C] A formal, public competitive bid document must be issued.

Source: Saskatchewan Health Authority, *Procurement and Competitive Bidding Policy*, pp. 2–3.
[A] *The Canadian Free Trade Agreement* is an intergovernmental trade agreement that came into force on July 1, 2017. Its purpose commits governments to a comprehensive set of rules to reduce and eliminate, to the extent possible, barriers to the free movement of persons, goods, services, and investments within Canada to establish an open, efficient, and stable domestic market. www.cfta-alec.ca (19 April 2022).
[B] *The New West Partnership Trade Agreement* is an accord between the Governments of British Columbia, Alberta, Manitoba, and Saskatchewan that creates Canada's largest, barrier-free, interprovincial market. www.newwestpartnershiptrade.ca/the_agreement.asp%20 (19 April 2022).
[C] *The Canada-European Union Comprehensive Economic and Trade Agreement* is a bilateral agreement between Canada and the European Union. It sets new standards for trade in goods and services, non-tariff barriers, investment, government procurement, and other areas such as labour and the environment. www.international.gc.ca/trade-commerce/trade-agreements-accords-commerciaux/agr-acc/ceta-aecg/ceta_explained-aecg_apercu.aspx?lang=eng (19 April 2022).

We found the Authority's guidance on selecting appropriate purchasing methods aligns with external trade agreements. For example, the *New West Partnership Trade Agreement* requires agencies to use the SaskTenders website to publicly tender purchases of goods and services over $75,000.[5]

The Authority's procurement policy also sets out guidance for when staff can use non-competitive purchasing methods (e.g., single or sole source purchases). See **Figure 4** for the exceptions used by the Authority.

Figure 4—Exceptions to Competitive Bidding Process

Sole Sourcing or Limited Sourcing: This process will be used when it is either not possible or practical to obtain multiple quotes or responses to tenders as a result of a very limited or specialized marketplace. In the case of sole sourcing, it is necessary to demonstrate that only one supplier is able to meet the needs of the Authority.
Emergency Situations: Purchasing where there is an unforeseeable emergency and the goods, materials and services cannot be obtained by means of an open purchasing procedure. The circumstances may include, but are not limited to, pandemic situations, protection of health, safety and well-being of workers, or prevention or relief of critical shortages of essential goods.
Standardization: Where a product or service has been standardized to a particular specification through a competitive bidding process, and continued standardization to the specific product can be justified. For example, periodic acquisition of equipment, specific consumables or phased-in equipment purchases over a period of time, where a competitive process has previously taken place.

Source: Saskatchewan Health Authority, *Procurement and Competitive Bidding Policy*, p. 3.

For purchases greater than $5,000 (and $20,000 for construction), the Authority expects staff to document sufficient rationale for use of non-competitive purchasing methods through its Sole Source and Exceptions Justification Form. Further, staff must obtain approval for all purchases in accordance with its written delegation of signing authority.

Comprehensive policies help reduce the risk of staff making purchases that are either inappropriate or not in accordance with the Authority's expectations. It also helps the Authority to comply with governing trade agreements, be fair and transparent with potential suppliers, and obtain best value.

4.3 Procurement Policy Not Always Followed When Using Credit Cards

The Saskatchewan Health Authority did not always follow its procurement policy, and used non-competitive purchasing methods, when buying goods and services over $5,000 on credit cards.

At February 28, 2022, the Authority had assigned 611 purchasing cards (i.e., credit cards) to staff.

In September 2021, the Authority drafted a purchasing card policy to apply to all cardholders. The Authority has not yet implemented this policy across the organization; it expects to do so in 2022–23.

[5] The Ministry of SaskBuilds and Procurement administers the SaskTenders website (www.sasktenders.ca) that is the primary gateway for public sector tender notices for Saskatchewan (7 April 2022).

In the meantime, Authority staff follow purchasing card policies previously implemented at various locations within the Authority. We found these policies, as well as the Authority's draft purchasing card policy, give staff clear and complete guidance on purchasing card use. For example, the Authority expects staff to generally use purchasing cards to buy small dollar value items (i.e., for purchases less than $5,000).

See **Figure 5** for further details on the Authority's purchasing card policies.

Figure 5—Key Content of the Authority's Current and Draft Purchasing Card Policies

The Authority's purchasing card policies appropriately set out:

- Responsibilities of cardholders (e.g., accountability for purchases, proper security of cards, requirements to submit monthly expense reports) and requirement for cardholders to acknowledge acceptance and understanding of these responsibilities in writing
- Types of unacceptable purchases (e.g., personal, capital asset)
- Single transaction limits and monthly card limits (transaction limits range from $500–$5,000, and monthly limits range from $2,000–$20,000)
- Monthly process for reconciling transaction statements to supporting receipts, and related approvals
- Expectation that cardholders must not split purchases to bypass single transaction limits

Source: Adapted from information provided by the Saskatchewan Health Authority.

Certain staff (e.g., maintenance, supply chain) have higher single transaction limits (e.g., $10,000) to allow them to do their job effectively. If staff need to make purchases in excess of their approved individual transaction limit, they can request a temporary increase to their limit.

We reviewed the individual transaction limits for a sample of five credit cardholders. We found their limits to be reasonable based on their job duties (e.g., supply chain). For two of these cardholders, we noted they each purchased one item greater than their existing individual transaction limits—we found the Authority properly approved temporary limit increases for these transactions.

Between April 1, 2020 and November 30, 2021, we found staff made 41 purchases on credit cards in excess of $5,000. Credit card purchases ranged from just over $5,000 to $34,500 in value. We tested a sample of 32 of these purchasing card transactions over $5,000 and found appropriate staff approved transactions, and transactions agreed to support (e.g., receipts). We found all purchases appeared to be for appropriate business purposes.

However, the Authority did not always comply with its procurement policy for these purchases, therefore may not have obtained best value in all instances. We found:

- Fifteen transactions where the Authority obtained goods or services from a sole or single supplier and did not document rationale, nor approval, to do so. Of these transactions, in three instances, we determined the Authority should have obtained three quotes prior to selecting the suppliers. For example, the Authority purchased vaccine temperature indicators from a supplier because it used the supplier in the past. The Authority should have obtained quotes to ensure it was still receiving the best value for the item.

- For six of the 15 transactions the Authority obtained from a single or sole source, management indicated the COVID-19 pandemic disrupted the supply chain; therefore, it had limited options to obtain the goods or services. However, staff did not complete the Sole Source and Exceptions Justification Form as expected by the procurement policy.

- For one transaction, staff purchased a capital-related item (office furniture worth $9,600), which is not allowed per the purchasing card policy.

- Three transactions where the Authority did not provide supporting information (e.g., quotes) to determine the purchasing method, which demonstrates the importance of a centralized IT system to store purchasing documents safely (see **Section 4.1**).

When the Authority does not follow its procurement policy when using credit cards to purchase goods and services over $5,000, it is at risk of not treating suppliers fairly and equitably, and may not obtain best value when making purchasing decisions.

1. **We recommend the Saskatchewan Health Authority follow its single and sole source requirements when using credit cards to purchase goods and services over $5,000.**

4.4 Requirements for Single and Sole Source Purchases Not Followed

The Saskatchewan Health Authority neither consistently documented rationale nor sought approval for the use of single and sole source purchases as expected in its procurement policy.[6]

We tested 23 single or sole source purchases made by the Authority—these purchases included buying goods and services such as water purification systems and software licences. Our testing of these purchases found the Authority:

- Did not complete the justification form for 17 purchases

- Did not properly complete the justification form and document its rationale for using single or sole source purchasing for two purchases

- Did not obtain appropriate approval for the purchase (e.g., approved by staff who did not have capital-asset signing authority) for three purchases

Through our testing of purchasing card transactions (see **Section 4.3**), we identified a further 15 single or sole sources purchases where the Authority did not document its rationale, nor its approval, for single or sole source purchases.

[6] The Chartered Institute of Procurement and Supply defines single source as purposely choosing a single supplier even though others are available. Sole source is when only one supplier for the required item is available. www.cips.org/en-sg/knowledge/procurement-topics-and-skills/strategy-policy/models-sc-sourcing--procurement-costs/single-sourcing-vs-sole-sourcing/ (13 April 2022).

When the Authority does not follow its policy when using single or sole source purchasing, the Authority is at risk of not treating suppliers fairly and equitably, and may not obtain best value when making purchasing decisions.

2. **We recommend the Saskatchewan Health Authority follow its procurement policy (e.g., document rationale) when using single or sole source purchasing methods.**

4.5 Purchase Initiation Not Properly Authorized

The Saskatchewan Health Authority did not always properly authorize the initiation of purchases consistent with its delegation of signing authority.

The Authority uses either contracts or purchase orders as legally-binding purchase documentation. Only Authority staff with written delegation of signing authority are authorized to sign contracts and purchase orders, hence making financial commitments to other parties on behalf of the Authority.

The Authority requires staff to use a contract or purchase order depending on the purchase threshold:

- For purchases between $5,000 and $75,000, individual business units and staff in various parts of the province are knowledgeable of suppliers frequently used for various types of purchases. After staff obtain three quotes, they issue a purchase order with purchase details including quantity and description, supplier information, and shipping location.

  The Authority requires staff with the appropriate delegation of authority to approve purchase orders.

- For purchases greater than $75,000, the Authority's Procurement Department determines sources of supply through the public tender process. The Authority requires staff to formally document the sourcing decision on its Procurement Confirmation Form that sets out the tender's details such as a preliminary description and specifications of the product or service, total approved budget, and contract term.

  The form must be approved by the Executive Director or Director of the area of responsibility, as well as the Director of Procurement.

We tested 41 purchases and found the Authority:

- Did not properly authorize the purchase orders for two of 28 purchases. For example, a manager approved a purchase over $50,000 instead of the appropriate director.

- Did not properly approve the Procurement Confirmation Form in four of 13 instances (one form was unsigned; three forms were signed by individuals who did not have the appropriate authority).

The Authority was unable to provide us with either the Procurement Confirmation Form for three purchases or the purchase orders for six purchases; therefore, we could not confirm proper authorization. This illustrates the importance of having a centralized IT system to store purchasing documents safely (see **Section 4.1**).

Inappropriate approvals for purchase initiation increases the risk of the Authority committing to purchases that either do not meet its needs or do not provide best value.

3. **We recommend the Saskatchewan Health Authority authorize the initiation of purchases consistent with its written delegation of signing authority.**

4.6 Standard Tender Documentation Used for Public Tenders

The Saskatchewan Health Authority maintains standard tender documentation to release to the public to help ensure tender bidders clearly understand not only what the Authority seeks to purchase, but also to promote fair and efficient competition.

The Authority uses subcommittees to conduct each of its public tenders. Subcommittees usually consist of three to five people typically including purchasing staff, subject matter experts (e.g., IT experts, medical staff), and individuals with prior experience about the type of purchase.

The Authority uses templates to guide subcommittee members in developing detailed tender documents (e.g., request for proposals) for the purchase of goods, services, and construction management services. The templates include considerations such as product quantities, any technical requirements, supply period, delivery timing, and product performance requirements. The templates also include sample evaluation criteria the subcommittee will use to evaluate bidder proposals.

We reviewed the Authority's tender templates and found the templates provide staff with sufficient guidance on the various specifications to include, as well as align with relevant authorities (e.g., legislation, policy, external trade agreements).

The Authority posted 171 public tenders between April 1, 2020 and February 3, 2022 on SaskTenders.

We tested 13 tenders and found the Authority:

- Provided sufficient descriptions of specifications to enable suppliers to bid on the tender (e.g., nature/quantity of goods or services, supplier requirements, timeframe)
- Included other requirements where necessary, such as warranty and completion dates for the tenders
- Used specifications that aligned with relevant authorities (e.g., external trade agreements)

- Communicated its purchasing process (e.g., process for addressing clarification questions, notification methods, tendering period) and evaluation criteria (including weightings)

Overall, we found suppliers were given sufficient time to prepare tender responses.

Having standard tender documentation promotes consistency across comparable purchases, and can save time. This also results in the Authority providing clear and fair information about the specific purchasing opportunity.

4.7 Supplier Evaluations for Tenders Not Consistently Documented

The Saskatchewan Health Authority inconsistently evaluated suppliers when tendering for the purchase of goods and services.

Subcommittee members use tender evaluation criteria to score each bid received on a tender. Purchasing staff combine the results from subcommittee members within a scoring matrix to provide an overall score for each proposal.

We tested 13 tenders and found the Authority used a subcommittee to evaluate the bids for 10 of these tenders. For these 10 tenders, we found each subcommittee consisted of individuals with relevant experience (e.g., engineering consultants, physicians, plant and maintenance managers), and subcommittee members evaluated bids to inform the scoring matrix.

However, in one instance, we found the evaluation criteria used by subcommittee members did not align with the criteria the Authority communicated in the tender documents (e.g., pricing in the tender document was weighted at 30% but 25% was used in the evaluation). We noted the Authority evaluated all of the bids using the same weighted criteria and selected the proposal with the highest score. This oversight did not impact the Authority's award decision. However, having differences in weighting from the original evaluation criteria does not align with good practice and decreases the evaluation process' transparency. This can increase the risk of dissatisfied suppliers or not selecting the appropriate supplier based on the established criteria.

In addition, for the three remaining tenders tested, we found the Authority:

- Received only one bid for two of the tenders. The Authority did not use the evaluation criteria to assess these two suppliers. Good practice suggests still completing the evaluation under such circumstances to determine whether the potential supplier meets the Authority's needs.

- Did not provide us with the evaluation support for one tender worth $726,000; therefore, we do not know whether the Authority fairly evaluated suppliers and awarded the contract based on best value. This could pose financial, legal, and reputational risks to the Authority. A centralized IT system to store purchasing documents will help to prevent this from happening in the future (see **Section 4.1**).

Not properly completing evaluations for all tenders increases the risk of selected suppliers not sufficiently meeting the Authority's needs. Without documented evaluations, the Authority cannot sufficiently support its decisions for supplier selection, and demonstrate achievement of best value.

4. **We recommend the Saskatchewan Health Authority consistently evaluate potential suppliers when tendering for the purchase of goods and services.**

4.8 Conflict of Interest Declarations Not Always Completed

Saskatchewan Health Authority staff involved in tender evaluations do not always declare conflicts of interest as required by policy.

The Authority's procurement policy requires tender subcommittee members to declare any potential or perceived conflicts of interest in accordance with the Authority's Conflict of Interest Policy. The Authority provides guidance to members on scenarios that may present a conflict of interest, such as a friendship or familial relationship with a potential supplier, or a direct or indirect financial interest in a potential supplier.

For eight of the 13 tenders we tested, we found subcommittee members completed conflict of interest declarations as expected. For one tender, we found a member declared a conflict of interest, and appropriately removed themselves from the subcommittee. For the remaining five tenders, the Authority was unable to provide us with the completed declarations. Having a centralized IT system to store purchasing documents should help to address this (see **Section 4.1**).

Staff with real or perceived conflicts of interest may be biased in their decision-making. Not requiring subcommittee members to complete conflict of interest declarations, or not effectively maintaining declarations, increases the risk of the Authority not being able to illustrate fair and equitable treatment of potential suppliers.

5. **We recommend the Saskatchewan Health Authority obtain conflict of interest declarations from tender subcommittee members, as required by its conflict of interest policy.**

4.9 Supplier Award Decisions Not Always Properly Authorized

The Saskatchewan Health Authority did not always properly authorize supplier award decisions.

Once the tender subcommittee determines the scoring matrix for a tender, the project lead prepares a recommendation for award using the Authority's Contract Authorization to Proceed Form. This form outlines key information on the decision for supplier selection (e.g., details of contract, budget, scores of all bidders). As indicated on the form, it must be approved in accordance with the Authority's delegation of authority. Approval of the form documents the Authority's approval to award a tender to the selected supplier.

We tested 13 tenders and found the Authority did not always properly authorize decisions for supplier selection. However, in all instances where the Authority provided support for the tenders (see **Section 4.7**), it appropriately awarded the contract to the highest scoring supplier.

We found the Authority:

- Did not authorize the supplier selection (i.e., unsigned form) for two tenders. In one instance, the Authority appropriately approved the contract with the selected supplier. However, in the other instance, the Authority also did not approve the related contract (i.e., the contract was also unsigned). See **Recommendation 7**.

- Did not authorize the supplier selection in accordance with its delegation of authority (e.g., an Executive Director should have approved the supplier selection rather than a Director) for one tender. We also found the contract was not appropriately approved, as an individual with capital-asset signing authority did not sign the contract as required. See **Recommendation 7**.

- Approved the supplier selection two days after signing a contract with the successful supplier for one tender.

The Authority was unable to provide us with the Contract Authorization to Proceed Form for one tender; therefore, we were unable to assess proper authorization. However, we found only one supplier bid on this tender, and the Authority appropriately approved the contract.

Section 4.12 further describes our findings and recommendation associated with the Authority's contract authorization.

4.10 Improved Communication of Supplier Award Decisions Needed

The Saskatchewan Health Authority did not consistently communicate supplier award decisions to suppliers as required.

Once the appropriate signing authority approves the recommended supplier for the tender award, the Authority notifies the successful bidder with a letter of intent. It also sends letters of regret to all unsuccessful bidders after it signs the contract with the successful bidder. Staff use template letters for communicating results, which appropriately notify bidders whether they were successful, or not.

We tested 13 tenders and found the Authority:

- Did not send letters of regret to the unsuccessful bidders for one tender

- Did not send out a letter of intent to the successful bidder for two tenders

The Authority was unable to provide support for five tenders; therefore, we were unable to assess whether communications with suppliers occurred. Having a centralized IT system to store purchasing documents may help address this (see **Section 4.1**).

The Authority has not set timelines for sending the letters to suppliers. However, we found the Authority sent letters in a timely manner, between 1–30 days after bidding closed.

In addition, the Authority requires staff to publicize contract award notices within 72 days of awarding the contract (e.g., posting notices on the SaskTenders website). Management noted it is the responsibility of the tender project lead to update SaskTenders' website.

For seven of the 13 tenders we tested, we found the Authority did not update the SaskTenders website with contract award details. We also found one instance where the Authority posted award details 142 days after awarding the contract. Management indicated the delay was due to staff oversight.

We also analyzed the status of 171 public tenders the Authority completed between April 1, 2020 and February 3, 2022. We found the Authority did not have contract award information posted on SaskTenders for approximately 75% of its public tenders during that period.

Not communicating supplier award decisions makes it difficult for the Authority to demonstrate that its purchasing process is fair and transparent, and it may be in violation of external trade agreements.

6. **We recommend the Saskatchewan Health Authority consistently communicate supplier award decisions for public tenders as required by its procurement policy.**

Through its public tender documents (e.g., request for proposal), the Authority communicates steps for bidders to request a debrief session, or to file a complaint.

The debrief process provides both the Authority and bidders (both successful and unsuccessful) an opportunity to provide comments and feedback on the public tender process. Between April 1, 2020 and February 3, 2022, the Authority held about 350 debriefs (an average of two bidders per purchase).

If a bidder feels either the Authority did not treat them fairly or the tender process was biased, they can file a complaint. The Authority will review relevant documents to resolve the complaint. Between April 1, 2020 and February 28, 2022, the Authority received two complaints. It resolved one complaint, but continues to resolve the other; both had allegations of unfair tender processes.

4.11 Robust Contract Templates Used

The Saskatchewan Health Authority established, and consistently used, robust contract templates when drafting and finalizing contracts with suppliers.

The Authority developed standard contract templates for the different types of goods or services it purchases (e.g., goods, services, construction). According to Authority management, in 2018, the Authority's legal counsel reviewed its contract templates. We assessed the templates and found they aligned with good practice.

The Authority uses either contracts or purchase orders as legally-binding purchase documentation. When staff use contracts, the Authority expects them to use these templates when drafting the contracts. For each of the 44 purchases we tested where the Authority had support, the Authority used the appropriate contract or purchase order as expected.

Maintaining robust standard wording of contracts (contract templates) helps organizations to save time on purchasing activities, and can reduce legal costs. They can also help both staff and suppliers consider and understand key aspects common to purchasing certain types of goods and services.

4.12 Some Contracts Not Properly Authorized

The Saskatchewan Health Authority did not always properly authorize contracts.

After the Authority approves the recommended supplier, it will enter into a contract (i.e., written contract or purchase order) with that supplier. For 37 of the 54 purchases we tested (made through tenders, quotes, and single or sole sourced purchasing methods), the Authority appropriately completed and authorized the contracts or purchase orders for these purchases.

However, for the remaining 17 purchases tested, we found:

- One written contract was not signed by either the Authority or the supplier.
- Five contracts (three written contracts; two purchase orders) were not approved in accordance with the Authority's delegation of signing authority. For example, the Authority purchased a piece of capital equipment for about $370,000, but individuals with capital-asset signing authority did not authorize the contract.
- Eleven contracts where the Authority was unable to provide us with the related purchase order or written contract; therefore, we were unable to assess the authorization associated with these contracts. Again, this further supports the need for having a centralized IT system to store purchasing documents (see **Section 4.1**).

Not executing contracts in accordance with expectations (e.g., not in accordance with delegation of signing authority) increases the risk of the Authority making inappropriate purchases, being vulnerable in contract disputes, and not receiving expected goods or services when needed.

7. We recommend the Saskatchewan Health Authority authorize contracts for goods and services in accordance with its delegation of authority.

4.13 Suppliers Paid Appropriately

The Saskatchewan Health Authority paid its suppliers consistent with approved purchase orders and contracts.

The Authority's Finance departments process supplier invoices. Authority staff are to ensure the payment is properly authorized and goods are received before the payment is made. The Authority pays suppliers after staff match invoices to approved purchase orders/contracts.

For each of the 43 purchases we tested (where support was provided), invoices/payment amounts matched approved purchase orders/contracts. For the other 11 purchases, the Authority was unable to provide us with support (e.g., contracts, invoices). Having a centralized IT system to store purchasing documents should help address this (see **Section 4.1**).

Also, as noted in various sections, the Authority is not identifying non-compliance with its procurement policies when processing payments. We found:

- Contracts are not always properly approved—see **Section 4.12**
- Sole and single source purchases are not sufficiently justified—see **Section 4.4**
- Purchases were not approved by the appropriate level of staff—see **Section 4.4**
- Purchase initiations (e.g., purchase orders) were not properly authorized—see **Section 4.5**

Staff responsible for processing payments can play an important role in detecting non-compliance with procurement policies and reinforcing their importance.

4.14 Validity of Suppliers Not Confirmed, Separation of Incompatible Duties Needed

The Saskatchewan Health Authority does not always document due diligence procedures taken to confirm the validity of suppliers before paying them, and has not adequately segregated incompatible duties related to paying suppliers.

Numerous staff within the Authority have the ability to change or set up new suppliers in various financial systems. As a result, there is not one comprehensive master listing of suppliers. The Authority was unable to tell us how many total suppliers it has in these various systems. Furthermore, it does not periodically review the list of suppliers and remove any suppliers no longer used. The Authority will have to ensure it removes any duplicate suppliers before it transfers suppliers into the new IT system—AIMS (see **Section 4.1**).

The Authority requires staff to complete a supplier change form when creating or changing supplier information. Supplier information in the various financial systems includes the supplier's name, vendor number, address, and banking details. The Authority expects staff to confirm the validity of suppliers (e.g., confirm GST or PST number, phone call) and appropriately approve the supplier change form prior to setting up a new supplier or changing a supplier's information.

We tested a sample of 29 supplier changes and found staff did not:

- Approve 15 supplier changes
- Maintain support to confirm validity for one supplier change

In addition, we found certain staff have the ability to both enter new suppliers into the financial system and approve invoices for payment. This increases the risk that staff could set up a fictitious supplier and bill the Authority for goods and service not provided.

We reported similar findings in our *2021 Report – Volume 2*, Chapter 11. We recommended the Saskatchewan Health Authority separate incompatible duties. The Standing Committee on Public Accounts agreed with this recommendation on March 1, 2022.

Not confirming the validity of suppliers before adding or updating them in the financial system, along with inadequately separating incompatible duties, increases the risk of fraud and not detecting errors. In addition, it increases the risk of making payments to fictitious suppliers.

4.15 Performance of Suppliers Not Periodically Assessed

The Saskatchewan Health Authority does not periodically assess supplier performance.

Various supply chain staff within the Authority meet daily (via virtual meetings) to discuss supply chain issues, supplier issues, and upcoming purchases. They maintain a daily huddle action-log that tracks progress on supply chain issues to help monitor issue resolutions. For example, we found staff documented when they expect to receive supplies or whether they should consider a substitute.

Per our review of the action-log between August 10, 2021 and March 21, 2022, staff did not note any supplier performance issues.

The Authority does not formally assess whether suppliers performed to a satisfactory level (e.g., timelines met, quality of the work acceptable) after the conclusion of the contract or after its receipt of goods and services.

Good practice suggests using formal processes to assess the performance of suppliers so an organization knows which suppliers it can use in the future. It also suggests documenting assessment results so it can be shared with all areas involved in purchasing decisions. This allows for appropriate consideration of supplier performance when making future purchasing decisions.

Assessing suppliers at the conclusion of a contract is important as assessments can affect whether suppliers are selected for future projects. Without a consistent process to assess and track supplier performance, the Authority increases its risk of using unqualified or inappropriate suppliers (e.g., use of suppliers who did not perform as expected in the past).

8. We recommend the Saskatchewan Health Authority establish a formal process to assess and track supplier performance.

5.0 SELECTED REFERENCES

Provincial Auditor of Saskatchewan. (2020). *2020 Report – Volume 1*, Chapter 10, *Saskatchewan Research Council—Purchasing Goods and Services*. Regina: Author.

Provincial Auditor of Saskatchewan. (2019). *2019 Report – Volume 1,* Chapter 8, *Northern Lights School Division No. 113—Purchasing Goods and Services*. Regina: Author.

Provincial Auditor of Saskatchewan. (2018). *2018 Report – Volume 1,* Chapter 10, *Saskatchewan Water Corporation—Purchasing Goods and Services*. Regina: Author.

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Chapter 6
Saskatchewan Liquor and Gaming Authority—Regulating Locally Manufactured Craft Alcohol

1.0 Main Points

Consumers are increasingly purchasing craft alcohol products made in Saskatchewan. Craft alcohol sales nearly doubled in 2020–21 compared to 2017–18.

The Alcohol and Gaming Regulations Act, 1997, assigns the Saskatchewan Liquor and Gaming Authority responsibility for regulating and controlling the manufacturing, possession, sale, and delivery of beverage alcohol in Saskatchewan, including locally manufactured craft alcohol. At November 30, 2021, the Authority had issued permits to 64 different craft alcohol producers in the province.

At November 30, 2021, the Authority had effective processes, except in the following areas, to regulate the production and sale of locally manufactured craft alcohol in Saskatchewan. It needs to:

- Obtain craft alcohol quality assurance results (i.e., product analysis reports from laboratories) every two years as required by its policy
- Inspect high-risk areas specific to craft alcohol manufacturing and use a risk-based approach when determining how frequently to inspect craft alcohol producers
- Renew craft alcohol permits prior to expiry
- Perform reasonability assessments of craft alcohol producers' monthly sales and production information to help ensure the collection and accuracy of all production levy revenue

Receiving product analysis reports and regularly inspecting high-risk areas specific to craft alcohol manufacturing helps ensure craft alcohol producers are producing alcohol that is safe to consume and is consistent with advertised alcohol content. Without effective processes, the public may face increased health and safety risks associated with the consumption of locally manufactured craft alcohol (e.g., consuming tainted alcohol, consuming alcohol with higher alcohol content than labelled).

Effective regulatory processes must also treat craft alcohol producers consistently and fairly (e.g., when renewing craft alcohol permits), and confirm the Authority receives all revenues (e.g., production levies) it should.

2.0 Introduction

This chapter reports the results of our audit of the Saskatchewan Liquor and Gaming Authority's processes to regulate the production and sale of locally manufactured craft alcohol in Saskatchewan.

Locally manufactured craft alcohol refers to craft alcohol products produced and sold in the province (e.g., cider, beer, distilled alcohol, wine). Craft alcohol means beverage alcohol produced by fermentation or distillation in accordance with policies outlined for craft breweries, craft distilleries, craft wineries, craft cideries, and craft refreshments; it does not include alcohol manufactured pursuant to a bottling-manufacturing permit (i.e., manufacturers who blend and repackage bulk alcohol purchased from elsewhere and do not ferment or distill their own products).[1]

Our audit did not examine the enforcement of laws related to the illegal production of craft alcohol, as this is not under the Authority's responsibility.[2]

2.1 Regulating Craft Alcohol

The Alcohol and Gaming Regulation Act, 1997, and *The Alcohol Control Regulations, 2016,* provide the Authority with the following responsibilities (see **Figure 1**) as it relates to regulating locally-manufactured craft alcohol producers.

Figure 1—The Authority's Provincial Regulatory Responsibilities for Craft Alcohol

- Approve an application for a permit subject to any terms and conditions that it considers appropriate (including determining the duration of the permit)
- Refuse any application for a permit
- Refer any application for a permit to the Liquor and Gaming Licensing Commission for a hearing when it determines it is in the public interest to do so[A]
- Inspect locally-manufactured craft alcohol producers
- Enforce terms and conditions, and legislation relating to permits
- Impose penalties against a producer for non-compliance with terms and conditions and/or legislation
- Suspend or cancel a permit

Source: *The Alcohol and Gaming Regulation Act, 1997*, s. 19(1).

[A] The Commission is an independent body of between three and seven members appointed by the Lieutenant Governor in Council. Its mandate is to ensure appropriate application of legislation and regulations governing liquor. The Commission, at the request of a permittee, reviews decisions of the Authority with respect to liquor and gaming licensing, registration, and cancellations/suspension matters within the Authority's jurisdiction, which includes all provincial liquor permittees. *The Alcohol and Gaming Regulation Act, 1997*, s. 21, 30.

At November 30, 2021, there were 64 locally-manufactured craft alcohol producers in the province. Craft alcohol producers have been in Saskatchewan, and regulated by the Authority, since the early 1990's.

As described in **Figure 2**, production and sale of craft alcohol in Saskatchewan over the past five years is increasing. There were over 50% more locally-manufactured craft alcohol producer permits in 2020–21 compared to 2016–17. In 2020–21, locally-manufactured craft alcohol products comprised 4.3% of the Authority's annual beverage alcohol sales.

[1] *Commercial Liquor Permittee Manual*, p. 101. www.slga.com/liquor/for-craft-producers (15 July 2021). The Authority also issues permits under clause 28(1)(c) of *The Alcohol Control Regulations, 2016*, to allow for the bottling of bulk alcohol. Under this permit, producers can blend and bottle alcohol without fermentation or distillation.

[2] Law enforcement agencies (e.g., municipal police services, RCMP) are responsible for enforcing laws related to the illegal production of alcohol.

Figure 2—Sales and Permits for the Authority's Liquor Segment of Locally Manufactured Craft Alcohol

	2016–17	2017–18	2018–19	2019–20	2020–21
Authority's Total Beverage Alcohol Quantity Sold[A] (thousand litres)	Not available[C]	90,459	88,074	84,939	92,502
Locally Manufactured Craft Alcohol Quantity Sold[A] (thousand litres)	Not available[C]	2,442	3,171	3,530	3,932
Market Share of Locally Manufactured Craft Alcohol Sales[A]	Not available[C]	2.7%	3.6%	4.2%	4.3%
Locally-Manufactured Craft Alcohol Producer Permits[B]	46	58	63	66	71

Source: Saskatchewan Liquor and Gaming Authority records.
[A] Includes both direct sales and sales through distributors.
[B] This may include more than one permit per craft alcohol producer if they produce more than one type of alcohol product (e.g., production of craft beer and craft spirits requires two separate permits).
[C] The Authority did not have this information available.

2.2 Importance of Effective Regulation of Locally Manufactured Craft Alcohol

Consumers rely on accurate information from alcohol manufacturers in order to make informed decisions regarding the type and quantity of alcoholic beverages consumed. Effective regulation of craft alcohol production reduces the risk of the public consuming unsafe alcohol or alcohol inconsistent with labelling (e.g., more alcohol in the product than stated may lead to consumer impairment greater than expected after consuming one serving).

In February 2019, a complaint received by the Saskatchewan Liquor and Gaming Authority resulted in the Authority temporarily shutting down a craft alcohol producer's taproom and the recall of some of the producer's spirits. Five of the products tested by the Authority from the producer had higher alcohol content than labelled. The difference in the alcohol content ranged from 0.2%–4.1%. The craft alcohol producer found its testing equipment improperly calibrated.[3]

The Authority follows Canadian industry-standard volume tolerances for alcohol. These vary based on the type of alcohol (e.g., wine, beer, spirits) and generally range from 0.3%–1.0% of declared alcohol content. For example, table wine can have the alcohol content vary by 1.0% of the declared alcohol content. The Authority verifies alcohol composition and safety by reviewing certificates of analysis that craft producers obtain from a laboratory. If a product does not meet acceptable tolerances, it will typically result in a product recall and suspended sales.

Without effective processes to regulate locally manufactured craft alcohol, the Authority faces increased risk that it may not fulfill its legislated responsibilities to help protect the public. As a result, the public may face increased health and safety risks associated with the consumption of locally manufactured craft alcohol (e.g., consuming tainted alcohol, consuming alcohol with higher alcohol content than stated on packaging).

[3] www.cbc.ca/news/canada/saskatchewan/slga-testing-minhas-sask-recall-taproom-1.5034712 (9 February 2022).

Effective regulatory processes must also treat craft alcohol producers consistently and fairly (e.g., when assessing permit applications or imposing sanctions for non-compliance), and confirm the Authority receives all revenues (e.g., production levies) it should.

3.0 AUDIT CONCLUSION

We concluded that, for the 12-month period ended November 30, 2021, the Saskatchewan Liquor and Gaming Authority had, other than the following areas, effective processes to regulate the production and sale of locally manufactured craft alcohol in Saskatchewan.

The Authority needs to:

- **Obtain craft alcohol quality assurance results (i.e., certificates of analysis) every two years as required by policy**
- **Inspect high-risk areas specific to craft alcohol manufacturing and use a risk-based approach when determining how frequently to inspect craft alcohol producers**
- **Renew craft alcohol permits prior to expiry**
- **Perform reasonability assessments of craft alcohol producers' monthly sales and production reporting to help ensure the collection of all production levies**

Figure 3—Audit Objective, Criteria, and Approach

Audit Objective:

The objective of this audit was to assess whether the Saskatchewan Liquor and Gaming Authority, for the 12-month period ended November 30, 2021, had effective processes to regulate the production and sale of locally manufactured craft alcohol in Saskatchewan.

Audit Criteria:

Processes to:

1. **Approve eligible craft alcohol producers to produce and sell craft alcohol**
   - Set appropriate requirements for craft alcohol producers consistent with legislation and good practice
   - Confirm applicants meet established requirements (e.g., use qualified staff, verify applicant information)
   - Issue permits timely with appropriate requirements to successful applicants
2. **Monitor compliance with permit and quality control requirements**
   - Set guidance for monitoring compliance with permit and quality control requirements (e.g., checklists, inspection procedures, certificates of analysis, product recall procedures, penalties, escalation processes for identification of non-compliance, enforcement of corrective action)
   - Set risk-based plans for inspecting permitted craft alcohol producers
   - Regularly assess compliance with permit and quality control requirements (e.g., use qualified staff, complete inspections in accordance with established processes, review certificates of analysis for new product lines)
   - Investigate complaints about craft alcohol producers in a timely manner
   - Analyze craft alcohol production and sales data collected to identify any irregularities or issues
3. **Address and report on non-compliance and product safety**
   - Require prompt action on non-compliance based on severity of non-compliance
   - Escalate action on continued non-compliance (e.g., cancel or suspend permit, report non-compliance to appropriate authorities)
   - Report information on non-compliance and related enforcement actions to senior management and the public

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's processes, we used the above criteria based on our related work, reviews of literature including reports of other auditors, and consultations with management and an external advisor. The Authority's management agreed with the above criteria.

We examined the Authority's policies and procedures relating to the regulation of locally manufactured craft alcohol. We assessed the Authority's permit application templates and permit conditions for consistency with legislation and good practice. We tested samples of permit approvals, permit renewals, inspections, and actions taken on identified non-compliance to verify the Authority followed its established procedures. In addition, we analyzed data to determine the frequency of Authority inspections, and analyzed monthly craft alcohol production information submitted by producers. We also used an independent consultant with subject matter expertise to help us identify good practice, and assess the Authority's processes.

4.0 KEY FINDINGS AND RECOMMENDATIONS

4.1 Locally-Manufactured Craft Alcohol Permit Requirements Consistent with Legislation

The Saskatchewan Liquor and Gaming Authority set requirements for craft alcohol producers consistent with legislation and good practice.

The Authority makes its Liquor Licensing and Inspection Services Branch responsible for permitting, inspecting, and monitoring craft alcohol producers. The Branch is part of the Authority's Regulatory Services Division. The Division is also responsible for permitting, inspecting, and monitoring commercial liquor permittees (e.g., restaurants, taverns, and retail stores that sell alcohol to the public).

In October 2016, the Authority published an updated, detailed *Commercial Liquor Permittee Policy Manual* that includes requirements for craft alcohol producers (manufacturers). The Manual is for both internal (i.e., staff) and external (e.g., public, applicant, producer) use, and is accessible to the public on the Authority's website.[4] The Authority last updated the Manual in January 2021.

See **Figure 4** for a summary of the Manual's contents.

Figure 4—Content of Commercial Liquor Permittee Policy Manual at January 2021

- **General Information:** how to use the manual; summary of permit classes (e.g., restaurant, tavern, manufacturing); summary of legislation
- **Process to Apply to Obtain a Permit:** summary of information required to apply for a permit; permit renewal process; permit fees
- **Manufacturer Permits:** facility standards; quality assurance requirements; packaging and labelling requirements; sale of products; record keeping, production levies, and reporting requirements; minimum and maximum production requirements of craft alcohol producers
- **Inspections:** overview of the Authority's regulatory processes to assess whether permittees comply with operating requirements
- **Disciplinary Action:** summarizes potential actions the Authority may take to address and correct identified non-compliance with operating requirements

Source: Adapted from the Authority's *Commercial Liquor Permittee Policy Manual*.

[4] www.slga.com/liquor/for-craft-producers (12 July 2021).

We found the Manual consistent with legislative requirements and good regulatory practice.[5] The Manual is sufficiently detailed and easy to understand. It outlines the requirements for an applicant to apply for a craft alcohol producer permit and outlines operating requirements of approved craft alcohol producers.

The Authority issues manufacturing permits to locally-manufactured craft alcohol producers for the production and sale of craft alcohol products. Permits cover facility standards, quality assurance, packaging and labelling, sale of manufactured products, delivery of products to consumers, sales to minors, record keeping, and provision of alcohol samples to customers. We found the permit requirements consistent with legislative requirements.

See **Figure 5** for the production levels for each type of craft alcohol in order for a locally-manufactured craft alcohol producer to be considered a craft producer, and therefore subject to regulation by the Authority.[6]

Figure 5—Craft Alcohol Manufacturing Production Levels

Alcohol Manufacturer Type	Production Level (litres)
Craft Distillery	250 – 350,000
Craft Winery	2,000 – 350,000
Craft Cidery	2,000 – 350,000
Craft Refreshments	2,000 – 350,000
Craft Brewery	5,000 – 3,000,000

Source: www.slga.com/liquor/for-craft-producers (12 July 2021).

We also found the Authority keeps craft alcohol applicants and producers informed of changes to operating requirements.

In November 2020, we noted the Authority emailed approved craft alcohol producers informing them of changes to its craft alcohol producer permit. A few months prior to implementing these changes, the Authority consulted with craft alcohol producers, obtaining their input on the proposed changes. Changes included introducing the concept of two types of craft alcohol producers (type 1 and type 2).[7] The Authority also changed the production levies charged based on the type of producer, increased the maximum annual production limit (i.e., how much a craft alcohol producer can produce and still be considered a locally-manufactured craft alcohol producer), and reduced the minimum annual production limits. We found this communication timely and easy to understand.

[5] The Authority updated the *Commercial Liquor Permittee Policy Manual* in January 2021 to include changes for craft type 1 and type 2 producers. In addition, the Authority is in the process of drafting a manual specific to alcohol manufacturers it regulates (currently a section in the *Commercial Liquor Permittee Policy Manual*).

[6] The Authority considers production levels that exceed that in **Figure 5** to be a regional or national manufacturer (e.g., Molsons). Regional and national manufacturers cannot distribute products directly to retailers and consumers like craft alcohol producers can. These manufacturers must apply to, and obtain approval from, the Authority to distribute their products through the Authority's distribution warehouse or an approved third-party warehouse. The Authority regulates national and regional alcohol manufacturers who produce alcohol in Saskatchewan; there is one permitted regional alcohol manufacturer at November 30, 2021. For example, a regional manufacturer is a brewery producing 3,000,001 to 40,000,000 litres of beer per year and a national manufacturer is a brewery exceeding 40,000,000 litres per year.

[7] Type 1 producers ferment 100% of their product on-site. Type 2 producers ferment less than 100% and source the remaining alcohol content from another manufacturer.

Having consistent and understandable publicly-available regulatory requirements for craft alcohol producers allows the Authority to be transparent in its requirements. This increases the ability for craft alcohol producers to follow the Authority's requirements, as well as potential applicants to understand the permit application process and requirements they will have to meet if they are successful in obtaining a permit.

4.2 Adequately Confirming Applicants Meet Requirements

The Saskatchewan Liquor and Gaming Authority effectively confirms applicants for craft alcohol production permits meet established requirements.

The Authority uses its *Commercial Liquor Permittee Policy Manual* application requirements as guidance to staff on what information the Authority requires applicants to submit with their application. See **Figure 6** for a summary of the Authority's craft alcohol producer permit approval process.

Figure 6—Craft Alcohol Producer Permit Approval Process

- **Receipt of permit application:** Licensing Specialist reviews application for completeness to ensure the applicant submitted all required documentation. Where an applicant fails to provide key information (e.g., criminal record checks for all shareholders, floor plan of proposed establishment approved by engineer that it meets building-code requirements), staff follow up with the applicant by phone or email.
- **Site inspection before production begins:** Inspector performs pre-permit inspection of business location verifying facility set-up meets operating requirements (e.g., equipment located as per floor plan, proper storage of ingredients).
- **Initial permit approved** in accordance with delegation of authority and issued to applicant to allow the production of craft alcohol.
- **Review of quality assurance reporting (i.e., lab test reports)** to determine whether craft alcohol products are safe for consumption.
- **Full permit approved** in accordance with delegation of authority and issued to applicant to allow the sale of craft alcohol produced (issued once quality assurance requirements met).

Source: Adapted from the *Commercial Liquor Permittee Policy Manual*.

The Authority set its craft alcohol permit operating requirements (e.g., approved to sell craft alcohol onsite and online for delivery, which product lines the producer has been approved to sell) based on *The Alcohol Control Regulations, 2016.* We also found these operating requirements consistent with good practice.

Once Liquor Licensing and Inspection Services Branch staff check that an applicant met all requirements, its IT system automatically generates an approval letter and permit based on applicant information. Having system-generated permits creates consistent permits. Permits expire every three years.

Our testing of eight craft alcohol producer permits (out of 16 total new craft alcohol producer permits issued between December 1, 2020 and November 30, 2021) found:

- All applicants provided up-to-date criminal record checks for shareholders who had greater than a 20% share.
- All applicants met the requirements for notifying the public of proposed new craft alcohol producers (i.e., advertising the proposed new business at least one day per week for two consecutive weeks) and no public objections received.

- All applicants provided a building inspection report and city/municipality approval for the business.
- All applicants paid the required application fee.
- Branch inspectors performed pre-permit inspections of the producer's premises with no concerning inspection findings (e.g., black mould).
- The Branch issued manufacturing permits, approved in accordance with the delegation of authority that contained permit conditions requiring applicants to submit required quality assurance reporting.
- All applicants submitted the required quality assurance reporting (lab test reports) for their first five unique products (e.g., for a craft beer producer, the producer submitted lab test reports for its first five unique beers). These lab test reports confirm the product's safety and reliability of craft alcohol content.
- The Branch issued full permits, approved in accordance with the delegation of authority that contained permit operating conditions consistent with good practice and legislation.

Our testing of producer permits also found Branch staff often wait on applicants to submit missing information. In some instances, a significant delay (e.g., two years) between when Branch staff received the initial application and issued the permit approval occurred because applicants were untimely in submitting missing information. As such, the Authority has not set a service standard for how timely staff must approve craft alcohol producer permit applications. Overall, we found the Authority conducted timely reviews of complete applications.

Having adequate processes to review and approve craft alcohol producer applications helps ensure the Authority only allows eligible producers to manufacture and sell craft alcohol in the province.

4.3 Permit Renewals Untimely

The Saskatchewan Liquor and Gaming Authority did not always send timely renewal reminders to craft alcohol permit holders, resulting in alcohol production without valid permits.

Craft alcohol producer permits expire after three years.

The Branch staff's process is to send renewal reminder letters to active permit holders one month (i.e., 30 days) in advance of the permit expiry date. Staff rely on the Saskatchewan Liquor and Gaming Authority's IT system to inform them when a renewal is coming due.

An error with the IT system, noticed by Authority staff in October 2021, resulted in the system not notifying staff when permit renewals were coming due. As a result, Branch staff did not send timely permit renewal letters from December 2020 to October 2021. The Authority resolved the issue with its IT system in November 2021.

Our testing of 10 permit renewals found the Authority did not issue nine renewal letters at least one month in advance of permit expiry, rather it sent these renewal letters three to 14 days before expiry.

Since Branch staff had not issued timely renewal reminders, our testing of 10 permit renewals (out of 12 total permit renewals between December 1, 2020 and November 30, 2021) found four instances where craft alcohol producers operated between three to 41 days without a valid permit. We also found that two of these producers without valid permits had produced at least some craft alcohol during this time.

The Authority's legislation does not allow craft alcohol producers to produce alcohol without a valid permit.[8]

The Branch's current process is to send renewal letters 30 days in advance of permit expiry. Our analysis of the 10 permit renewals tested found that it took, on average, 42 days from when Branch staff sent the renewal letter to when Branch staff issued an approved permit renewal. Therefore, the Branch should also consider sending permit renewal reminders more than 30 days prior to permit expiry.

While permit renewals were not always timely, we found renewed permits (once issued) contained permit conditions consistent with the Authority's regulations.

By not sending out timely permit renewal letters, there is an increased risk of craft alcohol producers forgetting to renew or not renewing their permit prior to expiry. This increases the risk of craft alcohol producers operating for an extended period without a valid craft alcohol permit, as required by legislation.

1. **We recommend the Saskatchewan Liquor and Gaming Authority renew locally-manufactured craft alcohol producer permits prior to expiry as required by *The Alcohol and Gaming Regulation Act, 1997*.**

4.4 Inspectors Qualified in Enforcement

Saskatchewan Liquor and Gaming Authority staff responsible for assessing whether applicants meet permit conditions and approved craft alcohol producers follow operating requirements have robust regulatory enforcement experience, but lack alcohol manufacturing expertise. Rather, the Authority relies on independent quality assurance processes to confirm reliability of craft alcohol content and safety.

The Liquor Licensing and Inspection Services Branch employed 22 staff at November 2021. The positions included one director, three managers, seven licensing specialists, one policy analyst, and 10 liquor inspectors. Branch staff are located in both Regina and Saskatoon.

The Authority appropriately uses job descriptions to set out expected educational and experience requirements for its staff. The Authority requires liquor inspectors to have a

[8] *The Alcohol and Gaming Regulation Act, 1997*, s. 92.

background in law enforcement or a regulatory environment. Law enforcement experience gives them the skills to effectively:

- Inspect whether producers comply with operating requirements
- Investigate complaints received

While we found all 10 liquor inspectors had significant experience in law enforcement or a regulatory environment, none of the inspectors had expertise in alcohol or food-related manufacturing. Having expertise of alcohol manufacturing processes would improve inspectors' abilities to identify whether producers manufacture alcohol inconsistent with good practice. The Authority provided some training to inspectors around the processes to manufacture alcohol in February 2021. For example, training topics included distilling and brewing, equipment used to manufacture alcohol, and packaging processes. Also, the use of a robust inspection checklist that considers all alcohol manufacturing-specific risks would assist inspectors in completing sufficient inspections (see **Section 4.6**).

The Authority does not rely on inspectors to perform craft alcohol quality reviews. Instead, it relies on its quality assurance process (i.e., independent laboratory certificates of analysis) to determine whether craft alcohol produced meets safety requirements.[9] See **Section 4.7** for more information about the Authority's quality assurance processes.

Having suitably trained staff to carry out inspections helps ensure these activities identify issues with alcohol manufacturing processes that may exist and helps protect the public.

4.5 Risk-Informed Inspection Plan Needed as Inspections Not Regularly Occurring

At November 2021, the Saskatchewan Liquor and Gaming Authority was not performing regular inspections of craft alcohol producers and had not developed a risk-informed inspection plan for craft alcohol producers.

The Authority performs ongoing inspections (after permits issued) on an ad hoc basis and relies on complaints (see the Authority's processes to investigate complaints in **Section 4.9**) as its means of monitoring whether craft alcohol producers follow established operating requirements (i.e., legislation, requirements in the *Commercial Liquor Permittee Policy Manual*). It assigns inspectors to certain craft alcohol producers in the province.

Branch inspectors perform a pre-permit inspection of the producer's premises before issuing a permit. There were 71 craft alcohol producer permits at March 31, 2021. For the 12-month period ended November 30, 2021, inspectors performed 10 inspections and 24 pre-permit inspections.

Once craft alcohol producers received an approved permit, the Authority did not always regularly inspect them. Our analysis found the average time between inspections was almost 12 months. We also found the Authority had not inspected 19 craft alcohol

[9] Craft alcohol producers send samples of their products to an approved laboratory (e.g., Liquor Control Board of Ontario) that analyzes the chemical composition and alcohol by volume. The laboratory report provided to the Authority is known as a certificate of analysis.

producers since their pre-permit inspection (almost 30% of permitted producers), with the longest time without an inspection being 36 months.

The Authority's IT system does not have the ability to run a report for management to review whether inspections occur as frequently as they should.

The Authority has not set an expectation for how often inspectors should periodically inspect craft alcohol producers. A risk-based inspection plan would help management determine when to inspect producers and when to follow up with inspectors who do not conduct timely inspections.

Having an inspection plan that states the required frequency of craft alcohol producer inspections will help reduce the risk of non-compliance going unnoticed for an extended period. It is good practice to develop inspection plans based on risk. Such plans use risks (e.g., non-compliance) to determine the nature and extent (frequency) of inspections.

Having a written risk-informed inspection plan would help the Authority allocate its resources to the highest priority areas, which is important as inspectors are also responsible for inspecting all commercial liquor permittees including craft alcohol producers.

2. **We recommend the Saskatchewan Liquor and Gaming Authority implement a risk-informed plan for inspecting locally-manufactured craft alcohol producers.**

4.6 Inspection Checklists Missing Key Alcohol Manufacturing Risks

Saskatchewan Liquor and Gaming Authority inspectors use checklists to guide craft alcohol inspections, but these checklists do not contain all key risk areas specific to manufacturing craft alcohol.

Up to October 2021, inspectors used a licensed-establishment inspection report (i.e., a checklist to document all types of liquor establishment inspections including restaurants and taverns) for documenting inspection findings. The checklist portion of this report focused on areas more specific to restaurants and taverns such as overserving customers, minors present, and whether the licensed establishment complies with requirements when hosting video lottery terminals (e.g., signage, records).

While serving customers or minors may be applicable to craft alcohol producers, these are not significant risks associated with manufacturing alcohol. Instead, the craft alcohol inspection checklist should focus on the unique risks associated with manufacturing. In October 2021, management drafted a new inspection checklist for craft alcohol producers; however, we did not see evidence of staff using this checklist between October and November 30, 2021. The new inspection checklist considers more risks associated with manufacturing, but still is not a complete listing of all manufacturing risks (see **Figure 7**).

Also, the old licensed-establishment inspection report did not require staff to consider whether craft producers complied with important Authority operating requirements such as:

- The Authority's quality assurance policy for craft producers (discussed further in **Section 4.7**)
- Maintaining adequate records of alcohol production information (e.g., amounts produced, sold, destroyed)
- Complying with Federal Government traceability requirements (e.g., recording product batch information on products such as to enable a product recall, if necessary)[10]

The new inspection checklist includes these operating requirements.

Figure 7—Craft Alcohol Manufacturing Risks, Related Consequences, and whether New Manufacturing Inspection Checklist Addresses each Risk

Manufacturing Risk	Consequence	Risk Addressed in New Manufacturing Inspection Checklist
Methanol not properly removed during distillation process (e.g., during the production of spirits)	Illness, blindness, or fatality if excessive methanol is ingested, inhaled, or absorbed through the skin (severe illness or worse can be caused by as little as 30 millilitres or 2 tablespoons)	Yes: requires inspector to check whether producer documented accurate product formulas (this would address how much product from each distillation phase to keep or discard)
Not listing allergens (e.g., oats, sulphites, gluten) on product label	Allergic reaction	Yes: requires inspector to check labelling requirements
Not using food-grade chemicals to clean manufacturing equipment	Illness	**No**
Not properly measuring and recording alcohol content	Excessive intoxication, or over charging when alcohol content is less than stated	Yes: requires inspector to confirm the producer has processes to determine and verify alcohol content, determine deviations, and calibrate equipment to test alcohol content
Continued fermentation if container is improperly sealed[A]	Injury to consumer if can/bottle bursts	**No**
Damage to glass bottles during bottling	Risk of consuming broken glass	**No**

Source: Manufacturing risks and consequences adapted from understanding of industry good practices.
[A] For example, in 2016, the Ontario alcohol regulator ordered a recall of certain craft alcohol in cans due to some cans bursting due to excessive internal pressure. torontosun.com/2016/11/08/concerns-over-bursting-beer-cans-prompt-lcbo-recall (17 February 2022).

In addition to adding further manufacturing risks, we identified the new manufacturing inspection checklist could be further improved by requiring inspectors to check compliance with certain Authority policies for craft alcohol. These could include checking whether craft alcohol producers obtain approval prior to purchasing bulk spirits, and meet requirements for collaboration manufacturing.[11,12]

[10] The Federal Government's traceability requirements are outlined in the *Safe Food for Canadians Regulations*, Part 5.
[11] The Authority requires craft producers to obtain its approval prior to purchasing each batch of bulk spirits from manufacturers outside the province. (*Commercial Permittee Liquor Policy Manual*, s.14.2(d)).
[12] Collaboration manufacturing is when two or more craft alcohol producers work together to create a product at a single production facility. The Authority requires the host manufacturer not only to always be present during production, but also to report the production in its monthly production reporting, and pay the production levy. *Collaboration Manufacturing by Saskatchewan Craft Alcohol Producers* policy, www.slga.com/liquor/for-craft-producers#Standalone Policies (1 June 2021).

Having inspection checklists that address all key risk areas associated with manufacturing alcohol, as well as address the Authority's policy requirements, would help Authority inspectors check whether craft alcohol producers comply with their permit operating requirements. These checks and balances also decrease the risk to public safety (e.g., consuming alcohol with a higher than labelled alcohol content).

3. **We recommend the Saskatchewan Liquor and Gaming Authority utilize a locally-manufactured craft alcohol inspection checklist addressing all key risks associated with alcohol manufacturing.**

4.7 Quality Assurance Processes Adequate, But Not Always Followed

The Saskatchewan Liquor and Gaming Authority requires craft alcohol producers to submit laboratory reports verifying products are safe for consumption, but does not follow up with producers who are delinquent in submitting required reporting every two years.

In **Section 4.2**, we describe that we found the Authority appropriately received the required quality assurance reports (certificates of analysis) prior to issuing a craft alcohol producer a permit to allow it to initially sell alcohol products to consumers.

We found the Authority had not been following up with producers who did not submit certificates of analysis. The Authority's quality assurance policy requires craft alcohol producers to submit certificates of analysis (lab test reports) for a minimum of one active product from each alcohol product line every two years.[13] For example, if the Authority permits a craft producer to produce craft beer and craft spirits, it would be required to submit updated lab reports for at least one beer and one spirit every two years. We found that the Authority is one of the few regulatory bodies across Canada that requires craft alcohol producers to submit certificates of analysis on an ongoing basis.

Authority staff maintain a listing of craft alcohol producers and due dates for required certificates of analysis. At November 5, 2021, we found over half of the permitted product lines on its tracking sheet (43 out of 83 product lines) required certificates; craft alcohol producers had not submitted these by the deadline, and the Authority had not followed up. Some of these craft alcohol producers had not provided certificates of analysis to the Authority for more than nine months past the deadline.

By not following up on overdue certificate of analysis renewals, there is an increased risk of craft alcohol producers producing alcohol that is not at advertised alcohol content or does not meet quality assurance standards. This increases the risk of an adverse impact on human health (i.e., illness, overconsumption). Also, following up on outstanding reports helps the Authority and craft alcohol producers confirm equipment is measuring alcohol content accurately.

4. **We recommend the Saskatchewan Liquor and Gaming Authority obtain certificates of analysis from locally-manufactured craft alcohol producers every two years as required by its quality assurance policy.**

[13] *Beverage Alcohol Quality Assurance Policy for Direct Distribution by Craft Producers*, www.slga.com/liquor/for-craft-producers#Standalone%20Policies (1 June 2021).

4.8 Adequately Documented Processes to Address Identified Non-Compliance

The Saskatchewan Liquor and Gaming Authority has adequately documented processes for when Liquor Licensing and Inspection Services Branch staff identify non-compliance by craft alcohol producers.

When inspectors identify non-compliance by a craft alcohol producer (via inspection or because of a complaint received), the Authority requires them to inform the producer of the identified non-compliance immediately. Inspectors do not determine corrective action on non-compliance. Instead, they inform their manager of the identified non-compliance, who makes a decision on whether the matter warrants enforcement action, such as a warning letter or other sanctions (e.g., administrative penalty [i.e., fines], suspension or cancellation of permit).[14] We found the Authority's policies on enforcement action consistent with the Authority's legislation.

If management determines the non-compliance requires enforcement action, the Authority established how timely it must inform producers and has an appropriate documented process to help ensure consistency in treatment. Inspectors must inform craft alcohol producers of the escalated enforcement action within 30 days of the identified non-compliance.

While the Authority does not have a template for staff to use when drafting correspondence for more severe forms of enforcement action, it uses only one person to draft this correspondence (i.e., Director, Liquor Licensing and Inspection Services Branch or Vice President, Regulatory Services Division depending on the type of enforcement action) to help ensure appropriate and consistent action. Therefore, senior management is aware of any severe instances of non-compliance and related enforcement action through this process.

For the 12-months ended November 30, 2020, inspectors performed nine inspections and 45 investigations (i.e., an assessment of a complaint received), while for the 12-months ended November 30, 2021, inspectors performed 10 inspections and 23 investigations. There were no instances where management took enforcement action (e.g., administrative penalty, cancellation or suspension of permit) during the 12-months ended November 30, 2021. We examined four inspections and four investigations and found none warranted enforcement action.

See **Figure 8** for the Authority's enforcement action over the past four years.

Figure 8—Craft Alcohol Enforcement Actions

	2017–18	2018–19	2019–20	2020–21
Educational guidance	2	7	4	0
Warnings	1	1	0	0
Sanctions[A]	2	5	2	1
Total	**5**	**13**	**6**	**1**

Source: Saskatchewan Liquor and Gaming Authority records for the fiscal year-ended March 31.
[A] Sanctions include both administrative penalties (i.e., fines) and permit suspension or cancellation.

[14] Administrative penalties are set in *The Alcohol Control Regulations, 2016*, Table 5. Penalties range from $500 to $10,000.

Quarterly, the Authority posts liquor permittees' instances of non-compliance (including craft alcohol producers) on its website. We found the information on its website sufficient for the public to understand the violation and to which permittee the non-compliance related.

By having a formalized process for taking effective, timely enforcement action, the Authority reduces the risk of craft alcohol producers continuing to not comply with the Authority's operating requirements. This also reduces the risk to public safety (e.g., consuming unsafe alcohol).

4.9 Timely and Adequate Complaint Resolution

Saskatchewan Liquor and Gaming Authority inspectors sufficiently resolve complaints received.

The Authority's IT system tracks all complaints received by the Liquor Licensing and Inspection Services Branch. When the Branch receives a complaint (e.g., producer operating in an unlicensed location), management reviews the complaint to determine whether it has merit. If a complaint has merit, management assigns an inspector to investigate the complaint further.

The Authority received 15 complaints during the 12-months ended November 30, 2021.

While the Authority has not set a formal expectation for how timely staff should resolve complaints received, our testing of four investigations of complaints received found staff conducted timely follow-up (e.g., within two days of receiving the complaint). Establishing a formal timeframe expectation would promote a consistent approach to complaint resolution amongst staff.

For each of the four complaints tested, staff contacted the craft alcohol producer and conducted an investigation. We found staff sufficiently investigated and documented the resolution of the complaints in the IT system.

Adequately resolving complaints received and reported by the public about craft alcohol producers enables the Authority to monitor and address situations that may identify producers not complying with operating or manufacturing requirements.

4.10 Analysis of Monthly Reported Craft Alcohol Sales Needed

The Saskatchewan Liquor and Gaming Authority does not assess the reasonability of alcohol production and sales information submitted by craft alcohol producers before billing for production levies.[15]

Craft alcohol producers pay the Authority a production levy on craft alcohol sold directly to consumers or retailers. Monthly, craft alcohol producers submit production and sales reporting to the Authority. The Authority uses this reported sales volume to determine how much production levy each craft alcohol producer must remit.

[15] The Authority charges craft alcohol producers a production levy (fee per litre sold) based on the type of alcohol produced (e.g., beer, wine, cider) and based on the type of producer (i.e., type 1 or type 2).

Production levy rates are lower than the markup that applies if craft producers sell craft products to the Authority (i.e., if the Authority's warehouse distributes craft products). For example, the production levy on the first 50,000 litres of spirits is up to $0.70 per litre of product versus the markup being 73% of the product's purchase price. See **Figure 9** for the production levies the Authority collected in each of the last five years.

Figure 9—Production Levies 2016–2021 (thousands of dollars)

2016–17	2017–18	2018–19	2019–20	2020–21
$369	$452	$767	$1,301	$2,902

Source: Saskatchewan Liquor and Gaming Authority records.

The Authority sets out its requirement for craft alcohol producers to report monthly production and sales information in its *Commercial Liquor Permittee Policy Manual*. The Authority expects producers to submit reporting on year-to-date production, direct sales, and returned products. Once received, Authority staff determine craft alcohol producers' production levy based on this information.

We found the Authority did not have evidence of staff following its process to assess the reasonability of production and sales information submitted by craft alcohol producers. This information drives the production levy the Authority charges producers, thus producers may have a bias to underreport sales.

We expected the Authority would formally review the reported data to assess for reasonability and follow up when it identified situations that may suggest risk of errors in the information reported. For example, significant changes in production or sales levels, and differences between opening inventory of one month and closing inventory of the prior month.

We analyzed producers' monthly reported information for the audit period by comparing opening inventory of one month to closing inventory of the prior month and recalculating production levies charged by the Authority. We found:

- The Authority charged the correct production levy rate based on the craft alcohol type the producer manufactures.
- The Authority calculated the production levy correctly (i.e., levy rate multiplied by litres of total sales).
- For 33 instances out of 594 items where opening inventory of one month did not agree with closing inventory of the prior month, we found no evidence of the Authority obtaining explanations for the differences from the producers. We consider these records to be at a higher risk of containing errors in reported amounts, and thus an incorrect production levy charged. Differences ranged from opening inventory being less than expected by more than 11,000 litres to being higher than expected by over 35,000 litres.

In 2021, the Authority's Internal Audit Branch completed an audit of a craft alcohol producer to assess whether the producer kept adequate records to support the annual production and sales information, and whether the Authority assessed an appropriate production levy

for 2019. Using financial information, invoices, inventory records, and sales records from the craft alcohol producer, the Authority determined the producer underreported its 2019 sales by about 2,000 litres, or about 2.6% of its annual 2019 total. This resulted in the Authority charging about $5,000 less production levy for 2019 than it should have.

By having ineffective processes to assess producer-prepared production and sales information, the Authority is at risk of receiving inaccurate production levies.

5. We recommend the Saskatchewan Liquor and Gaming Authority perform reasonability assessments of locally-manufactured craft alcohol producers' monthly sales and production reporting to help ensure collection of all production levies.

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Chapter 7
Saskatchewan Workers' Compensation Board—Administering Psychological Injury Claims

1.0 Main Points

The Saskatchewan Workers' Compensation Board (WCB) is responsible for administering workers' compensation claims in Saskatchewan, including psychological injury claims. Psychological injuries are often complex, generally more difficult to administer as a claim, and require more judgment than some other injuries (e.g., broken bone). WCB typically administers over 500 of these claims each year.

WCB revised its processes for administering compensation for psychological injuries due to changes in 2016 to *The Workers' Compensation Act, 2013,* that provides explicit rules for compensation for psychological injuries; these processes continue to evolve.

At December 31, 2021, WCB had effective processes, except in the following areas, to administer compensation claims for psychological injury. It needs to:

- Meet its target timeframe (i.e., within 14 business days) for assessing and communicating decision outcomes of psychological injury claim assessments. We found 17 of 30 claims we tested did not meet the target, and late claim decisions took between 15 and 43 business days to communicate. This may create delays for injured workers in receiving benefits and treatment.

- Regularly communicate with psychological injury claimants consistent with its expectations (i.e., check in every three weeks), to decrease the risk of WCB not adjusting workers' treatment plans if they are not progressing as expected.

- Establish formal guidance for what key information its Appeals Department requires to administer appeals and to communicate rationale of appeal outcomes. Lack of formal guidance increases the risk for unnecessary information requests or files containing insufficient information. This may result in delayed or unsupported appeal decisions, as well as further appeals occurring without documented decision rationale.

- Establish formal guidance for what information in psychological injury claim files WCB releases to employers during appeals. Staff having guidance on what claim file information to provide to employers decreases the risk of releasing confidential worker information. It also provides consistency in the instance of staff turnover.

- Conduct continuous quality reviews on psychological injury claim and appeal files.

Effective processes to administer psychological injury claims minimize delays in taking necessary steps for injured workers to receive appropriate support they need to improve their mental health, and return to work.

2.0 INTRODUCTION

The Saskatchewan Workers' Compensation Board (WCB) operates under the authority of *The Workers' Compensation Act, 2013*.

Section 20 of the Act provides WCB the exclusive jurisdiction to examine, hear, and determine whether an injury caused any condition or death with respect to compensation claimed, whether the injury arose from the course of employment, and the degree of functional impairment to a worker resulting from the injury. WCB is also responsible for determining and managing compensation provided to workers (e.g., employees unable to work due to injury) for accepted claims.

WCB protects registered employers from lawsuits when a workplace injury happens. It provides guaranteed benefits and programs to injured workers from different industries (e.g., healthcare, hospitality, transportation) as covered by the Act.

WCB uses premiums paid by employers in covered industries to fund costs of workers' compensation benefits and programs. It bases premiums on multiple factors such as claim costs, experience rating, and employer payroll.

The Workers' Compensation Act, 2013, section 28.1(1), describes a psychological injury as an injury (i.e., a diagnosable disorder), including post-traumatic stress disorder, as described in the Diagnostic and Statistical Manual of Mental Disorders.[1] Other psychological injury attributes can include anxiety, acute trauma, mood disorder, and depression.

We audited WCB's processes to administer compensation claims for psychological injury for the 12-months ended December 31, 2021.

2.1 Psychological Injury Claims

As shown in **Figure 1**, in 2021, for all types of injury claims received, less than 3% related to claims for psychological injuries; however, this proportion increased from 1.3% in 2016 when WCB made changes to its legislation.[2] In 2021, WCB accepted about 41% of claims for psychological injury compensation as compared to 28% in 2016.

In addition, as shown in **Figure 1**, although the duration of psychological injury claims are longer than for other types of injuries, the average claim cost is less.

[1] dsm.psychiatryonline.org/doi/book/10.1176/appi.books.9780890425596 (28 April 2021). The American Psychiatric Association publishes the Diagnostic and Statistical Manual of Mental Disorders (DSM) for the classification of mental disorders using a common language and standard criteria. The Manual does not include guidelines for treatment of any disorder, but rather provides criteria which guides in the assessment of and diagnosis for a psychological injury.

[2] Since 2016, WCB's legislation provides explicit rules for psychological injury compensation.

Figure 1—Saskatchewan WCB Claim Statistics

	2021	2020	2019	2018	2017	2016
Number of Workers Insured by WCB[A]	392,813	402,306	433,622	410,600	423,527	420,279
Total Claim Costs (in millions)	$336.2	$319.6	$281.0	$278.2	$230.2	$286.8
Total Number of all Claim Types Received by WCB	25,751	23,746	28,865	29,140	28,952	29,953
Average Duration in Days for All Claims[B]	40	45	42	42	40	43
Average Claim Costs for all Claims	**$18,802**	**$17,833**	**$13,100**	**$12,451**	**$10,355**	**$12,291**
Number of Psychological Injury Claims Received by WCB[C]	578	613	744	537	467	395
% of Psychological Injury Claims to All Types of Claims Received	2.2%	2.6%	2.6%	1.8%	1.6%	1.3%
Number of Psychological Injury Claims Accepted[C]	238	274	307	264	174	109
% of Psychological Injury Claims Accepted	41.2%	44.7%	41.2%	49.2%	37.3%	27.6%
Average Duration in Days for Psychological Injury Claims[B,C]	61	65	65	74	78	76
Average Claim Costs for Psychological Injury Claims[C]	**$15,667**	**$14,600**	**$11,999**	**$12,045**	**$9,242**	**$8,129**

Source: Saskatchewan Workers' Compensation Board 2021 records and 2020 Annual Report, pp. 8 and 54.
[A] Full-time equivalent (FTE) workers based on Statistics Canada average wage and WCB payroll information as of December 31. Does not include workers for self-insured employers.
[B] Total days of time loss divided by the number of claims during the year.
[C] From Saskatchewan Workers' Compensation Board records.

2.2 Importance of Mental Health

Good psychological health (mental health) is crucial to achieving overall health and well-being. The work environment can significantly affect mental health. Given an average Canadian worker spends 30 to 40 hours per week at work, it is important to maintain a psychologically healthy and safe workplace.[3]

Psychological illnesses are the number one cause of disability in Canada. It is estimated these illnesses cost the Canadian economy $51 billion per year, $20 billion of which results from work-related causes. Forty-seven percent of working Canadians consider work to be the most stressful part of daily life with mental health issues affecting mid-career workers the most, lowering the productivity of the Canadian workforce.[4] Poor mental health directly affects workers' well-being, their colleagues, and their families. Left unmanaged, poor workplace mental health can lead to increased absenteeism, workplace conflict, high turnover, low productivity, and increased use of disability and health benefits.

The longer an injury claim lasts, the higher the total compensation paid, which may result in higher premiums paid by employers. The longer workers are away from work with an injury, the less likely they are to return to employment. After one year of absence, only 20% of workers return to work.[5]

[3] Canadian Centre for Occupational Health and Safety. Mental Health. (2016). www.canada.ca/en/employment-social-development /services/health-safety/reports/psychological-health.html (21 March 2022).
[4] Ibid.
[5] The Canadian Society of Professionals in Disability Management, *Impact of Disability*, www.cspdm.ca/dm-in-context/impact-of-disability/ (21 September 2021).

Psychological injuries continue to rise in Saskatchewan with the highest number of psychological injuries occurring among first responders, and corrections and healthcare workers.[6] WCB revised its processes for administering compensation for psychological injuries due to changes in 2016 to *The Workers' Compensation Act, 2013,* that provides explicit rules for compensation for psychological injuries (further described in **Section 4.1**); therefore, these processes are relatively new. The number of submitted psychological injury claims and their average cost has increased since 2016.

Effective processes to administer psychological injury claims minimizes delays in taking necessary steps for injured workers to receive appropriate support they need to improve their mental health, and return to work.

3.0 AUDIT CONCLUSION

We concluded, for the 12-month period ended December 31, 2021, the Saskatchewan Workers' Compensation Board had effective processes, except in the following areas, to administer compensation claims for psychological injury.

WCB needs to:

- **Establish formal guidance for key information required for appeals; for communicating rationale for the Appeals Department's appeal outcomes; and for what claim file information to release to employers during appeals**
- **Regularly communicate with psychological injury claimants consistent with its expectations**
- **Meet its target timeframe for assessing and communicating outcomes of psychological injury claim decisions**
- **Conduct continuous quality reviews on psychological injury claim and appeal files**

Figure 2—Audit Objective, Criteria, and Approach

Audit Objective: Assess the effectiveness of the Saskatchewan Workers' Compensation Board's processes, for the 12-month period ending December 31, 2021, to administer compensation claims for psychological injury.

The audit did not examine the Board Appeal Tribunal's process to review appeals, and the medical review panel process. The audit did not question medical opinions of mental health providers about claims for psychological injury.

Audit Criteria:

Processes to:

1. **Establish psychological injury claim and appeal requirements consistent with legislation and good practice**
   - Set policies and procedures for administering claims and appeals (e.g., injury information from worker and employer, medical information)
   - Set performance measures and targets for administering claims and appeals
   - Communicate requirements about submitting claims and making appeals (e.g., eligibility, expected forms, and information) to stakeholders (e.g., workers, employers, medical practitioners)

[6] *Saskatchewan Workers' Compensation Board Annual Report for 2020*, p. 54.

2. **Assess psychological injury claim and appeal eligibility**
   - Use qualified personnel to assess eligibility of submitted claims or appeals (e.g., claims staff, mental health providers who provide medical information)
   - Obtain required information to support claims and appeals (e.g., report of injury, mental health assessment)
   - Screen eligibility (e.g., verify applicant information, assess applications meet established requirements, review and approval of outcome, update file with outcome)
   - Notify key stakeholders of assessment outcome and rationale timely (e.g., compensation benefits)
   - Periodically assess compensation benefits (e.g., adjust, extend)
   - Monitor adherence with expected processes (e.g., file reviews, quality control, internal audit work)
3. **Monitor performance of claim administration processes**
   - Analyze key performance information (e.g., measures and targets, trends, results of quality assurance, stakeholder feedback [e.g., complaints])
   - Adjust requirements as necessary
   - Periodically report key psychological injury claims information to senior management, the Board, and the public

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate WCB's processes, we used the above criteria based on our related work, reviews of literature including reports of other auditors, and consultations with management and an external advisor. WCB management agreed with the above criteria.

We examined WCB's criteria, policies, and procedures relating to administering compensation claims for psychological injury. We interviewed key staff. We tested a sample of claims files, including appeals to WCB's Appeals Department, to assess whether staff followed WCB's established processes. We also used an independent consultant with subject matter expertise in the area to help us identify good practice and assess WCB processes.

4.0 Key Findings and Recommendations

4.1 Psychological Injury Claim Requirements Consistent with Good Practice

The Saskatchewan Workers' Compensation Board set claim requirements consistent with good practice, and consistent with other jurisdictions.

Since 2016, *The Workers' Compensation Act, 2013* provides explicit rules for compensation for psychological injuries. For claims compensating for psychological injuries, the Act includes a rebuttable presumption that, unless proven otherwise, if a worker or former worker is diagnosed with a psychological injury, that injury is presumed to be an injury that arose out of and in the course of the worker's employment.[7,8]

Figure 3 shows the criteria WCB utilizes when assessing whether to accept a claim for compensation for a psychological injury.

Figure 3—WCB Psychological Injury Policy Requirements

A **psychological injury** is presumed to be an injury that arose out of and in the course of the worker's employment when all of the following criteria are met:

- The worker is, or the former worker was, exposed to a traumatic event
- The traumatic event arose out of and in the course of employment
- The traumatic event caused the worker or former worker to suffer a psychological disorder diagnosed in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- The psychological disorder is diagnosed by a psychologist or psychiatrist licensed to practice and make diagnoses

[7] A rebuttable presumption is an assertion that is taken to be true unless it can be proven otherwise.
[8] *The Workers' Compensation Act, 2013*, s.28.1(2).

A **traumatic event** means a single or series of events or incidents that arose out of and in the course of employment that may result in a psychological injury. This includes, but is not limited to:

- Direct exposure to actual or threatened death or serious injury to worker and/or others
- An event or series of events that are specific or sudden and generally accepted from a public perspective as being unusually shocking or horrific
- Workload or work-related interpersonal incidents that are excessive and unusual in comparison to pressures and tensions experienced in normal employment. These must be beyond the normal scope of maintaining employment from a public perspective

Source: Saskatchewan Workers' Compensation Board, *Injuries—Psychological (POL 02/2017)*.

We found the requirements above consistent with good practice. For example, WCB's definition of a traumatic event is consistent with the definition in literature from the American Psychiatric Association.

WCB's psychological injury criteria were generally consistent with other Canadian jurisdictions that also have a rebuttable presumption about psychological injuries. For example, all jurisdictions had set the qualifications needed for a professional to make a diagnosis, and required the traumatic event to be an identifiable event that occurred to the worker. All jurisdictions require the diagnosis be made using the Diagnostic and Statistical Manual of Mental Disorders.

We found at least nine jurisdictions have a rebuttable presumption for psychological injuries in legislation (see **Figure 4**). Similar to Saskatchewan, most jurisdictions stated the presumption generally in the legislation, and then provided detail in policies available to stakeholders. Regardless of where the detailed requirements are provided, psychological injury claims in each jurisdiction are adjudicated on their own merits, using the adjudicative principles set out in their respective policy manuals.[9]

Figure 4—Canadian Jurisdictions with a Rebuttable Presumption for Psychological Injury at June 2018

Application of the Presumption		Jurisdiction									
		BC	AB	AB[B]	SK	MB	ON	NB	NS	PEI	YK
Disease	Psychological injury	✔	✔		✔					✔	
	Post-traumatic stress disorder[A]			✔		✔	✔	✔	✔		✔
Occupation	All workers		✔		✔	✔				✔	
	First responders	✔		✔			✔	✔	✔		✔

Source: www.mun.ca/safetynet/projects/PTSD_Presumptive_Coverage.pdf (17 March 2022).
[A] These jurisdictions' rebuttable presumption is specific to post-traumatic stress disorder, which is a type of psychological injury.
[B] Alberta has two presumptions, one specific to first responders, and another that covers all workers.

Setting clear requirements consistent with good practice is necessary to administer psychological injury claims effectively.

[9] www.mun.ca/safetynet/projects/PTSD_Presumptive_Coverage.pdf (17 March 2022).

4.2 Requirements for Compensation Claims and Appeals Clearly Communicated

The Saskatchewan Workers' Compensation Board sufficiently communicated to stakeholders (e.g., workers, employers, and mental health providers [e.g., psychologists]) the requirements necessary to apply for psychological injury compensation benefits and submit appeals.

WCB uses its website to communicate requirements for submitting injury compensation applications, appeal applications and other information (e.g., progress reporting) to stakeholders. The website also provides access to necessary forms and process documents. We found the website easy to navigate, providing clear and sufficient information about applying for compensation benefits as well as for appeals.

WCB requires information from key stakeholders to adjudicate a psychological injury claim. It uses standard reporting forms for these stakeholders to submit claim information.

Providing stakeholders with accessible, easy to understand information about WCB's requirements to apply for compensation benefits and appeals keeps them informed on how the process works and what information WCB requires from each stakeholder. It also guides stakeholders to provide complete information.

4.3 Qualified Staff Adjudicate Psychological Claims and Appeals

The Saskatchewan Workers' Compensation Board uses qualified staff and advisors to adjudicate claims and assess appeals. It also uses qualified mental health providers for treatment of workers with psychological injuries.

Psychology Consultant

WCB retains an in-house psychology consultant (e.g., psychologist) to provide advice on complex cases and instances where an injured worker's treatment is not achieving expected results. We found the consultant to be appropriately qualified and their contract consistent with good practice.

Psychological Claims Staff

WCB's Operations Division is responsible for handling claims and benefit payments for injuries. In 2019, WCB reorganized its staff in this Division to make one specific unit solely responsible for assessing and managing psychological injury claims—the Psychological Injuries Unit. At November 2021, the Psychological Injuries Unit had eight positions; one manager, five case managers called Customer Care Facilitators (three in Regina and two in Saskatoon), a dedicated case management support staff, and a dedicated payment specialist. Other staff within WCB support this Unit.

Case managers may consult with WCB's psychology consultant to help guide decisions and treatment of workers with psychological injuries.

WCB appropriately uses job descriptions to set out expected educational and experience requirements for its staff involved in adjudicating claims. It expects case managers to have a diploma with four years of related experience or a degree plus one-year experience in claims management.[10]

WCB also provides comprehensive training for new case managers and a training manual that includes topics such as how to adjudicate a psychological injury claim, how to request medical reports or missing information, and how to assist clients to transition when no longer eligible for benefits. Our review of training materials found them to be consistent with WCB's current practice for adjudicating claims.

Appeals Department Staff

The Appeals Department is responsible for reviewing claim appeal information, along with making, and communicating, appeal decisions. At November 2021, the Appeals Department consisted of 11 positions (one manager and 10 appeals officers).

No formal training program exists for new appeals officers. However, appeals officers need a university degree and experience working with case management (e.g., previously worked as a case manager), or a diploma with six years of experience. Appeals officers may also take optional classes in administrative justice such as interpreting legislation and writing effective decisions.

We found all job descriptions (claims and appeals) to be consistent with good practice. We tested a total of 10 psychological claims or appeals staff and found their experience and education aligned with the requirements of their job descriptions.

Having qualified and trained staff in place to adjudicate claims, monitor treatment, and assess appeals helps workers and employers receive fair and consistent claim and appeal decisions, and appropriate treatment.

Mental Health Providers

WCB has an adequate process to accredit mental health providers (check credentials). At December 2021, WCB had a list of 20 accredited psychologists on its website (psychologists who agree with having their names publicly available). We found all psychologists registered with the Saskatchewan College of Psychologists, except one psychologist who moved to another province, and therefore was not registered in Saskatchewan.

Mental health providers diagnose workers' injuries and provide treatment for psychological injuries.

4.4 Objective Staff Adjudicate Claims

The Saskatchewan Workers' Compensation Board has a process for its staff to declare any conflicts of interest when adjudicating psychological injury claims. This helps to make sure staff remain objective.

[10] Degree or diploma in healthcare or disability management.

WCB restricts staff access to claim files when a staff member declares a conflict of interest. Once the file is restricted, staff must log in and note their purpose for accessing the file. We found file access information available in an ad hoc report indicating who accessed the file, on what date, and for what purpose. In our 30 psychological injury claim files tested, we found no declared conflicts of interest.

Staff are also required to acknowledge their understanding of WCB's code of conduct (includes conflict of interest) annually. For two case managers and two appeals officers tested, we found one of four staff signed off on the code of conduct in the last year as expected. The other three staff had signed off within the last seven years. WCB also provided targeted code of ethics and professional conduct training to all staff in 2018, including the four staff we tested. We encourage WCB to ensure staff acknowledge the code of conduct annually as it expects.

Having objective staff adjudicating psychological claims reduces the risk of bias, either real or perceived.

4.5 Appropriate Policies and Procedures for Adjudicating Claims

The Saskatchewan Workers' Compensation Board maintains up-to-date, clear policies and procedures to guide the adjudication of psychological injury claims.

Sufficient WCB policies and procedures exist to guide staff in assessing and managing compensation files. WCB's *Policy and Procedure Manual,* last updated November 2021, includes all compensation and appeal policies, including for psychological injuries.[11] The psychological injury policy came into effect in December 2016. On average, WCB administers over 500 psychological injury claims per year.

WCB's policies and procedures for psychological injuries address the following key areas:

- Forms used to obtain information to assess a claim such as worker, employer and mental health providers' initial and ongoing reports
- Defined processes to guide staff in assessing and managing claim files, including assessment requirements, criteria, and expectations/timing of communication with key stakeholders (e.g., workers, employers)
- Escalation processes—defines processes for escalating complex claims (e.g., appeals)
- Guidelines to calculate compensation benefits including formulas and prior weeks of work
- Delegation of Authority (i.e., establishes authority for case managers to approve or reject claims)

In practice, WCB reasonably identifies psychological injury situations that are more complex and may require medical expert advice. For example, a complex situation may

[11] www.wcbsask.com/sites/default/files/2021-11/SK%20WCB%20Policy%20%26%20Procedure%20Manual%20-%20November%202021.pdf (22 December 2021).

include a situation when a worker has pre-existing mental health conditions and, as a result, WCB has difficulty determining whether a worker's employment directly led to a traumatic event as defined in policy. WCB's processes confirm the impact of pre-existing conditions by obtaining a mental health assessment for the worker from a mental health provider.[12]

WCB told us it could take a lengthy amount of time to obtain a mental health assessment. Case managers try to avoid requesting these assessments due to the intensity and stress it can cause a claimant (i.e., typically takes a day to complete and requires the injured worker to discuss the traumatic event). Therefore, if there is reasonable evidence a traumatic event occurred, the case manager will not request this assessment.

The case manager requested a mental health assessment for the worker for two of the 30 psychological injury claims tested. We did not identify any claims that we tested where there was evidence the case manager should have requested a mental health assessment, but did not (e.g., complex situations identified above).

No specific guidance exists for when staff are required to seek medical advice from WCB's psychology consultant when adjudicating psychological injury claims. In our testing of 30 psychological injury claim files, we did not see any situations where case managers sought medical advice from the psychology consultant during the claim adjudication. WCB staff indicated that due to time constraints, staff do not often seek additional medical advice. We suggest WCB consider creating guidance for case managers as to when to use its psychology consultant when administering claims.

In our testing of the 12 accepted psychological injury claims, we found one instance where a case manager used the psychology consultant in a case where the worker was not progressing as expected during treatment. The psychology consultant recommended a change in mental health provider.

4.6 Appropriate Standardized Injury Forms Used

In order to assess psychological injury claims, the Saskatchewan Workers' Compensation Board case managers require complete information from workers, employers, and mental health providers. We found forms used to collect information were reasonable.

WCB collects information from key stakeholders (e.g., worker, employer, mental health providers) using standardized forms. This includes information that staff need to initially assess and adjudicate the psychological injury claim (e.g., injury details, medical support). It also collects information to manage ongoing claims (e.g., progress reports). WCB has made these forms available on its website.

WCB received initial injury reports from the worker and employer for all claims. WCB received the other forms as needed, depending on who the worker went to and treatment chosen. The most used standard forms include:

- **Employer's Initial Injury Report** and **Worker's Initial Injury Report**

[12] A mental health assessment is a psychological evaluation completed by a WCB-accredited mental health provider. It includes an assessment and diagnosis of a disorder or confirmation of a diagnosis, and recommended treatment and return-to-work plan.

- **Psychology—Initial Assessment Report**: Mental health providers complete this when they first see an injured worker
- **Psychology—Progress/Discharge Report**: Mental health providers complete this to update WCB about an injured worker's status
- **Physician—Initial Report**: Physician examining the worker completes this when they first see an injured worker who has a WCB injury claim
- **Physician—Progress/Discharge Report**: Physicians complete this to update WCB on the injured worker's status
- **Mental Health Assessment Template**: Mental health providers complete this when conducting a mental health assessment

We found WCB appropriately designed these forms to obtain the information it needs to adjudicate claims, except for the Psychology Initial Assessment Report and Mental Health Assessment templates. These forms request the user to obtain a Global Assessment of Functioning Score.[13] We found this scoring tool is no longer considered good practice in the psychology field since July 2021. WCB last reviewed these forms in 2017. We observed mental health providers completed this score (e.g., on mental health assessments). We suggest WCB revise these forms for this change in good practice.

Receiving complete and consistent information from workers, employers, and mental health providers allows WCB to adequately assess and adjudicate psychological injury claims.

4.7 Rationale Documented and Communicated to Stakeholders for Psychological Injury Claim Decisions

The Saskatchewan Workers' Compensation Board's case managers obtain sufficient support and document rationale when making decisions on psychological injury claim files, and appropriately communicate the claim decision to workers and employers.

Case managers make claim decisions (i.e., accept or deny application) based on information provided by the employer and worker in addition to medical information provided by a doctor (e.g., initial report from a general physician or psychologist the worker visited). These reports may include information on the worker's medical condition and status of their ability to continue their job duties (e.g., recommendation to be off work). Additionally, case managers use this information to assess whether there is evidence to suggest the worker is experiencing symptoms that align with a psychological injury diagnosis (e.g., post-traumatic stress disorder [PTSD]).

In our testing of 30 psychological injury claim files, we found case managers obtained sufficient information from stakeholders (e.g., workers, employers) in order to make decisions in accordance with WCB policies and legislation. For each of these claims, we found that case managers appropriately assessed claims, documented their decision to

[13] The Global Assessment of Functioning (GAF) is a numeric scale used by mental health clinicians and physicians to subjectively rate the social, occupational, and psychological function of an individual (e.g., how well one is meeting various problems in living). Scores range from 100 (extremely high functioning) to 1 (severely impaired).

accept or deny the claim, and included rationale for their decision (e.g., reference to relevant policy section, summary of case facts).

Of the 30 psychological injury claims we tested, case managers accepted 12 claims and denied 18 claims. This is comparable with WCB's overall claims acceptance average (41% as shown in **Figure 1**— accepted 238 of 578 claims received in 2021).

All 12 accepted psychological injury claims we tested contained either evidence of a formal diagnosis (e.g., mental health assessment or mental health provider's recommendation) or contained a strong correlation between a workplace incident and the worker's mental state (e.g., witnessed fatality at work, a first responder experiencing cumulative exposure to traumatic events).

WCB's policy is to accept a psychological injury claim with a diagnosis from a mental health provider.[14] In our testing of the 12 accepted claims, we found at the time the claim was accepted, two had a diagnosis from a mental health provider. We found the other 10 accepted psychological injury claims to be reasonable and consistent with good practice as there was strong evidence in all instances that a psychological injury occurred at work.

Once WCB receives evidence that a psychological injury occurred at work, it connects the injured worker to treatment where they receive a diagnosis and begin treatment with a mental health provider. In some instances, a worker may receive treatment during the adjudication process (i.e., prior to WCB decision), due to the importance of early intervention which may lead to decreased injury and claim duration and risk of further injury. For eight of 12 accepted psychological injury claims we tested, we found the worker accessed a mental health provider for treatment. For all these claims, the provider was included on the list of WCB accredited mental health providers. For the remaining four accepted claims tested, we found the claimant either had not yet started treatment at time of testing in early January 2022 (two of 12 were claims recently submitted in December 2021) or had not requested treatment (i.e., two of 12 returned to work with little time off and did not receive significant compensation).

In all 18 rejected psychological injury claims tested, it was apparent that the case manager would reject the claim, regardless of whether they obtained a formal diagnosis, as it would not meet the criteria (e.g., argument with co-worker or stress due to a negative performance review at work).

See **Figure 5** for further information about psychological injury claims by diagnosis and **Figure 6** by occupation.

Figure 5—Saskatchewan WCB 2021 Psychological Injury Claim Statistics by Diagnosis

Diagnosis	Accepted Claims	Rejected Claims
Anxiety	91	164
Post-Traumatic Stress Disorder	95	22
Stress	19	99
Depression	8	28
Other	25	19
Total	**238**	**332**

Source: Adapted from WCB 2021 records.

[14] The psychological disorder is diagnosed by a psychologist or psychiatrist licensed to practice and make diagnoses.

Figure 6—Top Five Saskatchewan Occupations with Accepted and Rejected Psychological Injury Claims in 2020

Accepted Claims		Rejected Claims	
Occupation		**Occupation**	
Correctional Service Officers	51	Nurse Aides	41
Paramedics	30	Registered Nurses	15
Registered Nurses	24	Community/Social Service Workers	15
Police Officers	23	Bus Drivers/Transit Operators	11
Nurse Aides	16	General Office Clerks/Food Counter Workers	Both of these occupations had 10

Source: Adapted from WCB 2020 records.

Additionally, WCB developed formal templates (i.e., decision letters) to guide staff when they communicate claim decisions to stakeholders. For all 30 psychological injury claim files we tested, we found that case managers appropriately communicated the claim decision to workers and employers.

Effectively communicating the status of injured workers' claim decisions reduces the risk that workers are unaware of their claim status or expectations that WCB may require of them (e.g., next steps for treatment). When WCB also informs both workers and employers, there is a reduced risk of miscommunication, which could lead to further delays or additional action (e.g., appeals).

4.8 Appropriately Paying and Monitoring Compensation Benefits

The Saskatchewan Workers' Compensation Board has an appropriate process to calculate and to monitor compensation benefits for psychological injury claim files.

Once a case manager accepts a claim, the payment specialist will work with the employer and worker to obtain information WCB requires for calculating the appropriate compensation benefits. The payment specialist verifies the accuracy of this information and enters it into WCB's system, which calculates the payment amount and schedule (e.g., biweekly payments).

The payment specialist periodically assesses whether the current payment is correct. For example, as a worker starts a gradual return-to-work plan, WCB may adjust the payment schedule to align with the modified work schedule. If the payment specialist determines an adjustment is necessary, they will update the information in the system to recalculate the benefit payment. On average, in 2021 WCB paid $15,667 per psychological injury claim.

In our testing of 10 psychological injury claim files with benefit payments, we found the payment specialist appropriately obtained sufficient information and calculated the benefit payment in accordance with legislation. Additionally, we observed that staff periodically and appropriately assessed whether benefit payments were correct (i.e., considered whether workers' status changed).

Periodically assessing compensation benefits decreases the risk that WCB may pay benefits that do not agree with current information (e.g., overpayments). Having processes to monitor benefit payments helps ensure they are paying workers and employers appropriate benefits.[15]

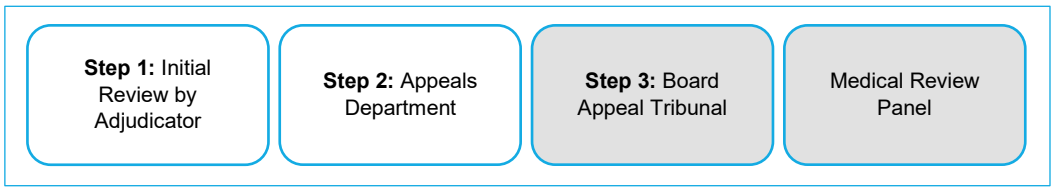
4.9 Guidance Missing for Appeal Decision Support and Communication

The Saskatchewan Workers' Compensation Board maintains up-to-date, clear policies and procedures to guide the assessment of psychological injury claim appeals; however, its guidance does not identify what information it needs from case managers for appeal files. WCB also does not provide sufficient guidance for communicating appeal decisions of psychological injury claims to workers and employers.

Workers or employers have the right to appeal WCB decisions on injury claims (e.g., denial of claim, termination of benefits). There are three steps in the appeals process as well as consideration by a medical review panel, with a formal decision at each appeal step. See **Figure 7**. The scope of this audit included the first two steps in the process.

- **Step One** (Initial Review): claim case managers answer questions from workers, employers, or advocates about decision disagreements either by phone or email[16]
- **Step Two** (Appeals Department): if a worker or employer still disagree after receiving the decision in step one, they can appeal in writing to WCB's Appeals Department

Figure 7—WCB Appeals Process



Source: Adapted from information provided by WCB.
The scope of this audit did not include the shaded processes, including step three (Board Appeal Tribunal), and the Medical Review Panel.

WCB's Appeals Department administered about 1,170 appeals in 2021 for all types of claims (2020: 1,400). About 50 appeals related to psychological injury claims, with 12% (six of 50) of claim decisions overturned after the appeal.

Appeals officers in the Appeals Department conduct file reviews and consider relevant legislation and policy when making an appeal decision (i.e., accept or deny). Appeals officers may also decide to return claim files to case managers to obtain additional, necessary information (e.g., whether worker had a permanent reduction of abilities, more information on worker history) to make appeal decisions. The case manager collects the information and returns the file to the appeals officer if the information does not change the case manager's decision.

[15] WCB reimburses employers who pay injured workers directly.
[16] Workers may decide to use the Office of the Workers' Advocate for assistance in making appeal decisions and for worker representation. www.saskatchewan.ca/business/safety-in-the-workplace/assistance-for-wcb-claims-and-appeals#how-the-owa-can-help (21 March 2022). WCB also has a Fair Practices Office to assist workers or employers with all questions related to WCB practices. www.wcbsask.com/fair-practices-office (21 March 2022).

Our testing of 10 Appeals Department files found:

- All 10 files included sufficient information to initiate an appeal including the appealable issue (e.g., denial of claim).
- All 10 appeal decisions appropriately supported by information in the injured worker's claim file.
- Two instances where an appeals officer returned psychological injury claim files to case managers. While the appeals officers followed the process to obtain additional information, we found inconsistencies in the information they considered significant enough to request. For example, requests for additional information (e.g., history of employment) did not directly align with the psychological injury criteria.
- In our testing of 10 Appeals Department files, we found appeals officers communicated the appeal decision (i.e., accept or deny). However, we found inconsistencies in the appeal decision rationale in 30% (three of 10) of communications to stakeholders (e.g., one item did not reference policy or legislation; two items with unclear supporting rationale).

We noted WCB does not have documented guidance for what key information appeals officers need in the file to support appeal decisions (e.g., information checklist for Appeals Department staff to consider during an appeal). This increases the risk that appeals officers request unnecessary information, or there is insufficient information in the file, which may result in delayed or unsupported appeal decisions.

In addition, we found the appeals decision template does not provide appeals officers with sufficient guidance on what information to communicate to stakeholders about the results (i.e., appeal decision) of the appeal and the rationale (e.g., how the decision aligns with policies and legislation). Inconsistently and not clearly communicating rationale for appeal results to stakeholders increases the risk of additional appeals and increased costs (e.g., Board appeals, additional conversations explaining decision) as stakeholders may not understand the decision and how the appeal decision aligns with policies and legislation.

1. **We recommend Workers' Compensation Board develop formal guidance about key information appeals officers need to support and communicate psychological injury claim appeal decisions to stakeholders.**

4.10 Guidance Needed When Releasing Claim Information

The Saskatchewan Workers' Compensation Board does not have sufficient guidance for staff on what information about a worker it expects to release to employers.

Employers may request a copy of a worker's claim file during an appeal. The claim file provides the employer with information about the claim and the worker's history. This

information helps employers make decisions on the claim's impact (e.g., decision to appeal, apply for cost relief).[17]

WCB has a privacy policy, which sets out the steps to take in sharing claim file information with stakeholders. Information to employers may include basis for decisions without disclosing specific personal or health information. However for appeals, no formal guidance exists for staff in deciding what specific information to provide to employers for purposes of an appeal (i.e., determining what information is relevant to the claim decision).

In our sample of 10 appeal files, one file contained a request from an employer for a copy of the worker's file. For this item, the reason for the appeal was the employer believed it did not receive sufficient information from its first request for information in the worker's file. For this item, during the appeal, we noted WCB identified the employer received insufficient information from WCB to make a decision on whether to apply for cost relief.

Not having guidance for staff on what file information WCB expects to provide to employers increases the risk that they may provide confidential worker information. This risk increases in the instance of staff turnover or new staff managing claims or appeals. Additionally, WCB may not provide sufficient information to inform the employer of its decision-making.

2. **We recommend Workers' Compensation Board develop formal guidance for staff on what file information for psychological injury claims to release when an employer requests information during an appeal.**

4.11 Performance Measures Established, But Not Consistently Met

The Saskatchewan Workers' Compensation Board established performance measures for assessing and managing psychological injury claim and appeal files; however, they inconsistently met those expectations (e.g., untimely claims assessments).

Claims

The Psychological Injuries Unit uses a monthly scorecard metric to monitor its performance in managing psychological injury claims. See **Figure 8** for some key performance measures within the scorecard.

Figure 8—Excerpts from Psychological Injuries Unit Scorecard

Performance Measure	Target during 2021	Results during 2021
Initial Claim Decision (i.e., time to make decision)	14 business days	Monthly average target met in 2 of 12 months
Three-week, proactive calling (i.e., staff contact the claimant at least once every three weeks)	90% of claims during the month	Met target in 1 of 12 months

Source: Adapted from information provided by WCB.

As shown in **Figure 8,** WCB expects staff to make decisions and communicate results within WCB's target of 14 business days. WCB did not meet its target in 10 of 12 months in 2021.

[17] WCB may provide cost relief (claim cost may not increase employer's premium) to employers if a worker's claim is determined to be eligible for cost relief. WCB may award cost relief if it determines the injury was from a pre-existing condition or injury following return to work.

We also found in our testing that staff are not always making decisions on claim files in a timely way. We found 17 of 30 claims we tested did not meet the 14-day target. Of the claims that did not meet this target, staff communicated the claim decision between 15 and 43 days (i.e., 1–29 days late) after WCB received the claim.

Not adjudicating claims on time creates delays for injured workers to begin receiving benefits and treatment.

3. **We recommend Workers' Compensation Board make decisions on psychological injury claim applications consistent with its established target (i.e., within 14 business days).**

As shown in **Figure 8**, WCB expects staff to contact the claimant at least once every three weeks. WCB met this expectation for only one month in 2021.

In our testing, we found in three of 12 claims where the claim extended beyond three weeks, WCB staff did not communicate with the worker (e.g., email, documented phone conversation) during the three-week period.

Regular communication with workers decreases the risk that their claim status may change or that WCB does not adjust the workers' treatment plans if they are not progressing as expected.

4. **We recommend Workers' Compensation Board regularly communicate with psychological injury claimants consistent with its established timeframe (i.e., at least every three weeks).**

Appeals

WCB has also set a goal to assess appeals and communicate the decision (i.e., accept or deny) to employers and workers within 30 days of an appeal's registration. This relates to all types of claims, not just psychological injury claims. The Appeals Department uses the average monthly appeal duration to monitor whether it meets this goal on a monthly basis. In 2021, the Appeals Department used a scorecard to track whether it achieved this goal; it met this goal for 10 months.

The Appeals Department reported some information quarterly to the Board. For example, it reported how many appeals it received but had not assessed. At September 30, 2021, the Appeals Department had a backlog of 64 appeals with none of these appeals older than 15 days.

In our testing of 10 appealed psychological injury claim files, we found two appeals where WCB did not meet its target to communicate the decision within 30 days. These two files ranged from 31 to 36 days (one to six days late).

Overall, WCB has adequate processes in place to periodically report key psychological injury claim information to senior management (i.e., monthly scorecards), the Board (i.e., quarterly statistics), and the public (i.e., annual report).

We found the Psychological Injuries Unit prepared and discussed the results of its measures during monthly meetings.

We found management provided appropriate reporting quarterly to the Board about psychological injury claims. For example, we found it provided a status update each quarter on WCB's decision to implement the Psychological Injuries Unit (e.g., creating a single point-of-contact for claimants).

We also found WCB's annual report included significant information on claims and appeals. For example, the 2020 annual report presented trends in the number of psychological injury claims received and accepted.

Having processes to establish and monitor key performance indicators helps WCB continue to improve the service it provides to stakeholders (e.g., efficiency of claim adjudications) and identify areas where they can improve (e.g., timely communication of decisions).

4.12 Continuous Quality Reviews Needed for Claims and Appeals

Injured worker claim files are subject to quality reviews; however, quality reviews did not occur as expected and the Saskatchewan Workers' Compensation Board has no established quality review process for claim and appeal files.

For the quality review of psychological injury claim files, the Manager of the Psychological Injuries Unit completes a review of each claim file at 12-weeks (i.e., system automatically generates a task for the Manager to review a claim file after it has been active for 12 weeks). WCB developed a checklist to guide staff when completing this review. However, during 2021, the Manager did not document evidence of these reviews, and we found no record of either the completed checklist or other evidence of this review in the claim file.

Additionally, WCB's Service Excellence department has a quality review program to look at a sample of injury claims (all types of injuries, not just psychological). When performing these reviews, staff examine whether the case manager obtained sufficient information, made an appropriate decision, and followed expected processes (e.g., regular communication with the worker, claim screened on time).

However, in 2021, Service Excellence did not conduct any quality reviews of psychological injury claim files, and did not perform as many quality reviews as planned. Its goal is to review 20 claim files per month (all types of injuries), or 240 files per year (out of about 26,000 total claims in 2021), for quality. Service Excellence completed 92 file reviews (about eight per month) in 2021. Staff indicated this was due to staffing issues (e.g., Service Excellence department is responsible for training new claims staff and WCB experienced higher than expected staff turnover).

WCB has not established a formal quality review process for its Appeals Department appeal files (all types of claims), including for psychological injury claim appeal files. WCB indicated it started developing a quality review program (e.g., hiring a quality review position); however, there is no formal process to review the quality of appeal files. During 2021, WCB did not complete any quality reviews of appeal files for psychological injury claims.

Not having an effective quality review process increases the risk of WCB not detecting instances of non-compliance with its policies and processes, or not identifying opportunities

to continually improve its processes. This increases the risk that injured workers may experience less than optimal outcomes such as delays in receiving appropriate treatment for injuries, as well as may increase the risk of additional appeals occurring.

5. **We recommend Workers' Compensation Board implement ongoing quality reviews for psychological injury claim and appeal files.**

4.13 Stakeholder Feedback Led to Improved Processes

The Saskatchewan Workers' Compensation Board has sufficient processes to obtain and track stakeholder feedback, and to consider whether staff can implement process improvements.

Case managers primarily address stakeholder concerns on a case-by-case basis as part of the ongoing claims management process. For example, if a worker has concerns about their treatment, they may discuss it with a case manager to resolve any concerns.

During 2021, WCB started using a central spreadsheet to track stakeholder feedback (e.g., complaints received). It uses this information to monitor how staff addressed situations stakeholders reported to WCB (e.g., steps taken to resolve conflict or concerns). It logged 23 complaints received from December 1, 2021 to February 24, 2022. We found the spreadsheet adequately documented WCB's resolution of complaints.

WCB uses feedback from stakeholders to update its processes and policies. For example, during 2021, WCB revised its process for psychological injury claims to have only one staff responsible for managing each claim (i.e., previously, separate staff adjudicate and manage an active claim). Claimants provided feedback that they appreciate having one dedicated case manager (e.g., helps improve communication efficiency, do not have to re-share traumatic details to multiple WCB staff).

Having adequate methods to assess current processes periodically, helps WCB adjust and improve its administration of psychological injury claims.

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Chapter 8
Sun West School Division No. 207—Supporting Students' Completion of Grades 10 to 12 Distance Education Courses

1.0 Main Points

Sun West School Division No. 207 provides distance education courses to Grades 10–12 students through its Distance Learning Centre. Students of the Centre include both those who reside within and outside of Sun West's divisional boundaries. Some students (60% of students registered at the Centre) take only distance education courses, while others take some online courses to supplement their in-person classes at another school. For the 2020–21 school year, the Centre taught over 3,900 courses to more than 2,100 Grades 10–12 students.

Other than the following areas where improvements are required, at November 30, 2021, Sun West had effective processes to support students in completing Grades 10–12 distance education courses. Sun West needs to:

- Identify and engage students who are behind in their coursework by consistently using its student inactivity phasing process, to support successful course completion
- Implement a course development policy that includes frequency of course reviews and detailed processes for updating courses
- Establish course completion-rate targets for students learning solely at the Distance Learning Centre to complete their Grades 10–12 courses. The target that Sun West has is only addressing around 20% of the population of students enrolled in Sun West distance education courses.
- Analyze key information related to distance learning to identify trends, issues and improvements, and provide regular written reports to its Board
- Improve its IT system to help monitor the timeliness of grading coursework to identify those teachers who are critically behind in grading, which can ultimately reduce student engagement and successful course completion
- Assess the need for ongoing focused professional development—distance education teachers benefit from training specific to an online learning environment

Improving its processes to better support students in successfully completing Grades 10–12 distance education courses may help Sun West's students graduate from high school. Successful completion of high school helps prepare students for a post-secondary education and for entering the workforce.

2.0 INTRODUCTION

This chapter outlines results from our audit of Sun West School Division No. 207's processes for supporting students to complete Grades 10 to 12 distance education courses for the period ending November 30, 2021.[1,2]

Students include individuals enrolled to take a Grade 10–12 distance education course from within, or outside of, Sun West's divisional boundaries, or other enrolments (e.g., adult learners, correctional inmates).

Distance education is the delivery of instruction to students through online or print-based resources, where students are in a different location than the course teachers.[3] Resources include both synchronous (e.g., real-time broadcasts) as well as asynchronous (e.g., on demand, pre-recorded) instructional resources.

2.1 Distance Education in Saskatchewan and in Sun West

The Education Act, 1995, assigns responsibility to Saskatchewan's Boards of Education (school boards) to provide educational courses to students residing within its school division.[4]

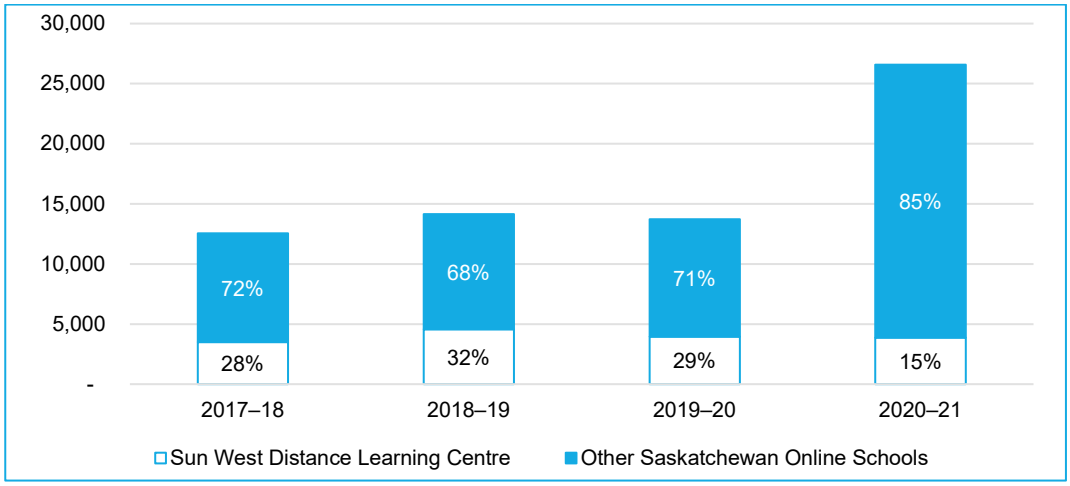
In 2021–22, 18 of the 27 provincial school divisions offered distance education courses to Saskatchewan students. The number of course registrations for Grades 10–12 distance education courses increased to over 26,000 course registrations in 2020–21 driven by the COVID-19 pandemic (see **Figure 1**).

Sun West is an entirely rural school division with no cities within its boundaries. It is located in west central Saskatchewan covering an area of 31,220 square kilometres.[5,6] It has 42 schools including 18 Hutterite colony schools, and 24 others located in 19 different communities (e.g., Davidson, Kindersley, Biggar).[7]

Sun West has the highest proportion of Grades 10 to 12 distance-education course registrations compared to the other individual distance education schools in the province. As shown in **Figure 1**, from 2017 to 2021, Sun West averaged 26% of the total number of provincial distance-education course registrations. In Saskatchewan, between 2017 and 2019, there were 13,000 Grade 10–12 students on average registered in distance education courses, which doubled (i.e., over 26,000) in 2021.

[1] This audit did not assess processes used to support students with intensive needs. See *2018 Report–Volume 1*, Chapter 11, pp. 157–178, for our work on supporting students with intensive needs.
[2] This audit also did not assess the alignment of the online courses' content with Ministry of Education curriculum requirements.
[3] At Sun West Distance Learning Centre, high school students mostly do online courses versus print-based learning, which is mostly used in primary grades or in unique circumstances for specific students.
[4] *The Education Act, 1995*, s. 85(1).
[5] *Sun West School Division #207 2020–21 Annual Report.* p. 7.
[6] Ibid., p. 6.
[7] Ibid., p. 6.

Figure 1—Saskatchewan School Divisions' Distance-Education Course Registrations for Grades 10–12



Source: Based on data received from the Ministry of Education on October 20, 2020, and February 1, 2022. Complete enrolment information for 2021–22 school year is not available.
Note: Other Saskatchewan Online Schools also includes registrations at regional colleges, independent and private schools in Saskatchewan.

Sun West offers a wide range of courses in all of its schools.[8] This includes distance education through online learning.[9] It uses online learning, through the Sun West Distance Learning Centre, to provide students with varying education options. Some students only attend the Distance Learning Centre, which means the students have no physical (i.e., bricks-and-mortar) school to attend.

It offers distance education for a full spectrum of kindergarten to Grade 12 courses. This includes all core and interest-based electives at the high-school level.[10]

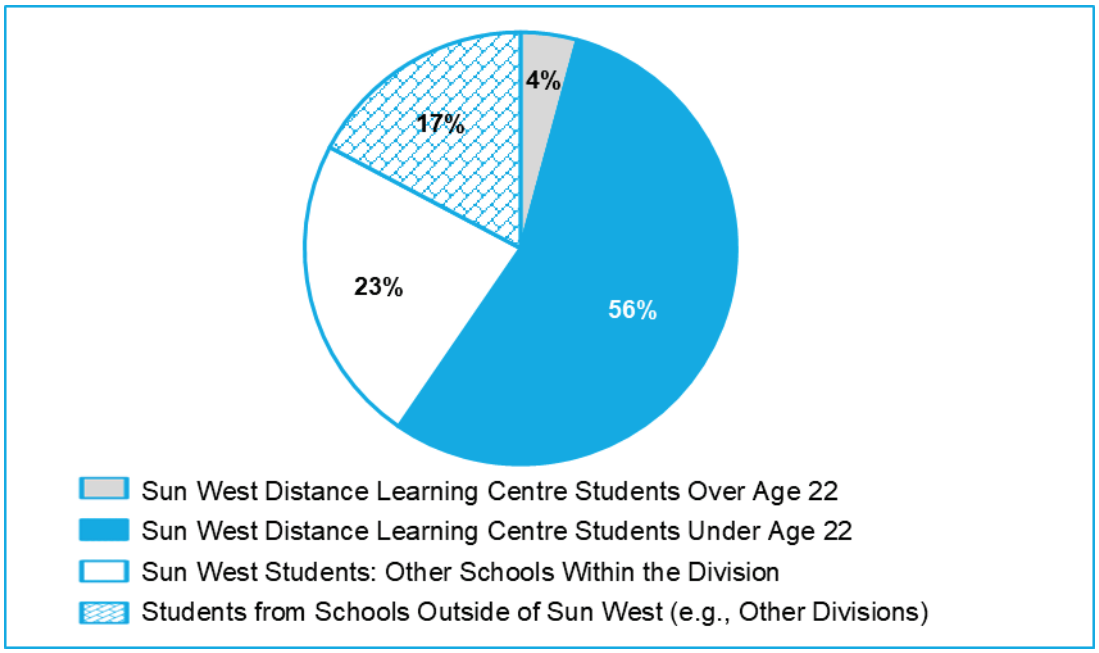
The Sun West Distance Learning Centre is responsible for developing and delivering its distance education courses, and is an option for:[11]

- Students under the age of 22 who want online credit, or to study online for various reasons; this option is free for students living within Sun West boundaries, and for a fee for those students living outside of Sun West boundaries
- Students enrolled in home-based education programs (no fee for students within Sun West boundaries)
- Inmates in correctional facilities through funding agreements with the Ministry of Corrections, Policing and Public Safety
- Adult students over age 22 (for a fee)

As shown in **Figure 2**, during the 2020–21 academic year, the majority of students (under age 22) who registered for Sun West's online courses reside within Sun West's boundaries (79%).

[8] *Sun West School Division #207 2020–21 Annual Report*, p. 11.
[9] The curriculum and course requirements for students enrolled in distance and traditional in-person education are the same.
[10] www.sunwestdlc.ca/ (2 March 2022).
[11] Starting in the 2020–21 school year, Sun West entered into agreements with other school divisions to allow them to use its materials to deliver courses to their students. Sun West is not directly involved in delivering these courses to these students.

Figure 2—Student Types Enrolled at the Sun West Distance Learning Centre in 2020–21



Source: Adapted from information provided by Sun West (15 November 2021).

2.2 Importance of Distance Education

Saskatchewan's population (and student enrolment) is increasingly urbanized. From 2017 to 2022, the enrolment in Saskatoon and Regina's school divisions increased by almost 5% (3,924 students), whereas for the same period, the enrolment of the other school divisions remained flat (overall decrease of 13 students).[12]

Ongoing growth in student enrolment in urban school divisions may affect the ability of rural school divisions to maintain an adequate supply of skilled teaching staff, and justify offering certain courses when only a few students show interest in taking them at times. In addition, the COVID-19 pandemic resulted in extended and intermittent school closures and/or student absences making in-person delivery of educational courses challenging, and in some cases, not feasible.

An increasing number of school divisions are turning to distance education to provide their students with a quality education.

High student engagement usually translates into better student outcomes, and distance education can make it more challenging for teachers to engage students.[13] While face-to-face and distance education have many similar challenges, educators need to consider additional factors to increase student engagement and success in a distance education environment, such as:

- Teacher resources (e.g., technology required to instruct courses)

[12] Adapted from the Provincial K–12 Student Enrolment Summary. www.publications.saskatchewan.ca/#/products/77115 (11 March 2022).
[13] Student engagement is the extent to which students identify with and value schooling outcomes, have a sense of belonging at school, participate in academic activities, strive to meet formal requirements of schooling, and make a serious personal investment in learning. Source: Willms, J.D., Friesen, S. & Milton, P., *What did you do in school today? Transforming classrooms through social, academic, and intellectual engagement*, (2009), p. 7.

- Student preparedness such as their maturity and self-discipline (e.g., in self-directed learning), computer literacy, and time-management skills to keep pace with the course[14]

  For example, educators may need to provide additional support or adjust their delivery methods where struggling students require more support than traditional students when they enroll in distance education courses as a 'last resort.'[15] An example of this is a student who was expelled from their school and turned to distance education as a means to complete their education.

- Teacher preparedness such as their ability to use various online programs; knowledge of designing learning experiences, and online instruction methods; training and efficacy in the distance education environment (e.g., knowing how to engage students effectively online); and levels of classroom synergy (e.g., creating meaningful interaction)[16, 17]

Not having effective processes to support distance education students increases the likelihood of students not completing courses, which in turn may adversely affect graduation rates. Students not successfully completing their high school education, or not developing essential skills to prepare them for a post-secondary education and the workforce, are at an increased risk of not being successful in life.

3.0 Audit Conclusion

Sun West School Division No. 207 had, other than the following areas, effective processes to support students to complete Grades 10 to 12 distance education courses for the period ending November 30, 2021.

Sun West needs to:

- **Identify and engage students who are behind in their coursework as expected**
- **Implement a course development policy that includes the frequency of course reviews and detailed processes for updating courses**
- **Establish course completion-rate targets for Distance Learning Centre-only students**
- **Conduct analysis on key information related to distance learning to identify trends, issues and improvements**
- **Regularly provide complete written reports outlining key distance learning information to its Board**
- **Assess the need for ongoing, focused professional development for teachers educating students in a distance education environment**

[14] www.academia.edu/2311478/Barbour_M_K_and_Reeves_T_C_2009_The_reality_of_virtual_schools_A_review_of_the_literature_Computers_and_Education_52_2_402_416 (11 March 2022).
[15] Adapted from www.uis.edu/ion/resources/tutorials/online-education-overview/strengths-and-weaknesses/ (11 March 2022).
[16] Learning experience refers to any interaction, course, program, or other experience in which learning takes place www.edglossary.org/learning-experience/ (11 March 2022).
[17] Adapted from www.uis.edu/ion/resources/tutorials/online-education-overview/strengths-and-weaknesses/ (11 March 2022).

Figure 3—Audit Objective, Criteria, and Approach

Audit Objective:

The objective of this audit was to assess whether Sun West School Division No. 207 had effective processes to support students to complete Grades 10 to 12 distance education courses for the period ending November 30, 2021.

This audit did not assess the alignment of the online courses' content with Ministry of Education curriculum requirements.

Audit Criteria:

Processes to:

1. **Plan distance education courses based on student educational needs**
   - Collect information on educational needs of registered students (e.g., access limitations, barriers to learning, individual learning plans [e.g., graduation timeline, required courses])
   - Allocate resources (e.g., teaching staff, training and support for teaching staff, educational tools) to support distance education students
   - Align distance education course design and delivery plans with effective online learning practice (e.g., frequency/type of teacher-student contact, technological platforms and tools, student engagement, student assessment)
2. **Deliver quality distance education courses to meet student needs**
   - Provide learning experience consistent with distance education course plans (design and delivery)
   - Collect relevant data to analyze program and teacher supports (e.g., feedback, student participation, student achievement)
   - Adjust supports as necessary

Audit Approach:

To conduct this audit, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate Sun West's processes, we used the above criteria based on reviews of literature including reports of other auditors and consultations with management. Sun West's management agreed with the above criteria.

We examined Sun West's policies and procedures and interviewed key staff supporting students completing distance education courses. We tested a sample of students to determine whether Sun West collected intake information from the students, communicated with the students throughout the courses, and maintained graduation plans. We also assessed Sun West's allocation of resources, training provided to teachers, and reports provided to the Board. We tested a sample of updated courses to assess course design. In addition, we used independent consultants with subject matter expertise in the area to help us identify good practice and assess Sun West's processes.

4.0 Key Findings and Recommendations

4.1 Policies and Plans Exist for Collecting Student Information

Sun West School Division No. 207 maintains up-to-date, clear, and understandable policies to guide collecting student information for distance education.

Sun West has sufficient policies to outline what application information to collect from prospective students seeking to register for distance education courses delivered through the Distance Learning Centre. Staff can access these policies online.

We tested Sun West's two distance-learning policies and found both policies up-to-date.[18] Policy updates occurred in the last three years. Updating policies regularly is consistent with good practice (i.e., every three to five years), and policy content aligned with good practice for distance education.

[18] Administrative Procedure 230: *Distance Learning* and Board Policy 18—*21st Century Competencies*.

Collecting relevant student information helps Sun West assess a student's ability to be successful in a distance education environment. It also identifies what additional supports to provide to the student. Some considerations at the admission stage include:

- Student's past aptitude in the subject area in either a traditional or distance learning environment
- Student's independent learning skills for the type of distance education considered
- When and where the student will work on the distance education course
- Availability of an on-site adult mentor
- Proof of Saskatchewan residency[19]

In addition, Sun West collects information from students about educational goals and the reasons students participate in distance education. For example, students playing a demanding sport may need extended periods away from school for training or events (e.g., junior hockey player, professional snowboarder).

In the 32 student files we tested, we found that Sun West collected consistent student information as set out in its policy. Sun West uses online student application forms to help ensure consistency and completeness of the information collected.

For students in Grades 10–12, Sun West documents students' educational goals in a graduation plan that tracks graduation requirements, course progress, and completion (credits earned toward graduation).[20] We found that all 30 student files we tested contained the required graduation plan.[21] We also found Sun West invited parents or guardians to provide input into the plan. Maintaining a graduation plan for students is good practice because it helps ensure Grade 10–12 students stay on track to meet credit requirements for graduation, and prepare for their future (e.g., post-secondary education).

Having clearly written and up-to-date policies helps Sun West consistently and effectively communicate expected processes for collecting student information to staff. Requiring graduation plans to identify student goals assists teachers in supporting student success.

4.2 Course Design Policy Needed

Sun West School Division No. 207 has a process and methodology to design new online courses and update existing courses, but does not have a policy outlining the procedures for and frequency of course reviews.

Sun West develops new courses, and periodically updates existing courses, based on feedback from teachers and students, as well as curriculum changes.

[19] Sun West does not provide online learning to students who reside outside of Saskatchewan.
[20] Sun West uses graduation plans to track key information for its students. Students who primarily attend a physical school, but also take some distance education classes at the Distance Learning Centre, do not have a graduation plan with the Distance Learning Centre because the majority of the student's credits would come from their home school, which would provide the student support to graduate from high school.
[21] Not all students enrolled in distance education courses require a graduation plan. For example, adult students who are upgrading their marks to meet college admission requirements do not have a graduation plan maintained by Sun West.

Sun West uses a course design model when creating a new course. The model includes five phases of instructional design: analysis, design, development, implementation, and evaluation. This model is a robust model for building effective courses and aligns with good practice for instructional design.[22]

Sun West updates existing courses usually based on necessity, which primarily comes about because of curriculum changes issued by the Ministry of Education.[23] Good practice suggests periodic reviews of course materials to allow for updates based on course feedback from teachers. We found there is no periodic review process for online courses by Sun West. According to management's tracking spreadsheets, Sun West last updated around 19 Grades 10–12 courses between four and 14 years ago. Teachers use online courses year after year.

To further guide course updates, Sun West collected teacher feedback in fall 2021. Survey questions included feedback on students' ability to get started on the course materials, remain on pace to complete the course on time, difficulty of course materials, and other overall comments.

We tested three Sun West courses updated during our audit period and found the updates occurred because of teacher feedback and curriculum updates. Overall, Sun West structured the updated courses well and designed them consistent with good practice.

Teachers and course design staff collaborate to create and update distance education courses. The design team saves documentation of meetings, plans, curriculum, and other relevant documents in their project management software.[24] We reviewed this documentation for one updated course and found key documents included minutes from the development-planning group's meeting and midpoint meeting, as well as course plan, outcome maps, and documentation of all discussions on the software's chat-board. Although this process is adequate, Sun West has no written policy that sets out course design methodology and review processes.

The lack of policy to guide course design methodology and regular course reviews increases the risk of course design inconsistencies and courses not being up-to-date, especially in the event of key staff turnover.

1. **We recommend Sun West School Division No. 207 implement a course development policy, including the frequency of course reviews for distance education.**

4.3 Supports for Distance Education Students Provided

Sun West School Division No. 207 utilizes supports to help students successfully complete distance education courses.

[22] Sun West uses the ADDIE Model of Instructional Design educationaltechnology.net/the-addie-model-instructional-design/ (4 March 2022).
[23] In Saskatchewan, the Ministry of Education is responsible for curriculum design with school divisions implementing the mandated curriculum. The Ministry does not monitor or assess whether school divisions follow the curriculum (it expects school divisions to monitor themselves).
[24] Sun West's project management software allows collaboration and sharing among all members assigned to the team.

At November 2021, Sun West's Distance Learning Centre employed approximately 62 full time equivalent staff, with 31 directly involved in teaching Grades 10–12 courses. In 2020–21, the Distance Learning Centre had over 2,100 students registered in distance education courses. We found Sun West has appropriate mechanisms in place to determine and to provide supports for distance education students. These mechanisms include:

- **Teacher Allocations:** Sun West allocates teachers to online courses based on teaching workloads, and tracks other teacher responsibilities (e.g., other professional activity the teacher is responsible for within the school, such as designing a course or leading an asynchronous broadcast of a course) to ensure allocations are appropriate.

  Sun West's initial allocations aim to balance utilization rates across all teaching staff. Sun West assigns between 200–240 students per teacher in a year, assuming the teacher is full time and has no other responsibilities.[25] If students register for a distance education course during the year, Sun West assigns the student to a teacher with a lower utilization rate. We tested a sample of five teachers and found teacher allocations were reasonable (teachers were 90–100% allocated). Sun West's process to assign and monitor teacher workloads aligns with good practice to ensure teachers have adequate availability to support students.

- **Access to Technology:** Sun West staff have access to appropriate technology (e.g., internet, laptops, IT platforms) to engage in distance education.

  We observed all staff and students have access to the Distance Learning Centre's IT platforms, which allow them to engage in their courses, communicate, submit assignments, and receive feedback. Teachers also have access to items such as headsets for communicating with students verbally or for use in video conferencing.

  Students registered for distance education courses must provide their own technology (e.g., computer and an internet connection).

- **Student Orientation:** We confirmed Sun West provides a live orientation for high school students to outline expectations and orient students for the online learning environment. Several members of Sun West present during the orientation to provide information on their services, and to welcome students to the distance education community. Sun West also posts the video online so students can refer to it if they were unable to attend live.

- **Course Outline and Expectations:** Sun West has written communication provided at the beginning of each course to outline expectations and assessments. We found for all 30 students we tested, teachers clearly communicated course expectations to the student at the beginning of the course.

  We also reviewed three online courses and found the course design for each included a topic on assessment and evaluation at the start of the course. This provides students with information on the course outline, as well as a breakdown of the weighting of grades. This resource is available in students' online course materials.

[25] The number of students assigned varies by the type of class—teachers have fewer students for classes such as English language arts and more students for classes such as math.

- **Ongoing Communication with Students:** We found in our testing of 30 student files that teachers reached out to students to check-in, provide guidance, answer questions, and discuss progress in the course. Examples of common emails we saw included teachers notifying students about what they should be working on for the week, and what coursework the student should have completed at the time of the communication. Teachers communicated with students through email and phone calls. Parents or guardians also have access to student information through the IT platform.

  We found that teachers provide adequate communication to students and parents throughout courses. Consistent communication between the teacher and student promotes engagement in the student's education, and can result in increased course completion rates.

Appropriately allocating resources supports student success by making sure they have access to what they need.

4.4 Better Monitoring Needed as to Whether Assignments Marked Timely

Sun West School Division No. 207 has set out expectations for teachers to respond to students, which includes marking assignments and exams, and getting grades to students within three to five business days. Teachers and administrative staff monitor marking of ongoing coursework; however, Sun West's overall monitoring system for assignment marking has flaws that reduces its effectiveness.

Sun West's IT system is supposed to provide teachers and administrative staff with the ability to monitor teachers' marking workloads by viewing the assignments waiting to be marked. We reviewed a report of outstanding assignments at January 7, 2022 and the system indicated there were over 1,000 outstanding assignments that students submitted between September 1, 2021 and December 17, 2021.[26] However, this number is likely much higher than actual because there are flaws in the IT system and its design that prevents accurate reporting on outstanding assignments. Flaws include:

- Assignments waiting to be marked in the system include items not included in student assessments or their related final grade for a course (e.g., practice quizzes for the student's benefit that a teacher will not mark but that the IT system tracks)

- The IT system adds an additional assignment for all students in a course when a teacher provides an additional assignment only for a specific individual student's needs. These additional items then appear as outstanding or waiting to be marked.

- The IT system does not allow for removal of irrelevant or superseded documents while students are active in the system. For example, at January 7, 2022, the system showed September 2016 (1,957 days) as the date for the oldest outstanding assignment. This is a system issue as this assignment is not outstanding.

[26] Winter break for students and teachers started on December 17, 2021; therefore, we did not include assignments submitted during this break in our assessment.

Sun West was aware of these issues, and plans to fix them during the summer to improve the IT system in the fall 2022.

The updates to the IT system will support accurate monitoring of teachers meeting the three-to-five day marking turnaround time.

Not having a system to effectively monitor timeliness of teachers returning marked assignments to students increases the risk that Sun West is unaware of teachers who are critically behind, and where students are not able to apply learning to future assignments. This ultimately can reduce student engagement and success in completing courses.

2. **We recommend Sun West School Division No. 207 monitor the timeliness of teachers marking distance education coursework in accordance with its policy.**

4.5 Student Inactivity Policy Not Consistently Followed

Sun West School Division No. 207 has a policy to identify and engage students falling behind in courses through an inactive student phasing process, but does not consistently follow its policy. The policy requires teachers to communicate with students falling behind.

If the student is not engaging and the teacher is concerned about their progress, the teacher initiates the phasing process (**Figure 4**).[27] Sun West relies on teachers' professional judgment to identify when to enter students into the phasing process, which is reasonable. For example, we saw one student that a teacher chose to keep in phase one based on their communications and the student's progress—this student successfully completed the class.

Figure 4—Inactive Student Phasing Process

Phase One: Staff communicate with students falling behind in coursework, encouraging them to develop and communicate a plan to catch up and ultimately complete the course. Students have one week to respond, or they will move to phase two.
Phase Two: Students lose access to online course materials, and now must submit a written plan online to the teacher to have access restored. Students have two weeks to submit this plan, or they will move to phase three.
Phase Three: Students are dropped from the course due to inactivity, the course will no longer appear online to the student.

Source: Adapted from Sun West's Operations Manual—*Student Inactive Process*.

Sun West staff send email notifications about the phasing process to students once a week indicating the details of the student's phase and advising them to contact their teacher immediately. These email notifications require the student to take accountability for their educational goals and to work with their teacher to develop a plan to complete the course.

We tested a sample of 25 students in the phasing process and found that 16 students received phasing notification emails as expected, but nine students did not receive these emails as expected. For the nine students who did not receive phasing notification emails, we found Sun West did not follow its established phasing policy for student inactivity. None of these nine students completed the course in the current semester.

[27] Sun West DLC Policy, *Student Inactive Process—2021/2022*. Sun West does not typically apply the phasing policy to students affiliated with another school, or over age 18.

Inconsistent application of its student inactivity policy increases the risk Sun West teachers may miss the opportunity to re-engage students to complete their courses.

3. **We recommend Sun West School Division No. 207 consistently apply its student inactivity policy to engage distance education students falling behind in courses.**

4.6 Teachers Receive Comprehensive Orientation, But Focused Training on Distance Education Requires Consideration

Sun West School Division No. 207 provides comprehensive orientation to new distance education teachers, as well as ongoing professional development to all teaching staff throughout the year. Good practice suggests distance education teachers take professional development specific to distance-education teaching methods to engage students effectively.

Sun West provides a comprehensive three-day orientation to new distance education teachers during their onboarding process. The orientation includes topics such as operating technology (e.g., software, video conferencing), understanding processes, and student assessment practices. We interviewed three new teachers at the Distance Learning Centre during 2021, and they all agreed the orientation provided relevant information on systems and processes for the distance-education teaching environment. New staff also had the opportunity to meet with and learn from experienced teachers instructing the same grade level or subjects. We found the new teacher orientation is comprehensive and aligns with good practice.

Teachers also participate in periodic professional development days. We assessed the content offered for two professional development days by reviewing the agendas and found Sun West provided teachers with numerous options to attend various training sessions with topics ranging from student achievement and engagement to curriculum. We found all topics relevant to the teaching environment, including for distance education. Sun West also collects teacher feedback via survey after the training to inform future professional development days.

Sun West's online teachers participate in about 16 days of professional development annually, which is consistent with good practice for in-class teachers. Some other jurisdictions in Canada (e.g., Nova Scotia, Ontario), provide an additional 20 hours of training specific to online teaching. It is good practice to provide online teachers with professional development specific to the online teaching environment (e.g., methods to engage students online).

Not assessing good practice for distance education teachers' professional development increases the likelihood teachers may not receive appropriate training to have the necessary tools to effectively engage and support students in the distance education environment.

4. **We recommend Sun West School Division No. 207 assess the need for ongoing focused professional development for teachers working in the distance education environment.**

4.7 Specific Targets, Analysis and Reporting of Key Distance Learning Information Needed

Sun West School Division No. 207 collects key information on student success; however, it does not have a specific course completion-rate target for its Distance Learning Centre students, and it does not analyze key trends. In addition, not only does Sun West not have a standardized Board reporting mechanism, but the reports also lack analysis.

Sun West's target for successful completion of distance education courses for certain students (Sun West students that attend other schools within the Division) is 90%.[28] Sun West has not set targets for other groups of distance education students. Putting performance targets in place can be an important way of tracking progress in achieving success.

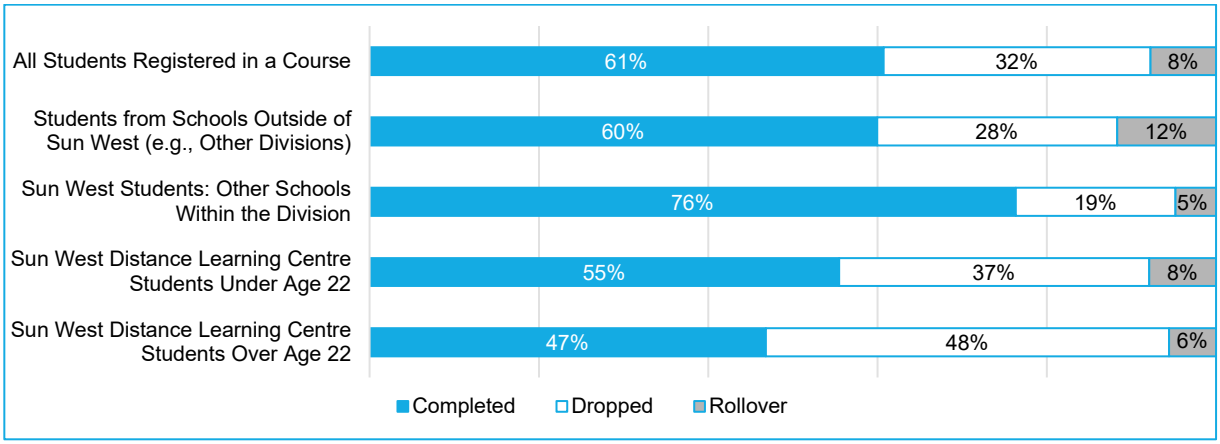
As shown in **Figure 2**, 60% of students who register for distance education courses are students solely of the Distance Learning Centre (i.e., they attend no physical school, therefore, they only receive online teacher support). This group of students represent the largest portion of Sun West's distance education students and yet Sun West does not have a course completion rate that it is striving to achieve for this set of students.

Not having a target completion rate for the majority of its distance education students increases the risk that Sun West is not appropriately assessing its students' successes and challenges, and taking related actions to provide support to those students.

5. **We recommend Sun West School Division No. 207 establish target course completion rates for its students who solely attend the Distance Learning Centre.**

As shown in **Figure 5**, Sun West is not meeting its 90% target for Sun West students that attend other schools within the Division (76% completion rate), and the completion rate for other groups of students ranged from 47% to 60%. For 2020–21, all students registered in online courses through Sun West were successful in completing courses 61% of the time.

Figure 5—2020–21 School Year Distance Education Course Completion Rates



Source: Based on data from Sun West. Dropped indicates incomplete.
*Note: percentages may not add to 100% due to rounding.

[28] *Sun West DLC 2019–2022 Strategic Plan*, p. 5.

We found that Sun West appropriately collects information on:

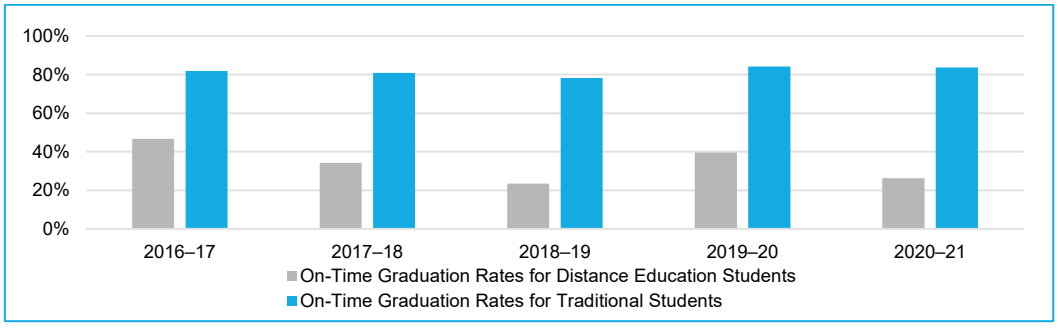
- Distance education course completion rates
- Rollover rates (i.e., students who did not complete their course in semester one roll the course over to semester two)
- Course drop rates (i.e., incomplete courses)

Sun West does not conduct analysis on the above information to determine trends or possible systemic issues (e.g., course design, certain courses with low completion rates).

Course completion rates directly influence graduation rates, as students need a certain number of credits to complete high school. Sun West's divisional goal was that by June 2021, 90% of Sun West's face-to-face students and 60% of its distance education students will graduate within three years of starting Grade 10.[29]

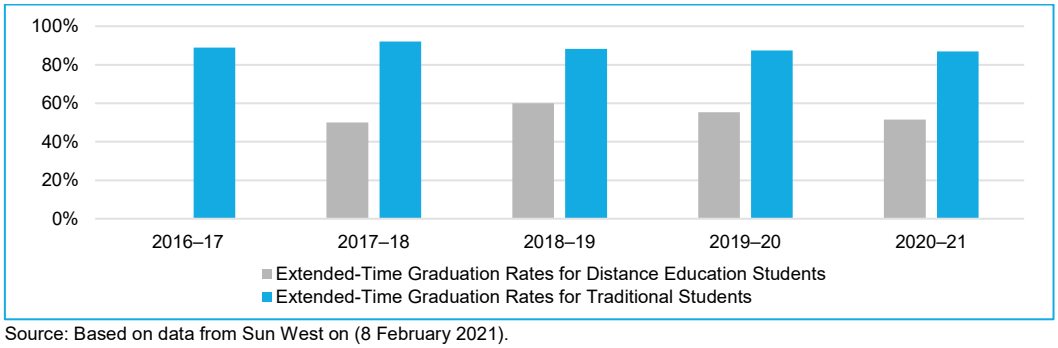
As shown in **Figure 6** and **Figure 7**, the on-time and extended-time graduation rates for Distance Learning Centre students lag behind their in-person learning counterparts, and do not meet the 60% goal. Sun West noted that the lower completion and graduation rates are in part due to the types of students who register for distance education (i.e., often students who struggle in a physical school). However, more analysis of potential root causes for low completion rates would help Sun West determine whether additional support could increase student success (e.g., targeted professional development).

Figure 6—Sun West's On-Time Graduation Rates From 2016 to 2021



Source: Based on data from Sun West (8 February 2021).
On-time graduation is within three years of starting Grade 10 (within five years for extended-time graduation).

Figure 7—Sun West's Extended-Time Graduation Rates From 2016 to 2021



Source: Based on data from Sun West on (8 February 2021).
Extended-time graduation is within five years of starting Grade 10 (within three years for on-time graduation).
*There is no data for distance education students' extended-time graduations for 2016–17.

[29] *Sun West School Division #207, 2020–21 Annual Report.* p. 25.

Not analyzing student completion rates increases the risk that Sun West may not identify issues affecting student success such as course design or engagement and take action.

6. **We recommend Sun West School Division No. 207 analyze key information related to supporting students' completion of Grades 10 to 12 distance education courses to identify potential issues and take action.**

Sun West shares information on course completion rates of students attending its Distance Learning Centre with its Board. It plans to provide this information two or three times per year, which is appropriate based on the two-semester system used by the Distance Learning Centre. We found Sun West also prepares appropriate monthly financial reports (e.g., budget to actual, revenue and expense comparatives) for the Board.

We found Board reports lacked consistent data and analysis for the online courses delivered by the Distance Learning Centre.

We observed the Board only received one written report on student completion rates in 2020–21 (February 2021). Sun West management indicated it verbally presented the remaining two updates on distance learning courses. Providing written information in advance of Board meetings allows Board members time to read the information and formulate questions.

The February 2021 written report only included completion rates for Sun West students who attend other schools within the Division. It excluded students of the Distance Learning Centre (as shown in **Figure 5**, students from other schools within the Division had a 76% completion rate, a higher completion rate than the average for all students at 61%). Providing Board reports with complete information allows for comparison across the learning environments while also helping to ensure decision-makers have all relevant information.

We also found that data calculations were sometimes inconsistent for Board reporting purposes. For example, Sun West calculated completion rates for semesters one and two of 2020–21 differently, which does not allow for comparative analysis.

As shown in **Figure 5**, Sun West's average distance-education course completion rate for the 2020–21 school year was 61% for all distance education students. Sun West is not meeting its target for its other schools within the Division (i.e., target of 90% compared to actual 76% completion rates for distance education courses). Board reports do not provide analysis or reasons for these completion rates, including whether they are lower than expected and why.

Not providing the Board with regular written reports and analysis, including complete and consistent information about Sun West's distance education, increases the risk that the Board is unable to understand the overall successes and challenges of the Distance Learning Centre. Furthermore, without analysis in written reports, Sun West may not know whether its targets are attainable, or require revisiting.

7. **We recommend Sun West School Division No. 207 regularly provide complete written reports and analysis to its Board about supporting students' completion of Grades 10 to 12 distance education courses.**

5.0 SELECTED REFERENCES

Provincial Auditor of Saskatchewan. (2019). *2019 Report – Volume 2*, Chapter 20, *Chinook School Division No. 211—Supporting Grade 2 Students in Achieving Grade Level in Math*. Regina: Author.

Provincial Auditor of Saskatchewan. (2018). *2018 Report – Volume 1*, Chapter 11, *Saskatoon School Division No. 13—Supporting Students with Intensive Needs*. Regina: Author.

Provincial Auditor of Saskatchewan. (2016). *2016 Report – Volume 1*, Chapter 11, *North East School Division No. 200—Increasing Grade 3 Students Reading at Grade Level*. Regina: Author.

Tasmanian Audit Office. (2014). *Report of the Auditor-General No. 13 of 2013–14—Teaching quality in public high schools*. 2014. Tasmania: Author.

Follow-Up Audits

Chapter 9
Modernizing Government Budgeting and Reporting

1.0 Main Points

Although the Government of Saskatchewan has good summary budgeting and financial reporting practices, it had not embedded key aspects of these practices into law as of March 2022.

Currently the Government prepares an annual Summary Budget, which includes the planned financial activities of the Government as a whole. The Government prepares annual Summary Financial Statements using Canadian generally accepted accounting standards.[1] Standards exist to help provide quality information. As standards can evolve in ways that significantly impact the Government's financial position and results, it is important to make sure the Government consistently follows the standards. Providing quality financial information helps legislators and the public hold the Government to account for the use of public money.

Embedding the existing practices in law for the Summary Budget and Summary Financial Statements would help ensure the Government's good governance practices are sustained to support credibility of financial information. Timely and high-quality financial information allows legislators and the public to easily monitor the actions of the Government.

2.0 Introduction

Publishing financial reports on plans and actual results is a key way governments show their stewardship of public money to legislators and the public. Providing quality and timely financial reporting can build trust in governments.

This chapter describes our third follow-up of the Government's actions on the recommendations we first made in 2013 relating to modernizing the Government's budgeting and financial reporting.[2]

Our 2013 Special Report reported that Saskatchewan's budgeting and financial reporting legislation and practices used in 2013 were outdated and not in sync with other provinces. We made 11 recommendations. By April 2019, the Government addressed eight of the recommendations.[3]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Government's progress toward meeting our recommendations, we used the relevant criteria from the original audit.

[1] The Canadian Public Sector Accounting Board establishes Canadian public sector accounting standards. The Board is an independent body created to serve the public interest by establishing accounting standards for the public sector.
[2] *2013 Special Report—The Need to Change—Modernizing Government Budgeting and Financial Reporting in Saskatchewan* (22 March 2022).
[3] *2016 Report – Volume 1*, Chapter 18, pp. 231–236; *2019 Report – Volume 1*, Chapter 45, pp. 371–377.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at March 4, 2022, and the Government's actions up to that date.

3.1 Interim Public Financial Reporting Formally Required

We recommended the Government of Saskatchewan formally require interim public financial reporting on the Summary Budget. *(2019 Report – Volume 1,* p. 374, Recommendation 1; Public Accounts Committee agreement February 26, 2020)

Status—Implemented

The Government of Saskatchewan formally requires and publishes quarterly financial reports on the Summary Budget.

In April 2019, Treasury Board approved a policy to require interim public financial reporting on the Summary Budget.

We found the Government prepared, and made public, quarterly interim reports during 2020–21 and 2021–22. We noted the Government prepared these interim reports using the same basis of presentation as the Summary Budget, as expected.

Formally requiring interim public financial reporting on the Summary Budget helps ensure legislators and the public have appropriate and timely information to monitor the Government's financial decisions.

3.2 Summary Budgeting Practices Not Embedded in Law

We recommended the Government of Saskatchewan seek changes to legislation that would require it to provide the Legislative Assembly with a Summary Budget (i.e., budget reflecting the activities of the entire Government) and consider providing a multi-year Summary Budget. *(2013 Special Report – The Need to Change – Modernizing Government Budgeting and Reporting in Saskatchewan,* p. 16, Recommendation 2; Public Accounts Committee agreement June 17, 2015)

Status—Not Implemented

As of March 2022, the Government of Saskatchewan had not updated the law (Acts or Regulations) to require a Summary Budget reporting the planned financial activities of the Government as a whole for the next fiscal year. It has created such a budget since 2014–15, and in April 2019 Treasury Board approved a policy requiring a Summary Budget. Ministry of Finance management indicated the Government does not plan to include this requirement in legislation.

Governments use budgets to communicate to legislators and the public the expected costs of their plans for the upcoming year or years, and to show how they plan to use public resources. Legislators and the public need this information to hold the Government to account.

The Saskatchewan Provincial Budget includes a Summary Budget and some multi-year budget information. Consistent with good practice, the Government generally tables its Budget prior to the start of the fiscal year to which the budget relates.

As shown in **Figure 1**, unlike six out of nine other Canadian provincial governments, the Government of Saskatchewan is not required by law to prepare a Summary Budget for tabling in the Assembly. Saskatchewan, in common with almost all provinces, provides multi-year summary budgets using the same accounting policies as their summary financial statements. By law, one province must use the same accounting policies as used in its summary financial statements when preparing them; and four must prepare multi-year summary budgets (e.g., three to five years).

Figure 1—Summary Budget Information Provided to Assemblies by Legislation (shaded cell) and in Practice (unshaded cell) as of March 2022

Nature of Budget Information Provided to Assemblies	SK	BC	AB	MB	ON	QC	NB	NS	PEI	NL
Summary budget	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Use same accounting policies as summary financial statements	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Includes multi-year summary budget	Y	Y	Y	Y	Y	Y	N	Y	Y	N

Source: Provincial summary budgets and related legislation.
Abbreviations: Saskatchewan (SK), British Columbia (BC), Alberta (AB), Manitoba (MB), Ontario (ON), Quebec (QC), New Brunswick (NB), Nova Scotia (NS), Prince Edward Island (PEI), Newfoundland & Labrador (NL)

Embedding summary budget reporting practices into law would ensure legislators and the public continue to receive a Provincial Budget with a summary focus. In addition, embedding key practices into law would demonstrate to legislators and the public a commitment to sustain the current summary budget reporting practices.

3.3 Use of Canadian Public Sector Accounting Standards for Summary Reporting Not Embedded in Law

We recommended the Government of Saskatchewan seek changes to *The Financial Administration Act, 1993* to require the use of Canadian public sector standards established by the Canadian Public Sector Accounting Board in preparation of the Summary Financial Statements. *(2013 Special Report – The Need to Change – Modernizing Government Budgeting and Reporting in Saskatchewan,* p. 32, Recommendation 10; Public Accounts Committee agreement June 17, 2015)

Status—Not Implemented

As of March 2022, the Government of Saskatchewan has not updated the law to require its well-established practice of using Canadian public sector accounting standards to prepare the Summary Financial Statements. It has used these standards since 1992, consistent with Treasury Board policies.

Similar to most other Canadian provincial governments, a law gives the Government (e.g., Treasury Board) the authority to set the accounting policies for the Summary Financial Statements.[4] In Saskatchewan, Treasury Board policy requires the use of generally accepted accounting principles for the public sector as recommended by the Canadian Public Sector Accounting Board to prepare the annual Summary Financial Statements.[5] It also requires Treasury Board approval for exceptions.[6] Treasury Board set out this policy in the Financial Administration Manual, section 2210, and, in April 2019, confirmed this decision. Since 1992, the Government has not made any exceptions to using Canadian generally accepted accounting policies to prepare the Summary Financial Statements.

In September 2018, the Canadian federal and provincial auditor generals noted, in a joint letter to the Canadian Public Sector Accounting Board, that many Canadian governments currently use Canadian public sector accounting standards to prepare their financial statements on a voluntary basis. They further noted the Canadian legislative audit community would like to see generally accepted accounting principles embedded in federal and provincial legislation as this would assist in ensuring that public sector financial reporting is in the public interest.[7]

At March 2022, British Columbia is the one province with legislation requiring the Government to follow Canadian public sector accounting standards or, with Treasury Board approval, to use generally accepted accounting principles applicable in a jurisdiction outside Canada that have been set by a recognized standard setting organization in that jurisdiction.[8]

Requiring the Government of Saskatchewan, by law, to use Canadian generally accepted accounting principles to prepare its Summary Financial Statements would be consistent with legal requirements already placed on Saskatchewan municipalities, and on publicly traded companies.

For example,

- Since 2005, provincial laws require Saskatchewan municipalities to prepare their financial statements using Canadian public sector accounting standards[9]

- Canadian securities regulators require publicly traded companies to use generally accepted accounting principles for publicly accountable enterprises (i.e., International Financial Reporting Standards) in preparing their annual financial statements[10]

[4] *The Financial Administration Act, 1993*, s. 16. The Provincial Comptroller shall prepare the Summary Financial Statements of the Government of Saskatchewan for each fiscal year in accordance with the accounting policies established by the Treasury Board (requirement in place since 1993).
[5] The Canadian Public Sector Accounting Board establishes accounting standards for the public sector in Canada, and provides guidance for financial and other performance information reported by the public sector.
[6] Financial Administration Manual 2210 SFS Accounting Policies, applications.saskatchewan.ca/fam/pdf/2210.pdf (22 March 2022).
[7] The letter dated September 28, 2018, is signed by 12 Auditor Generals (representing Canada and the territories, 10 provinces, and Bermuda). It is a joint response to the May 2018 Consultation Paper: Reviewing PSAB's Approach to International Public Sector Accounting Standards. www.frascanada.ca/en/public-sector/documents (22 March 2022).
[8] *The Budget Transparency and Accountability Act* (British Columbia), s. 23.1, requires the Government of British Columbia to follow Canadian public sector accounting standards or, with Treasury Board approval, use generally accepted accounting principles applicable in a jurisdiction outside Canada that have been set by a recognized standard setting organization in that jurisdiction. www.bclaws.ca/civix/document/id/complete/statreg/00023_01 (22 March 2022).
[9] *The Municipalities Act* (s. 185), *The Cities Act* (s. 155), *The Northern Municipalities Act, 2010* (s. 207).
[10] www.osc.gov.on.ca/documents/en/Securities-Category5/ni_20160113_52-107_unofficial-consolidated.pdf (22 March 2022).

Embedding in law the requirement to use Canadian public sector accounting standards to prepare the Summary Financial Statements would help ensure legislators and the public continue to receive quality financial statements. In addition, such a requirement could reduce the risk of use of accounting standards that do not follow Canadian public sector accounting standards in the preparation of future financial statements, as has occurred in recent years in other provinces.[11] Quality audited financial statements are the foundation for financial reporting. Financial reporting assists legislators and the public in understanding the Government's financial performance and holding them accountable for it.

[11] As of March 22, 2022, independent auditor reports of Auditor Generals of the following Canadian provinces cited that their related government did not follow Canadian public sector accounting standards in the preparation of that government's most recent summary financial statements: British Columbia and Manitoba.

Chapter 10
Energy and Resources—Auditing Producer Returns for Non-Renewable Resources

1.0 Main Points

By October 2021, the Ministry of Energy and Resources partially implemented three recommendations and did not implement two recommendations in relation to auditing producer royalty and tax returns.

Since our 2019 audit, the Ministry updated its audit manual to better align with current audit practice, allocated estimated hours for each audit it expects to complete, and estimated the number of audits it anticipated completing during the year.

The Ministry still needs to:

- Develop a plan to reduce the backlog of existing audits (e.g., six years behind on potash audits)
- Consistently document audit work in files in accordance with expectations established in its audit manual
- Further develop its audit manual to include other required key audit documentation (e.g., data reliability assessments)
- Establish what it defines as a timely and quality audit file review, and meet this expectation
- Periodically monitor the status of ongoing audits to identify audit delays or inefficiencies

To be effective, the Ministry's audits of producer royalties and taxes must be timely and executed properly. In 2019–20, the Ministry's audits resulted in reassessments of additional production taxes and royalties totalling about $21.1 million, and refunds of $8.3 million.

2.0 Introduction

The Ministry of Energy and Resources levies and collects revenue, on behalf of the Government, from the production and sale of Saskatchewan's non-renewable resources. In Saskatchewan, non-renewable resources primarily consist of oil, natural gas, potash, uranium, and coal. Different provincial acts and regulations govern the royalty and tax structures for each of the resources.[1]

[1] The Ministry of Energy and Resources is responsible for administering the *Crown Minerals Act* and *The Mineral Taxation Act, 1983*. These acts each give Cabinet the authority to make regulations related to production tax on non-renewable resources (e.g., *The Potash Production Tax Regulations*) and levying royalties (e.g., *The Crown Mineral Royalty Regulations, The Subsurface Mineral Royalty Regulations*). Production taxes on non-renewable resources are based on produced volume of non-renewable resources. Royalties are payments in return for permission to use government lands. Royalties for non-renewable resources are based on the value of non-renewable resources produced on leased crown lands.

Laws require each producer's individual mine/project to submit relevant production taxes and royalties to the Ministry each quarter. Initially, producers submit them based on estimations of their production activity. Then, for the end of the calendar year, producers must submit them based on actual results (e.g., for December 31 year-end, taxes and royalties submitted by March 31). Producers must submit returns showing the basis of their determination for production taxes and royalties.

The Ministry has an Audit Unit within the Revenue and Business Systems Branch responsible for determining whether producers comply with applicable royalty and tax legislation, and remit royalties and taxes in accordance with relevant legislation. The Audit Unit employs 11 full-time equivalent staff, and had a budget of $805,488 in 2020–21. As shown in **Figure 1**, the Audit Unit completed 30 audits in 2020–21.

Figure 1—Audits Completed by the Ministry in 2020–21

Resource	Audits Completed	Number of Producers
Enhanced Oil Recovery	20	10
Uranium	1	1
Coal	0	0
Potash Profit Tax	1	1
Potash Crown Royalty	8	2
Total	**30**	**14**

Source: Ministry of Energy and Resources 2020–21 Audit Statistics.

2.1 Focus of Follow-Up Audit

This chapter describes our follow-up audit of management's actions on five recommendations we first made in 2019.

Our *2019 Report – Volume 1*, Chapter 4, concluded that for the 12-month period ending December 31, 2018, the Ministry of Energy and Resources had, other than the matters reflected in our five recommendations, effective processes to assess the completeness and accuracy of producer royalty and tax returns for potash, uranium, coal, and enhanced oil recovery.[2]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Ministry agreed with the criteria in the original audit.

In this follow-up audit, we interviewed Ministry staff responsible for auditing producer returns; examined relevant documents including the Ministry's audit plan and audit manual; and tested a sample of audit files.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at October 15, 2021, and the Ministry's actions up to that date.

[2] *2019 Report – Volume 1*, Chapter 4, pp. 43–59.

3.1 Clear, Long-Term Plan to Eliminate Audit Backlog Still Needed

We recommended the Ministry of Energy and Resources estimate staff time and costs required to audit producer returns for non-renewable resources production taxes and royalties. *(2019 Report – Volume 1,* p. 51, Recommendation 1; Public Accounts Committee agreement February 9, 2021)

Status—Partially Implemented

As of October 2021, the Ministry of Energy and Resources established a process to estimate staff time and costs required to complete planned audits during the year. However, the Ministry still needs to establish a long-term plan to eliminate the backlog of audits.

The Ministry has a goal to conduct all audits within two years of the filing date (i.e., auditing returns filed in March 2021 by March 2023).

The Ministry is currently up to six years behind on potash audits (i.e., outstanding audits exist for 2015), six years on enhanced oil recovery (EOR) audits (i.e., outstanding audits from 2015), four years on coal audits (i.e., outstanding audits from 2017) and five years on uranium audits (i.e., outstanding audits from 2016). At March 2021, the total number of audits outstanding from March 2020 and earlier is 101 audits. As noted in **Figure 1**, the Ministry completed 30 audits in 2020–21.

The Ministry's Audit Unit develops an annual audit plan, which now includes estimated audit hours (i.e., audit staff time) required to complete audits during the upcoming year. The Ministry uses past experience (i.e., audit staff hours used) to estimate the average audit time required for each future audit.

The Ministry also established a process to estimate the total available hours for each audit staff. We found that the Ministry reasonably estimated the number of audits it expects to complete with the current staff resources available. Although the Ministry focuses its resources on the oldest audits first, it does not have a plan to catch up on the existing audit backlog.

Not completing audits in a timely manner increases the risk of more costly and time-consuming audits resulting from potential changes to legislation, producer operations, or personnel, which increases audit complexity and time.

3.2 Maintaining an Updated Audit Manual in Progress

We recommended the Ministry of Energy and Resources maintain its audit manual used during audits of non-renewable resources production taxes and royalties. *(2019 Report – Volume 1,* p. 53, Recommendation 2; Public Accounts Committee agreement February 9, 2021)

Status—Partially Implemented

The Ministry of Energy and Resources reviewed and updated its audit manual at March 31, 2020, but further work is required to define audit processes and expectations for audit staff.

The Ministry revised the audit manual including documentation of some key audit information such as guidance to auditors when calculating materiality on audit files, as well as guidance to complete risk assessments when planning audits (e.g., considering prior audit results for higher risk areas).

Although the Ministry updated its manual, further revisions are required to reflect current practices of the Audit Unit and establish expectations for file documentation. We found:

- The manual does not include expectations for what the Ministry considers as timely audit work completion (e.g., audit completion compared to when the producer filed the return).

- The manual does not include guidance on communicating timely audit results. For example, it does not include timeframes for providing results to producers after completing field work (e.g., within 30 days).

In addition, the updated manual does not provide sufficient guidance on the documentation of several key audit areas. For example, it did not provide guidance on:

- Assessing whether the underlying data used to prepare returns is reliable

- Establishing what is a timely and quality review of an audit file (e.g., prior to issuing additional notice of assessments or refunds to a producer)

While the Ministry made some updates to its audit manual, it has not established a frequency policy or expectation for when it plans to review and update the audit manual to reflect current practice. Developing an expectation to periodically review the manual helps prevent the risk that the manual is outdated and auditors are not completing audits in accordance with Ministry expectations.

Not having established expectations for timely audit work completion, audit results communication, or audit work review increases the risk of delays or problems in completing audits (e.g., can increase interest expenses, delay payment, impact reporting accuracy). In addition, not having an established frequency for reviewing the audit manual increases the risk of outdated procedures.

3.3 Audit File Documentation Improving

We recommended the Ministry of Energy and Resources consistently document key audit decisions, audit procedures, and results of audit work in files of audits of producer returns for non-renewable resources production taxes and royalties. *(2019 Report – Volume 1,* p. 55, Recommendation 3; Public Accounts Committee agreement February 9, 2021)

Status—Partially Implemented

The Ministry of Energy and Resources developed tools (e.g., program checklists) to assist auditors in documenting audit work; however, we found staff inconsistently use these tools to document audit work.

Some template examples the Ministry developed include:

- Audit program checklists to guide the expected audit procedures for each resource audit
- Audit plan template for each non-renewable resource
- Audit report template

Of the 10 audit files we tested, we identified the following inconsistencies in documentation in the related audit file:

- Ten files did not document consideration of the reliability of data received from producers (i.e., assessing whether producer data was complete or accurate)
- Two audit files did not have the appropriate audit program checklist completed (i.e., the program checklist guides auditors through the expected audit procedures)
- Ten audit files did not include detailed evidence of the procedures the auditor performed (e.g., evidence of verifications the auditor completed)
- Six audit files did not have a completed post-audit verification checklist[3]

Inconsistent and incomplete documentation in audit files can result in having insufficient and inappropriate support for audit results. In addition, inconsistent and incomplete documentation may result in expending additional resources in the event of a disagreement with a producer on audit findings.

3.4 Quality Review Process Still Needed

We recommended the Ministry of Energy and Resources complete quality reviews of audit files of producer returns for non-renewable resources production taxes and royalties before finalizing audit results. *(2019 Report – Volume 1,* p. 56, Recommendation 4; Public Accounts Committee agreement February 9, 2021)

Status—Not Implemented

The Ministry of Energy and Resources still needs to define what a quality review should include and what it considers a timely review. Additionally, the Ministry needs to establish and follow expectations for completing reviews of audit files.

While the Ministry developed tools to assist in file reviews (e.g., audit review form), it has not formalized expectations in its audit manual for file reviews. The manual does not

[3] The post-audit verification checklist is used by the Ministry as an additional audit file review tool to verify that all required documentation is included. Another auditor within the Unit will complete the checklist when they review the file.

indicate what documents the Ministry expects a reviewer to assess (e.g., audit plan, audit report) and what it considers as timely review (e.g., 30 days after file submitted for review).

In practice, the file should have evidence of sign-off on key audit documents such as the audit plan, audit report, and audit review form. Of the 10 audit files we tested, we found:

- Six audit files had evidence where the reviewer signed off on each of these documents. For the remaining files, the reviewer did not sign off on at least one of the documents.
- Eight audit files showed evidence that the Ministry completed the review after communication with producers (i.e., notice of assessment, audit proposal sent to producer). The review did not result in changes to the final assessment for any of these files.

Not having an established timely review process for quality increases the risk of Ministry staff identifying errors after a producer has already made payment or received a refund.

3.5 Further Improvements Needed to Monitor Audit Status

We recommended the Ministry of Energy and Resources routinely monitor actual-to-planned staff time and costs to audit producer returns for non-renewable resources production taxes and royalties. *(2019 Report – Volume 1,* p. 58, Recommendation 5; Public Accounts Committee agreement February 9, 2021)

Status—Not Implemented

The Ministry of Energy and Resources had not developed a process to monitor actual-to-planned staff time and costs or delays in ongoing audits.

The Ministry maintains an audit statistics spreadsheet that provides information on the number of, and total hours for, completed audits within a year. However, the Ministry does not routinely update this spreadsheet for costs or time incurred to date (i.e., staff only update the spreadsheet as they complete audits). There is no process established allowing management to identify potential issues earlier in the audit process or to identify audits that may be delayed or incurring additional costs (e.g., over budget).

Senior management does not receive information to enable monitoring whether the Audit Unit has completed audits when planned. The Ministry planned to complete 46 audits in 2020–21 and completed 30 audits. Although the Ministry implemented a budget and resource estimation process as noted in **Section 3.1** above, the Ministry does not formally document variance explanations or rationale for delays in completing an audit.

Routinely comparing actual resources used to date would help assess whether the Audit Unit achieves its plans and, if not, allow for timely decisions on required adjustments.

Chapter 11
Environment—Regulating Landfills

1.0 Main Points

By December 2021, the Ministry of Environment implemented the two remaining recommendations related to regulating landfills.

The Ministry developed and updated guidance documents for landfills and transfer stations, as well as drafted codes of practice it expects to include in legislation. Having standardized guidance encourages operators to build, operate, and close landfills by the same set of standards.

The Ministry also completed, at least annually, landfill inspections it classified as high risk. Annual inspections confirm whether landfills operate in compliance with permit requirements and the law, which enhances environmental and public safety.

2.0 Introduction

The Ministry of Environment regulates waste management and enforces landfill and transfer station compliance through province-wide legislation under *The Environmental Management and Protection Act, 2010.* Municipalities and private companies own and operate landfills throughout the province.

Saskatchewan generates the second-highest amount of waste per capita in Canada after Alberta.[1] From 2010 to 2018, Saskatchewan's waste generation trended downward (i.e., from 845 kg/per capita to 744 kg/per capita).[2] From 2015 to 2021, the number of operating municipal landfills decreased significantly from 500 in 2015 to 139 in 2021.[3]

This chapter describes our follow-up audit of management's actions on the recommendations we first made in 2013 about the Ministry of Environment's processes to regulate landfills.[4] By January 2020, the Ministry implemented seven of the nine recommendations.[5]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Ministry management agreed with the criteria in the original audit.

To perform our follow-up of the recommendations, we discussed actions taken with management and reviewed relevant documents (e.g., Ministry inspection records, guidance documents).

[1] conferenceboard.ca/hcp/provincial/environment/waste.aspx/ (3 January 2022).
[2] Ministry of Environment, *Saskatchewan's Solid Waste Management Strategy Annual Report 2020–21*, (2021), p. 11.
[3] Ibid., p. 12.
[4] *2013 Report – Volume 2*, Chapter 29, pp. 205–217.
[5] *2020 Report – Volume 1*, Chapter 16, pp. 211–214.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at December 31, 2021, and the Ministry's actions up to that date.

3.1 Landfill Guidance Documents Published

We recommended the Ministry of Environment adopt guidance on landfills from the proposed Environmental Code as operating practice. *(2013 Report – Volume 2,* p. 210, Recommendation 1; Public Accounts Committee agreement April 30, 2014)

Status—Implemented

As of December 31, 2021, the Ministry of Environment developed and published new guidance documents (e.g., Composting Guidance Document—Design and Operations Plan) and updated existing guidance documents (e.g., Landfill Closure Guidance) for landfill and transfer station operators. It also intends to include requirements for transfer stations and composting facilities in legislation (e.g., Environmental Code Chapters) by 2023 and for landfills by 2025.

By December 2021, the Ministry has guidance documents for landfill design and operation, composting design and operation, and landfill closure. These documents are available for operators on the Ministry's Solid Waste Management publications website.[6]

Providing consistent guidance for landfills supports operators to build, operate and close landfills by the same standards.

The Ministry also drafted Environmental Code Chapters for transfer stations and composting facilities in 2020–21. The Ministry set a timeframe for receiving stakeholder feedback on these comprehensive Chapters before obtaining approval to include them in legislation, which it anticipates in 2022–23.

The Ministry is also finalizing its review of new solid-waste regulations that will inform the decision on whether the Ministry creates a separate Chapter on landfills or if this information will be included in revised regulations. The new Chapter or regulation will cover everything from landfill construction to closure. The Ministry expects to have this legislation in place by January 2025.

Embedding codes of operating practice in law provide standard guidance and promote environmentally-sound management practices.

3.2 Landfills Frequently Inspected

We recommended the Ministry of Environment perform landfill inspections in accordance with its established frequency requirements. *(2013 Report – Volume 2,* p. 212, Recommendation 3; Public Accounts Committee agreement April 30, 2014)

Status—Implemented

[6] publications.saskatchewan.ca/#/categories/33 (8 February 2022).

The Ministry of Environment followed its Inspection Frequency Guidelines and inspected landfills classified as high risk, at least annually or explained why not.

The Ministry expects each of its five Environmental Protection Officers to complete 10 to 15 landfill inspections per year (e.g., up to 75 total inspections annually). As of December 31, 2021, Ministry staff completed annual inspections for 12 of 16 high-risk landfills. For the remaining four high-risk landfills with no inspection completed, staff documented rationale for why an annual inspection was not completed (e.g., landfill staff working on compliance items).

Timely inspections determine whether landfills operate in compliance with permit requirements and the law. Permit requirements and laws exist to enhance environmental and public safety. The use of inspections is a key enforcement tool to assist the Ministry in fulfilling its regulatory role and to foster compliance.

Chapter 12
Financial and Consumer Affairs Authority—Regulating Motor Vehicle Dealers to Protect Consumers

1.0 Main Points

By February 2022, the Financial and Consumer Affairs Authority improved its processes to regulate motor vehicle dealers to protect consumers, but still has work to do. It implemented two recommendations and partially implemented one of the other two recommendations we made in 2020.

The Authority implemented a new policy and procedures manual for inspecting motor vehicle dealers. It also formally monitored the completion of motor vehicle dealer inspections compared to its inspection plan.

While the Authority developed a framework for selecting motor vehicle dealers for inspection, based on a formal analysis of key risks, it had not yet fully implemented this framework. Using clearly defined risk factors to select motor vehicle dealers for inspection can help the Authority ensure it focuses its limited inspection resources on dealers at a higher risk of non-compliance.

In addition, the Authority has not developed a process to formally analyze the results of its enforcement activities for motor vehicle dealers. Analyzing enforcement activity results (such as non-compliance trends) can help focus enforcement resources on areas that can best promote compliance.

A well-defined, risk-informed approach can help build Saskatchewan motor vehicle consumers' confidence in the Government's ability to protect their consumer rights.

2.0 Introduction

The Financial and Consumer Affairs Authority is a Treasury Board Crown corporation created to protect Saskatchewan consumers, public interests, and businesses by providing effective, balanced and timely market regulation.[1] The Authority is dedicated to advancing the interests of consumers by ensuring fair trading conduct and minimizing opportunities for unfair, unlawful, or deceitful commercial activity. It is specifically responsible for regulating financial securities and services, insurance and real estate, pensions, and consumer-related businesses, including motor vehicle dealers.

The Consumer Protection Division is responsible for regulating consumer protection in Saskatchewan. This includes market regulation; sector-specific business and salesperson licensing; complaint investigation; education initiatives; inter-agency and inter-jurisdictional cooperation; and enforcement action across nine industries, including motor vehicle dealers.[2] There were 841 motor vehicle dealers in Saskatchewan at March 31, 2022.

[1] Financial and Consumer Affairs Authority of Saskatchewan, *Annual Report 2020/21,* p. 7.
[2] Ibid., p. 11.

2.1 Focus of Follow-Up Audit

This chapter describes our first follow-up audit of management's actions on the recommendations we made in 2020 about the Authority's processes to regulate motor vehicle dealers to protect consumers.[3]

Our *2020 Report – Volume 1*, Chapter 7, concluded that for the 12-month period ended December 6, 2019, the Financial and Consumer Affairs Authority had effective processes except in a few areas. We made four recommendations.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Authority agreed with the criteria in the original audit.

Our audit approach included discussing actions taken with Authority management and reviewing key documents provided by management (e.g., Board reports, policy and procedures manual, risk-based inspection framework).

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at February 25, 2022, and the Financial and Consumer Affairs Authority's actions up to that date.

3.1 Risk-Based Approach for Inspections Developed, But Not Yet Fully Implemented

> ***We recommended the Financial and Consumer Affairs Authority select motor vehicle dealers for inspection based on a formal analysis of key risks for non-compliance.*** *(2020 Report – Volume 1,* p. 76, Recommendation 1; Public Accounts Committee has not yet considered this recommendation as of May 4, 2022)
>
> **Status**—Partially Implemented

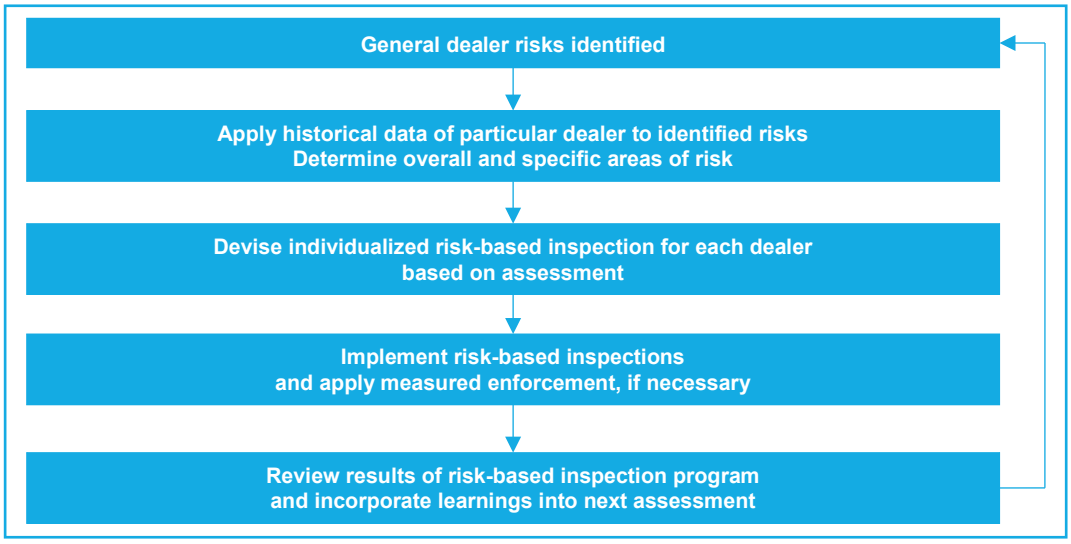
The Financial and Consumer Affairs Authority developed a well-defined risk framework it plans to use to select motor vehicle dealers for inspection. However, the Authority has not yet fully used this framework to analyze key risks in selecting motor vehicle dealers to inspect.

In summer 2020, the Authority developed its *Risk Based Inspection Program* containing a robust risk-based dealer inspection framework (Framework). The Authority designed the Framework to make informed decisions in its allocation of resources; focus attention on proactive risk reduction through targeted inspections; reduce unnecessary regulatory burdens; and focus attention on outcomes in regulatory decision-making.[4]

[3] *2020 Report – Volume 1,* Chapter 7, pp. 65–82.
[4] Financial and Consumer Affairs Authority, *Consumer Protection Division Risk Based Inspection Program*, p. 4.

The Framework has five steps, as shown in **Figure 1**, and is cyclical in nature, building upon past analysis and dealer history. The Framework will be applied across dealers, at least annually, but can be applied more often if any new concerns arise, such as recent compliance action against the motor vehicle dealer.

Figure 1—Motor Vehicle Dealer Inspection Framework



Source: *Consumer Protection Division Risk Based Inspection Program.*

In addition, the Authority developed a list of risk factors to consider when assessing the risk for each motor vehicle dealer, as shown in **Figure 2**. The Authority's guidance requires consideration of both the likelihood that the risk factor will occur and the expected impact.

Figure 2—Risk Factors Considered in Motor Vehicle Dealer Risk Assessment

Vehicle Safety Factors:	
• Dealer sells rebuilds • Dealer routinely inspects all vehicles for safety • Dealer has been warned by the Authority for selling unsafe vehicles in the last three years	• Dealer routinely inspects off-lease vehicles for safety • Dealer imports vehicles for resale • Dealer sells under $5,000 vehicles
Dealer Operations Factors:	
• Dependence on consignments for business • Volume of salesperson turnover	• Delinquency in paying Consumer Protection Division (CPD) licensing fees
Business Office Factors:	
• Documentation is compliant with legislative authorities • Dealer does leasing • Dealer does sub-prime loans • Dealer has internal controls in place for handling consumer information	• Privacy Policy—Does a dealer ensure consumer privacy in all sales/leases? • Financial security claims in the past five years • Dealer maintains full documentation review with consumer prior to sale
Dealer Compliance Factors:	
• Last inspection of dealer • Results of previous dealer inspection • Warning letters in the past five years • Undertaking (Voluntary Compliance Agreements) in the previous five years • Compliance orders in the previous five years • Suspensions/Conditions—as a result of compliance activity	• Level of cooperation with CPD complaint and investigation process • Level of cooperation with licensing—payment of all fees • Action by other regulatory bodies against dealer • Volume of substantiated complaints

Source: Adapted from the *Consumer Protection Division Risk Based Inspection Program* Appendix A: Risk Based Dealer Inspection Summary Template.

The Authority conducted 40 inspections of motor vehicle dealers in 2021–22; however, we found the Authority did not fully use its new Framework when selecting motor vehicle dealers for inspection during their 2021–22 fiscal year. It did utilize some factors of the Framework, including considering the date of the dealer's last inspection, results of previous inspections or investigations, and the sale of consignment vehicles.

Management indicated they plan to use the Framework once they obtain some additional information from motor vehicle dealers (e.g., number of salespeople turnover/changes at the dealership; whether the dealer sells rebuilds; whether the dealer imports vehicles for resale; inventory level changes compared to previous year at the dealership; number of unpaid lien claims against the dealership) and are able to automate key aspects of the vehicle dealers' inspection rating process in its Registration Licensing System. Management expects to update its Registration Licensing System in 2022–23.

Not fully assessing risk factors when selecting licensed motor vehicle dealers for inspection increases the risk of an inconsistent selection process, and using inspection resources on dealers at lower risk of non-compliance. Documenting the rationale for selecting dealers helps to demonstrate the use of a fair and consistent regulatory approach.

3.2 Updated Policy and Procedures Manual for Inspections of Motor Vehicle Dealers Implemented

> ***We recommended the Financial and Consumer Affairs Authority update and implement a policy and procedures manual for inspections of motor vehicle dealers.*** *(2020 Report – Volume 1,* p. 79, Recommendation 2; Public Accounts Committee has not yet considered this recommendation as of May 4, 2022)
>
> **Status**—Implemented

In April 2020, the Financial and Consumer Affairs Authority implemented a new policy and procedures manual, the *Consumer Protection Division Compliance Policy and Procedures Manual* (Manual).

The Manual documents the policy and procedures that support the Authority's efforts to promote compliance and to enforce laws regulating the vehicle sales industry in Saskatchewan.[5]

The Manual includes:

- Roles and responsibilities for the Authority's staff
- Requirements for dealer liaison visits[6]
- Requirements for inspections, including communication specifications
- Requirements for investigations
- Guidance around enforcement actions

[5] Financial and Consumer Affairs Authority, *Compliance Policy and Procedures Manual*, p. 4.
[6] Dealer liaison visits are regular contact with vehicle dealers, whether in person, via phone or email, meant to foster relationships with the motor vehicle dealers and the Authority.

For all of the five inspections we tested (conducted since April 2020), the Authority followed its established procedures. It completed the inspection as expected and communicated the results of inspections in a timely manner (e.g., generally within one month of the inspection).

Having updated policies and procedures that reflect the Authority's current practices enables more effective training and understanding of staff.

3.3 Monitoring the Completion of Vehicle Dealer Inspections

We recommended the Financial and Consumer Affairs Authority formally monitor the completion of motor vehicle dealer inspections compared to inspection plans. *(2020 Report – Volume 1,* p. 80, Recommendation 3; Public Accounts Committee has not yet considered this recommendation as of May 4, 2022)

Status—Implemented

The Financial and Consumer Affairs Authority monitors the completion of motor vehicle dealer inspections compared to its inspection plans.

We found, at the beginning of the fiscal year, inspectors and the Director of the Consumer Protection Division agreed on which motor vehicle dealers to inspect for the year (i.e., 40 inspections). The inspectors then tracked the planned inspections and key information about the inspections (e.g., date of planned inspection, date report sent to licensee, date inspection results reviewed by Director) in a spreadsheet.

At February 17, 2022, we found the Authority had completed 79% of the inspections planned for the year ended March 31, 2022. We also found the Authority's staff properly recorded an explanation when they did not complete a planned inspection.

Formally monitoring the completion of its annual inspection plan increases the likelihood of the Authority effectively using inspections as a proactive enforcement activity.

3.4 Analysis of Enforcement Activity Results Needed

We recommended the Financial and Consumer Affairs Authority formally analyze the results of its enforcement activities for motor vehicle dealers to support a risk-informed enforcement approach. *(2020 Report – Volume 1,* p. 81, Recommendation 4; Public Accounts Committee has not yet considered this recommendation as of May 4, 2022)

Status—Not Implemented

The Financial and Consumer Affairs Authority does not formally analyze the results of its enforcement activities.

We found the Authority does not formally document its analysis of non-compliance trends and other findings from inspections and complaint investigations. Rather, management indicated they informally track trends and results of motor vehicle dealer inspections.

Management indicated they are currently working on a process to document and report analysis of non-compliance trends. They expect to report trend analysis to senior management starting in 2022–23.

Lack of formal analysis of enforcement activity results (such as non-compliance trends) for motor vehicle dealers increases the risk of not focusing enforcement resources on the highest risk areas of non-compliance or on areas that can best promote compliance. Taking a well-defined, risk-informed approach may best protect Saskatchewan purchasers of motor vehicles and could result in a gain of consumers' confidence in the Government's ability to protect consumer rights.

Chapter 13
Health—Detecting Inappropriate Physician Payments

1.0 Main Points

Each year, the Ministry of Health pays over $500 million to about 1,850 physicians under a fee-for-service arrangement. The Ministry directly compensates physicians at agreed-upon rates for specific services provided to residents with valid health coverage. On average, physicians submit approximately 364,000 billing claims every two weeks. The Ministry cannot practically confirm the validity of all billings before paying physicians. As such, the Ministry must have effective processes to detect inappropriate physician payments.

By December 2021, the Ministry had made some progress in developing an IT system that will help identify inappropriate physician payments. It expects the new IT system to be operational in late 2022.

Without the new IT system, the Ministry has yet to complete a comprehensive risk-based strategy to detect inappropriate physician billings for insured services before processing payments. Also, it has not yet assessed options to conduct more investigations into physicians' billing practices. The Ministry expects the development of the new IT system to help improve its investigations of inappropriate physician billings.

Strong processes to detect inappropriate physician payments will help ensure taxpayers only pay for eligible services.

2.0 Introduction

This chapter describes our second follow-up of management's actions on the recommendations we made in 2017.

In 2017, we assessed the Ministry of Health's processes to detect inappropriate fee-for-service payments to physicians. Our *2017 Report – Volume 1*, Chapter 6, concluded that the Ministry had, except for the recommendation areas, effective processes to detect inappropriate fee-for-service payments to physicians.[1] We made four recommendations. By December 2019, the Ministry implemented two of the four recommendations.[2]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Ministry management agreed with the criteria in the original audit.

To perform this follow-up audit, we discussed actions taken with management and reviewed the relevant documentation on the actions taken toward our recommendations (e.g., identified risks of inappropriate physician billings for insured services).

[1] *2017 Report – Volume 1*, Chapter 6, pp. 65-80.
[2] *2020 Report – Volume 1*, Chapter 17, pp. 215-220.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at December 31, 2021, and the Ministry of Health's actions up to that date.

3.1 Risk-Based Strategy Expected with New IT System

We recommended the Ministry of Health use a comprehensive risk-based strategy to detect inappropriate physician billings for insured services before making payments. (*2017 Report – Volume 1*, p. 76, Recommendation 1; Public Accounts Committee agreement June 12, 2018)

Status—Partially Implemented

The Ministry of Health has not formally established a risk-based strategy to detect inappropriate physician billings before making payments. It expects to do so in conjunction with the development of a new IT system for processing physician billings.

During our 2020 follow-up audit, we found the Ministry identified some general risk areas related to inappropriate physician billings (e.g., need for more education to those submitting billings, limited capabilities of the current IT system), but had not completed detailed work to develop a risk-based strategy.

The Ministry's pre-verification process to check the validity of fee-for-service billings remains simplistic. It continues to require manual intervention. The Ministry's claims-processing IT system is rules-based using edit checks and requires labour-intensive assessment processes to confirm the validity of billings in every two-week payment cycle.

Since 2020, the Ministry focused its efforts on acquiring a new IT system that should enable the Ministry to more efficiently assess significant amounts of data to identify suspicious activity associated with physician billings. In winter 2020, the Ministry posted a tender for development of a new IT system and, in June 2021, signed a 12-year agreement with a software vendor for development and maintenance of the new IT system. The Ministry expects the IT system to be operational in late 2022.

Management indicated the Ministry plans to develop a more robust set of rules within the new IT system to detect inappropriate or incorrect billings before processing payments to physicians. This will support a detailed, risk-based strategy to detect inappropriate physician billings for insured services, before making payments.

Having a comprehensive risk-based strategy to detect inappropriate physician billings before payment would reduce the amount of effort needed to assess and collect inappropriate payments back from physicians.

3.2 Assessment of Options to Increase Investigations Still Required

We recommended the Ministry of Health assess options to conduct more investigations into physician billing practices that it suspects of having inappropriately billed the Government. (*2017 Report – Volume 1*, p. 79, Recommendation 4; Public Accounts Committee agreement June 12, 2018)

Status—Partially Implemented

The Ministry of Health has not yet assessed options to conduct more investigations into physician billing practices. However, it expects the new IT system for processing physician billings to help improve its investigation of inappropriate billings.

Since our 2020 follow-up audit, the Ministry did not identify any additional options to conduct more investigations into physician billing practices.

The Ministry anticipates its new IT system to enable more data analysis to further identify inappropriate billings. Management told us they plan to use this analysis to create additional IT system controls to stop these billings before payment occurs and to assess where more investigations are needed.

Under the current IT system, the Ministry continues to run routine data analytics on physician payments. These analytics identify when a physician billed for services and/or received payments outside of the normal practice pattern for the physician's peer group (i.e., specialty area). If billings or payments fall outside of normal practice, the Ministry may investigate further and request the physician provide documentation to support their billings to determine whether inappropriate billings and payments occurred.

When the Ministry determines that a physician billed inappropriately, the Ministry recovers these payments. The Ministry also refers cases to the Joint Medical Professional Review Committee (further discussed below) for further investigation when the individual physician's pattern of billing departs from the physician's peer group.

As a result of Ministry-led investigations, the Ministry recovered payments made to physicians for inappropriate billings of insured services as summarized in **Figure 1**. The decreased amount of recoveries in 2020–21 is a result of multiple factors, such as fewer medical services provided during the COVID-19 pandemic (e.g., less surgeries) and approximately 800 fee-for-service physicians opted to provide services under a temporary pandemic contract instead of billing the Ministry directly for each service provided.

Figure 1—Summary of Billing Payment Recoveries from 2017–2021

Fiscal Year	Recovered
2020–21	$ 161,241
2019–20	$ 425,883
2018–19	$ 458,103
2017–18	$ 222,383

Source: Adapted from information provided by the Ministry of Health.

The Joint Medical Professional Review Committee continues to have the authority to investigate physician-billing practices, and to determine and order recovery payments for inappropriate billings under the fee-for-service arrangement with physicians.[3] The Ministry identifies physicians as having potentially inappropriate billings and then refers them to the Review Committee. At December 2021, the Ministry referred six physicians to the Review Committee as having potentially inappropriate billings in 2021–22, with another nine referrals still pending the Committee's review.

We found Joint Medical Professional Review Committee activities did not change from those used during the 2017 audit. As shown in **Figure 2**, the Review Committee continues to meet eight or nine times a year to conduct committee business, including completing one new investigation at each meeting and reviewing updates on about 30 ongoing cases. The small number of investigations the Review Committee completes each year as compared to the larger number of instances of potentially inappropriate billings suggests the current process is insufficient in the timely recovery of overpayments.

Figure 2—Number of Meetings Held and Investigations Completed by the Review Committee

Fiscal Year	Meetings Held	Investigations Completed
2020–21	9	7
2019–20	9	8
2018–19	9	7
2017–18	8	6

Source: Adapted from information provided by the Ministry of Health.

Figure 3 shows total amounts the Review Committee ordered physicians to repay in the past four years. While these amounts are higher than what we found during our 2017 audit ($1.2 million for 2016–17), the amount of annual recoveries ordered is less than 1% of the total fee-for-service payments for this period.[4]

Figure 3—Amount of Recovery Ordered by the Review Committee

Fiscal Year	Number of Physicians	Ordered Recovery Amount
2020–21	7	$ 2,035,232
2019–20	8	$ 1,783,770
2018–19	7	$ 1,598,881
2017–18	6	$ 1,789,853

Source: Adapted from information provided by the Ministry of Health.

By having more ways to conduct investigations into physician billing practices, the Ministry may identify and recover more inappropriate billings. In addition, this would reinforce with physicians the importance of having appropriate fee-for-service billing practices.

[3] *The Saskatchewan Medical Care Insurance Act* gives the Joint Medical Professional Review Committee the authority to investigate physician-billing practices. The Review Committee is comprised of six members: the Saskatchewan Medical Association, the College of Physicians and Surgeons, and the Ministry of Health; each appoint two members.

[4] In 2020–21, the Review Committee ordered recovery of $2.04 million compared to greater than $500 million paid annually under the fee-for-service arrangement.

Chapter 14
Horizon School Division No. 205—Maintaining Facilities

1.0 Main Points

By January 2022, Horizon School Division No. 205 improved its processes to maintain its facilities. The Division implemented one recommendation and partially implemented four recommendations we originally made in our 2020 audit.

The Division:

- Progressed in adding unique asset identification tags for significant components and updating information on these components in its maintenance IT system. This identification method enhances the Division's ability to plan, track, and monitor the maintenance of its facilities and their significant components.

- Actively used its maintenance IT system to track information on its maintenance activities (e.g., service requests, preventative maintenance tasks and their status). However, the Division needs to effectively monitor timelines to complete maintenance activities, as well as keep information on completed tasks and service requests up-to-date (i.e., accurate).

  Improved use of the maintenance IT system will assist the Division in prioritizing maintenance deficiencies and in monitoring maintenance completion.

- Began prioritizing maintenance on deficiencies found during fire protection and suppression system inspections; however, it did not always address identified deficiencies timely.

  Prioritizing important maintenance deficiencies can help the Division avoid non-compliance with applicable codes and provide safe environments for all students, staff, and the public.

- Gave the Division's Board of Education periodic (i.e., monthly, annual) maintenance reports that included information on facilities with higher maintenance concerns, year-over-year trends on facility conditions, and outstanding maintenance activities.

  Sufficient analysis and reporting of maintenance results enables the Board to assess whether the Division effectively maintains its facilities and significant components, and efficiently uses maintenance funding.

Maintenance is one key aspect of asset management. In general, maintenance costs rise as infrastructure ages. As such, the consequences of not conducting effective maintenance and repairs on facilities includes potential health and safety problems for users (administrators, staff, and students), reduced quality of space, loss of facility value, higher future repair costs, and facilities not meeting their expected service life (e.g., replacing a building earlier than intended).

2.0 INTRODUCTION

2.1 Background

Under *The Education Act, 1995*, and related regulations, the Ministry of Education is responsible for providing leadership and direction to the pre-kindergarten through Grade 12 education sector. This includes providing school divisions with leadership in all areas, which includes facility maintenance. The Act requires the Ministry to review and approve school divisions' estimated expenditures and significant capital projects.[1] Each year, the Ministry gives divisions funding to operate, including facility maintenance funding.

The Ministry expects divisions to maintain facilities in satisfactory operating condition.[2]

The Act gives each school division's Board of Education the authority to administer and manage the educational affairs of its division and to exercise general supervision and control over the schools in the school division.

Under the Act, a school division is responsible for:

- Providing and maintaining school accommodation, equipment, and facilities necessary for the educational programs and instructional services approved by the school division for each of its schools
- Setting out procedures with respect to the maintenance of school accommodations for maintaining satisfactory standards of comfort, safety and sanitation for students and other users

Horizon School Division No. 205 is located in central Saskatchewan. The Division owns 38 of the 43 schools it operates.[3] In 2020–21, the Division spent $3.8 million (2019–20: $1.8 million) specifically on maintenance of its facilities (e.g., contracted maintenance, renovations, supplies).[4]

2.2 Focus of Follow-Up Audit

This chapter describes our first follow-up audit of management's actions on the recommendations we made in 2020.

In 2020, we assessed Horizon School Division No. 205's processes to maintain its facilities. Our *2020 Report – Volume 1*, Chapter 8, concluded that for the 12-month period ended September 30, 2019, the Division had effective processes to maintain its facilities, except for the areas outlined in our five recommendations.

[1] *The Education Act* requires the Ministry to approve capital projects of school divisions costing more than $1 million (i.e., major), which include renovations to buildings. The Ministry may also supply school divisions with capital grants to help fund renovations (s. 311) and to assist with preventative maintenance and repairs costing less than $1 million (i.e., minor). It may appoint a person to provide advice with respect to approval of plans for the maintenance of school buildings (s. 4(1.1) (k)).
[2] *Ministry of Education Preventable Maintenance and Renewal Funding Program Policy Guidelines*, Revised July 1, 2017, pubsaskdev.blob.core.windows.net/pubsask-prod/87251/87251-PMR_Funding_Program – Guidelines.pdf (9 March 2022).
[3] The Division supplies staff and support to five schools in its area it does not own—three Hutterite schools, a village-owned school, and a school on George Gordon First Nation.
[4] Adapted from information obtained from Horizon School Division No. 205's financial system.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Division's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Division management agreed with the criteria in the original audit.

To perform this follow-up audit, we reviewed facility maintenance policies and procedures, interviewed facilities management staff, and reviewed documentation in the maintenance IT system for significant components (e.g., fire alarm inspection certificates). We also conducted analysis and tested information documented in its maintenance IT system (e.g., time to complete service requests and preventative maintenance tasks). In addition, we reviewed facility maintenance reports presented to the Board.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at January 31, 2022, and Horizon School Division No. 205's actions up to that date.

3.1 Need to Identify and Address Fire Protection and Suppression System Deficiencies in a Timely Way

We recommended Horizon School Division No. 205 prioritize all identified maintenance deficiencies associated with fire protection and suppression systems and boilers to enable determination of the nature and timing of necessary maintenance. *(2020 Report – Volume 1,* p. 92, Recommendation 1; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Horizon School Division No. 205 had current boiler inspections done but did not always have updated fire protection and suppression system inspection certificates in its IT system, nor did it always address deficiencies found during inspections in a timely way.

All 16 boilers we tested had current inspection certificates.

The Division uses its IT system to track the inspection results of its fire protection and suppression systems. The Division indicated it does not have the in-house capacity (i.e., personnel skills) to conduct fire protection and suppression system inspections.[5] Therefore, the Division has contracted with third-party inspectors to inspect these systems, which are to occur annually. Once the contracted inspector completes an inspection, the Division receives an inspection certificate and is supposed to upload the certificate to its IT system.

We found the Division did not have an updated inspection certificate in its IT system for three of the eight fire protection and suppression systems we tested. Two of these systems were overdue for an annual inspection by approximately two months (i.e., expired

[5] The Division considers fire alarms and sprinklers to be part of its fire protection and suppression systems.

inspection certificate on file) at January 2022; one system had an inspection done but the certificate was not on file. Management told us inspectors experienced delays in completing inspections because of the COVID-19 pandemic.

During annual inspections, the contracted inspector identifies and documents deficiencies (e.g., fire extinguishers due for replacement, emergency lights failed 30-minute test) with the Division's fire protection and suppression systems on the inspection certificates. For example, emergency lights need to be kept in working order in order to guide people to safety quickly and effectively in the event of a fire. The Division uses the third-party inspectors to resolve any identified deficiencies.

For the eight fire protection and suppression systems tested, we found three instances where the inspector identified deficiencies, but the Division had not addressed the deficiencies as at November 2021. Fire suppression system components need periodic replacing to keep the system fully functioning. Management told us it delayed the completion of repairs to the three fire suppression systems until a time when staff and students were away from the school (i.e., scheduled repairs during Easter break [April 2022] to avoid sprinklers leaking water onto staff and students).

For the 16 boilers we tested, we found two instances where the inspector identified deficiencies.[6] One of the boilers had identified deficiencies addressed in January 2022. Management told us the remaining deficiency was delayed in getting addressed as the contractor was waiting on parts needed to make the repair (vendor projected a four-month delivery delay).

Prioritizing inspections as well as identified maintenance deficiencies associated with fire protection and suppression systems provide safe environments for all students and staff.[7]

3.2 Tracking of All Significant Components In Progress

We recommended Horizon School Division No. 205 develop a strategy to better use its maintenance IT system to plan, track, and monitor maintenance of its facilities and significant components. *(2020 Report – Volume 1,* p. 92, Recommendation 2; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Horizon School Division No. 205 began the process of including all its significant components in its maintenance IT system to enable better tracking of completed and uncompleted maintenance, but still has more work to do.

As of January 2022, the Division has not developed a strategy to better use its maintenance IT system to plan, track, and monitor maintenance of its facilities and significant components. The Division considers assets such as heating, cooling, ventilation systems;

[6] The Division employs staff who resolve any deficiencies identified during boiler inspections.
[7] Saskatchewan adopts the National Fire Code by regulation under provisions of *The Fire Safety Act* as the standard for fire safe operation of buildings and facilities. The National Fire Code establishes three core objectives: safety, health, and fire protection of buildings and facilities.

roofs; and fire protection and suppression systems to be significant. However, it has not documented its definition of a significant component. A clear definition would assist future staff in understanding which assets the Division considers significant components and require tracking.

The Division uses unique asset barcodes to identify and track each significant component. Facilities management staff (e.g., an electrician and plumbers) attached asset barcodes on all major building components such as heating systems, fire alarm panels, and HVAC units. However, the Division indicated that it still has three to five more years of work to complete attaching asset barcodes on all of the Division's assets (i.e., both significant and insignificant components).

The Division plans to update information on significant components in its maintenance IT system as it replaces and installs them. Division staff will record asset condition and useful life for significant components.

The maintenance IT system uses condition and expected replacement year information for significant components to calculate a facility condition index and amount of deferred maintenance.[8] Of the six significant components we tested, we found:

- Three components where the IT system did not contain information on the asset's condition
- One component where the IT system did not contain information on the asset's life expectancy

Tracking key information for all significant components in the maintenance IT system would enhance the Division's ability to plan for and monitor the maintenance of its facilities and significant components. It would also enable the Division to use the system to monitor changes in the facility condition index and in deferred maintenance to help determine whether it is doing the right maintenance at the right time.

3.3 Proper Updates in the Maintenance IT System Needed

We recommended staff of Horizon School Division No. 205 maintain up-to-date and accurate information in its maintenance IT system about completion of assigned maintenance activities. *(2020 Report – Volume 1,* p. 97, Recommendation 3; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Horizon School Division No. 205 staff are not always documenting, in the Division's IT systems, the completion of maintenance activities performed or accurately reflecting the work outstanding to resolve a maintenance activity.

[8] Facility condition index is a performance indicator used to evaluate the current condition of a building. It is measured on a scale of 0% to 100%, with a lower percentage showing a building is in poorer condition.

The Division expects staff to complete assigned maintenance (service request/ preventative maintenance) within assessed priority or stated timeframes, and document the completion of maintenance in the appropriate module of the maintenance IT system.[9,10]

For 50 service requests we tested, we found staff had not appropriately updated the IT system for nine service requests:

- Five urgent service requests (out of 10 tested) completed later than expected, ranging from one to six days late. An example of an urgent request was the repair of a leaking roof.

  Management noted that in two instances, staff completed the repair, but had not updated the system accordingly. In two more instances, staff did a preliminary fix to address urgent service requests and should have updated the system to downgrade the priority rating for the remainder of the fix. For the remaining instance, staff had not completed timely repair, with no explanation in the system as to why. Documenting the completion of maintenance service requests or reasons why maintenance was not completed gives management key information to enable monitoring of maintenance staff performance.

- One high-priority service request (out of 10 tested) completed one day later than expected; however, staff should have downgraded the priority based on their assessment (e.g., management did not agree with the high-priority rating).

- Three medium-priority service requests (out of seven tested) completed later than expected, ranging from five to 61 days past the expected completion date. Management told us, in all instances, staff should have downgraded the service request in the system to low priority, but had not.

- Division staff completed all 23 low-priority service requests within the expected period.

For 18 preventative maintenance tasks we tested, we found:

- Two March 2022 monthly maintenance tasks marked as completed in the system at October 2020 and January 2021, which was not possible (i.e., work was planned monthly)

- Division staff completed the remaining 16 tasks within the expected timeframe

Effectively monitoring the completion status of maintenance activities helps ensure Division staff complete maintenance as expected, which reduces further deficiencies with the Division's facilities or significant components.

[9] Preventative maintenance tasks are routine repairs and inspections intended to assist in systematic correction of emerging failures before they occur, or before they develop into major defects. Service requests are requests for minor maintenance (reactive maintenance) initiated through the service request module.

[10] The Division classifies service requests into four priorities: urgent, high, medium and low. It expects maintenance staff to address urgent service requests within one day; high-priority service requests within five days; medium-priority service requests within 15 days; and low-priority requests are schedule and weather-dependent. In our sample, facilities management staff closed low-priority service requests between one and 44 days.

We recommended Horizon School Division No. 205 actively monitor the timeliness of completion of requested and expected maintenance. *(2020 Report – Volume 1,* p. 98, Recommendation 4; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Horizon School Division No. 205 monitors completion timeliness of requested and expected maintenance, but does not check the quality of information tracked in its maintenance IT system.

The Division assigns clear responsibility for staff to monitor maintenance activity performance, and its maintenance procedures require the Manager of Facility Services to monitor the ongoing operation of clean, safe, and well-maintained facilities. Management indicated it reviews information in the maintenance IT system weekly and monthly to capture any lagging service requests or preventative maintenance tasks, but it does not verify the quality of the information.

Without effectively monitoring the timeliness of maintenance activity completion and reviewing maintenance information in the maintenance IT system for quality, there is increased risk of maintenance not being completed as expected.

3.4 Regular Maintenance Reports Provided to the Board

We recommended Horizon School Division No. 205 provide its Board with periodic, comprehensive maintenance reports about the results of its maintenance activities (e.g., facilities' condition, deferred maintenance) and anticipated impact to inform decision-making. *(2020 Report – Volume 1,* p. 99, Recommendation 5; Public Accounts Committee agreement January 12, 2022)

Status—Implemented

Since 2020, Horizon School Division No. 205's management began providing the Board with annual reporting about the facility condition index of its schools and planned versus completed preventative maintenance activities. Management continued providing monthly reports on its maintenance activities.

The Division's Board Policy Handbook requires management to provide the Board with periodic reports on maintenance activities, along with information about facility project budgets, schedules, and variance reports.

The Board receives:

- Monthly reports (Facility Services Report): includes planned maintenance costs, project status updates (i.e., timelines associated with the maintenance task and indication whether still on schedule).

- Annual year-over-year facility condition index report: provides the Board with information on the overall condition of a facility based on deferred maintenance costs and replacement cost of the building. This shows whether the Division is doing the right maintenance at the right time. As of December 31, 2021, of the 38 schools owned by the Division, 36 schools had a facility condition index of poor or critical.

- Annual preventative maintenance reconciliation report: provides the Board with information on the amount of preventative maintenance funding carried forward from the previous fiscal year; how much the Division invested into preventative maintenance activities in the current period; and how much funding remained from preventative maintenance tasks not completed by year end. The report also breaks down completed maintenance activities (by school) and lists those maintenance activities still in progress.

- Annual three-year maintenance plan: provides the Board with information on upcoming planned preventative maintenance activities, the associated costs, and at which schools the work will occur.

We found the Board received comprehensive reporting to have an adequate understanding of the current state of the Division's schools, to determine how timely the Division completes maintenance activities, and to determine what upcoming maintenance activities will occur (and the associated costs).

Providing sufficient analysis and reporting of maintenance results allows the Board to assess whether the Division effectively maintains its facilities and significant components, and whether maintenance funding is sufficient and efficiently used.

Chapter 15
Northern Lights School Division No. 113—Purchasing Goods and Services

1.0 Main Points

Northern Lights School Division No. 113 purchases various goods and services to deliver educational services to students in northern Saskatchewan. In 2020–21, the Division bought more than $19 million of goods and services.[1]

Of the 14 recommendations we first made in 2019, the Division partially implemented eight recommendations, and made limited progress on six recommendations by March 2022. The Division improved some of its processes to purchase goods and services, but has more work to do, including:

- Approve and implement its revised purchasing administrative procedure
- Update its credit card guidelines to align with good purchasing practices, and actively monitor cardholders' adherence with its purchase card guidelines
- Agree purchases on monthly fleet card invoices to supporting receipts prior to making payment
- Establish a standard minimum amount of time to allow suppliers to respond to tenders
- Take steps to ensure it separates incompatible purchasing duties
- Validate suppliers and keep the supplier listing up to date

Further, we found that staff continued to not always follow existing purchasing requirements. They did not follow requirements for single and sole source purchases, consistently document evaluation of suppliers, maintain appropriate documentation of tender communications with suppliers, properly authorize contracts, or consistently document receipt of heating fuel purchases.

Strong processes to purchase goods and services supports transparency, fairness, and achievement of best value in purchasing activities.

2.0 Introduction

2.1 Background

Northern Lights School Division No. 113 is a rural school division located in northern Saskatchewan serving a predominantly First Nations and Métis school population. The Division has 22 schools located in 17 communities.[2] It has over 3,800 students, and a staff of about 682 full-time equivalent positions.[3]

[1] *Northern Lights School Division 113 Annual Report 2020–21*, p. 65.
[2] Ibid., p. 8.
[3] Ibid., pp. 28–29.

The Division buys various goods and services such as maintenance, office supplies, learning resources (e.g., textbooks, library books, equipment), student transportation, and other supplies and materials necessary for course instruction, and to provide education services.

2.2 Focus of Follow-Up Audit

This chapter describes our first follow-up audit of management's actions on the recommendations we made in 2019.

In 2019, we assessed the Division's processes to purchase goods and services. Our *2019 Report – Volume 1*, Chapter 8, concluded Northern Lights School Division No. 113 did not have effective processes to purchase goods and services. We made 14 recommendations.[4]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Division's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Division agreed with the criteria in the original audit.

To perform our follow-up audit, we discussed actions taken with Division management. We assessed the Division's purchasing process by examining purchasing documentation (e.g., policies, administrative procedures, tender documents, purchase orders, contracts, invoices). We tested samples of purchases including tenders, single and sole source purchases, heating fuel purchases, and purchase card transactions to assess the operating effectiveness of the Division's processes.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at March 8, 2022, and the Division's actions up to that date.

3.1 Updated Purchasing Policies Not Approved Nor Fully Implemented

We recommended Northern Lights School Division No. 113 update its purchasing requirements to:

- ***Align with applicable external trade agreements;***
- ***Establish requirements for staff involved with purchases to declare real or perceived conflicts of interest;***
- ***Set out requirements for the use of different purchasing methods; and***
- ***Incorporate expectations for use of contracts.***

(2019 Report – Volume 1, p. 127, Recommendation 1; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

[4] *2019 Report – Volume 1*, Chapter 8, pp. 121–140.

We recommended the Board of Education of Northern Lights School Division No. 113 approve the Division's key policies related to the purchases of goods and services. *(2019 Report – Volume 1,* p. 131, Recommendation 6; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 made some improvements to its purchasing requirements; however, the Division needs to ensure it implements its purchasing requirements.

The Division sets out its purchasing requirements through Board policies and Division administrative procedures.

In October 2020, the Board approved *Board Policy 16—Purchasing* that sets out the Division's key procurement principles as follows:

- Procurement shall be conducted in such a way that is transparent and fair, and achieves best overall value for the Division
- Reporting of significant procurement compliance concerns to the Board's Audit and Risk Committee
- Compliance of all procurement activity with the *New West Partnership Trade Agreement* and the *Canadian Free Trade Agreement*

We found the Division did not always comply with the provisions of the external trade agreements. We tested six tenders and found in four tenders, the Division's tender documents did not acknowledge trade agreements where applicable. See also **Section 3.6** (tender communication not always maintained).

In six tenders tested, we found the Division discontinued use of its local supplier preference provision when tendering for goods and services. Previous use of this provision was inconsistent with the terms of applicable external trade agreements (e.g., *New West Partnership Trade Agreement* and the *Canadian Free Trade Agreement*).

The updated policy also expects Division staff involved in purchasing decisions to declare any real or perceived conflicts of interest (e.g., staff ownership interest in a supplier). We tested six tenders and found Division staff involved in purchasing decisions did not declare any conflicts of interest.

The Board's policy also requires Division staff to complete acquisitions of goods and services, as well as competitive bids, in accordance with the Division's purchasing administrative procedure.

In October 2020, the Division drafted a revised administrative procedure that includes the following guidance:

- Requirements and thresholds for the use of different purchasing methods such as quotes and tenders

- Expectations for use of purchase orders and contracts

At March 2022, the Division had not implemented its revised administrative procedure, and its Board had not approved it.

For the 11 purchases we tested, we found one purchase where, based on the nature of the purchase (e.g., one-time transaction), the Division should have obtained a purchase order. In this instance, the Division did not complete a purchase order or a contract. We also found further instances of non-compliance with its existing and revised administrative procedure—see **Sections 3.6, 3.7, 3.10,** and **3.11** (e.g., maintaining tender communications with suppliers, separating incompatible purchasing duties, validating new suppliers).

Establishing guidance about the use of different purchasing methods will provide clarity to staff and help the Division to purchase goods and services in a consistent manner. Not having clear expectations on the use of written contracts increases the risk of staff not using an appropriate form of contract, possibly exposing the Division to unwanted legal or financial risks.

3.2 Single and Sole Source Purchasing Policy Not Always Followed

We recommended Northern Lights School Division No. 113 set out, in writing, its requirements for using single or sole source purchasing.
(2019 Report – Volume 1, p. 128, Recommendation 2; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 set out, in writing, its requirements for using single and sole source purchasing, however, staff did not always follow it.

In October 2020, the Board approved a policy requiring the Division to document, for the Chief Financial Officer's approval, appropriate rationale for using single and sole source purchasing.

The Division's draft purchasing administrative procedure contains further guidance on the conditions when staff can use single and sole source purchasing, such as when an emergency condition exists or when goods or services are only available from a sole source. At March 2022, the Division had not implemented its revised administrative procedure.

We tested five single and sole source purchases and found the Division did not:

- Document consideration of alternate procurement methods.
- Document justification for the purchase. The Division subsequently provided us with reasonable rationale for its decision for one purchase; however, for the other four purchases, it could have obtained the goods or services from other suppliers.
- Approve the procurement method.

Without established requirements for using single or sole source purchasing methods, the Division is at risk of not facilitating fair and equitable treatment of suppliers and may not obtain best value when making purchasing decisions.

Good purchasing practices also require organizations to track the use of single and sole source purchases for additional monitoring; the Division has not implemented a process to do so.

3.3 More Robust Credit Card Guidelines and Active Monitoring of Staff Compliance Needed

We recommended Northern Lights School Division No. 113 revise its purchase card guidelines to align with good purchasing practices (e.g., required approvals, processes for changing transactions limits, restrictions on use). *(2019 Report – Volume 1,* p. 130, Recommendation 3; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

We recommended Northern Lights School Division No. 113 actively monitor adherence of cardholders with its purchase card guidelines. *(2019 Report – Volume 1,* p. 130, Recommendation 4; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

Northern Lights School Division No. 113 has not revised its purchase card guidelines to align with good purchasing practices, such as setting out all required approvals and restrictions for card use. In addition, the Division does not actively monitor cardholders' adherence with its purchase card guidelines.

In September 2019, the Division drafted revised purchase card guidelines setting out the process for new cardholders to obtain a purchase card, as well as for changing cardholder transaction limits, including required approvals. Further, the guidelines expect approvers to regularly monitor purchase card transactions for unacceptable purchases.

However, the Division has not set out in its guidelines:

- Required approvals for purchase card transactions. If the purchase card guidelines do not reflect the Division's expectations for transaction approval, an increased risk of staff inappropriately approving transactions exists.

- Detailed restrictions on the use of purchase cards. Good purchasing practices include examples of unacceptable purchases (e.g., purchases intended to bypass the Division's competitive bidding process, splitting transactions to bypass purchase card transaction limits). Detailed guidance regarding appropriate use of purchase cards would reduce the risk that staff inappropriately use their purchase cards.

At March 2022, the Division had not implemented its revised purchase card guidelines.

We tested 10 purchase card statements and found that cardholders submitted monthly reconciliations supported by receipts, and superintendents or the Chief Financial Officer appropriately approved the reconciliations.

However, our testing identified one transaction where the cardholder split the purchase as the total transaction was over the cardholder's individual purchase limit. The Division expects supervisors of cardholders to monitor compliance, and follow up with cardholders about identified non-compliance with its purchase card guidelines. The Division was unaware of the deficiency we found in our testing. Further, we found the Division did not capitalize the purchased item as expected by the Division's capital asset policy.

We also tested eight cardholder limit changes and found that for three changes the Division did not maintain support or evidence of approval for the change. Without following procedures for making changes to cardholder limits, the Division may not revise limits when necessary, which leaves it susceptible to fraudulent transactions.

The Division continues to have purchase cards issued in the name of schools instead of in the name of cardholders, which does not align with good practice. At October 2021, the Division assigned 15 of its 46 purchase cards to schools. Between November 2020 and October 2021, the Division spent about $169,000 on purchases on these cards, which is approximately 25% of its total spending on purchase cards during that period. Assigning cards to schools reduces the Division's ability to hold specific staff accountable for their purchasing decisions, and increases the risk of misuse.

3.4 Fleet Card Purchases Not Reconciled Prior to Making Payment

We recommended Northern Lights School Division No. 113 agree purchases on monthly fleet card invoices to supporting receipts prior to making payment. *(2019 Report – Volume 1,* p. 131, Recommendation 5; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

Northern Lights School Division No. 113 does not agree purchases on monthly fleet card invoices to supporting receipts prior to making payment.

The Division has not established a process to agree purchases on monthly fleet card statements to supporting receipts. The Division's school transportation fleet policy gives staff direction on expected use of its passenger vans requiring staff to complete a monthly travel log for each van including details of its use during the month (e.g., date, destination, purpose of trip), supported by fuel receipts.

We found that the Division does not monitor receipt of the monthly travel logs for each of its passenger vans. In addition, staff do not agree or append individual fuel vehicle receipts to the monthly fleet card invoices.

Not agreeing fleet card receipts to purchases on monthly fleet card statements prior to payment increases the risk of the Division paying for inappropriate purchases, and not promptly detecting fleet card misuse.

3.5 Supplier Evaluations for Tenders Not Consistently Completed

We recommended Northern Lights School Division No. 113 consistently document its evaluation of suppliers when tendering for the purchase of goods and services. *(2019 Report – Volume 1,* p. 133, Recommendation 7; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 did not consistently document its evaluation of suppliers when tendering for the purchase of goods and services.

The Division's current purchasing administrative procedure requires it to evaluate suppliers using the criteria outlined in tender documents. We found for three of the six tenders we tested, the Division did not document its evaluation of suppliers. In these three instances, the Division only received one bid on each tender. Consistent with good purchasing practices, the Division should still evaluate the bids it receives to ensure the supplier can meet its needs, and it receives fair value.

When the Division does not document its evaluation of bids, it is not complying with its purchasing requirements. In addition, it cannot sufficiently support its supplier selection decision, and demonstrate achievement of best value for purchasing decisions.

3.6 Tender Communications With Suppliers Not Maintained

We recommended Northern Lights School Division No. 113 maintain appropriate documentation of its tender communications with suppliers. *(2019 Report – Volume 1,* p. 134, Recommendation 8; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 set out expectations to maintain documentation of its tender communications with suppliers, but it does not always do so.

The Division's Board policy on purchasing requires it to ensure all procurement follows the standards set out in external trade agreements. These agreements require the Division to post contract award information on the SaskTenders website.[5,6] Further, the Division's draft purchasing administrative procedure requires it to release the successful bidder's name and award results to all bidders after an award is made. As at March 2022, the Division had not implemented this revised administrative procedure.

For six tenders we tested, we found:

- Four tenders with no documentation of the Division's communications with suppliers. The Division told us it communicated with the suppliers through phone calls or text messages. When it communicated in this manner, we were unable to assess whether

[5] SaskTenders is the primary gateway for public sector tender notices in Saskatchewan. The Ministry of SaskBuilds and Procurement administers the SaskTenders website (www.sasktenders.ca).
[6] Requirements include the successful supplier's name and address, contract award value, and award date.

the Division approved the supplier selection before it communicated with the successful supplier or whether timely communication occurred.

- Five tenders where the Division did not comply with the external trade agreements regarding posting a contract award notice on the SaskTenders website.

If the Division does not maintain appropriate documentation of its communications with suppliers, it can be difficult for the Division to demonstrate that its purchasing process is fair and transparent, and it may be in violation of external trade agreements.

3.7 Reasonable Time Needed to Respond to Tenders

We recommended Northern Lights School Division No. 113 establish a standard minimum amount of time to allow suppliers to respond to tenders. *(2019 Report – Volume 1,* p. 135, Recommendation 9; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

Northern Lights School Division No. 113 does not provide suppliers with a standard minimum amount of time to respond to tenders.

Management told us that the Division tries to give suppliers 21 days to respond to tenders.

The Division's draft purchasing administrative procedure sets out a minimum of 21 days to allow suppliers to respond to tenders, as well as provides guidance on using a shorter timeframe. The Division considered guidance outlined in the external trade agreements in determining its standard minimum tendering time. At March 2022, the Division had not implemented this revised administrative procedure.

For the six tenders we tested, the Division allowed a tendering time of at least 21 days for two tenders. For the four other tenders, the Division allowed a tendering time of between 11 and 18 days, and received two or fewer supplier bids for these tenders. The Division may not have provided suppliers with sufficient time to respond to the tenders, and it did not have sufficient rationale to support the use of a shortened response time.

Not providing suppliers with sufficient time to prepare tender responses increases the likelihood of suppliers choosing not to respond, resulting in the Division having fewer options to acquire the goods or services it needs. Fewer options may increase the risk of not achieving best value. Providing a standard minimum time also helps ensure the Division treats suppliers fairly and equitably.

3.8 Purchase Order Template Not Sufficiently Robust

We recommended Northern Lights School Division No. 113 periodically assess the robustness of the service contract and purchase order templates used for purchasing goods and services. *(2019 Report – Volume 1,* p. 136, Recommendation 10; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 updated its service contract template, but its purchase order template continues to not include all clauses that are necessary in a sound contract.

We found the Division improved its service contract template to include clauses addressing performance, indemnification, insurance requirements, severability, and survival. However, we also found that its standard purchase order template did not contain terms and conditions pertaining to delivery, liability, or authorization of changes to terms and conditions.

Not having robust templates increases legal or financial risks where purchase arrangements do not sufficiently address relevant purchase terms.

3.9 Contracts Not Always Properly Authorized

We recommended Northern Lights School Division No. 113 maintain complete documentation of properly authorized contracts with suppliers before the Division receives the related goods or services. *(2019 Report – Volume 1,* p. 136, Recommendation 11; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 established a process to maintain complete documentation of contracts, but did not always obtain authorization in accordance with its delegation of authority.

The Division's Chief Financial Officer or Superintendent of Facilities centrally maintains copies of contracts. For the 11 purchases with contracts we tested (made through tenders and single or sole source purchases), we found the Division signed contracts on time (e.g., before the goods or services were received) and maintained complete contract documentation (e.g., contract signed by both the Division and the supplier).

However, we found two contracts that the Division did not authorize in accordance with its delegation of authority. For example, one contract worth $109,000 was signed by the Superintendent of Facilities instead of the Chief Financial Officer, as required by the delegation of authority. Not following controls over contract authorization increases the risk of unknown financial liabilities or commitments, or misuse of Division funds.

3.10 Incompatible Purchasing Duties Not Separated

We recommended Northern Lights School Division No. 113 separate incompatible purchasing duties (e.g., initiating purchases, tendering, receiving goods or services, approving invoices for payment, adding suppliers to the financial system), and closely monitor transactions where it is not feasible to do so. *(2019 Report – Volume 1,* p. 137, Recommendation 12; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

Northern Lights School Division No. 113 has neither taken steps to ensure it separates incompatible purchasing duties, nor to monitor transactions where it does not separate incompatible purchasing duties.

In October 2020, the Division updated its draft purchasing administrative procedure to separate responsibilities of those managing the purchasing process (e.g., purchase initiation, receipt of goods) from those responsible for approving the purchase. At March 2022, the Division had not implemented this revised administrative procedure.

We tested 31 purchases and found the Division did not always leave evidence to support that it appropriately segregated purchasing duties. We found:

- Four purchases where the Division did not prepare a requisition or a purchase order when it would have been reasonable to do so, therefore we could not determine who initiated the purchase
- Eight purchases where the Division did not document that goods or services were received
- Three purchases where the Division did not approve the payment in accordance with its delegation of signing authority
- Eight purchases where the Division did not appropriately segregate receipt of goods or services from payment approval

At times, it is not feasible for organizations to separate all incompatible purchasing duties. Where it is not possible to do so, good practice is to actively identify instances where separation of the duties is not possible, and monitor the appropriateness of those purchases.

The Division has also not appropriately restricted who can add new suppliers to its financial system. We found the Division, through its assignment of IT user access, gave two individuals incompatible responsibilities; these individuals can approve invoices for payment and add suppliers to the Division's financial system.

Not segregating incompatible purchasing duties between different individuals increases the risk of fraud, and not detecting errors.

3.11 Validity Check of Supplier Information Needed

We recommended Northern Lights School Division No. 113 document its due diligence procedures used to validate suppliers before entering them into its financial system, and keep the supplier listing in its financial system up-to-date. *(2019 Report – Volume 1,* p. 139, Recommendation 13; Public Accounts Committee agreement January 12, 2022)

Status—Not Implemented

Northern Lights School Division No. 113 does not document due diligence procedures to validate suppliers prior to entering them into the financial system, nor properly maintain its listing of suppliers included in its financial system.

The Division informally assesses the validity of suppliers upon receipt of invoices for payment (i.e., after suppliers provide goods or services). The Division's draft purchasing administrative procedure includes a requirement for staff to validate vendors prior to purchasing goods or services from that vendor. At March 2022, the Division had not implemented this revised administrative procedure.

We tested 18 new suppliers in the Division's financial system by assessing the validity of each supplier through internet searches and review of invoices. We found each supplier valid.

Not carrying out sufficient due diligence processes to confirm the validity of suppliers before entering them into the financial system increases the risk of making payments to fictitious suppliers.

The Division also does not monitor the supplier listing in its financial system to remove suppliers that are no longer relevant, or to remove duplicate suppliers. Through our testing of supplier validity, we identified one newly added supplier that already existed in the financial system. At November 2021, the Division's supplier list included over 8,500 vendors.

Periodic maintenance of suppliers included in the financial system reduces the risk of duplicate or fraudulent payments and helps monitor the existence of fictitious suppliers.

3.12 Receipt of Heating Fuel Purchases Not Always Documented

We recommended Northern Lights School Division No. 113 require staff to document the receipt of heating fuel purchases and to adhere to its delegation of authority when approving invoices for payment. *(2019 Report – Volume 1,* p. 139, Recommendation 14; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

Northern Lights School Division No. 113 does not consistently document the receipt of goods for heating fuel purchases.

As discussed in **Section 3.10**, the Division has not implemented its revised purchasing administrative procedure to address separation of incompatible purchasing duties (e.g., separation of receipt of goods and services from payment approval). The Division informally communicates its expectation to staff not only to confirm the delivery of heating fuel when delivery occurs, but also that appropriate individuals approve those invoices.

We tested 30 heating fuel payments and found the Division appropriately approved invoices. However, for two purchases, we found the Division did not leave evidence of goods received. The size of these purchases ranged between $500 and $2,500. Between October 2020 and November 2021, the Division spent about $1.1 million on heating fuel.

When the Division does not document receipt of purchases, there is an increased risk of the Division paying for goods and services that it did not receive.

Chapter 16
Saskatchewan Government Insurance—Confirming Only Qualified Drivers Remain Licensed

1.0 Main Points

By February 2022, Saskatchewan Government Insurance (SGI) implemented the one remaining recommendation we reported in 2016 in relation to confirming only qualified drivers remain licensed.

SGI has clear, formal guidance on timeframes to record driver information into its computer system used to administer driver's licences. Staff entered driver information about out-of-province summary offence tickets into the AutoFund IT system within the 14 days outlined in its procedures.

By entering traffic offence information within its expectations, SGI can commence their disciplinary process for unsafe drivers in a timely matter.

2.0 Introduction

The Traffic Safety Act makes SGI responsible for issuing licences to eligible drivers, and confirming that only qualified drivers remain licensed to operate motor vehicles. It may suspend or revoke licences from individuals whose habits or conduct make their operation of a motor vehicle a source of danger to the public. Alternatively, it may sanction them (e.g., require the completion of a defensive driving course).

SGI, on behalf of the Saskatchewan Auto Fund, registers vehicles, licenses drivers, and provides related services to approximately 800,000 drivers and approximately 1.2 million vehicles and trailers in Saskatchewan.[1] Enforcement (e.g., policing) of traffic safety laws is the responsibility of law enforcement—not SGI.

This chapter describes our third follow-up audit of management's actions on the recommendations we made in 2016 about SGI's processes to confirm only qualified drivers remain licensed to operate motor vehicles.[2] By November 2019, SGI implemented four of our five recommendations.[3]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate SGI's progress toward meeting our recommendation, we used the relevant criteria from the original audit. SGI's management agreed with the criteria in the original audit.

To carry out our follow-up audit, we interviewed SGI staff and examined guidance provided to staff. We assessed whether SGI followed its guidance for entering out-of-province driver information into its computer system.

[1] *2020–21 Saskatchewan Auto Fund Annual Report,* p. 6.
[2] *2016 Report – Volume 1,* Chapter 15, pp. 181–199.
[3] *2018 Report – Volume 1,* Chapter 27, pp. 281–285 and *2020 Report – Volume 1,* Chapter 23, pp. 241–243.

3.0 STATUS OF RECOMMENDATION

This section sets out each recommendation including the date on which the Standing Committee on Crown and Central Agencies agreed to the recommendation, the status of the recommendation at February 11, 2022, and SGI's actions up to that date.

3.1 Written Guidance for Updating Driver Information Followed

> ***We recommended Saskatchewan Government Insurance establish written guidance outlining expected timeframes for entry of driver information into the computer system used to administer driver's licences.*** (*2016 Report – Volume 1*, p. 188, Recommendation 1; Standing Committee on Crown and Central Agencies agreement December 1, 2016)
>
> **Status**—Implemented

SGI staff entered driver information and traffic offences occurring out-of-province into its computer system in accordance with its written guidance.[4]

SGI uses the AutoFund IT system to track and maintain key information about drivers. SGI's Driver Programs Procedure Manual provides written guidance for staff to document out-of-province summary offence tickets within 14 days of receipt of the manual ticket through the mail.

In all 30 out-of-province summary offence tickets tested, we found SGI entered the information into its AutoFund system within 14 days.

SGI received more than 16,000 out-of-province summary offence tickets for the period of December 1, 2019 to January 31, 2022.

By entering traffic offence information within its expectations, SGI can commence their disciplinary process for unsafe drivers in a timely matter.[5]

[4] As reported in our *2020 Report – Volume 1*, Chapter 23, as of November 2019, SGI implemented this recommendation for criminal code convictions, vehicle impoundments, and roadside suspensions.
[5] Per *The Driving Licensing and Suspension Regulations, 2006*, SGI may assign unsafe drivers demerit points, require further education, or suspend or cancel licences.

Chapter 17
Saskatchewan Government Insurance—Monitoring Automated Speed Enforcement Fines

1.0 Main Points

Saskatchewan Government Insurance (SGI), on behalf of the Auto Fund, operates the Automated Speed Enforcement Program under *The Traffic Safety Act* and related regulations.

By February 2022, SGI implemented all four recommendations we made in our 2019 audit about monitoring automated speed enforcement fines.

SGI updated all contracts with key parties for the Automated Speed Enforcement Program. It also enforced provisions in its contracts, leading to all police services and the service provider consistently issuing fines to out-of-province vehicles.

Moreover, SGI periodically monitored rejected violations to check whether the service provider and police services follow its policies. SGI also received audit reports annually to confirm that its service provider effectively maintained the integrity of data in the IT system used to process Program fines.

2.0 Introduction

The Saskatchewan Auto Fund registers vehicles, licenses drivers, and provides related services to about 800,000 drivers and approximately 1.2 million vehicles and trailers in Saskatchewan.[1]

Since June 2014, Saskatchewan Government Insurance, on behalf of the Auto Fund, operates the Automated Speed Enforcement Program under *The Traffic Safety Act* and related regulations. *The Traffic Safety Act* allows for the use of vehicle photographs from speed monitoring devices, as well as places restrictions on the use of those photographs and speed monitoring devices.[2] *The Traffic Safety (Speed Monitoring) Regulations* set requirements about the use of speed monitoring devices in Saskatchewan.[3]

SGI has contracts with various parties (e.g., police services, municipalities) in four different regions of the province to use speed monitoring devices (i.e., cameras). See **Figure 1** for the number of cameras in each region and the number of fines issued.

[1] *2020–21 Saskatchewan Auto Fund Annual Report*, p. 6.
[2] *The Traffic Safety Act,* s. 259.1.
[3] Enforcement (e.g., policing) of traffic safety laws is the responsibility of law enforcement—not SGI.

Figure 1—Speed Monitoring Devices in Saskatchewan and Fines Issued

Region	Cameras	Locations in Rotation	Fines Issued (for 12-months ended November 30, 2021)
Moose Jaw	3	4	24,010
Regina	3	10	19,871
Saskatoon	2	10	23,353
Wakaw	1	2	2,318
Total	**9**	**26**	**69,552**

Source: Adapted from information provided by Saskatchewan Government Insurance.

This chapter describes our follow-up audit of management's actions on the recommendations we made in 2019. Our *2019 Report – Volume 1*, Chapter 11, concluded that for the 12-month period ended September 30, 2018, SGI had, other than the areas of our recommendations, effective processes to monitor that fines issued from its Automated Speed Enforcement program were accurate and reliable. We made four recommendations.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate SGI's progress toward meeting our recommendations, we used the relevant criteria from the original audit. SGI's management agreed with the criteria in the original audit.

To carry out our follow-up audit, we interviewed SGI staff responsible for the Automated Speed Enforcement Program. We examined and assessed relevant documents including the updated contracts with key parties, management's violation rejection analysis, meeting minutes with key parties, and tickets issued during the 12-months ended November 30, 2021.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Crown and Central Agencies agreed to the recommendation, the status of the recommendation at February 15, 2022, and SGI's actions up to that date.

3.1 Written Contracts with Key Parties Maintained and Enforced

We recommended Saskatchewan Government Insurance maintain enforceable formal written contracts with each party that is key to delivering its automated speed enforcement program. *(2019 Report – Volume 1,* p. 179, Recommendation 1; Standing Committee on Crown and Central Agencies agreement August 23, 2021)

Status—Implemented

We recommended Saskatchewan Government Insurance consistently enforce all provisions of its automated speed enforcement program contracts with participating municipal police. *(2019 Report – Volume 1,* p. 181, Recommendation 2; Standing Committee on Crown and Central Agencies agreement August 23, 2021)

Status—Implemented

Saskatchewan Government Insurance updated and enforced all contracts with key parties for the Automated Speed Enforcement Program.

At February 2022, SGI had enforceable written contracts with all municipalities and police services that deliver the Program. SGI and key party representatives signed each contract.

Since the 2019 audit, SGI changed the third-party service provider responsible for maintaining and operating the technology for the Program, and for processing violations (photographs taken). SGI signed a contract with a new service provider in January 2020.

Overall, we did not note any significant changes to its contracts, except the inclusion of additional provisions enabling SGI to better monitor the service provider (i.e., periodically receive IT-related audit reports on processes to maintain data), and requiring the service provider to process violations within five business days. See **Section 3.2** for more details on the IT-related audit reports.

To monitor whether contracted key parties fulfil their obligations, SGI held regular meetings with them since March 2020. During these meetings, management discussed a variety of issues, including issues with camera equipment, maintenance, and processing times.

Furthermore, since March 2020, SGI performs a semi-annual review of processing times to monitor that police services issue tickets within six months of the violation.[4] We found that all police services issued tickets within six months of the violation date (average of 27 days) for the 12-months ended November 30, 2021. Additionally, we found all police services consistently issued tickets to out-of-province vehicles in accordance with SGI's policies. We note Moose Jaw had the highest percentage of out-of-province tickets at 77% of total tickets issued due to the location of the cameras.

By having up-to-date and enforceable contracts with key parties, SGI can monitor that key parties are fulfilling obligations of each contract. Consistently issuing tickets to all registered owners of out-of-province vehicles caught speeding provides equitable treatment of registered owners of in- and out-of-province vehicles.

3.2 Speed Enforcement IT System Monitored

We recommended Saskatchewan Government Insurance periodically determine whether its service provider sufficiently maintains the integrity of data in the IT system the service provider uses to process automated speed enforcement program fines. *(2019 Report – Volume 1,* p. 182, Recommendation 3; Standing Committee on Crown and Central Agencies agreement August 23, 2021)

Status—Implemented

Starting in 2020, Saskatchewan Government Insurance receives audit reports annually to monitor its service provider's IT system used to process Automated Speed Enforcement Program fines, including the integrity of data.

[4] *The Summary Offences Procedure Act, 1990,* s. 4(3) requires agencies to issue tickets within six months of the violation date.

We found SGI reviewed the audit report from its service provider to assess whether the service provider sufficiently maintained the integrity of data in the automated speed enforcement system. We confirmed that for the 12-month period ended June 30, 2021, the service provider had effective controls over the IT system according to the independent audit report.

By periodically assessing the integrity of data in the automated speed enforcement IT system, SGI can confirm whether the service provider sufficiently protects this data.

3.3 Rejected Violations Monitored

We recommended Saskatchewan Government Insurance periodically determine whether its service provider or police services of participating municipal governments rejected automated speed enforcement program photograph violations in accordance with its policies. *(2019 Report – Volume 1,* p. 184, Recommendation 4; Standing Committee on Crown and Central Agencies agreement August 23, 2021)

Status—Implemented

Saskatchewan Government Insurance periodically monitors rejected violations to check whether the third-party service provider and police services follow its policies.

A rejected violation is where a violation occurs (motorist exceeds the speed threshold and a photograph of the motorist's vehicle is taken), but the service provider or police services does not issue a ticket to the registered owner of the vehicle.

Since the 2019 audit, SGI provided a listing of possible rejections to the service provider and police services. The list includes controllable rejects (e.g., clarity of plate, equipment issue) and uncontrollable rejects. Uncontrollable rejects are out of SGI, its service provider, and police services' control (e.g., missing or damaged plates, obstructed plates due to snow or mud). When the service provider or police services reject a violation in the system, they now document one of the reasons from the list in the system.

Starting in January 2020, SGI analyzes violation rejections quarterly to identify any unexpected trends. In our review of SGI's rejection analysis, we noted that rates for controllable rejects declined in 2021 compared to 2020 (e.g., over 400 controllable rejects in 2021 third quarter; 2020 third quarter: over 1,900 controllable rejects).

SGI meets biweekly with key parties from each region responsible for the Program. We tested five biweekly meetings and found that for all five meetings, SGI discussed issues related to equipment and rejected violations.

By improving its monitoring of rejected violations, SGI better understands whether the service provider and applicable police services issue all tickets that should be issued and whether they comply with SGI's Program policies. Better monitoring also helps ensure equitable treatment of violations.

Chapter 18
Saskatchewan Health Authority—Delivering Accessible and Responsive Ground Ambulance Services in Southwest Saskatchewan

1.0 Main Points

By December 2021, the Ministry of Health and the Saskatchewan Health Authority implemented five of six remaining recommendations we first made in our 2016 audit around accessible and responsive ground ambulance services in southwest Saskatchewan (i.e., Swift Current and surrounding area).

The Authority improved its monitoring of ambulance operators' compliance with expected ambulance response times. Authority management receives regular reporting showing overall compliance rates for all ambulance services, along with monthly reporting from ambulance operators in the southwest area providing explanations when ambulance response times are longer than expected.

In November 2019, the Authority and the Ministry consulted with representatives of ambulance services across the province. Using an analysis of current staffing needs compared to service demand, the Authority submitted a plan to the Ministry outlining different ambulance service options for certain areas of the province where service gaps exist (e.g., where ambulance operators cannot provide 24/7 services). The Ministry intends to consider this plan as part of its budgeting process for 2022–23.

Since our 2016 audit, the Ministry and the Authority developed a performance-based contract template for the provision of ambulance services. At December 2021, the Authority signed 28 new contracts for 32 privately-owned ground ambulance services in Saskatchewan, including four out of five ambulance services available in Swift Current and surrounding area.

Once the Authority signs performance-based contracts with all 53 privately-owned ambulance service providers in the province, and implements a new dispatch IT system, it will have better information about service quality. The Authority plans to use this information to improve its key performance results measurement and reporting. Collecting better performance information will allow the Authority to regularly assess the success of its ground ambulance services.

2.0 Introduction

2.1 Background

Ambulance services are a critical component of the provincial healthcare system, providing patients with emergency lifesaving treatment and transport to necessary levels of care. Ambulance services stabilize and improve patients' conditions at emergency scenes, as well as during transfers to and between healthcare facilities.

Under *The Provincial Health Authority Act*, the Saskatchewan Health Authority is responsible for the planning, organization, delivery and evaluation of its health services. This includes delivering accessible and responsive ground ambulance services to the people of Saskatchewan as outlined in *The Ambulance Act*.

The Ministry of Health remains responsible for the strategic direction of the healthcare system and for *The Ambulance Act*.

Accessible and responsive ambulance services can be challenging because of the geographic spread and remoteness of some communities in rural Saskatchewan, including Swift Current and surrounding area. In 2021, this area had a population of about 45,000 people spread over a land mass of approximately 44,000 square kilometers with one urban centre, Swift Current, with a population of 18,194.[1]

To provide the Ministry-established target of a 30-minute ambulance response time for rural areas, the former Cypress health region located ground ambulance operators in various places including in and around Swift Current.[2] As of December 2021, this area had 12 ambulance services using a mix of Authority-owned ambulances and contracted ambulance service providers.

2.2 Focus of Follow-Up Audit

Our *2016 Report – Volume 2*, Chapter 25, concluded that, for the period from September 1, 2015 to August 31, 2016, the former Cypress Regional Health Authority had effective processes to deliver accessible and responsive ambulance services, except in a few areas.[3] We made seven recommendations. By our first follow-up audit reported in our *2019 Report – Volume 2*, Chapter 39, the Saskatchewan Health Authority implemented one of seven recommendations and made some progress on three other recommendations.[4]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Saskatchewan Health Authority's and the Ministry of Health's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Saskatchewan Health Authority management agreed with the criteria in the original audit.

To complete this follow-up audit, we interviewed key Authority and Ministry staff, and examined relevant ambulance service records, reports, and contracts.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at December 31, 2021, and the Saskatchewan Health Authority and Ministry of Health's actions up to that date.

[1] Covered Population/Saskatchewan Health Coverage Reports/By Regions and Communities www.opendata.ehealthsask.ca/MicroStrategyPublic/asp/Main.aspx (2 February 2022).
[2] In 2017, the Cypress health region became part of the Saskatchewan Health Authority. The former region covered the southwest part of the province including Swift Current and surrounding area.
[3] *2016 Report – Volume 2*, Chapter 25, pp. 123–142.
[4] *2019 Report – Volume 2*, Chapter 39, pp.293–302.

3.1 Province-Wide Assessment of Ambulance Services Completed

We recommended the Ministry of Health, along with the Saskatchewan Health Authority, formally assess whether the distribution of ambulance services are optimal for responding to patient demand. (*2016 Report – Volume 2*, p. 131, Recommendation 1; Public Accounts Committee agreement February 26, 2019)

Status—Implemented

The Saskatchewan Health Authority and the Ministry of Health conducted a sufficient analysis of supply and demand for ground ambulance services across the province, considering input from ambulance operators.

In November 2019, the Authority and the Ministry consulted with ambulance service representatives across Saskatchewan. The Authority collected input from private ambulance operators on their current staffing needs and compared it to the demand for services in those areas. The Authority's analysis also assessed the distribution of medical first-responders and access to community paramedicine.[5]

In summer 2021, the Authority provided the Ministry a three-year plan for supporting ambulance services in certain geographical areas. The plan noted the challenges ambulance operators face including the inability to recruit and retain staff in rural and remote areas, as well as staff burnout. The Ministry of Health planned to consider the Authority's recommendations to support ground ambulance operators struggling to meet contractual expectations during its budgeting process for 2022–23.

Assessing the current distribution of ambulance services and determining where it is not meeting patient demand provides the Ministry and the Authority information for better decision-making, and helps ensure patients receive timely and responsive ambulance care when needed.

3.2 New Contracts Being Signed

We recommended the Ministry of Health consider updating The Ambulance Act related to contracted ground ambulance service providers to align with contract management best practices. *(2016 Report – Volume 2,* p. 134, Recommendation 3; Public Accounts Committee agreement February 26, 2019*)*

Status—Implemented

We recommended the Saskatchewan Health Authority update its contracts related to the provision of ground ambulance services to include service quality expectations and periodic reporting on them. *(2016 Report – Volume 2*, p. 133, Recommendation 2; Public Accounts Committee agreement February 26, 2019*)*

Status—Implemented

[5] Community paramedicine is a model of care whereby paramedics apply their training and skills in "non-traditional," community-based environments (outside the usual emergency response/transport model).

The Ministry of Health considered contract management best practices when it directed the Authority to develop a performance-based contract template for contracted ground ambulance service providers instead of making changes to *The Ambulance Act*. Incorporating service quality expectations into new contracts helps the service providers understand the service the Authority expects them to provide and also allows the Authority to hold them accountable for the quality of service provided.

The Ambulance Act, which came into effect in 1989, appropriately recognizes that using contracted ground ambulance service providers helps deliver adequate provincial ambulance coverage. Since 2019, the Authority made progress in signing new performance-based contracts with service providers.

Since our 2016 audit, the Ministry, the Authority, and contracted ambulance service providers' representatives developed a standard performance-based contract template. This template requires the closest ground ambulance to respond to an emergency call. In addition, contracted service providers are required to regularly report on service delivery (e.g., call volumes), safety (e.g., incidents, grievances), and quality of service (e.g., service availability).

At December 2021, the Authority signed 28 new contracts for 32 privately-owned ground ambulance services in the province; there are 53 contracted ground ambulance service providers in Saskatchewan. In addition, the Authority is arbitrating or mediating with an additional five service providers, as well as either working on signing new contracts with remaining service providers or planning to notify them of contract renewals in 2022–23. It terminated one contract with a contracted ground ambulance service provider since our last follow-up in 2019.

In Swift Current and surrounding area, we found the Authority signed new contracts with four of the five privately-owned ground ambulance operators in the area. It is in the process of signing the fifth contract that serves the Ponteix community.

Signed contracts outlining clear service expectations allows the Authority to hold contracted ground ambulance service providers accountable for their service quality.

3.3 Consistent Monitoring of Response Times and Reporting of Incidents

We recommended the Saskatchewan Health Authority monitor response times against targets for all ground ambulance operators on a regular basis (e.g., monthly or quarterly). *(2016 Report – Volume 2,* p. 140, Recommendation 5; Public Accounts Committee agreement February 26, 2019*)*

Status—Implemented

We recommended the Saskatchewan Health Authority follow its established policy to obtain completed incident reports (for instances when ground ambulance response times do not meet targets) so it can determine required actions. *(2016 Report – Volume 2,* p. 140, Recommendation 6; Public Accounts Committee agreement February 26, 2019*)*

Status—Implemented

Since our 2019 follow-up audit, the Saskatchewan Health Authority improved its response time monitoring for all ambulance operators in southwest Saskatchewan. We also found that all operators, whether Authority-operated or contracted, consistently provided regular reporting with explanations when responses took longer than expected (referred to as incidents).

The Authority continues to expect all operators to respond to calls within specified timeframes 90% of the time (e.g., all calls are to be responded to within 30 minutes in rural areas and nine minutes in urban areas), which are outlined in new performance-based agreements.

The Emergency Medical Services Manager for southwest Saskatchewan receives data from the Regina dispatch centre on the total number of calls, how long it took operators to respond to each call, and compliance rates of expected timeframes for the period. The Manager receives these reports quarterly for operators in rural areas (e.g., Cabri, Maple Creek) and monthly for urban areas (i.e., Swift Current).

In cases where it takes longer to respond to a call than expected, operators are to provide an explanation to the Authority by way of the Emergency Medical Services Manager who receives these incident reports monthly. We reviewed reports from all operators for July and September 2021, and found that operators consistently provided explanations for calls where response times took longer than expected. As many of the ambulance operators service rural areas, a majority of calls took longer due to either the distance an ambulance needed to travel or operators already responding to another call.

Monitoring response times and reviewing incident reports explaining why response times were not met allows the Authority to assess whether delays contribute to negative patient care and to make future adjustments to ground ambulance service delivery.

3.4 Key Measures and Periodic Reporting Not Yet Developed

We recommended the Saskatchewan Health Authority report to senior management, the Board, and the public actual results against key measures to assess the success of its ground ambulance services at least annually.

(2016 Report – Volume 2, p. 141, Recommendation 7; Public Accounts Committee agreement February 26, 2019*)*

Status—Not Implemented

The Saskatchewan Health Authority had not finalized the nature and timing of its reports about the success of its ground ambulance services. Neither the Board, senior management, nor the public received reports on key measures related to the delivery of ground ambulance services.

For example, Ontario provides the public with regional response times compared to standard response times, along with dispatch 9-1-1 call volumes and average response times.[6]

[6] www.health.gov.on.ca/en/pro/programs/emergency_health/land/responsetime.aspx (16 February 2022).

Management noted that it intends to create an annual provincial Emergency Medical Services report with trends and analysis. It further notes that once it updates all performance-based contracts with contracted ambulance service providers, and a new dispatch IT system is in place, it will have better information about service quality. As we describe in **Section 3.2**, the Authority is working on signing new performance-based contracts with service providers and expects the new IT system to be implemented in fall 2022.

Periodic measuring and reporting on key performance results would enable better oversight of the quality of the Authority's ground ambulance service delivery.

Chapter 19
Saskatchewan Health Authority—Efficient Use of MRIs in Regina

1.0 Main Points

By February 2022, the Saskatchewan Health Authority implemented one recommendation and continues to make progress on the three other remaining recommendations we originally made in 2017 about the efficient use of magnetic resonance imaging (MRI) services in Regina.

At December 31, 2021, Regina had 4,333 patients waiting for MRI scans (as compared to 2,610 patients at the time of our 2017 audit).

The Authority regularly reviews and analyzes weekly and monthly MRI data to determine causes of significant waits of patients for MRI services. The reviews identify anomalies (e.g., significant decrease in the number of MRI scans provided in a specific location), staff shortages (e.g., technologists), and other issues. The Authority also regularly monitors the timeliness of MRI services that contracted private MRI operators provide.

The Authority has not yet formally assessed the quality of MRI services that radiologists, including private operator radiologists, provide; however, the Authority is in the process of developing a peer-review program to do so. Once the Authority develops a process to monitor the quality of MRI scans, it needs to determine the nature and timing of reporting about MRI service quality to better monitor service delivery.

Having timely and quality MRI services helps facilitate appropriate diagnosis, treatment plans, and helps to improve patients' outcomes.

2.0 Introduction

2.1 Background

Under *The Provincial Health Authority Act*, the Saskatchewan Health Authority is responsible for the planning, organization, delivery and evaluation of the health services that it provides. This includes provision of MRI services.

Efficient use of MRI services can support timely diagnosis and monitoring of injuries and disease. Effective MRI services involve patients receiving quality scans within an appropriate timeframe, and physicians appropriately using MRIs as diagnostic tools after obtaining reliable interpretations of the scans within a reasonable timeframe.

The Authority has eight MRI scanners in six Saskatchewan hospitals located in:

- Dr. F.H. Wigmore Regional Hospital in Moose Jaw
- Regina General Hospital (two)
- Saskatoon City Hospital
- Royal University Hospital (two) in Saskatoon
- St. Paul's Hospital in Saskatoon
- Lloydminster Hospital[1]

In 2020–21, the six hospitals provided approximately 33,500 MRI scans.[2] In addition, the Authority contracted two licensed private-imaging operators to supplement hospital-based MRI services in Regina and Saskatoon.[3] The contracts require the licensed private operators to conduct a total of 10,000 MRI scans each year.

The Patient Choice Medical Imaging Act gives Saskatchewan residents the option of personally paying for MRI services through a licensed private operator. The Act requires private operators to provide a free MRI scan to an individual on the public MRI waitlist for each scan personally paid for by residents (i.e., one-for-one model). In 2020–21, the Authority received 2,142 MRI scans through the one-for-one model.

2.2 Focus of Follow-Up Audit

This chapter describes our second follow-up audit of management's actions on the recommendations we first made in 2017.

In 2017, we assessed the Saskatchewan Health Authority's processes for efficient use of MRIs in Regina. Our *2017 Report – Volume 1*, Chapter 10, concluded the Authority had effective processes other than the areas identified in our seven recommendations.[4] By January 2020, the Authority implemented three of the seven recommendations.[5]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Authority's management agreed with the criteria in the original audit.

To complete this follow-up, we interviewed key staff at the Authority, and examined its reports and other relevant documents related to MRI services.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at February 28, 2022, and the Authority's actions up to that date.

[1] Patients in Lloydminster can receive MRI services at the community-based scanner provided through a contract between the Saskatchewan Health Authority, Alberta Health Services, and Lloydminster Medical Imaging.
[2] saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/medical-imaging-wait-times#supply-and-demand (5 April 2022).
[3] saskatchewan.ca/residents/health/accessing-health-care-services/medical-imaging/procedures/magnetic-resonance-imaging-exam#service-locations (29 March 2022).
[4] *2017 Report – Volume 1*, Chapter 10, pp. 133–146
[5] *2020 Report – Volume 1*, Chapter 25, pp. 247–255.

3.1 MRI Data Regularly Analyzed

We recommended the Saskatchewan Health Authority regularly analyze MRI data to determine causes of significant waits of patients for MRI services. *(2017 Report – Volume 1,* p. 140, Recommendation 1; Public Accounts Committee agreement June 13, 2018)

Status—Implemented

The Saskatchewan Health Authority regularly analyzes MRI data to determine causes of significant waits of patients for MRI services.

The Authority uses data from its IT system called the Radiology Information System (RIS) to closely monitor completion of MRI scans. Since our 2020 follow-up audit, the Authority continued to use detailed reports to help staff analyze its data about MRI services. In addition, it developed new reporting tools to help monitor MRI services. Examples of weekly and monthly reports reviewed by senior management include:

- The community MRI contract target report—sets out the number and type of MRIs provided by its contracted private-imaging operators compared to their target number of MRIs expected under the contract with the Authority. The Authority began using this report to monitor MRIs provided by private operators in 2020–21.
- Wait-time buckets report—shows MRI exams outstanding at a point in time filtered by priority level and by specific categories (e.g., cardiac, spine).[6] The Authority began using this report in 2021–22.
- Provincial patient count report—shows the number of patients receiving MRIs by patient type (i.e., emergency, inpatient, outpatient) across facilities.
- MRI waitlist analysis monthly rollup report—provides the number of patient requests waiting in three areas (i.e., Regina, Saskatoon, Moose Jaw) by priority level.

At December 31, 2021, Regina had 4,333 patients waiting for MRI scans. Of those, 1,245 (28%) had not waited for more than seven days for an MRI in Regina. As shown in **Figure 1,** there was an increase of patients waiting by each priority level since 2019.[7] Authority management indicated that demand continues to exceed capacity for MRI services.

Figure 1—Number of Patients Waiting to be Scheduled for a Regina MRI by Priority Level

MRI Priority Level	At December 31, 2019			At December 31, 2021		
	More than 7 days	More than 30 days	More than 90 days	More than 7 days	More than 30 days	More than 90 days
Level 2 (Urgent)	5	9	0	14	21	20
Level 3 (Semi-Urgent)	482	345	66	561	647	539
Level 4 (Non-Urgent)	241	271	77	207	528	551
Total number of patients	**728**	**625**	**143**	**782**	**1,196**	**1,110**

Source: Adapted from information provided by the Saskatchewan Health Authority.

[6] The Authority classifies MRIs in four priority levels: Level 1 (emergency) MRI done within 24 hours; Level 2 (urgent) within 2-7 days; Level 3 (semi-urgent) within 8-30 days; and Level 4 (non-urgent) within 31-90 days.
[7] At December 31, 2019, Regina had 3,237 patients waiting for MRI scans—1,741 (54%) had not waited for more than seven days.

Senior management discuss (via email, informal meetings) and analyze the weekly and monthly reports to help identify issues such as anomalies (e.g., significant decrease in the number of MRI exams provided in a specific location), staffing issues (e.g., shortage of technologists), and whether private operators are meeting contracted MRI targets.

The Authority also uses its Medical Imaging Executive Committee to discuss MRI services. At each meeting, management provides an update on MRI wait times and service demands. For example, in November 2020, management indicated there was a backlog of Level 2 (i.e., urgent) MRIs and were developing a strategy to decrease wait times (e.g., investing in staff overtime to help address backlogs).

Systematic data analysis on MRI services can help identify root causes for delays and opportunities to enhance efficiency.

3.2 Quality of MRI Services Not Yet Assessed

We recommended the Saskatchewan Health Authority formally and systematically assess the quality of MRI services that radiologists provide. (*2017 Report – Volume 1*, p. 143, Recommendation 4; Public Accounts Committee agreement June 13, 2018)

Status—Partially Implemented

We recommended the Board of the Saskatchewan Health Authority receive periodic reports on the timeliness and quality of MRI services, including actions taken to address identified deficiencies. (*2017 Report – Volume 1*, p. 146, Recommendation 7; Public Accounts Committee agreement June 13, 2018)

Status—Partially Implemented

The Saskatchewan Health Authority does not formally and systematically assess the quality of MRI services radiologists provide, but work is underway. It expects to provide senior management with periodic reports on the quality of MRI services once it assesses the quality of those services.

The Authority revised its reporting so the Board no longer receives and reviews periodic reports on MRI services. Rather, this is now the responsibility of Authority senior management.[8]

In June 2019, the Authority began working with eHealth to develop an IT system to help assess the quality of radiologists' interpretations of MRI scans. It plans to use the system to support formal peer reviews of the scans performed. Because of the COVID-19 pandemic, the Authority put this project on hold. The Authority continues to work with eHealth and plans to implement the IT system in 2022–23.

Once the Authority develops a process to assess the quality of MRI services provided, senior management expects to determine the nature and timing of reporting required about MRI service quality.

[8] As reported in our *2020 Report – Volume 1*, Chapter 25, the Authority provided the Board and senior management with periodic reports on the timeliness of MRI services. We found the Authority continued to provide senior management with such reports.

Without formally and systematically assessing the quality of MRI services that radiologists provide, the Authority does not know whether they are providing reliable MRI services. Accurate interpretation of MRI scans can be crucial to proper diagnosis and treatment plans for patients.

3.3 Better Monitoring of MRI Service Quality Provided by Private Operators Needed

We recommended the Saskatchewan Health Authority regularly monitor the quality and timeliness of MRI services that contracted private MRI operators provide. *(2017 Report – Volume 1,* p. 144, Recommendation 6; Public Accounts Committee agreement June 13, 2018)

Status—Partially Implemented

The Saskatchewan Health Authority does not sufficiently monitor the quality of MRI services contracted private-imaging operators provide; however, it is monitoring the timeliness of MRI services that private operators provide.

The Authority has contracts with two private MRI operators, with the private MRI operator in Regina contracted for 5,500 MRI scans per year.[9]

The Authority uses detailed reports to help staff analyze its data about timeliness of MRI services provided by contracted private MRI operators.

As described in **Section 3.1**, the Authority monitors the MRIs provided by the private operators to ensure the operators are meeting the yearly contracted targets (e.g., 5,500 MRIs in Regina). In 2020–21, the private operator delivered 5,225 MRI scans in Regina.

The Authority tracks the number of exams private contractors complete each week and compares it to the operators' weekly target (e.g., 103 weekly exams in Regina). The Authority uses this report to monitor whether it provides the operators with the appropriate number and type of MRI requisitions (e.g., semi-urgent and non-urgent requests) to meet the contracted targets.

The Authority also reviews weekly data in relation to MRIs for specific body parts (e.g., cardiac, chest/abdomen/pelvis, extremities, head/neck, spine), as the private operators also have specific targets for each body part as well as their overall yearly targets. For example, the Authority expects the private operator in Regina to provide 1,900 head/neck and 1,600 spine MRIs each year.

Each week, staff review the list of MRIs sent to the private operators. Authority staff follow up with the private operators if they did not schedule MRI requests in a timely manner to understand the reasons why (e.g., operator unable to contact a patient).

In addition, the Authority completes daily checks in the Radiology Information System to determine whether radiologists (including private operator radiologists) complete timely reports for the ordering physicians following MRI exams. We found the Authority tracks the

[9] One private operator operates in both Regina and Saskatoon. The second operator operates solely in Saskatoon.

number of draft or unsigned reports over 14 days, over seven days, and under seven days by radiologist. It sends periodic emails to follow up on outstanding reports.

As described in **Section 3.2**, the Authority does not yet monitor the quality of MRI services radiologists provide (including private operators). It expects to do so in 2022–23.

Not monitoring the quality of MRI services provided by the Authority and private operator radiologists can affect whether a patient receives an appropriate diagnosis or treatment plan.

Chapter 20
Saskatchewan Health Authority—Medication Management in Long-Term Care Facilities in Kindersley and Surrounding Area

1.0 Main Points

The Saskatchewan Health Authority is responsible for establishing and enforcing policies and procedures so long-term care residents get the right medication at the right dosage when required.

By January 2022, the Authority fully implemented the two remaining recommendations we made in 2014 related to medication management for long-term care residents in facilities located in Kindersley and surrounding area.

The Authority implemented a process to audit whether long-term care facilities adhere to policies requiring informed consent from residents or their designated decision-makers for the use of medication as a restraint or for changes in high-risk medications.[1] This process contributed toward the Authority improving its documentation of informed consent.

Having informed consent reduces the risk a long-term care resident or their designated decision-maker is unaware of a medication's effects and the influence it may have on a resident's quality of life.

2.0 Introduction

As of January 31, 2022, the Saskatchewan Health Authority had 489 long-term care beds in 13 long-term care facilities in Kindersley and surrounding area.

In 2014, we assessed the Authority's processes related to medication management in long-term care facilities located in Kindersley and surrounding area. Our *2014 Report – Volume 2*, Chapter 35, concluded the Authority did not have effective processes to manage medication plans for residents in those long-term care facilities.[2] We made 17 recommendations. By December 2019, the Authority implemented 14 of these 17 recommendations. In addition, we determined one recommendation was no longer relevant.[3]

This chapter includes our third follow-up audit on the two outstanding recommendations.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Authority's management agreed with the criteria in the original audit.

[1] High-risk medications are defined as medications included on the AGS Beers Criteria® guidelines that lists medications at higher risk for potentially inappropriate use in older adults.
[2] *2014 Report – Volume 2*, Chapter 35, pp. 235–255.
[3] *2017 Report – Volume 2*, Chapter 37, pp. 261–268; *2020 Report – Volume 1*, Chapter 27, pp. 259–262.

To complete the audit, we visited three long-term care facilities in Kindersley and surrounding area, reviewed established policies, tested a sample of resident files, and reviewed the results of compliance audits completed by facility staff.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at January 31, 2022, and the Authority's actions up to that date.

3.1 Monitoring for Informed Written Consent

We recommended the Saskatchewan Health Authority follow its policy to obtain informed written consent from long-term care residents or their designated decision-makers before using medication as a restraint. *(2014 Report – Volume 2,* p. 251, Recommendation 13; Public Accounts Committee agreement September 17, 2015)

Status—Implemented

We recommended the Saskatchewan Health Authority implement a policy requiring informed written consent from long-term care residents or their designated decision-makers for changes in high-risk medication. *(2014 Report – Volume 2,* p. 250, Recommendation 12; Public Accounts Committee agreement September 17, 2015)

Status—Implemented

In 2021, the Saskatchewan Health Authority implemented a process to audit whether long-term care facilities adhere to policies requiring informed written consent from residents or their designated decision-makers for the use of medication as a restraint or for changes in high-risk medications. As a result, it also improved its informed consent documentation since our last follow-up in 2019.

The Authority's policies in Kindersley and surrounding area require documented informed consent from the resident or their decision-maker when medication is used as a chemical restraint, as well as when a change in a high-risk medication occurs.

Since our last follow-up, the Authority implemented a process (i.e., work standard) to audit whether long-term care facilities in Kindersley and surrounding area adhere to its policies requiring informed consent. Beginning in 2021, facility staff started auditing a sample of resident files (i.e., 10% of residents, or a minimum of five) each month to determine whether the files contained documentation of informed consent. Facility staff accumulate audit results monthly and report the information to the three Directors responsible for long-term care facilities in the area, who then discuss results with staff.

We tested a sample of resident files at three long-term care facilities to determine whether facility staff documented informed consent from residents or their decision-makers when using medication as a chemical restraint, or when a change in a high-risk medication

occurred. We found 86% of client files included documentation of consent when using medication as a chemical restraint, and 73% of the files included documentation of consent for changes in high-risk medications. These results improved from our 2019 follow-up.[4]

When comparing our testing results with the results from the Authority's monthly audits, we found our results aligned with those of the Authority. In addition, the Authority's audit results for the three facilities we visited improved between April and December 2021—a 40% improvement associated with high-risk medications and a 20% improvement for medication used as a chemical restraint.

Having informed consent documentation reduces the risk a long-term care resident or their designated decision-maker may be unaware of a medication's effects, as well as the influence these medications may have on a resident's quality of life.

Implementation of a monitoring process, such as periodic audits, is an effective tool to promote staff compliance with informed consent requirements.

[4] In our 2019 follow-up, we found 53% of client files tested included documentation of consent when using medication as a chemical restraint, and 69% of the files included documentation of consent for changes in high-risk medications.

Chapter 21
Saskatchewan Health Authority—Preventing and Controlling Hospital-Acquired Infections in the Regina General and Pasqua Hospitals

1.0 Main Points

The Saskatchewan Health Authority is responsible for keeping patients safe, including in hospitals. Infections acquired in hospitals can extend a patient's hospital stay and may lead to increased complications and treatment costs.

By February 2022, the Authority made some progress to improve its processes to prevent and control hospital-acquired infections at the Regina General and Pasqua Hospitals, but further work is needed.

The Authority makes training on infection prevention and control practices available on its website to its hospital staff responsible for patient care. However, the training is not mandatory, and staff are not sufficiently aware of its availability. Periodic staff training reinforces the importance of strong infection prevention and control practices thereby reducing the risk of inappropriate actions that may increase infection transmission.

The Authority is not yet using external observers to conduct regular direct observation hand-hygiene compliance audits. As well, it does not monitor hand-hygiene compliance rates and whether patient-care units take action to address low compliance rates. We reviewed three units and found one unit with low hand-hygiene compliance rates (i.e., less than 55%). Also, we found unit managers were inconsistently aware of their units' compliance rates. Actively holding patient-care units with unacceptable hand-hygiene compliance rates accountable increases timely corrective actions, and reduces patient and staff risk of hospital-acquired infections.

In addition, the Authority needs to regularly give senior management a written analysis of emerging risks and causes based on trends of hospital-acquired infections. While senior management continues to receive quarterly reports showing historical infection rates in Regina hospitals (i.e., back to 2019), the reports do not include trend analysis or potential root causes for the changes. Without routine analysis of infection trends and linkage to audit results of infection prevention and control practices, the Authority may not sufficiently make changes to protect staff and patients from hospital-acquired infections.

2.0 Introduction

The Provincial Health Authority Act makes the Saskatchewan Health Authority responsible for planning, organizing, delivering, and evaluating provincial health services. *The Provincial Health Authority Administration Regulations* specify that health services include disease and injury prevention services.

Regina General Hospital and Pasqua Hospital are the two major hospitals providing healthcare services to people of southern Saskatchewan. For the year ending March 31, 2021, about 33,800 people were admitted to these two hospitals.[1]

A hospital-acquired infection is an infection that a patient acquires while in a hospital that was not present or incubating on admission.[2] Examples of common hospital-acquired infections include infections caused by organisms such as Clostridium difficile (CDI), Methicillin-resistant staphylococcus aureus (MRSA), and Vancomycin-resistant enterococcus (VRE).[3,4,5] COVID-19 is another example of an infection patients can acquire while in hospital.

Such infections can extend a patient's hospital stay, and may lead to additional complications and treatment costs. Having an effective infection prevention and control program can help reduce the burden associated with hospital-acquired infections, reduce the length of hospital stay, and lower costs related to the treatment of infections.

2.1 Focus of Follow-Up Audit

This audit assessed the status of four recommendations made in our *2018 Report – Volume 2*, Chapter 24, about the Saskatchewan Health Authority's processes to prevent and control hospital-acquired infections in the Regina General and Pasqua Hospitals. We concluded for the 12-month period ended August 31, 2018, the Authority had, other than the areas identified in our four recommendations, effective processes.[6]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Authority's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Authority's management agreed with the criteria in the original audit.

To complete this follow-up audit, we interviewed key Authority staff responsible for infection prevention and control in Regina hospitals. We examined and assessed relevant documentation including policies and procedures, hand-hygiene audit compliance reports, infection rate reports, as well as one of the Authority's online training modules.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at February 28, 2022, and the Authority's actions up to that date.

[1] Information provided by the Saskatchewan Health Authority.
[2] World Health Organization, *Health care without avoidable infections, The critical role of infection prevention and control*, (2016), p. 4.
[3] Clostridium difficile is a bacterial spore that causes irritation in the bowel leading to severe cramps and diarrhea.
[4] Methicillin-resistant staphylococcus aureus is a bacterium resistant to common antibiotics and affects the heart, lungs, bones, joints, and/or bloodstream.
[5] Vancomycin-resistant enterococcus is a bacterium resistant to common antibiotics and causes severe urinary tract infections.
[6] *2018 Report – Volume 2*, Chapter 24, pp. 151–167.

3.1 Staff Unaware of Available Training

We recommended the Saskatchewan Health Authority give hospital staff, responsible for patient care, formal training updates on infection prevention and control practices at least annually. *(2018 Report – Volume 2,* p. 158, Recommendation 1; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority makes training on infection prevention and control practices available on its website to its hospital staff responsible for patient care; however, the training is not mandatory and staff are not sufficiently aware of its availability.

In 2019, the Authority launched the Saskatchewan Health Training online platform. It includes various learning modules with one specific to infection prevention and control practices. The module includes an overview of:

- Routine practices (e.g., point-of-care risk assessments, cleaning techniques)
- Chain of infection (explaining how infection spreads)
- Hand hygiene (outlines when to perform hand hygiene, such as after risk of exposure to bodily fluid)
- Personal protective equipment (PPE) (information on how to put on and take off)

We found the module includes training videos (e.g., how to conduct proper hand hygiene) and links to standard procedures for proper donning and removal of PPE. In addition, we found the module aligns with standards set out by Accreditation Canada in relation to key components of infection prevention and control practices.

The Authority expects staff to complete this training annually; however, the training is not mandatory, and the Authority does not track who takes the training. We also found not all staff are aware of the training. During our discussions with three unit nurse managers, two were unaware of the training available to them and their staff. Authority management acknowledged its need to improve communication with all hospital staff (e.g., nursing, housekeeping) about available training.

The Authority also indicated that once it implements the new Administrative Information Management System (AIMS) in 2022–23, it expects the annual refresher training will become mandatory and managers can start using the system to track staff completion of the training.

In addition to the training described above, we found the Authority maintained and updated various infection prevention and control procedures associated with the COVID-19 pandemic. For example, it developed COVID-19 infection prevention and control guidance for acute care settings outlining procedures such as screening; hand hygiene; point-of-care risk assessments; continuous mask use and eye protection; PPE; and environmental cleaning and disinfection. We found the Authority periodically held virtual town-hall presentations to inform staff about changes to protocols and guidance during the

pandemic. For example, in July 2021, the Authority provided an overview of the PPE guidance, the current precautions, and changes to the visitor protocols in the Authority's facilities. The Authority also provided various safety bulletins on its website providing healthcare workers with ongoing direction about recommended safety guidelines, processes, and PPE supply.

Periodic refresher training helps keep staff up-to-date, and provides an opportunity to reinforce the importance of key activities to prevent and control hospital-acquired infections. Without periodic refresher training, it increases the risk of inappropriate practices that may increase infection transmission, and compromise the wellness and health of patients and staff.

3.2 External Observers Not Conducting Hand-Hygiene Compliance Audits

We recommended the Saskatchewan Health Authority use external observers to conduct regular direct observation hand-hygiene compliance audits in its hospitals. *(2018 Report – Volume 2,* p. 161, Recommendation 2; Public Accounts Committee agreement March 1, 2022)

Status—Partially Implemented

The Saskatchewan Health Authority does not use external observers to conduct regular direct observation hand-hygiene compliance audits in its hospitals.

In summer 2021, the Authority recognized the need for a consistent approach for collecting and analyzing hand-hygiene observations across the province. As a result, it signed a project agreement for a new IT system for hand-hygiene audits and began a system trial in January 2022. The Regina hospitals are part of this trial, which involves staff within patient-care units (i.e., not external observers) using the IT system to conduct monthly hand-hygiene audits.

If the trial is successful, the Authority indicated it plans to train a pool of staff to be hand-hygiene auditors. It expects to assign these auditors to patient-care units to conduct external direct observation hand-hygiene audits by fall 2022.

Not using external observers to conduct hand-hygiene compliance audits increases the risk of observation bias and having inaccurate compliance rates.[7] This may increase the risk of the Authority not taking sufficient or timely action to improve staff hand-hygiene practices. This in turn places patients and staff at greater risk of hospital-acquired infections.

[7] During our 2018 audit, we found the Authority used external observers to conduct a series of direct observation hand-hygiene compliance audits in the Regina hospitals in May 2017. The compliance rate for these audits were significantly lower than the rates for audits where patient-care units had one of their own staff members complete the observations. Some units had a 60–70% difference in compliance rates between these two types of audits—suggesting actual compliance rates for hand hygiene may be significantly different than reported (i.e., depending on who completes the observations).

3.3 Hand-Hygiene Compliance Rates Not Monitored

We recommended the Saskatchewan Health Authority actively monitor actions taken by Regina hospitals' patient-care units with lower than acceptable hand-hygiene compliance rates. *(2018 Report – Volume 2,* p. 163, Recommendation 3; Public Accounts Committee agreement March 1, 2022)

Status—Not Implemented

The Saskatchewan Health Authority does not monitor hand-hygiene audit compliance rates and whether units take action to address low compliance rates. In addition, it has not set an acceptable hand-hygiene compliance rate to enable managers in Regina hospitals' patient-care units to assess when they should take action.

The Authority expects unit managers to monitor hand-hygiene compliance rates and develop action plans to address lower than acceptable hand-hygiene compliance rates. However, we found the Authority has not set what it considers an acceptable compliance rate that would trigger an action plan (e.g., compliance rate less than 90%). The Authority indicated the provincial Infection Prevention and Control Team plans to meet by fall 2022 to determine an acceptable compliance rate.

As of February 2022, the Authority does not sufficiently monitor hand-hygiene compliance rates and whether units take action to address low compliance rates.

Staff within patient-care units (e.g., clinical nurse educators) are responsible for posting the results of their units' hand-hygiene compliance audits on their units' visibility walls.[8] In one of the three patient-care units we reviewed, the unit had low compliance rates associated with its hand-hygiene audits. In December 2021 and January 2022, the unit's compliance rates were 50% and 55% respectively.[9] The unit did not develop an action plan to address the low compliance rates. We found the other two patient-care units tested had compliance rates exceeding 80%. However, we found the managers for these two units were unaware of their units' compliance rates.

The Authority is piloting a new IT system for hand-hygiene audits and anticipates using reports from this system to determine whether there is any correlation between the location of increased infection transmissions and low hand-hygiene compliance rates.

Without setting an acceptable hand-hygiene compliance rate target, patient-care unit managers do not know when they should develop an action plan to address low compliance rates. Without action plans, unit managers may not actively reinforce the importance of good hand-hygiene practices, or take sufficient steps to improve hand-hygiene activities of staff in their unit.

Actively holding patient-care units with unacceptable hand-hygiene compliance rates accountable increases timely corrective actions, and reduces patient and staff risk of hospital-acquired infections.

[8] A visibility wall is an essential element of daily management—it provides a permanent location to easily view the work of the organization or unit. www.rqhealth.ca/department/quality-improvement-and-planning/visibility-walls (21 March 2022).
[9] In our 2018 audit, we found the Authority had an average compliance rate between 80% and 87% for hand-hygiene audits completed by staff within each patient-care unit in its two Regina hospitals between September 2017 and June 2018.

3.4 Better Analysis of Hospital-Acquired Infection Causes Needed

We recommended the Saskatchewan Health Authority regularly give senior management a written analysis of emerging risks and causes based on trends of hospital-acquired infections. *(2018 Report – Volume 2,* p. 166, Recommendation 4; Public Accounts Committee agreement March 1, 2022)

Status—Not Implemented

The Saskatchewan Health Authority does not give senior management a written analysis of emerging risks and causes based on trends of hospital-acquired infections.

The Authority continues to track the number of hospital-acquired infections by unit in each facility. As shown in **Figure 1**, the number of infections for each type of hospital-acquired infection decreased since 2017–18. The Authority indicated this was due to fewer outbreaks, as well as increased use of PPE and safety precautions during the COVID-19 pandemic.

Figure 1—Number of Infections by Organism Acquired at Regina General and Pasqua Hospitals

Organism	2017–18	2018–19	2019–20	2020–21
Regina General Hospital				
Vancomycin-resistant enterococcus (VRE)	94	11	46	4
Methicillin-resistant staphylococcus aureus (MRSA)	52	3	4	6
Clostridium difficile (CDI)	41	3	3	4
Pasqua Hospital				
Vancomycin-resistant enterococcus (VRE)	112	9	32	64
Methicillin-resistant staphylococcus aureus (MRSA)	26	3	2	2
Clostridium difficile (CDI)	19	9	13	11
Total	**344**	**38**	**100**	**91**

Source: Adapted from information provided by the Saskatchewan Health Authority.

In addition, we found the Authority tracked hospital-acquired COVID-19 infections since March 2020.[10] During the period of April 1, 2020 to January 16, 2022, the Authority had 24 and 12 patients with hospital-acquired COVID-19 infections in the Regina General and Pasqua Hospitals, respectively.[11]

Senior management continues to receive quarterly reports on bloodstream infection rates for MRSA and VRE—this aligns with good practice. We observed two quarterly reports and found the reports showed historical infection rates in the hospitals to identify trends. However, we found the reports do not include trend analysis or potential root causes for the changes.

[10] When determining hospital-acquired COVID-19 infections in the Regina General and Pasqua Hospitals, the Authority uses best clinical judgment along with the following criteria: patient symptoms begin at least seven or more calendar days after admission to the reporting hospital, or a patient is re-admitted with a positive COVID-19 test result less than seven days after discharge from hospital.

[11] Adapted from information provided by the Saskatchewan Health Authority.

The Authority explained it is the provincial epidemiologist's responsibility to analyze results to identify emerging risks and causes associated with hospital-acquired infections. Due to a vacancy for the epidemiologist position since September 2019, the Authority has not completed an infection rate analysis. The Authority filled this position in January 2022 and expected the new epidemiologist to begin analyzing infection rates.

We also found the Authority continued to collect data about CDI infections at both hospitals. However, due to the epidemiologist vacancy, senior management did not receive an analysis of CDI infections over the past 18 months. The Authority explained this is a high-priority for the newly hired epidemiologist.

Without routine analysis of infection trends and linkage to audit results of infection prevention and control practices, the Authority may not sufficiently protect staff and patients from hospital-acquired infections. The Authority may also miss identifying opportunities for improvement at hospitals and units therein with higher than normal rates of hospital-acquired infection.

Chapter 22
Saskatchewan Workers' Compensation Board—Coordinating Injured Workers' Return to Work

1.0 Main Points

The Saskatchewan Workers' Compensation Board (WCB) is still in the early stages of addressing six recommendations we made in our 2016 audit related to its processes for coordinating workers' return to work. Return-to-work programs are essential to get an injured worker back to suitable and productive employment.

WCB refers to a time-loss claim as claims resulting from reported workplace injury where an injured worker cannot work. WCB reported it accepted 7,963 time-loss claims in 2021 and 7,134 in 2020. WCB's average annual claim duration target is 38 days. The average claim duration was 40.24 days in 2021 and 45.27 days in 2020.

WCB is undertaking a significant claims transformation process initiative under its broader five to seven year Business Transformation Program established in 2020. The transformation affects all six outstanding recommendations. WCB expects to leverage the functionality of a new claims IT system and update to its processes not only to address the six recommendations, but also to support the best outcomes for its customers, claims processes, structures, and systems.

WCB plans to implement the recommendations by December 2025.

2.0 Introduction

This chapter describes our second follow-up of management's actions on our 2016 recommendations as of January 31, 2022.

In 2016, we assessed the Saskatchewan Workers' Compensation Board's processes to coordinate injured workers' return to work. Our *2016 Report – Volume 2*, Chapter 31, concluded that for the 12-month period ended August 31, 2016, other than in the areas of the six recommendations we made, WCB had effective processes to effectively coordinate workers' return to work.[1] In our follow-up audit in *2019 Report – Volume 2*, Chapter 43, some initial work began on implementing the recommendations we made in 2016.[2]

WCB operates under the authority of *The Workers' Compensation Act, 2013*. By law, WCB has the duty to consult and cooperate with injured workers in the development of rehabilitation plans intended to return them to positions of independence in suitable, productive employment.[3]

[1] *2016 Report – Volume 2*, Chapter 31, pp. 217–233.
[2] *2019 Report – Volume 2*, Chapter 43, pp. 318–321.
[3] Section 19(1) of *The Workers' Compensation Act, 2013*.

WCB delivers workplace insurance to Saskatchewan employers and benefits to Saskatchewan workers when they are hurt at work.[4] It has a return-to-work program as expected by the Act. The Act recognizes that injured workers, employers, healthcare professionals, and WCB must work together in a return-to-work program. It assigns responsibilities to each group.[5]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate WCB's progress toward meeting our recommendations, we used the relevant criteria from the original audit. WCB's management agreed with the criteria in the original audit.

At January 31, 2022, WCB is undertaking a three to five year claims transformation process initiative under its broader multi-year Business Transformation Program. This transformation affects all of the six outstanding recommendations. The transformation initiative includes reshaping its claim processes, systems, and structures. As a result, our audit work included discussions with management and examining plans to change processes.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation and the status of the recommendation at January 31, 2022.

3.1 Working to Actively Obtain Requested Reports Timely

We recommended, for claims requiring recovery and return-to-work plans, Saskatchewan Workers' Compensation Board consistently record its communications with injured workers, employers, and healthcare professionals. *(2016 Report – Volume 2, p. 225,* Recommendation 1; Public Accounts Committee agreement October 10, 2018)

Status—Partially Implemented

We recommended, for claims requiring recovery and return-to-work plans, Saskatchewan Workers' Compensation Board actively obtain requested reports (e.g., injury and recovery progress reports) from injured workers, employers, and healthcare professionals. (*2016 Report – Volume 2*, p. 226, Recommendation 2; Public Accounts Committee agreement October 10, 2018)

Status—Partially Implemented

Saskatchewan Workers' Compensation Board is still in the early stages of improving its processes to record communication with injured workers, employers, and healthcare professionals. It also still needs to actively obtain reports from injured workers, employers, and healthcare professionals. WCB continues to work on process improvements as part of its claims transformation initiative (to be complete by December 2025).

[4] www.wcbsask.com/about-us (20 October 2021).
[5] *The Workers' Compensation Act, 2013*, s. 44(1)(a), 51, 53, 55–57.

In 2019, we found WCB changed its expectations for initial contact with injured workers from 10 business days to five business days of assigning cases to its Case Management Unit. Regardless of the standard used, five or 10 business days, initial communication with injured workers occurred within the expected timeframe for 83% of cases tested. This means 17% of the time, injured workers were not having initial contact with WCB in a timely manner, which affects timely return to work.[6] At January 2022, WCB management indicated challenges regarding timely communications with injured workers continue to exist.

As part of its claims transformation initiative, WCB is developing and testing new communication standards with injured workers and employers. It plans to pilot employer communication standards in spring 2022, and complete the overall transformation initiative by December 2025.

In 2019, WCB set expectations for the receipt of medical reports for certain healthcare providers. For example, receipt of an initial assessment report from a healthcare provider is expected within three business days of the injured worker's initial appointment. In the past, we found WCB was not always receiving initial and progress reports timely from healthcare providers.[7] WCB management indicated delays continue to occur.

As part of the claims transformation initiative, WCB identified its first priority is to update injured workers' reports required from healthcare providers to only include relevant information to enhance the recovery and return-to-work process.[8] This work is planned for 2022. WCB also intends to implement a future IT system to allow for electronic reporting capability from healthcare providers by December 2025.

Without early communication to obtain complete information from injured workers, employers, and healthcare professionals, WCB is unable to coordinate an accurate and timely return-to-work plan.

3.2 Complete Return-to-Work Plans Dependent on Complete Information

> ***We recommended, for claims requiring recovery and return-to-work plans, Saskatchewan Workers' Compensation Board verify the completeness and currency of those plans and the agreement of injured worker and related employer with the plan****. (2016 Report – Volume 2,* p. 228, Recommendation 3; Public Accounts Committee agreement October 10, 2018)
>
> **Status**—Not Implemented

Saskatchewan Workers' Compensation Board still needs to verify completeness and currency of recovery and return-to-work plans. WCB plans to make process improvements as part of its claims transformation initiative (to be complete by December 2025).

[6] *2019 Report – Volume 2,* Chapter 43, pp. 318–319, testing from August 1, 2017 to August 31, 2019.
[7] Ibid.
[8] Injured Worker Reports include all relevant information to the injury sustained such as type of injury, injury date, and injury cause.

In 2019 we found, WCB was assessing how to standardize its recovery and return-to-work plans and promote consistency in creating and completing the plans. At that time, 30% of the files tested lacked a documented return-to-work plan.[9] At January 2022, WCB management indicated return-to-work plan documentation challenges continue to exist.

WCB management noted process improvements outlined in **Section 3.1**, which will support receipt of necessary information in a timely manner, are expected to assist in completing timely and accurate return-to-work plans. For example, electronic reporting capability will support timely receipt and documentation of all necessary information.

Incomplete or missing return-to-work plans increase the risk of WCB not knowing whether injured workers receive appropriate support (e.g., WCB staff may not know they need to arrange for alternate healthcare appointments thus delaying recovery and the workers return to work).

3.3 Working to Identify Impediments to Recovery

> ***We recommended, for claims with recovery and return-to-work plans, Saskatchewan Workers' Compensation Board identify and address impediments to timely recovery of injured workers within a reasonable timeframe.*** (*2016 Report – Volume 2*, p. 230, Recommendation 4; Public Accounts Committee agreement October 10, 2018)
>
> **Status**—Not Implemented

Saskatchewan Workers' Compensation Board is beginning to work to identify and address impediments to timely recovery of injured workers since the last follow-up audit in 2019. WCB plans to use its future IT system (to be implemented by December 2025) to identify high-risk claims and help build appropriate return-to-work plans.

WCB undertakes a secondary assessment to determine why an injured worker is not progressing as expected.[10] In 2019, we found WCB outlined when it needed to conduct a secondary assessment based on set criteria (e.g., a broken arm should heal in four to six weeks but did not). However, with inconsistent documentation in the recovery and return-to-work plans (see also **Section 3.2**), it was not always clear when secondary assessment is required.

As part of the claims transformation initiative, in December 2021, WCB began to identify impediments (e.g., case complexity) to injured workers successfully returning to work. It is working on a risk-based model to help identify high-risk (to recovery and/or return to work) claims to help build appropriate return-to-work plans. It plans to pilot the model in 2022. It then expects to use its future IT system (to be implemented by December 2025) to identify high-risk claims.

Without an effective process for WCB to identify and address impediments for a timely return-to-work plan, injured workers may not be receiving appropriate treatments and/or interventions to ensure their recovery within a reasonable timeframe.

[9] *2019 Report – Volume 2*, Chapter 43, p. 320.
[10] Ibid.

3.4 Automation Expected to Support Complete Reports

We recommended Saskatchewan Workers' Compensation Board educate injured workers, employers, and healthcare professionals to increase their submission of properly completed injury and progress reports for the return-to-work program. *(2016 Report – Volume 2,* p. 231, Recommendation 5; Public Accounts Committee agreement October 10, 2018)

Status—Partially Implemented

Saskatchewan Workers' Compensation Board made progress in educating stakeholders (e.g., injured workers, employers, and healthcare professionals) to increase submission of properly completed injury and progress reports and expects its future IT system to enhance reporting from healthcare providers.

In 2019, we found WCB continued to provide information (e.g., presentations, brochures) regarding its return-to-work program to various stakeholders. WCB provided information on its website for stakeholders identifying the importance of each party's role in the program and the expected report submission times and frequency. WCB often did not receive requested information on time and, where it did receive requested information, at times, it was incomplete.[11] Some of the documents provided to stakeholders (e.g., support packages for healthcare providers) outlined report submission timing while others discussed the need for timely report submissions, but did not define what the WCB considers timely.[12]

In addition, WCB plans to promote the National Institute of Disability Management and Research's education models in disability management and return to work to employers and its staff in 2022. This will assist in educating employers and staff on key information needed to support return-to-work plans.

WCB plans to implement a new IT system and address this recommendation by December 2025.

Not receiving timely and complete reporting from employers, injured workers and healthcare professionals may negatively impact an injured worker's treatment, recovery and return to work.

3.5 Monitoring the Success of the Return-to-Work Program to Come

We recommended Saskatchewan Workers' Compensation Board track and analyze key information about the quality and timeliness of its return-to-work program. (*2016 Report – Volume 2*, p. 232, Recommendation 6; Public Accounts Committee agreement October 10, 2018)

Status—Not Implemented

[11] *2019 Report – Volume 2,* Chapter 43, p. 321.
[12] Ibid.

Saskatchewan Workers' Compensation Board still needs to track and analyze key information about quality and timeliness of its return-to-work program. WCB continues to work on process improvements as part of its claims transformation initiative.

In 2019, WCB indicated it was in the early stages of identifying the analytic tools it needed to evaluate its return-to-work program.[13]

WCB expects its planned new IT system to have the functions to analyze key information (e.g., high-risk claims). WCB expects to implement the new IT system by December 2025.

Not tracking and analyzing key information about the quality and timeliness of its return-to-work program increases the risk of WCB not identifying opportunities to use this program to reduce the duration of time-loss claims and return injured workers to work.

[13] *2019 Report – Volume 2*, Chapter 43, p. 321.

Chapter 23
Saskatoon School Division No. 13—Supporting Students with Intensive Needs

1.0 Main Points

By April 2022, Saskatoon School Division No. 13 improved its processes to support Kindergarten to Grade 8 students with intensive needs. Of the 11 recommendations we first made in 2018, the Division implemented six recommendations and made progress on the other five recommendations.

The Division regularly analyzed trends in the number of Kindergarten to Grade 8 students with intensive needs, and their categories of needs. The Division used this data to help it estimate future enrolment of students with intensive needs as well as the staff needed to support those students. It also maintained consistent and accessible documentation on key discussions, decisions, and steps taken to support students with intensive needs, and student assessment information in students' cumulative files. Although, the Division has not set expected timeframes for completing assessments.

The Division established expectations for school staff to retain evidence of parents' agreement on learning plans and complete regular student progress reports; however, school staff did not always do so. Not documenting agreement with parents on learning plans and formally assessing students' progress regularly may negatively affect student success.

The Division also indicated it is developing reporting that will assist in centrally monitoring individual learning plan goal attainment. Monitoring whether students are progressing against goals as expected would help the Division and its Board determine whether the Division is providing sufficient support to students with intensive needs.

2.0 Introduction

2.1 Background

Saskatoon School Division No. 13 is an urban school division located in the city of Saskatoon. It has just over 2,600 full-time equivalent staff, including approximately 1,400 FTE classroom teachers, and 650 FTE educational staff in other positions (e.g., educational assistants, speech language pathologists).[1] The Division has about 25,000 students of which approximately two-thirds are Kindergarten to Grade 8 students.[2]

The Education Act, 1995 requires school boards to reasonably accommodate students with intensive needs in the regular program of instruction.[3] Students with intensive needs are

[1] *The Board of Education of the Saskatoon Public School Division No. 13 of Saskatchewan 2020-21 Annual Report*, p. 37.
[2] Ibid., p. 36.
[3] Section 178(9) of *The Education Act, 1995.*

those assessed as having a capacity to learn that is compromised by a cognitive, social-emotional, behavioural, or physical condition.

At April 2022, the Division had 1,136 Kindergarten to Grade 8 students identified as having intensive needs, a 3% decrease since 2017–18. If school boards cannot accommodate these students in regular programing, the Act expects them to provide special programing to meet those students' learning needs. Approximately 35% of the Division's intensive needs students are in specialized programs.[4]

The Education Regulations, 2019 places further expectations on school divisions in identifying students with intensive needs, and providing them with services. For example, upon request a school division's Director of Education must direct an assessment to be conducted to determine whether a student has intensive needs.[5] Further, school boards are responsible for making programs and supports available to students with intensive needs, at no cost to parents, using qualified individuals to provide programs/supports.[6]

2.2 Focus of Follow-Up Audit

This chapter describes our follow-up audit of management's actions on the recommendations we made in 2018.

In 2018, we assessed the Division's processes for supporting Kindergarten to Grade 8 students with intensive needs. Our *2018 Report – Volume 1*, Chapter 11, concluded the Division had effective processes, except in the areas reflected in our recommendations. We made 11 recommendations.[7]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Division's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Division agreed with the criteria in the original audit.

To perform our follow-up audit, we discussed actions taken with Division management. We assessed the Division's processes by examining policies and other guidance that relate to providing supports for Kindergarten to Grade 8 students with intensive needs. We tested a sample of student files at five Kindergarten to Grade 8 schools to assess operating effectiveness of the Division's processes.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at April 22, 2022, and the Division's actions up to that date.

[4] The Division offers specialized programs targeted to students with specific needs (e.g., behavioural challenges, intellectual disabilities). Programs include the Autism Support Program and Functional Life Skills; the Division also has a specialized school for students with severe or multiple disabilities (John Dolan School).
[5] Section 48(5) of *The Education Regulations, 2019*.
[6] Section 50(1) of *The Education Regulations, 2019*.
[7] *2018 Report – Volume 1*, Chapter 11, pp. 157–178.

3.1 Forecast and Analysis of Students with Intensive Needs and Related Staffing Completed

We recommended Saskatoon School Division No. 13 formally estimate the future enrolment of Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 167, Recommendation 1; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

We recommended Saskatoon School Division No. 13 analyze trends in the number of Kindergarten to Grade 8 students with intensive needs, and their categories of intensive needs. *(2018 Report – Volume 1,* p. 169, Recommendation 2; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

We recommended Saskatoon School Division No. 13 document its determination of staff needed to support Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 169, Recommendation 3; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

Saskatoon School Division No. 13 estimated future enrolment of Kindergarten to Grade 8 students with intensive needs, as well as the staff needed to support those students. The Division also regularly analyzed trends in the number of Kindergarten to Grade 8 students with intensive needs, and their categories of needs.

By April 2022, the Division analyzed year-over-year changes in enrolment of students with intensive needs. At April 2022, the Division had 1,136 Kindergarten to Grade 8 students with intensive needs enrolled. The Division used its analysis to estimate future enrolment of students with intensive needs (i.e., for the next five years). The Division also used this analysis to estimate the number of staff it will need to support those students. We found the Division's process to prepare its estimates and analysis reasonable.

Reliable estimates of future enrolment of students with intensive needs gives the Division better information to determine resources (e.g., resource teachers, educational assistants) to support those students.

Since October 2020, the Coordinator, Special Education, provides Division senior management with monthly reports that include current statistics on the number of students with intensive needs, and their category of needs. We found the monthly reports included:

- Analysis on changes in the intensive needs students population (e.g., changes in the number of students with autism)
- Number of students recently designated as having intensive needs
- Number of students requiring the support of an educational assistant

Analyzing trends in the number of students with intensive needs, and their categories of intensive needs will help the Division make resourcing decisions, as well as inform the Division's future estimates of intensive needs students and related staffing.

3.2 Consistent and Accessible Documentation Maintained

We recommended Saskatoon School Division No. 13 require schools to consistently document key consultations, decisions, and action items resulting from their meetings for Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 171, Recommendation 4; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

We recommended Saskatoon School Division No. 13 require consistent and accessible documentation of key discussions, decisions, and steps taken to implement learning plans for Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 174, Recommendation 8; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

Saskatoon School Division No. 13 requires schools to maintain consistent and accessible documentation on key discussions, including decisions and steps taken to support students with intensive needs.

The Division has guidance setting out expectations and best practices for school TEAMS meetings.[8] The guidance includes reference materials and record-keeping templates that provide school TEAMS guidance on steps to prepare for TEAMS meetings, including documentation to gather and include in the agenda.

Further, the Division has outlined expectations for record keeping for TEAMS meetings including:

- Tracking concerns, strategies implemented, responses to interventions, action plans and staff responsible
- Tracking referrals for assessments
- Following and monitoring students who are not yet designated intensive needs, or students who are improving

School TEAMS use Division-supplied IT software (called OneNote) to record information about their meetings. The Division uses a student supports IT system (called CLEVR) to organize and track individual planning and reporting information (e.g., learning plans, progress reports) for students with intensive needs. All school TEAMS members have access to the IT software and the student supports IT system.

[8] Each school has a group—referred to as school TEAMS—comprised of both school staff (e.g., principals, resource teachers) and Division professionals (e.g., speech language pathologist, educational psychologist) who are responsible for deciding appropriate supports for students with intensive needs.

We tested 31 files of students with intensive needs and found that the Division documented key discussions, decisions, and steps to implement student learning plans in its IT software and student supports IT system.

Maintaining consistent and accessible documentation on key discussions, decisions and steps taken to support students with intensive needs helps students to receive timely supports. This also reduces the risk of repeating intervention strategies found to be ineffective for students with intensive needs.

3.3 Student Assessment Information Maintained

We recommended Saskatoon School Division No. 13 maintain in student cumulative files assessment information related to Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 171, Recommendation 5; Public Accounts Committee agreement September 25, 2019)

Status—Implemented

Saskatoon School Division No. 13 maintained assessment information related to Kindergarten to Grade 8 students with intensive needs in student cumulative files as expected.

The Division expects school staff to maintain certain information, such as student learning plans and assessment reports (e.g., diagnostic reports from psychologists or speech language pathologist), in students' cumulative files in line with its policy.[9] We found the Division's policy aligned with guidance from the Ministry of Education.[10]

We tested 31 student files and found all of the files contained assessment information as expected.

Maintaining assessment information on student cumulative files allows this information to be accessible to parents and to school staff in order to provide sufficient supports to students with intensive needs.

3.4 Expected Timeframes for Completing Assessments Needed

We recommended Saskatoon School Division No. 13 provide guidance on expected timelines for completion of assessments of Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 172, Recommendation 6; Public Accounts Committee agreement September 25, 2019)

Status—Partially Implemented

Saskatoon School Division No. 13 analyzed average time to complete assessments, but it has not yet provided guidance to Division professionals on expected timelines.

[9] School staff refers to staff such as school principals, vice principals, resource teachers, special education teachers, and classroom teachers.

[10] Student Cumulative Record Guidelines 2019 (pubsaskdev.blob.core.windows.net/pubsask-prod/83639/Student%252BCumulative%252BRecord%252BGuidelines%252B2019.pdf) (22 April 2022).

Division professionals (e.g., speech language pathologist, educational psychologist) track the time it takes from when they receive assessment referrals from school TEAMS to when they complete the assessment. Using this information, the Division analyzed the average time taken to complete assessments during the 2020–21 school year. Overall, there were 589 assessments completed during that period. The Division found it takes, on average:

- 51 school days (approximately 10 weeks) to complete a speech language assessment
- 41 school days (approximately eight weeks) to complete a psychological assessment

The Division indicated it plans to set out, in guidance, 30 school days as an expected timeframe to complete the assessment process for the 2022–23 school year.

Delays in completing assessments may cause delays in implementing learning supports for students with intensive needs, which in turn, may negatively impact students' success.

3.5 Parent Agreement on Learning Plans Not Always Documented

We recommended Saskatoon School Division No. 13 retain evidence of agreement on learning plans for Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 173, Recommendation 7; Public Accounts Committee agreement September 25, 2019)

Status—Partially Implemented

Saskatoon School Division No. 13 did not always retain evidence of agreement on learning plans for Kindergarten to Grade 8 students with intensive needs.

Annually, the Division expects school staff to meet with parents to discuss a student's learning plan, and sign-off and agree with the plan. If school staff are unable to meet with parents, the Division expects school staff to document, in the learning plan, their attempts to meet with parents to obtain agreement on the plan (e.g., phone calls, emails).

We tested 30 student files, and found for five students, school staff did not document agreement with parents on learning plans, or their attempts to obtain agreement. School staff indicated they attempted to contact parents, but did not document this in the learning plan. These files did not contain any indication of disagreement with parents on learning plans.

Documenting agreement of learning plans shows that school staff and parents agree on the Division's approach to address student needs and their involvement. Not having documented agreement between school staff and parents on the learning plan may affect student success.

3.6 Progress Reports Not Always Completed

We recommended Saskatoon School Division No. 13 regularly monitor students' progress in achieving goals set out in learning plans for Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 174, Recommendation 9; Public Accounts Committee agreement September 25, 2019)

Status—Partially Implemented

Saskatoon School Division No. 13 did not always regularly monitor students' progress in achieving their learning plan goals.

The Division expects school staff to complete reports on each student's progress in meeting the goals set out in each student's learning plan at least twice a year.[11] The Division also expects school staff to include the year-end progress report in the student's cumulative file.

We found school staff did not complete progress reports as expected for two of 24 student files we reviewed. Also, we found school staff did not include year-end progress reports in students' cumulative files for eight of 24 student files we reviewed.

Not regularly assessing students' progress in meeting learning plan goals increases the risk that the Division does not make timely adjustments to the learning goals, which may impact student success.

3.7 Division Monitoring of Results Needed

We recommended Saskatoon School Division No. 13 centrally monitor whether schools sufficiently support Kindergarten to Grade 8 students with identified intensive needs to enable students to progress towards their individual learning goals. *(2018 Report – Volume 1,* p. 175, Recommendation 10; Public Accounts Committee agreement September 25, 2019)

Status—Partially Implemented

Saskatoon School Division No. 13 does not formally monitor on a division-wide basis or on a school-by-school basis whether students with intensive needs are progressing against individual learning plan goals as expected.

The Division monitors the allocations of specialized supports, such as educational assistants and assistive technology (e.g., laptops, tablets) for students with intensive needs. At April 2022, the Division indicated it had 548 FTE educational assistants for students with intensive needs (compared to 336 FTEs at the time of our 2018 audit).[12] The Division also tracks special education program referrals and waitlists. For example, at April 2022, there were 24 students on waitlists for the Division's special education programs.

[11] Starting with the 2021–22 school year, the Division changed the expectation for progress reports to twice per year from three times.

[12] At April 2022, the Division indicated total FTE educational assistants included 94 FTEs funded through Jordan's Principle. Jordan's Principle is an initiative to provide First Nations children with access to health, education, or social supports. www.sac-isc.gc.ca/eng/1568396042341/1568396159824 (29 April 2022).

The Division indicated it is working with its student supports IT system vendor (as well as with other school divisions) to develop reporting that will assist the Division to centrally monitor individual learning plan goal attainment. It expects to use this reporting during the 2022–23 school year.

Monitoring whether students are progressing against individual learning plan goals as expected would help the Division determine whether it provides sufficient support to students with intensive needs. The information would also help the Division to evaluate resource deployment to schools to support students with intensive needs.

3.8 Some Reporting on Learning Supports Provided

We recommended Saskatoon School Division No. 13 provide senior management and its Board of Education with enough information to determine the sufficiency of learning supports for Kindergarten to Grade 8 students with intensive needs. *(2018 Report – Volume 1,* p. 177, Recommendation 11; Public Accounts Committee agreement September 25, 2019)

Status—Partially Implemented

Saskatoon School Division No. 13 provides senior management and its Board of Education with some information on the supports provided to students with intensive needs, but it could provide more.

During the school year, the Coordinator, Special Education, provides Division senior management with monthly reports on the number of students with intensive needs, and their category of needs (see **Section 3.1**). We found the monthly reports also contained information on student placements in specialized programs, and related waitlists.

In November 2021, the Division provided its Board with an overview of its programs and processes to support students with intensive needs, as well as trends in the number and categories of student with intensive needs. For example, the number of students diagnosed with autism spectrum disorder increased from 19% of students with intensive needs to 26% of students with intensive needs between 2017–18 and 2020–21.

The Division indicated it is working with its student supports IT system vendor to develop reporting that will assist the Division to centrally monitor individual learning plan goal attainment. This reporting would also help the Division determine whether it is providing sufficient support to students with intensive needs (see **Section 3.7**).

Providing senior management and the Board with information to determine the sufficiency of learning supports would assist the Division to assess whether it provides students with educational services that are consistent with those students' educational needs and abilities, and sufficiently accommodate all students with intensive needs.

Chapter 24
SaskEnergy—Keeping Existing Transmission Pipelines Operating Safely

1.0 Main Points

By December 2021, SaskEnergy implemented the three outstanding recommendations we first made in our 2020 audit related to keeping existing transmission pipelines operating safely.

SaskEnergy owns and operates about 15,000 kilometres of natural gas transmission lines to deliver natural gas to more than 400,000 residential, farm, commercial, and industrial customers located throughout Saskatchewan.[1]

SaskEnergy now has documented rationale for how often it conducts block valve, leak survey, and depth of cover inspections to monitor pipeline conditions and assess the risk of pipeline failure (e.g., natural gas leakage). Documented rationale not only shows how SaskEnergy addresses key risks, but also helps personnel understand the basis for planned inspection frequency.

SaskEnergy implemented clear expectations as to when to receive final reports for pipeline inspections from contractors, and when staff are to review, approve, and enter them into its risk-modelling IT system. In addition, it improved timeliness of entering inspection activities and repair results into appropriate IT systems. For example, we found staff entered inspection and repair results within two months of completion, which aligns with good practice. Up-to-date IT systems support effective decision-making about upcoming inspection plans and repairs.

Having effective processes to operate pipelines safely, reduces the risk of fires or explosions caused by ignition of leaking natural gas from transmission pipelines.

2.0 Introduction

SaskEnergy is responsible for the safe operation of its natural gas transmission pipelines.[2] In 2020, SaskEnergy reported to its regulator (the Ministry of Energy and Resources) three incidents related to transmission pipelines. These incidents resulted in the release of about 8,000 cubic meters of natural gas. In 2021, six incidents resulted in about 11,000 cubic meters of natural gas release.[3]

This chapter describes our follow-up audit of management's actions on the three recommendations we made in 2020. Our *2020 Report – Volume 1*, Chapter 11, concluded that for the 12-month period ended January 31, 2020, SaskEnergy Incorporated had,

[1] SaskEnergy Incorporated, *2020–21 Annual Report,* p. 4.
[2] *The SaskEnergy Act*, s. 15.
[3] Saskatchewan Upstream Oil and Gas IRIS Incident Report. Saskatchewan. Oil and Gas News, Bulletins, Statistics and Reports. www.saskatchewan.ca/business/agriculture-natural-resources-and-industry/oil-and-gas/oil-and-gas-news-and-bulletins (9 February 2022).

except in the areas of three recommendations, effective processes to keep existing natural gas transmission pipelines operating safely.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate SaskEnergy's progress toward meeting our recommendations, we used the relevant criteria from the original audit. SaskEnergy's management agreed with the criteria in the original audit.

To complete this follow-up audit, we interviewed key SaskEnergy staff, and examined policies, plans, and other records related to inspections of natural gas transmission pipelines. We also tested a sample of pipeline inspections, surveys, and repairs to assess whether inspection results were entered into appropriate IT systems.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Crown and Central Agencies agreed to the recommendation, the status of the recommendation at December 31, 2021, and SaskEnergy's actions up to that date.

3.1 Expected Frequency for All Pipeline Inspections Documented

We recommended SaskEnergy Incorporated document the rationale for how often it carries out each of its transmission pipeline inspection activities. (*2020 Report – Volume 1*, p. 143, Recommendation 1; Crown and Central Agencies Committee agreement August 23, 2021)

Status—Implemented

SaskEnergy updated its Pipeline Integrity Management Program to include rationale for the frequency of its transmission pipeline inspection activities it did not previously document (i.e., block valves, depth of cover, leak surveys).

The Program's purpose is to maintain the safety and reliability of natural gas pipelines and other materials forming part of the transmission pipelines (e.g., block valves), to manage risks, and to keep employees, the public, and the environment safe.[4] The Program describes a series of inspection activities designed to detect pipeline defects such as corrosion and cracking.

In spring 2020, SaskEnergy staff updated the Program to document rationale for frequency of block valve inspections, leak surveys, and depth of cover inspections, which were not documented during our original audit in 2020. See **Figure 1** for a description of these three inspections and planned frequency for each.

[4] SaskEnergy, *Pipeline Integrity Management Program*.

Figure 1—Major Transmission Pipeline Inspection Activities and Planned Frequency

Activity	Description	Planned Inspection Frequency
Block Valve Inspections	Looks for corrosion, cracking, leaks, and damage of block valves (areas that cannot be inspected by, or may not provide accurate results, through an in-line inspection) Block valves are used to stop the flow of natural gas through a pipe (about 400 valves in the transmission pipeline system)	Inspect approximately 20 of 400 block valves each year (i.e., all block valves inspected over a 20-year period) Prioritizes inspections based on the combined risk of the pipeline the block valve is designed to control
Depth of Cover Surveys	Assesses the depth of the ground soil covering the pipeline to ensure it is sufficient	Completed depth of cover surveys of all non-class 1 pipelines in 2021 (see **Section 4.0** for class information) Ongoing monitoring for depth of cover through other inspection activities (e.g., geo-hazard inspections) for high-risk areas
Leak Surveys	Identifies dead spots in vegetation along the pipelines and senses gas (technology varies on survey type) indicating a pipeline is leaking natural gas	Conduct an aerial leak survey on the entire transmission pipeline system annually Conduct ground leak surveys on class 2 and 3 locations annually (see **Section 4.0** for class information) Conduct ground leak survey on the entire transmission system on a four-year cycle

Source: Adapted from various SaskEnergy documents and records.

SaskEnergy established the frequency of these inspections based on its staff's (e.g., pipeline operators) professional judgment and understanding of current industry practices.[5] SaskEnergy outlined rationale for inspection frequency based on risks related to different types of pipeline defects (e.g., corrosion, cracking and dents), as well as risks related to external interference or the environment surrounding the pipeline (e.g., ground movement).

We found SaskEnergy completed depth of cover and leak survey inspections as planned, but only completed a portion of expected block valve inspections due to budget constraints for the period of October 2020 to November 2021 (i.e., completed five inspections compared to 11 planned). SaskEnergy plans to catch up on the remaining current year's block valve inspections in 2022–23.

Having documented rationale for the planned frequency of all types of inspection activities aids SaskEnergy in ensuring its plans adequately address pipeline integrity risks.

3.2 Timely Inclusion of Completed Inspection Results and Repairs in IT Systems

We recommended SaskEnergy Incorporated implement timeframes for including the results of inspections of transmission pipelines into its risk-modelling IT system. (*2020 Report – Volume 1*, p. 148, Recommendation 2; Crown and Central Agencies Committee agreement August 23, 2021)

Status—Implemented

[5] Canadian Standards Association (CSA) Z662 is a standard governing oil and gas pipeline systems. CSA Z662-19 generally expects pipeline operators to use professional judgment to set the timing and frequency of inspection activities.

We recommended SaskEnergy Incorporated include the results of key inspection activities and repairs done during the year in its pipeline data storage IT system within specified timelines. (*2020 Report – Volume 1*, p. 148, Recommendation 3; Crown and Central Agencies Committee agreement August 23, 2021)

Status—Implemented

SaskEnergy developed a mechanism to include inspection results and repair activities within its IT systems in a timely manner.

In-line inspections are a primary inspection activity to gather information about the structure and integrity of transmission pipelines.[6] Inspection results provide current information about pipeline condition and timely entry into IT systems support reliable assessments of pipeline condition and effective decision-making. SaskEnergy uses contractors to conduct in-line inspections.

SaskEnergy developed a tracking tool (i.e., spreadsheet) to monitor when it receives in-line inspection reports from contractors, reviews reports, conducts assessments, and approves them. The tool also tracks when staff enter inspection results and SaskEnergy's risk assessments into its IT system.

SaskEnergy uses the timeframes contractors include in their requests for proposals (e.g., 35 days for magnetic flux leakage in-line inspections) to guide when contractors are to submit final inspection reports. SaskEnergy tracks expected and actual report submission times.

SaskEnergy also developed reasonable timeframes for its staff's internal review of inspection results and tracks whether it meets its deadlines. For example, SaskEnergy aims to complete its review of an inspection report within 15 days of final report receipt, and conduct risk assessment and update its risk-modelling IT system within 25 days following its review of the report.

For the period of October 2020–November 2021, contractors sent SaskEnergy 18 final reports averaging 41 days from the date of completed inspection (e.g., ranging from 26 to 64 days). On average, SaskEnergy assigned risk ratings and entered this information into the risk-modelling IT system within 10 days of reports being reviewed (e.g., ranging from three to 15 days).

We tested three in-line inspection reports and found SaskEnergy followed its established process for review, assessment, and approval of in-line inspections, including documenting when each step was performed and by whom. SaskEnergy entered risk assessments based on these three inspection reports into its risk-modelling IT system within 15 days of its review of the reports.

Having final inspection results about the most recent pipeline condition in its risk-modelling IT system supports more reliable assessments of pipeline integrity. Reliable assessments of pipeline integrity in turn support the development of appropriate inspection plans and reduces the risk of pipeline failures.

[6] In-line inspections provide non-destructing examination of the pipeline performed by equipment that can travel internally along a pipeline of six inches in diameter or greater. SaskEnergy uses several different in-line inspection tools; each tool has a different purpose (e.g., to find corrosion, stress corrosion, cracking, dents, seam defects, or to map the pipeline).

In addition, we found SaskEnergy improved its process to enter results of other inspection and repair activities (e.g., block valve inspections) into appropriate IT systems. SaskEnergy continues to have a target of entering all inspection activities by the end of fiscal year to support the development of its upcoming annual inspection plan. We tested two in-line inspections, one block valve inspection and one pipeline repair and found SaskEnergy entered each of the activities into appropriate IT systems within two months of completion—this aligns with good practice.

By December 31, 2021, SaskEnergy had not yet entered the results from depth of cover inspections into its IT system, but planned to do so by March 31, 2022. This timing does not impact future SaskEnergy inspection plans. Management indicated they plan to assess, in 2022–23, the need for completing future depth of cover inspections given the positive inspection results and the fact that other routine inspection activities will monitor depth of cover (as described in **Figure 1**).

Having up-to-date data in IT systems that reflect current, reliable assessments of pipeline condition better support decisions about future inspection plans and repairs.

4.0 TRANSMISSION PIPELINE BY CLASS

SaskEnergy classifies its transmission pipelines based on the CSA Z662 standard requirements using population density in a specified geographical area.

Figure 2—SaskEnergy's Transmission Pipeline by Class

Class	Description	Number of Kilometers	% of Total Kilometers
1	10 or less residences	14,880	99.2%
2	11–45 residences, a building or outside area with 20 or more people during normal use (e.g., playground or recreation area), and/or an industry such as a chemical plant	92	0.6%
3	46 or more residences	30	0.2%
4	Mostly apartments and condominiums with four or more stories	0	0.0%
	Total	**15,002**	**100%**

Source: Adapted from www.rds.oeb.ca/CMWebDrawer/Record/682652/File/document (5 January 2022) and SaskEnergy records.

Chapter 25
SaskPower—Maintaining Above-Ground Assets Used to Distribute Electricity

1.0 Main Points

Both industry and households rely on the availability of power by way of electricity. Power helps us communicate, heat our homes, cook our food, and enjoy technology; it is also critical to economic growth and security.

SaskPower maintains one of the largest electricity distribution systems in Canada.[1] Effective maintenance reduces the risk of unplanned power outages or power blackouts during peak times and higher costs of supplying power, so customers have a safe, reliable source of electricity.

By March 2022, we found SaskPower made good progress by implementing five of seven recommendations we first made in 2018 about its processes to maintain above-ground distribution assets.

SaskPower is implementing a broader strategy for managing its distribution assets to focus on an asset's lifecycle from purchase to decommission. Adopting this strategy resulted in changes in many areas, including changing how employees complete maintenance work and how senior management makes key maintenance decisions. SaskPower formally assessed risks to support its strategies for inspections and preventative maintenance; determined and gathered condition and other information about above-ground distribution assets; and formally prioritized maintenance to support a risk-informed allocation of resources over the longer term.

While we found SaskPower made significant progress in its processes to analyze and report on maintenance status for above-ground distribution assets, it needs to formally determine the consequences of deferring corrective maintenance.

SaskPower's regular quarterly reports to senior management also need to include all planned maintenance activities and the consequences of not completing planned preventative and corrective maintenance. Senior management needs robust reports to effectively assess whether the right maintenance is being done at the right time to help reduce the risk of power outages and safety issues, and manage costs.

2.0 Introduction

SaskPower is the principal supplier of electricity in Saskatchewan, under the mandate and authority of *The Power Corporation Act*. Each year, it generates, transmits, and distributes power to nearly 545,000 customers over approximately 652,000 square kilometres.[2]

[1] SaskPower, *2022 and 2023 Rate Application*, p. 15.
[2] SaskPower, *SaskPower 2020–21 Annual Report*, pp. 3 and 11.

SaskPower is responsible for the maintenance and capital replacement/refurbishment of assets used to distribute electricity—both above ground and below. SaskPower planned to spend about $14 million on maintenance and $157 million on capital replacement/refurbishment in 2021–22 for approximately $2.8 billion of distribution assets.[3,4] It must spread these costs across a modest number of customers (i.e., average of three customer accounts per circuit kilometre).[5,6]

Figure 1 describes the above-ground assets used to distribute electricity included in our follow-up audit.[7]

Figure 1—Description of Above-Ground Distribution Assets Included in Follow-Up Audit

Asset Type	Purpose
Voltage Regulator	• Continually adjusts (raises or lowers) the voltage on the distribution system to ensure customers receive power within acceptable limits
Recloser	• Automatically isolates the distribution system to protect the public and prevent irreparable damage to assets from a sustained short circuit • Improves service continuity by automatically isolating and restoring power to power lines during momentary interruptions, such as from lightning or wildlife contacts
Overhead Switch	• Enables isolation of a power-line section, resulting in fewer customers affected when an outage is required for scheduled maintenance or repairs; allows customers to be serviced from different feeders during a power outage so electricity can be restored while repairs are ongoing
Capacitor Bank	• Stores electrical energy to help tune and optimize the operation of the distribution network, thereby deferring the need and expense of additional capacity on the electrical delivery system
Poletop Transformer	• Transforms higher voltages from distribution power lines down to a useable voltage that end users can utilize; provided as close to customers' sites as possible to avoid energy losses amplified at lower voltages
Power-Line Conductor	• Electrical wires and associated hardware that transmit electrical energy along long distances; consists of one or more conductors (i.e., physical wire) suspended by towers or poles, often in groups of three.

Source: Developed by the Provincial Auditor of Saskatchewan based on research, and SaskPower's records.

Planning for and completing required maintenance is essential for providing customers with a reliable source of power in a safe and cost-effective way.

2.1 Focus of Follow-Up Audit

This chapter describes our first follow-up audit of management's actions on the seven recommendations we made in our *2018 Report – Volume 2*, Chapter 25, about maintaining above-ground assets used to distribute electricity.[8]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate SaskPower's progress toward meeting our recommendations, we used the relevant criteria

[3] SaskPower, *SaskPower 2020–21 Annual Report*, p. 81.
[4] SaskPower's financial records.
[5] SaskPower, *SaskPower 2020–21 Annual Report*, p. 13.
[6] By comparison, Manitoba Hydro has seven customer accounts per circuit kilometre and Enmax in Alberta has 80 customer accounts per circuit kilometre. SaskPower, *2022 and 2023 Rate Application*, p. 15.
[7] Wood poles were excluded from this follow-up audit as we did not find significant gaps in SaskPower's processes related to this type of asset in our original audit.
[8] *2018 Report – Volume 2*, Chapter 25, pp. 169–189.

from the original audit. SaskPower's management agreed with the criteria in the original audit.

To conduct this follow-up audit, we discussed actions taken with management, examined supporting documents (e.g., asset-management risk framework, lifecycle asset management plans, maintenance plans, reports to senior management), and assessed data analysis completed by SaskPower about its asset inventory and inspections.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Crown and Central Agencies agreed to the recommendation, the status of the recommendation at March 4, 2022, and SaskPower's actions up to that date.

3.1 Risks Formally Assessed

> ***We recommended Saskatchewan Power Corporation formally assess the risks associated with its inspection and preventative maintenance strategies for above-ground assets used to distribute electricity.*** *(2018 Report – Volume 2,* p. 177, Recommendation 1; Standing Committee on Crown and Central Agencies agreement September 17, 2019)
>
> **Status**—Implemented

SaskPower developed and used an asset-management risk framework to formally assess the risks associated with its inspection and preventative maintenance strategies for above-ground assets used to distribute electricity.

In 2019, SaskPower developed its *Distribution Line Asset Management—Risk Framework* based on industry good practice identified through SaskPower's participation in an international power utility working group (i.e., CEATI: Centre for Energy Advancement through Technological Innovation). The Framework sets out a process for assessing the likelihood and impact of risk for each type of above-ground distribution asset. SaskPower assesses impact based on its key business values such as: company disruption, public safety, employee safety, financial return and benefits, asset risk, environmental stewardship, and security. SaskPower also uses an industry standard to quantify impacts based on actual outage data as well as customer type and power usage profiles. SaskPower's engineers use their judgment and knowledge to develop a risk matrix to determine the prioritization of each asset type.

We found SaskPower used its Framework to assess risk for each of the above-ground distribution asset types, and used the resulting risk assessment to determine asset maintenance priorities. SaskPower also used the risk assessment to support the frequency of preventative maintenance, including inspections. For example, SaskPower considers reclosers as higher risk and requires annual preventative maintenance (including inspections, repairing contacts, and replacing backup batteries). Whereas it considers overhead power-line conductors lower risk that do not require preventative maintenance.

Formal risk assessments to support preventative maintenance help ensure SaskPower completes the right maintenance at the right time to limit asset failure and safety issues, and effectively use maintenance resources.

3.2 Expected Asset Condition Documented

We recommended, for above-ground assets used to distribute electricity that Saskatchewan Power Corporation plans to maintain, it determine the condition to which it expects to maintain each type of those assets. *(2018 Report – Volume 2,* p. 179, Recommendation 2; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Implemented

SaskPower determined the condition to which it expects to maintain each type of above-ground asset used to distribute electricity.

In 2019, SaskPower developed its *Distribution Line Asset Management—2019/20 Life Cycle Asset Management Plans* for each of the six above-ground distribution asset types outlined in **Figure 1**, along with several other asset types. These plans include an asset health/condition index based on industry good practice (i.e., CEATI) for each asset type that requires maintenance.[9] In addition, the plans document the condition parameters (i.e., the expected asset condition) indicating when corrective action, such as repair or replacement, is required. In 2022, SaskPower expanded these plans to include additional distribution asset types.

Determining the acceptable condition for assets helps to focus maintenance resources on assets with an asset condition index below the optimal level.

3.3 Asset and Condition Data Maintained in IT Systems

We recommended Saskatchewan Power Corporation consistently maintain in its IT systems key information about its above-ground assets used to distribute electricity to support evidence-based decision-making. *(2018 Report – Volume 2,* p. 181, Recommendation 3; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Implemented

We recommended Saskatchewan Power Corporation maintain up-to-date information about the condition of its above-ground assets used to distribute electricity to support risk-informed asset planning. *(2018 Report – Volume 2,* p. 182, Recommendation 4; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Implemented

[9] Asset health indexing is an asset condition assessment technique which uses a grading scale from 0 (very poor condition) to 100 (very good condition) based on probability of asset failure and severity of asset degradation. Source: *SaskPower Distribution Line Asset Management—2019/20 Life Cycle Asset Management Plans*.

SaskPower maintained key information about its above-ground assets used to distribute electricity in its IT systems, including up-to-date condition information.

In 2019, SaskPower developed a plan to improve its data collection processes based on a review of its business processes to determine how it should be planning and completing maintenance, and what IT systems it requires to support that work. As a result of this plan, SaskPower began updating various IT systems in 2019, with some identified changes to improve its IT capabilities still ongoing at March 2022.

Unique Identifier Used For New Assets

To support efficient data collection and analysis, SaskPower created a standard asset tag with a unique identifier that SaskPower's above-ground distribution asset manufacturers attach to all newly purchased assets. As SaskPower replaces assets, all above-ground distribution assets will gradually have these unique identifier asset tags installed.

The manufacturers also provide required information (e.g., asset tag identifier, manufacturer, model, year manufactured, serial number) about each asset so SaskPower can upload it into its IT systems at the time of purchase. SaskPower's employees check this data for completeness and accuracy before they upload the data. A unique identifier enables linking or matching of key information between systems.

Periodic Inspections Used to Obtain Up-to-Date Asset and Condition Information

SaskPower uses periodic inspections to gather data about existing assets, as well as to update information about asset conditions. To increase data quality and efficiency, SaskPower improved its existing digital forms, and also added more digital forms for documenting its maintenance activities.

Employees update information about the assets and document inspection results using digital forms. The forms use drop-down menus to make updating information easier and more consistent to support data analytics. The forms also include built-in checks to help ensure employees document all steps of the inspection. Employees upload the inspection results to the corporate network, where office employees monitor it to ensure timely upload of all inspection data.

While doing inspections, SaskPower employees scan the barcode of newer assets using portable IT devices or input the asset number of older assets to obtain information about them (e.g., manufacturer, age, location, previous inspection results). The employees check that the asset information is accurate and complete, or update this information as needed.

SaskPower uses quarterly reports of inspections to monitor the status of inspection completion. We found the two quarterly reports we tested showed most inspections occurring as planned. **Figure 2** sets out a comparison of 2021–22 planned and actual inspections completed by December 31, 2021.

Figure 2—Inspection Completion at December 31, 2021

Asset Type	2021–22 Annual Inspection Target (%)	Actual Inspections Completed at December 31, 2021 (9 months) (%)[A]
3-Phase Voltage Regulators	95	54
1-Phase Voltage Regulators	95	44
Reclosers	90	69
Overhead Switches	90	80
Capacitor Banks	95	91
Poletop Transformers	N/A – run to fail[B]	
Power-Line Conductor	N/A – run to fail[B]	

Source: Developed by the Provincial Auditor of Saskatchewan based on SaskPower's records.
[A] Inspections do not occur evenly throughout the year.
[B] Run to fail assets do not have routine maintenance completed as it is cheaper to replace them if they fail, and they do not pose significant risk of outage or to public safety.

Asset Data Completeness and Quality Monitored

During 2021, SaskPower prepared reports to monitor completeness and quality of its asset data. For example, management analyzed data to identify whether information was missing for an asset or unacceptable (e.g., location unknown is an invalid response). Employees then obtain or update the data based on inspections.

We found the two reports we examined indicated SaskPower had reasonably complete data for the majority of its above-ground distribution assets. **Figure 3** outlines SaskPower's assessment of its data completeness at December 29, 2021.

Figure 3—Asset Data Completeness at December 29, 2021

Asset Type	Quantity	Data Completeness (%)[A]
Voltage Regulator	1,250	68.2
Recloser	2,972	69.1
Overhead Switch	3,972	66.3
Capacitor Bank	1,140	90.6
Poletop Transformer	117,100	83.2
Power-Line Conductor	89,967 km	98.2

Source: Developed by the Provincial Auditor of Saskatchewan based on SaskPower's records.
[A] SaskPower determines the number of assets with valid data for each attribute (e.g., asset identifier, date manufactured) of each asset type, and applies a weighted average to determine the overall data completeness percentage for each asset type.

SaskPower also updated its processes to reconcile asset data between different IT systems. For example, it reconciled the number of voltage regulators and reclosers between its asset inventory and financial IT systems, and investigated differences to resolve issues. As shown in **Figure 4**, we found significantly fewer differences between these systems at February 2022 compared to our original audit in 2018.

Figure 4—Difference in Number of Regulators and Reclosers in IT Systems at February 2022 and 2018

	February 2022		February 2018	
	Voltage Regulators	Reclosers	Voltage Regulators	Reclosers
Asset System (Electric Office)	1,244	2,978	1,217	2,572
Work Order System (SAP)	1,303	3,004	1,580	4,035
% Difference	4.7%	0.9%	30%	57%

Source: Developed by the Provincial Auditor of Saskatchewan based on information available in SaskPower's IT systems.

Consistently maintaining key information about above-ground distribution assets (such as manufacturer, age, asset condition) within IT systems helps ensure sufficient information is available to support risk-based maintenance planning.

3.4 Maintenance Formally Prioritized

We recommended Saskatchewan Power Corporation formally prioritize its maintenance of above-ground assets used to distribute electricity to support risk-informed allocation of resources over the longer term. *(2018 Report – Volume 2,* p. 183, Recommendation 5; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Implemented

SaskPower formally prioritized maintenance of its above-ground assets used to distribute electricity to support risk-informed allocation of resources over the longer term.

SaskPower created five-year rolling and annual preventative and planned corrective maintenance plans based on risk assessments and available budget. Maintenance deferred from prior years was given a higher priority than new maintenance with a similar priority level.

SaskPower's employees identify corrective maintenance while completing inspections or other work. The employees assess the urgency of these maintenance issues (e.g., public safety or outage risk). If the issue can wait more than six months to be addressed, the employee records that in the inspection form so it can be scheduled as part of the next year's maintenance plan (i.e., planned corrective maintenance). We found SaskPower included planned corrective maintenance in the annual plan based on its prioritization level—**Section 3.5** discusses completion of this maintenance. Planned corrective maintenance for all distribution assets represented about 13% of budgeted costs for all preventative and corrective maintenance for all distribution assets in 2021–22.

If an issue identified during inspection is urgent, the employee requests corrective maintenance occur right away and the manager approves this work (unplanned corrective maintenance). If it is not highly urgent, but requires correction in the near term (less than six months), the employee enters the request into an IT system where the manager schedules the work in the near term (unplanned corrective maintenance). We found reports for the nine-month period ending December 31, 2021 showed SaskPower generally

completed unplanned corrective maintenance (over 70% of unplanned corrective maintenance activities for all distribution assets including above-ground distribution assets), supporting this maintenance was given priority as expected.

Prioritizing maintenance helps to focus maintenance resources on the highest risk assets.

3.5 Consequences of Deferring Corrective Maintenance Not Formally Assessed

We recommended where Saskatchewan Power Corporation does not follow its plan for maintaining above-ground assets used to distribute electricity, it formally assess the consequences of not completing such maintenance. *(2018 Report – Volume 2,* p. 185, Recommendation 6; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Partially Implemented

SaskPower formally assessed the consequences of not completing preventative maintenance for above-ground distribution assets, but did not formally assess the consequences of not completing corrective maintenance for these assets.

SaskPower uses quarterly reports from its inspection IT system to monitor completion of preventative and corrective maintenance work compared to plans.

When SaskPower identifies a change or cancellation is required for preventative maintenance (e.g., inspections, cleaning and oiling an operational asset part), management prepares a Planned Maintenance Change Control Communication Form.[10]

This form documents:

- Maintenance to be deferred or cancelled, and why
- When maintenance will be completed or alternate action taken to manage related risks
- How deferring or cancelling maintenance may impact residual asset risk scores
- What consequences may occur (e.g., public safety risk, outage)

While SaskPower did not have significant changes in 2021–22 to its planned preventive maintenance for above-ground distribution assets, we found it used this process to document consequences of not completing maintenance for other distribution assets (e.g., some padmount switch cleaning for underground distribution assets cancelled due to unavailability of contractors to complete the work along with a replacement strategy used to manage the resulting short-term risk).

At December 31, 2021 (nine months into the fiscal year), SaskPower reported it completed over 70% of unplanned and less than 10% of planned corrective maintenance. SaskPower acknowledged it has not implemented a process to assess the consequences of not

[10] For minor maintenance deferrals (e.g., standing water interfering with ability to complete maintenance tests), SaskPower builds the deferred maintenance into its next annual maintenance planning cycle, and does not require the form to be completed.

completing corrective maintenance. Management indicated it has initiated process development for planned corrective maintenance that it intends to implement in 2022–23, which will include assessing the consequences of not completing corrective maintenance.

Formally determining the consequences of not completing planned corrective maintenance, decreases the risk of failure of distribution assets that can contribute to more and/or longer unplanned power outages and higher costs for repairing or replacing assets.

3.6 Reports to Senior Management Improving

We recommended Saskatchewan Power Corporation regularly report to its senior management on the status of its maintenance activities and, if applicable, the consequences of not completing planned maintenance for above-ground assets used to distribute electricity. *(2018 Report – Volume 2,* p. 187, Recommendation 7; Standing Committee on Crown and Central Agencies agreement September 17, 2019)

Status—Partially Implemented

SaskPower reported quarterly to its senior management on the status of its maintenance activities, but the reports did not include all maintenance activities and did not include the consequences of not completing planned maintenance for above-ground distribution assets.

Although SaskPower does not have a written policy or guidance setting reporting requirements (e.g., to explain differences between planned and actual results, and the related consequences), it reports quarterly to its Operations Executive Advisory Committee about the status of maintenance activities. The reports include, for each asset type and total, comparisons of budgeted to actual costs and planned to actual number of activities (e.g., number of inspections) completed, including percentage of activities completed and budget spent.

However, the reports provided to the Committee did not provide forecasts to year end or written explanations of differences between planned and actual results. Nor did the reports explain the consequences of deferred maintenance (e.g., public safety risks, potential outages, impact on future maintenance or capital asset costs). Management indicated that it provides verbal explanations of differences between planned and actual results discussed at meetings. We found speaking notes contained some information that explained differences, but did not explain consequences of deferring maintenance. Written reports support effective discussion and reference for decision-making.

We found the quarterly reports did not include maintenance activities formally cancelled or deferred. In addition, the reports did not include certain preventative maintenance activities (e.g., rural poletop transformer grounding tests) set out in separate planning documents from the main annual maintenance plan.

We found SaskPower's reporting processes on unplanned corrective maintenance were less mature. SaskPower did not separately budget for unplanned corrective maintenance, so it used the average actual costs from the prior three years as a proxy for the budget. These unplanned corrective maintenance activities were not prioritized using the same

method as preventative and planned corrective maintenance, so SaskPower approximated the prioritization categories. Management advised us it plans to review corrective maintenance processes in 2022–23, which will consider information needed to support better reporting.

Complete reports to senior management explaining differences between planned and actual maintenance completed and about the consequences of not completing expected maintenance for above-ground distribution assets helps senior management to correctly assess whether the right maintenance is being done at the right time to help reduce the risk of power outages and safety issues, and manage costs.

Chapter 26
Social Services—Monitoring Foster Families

1.0 Main Points

At September 2021, the Ministry of Social Services used 488 foster families to provide care for 858 children requiring protection and out-of-home care.

By November 2021, the Ministry improved some of its processes to monitor whether foster families provide a safe and secure environment for children in care. It implemented two of the six recommendations we initially made in 2020.

The Ministry consistently conducted annual home safety checks and obtained annual criminal record self-declarations for newly approved foster families.

However, the Ministry still needs to consistently complete background checks on all adults in a foster home to identify any previous involvement (e.g., history of child abuse, neglect) with the Ministry prior to approving new foster families. For one file we tested, the Ministry did not perform a background check until 11 months after approving the foster family. Not completing the necessary background checks for all adults in a foster home may result in a potential threat to a child's safety when placed in the home.

The Ministry now requires periodic criminal record checks (i.e., every three years) on all adults residing in approved foster homes. However, the Ministry has not yet developed policies and procedures, or an implementation plan for obtaining periodic criminal record checks. These checks reduce the risk the Ministry has incomplete or inaccurate information about criminal charges against members of foster families, which reduces risks to children in foster homes.

The Ministry improved its compliance rate for completing annual review reports of individual foster families since our original audit in 2020. Our testing showed the Ministry had a 90% compliance rate compared to 53% in our original audit.

However, annual review reports are not always completed on time, and supervisory review and formal approval (i.e., signatures) of the reports are considerably late. The Ministry plans to provide additional training on completing annual review reports in 2022–23. Delays in completing annual review reports may result in foster families not receiving timely and necessary training and support, and reduces the Ministry's ability to take timely and appropriate action.

2.0 Introduction

The Ministry of Social Services provides care for children requiring protection and out-of-home care. *The Child and Family Services Act* requires the Ministry of Social Services to investigate reports when there are reasonable grounds to believe a child is in need of protection due to physical, sexual, or emotional abuse, or neglect. Children come into care under the authority of the Act either through voluntary agreement between the Ministry and

the biological parents, or by a court order.[1] The Ministry may place children in out-of-home care with extended family networks or within the child's cultural community, residential group homes, or foster homes.

At September 30, 2021, there were 858 children living in 488 foster homes.[2] Each foster home had, on average, 1.8 children. There were 120 of 488 homes that did not have children in care at that time.[3]

In 2020–21, the Ministry of Social Services provided $31.1 million in support to foster-care families (e.g., monthly payment for basic expenses, special needs care).[4]

The responsibility of the foster family is to provide foster children safe, healthy and nurturing relationships, and a family environment with the goal to provide opportunities for the healing, growth, development, and support of the children so that they may be reunited with their biological family.[5]

The Ministry must ensure children placed in foster homes are well cared for and safe, as well as that foster families receive ongoing support and provide quality services. Effectively monitoring children's safety, and providing needed support to foster families is crucial in contributing to foster children's health and well-being.

2.1 Focus of Follow-Up Audit

This audit assessed the status of six recommendations made in our *2020 Report – Volume 1*, Chapter 12, about the Ministry of Social Services' processes to monitor whether foster families provide a safe and secure environment for children in care. We concluded for the 12-month period ended December 31, 2019, the Ministry had, other than the areas identified in our six recommendations, effective processes.[6]

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Ministry's progress toward meeting our recommendations, we used the relevant criteria from the original audit. Ministry management agreed with the criteria in the original audit.

To complete this follow-up audit, we interviewed key Ministry staff, and examined policies, procedures, and other records relating to monitoring foster families. We also tested a sample of foster families' files.

3.0 Status of Recommendations

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at November 30, 2021, and the Ministry of Social Services' actions up to that date.

[1] Saskatchewan Foster Families Association, *A Guide for Caregivers: Third Edition Handbook*, 2021, p. 7. www.sffa.sk.ca/files/pdfs/SFFA-Handbook-3rd-Edition-2021-09-28.pdf (11 March 2022).
[2] www.saskatchewan.ca/residents/family-and-social-support/putting-children-first (1 December 2021).
[3] Information provided by the Ministry of Social Services.
[4] Ibid.
[5] Saskatchewan Foster Families Association, *A Guide for Caregivers: Third Edition Handbook*, 2021, p. 6.
[6] *2020 Report – Volume 1*, Chapter 12, pp. 155–173.

3.1 Not All Required Background Checks Completed

We recommended the Ministry of Social Services complete all required background checks prior to approving foster families. *(2020 Report – Volume 1,* p. 160, Recommendation 1; Public Accounts Committee agreement March 2, 2022)

Status—Partially Implemented

The Ministry of Social Services does not complete all the required background checks prior to approving new foster families.

Before approving applicants to become foster care providers, the Ministry requires staff to complete two background checks. Staff are responsible for:

- Requesting a criminal record check/vulnerable sector check for each applicant and any other adult 18 years of age or older, including adult children, living in the home
- Conducting a Ministry record check in its case-management IT system to identify any previous involvement (e.g., history of child abuse, neglect) with the Ministry

If any criminal charges or past history concerns arise, the Ministry may deny the fostering application.

The Ministry approved 52 new foster families between September 2020 and August 2021.

We tested five new foster families and found all five files had criminal record checks completed for all adults residing in the homes prior to Ministry approval for fostering.

However, we found staff did not always complete the Ministry record check on all adults residing in the home prior to Ministry approval for fostering. We found:

- In one file, during our initial testing of five foster families, staff completed the Ministry record check 11 months after the Ministry approved the family for fostering. There were no concerns when staff finally completed the Ministry record check.
- In one file, during our testing of an additional five foster families, staff completed the Ministry record check five days after the Ministry approved the family for fostering. There were no concerns when staff completed the Ministry record check.

Not completing the required Ministry record check for all applicants and adult residents in a foster home prior to approving a home may result in a potential threat to a child's safety when placed in the home.

3.2 Periodic Criminal Record Checks Will Be Required

We recommended the Ministry of Social Services require periodic criminal record checks on all adults residing in approved foster homes*. (2020 Report – Volume 1,* p. 164, Recommendation 4; Public Accounts Committee agreement March 2, 2022)

Status—Partially Implemented

The Ministry of Social Services determined all adults in foster homes should provide criminal record checks every three years, but it has not yet formalized the process for doing so.

At the time of our original audit in 2020, the Ministry did not require foster parents and other adults in the foster home to provide it with periodic criminal record checks after its initial approval of the home. This meant some foster homes had been fostering for 29 years since first approved and the Ministry had not obtained an updated criminal record check.[7]

In 2020–21, the Ministry analyzed the criminal record check practices in other Canadian provinces and found many provinces require periodic criminal record checks for foster families. For example, in British Columbia, foster families are required to have criminal record checks done every three years.

Based on the analysis, in October 2021, the Ministry decided to require all adults in foster homes to provide criminal record checks every three years. However, the Ministry has not yet developed policies and procedures for this, or an implementation plan.

Requiring regular criminal record checks decreases the risk of children in foster homes residing in an unsafe environment. It also increases public confidence in the Ministry providing safe and secure environments for children in its care.

3.3 Key Aspects of Foster Family Annual Reviews Completed as Required

We recommended the Ministry of Social Services consistently follow its standard to conduct annual home safety checks at foster homes. *(2020 Report – Volume 1,* p. 163, Recommendation 2; Public Accounts Committee agreement March 2, 2022)

Status—Implemented

We recommended the Ministry of Social Services obtain annual criminal record declarations for all adults residing in approved foster homes. *(2020 Report – Volume 1,* p. 164, Recommendation 3; Public Accounts Committee agreement March 2, 2022)

Status—Implemented

The Ministry of Social Services completes key aspects of foster homes' annual reviews as required.

The Children's Services Manual requires the Ministry to review each foster family at least annually. Part of this review includes performing a home safety check and obtaining criminal record self-declarations regarding any criminal charges or convictions.

[7] *2020 Report – Volume 1*, Chapter 12, p. 164.

Home safety checks confirm a foster home remains safe. Resource workers use a standard home safety checklist to assess:

- Sleeping and bedroom accommodations (e.g., no more than two children should be in a room)
- Fire safety (e.g., properly installed and functioning smoke alarm)
- Firearm and weapon safety (e.g., storage of firearms in accordance with federal legislation)
- Water safety (e.g., supervision of children when they are in, on, or around water, appropriate covering of swimming pools and hot tubs)
- General home safety (e.g., handrails installed where needed, drinkable water available)

The Ministry also relies on foster families and other adults living in the home to self-declare any criminal charges or convictions by signing a criminal record declaration annually.

We found staff completed the annual home safety checklist and obtained the criminal record self-declarations for all 30 foster family files we tested.

Performing home safety checks and obtaining annual criminal record self-declarations for all adults living in a foster home decreases the risk of children living in an unsafe environment and for potentially being mistreated.

3.4 Annual Review Reports Not Completed or Reviewed Timely

We recommended the Ministry of Social Services consistently follow its standard to complete annual review reports of individual foster families.

(2020 Report – Volume 1, p. 165, Recommendation 5; Public Accounts Committee agreement March 2, 2022)

Status—Partially Implemented

The Ministry of Social Services improved its compliance with completing annual review reports of individual foster families. However, annual review reports are not completed timely and supervisory review and formal approval (i.e., signatures) of the reports are considerably late.

The Ministry requires resource workers to complete an annual review of each foster family to assess whether the family still meets the Ministry's requirements for fostering.[8] As part of the review, resource workers assess the foster family's strengths, skills, and/or supports needed according to five competencies: protecting and nurturing children, meeting children's developmental needs, supporting family relationships, connecting children to nurturing relationships intended to last a lifetime, and working as a member of a professional team.

[8] Annual reviews are completed within a calendar year.

The Ministry requires resource workers to complete an annual review report once they complete their assessment, collect all the necessary documentation (e.g., home safety check, criminal record self-declarations), and meet with foster families about the review's results. Management expects the resource worker and supervisor to sign the annual review report within two weeks after it is complete.

We tested 30 foster family files and found:

- Four foster families did not receive a 2020 annual review report even though supporting documentation (e.g., home safety check) was gathered. At time of testing (September 2021), the 2021 annual review report had not yet been completed either.[9] Therefore, these foster families fostered children for almost two years without the Ministry formally assessing whether the family still meets its requirements for fostering.

- Twenty-six foster families received an annual review report in 2020 or 2021.

Based on our testing, we found the Ministry significantly improved its compliance rate for completing annual review reports since our original audit in 2020. Our testing showed the Ministry had a 90% compliance rate compared to 53% in our original audit. It also showed the Ministry exceeded its 85% compliance rate goal.

However, we found that resource workers do not always complete annual review reports timely. Out of 26 completed annual review reports, 10 were done between 3–30 weeks after meeting with foster families and receiving supporting documentation.

In addition, supervisors did not always sign the annual review reports within two weeks after the reports were complete as expected. We found 12 out of 26, or 46%, of completed annual review reports were signed more than three weeks after report completion (ranging from 3–49 weeks late) or not at all (two annual review reports). Management indicated reasons for delays in completing and signing annual review reports related to workers needing extra time to edit the reports after initial supervisory review, staff working from home, staff turnover, and vacations.

Lack of timely supervisory review and approval (i.e., supervisory signature) of annual foster family reviews, reduces the Ministry's ability to take timely and appropriate action (e.g., to provide training or remove children from a home) in cases when a foster family is no longer suitable for fostering or needs additional support.

Delays in completing annual review reports, which formally assess a foster family's strengths and weaknesses, may result in foster families not receiving timely and necessary training and support to provide quality care to children placed within their homes.

[9] In one case, the Ministry attempted to contact the family multiple times to complete the annual review report. There were no children in care in 2020 or 2021, and the Ministry was working on closing this foster home at November 2021.

3.5 More Training on Conducting Annual Review Reports Needed

We recommended the Ministry of Social Services train staff responsible for monitoring foster families specifically on conducting annual reviews.

(2020 Report – Volume 1, p. 166, Recommendation 6; Public Accounts Committee agreement March 2, 2022)

Status—Partially Implemented

The Ministry of Social Services provided staff with some training related to monitoring foster families, but plans to deliver training more specific to completion of annual reviews and final reports.

In spring 2021, the Ministry delivered online training to resource workers, supervisors, and managers related to monitoring foster families. The training covered such topics as establishing and maintaining relationships with foster families, completing annual reviews, formal reviews if concerns with quality of care identified, and investigations at foster homes. There were 59 staff registered for the training, but only 46 attended.

The Ministry is developing training material for its resource workers with greater emphasis on applying critical thinking and integrated practice strategies during completion of annual reviews.[10] This may help workers complete quality annual review reports and decrease delays in completing and reviewing the reports (see **Section 3.4**). It plans to develop training materials by the end of 2021–22 and provide training to resource workers, supervisors, and managers in 2022–23.

Ongoing training may aid staff to conduct quality annual reviews and prepare reports within required timeframes. It would also help to build capacity for staff to serve as mentors and support for foster families. In addition, training supports compliance with policies and standards, and provides opportunities to share good practices and efficiencies.

[10] Integrated practice strategies is a child welfare casework approach designed to help all key stakeholders involved with a child (e.g., foster parents, parents, extended family, child welfare workers, supervisors, and managers) to keep a clear focus on assessing and enhancing child safety at all points in the case process.

Chapter 27
St. Paul's Roman Catholic Separate School Division No. 20—Adapting Technology for Learning in Elementary Schools

1.0 Main Points

By January 2022, St. Paul's Roman Catholic Separate School Division No. 20 improved its processes to adapt technology for learning in elementary schools. The Division implemented five recommendations, and partially implemented one recommendation we originally made in our 2019 audit.

The Division:

- Collected information from key stakeholders (e.g., teachers, parents) to determine the extent of technology use in the classroom, and plans to continue to collect information on future technology integration periodically through its technology refresh process. It also shared its mission and belief statements for technology integration with key stakeholders, and provided guidance and resources to support these statements.

  Knowing both the current level of technology integration in the classroom, and determining the desired level of integration helps the Division determine how much effort it needs to make in supporting and encouraging teachers to use technology in classroom instruction. It also helps the Division assess whether its current efforts are helping teachers use technology in meaningful ways.

- Completed a cost-benefit analysis for student devices, and provided a listing to schools going through the technology refresh process showing which devices are most suited for education, at the best cost.

  Periodically performing cost-benefit analysis helps ensure the Division uses resources efficiently.

- Improved its technology refresh process to link purchasing decisions to its Educational Technology Handbook, considered current technology in use, and collected insights from school staff.

The Division is working toward periodically verifying the existence and location of its educational IT assets. This includes a comprehensive IT asset count at all schools in 2022, and counting IT assets at certain schools every four years during their technology refresh process.

Technology serves as a significant aspect of modern education. Having strong processes to support and encourage its use in classroom instruction helps students develop essential competencies to succeed.

2.0 INTRODUCTION

2.1 Background

The Education Act, 1995, assigns Boards of Education (school boards) responsibility for administration and management of schools, with oversight from the Ministry of Education.[1] The Act makes school boards responsible for exercising general supervision and control over the schools in the school division. School boards approve administrative procedures pertaining to the internal organization, management, and supervision of schools.

St. Paul's Roman Catholic Separate School Division No. 20 (with 43 elementary schools located in Saskatoon, Martensville, Warman, Humboldt, and Biggar) recognizes that technology is a significant aspect of modern education. Its educational technology mission is to be a faith-based community adapting technology to enrich learning and promote excellence in education.[2]

Each year, the Division spends about $480,000 on student technology devices used in schools (i.e., devices like computers, iPads, tablets for student use).[3] As shown, in **Figure 1**, at January 2022, it supplied schools with a variety of devices for student use.

Figure 1—Number of Division's Technology Devices by Type at January 2022

Device Type	Device Quantity
Classroom iPads	3,641
Laptops	3,391
Chromebooks	2,989
Computers	1,653
Smartboards	639
Tablets	30
3D Printers	9

Source: Based on data provided by St. Paul's Roman Catholic Separate School Division.

2.2 Focus of Follow-Up Audit

This chapter describes our follow-up audit of management's actions on the recommendations we made in 2019.

In 2019, we assessed St. Paul's Roman Catholic Separate School Division No. 20's processes to adapt technology for learning in elementary schools. Our *2019 Report – Volume 2*, Chapter 25, concluded that for the 16-month period ended June 30, 2019, St. Paul's Roman Catholic Separate School Division No. 20 had, except for the areas of our recommendations, effective processes to adapt technology for learning in elementary schools.[4] We made six recommendations.

[1] *The Education Act, 1995*, s. 85(1).
[2] Greater Saskatoon Catholic Schools *2021/22 Learning Services Educational Technology Plan*.
[3] This cost figure does not include costs of internet, agreements with Microsoft, software, parts needed to fix devices, or human resources.
[4] *2019 Report – Volume 2*, Chapter 25, pp. 223–236.

To conduct this audit engagement, we followed the standards for assurance engagements published in the *CPA Canada Handbook—Assurance* (CSAE 3001). To evaluate the Division's progress toward meeting our recommendations, we used the relevant criteria from the original audit. The Division's management agreed with the criteria in the original audit.

To perform our follow-up audit, we discussed actions taken with Division staff and reviewed key documents, such as the *Educational Technology Plan* and *Educational Technology Handbook*, surveys conducted by the Division, and documentation supporting purchases of new devices. We tested a sample of schools that received refreshed technology during the year to assess the operating effectiveness of the Division's processes.

3.0 STATUS OF RECOMMENDATIONS

This section sets out each recommendation including the date on which the Standing Committee on Public Accounts agreed to the recommendation, the status of the recommendation at January 31, 2022, and St. Paul's Roman Catholic Separate School Division's actions up to that date.

3.1 Current State of Technology Use in Classrooms Determined

> ***We recommended St. Paul's Roman Catholic Separate School Division No. 20 periodically determine the extent it has integrated technology use into its elementary school classroom instruction.*** *(2019 Report – Volume 2*, p. 231, Recommendation 1; Public Accounts Committee agreement January 12, 2022)
>
> **Status**—Implemented

St. Paul's Roman Catholic Separate School Division No. 20 developed a process to periodically collect information from key stakeholders (e.g., school staff, parents) to determine the extent of technology use in classrooms.

In June 2020, the Division surveyed school staff on technology in education. We found teachers at the schools we tested completed the survey. The Division received 655 responses to the survey. Key topics in the staff survey related to integration of technology in learning, availability of supports, and student engagement in the online environment.

The Division also surveyed parents/students in June 2020. The parent survey focused on their experience with online learning during the COVID-19 pandemic. Approximately 75% of survey responses showed a positive experience with online learning.

Going forward, the Division plans to survey teachers at the schools due for a technology update (rotationally every four years), to help inform planning and purchasing decisions for new technology at those schools. As a result, the Division will survey and provide new technology to approximately 13 schools each year.

By completing a comprehensive survey in 2020, and periodically surveying school staff going forward, the Division will remain informed of the extent of technology use and future needs in elementary school classroom instruction.

3.2 Supporting Technology Use in Classrooms

We recommended St. Paul's Roman Catholic Separate School Division No. 20 determine the extent it wants to integrate technology use in its elementary schools' classroom instruction and by when. *(2019 Report – Volume 2*, p. 231, Recommendation 2; Public Accounts Committee agreement January 12, 2022)

Status—Intent of Recommendation Implemented

Due to the COVID-19 pandemic shifting education to an online learning environment, St. Paul's Roman Catholic Separate School Division No. 20 needed to increase the integration of technology into its elementary schools' classroom instruction since March 2020. It did this by creating and sharing guidance with staff outlining how to effectively instruct students virtually. The Division also developed a new technology-sharing program that supports teachers in integrating technology in classrooms. Also, in its *2021–22 Education Technology Handbook*, the Division states it wants increased access to technology resources for students.

In March 2020, the Division needed to move to an online learning model because of the pandemic. As a result, Division staff had to quickly adopt technology integration into their classroom instruction within a short timeframe. The Division's Educational Technology team created and distributed two guidelines, one for online learning and one for blended learning, to help staff manage this change.[5,6]

These guidelines outlined the need for teachers to create an environment for learning, how to ensure teachers still followed the curriculum, and outlined how teachers should assess (i.e., grade) students. We found these documents also addressed the use of technology, as they required teachers to provide online tools to students not only to support learning, but also to allow students to share, present and publish their learning.

In order for Division staff to effectively provide online instruction to students, the Division had to ensure teachers knew how to operate the available technology. The Division did this by creating an online resource centre for teachers to access training and instructional videos on how to use available technology (e.g., YouTube tutorials). We found the Division appropriately tracked how many users (i.e., staff) accessed the information on its online resource centre. The Division's YouTube tutorials received over 70,000 views and its teacher resource centre had over 1,700 viewers since March 2020.

During the 2021–22 school year, the Division also deployed a new program (ConnectEd), which gave teachers access to technology for use in classroom learning. The program allows teachers to sign up for one, six-week block of time where a technology cart (i.e., a portable cart that contains iPads or Chromebooks) is available for the teacher's use in lessons that involve technology. It purchased six technology carts for distribution throughout the Division; the Division moves carts between schools.

[5] The Division defines online learning as a school-based, formal education where the learning group is separated, and where interactive systems are used to connect learners, resources and instructors.
[6] The Division defines blended learning as at least in part through online learning, with some element of student control over time, place, path and/or pace; at least in part in a supervised bricks-and-mortar location (i.e., school) away from home.

We found the Division issued a survey to teachers asking what their preferred devices were (i.e., tablets, laptops), which weeks the teacher wanted access to the cart, what the teacher intended to use the technology for in the classroom, and what support the teacher required to operate the technology. The Division noted it has seen a positive response to this program and that teacher demand for ConnectEd exceeded their available supply of resources.

Determining the current state of technology use in schools means the Division can reasonably assess whether its current actions are sufficient and appropriate.

> ***We recommended St. Paul's Roman Catholic Separate School Division No. 20 communicate its future vision of integrating technology in the classroom to its teachers.*** *(2019 Report – Volume 2*, p. 232, Recommendation 3; Public Accounts Committee agreement January 12, 2022)
>
> **Status**—Implemented

St. Paul's Roman Catholic Separate School Division No. 20 developed mission and belief statements related to how it wants to integrate technology use in its elementary schools' classroom instruction and communicated these to staff in its *2021–22 Education Technology Handbook*.

The Division set five belief statements in its Technology Handbook. Its belief statements are:

- Technology is an integral part of education
- All stakeholders are invited to have a voice
- Students and teachers work to achieve curricular outcomes by adapting technology
- Professional development opportunities for teachers/staff are critical for the effective integration of technology[7]
- Technology must be student-centered and used to empower students by developing skills to meet their diverse needs as global and digital citizens[8]

We compared the Division's key actions to integrate technology in the classroom (e.g., surveying teachers on planned technology use, establishing guidelines for online learning) to the belief statements. We found the Division took appropriate action to address each one of its belief statements.

Establishing and communicating a clear vision helps engage teachers in meaningful use of technology in classrooms.

[7] The Division offered Division-wide professional development on such topics as how to make the most of iPad use and how to perform student assessments using its online assessment system, and also provided professional development (e.g., Tech on Tap) after school.
[8] Greater Saskatoon Catholic Schools *2021/22 Education Technology Handbook*, p. 1.

3.3 Existence of Devices Not Periodically Confirmed

We recommended St. Paul's Roman Catholic Separate School Division No. 20 periodically verify the existence and location of educational technology devices available in its elementary schools. *(2019 Report – Volume 2*, p. 233, Recommendation 4; Public Accounts Committee agreement January 12, 2022)

Status—Partially Implemented

By January 2022, St. Paul's Roman Catholic Separate School Division No. 20 developed a process to verify the existence and location of educational technology devices, but had not yet implemented it.

The Division identified its prior IT system used to track educational technology devices' locations was outdated and needed replacement. In 2021, the Division found a replacement IT system to track these devices. As the Division purchases new educational technology devices, Division staff enter these devices' details into its new IT system. See **Figure 1** for number of technology devices at January 2022.

The Division updates educational technology devices provided to schools on a four-year rotational cycle.[9] Every four years, it allocates a budget to each school to buy some new technology devices for classroom use. We found the Division developed a listing of all schools, and assigned each school a year in which their technology update will occur.

In addition, the Division scheduled all schools to have their educational technology devices counted (i.e., asset counts). It planned to conduct these initial asset counts between January and May 2022. However, the Division delayed these counts because of COVID-19 restrictions.

It is important to periodically verify the accuracy of the listing of devices to decrease the risk of not detecting missing devices, or not knowing the location of devices. This could result in devices being unavailable for teachers and students to use in the classroom.

3.4 Cost-Benefit Analysis Conducted for Purchases

We recommended St. Paul's Roman Catholic Separate School Division No. 20 periodically assess the cost-benefit of its decision for using differing device brands and IT platforms for classroom use in its elementary schools. *(2019 Report – Volume 2*, p. 234, Recommendation 5; Public Accounts Committee agreement January 12, 2022)

Status—Implemented

St. Paul's Roman Catholic Separate School Division No. 20 analyzed the cost versus benefit for its decisions to purchase and support different brands and IT platforms for its elementary schools.[10] The Division initiated research in this area in late 2019 and finalized its analysis in January 2022.

[9] Some schools also receive technology donations or have the ability to use in-school funds to purchase additional technology for the school (e.g., through their school community councils)—this varies from school-to-school.
[10] An IT platform is software (operating system) on which to run software applications.

The Division performed an assessment to determine whether it could reduce the number of brands it allowed schools to purchase. Based on the responses to surveys issued to teachers (see **Section 3.1**) the Division noted technology use activities could be grouped into three categories:

- **Consumption**: devices used for internet research purposes
- **Creativity**: devices used for artistic purposes (e.g., editing photography, video production, animation)
- **Content specific**: devices used for technical learning (e.g., computer programming, robotics)

The Division created a standard listing of one or two devices determined to be most suitable for each technology use activity. The Division allocated $400,000 for 2021–22 (2020–21: $360,000) for new student devices as part of the refresh process.

Periodically and formally analyzing the cost-benefit of its decisions to both purchase and support multiple brands of devices using different platforms allows the Division to use its limited resources efficiently. As a result, the Division can reduce the risk of paying more for devices and decrease technology support costs.

3.5 Technology Usage Information Collected to Support Purchasing Decisions

> ***We recommended St. Paul's Roman Catholic Separate School Division No. 20 better link technology purchasing decisions to its Educational Technology Plan (or equivalent documents).*** *(2019 Report – Volume 2*, p. 236, Recommendation 6; Public Accounts Committee agreement January 12, 2022)
>
> **Status**—Implemented

St. Paul's Roman Catholic Separate School Division No. 20 linked purchasing decisions to its Educational Technology Handbook. The Handbook contains the Technology Integration Matrix, which is a tool to help teachers examine their level of technology integration into the curriculum to support quality student instruction, which the Division incorporated in the technology refresh survey in fall 2020.

As noted in **Section 3.3**, every four years the Division updates educational technology devices provided to schools. The Division's process to update these devices includes:

- Update current device inventory listings for hardware (computers, laptops, Chromebooks, iPads) considering the age and current performance of the devices
- Survey staff at affected schools to understand current practices, goals and determine future technology needs
- Educational Technology Team works with the school to select devices and order them by making purchases through tendering processes[11]

[11] Greater Saskatoon Catholic Schools *Technology Refresh Process*.

The survey sent to teachers during the technology update process, starting in fall 2020, provides the Division with insight into where the teacher is now, where the teacher wants to go, and how the Educational Technology Team can support the teacher going forward. It also appropriately includes a direct link to the Division's Technology Integration Matrix (see **Section 4.0**). It asks teachers to consider where they currently are on the Technology Integration Matrix in relation to the learning environment, curriculum, student assessments, and teacher instruction.

For the two schools we tested going through the technology update process, we found the Division documented consultation with the school, received survey results, reviewed existing technology, and ordered devices that aligned with the school's identified needs. For the schools tested, teachers also provided their self-assessment of where they were on the Technology Integration Matrix.

Effectively using assessment information from schools when purchasing technology provides the Division with valuable information about where schools are at in technology integration and helps support purchasing decisions.

4.0 DIVISION TECHNOLOGY INTEGRATION MATRIX

	Entry	Adoption	Adaptation	Infusion	Transformation
Environment	Students primarily work alone in highly structured activities using technology. 21st Century Skills are not explicitly taught.	Students are allowed the opportunities to utilize collaborative tools in conventional ways. Digital citizenship is encouraged.	Students have opportunities to choose or modify the technology-related tools most appropriate to facilitate and enhance collaborative work.	Students select technology tools to facilitate and enhance collaboration in all aspects of their learning while modeling 21st Century Skills and Digital Citizenship.	Students work seamlessly through projects fully aware of 21st Century Skills and Digital Citizenship using any appropriate technologies available.
Curriculum	Technology used to deliver information to students.	Students begin to choose technology tools based on curricular outcomes that they know.	Students have opportunities to choose and manipulate technology tools to assist them in their understanding based on their progress towards curricular outcomes.	Students focus on learning tasks, and purposefully combine technology tools to design desired outcomes based on their own ideas.	Students use technology to construct, share, and publish new knowledge to an appropriate audience.
Assessment	Students receive directions, guidance, and feedback from technology, rather than using technology tools to set goals, plan activities, monitor progress and evaluate results.	From time to time, students have the opportunity to use technology to either plan, monitor, or evaluate an activity.	Students have opportunities to select and modify the use of technology tools to facilitate goal-setting, planning, monitoring, and/or evaluating specific activities.	Students use technology tools to set goals, plan activities, monitor progress, redo work based on self, peer and teacher feedback and evaluate results based on their understanding of the curricular outcomes.	Students are taught to think about their thinking and their learning (metacognition) supported by technology tools.
Instruction	Students use technology in substitution of other tools to complete assigned activities that are generally unrelated to real world problems.	Students are allowed opportunities to employ technology tools to connect content-specific activities that are based on real-world problems.	Students have opportunities to select and utilize the appropriate technology tools and digital resources to solve problems based on real world problems.	Students select appropriate technology tools to complete authentic tasks across disciplines.	Students participate in meaningful projects that require problem solving strategies, and facilitate global awareness, through the utilization of technology tools.

Source: Adapted from Greater Saskatoon Catholic Schools 2021-2022 Education Technology Handbook.

Appendix 1
Agencies Subject to Examination under *The Provincial Auditor Act* and Status of Audits

The Office of the Provincial Auditor's goal is to give the Legislative Assembly timely Reports on the results of our examinations. We do not delay our Reports to accommodate incomplete audits, but rather include the results in a future Report. We also aim to report the results of our annual integrated audits of agencies with December fiscal year-ends in the spring (i.e., Report – Volume 1) and agencies with March fiscal year-ends in the fall (i.e., Report – Volume 2). We report the results of our follow-up and performance audits in the Report following their completion.

The table below lists the agencies subject to examination under *The Provincial Auditor Act* at December 31, 2021, along with their fiscal year-end. Agencies subject to our examination include ministries, Crown agencies, Crown-controlled corporations, special purpose and trust funds, other agencies that administer public money, and offices of the Legislative Assembly.

For each of these agencies, the table sets out the status of our annual integrated audits at May 4, 2022 It also indicates whether we are reporting, or have reported, matters for the Assembly's attention within the last 12 months, and if so, it identifies the relevant Report.

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Government of Saskatchewan—Summary Financial Statements	March 31	Complete	Yes/2022 V1
Ministries and Secretariats:			
Ministry of Advanced Education	March 31	Complete	Yes/2021 V2
Ministry of Agriculture	March 31	Complete	No
Ministry of Corrections, Policing, and Public Safety	March 31	Complete	Yes/2021 V2
Ministry of Education	March 31	Complete	Yes/2021 V2 & 2022 V1
Ministry of Energy and Resources	March 31	Complete	Yes/2021 V2 & 2022 V1
Ministry of Environment	March 31	Complete	Yes/2022 V1
Ministry of Finance	March 31	Complete	Yes/2021 V2
Ministry of Government Relations	March 31	Complete	Yes/2021 V2
Ministry of Health	March 31	Complete	Yes/2021 V2 & 2022 V1
Ministry of Highways	March 31	Complete	Yes/2021 V2
Ministry of Immigration and Career Training	March 31	Complete	Yes/2021 V2
Ministry of Justice and Attorney General	March 31	Complete	Yes/2021 V2
Ministry of Labour Relations and Workplace Safety	March 31	Complete	No
Ministry of Parks, Culture and Sport	March 31	Complete	No
Ministry of SaskBuilds and Procurement	March 31	Complete	No
Ministry of Social Services	March 31	Complete	Yes/2021 V2 & 2022 V1
Ministry of Trade and Export Development	March 31	Complete	No
Executive Council	March 31	Complete	Yes/2021 V2

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Firearms Secretariat	March 31	Note 4	
Public Service Commission	March 31	Complete	Yes/2022 V1
Crown Agencies:			
Agricultural Credit Corporation of Saskatchewan	March 31	Complete	No
All Nations' Healing Hospital Inc.	March 31	Complete	Yes/2021 V2
Bethany Pioneer Village Inc.	March 31	Complete	No
Border-Line Housing Company (1975) Inc.	March 31	Complete	No
Carlton Trail College	June 30	Complete	No
Century Plaza Condominium Corporation	March 31	Complete	No
Chinook School Division No. 211	August 31	Complete	No
Christ the Teacher Roman Catholic Separate School Division No. 212	August 31	Complete	No
Circle Drive Special Care Home Inc.	March 31	Complete	No
Community Initiatives Fund	March 31	Complete	No
Conseil des Écoles Fransaskoises No. 310	August 31	Complete	No
Creative Saskatchewan	March 31	Complete	No
Creighton School Division No. 111	August 31	Complete	No
Cumberland College	June 30	Complete	No
Cupar and District Nursing Home Inc.	March 31	Complete	No
Duck Lake and District Nursing Home Inc.	March 31	Complete	No
eHealth Saskatchewan	March 31	Complete	Yes/2021 V2
Financial and Consumer Affairs Authority of Saskatchewan	March 31	Complete	Yes/2022 V1
Foyer St. Joseph Nursing Home Inc.	March 31	Complete	No
Global Transportation Hub Authority, The	March 31	Complete	No
Good Spirit School Division No. 204	August 31	Complete	No
Government House Foundation, The	March 31	Complete	No
Great Plains College	June 30	Complete	No
Health Quality Council	March 31	Complete	No
Health Shared Services Saskatchewan (3sHealth)	March 31	Complete	Yes/2022 V1
Holy Family Roman Catholic Separate School Division No. 140	August 31	Complete	No
Holy Trinity Roman Catholic Separate School Division No. 22	August 31	Complete	No
Horizon School Division No. 205	August 31	Complete	Yes/2022 V1
Île-à-la Crosse School Division No. 112	August 31	Complete	No
Innovation Saskatchewan	March 31	Complete	No
Jubilee Residences Inc.	March 31	Complete	No
Lakeview Pioneer Lodge Inc.	March 31	Complete	No
Law Reform Commission of Saskatchewan	March 31	Complete	No
Light of Christ Roman Catholic Separate School Division No. 16	August 31	Complete	No
Living Sky School Division No. 202	August 31	Complete	No
Lloydminster Public School Division No. 99	August 31	Complete	No

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Lloydminster Roman Catholic Separate School Division No. 89	August 31	Complete	No
Lumsden & District Heritage Home Inc.	March 31	Complete	No
Lutheran Sunset Home of Saskatoon	March 31	Complete	No
Mennonite Nursing Homes Inc.	March 31	Complete	No
Métis Development Fund	December 31	Complete	No
Mont St. Joseph Home Inc.	March 31	Complete	No
Municipal Financing Corporation of Saskatchewan	December 31	Complete	No
Municipal Potash Tax Sharing Administration Board	December 31	Complete	No
North East School Division No. 200	August 31	Complete	No
North West College	June 30	Complete	No
Northern Lights School Division No. 113	August 31	Complete	Yes/2022 V1
Northlands College	June 30	Complete	Yes/2021 V2
Northwest School Division No. 203	August 31	Complete	No
Oliver Lodge	March 31	Complete	No
Operator Certification Board	March 31	Complete	No
Parkland College	June 30	Complete	No
Prairie Agricultural Machinery Institute	March 31	Complete	Yes/2021 V2
Prairie South School Division No. 210	August 31	Complete	Yes/2022 V1
Prairie Spirit School Division No. 206	August 31	Complete	No
Prairie Valley School Division No. 208	August 31	Complete	No
Prince Albert Roman Catholic Separate School Division No. 6	August 31	Complete	No
Providence Place for Holistic Health Inc.	March 31	Complete	No
Provincial Archives of Saskatchewan	March 31	Complete	No
Provincial Capital Commission	March 31	Complete	Yes/2021 V2
Qu'Appelle Diocesan Housing Company	March 31	Complete	No
Radville Marian Health Centre Inc.	March 31	Complete	No
Raymore Community Health and Social Centre	March 31	Complete	Yes/2021 V2
Regina Lutheran Housing Corporation	March 31	Complete	No
Regina Roman Catholic Separate School Division No. 81	August 31	Complete	No
Regina School Division No. 4	August 31	Complete	Yes/2022 V1
Santa Maria Senior Citizens Home Inc.	March 31	Complete	No
Saskatchewan Apprenticeship and Trade Certification Commission	June 30	Complete	No
Saskatchewan Arts Board, The	March 31	Complete	Yes/2021 V2
Saskatchewan Association of Health Organizations Inc.	March 31	Complete	No
Saskatchewan Cancer Agency	March 31	Complete	No
Saskatchewan Centre of the Arts	March 31	Complete	No
Saskatchewan Crop Insurance Corporation	March 31	Complete	Yes/2021 V2
Saskatchewan Health Authority	March 31	Complete	Yes/2021 V2 & 2022 V1
Saskatchewan Health Research Foundation	March 31	Complete	No

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Saskatchewan Heritage Foundation	March 31	Complete	No
Saskatchewan Housing Corporation	December 31	Complete	No
Saskatchewan Impaired Driver Treatment Centre Board of Governors	March 31	Complete	No
Saskatchewan Indian Gaming Authority Inc.	March 31	Complete	Yes/2021 V2
Saskatchewan Legal Aid Commission	March 31	Complete	Yes/2021 V2
Saskatchewan Liquor and Gaming Authority	March 31	Complete	Yes/2021 V2 & 2022 V1
Saskatchewan Lotteries Trust Fund for Sport, Culture and Recreation	March 31	Complete	No
Saskatchewan Polytechnic	June 30	Complete	Yes/2021 V2
Saskatchewan Public Safety Agency	March 31	Complete	Yes/2021 V2
Saskatchewan Research Council	March 31	Complete	No
Saskatchewan Rivers School Division No. 119	August 31	Complete	No
Saskatoon Convalescent Home	March 31	Complete	No
Saskatoon School Division No. 13	August 31	Complete	Yes/2022 V1
SaskBuilds Corporation	March 31	Complete	No
Sherbrooke Community Society Inc.	March 31	Complete	No
SLGA Holding Inc.	March 31	Complete	No
SLGA Retail Inc.	March 31	Complete	No
Société Joseph Breton Inc.	March 31	Complete	No
South East Cornerstone School Division No. 209	August 31	Complete	No
Southeast College	June 30	Complete	No
Spruce Manor Special Care Home Inc.	March 31	Complete	No
St. Ann's Senior Citizens Village Corporation	March 31	Complete	No
St. Anthony's Hospital	March 31	Complete	No
St. Joseph's Home for the Aged	March 31	Complete	No
St. Joseph's Hospital (Grey Nuns) Gravelbourg	March 31	Complete	No
St. Joseph's Hospital of Estevan	March 31	Complete	No
St. Joseph's Integrated Health Centre Macklin	March 31	Complete	No
St. Paul Lutheran Home of Melville	March 31	Complete	No
St. Paul's Roman Catholic Separate School Division No. 20	August 31	Complete	Yes/2022 V1
St. Paul's (Grey Nuns) of Saskatoon	March 31	Note 1	
St. Peter's Hospital	March 31	Complete	No
Strasbourg and District Health Centre	March 31	Complete	No
Sun West School Division No. 207	August 31	Complete	Yes/2022 V1
Sunnyside Adventist Care Centre	March 31	Complete	No
TecMark International Commercialization Inc.	March 31	Note 1	
The Salvation Army—William Booth Special Care Home	March 31	Complete	No
Tourism Saskatchewan	March 31	Complete	No
Warman Mennonite Special Care Home Inc.	March 31	Complete	No
Water Security Agency	March 31	Complete	Yes/2021 V2

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Western Development Museum	March 31	Complete	Yes/2021 V2
Workers' Compensation Board	December 31	Complete	Yes/2022 V1
CIC Crown Corporations and related agencies:			
101069101 Saskatchewan Ltd.	March 31	Note 1	
Avonlea Holding, Inc.	March 31	Note 1	
Battleford International, Inc.	March 31	Note 1	
Bayhurst Energy Services Corporation	March 31	Note 1	
Bayhurst Gas Limited	March 31	Note 1	
BG Storage Inc.	March 31	Note 1	
Bruno Holdings Inc.	March 31	Note 1	
CIC Asset Management Inc.	March 31	Complete	No
Coachman Insurance Company	December 31	Complete	No
Crown Investments Corporation of Saskatchewan	March 31	Complete	No
DirectWest Canada Inc.	March 31	Note 1	
DirectWest Corporation	March 31	Complete	No
Manalta Investment Company Ltd.	March 31	Note 1	
Many Islands Pipe Lines (Canada) Limited	March 31	Note 1	
Nokomis Holding, Inc.	March 31	Note 1	
Northpoint Energy Solutions Inc.	March 31	Complete	No
Qu'Appelle Holding, Inc.	March 31	Note 1	
Saskatchewan Auto Fund	March 31	Complete	No
Saskatchewan First Call Corporation	March 31	Note 1	
Saskatchewan Gaming Corporation	March 31	Complete	Yes/2021 V2
Saskatchewan Government Insurance	March 31	Complete	Yes/2022 V1
Saskatchewan Opportunities Corporation	March 31	Complete	No
Saskatchewan Power Corporation	March 31	Complete	Yes/2022 V1
Saskatchewan Telecommunications	March 31	Complete	No
Saskatchewan Telecommunications Holding Corporation	March 31	Complete	No
Saskatchewan Telecommunications International, Inc.	March 31	Complete	No
Saskatchewan Telecommunications International (Tanzania) Ltd.	March 31	Note 1	
Saskatchewan Water Corporation	March 31	Complete	No
SaskEnergy Incorporated	March 31	Complete	Yes/2022 V1
SaskTel International Consulting, Inc.	March 31	Note 1	
SaskTel Investments, Inc.	March 31	Note 1	
SecurTek Monitoring Solutions, Inc.	March 31	Complete	No
SGC Holdings, Inc.	March 31	Complete	No
SGI CANADA Insurance Services Ltd.	December 31	Complete	No
Shellbrook Holding, Inc.	March 31	Note 1	
TransGas Limited	March 31	Note 1	

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Special purpose and trust funds including pension and benefit plans:			
Capital Pension Plan	March 31	Complete	No
Commercial Revolving Fund	March 31	Complete	No
Correctional Facilities Industries Revolving Fund	March 31	Complete	No
Criminal Property Forfeiture Fund	March 31	Complete	No
Crop Reinsurance Fund of Saskatchewan	March 31	Complete	No
Doukhobors of Canada C.C.U.B. Trust Fund	May 31	Complete	No
Extended Health Care Plan	December 31	Complete	No
Extended Health Care Plan for Certain Other Employees	December 31	Complete	No
Extended Health Care Plan for Certain Other Retired Employees	December 31	Complete	No
Extended Health Care Plan for Retired Employees	December 31	Complete	No
Fish and Wildlife Development Fund	March 31	Complete	No
General Revenue Fund	March 31	Note 2	
Health Shared Services Saskatchewan Core Dental Plan	December 31	Delayed	
Health Shared Services Saskatchewan Disability Income Plan – CUPE	December 31	Delayed	
Health Shared Services Saskatchewan Disability Income Plan – SEIU	December 31	Delayed	
Health Shared Services Saskatchewan Disability Income Plan – General	December 31	Delayed	
Health Shared Services Saskatchewan Disability Income Plan – SUN	December 31	Delayed	
Health Shared Services Saskatchewan Group Life Insurance Plan	December 31	Delayed	
Health Shared Services Saskatchewan In-Scope Extended Health/Enhanced Dental Plan	December 31	Delayed	
Health Shared Services Saskatchewan Out-of-Scope Extended Health/Enhanced Dental Plan	December 31	Delayed	
Health Shared Services Saskatchewan Out-of-Scope Flexible Health/Spending Plan	December 31	Delayed	
Impacted Sites Fund	March 31	Complete	No
Institutional Control Monitoring and Maintenance Fund	March 31	Complete	No
Institutional Control Unforeseen Events Fund	March 31	Complete	No
Judges of the Provincial Court Superannuation Plan	March 31	Complete	No
Liquor Board Superannuation Plan	December 31	Complete	No
Livestock Services Revolving Fund	March 31	Note 3	
Municipal Employees' Pension Commission	December 31	Complete	No
Northern Municipal Trust Account	December 31	Delayed	Yes/2021 V2
Oil and Gas Orphan Fund	March 31	Complete	No
Pension Plan for the Non-Teaching Employees of the Saskatoon School Division No. 13	December 31	Delayed	
Power Corporation Superannuation Plan	December 31	Complete	No
Provincial Mediation Board Trust Accounts	March 31	Complete	No
Public Employees Benefits Agency Revolving Fund	March 31	Complete	No

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Public Employees Deferred Salary Leave Fund	December 31	Complete	No
Public Employees Dental Fund	December 31	Complete	No
Public Employees Disability Income Fund	December 31	Complete	No
Public Employees Group Life Insurance Fund	December 31	Complete	No
Public Employees Pension Plan	March 31	Complete	No
Public Service Superannuation Plan	March 31	Complete	No
Public Guardian and Trustee of Saskatchewan	March 31	Complete	Yes/2021 V2
Queen's Printer Revolving Fund	March 31	Complete	No
Residential Tenancies, Office of—Director's Trust Account	March 31	Complete	No
Sask 911 Account	March 31	Complete	No
Saskatchewan Agricultural Stabilization Fund	March 31	Complete	No
Saskatchewan Government Insurance Service Recognition Plan	December 31	Complete	No
Saskatchewan Government Insurance Superannuation Plan	December 31	Complete	No
Saskatchewan Pension Annuity Fund	March 31	Complete	No
Saskatchewan Pension Plan	December 31	Complete	No
Saskatchewan Power Corporation Designated Employee Benefit Plan	December 31	Complete	No
Saskatchewan Power Corporation Severance Pay Credits Plan	December 31	Complete	No
Saskatchewan Power Corporation Supplementary Superannuation Plan	December 31	Complete	No
Saskatchewan Research Council Employees' Pension Plan	December 31	Complete	No
Saskatchewan Snowmobile Fund	March 31	Complete	No
Saskatchewan Student Aid Fund	March 31	Complete	No
Saskatchewan Professional Teachers Regulatory Board	August 31	Complete	No
Saskatchewan Technology Fund	March 31	Note 3	
Saskatchewan Telecommunications Pension Plan	March 31	Complete	No
Saskatchewan Water Corporation Retirement Allowance Plan	December 31	Complete	No
SaskEnergy Retiring Allowance Plan	December 31	Complete	No
School Division Tax Loss Compensation Fund	March 31	Complete	No
Social Services Central Trust Account	March 31	Complete	No
Social Services Valley View Centre Grants and Donations Trust Account and Institutional Collective Benefit Fund	March 31	Complete	No
Social Services Valley View Centre Residents' Trust Account	March 31	Complete	No
Staff Pension Plan for Employees of the Saskatchewan Legal Aid Commission	December 31	Complete	No
Teachers' Dental Plan	December 31	Complete	No
Teachers' Disability Plan	June 30	Complete	No
Teachers' Group Life Plan	August 31	Complete	No

Agency	Fiscal Year-End [A]	Status on May 4, 2022 [B]	Matters Reported / Related Report(s) [C]
Teachers' Superannuation Plan	June 30	Complete	No
Training Completions Fund	March 31	Complete	No
Transportation Partnerships Fund	March 31	Complete	No
Victims' Fund	March 31	Complete	Yes/2021 V2
Water Security Agency Retirement Allowance Plan	March 31	Complete	No
Offices of the Legislative Assembly:			
Advocate for Children and Youth, Office of the	March 31	Complete	No
Board of Internal Economy/Legislative Assembly Service/Office of the Speaker	March 31	Complete	No
Chief Electoral Officer, Office of the	March 31	Complete	No
Conflict of Interest Commissioner, Office of the	March 31	Complete	No
Information and Privacy Commissioner, Office of the	March 31	Complete	No
Ombudsman and Public Interest Disclosure Commissioner, Office of the	March 31	Complete	No
Other Agencies:			
Pension Plan for the Eligible Employees at the University of Saskatchewan	December 31	Delayed	
Pension Plan for the Academic and Administrative Employees of the University of Regina	December 31	Delayed	
Technical Safety Authority of Saskatchewan	June 30	Complete	Yes/2021 V2
University of Regina Non-Academic Pension Plan	December 31	Delayed	
University of Regina	April 30	Complete	No
University of Saskatchewan 1999 Academic Pension Plan	December 31	Delayed	
University of Saskatchewan 2000 Academic Money Purchase Pension Plan	December 31	Delayed	
University of Saskatchewan Academic Employees' Pension Plan	December 31	Delayed	
University of Saskatchewan and Federated Colleges Non-Academic Pension Plan	December 31	Delayed	
University of Saskatchewan	April 30	Complete	No

Note 1: These entities are wholly- or partially-owned subsidiary corporations that are included in the consolidated financial statements of a parent Crown agency.

Note 2: The Ministry of Finance does not prepare financial statements for this Fund.

Note 3: This entity had no active operations.

Note 4: New Ministry established September 2021. March 31, 2022 will be the first period-end audited by this Office.

[A]

Fiscal Year-end	Year of last completed integrated audit
March 31	2021
April 30	2021
May 31	2021
June 30	2021
August 31	2021
September 30	2021
December 31	2021

[B] "Complete" – the audit was complete.
"Delayed" – the audit was delayed.

[C] "No" – no significant issues reported.
"Yes/2022 V1" – significant issues are reported in our *2022 Report – Volume 1*.
"Yes/2021 V2" – significant issues are reported in our *2021 Report – Volume 2*.

Appendix 2
Report on the Financial Statements of Agencies Audited by Appointed Auditors

1.0 PURPOSE

This Appendix summarizes the Office of the Provincial Auditor's views on the financial statements of agencies audited by appointed auditors. It lists audits in which the Office participated for fiscal periods ending between July 1, 2021 and December 31, 2021.

2.0 BACKGROUND

Under *The Provincial Auditor Act*, the Provincial Auditor retains overall responsibility for audits of all Crown agencies and Crown corporations regardless of who does the audit. The Legislative Assembly allows the Government to appoint auditors to audit certain Crown agencies and Crown corporations annually. **Figure 1** sets out the objectives of the annual audits—we refer to them as annual integrated audits.

The Office, the Crown agencies, Crown corporations, and the appointed auditors use the recommendations of the *Report of the Task Force on Roles, Responsibilities and Duties of Auditors* to serve the Assembly's needs efficiently and effectively.[1,2] The Office includes the results of annual integrated audits done by appointed auditors in our Reports to the Assembly. As the Task Force Report expects, the Office provides the Assembly with its views and participation in the audits of agencies' financial statements with an appointed auditor.

Figure 1—Objective of Annual Integrated Audits

The objectives of each annual integrated audit are to form the following opinions and to report the results to the Legislative Assembly:

- An opinion on the financial-related rules and procedures used by the agency to safeguard public resources.
- An opinion on the agency's compliance with the authorities governing its activities related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.
- An opinion on the reliability of the agency's financial statements. The appointed auditors' reports on the reliability of each Crown agency and each Crown corporation's financial statements accompany the respective financial statements.

The Government's Summary Financial Statements include the financial results of all agencies controlled by the Government. *Public Accounts 2021–22 – Volume 1* will include the Office's independent auditor's report on the Government's Summary Financial Statements for the year ended March 31, 2022.

[1] For a copy of this report, see www.auditor.sk.ca. The Task Force recommended that the Office give the Assembly a report listing the agencies whose annual integrated audits it participated in.

[2] In June 1994, the *Report of the Task Force on Roles, Responsibilities and Duties of Auditors* recommended how the audit system for Crown Investments Corporation of Saskatchewan and its subsidiary Crown corporations could function more efficiently and effectively. In April 1995, Treasury Board decided that all Crown corporations and agencies should comply with these recommendations.

3.0 The Office's Views on Financial Statements Audited by Appointed Auditors

The table below provides the Office's views and participation on each financial statement audit completed by an appointed auditor for fiscal years ending between July 1, 2021 and December 31, 2021. As noted below, sometimes the Office varies the extent of its participation.

The table groups agencies and corporations by school divisions; other Crown agencies, special purpose and trust funds; and CIC, its subsidiary Crown corporations, and other related entities. It lists each Crown agency or corporation with financial statements that are audited by an appointed auditor, the appointed auditor's name, the agency's year-end date, whether the Office participated in the audit, and whether the agency's financial statements are reliable.

Listing of the Office's Involvement in Financial Statement Audits of Agencies with an Appointed Auditor

Agency Name	Appointed Auditor	Year-End Date	PAS* Participated in Audit	Financial Statements are Reliable
School Divisions				
Chinook School Division No. 211	Stark & Marsh Chartered Professional Accountants LLP	August 31	See [A]	Yes
Christ the Teacher Roman Catholic Separate School Division No. 212	Miller Moar Grodecki Kreklewich & Chorney Chartered Professional Accountants	August 31	See [A]	Yes
Conseil des Écoles Fransaskoises No. 310	MNP LLP	August 31	See [A]	Yes
Creighton School Division No. 111	Kendall & Pandya Chartered Professional Accountants	August 31	See [A]	Yes
Good Spirit School Division No. 204	Miller Moar Grodecki Kreklewich & Chorney Chartered Professional Accountants	August 31	See [A]	Yes
Holy Family Roman Catholic Separate School Division No. 140	Grant Thornton LLP	August 31	See [A]	Yes
Holy Trinity Roman Catholic Separate School Division No. 22	Virtus Group LLP	August 31	See [A]	Yes
Horizon School Division No. 205	MNP LLP	August 31	See [A]	Yes
Île-à-la Crosse School Division No. 112	Vantage Chartered Professional Accountants	August 31	See [A]	Yes
Light of Christ Roman Catholic Separate School Division No. 16	Vantage Chartered Professional Accountants	August 31	See [A]	Yes
Living Sky School Division No. 202	Holm Raiche Oberg P.C. Ltd. Chartered Professional Accounts	August 31	Yes	Yes
Lloydminster Roman Catholic Separate School Division No. 89	MNP LLP	August 31	Yes	Yes

Agency Name	Appointed Auditor	Year-End Date	PAS* Participated in Audit	Financial Statements are Reliable
Lloydminster Public School Division No. 99	Vantage Chartered Professional Accountants	August 31	Yes	Yes
North East School Division No. 200	MNP LLP	August 31	See [A]	Yes
Northern Lights School Division No. 113	Deloitte LLP	August 31	See [A]	Yes
Northwest School Division No. 203	Grant Thornton LLP	August 31	See [A]	Yes
Prairie South School Division No. 210	Deloitte LLP	August 31	See [A]	Yes
Prairie Spirit School Division No. 206	MNP LLP	August 31	Yes	Yes
Prairie Valley School Division No. 208	MNP LLP	August 31	Yes	Yes
Prince Albert Roman Catholic Separate School Division No. 6	MNP LLP	August 31	See [A]	Yes
Regina Roman Catholic Separate School Division No. 81	Dudley & Company LLP	August 31	See [A]	Yes
Regina School Division No. 4	MNP LLP	August 31	Yes	Yes
Saskatchewan Rivers School Division No. 119	MNP LLP	August 31	Yes	Yes
Saskatoon School Division No. 13	Deloitte LLP	August 31	Yes	Yes
South East Cornerstone School Division No. 209	Virtus Group LLP	August 31	See [A]	Yes
St. Paul's Roman Catholic Separate School Division No. 20	MNP LLP	August 31	Yes	Yes
Sun West School Division No. 207	Close Hauta Bertoia Blanchette Chartered Professional Accountants	August 31	See [A]	Yes
Other Crown Agencies, Special Purpose and Trust Funds				
Métis Development Fund	Deloitte LLP	December 31	Yes	Yes
Municipal Employees' Pension Commission	KPMG LLP	December 31	Yes	Yes
Municipal Financing Corporation of Saskatchewan	Dudley & Company LLP	December 31	Yes	Yes
Pension Plan for the Non-Teaching Employees of the Saskatoon School Division No. 13	Deloitte LLP	December 31	Yes	Delayed
Saskatchewan Housing Corporation	KPMG LLP	December 31	Yes	Yes
Saskatchewan Pension Plan	KPMG LLP	December 31	Yes	Yes
Saskatchewan Professional Teachers Regulatory Board	Virtus Group LLP	August 31	Yes	Yes
Saskatchewan Research Council Employees' Pension Plan	Deloitte LLP	December 31	Yes	Yes
Workers' Compensation Board	PricewaterhouseCoopers LLP	December 31	Yes	Yes

Agency Name	Appointed Auditor	Year-End Date	PAS* Participated in Audit	Financial Statements are Reliable
CIC, its Subsidiary Crown Corporations & Other Related Entities				
SGI Canada Insurance Services Ltd.	KPMG LLP	December 31	Yes	Yes
Coachman Insurance Company	KPMG LLP	December 31	Yes	Yes
Saskatchewan Government Insurance Superannuation Plan	KPMG LLP	December 31	Yes	Yes
Power Corporation Superannuation Plan	Deloitte LLP	December 31	Yes	Yes

* PAS—Provincial Auditor of Saskatchewan

A The Office reviewed the opinions of the appointed auditor on the reliability of financial statements, effectiveness of processes to safeguard public resources, and compliance with authorities. We also reviewed the appointed auditor's audit findings (including summary of errors) reported to the Boards of the agencies. Where necessary, we followed up with the appointed auditor to clarify issues reported.

Appendix 3
Samples of Opinions Formed in Annual Audits of Ministries, Crown Agencies, and Crown-Controlled Corporations

The scope of the Office of the Provincial Auditor's audit work includes the Government as a whole, sectors or programs of the Government, and individual government agencies (see **Appendix 1**). *The Provincial Auditor Act* requires the Office to use generally accepted assurance standards published by CPA Canada to carry out its audits (e.g., integrated, performance, follow-up).

Individual government agencies are subject to annual integrated audits. In general, annual integrated audits examine the effectiveness of financial-related controls, compliance with financial-related authorities, and the reliability of financial statements (for agencies that prepare them).

The following are samples of audit opinions formed as part of the annual integrated audits.

1.0 Effectiveness of Internal Controls (Financial-Related)

We have undertaken a reasonable assurance engagement of [Agency]'s operating effectiveness of internal controls as of [Year End] to express an opinion as to the effectiveness of its internal controls related to the following objectives:

- To safeguard public resources. That is, to ensure its assets are not lost or used inappropriately; to ensure it does not inappropriately incur obligations; to establish a financial plan for the purposes of achieving its financial goals; and to monitor and react to its progress toward the objectives established in its financial plan.
- To prepare reliable financial statements.
- To conduct its activities following laws, regulations, and policies related to financial reporting, safeguarding public resources, revenue raising, spending, borrowing, and investing.

CPA Canada defines control as comprising those elements of an organization that, taken together, support people in the achievement of the organization's objectives. Control is effective to the extent that it provides reasonable assurance that the organization will achieve its objectives.

[Agency]'s management is responsible for effective internal controls related to the objectives described above. Our responsibility is to express an opinion on the effectiveness of internal controls based on our audit.

We used the control framework included in COSO's *Internal Control–Integrated Framework* to make our judgments about the effectiveness of [Agency]'s internal controls. We did not audit certain aspects of internal controls concerning the effectiveness, economy, and efficiency of certain management decision-making processes.

We conducted our reasonable assurance engagement in accordance with Canadian Standard on Assurance Engagements (CSAE) 3001, *Direct Engagements*. This standard requires that we plan and perform this engagement to obtain reasonable assurance as to the effectiveness of [Agency]'s internal controls related to the objectives stated above. The nature, timing and extent of procedures performed depends on our professional judgment, including an assessment of the risks of material misstatement, whether due to fraud or error, and involves obtaining evidence about the effectiveness of internal controls. An audit includes obtaining an understanding of the significant risks related to these objectives, the key control elements and control activities to manage these risks, and examining, on a test basis, evidence relating to control.

Reasonable assurance is a high level of assurance, but is not a guarantee that an engagement conducted in accordance with this standard will always detect a material misstatement when it exists.

Our audit on the effectiveness of [Agency]'s internal controls related to the above objectives does not constitute an audit of internal control over financial reporting performed in conjunction with an audit of financial statements in *CPA Canada Handbook—Assurance* Section 5925 *An Audit of Internal Control over Financial Reporting that is Integrated with an Audit of Financial Statements*.

Control can provide only reasonable and not absolute assurance of achieving objectives reliably for the following reasons. There are inherent limitations in control including judgment in decision-making, human error, collusion to circumvent control activities, and management overriding control. Cost/benefit decisions are made when designing control in organizations. Because control can be expected to provide only reasonable assurance and not absolute assurance, the objectives referred to above may not be achieved reliably. Also, projections of any evaluation of control to future periods are subject to the risk that control may become ineffective because of changes in internal and external conditions, or that the degree of compliance with control activities may deteriorate.

We believe the evidence we obtained is sufficient and appropriate to provide a basis for our opinion.

In our opinion, subject to the limitations noted above, [Agency]'s internal controls were operating effectively, in all material respects, to meet the objectives stated above as of [Year End] based on COSO's *Internal Control–Integrated Framework*.

[If control is not effective in all material respects, describe the risk or significant deficiency, and indicate which objective is affected. The report should state whether the deficiency resulted from the absence of control procedures or the degree of compliance with them.]

This report is provided solely for the purpose of assisting the Provincial Auditor in discharging their responsibilities and for preparing their annual report to the Legislative Assembly of Saskatchewan and is not to be referred to or distributed to any person who is not a member of management or the Board of [Agency], its supervising agencies or the Office of the Provincial Auditor and should not be used for any other purpose. Any use that a third party makes of information contained in this report, or any reliance or decisions based on such information, is the responsibility of such third parties.

We accept no responsibility for loss or damages, if any, suffered by any third party as a result of decisions made or actions taken based on information contained in this report.

We have complied with the ethical requirements of the Chartered Professional Accountants of Saskatchewan—*Rules of Professional Conduct* founded on fundamental principles of integrity, objectivity, professional competency and due care, confidentiality, and professional behaviour.

We apply the *Canadian Standard on Quality Control 1* issued by CPA Canada and, accordingly, maintain a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

2.0 COMPLIANCE WITH LEGISLATIVE AUTHORITIES

We have undertaken a reasonable assurance engagement of [Agency]'s compliance with the provisions of the following legislative and related authorities pertaining to its financial reporting, safeguarding of assets, spending, revenue raising, borrowing, and investment activities during the year ended [Year End]:

(List all legislative and related authorities covered by this report. This list must include all governing authorities).

Compliance with the provisions of the stated legislative and related authorities is the responsibility of management of [Agency]. Management is also responsible for such internal control as management determines necessary to enable the [Agency]'s compliance with the specified requirements.

Our responsibility is to express a reasonable assurance opinion on [Agency]'s compliance based on the evidence we have obtained.

We conducted our reasonable assurance engagement in accordance with Canadian Standard on Assurance Engagements (CSAE) 3531 *Direct Engagements to Report on Compliance*. This standard requires that we plan and perform this engagement to obtain reasonable assurance whether [Agency] complied with the criteria established by the legislation and related authorities referred to above, in all significant respects. A reasonable assurance compliance reporting engagement involves performing procedures to obtain evidence about the entity's compliance with the specified requirements. The nature, timing and extent of procedures selected depends on our professional judgment, including an assessment of the risks of significant non-compliance, whether due to fraud or error.

Reasonable assurance is a high level of assurance, but is not a guarantee that an engagement conducted in accordance with this standard will always detect a material misstatement when it exists.

We believe the evidence we obtained is sufficient and appropriate to provide a basis for our opinion.

In our opinion, for the year ended [Year End], [Agency] has complied, in all significant respects, with the provisions of the aforementioned legislative and related authorities.

We do not provide a legal opinion on the [Agency]'s compliance with the aforementioned legislative and related authorities.

(The report should provide adequate explanation with respect to any reservation contained in the opinion together with, if relevant and practicable, the monetary effect.)

This report is provided solely for the purpose of assisting the Provincial Auditor in discharging their responsibilities and for preparing their annual report to the Legislative Assembly of Saskatchewan and is not to be referred to or distributed to any person who is not a member of management or the Board of [Agency], its supervising agencies or the Office of the Provincial Auditor and should not be used for any other purpose. Any use that a third party makes of information contained in this report, or any reliance or decisions based on such information, is the responsibility of such third parties.

We accept no responsibility for loss or damages, if any, suffered by any third party as a result of decisions made or actions taken based on information contained in this report.

We have complied with the ethical requirements of the Chartered Professional Accountants of Saskatchewan—*Rules of Professional Conduct*, founded on fundamental principles of integrity, objectivity, professional competency and due care, confidentiality, and professional behaviour.

We apply the *Canadian Standard on Quality Control 1* issued by CPA Canada and, accordingly, maintain a comprehensive system of quality control, including documented policies and procedures regarding compliance with ethical requirements, professional standards, and applicable legal and regulatory requirements.

3.0 RELIABILITY OF FINANCIAL STATEMENTS

This opinion is formed for government agencies preparing financial statements. Ministries do not prepare financial statements.

Opinion

We have audited the financial statements of [Agency], which comprise [the statement of financial position] as at [Year End[s]], and the [statement of operations and accumulated surplus], [statement of remeasurement gains and losses], [statement of changes in net financial assets] and [statement of cash flows] for the year[s] then ended, and notes to the financial statements, including a summary of significant accounting policies.

In our opinion, the accompanying financial statements present fairly, in all material respects, the financial position of [Agency] as at [Year End[s]], and [insert appropriate wording to describe financial results] for the year[s] then ended in accordance with [insert name of the acceptable financial reporting framework].

Basis for Opinion

We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Statements* section of our report. We are independent of [Agency] in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

[Insert the following paragraphs if you expect to receive all or some of the other information (i.e., annual report that includes financial statements) prior to the date of the auditor's report and the auditor does not expect to identify a material misstatement of the other information. If you do not expect to receive other information prior to the date of the auditor's report, then there are no reporting requirements. The Other Information section can be removed from the auditor's report.]

Other Information

Management is responsible for the other information. The other information comprises the information included in [X report], but does not include the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or any knowledge obtained in the audit, or otherwise appears to be materially misstated. If, based on the work we have performed on this other information, we conclude that there is a material misstatement of this other information, we are required to report that fact in this auditor's report. We have nothing to report in this regard.

Responsibilities of Management and Those Charged with Governance for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with [insert the name of the acceptable financial reporting framework] for Treasury Board's approval, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing [Agency's] ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless management either intends to liquidate the [Agency] or to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the [Agency's] financial reporting process.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the [Agency's] internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the [Agency's] ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the [Agency] to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control identified during the audit.