DEPARTMENT OF HEALTH

2025

Emergency Health Services

Chapter 2

Volume II: Performance Audit
Independent Assurance Report

AUDITOR GENERAL OF NEW BRUNSWICK
VÉRIFICATEUR GÉNÉRAL DU NOUVEAU-BRUNSWICK

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Department of Health

EMERGENCY HEALTH SERVICES

Chapter 2 Highlights

Incomplete key performance indicators	Emergency department wait times exceed established targets	Budget not aligned with service delivery needs
No comprehensive strategy to address excessive wait times		

OVERALL CONCLUSION:

Our audit work concluded that the Department of Health does not have effective oversight mechanisms in place to ensure timely access to, and adequate reporting on, emergency health services.

Results at a Glance

EMERGENCY HEALTH SERVICES

Access to emergency health services is not timely

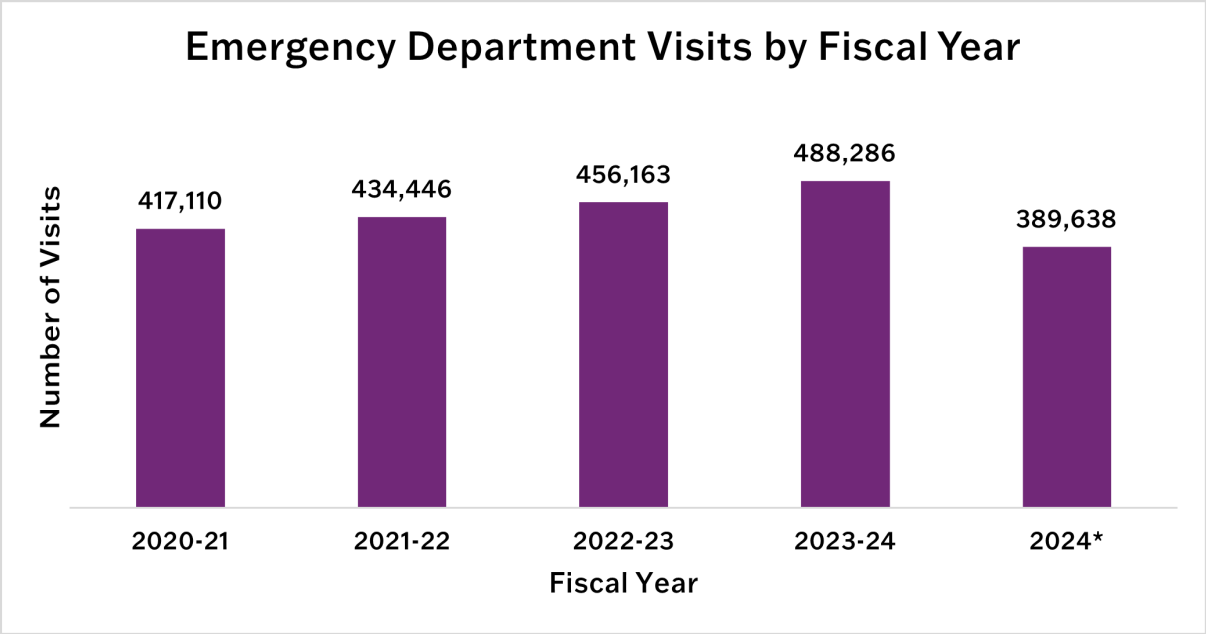
FINDINGS	
	**No** strategy to address excessive wait times
	Only **34%** of emergency department visits met the key performance indicator (KPI) wait time targets from triage to physician assessment
	**Lack of monitoring** to analyze gaps and risk areas
	Budget for regional health authorities (RHAs) does **not** consider current needs for emergency services
	**Inconsistent** record keeping practices

About the Audit

INTRODUCTION TO THE AUDIT

2.1 Emergency departments provide care for patients with a range of medical issues, from minor ailments to life-threatening emergencies. These health care facilities are designed to provide care to the most life-threatening cases first.

2.2 Since 2020, there were over 400,000 visits per year at emergency departments in New Brunswick. Between fiscal years 2020-2021 and 2023-2024, the number of visits had increased by 17%.



Source: Prepared by AGNB based on data from Regional Health Authorities (RHAs), (unaudited)
**April 1, 2024, to December 31, 2024*

2.3 The R*egional Health Authorities Act* provides for the delivery and administration of health services. This Act states that the Minister of Health is responsible for the strategic direction of the health care system and may:

- establish goals, objectives and standards for the provision of health services in the Province or areas of the Province
- establish performance measures and targets to promote the effective and efficient utilization of health services
- conduct financial, human resource and information technology planning for the health care system

2.4 The operations of emergency health care in New Brunswick are carried out by the two regional health authorities (RHAs) across 22 emergency departments.

WHY WE CHOSE THIS TOPIC

2.5 Access to emergency health services is a crucial part of New Brunswick's healthcare system. Timely access increases the positive health outcomes for patients in the Province.

AUDITEE

2.6 Our auditee was the Department of Health (the Department). We also made inquiries and obtained audit evidence from the two RHAs: Horizon Health Network (Horizon) and Vitalité Health Network (Vitalité).

AUDIT SCOPE

2.7 For the purpose of our audit, emergency health services encompasses emergency department services and urgent priority addiction and mental health services.

2.8 The audit covered the period from April 1, 2020, to December 31, 2024. Information outside of this period was also collected and examined as deemed necessary. As part of our work, we reviewed relevant legislation, policy, annual reports, guidelines and data on access to emergency departments and urgent priority addiction and mental health services. We also interviewed staff from the Department and from the two RHAs and visited emergency departments.

2.9 More details on the audit objectives, criteria, scope, and approach we used in completing our audit can be found in Appendix II and Appendix III.

AUDIT OBJECTIVE

2.10 Our audit objective was to determine if the Department of Health has effective oversight mechanisms in place to ensure timely access to, and adequate reporting on, emergency health services.

CONCLUSION

2.11 Our audit work concluded that the Department of Health does not have effective oversight mechanisms in place to ensure timely access to, and adequate reporting on, emergency health services. Overall, we found that the Department of Health:

- has not monitored relevant key performance indicators to ensure timely access to emergency health services
- has not established a comprehensive strategy to address gaps in timely access to emergency departments

- has not established or provided a budget that is aligned with achieving the overall goal of timely access to emergency departments
- has not provided complete public reporting on access to emergency departments

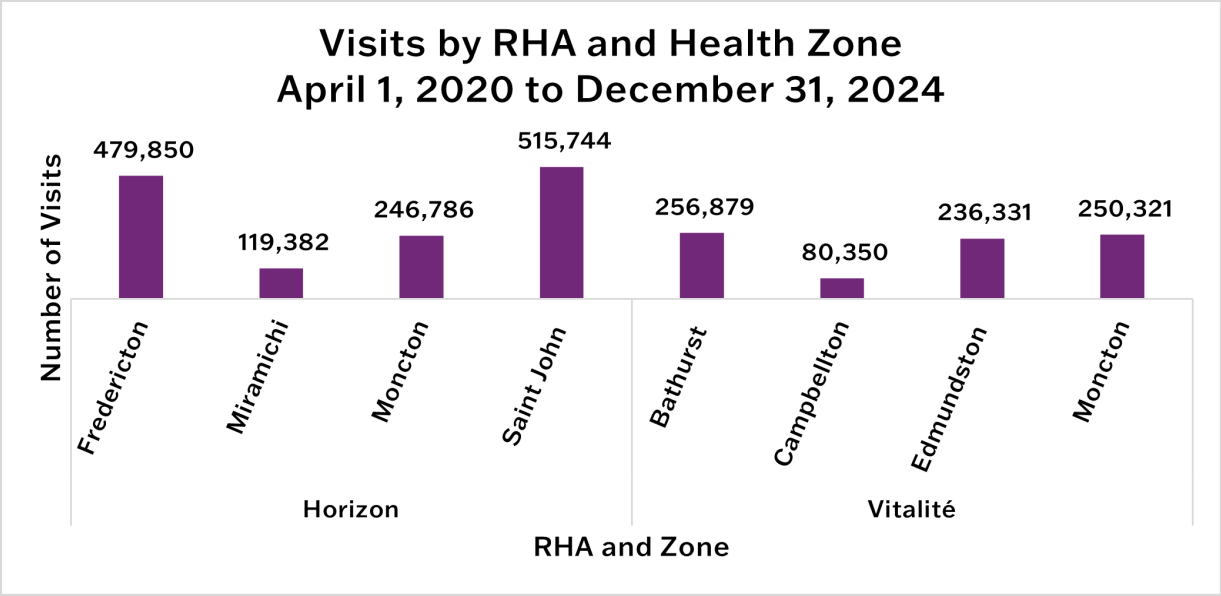
Background

2.12 The Department of Health is responsible for the planning, funding, and monitoring of hospital services, including emergency department services.

2.13 The Acute Care Branch within the Department of Health is responsible for hospital operations, working with the RHAs on the planning and delivery of acute health care across the Province's seven health zones.

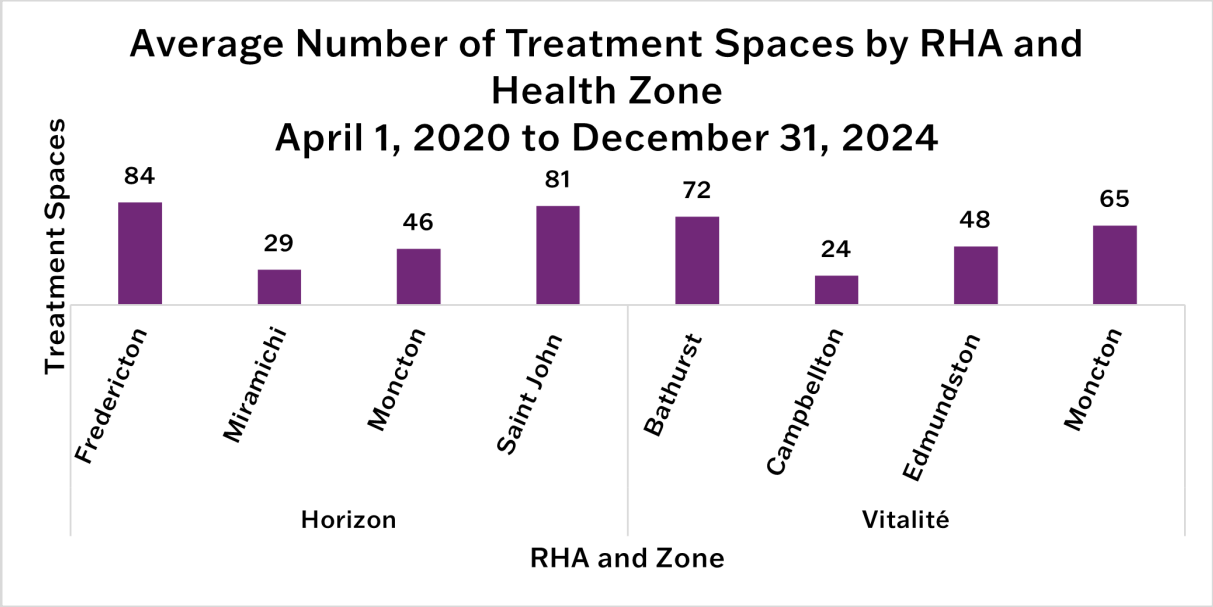
2.14 The RHAs are responsible for the delivery of hospital services to New Brunswickers.

2.15 The number of emergency department visits by RHA and health zone during the audit period were as follows:



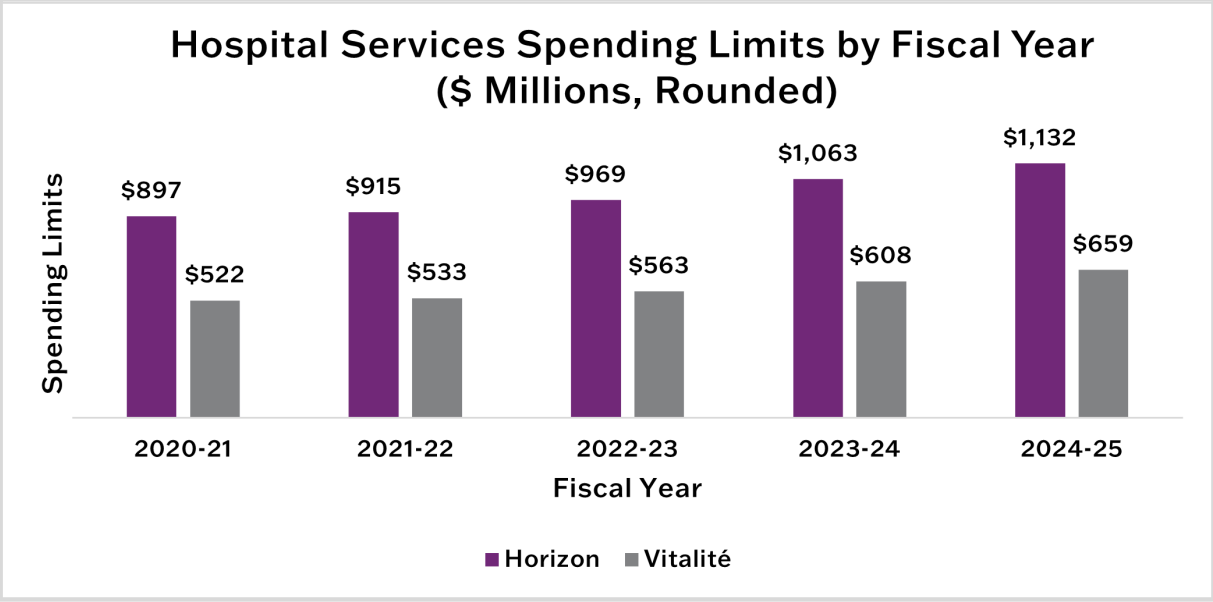
Source: Prepared by AGNB based on data from RHAs (unaudited)

2.16 Emergency departments are divided into treatment spaces, some of which are private rooms and others are shared spaces. The average number of emergency department treatment spaces by RHA and health zone during the audit period is as follows:



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.17 To provide hospital services, the Department provides approved spending limits to each RHA. The chart below shows the spending limits by fiscal year:



Source: Prepared by AGNB based on data from RHAs (unaudited)

Accountability Framework Only Contains One KPI Related to Emergency Departments

2.18 The Department's role is to provide oversight to emergency health services. The *Regional Health Authorities Act* requires the Department to establish reporting requirements for the RHAs on their performance.

2.19 Section 7 of the *Regional Health Authorities Act* stipulates that the Minister of Health shall establish an accountability framework that includes direction to the RHAs on establishing performance measures and reporting requirements.

2.20 The purpose of the accountability framework is to:

- describe the role of the Minister of Health, other ministers and the RHAs and specify the responsibilities each has towards the other within the provincial health care system
- provide direction to the RHAs on establishing strategic objectives, performance measures and reporting requirements

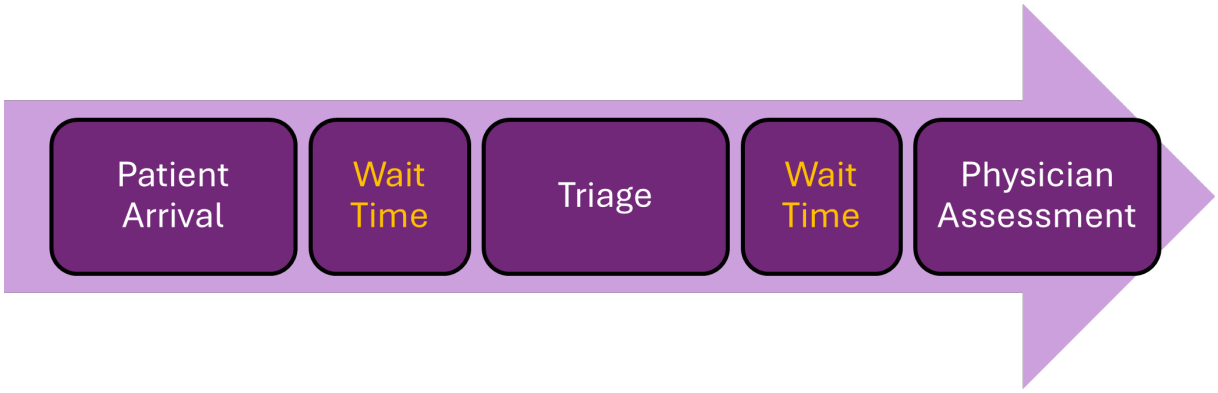
2.21 For the duration of our audit period, the accountability framework was not established, however, it was completed subsequently in April 2025. We examined the accountability framework and determined that it only contained one KPI related to emergency departments. The KPI noted was the 30-minute wait time target to see a physician for patients triaged as level III. This KPI does not consider overall performance of emergency departments, including the wait time of patients triaged at any of the other four levels.

Recommendation

2.22 We recommend that the Department of Health review the accountability framework to ensure that performance indicators related to emergency departments cover the full scope of patients served.

No KPI For Wait Time Between Arrival and Triage

2.23 Patient flow through an emergency department involves a few key steps. Patients are triaged after arrival to the emergency department. Following triage, patients are assessed by a physician.



2.24 Triage is the process of assessing the urgency of a patient's condition based on the Canadian Triage and Acuity Scale (CTAS).

2.25 The triage level assigned to a patient determines their priority level and expected wait time to be seen by a physician. These times are measured between triage and physician assessment. The following key performance indicators, based on CTAS, have been applied by Horizon and Vitalité:

Level	Acuity	Should be seen by physician within
I	Resuscitation	Immediate (0 minutes)
II	Emergent	15 minutes
III	Urgent	30 minutes
IV	Less Urgent	60 minutes
V	Non-Urgent	120 minutes

2.26 CTAS guidelines indicate that triage should occur no more than 10 minutes after arrival. However, this target has not been adopted by either the Department or the RHAs.

2.27 We examined data for our audit period and found that not all facilities capture time of arrival. None of the Vitalité facilities record arrival times, while six out of 13 Horizon facilities do.

2.28 Arrival to triage is a critical time because patients have not yet been assessed, and their priority level is not yet known. Any delay in treatment could pose health risks and impact patient outcomes.

Recommendation

2.29 We recommend that the Department of Health establish measurable key performance indicators pertaining to the wait time between arrival and triage.

Department Not Utilizing Performance Reporting

2.30 Section 5.1 of the *Regional Health Authorities Act* states that the Minister of Health may, "establish performance measures and targets to promote the effective and efficient utilization of health services."

2.31 We were informed by the Department that they receive reports on indicators such as volume of emergency department visits per CTAS level, however, these reports do not include achievement of wait time KPIs. The RHAs analyze and monitor wait time data against KPIs, but this information is not obtained by the Department.

2.32 We obtained and analyzed a copy of the Department's volume report and found that overall emergency department visits increased by 17% between fiscal years 2020-2021 and 2023-2024. The following three facilities increased their annual visits by more than 50% during this period:

- Grand Falls General Hospital
- Hotel-Dieu of St. Joseph (Perth-Andover)
- Hotel-Dieu Saint-Joseph de Saint-Quentin

2.33 Performance should be monitored and assessed against established targets. Without understanding emergency department wait times and KPI achievement, the Department does not know what gaps may exist in delivering timely access, in order to make strategic decisions and to allocate resources.

Recommendation

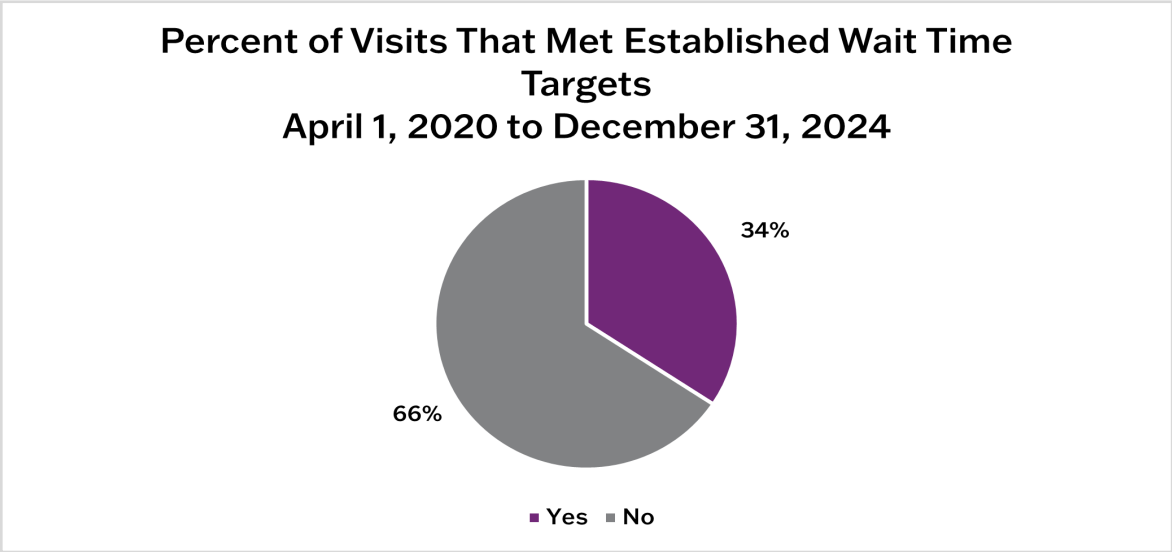
2.34 We recommend that the Department of Health review performance data on emergency department wait times to identify and address risks to achieving timely service delivery.

Wait Times Exceed Established Performance Measures

2.35 Timely access to emergency health services is essential to ensure positive patient outcomes. Long wait times may result in poorer outcomes and are a key factor in patients leaving the emergency department without being seen by a physician.

2.36 Based on the data obtained from the RHAs, there were 249,158 patients who left the emergency departments without being seen by a physician during our audit period.

2.37 We analyzed data for 1,464,557 emergency department visits. We found that 66% of these visits did not meet the established CTAS targets for wait time from triage to physician assessment.



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.38 We further examined these targets by CTAS level, and the results were as follows:

Level	Target	Number of Patients	Rate of Target Achievement
I	Immediate	6,557	56%
II	15 minutes	202,138	25%
III	30 minutes	502,567	24%
IV	60 minutes	655,482	39%
V	120 minutes	97,813	71%

2.39 Data records from the RHAs indicated there were 2,185,643 emergency department visits across the Province during the audit period. However, we were unable to analyze 471,928 records due to incomplete data.

2.40 1,030 records showed wait times that exceeded one week:

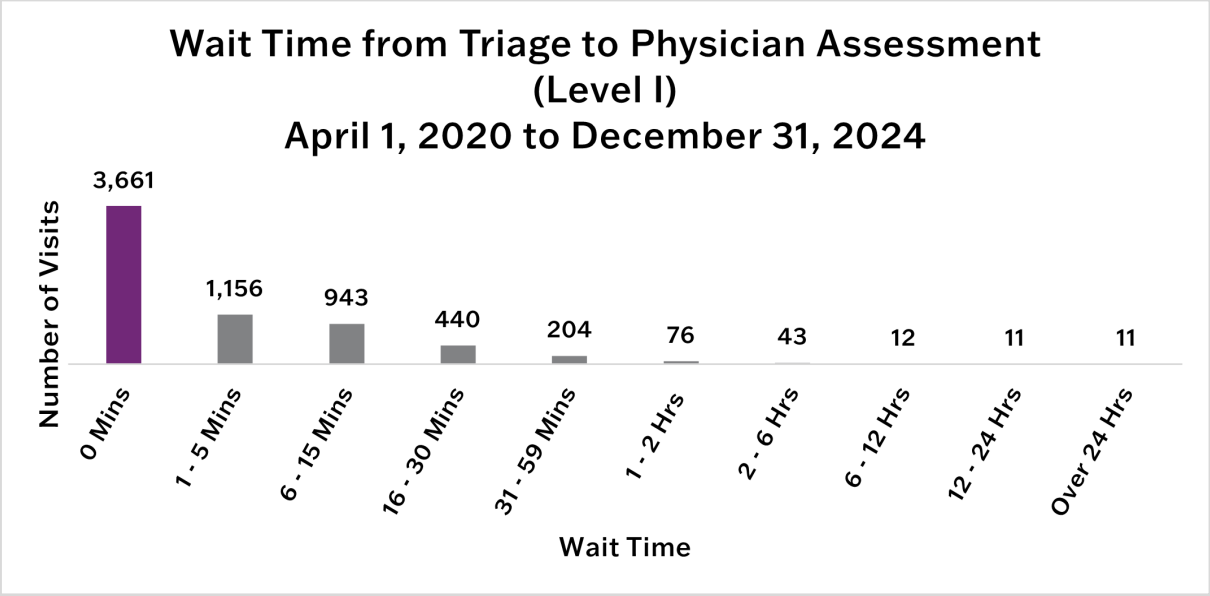
- we reviewed 20 of these in detail and found that all the items were the result of data errors
- five records indicated a patient waited 20 years or more to be seen
- nine records had physician assessment dates that were post-dated

LEVEL I

2.41 Level I is the most urgent priority in the CTAS. These patients require resuscitation and should be seen immediately.

2.42 Over the course of our audit period, 6,557 visits were assigned a triage level I. Data indicated:

- 44% of these visits were not seen by a physician within the targeted time frame
- 77 patients waited over two hours from triage to physician assessment, with 11 noted as more than 24 hours



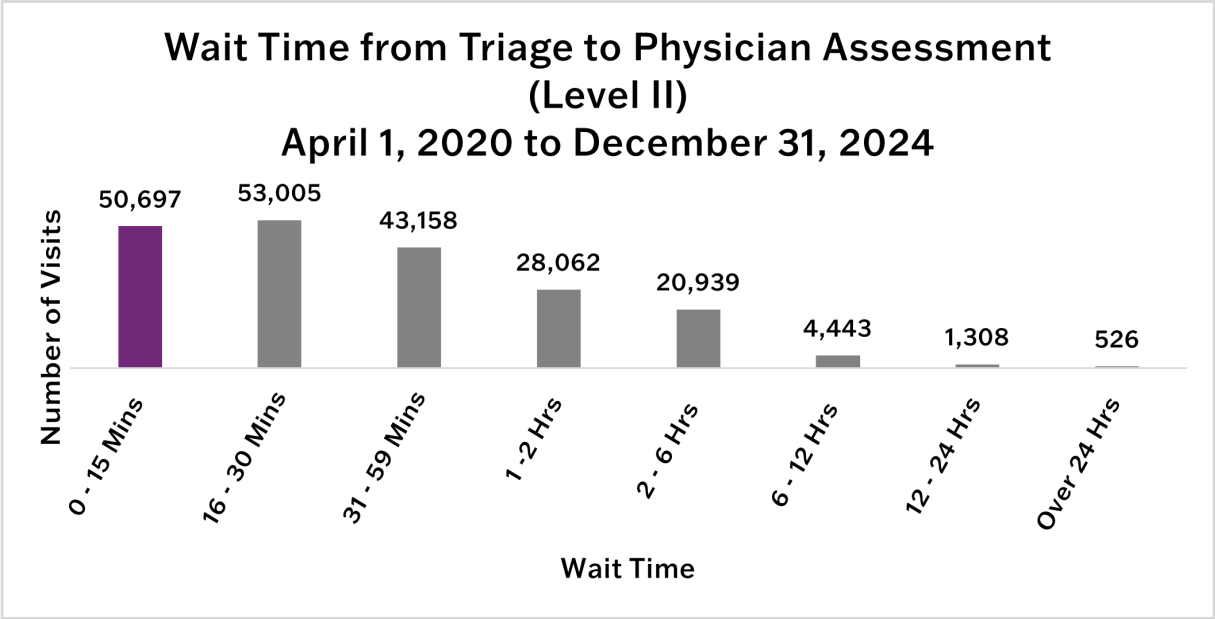
Source: Prepared by AGNB based on data from RHAs (unaudited)

LEVEL II

2.43 Level II on the CTAS scale is assigned to patients that have emergent health issues. Examples include severe head injuries or chest pain. The CTAS indicates these patients should be seen by a physician within 15 minutes.

2.44 During our audit period, 202,138 visits were assigned a triage level II. Data indicated:

- 75% of these visits were not seen by a physician within the targeted time frame
- 27,216 patients waited over two hours from triage to physician assessment, with 526 waiting more than 24 hours



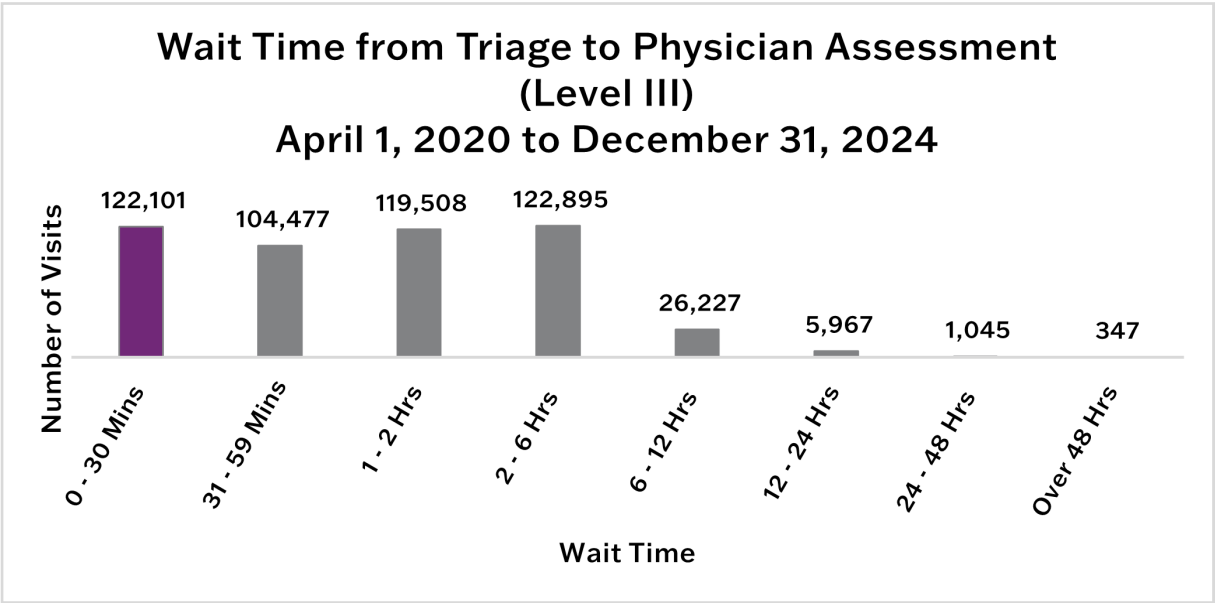
Source: Prepared by AGNB based on data from RHAs (unaudited)

LEVEL III

2.45 Level III on the CTAS is assigned to patients who have urgent health issues. Examples include fractures and dislocations. The CTAS indicates these patients should be seen by a physician within 30 minutes.

2.46 Over the course of the audit period, 502,567 visits were assigned a triage level III. Data indicated:

- 76% of these visits were not seen within the targeted time frame
- 33,586 patients waited over six hours from triage to physician assessment, with 347 waiting over 48 hours



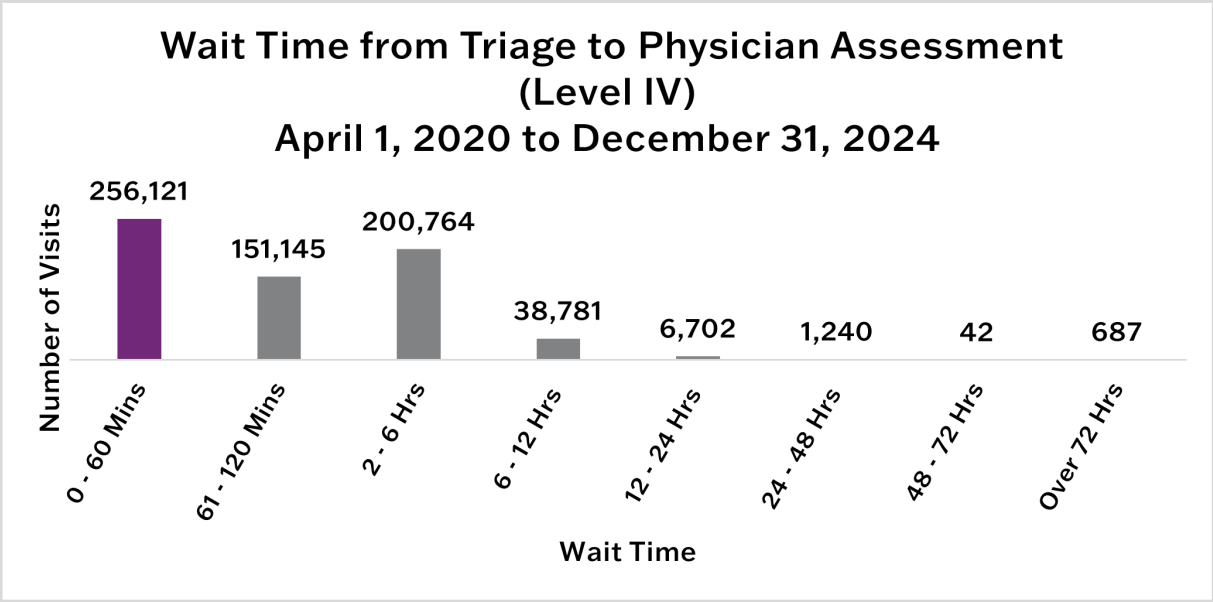
Source: Prepared by AGNB based on data from RHAs (unaudited)

LEVEL IV

2.47 Level IV on the CTAS is assigned to patients with less urgent health issues such as the flu or earache. The CTAS indicates these patients should be seen by a physician within 60 minutes.

2.48 Level IV was the most commonly assigned CTAS level. Over the course of the audit, 655,482 visits were assigned this level. Data indicated:

- 61% of these visits were not seen by a physician within the targeted time frame
- 8,671 patients waited over 12 hours from triage to physician assessment, with 687 waiting over 72 hours



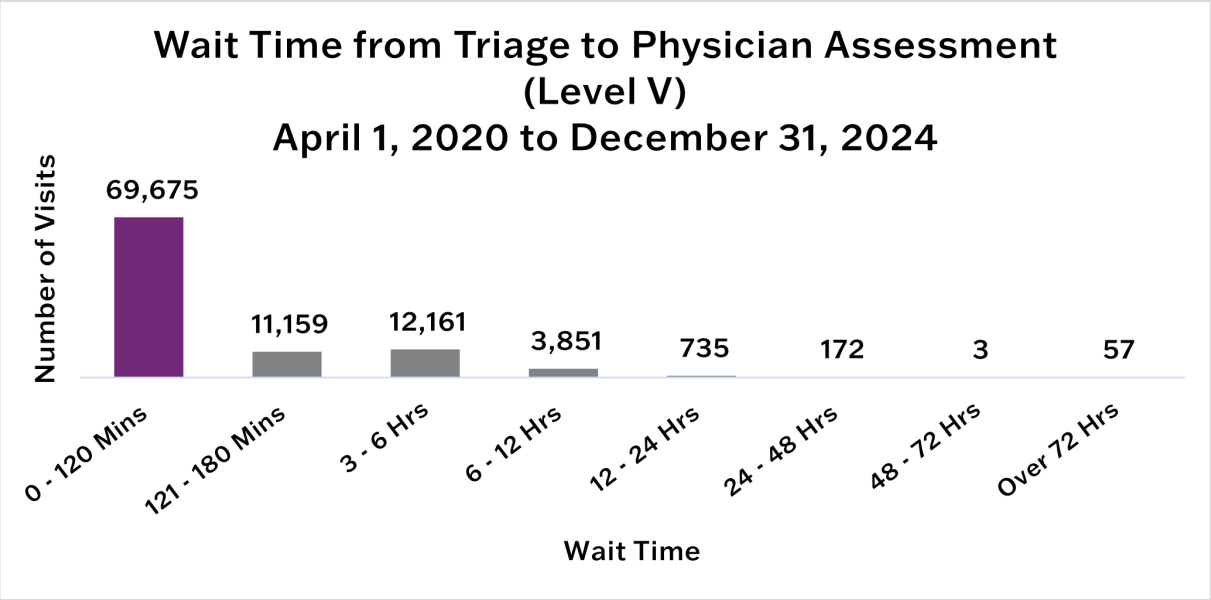
Source: Prepared by AGNB based on data from RHAs (unaudited)

LEVEL V

2.49 Level V is for non-urgent cases and is the lowest priority assigned in the CTAS. Examples include minor lacerations and sprains. The CTAS indicates these patients should be seen by a physician within 120 minutes.

2.50 Over the course of the audit, 97,813 patients were assigned a triage level V. Data indicated:

- 29% of these visits were not seen by a physician within the targeted time frame
- 967 patients waited over 12 hours from triage to physician assessment, with 57 waiting over 72 hours



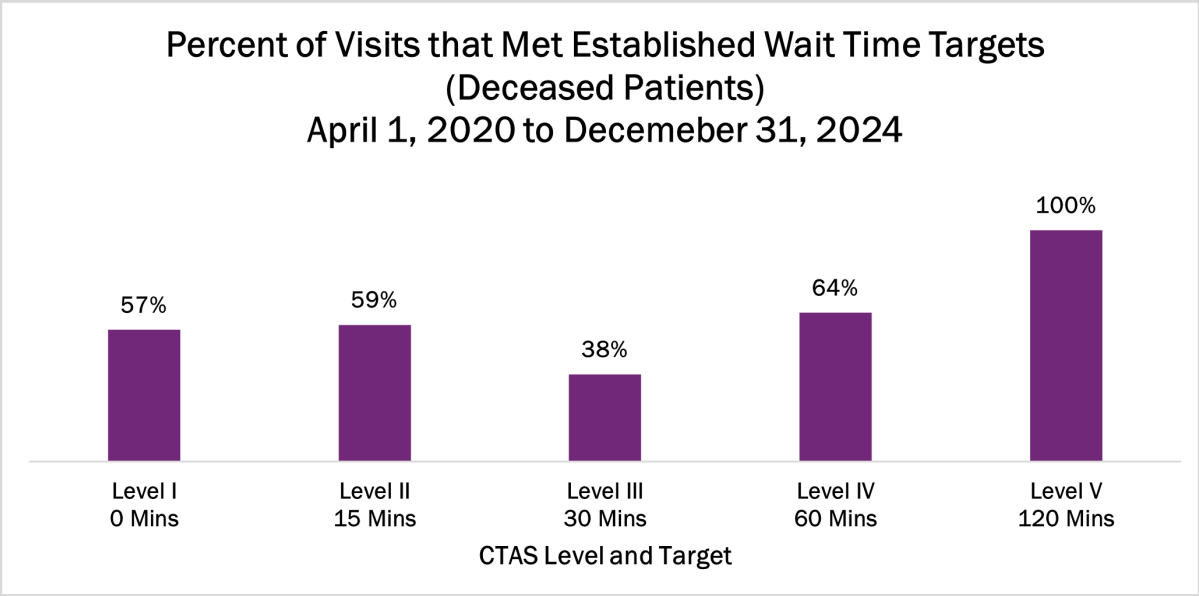
Source: Prepared by AGNB based on data from RHAs (unaudited)

Opportunity to Evaluate Risk

NO REVIEW OF WAIT TIME DATA RELATED TO DECEASED INDIVIDUALS

2.51 During our audit period we found that 2,199 emergency department patients were pronounced deceased subsequent to their arrival.

2.52 We examined the time patients waited between triage and their initial assessment by a physician for 1,287 deaths. Overall, we found that 43% of these patients were not seen within the CTAS target time frame. Achievement by CTAS level is shown below:



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.53 The Department does not obtain information on deaths in emergency departments such as associated wait times. It is a missed opportunity for the Department to understand contributing factors into these cases and how strategies and resources may contribute to improved outcomes.

Recommendation

2.54 We recommend that the Department of Health review data on deceased individuals to evaluate risks and opportunities in developing strategies to improve results.

Lack of Comprehensive Strategy

2.55 Pursuant to section 6 of the *Regional Health Authorities Act*, "The Minister shall establish … a provincial health plan which shall include the provincial objectives and priorities for the provision of health services in the Province."

2.56 In 2021 the Department established a five-year provincial plan. Provincial objectives and priorities in this plan included:

- fully address the wait list for access to primary health care
- empower New Brunswickers to proactively manage their health with access to their own health information through MyHealthNB
- expansion of pharmacists' roles and access to primary care
- reduce wait times for patients experiencing an addiction or mental health crisis

2.57 While these priorities may help to reduce emergency department wait times, the plan did not contain specific objectives or priorities to address all gaps in access to emergency departments.

2.58 As the Department was not monitoring emergency department wait time data, this information was not available to inform the strategy.

2.59 We inquired with the Department if their strategies are achieving results and were informed that the Department has not been actively monitoring the extent to which these actions have diverted patients from emergency departments.

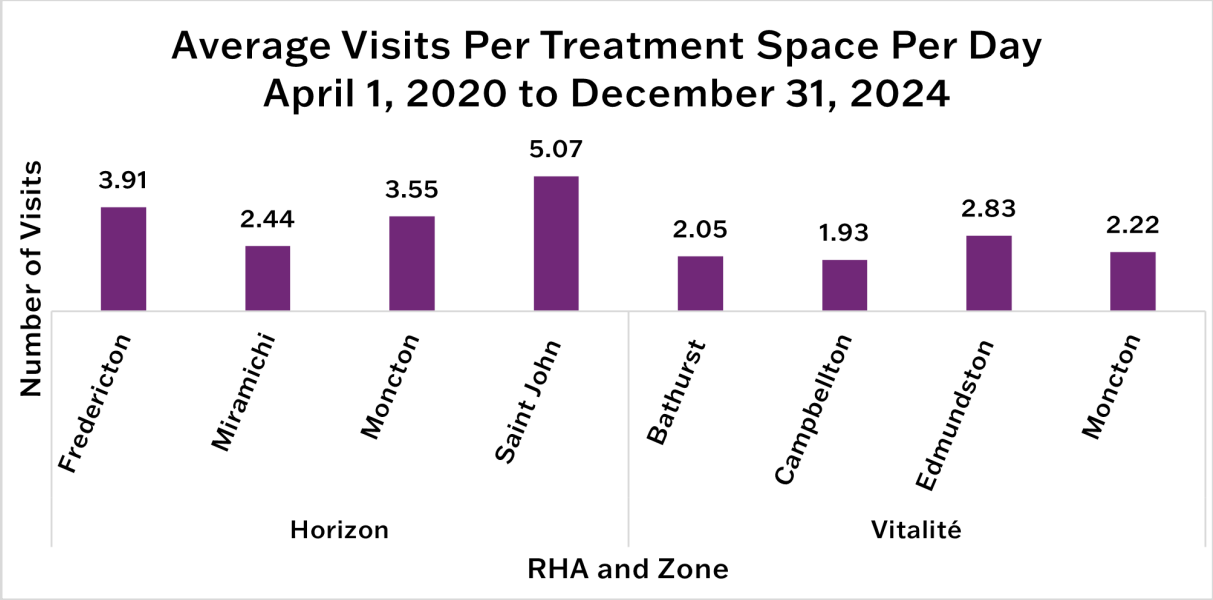
Recommendations

2.60 We recommend that the Department of Health develop a comprehensive strategy to address emergency department needs including expected outcomes, timelines and resources required.

2.61 We recommend that the Department of Health monitor and report on achievement of strategy results.

Insufficient Treatment Spaces in Emergency Departments

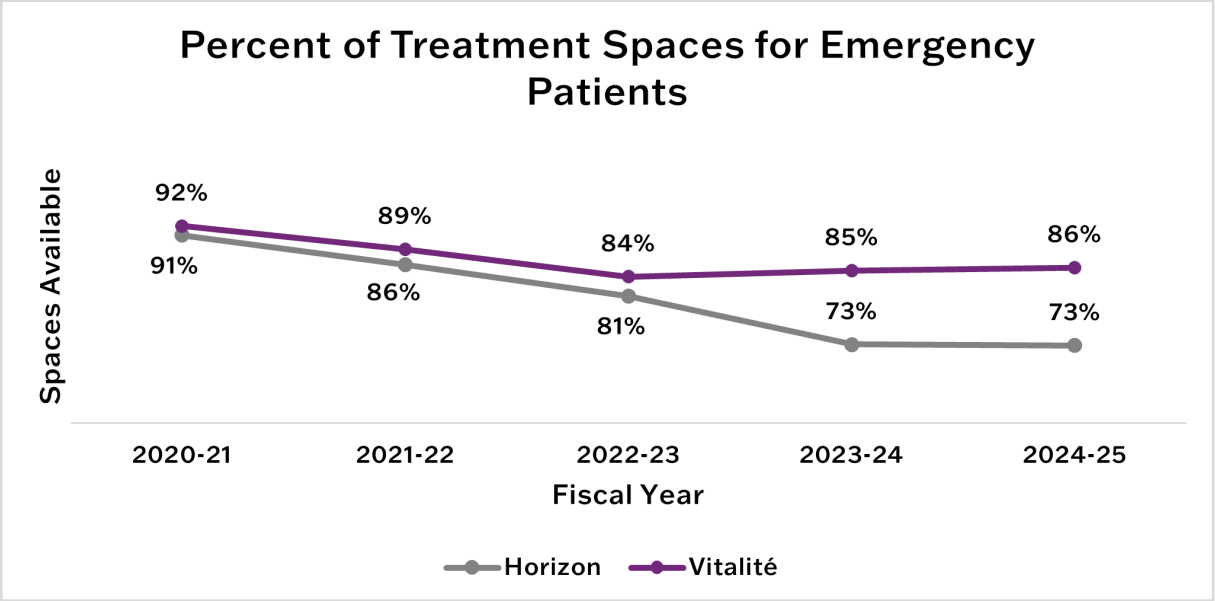
2.62 We reviewed treatment space availability in each emergency department. We analyzed the average number of visits per treatment spaces per day and the results were as follows:



Source: Prepared by AGNB based on data from RHAs (unaudited)

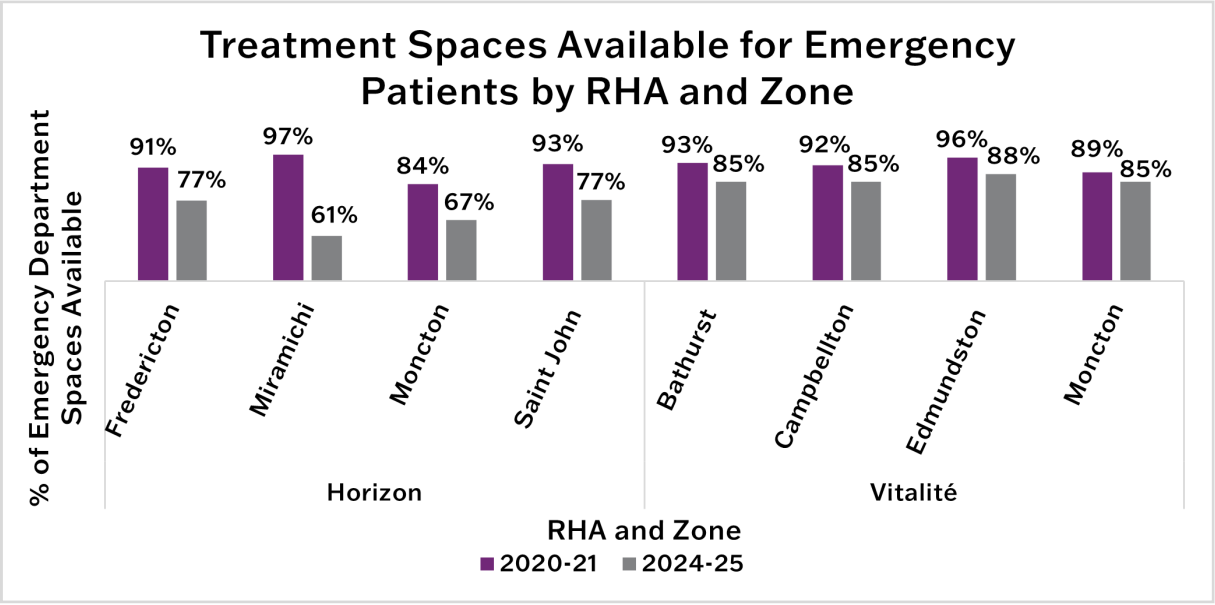
2.63 During discussions with staff in the RHAs we were informed that many spaces were occupied by patients from other hospital units which limited the availability for emergency cases.

2.64 Between April 1, 2020 and December 31, 2024, the percentage of treatment spaces available for emergency cases declined by 20 percentage points at Horizon and seven percentage points at Vitalité.



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.65 The chart below shows the change in available treatment spaces for emergency cases from fiscal 2020-2021 to fiscal 2024-2025. Across all zones, the number of available spaces has decreased throughout the audit period as follows:



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.66 As part of our work, we visited the emergency departments at the following hospitals:

- Dr. Everett Chalmers Regional Hospital
- Dr. Georges-L.-Dumont University Hospital Centre
- The Moncton Hospital

2.67 During these visits, we observed the emergency department facility, patient flow process and had discussions with staff.

2.68 We made the following observations during these visits:

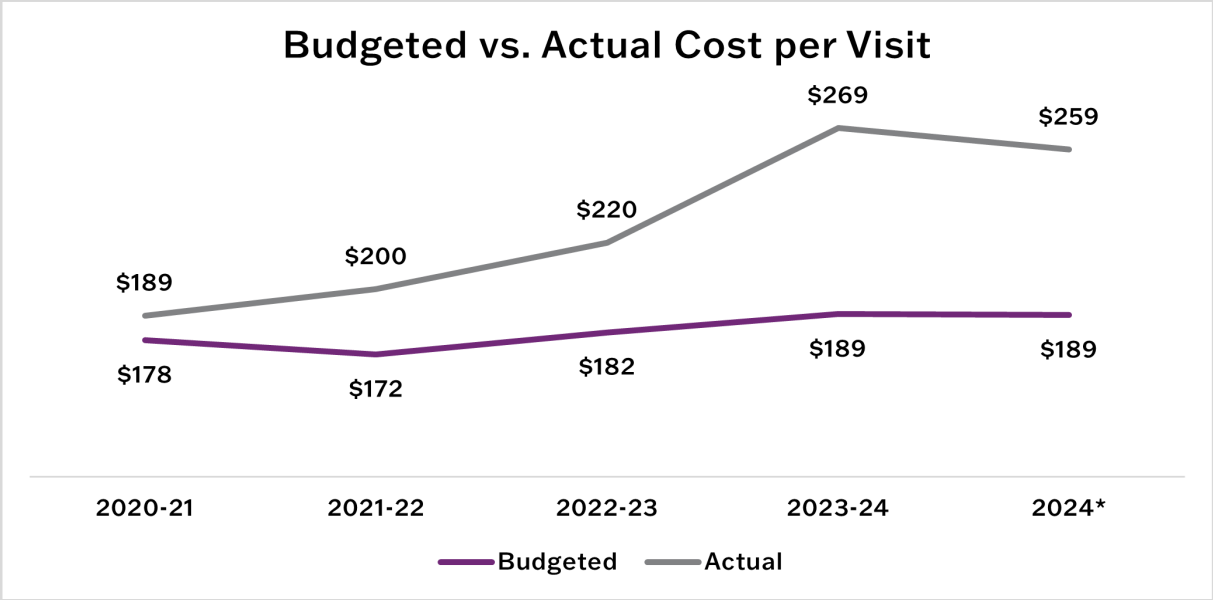
- non-traditional spaces such as hallways, offices and storage areas were used for treatment
- staff reported instances where physicians were available but unable to see patients due to insufficient treatment spaces
- patients from other units were occupying emergency department beds due to a lack of hospital bed space

2.69 Horizon commissioned a report, completed in June of 2023 on the Dr. Everett Chalmers Regional Hospital (DECRH). This report found that the DECRH's emergency department is sized to accommodate roughly half of the annual visits it is currently experiencing. The emergency department currently has 35 treatment spaces and would require 50 to meet the current population. By 2041, the need is projected to grow to 62 spaces.

2.70 Similar reports were not available for other facilities.

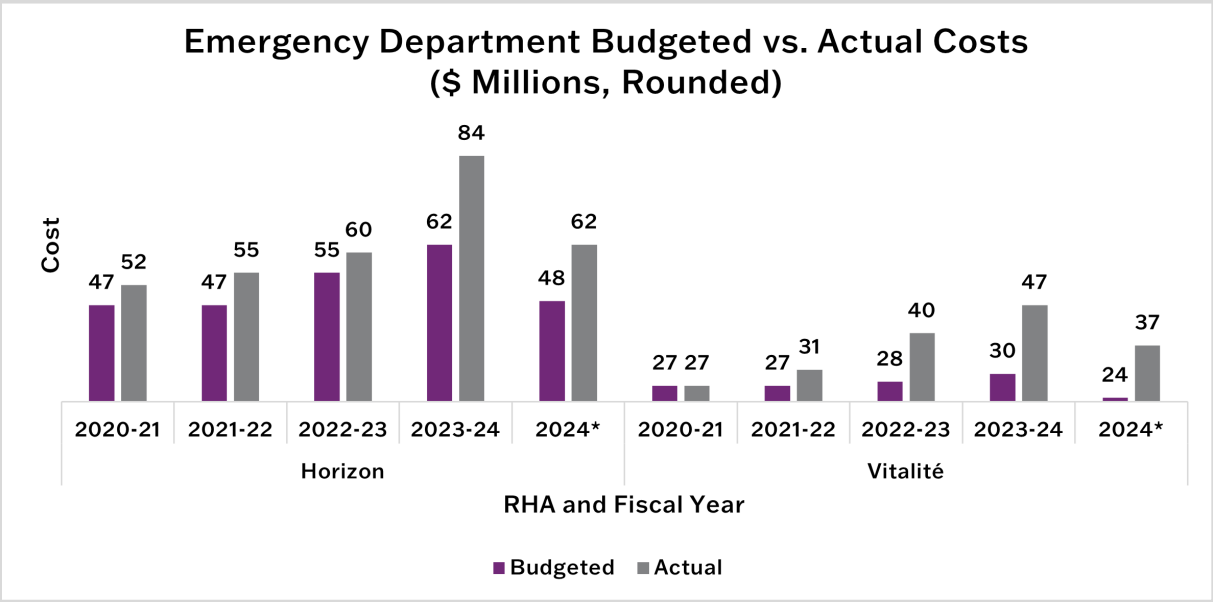
Budget for Emergency Departments Not Based on Need

2.71 The Department provides each regional health authority with an overall operating budget each year to fund healthcare services, including the operation of emergency departments. The regional health authorities allocate this amount to each line of business. The budget to actual cost per visit by fiscal year was as follows:



Source: Prepared by AGNB based on data from RHAs (unaudited)
**April 1, 2024, to December 31, 2024*

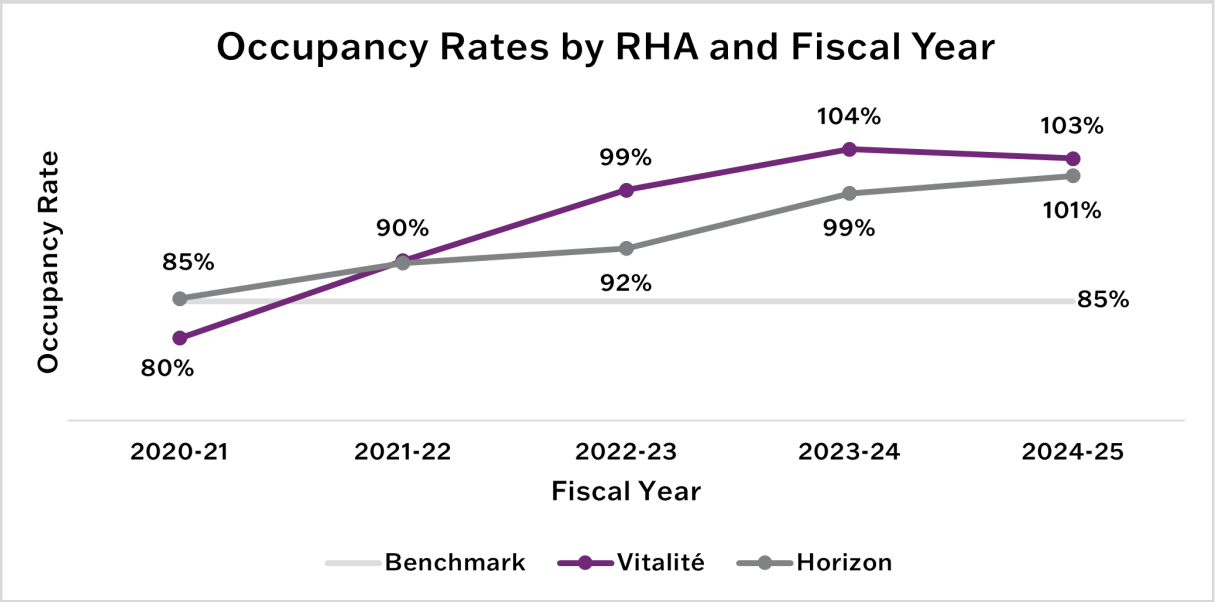
2.72 We reviewed funding letters from the Department and found that between $1.4 and $1.8 billion was allocated annually to the RHAs for hospital services between fiscal years 2020-2021 and 2024-2025. The RHAs allocate this amount to their various lines of business. A breakdown of budget and actuals by RHA and fiscal year for emergency departments is shown below:



Source: Prepared by AGNB based on data from RHAs (unaudited)
**April 1, 2024, to December 31, 2024*

2.73 The Department informed us that the current base budget was established prior to 2008. They were unable to clearly demonstrate how the base budget amounts were calculated. Prior years' amounts are carried forward with adjustments for new projects or initiatives. At the time of establishment, the budget amounts were based on an occupancy rate of 85%.

2.74 According to data provided by the RHAs, the average occupancy rate for each health authority exceeded 85% in four of the past five fiscal years, with Vitalité reaching over 100% in fiscal year 2023-2024. We were informed by the RHAs that emergency department treatment spaces are often used when other departments within the hospital exceed their capacity. We also observed non-traditional spaces being used when capacities are exceeded. This indicates that the calculation, based on 85% occupancy, no longer represents the actual patient volumes in emergency departments.



Source: Prepared by AGNB based on data from RHAs (unaudited)

2.75 No other information on how the base budget was established was known or available in the Department.

2.76 Without a clear understanding of how the base budget is calculated, it would be difficult for the Department to assess whether actual results align with what the funding was intended to achieve. Furthermore, where additional funding is requested, it is not clear whether amounts were originally included for that purpose in the base amount.

2.77 On April 17, 2025, the Department announced its plan to formally review the base budget for New Brunswick's overall health system.

Recommendations

2.78 We recommend that the Department of Health conduct its base budget review to ensure that sufficient resources are provided to the regional health authorities for the services delivered.

2.79 We recommend that the Department of Health retain supporting documentation and calculations that show how amounts were determined for each annual budget.

Incomplete Reporting on Performance

2.80 We examined the Department's public reporting over our audit period and found that the Department does not report on access to emergency departments, including wait times. However, we noted that Horizon, as part of its performance dashboard, reported on targets, results and trends for CTAS level III wait times. Vitalité does not publish data on targeted or actual wait times.

2.81 Without complete reporting on performance, the public is not aware of how well the targets are achieved.

Recommendation

2.82 We recommend that the Department of Health ensure the public has timely access to reporting on access to emergency departments, including on Canadian Triage and Acuity Scale level wait times and on the performance of short- and long- term strategies to address gaps.

Urgent Priority Addiction and Mental Health Services

2.83 In the Department, the Addiction and Mental Health Services (AMHS) Branch works closely with the RHAs to plan, fund and monitor addiction and mental health policies and programs.

2.84 Access to AMHS is delivered in three stages: the referral, the assessment, and treatment or service. The referral is the initial request for service, and the assessment involves an appointment with the client where a clinician completes a standardized assessment tool to help determine if service is required and the individual's priority level.

NO MONITORING OF PERFORMANCE

2.85 The *Mental Health Services Act* governs the conduct and coordination of mental health services in New Brunswick. This Act states that the Minister may establish, monitor and review standards respecting mental health services.

2.86 The Department does not monitor KPI achievement pertaining to urgent priority addiction and mental health services. Regular analysis by the Department would help identify gaps in providing timely service, and to support corrective action.

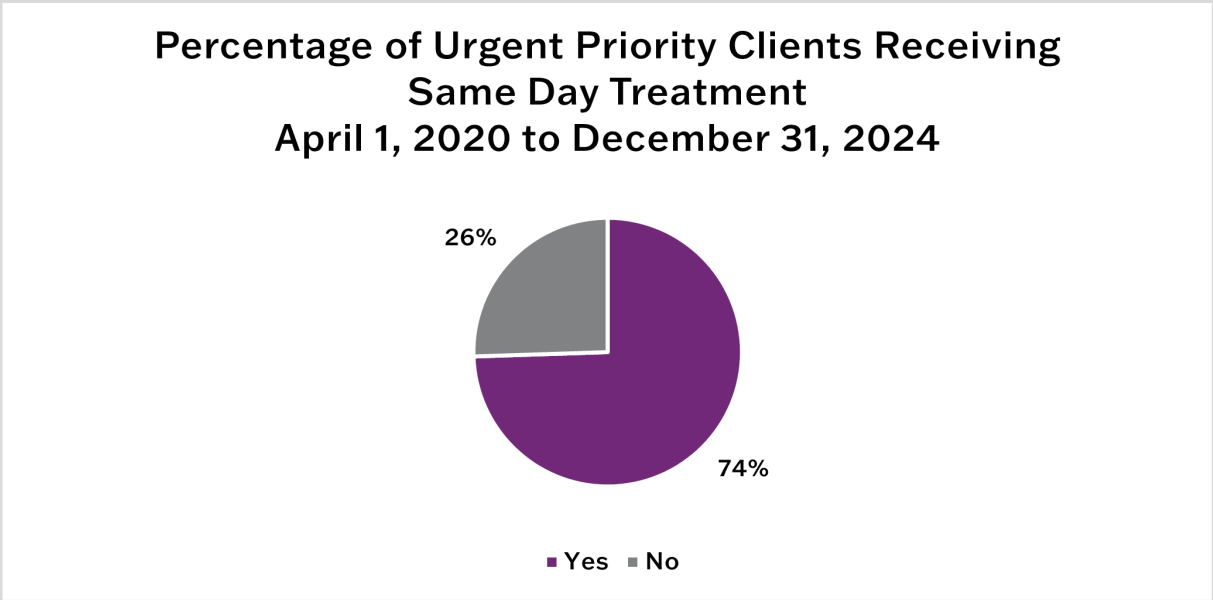
Recommendation

2.87 We recommend that the Department of Health monitor access to urgent priority addiction and mental health services.

WAIT TIME KPI MET 74% OF THE TIME

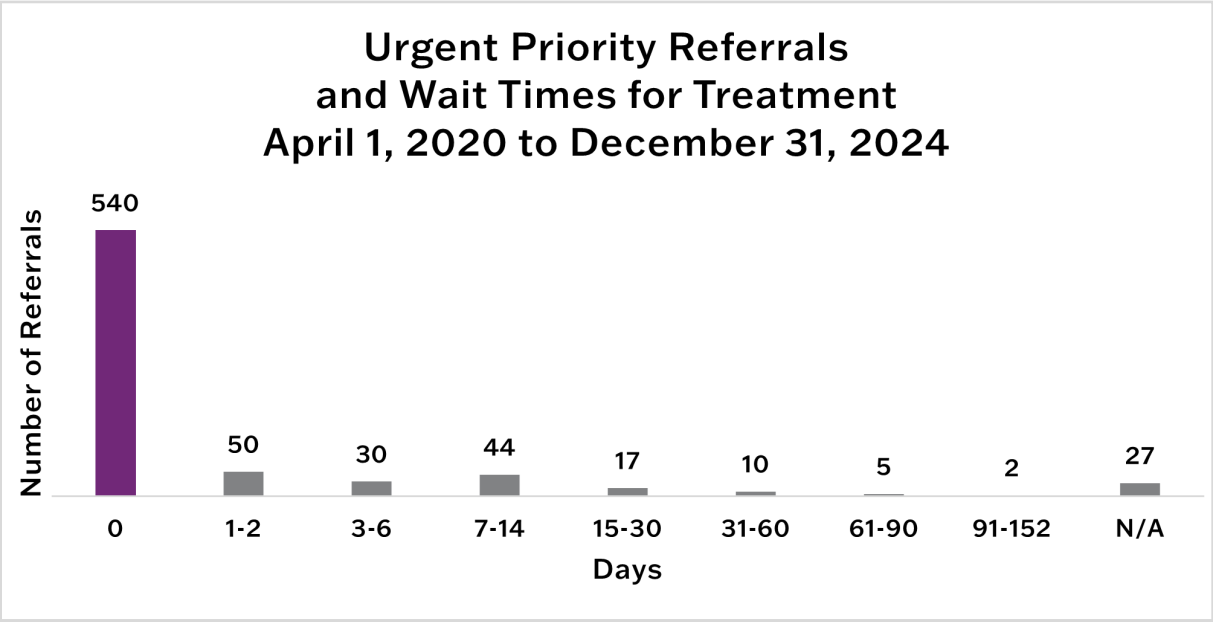
2.88 The Department defines an individual as having an urgent priority level when the client presents an imminent danger to themselves or others. The established KPI for urgent priority AMHS is for a treatment or service to be provided the same day as requested.

2.89 Between April 1, 2020 and December 31, 2024, 725 clients were assigned an urgent priority classification. We found that 26% of these clients did not receive same day services:



Source: Prepared by AGNB based on data from the Department (unaudited)

2.90 The graph below details the wait time between assessment and treatment. In 27 cases, the wait time was unable to be determined due to missing data. One record indicated a patient waited 152 days for treatment.



Source: Prepared by AGNB based on data from the Department (unaudited)

Recommendation

2.91 We recommend that the Department of Health perform a root cause analysis to determine why the urgent addiction and mental health target is not being met and implement strategies for improvement.

Appendix I:

RECOMMENDATIONS AND RESPONSES

Par. #	Recommendation	Entity's Response	Target Implementation Date
We recommend that the Department of Health:			
2.22	review the accountability framework to ensure that performance indicators related to emergency departments cover the full scope of patients served.	**Agree** On May 1, 2025, the Minister of Health issued an accountability framework to the Board Chairs of each Regional Health Authority. The accountability framework contains reporting requirements of the regional health authorities, in alignment with the *Regional Health Authority Act*.	In progress
2.29	establish measurable key performance indicators pertaining to the wait time between arrival and triage.	**Agree** Work is underway with planning, monitoring, measurement, and evaluation of the health care system performance. The Department will establish key performance indicators between arrival and triage, and work with the Regional Health Authorities on consistent data capture and timely reporting.	Q1 2026-2027
2.34	review performance data on emergency department wait times to identify and address risks to achieving timely service delivery.	**Agree** The Department will leverage the Accountability Framework to access timely data on key performance indicators to identify and address risks to achieving timely service.	Q4 2025-2026
2.54	review data on deceased individuals to evaluate risks and opportunities in developing strategies to improve results.	**Agree** The Department will request data from the RHAs specific to the deceased individuals to inform a risk index. The Department will review the data and manage the risk log, and take appropriate actions as required.	Q4 2025-2026
2.60	develop a comprehensive strategy to address emergency department needs including expected outcomes, timelines and resources required.	**Agree** The Department will work with the Regional Health Authorities to develop a comprehensive strategy to address Emergency Department pressures, detailing key objectives, measurable impacts, timeline and resources.	Q4 2026-2027

Par. #	Recommendation	Entity's Response	Target Implementation Date
2.61	monitor and report on achievement of strategy results.	**Agree** The Department commits to developing a strategy, and monitoring and reporting results to Health System Partners.	Q1 2027-2028
2.78	conduct its base budget review to ensure that sufficient resources are provided to the regional health authorities for the services delivered.	**Agree** The Department of Health has commenced a base budget review and expects the review to be completed by spring of 2026.	Q1 2026-2027
2.79	retain supporting documentation and calculations that show how amounts were determined for each annual budget.	**Agree** After completing the base budget review, the Department of Health plans to retain the supporting documentation to ensure a clear understanding of how the base budget was calculated.	Q1 2026-2027
2.82	ensure the public has timely access to reporting on access to emergency departments, including on Canadian Triage and Acuity Scale level wait times and on the performance of short- and long- term strategies to address gaps.	**Agree** The Department will engage with the Regional Health Authorities on feasibility of wait time data availability and align on publication of appropriate data for the public.	Q4 2029-2030
2.87	monitor access to urgent priority addiction and mental health services.	**Agree** The Department of Health will establish a continuous monitoring process for the urgent priority addiction and mental health services.	Q4 2026-2027

Par. #	Recommendation	Entity's Response	Target Implementation Date
2.91	perform a root cause analysis to determine why the urgent addiction and mental health target is not being met and implement strategies for improvement.	**Agree** The Department of Health, in collaboration with the Regional Health Authorities, will perform a root cause analysis to determine why the target is not being met.	Q4 2026-2027

Appendix II: Audit Objective and Criteria

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

Objective	**To determine whether the Department of Health has effective oversight mechanisms in place to ensure timely access to, and adequate reporting on, emergency health services.**
Criterion 1	The Department of Health should establish and monitor relevant key performance indicators to ensure timely access to emergency health services.
Criterion 2	The Department of Health should have short and long-term strategies to address any gaps in timely access to emergency health services.
Criterion 3	The Department of Health should establish and provide a budget that is aligned with achieving the overall goal of timely access to emergency health services.
Criterion 4	The Department of Health should provide timely public reporting on the timeliness of access to emergency health services.

Appendix III: Independent Assurance Report

This independent assurance report was prepared by the Office of the Auditor General of New Brunswick (AGNB) on the Department of Health and its role with respect to emergency health services. Our responsibility was to provide objective information, advice, and assurance to assist the Legislative Assembly in its scrutiny of the Department of Health with respect to emergency health services.

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 the Canadian Standard on Quality Management 1 – Quality Management for Firms That Perform Audits or Reviews of Financial Statements, or Other Assurance or Related Services Engagements. This standard requires our office to design, implement, and operate a system of quality management, including policies or 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
- confirmation that the findings in this report are factually based

PERIOD COVERED BY THE AUDIT

The audit covered the period between April 1, 2020, to December 31, 2024. 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 outside of this period as deemed necessary.

DATE OF THE REPORT

We obtained sufficient and appropriate audit evidence on which to base our conclusion on November 19, 2025 in Fredericton, New Brunswick.