Chapter 3

Department of Health & EM/ANB Inc. - Ambulance Services

Contents

AUDITOR GENERAL OF NEW BRUNSWICK | VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

Ambulance Services – Department of Health & EM/ANB Inc.

Report of the Auditor General – Volume I, Chapter 3 - August 2020

Why Is This Important?

- Quality of ambulance services matters because health outcomes could be impacted in life or death situations.
- Management of the provincial ambulance service has been contracted to the private sector, including responsibility for a $110 million annual budget.
- Management fees paid to the private sector contractor, Medavie Health Services New Brunswick (MHSNB), averaged $3.2 million annually and exceeded $38 million over 12 years.

Overall Conclusions

- The legislative framework and governance structure chosen by government does not provide sufficient oversight of ambulance services due to numerous inherent conflicts and requires significant improvement.
- Poorly structured contract allowed for questionable payments for paramedic vacancies. This in turn created a disincentive for Medavie Health Services New Brunswick to fix significant operational challenges.
- Contract allowed invalid and excessive use of exemptions, which made 911 response time results inaccurate.

What We Found

Weak Governance and Control Structure

- The CEO position of EM/ANB combined with the role as President of Medavie Health Services New Brunswick (MHSNB) creates a conflict of interest
- Board composition inhibits independence from the Department of Health
- EM/ANB lacks enabling legislation and its mandate is unclear
- EM/ANB is not subject to the *Conflict of Interest Act*
- Conflicts of interest exist with no repercussions
- Contract design compromises the board's influence over its own CEO
- MHSNB employees may be inclined to develop EM/ANB's strategies toward maximizing MHSNB's financial award

Contract Allowed Questionable Basis of Payments

- Paramedic shortages created over $8 million in payments to MHSNB, providing an incentive to maintain low staffing levels
- EM/ANB's method for budgeting payroll provided the means for questionable payments to MHSNB

Contract Allowed Excessive Use of Exemptions & Ambiguous Performance Measures

- Method of performance measurement put rural and remote communities at a disadvantage
- Contract allowed excessive use of full deployment exemptions, which caused an overstatement of response time performance
- Contract allowed exemptions when actual cause of delay was distance, out-of-service units and driver error

Key Findings and Observations Table

Ambulance Services – Department of Health & EM/ANB Inc.

Paragraph	Key Findings and Observations
	Governance, Independence and Accountability
3.46	*EM/ANB lacks enabling legislation and its mandate is unclear*
3.49	Ambulance Services Act *missing important governance components*
3.50	*Overall direction for ambulance services lacks clarity*
3.52	*Board composition created a complex management relationship*
3.53	*Board composition inhibits independence*
3.55	*Conflicts of interest may prevent board from acting in best interests of EM/ANB*
3.57	*Board fails to recognize and mitigate conflicts of interest*
3.59	*Despite conflicts of interest, board members did not recuse themselves from decision-making process*
3.60	*Risk of board members not acting in best interests of EM/ANB went unmitigated*
3.62	*Contract compromised the board's influence over its CEO*
3.64	*Not possible for the board to select a CEO*
3.65	*Unlikely board members could vote objectively on the selection of CEO*
3.66	*Board does not have influence over compensation paid to CEO*
3.67	*Board does not evaluate performance of CEO*
3.69	*Lack of control calls into question board's influence over CEO*
3.72	*No evidence board challenged CEO's strategy for EM/ANB to ensure alignment with obligations to Department*
3.75	*Board does not regularly review annual plans of EM/ANB*
3.76	*Neglecting to review annual plans reduced effectiveness of board's decision-making*
3.79	*Board did not receive reports from Performance Management Oversight Advisory Committee after 2017*
3.85	*PMOAC did not follow up on information request to MHSNB*
3.88	*Board did not have sufficient information to effectively oversee contract*

Key Findings and Observations Table (Continued)

Paragraph	Key Findings and Observations
3.89	*Board does not request or receive information necessary to fully assess EM/ANB's performance*
3.92	*Lack of detail recorded in the board minutes*
	Contract Allowed Questionable Basis of Payments
3.96	*Paramedic shortages created over $8 million in surplus payments to MHSNB, providing an incentive to maintain low staffing levels*
3.100	*Budgeted payroll costs used in payment calculation assumed full utilization of ambulances*
3.102	*Overbudgeted payroll costs provided means for questionable payments to MHSNB*
3.104	*The contract does not clearly define the performance expectations or restrictions related to budget surplus payments*
3.106	*Contract did not explicitly state how budget savings could be achieved*
3.107	*Lack of restrictions in the contract on targeted savings provided opportunity for MHSNB to neglect filling vacant positions*
3.109	*Department did not hold EM/ANB or MHSNB accountable for cost savings*
3.111	*Calculation for budget surplus payments did not explain how savings were achieved*
3.112	*Process eroded Department's ability to hold MHSNB accountable for achieving savings*
3.114	*Calculations of budget surplus payments were based on subjective factors*
3.118	*Adjustments further introduced subjectivity to the budget surplus payment calculation*
3.119	*Excluded expenses would have lowered surplus payments to MHSNB*
	Contract Allowed Excessive Use of Exemptions & Ambiguous Performance Measures
3.121	*Contractual requirement of continuous and uninterrupted service not well defined*
3.125	*Unclear what would constitute service interruption*
3.126	*Lack of clarity weakens ability of Department to hold EM/ANB accountable for maintaining service levels*
3.127	*Performance-based payments introduced a quality of service bias, detrimental to rural areas*
3.131	*19 of 67 communities fell below 90% performance expectation*

Key Findings and Observations Table (Continued)

Paragraph	Key Findings and Observations
3.132	*Communities' results below performance standard had no effect on performance-based payments to MHSNB*
3.133	*Performance-based payments introduced a bias toward achieving high performance in areas of greater population density*
3.134	*Performance measures put rural and remote communities at a disadvantage*
3.136	*Contract allowed excessive use of full deployment exemptions, which overstated response time performance results*
3.140	*Exemptions brought response rate from below 90% to exceed 92%*
3.141	*76% of exemptions were for full deployment*
3.143	*No limit on how frequently full deployment exemptions are claimed*
3.144	*Saint John and Moncton appear to have higher than daily use of full deployment exemptions*
3.145	*System Status Plan appeared to understate resource requirements*
3.148	*Number of paramedics required per the System Status Plan unchanged from original contract*
3.150	*Holding System Status Plan constant increased probability of full deployment exemptions*
3.151	*Excessive use of full deployment exemptions masked apparent severity of increasing call volumes*
3.154	*Overstatement of response time performance reported*
3.155	*Eliminating all full deployment exemptions from Saint John would have eliminated performance-based payments for South region*
3.157	*Contract allowed overuse of full deployment exemptions, which masked operational challenges at EM/ANB*
3.160	*No requirement to identify actual causes of response times which exceeded contract requirements*
3.161	*Full deployment exemptions were used for distance, out-of-service units and driver error*
3.162	*Full deployment exemptions reduced emphasis on areas of improvement*
3.164	*Dynamic Deployment left wide geographic areas uncovered*

Key Findings and Observations Table (Continued)

Paragraph	Key Findings and Observations
	Other Performance Management Weaknesses
3.165	*Corporate and strategic plans lack performance measures to demonstrate outcomes*
3.168	*No clear measure of effectiveness of completed initiatives*
3.170	*Few objectives related to contractual areas other than response times*
3.171	*KPIs failed to capture and measure operational challenges*
3.174	*No KPIs used for Official Languages Plan*
3.176	*Performance-based payments do not include KPIs related to human resources, despite effect of out-of-service units on operations*
3.178	*Duration of out-of-service units totalled over 95,000 hours*
3.179	*Out-of-service units not included as part of performance-based payments*
3.180	*KPIs do not capture opportunities for improvement*
3.181	*Hospital off-load delays require paramedic to remain with patient*
3.182	*82% of arrivals at the four major hospitals had off-load delays exceeding 25 minutes.*
3.185	*Most KPIs did not include progressive targets*
3.186	*Contractual performance indicators remained largely unchanged*
3.188	*10-year contract term makes it difficult for Department to adjust service level expectations*
3.189	*No mechanism for parties to set new performance targets*
	Other Conflicts of Interest
3.195	*CEO position of EM/ANB combined with the role as President of MHSNB creates a conflict of interest*
3.197	*CEO would be inclined to act in interests of their employer, MHSNB*
3.198	*Corporate strategy for EM/ANB was drafted by employees of MHSNB*
3.199	*MHSNB's employees may be inclined to develop EM/ANB's strategies toward maximizing MHSNB's financial award*
3.200	*EM/ANB is not subject to the* Conflict of Interest Act
3.202	*EM/ANB is not listed in Schedule A of the Act's regulations*
3.205	*Conflict of interest existed with no repercussions*

Recommendations and Responses

Recommendation	Department's response	Target date for implementation
We recommend:		
3.51 The Department formalize the mandate and governance for EM/ANB in legislation and provide mandate letters to EM/ANB with the annual budget approval.	*The Department of Health will explore legislative options to reinforce oversight, accountability and governance of ambulance services.* *EM/ANB currently operates as a not-for-profit corporation under the New Brunswick Companies Act and its operation of land and air ambulance services are regulated by the Ambulance Services Act.* *EM/ANB's mandate is outlined within its bylaws as required by its current legislation and direction is provided to the organization by the Department of Health through a series of yearly budget letters.* *This legislative framework has been in place for 30 years to provide regulation and oversight to third-party ambulance providers.*	*Fiscal Year 2021-22*
3.56 The board by-laws be amended to change the composition of the board to include members independent of the Department.	*The Department of Health and EM/ANB agree with the recommendation.* *The addition of independent board members would increase transparency and oversight over the operations of EM/ANB. Changes to the composition of the board will be brought forward in the current fiscal year.*	*Fiscal Year 2020-21*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.61 The board enforce its conflict of interest policy and periodically review the effectiveness of the policy in mitigating conflict of interest risk.	*The Department of Health and EM/ANB agrees with the recommendation.* *The current by-laws and Conflict of Interest policy denotes that members must declare a conflict of interest on any matter before the board and cannot participate in discussions and/or votes on the matter.* *The Board will continue to have Declaration of Conflict of Interest as a standing agenda item for meetings of the board and its committees and ensure adequate documentation where applicable.* *The Conflict of Interest Policy will be reviewed regularly as part of regular policy review within the board process.*	*Immediately*
3.70 EM/ANB enabling legislation strengthen and clarify board authority with respect to hiring, compensation, performance and termination of the CEO.	*The Department of Health will assess this recommendation in the context of its review of the governance structure and legislative oversight model.*	*Fiscal Year 2021-22*
3.71 The board hire an independent CEO upon future contractual amendment or renegotiation.	*The Department of Health will assess this recommendation in the context of its review of the governance structure and legislative oversight model.*	*Fiscal Year 2021-22*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.77 The board evaluate EM/ANB's annual corporate plans as part of its review of the CEO and MHSNB's performance and compare them to EM/ANB's annual report and obligations to the Department.	*The Board of EM/ANB agrees with this recommendation.* *The Board currently reviews EM/ANB's annual corporate plan and received quarterly reports from the CEO on the progress of initiatives against its objectives.* *MHSNB's performance is measured against both contractual key performance indicators and as well as a broader suite of indicators that measure health and safety outcomes.* *The Board of EM/ANB will ensure that these processes are better documented through the board minutes.*	*Fiscal Year 2020-21*
3.78 The board establish a performance management framework for EM/ANB and evaluate its performance annually.	*The Board of EM/ANB agrees with this recommendation.* *On a quarterly basis, the committees of the board (Finance and Performance, Quality and Patient Safety, Medical and Professional Advisory) report on quarterly financial, operational and clinical outcomes from EM/ANB.* *The Board and its committees will continue efforts to enhance this performance management framework.*	*Fiscal Year 2020-21*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.94 The terms of reference of each standing committee require an annual written report to the Board of Directors to demonstrate the sub-committees are operating as intended.	*The Board of EM/ANB agrees with the recommendation.* *The standing committees currently provide written reports to the Board at each quarterly meeting. The terms of reference of the committees will be modified to instruct an annual report in the last quarter of the fiscal year.*	*Fiscal Year 2020-21*
3.95 The board improve its recording of minutes to increase transparency.	*The Board of EM/ANB agrees with the recommendation.* *Board minutes will be expanded to capture additional information as it pertains to its review of documentation emanating from its committees.*	*Immediately*
3.103 EM/ANB calculate budget surplus payments based on flexible budget amounts which reflect the anticipated spending for the fiscal year.	*The Department of Health and EM/ANB agrees with the intent of this recommendation which ensure that the yearly budget better reflects actual costs of operating ambulance services.* *Such an amendment to the third-party management contract would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.108 The board define restrictions around budget surplus payments to exclude circumstances which may decrease the quality of the delivery of ambulance services.	*The Department of Health and EM/ANB agrees with the intent of this recommendation to remove any financial incentives that might lead to a decrease quality or safety of care.* *As an example, the contract which governs the Extra-Mural Program excludes clinical savings from the cost-sharing formula. This could potentially serve as a model to renew the ambulance services contract.* *Such an amendment to the third-party management contract would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*
3.113 The board ensure EM/ANB or MHSNB substantiate how savings are achieved to demonstrate the value provided through cost savings claimed under the contract for ambulance services.	*The Department of Health and EM/ANB agree with this recommendation.* *Currently, both parties receive regular financial reports from EM/ANB detailing actuals against budget and are aware of where savings are being made.* *The Board of EM/ANB will request additional information on variances through its Finance and Performance Committee to ensure that these are substantiated on the public record.*	*Fiscal Year 2020-21*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.135 EM/ANB introduce a more balanced suite of key performance indicators as the basis for performance-based payments to incentivise MHSNB toward high performance in all New Brunswick communities.	*The Department of Health and the Board of EM/ANB agree with this recommendation.* *EM/ANB currently publishes actual performance at the community-level monthly to ensure transparency. The Board of EM/ANB will explore pay-for-performance models that would ensure a minimum standard exists across the province below which there would be financial implications for the third-party manager.* *Such an amendment to the third-party management contract would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*
3.152 The Department and EM/ANB introduce controls to minimize the frequency of use of full deployment exemptions or discontinue the use of exemptions.	*The Department and the Board of EM/AMB agree with this recommendation.* *Current exemptions have been in place since the inception of this contract to ensure that the third-party manager is only held responsible for events which it can control. Full deployment exemptions are often linked to lack of human resources which can be attributed in part to the third-party's ability to recruit and retain personnel.* *The elimination, or reduction of allowable exemptions would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.153 The EM/ANB board require MHSNB revise the System Status Plan to update the detailed specifications as to the ambulances, facilities and human resources required to be deployed to achieve performance standards.	*The Department and the Board of EM/AMB agree with this recommendation.* *The Board of EM/ANB will undertake a review of the System Status Plan to ensure that response times are maintained at an acceptable level in all New Brunswick communities.*	*Fiscal Year 2021-22*
3.163 The Department and EM/ANB revise the exemption approval guide to prevent the invalid use of full deployment exemptions or discontinue the use of exemptions.	*The Department and the Board of EM/AMB agree with this recommendation.* *Current exemptions have been in place since the inception of this contract to ensure that the third-party manager is only held responsible for events which it can control. Full deployment exemptions are often linked to lack of human resources which can be attributed in part to the third-party's ability to recruit and retain personnel.* *The elimination, or reduction of allowable exemptions would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.191 The board implement progressive performance targets to incentivize MHSNB to achieve continuous improvement for the duration of the contract.	*The Department and the Board of EM/AMB agree with this recommendation.* *The third-party contract for the management of the Extra-Mural Program includes progressive performance targets that are renewed or changed once full performance is achieved. This could serve as a model for changes to the ambulance services contract.* *Such an amendment to the third-party management contract would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*
3.192 EM/ANB improve tracking, and follow-up of strategic and corporate initiatives and include measurable outcomes in its plans.	*The Department and the Board of EM/ANB agree with this recommendation.* *The Board currently reviews EM/ANB's annual corporate and received ongoing reports from the CEO on the progress of initiatives.* *The Board will reinforce these processes and ensure they are better captured in documentation.*	*Fiscal year 2020-21*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.193 The board expand key performance indicators for performance-based payments to include all areas of operations, such as human resources, fleet and official languages.	*The Department and the Board of EM/ANB agree with this recommendation.* *These broader performance measures are already monitored through the board committees. They could be considered for inclusion within the contract to balance current efficiency and response time measures with quality and patient safety outcomes.* *Such an amendment to the third-party management contract would be considered in the context of a future renegotiation of the agreement.*	*Fiscal Year 2021-22*
3.194 The Department coordinate with the Regional Health Authorities and EM/ANB to implement solutions to reduce the impact of off-load delays.	*The Department and the Board of EM/ANB agrees with this recommendation.* *The Department of Health will direct the Regional Health Authorities and EM/ANB to define solutions to resolve the issue of offload delays which have a direct impact on ambulance response times in New Brunswick communities.* *This metric will continue to be tracked and reported on quarterly by the Board of EM/ANB as a priority.*	*Fiscal year 2020-21*

Recommendation	Department's response	Target date for implementation
We recommend:		
3.206 The Executive Council Office review the Conflict of Interest Regulation under the *Conflict of Interest Act* and amend the regulation to include all relevant Crown corporations in Schedule A, including EM/ANB Inc.	*There is concurrent statutory authority in the enabling legislation of many Crown corporations to develop their own conflict of interest by-laws and/or policies. Executive Council Office will explore a more consistent approach through a review of the* Conflict of Interest Act *and regulation.*	*Fall 2021*

Audit Introduction

3.1 Under the *Ambulance Services Act*, the Minister of Health is responsible for delivery of ambulance services. These services are provided through an ambulance services agreement (ambulance license) between the Department of Health (the Department) and EM/ANB Inc. (EM/ANB), formerly Ambulance New Brunswick Inc. EM/ANB, a Crown corporation, facilitates land and air ambulance services for the citizens of New Brunswick. EM/ANB has contracted the management of these services to Medavie Health Services New Brunswick Inc. (MHSNB), formerly New Brunswick EMS Inc., a private corporation and subsidiary of Medavie Inc.

3.2 The contract between EM/ANB and MHSNB provides the framework for delivery of ambulance services in New Brunswick. Amongst other contractual terms, EM/ANB and MHSNB are required to: *"assure continuous and uninterrupted Ambulance Service in the Province of New Brunswick"*[1]. Consistent program delivery is critical to ensure New Brunswickers can use this essential service.

Why we chose this topic

3.3 We chose to audit ambulance services for the following reasons:

- the delivery of ambulance services is a critical component of the public health system for all citizens of New Brunswick;
- quality of ambulance services matters because health outcomes could be impacted in life or death situations;
- ambulance services are subject to a high level of public scrutiny;
- management of EM/ANB has been contracted to the private sector, including responsibility for its $110 million annual budget; and
- Management fees paid to the private sector contractor, MHSNB, averaged $3.2 million annually and exceeded $38 million over 12 years.

[1] Ambulance Service Agreement between Ambulance New Brunswick Inc. and Medavie Health Services New Brunswick Inc.

Audit Objective

3.4 The objectives of this audit were to determine whether:

- The Department of Health's governance structures and processes established for EM/ANB set a framework for effective oversight.
- EM/ANB's contract for ambulance services is designed and managed to achieve expected objectives.

Audit Scope

3.5 Our audit covered the Department of Health and EM/ANB's administration of ambulance services. Our auditees were the Department of Health and EM/ANB; however, we collected audit evidence from MHSNB when deemed necessary. Through the duration of our audit, all parties involved were exceptionally accommodating and cooperative.

3.6 Our audit covered the period between April 1, 2017 and March 31, 2019. This is the period to which our audit conclusions apply. However, to gain a more complete understanding of the subject matter of our audit, we also examined certain matters that preceded the starting date of our audit. More details on audit objectives, criteria, scope and approach we used in completing our audit can be found in Appendix I and Appendix II.

Timeline and Subsequent Events

3.7 In January 2018, Ambulance New Brunswick accepted responsibility for the extra-mural nursing program in New Brunswick and became EM/ANB. Extra-mural services are beyond the scope of our audit.

3.8 In March 2020, EM/ANB was accredited with exemplary standing following an assessment by Accreditation Canada, a not-for-profit organization that provides accreditation for healthcare organizations across Canada. The scope of Accreditation Canada's work focused on extra-mural services and included governance, which was also a focus of our audit. However, Accreditation Canada's perspective did not appear to consider the relationships of EM/ANB to the Department of Health and Medavie Health Services New Brunswick. For the purposes of our audit, we did not place reliance on the content of Accreditation Canada's final report.

3.9 A diagram of significant events which occurred during the ambulance services contracts can be found in Appendix III.

3.10 Details of subsequent events that occurred after our audit period of March 31, 2019 can be found in Appendix IV. We determined it is unlikely these events would substantially change our audit conclusions.

Definitions

3.11 A table of definitions can be found in Appendix V

Conclusions

3.12 We concluded:

- The legislative framework and governance structure chosen by government does not provide sufficient oversight of ambulance services due to conflicts of interest and requires significant improvement.
- Poorly structured contract allowed for questionable payments for paramedic vacancies. This in turn created a disincentive for Medavie Health Services New Brunswick to fix significant operational challenges.
- Contract allowed invalid and excessive use of exemptions, which made 911 response time results inaccurate and led to financial benefit for Medavie Health Service New Brunswick.

Background Information

3.13 The legal form of EM/ANB is a not-for-profit corporation under the *New Brunswick Companies Act*. Created in June 2007, EM/ANB has been delegated responsibility for delivery of ambulance services within New Brunswick. The creation of EM/ANB integrated the operations of 39 separate ambulance operators and 54 separate contracts into one central operation. As a result, EM/ANB became the employer of all paramedics in the New Brunswick.

3.14 According to EM/ANB's inaugural annual report in 2007/08, the centralization of New Brunswick's ambulance service had several advantages, including:

- enhancement of paramedic training to achieve standardized clinical skill levels;
- elimination of standby "on call" shifts and additional "on site" shifts;

- call taking and dispatch consolidation into one communications centre;
- new province-wide clinical protocols development;
- ambulances and clinical equipment standardization; and
- consistent performance expectations and measurement throughout the Province.

3.15 As per the *Ambulance Services Act*, EM/ANB is the responsibility of the Minister of Health. The Department issued the license to operate ambulances in New Brunswick to EM/ANB in December 2007. EM/ANB is governed by a board of directors comprised almost entirely of Department employees. We consider EM/ANB a Crown corporation for the following reasons:

- it is substantially funded through an operating grant provided by the Province;
- its employees are public servants under part III of government;
- it is included in the Province's public accounts as a controlled, consolidated entity of government; and
- its mandate letter, issued by the Minister of Health on November 29th, 2019, identified EM/ANB as a Crown corporation.

Contractual Responsibilities

3.16 The ambulance license outlines responsibilities of both the Minister and EM/ANB. The responsibilities of EM/ANB include:

- provide patient care and transportation services on a 24-hour basis, 365 days of the year, including but not limited to the geographic area of New Brunswick;
- retain such personnel as are required;
- ensure provision and maintenance of all assets required;
- collect and retain fees as established by the Minister; and

- prepare and submit to the Minister such reports, records and documents the Minister may require.

3.17 Under the ambulance license, responsibilities of the Minister include:

- plan, fund, regulate and monitor ambulance services;
- provide medical direction for ambulance services and establish medical protocols;
- participate in labour negotiations respecting employees of EM/ANB as required; and
- set fees for ambulance services.

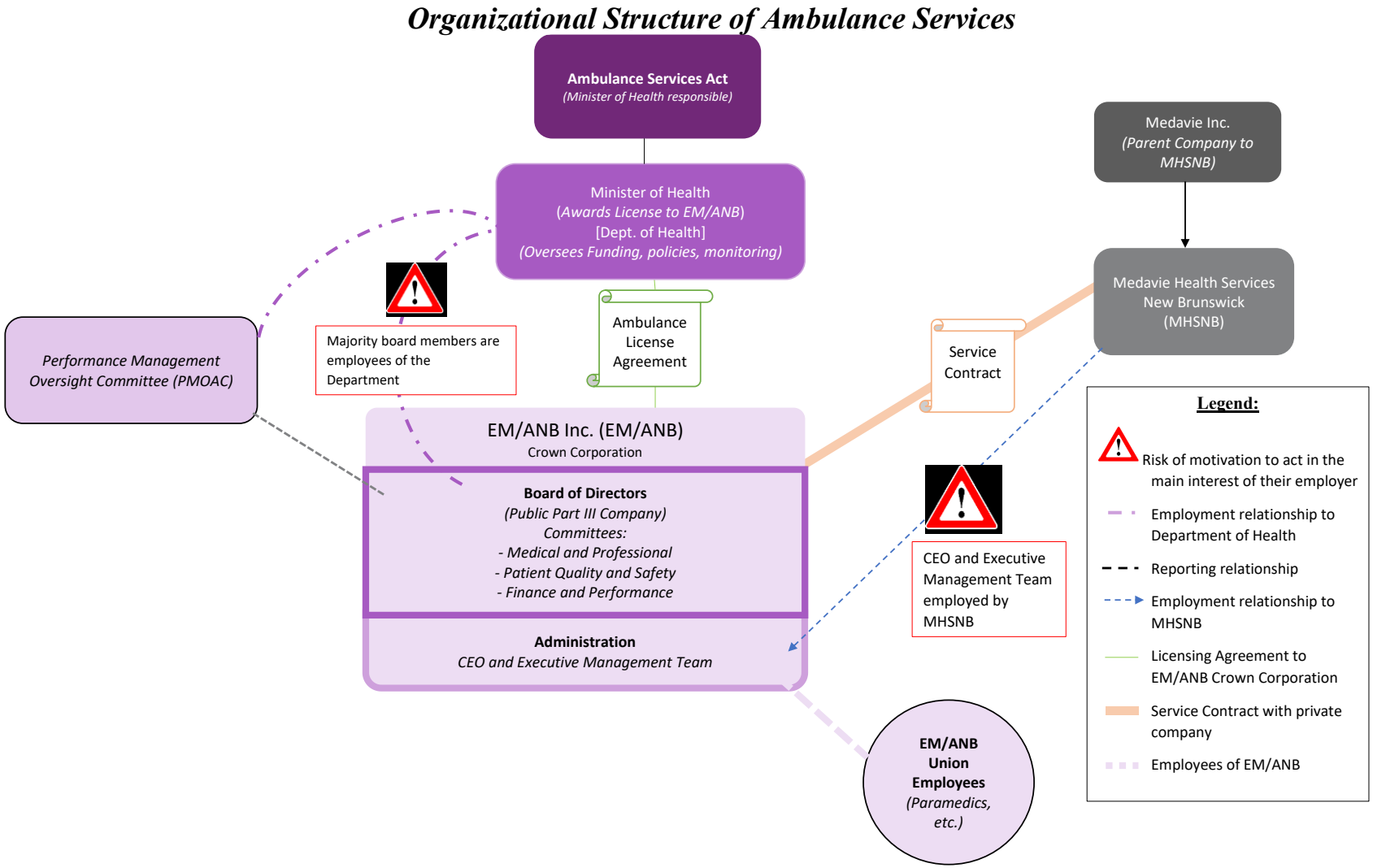
3.18 EM/ANB initially entered into the contract with MHSNB in June 2007 for the management of ambulance services. The Chief Executive Officer (CEO) and executive management team of EM/ANB are employees of MHSNB, whose services are provided to EM/ANB under the contract. The CEO of EM/ANB is also President of MHSNB.

3.19 MHSNB provides management of land and air ambulance services in the Province. The scope of MHSNB's responsibility includes:

- operate the ambulance dispatch via the Medical Communications Management Centre;
- develop and maintain continual quality improvement;
- acquire, manage and maintain assets required to operate ambulance services;
- recruit, hire and dismiss on behalf of EM/ANB;
- provide EM/ANB's management function including CEO and other senior employees;
- report on performance as required by the contract; and
- provide project services upon request by EM/ANB, provided EM/ANB covers all incremental costs incurred by MHSNB.

3.20 Exhibit 3.1 shows the reporting structure for ambulance services. The role of the board is to operate its sub-committees and report to the Minister of Health. The Department is tasked with directing policies and defining standards, providing funding to EM/ANB per the ambulance license, and providing oversight over EM/ANB through monitoring activities.

Exhibit 3.1 - Organizational Structure of Ambulance Services



Source: Created by AGNB with information from the Department

3.21 We identified risks related to the overall organizational design for delivering ambulance services, as well as its governance structure.

3.22 The majority of EM/ANB's board of directors are also employees of the Department, with no impartial membership from the public. We identified the risk that both Department employees and MHSNB employees may be inclined to act in the best interest of their respective employers, rather than EM/ANB.

3.23 As EM/ANB and MHSNB share an executive team, it is difficult for the two organizations to operate independently which creates various inherent conflicts. The Department has formed committees and working units to help address the conflicts.

3.24 We discuss our findings related to these risks further in the section titled *Weak Governance and Control Structure* of this report.

Net Cost of Ambulance Services and Payment Structure

3.25 The Department provides EM/ANB with an annual budget to cover the cost of delivering the service. The contract states budget surpluses, if they occur, are to be shared 50/50 between MHSNB and EM/ANB. In addition, there was an annual management fee. Upon expiration of the contract in 2017, a new ten-year contract was signed wherein the management fee was replaced with a performance-based payment and a cap of $1.1 million was put on MHSNB for its share of surpluses.

3.26 Exhibit 3.2 shows the net cost of ambulance services to the Department for the five years ending in 2018/19. The funding grant is the sum of payments to EM/ANB from the Department to cover ambulance operations as well as contributions made by the Department to EM/ANB's Asset Replacement and System Enhancement Fund for the acquisition of capital assets.

Exhibit 3.2 - Five-Year Net Cost of Ambulance Services (millions)

Five-Year Net Cost of Ambulance Services ($ millions)

	Fiscal Year				
	2014/15	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Funding Grant and Capital Asset Funding	$100.08	$100.95	$106.13	$110.17	$117.72
Billing Revenue	(3.18)	(3.70)	(3.59)	(3.88)	(3.77)
Department's portion of EM/ANB surplus	(2.22)	(2.13)	(2.01)	(1.17)	(1.45)
Net cost to the Department	**$94.68**	**$95.12**	**$100.53**	**$105.12**	**$112.50**

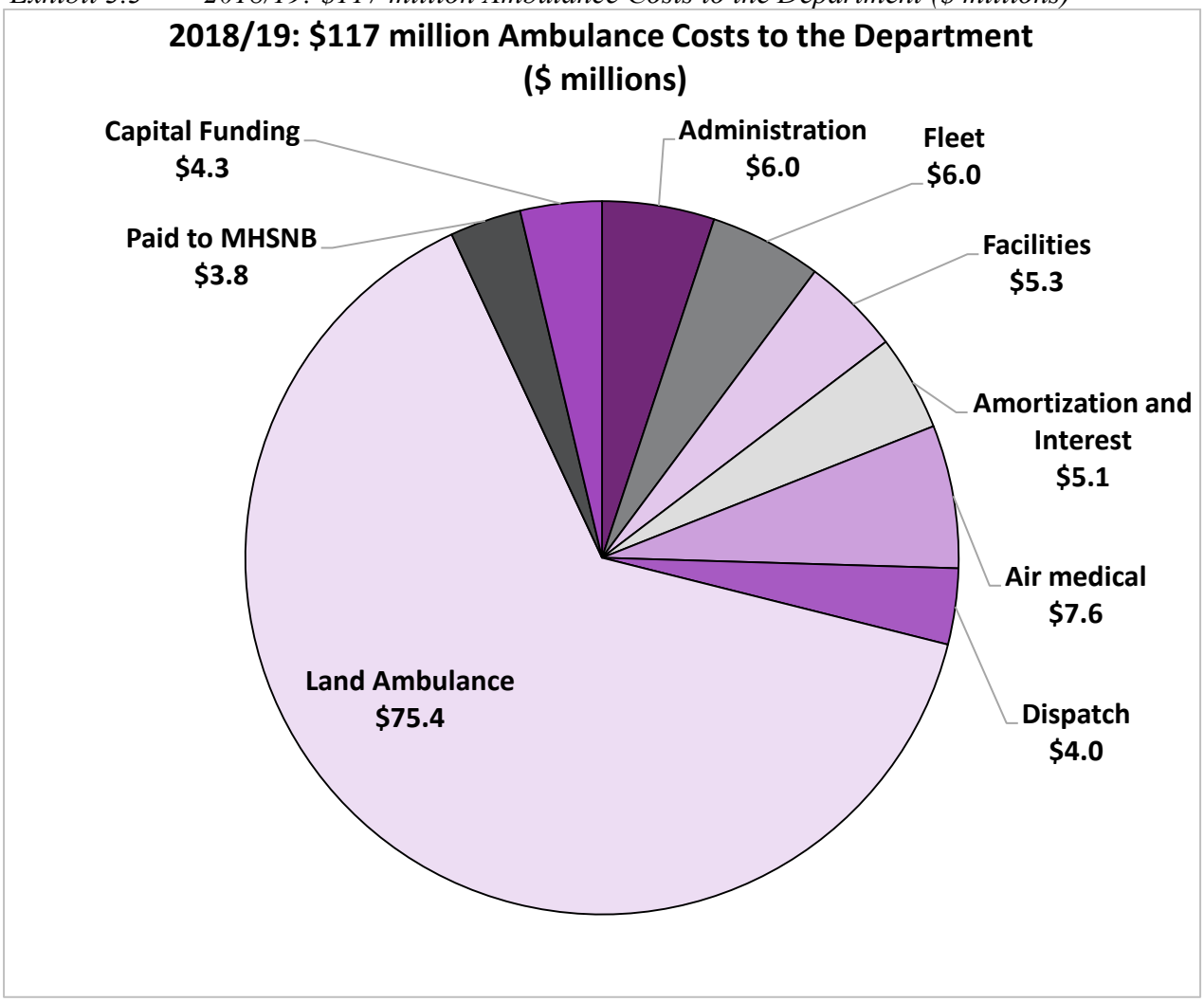
Source: Created by AGNB from EM/ANB financial statements

3.27 Cost to the Department is partially offset by billing revenue. EM/ANB charges invoices to individuals for the use of ambulances under certain conditions. Also, EM/ANB's portion of the 50% surplus arrangement was refunded to the Department.

3.28 Exhibit 3.3 shows the breakdown of the $117 million Funding Grant and Capital Asset Funding in 2018/19. According to EM/ANB's annual report, $75.4 million was allocated to land ambulance. This primarily paid the wages of paramedics but also included reimbursement to MHSNB for salaries of management or non-union employees.

3.29 In 2018/19, approximately 180 management or non-union positions related to ambulance services at EM/ANB were occupied by MHSNB employees. Gross earnings for those employees totalled $8.9 million. This does not, however, include the EM/ANB CEO's salary as it is funded through the extra mural administrative budget.

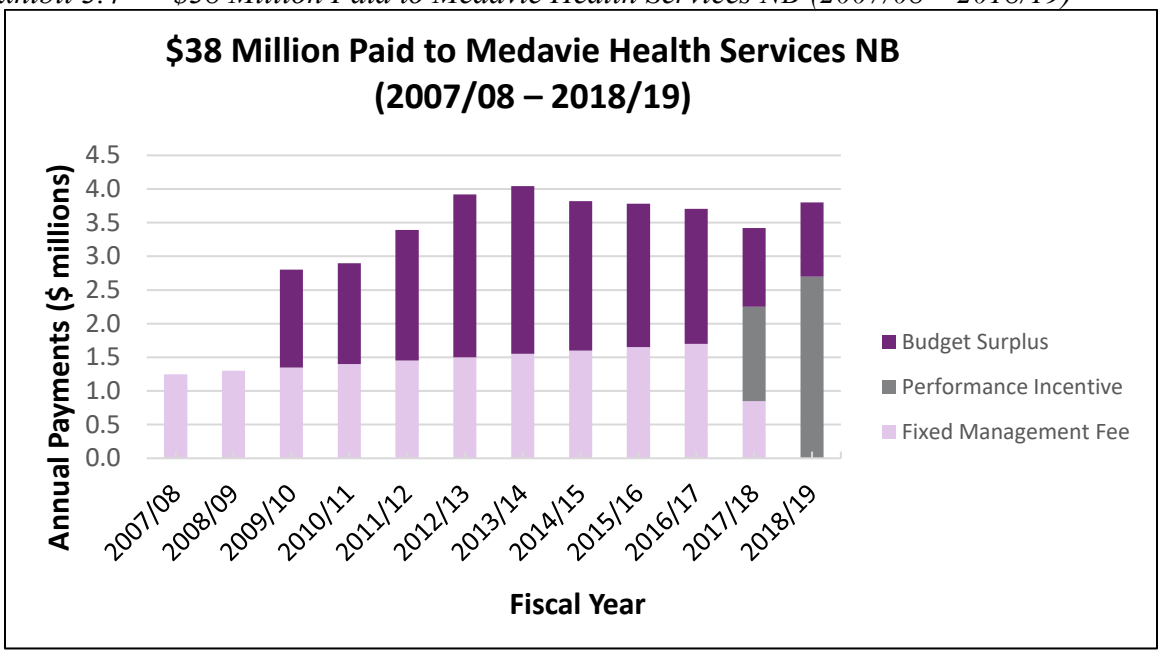
Exhibit 3.3 - 2018/19: $117 million Ambulance Costs to the Department ($ millions)



Source: Created by AGNB from EM/ANB 2018/19 financial statements

3.30 Exhibit 3.4 shows the historical payments made to MHSNB for management services under the initial ten-year contract and the first two years after renegotiation.

Exhibit 3.4 - $38 Million Paid to Medavie Health Services NB (2007/08 – 2018/19)



Source: Chart prepared by AGNB with information provided by Medavie Health Services NB

3.31 The Department paid over $38 million to MHSNB over the twelve-year period. These payments are in addition to payroll expenses for MHSNB employees and goods procured by MHSNB on behalf of EM/ANB. Total annual payments for management services have ranged from $1.3 million in 2007/08 to $4.1 million in 2013/14 for an average of $3.2 million per year.

3.32 Under the contract, if EM/ANB achieves a surplus, MHSNB is entitled to 50%. Budget surplus payments in Exhibit 3.4 represent MHSNB's portion of surpluses. The total of budget surpluses paid to MHSNB is $18.4 million out of a total $38 million during the 12 years. Fixed management fees accounted for $15.6 million during the 12 years.

3.33 Upon contract renegotiation in 2017, fixed management fees were replaced with performance incentive payments. MHSNB now receives payment based on meeting or exceeding target key performance indicators (KPIs). Fiscal year 2017/18 was a transitional year where payment was made using a combination of terms between the old and new contract.

3.34 In 2018/19, the current contract removed the fixed management fee payment and the payment for budget surplus was capped at $1.1 million. The remaining $2.7 million was awarded upon meeting annual KPIs, for a total payment to MHSNB of $3.8 million.

Performance Expectations

3.35 In 2007, MHSNB introduced a dynamic deployment system. The concept of dynamic deployment attempts to optimize ambulance coverage at any given time. When an ambulance is dispatched to a call, nearby ambulances move strategically in an attempt to ensure no area is left without coverage.

Source: EM/ANB Annual Report 2017/18

The contract sets out resources needed to achieve performance expectations

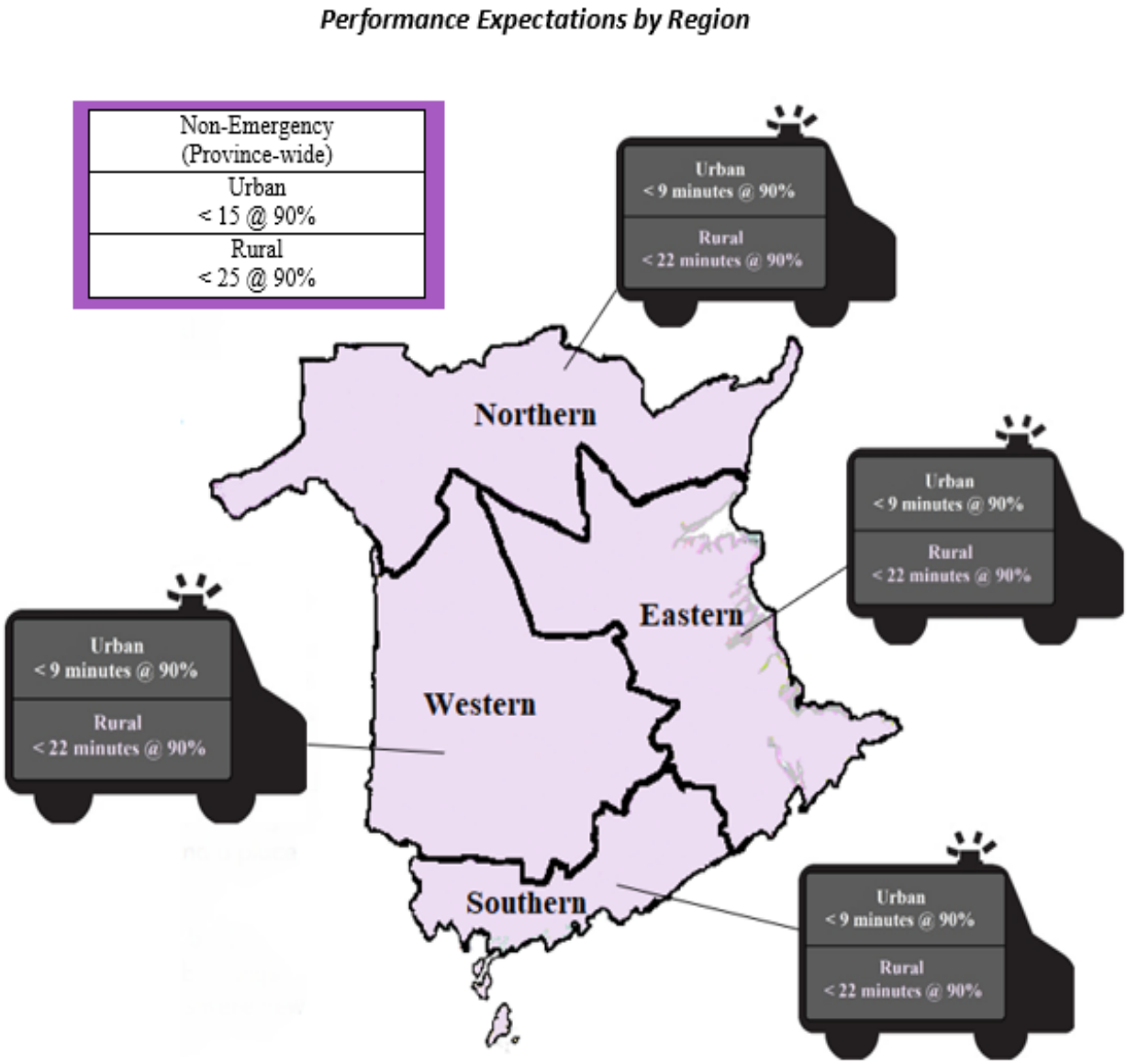
3.36 The execution of dynamic deployment is informed by MHSNB's model; the System Status Plan. Under the contract, the System Status Plan includes detailed specifications as to the ambulances, facilities and human resources to be deployed to achieve performance standards. The number of ambulances, paramedics, dispatchers, etc. are detailed in Schedule "B" of both the original contract and the renegotiated contract. MHSNB and EM/ANB agreed, by signing the contract, that these resources were sufficient to achieve the performance expectations within the contract.

Emergency response performance measured by combining rural and urban areas in each of four regions

3.37 The contract divides the Province into four geographic regions, designated Northern, Southern, Eastern and Western. Emergency and non-emergency response performance are measured by combining rural and urban areas in each of the four regions and within the Province, respectively.

3.38 Exhibit 3.5 shows the performance expectation which has been in place since inception of the original contract. The expectation has been that ambulances respond to 911 emergency calls within nine minutes in urban areas and 22 minutes in rural areas, 90% of the time. The expectation for responses to non-emergency calls, or where there is no perceived threat to life or limb, are 15 and 25 minutes, respectively.

Exhibit 3.5 - Performance Expectations by Region



Source: Created by AGNB with information from the Department

3.39 Exhibit 3.6 shows which communities are designated as urban within the ambulance system in New Brunswick. Outside of these communities, the 22-minute emergency response time expectation applies.

Exhibit 3.6 - Communities Designated as Urban Under the Contract

Communities Designated as Urban Under the Contract

Urban Communities (alphabetically)	
Bathurst	Moncton
Campbellton	Oromocto
Dieppe	Quispamsis
Edmundston	Riverview
Fredericton	Rothesay
Grand Bay-Westfield	Sackville
Grand Falls	Saint John
Miramichi	Woodstock

Source: Excerpt from The Ambulance Services Agreement (contract) with Medavie Health Services NB

3.40 The System Status Plan includes deployment plans which specify, by service district, how many ambulances should be deployed at any given time to respond to the anticipated call volume for each area. Service districts are groupings of communities, both rural and urban, in a given geographic area.

Ambulances are moved around as needed to provide best coverage using dynamic deployment

3.41 Each deployment plan describes what ambulance stations or posts are expected to be covered at any given time. The stations and posts are prioritized so that, when ambulances become occupied, other ambulances can be moved under dynamic deployment to provide the best coverage with the resources available.

3.42 Deployment plans also specify the minimum number of ambulances required to ensure a reasonable expectation of response within contractual times. This is referred to as the Emergency Cut-off. If one service district is below Emergency Cut-off and neighboring districts are above, the deployment plans allow for neighboring districts to provide coverage. The deployment plans make suggestions about where ambulances might be pulled from to provide additional coverage between districts if needed.

Operational Challenges

3.43 Operational challenges exist for EM/ANB, which are not made apparent within the current suite of KPIs presented in the performance compliance section of its annual reports.

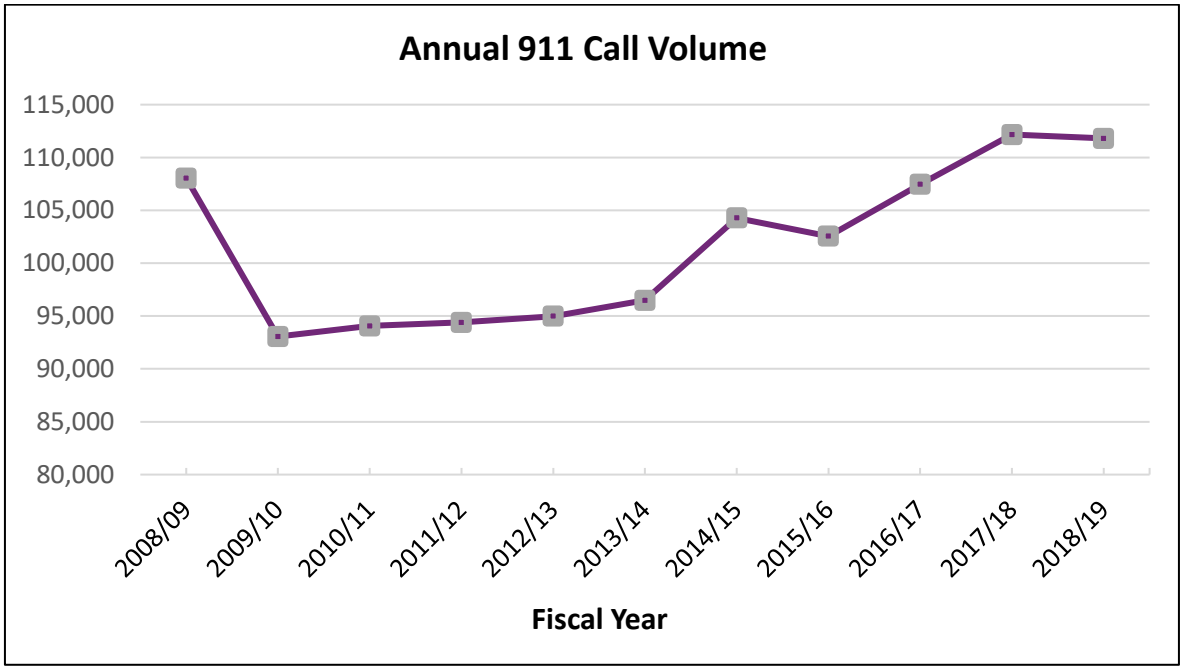
96 vacant permanent paramedic positions in 2019

3.44 In EM/ANB's inaugural annual report for 2007/08, the self-reported number of vacant paramedic positions was 150. The report stated paramedic staffing was EM/ANB's key challenge at that time. MHSNB indicated to us the level of vacancy has been consistent since 2007. As of 2019, MHSNB has indicated the number of vacant permanent paramedic positions is 96.

Steady increase in call volume since 2009/10

3.45 MHSNB has indicated the need for additional resources is increasing due to increasing call volume. Exhibit 3.7 shows annual call volume for the 11 years from 2008/09 fiscal through 2018/19. After a particularly high-volume year in 2008/09, the graph shows a steady increase in call volume from 93,000 ambulance calls in 2009/10 through to 112,000 in 2018/19. According to EM/ANB's 2009/10 annual report, the decrease in call volume was attributable to a reduction in patient transfers after the introduction of ambulance fees.

Exhibit 3.7 - Annual 911 Call Volume



Source: Created by AGNB with information from EM/ANB's annual reports

Weak Governance and Control Structure

EM/ANB lacks enabling legislation and its mandate is unclear

3.46 We found EM/ANB lacks enabling legislation and its mandate is unclear.

3.47 We expected EM/ANB, like other Crown corporations, would have an enabling act providing the overall objective of the organization, board composition, and authority. As a Crown corporation, within the group comprising the health care segment of the Province, our expectation was EM/ANB would follow a similar configuration to that of the Regional Health Authorities. Both Regional Health Authorities; Vitalité Health Network and Horizon Health Network, have enabling legislation within the *Regional Health Authorities Act.*

3.48 Similarly, we expected the Minister of Health would submit, annually, a mandate letter to EM/ANB to accompany its funding approval letter and provide a more detailed strategic direction.

Ambulance Services Act *missing important governance components*

3.49 We sought to review enabling legislation and mandate letters for EM/ANB to evaluate how well the contract was designed to align with EM/ANB's goals. However, we found the *Ambulance Services Act* does not contain a mandate for EM/ANB, nor does it prescribe its board composition or authority. Neither enabling legislation nor mandate letters existed to provide direction to EM/ANB during the period of our audit. However, we did note a mandate letter for EM/ANB was drafted and signed by the Minister of Health on November 29, 2019, during the conducting of our audit and subsequent to our audit period.

Overall direction for ambulance services lacks clarity

3.50 Without enabling legislation or mandate letters, the overall direction for EM/ANB lacks clarity and does not carry the weight of law. This weakens the Department's control over the Crown corporation. Without a clear mandate, it is difficult to assess whether the various agreements, contracts and corporate strategy are in alignment.

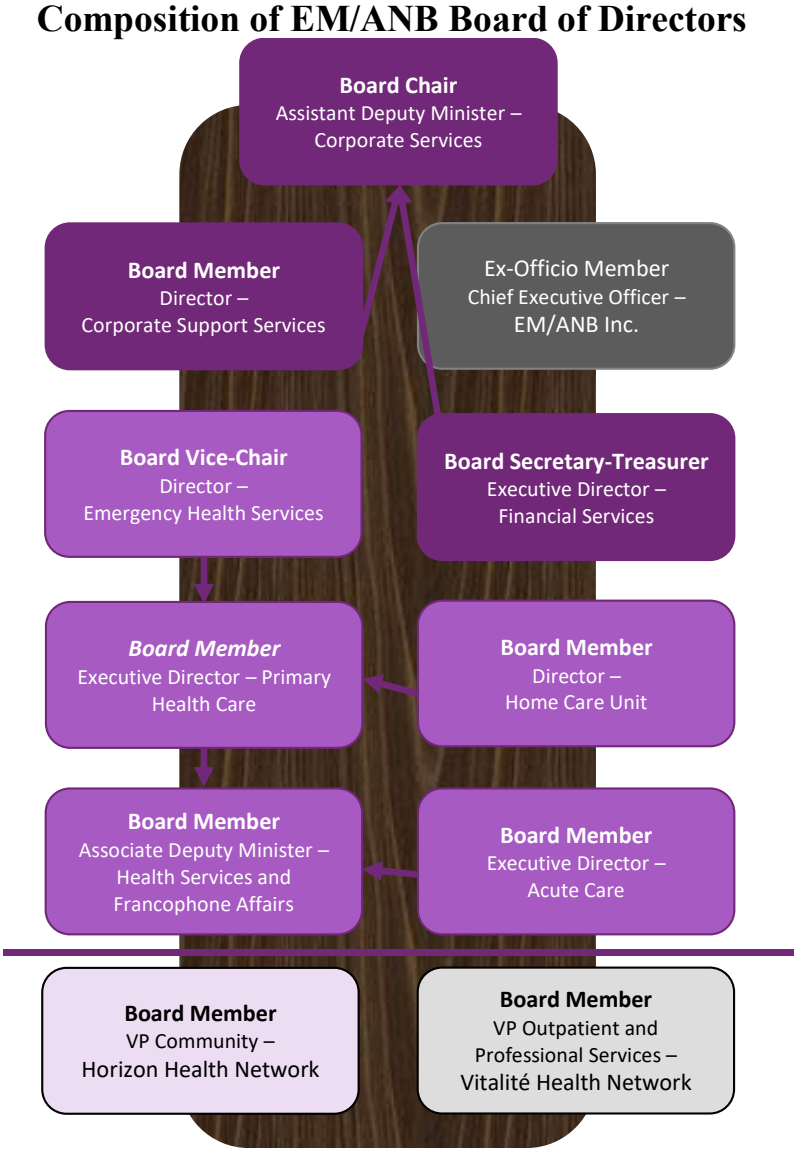
Recommendation

3.51 We recommend the Department formalize the mandate and governance for EM/ANB in legislation and provide mandate letters to EM/ANB with the annual budget approval.

Board composition created a complex management relationship

3.52 Exhibit 3.8 shows the composition of the board. All but two members of the board are employees of the Department. This created a complex management relationship within the board. For example, two board members reported directly to the board chair in their capacity as employees of the Department. Four other board members reported directly to other board members in their capacity as employees of the Department. The remaining two members were employees of the Regional Health Authorities.

Exhibit 3.8 - Composition of EM/ANB Board of Directors as of 2017/18



Source: Created by AGNB with information provided by the Department

Board composition inhibits independence

3.53 We found the board composition inhibits independence largely due to the fact most of the board members are employees of the Department.

3.54 We expected to see public representation, or members independent of the Minister of Health, acting as board members to improve the overall independence of the board. We view this as best practice for Crown corporations to improve public accountability and objectivity by reducing competing priorities amongst board members.

Conflicts of interest may prevent board from acting in best interests of EM/ANB

3.55 Under this arrangement, it may have been difficult for individual board members to question or challenge other members of the board, given the nature of their reporting relationships within the Department. Moreover, the EM/ANB board by-laws state membership of any board member may be terminated on written notice to the company by the Minister of Health. This further creates a conflict of interest for board members, who may be inclined to act in the best interest of the Minister or the Department as opposed to EM/ANB.

Recommendation

3.56 We recommend the board by-laws be amended to change the composition of the board to include members independent of the Department.

Board fails to recognize and mitigate conflicts of interest

3.57 We found the board fails to recognize and mitigate perceived or actual conflicts of interest.

3.58 We expected to find board members declare potential conflicts of interest during meetings and discuss whether recusal is necessary. Due to their roles as employees of the Department, we expected occasional conflicts would arise. However, we found this practice was not followed.

Despite conflicts of interest, board members did not recuse themselves from decision-making process

3.59 In September 2017, the board delegated spending authority on the Asset Replacement and Systems Enhancement Fund to the board vice-chair and the board chair. We view any board member to be in conflict of interest where the subject of a board vote is to delegate authority to themselves. We would have expected both vice-chair and chair to recuse themselves from their respective delegation votes. Despite the conflict of interest each had in participating in the vote, neither member recused themselves from the decision-making process.

Risk of board members not acting in the best interests of EM/ANB went unmitigated

3.60 The board does have a conflict of interest policy, however; we found it was not followed. Without requiring board members follow its conflict of interest policy, and declare conflicts of interest, the risk of board members not acting in the best interest of EM/ANB went unmitigated. This left EM/ANB vulnerable to undue influence of departmental goals on corporate decision making.

Recommendation

3.61 We recommend the board enforce its conflict of interest policy and periodically review the effectiveness of the policy in mitigating conflict of interest risk.

Contract compromised the board's influence over its CEO

3.62 We found the design of the contract compromised the board's influence over its own CEO.

3.63 Typically, a corporate board of directors has a single employee; a CEO. We expected the board would employ the CEO of EM/ANB to maintain control over:

- selection;
- salary and compensation package; and
- performance evaluations of the CEO.

Not possible for the board to select a CEO

3.64 The CEO of EM/ANB is not selected by the board. MHSNB selects the CEO and presents its selection to the Minister. According to the board's bylaws, the Minister then recommends to the board the CEO be approved. It is not possible for the Minister of Health or the board to select a CEO, other than one presented by MHSNB, without being in breach of the contract.

Unlikely board members could vote objectively on the selection of CEO

3.65 The board is required to vote on the recommendation set forth by the Minister. However, due to board members' lack of independence as employees of the Minister, it is unlikely they could vote objectively on the selection of the CEO.

Board does not have influence over compensation paid to CEO

3.66 The board does not have influence over the amount or type of compensation paid to the CEO. Compensation for the CEO and executive management of EM/ANB is allocated by MHSNB from the annual contract budget provided by the Department and the board does not have influence over this compensation.

Board does not evaluate performance of CEO

3.67 The board does not evaluate performance of individuals employed by MHSNB, including the CEO. As such, the board could not have taken corrective action against the CEO should the results of any evaluations identify areas for improvement.

3.68 The board has authority to remove the CEO; however, selections for the Minister's consideration are again limited to what is put forth by MHSNB.

Lack of control calls into question board's influence over CEO

3.69 Inability to control these aspects of employment, due to the terms of the contract, calls into question whether the board has sufficient authority and influence over its CEO to ensure strong performance.

Recommendations

3.70 We recommend EM/ANB enabling legislation strengthen and clarify board authority with respect to hiring, compensation, performance and termination of the CEO.

3.71 We recommend the board hire an independent CEO upon future contractual amendment or renegotiation.

No evidence board challenged CEO's strategy for EM/ANB to ensure alignment with obligations to Department

3.72 We found no evidence the board challenged the CEO's strategy for EM/ANB to ensure it aligns with EM/ANB's obligations to the Department.

3.73 We expected to see elements of EM/ANB's corporate strategy and annual plans be discussed amongst board members and documented in board minutes. The review should have determined how well strategy and annual plans aligned with EM/ANB's mandate as prescribed by the Department.

3.74 We reviewed board minutes to determine whether the board reviews and approves corporate strategy. Each board meeting includes a CEO update; however, meeting minutes do not reflect any discussion of what was presented. The strategic plan was mentioned once in the minutes for 2018 and 2019, however, there was no detailed record of discussion.

Board does not regularly review annual plans of EM/ANB

3.75 The board does not regularly review annual plans of EM/ANB and does not compare annual plans against information in annual reports. Overall, the board does not appear to challenge the CEO on the corporate strategy of EM/ANB, nor does it use the review of annual plans as an

opportunity to evaluate the performance of the CEO and MHSNB.

Neglecting to review annual plans reduced effectiveness of board's decision-making

3.76 Not reviewing annual plans against results in EM/ANB's annual reports reduced the board's effectiveness in reviewing the overall performance of EM/ANB. This inhibits the board's ability to evaluate the vision of its CEO and the performance of MHSNB. This lack of monitoring reduced the effectiveness of the board's decision-making process in meeting its obligations to the Department under the ambulance license.

Recommendations

3.77 We recommend the board evaluate EM/ANB's annual corporate plans as part of its review of the CEO and MHSNB's performance and compare them to EM/ANB's annual report and obligations to the Department.

3.78 We recommend the board establish a performance management framework for EM/ANB and evaluate its performance annually.

Board did not receive reports from Performance Management Oversight Advisory Committee after 2017

3.79 We found the board did not receive reports from the Performance Management Oversight Advisory Committee after 2017.

3.80 We expected EM/ANB, as the holder of the contract, to be solely responsible for contract management. However, as the executive leadership of EM/ANB are employed by MHSNB, it was necessary for the Department, including board members, to perform this function.

3.81 Part of the solution was to establish the Performance Management and Oversight Advisory Committee (PMOAC) to perform the contract management function and report to each board meeting.

3.82 The chair of PMOAC was also vice-chair of the EM/ANB board and membership consisted of departmental employees and select employees of MHSNB. Existing outside of the board, the PMOAC met throughout the year and was meant to report to the board:

- reviews of KPIs for all aspects of MHSNB's operations;
- reviews of contractually required reports;

- advice on financial affairs related to EM/ANB goals; and
- recommendations relating to equipment, technology, safety and other resources.

3.83 The PMOAC performed many of the functions EM/ANB management would normally have performed, including oversight of the contractual performance of MHSNB.

3.84 From our review of PMOAC minutes, we noted the PMOAC:

- only considered performance indicators that were contained in the contract;
- was inconsistent in its follow-up on reports and information requested from MHSNB;
- chair did not provide formal reports to the board; and
- did not provide advice on financial affairs related to EM/ANB goals.

PMOAC did not follow up on information request to MHSNB

3.85 In one instance, PMOAC formally requested MHSNB's out-of-service units and human resources reports, but we did not find evidence MHSNB ever supplied them. There was no indication within the PMOAC minutes that this request was followed up on.

3.86 We expected to see records of PMOAC reports, with a detailed summary of what was presented, in board meeting minutes.

3.87 We reviewed the board minutes to determine how frequently the PMOAC reported to the board. Although the PMOAC was required to report to the board at each meeting and provide an annual report, there were no PMOAC presentations to the board after 2017.

Board did not have sufficient information to effectively oversee contract

3.88 Without including the PMOAC in its deliberations, it appeared the board did not have sufficient information to effectively oversee the contract. However; the chair of the PMOAC was also a member of the board and may have provided informal updates.

Board does not request or receive information necessary to fully assess EM/ANB's performance

3.89 We found the board does not request or receive the information necessary to fully assess the performance of EM/ANB.

3.90 In our review of the board and sub-committees, we noted:

- the Finance and Performance Committee does not appear to challenge or report on the performance of MHSNB in fulfilling the terms of the contract; and
- the Governance and Nominating Committee was created but had not met during our audit period.

3.91 We expected to see sub-committees of the board providing annual reports to the board to allow for matters of importance to be discussed amongst board members and to improve transparency.

Lack of detail recorded in the board minutes

3.92 It was unclear what was provided to the board or what was discussed during the meetings due to a lack of clarity and detail recorded in the board minutes.

3.93 Without effective use of sub-committees and a rigorous review of performance reporting, it appeared the board did not have sufficient information to effectively oversee EM/ANB.

Recommendations

3.94 We recommend the terms of reference of each standing committee require an annual written report to the Board of Directors to demonstrate the sub-committees are operating as intended.

3.95 We recommend the board improve its recording of minutes to increase transparency.

Contract Allowed Questionable Basis of Payments

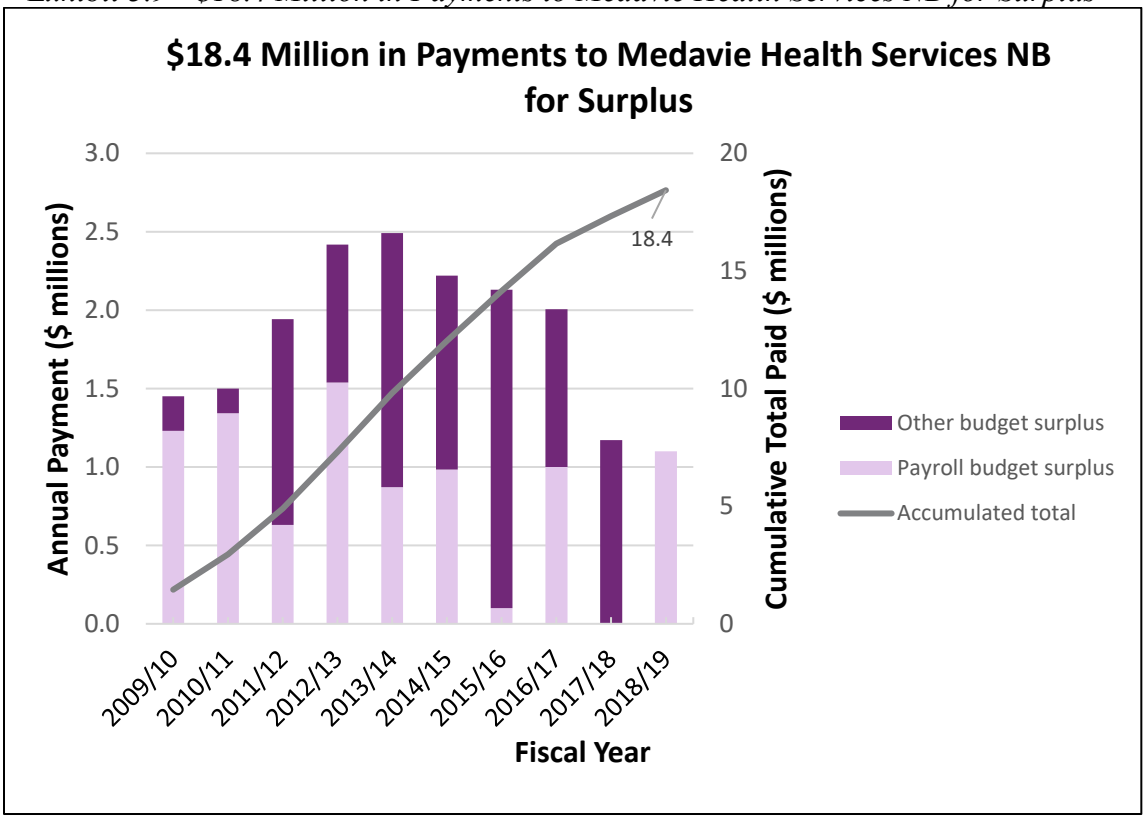
Paramedic shortages created over $8 million in surplus payments to MHSNB, providing an incentive to maintain low staffing levels

3.96 We found paramedic shortages created over $8 million in surplus payments to MHSNB, providing an incentive to maintain low staffing levels.

3.97 The Department provides funding for ambulance services to EM/ANB; however, these funds are managed by MHSNB. Under the contract, if MHSNB achieves a surplus they are entitled to keep 50% of the surplus amount.

3.98 Exhibit 3.9 shows surplus payments to MHSNB since the inception of the original contract. The initial two fiscal years are not shown as no surplus payment was made. MHSNB was paid a total of $18.4 million for budget savings over the following ten-year period. Payroll variances contributed most significantly to surpluses during that time, totalling $8.8 million.

Exhibit 3.9 - $18.4 Million in Payments to Medavie Health Services NB for Surplus



Source: Created by AGNB with information from Medavie Health Services NB

Source: EM/ANB Annual Report 2017/18

3.99 We expected that any surplus calculation of budgeted payroll would use a flexible approach where labour costs are adjusted based on anticipated spending, given employee vacancies and typical over-time hours.

Budgeted payroll costs used in payment calculation assumed full utilization of ambulances

3.100 Budgeted annual payroll costs for paramedics, used in the budget surplus payment calculation, were determined using the System Status Plan in effect as of March 31, 2017. It assumed full utilization of ambulances and no paramedic vacancies. Full utilization would require EM/ANB hire all the paramedics needed during the year or make up for the shortage with over-time.

3.101 Payroll costs appeared to have been overbudgeted within the basic contract amount upon renegotiation of the contract and appeared to ultimately provide the payroll variance. Considering EM/ANB's history of vacancies and out-of-service time, it was unlikely this method accurately predicted labour costs. Additionally, this method of determining the budget for labour is consistent with the original contract, suggesting payroll costs have been overbudgeted over the 12 years of both contracts.

Overbudgeted payroll costs provided means for questionable payments to MHSNB

3.102 Overbudgeted expense categories directly impacted the apparent budget savings, which provided the basis for budget surplus payments under the contract. In our view, calculating labour cost based on full utilization of ambulances within the budget provided the means for

inappropriately paying MHSNB (based, circumstantially, on its failure to fill paramedic vacancies). This provided an incentive to MHSNB to overestimate the paramedic requirement or maintain low staffing levels while still meeting performance obligations.

Recommendation

3.103 We recommend EM/ANB calculate budget surplus payments based on flexible budget amounts which reflect the anticipated spending for the fiscal year.

The contract does not clearly define the performance expectations or restrictions related to budget surplus payments

3.104 We found EM/ANB's contract with MHSNB does not clearly define performance expectations or restrictions related to budget surplus payments.

3.105 We expected the contract to have clearly defined performance expectations related to budget surplus payments, as this appears to be an incentive to encourage cost savings. We expected any payments related to achieving budget savings would have restrictions in place to avoid any negative impacts to service delivery via cost-cutting measures.

Contract did not explicitly state how budget savings could be achieved

3.106 The contract did not explicitly state how budget savings could be achieved. It was unclear where opportunities existed to achieve savings in delivery of ambulance services and the Department did not specify which budget areas could be targeted for savings.

Lack of restrictions in the contract on targeted savings provided opportunity for MHSNB to neglect filling vacant positions

3.107 In our view, it was questionable to allow MHSNB full autonomy in deciding where to reduce cost. Not placing restrictions in the contract on targeted savings provided opportunity for MHSNB to neglect filling vacant positions and maximize the budget surplus payments.

Recommendation

3.108 We recommend the board define restrictions around budget surplus payments to exclude circumstances which may decrease the quality of the delivery of ambulance services.

Department did not hold EM/ANB or MHSNB accountable for cost savings

3.109 We found the Department did not hold EM/ANB or MHSNB accountable for demonstrating how cost savings used in the surplus payment calculation were achieved.

3.110 In the 2019 Report of the Auditor General of New Brunswick, Volume II, released December 2019, we stated: "*In fulfilling its stewardship function over taxpayers' money, government is expected to hold all funding*

recipients accountable for monies received and results achieved". In our view, any contract with incentives for budget savings should include provisions for strict monitoring of where cost savings are achieved.

Calculation for budget surplus payments did not explain how savings were achieved

3.111 We expected the Department to require MHSNB to report on initiatives implemented to achieve savings. Instead, the calculation for budget surplus payments was based on a budget-to-actual comparison report for the year. Expense categories in MHSNB's report did not match categories in budget approval documents used by the Department. Further, the report did not provide detailed budget-to-actual variance analysis to explain how savings were achieved.

Process eroded Department's ability to hold MHSNB accountable for achieving savings

3.112 Because MHSNB reported expenses did not match budget categories and lacked detailed variance analysis, it would have been difficult for the Department to reconcile this report to what was approved in the budget and perform a critical analysis prior to approving budget surplus payments. In our view, the process lacked transparency and eroded the Department's ability to hold MHSNB accountable for achieving savings.

Recommendation

3.113 We recommend the board ensure EM/ANB or MHSNB substantiate how savings are achieved to demonstrate the value provided through cost savings claimed under the contract for ambulance services.

Calculations of budget surplus payments were based on subjective factors

3.114 We found calculations of budget surplus payments were based on subjective factors.

3.115 We expected the calculation for determining the budget surplus payments would be objective. Any exclusions or adjustments in the calculation should have had the explicit purpose of maintaining the integrity of ambulance services.

3.116 We reviewed the budget surplus payment calculations, which exclude certain costs as outlined in the contract. The excluded categories related to, among other things:

- fuel;
- major medical supplies;
- incremental cost to MHSNB of any extraordinary occurrences;
- impact of inflation;

- the cost attributable to the failure of EM/ANB to replace capital assets; and
- incremental cost of kilometres driven by all vehicles in excess of contract specifications.

3.117 Adjustments to exclude fuel and medical supplies costs effectively reduced the incentive for MHSNB to pursue cost-cutting measures in these areas. As a result, the Department bears the budget risk for these categories.

Adjustments further introduced subjectivity to the budget surplus payment calculation

3.118 Categories such as extraordinary circumstances or failure to replace assets were not well defined in the contract. The extent to which MHSNB is expected to anticipate extraordinary circumstances, for example, is not clear. It is not explicit in the contract what circumstances are eligible for a claim under these adjustments, and this further introduced subjectivity to the budget surplus payment calculation.

Excluded expenses would have lowered surplus payments to MHSNB

3.119 We found excluded costs would have lowered surplus payments to MHSNB.

3.120 In our analysis of budget surplus payment calculations, we calculated the total impact of adjustments to exclude certain costs during the 10-year period. The costs adjusted out of the calculation during that time had a total impact of -$2.5 million. Had these been included; the costs would have reduced payments to MHSNB related to budget surplus by $1.2 million over the 10-year period.

Contract Allowed Excessive Use of Exemptions & Ambiguous Performance Measures

Contractual requirement of continuous and uninterrupted service not well defined

3.121 We found the contractual requirement of continuous and uninterrupted service is not well defined.

3.122 We compared EM/ANB's responsibilities to the Department with that of MHSNB's contractual responsibilities. We noted EM/ANB, through the contract, has delegated much of its responsibility to MHSNB.

3.123 We expected the contract would provide a clear directive for MHSNB to achieve alignment with EM/ANB's mandate.

3.124 We reviewed the contract and found section 1.1 of the contract states: *"[EM/ANB] is required to assure continuous and uninterrupted Ambulance Service in the Province of New Brunswick"*

Unclear what would constitute service interruption

3.125 It is unclear what would constitute a service interruption or break in the continuity of service under the contract. The ambulance license states EM/ANB is required to provide patient care and transportation services on a 24-hour basis, 365 days of the year. Without a detailed definition of either of these requirements, it is unclear whether some operational issues within the ambulance service would constitute a breach.

Source: Radio-Canada archives

Lack of clarity weakens ability of Department to hold EM/ANB accountable for maintaining service levels

3.126 This lack of clarity weakens the ability of the Department to hold EM/ANB or MHSNB accountable for maintaining service levels. The contract constitutes the primary source of resolution for any potential conflict between the interests of MHSNB and EM/ANB. As such, the integrity of ambulance services relies on the design quality of the performance measurement framework and payment structure within the contract.

Performance-based payments introduced a quality of service bias, detrimental to rural areas

3.127 Performance-based payments introduced a bias toward achieving high performance in areas of greater population density, to the detriment of rural or remote communities where 911 emergencies occur less frequently. Response times were the primary measure by which the performance incentives were paid in both 2017/18 and 2018/19. The contract also provides incentives for performance in language of service and patient transfers; however, the KPIs and targets for these responsibility areas were still in development at the time of our audit.

3.128 Under the contract, the most significant basis for performance-based payments was response time. MHSNB was eligible for an additional $650,000 annually based on the frequency with which they responded to 911 calls within the expected response times.

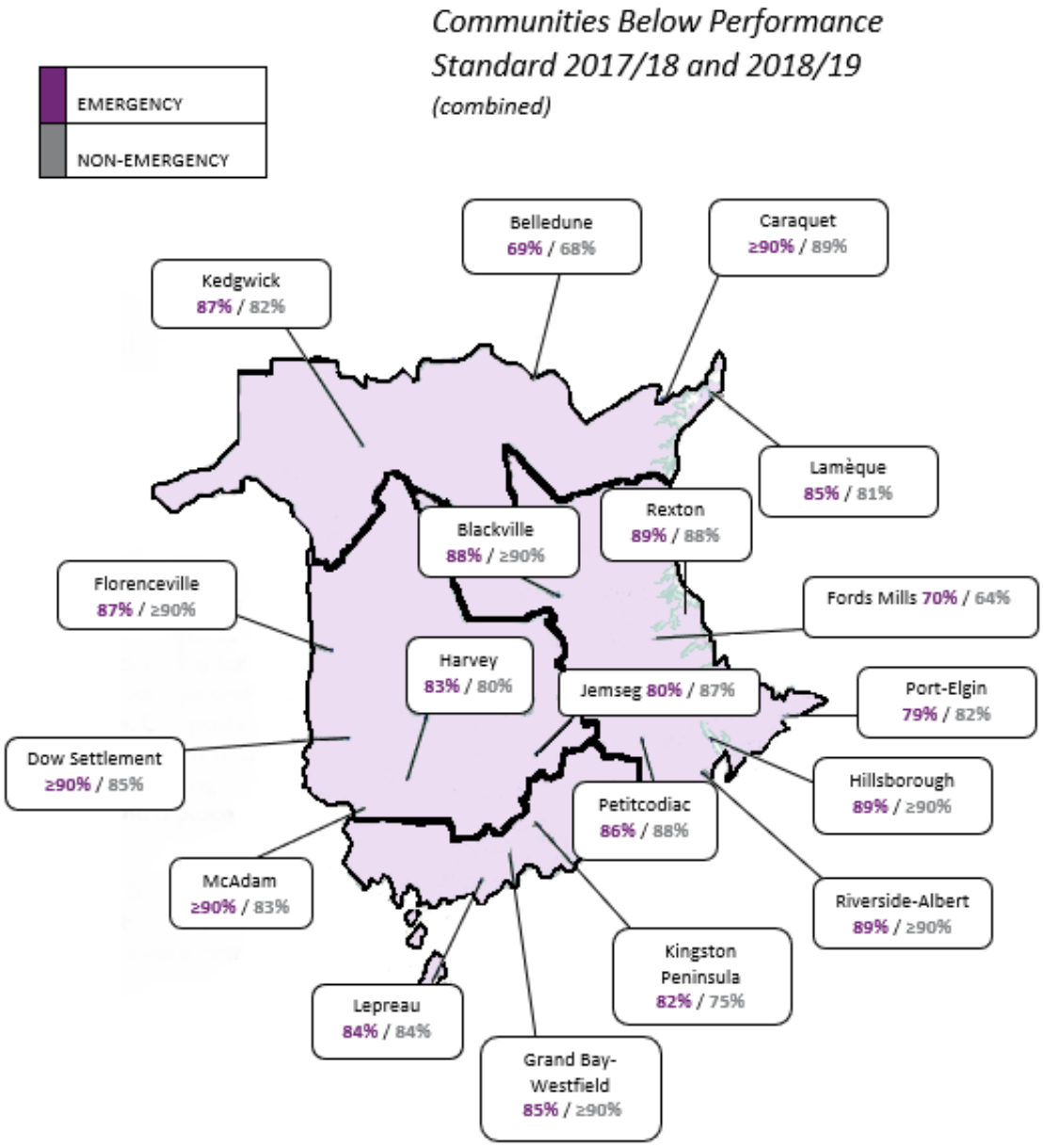
3.129 Performance based payments were awarded when ambulances arrived on-scene within the required response time, on average, 90% of the time. The incentive increased incrementally up to a target of 92%.

3.130 We analyzed ambulance call data to determine how the response time KPI may have influenced MHSNB performance in the delivery of ambulance services to New Brunswick communities.

19 of 67 communities fell below 90% performance expectation

3.131 We recalculated performance results by community for the two fiscal years 2017/18 and 2018/19 combined. Exhibit 3.10 shows, out of 67 communities, 19 fell below the 90% performance expectation in responding to emergencies, non-emergencies or both.

Exhibit 3.10 - Communities below performance standard 2017/18 and 2018/19 (combined)



Source: Created by AGNB with information from the Medavie Health Services NB

Communities' results below performance standard had no effect on performance-based payments to MHSNB

3.132 We were surprised to find performance falling below expectation in these communities had no effect on performance-based payments to MHSNB. MHSNB received full performance-based compensation in both fiscal years 2017/18 and 2018/19. This was due to how they are combined within four major regions and communities with greater population density, like urban areas, tend to impact the performance outcome more significantly.

Performance-based payments introduced a bias toward achieving high performance in areas of greater population density

3.133 We tested various scenarios to determine if response times below performance expectation in rural communities impacted incentive payments to MHSNB. In our view, combining communities to calculate performance-based payments has introduced a bias toward achieving high performance in areas of greater population density, to the detriment of rural or remote communities where 911 calls occur less frequently.

Performance measures put rural and remote communities at a disadvantage

3.134 The resulting performance measures put rural and remote communities at a disadvantage by reducing the emphasis on achieving performance expectations in these areas. In this way, MHSNB is given the opportunity to focus resources on urban areas while having decreased performance in outlying communities and without impacting its performance-based payments.

Recommendation

3.135 We recommend EM/ANB introduce a more balanced suite of key performance indicators as the basis for performance-based payments to incentivise MHSNB toward high performance in all New Brunswick communities.

Contract allowed excessive use of full deployment exemptions, which overstated response time performance results

3.136 We found the contract allowed for excessive use of full deployment exemptions, which overstated response time performance results.

3.137 The response time percentage calculation included the use of certain exemptions for 911 calls. These exemptions were offered in addition to the 10% allowance already built in to the 90% performance expectation. Exemptions were meant to capture circumstances beyond the control of MHSNB which caused the ambulance to arrive on-scene beyond the time required under the contract. Requests were submitted by MHSNB for exemptions each month and the Department reviewed and approved the submissions. See

Appendix VI for a list of all possible exemptions listed within the exemption approval guide.

3.138 Full deployment exemptions are currently claimed for calls when the number of ambulances available in a service district is below Emergency Cut-off. Emergency Cut-off represents the minimum number of ambulances required to ensure a reasonable expectation of response within contractual times. This can happen due to a significant event requiring multiple ambulances to respond or, more frequently, due to multiple concurrent 911 calls.

3.139 We analyzed the use of exemptions to determine:

- their impact on the overall performance result;
- the appropriateness of the use of exemptions; and
- whether exemptions have been approved in accordance with the contract.

Exemptions brought response rate from below 90% to exceed 92%

3.140 Approximately 5,500 exemptions were approved during fiscal 2017/18 and 2018/19. The exempted calls represented 3.4% of total calls responded to during the period. This was significant because it changed the combined 911 emergency response rate from falling below the 90% performance expectation to exceeding the 92% maximum threshold for performance payments. In both fiscal years reviewed, MHSNB received the full financial award for meeting or exceeding 92% response rate.

76% of exemptions were for full deployment

3.141 We reviewed the composition of the 5,500 exemptions and found 76% of exemptions were for full deployment. Most full deployment exemptions, 72%, were claimed in urban areas.

3.142 Under the contract, the System Status Plan is expected to specify the ambulances, facilities and human resources required to achieve performance standards. In our view, no exemption should be provided where the System Status Plan is failing to anticipate call volumes or where the System Status Plan has not identified how many resources are required in a service district.

No limit on how frequently full deployment exemptions are claimed

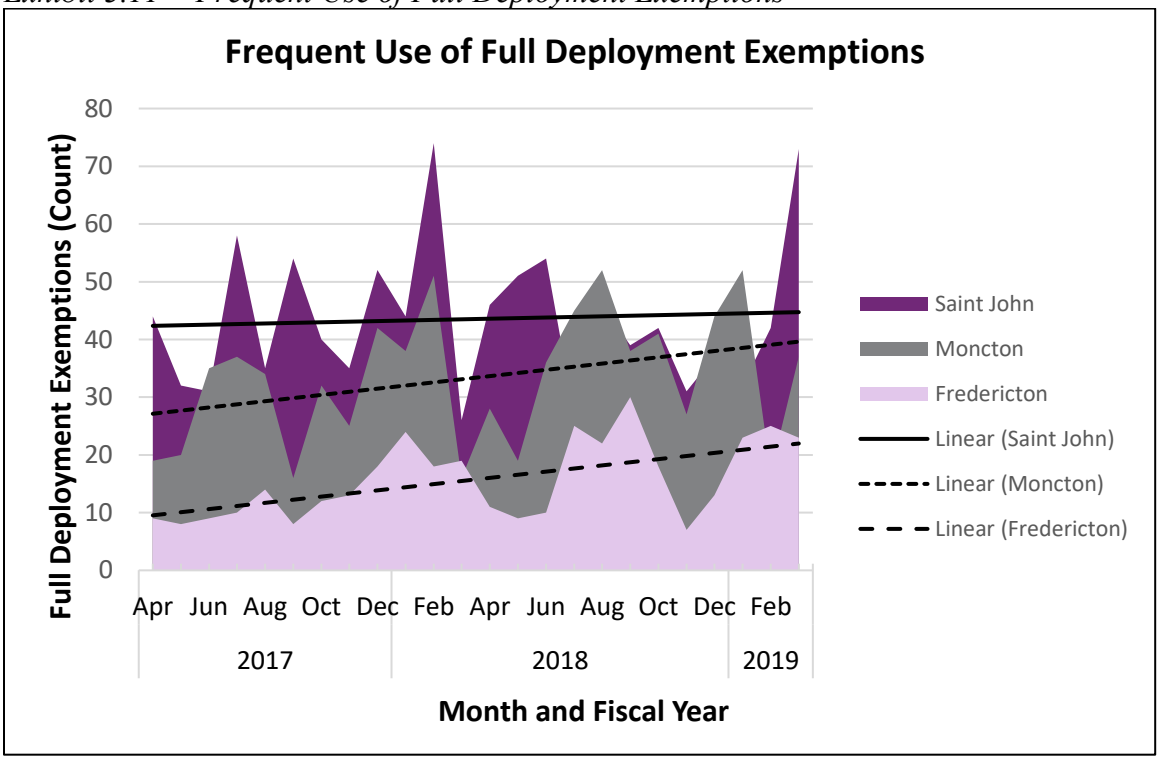
3.143 According to MHSNB and the Department, full deployment exemptions are meant to capture acute resource shortages deemed beyond the control of MHSNB. This is not explicitly stated in the exemption approval guide, and no definition of acute was provided by the Department or

MHSNB. In addition, there is no limit on how frequently full deployment exemptions can be claimed in a service district. We expected that EM/ANB would define the frequency of full deployment exemptions which would establish a predictable pattern and no longer be considered acute.

Saint John and Moncton appear to have higher than daily use of full deployment exemptions

3.144 We analyzed the frequency of use of full deployment exemptions and found over 2,000 were claimed in the three largest cities in New Brunswick during 2017/18 and 2018/19. This represents over half of all full deployment exemptions claimed in New Brunswick during that time. Exhibit 3.11 shows the usage trends in these cities. Saint John and Moncton appear to exceed a daily frequency of use of full deployment exemptions. Both cities' trend lines exceeded 30 claims per month.

Exhibit 3.11 - Frequent Use of Full Deployment Exemptions



Source: Created by AGNB with information from Medavie Health Services NB

System Status Plan appeared to understate resource requirements

3.145 We found the System Status Plan does not appear to forecast enough required resources, indicating understaffing problems are more severe than reported to us.

3.146 With this frequency of use, full deployment exemptions in the three cities appear to be routine as opposed to relating to acute resource shortages. This suggests the System Status Plan is failing to anticipate resource requirements. Designing the System Status Plan to anticipate resource requirements is an area of responsibility for MHSNB and, therefore, cannot be considered beyond its control.

3.147 We asked MHSNB and the Department what was driving the use of full deployment exemptions in Saint John. The following key factors were identified:

- increased 911 call volume;
- unscheduled transfers and increased transfer duration times;
- offload delays; and
- ambulance out-of-service time.

Number of paramedics required per the System Status Plan unchanged from original contract

3.148 MHSNB indicated the System Status Plan has remained very similar since its inception and the resources added since that time have not kept pace with the additional call volume. The number of paramedics required per the System Status Plan included in EM/ANB and MHSNB's contract renegotiation in 2017 was identical to that of the System Status Plan included in the original contract.

3.149 It appears the System Status Plan included in the 2017 contract renegotiation did not reflect the ambulances, facilities and human resources required to be deployed to achieve required performance standards. As we previously noted, budgeted annual payroll costs for paramedics, used in the budget surplus payment calculation, were determined using the System Status Plan. It assumed full utilization of ambulances and no paramedic vacancies. However, if the System Status Plan was incorrect, this also suggests paramedic vacancy is higher than what is being reported by MHSNB currently.

Holding System Status Plan constant increased probability of full deployment exemptions

3.150 Given the persistent increasing call volume, holding the System Status Plan constant increased the probability that districts would fall below Emergency Cut-off at any given time. This contributed to more frequent use of full deployment exemptions.

Excessive use of full deployment exemptions masked apparent severity of increasing call volumes

3.151 In our view, key factors driving full deployment exemptions identified above are persistent issues which have accumulated over a long period of time and do not meet the criteria of acute resource shortages beyond the control of MHSNB. The excessive use of full deployment exemptions overstated response time performance results and masked the apparent severity of increasing call volumes over time.

Recommendations

3.152 We recommend the Department and EM/ANB introduce controls to minimize the frequency of use of full deployment exemptions or discontinue the use of exemptions.

3.153 We recommend the EM/ANB board require MHSNB revise the System Status Plan to update the detailed specifications as to the ambulances, facilities and human resources required to be deployed to achieve performance standards.

Overstatement of response time performance reported

3.154 We found the excessive use of full deployment exemptions caused an overstatement of the response time performance reported.

Eliminating all full deployment exemptions from Saint John would have eliminated performance-based payments for South region

3.155 We analyzed the effect of reducing or eliminating the full deployment exemptions in Saint John on the combined 2017/18 and 2018/19 result. We used a scenario analysis, assuming a reduction to full deployment exemptions claimed for the city by half or in full. The result of halving the exemptions for Saint John would have lowered performance-based payments to MHSNB for the Southern region. Eliminating all full deployment exemptions from the city would have eliminated performance-based payments for the Southern region during this time.

3.156 In our view, the overly frequent use of full deployment exemptions in Saint John caused an overstatement of the performance result reported for the Southern region. Whether this also caused an overpayment depends on what frequency of full deployment exemptions could be considered reasonable. As such, without a contractual definition of what constitutes an acute circumstance, the overpayment is undeterminable.

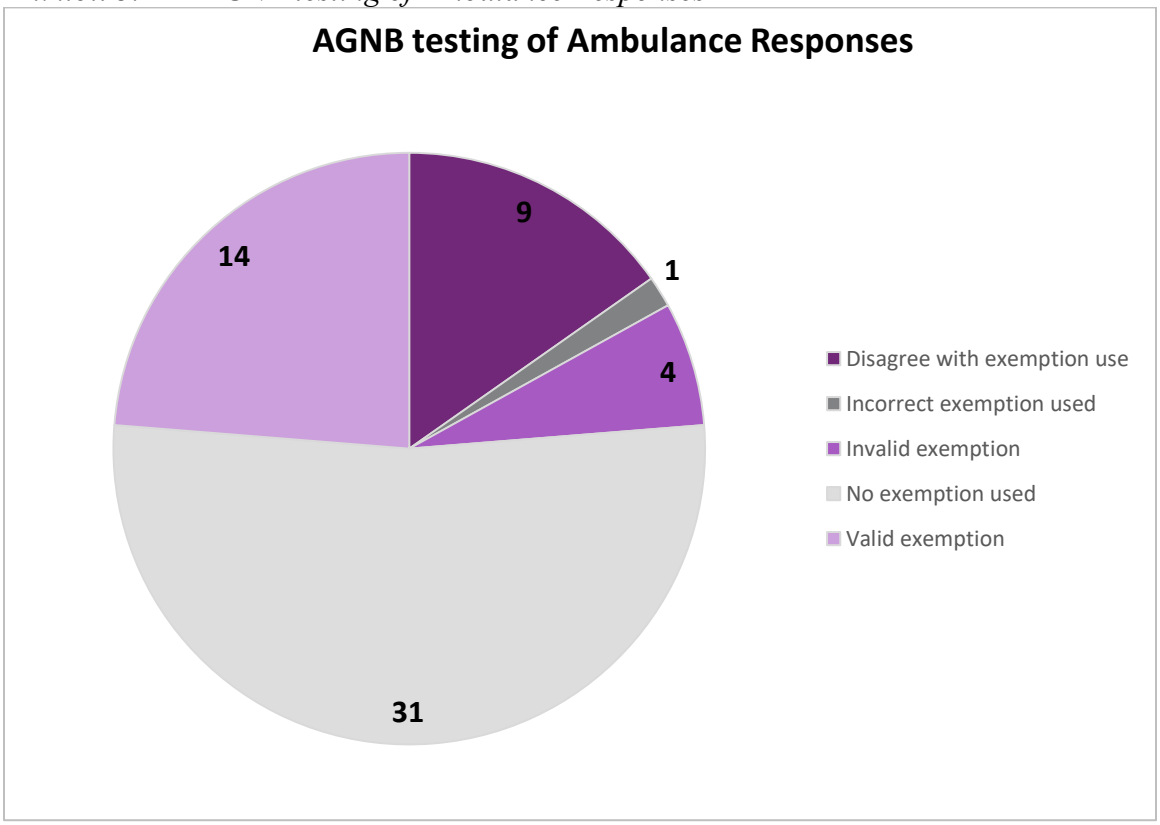
Contract allowed overuse of full deployment exemptions, which masked operational challenges at EM/ANB

3.157 The overuse of full deployment exemptions masked operational challenges at EM/ANB and allowed MHSNB to meet performance targets. The result was a reduction in the emphasis on resolving those operational challenges.

3.158 Exhibit 3.12 summarizes our testing of a sample of ambulance responses which did not meet the required response time. We selected our sample based on our assessment of risk from three main categories:

- communities with low performance results;
- communities with a wide geographic coverage area; and
- where there were out of service ambulances in the community.

Exhibit 3.12 - AGNB testing of Ambulance Responses



Source: Created by AGNB

3.159 The test consisted of a sample of 59 ambulance responses. The composition of our observations under the test follow:

- Nine responses qualified for exemptions under the guidance for approval document; but AGNB disagreed with the guideline and use of the exemption;
- one response AGNB disagreed with the use of the exemption, but the use of a different exemption would have been acceptable;
- four responses were approved for exemptions where the qualifications under the exemption approval guide were not met;
- 31 responses did not qualify for exemption and no application for an exemption was made; and
- 14 responses had exemptions which appeared to be valid.

No requirement to identify actual causes of response times which exceeded contract requirements

3.160 As shown in Exhibit 3.12, AGNB disagreed with the application of exemptions in nine of 59 responses. Although the criteria for exemption were met, a detailed review of these cases revealed that the true cause of delay related to circumstances not eligible for exemption. Exemptions are approved according to the exemption approval guide and there is no requirement to identify the actual cause of response times exceeding contract requirements. In these nine cases, this caused the use of invalid exemptions.

Full deployment exemptions were used for distance, out-of-service units and driver error

3.161 We expected full deployment exemptions would only be used where the response time could not be met because the nearest station or post was unoccupied due to call volume. However, there were cases where the actual cause of a late arrival was distance, out-of-service ambulances or driver error as described in Appendix VII.

Full deployment exemptions reduced emphasis on areas of improvement

3.162 Allowing the use of full deployment exemptions where the actual cause is not an acute resource shortage decreases the apparent severity of the actual issue. This reduces the emphasis on areas of improvement, since full deployment exemptions are considered beyond the control of MHSNB. Further, the misuse of full deployment exemptions over-states the performance result for response times.

Recommendation

3.163 We recommend the Department and EM/ANB revise the exemption approval guide to prevent the invalid use of full deployment exemptions or discontinue the use of exemptions.

Other Observations from Testing

Dynamic Deployment left wide geographic areas uncovered

3.164 In our testing of ambulance responses which did not meet the contractual obligation response time, we made several observations which, in our view, revealed some of the vulnerabilities within the ambulance system. Included were instances where circumstances and the use of dynamic deployment left wide geographic areas uncovered. See Appendix VII for specific examples.

Other Performance Management Weaknesses

Corporate and strategic plans lack performance measures to demonstrate outcomes

3.165 We found corporate and strategic plans lack performance measures to demonstrate outcomes.

3.166 We expected strategic plans would include objectives designed to improve performance under each area of the contract. Absence of these objectives would impede the ability of the Department and the board to critically evaluate performance under the contract.

3.167 We reviewed corporate planning documents to determine where initiatives to improve services were targeted and whether KPIs were used to evaluate effectiveness of the initiatives.

No clear measure of effectiveness of completed initiatives

3.168 While objectives within these plans are presented with a target date for implementation and status indicator, there is no descriptor of the outcomes each initiative has achieved or is meant to achieve. There is no clear measure of the effectiveness of completed initiatives, or what measures will be used to determine if the objective was effectively implemented.

3.169 For example, we noted an objective to develop a non-emergency transfer system as part of EM/ANB's most recent strategic plan. The desired outcome of this objective was stated to "provide better customer service to our patients and health partners". There was no indication of what metrics would be used to evaluate the degree to which better customer service was provided, or the overall effectiveness of the initiative. The absence of these details restricts the board from prioritizing and critically evaluating its strategic objectives.

Few objectives related to contractual areas other than response times

3.170 While some strategic objectives would impact response times, no specific objectives were designed to improve response times and there were few objectives directly related to other contractual areas.

KPIs failed to capture and measure operational challenges

3.171 We found EM/ANB's key performance indicators are not comprehensive and failed to capture and measure operational challenges.

3.172 Exhibit 3.13 shows a list of MHSNB responsibility areas along with the corresponding metrics, incentives and AGNB's evaluation of each.

Exhibit 3.13 - Medavie Health Services NB Responsibility Areas and KPIs

Medavie Health Services NB responsibility areas and KPIs

Contractual Responsibility	*Current Measure of Performance*	*Contractual KPI-based Incentive or Penalty*	*AGNB Assessment of KPI*
Air Ambulance	Patients by priority (count)	None	Current measure indicates usage frequency but does not indicate quality of Air Ambulance performance
Fleet Management	None	None	Performance not measured
Human Resources	HR Profile (language of service) Sick time WorkSafe NB	None	Current measures lack performance targets
Land Ambulance	Percentage of responses where ambulance arrives on scene within contractual requirement (exemptions apply)	Up to $650,000 for emergency and non-emergency responses Up to $400,000 on achievement of milestones related to patient transfers Penalty (for falling below 90%): • $50 per emergency call • $10 per non-emergency call	As previously mentioned: • Method of calculating response time percentage puts rural communities at a disadvantage. • Exemptions overstated response time performance results. No KPI for patient transfers despite performance incentive

Exhibit 3.13 - Medavie Health Services NB Responsibility Areas and KPIs (Continued)

Contractual Responsibility	Current Measure of Performance	Contractual KPI-based Incentive or Penalty	AGNB Assessment of KPI
Medical Communications Management Centre	Call Processing Times: Phone pickup/data entry completed within 90 seconds, 90% of the time	Penalty: $10/call not meeting protocol up to 90% of the time	Penalties not considered punitive
Official Languages	None	$350,000 awarded for development of Official Languages Plan Up to $350,000 annually, based on metrics undrafted at the time of our audit	No KPI for Official Languages
Other: Data Entry Documentation Customer Service Reporting	 Entry into database within 10 business days of the time care is provided, 90% of the time Entry into data base within 30 days of initial data entry date >90% satisfaction Contract reports provided within 5 days of due date, 100% of time	Penalties: $10/penalty for patient care records not meeting standards $5000 per percentage point that customer satisfaction falls below 90% (up to $50,000 annually) $50/late report	Penalties not considered punitive

Source: Created by AGNB with information from the Department

3.173 Certain areas of MHSNB's responsibility, such as fleet management and human resources, did not have performance targets to measure against. Failure to measure performance in these areas creates a risk that operational challenges will not be captured. Measurable targets would

help management and the board determine opportunities for improvement in these areas.

No KPIs used for Official Languages Plan

3.174 We also found that no KPI's have been used for the Official Languages Plan, despite this being a requirement for payment under the contract beginning in April 1, 2018. Per discussion with the Department, these metrics were not agreed to until December 2019.

3.175 We did note the contract includes penalties for non-compliance with some performance targets. However, in our view, these penalties are minor, non-punitive and would be difficult to impose if MHSNB did not self-identify non-compliance.

Performance-based payments do not include KPIs related to human resources, despite effect of out-of-service units on operations

3.176 We found performance-based payments do not include KPIs related to human resources, despite the significant effect out-of-service units are having on EM/ANB operations.

3.177 According to EM/ANB's website: "*The reasons for ambulances being out of service can include stress management after a critical incident, mechanical failure on a truck, inspection, fatigue management of crew members, a motor vehicle accident and no staff available, among other reasons.*"[2]

Duration of out-of-service units totalled over 95,000 hours

3.178 Data obtained from EM/ANB's computer-aided dispatch system showed over 6,400 instances of out-of-service units with a duration of eight hours or more occurred during 2017/18 and 2018/19. In total, the duration of out of service units totalled over 95,000 hours during this period. In each instance, comments indicated the reason for out of service was no staff available.

Out-of-service units not included as part of performance-based payments

3.179 We note, in Appendix VII, some examples the impact out-of-service units have had on ambulance services. The effect of significant operational challenges, such as out-of-service units, does not appear to be included as part of MHSNB's performance-based payments under the contract. As MHSNB is responsible for managing human resources

[2] https://ambulancenb.ca/en/accountability/data-out-of-service-hours

under the contract, we expected to see this inclusion upon the renegotiation of the contract given this issue has persisted for several years.

KPIs do not capture opportunities for improvement

3.180 By contrast, EM/ANB's annual reports reflect a high level of performance, routinely exceeding targets as defined under the performance-based payment structure. As such, it appears the KPIs, which form the basis for performance-based payments, do not capture opportunities for improvement in ambulance services.

Hospital off-load delays require paramedic to remain with patient

3.181 In addition to out of service units, MHSNB indicated ambulances experience delays due to long wait times at hospitals, referred to as off-load delays. Depending on the severity of the individual case, the hospital may not admit the patient immediately. Paramedics are required to remain with their patient until they are admitted to a hospital. MHSNB considers an off-load that takes longer than 25 minutes to be delayed.

82% of arrivals at the four major hospitals had off-load delays exceeding 25 minutes

3.182 Exhibit 3.14 shows arrivals to four major hospitals in New Brunswick from June 2018 through March 2019. The hours of delay indicate how long ambulances waited above the expected 25 minute off-load time for all calls. Ambulances were occupied for over 3,600 hours due to unanticipated wait times at hospitals. 82% of arrivals were delayed more than 25 minutes.

Exhibit 3.14 - Off-load Delays June 2018 through March 2019

Off-load Delays June 2018 through March 2019			
Hospital	**Number of Ambulance Arrivals**	**Percentage of Arrivals Delayed (beyond 25 minutes)**	**Hours of Delay (beyond 25 minutes)**
The Moncton Hospital	4142	86%	1724
Saint John Regional Hospital	2542	77%	702
Dr. Georges-L.-Dumont University Hospital Centre	1993	79%	887
Dr. Everett Chalmers Regional Hospital	776	81%	299
Total	**9453**	**82%**	**3614 Hrs**

Source: Created by AGNB from information provided by Medavie Health Services NB (unaudited)

3.183 Prior to June 2018, off-load delay tracking was less detailed. MHSNB indicated that ambulances experienced over 1300 off-load delay hours in these hospitals in calendar year 2017.

3.184 Under the renegotiated contract, performance-based payments are calculated incrementally from 90% to 92% for emergency and non-emergency response times. Scaled targets for payment can give incentive for the service provider to continue to meet service expectations and promote continuous improvement.

Most KPIs did not include progressive targets

3.185 We found all other KPIs did not include progressive targets.

Contractual performance indicators remained largely unchanged

3.186 We expected KPIs to include progressive targets, including base and stretch goals. While the renegotiated contract offered a progressive target as part of the payment model, the other contractual performance indicators remained static and largely unchanged, despite EM/ANB having consistently reported these targets as met or exceeded.

3.187 Without dynamic performance targets, there is less incentive for MHSNB to strive for improved performance over the duration of contract. The inclusion of these targets would provide further incentive for MHSNB to achieve continuous improvement.

10-year contract term makes it difficult for Department to adjust service level expectations

3.188 Given the contract term of ten years, we found it would be difficult for the Department to adjust service level expectations outside of what has been contractually stated.

No mechanism for parties to set new performance targets

3.189 We were informed MHSNB has historically met contractual performance metrics over the course of the contract. However, there was no mechanism for the parties to set new performance targets once previous targets were met.

3.190 This prevents the Department from making changes to performance measures over the course of the contract and restricts the Department from promoting continuous improvement and aligning a comprehensive KPI suite with the contract.

Recommendations

3.191 We recommend the board implement progressive performance targets to incentivize MHSNB to achieve continuous improvement for the duration of the contract.

3.192 We recommend EM/ANB improve tracking, and follow-up of strategic and corporate initiatives and include measurable outcomes in its plans.

3.193 We recommend the board expand key performance indicators for performance-based payments to include all areas of operations, such as human resources, fleet and official languages.

3.194 We recommend the Department coordinate with the Regional Health Authorities and EM/ANB to implement solutions to reduce the impact of off-load delays.

Other Conflict of Interest

CEO position of EM/ANB combined with the role as President of MHSNB creates a conflict of interest

3.195 We found the CEO position of EM/ANB combined with the role as President of Medavie Health Services New Brunswick (MHSNB) creates a conflict of interest.

3.196 We expected to see an independent CEO appointed by the board as an employee of the board, advocating in the best interest of EM/ANB.

CEO would be inclined to act in interests of their employer, MHSNB

3.197 As the CEO of EM/ANB is also President of MHSNB, a for-profit company, we believe this dual role creates a conflict of interest. It would be difficult for a CEO to act in the best interest of both parties at the same time. The CEO currently has a contract of employment with MHSNB, whereas their duty to EM/ANB is through the contract of services. In our view, a CEO in this situation would be inclined to act in the interest of their employer.

Corporate strategy for EM/ANB was drafted by employees of MHSNB

3.198 The corporate strategy for EM/ANB was drafted by employees of MHSNB. As MHSNB's employees are not impartial, they could not objectively develop strategy in consideration of:

- the extent to which the contract provides avoidance of risk to EM/ANB;
- whether the contract represents a favorable value proposition for EM/ANB; and
- evaluating alternatives to continuing with the contract.

MHSNB's employees may be inclined to develop EM/ANB's strategies toward maximizing MHSNB's financial award

3.199 MHSNB employees have a conflict of interest because they may be inclined to develop EM/ANB's strategies toward maximizing MHSNB's financial award under the contract. This would not guarantee management decision-making is optimized to provide the best quality of service possible.

***EM/ANB is not subject to the* Conflict of Interest Act**

3.200 We found EM/ANB is not subject to the *Conflict of Interest Act.*

3.201 We expected EM/ANB would be required to adhere to Section 4 of the *Conflict of Interest Act*, which states: *"It is a conflict of interest for a person who is a head of a Crown corporation… to be a[n]… officer of a[n]… incorporated*

company, holding or engaging in… a contract or agreement with Her Majesty, or with a… department or agency with respect to the public service of the Province or under which any public money of the Province is expended for any service or work"[3]

EM/ANB is not listed in Schedule A of the Act's regulations

3.202 The Department stated EM/ANB is not in contravention of the act as EM/ANB is not listed in Schedule A of the Act's regulations. Schedule A details which Crown corporations fall under the *Conflict of Interest Act*.

3.203 We expected the *Conflict of Interest Act* to apply to all Crown corporations. We found that only eight Crown corporations are listed under Schedule A of the Act's regulations. In our view, this omission may undermine the effectiveness of the Integrity Commissioner, who is responsible for administering the Act. The Commissioner performs a key role in maintaining the integrity of Crown corporations.

3.204 Despite EM/ANB's exclusion from this legislation, we expected to see the Department consider the spirit of this act as part of contractual negotiations.

Conflict of interest existed with no repercussions

3.205 Neglecting to include EM/ANB in Schedule A of the *Conflict of Interest Act* regulations allowed a conflict of interest to exist and persist with no repercussions.

Recommendation

3.206 We recommend the Executive Council Office review the Conflict of Interest Regulation under the *Conflict of Interest Act* and amend the regulation to include all relevant Crown corporations in Schedule A, including EM/ANB Inc.

[3] *Conflict of Interest Act*, RSNB 2011, c129

Appendix I – Audit Objectives and Criteria

The objective and criteria for our audit of the Department of Health Ambulance Services are presented below. The Department of Health senior management reviewed and agreed with the objective and associated criteria.

Objective 1	To determine whether Department of Health's governance structures and processes established for EM/ANB set a framework for effective oversight.
Criterion 1	The Department of Health's governance and oversight structure should ensure ambulance services, provided by EM/ANB, are delivered with independence and accountability.
Criterion 2	EM/ANB's board of Directors should select, evaluate and enable the CEO.
Criterion 3	EM/ANB's board of Directors should approve strategic organizational goals and policies.
Criterion 4	EM/ANB's board of Directors should have a risk management policy framework for ANB and establish appropriate risk tolerance levels.
Criterion 5	EM/ANB's board of Directors should have a performance management framework for EM/ANB and be monitoring its performance.
Objective 2	To determine whether EM/ANB's contract for ambulance services is designed and managed to achieve expected objectives.
Criterion 1	EM/ANB's contract should include clearly defined and measurable performance objectives.
Criterion 2	EM/ANB should have a performance management framework for the contract and be monitoring its performance.
Criterion 3	EM/ANB's contract should promote continuous improvement through progressive performance targets.

Source of Criteria: Developed by AGNB based on review of legislation, best practices and reports by other jurisdictions' Auditors General. Further guidance was taken from works published by *Canadian Audit & Accountability Foundation*.

Appendix II – About the Audit

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick on the Department of Health's delivery of ambulance services. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Health's governance of EM/ANB and contract management practices in its contract with Medavie Health Services New Brunswick.

All work in this audit was performed to a reasonable level of assurance in accordance with the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance.

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

In conducting the audit work, we have complied with the independence and other ethical requirements of the Rules of Professional Conduct of Chartered Professional Accountants of New Brunswick and the Code of Professional Conduct of the Office of the Auditor General of New Brunswick. Both the Rules of Professional Conduct and the Code are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality, and professional behaviour.

In accordance with our regular audit process, we obtained the following from management:

- confirmation of management's responsibility for the subject under audit;
- acknowledgement of the suitability of the criteria used in the audit;
- confirmation that all known information that has been requested, or that could affect the findings or audit conclusion, has been provided; and
- confirmation that the findings in this report are factually based.

Period covered by the audit:

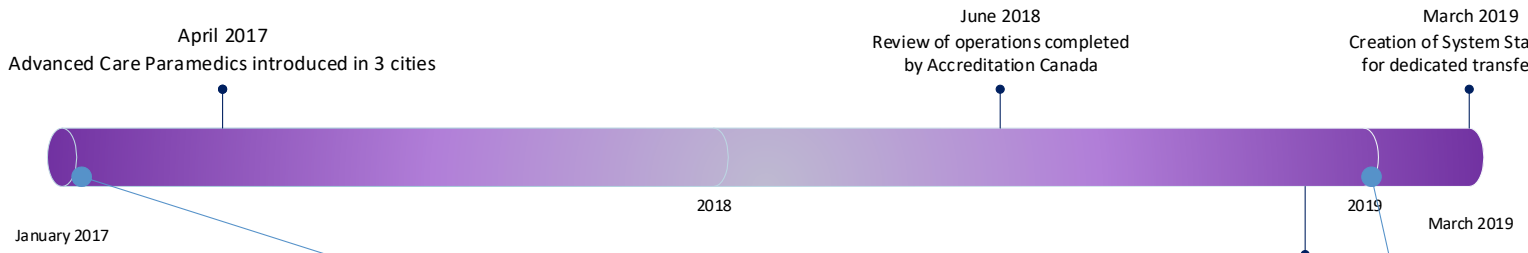
The audit covered the period between April 1, 2017 and March 31, 2019. This is the period to which the audit conclusion applies. However, to gain a more complete understanding of the subject matter of the audit, we also examined certain matters that preceded the starting date of the audit.

Date of the report:

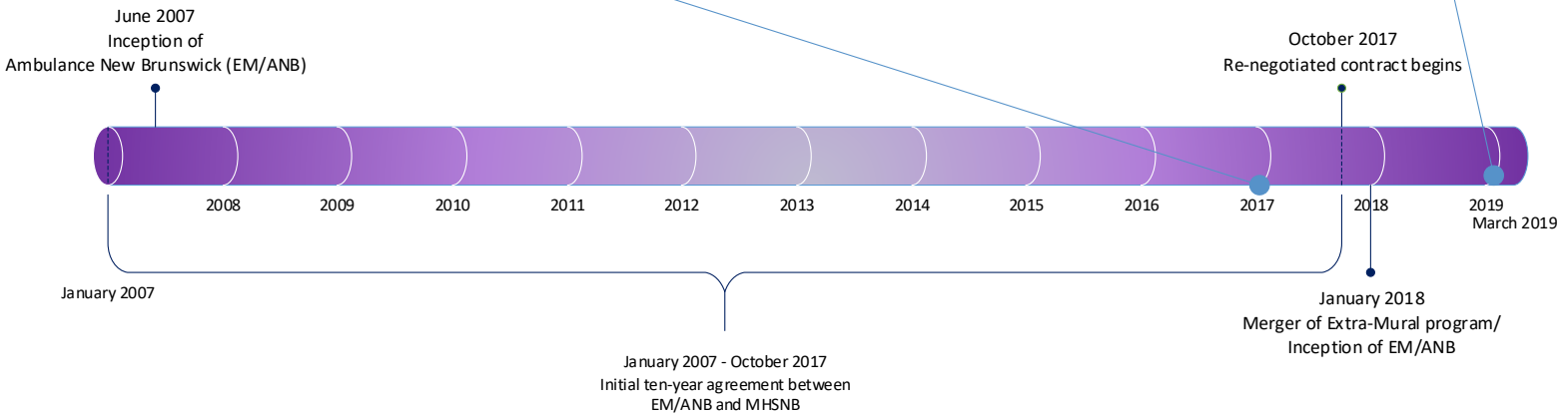
We obtained sufficient and appropriate audit evidence on which to base our conclusion on August 11, 2020, in Fredericton, New Brunswick.

Appendix III – Timeline of Events

Operational Timeline



Contractual Timeline



Appendix IV – Subsequent Events

Under the Canadian Standard on Assurance Engagements (CSAE) 3001 – Direct Engagements set out by the Chartered Professional Accountants of Canada (CPA Canada) in the CPA Canada Handbook – Assurance; paragraph 66 states the following in respect to subsequent events:

> *When relevant to the engagement, the practitioner shall consider the effect on the underlying subject matter and on the assurance report of events up to the date of the assurance report, and shall respond appropriately to facts that become known to the practitioner after the date of the assurance report that, had they been known to the practitioner at that date, may have caused the practitioner to amend the assurance report.*

The subjects below were matters which occurred outside of our period of audit but were significant undertakings by the auditee in respects to ambulance services.

Accreditation process undertaken by EM/ANB

We were informed that EM/ANB board has undertaken a governance accreditation process through Accreditation Canada. This process began in Fall 2019 and a final report was delivered in March 2020.

Dissolution of the Performance Management Oversight Committee

We were made aware the PMOAC was in the process of dissolution during December 2019, with its role to be replaced by the various board sub-committees.

Creation of System Status Plan for dedicated transfer units

We were informed the System Status Plan was amended in March 2019 to reroute part of the fleet into a second, separate System Status Plan for patient transfers. The effect of this change reduced the number of ambulances in some communities' System Status Plan for 911 calls.

Development of performance-based payments for the Official Languages Plan

Under the contract, EM/ANB and MHSNB were "*to develop metrics and associated remuneration drawn from the revised ANB Official Languages Strategic Plan*" for the fiscal year beginning April 1, 2018. We were informed by the EM/ANB board the KPIs associated with this plan were agreed to in principle in December 2019.

Mandate letter for EM/ANB

A mandate letter for EM/ANB was drafted and signed by the Minister of Health on November 29, 2019. We were made aware through discussions with the Department that no mandate letter had been provided in the recent preceding years.

Appendix V – Definitions

Term	Defined
The Ambulance License (Department of Health and EM/ANB)	Ambulance Services Agreement entered into in June 2007 between Ambulance New Brunswick (now EM/ANB) and the Department of Health. The ambulance license exists to outline the responsibilities of both the Minister and EM/ANB in the delivery of ambulance services.
Asset Replacement and System Enhancement Fund	A fund held in trust for the purpose of replacing tangible assets and further enhancing systems used by EM/ANB.
Billing Revenue	Amount of revenue received by EM/ANB from patients for use of land or air ambulances.
Surplus Payment	A contractual feature of the contract between EM/ANB and MHSNB in which 50% of EM/ANB's operating surplus is included as payment to MHSNB. Previously, this amount was uncapped. Under the current contract, surplus payment is capped at $1.1 million.
The Contract (EM/ANB and MHSNB)	*Ambulance Services Agreement*, initial entered during June 2007 between Ambulance New Brunswick (now EM/ANB) and NB EMS (now Medavie Health Services New Brunswick). The contract was renegotiated and entered into in October 2017 after the ten-year term of the initial contract expired.
Deployment Plans	Model depicting the stations and posts required to be occupied by ambulances at a given time to achieve contractual required response times. Deployment plans specify the priority of stations to be maintained when resources are restricted, and where additional resources can be drawn from when circumstances warrant pulling resources from another service district.
Dynamic Deployment	*"An ambulance management strategy where 911 call demand coverage is maximized continuously through time. Unlike static deployment where dispatched ambulances leave a coverage gap until they return to their home-base after service, dynamic deployment redeploys idle ambulances to different locations if that leads to an increase in demand coverage.[4]"*

[4] https://repository.arizona.edu/handle/10150/603515

Appendix V – Definitions (continued)

EM/ANB	Corporation granted the license to provide land and air services in New Brunswick. EM/ANB Inc. is under the control of the Minister of Health and management of the corporation has been contracted to Medavie Health Services New Brunswick.
Emergency Cut-Off	A level within a deployment plan which indicates the minimum amount of resources needed to ensure a reasonable expectation of response within contractual times.
Exemptions	For the purposes of calculating response times, the service time of certain calls are adjusted to be within contractual requirements due to factors considered beyond the control of MHSNB. See Appendix VI for a list of qualifiers for exemption.
Extra-mural	Health services program delivering *acute, palliative, chronic, rehabilitative and supportive care services*[5] to New Brunswickers in their homes and communities. The extra-mural program is under control of Minister of Health and was merged into creation of EM/ANB in January 2018.
Flexible Budget	A budget adjusted automatically to reflect planned costs for the actual level of activity during a period.
Full Deployment Exemption	A frequently used exemption caused by a deployment plan falling below Emergency Cut-Off due to increased call volume within a service district. See Appendix VI for a list of qualifiers for exemption.
Funding Grant	Annual budget amount provided by the Department of Health to EM/ANB to fund ambulance services and managed by MHSNB on behalf of EM/ANB.
KPIs	Abbreviation of Key Performance Indicators; quantifiable measures used to evaluate the success of EM/ANB/MHSNB in meeting performance objectives and standards.
Management Fee	A fixed interval fee for service included as payment to MHSNB under initial contract (2007-2017). Replaced with performance-based payment under current contract (2017 – 2027).

[5] https://extramuralnb.ca/en/what-we-do/

Appendix V – Definitions (continued)

Medical Communications Management Centre	"*Based in Moncton, the centralized ambulance dispatch centre is known as MCMC (Medical Communications Management Centre). Working in the centre are emergency medical dispatchers (EMDs), who respond to emergency medical calls, coordinate inter-facility transfers, dispatch our EMS land and air crews, and provide moral support and life-saving advice and instruction to patients in medical distress and 911 callers.*[6]*"*
MHSNB	Medavie Health Services New Brunswick; a for-profit subsidiary of Medavie Inc. and counter-party to the contract with EM/ANB. MHSNB is responsible for providing the management of ambulance services.
Off-load Delay	Paramedics are required to wait with a patient until the patient is triaged into a hospital. During this period, paramedics are unable to respond to any emergency or non-emergency calls. Instances where an offload exceeds 25 minutes are considered off-load delays.
Out-of-service Unit	A term used to describe an instance where an ambulance cannot respond to an emergency or non-emergency call. Instances include mechanical failures, inspections, accidents, or no staff available to operate the unit.
Performance-based Payment	An incentive feature included as part of the current contract between EM/ANB and MHSNB (2017-present). Includes up to $2.7 million payable to MHSNB upon meeting contractually-stated performance targets.
PMOAC	Performance Management Oversight Advisory Committee; a committee comprised of departmental and select MHSNB employees. The PMOAC exists external to the EM/ANB board and is responsible for reporting to the board on matters related to KPIs, performance of MHSNB under the contract, and financial affairs (amongst other things).

[6] https://ambulancenb.ca/en/what-we-do/services/

Appendix V – Definitions (continued)

Response time Percentage	The percentage of calls in which an ambulance arrives on-site within its contractually stated times: • Emergency (Urban): 9 minutes • Emergency (Rural): 22 minutes • Non-emergency (Urban): 15 minutes • Non-emergency (Rural): 30 minutes Response time percentage is calculated as number of calls compliant in contractual response times as a percentage of total calls (adjusted for exemptions – see *Exemptions*).
Service District	Grouping of communities (rural and urban), which a deployment plan is designed to service.
System Status Plan	Detailed specifications as to the ambulances, facilities, and human resources to be deployed to achieve performance standards, as designed by MHSNB. Resources required within the System Status Plan were contractually agreed to by both parties in the 2007 contract and again, upon renegotiation, in 2017.

Appendix VI – Qualifiers for Exemptions

Below is an excerpt (paraphrased) from the Exemption & Exception Reporting & Approval Guide

Full Deployment
Assigned ambulance exceeds the contractual response time within an area in the System Status Plan when the district is below Emergency Cut-Off.

4/10 Rule
911 call is assigned less than 4 minutes (Urban) or less than ten minutes (Rural) of a previous call within a district in the System Status Plan when at Emergency Cut-Off.

Reassigned to a Higher Priority
Assigned unit is diverted to a higher priority call and one or more subsequent units must be assigned to the original call.

Higher to a Higher Priority
Non-emergency is upgraded to an emergency.

Staged Calls
Ambulance is assigned a call and requested to wait at an assigned location until it is safe to enter. The arrived at scene time will be considered when they report they are at the staged location.

Unknown Location
Response location is not clearly defined and is the cause for the delay.

Incorrect/Changed Location
Original address provided is determined to be incorrect or has changed from the actual scene, location which caused the delayed response.

Delay due to Ferry/Train
Delay due to ferry or train: the time lapse for the delay will be deducted from the total response time.

Delay due to Unknown Detour or Construction
Ambulance must change the route it was taking to get to the scene of the call or encounters construction creating a delay.

Technology Failure
Equipment fails creating a loss in communication and ability to send the responding ambulance to a call, or verify the ambulance arrived on scene.

Vehicle Failure
Responding vehicle has an issue and is delayed or cannot continue responding to the call.

Mutual Aid
Response time standards are not applicable when completed by external agencies.

Weather
Adverse weather conditions affect call response.

Appendix VII – Observations from Ambulance Response Testing

Below are observations made during the testing of ambulance responses.

Full Deployment Exemptions Used for Distance

In several instances, full deployment exemptions were used, but no station or post existed closer to the scene location as compared to where the ambulance responded from. In these cases, the responding ambulance would have been dispatched even if all ambulances were available at that time, as the System Status Plan did not provide a strategic location closer to the scene. In these cases, the issue was distance and the response times recorded should not be eligible for exemption.

We analyzed the geographic coverage of the communities' ambulances and found several are responding to remote locations where it would be unlikely they could respond within the required response time. In these areas, it is unlikely full deployment would ever be the cause of a late arrival.

Allowing full deployment exemptions in remote areas, or where the primary cause of a late arrival is distance, reduces the apparent severity of the challenges in providing full geographic coverage in New Brunswick.

In AGNB's view, allowing full deployment exemptions where distance caused the delay falsely presents favorable response time performance, reducing the emphasis on addressing geographical coverage issues.

Full Deployment Exemptions Use Based on Circumstances in Neighboring Community

System Status Plan service districts contain multiple communities. We observed one example of full deployment exemption use where an ambulance was responding to a 911 call within its own community of Grand Bay-Westfield and was eligible for full deployment exemption due to the number of ambulances occupied in the neighboring city of Saint John. This was possible because both communities are in the same service district, and the service district was below Emergency Cut-off.

Allowing exemptions in Grand Bay-Westfield based on the circumstances in Saint John reduced the objectivity of performance measure for Grand Bay-Westfield. In this case, the performance of Grand Bay-Westfield could be falsely overstated due to the ambulance activity in Saint John. This would, by extension, reduce the emphasis on addressing performance issues specific to Grand Bay-Westfield. It is possible for this to happen in any service district. However, it should be noted the risk was elevated to some degree in the service districts of Saint John, Fredericton and Moncton due to the frequent use of full deployment in those cities.

In AGNB's view, allowing circumstances in neighboring communities to drive exemptions falsely presents favourable response time performance, reducing the apparent severity of localized performance issues.

Appendix VII Observations from Ambulance Response Testing (continued)

Full Deployment Exemptions Used for Out-Of-Service Units

We observed instances where a full deployment exemption was claimed, but the closest station to the scene was unmanned due to an ambulance being out-of-service. In these cases, the stations were unmanned due to prioritization under the System Status Plan, and an ambulance would have been available to respond if all ambulances were active during the shift. The district may have been below Emergency Cut-off with or without ambulances responding from other districts under dynamic deployment, however, the actual cause of the delay was out-of-service ambulances.

Allowing full deployment exemptions where the actual cause of delay is out-of-service ambulances reduced the apparent severity of the operational challenge of providing ambulance coverage where ambulances are absent.

In AGNB's view, allowing full deployment exemptions where out-of-service is the issue provided an overstatement of response time performance, reducing the emphasis on addressing resource issues.

Full Deployment Exemptions Used for Driver Error

We observed instances of full deployment exemptions claimed where the responding ambulance was within a proximity to the scene which should have allowed a response time within the contractual requirement. In these cases, a sub optimal route was taken. Though the district was below Emergency Cut-off, the actual cause of the delay was driver error.

Allowing full deployment exemptions where the actual cause of delay is driver error reduced the apparent severity of the operational challenge of ensuring ambulances take the most efficient route to the scene.

In AGNB's view, allowing full deployment exemptions where driver error is the issue provided an overstatement of response time performance, reducing the emphasis on providing training opportunities or technical solutions to remediate the issue.

Appendix VII Observations from Ambulance Response Testing (continued)

Use of Dynamic Deployment Leaves Wide Geographic Areas Uncovered

We observed instances where the closest station to a scene was able to respond because an ambulance was backfilling the position under the design of the System Status Plan. In these cases, dynamic deployment yielded a positive result. By contrast, however, we also observed instances where ambulances backfilling under dynamic deployment left wide geographic areas uncovered:

- **Perth-Andover Service District**
    - In one instance, both the Perth-Andover and Woodstock service districts had out of service units. Perth-Andover and Florenceville stations should have been manned per the Perth-Andover district's System Status Plan, but the Florenceville ambulance was in Hartland to provide support to the Woodstock service district. Whereas Florenceville station should have been able to respond in 15 minutes, the response time from Hartland was 29 minutes.
- **Bathurst and Campbellton Service Districts**
    - In several instances, Belledune was left unmanned due to a combination of out-of-service units, its low priority level on the Campbellton service district System Status Plan and its proximity to the busy service district of Bathurst. The absence of an ambulance in Belledune left a wide geographic area uncovered:
        - In one instance, the Campbellton service district was brought below Emergency Cut-off to aid the Bathurst service district from Belledune. This was done as an emergency measure as Bathurst had zero ambulances available to respond at that time. Belledune, however, was not backfilled due to its priority level on Campbellton's System Status Plan.
        - In another instance, response to a scene in Bathurst took ten minutes. The scene was less than five minutes from the Bathurst station, but the Bathurst ambulance was already responding to a 911 call. An ambulance was dispatched from Belledune to respond, but the Bathurst ambulance became available and responded before Belledune arrived on scene. The Belledune ambulance was then brought into Bathurst to provide coverage and Belledune was not backfilled due to Belledune's priority level on the Campbellton district's System Status Plan.
        - In another instance, response to a scene in Belledune took 41 minutes. The scene was located less than five minutes from the Belledune station. The Belledune ambulance was out-of-service and no coverage was provided due to Belledune's priority on the

Campbellton service district's System Status Plan. In this case, the Belledune ambulance came back into service due to a shift change before aid was able to arrive from outside the community.

- In another instance, response to a scene in Lorne took 25 minutes. The scene was located less than ten minutes from the Belledune station. The Belledune ambulance was out-of-service and no coverage was provided due to Belledune's priority on the Campbellton service district's System Status Plan. The responding ambulance came from Dalhousie.

- **Sussex Service District and Blacks Harbour and St. Stephen Service District**
  - In one instance, Kingston was left unmanned due to its priority on the Sussex service district's System Status Plan and its proximity to the busy service district of Saint John. Kingston is a remote area and it would be difficult to respond to that area from the nearest station in Hampton. In this instance, responding to the scene in Kingston took just under 25 minutes from Hampton whereas the Kingston station was less than five minutes away. The absence of an ambulance in Kingston left a wide geographic area uncovered. Priorities have since changed on the Sussex service district System Status Plan to ensure coverage is now maintained in Kingston.
  - In one instance, the Lepreau station was left unmanned due to its proximity to the busy service district of Saint John. It was dispatched to provide coverage to the city. The absence of an ambulance in Lepreau left a wide geographic area uncovered. In this case, responding to a scene in Musquash took 23 minutes from Saint John whereas it was a ten-minute drive from the Lepreau station.

MHSNB indicated to us part of its strategy to maintain service levels in Saint John, despite resource constraints, has been to draw resources in from surrounding communities using dynamic deployment.

In our view, this reinforces our observation the design of ambulance services in New Brunswick has put rural and remote communities at a disadvantage.