Office of the Auditor General of Ontario

Annual Report 2019

Volume 1

Office of the Auditor General of Ontario

To the Honourable Speaker
of the Legislative Assembly

In my capacity as the Auditor General, I am pleased to submit to you Volume 1 of the *2019 Annual Report* of the Office of the Auditor General of Ontario to lay before the Assembly in accordance with the provisions of section 12 of the *Auditor General Act*.

Bonnie Lysyk, MBA, FCPA, FCA
Auditor General

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Table of Contents

Bonnie Lysyk
Auditor General of Ontario

Reflections

This year's Annual Report, my seventh since becoming Auditor General, is tabled in four volumes. V**olume 1** includes 13 value-for-money audit reports, as well as chapters on our audit of the Public Accounts and on government advertising. **Volume 2** contains three chapters of our work in the area of the environment—the first report issued under our expanded responsibilities outlined in the *Environmental Bill of Rights, 1993*. **Volume 3** includes four audits we conducted on justice and corrections in Ontario. Our follow-up work on previously issued recommendations by our Office and by the Standing Committee on Public Accounts is presented in **Volume 4**. Each volume contains its own reflection preamble.

Many of our reports this year in **Volume 1** address specific programs and practices that impact public safety and the well-being of Ontarians. They include Acute-Care Hospital Patient Safety and Drug Administration, Addictions Treatment Programs, Chronic Kidney Disease Management, Commercial Vehicle Safety and Enforcement, Food Safety Inspection Programs, Food and Nutrition in Long-Term-Care Homes, Health and Safety in the Workplace, and the Ontario Disability Support Program. Even our audit on the Office of the Chief Coroner and Ontario Forensic Pathology Service relates to the safety and well-being of Ontario residents. Our reports in **Volume 2** and **Volume 3** also touch on elements of public health and safety.

Three other value-for-money reports in this volume—Ontario Financing Authority, Provincial Support to Sustain the Horse-Racing Industry and Oversight of Time-Limited Discretionary Grants—relate more directly to financial decision-making by the province. A final value-for-money report is more IT-focused: Technology Systems (IT) and Cybersecurity at the Ontario Lottery and Gaming Corporation.

The following sections provide a synopsis of some of our key observations and findings. A commonality of many of the audits this year is the need for better information and transparency to support decisions and choices. This applies to information needed by decision-makers who can impact the funding and delivery of programs and services. This also applies to Ontarians in general, who must make choices when they need and use public-sector and broader-public-sector programs and services.

Health and Medical Services

Acute-Care Hospital Patient Safety and Drug Administration—Data collected by the Canadian Institute for Health Information shows that between 2014/15 and 2017/18, nearly six of every 100 patients experienced some form of harm during treatment in an acute-care hospital in Ontario. While this indicates that most patients do not experience harm, we noted that this is the second-highest rate of hospital patient harm reported in

Canada, after Nova Scotia. Other incidences of harm include patient safety "never-events"—preventable incidents such as the occurrence of serious pressure ulcers. Such events occurred a total of 214 times over the last four years in six of the 13 hospitals that we audited; somewhat surprisingly, the other seven hospitals we visited did not even track this data. We also found that current laws and practices in Ontario make it difficult for hospitals to address concerns about physicians and nurses found to lack competence and cause harm to patients; it can be difficult, costly and time-consuming for hospitals to fire these individuals, and hospitals may be constrained from readily warning other institutions that consider hiring these individuals.

Addictions Treatment Programs—According to the Canadian Mental Health Association, it is estimated that approximately 10% of the population in Ontario uses substances problematically, and many may well be in need of mental health and addictions services. Currently, the Ministry of Health allocates funding for addictions treatment services without determining the need for each type of service across the province and without evaluating the effectiveness of addictions treatment service providers. Given that Ontario committed to spend about $3.8 billion over the 10 years from 2017/18 to 2026/27 for these services, the allocation and use of those funds needs to be reviewed so that the monies can better meet the needs of Ontarians. Also in need of review are unusual or suspicious instances of opioid dispensing—such as opioids "prescribed by" physicians and dentists with inactive licences. From 2014/15 to 2018/19, about 88,000 instances of dispensed opioids were associated with about 3,500 prescribers with inactive licences dating back to 2012 or earlier, including prescribers who were deceased. Notwithstanding the launching of a provincial Opioid Strategy in 2017, between August 2017 and March 2019, opioid-related deaths rose 70%, opioid-related emergency department visits more than doubled and opioid-related hospitalizations grew over 10%. Emerging areas such as cannabis legalization and vaping require a formal assessment to identify whether additional prevention and treatment services are needed.

Chronic Kidney Disease Management—The prevalence of chronic kidney disease is on the rise in Ontario, leading to a higher need for dialysis treatment and a greater demand for kidney transplants. Our audit noted a need for improvements to the referral process, the alignment of dialysis capacity to regional needs, and lengthy kidney transplant wait times. In 2017/18, about 8,700 patients whose lab test results indicated they would benefit from referral from their primary care provider to a kidney-care specialist did not get this referral and went straight to dialysis. The referral could lead to multidisciplinary care that not only prepares the patient for treatment but can forestall the need for treatment. With regard to alignment of capacity to need, we noted that the occupancy rate of the 94 dialysis locations across Ontario ranged from 26% to 128%. In the last five years, the average wait time for the approximately 1,200 patients waiting each year for a deceased-donor kidney transplant was about four years, too long for those who became too ill for a transplant or died while waiting.

Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)—The Office, which operates within the Ministry of the Solicitor General, has a broad mission: where death is sudden or unexpected, it is to conduct high-quality death investigations that support the administration of justice and the prevention of premature death. The Office is not sufficiently meeting its mission by analyzing data and following up on the implementation of its recommendations. Also, coroners perform death investigations with little supervision, and we found many instances where coroners performed investigations on former patients and billed for more than 24 hours of coroner and physician services in one day. The Office also does not check to ensure coroners completed required training, does not test coroners for competence, and does not have a policy for suspending or removing coroners who are under practice restrictions by the College of

Physicians and Surgeons of Ontario. We found 16 coroners who had performed death investigations while under practice restrictions by the College.

Social Services

Ontario Disability Support Program (ODSP)—ODSP was last audited by our Office in 2008/09. At the same time as more taxpayer funds are allocated to support ODSP (the annual cost of the program has increased by about 75%, from $3.1 billion in 2008/09 to approximately $5.4 billion in 2018/19), more weaknesses in program administration have come to light, some of them obvious and significant. Given the administrative weaknesses, it now appears likely that support payments, intended only for people who are disabled, could be received by those who are either financially or medically ineligible. Two-and-a-half percent of Ontarians are on ODSP, which is the highest rate among all Canadian provinces' disability programs.

Food Safety and Nutrition

Food Safety Inspection Programs—We found that the risk of a mass foodborne-illness outbreak in Ontario is likely low, thanks to systems and procedures in place for keeping the Ontario food supply safe. As well, about 98% of meat samples tested from provincially inspected slaughterhouses did not contain harmful drug residues. However, just one diseased animal or one unclean restaurant can give rise to small-scale food incidences causing illness. Every year, foodborne illnesses in Ontario account for 70 deaths, 6,600 hospitalizations, 41,000 visits to hospital emergency rooms and 137,000 visits to physicians' offices. Areas where food safety could be further improved included more stringent or clearer requirements for agricultural pesticide use, licensing of fish processors and food labelling; consistently quicker inspection by public health units of food premises linked to foodborne-illness complaints; and more transparent and consistent public disclosure of the results of inspections of food premises.

Food and Nutrition in Long-Term-Care Homes—While the number of residents living in long-term-care homes has increased by only 2% in the last 10 years, the residents' overall cognitive performance has declined, as demonstrated, for example, by an increase in people with dementia from 56% in 2009 to 64% in 2019. Residents with dementia need more assistance to eat and drink, and we found that the Ministry of Long-Term Care and the long-term-care homes did not have sufficient procedures to ensure they got this assistance. Home menus also were not providing optimal nutrition to residents: they contained up to 93% more sugar than recommended, up to 59% more sodium, and up to 34% less fibre. Procedures for preventing and controlling infections such as gastroenteritis were also in need of improvement; significantly, we observed that, on average, only 19% of residents had their hands washed before or after a meal.

Safety at Work and on the Road

Health and Safety in the Workplace—Ontario had the lowest lost-time workplace injury rate in Canada over the nine-year period from 2009 to 2017 (the most recent year for which data is available). It also had the second-lowest fatality rate in Canada for workplace fatalities and occupational diseases on average from 2013 to 2017. However, our audit cautioned against complacency. Notwithstanding these results, in 2018, 85 people died at work in Ontario, while another 62,000 were absent from work because of a job-related injury. Further, 143 people died from an occupational disease in 2018, the rate of people taking time off work as a result of a jobsite injury has increased since 2016, and the number of injuries in the industrial and health-care sectors increased over the last five years by 21% and 29%, respectively. Work-place related illness, injury and death can be better addressed with improvements in the province's enforcement of employer safe practices and comprehensive inspections. Efforts are not preventing many employers from continuing the same unsafe

practices. We found that many companies inspected at least three times during the past six fiscal years were issued orders for repeated violations and contraventions relating to the same type of unsafe work practises. As well, over the last four-and-a-half years, comprehensive inspections had been completed for only 23 of more than 550 mining operations, while only one of 39 underground mines had undergone an engineering review for the top three hazards.

Commercial Vehicle Safety and Enforcement—Collisions involving commercial vehicles have a higher risk of injury and death due to the size and weight of the vehicles (these vehicles include trucks and trailers with a gross weight over 4,500 kilograms and buses seating 10 or more passengers). In most of the years between 2008 and 2017, Ontario had higher fatality and injury rates for commercial vehicles than the rates in Canada and the United States. Given this, we were concerned that the number of roadside inspections the Ministry of Transportation conducted that identify driver violations and mechanical defects decreased between 2014 and 2018, from over 113,000 to fewer than 89,000. If the Ministry had continued to conduct as many inspections between 2015 and 2018 as it did in 2014, it could have removed as many as 10,000 additional unsafe commercial vehicles or drivers from Ontario's roads based on historical inspection results. The Ministry had not inspected any of the commercial vehicles of 56% of Ontario's 60,000 trucking carriers in the last two years, including many carriers with a poor collision history. The Ministry does not require Service Ontario to ask commercial vehicle owners for proof their commercial vehicle has passed inspection to get their licence plates renewed, so it does not know how many commercial vehicles are operating without an up-to-date inspection certificate. The Ministry also allows commercial drivers to be tested for their licences by their own carriers. Between 2014/15 and 2018/19, 25% of the 106 carriers that test their own drivers ranked among the worst 1% of all carriers for at-fault collisions.

Other Government Services

Technology Systems (IT) and Cybersecurity at Ontario Lottery and Gaming Corporation (OLG)—OLG's gaming customers and all Ontarians have an interest in the fairness and integrity of OLG's gaming operations, and the security of their personal information after it is collected by OLG. We found that OLG information security systems and management, including cybersecurity and encryption standards, needed to be strengthened. In November 2018, the OLG iGaming IT system was attacked by a hacker, making it unavailable for 16 hours and impacting customer experience.

Provincial Support to Sustain the Horse-Racing Industry—The horse-racing industry as a gaming operation has been in decline in Ontario since the legalization of lotteries in 1969, with wagers by Ontarians on Ontario races decreasing by 44% in the last 10 years. In 1996, the province began providing the industry with funding support; almost 25 years later, the industry is no closer to being self-sustaining. Ontario's 15 racetracks currently receive annual subsidies of close to $120 million, and the 11 racetracks that host slot machines receive a further $140 million annually from private casino operators selected by OLG to cover leasing and other costs. A 19-year contract that took effect April 1, 2019, will provide further guaranteed funding. For all the financial support racetracks have received and will continue to receive, they are remarkably lacking in transparency and public accountability. Only one racetrack posts its financial statements on its website, and there is no public reporting of key performance indicators by racetrack, including gross wagering, wagering commissions, purses paid, and the current number of people working in the industry.

Oversight of Time-Limited Discretionary Grants—We examined the $3.9 billion the government provided to third parties as time-limited discretionary grants to fund activities intended to benefit the public and help achieve public-policy

objectives. We found that, although the entities that receive grants directly from ministries and the amounts received are identified in the province's Public Accounts, the amounts the entities then disburse to other parties are not identified there. In 2018/19, about $400 million was disbursed to these other parties. Also, some organizations received grants under ministerial discretion even though they did not meet the program's evaluation criteria. In the last three years, this mode of providing grants was especially prevalent for the Ministry of Heritage, Sport, Tourism and Culture Industries' Celebrate Ontario grant program, which provided almost $6 million in funding through ministerial discretion to 132 applicants that had not achieved the minimum required evaluation score set by the Ministry.

Ontario Financing Authority (OFA)—The OFA was created in 1993, following the 1990 recession, to manage the province's debt, borrowing, investing and cash management programs. The province's net debt rose from $81 billion in 1993/94 to $338 billion by 2018/19. We found that the OFA has been effective in its investing operations and assessing short-term risks. But it is not fully analyzing long-term debt sustainability—the province's future ability to repay debt. It has focused on the current year and the upcoming two fiscal years. This leaves the Ministry of Finance without the information needed to establish long-term targets to manage debt. The OFA could also save significant interest and operating expenses for the province by reducing its excess liquid reserve, expanding its use of debt auctions and directly handling the borrowing of public bodies.

Acknowledgements

I want to thank the members of the all-party Standing Committee on Public Accounts for their support and dedicated service to Ontarians.

I also want to thank my team of professionals for their excellent work during the year and their significant contributions to this Annual Report.

On behalf of our Office, I would also like to acknowledge and express my sincere thank you to someone from our Executive Team whom we will dearly miss –Rudolph (Rudy) Chiu, Assistant Auditor General. Rudy led our Health, Energy and Justice portfolio in planning, performing and reporting on many significant audits in this and past years. He will be retiring in December 2019 after dedicating over 37 years of public service to our Office and the Legislature.

I would like to welcome two new members to our Executive Team—Jerry DeMarco, who joined our Office in August 2019, assuming the role of Assistant Auditor General, Commissioner of the Environment; and Richard (Rick) Kennedy, who joined our Office in November 2019 as an Assistant Auditor General. Rick will be assuming responsibility for the Health, Energy and Justice portfolio.

I am also appreciative of how our outstanding Panel of Senior Advisors shares its extensive knowledge, insight, judgment and advice with us throughout the year.

Others to thank include the many people in the public and broader public sectors who were involved in our work for their assistance and cooperation in the completion of this year's audits, and the various experts who shared their knowledge and advice with us. As well, we thank the external accounting firms that provided us with assistance during the past year and whose relationships with us we value.

My team and I look forward to continuing to serve the Legislative Assembly and, through it, the citizens of Ontario.

Sincerely,

Bonnie Lysyk, MBA, FCPA, FCA
Auditor General of Ontario

Our Team

It takes a massive effort by many people to perform the research, audit, writing and administrative-support work required to produce an Annual Report of this scope and substance. The following is a list of the people with our Office who worked to produce this Report:

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Chapter 1

Summaries of Value-for-Money Audits

3.01 Acute-Care Hospital Patient Safety and Drug Administration

Patient safety refers to reducing the risk of unintentional patient harm through policies and procedures that hospitals design, implement and follow. Patient safety incidents—such as hospital-acquired infections and medication errors—can be caused by poorly designed systems and processes and unsafe human acts in the delivery of hospital care.

In this report, we focused on patient safety in acute-care hospitals, where patients primarily receive active short-term treatment. Under the *Public Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and to take steps to prevent similar incidents from occurring in the future. However, current laws and practices in Ontario make it difficult for hospitals to address concerns with the safety of care provided by some nurses and doctors.

Hospital data collected by the Canadian Institute for Health Information shows that each year, among the more than 1 million patient discharges from Ontario acute-care hospitals, approximately 67,000 patients were harmed during their hospital stays. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital.

While the majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals we visited are committed to patient safety, our audit found that more can be done to improve patient safety.

Among our significant findings:

- Current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety. Non-disclosure arrangements negotiated by unions with hospitals can result in potential new employers not being made aware of nurses' poor past performance.
- Nurses that acute-care hospitals have found lack competence and who have been terminated or banned continue to pose a risk to patient safety. (Agency nurses who are found incompetent may be banned by hospitals). We reviewed a sample of nurses who were terminated or banned for lack of competence in the past seven years from nine hospitals that we visited. After their first termination or banning, 15 of the nurses subsequently worked at another hospital or for another agency. We noted that four of them were either subsequently terminated or banned again for lack of competence.
- Patient safety culture at different hospitals varies significantly, from excellent to poor and failing. We obtained the most recent staff survey results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."

- Patient safety "never-events" have occurred at most of the acute-care hospitals we visited. Health Quality Ontario and the Canadian Patient Safety Institute have identified 15 patient safety "never-events"—preventable incidents that could cause serious patient harm or death. We found that since 2015, 10 out of the 15 never-events have occurred a total of 214 times over the last four years in six of the 13 hospitals that we audited.
- Acute-care hospitals do not always follow best practices for medication administration. From 2012 to 2018, hospitals in Ontario reported to the Canadian Institute for Health Information 154 critical patient safety incidents involving administration of medications. Thirty-nine of these incidents resulted in a patient's death. We found that three of the hospitals we visited did not comply with best practices for the administration of high-risk medications.

3.02 Addictions Treatment Programs

The Ministry of Health (Ministry) is the primary funder and overseer of addictions services in Ontario. In 2018/19, about $212 million was spent by about 200 addictions treatment service providers to treat over 76,700 clients, largely through three main types of programs: non-residential, residential and withdrawal management or detox.

Between 2014/15 and 2018/19, spending on addictions treatment programs grew almost 25% from $170 million to $212 million. Since August 2017, an additional $134 million was spent on the Ministry's Opioid Strategy. Despite this increased spending, we found that wait times for addictions treatment, repeat emergency department visits for substance-use conditions, as well as opioid-related emergency department visits, hospitalizations and deaths continue to increase.

As Ontario has committed to investing $3.8 billion over 10 years (from 2017/18 to 2026/27) for mental health and addictions services, it is important that going forward, funding for addictions services is allocated appropriately to meet the needs of Ontarians.

Our significant observations include:

- Longer wait times for addictions treatment leads to people being hospitalized or dying before receiving treatment. Between 2014/15 and 2018/19, wait times for all addictions treatment programs increased. Service providers informed us that they were aware of their clients dropping off wait lists for treatment programs because they were hospitalized or incarcerated, had attempted suicide or even died while waiting for treatment.
- Insufficient community-based addictions services causes more people to seek treatment from emergency departments. Between 2014/15 and 2018/19, visits to emergency departments for substance-use conditions increased by almost 40% and repeat unscheduled visits to emergency departments within 30 days for substance-use conditions increased almost 50%.
- The Ministry funds addictions treatment service providers without evaluating the effectiveness of their programs. The Ministry only requires that service providers submit information on their spending and service activity, but has not collected any information on their performance to assess their programs' effectiveness.
- The Ministry requires service providers to follow standards that only apply to withdrawal management programs but not to non-residential and residential programs. This results in significant differences among service providers for the same types of programs.
- The impact of emerging issues, including cannabis legalization and vaping, need further monitoring to identify whether additional addictions prevention and treatment services are necessary. In September 2019, three incidents of

vaping-related severe lung disease were under review in Ontario.

Another set of significant findings relates to the Ministry's Opioid Strategy (Strategy), which was launched in August 2017.

- Despite spending about $134 million on the Strategy, between 2016 and 2018, opioid-related deaths rose 70%, opioid-related emergency department visits more than doubled and opioid-related hospitalizations grew over 10%.
- Most of the Strategy's funding for treating opioid addictions is not allocated to the regions with the highest need. Of the over $58 million the Ministry allocated to Local Health Integration Networks (LHINs) for opioid addictions treatment, only one-third was allocated based on factors that reflect regional needs such as population size, opioid-related deaths, emergency department visits and hospitalizations. The remainder was equally distributed among the LHINs.
- Ontario does not provide all health-care providers who can prescribe opioids with access to a provincial system containing the history of opioid prescriptions dispensed to patients. Therefore, prescribers may have to rely on information self-disclosed by their patients. This can lead to inappropriate or excessive opioid prescriptions because prescribers are unable to verify whether their patients have already received opioids prescribed and dispensed by others.
- Information on unusual or suspicious instances where opioids were dispensed—such as high dosages or when the licence of the prescribing physician or dentist is inactive—is not proactively shared with regulatory colleges on a regular basis for investigation.
- The Ministry has neither determined whether the number or capacity of Consumption Treatment Services sites align with regional needs nor ensured each site operates consistently.

3.03 Chronic Kidney Disease Management

The prevalence of chronic kidney disease is on the rise in Ontario, leading to a higher need for dialysis treatment and a greater demand for kidney transplants. Over the last decade, the number of Ontarians with end-stage renal (kidney) disease has grown over 37% from about 14,800 people to about 20,300 people.

The Ontario Renal Network (Renal Network), a division of Cancer Care Ontario (CCO), is responsible for advising the Ministry of Health (Ministry) on chronic kidney disease management, determining funding to each of the 27 Regional Renal Programs in Ontario, and leading the organization of chronic kidney disease services (excluding transplants, which fall under the responsibility of the Ministry, Trillium Gift of Life Network (Trillium Network) and six adult kidney transplant centres).

In 2018/19, the Renal Network's expenditures on chronic kidney disease services was approximately $662 million, and the Ministry provided approximately $20 million to transplant centres for funding about 700 kidney transplants.

The Ontario government plans to integrate multiple provincial agencies, including the Renal Network within CCO and the Trillium Network, into a single agency called Ontario Health, so it is important that going forward, renal services are better co-ordinated to meet the needs of Ontarians.

The following are some of our significant findings.

- In 2017/18, over 40% (or about 8,700) of patients in Ontario who met the Renal Network's referral criteria were not referred by their primary-care providers to a nephrologist (a physician specializing in kidney care) even though these patients' lab test results indicated that they would benefit from a nephrology visit.
- Before starting dialysis, patients should receive at least 12 months of multidisciplinary care in Multi-Care Kidney Clinics, which

help patients manage chronic kidney disease and educate patients on the treatment options available. However, of the approximately 3,350 patients who started dialysis in 2018/19, about 25% received less than 12 months of care in a clinic while 33% did not receive any clinic care prior to starting dialysis.

- Capacity for in-centre dialysis in a hospital or clinic does not align with regional needs. Twenty-seven Regional Renal Programs have a total of 94 in-centre dialysis locations across Ontario with a capacity to serve about 10,200 patients. While the occupancy rate of all locations is about 80% on average, it ranges from 26% to 128% depending on location.
- Promoting the use of home dialysis has been part of the Renal Network's strategic direction since 2012, but the home dialysis usage rate still has not met the Renal Network's target. The rate varies significantly (16% to 41%) among the 27 Regional Renal Programs, and only six met the current target of 28%.
- Wait list and wait times for deceased-donor kidney transplants remain long. In each of the last five years, approximately 1,200 patients on average were waiting for a deceased-donor kidney transplant and the average wait time was approximately four years. Patients have to undergo dialysis as well as continuous testing and evaluation to stay on the wait list, creating mental and physical burdens on patients and resulting in significant costs to the health-care system.
- Apart from the 27 Regional Renal Programs funded and overseen by the Renal Network, the Ministry also funds and oversees seven Independent Health Facilities that provide dialysis. With no complete oversight of and information on dialysis across the province, it is difficult for the Renal Network to effectively plan and measure renal care in Ontario.
- While the Trillium Network and the Renal Network established a data-sharing agreement in September 2017 to capture patients' complete transplant journeys, inaccurate and incomplete transplant data have caused difficulty in measuring and reporting transplant activities.
- The Renal Network has not reviewed its funding amounts for most chronic kidney disease services since implementing them between 2012/13 and 2014/15, even though they were meant to be a starting point. Through our review of expenditures of the five Regional Renal Programs we visited, we found possible surpluses of $37 million over the last five years.
- Base funding for kidney transplants is unchanged since 1988 and does not align with the actual cost. The current funding rate per kidney transplant is approximately $25,000. However, the average cost reported for a deceased-donor kidney transplant, including pre-transplant and pre-operative care provided by transplant centres, was $40,000, ranging from about $32,000 at one centre to $57,000 at another.

3.04 Commercial Vehicle Safety and Enforcement

The Ministry of Transportation (Ministry) has estimated that Ontario's truck traffic increased 10% from 2009 to 2018. Truck traffic is daily truck volumes on Ontario roads, including trucks not registered in Ontario. Collisions involving commercial vehicles have a higher risk of injury and death due to the size of the vehicles involved.

Although Ontario compares favourably to Canada as a whole and the United States for overall road safety, Ontario had a higher fatality and injury rate then Canada as a whole and the United States in the majority of years between 2008 and 2017 when evaluating only commercial vehicles.

According to the Ministry, the direct social cost of large truck collisions in Ontario from 2011 to 2015 (the most recent data available) was $2 billion. This

includes costs related to property damage, health care, police, courts, fire and ambulance services, tow trucks and traffic delays.

From 2014/15 to 2018/19, the Ministry spent over $200 million on commercial vehicle enforcement.

Some of our significant findings include the following:

- The number of roadside inspections of commercial vehicles the Ministry conducted decreased from over 113,000 in 2014 to fewer than 89,000 in 2018. If the Ministry had continued to conduct as many inspections between 2015 and 2018 as it did in 2014, it could have removed as many as 10,000 additional unsafe commercial vehicles or drivers from Ontario's roads.
- Although the Ministry introduced a framework in 2015 to increase the consistency of the decisions its enforcement officers make, we found significant differences across the province in the rate at which officers lay charges and remove unsafe vehicles from the road. For example, in 2018, one district laid charges in over 30% of roadside inspections, while another laid charges in fewer than 8% despite finding violations in over 40% of inspections.
- The majority of carriers (operators of commercial vehicles) have not had a vehicle inspection in the past two years, including carriers with poor collision histories. The Ministry had not inspected any of the commercial vehicles of 56% of Ontario's 60,000 carriers in the last two years. This included many carriers at the highest risk of future collision.
- Most roadside inspections are performed on provincial highways, allowing "local haulers" to avoid inspection. Over 90% of roadside inspections are conducted by Ministry enforcement officers, usually at truck inspection stations on provincial highways. This indicates that drivers and carriers could purposely avoid roadside inspection by driving on municipal roads.
- All drivers must complete Mandatory Entry-Level Training before they can apply for a Class A licence, required to drive a tractor-trailer, but the Ministry has not extended this requirement to other licence classes. We found that drivers of large trucks that do not require a Class A licence—for example, a dump truck—were involved in more collisions and injuries per registered truck than drivers of tractor-trailers.
- The Ministry approves colleges, government organizations, safety organizations and private businesses, including carriers, to train and test drivers for commercial drivers' licences under the Driver Certification Program. We analyzed carriers that test their own drivers and found that drivers who took their road test with carriers between 2014/15 and 2018/19 had a pass rate of 95% compared with just 69% at DriveTest centres. We found that 25% of the 106 carriers testing their own drivers under the program ranked among the worst 1% of all carriers for at-fault collision performance.
- In Ontario, commercial vehicle drivers are not subject to mandatory drug and alcohol testing either before or during their employment. In addition, Ontario drivers who hold a prescription for medical marijuana may operate a commercial vehicle with marijuana present in their system as long as they are not legally impaired, unlike those who use it recreationally.
- Many Motor Vehicle Inspection Station garages are ordering excessive quantities of inspection certificates without investigation by the Ministry. Excessive ordering creates the risk that garages could be distributing or selling inspection certificates they order but do not need, or are issuing certificates without actually inspecting vehicles.

3.05 Food and Nutrition in Long-Term-Care Homes

More than 77,000 adults live in Ontario's 626 long-term-care homes. The Ministry of Long-Term Care (Ministry) funds the homes to provide residents with 24-hour nursing care and help with daily living activities in a protective and supportive environment.

At the time of our audit, the average age of residents in Ontario's long-term-care homes was 83. However, compared with 2009, the current cohort of residents are more cognitively impaired and require more assistance with daily living, including eating and drinking. It was estimated that in 2016, there were 228,000 long-term-care home residents living with dementia. This number was expected to grow to over 430,000 by 2038. Providing food and nutrition services to residents will become more challenging for long-term-care homes with the expected increase in the prevalence of dementia.

The Ministry inspects long-term-care homes on aspects related to food, such as dining room observation, menu planning and evaluating nutritional and hydration risks to residents. As well, Ontario's 35 public health units, which are co-funded by the Ministry of Health and municipalities, inspect the homes for food-safety concerns such as food temperature control, food-area sanitation, pest control and food-preparation practices.

Our audit found that the long-term-care homes were not consistently providing residents with sufficient and high-quality food and nutrition care.

Our more significant audit findings include:

- Residents typically wait an average of 43 minutes to receive breakfast, compared to 29 minutes during lunch and 24 minutes during dinner, because personal support workers have other responsibilities in the morning to help residents get ready for the day. As well, over a two-week period in February 2019, one in eight, or 13% of meals served at the long-term-care homes we visited did not have a full complement of staff reporting to work on those days.
- Long-term-care staff do not consistently follow the residents' plans of care, increasing the risk that residents may be eating the wrong food. Plans of care define the level of care residents require for various aspects of their living activities, including eating. Between January 2017 and May 2019, the Ministry noted 56 homes that failed to follow a resident's plan of care, with 29% of these homes having repeated non-compliance issues in the same area.
- Menus do not have the nutrients for residents, recommended by the Dietary Reference Intakes. While we found that homes' menus had sufficient protein, they contained too much sugar, ranging from 40% to 93% over recommended amounts; too much sodium, ranging from 32% to 59% over; and not enough fibre, ranging from 19% to 34% under recommended amounts.
- In three of the five long-term-care homes we visited, some food used to make meals was past its best-before date. Two of these homes served that food to residents; one of the food items was three months beyond the best-before date. Food past its best-before date may still be safe, but can lose some of its freshness, flavour and nutritional value, and undergo a change in texture.
- Only 19% of residents were observed to have washed their hands to prevent and control infections. We also observed that 76% of staff practised proper hand hygiene directly before or after the meal. According to the Ministry of Health, long-term-care homes could prevent 20% of infections through adherence to an infection prevention and control program that includes proper hand hygiene.
- The Ministry does not require long-term-care homes to report on performance indicators related to food and nutrition. Such indicators could include the percentage of residents at high nutritional risk, ratio of staff to residents who need help eating and satisfaction of residents, and families with respect to food and dining.

3.06 Food Safety Inspection Programs

Foodborne illnesses in Ontario account for 41,000 visits to hospital emergency rooms and 137,000 visits to physicians' offices each year. Contaminated food kills about 70 people in the province annually and sends another 6,600 to hospital.

Contamination of food can happen at any point in the food-supply chain, from the farm to transport to preparation and packaging.

In Ontario, prevention of foodborne illness is the responsibility of all three levels of government, which license and inspect food producers and food premises as follows:

- Meat, produce, fish and dairy produced, processed and consumed only in Ontario are generally the responsibility of the Ontario Ministry of Agriculture, Food and Rural Affairs (Ministry of Agriculture).
- Food premises are inspected by 35 Public Health Units in municipalities across Ontario funded by the Ontario Ministry of Health, and by the municipalities in which they are based.
- Food imported into Ontario from other provinces or countries, or produced in Ontario for export outside the province, is inspected by the federal Canadian Food Inspection Agency (CFIA).

Forty-five percent of agriculture food products sold in Ontario are produced or processed within the province; the remaining is imported from other provinces and countries, which means it is licensed and inspected by the federal CFIA.

The Ministry of Agriculture spent about $39.5 million in the 2018/19 fiscal year on food-safety licensing, inspections and other related services, while the Ministry of Health and municipalities spent about $63.1 million the same year to fund Public Health Units. Total average annual spending by the two ministries and municipalities over the last five years on food safety was about $105.7 million.

Some of our most significant findings include the following:

- Ninety-eight percent of slaughterhouse meat tested negative for harmful drug residue, but in the 2% of cases of positive drug-residue test results, there was no follow-up with the farmers who raised the animals to prevent repeat occurrences.
- The *Cosmetic Pesticides Ban Act* lists 131 pesticides that cannot be used for cosmetic groundskeeping, in parks and yards for example, because of potential health and environmental concerns. However, their use is allowed in agriculture for operational and economic reasons. Between 2014 and 2018, the Ministry of Agriculture tested about 1,200 Ontario-grown produce samples and found residues of 14 banned pesticides that exceeded Health Canada limits a total of 76 times.
- Fish processors who sell only in Ontario do not require a licence to operate. The Ministry of Agriculture, therefore, may not be able to close them because there is no licence to revoke if inspectors identify serious food-safety deficiencies.
- Businesses operating solely within Ontario can market their products as "organic" even if they are not certified to the Canadian Organic Standards. In comparison, Quebec, Manitoba, Alberta, British Columbia, New Brunswick and Nova Scotia all have laws requiring that organic food be certified to the Canadian Organic Standards, even when it is sold only within their borders. We also noted that routine sample testing of produce for pesticides residue is not required for the CFIA organic certification process.
- The degree of public disclosure of inspection results for food premises, along with the inspection grading systems used by the 35 Public Health Units, varied across the province and led to inconsistent information provided to the public across Ontario.

- Based on our review of inspection reports from 2016 to 2018 at five Public Health Units, we found that for those foodborne-illness complaints that required food premises inspections, Public Health Units consistently did not inspect 20% of food premises within two days of receiving the complaint. The Public Health Units we visited informed us that a two-day timeline is considered a best practice.
- While not all special events require inspections, we found that only about 12% of all special events in 2018 within the jurisdictions of the five Public Health Units we visited were inspected. According to the US Centers for Disease Control and Prevention, special events can be high risk because the usual safety features of a kitchen may not be available at outdoor events.

3.07 Health and Safety in the Workplace

The Occupational Health and Safety Program is responsible for administering the *Occupational Health and Safety Act* (Act) in Ontario. The Program, which is part of the Ministry of Labour, Training and Skills Development (Ministry), spent about $200 million in 2018/19 for prevention and enforcement activities. Almost half of this funding goes to six external health and safety associations to consult with and train businesses and workers on how to maintain a safe workplace. The Ministry recovers its costs to administer the Act from the Workplace Safety and Insurance Board (WSIB), which derives its revenue primarily from premiums paid by employers to insure their workers.

In 2018, 85 people in Ontario died at work and an additional 62,000 were absent from work because of a work-related injury. In addition, another 143 people died from an occupational disease. Between 2014 and 2018, the number of employers, supervisors or workers prosecuted and convicted for violating the Act totalled 1,382, or about 276 annually. Financial penalties imposed totalled $62.1 million.

Compared to other Canadian jurisdictions, Ontario had consistently one of the lowest worker lost-time injury rates over the 10-year period from 2008 to 2017. In fact, it has had the lowest rate of any province since 2009. As well, with regards to fatalities from workplace injuries or occupational diseases, we calculated that Ontario had the second-lowest fatality rate in Canada on average from 2013 to 2017. However, Ontario should not become complacent when it comes to occupational health and safety. Injury rates for workers who lost time from work as a result of a workplace injury began to decrease from 2009, but have increased since 2016. Further, the number of injuries in the industrial and health-care sectors has increased over the last five years by 21% and 29%, respectively.

Some of our significant audit findings include:

- The Ministry's enforcement efforts are not preventing many employers from continuing the same unsafe practices. We reviewed companies inspected at least three times during the past six fiscal years and found that many of these companies have been issued orders for violations and contraventions relating to the same type of hazard in multiple years. For example, in the construction sector, 65% of companies we reviewed had repeatedly been issued orders relating to fall protection hazards.
- The Ministry's information system contains only 28% of all businesses in Ontario, leaving many workplaces uninspected. The Ministry does not maintain an inventory of all businesses that are subject to inspection under the *Occupational Health and Safety Act*. This is because there is no requirement for businesses to register with or notify the Ministry when they start operating or close down. Instead, the inventory is updated only when the Ministry's contact centre receives a complaint or an incident report, or if an inspector

happens to notice a new, unrecorded workplace in their area of inspection.

- The Ministry does not identify workplaces for inspection where workers are more likely to get injured, often leaving companies with the highest injury rates uninspected. Although the Ministry uses WSIB injury data and its own compliance data to identify high-risk or workplace/worker characteristics for developing enforcement strategies, it does not use this data to identify, rank and select specific higher-risk workplaces for inspection.
- The Ministry provides health and safety associations with about $90 million in funding per year, but does not know how effective the associations have been at helping to prevent occupational injury or disease. The Ministry assesses the associations' performance solely on outputs (for example, number of training hours provided) rather than the effectiveness of their prevention efforts (for example, changes in the rates of injuries and fatalities in businesses that received their training services).
- The Ministry does not require health and safety associations to account for or repay surplus funding owed to the government. Under the transfer-payment agreements with the Ministry, the associations are not allowed to retain any portion of unused funding at year's end. In addition to government funding, all five training associations also generate revenue from private sources. None of the associations, however, track what portion of expenses relate to activities funded by the government, and the Ministry does not require them to do so. We estimated the Ministry's share of the associations' total recoverable surplus to be approximately $13.7 million. In January 2019, the Ministry reduced fourth-quarter payments by $2.9 million to the associations and in April 2019, announced a $12-million reduction to their funding. Associations were permitted to use their accumulated surpluses to offset this.

3.08 Office of the Chief Coroner and Ontario Forensic Pathology Service

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) operates within the Ministry of the Solicitor General. The Office conducts investigations and inquests to ensure that no death is overlooked, concealed or ignored, and establishes death review committees that have specialized expertise in certain types of deaths to support death investigations. Recommendations made through these processes help improve public safety and prevent death in similar circumstances.

Since 2009, the Office has been led by both a Chief Coroner, responsible for death investigations and the work of coroners and inquests, and a Chief Forensic Pathologist, responsible for the work of forensic pathologists and pathologists who perform autopsies. The Office's total expenditures for both coroner and pathology services in 2018/19 were about $47 million. In 2018, the Office conducted about 17,000 death investigations. In almost half of these cases, an autopsy was performed.

Coroners perform death investigations for types of deaths defined by the Coroners Act (Act)—mostly those that are sudden and unexpected. Coroners in Ontario are physicians, or medical doctors, who usually have a medical practice in addition to their fee-for-service work as coroners. Currently, about 70% of the about 350 licensed physicians who work as coroners have a background in family medicine.

Our significant findings include:

- Coroners perform death investigations with little supervision and many deficiencies have gone undetected. Coroners have performed death investigations on their former patients, billed for more than 24 hours of coroner and physician services in one day, and conducted death investigations while under practice restrictions by the College of Physicians and Surgeons of Ontario (College).
- The Office's policy requires autopsy reports of criminally suspicious cases to be peer-reviewed by a centrally assigned reviewer on

a rotation list. However, some forensic pathologists do not follow this process and instead choose their reviewer.

- The only structured training required for a physician to work as a coroner is a five-day course, with neither a check to ensure course completion nor a competency examination. Refresher training is only required after the initial course if quality issues are identified. However, the Office's quality assurance unit identified significant errors in 18% of 2017 coroner reports. The reports were incorrect, incomplete, or did not meet the standards of the Office—even after the regional supervising coroners had reviewed them.
- The Office does not have a documented policy for suspension or removal of coroner appointments for those under practice restrictions by the College. We found that 16 coroners had performed death investigations while under practice restrictions by the College. One of these coroners was restricted by the College from prescribing narcotics in 2012 but had investigated 19 cases since then where the death was as a result of drug toxicity.
- Bodies that need autopsies are often stored with other bodies in the hospital morgue. In 2019, one hospital-based regional forensic pathology unit conducted an autopsy on the wrong body. Due to limited capacity, regional units have stored bodies in hospital hallways and other rooms.
- Deaths are not always reported to the Office as required by law. In 2018, about 2,000 deaths, including those that resulted from pregnancy, fractures, dislocations or other trauma, were under-reported to the Office and so were not investigated.
- The Office does not require its coroners to provide it with documented reasons when they conclude a death investigation is not needed. While the Office does not track how frequently coroners do not provide reasons, our audit found that in about 56% of the cases we sampled, the coroner did not do so.
- The Death Investigation Oversight Council is not effectively fulfilling its legislative mandate to oversee the Office due to its limited authority. The Council is the primary oversight for the Office's activities, but its recommendations are non-binding. As well, it was not informed of key decisions such as the closure of a hospital-based regional forensic pathology unit.

3.09 Ontario Disability Support Program

The Ontario Disability Support Program (ODSP) is a social assistance program under the Ministry of Children, Community and Social Services (Ministry). The program provides income support for Ontarians with disabilities who are in financial need. An employment-support program is also available to ODSP recipients to help them prepare for, obtain, or maintain a job so that they can live as independently as possible. In 2018/19, the Ministry provided ODSP income support to more than 510,000 individuals comprising recipients and their qualifying family members.

Since our last audit of ODSP in 2009, the cost of the program has increased by approximately 75% from $3.1 billion to approximately $5.4 billion in 2018/19. A significant contributing factor to the program's rising cost is the increase in the number of individuals and families receiving ODSP. Since 2008/09, the average monthly number of ODSP cases—a single individual or a family unit—has increased by 50%. However, despite this significant increase to the caseload and program cost, we found that the Ministry has not investigated or studied the key reasons for caseload growth to identify whether corrective action in its delivery and administration of the program is needed.

Our significant findings include the following:

- Over 40% of ODSP applicants are confirmed to be disabled after a cursory review of their

application, representing a 56% increase from the time of our last audit. The Ministry determined these applicants to be disabled and to qualify for ODSP through its triage process, which is an expedited process intended to be a cursory review of a completed application to determine whether the medical evidence clearly identifies an applicant is disabled.

- The Ministry had no process to assess the appropriateness of disability approval decisions. We found that in almost 20% of the approved applications we reviewed, it was not clear from the application and the adjudicator's rationale how the applicant met the definition of a person with a disability.
- The Ministry rarely sets medical reviews to confirm recipients are still eligible for ODSP. Across all stages of adjudication, the number of approved disability applications that were approved as disabled-for-life increased from 51% at the time of our last audit to 80% in 2018/19. In over 40% of the cases we reviewed, it was not clear how the adjudicator made the decision that no medical review was required.
- The Social Benefits Tribunal continues to overturn about 60% of the Ministry's not-disabled decisions appealed to the Tribunal. The rate of overturned Ministry decisions at the Tribunal varied from as low as 28% for one member to 93% in the case of another member, but there is no internal decision review at the Tribunal for quality or consistency.
- Caseworkers often do not complete mandatory verification checks with third parties such as the Canada Revenue Agency and Equifax Canada Inc. to confirm that applicants are financially eligible for ODSP.
- Ineligible recipients likely remain on ODSP because caseworkers rarely assess recipients' ongoing eligibility, which can lead to overpayments.
- Between April 2015 and March 2019, the Ministry carried out only about 8,300 eligibility verifications instead of the over 508,000 it should have performed according to its directives to identify overpayments and remove ineligible recipients from the program. Based on the level of overpayments identified in the cases it completed in 2017/18 that we sampled, we calculated the Ministry might have identified a further $375 million in overpayments and terminated a further 11,700 cases, leading to annual savings of approximately $165 million.
- Approximately 42,000 fraud allegations have not been investigated on time, and caseworkers are not trained to investigate fraud to ensure only eligible recipients are receiving income support.
- Since the time of our last audit in 2009, the Ministry has overpaid recipients nearly $1.1 billion and written off approximately $400 million in overpayments.
- Employment outcomes for individuals on ODSP are not improving. Fewer than 2% of disabled adults are referred to the Ministry's employment supports, and about 75% of dependent family members who are not disabled are not participating in mandatory Ontario Works employment assistance activities, reducing the likelihood of these individuals obtaining employment and reducing their family's dependence on ODSP.

3.10 Ontario Financing Authority

In 1993, following the 1990 recession, the provincial government created the Ontario Financing Authority (OFA) to manage the province's debt, borrowing and investing. The OFA reports to the Ministry of Finance (Ministry). Its responsibilities also include managing the province's liquid reserves, which represent borrowed funds held as cash and short-term investments. As well, the OFA provides financial advice to the government and manages the operations of the Ontario Electricity Financial Corporation. In addition, public-sector bodies, such

as hospitals, universities and agencies, can do their borrowing through the OFA.

Since 1993/94, the average annual increase in net debt—the difference between the province's total financial liabilities and assets—was $10.3 billion. By 2018/19, net debt had risen to $338 billion from $81 billion in 1993/94.

The OFA was effective in its investing operations and assessing short-term risks. However, the OFA has not sufficiently analyzed long-term debt sustainability—that is, the province's future ability to repay debt. The Ministry, in turn, has not established long-term targets in conjunction with the government to inform debt and expenditure decision-making by using an analysis of debt sustainability that considers the impact of and recovery steps needed to respond to potential economic shocks.

The lack of long-term debt sustainability planning could prolong the effects of a future economic shock.

We found that the OFA incurred significant costs that it did not formally assess to demonstrate that the province obtained value for them. The OFA should assess the potential for future significant savings, in the areas highlighted below:

- As of March 31, 2019, public government bodies had borrowed $7.7 billion outside the OFA, resulting in $258 million in additional interest costs because the public bodies borrowed directly, rather than through the OFA, which can get lower interest rates. The public bodies acquired this debt at a higher cost, primarily because they did not know they could borrow through the OFA, or the OFA would not provide their desired repayment terms.
- The OFA spent $508.9 million on commissions to groups of banks, called syndicates, between 2014/15 and 2018/19 to issue its domestic debt. The OFA has not formally assessed whether to expand its use of debt auctions, which do not carry any significant costs to the province and are commonly used by public borrowers of its size.
- The OFA issued debt in foreign markets over the last five years that cost the province $47.2 million more in interest costs than if the debt had been issued in Canada. We found no evidence that the OFA assessed whether these increased costs were needed for the province to manage the risk associated with issuing debt.
- Excess liquid reserves cost up to $761 million in additional interest payments over the last five years because the province earns less interest on the reserves than it pays on funds borrowed to maintain the reserves. The OFA has never had to use the liquid reserves, which were $32.6 billion on average in fiscal 2018/19, because it always has been able to borrow to meet short-term needs even during the 2008 financial crisis. While maintaining sufficient liquid reserves is important for reducing the province's risk of not meeting its short-term needs, the OFA has not conducted a cost/benefit analysis to determine the optimal amount of liquid reserve to hold so that these needs are met without excess costs.
- Between 2007/08 and 2018/19, the OFA charged the public government bodies that have borrowed through it administrative costs that are also funded by the Ministry of Finance. As of October 2019, a $32.2-million surplus was being held in a bank account and has not been invested to earn interest at a higher rate or used to reduce the province's debt.
- Compliance with the province's implementation of an accounting standard could result in $54 million of additional annual interest costs to avoid financial statement volatility. An anticipated change in a key accounting standard in 2021/22 will result in fluctuations appearing in the annual financial statement debt if the OFA's current approach to managing fluctuations appearing in the annual financial statement currencies and the Canadian dollar is used, but not if a more

expensive approach is used. The OFA told us it was considering using the more expensive approach to better align the debt in the financial statements with the provincial budget.

3.11 Oversight of Time-Limited Discretionary Grants

The province provides about $3.9 billion annually in time-limited grants to third parties to pay for activities that are intended to benefit the public and help achieve public policy objectives. These grants are discretionary, meaning the province is not required to provide funding for these activities to meet statutory obligations. The ministries are responsible for determining the level of funding for their specific grant programs in their annual budgets, based on their objectives and priorities. The Treasury Board Secretariat is responsible for reviewing the final allocation of these grants for each ministry based on government priorities, political direction and the economic climate.

The following are our significant findings:

- The government reports all grant payments together in the Public Accounts and the Estimates of the Province of Ontario, without differentiating between those for time-limited activities (funded through discretionary grants) and those for the delivery of government services (for example, to hospitals for health care or to school boards for education). Without being able to identify which grant payments are for time-limited projects and which are for ongoing programs, Members of Provincial Parliament do not have the necessary information on which to base funding allocation decisions in times of fiscal constraint or changing government priorities.
- Public disclosure of government grants is not always consistent or transparent. For grant recipients that are paid directly by ministries, their names and amounts received are disclosed in the province's public accounts. However, we identified eight organizations that received $402 million in grant funding from the province in 2018/19 and then disbursed those funds to other parties which were not disclosed in the public accounts. While some of these flow-through organizations listed the grant recipients and amounts awarded to them on their own websites, disclosure of grant recipient information was inconsistent and difficult to find.
- Some grant recipients that did not meet evaluation criteria received funding under ministerial discretion. From 2016/17 to 2018/19, all applicants to the Ministry of Heritage, Sport, and Tourism and Culture Industries' (Ministry) Celebrate Ontario grant program that achieved the minimum required score were approved for grant funding. However, the grant program also provided almost $6 million in funding through ministerial discretion to 132 applicants that had not achieved the minimum required evaluation score. The explanation justifying these approvals was that these applications fell under a certain priority category, but there was no other documented justification on file explaining why the Minister chose to fund a certain applicant over another in the same category that had a higher score. The Ministry did not request an exemption from Treasury Board as required by the Transfer Payment Accountability Directive for the grants that were awarded under ministerial discretion.
- Most grant programs do not consider an applicant's need for funding during the selection process. Only two of the 15 grant programs we reviewed considered the need for grant funding as part of the selection process. We noted that the Ontario Scale-Up Vouchers Program, whose objective is to accelerate the growth of start-up technology companies, provided $7.65 million in 2018/19 to businesses that already had a significant amount of resources available to them. Prior to receiving support from the program, 27 recipients combined had raised $491 million in capital.

- Ministries rely mostly on self-reported information to assess whether the recipients used grant funding as intended. In our review of 15 grant programs, we selected a sample of recipients and noted some recipients had claimed ineligible expenditures. For example, under the Ontario 150—Partnerships program, the Ministry provided $75,000 in funding to an organization to promote women's engagement in politics and to host an event at Queen's Park. However, the organization claimed the majority of the expenditures for consulting work performed by its executive director at a rate of $675 per day, even though regular staff salaries were not eligible for funding under this program.
- Ministries do not verify the performance results reported by recipients for reasonableness. One recipient we spoke with informed us that they simply guessed at the number of attendees and the amount spent by visitors at their event. The Ministry had deemed some performance results unreliable but did not follow up with recipients and did not take this into consideration in future grant funding decisions.

3.12 Provincial Support to Sustain the Horse Racing Industry

The province has been supporting the horse racing industry through various initiatives since 1996. Ontario's 15 racetracks currently rely on annual government funding of close to $120 million to subsidize the horse racing industry in the province. In addition, 11 of these racetracks receive about $140 million in annual lease revenues from the Ontario Lottery and Gaming Corporation (OLG) to host slot machines and cover the cost of valet parking and food services. Current government agreements do not require that these annual lease revenues be used to support horse racing operations.

Horse racing as a gaming operation has been in decline in Ontario since the legalization of lotteries in 1969. Over the last 10 years, from 2008/09 to 2018/19, Ontarians' wagering on Ontario races and races outside the province has decreased by 44% and 15% respectively. Wagering by other Canadians on Ontario races has also decreased by 48%.

In 2018/19, gross wagering on horse racing in Ontario totalled $1.6 billion, including bets on Ontario races placed from outside Ontario and bets placed inside the province on races held elsewhere. Of the $1.6 billion total, Ontario racetracks paid out 87.3% to winning bettors and kept 12.7% or $203 million in gross commissions, before taxes and operating costs. However, these wagering commissions have not been sufficient for the industry to cover racetrack operating costs and purses, the prize money paid to horse owners.

Although the horse racing industry receives a significant amount of public funding, it lacks transparency and public accountability. Of the 15 racetracks, only one posts its financial statements on its website. There is no public reporting of gross wagers collected, wagering commissions by racetrack, how the provincial tax reduction on wagering is shared between the various racetracks and horse people, purses paid by racetracks, revenue and expenses related to a racing operation separate from other operations, and key statistics such as the current number of people working in the industry.

Our audit found these significant concerns:

- The goal of the five-year, $500-million Horse Racing Partnership Funding Program that ran from 2014/15 to 2018/19 was to support racetracks in becoming more self-sustaining. However, the industry is not significantly closer to that goal than it was in 2013. In each of the five years, provincial funding consistently covered about 60% of purses paid to winning horse owners. Without government support, including lease revenue from hosting slot machines, all racetracks combined would have an operating shortfall of $170 million.

- With the introduction of the new 19-year funding agreement on April 1, 2019, the objective of government funding changed from transitioning the industry to become self-sustaining, to sustaining the industry for a long period of time. The agreement currently provides about $120 million to the industry annually. Annual provincial funding is expected to drop to $63.4 million by 2026/27, primarily due to a reduction in purse funding to the Woodbine Entertainment Group, since the Woodbine and Mohawk racetracks are expanding gaming operations and are expected to earn additional casino lease revenue.
- The new long-term funding agreement does not include any clauses that would allow the province to terminate the agreement without cause. Furthermore, annual funding under the agreement is not reduced if a racetrack closes. Instead, the money will be redistributed among the remaining racetracks.
- Ontario has more racetracks than comparable jurisdictions, without sufficient wagering income to support them. Ontario currently has 15 racetracks. When compared to racetracks in the United States, Ontario serves fewer people per racetrack than the states of California, Florida, New York, Pennsylvania and Ohio. Ontario has nine more racetracks than Pennsylvania, and six more than Florida, which has a 46% higher population than Ontario.
- The Woodbine Entertainment Group (Woodbine) has a significant role in the latest long-term funding agreement with OLG. Woodbine holds two of 11 seats on the Ontario Racing Board, which is responsible for administering the new funding agreement, setting race days and distributing funding to racetracks. Ontario Racing Management, which supports operations for Ontario Racing's Board, is a wholly owned subsidiary of Woodbine. Also, the agreement includes language that effectively cancels the agreement if Woodbine's role is changed or eliminated.

3.13 Technology Systems (IT) and Cybersecurity at Ontario Lottery and Gaming Corporation

The Ontario Lottery and Gaming Corporation (OLG) is responsible for conducting and managing the following four lines of business: province-wide lottery games (lottery), PlayOLG.ca Internet gaming (iGaming), Charitable gaming centres (cGaming), and 26 casinos (casinos) currently operating in Ontario.

OLG develops and maintains the IT systems for its lottery games. However, IT systems for iGaming, cGaming and casinos are owned by IT vendors and used by OLG in accordance with licensing agreements. OLG oversees the operations of iGaming and cGaming and also oversees the casinos, but organizations under contract to OLG (that is, casino operators) manage the casinos' day-to-day operations.

Although OLG also administers the Ontario government's funding program for horse racing, the IT systems specifically used for the horse-racing industry are operated by private-sector operators.

OLG is regulated by the Alcohol and Gaming Commission of Ontario, which has set the minimum age for gambling at 19, and tests the design of OLG's games for the games' integrity and to ensure that players receive a fair payout.

OLG contributed about 45% of the total $5.47 billion in non-tax revenue generated in 2018/19 by provincial government business enterprises, such as the Liquor Control Board of Ontario, Ontario Power Generation Incorporated, Hydro One Limited and the Ontario Cannabis Retail Corporation.

In the past five years, OLG paid $651 million to 68 IT vendors that provide critical IT services to support its business operations. Any interruption to OLG's lines of business has the potential to reduce the province's revenue and impact OLG's gaming customers' experience.

The following are some of our significant findings:

- OLG needs to strengthen its oversight of IT vendors so that they deliver services and safeguard customer information more effectively and in accordance with the performance expectations in their contracts.
- OLG does not thoroughly review IT vendors' performance upon contract renewal to assess whether the vendor met OLG's performance expectations under its previous contract.
- Although OLG conducts regular vulnerability assessments, OLG has not regularly performed security tests, such as penetration testing for its lottery and iGaming lines of business, to further identify potential vulnerabilities.
- Personal information of OLG customers is encrypted to prevent external access to it; however, seven OLG employees have access to the information in an unencrypted form, which increases the risk of customers' personal information being read for inappropriate purposes. In addition, we found that two casinos do not comply with OLG information security standards and do not encrypt OLG customer data within their IT systems.
- There are opportunities to strengthen cybersecurity practices in the IT systems used in casinos, lottery and iGaming. For example, although OLG contracts with an external IT vendor to assess the technical controls behind the random number generator for its lottery system and evaluate the software formula to confirm that the system is able to generate suitable random numbers, we noted that OLG does not review the software source code for cybersecurity weaknesses using industry best practices.
- OLG has not developed and tested a comprehensive disaster recovery strategy for its entire IT system environment. Although there are disaster recovery strategies developed and tested for IT systems for each individual line of business, we noted that OLG does not have a comprehensive strategy that incorporates all IT systems cohesively, even after it had a significant event occur that should have triggered OLG to prepare one.
- OLG has initiated major IT projects across its various lines of its business. OLG implemented 33 IT projects within budget; however, the remaining 11 were over budget in the last five years ($91 million sampled over a total of $232 million spent), and had delays and cost overruns of over $10 million.

Chapter 2

Public Accounts of the Province

1.0 Summary

For the second year in a row, our audit opinion on the province's consolidated financial statements is unqualified. Based on our audit work, we have concluded that the province's consolidated financial statements for 2018/19 are fairly presented and free from material errors.

Instrumental to our issuance of unqualified opinions in 2017/18 and 2018/19 were accounting changes made in 2018 that were maintained in the current fiscal year. The province recorded a full valuation allowance on the pension assets for both the Ontario Teachers' Pension Plan (OTPP) and the Ontario Public Service Employees' Union Pension Plan, discontinued the inappropriate application of rate-regulated accounting originating with the Fair Hydro Plan, and recorded its full financial impact.

As a result of a change in Canadian generally accepted auditing standards, the auditor's report issued for 2018/19 looks different from previous reports issued. The opinion paragraph and basis for the opinion are now the first two paragraphs included in the report (instead of the last paragraphs under the old format), and there is a new section related to other accompanying information being consistent with the financial statements.

During 2018/19, the province made the decision to discontinue printing Volume 2 of the Public Accounts of Ontario. Volume 2 consisted of the individual financial statements of the significant provincial corporations, boards and commissions whose activities are included in the province's consolidated financial statements. The province instead opted to set up a website with links to the entities' web pages containing financial information. The website includes the financial statements of the broader public sector (i.e., of hospitals, school boards and colleges), which were not included in the printed version of Volume 2. However, all Volume 2 entities' financial statements were not posted and available to the public through the website as early as they were in previous years, when they were printed in Volume 2.

In May 2019, the government repealed the *Fiscal Transparency and Accountability Act, 2004*, and replaced it with the *Fiscal Sustainability, Transparency and Accountability Act, 2019* (Act). The Act requires that the government meet certain reporting requirements and that we review the government's compliance with the Act. The government has met all reporting deadlines as of October 2019.

We audited the Independent Electricity System Operator (IESO) for the year ended December 31, 2018, and issued an unqualified opinion based on the IESO restating prior year balances to correct the accounting for the IESO Administered Market Accounts, rate-regulated accounting and the discount rate used for non-registered pension and other employee benefit plans.

We also audited the Ontario Cannabis Retail Corporation (OCRC) for the year ended March 31, 2019. Because of OCRC issues with the integrated reporting of data from its key IT systems, we performed extensive audit testing and expended

considerable time and effort in confirming the reliability and accuracy of information from OCRC's IT systems. On September 5, 2019, we issued an unqualified opinion on the March 31, 2019, financial statements.

The province's growing debt burden with its interest impact on program expenses also remains a concern since we first raised the issue in 2011. This year, as in the past, we present the critical implications of the growing debt for the province's finances.

This year, we revisit two factors that give rise to the province's net pension asset in OTPP before any valuation allowance. The two factors are actual investment returns exceeding expected rates of return and cash contributions exceeding pension expense. In addition, we consider what types of factors or changes in the government environment could lead to a reduction in net pension assets, with a corresponding release of valuation allowance, such as changes in collectively bargained agreements, changes in discount rates used or changes in long-term actuarial assumptions that increase pension expense.

Each year since our *2008 Annual Report*, we have raised the issue of the government legislating accounting practices that may not be consistent with Canadian Public Sector Accounting Standards (PSAS). Ontario legislation does not formally state that Ontario's financial statements should be prepared in accordance with Canadian PSAS. Instead, current legislation permits Ontario to legislate accounting treatments, such as the Fair Hydro Plan. When legislated accounting is used, we have and would continue to highlight this to the Legislative Assembly and the public. Canadian PSAS are the most appropriate accounting standards for the province to use in preparing its consolidated financial statements because they ensure that information provided by the government about the surplus and the deficit is fair, consistent and comparable to data from previous years and from peer governments. This allows all legislators and the public to better assess government management of the public purse. The government is working to formalize in legislation the requirement that the province's financial statements will be prepared in accordance with Canadian PSAS.

This chapter contains three recommendations, consisting of four action items, to address our observations.

2.0 Background

Ontario's Public Accounts consist of the province's Annual Report, including the province's consolidated financial statements, and two supplementary volumes of additional financial information. The Public Accounts for the fiscal year ending March 31, 2019, were prepared under the direction of the Minister of Finance, as required by the *Financial Administration Act*, and the President of the Treasury Board.

The government as the governing body is responsible for ensuring that consolidated financial statements, including many amounts based on estimates and judgment, are presented fairly. Senior management in the Ministry of Finance and Treasury Board Secretariat are responsible for ensuring that an effective system of internal controls, with supporting procedures, is in place to authorize transactions, safeguard assets and maintain proper records.

Under the *Auditor General Act*, our Office is responsible for the annual audit of these consolidated financial statements. The objective of our audit is to obtain reasonable assurance that the statements are free of material misstatements—that is, free of significant errors or omissions. The consolidated financial statements, along with the Auditor General's Independent Auditor's Report, are included in the province's Annual Report.

The province's 2018/19 Annual Report also contains a Financial Statement Discussion and Analysis section that provides additional information regarding the province's financial condition and fiscal results for the year ended March 31, 2019. Providing such information is intended to enhance

the fiscal accountability of the government to both the Legislative Assembly and the public.

The two supplementary volumes of the Public Accounts consist of the following:

- Volume 1—unaudited statements from all ministries and a number of schedules providing details of the province's revenue and expenses, its debts and other liabilities, its loans and investments, and other financial information; and
- Volume 3—detailed unaudited schedules of ministry payments to vendors and transfer-payment recipients.

Starting in 2018/19, the previous Volume 2 (audited financial statements of significant provincial corporations, boards and commissions whose activities are included in the province's consolidated financial statements) is no longer part of the Public Accounts. The province has provided a website (**www.ontario.ca/page/public-accounts-ontario-2018-19#section-4**) with links to the web pages of government organizations, trusts under administration, government business enterprises and other government organizations that show their financial statements. In addition, this website also has links to the web pages of consolidated entities from the broader public sector (i.e., hospitals, school boards and colleges), which is additional information not previously contained in the Volume 2 hard copy. However, as noted in **Section 3.7**, many financial statements that were in the Volume 2 (hard copy and soft copy) last year were not available for viewing when the Public Accounts were released this year.

Our Office reviews the information in the province's Annual Report and in Volume 1 of the Public Accounts for consistency with the information presented in the province's consolidated financial statements.

The *Financial Administration Act* requires that, except in extraordinary circumstances, the government deliver its Annual Report to the Lieutenant Governor in Council within 180 days of the end of the fiscal year. The deadline for this year was September 27, 2019. The two supplementary volumes must be submitted to the Lieutenant Governor in Council within 240 days of the end of the fiscal year. Upon receiving these documents, the Lieutenant Governor in Council must lay them before the Legislative Assembly or, if the Assembly is not in session, make the information public and then lay it before the Assembly within 10 days of the time it resumes sitting.

This year, the government released the province's 2018/19 Annual Report and consolidated financial statements, along with the two Public Accounts supplementary volumes, on September 13, 2019, meeting the legislated deadline.

The Auditor General's audit opinion on the province's consolidated financial statements was unqualified for the second year in a row. An unqualified opinion in the public sector should be considered just as noteworthy as a qualified audit opinion. An unqualified opinion means that the consolidated financial statements are free from material errors. The unqualified audit opinion on the province's consolidated financial statements is discussed in **Section 3.0** below.

3.0 The Province's 2018/19 Consolidated Financial Statements

3.1 Auditor's Responsibilities

As the Legislature's independent auditor of the province's consolidated financial statements, the Auditor General's objective is to express an opinion on whether the financial statements are free of material misstatements and are prepared in accordance with Canadian Public Sector Accounting Standards (PSAS), so that they give a true and fair view of the financial position and results of the province. It is this independence, combined with the professional obligation to comply with established Canadian Auditing Standards and relevant

ethical requirements, that enables the Auditor General to issue an opinion that provides users with confidence in the province's consolidated financial statements.

To enable the Auditor General to form her opinion, our Office collects sufficient appropriate audit evidence and evaluates it to determine whether the financial statements are free of material misstatements. This includes assessing the government's preferred accounting treatments of certain transactions and analyzing their appropriateness under Canadian PSAS.

Our assessment of what is material (significant) and immaterial (insignificant) is based primarily on our professional judgment. In making this assessment, we seek to answer the following question: "Is this error, misstatement or omission significant enough that it could affect decisions made by users of the province's consolidated financial statements?" If the answer is yes, then we consider the error, misstatement or omission as material.

To help us make this assessment, we determine a materiality threshold. This year, as in past years, and consistent with most other legislative auditors in provincial jurisdictions, we set our threshold at 0.5% of the greater of government expenses or revenue for the year.

Our audit is conducted on the premise that management has acknowledged certain responsibilities that are essential to the conduct of the audit in accordance with Canadian Auditing Standards. These responsibilities are discussed below.

3.2 Governing Body's and Management's Responsibilities

The auditor's report distinguishes between the responsibilities of the governing body, management and of the auditor with respect to a financial statement audit. Management is responsible for the preparation of the financial statements in accordance with Canadian PSAS. The auditor examines the financial statements in order to express an opinion as to whether the financial statements have been prepared in accordance with Canadian PSAS. The division of responsibility between management and the auditor is fundamental and preserves the auditor's independence, a cornerstone of the auditor's report.

In addition to the preparation of the financial statements and having the relevant internal controls, management is also required to provide the auditor with all information relevant to the preparation of the financial statements, additional information that the auditor may request, and unrestricted access to individuals within the entity who the auditor determines are necessary to obtain audit evidence. Canadian Auditing Standards are clear on these requirements, and their fulfilment is formally communicated to the auditor in the form of a signed management representation letter at the end of the audit.

When a transaction occurs, it is management's responsibility to identify the applicable accounting standards, determine the implications of the standards on the transaction, decide on an accounting policy and ensure that the financial statements present the transaction in accordance with the applicable financial reporting framework (which for governments is Canadian PSAS). The auditor must be proficient in the applicable financial reporting framework in order to form an independent opinion on the financial statements, and may perform procedures similar to those performed by management to identify the applicable standards and understand the implications of the standards on the accounting transaction. However, unlike management, the auditor does not select an accounting policy or the bookkeeping entries for the organization. These decisions are in the hands of management—in Ontario's case, the Treasury Board Secretariat and the Ministry of Finance, both with support from the Office of the Provincial Controller Division.

The governing body is responsible for overseeing management's processes for identifying risks of fraud and implementing controls to mitigate risks and overseeing the financial reporting process. In addition, the governing body is responsible for reinforcing ethical behaviours through active oversight.

When there are disagreements between an auditor and the governing body and/or management on the application or adequacy of accounting policies, the auditor must assess the materiality or significance of the issue to the overall financial statements in forming the audit opinion. If the issue is material, it results in a qualified opinion, in which the auditor concludes that the financial statements are fairly presented except for the items described in the basis for the qualification. Again, this distinguishes the role of management and auditor such that the auditor examines the financial statements to express an opinion, whereas management prepares the financial statements.

The Office of the Auditor General may make suggestions about the consolidated financial statements, but this does not change management's responsibility for the financial statements. Similarly, the government may seek external advice on accounting treatments for certain transactions. In such situations, the government still has the ultimate responsibility for the decisions made, and the use of external advisers does not diminish, change or serve as a substitute for the government's accountability as the preparer of the province's consolidated financial statements.

3.3 The Independent Auditor's Report

The auditor's report used in Canada looks different this year. The changes were approved by the Audit and Assurance Standards Board, which sets Canadian Auditing Standards for financial statements, and were effective for all audits ending on or after December 15, 2018.

The auditor's report, which is issued at the conclusion of an audit engagement, comprises:

- an opinion paragraph containing an expression of opinion on the financial statements and a reference to the applicable financial reporting framework used to prepare the financial statements;
- a basis for the opinion paragraph that explains that the audit was conducted in accordance with Canadian generally accepted auditing standards;
- a new section titled "Other Accompanying Information" that contains the independent auditor's report and explains management's, the governing body's and the auditor's responsibilities for other information and includes the auditor's conclusion about whether the other information is materially consistent with the financial statements or the knowledge obtained in the audit (this section was added because the province prepares other information like annual reports);
- a description of the responsibilities of management and the governing body for the proper preparation and oversight of the financial statements in accordance with the applicable financial reporting framework;
- a description of the auditor's responsibility to express an opinion on the financial statements, conclude on the appropriateness of management's use of the going concern basis of accounting and the scope of the audit; and
- additional paragraphs describing the group audit engagement, communication with those charged with governance, and an explicit statement that the auditor is independent of the entity audited and has fulfilled the auditor's other relevant ethical responsibilities.

The auditor's report may further include:

- an Emphasis of Matter paragraph that refers to a matter appropriately presented or disclosed in the financial statements that, in the auditor's judgment, is of such importance that it is fundamental to users' understanding of the financial statements; and
- an Other Matter paragraph that refers to a matter other than those presented or disclosed in the financial statements that, in the auditor's judgment, is relevant to a user's understanding of the audit, the auditor's responsibilities or the auditor's report.

3.4 The Significance of an Unqualified Audit Opinion

The independent auditor's report is the way the auditor communicates to users of the financial statements his or her opinion as to whether the financial statements of an entity are presented fairly. After the audit of the financial statements is completed, the auditor can sign one of four possible opinions:

- **Unqualified, or clean, opinion:** The financial statements present fairly, in all material respects, the financial position and results of the entity.
- **Qualified opinion:** The statements contain one or more material misstatements or omissions.
- **Adverse opinion:** The statements do not fairly present the financial position, results of operations and changes in financial position, as per generally accepted accounting principles.
- **No opinion or disclaimer of opinion:** It is not possible to give an opinion on the statements because, for example, key records of the entity were destroyed and thus unavailable for examination.

An unqualified audit opinion indicates financial statements are reliable. When an auditor issues a qualified opinion, he or she is expressing concern about the entity's compliance with the accounting standards issued by the standard setter (e.g., the Public Sector Accounting Board), or about the auditor's ability to obtain sufficient and appropriate information on the financial statements. An audit qualification is generally a rare occurrence—unqualified opinions are far more frequent. However, the fact that unqualified opinions are common does not mean they are not significant or noteworthy.

For the second year in a row, the Auditor General of Ontario has issued an unqualified opinion on the province's consolidated financial statements. This means that the consolidated financial statements can be relied on to fairly and accurately present the province's fiscal results for the year ended March 31, 2019, in all material respects.

3.5 Key Audit Matters

The Auditing and Assurance Standards Board is proposing, through an exposure draft, to expand the requirements for auditors to communicate key audit matters. If the exposure draft is approved, the Office will need to include key audit matters for the March 31, 2023, audit (effective for years ending on or after December 15, 2022).

Key audit matters could include:

- areas identified as significant risks or involving significant management or auditor judgment;
- areas in which the auditor encountered significant difficulty, for instance in obtaining sufficient and appropriate audit evidence; and
- circumstances that required a modification to the auditor's planned audit approach, including as a result of a significant deficiency in internal control.

The standard on communicating key audit matters is currently discretionary, unless the auditor is required to communicate these matters by law or regulation. We currently communicate significant matters arising from the audit in this chapter of our Annual Report, and we also communicate them during the audit process to senior management and those charged with governance.

3.6 The 2018/19 Audit Opinion

The *Auditor General Act* requires that we report annually on the results of our examination of the province's consolidated financial statements. The Independent Auditor's Report to the Legislative Assembly on the province's consolidated financial statements for the year ended March 31, 2019, is reproduced on the following three pages.

Office of the Auditor General of Ontario
Bureau de la vérificatrice générale de l'Ontario

INDEPENDENT AUDITOR'S REPORT

To the Members of the Legislative Assembly of the Province of Ontario

Opinion

I have audited the accompanying Consolidated Financial Statements of the Province of Ontario, which comprise the Consolidated Statement of Financial Position as at March 31, 2019, and the Consolidated Statements of Operations, Change in Net Debt, Change in Accumulated Deficit, and Cash Flow for the year then ended, and notes to the Consolidated Financial Statements, including a summary of significant accounting policies.

In my opinion, the accompanying Consolidated Financial Statements present fairly, in all material respects, the consolidated financial position of the Province of Ontario as at March 31, 2019, and the consolidated results of its operations, the consolidated changes in its net debt, the consolidated change in its accumulated deficit and its consolidated cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion

I conducted my audit in accordance with Canadian generally accepted auditing standards. My responsibilities under those standards are further described in the Auditor's Responsibility for the Audit of the Consolidated Financial Statements section of this report. I am independent of the Province of Ontario in accordance with the ethical requirements that are relevant to my audit of the Consolidated Financial Statements in Canada, and I have fulfilled my other ethical responsibilities in accordance with these requirements. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.

Other Accompanying Information

The Government of Ontario (Government) is responsible for the information in the 2018-19 Public Accounts of Ontario Annual Report.

My opinion on the Consolidated Financial Statements does not cover the other information accompanying the Consolidated Financial Statements and I do not express any form of assurance conclusion thereon.

In connection with my audit of the Consolidated Financial Statements, my responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the Consolidated Financial Statements or my knowledge obtained during the audit, or otherwise appears to be materially misstated.

If, based on the work I have performed on this other information, I conclude that there is a material misstatement of this other information, I am required to report that fact in this auditor's report. I have nothing to report in this regard.

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Responsibilities of Management and Those Charged with Governance for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these Consolidated Financial Statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of Consolidated Financial Statements that are free from material misstatement, whether due to fraud or error.

In preparing the Consolidated Financial Statements, management is responsible for assessing the Province of Ontario's ability to continue as a going concern, disclosing, as applicable, matters relating to going concern and using the going concern basis of accounting unless the Government either intends to cease operations, or has no realistic alternative but to do so.

Those charged with governance are responsible for overseeing the Province of Ontario's financial reporting process.

Auditor's Responsibility for the Audit of the Consolidated Financial Statements

My objectives are to obtain reasonable assurance about whether the Consolidated Financial Statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these Consolidated Financial Statements.

As part of an audit in accordance with Canadian generally accepted auditing standards, I exercise professional judgment and maintain professional skepticism throughout the audit. I also:

- Identify and assess the risks of material misstatement of the Consolidated Financial Statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.

- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Province of Ontario's internal control.

- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.

- Conclude on the appropriateness of management's use of the going concern basis of accounting and based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Province of Ontario's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the consolidated financial statements or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the Province of Ontario to cease to continue as a going concern.

- Evaluate the overall presentation, structure and content of the Consolidated Financial Statements, including the disclosures, and whether the Consolidated Financial Statements represent the underlying transactions and events in a manner that achieves fair presentation.

The audit of the Consolidated Financial Statements is a group audit engagement. As such, I also obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the group to express an opinion on the Consolidated Financial Statements. I am responsible for the direction, supervision and performance of the group audit and I remain solely responsible for my audit opinion.

I communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control identified during the audit.

I also provide those charged with governance with a statement that I have complied with relevant ethical requirements regarding independence, and to communicate with them all relationships and other matters that may reasonably be thought to bear on my independence, and where applicable, related safeguards.

Toronto, Ontario
August 16, 2019

Bonnie Lysyk, MBA, FCPA, FCA, LPA
Auditor General

3.7 Volume 2 of the Public Accounts of Ontario

Prior to 2018/19, Volume 2 of the Public Accounts was one of three supplementary reports that the government printed and made available at the same time as the release of the province's consolidated financial statements. It included the audited financial statements of the provincial corporations, boards and commissions whose activities are included in the province's consolidated financial statements, as well as other miscellaneous audited financial statements.

The province is no longer issuing Volume 2 in the same format as the rest of the Public Accounts. Instead, the government has set up a website (**www.ontario.ca/page/public-accounts-ontario-2018-19#section-4**) with links to web pages showing the financial statements of each government organization, trust under administration, business and other type of organization in Schedule 8 of the province's consolidated financial statements.

We have noted that these organizations' financial statements were not all promptly posted on these web pages when the Public Accounts were released on September 13, 2019. In the past, if an organization's audited financial statements were not available at the same time as the release of Public Accounts, a disclosure was made in Volume 2, and the statements were posted to the government's website as they became available. There were only five instances over the past three years when an organization's audited financial statements were not made available at the same time as the release of the Public Accounts.

In contrast, when the province released the 2018/19 Public Accounts on September 13, 2019, the audited financial statements of only 21 out of 66 organizations formerly in Volume 2 were available in the links on the new website. By November 13, 2019, the audited financial statements of an additional 14 agencies were accessible through the website, bringing the total to 35 (53%).

The government also included links for broader-public-sector organizations—specifically, 246 public hospitals, colleges, school boards and school authorities. (The financial statements of these organizations had not been included in the former Volume 2.) Making the financial statements of the broader-public-sector organizations available is a positive step toward improving transparency for the public. On September 13, 2019, 67% of the financial statements of hospitals, colleges, school boards and school authorities were available through the website. By November 13, 2019, the percentage had risen to 96%.

The province's senior management informed us that one key reason for the change from producing a hardcopy Volume 2 to this website was done for cost-efficiency purposes, as it would reduce printing costs. However, the implementation of this change has negatively impacted the timeliness of the availability of the organizations' and agencies' financial statements. These entities, which are part of the consolidated financial statements, are accountable to the responsible Minister (and ultimately to the Legislature and the public) for fulfilling their legislative obligations, effectively managing the resources they use and maintaining the appropriate standards for any services they provide. To perform their duties, they either use public funds allocated to them by the government or generate their own funds. The audited financial statements are a key accountability and transparency mechanism, and the timeliness of their publication is important to maintain their relevance for legislators and the public.

The government established the Agencies and Appointments Directive (for provincial agencies, short-term advisory bodies and special advisors) and the Broader Public Sector Business Documents Directive (for colleges, school boards and hospitals) to set out the rules and accountability for agencies and broader-public-sector organizations and remuneration guidance for government appointments. The Agencies and Appointments Directive includes a requirement for agencies to post their

annual reports on a provincial agency or government website within established timelines. (Advisory agencies and agencies with differing legislated requirements are the only exceptions.) The agency's financial statements are included as part of its annual report. The timelines include dates for providing the annual report to the responsible Minister, dates by which the Minister needs to table the annual report in the Legislature and dates by which the entity must publicly post the annual report after tabling. The Agencies and Appointments Directive does not include any guidance or requirements for financial statements to be made available within a specific date separate from the annual report requirements. The Broader Public Sector Business Documents Directive includes a requirement for broader-public-sector organizations to post financial statements on their website within a specific date from their being issued. The date requirements within the Agencies and Appointment Directive and the Broader Public Sector Business Documents Directive do not align with the release of the Public Accounts.

RECOMMENDATION 1

To increase the transparency of the province's consolidated financial statements, we recommend that the Treasury Board Secretariat:

- incorporate electronic copies of the organizations' financial statements, which are consolidated into the Public Accounts, into the Volume 2 website; and
- advise the government to revise the Agencies and Appointments Directive and the Broader Public Sector Business Documents Directive to specify the posting of an agency's audited financial statements on the agency's or government's website no later than the Public Accounts release date.

TREASURY BOARD SECRETARIAT RESPONSE

The province is committed to supporting full transparency and accountability in its reporting to the public, the Legislature and other users.

The change in format of the former Volume 2 of the Public Accounts from a printed version to electronic is consistent with the government's Digital First Initiative. The expansion to include the financial statements of the broader public sector increased transparency for the public. The province will work on ensuring the timely and complete disclosure of the audited financial statements of its consolidated organizations at the time of the release of the Public Accounts.

The Office of the Provincial Controller Division will work with ministries so that financial statements of organizations that were previously published in paper form will be available in digital form at the same time that other supplementary volumes of the Public Accounts are issued each year.

3.8 Update on Net Pension Assets in the 2018/19 Consolidated Financial Statements

As at March 31, 2019, the government reported pension assets before any valuation allowance from the Ontario Teachers' Pension Plan (OTPP) of $16.176 billion ($13.635 billion in 2017/18) and from the Ontario Public Service Employees' Union Pension Plan (OPSEUPP) of $1.105 billion ($1.014 billion in 2017/18), for a total of $17.281 billion ($14.649 billion in 2017/18).

In order to comply with Canadian PSAS, a full valuation allowance against these assets in pension plans the government co-sponsors with its employees continues to be recorded to reflect that the government does not have the unilateral right to reduce its minimum contributions or withdraw surplus without reaching a formal agreement with the plans' other joint sponsors. The government does

not have a legally enforceable right to benefit from the pension assets because agreements with the other joint sponsors were not obtained in 2015/16, 2016/17, 2017/18, and 2018/19.

As a result, a full valuation allowance was taken against the pension assets of OTPP and OPSEUPP in the consolidated financial statements of the province for the years ended March 31, 2018 and 2019.

The effect of recording the full valuation allowance against the increasing net pension assets for the OTPP and the OPSEUPP on the consolidated statement of operations was an increase in the province's reported annual deficit for 2018/19 by $2.632 billion ($2.220 billion in 2017/18).

3.8.1 Revisiting Trends in the Province's Net Pension Asset in OTPP

In **Chapter 4**, **Section 4.01** of our *2016 Annual Report*, we examined key concepts underlying the province's pension liability and pension expense, how they are calculated and what factors influence the amounts reported in the consolidated financial statements.

In that section, we highlighted that a pension asset arises when total contributions by the sponsor of a defined-benefit plan plus interest income are greater than all pension expenses since the plan's inception. We explored two factors that give rise to the province's net pension asset in OTPP before any valuation allowance. In particular:

- If a plan trust consistently produces returns that are greater than the expected rate of return, the unamortized actuarial gain balance will grow, and so, too, will the annual amortization of those gains through pension expense. This reduces pension expense over time, which contributes to higher net pension asset balances if all other factors are held constant.
- If cash contributions from plan members and government sponsors exceed pension expense, the net pension asset will grow. This can happen for several reasons, including, but not limited to, pension expense being suppressed by consistently exceptional returns and the fact that funding decisions must be approved by other employers or employees' collective bargaining, which creates a practical barrier to making frequent, short-term adjustments in contribution levels.

Actual Investment Returns Exceed Expected Rates of Return

As at March 31, 2019, the public-sector pension plan with the largest accrued pension benefit asset continued to be that of the OTPP. **Figure 1** shows the OTPP's actual rate of return on plan assets relative to the provincial sponsor's expected rate of return for the last 10 years. Except for two notable exceptions, the OTPP's assets have consistently generated returns well in excess of the province's expected rate of return. The two exceptions were in the year of the global financial crisis (2008), and in the most recent years of US market uncertainty.

The overall trend of strong returns has continued to place pressure on the balance of the pension asset through the ongoing accumulation and subsequent amortization of unamortized actuarial gains.

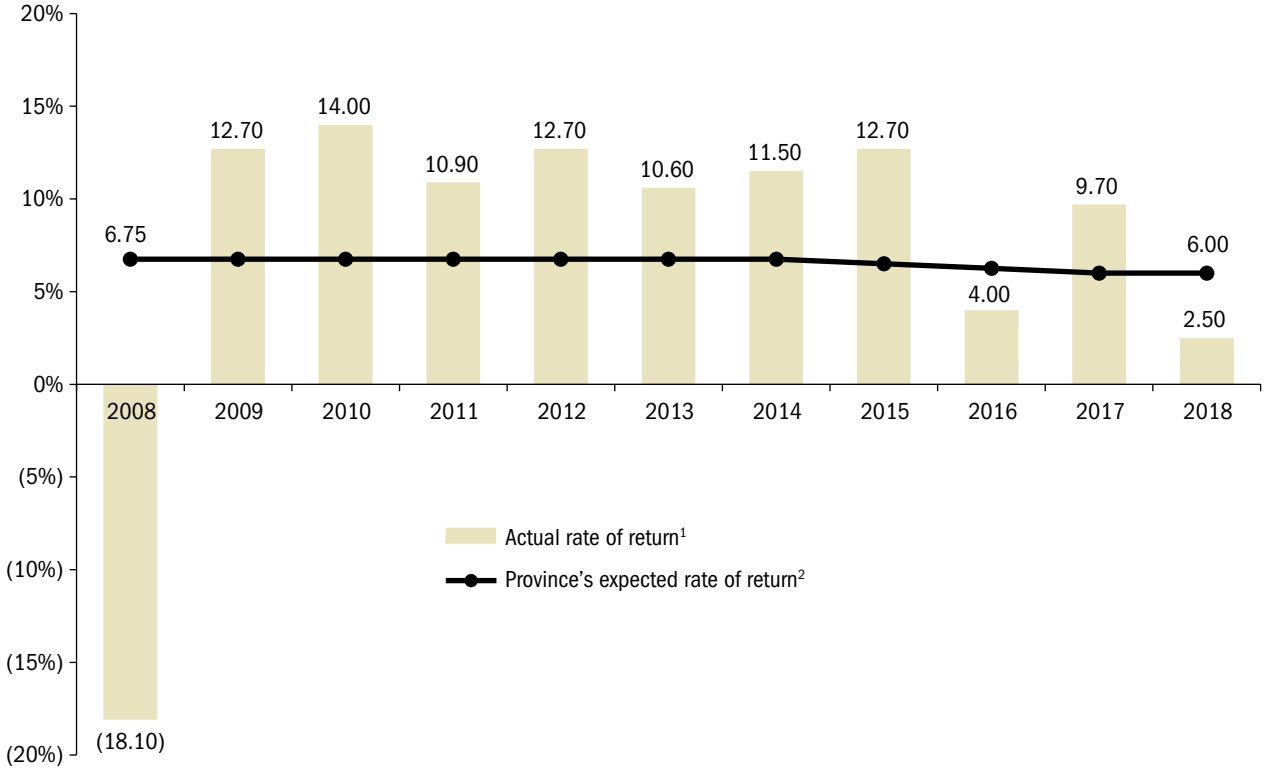
For example, net interest income on the accrued pension asset reduced pension expense by $1,512 million in 2018/19. Amortization of the accumulated actuarial gains also reduced pension expense by a further $923 million for the year ended March 31, 2019.

Cash Contributions Exceeding Pension Expense

While the OTPP's rate of investment returns exceeds the discount rate used by the province to calculate its pension obligations, the province and employee joint sponsors have maintained a consistent level of cash contributions. These two factors combined have resulted in contributions exceeding pension expense, which is the significant driver in the growth of the province's accrued benefit asset in the OTPP.

Figure 1: Ontario Teachers' Pension Plan Actual Rate of Return vs. Province's Expected Rate of Return, 2008–2018

Sources of data: *Ontario Teachers' Pension Plan 2018 Annual Report* and the Public Accounts of Ontario



1. Total-fund net return reported by Ontario Teachers' Pension Plan.
2. As at the beginning of the year.

Figure 2 shows the growth of the accrued benefit asset of the OTPP since the 2009/10 fiscal year and how this is driven by the excess of annual cash contributions over pension expense. The trend of an increasing net pension asset, which continues to grow at an increasing pace, has continued in the three years since we last published this trend analysis.

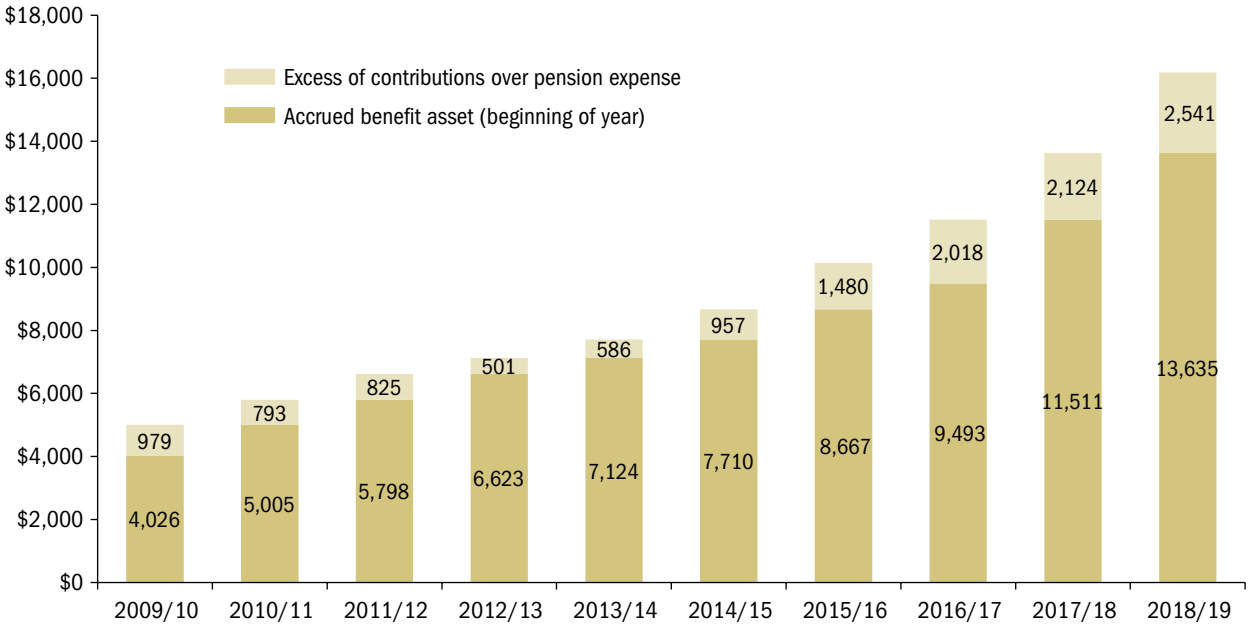
As we noted in our *Review of the 2018 Pre-Election Report on Ontario's Finances*, if not for the recording of a valuation allowance, the province would have recorded pension revenue (instead of pension expense) from the OTPP while continuing to match employees' cash contributions at a steady rate. The widening gap between the government's calculated pension revenue before any valuation allowance and the province's pension contributions to the OTPP totals $6.7 billion over the last three years. The recording of a full valuation allowance eliminates this gap, which avoids distorting the reported resources available for government decision-makers to allocate in their fiscal planning.

3.8.2 Factors that Reduce Net Pension Assets

Much of our published analysis to date has focused on the growing net pension assets of the OTPP and the OPSEUPP and the resulting accounting implications for the consolidated financial statements of the province.

In this section, we consider what types of factors or changes in the government environment could lead to a reduction in net pension assets, with a corresponding release of valuation allowance. The following non-exhaustive list of factors are meant

Figure 2: Ontario Teachers' Pension Plan Accrued Benefit Asset Growth, 2009/10–2018/19 ($ million)
Source of data: Office of the Provincial Controller Division



to be illustrative of the types of changes that could lead to a reversal of the growing accounting trend observed over the past 17 years:

- substantive changes in the negotiated agreements governing the OTPP and the OPSEUPP;
- a change in the discount rate used by the sponsor to measure the pension obligations;
- future underperformance of pension asset portfolios; and
- changes in the long-term actuarial assumptions that increase pension expense.

Changes to Negotiated Pension Agreements

We have examined this factor in some capacity in Chapter 2 of each of our Annual Reports between 2016 and 2018. We continue to engage in open dialogue with the Office of the Provincial Controller Division (OPCD) on the appropriate accounting treatment of any net pension assets of the OTPP and the OPSEUPP.

We have maintained that if the government is able to obtain a formal agreement with the plans' other joint sponsors to take a contribution holiday or reduce minimum contributions, we will need to assess whether the substance of the contractual arrangement would warrant a reversal (in part or full) of the valuation allowance for each plan.

Changes in the Discount Rate Used for Accounting Purposes

Canadian PSAS Section 3250, *Retirement Benefits*, does not prescribe what discount rate the preparer of financial statements should use in calculating a net pension obligation or surplus. Instead, it guides the preparer to use its cost of borrowing or the expected rate of return on plan assets in determining the discount rate. The government has chosen to use the expected rate of return on plan assets, allowing it to set the discount rate for calculating its net pension obligations on the OTPP and the OPSEUPP at 5.80% and 5.75%, respectively, as at March 31, 2019. The historical performance of the pension plans' assets supports these rates.

In contrast, if the province had chosen to use its cost of borrowing to determine its discount rate, the discount rate would have been significantly lower, because the cost of borrowing is typically referenced to the current yield of long-term, publicly

traded bonds issued by the province. Borrowing rates also land much closer to the rates used by the OTPP and the OPSEUPP for their own accounting and funding purposes. For example, for its separate audited financial statements, the OTPP discloses that it uses market rates of bonds issued by the province, which have characteristics similar to the OTPP's liabilities. This approach yielded a discount rate of 3.20% as at December 31, 2018.

Regardless of available discount rate options under current standards, we are actively monitoring developments in PSAS for pension plans. The Public Sector Accounting Board (PSAB) is carrying out a project to review Canadian PSAS Section 3250, *Retirement Benefits* and Section 3255, *Post-Employment Benefits*. To date, the project has focused on fundamental issues, such as deferral provisions, discount rate guidance, and non-traditional pension plans. Ultimately, PSAB intends to draft a new standard on employment benefits that replaces Canadian PSAS Sections 3250 and 3255.

PSAB's new standard on employment benefits could potentially have a significant impact on the province's accounting for the net pension assets of the OTPP and the OPSEUPP. In particular, changes to the current discount guidance could have the effect of partially or completely eliminating the net pension assets in both plans. PSAB is considering alternative discount-rate approaches, which include using prescribed rates based on the market yield of high-quality debt instruments or risk-free debt instruments. These bases would also result in a significantly lower discount rate.

To illustrate the significance of the discount-rate assumption, consider that as at March 31, 2019, a decrease in the province's discount rate for the OTPP of 25 basis points would have increased the province's total pension obligation by more than $4 billion. While this change would not show up immediately in the province's total pension liability, it would have a future impact of increasing the pension liability and pension expense over the course of many years.

Therefore, a decrease of 260 basis points (the current difference between the discount rates used by the province of 5.80% and the OTPP of 3.20%) would result in a dramatic increase in the calculated net pension obligation of the OTPP on the consolidated financial statements of the province. A change of this magnitude would very likely eliminate the net pension assets in the OTPP to the point of reporting a plan deficit.

Underperformance of Pension Asset Portfolios

Underperforming pension asset portfolios are not a desirable outcome for government sponsors, pension plan members or pension plans themselves. However, in the event that the OTPP and the OPSEUPP were to experience investment returns that are consistently below the expected rate of return for a sustained period of time, the growth in the net pension asset would slow down, and eventually, given enough accumulated actuarial losses, the net pension asset would begin to grind down. Essentially, the upward force on the net pension asset from the OTPP's recent string of greater-than-expected investment returns would reverse itself in the event of a sustained number of years like 2008 or 2018 (see **Figure 1**).

Changes in Other Long-Term Actuarial Assumptions

Similar to a decrease in discount rates, other changes to long-term actuarial assumptions can increase pension expense and cause the net pension asset to decrease, all other factors being equal. However, it is unlikely that any of these levers individually would have the profound impact that a significant change in the pension discount rate would produce. Nevertheless, they are inputs that affect the mathematics underlying the pension measurement model used by actuaries to determine a sponsor's obligation and annual expense and are therefore worth mentioning. These assumption changes include but are not limited to:

- an increase in inflation rates;

- an increase in salary escalation rates;
- an increase in life expectancy or decrease in mortality; and
- an increase in the average age of retirement.

3.9 Accounting Advisory Services to Entities Consolidated into the Public Accounts

Over the past few years, we have commented on external advisors in this chapter. In our *2017* and *2018 Annual Reports*, we recommended that the Treasury Board Secretariat and OPCD provide us with copies of contracts relating to any advisors it uses for accounting advice and opinions. OPCD provided our Office with three contracts for advisors it engaged for accounting advice in 2016/17, two additional contracts in 2017/18 and one contract for an advisor it engaged in 2018/19. These advisors provided advice and guidance to supplement OPCD's internal analysis of significant accounting issues. OPCD has also agreed to request its external advisors to notify the Auditor General of their engagement, as required under the Code of Professional Conduct of the Chartered Professional Accountants of Ontario.

The interests of the Treasury Board Secretariat, the Ministry of Finance and the Office of the Auditor General are best served when there is full disclosure on the intent and use of external advisors. This is also true of other ministries and agencies consolidated into the financial statements of the province. For this reason, any work performed by external advisors in formulating an accounting position should be shared with the Office of the Auditor General as soon as possible, as part of the audit of the consolidated financial statements and before final accounting positions are taken. To this end, we are working with the Treasury Board Secretariat, the Ministry of Finance and OPCD to develop guidance that can be used by all ministries and agencies when contracting for accounting advice.

Over the past few years, both OPCD and our Office have assigned designated staff with the purpose of strengthening internal accounting competencies and improving the quality of external financial reporting throughout the Ontario public sector. The two teams of staff have worked closely over the past two years to proactively address accounting issues affecting the Public Accounts.

We are working with OPCD to reduce costs where the procurement of external accounting advice is not needed given the accounting staff expertise in the OPCD and our Office. Early involvement in identifying and addressing accounting issues in the public sector that could impact the province's consolidated financial statements is important and cost effective.

In addition, we have worked with the external auditing firms to safeguard their independence when they perform accounting advisory work for ministries and agencies. As part of the audit of the province's consolidated financial statements, we interact with and use the work of external auditing firms for components identified by us in accordance with Canadian Auditing Standards 600 (*Special Considerations—Audits of Group Financial Statements*). We request that each external auditing firm confirm their independence at the provincial level when responding back to us. To assist with that confirmation, we have requested that the firm confirm that they have not provided accounting advice or accounting advisory services to:

- the Ministry that the entity, for which the firm servers as external auditor, reports into;
- Treasury Board Secretariat; and
- any other ministries, agencies and Crown corporations that are involved in related party transactions with the entity the firm audits.

3.10 Standing Committee on Public Accounts

Over the past few years, the Standing Committee on Public Accounts has held public hearings and issued reports on the Public Accounts of the province. Specifically, reports were tabled on May 17, 2017, related to **Chapter 2** of our

2015 Annual Report (see **Chapter 3 Section 3.06** of Volume 2 (follow-up volume) of our *2018 Annual Report* for the status update on the recommendations made) and May 3, 2018, related to **Chapter 2** of our *2017 Annual Report* (see **Chapter 3 Section 3.04** in the follow-up volume of this year's Annual Report for the status update on the recommendations made). In addition, the Standing Committee on Public Accounts held a public meeting on April 3, 2019, on **Chapter 2** of our *2018 Annual Report*.

The Standing Committee on Public Accounts has covered the following items, amongst others, in their reports related to Chapter 2 over the past few years:

- Ontario's Debt Burden;
- Financial Statement Discussion and Analysis;
- Legislative Accounting;
- Funding of Liabilities for Contaminated Sites;
- The Financial Statements of IESO;
- Pension Accounting in Ontario;
- Use of External Consultants—the Committee had concerns over the independence of external auditing firms and the interaction of the external auditing firms and our Office; and
- Issues Affecting Prior Years' Qualifications—the Committee had concerns over the accounting treatments for rate-regulated accounting, the Fair Hydro Plan, market accounts and the net pension assets of the Ontario Teachers' Pension Plan and Ontario Public Service Employees' Union Pension Plan that gave rise to the qualifications in 2016 and 2017.

4.0 *Fiscal Sustainability, Transparency and Accountability Act, 2019*

In May 2019, the government repealed the *Fiscal Transparency and Accountability Act, 2004*, and replaced it with the *Fiscal Sustainability, Transparency and Accountability Act, 2019* (Act). Under the Act, the government is required to:

- develop a debt burden reduction strategy, including setting out net-debt-to-GDP objectives and plans for reducing the debt burden;
- incorporate sustainability into the province's fiscal policies;
- release the annual Budget by March 31 each year, except for years in which a general election takes place to allow a new government additional time to develop its first multi-year fiscal plan;
- provide a rationale for running deficits in the introductory section of the annual Budget;
- impose monetary penalties on the Premier and the Minister of Finance for missing reporting deadlines stipulated in the Act; and
- post a public statement to explain the rationale for any missed public reporting deadlines, and the revised deadline by which the affected report will be released.

In addition, the Act requires the Auditor General of Ontario to annually review the Minister's compliance with the Act.

Figure 3 shows the reports that are subject to the financial penalty and public statement requirements.

The Auditor General has determined that the communication of the Minister's compliance with the Act will be through Chapter 2.

Figure 4 shows that as of November 6, 2019, the Minister complied with all requirements of the Act.

5.0 Independent Electricity System Operator

As communicated in our *2018 Annual Report*, the Independent Electricity System Operator (IESO) appointed us to perform its December 31, 2018, financial statement audit. We performed our audit procedures between November 2018 and February 2019. We received the full co-operation of

Figure 3: Reports by the Minister of Finance and Premier Subject to Financial Penalty and Public Statement Requirements

Source of data: *Fiscal Sustainability, Transparency and Accountability Act, 2019*

Report	Deadline
Budget	March 31
First-Quarter Finances	August 15
Mid-Year Review (Fall Economic Statement)	November 15
Third-Quarter Finances	February 15
Long-Term Report	Two years following a general election
Quarterly Ontario Economic Accounts	Within 45 days after each of Statistics Canada's Quarterly National Income and Expenditure Accounts

Figure 4: Compliance with Financial Penalty and Public Statement Requirements, May–November 2019

Prepared by the Office of the Auditor General of Ontario

Report	Deadline	Date Available	Requirement Met
First-Quarter Finances	Aug 15, 2019	Aug 15, 2019	Yes
Quarterly Ontario Economic Accounts, First Quarter	Jul 15, 2019[1]	Jul 12, 2019	Yes
Quarterly Ontario Economic Accounts, Second Quarter	Oct 15, 2019[2]	Oct 11, 2019	Yes
Mid-Year Review (Fall Economic Statement)	Nov 15, 2019	Nov 6, 2019	Yes

1. Statistics Canada's Gross Domestic Product and Income and Expenditure Accounts for the first quarter of 2019 were released on May 31, 2019, making the Minister's reporting deadline July 15, 2019.
2. Statistics Canada's Gross Domestic Product and Income and Expenditure Accounts for the second quarter of 2019 were released on August 31, 2019, making the Minister's reporting deadline October 15, 2019.

management and the board. The Auditor General signed an unqualified Independent Auditor's Report on February 27, 2019. The financial statements include a restatement of prior year balances to correct the accounting for the IESO-administered Market Accounts, rate-regulated accounting and the discount rate used for non-registered pension and other employee benefit plans.

At the conclusion of our audit, we agreed with the IESO that it move forward with a request-for-proposal process to appoint a new auditor for its December 31, 2019, financial statement audit. A private auditing firm was selected from a bid process to conduct next year's financial statement audit.

6.0 Ontario Cannabis Retail Corporation

In April 2017, the federal government introduced legislation to legalize and regulate recreational cannabis in Canada. The proposed federal *Cannabis Act* created rules for producing, possessing and selling non-medical cannabis across Canada. On June 21, 2018, the *Cannabis Act* received Royal Assent and the federal government announced that the *Cannabis Act* would come into force on October 17, 2018.

In September 2017, in anticipation of the federal legalization of cannabis, the then government of Ontario announced its plan for the retail and distribution of recreational cannabis in Ontario. Under the proposed approach, the Liquor Control Board of Ontario (LCBO) would oversee the set-up

of a separate corporation responsible for the retail of recreational cannabis. The corporation would open approximately 150 stand-alone stores by 2020 and include an online distribution channel. On December 12, 2017, the then government passed the *Ontario Cannabis Retail Corporation Act* (OCRC Act) to establish the Ontario Cannabis Retail Corporation (Corporation), which now operates under the name Ontario Cannabis Store.

Under the initial OCRC Act, the Corporation had the exclusive right to sell recreational cannabis in Ontario through all possible means (online, wholesale and retail). Prior to and during the Corporation's set-up and initial operations, the LCBO worked with the government to draft the strategic vision for the development and implementation of the Corporation's business model. Under the LCBO's direction, the Corporation decided to adopt a cloud-based approach for its information technology (IT) systems. Those systems included e-commerce for online sales, the general ledger system and the payroll system. The Corporation relied primarily on outsourced IT systems and services, including for its accounting and financial reporting—a first for a government agency in Ontario. For example, the Corporation contracted with Shopify to deliver an IT solution that would allow it to manage its retail and e-commerce operations, and be integrated with its inventory, distribution, supply chain, accounting and finance systems.

In August 2018, following the 2018 Ontario provincial election, the new government announced that it was introducing a private retail model and that the Corporation would not run physical retail stores. Up until this point, the Corporation was operating under the assumption that it would be responsible for both physical and online retail channels, and had incurred start-up costs in preparation for the launch of its physical retail stores. Effective October 17, 2018, the government amended the OCRC Act to prohibit the Corporation from operating its own retail stores. The Corporation retained the exclusive right to sell cannabis in Ontario both online and wholesale to licensed cannabis retail stores.

On October 17, 2018, the Corporation began selling recreational cannabis online to consumers in Ontario. Shortly after opening for business, the Corporation encountered significant difficulties in processing the high volume of sales orders and making timely deliveries to customers. During the Corporation's first two weeks of sales, the Office of the Ombudsman of Ontario received more than 1,000 complaints about the Ontario Cannabis Store—most commonly regarding delayed deliveries, billing and poor customer service issues. Some of the delays and billing problems stemmed from issues that the Corporation was experiencing with the communication between its various IT systems. In addition, rotating labour action at Canada Post impacted the Corporation's ability to make timely deliveries to its customers.

As appointed under the OCRC Act, we conducted the audit of the Corporation's financial statements for the fiscal year ended March 31, 2019. During this fiscal year, the Corporation encountered data integration issues with its key IT systems. As a result, we performed extensive audit testing to confirm the reliability and accuracy of information from the Corporation's IT systems. At the time of writing, the Corporation was actively working toward resolving their ongoing data integration issues.

On September 5, 2019, the Auditor General issued an unqualified opinion on the Corporation's financial statements for the fiscal year ended March 31, 2019.

RECOMMENDATION 2

In order for the Ontario Cannabis Retail Corporation to operate effectively, we recommend that it develop a plan and take all steps necessary to expedite the resolution of data integration issues between its key IT systems.

ONTARIO CANNABIS RETAIL CORPORATION RESPONSE

The Ontario Cannabis Retail Corporation, operating as the Ontario Cannabis Store (OCS), is

finalizing its resolution plan, with timelines and accountabilities to address the issues. The OCS currently expects to automate and internalize its external sales audit tool by January 2020 and advises that it has accelerated continuing efforts to strengthen data integrations between IT systems with a more robust and reliable data architecture, for completion in mid-2020.

7.0 Ontario's Debt Burden

We commented in previous annual reports on Ontario's growing debt burden, attributable to Ontario's large deficits and its investments in capital assets such as infrastructure. We do so again this year.

In reporting on the province's debt burden, the government restated Ontario's debt figures in the 2018/19 consolidated financial statements. Specifically, the government reduced the total debt from the Ontario bonds and treasury bills repurchased and held by the province in order to be in accordance with Canadian PSAS.

As a result, Ontarians now have a truer picture of Ontario's debt. We noted that the province has relied on historically low interest rates to keep its debt-servicing costs relatively stable, but the debt itself, whether measured as total debt, net debt or accumulated deficit, continues to grow, as illustrated in **Figure 5**. The three measures of debt are defined below:

- *Total debt* is the total amount of borrowed money the government owes to external parties, and consists of bonds issued in public capital markets, non-public debt, treasury bills and US commercial paper. Total debt provides the broadest measure of a government's debt load.
- *Net debt* is the difference between the government's total liabilities and its financial assets. Liabilities consist of all amounts the government owes to external parties, including total debt, accounts payable, pension and retirement obligations, and transfer-payment obligations. Financial assets are those that theoretically can be used to pay off liabilities or finance future operations, and include cash, accounts receivable, temporary investments and investments in government business enterprises. Net debt provides a measure of the amount of future revenues required to pay for past government transactions and events.
- *Accumulated deficit* represents the sum of all past annual deficits and surpluses of the government. It can also be derived by deducting the value of the government's non-financial assets, such as its tangible capital assets, from its net debt.

Figure 5: Total Debt, Net Debt and Accumulated Deficit, 2013/14–2021/22 ($ million)

Sources of data: March 31, 2019, Province of Ontario Consolidated Financial Statements; 2019 Ontario Budget; 2019 Ontario Economic Outlook and Fiscal Review; and the Ministry of Finance

	Actual						Estimate		
	2013/14	2014/15	2015/16	2016/17	2017/18[1]	2018/19[1]	2019/20	2020/21	2021/22
Total debt[2]	292,196	311,762	321,191	325,128	337,411	354,264	378,319	385,700	394,000
Net debt[3]	276,169	294,557	306,357	314,077	323,834	338,496	353,743	365,822	375,719
Accumulated deficit[3]	184,835	196,665	203,014	205,939	209,023	216,642	224,666	230,330	234,749

1. March 31, 2019 Province of Ontario Consolidated Financial Statements.
2. Restated for the buyback of Ontario's own bonds and treasury bills.
3. Restated and as per the 2019 Ontario Budget, 2019 Ontario Economic Outlook and Fiscal Review, and the Ministry of Finance.

7.1 Main Contributors to Net Debt

The province's growing net debt is attributable to its large annual operating deficits, along with its expenditures on capital assets such as buildings and other infrastructure and equipment, whether acquired directly or through public-private partnerships. This extends to assets acquired for the government or its consolidated organizations, such as public hospitals, as illustrated in **Figure 6**.

The province will continue to have annual deficits over the next three years, and net debt will continue to rise as the government borrows to finance its operations.

In the last 10 years, Ontario's net debt has increased by 99.6%, from $169.6 billion beginning in 2009/10 to $338.5 billion in 2018/19, and is estimated to increase by an additional $37.2 billion, or 11%, in the next three years, resulting in an overall increase of 122%. We estimate net debt will be $375.7 billion by 2021/22.

To put this in perspective, the amount of net debt owed by each resident of Ontario on behalf of the government will increase from about $13,162 per person at the beginning of 2009/10 to about $24,900 per person in 2021/22. In other words, it would cost every Ontarian $24,900 to eliminate the province's net debt in 2021/22. In 2018/19, the amount of net debt owed by each resident of Ontario was $23,633.

7.2 Ontario's Ratio of Net Debt to GDP

A key indicator of the government's ability to carry its debt is the level of debt relative to the size of the economy, or more specifically to the market value of goods and services produced by the economy (known as the gross domestic product, or GDP). This ratio of net–debt-to-GDP measures the relationship between a government's obligations and its capacity to raise the funds needed to meet them. It

Figure 6: Net Debt Growth Factors, 2012/13–2021/22 ($ million)

Sources of data: March 31, 2019, Province of Ontario Consolidated Financial Statements; 2019 Ontario Budget; 2019 Ontario Economic Outlook and Fiscal Review; and the Ministry of Finance

	Restated Net Debt Beginning of Year[1]	Deficit/ (Surplus)[1]	Expenditures on Capital Assets[2]	Miscellaneous Adjustments[3]	Restated Net Debt End of Year[1]	Increase/ (Decrease)
Actual						
2012/13	241,912	10,662	7,784	(411)	259,947	18,035
2013/14	259,947	11,530	5,600	(908)	276,169	16,222
2014/15	276,169	11,268	6,509	611	294,557	18,388
2015/16	294,557	5,346	5,471	983	306,357	11,800
2016/17	306,357	2,435	4,752	533	314,077	7,720
2017/18	314,077	3,672	6,584	(499)	323,834	9,757
2018/19	323,834	7,435	7,000	227	338,496	14,662
Estimated						
2019/20	338,496	9,000	11,600	(5,353)	353,743	15,247
2020/21	359,943	6,700	11,000	(5,621)	365,822	12,079
2021/22	372,300	5,400	10,400	(5,903)	375,719	9,897
Total over 10 years	**–**	**73,448**	**76,700**	**(16,341)**	**–**	**133,807**

1. Restated for the net pension assets and the Fair Hydro Plan.
2. Includes expenditures on government-owned and broader-public-sector land, buildings, machinery and equipment, and infrastructure assets capitalized during the year, less annual amortization and net gains reported on sale of government-owned and broader-public-sector tangible capital assets for fiscal years 2012/13 to 2018/19.
3. Unrealized Fair Value Losses/(Gains) on the Ontario Nuclear Funds Agreement (ONFA) Funds held by Ontario Power Generation Inc. and accounting changes.

is an indicator of the burden of government debt on the economy.

If the amount of debt that must be repaid relative to the value of the GDP is rising—in other words, if the ratio is rising—it means the government's net debt is rising faster than the provincial economy and is becoming a growing burden.

Figure 7 shows that the province's net debt-to-GDP ratio remained constant from 2003/04 (27.5%) to 2007/08 (26.6%). However, it has been trending upward since then, reflecting factors such as significantly increased borrowing to fund annual deficits and infrastructure spending. Ontario's net-debt-to-GDP ratio rose from 26.6% before the 2008/09 recession to 39.6% in 2018/19. We project Ontario's net debt will increase by $37.2 billion over the next three years, resulting in the net-debt-to-GDP ratio rising to 39.8%.

The previous government committed to reducing the net-debt-to-GDP ratio to its pre-recession level of 27% by 2029/30 but excluded it from its 2018 Budget. In the 2019 Budget, the current government introduced the *Fiscal Sustainability, Transparency and Accountability Act, 2019* (Act), a revised framework from the previous *Fiscal Transparency and Accountability Act, 2004*. The Act requires the government to develop a debt burden reduction strategy that aims to have the net-debt-to-GDP ratio at levels less than 40.8% by 2022/23, as announced in the 2019 Provincial Budget. This includes a requirement for the Minister of Finance to set out in the annual budget the government's net-debt-to-GDP ratio and its plans for reducing the debt burden and monitoring progress on doing so. The government, legislators and the public need to be mindful of Ontario's debt level and the relationship of net debt to GDP.

We noted in our previous Annual Reports that many experts believe when a jurisdiction's net-debt-to-GDP ratio rises above 60%, that jurisdiction's fiscal health is at risk and is vulnerable to unexpected economic shocks.

We also noted that it is an oversimplification to rely on just one measure to assess a government's borrowing capacity, because that measure does not take into account that government's share of federal and municipal debts. In Ontario's case, if the province's share of those debts was included in its indebtedness calculations, the net debt would be considerably higher. However, consistent with debt-measurement methodologies used by most jurisdictions, we have focused throughout our analysis predominantly on the provincial government's direct net debt.

Figure 8 shows the net debt of Ontario compared to other provinces and the federal government, along with their respective ratios of net debt to GDP for the 2017/18 and 2018/19 fiscal years. Generally, the western provinces have a significantly lower net-debt-to-GDP ratio than Ontario and the Atlantic provinces, and Quebec has a higher ratio than Ontario.

Figure 7: Ratio of Net Debt to Gross Domestic Product (GDP), 2003/04–2021/22

Sources of data: March 31, 2019, Province of Ontario Annual Report–Financial Statement Discussion and Analysis; 2019 Ontario Budget; and the 2019 Ontario Economic Outlook and Fiscal Review

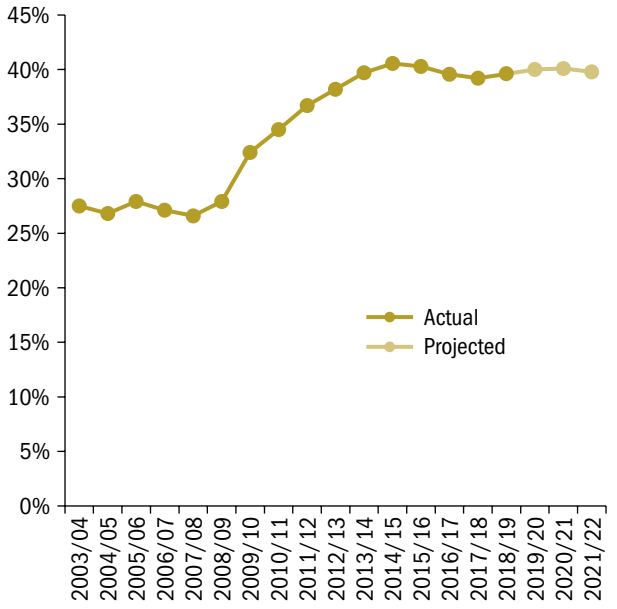


Figure 8: Net Debt and the Net-Debt-to-GDP Ratios of Canadian Jurisdictions, 2017/18 and 2018/19

Sources of data: Province of Ontario Annual Report and Consolidated Financial Statements; Annual Reports and Consolidated Financial Statements of other provincial jurisdictions; and federal budgets and budget updates, budgets and Ministry of Finance report of provincial jurisdictions

	2017/18		2018/19	
	Net Debt ($ million)	Net Debt to GDP (%)	Net Debt ($ million)	Net Debt to GDP (%)
AB	19,344	5.8	27,477	7.9
SK	11,288	14.2	11,834	14.4
BC	41,834	14.8	42,134	14.3
PE	2,129	32.0	2,124	30.5
MB	24,365	34.5	24,999	34.6
NS	14,959	35.0	15,011	34.1
Federal	752,887	35.2	772,124	34.8
NB	13,926	38.6	13,959	37.4
ON	323,834	39.2	338,496	39.6
QC	176,543	42.3	172,558	39.7
NL	14,674	45.2	15,374	44.7

7.3 Other Measures to Assess Government Debt Levels

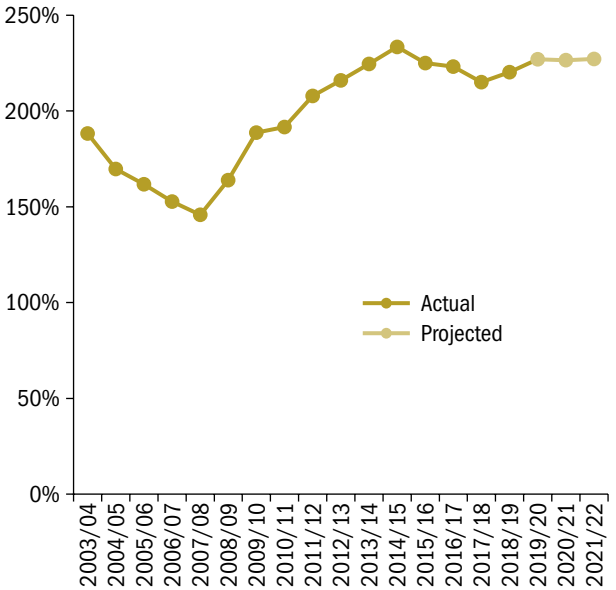
7.3.1 Net Debt as Percentage of Total Annual Revenue

Another useful measure of government debt is net debt as a percentage of total annual revenue, an indicator of how much time it would take to eliminate the debt if the province spent all of its revenues only on debt repayment. For instance, a percentage of 250% indicates that it would take 2.5 years to eliminate the provincial debt if all revenues were devoted exclusively to it.

As shown in **Figure 9**, this percentage declined from about 188% in 2003/04 to about 146% in 2007/08, reflecting the fact that the province's net debt grew at a slower pace than annual provincial revenue. However, the percentage has increased steadily since 2007/08, and is expected to reach 227% by 2021/22. The percentage currently sits at 220%. This increasing percentage indicates the province's net debt burden has relatively less revenue to support it.

Figure 9: Net Debt as a Percentage of Total Annual Revenue, 2003/04–2021/22

Sources of data: March 31, 2019, Province of Ontario Annual Report–Financial Statement Discussion and Analysis; 2019 Ontario Budget; 2019 Ontario Economic Outlook and Fiscal Review; and the Ministry of Finance



7.3.2 Ratio of Interest Expense to Total Revenue

Interest expense is the cost of servicing total debt. Increases in interest expense can directly affect the quantity and quality of programs and services that the government can provide; the higher the proportion of government revenues going to pay interest costs on past borrowings, the lower the proportion available for spending in other areas. In the 2019 Ontario Economic Outlook and Fiscal Review, the government forecast that in 2019/20, it would spend $12.9 billion in interest payments to service the province's debt.

The interest-expense-to-revenue ratio illustrates the extent to which servicing past borrowings takes a greater or lesser share of total revenues.

As **Figure 10** shows, interest rates have been at historic lows since the beginning of this decade, and the actual interest-expense-to-total-revenues ratio held steady at around 9.0% from 2010/11 to 2014/15. In 2016/17, the government retroactively consolidated the broader public sector on a line-by-line basis, which increased both interest expense and revenue reported in the province's consolidated financial statements. The ratio stood at 8.1% in 2018/19 and is projected to be 8.4% in 2021/22. This means approximately 8.4 cents of every dollar in government revenue will go towards paying interest on debt by 2021/22.

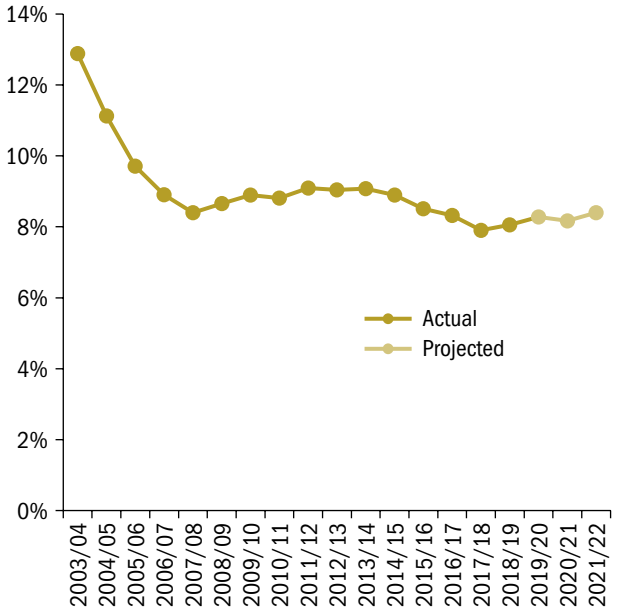
The debt exposes the province to further risks, the most significant being interest-rate risk. As noted above, interest rates in the past few years have been at record low levels, enabling the government to keep its annual interest expense relatively steady even as its total borrowing has increased significantly. Interest rates began to rise in 2017/18 until October and remained unchanged for the remainder of the fiscal year. The risk remains that if interest rates increase, the government will have considerably less flexibility to provide public services, such as health care and education, because a higher proportion of revenues will be required to pay interest on the province's outstanding debt.

As we noted in previous Annual Reports, the government has mitigated its interest-rate risk to some extent by increasing the weighted average term of its annual borrowings in order to take advantage of the current low rates. However, the Bank of Canada raised its key lending rate twice between April 1, 2018, and November 13, 2019. When the government refinances debt at a higher interest rate than that paid on maturing debt, then the average interest expense on government debt will rise. This means more money will go towards interest expense, therefore contributing to increasing the annual deficit.

The ratio of interest expense to revenue is expected to continue to rise in the near future as more interest will be paid on the accumulated debt, meaning the government will have less flexibility to respond to changing economic circumstances. Past governments' borrowing and debt-servicing decisions mean a growing portion of revenues will not be available for other current and future government programs.

Figure 10: Ratio of Interest Expense to Total Revenue, 2003/04–2021/22

Sources of data: March 31, 2019, Province of Ontario Annual Report–Financial Statement Discussion and Analysis; 2019 Ontario Budget; and the 2019 Ontario Economic Outlook and Fiscal Review



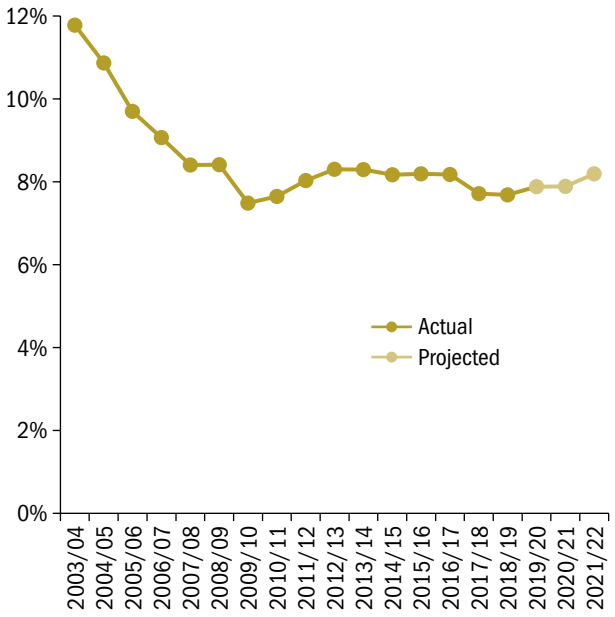
7.4 Consequences of High Indebtedness

Our commentary last year highlighted the consequences for the province of carrying a large debt load—and the same observations remain relevant this year. They include the following:

Debt-servicing costs cut into funding for other programs: As debt grows, so do interest costs. As interest costs consume a greater proportion of government resources, there is less to spend on other things. To put this "crowding-out" effect into perspective, interest expense is currently the province's fourth-largest annual expenditure behind health, education, and children's and social services. As shown in **Figure 11**, interest rates have been at historic lows since the beginning of this decade, and actual interest-expense-to-total expenses has ranged from 7.7% to 8.3% between 2010/11 and 2018/19. In the 2019 Ontario Economic Outlook and Fiscal Review, the province forecast interest expense would increase to $12.9 billion, or about 8.4% of total expenses, by 2021/22.

Figure 11: Interest Expense to Total Expense, 2003/04–2021/22

Sources of data: March 31, 2019, Province of Ontario Consolidated Financial Statements; 2019 Ontario Budget; 2019 Ontario Economic Outlook and Fiscal Review; and the Ministry of Finance



Greater vulnerability to interest rate increases: Ontario has been able to keep its annual interest expense relatively steady, even as its total borrowing has increased significantly. For example, it was paying an average effective interest rate of about 8.4% in 1999/2000, but that dropped to 3.6% in 2018/19. However, if interest rates start to rise again, the government will have considerably less flexibility to provide public services because it will have to devote a higher proportion of its revenue to interest payments.

Potential credit-rating downgrades could lead to higher borrowing costs: Prepared by specialized agencies, credit ratings assess a government's creditworthiness based largely on its capacity to generate revenue to service its debt. The four main credit rating agencies are Moody's Investors Service (Moody's), Standard and Poor's Global Ratings (S&P), DBRS Morningstar (previously DBRS), and Fitch Ratings (Fitch). To assign a rating, agencies consider such factors as a government's economic resources and prospects, industrial and institutional strengths, financial health, financial management and debt management practices, liquidity, access to capital, and susceptibility to major risks.

In 2018, Moody's downgraded its rating for Ontario's debt from Aa2 to Aa3, and Fitch revised its rating outlook from stable to negative, reflecting their assessment of the province's increased credit risk. In 2019, Moody's' rating and outlook remained unchanged, while Fitch revised the rating outlook to stable. DBRS Morningstar and S&P have issued unchanged ratings since 2009 and 2015 respectively. The four main agencies cited several concerns regarding Ontario's credit outlook, including the province's high and rising debt burden, the projection of ongoing deficits, and the risk of a future economic downturn.

A credit rating can affect the cost of future borrowing, with a lower rating indicating that an agency believes there is a relatively higher risk that a government will default on its debt. Generally, investors will lend to that government only

in return for a greater risk premium, in the form of higher interest rates. A rating downgrade could also shrink the potential market for a government's debt, because some investors will not hold debt below a certain rating.

7.5 Final Thoughts on Ontario's Debt Burden

Ultimately, decisions about how much debt the province should carry, and the strategies to pay down that debt, are questions of government policy and thus the sole prerogative of the government.

Government debt has been described as a burden on future generations, especially debt used to finance operating deficits (in contrast to debt used to finance infrastructure, which is more likely to leave behind tangible capital assets that benefit future generations). In the 2019 Budget, the government aimed to have the net-debt-to-GDP ratio at less than 40.8% by 2022/23.

Our Office performed a value-for-money audit on the Ontario Financing Authority's management of the province's debt (see **Chapter 3, Section 3.10**), and its recommendations are also applicable here.

8.0 Update on Workplace Safety and Insurance Board

The Workplace Safety and Insurance Board (WSIB) is a statutory corporation created by the *Workplace Safety and Insurance Act, 1997* (Act). Its primary purpose is to provide income support and medical assistance to workers injured on the job. The WSIB receives no funding from government; it is financed through premiums on employer payrolls.

Over the past decade, we raised a number of concerns about significant growth in the WSIB's unfunded liability, which is the difference between the value of the WSIB's assets and its estimated financial obligations to pay benefits to injured workers. Our *2009 Annual Report* discussed the risk that the growth and magnitude of the unfunded liability posed to the WSIB's financial viability, including the ultimate risk of the WSIB being unable to meet its existing and future commitments to provide worker benefits.

As of June 30, 2010, the WSIB's unfunded liability had grown to almost $13 billion. In September 2010, the WSIB announced an independent funding review to obtain advice on how to best ensure the long-term financial viability of Ontario's workplace safety and insurance system. The May 2012 report contained a number of recommendations, in particular calling for a new funding strategy for the WSIB with the following key elements:

- realistic assumptions, including a discount rate based on the best actuarial advice;
- moving the WSIB as quickly as feasible beyond a "tipping point" of a 60% funding Sufficiency Ratio (a tipping point is a crisis in which the WSIB would not be able to generate sufficient funds to pay workers' benefits within a reasonable time frame and by reasonable measures); and
- putting the WSIB on course to achieve a 90%–110% funding Sufficiency Ratio within 20 years.

In response to our concerns and to the recommendations of the report, the government passed Ontario Regulation 141/12 under the Act in June 2012. Effective January 1, 2013, it required the WSIB to ensure it meets the following funding Sufficiency Ratios by specified dates:

- 60% on or before December 31, 2017;
- 80% on or before December 31, 2022; and
- 100% on or before December 31, 2027.

The government at the time also passed Ontario Regulation 338/13 in 2013. It came into force on January 1, 2014, and changed the way the WSIB calculates the funding Sufficiency Ratio by changing the method used to value its assets and liabilities. Our Office concurred with this amendment.

Figure 12: Workplace Safety and Insurance Board (WSIB) Operating Results and Unfunded Liability, 2018 and 2017 ($ million)

Source of data: WSIB Financial Statements

	2018	2017
Revenue		
Net premiums	4,956	4,779
Net investment (loss) income	(519)	2,914
	4,437	**7,693**
Expenses		
Benefit costs	1,827	3,147
Loss of Retirement Income Fund contributions	56	56
Administration and other expenses	474	409
Legislated obligations and commitments	269	252
Remeasurement of employee defined benefit plans	(268)	273
Other items	(86)	32
	2,272	**4,169**
Total Comprehensive Income	**2,165**	**3,524**
Less: Non-controlling Interests	(29)	309
Total Comprehensive Income Attributable to WSIB Stakeholders	**2,194**	**3,215**
Net Assets (Unfunded Liability)	**1,484**	**(710)**

The WSIB issues quarterly Sufficiency Reports and an Economic Statement to stakeholders annually. As of December 31, 2018, under Regulation 141/12 as amended by Regulation 338/13, the WSIB reported a Sufficiency Ratio of 108.0% (in 2017, the Sufficiency Ratio was 95.8%). This means the WSIB has already achieved its December 31, 2027, funding requirement.

The WSIB now incorporates its annual update of the Sufficiency Plan within the Economic Statement, in which it describes the measures taken to improve its funding Sufficiency Ratio. The most recent plan is available on the WSIB website.

The WSIB's operational and financial performance was strong in 2018, as illustrated in **Figure 12**, which provides a summary of the WSIB's operating results and unfunded liability compared to 2017.

The WSIB's continued strong operating performance in 2018 resulted from premiums exceeding what was needed to cover claims and administrative costs, fewer claims, and better recovery and return to work.

9.0 Use of Legislative Accounting Standards

Canadian PSAS have been widely adopted by Canadian federal, provincial, territorial and local governments as the basis for preparation of their financial statements.

Over time, standards were developed to address increasingly complex transactions and emerging financial issues. When changes to standards have a significant impact on the accounting for and measurement of transactions affecting the annual deficit/surplus or net debt, governments may be reluctant to adopt them to the extent that they generate potential volatility in annual reported results.

As discussed in our *2018 Annual Report*, the previous government passed legislation in 2008, 2009, 2011 and 2012 giving it the ability to make regulations for specific accounting treatments in place of the wholesale application of independently established accounting standards. Initially, the use

of regulations did not deviate materially from Canadian PSAS. For example:

- In 2011, a regulation under the *Financial Administration Act* directed Hydro One, at the time wholly owned by the Ontario government, to prepare its financial statements in accordance with US generally accepted accounting principles (GAAP), effective January 1, 2012. Subsequently, the *Financial Administration Act* was changed to make this regulation no longer apply to Hydro One once it made its initial public offering on the Toronto Stock Exchange in 2015. The government also required another wholly owned government business enterprise, Ontario Power Generation (OPG), to prepare its financial statements in accordance with US GAAP. When the government chose to use US GAAP, rather than International Financial Reporting Standards (IFRS) as required by Canadian PSAS, to record the results of Hydro One and OPG in the province's consolidated financial statements, we examined the differences between IFRS and US GAAP, and concluded these differences had no material effect on the province's annual deficit. The government adopted IFRS for the purposes of recording the results of OPG and Hydro One in the province's March 31, 2017, consolidated financial statements.
- Ontario government regulations require transfers for capital acquisitions and transfers of tangible capital assets to be accounted by recipients as "deferred contributions." The deferred amounts are to be brought into revenue by transfer recipients at the same rate as they recognize amortization expense on the related assets. This prescribed accounting treatment is in accordance with PSAS.

Subsequent to 2011, regulations and legislation were used to deviate from Canadian PSAS as follows:

- The 2012 Budget further amended the *Financial Administration Act* to provide the government with full authority to make regulations regarding the accounting policies and practices used to prepare its consolidated financial statements. This legislated provision was used in connection with the preparation of the 2015/16 consolidated financial statements. A time-limited regulation was passed requiring a full valuation allowance to be recorded for jointly sponsored pension plans, which while in effect was in accordance with Canadian PSAS.
- Most recently, as noted in our Special Report titled *The Fair Hydro Plan: Concerns about Fiscal Transparency, Accountability and Value for Money*, we expressed concerns about the government legislating a complex accounting/financing structure to improperly avoid showing an annual deficit and increases in net debt. The "legislated accounting" referred to the government creating a regulatory asset through legislation. This "asset" represented the difference between what electricity generators are owed and the lesser amount being collected from electricity ratepayers as a result of the government policy decision to reduce electricity rates without the involvement of an independent regulator. Without the legislated accounting, the difference would be recorded as an expense rather than as an asset in the province's consolidated financial statements. As described in our *2018 Annual Report*, the government corrected the accounting to comply with PSAS in the March 31, 2018, consolidated financial statements.

We have raised the issue of legislated accounting on a number of occasions in our previous Annual Reports. It is critical that Ontario continue to prepare its financial statements in accordance with generally accepted accounting principles, specifically those of Canadian PSAS, in order to maintain its financial reporting credibility, accountability and transparency.

If the government reports a deficit or surplus under a legislated accounting treatment that is materially different than what it would be using Canadian PSAS, the Auditor General is compelled to include a qualification in her audit opinion.

RECOMMENDATION 3

To ensure consistent use of Canadian Public Sector Accounting Standards, we recommend that the government formalize a process to follow the accounting standards established by the Canadian Public Sector Accounting Board to avoid using legislation or regulations to prescribe accounting treatments.

TREASURY BOARD SECRETARIAT RESPONSE

The province is committed to preparing its financial statements in accordance with generally accepted accounting principles in order to provide high-quality financial reports that support transparency and accountability in reporting to the public, the Legislature and other users.

10.0 Ongoing Accounting Standards Matters

Canadian PSAS continue to be the most appropriate standards for the province to use in preparing its consolidated financial statements. Following PSAS ensures that information provided by the government about the annual deficit or surplus is fair, consistent and comparable to previous years, allowing legislators and the public to assess the government's management of the public purse. Ontario's provincial budget is also prepared on the same basis as its consolidated financial statements.

However, the Public Sector Accounting Board (PSAB) faces challenges in reaching a consensus among its various stakeholders, including financial-statement preparers and auditors, on what accounting standards are most appropriate for the public sector.

We discuss three significant accounting issues that have posed a significant challenge to PSAB over the past few years: the use of financial instruments in the public sector, the use of rate-regulated accounting in government business enterprises and accounting for public-private partnerships. PSAB's final accounting-standard determination will affect the way the province accounts for these items and will have a significant impact on the province's reported financial results.

10.1 Financial Instruments

Financial instruments include provincial debt, and derivatives such as currency swaps and foreign-exchange forward contracts. PSAB's project to develop a new standard for reporting financial instruments began in 2005, with a key issue being whether changes in the fair value of derivative contracts held by governments should be reflected in their financial statements and, in particular, whether such changes should affect a government's annual deficit or surplus.

In March 2011, PSAB approved a new public-sector accounting standard on financial instruments that was slated to become effective for fiscal periods beginning on or after April 1, 2015. The new standard provides guidance on the treatment of government financial instruments and is similar to comparable private-sector standards.

One of its main requirements is for certain financial instruments, including derivatives, to be recorded at fair value, with any unrealized gains or losses on these instruments recorded annually in a new financial statement of remeasurement gains and losses.

Some financial-statement preparers in Canadian jurisdictions, including Ontario, do not support the introduction of these fair-value remeasurements and the recognition of unrealized gains and losses. Ontario's view is that it uses

derivatives solely to manage foreign currency and interest-rate risks related to its long-term-debt holdings, and that it has both the intention and ability to hold these derivatives until the debts associated with them mature.

Accordingly, remeasurement gains and losses on the derivatives and their underlying debt would offset each other over the total period that such derivatives are held, and therefore would have no real economic impact on the government.

Ontario financial-statement preparers argue that recording paper gains and losses each year would force the province to inappropriately report the very volatility that the derivatives were acquired to avoid. This, in their view, would not reflect the economic substance of government financing transactions and would not provide the public with transparent information on government finances.

In response to such concerns, PSAB committed to reviewing the new financial-instruments standard by December 2013. PSAB completed its review of *Section PS 2601, Foreign Currency Translation*, and *Section PS 3450, Financial Instruments*, and in February 2014 confirmed the soundness of the principles underlying the new standard.

PSAB deferred the effective date for these new standards to fiscal years beginning on or after April 1, 2016. In 2015, however, PSAB extended the effective date for the new standard to April 1, 2019, for senior governments to allow further study of reporting options for these complex financial instruments. In 2018, PSAB further extended the effective date for the new standard to April 1, 2021, and will be issuing an exposure draft to improve the transitional provisions and potentially address other non-hedge accounting issues raised during the consultation process.

Since February 2016, PSAB staff have been consulting with the government and not-for-profit stakeholders on implementation issues of the financial-instruments standard. The senior government community has communicated the need for a hedge accounting standard during these consultations. PSAB noted that its staff, in collaboration with stakeholders, have identified certain timing issues in the new financial-instruments standard that may impact a government's annual surplus or deficit in a manner that is unrepresentative of the underlying transactions. In its *Section PS 2601, Foreign Currency Translation*, PSAB stated that given "responses to due process documents issued during the financial instruments project, and the lack of consensus internationally on a hedge accounting model, PSAB has decided to adopt an approach that does not include hedge accounting." PSAB reconfirmed its decision to exclude a formal hedge accounting standard from the PS 3450 suite of standards at its Board meeting in March 2018.

In January 2019, PSAB released an exposure draft for comment containing narrow-scope amendments to PS 3450. At present, PS 3450 would require the province to derecognize its repurchased debt, which could result in gains or losses recorded to the statement of operations. PSAB is proposing to change PS 3450 so that the province would not need to derecognize the repurchased debt, and avoid recognizing any gains or losses. Instead, the province would offset the repurchased debt against the original liability in its statement of financial position (i.e., the debt liability is presented net of repurchased debt).

10.2 Use of Rate-Regulated Accounting in Government Business Enterprises

Rate-regulated accounting was developed to recognize the unique nature of entities such as electric utilities whose rates are regulated by an independent regulator under most regulatory frameworks. Rate-regulated accounting is a commonly accepted practice in the US, especially among privately owned, government-regulated utilities. Subject to many prescriptive rules, rate-regulated accounting is used by these privately owned utilities to spread out large capital expenditures—for example, construction of a new power plant—over a longer term based on the reasonable expectation that

future government-approved rate increases will allow for the eventual recovery of today's capital outlays. The independent government regulator often allows the privately owned entity to recover certain current-year costs from the ratepayer in future years, and these deferred costs are typically set up under rate-regulated accounting as assets on the entity's statement of financial position. Under normal accounting principles, these costs would be expensed in the year incurred.

Rate-regulated accounting is used by two of the province's government-controlled business enterprises, Ontario Power Generation (OPG) and Hydro One, whose rates to customers are approved by the Ontario Energy Board, a government regulator. Rate-regulated accounting is currently allowable under Canadian generally accepted accounting principles, and in turn under Canadian public-sector accounting standards, for government business enterprises.

As noted above, rate-regulated accounting provisions outline the need for an independent regulatory body to set rates. We note that, since the government controls both the regulator and the regulated entities, it has significant influence on which costs Hydro One and OPG will recognize in a given year. This could ultimately affect both electricity rates and the annual deficit or surplus reported by the government.

In our previous Annual Reports, we outlined that the era of rate-regulated accounting appeared to be ending for jurisdictions like Canada because they were converting to International Financial Reporting Standards (IFRS), developed by the International Accounting Standards Board (IASB), in 2012. Our comments were based on the fact that, in January 2012, Canada's Accounting Standards Board (AcSB) reaffirmed that all government business enterprises should prepare their financial statements in accordance with IFRS for fiscal years beginning on or after January 1, 2012. At that time, IFRS standards did not include accounting provisions that addressed rate-regulated activities and so, by default, IFRS standards did not permit rate-regulated accounting.

However, the rate-regulated accounting landscape has continued to evolve since then. Efforts to harmonize US generally accepted accounting policies (US GAAP) and IFRS were in place as Canada converted to IFRS in 2012. At that time, US GAAP allowed for, and continues to allow for, rate-regulated accounting. The appropriateness of rate-regulated accounting has been discussed as part of the efforts to harmonize US GAAP and IFRS. As these discussions were taking place, Canada's AcSB granted a one-year extension in March 2012 to the mandatory IFRS changeover date for entities with qualifying rate-regulated activities. Multiple one-year extensions to defer adoption of IFRS by these entities followed over the next few years.

An interim IFRS standard—*IFRS 14, Regulatory Deferral Accounts*—was issued in January 2014 as an attempt to ease the adoption of IFRS for rate-regulated entities by allowing them to continue to apply existing policies for their deferred rate-regulated balances upon adoption of IFRS starting on January 1, 2015. Essentially, IFRS 14 provides a first-time adopter of IFRS with relief from having to derecognize their rate-regulated assets and liabilities until the IASB completes its comprehensive review on accounting for such assets and liabilities.

In July 2019, the IASB met to discuss the development of a new accounting model for regulatory assets and liabilities under IFRS. The proposed model's core principle is that an entity with rate-regulated activities applying IFRS recognizes regulatory assets and liabilities, along with the movement between its opening and ending balances as regulatory income and expense. While the model is similar in many ways to US GAAP in its recognition of regulatory assets and liabilities, it differs in some key respects.

The next phase of the IASB's review of rate-regulated accounting is to release an exposure draft of a new standard to replace IFRS 14. The IASB expects to publish the exposure draft in the first quarter of 2020. Until the issuance of the new standard, it is uncertain what financial impact the differences—between the standard and US GAAP—will have on

the accounting for regulatory assets and liabilities by government business enterprises.

The use of rate-regulated accounting in government business enterprises, such as OPG and Hydro One, has a significant impact on the government's financial statements. For example, OPG recognized $6.7 billion in net rate-regulated assets as of March 31, 2019. Future reporting under IFRS that does not accommodate rate-regulated accounting in a government business enterprise would increase the volatility of Hydro One and OPG's annual operating results. This in turn would lead to volatility in the province's annual deficit or surplus and may impact the government's revenue and spending decisions.

We will continue to monitor the development of standards impacting the use of rate-regulated accounting in government business enterprises.

10.3 Public Private Partnerships

In a traditional procurement, governments directly build and operate their infrastructure projects. This means that the government is accountable for all associated risks such as cost overruns, delays or financing risks. Public Private Partnerships (P3) is an alternative finance and procurement model for infrastructure projects that allows public-sector entities to transfer risks of the project to private-sector entities.

Under the P3 model, project sponsors in the public sector—such as provincial ministries, agencies or broader-public-sector entities such as hospitals and colleges— establish the scope and purpose of the project, while construction of the project is financed and carried out by the private sector. Payments for most projects are made either when the projects are substantially completed or at regular agreed-upon intervals. In some cases, the private sector will also be responsible for the maintenance and/or operation of a project for 30 years after its completion.

P3 contracts are complex. Each contract is unique and there are different levels of risks between the public and private sectors based on negotiated arrangements. PSAB issued a Statement of Principle on P3 accounting to provide additional guidance in July 2017, presenting key principles that PSAB expects to include in a future exposure draft that is expected to be released in fall 2019.

We will continue to monitor the development of standards impacting the use of public private partnerships.

11.0 Public Sector Accounting Board Initiatives

This section outlines some additional items that PSAB has been studying over the past year that might affect the preparation of the province's consolidated financial statements in the future.

11.1 Concepts Underlying Financial Performance

PSAB's existing conceptual framework is a set of interrelated objectives and fundamental principles that support the development of consistent accounting standards. Its purpose is to instill discipline into the standard-setting process to ensure that accounting standards are developed in an objective, credible and consistent manner that serves the public interest.

In 2011, PSAB formed the Conceptual Framework Task Force in response to concerns raised by several governments regarding current and proposed standards that they contend cause volatility in reported results and distort budget-to-actual comparisons. The task force's objective was to review the appropriateness of the concepts and principles in the existing conceptual framework for the public sector.

To this end, the task force issued three consultation papers: Characteristics of Public Sector Entities (2011), Measuring Financial Performance in Public Sector Financial Statements (2012) and Conceptual Framework Fundamentals and the Reporting Model (2015).

In May 2018, the task force issued a statement of concepts and a statement of principles. The statement of concepts proposed a revised conceptual framework that would replace two existing sections: PS 1000, Financial Statement Concepts and PS 1100, Financial Statement Objectives, while the statement of principles proposed changes to the current financial statement presentation.

PSAB plans to issue exposure drafts for a revised conceptual framework and a revised financial statement presentation standard in 2020.

11.2 Review of International Strategy

In its most recent strategic plan, PSAB signaled its intent to review its approach to International Public Sector Accounting Standards (IPSAS) as set out by the International Public Sector Accounting Standards Board (IPSASB).

In March 2018, PSAB issued a consultation paper to solicit input from stakeholders on the criteria that PSAB should apply in developing its international strategy. PSAB also presented four options for convergence with IPSAS.

In May 2019, PSAB issued a second consultation paper seeking feedback from stakeholders on which international strategy option best meets the Canadian public interest. The four international strategy options presented were:

- **Status quo:** PSAB continues with the existing standard-setting process. PSAB may continue to refer to the work of other standard-setters as desired.
- **Adapt IPSAS principles when developing future standards:** PSAB will continue to develop standards, but future standards must be developed based on IPSAS standards. PSAB will set out guidelines for circumstances in which a departure from IPSAS standards would be permitted.
- **Adapt IPSAS principles except when a departure is permitted:** All IPSAS standards will be adopted on a retroactive basis at a defined transition date. PSAB will develop guidance on when IPSAS might be modified.
- **Adopt IPSAS:** Full adoption of all IPSAS standards. PSAB would not have the ability to modify IPSAS standards for the Canadian environment.

PSAB accepted feedback on these proposals until September 30, 2019. PSAB intends to decide on the future of its international strategy by early 2020.

11.3 Asset Retirement Obligations

In March 2018, PSAB approved a new standard that addresses the reporting of legal obligations associated with the permanent removal of tangible capital assets from service (for example, retirement). The new standard, *PS 3280, Asset Retirement Obligations*, addresses tangible capital assets currently in productive use, such as the decommissioning of a nuclear reactor, as well as tangible capital assets no longer in productive use, such as solid-waste landfill sites.

The new standard is effective for fiscal periods beginning on or after April 1, 2021, although earlier adoption is permitted.

The new section requires that a retirement obligation be recognized in the following circumstances:

- There is a legal obligation to permanently remove retirement costs in relation to a tangible capital asset from service. Legal obligations can arise from legislation, contracts and promissory estoppel (the legal doctrine that stops a person from going back on a promise even if a legal contract does not exist, with the result that the benefit of the promise still goes to the party to whom the promise was made).
- The past transaction giving rise to the liability, such as the acquisition, construction, development or normal use of an asset, has already occurred.
- There is an expectation that future economic benefits will be given up.

- A reasonable estimate can be made. The estimate of the liability includes costs directly attributable to the retirement activities, including the post-retirement operation, maintenance and monitoring of the asset. A present-value technique is often the best method for estimating the liability.

Upon recognition of the liability, the entity would increase the carrying amount of the related tangible capital asset by the same amount as the liability. The cost included in the carrying amount of the tangible capital asset should be allocated to expense in a rational and systematic manner. This could include amortization over the remaining useful life of the related tangible capital asset, or a component thereof.

If the related asset is no longer in productive use, or if the related asset is not recognized for accounting purposes, the related retirement costs would be recorded as an expense.

11.4 Revenue

In June 2018, PSAB approved a new standard on the recognition, measurement and presentation of revenues. The new standard, *PS 3400, Revenue*, addresses revenues that arise in the public sector but fall outside of the scope of *PS 3410, Government Transfers* and *PS 3510, Tax Revenues*.

PS 3400 is effective for fiscal periods beginning on or after April 1, 2022, although earlier adoption is permitted.

Revenues from an exchange transaction are recognized as or when the public-sector entity satisfies the performance obligation. Performance obligations may be satisfied at a point in time or over a period of time, depending on which method best depicts the transfer of goods or services to the payor.

Unilateral revenues are recognized when there is the authority and a past event that gives rise to a claim of economic resources.

11.5 Employment Benefits

In December 2014, PSAB approved an Employment Benefits project to improve the existing PSAS sections by taking into account changes in the related accounting concepts and new types of pension plans that were developed since the existing sections were issued decades ago. The project aims to review the existing sections, *PS 3250, Retirement Benefits* and *PS 3255, Postemployment Benefits, Compensated Absences and Termination Benefits*.

In November 2016, PSAB issued an invitation to comment on the deferral of actuarial gains and losses. Governments and other public-sector entities need to make significant assumptions when valuing pension plan obligations and plan assets. Actuarial gains and losses measure the differences between these assumptions and the plans' experience, plus any updates to the assumptions. In the past, it was common accounting practice in Canada to defer such gains and losses over an extended period. However, over the past decade, other accounting frameworks in Canada have moved toward an immediate-recognition approach. The invitation to comment sought input from stakeholders as to whether deferral is still an appropriate choice in the public sector.

In November 2017, PSAB issued an invitation to comment on discount rates. The discount rate is a key economic assumption in measuring employment benefits. A small change in the discount rate can significantly impact the value of the benefit obligation and related expenses. The current guidance is not prescriptive and can result in a wide range of practices. The invitation to comment explored alternative approaches to determining the discount rate, including the market yield of high-quality debt instruments, an approach used by many other standard-setters.

In October 2018, PSAB issued a third invitation to comment addressing non-traditional pension plans. Non-traditional pension plans include joint defined-benefit plans, multiemployer and multiple-employer defined-benefit plans, plans that provide

target, rather than guaranteed, benefits, and plans with provisions that share risk between the employer and plan member.

The invitation to comment proposes that a government or other public-sector entity with a non-traditional pension plan recognize its share of the accrued benefit obligation in its financial statements, reflecting the substance of the terms in the plan and taking into consideration relevant factors, facts, events and circumstances.

PSAB accepted feedback from stakeholders until February 1, 2019.

11.6 Financial Instruments—Narrow-Scope Amendments

In January 2019, PSAB issued an exposure draft proposing narrow-scope amendments to *PS 3450, Financial Instruments*.

The most significant proposal in the exposure draft concerns the accounting for debt buybacks, also known as bond repurchase transactions. A government may issue a debt instrument and then purchase this debt through a secondary market. Under the existing guidance, this is accounted for as a debt extinguishment, resulting in the derecognition of both the asset and the liability in the government's financial statements. The exposure draft proposes that such bond repurchase arrangements not be derecognized until the debt instrument is legally cancelled, extinguished or discharged.

PSAB accepted feedback from stakeholders until May 1, 2019.

12.0 Statutory Matters

Under section 12 of the *Auditor General Act*, the Auditor General is required to report on any Special Warrants and Treasury Board Orders issued during the year. In addition, section 91 of the *Legislative Assembly Act* requires that the Auditor General report on any transfers of money between items within the same vote in the Estimates of the Office of the Assembly.

12.1 Legislative Approval of Expenditures

Shortly after presenting its budget, the government tables detailed Expenditure Estimates in the Legislative Assembly outlining, on a program-by-program basis, each ministry's planned spending. The Standing Committee on Estimates (Committee) reviews selected ministry estimates and presents a report on this review to the Legislature. Orders for Concurrence for each of the estimates selected by the Committee, following a report by the Committee, are debated in the Legislature for a maximum of two hours before being voted on. The estimates of those ministries that are not selected are deemed to be passed by the Committee, reported to the Legislature and approved by the Legislature.

After the Orders for Concurrence are approved, the Legislature still needs to provide its final approval for legal spending authority by approving a Supply Act, which stipulates the amounts that can be spent by ministries and legislative offices, as detailed in the estimates. Once the Supply Act is approved, the expenditures it authorizes are considered to be Voted Appropriations. The *Supply Act, 2019*, which pertained to the fiscal year ending March 31, 2019, received Royal Assent on March 26, 2019.

The Supply Act does not receive Royal Assent until after the start of the fiscal year—and sometimes even after the related fiscal year is over—so the government usually requires interim spending authority prior to its passage. For the 2018/19 fiscal year, the Legislature passed two acts allowing interim appropriations—the *Interim Appropriation for 2018-2019 Act, 2017* (Interim Act) and the *Supplementary Interim Appropriation for 2018-2019 Act, 2018* (Supplementary Act). These two acts received Royal Assent on December 14, 2017, and December 6, 2018, respectively, and authorized

the government to incur up to $138.8 billion in public-service operating expenditures, $5.8 billion in capital expenditures, and $294.2 million in legislative office expenditures. Both acts were made effective as of April 1, 2018, and provided the government with sufficient authority to allow it to incur expenditures from April 1, 2018, to when the *Supply Act, 2019*, received Royal Assent on March 26, 2019.

Because the legal spending authority under the Interim Act and the Supplementary Act was intended to be temporary, both were repealed when the *Supply Act, 2019*, received Royal Assent. The *Supply Act, 2019*, increased authorized public service operating expenditures from $138.8 billion to $140.7 billion and decreased total authorized public-service capital expenditures from $5.8 billion to $5.1 billion, while total authorized expenditures of the legislative offices remain unchanged at $0.3 billion.

12.2 Special Warrants

If the Legislature is not in session, section 1.0.7 of the *Financial Administration Act* allows for the issuance of Special Warrants authorizing the incurring of expenditures for which there is no appropriation by the Legislature or for which the appropriation is insufficient. Special Warrants are authorized by Orders-in-Council and approved by the Lieutenant Governor on the recommendation of the government.

No Special Warrants were issued for the fiscal year ending March 31, 2019.

12.3 Treasury Board Orders

Section 1.0.8 of the *Financial Administration Act* allows the Treasury Board to make an order authorizing expenditures to supplement the amount of any Voted Appropriation that is expected to be insufficient to carry out the purpose for which it was made. The order may be made only if the amount of the increase is offset by a corresponding reduction of expenditures to be incurred from other Voted Appropriations not fully spent in the fiscal year. The order may be made at any time before the government closes the books for the fiscal year. The government considers the books to be closed when any final adjustments arising from our audit have been made and the Public Accounts have been published and tabled in the Legislature.

Even though the *Treasury Board Act, 1991*, was repealed and re-enacted within the *Financial Administration Act* in December 2009, subsection 5(4) of the repealed act was retained. This provision allows the Treasury Board to delegate any of its duties or functions to any member of the Executive Council or to any public servant employed under the *Public Service of Ontario Act, 2006*. Such delegations continue to be in effect until replaced by a new delegation. Since 2006, the Treasury Board has delegated its authority for issuing Treasury Board Orders to ministers to make transfers between programs within their ministries, and to the Chair of the Treasury Board for making program transfers between ministries and making supplementary appropriations from contingency funds. Supplementary appropriations are Treasury Board Orders in which the amount of an appropriation is offset by a reduction to the amount available under the government's centrally controlled contingency fund.

Figure 13 summarizes the total value of Treasury Board Orders issued for the past five fiscal years.

Figure 14 summarizes Treasury Board Orders for the fiscal year ending March 31, 2019, by month of issue.

According to the Standing Orders of the Legislative Assembly, Treasury Board Orders are to be printed in *The Ontario Gazette*, together with explanatory information. At the time of writing, orders issued for the 2018/19 fiscal year were expected to be published in *The Ontario Gazette* in November 2019. A detailed listing of 2018/19 Treasury Board Orders, showing the amounts authorized and expended, is included in Exhibit 4 of this report.

Figure 13: Total Value of Treasury Board Orders, 2013/14–2017/18 ($ million)

Source of data: Treasury Board

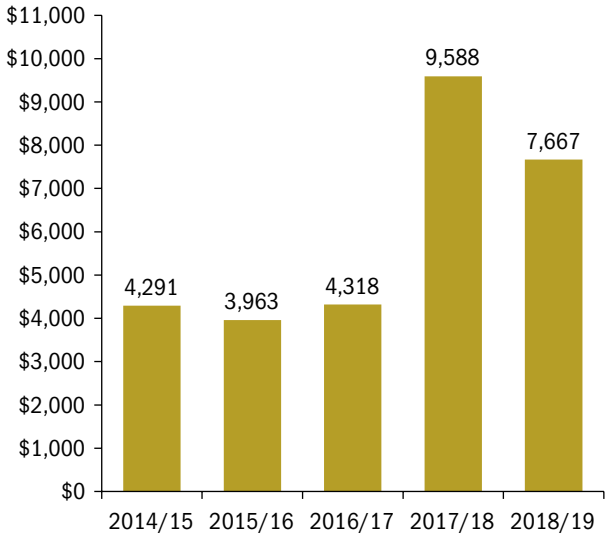


Figure 14: Total Value of Treasury Board Orders by Month Relating to the 2018/19 Fiscal Year

Source of data: Treasury Board

Month of Issue	#	Authorized ($ million)
April 2018–February 2019	28	3,209
March 2019	36	3,510
April 2019	22	285
May 2019	–	–
June 2019	6	663
Total	**92**	**7,667**

12.4 Transfers Authorized by the Board of Internal Economy

When the Board of Internal Economy authorizes the transfer of money from one item of the Estimates of the Office of the Assembly to another item within the same vote, section 91 of the *Legislative Assembly Act* requires that we make special mention of the transfer(s) in our Annual Report.

Accordingly, **Figure 15** shows the transfers made within Votes 201 and 202 with respect to the 2018/19 Estimates.

Figure 15: Authorized Transfers Relating to the Office of the Assembly, 2018/19 Fiscal Year

Source of data: Board of Internal Economy

From:		$
201-6	Sergeant at Arms and Precinct Properties	(52,300)
202-2	Office of the Information and Privacy Commissioner	(99,700)
202-3	Office of the Integrity Commissioner	(426,500)
To:		
201-13	Facility Upgrades	52,300
202-1	Environmental Commissioner	99,700
202-4	Office of the Provincial Advocate for Children and Youth	426,500

12.5 Uncollectible Accounts

Under section 5 of the *Financial Administration Act*, the Lieutenant Governor in Council, on the recommendation of the Minister of Finance, may authorize an Order-in-Council to delete from the accounts any amounts due to the Crown that are the subject of a settlement or deemed uncollectible. The amounts deleted from the accounts during any fiscal year are to be reported in the Public Accounts.

In the 2018/19 fiscal year, receivables of $608 million due to the Crown from individuals and non-government organizations were written off. (The comparable amount in 2017/18 was $353 million.) The write-offs in the 2018/19 fiscal year related to the following:

- $445.5 million for extinguishing a loan to Old Carco LLC (Chrysler LLC);
- $45.1 million for uncollectible receivables under the Student Support Program ($45.8 million in 2017/18);
- $24.3 million for uncollectible corporate tax ($43.2 million in 2017/18);
- $22.5 million for uncollectible clawback of a conditional grant under the Forest Sector Prosperity Fund;
- $19.2 million for uncollectible employer health tax ($17.1 million in 2017/18);

- $12.7 million for uncollectible receivables under the Ontario Disability Support Program ($34.4 million in 2017/18);
- $11.5 million for uncollectible retail sales tax ($25.4 million in 2017/18); and
- $27.2 million for other tax and non-tax receivables ($37.1 million in 2017/18).

There was no 2018/19 write-off for the 2017/18 $150-million write-off for extinguishing a loan to U.S. Steel Canada (Stelco).

Volume 1 of the 2018/19 Public Accounts summarizes the write-offs by ministry. Under the accounting policies followed in the preparation of the province's consolidated financial statements, a provision for doubtful accounts is recorded against accounts receivable balances. Most of the write-offs had already been expensed in the government's consolidated financial statements. However, the actual write-off in the accounts required Order-in-Council approval.

Chapter 3

Reports on Value-for-Money Audits

Our value-for-money (VFM) audits examine how well government ministries, organizations in the broader public sector, agencies of the Crown and Crown-controlled corporations manage their programs and activities. These audits are conducted under subsection 12(2) of the *Auditor General Act*, which requires that the Auditor General, an independent officer of the Legislative Assembly of Ontario, report on any cases where we have found money spent without due regard for economy and efficiency, or where appropriate procedures were not in place to measure and report on the effectiveness of service delivery. Where relevant, such audits also include compliance issues. In essence, VFM audits delve into the underlying operations of the ministry program or organization being audited to assess both their cost-effectiveness and the level of service they deliver to the public. This chapter contains the conclusions, observations and recommendations for the VFM audits conducted in the past audit year.

The ministry programs and activities and the organizations in the broader public sector audited this year were selected by the Office's senior management on the basis of selection criteria including the financial impact of a program or organization, its significance to the Legislative Assembly, related issues of public sensitivity and safety, and the results of past audits and related follow-up work.

We conducted our work and reported on the results of our examination in accordance with the Canadian Standard on Assurance Engagements—Direct Engagements issued by the Auditing and Assurance Standards Board of the Chartered Professional Accountants of Canada. These standards involve conducting the tests and other procedures that we consider necessary, including obtaining advice from external experts when appropriate to obtain a reasonable level of assurance.

Our Office applies Canadian Standards on Quality Control and, as a result, maintains a comprehensive quality control system that includes documented policies and procedures with respect to compliance with the code of professional conduct, professional standards and applicable legal and regulatory requirements. We have complied with the independence and other ethical requirements of the Code of Professional Conduct issued by the Chartered Professional Accountants of Ontario, which are founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.

Before beginning an audit, our staff conduct in-depth research into the area to be audited and meet with representatives of the auditee to discuss the focus of the audit, including our audit objectives and criteria. During the audit, staff maintain an ongoing dialogue with the auditee to review the progress of the audit and ensure open communications. At the conclusion of the audit fieldwork, significant issues are discussed with the auditee and a draft audit report is prepared. Senior audit staff then meet with senior management from the auditee to discuss the draft report and the management responses to our

recommendations. In the case of organizations in the broader public sector, discussions are also held with senior management of the funding ministry.

Once the content and responses for each VFM audit report are finalized, the VFM audit reports are incorporated as sections of this chapter of the Annual Report.

Ministry of Health

Acute-Care Hospital Patient Safety and Drug Administration

1.0 Summary

Although patients visit hospitals in order to address health concerns and receive health-care services, there are some instances where patients can be unintentionally harmed as a result of the care provided during their visit.

Patient safety refers to reducing the risk of patient harm through policies and procedures that hospitals design, implement and follow. Patient safety incidents—such as hospital-acquired infections and medication errors—can be caused by poorly designed systems and processes and unsafe human acts in the delivery of hospital care.

As of April 1, 2019, there were 141 public hospitals in Ontario, operating on a total of 224 sites. These include 123 acute-care hospitals, where patients primarily receive active short-term treatment; eight chronic-care and rehabilitation hospitals for patients with long-term needs; four specialty psychiatric hospitals; and six hospitals that provide a variety of out-patient and rehabilitation services. In this report we focused on patient safety in acute-care hospitals, and we use the word "hospitals" to refer only to acute-care hospitals.

Under the *Public Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and to take steps to prevent similar incidents from occurring in the future. Non-governmental organizations, such as Accreditation Canada, also inspect and accredit hospitals to assess whether they comply with standards that focus on patient safety.

Public hospitals in Ontario are corporations accountable to their own boards and directly responsible for their own day-to-day management. Hospitals are required by law to monitor and report on various patient safety indicators, and to comply with relevant standards and legislation.

Hospital data collected by the Canadian Institute for Health Information shows that each year, among the more than 1 million patient discharges from Ontario acute-care hospitals, on average approximately 67,000 patients were harmed during the hospital stay. Between 2014/15 and 2017/18, nearly six of every 100 patients experienced harm while in hospital. This is the second-highest rate of hospital patient harm in Canada, after Nova Scotia.

Public concern with the safety of health care has increased in recent years due to growing research on the impact that medical errors and hospital-acquired infections have on patients and on the health-care system.

While the vast majority of patients in Ontario receive safe care in hospital, and the acute-care hospitals we visited are committed to patient safety, our audit found that more can be done to improve patient safety. Current laws and practices in Ontario make it difficult for hospitals to address concerns with the safety of care provided by some nurses and doctors. Staff survey results at Ontario

hospitals varied significantly, rating Ontario hospital patient safety practices from excellent to poor and failing, and many hospitals did not fully comply with required patient safety practices.

Among our significant findings:

- **Current practices in Ontario put confidentiality about nurses' poor performance ahead of patient safety.** Non-disclosure arrangements negotiated by unions with hospitals can result in potential new employers not being made aware of a nurses' poor past performance. Because of concerns about potential civil legal actions, during an employment reference check hospitals may not freely share with potential employers a nurse's complete and truthful employment and performance history. We found that such practices can mislead hiring hospitals and pose an increased risk to patient safety. For instance, on October 16, 2018, one hospital fired a nurse for a very serious breach of mandatory patient care standards resulting in a patient's death. The hospital reported the termination a few days later to the College of Nurses of Ontario. However, as of July 31, 2019, the College had not yet completed its investigation. The termination was treated as a resignation and the nurse currently works for another hospital. Some jurisdictions in the United States have specific legislation in place that protects hospitals from liability associated with any civil legal action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.
- **Nurses who hospitals have found lack competence and who have been terminated or banned continue to pose a risk to patient safety.** We reviewed a sample of nurses who were terminated for lack of competence and/or inappropriate conduct, and agency nurses that were banned, in the past seven years in nine of the 13 hospitals we visited. (Agency nurses who are found incompetent may be banned by a hospital.) After their first termination or banning, 15 of the nurses subsequently worked at another hospital or for another agency. We noted that four of them were either subsequently terminated or banned again for lack of competence. For example, one nurse who currently works as an agency nurse was, between May 2016 and March 2019, terminated from two hospitals and also banned from a third hospital for lack of competence.
- **Information about nurses available to prospective employers limits the employers' ability to assess past performance issues.** The *Regulated Health Professions Act* limits the information the College of Nurses of Ontario is able to share with hospitals and with any other member of the public with respect to reports received about nurses terminated by other hospitals. Hospitals have also informed us that if they contact the College to obtain information about a prospective nurse employee, they are usually referred to the nurse's public profile, which does not have information on ongoing investigations and may have incomplete information. Therefore, when hospitals or agencies hire these nurses they do not have access to a complete record of their past employment history and performance issues.
- **As noted in our 2016 audit of Large Community Hospital Operations, hospitals are not able to quickly and cost-effectively terminate physicians who hospitals have found lack competence.** In our 2016 audit, we recommended that the Ministry evaluate this problem. However, in our current audit, we found that this problem still persists. For instance, the disciplining of one physician who a hospital found to have practice issues took about four years and cost the hospital over $560,000. An ongoing disciplinary process against this same physician at a second and third hospital,

where the physician currently works, has so far cost the two hospitals over $1 million. In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers through the liability insurance reimbursement program through which the Ministry reimburses physicians for enrolling in the Canadian Medical Protective Association that provides lawyers to represent physicians. We noted that in 2016/17, the Ministry of Health reimbursed physicians $256 million for costs of the Medical Liability Protection Reimbursement Program. In 2017/18, the amount was $326.4 million, an increase of $70.4 million, or 27.5%.

- **Patient safety culture at different hospitals varies significantly, from excellent to poor and failing.** We obtained the most recent staff survey results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."
- **Patient safety "never-events" have occurred at six of the hospitals we visited.** Health Quality Ontario and the Canadian Patient Safety Institute have identified 15 patient safety "never-events"—incidents that could cause serious patient harm or death and that are preventable using organizational checks and balances. According to these organizations, these events should never occur in hospitals. Yet we found that since 2015, 10 out of the 15 never-events have occurred a total of 214 times in six out of the 13 hospitals that we audited. However, we found that none of the six hospitals set any targets in their quality improvement plans to eliminate the occurrence of these events. One hospital we audited, Humber River Hospital, estimated that by reducing the occurrence of pressure ulcers—including serious pressure ulcers, one of the most common never-events—by about half, the hospital could save between $1.8 million to $3.7 million over two years. We also found that unlike hospitals in Saskatchewan and Nova Scotia, which are required to report never-events to their health ministries, Ontario hospitals are not required to track or report never-events to Health Quality Ontario, Local Health Integration Networks or the Ministry.
- **Between 2014 and 2019, over half of hospitals did not fully comply with required patient safety practices.** We obtained from 114 acute-care hospitals their most recent Accreditation Canada report between 2014 and 2019 and found that 18 hospitals did not comply with five or more required practices that are central to quality and patient safety. For example, Accreditation Canada found that some hospitals did not have strategies in place to help prevent patient falls and pressure injuries, while other hospitals did not meet the required communication practice to ensure that information is transferred when patients move between care units within the hospital. Washing and sterilization of reusable surgical tools and medical devices is an area where hospitals did not fully meet a significant number of high-priority criteria for infection prevention. If these practices are not complied with, a hospital is required to submit evidence of corrective actions to Accreditation Canada. Nevertheless, as Accreditation Canada conducts its visits every four years, it is unknown for how long prior to the visit hospitals did not have these required patient safety practices in place.
- **Hospital pharmacies do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications, but compliance is**

improving. In 2013, 1,202 hospital patients at four hospitals in Ontario—Windsor, London, Lakeridge and Peterborough—were infused with the wrong concentration of chemotherapy medication. In response to this incident, the College started annual inspections of hospital pharmacies in 2014 to assess their compliance with standards aimed at ensuring patient safety. Yet in 2018, hospital pharmacies on average fully met less than half of the 50 standards, which relate to the sterile preparation and mixing of intravenous medications. In response to the College's requirement for improvement, early inspection results from 2019 shared with us by the College showed that pharmacies' compliance has improved. However, on our visits to five hospitals, we found that some hospitals are not properly cleaning and disinfecting their sterile-rooms and the equipment used in the preparation and mixing of intravenous medications.

- **Hospitals do not always follow best practices for medication administration.** From 2012 to 2018, hospitals in Ontario reported to the Canadian Institute for Health Information 154 critical patient safety incidents involving administration of medications. Thirty-nine of these incidents resulted in a patient's death. We found that three of the hospitals we visited did not always comply with best practices for the administration of high-risk medications, such as using an independent double-check to verify medication and dosage, witnessing patients taking and swallowing medications, or confirming the identities of patients. Our expert told us that not following these best practices increases the likelihood of patient harm and/or death.
- **Hospitals do not always follow best practices for nursing shift changes that could reduce the risk of medication errors.** We found that six out of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes, which recommends, if possible, conducting shift changes at the patient's bedside and involving the patient and the family (with the consent of the patient) in the process. In this way, the patient and/or family can identify any missing information or miscommunication between the nurses during shift change that could, for example, lead to medication administration errors causing patient harm.
- **Hospital staff may not be washing their hands as frequently as reported.** Although in 2018/19, hand-washing compliance before patient contact and after patient contact reported by hospitals was about 90% and 93%, respectively, we found that these results may be inflated due to the way they are observed and recorded. One hospital study found that hospital staff washed their hands 2.5 times more often when they saw an auditor observing and recording their hand-washing rate than when an auditor was not identifiable. Another study found that while the hand-washing compliance rate as observed by the auditor was 84%, the rate as observed by covert observation auditors was actually 50%. Hospital-acquired infections such as *C. difficile* are commonly spread via the hands of health-care workers. One hospital estimated that patients who acquired *C. difficile* while in its hospital required additional treatment costing an average of $9,000 per patient, or $1.6 million overall. In the past five years, 12,208 hospital-acquired *C. difficile* infections were reported in Ontario, an average of about 2,440 people each year. This suggests the additional treatment costs to the provincial health-care system as a result of these infections are substantial.

This report contains 22 recommendations, with 38 action items, to address our audit findings. **Appendix 8** lists our recommendations, and shows the stakeholders they are addressed to.

Overall Conclusion

Our audit concluded that the hospitals we visited have effective processes in place to investigate and learn from patient safety incidents. However, the Ministry and hospitals are not doing all that could be done to improve patient safety. Nurses that hospitals have found lack competence and who have been terminated or banned are rehired at other hospitals and/or agencies and continue to pose a risk to patient safety, because confidentiality about nurses' poor performance is put ahead of patient safety. Hospitals are not able to quickly and cost-effectively deal with physicians who hospitals find lack competence and harm patients. Hospitals do not always comply with some required patient safety practices and standards. For example, staff do not wash their hands as frequently as required, which contributes to the spread of hospital-acquired infections among patients, and best practices are not always followed when medications are administered to patients and during nurse shift changes, which contributes to medication administration errors. Hospital pharmacies also do not fully comply with their own standards for the sterile preparation and mixing of hazardous chemotherapy and non-hazardous intravenous medications.

OVERALL RESPONSE FROM OHA

The Ontario Hospital Association (OHA) appreciates the Auditor General's work to enhance patient safety. Patient safety remains the most important priority for Ontario hospitals, and every effort is made to ensure that patients and clients receive the highest-quality care possible.

Over the past decade, Ontario hospitals have been seeking to embed a culture of safety and quality within their organizations. Hospitals have worked closely with Accreditation Canada and others to implement best practices on quality and safety. This includes making required changes to high-priority areas like organizational culture, incident disclosure and management, medication reconciliation, surgery checklists, infection control and risk assessment.

Hospitals are also required to create and share an annual Quality Improvement Plan that provides measurable targets and have a Quality Committee at the board level, making a strong statement about the permanence of quality as an organizational strategy. Most importantly, hospitals routinely undertake comprehensive reviews of patient safety and critical incidents, which is an important part of quality improvement efforts in hospitals. While significant foundational progress has been made, Ontario hospitals recognize that there is still more to do.

The recommendations included in the Auditor General's 2019 report provide an opportunity for hospital leadership to reflect on what's needed within their organizations to further improve patient safety. In addition to existing work, the OHA will continue to share best practices, support hospital boards as they work to identify areas of improvement within their organizations, and work closely with the Ministry of Health and other patient safety stakeholder organizations as changes are made to improve safety and quality system-wide.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) appreciates the comprehensive audit conducted by the Auditor General and welcomes the recommendations in the report. The safety of Ontario's patients is of utmost concern to the Ministry, and it is committed to a safe and reliable publicly funded hospital system.

The safety of Ontario's patients is a responsibility shared by providers, organizations, health system associations and the Ministry. Although the Ministry recognizes that there continues to be a need for improvements, steps have been taken to strengthen patient safety in health-care institutions across the province.

Ontario Health has a clear mandate to provide leadership on patient safety, through the public reporting of patient safety data and the development of clinical and quality standards for patient care and safety.

Key investments in quality improvement have also led to the delivery of safer, more reliable care in hospitals across the province. For instance, the Ministry has supported the implementation of the National Surgical Quality Improvement Program—Ontario.

Ontario hospitals that participated in the program reported better outcomes, shorter patient hospital stays and fewer surgical complications. As of March 2019, the province saw a 27% reduction in post-surgical infections among participating hospitals. This program also led to a 51% reduction in the rate of post-surgical urinary tract infections.

Performance on key patient safety indicators has also improved. According to 2017/18 data published by the Canadian Institute for Health Information, Ontario performs as well or better than the Canadian average on obstetric trauma, worsened pressure ulcers in long-term care, falls in the last 30 days in long-term care, and potentially inappropriate medication prescribed to seniors.

The Ministry will continue to identify opportunities for improvement in partnership with front-line providers and support institutions across the province as they work to deliver safe and reliable to care.

2.0 Background

2.1. Overview of Hospital Patient Safety

Patient safety practices are the set of policies and procedures hospitals have in place to reduce the risk of patient harm. Incidents of patient harm can be organized into the four types listed in **Figure 1**.

2.1.1 Hospital Patient Harm Statistics

Canada

Conducted in 2004, the *Canadian Adverse Events Study* remains the most comprehensive study of patient safety in Canada to date. This foundational study of patient safety across 20 hospitals in Canada, four of which are located in Ontario, found that 7.5% (187,500) of all (2.5 million) hospital patients admitted annually to hospitals in Canada were unintentionally harmed by the care

Figure 1: Four Types of Patient Harm Incidents and Examples of Each

Source of data: Canadian Institute for Health Information and Canadian Patient Safety Institute

Type	Example
1. **Health-Care/Medication-Related Incidents** Harm related to general care provided and/or medication administered during a hospital stay.	A nurse administers the wrong medication to a patient.
2. **Hospital-Acquired Infections** Infections acquired during a hospital stay, including those related to or following a medical or surgical procedure.	A patient acquires a blood infection while receiving medication intravenously (directly into the vein).
3. **Patient Accidents** In-hospital injuries (e.g., fractures, dislocations, burns) due to an accident, not directly related to medical or surgical procedures.	An elderly patient slips and falls in the hallway, resulting in a hip fracture.
4. **Procedure-Related Incidents** Surgical and medical procedure errors and abnormal reactions to or complications from, surgical or medical procedures.	A sponge or instrument is mistakenly left inside the patient following a surgery.

Figure 2: Hospital Patient Harm Rate in International Jurisdictions and Canada
Prepared by the Office of the Auditor General of Ontario

Country	Patient Harm Rate (%)	Year Study Published
United States	7.7	2013
United States	13.5	2010
Spain	8.4	2006
Australia	8.3	2006
Canada	7.5	2004

they received in hospitals. The result for these patients was longer hospital stays and, in some cases, disability. The study also found that in one year, between 9,000 and 24,000 deaths caused by patient safety incidents could have been prevented. A more recent 2016 study, *Measuring Patient Harm in Canadian Hospitals*, found that on any given day, more than 1,600 hospital beds across Canada are occupied by a patient who suffered harm that extended their hospital stay. As seen in **Figure 2**, Canada's patient harm rate is similar to the rates reported in other international jurisdictions, such as the United States, Australia and Spain.

Ontario

Between April 2014 and March 2018, Ontario acute-care hospitals reported to the Canadian Institute for Health Information, a not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians, almost 270,000 individual preventable patient harm incidents. One of the most common types of incidents is infections. In **Figures 3** and **4** we compare Ontario's results to the other provinces' and territories' results for the years 2014/15–2016/17. **Figure 3** compares the average number of hospital discharges per year with at least one occurrence of patient harm, and **Figure 4** shows the annual rate of occurrences of patient harm per 100 hospital discharges.

Ontario has the highest average number of discharges with at least one occurrence of harm in Canada. Comparatively, the province's 5.8% rate of hospital harm is the second-highest in Canada.

2.1.2 Hospital Patient Safety Governance Structure

Ontario hospitals are corporations accountable to their own boards and directly responsible for their own day-to-day management. Under the *Excellent Care for All Act, 2010* (Act), hospitals are required to:

- establish a service quality committee of the board, responsible for monitoring and reporting to the board on the overall quality of services and safety of care provided;
- develop annual quality improvement plans, which outline how a hospital will improve the quality of care it provides in the coming year;
- conduct regular surveys of patients and staff to assess patient safety and quality of care culture; and
- investigate all patient safety incidents and take steps to prevent similar incidents from occurring in the future.

Governance

Under the *Public Hospitals Act, 1990*, and the *Excellent Care for All Act, 2010*, hospitals must establish governance and reporting structures to monitor and address patient safety concerns. **Appendix 1** shows an example of the governance structure and required committees for Ontario hospitals, and describes their key responsibilities.

Depending on the hospital's size, the complexity of offered care services and the hospital's resources, hospitals could establish additional internal subcommittees and working groups to address patient safety issues.

Each hospital is required to enter into a Service Accountability Agreement with its Local Health Integration Network. This agreement outlines a hospital's accountability and performance expectations and includes measurement and

Figure 3: Provincial and Territorial Average Acute-Care Hospital Discharges per Year with at Least One Occurrence of Harm, 2014/15–2016/17

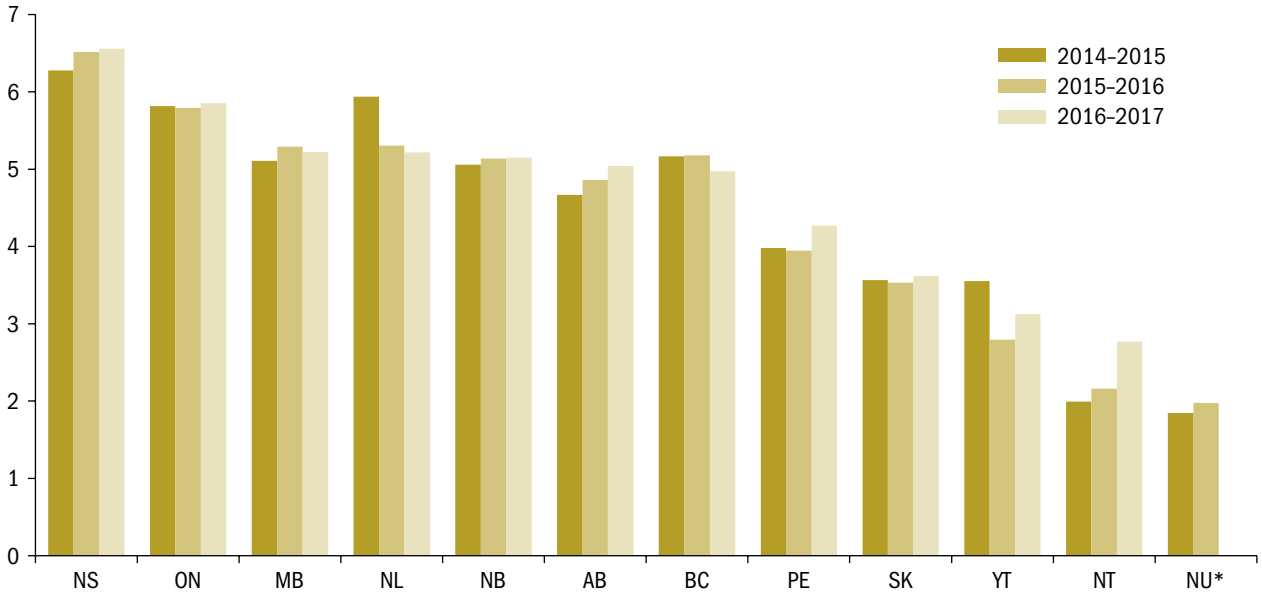
Source of data: Canadian Institute for Health Information

Province/Territory*	Average # of Discharges per Year	Average # of Discharges per Year with at Least 1 Occurrence of Harm	Rate of Discharges with Harm (%)
Nova Scotia	89,458	5,770	6.5
Ontario	**1,150,194**	**66,951**	**5.8**
Newfoundland and Labrador	52,165	2,861	5.5
Manitoba	125,868	6,554	5.2
British Columbia	412,049	21,033	5.1
New Brunswick	80,817	4,133	5.1
Alberta	384,487	18,666	4.9
Prince Edward Island	14,243	579	4.1
Saskatchewan	134,338	4,798	3.6
Yukon	3,170	100	3.2
Northwest Territories	4,804	111	2.3
Nunavut	1,754	34	1.9

* Data from Quebec is excluded due to methodological issues.

Figure 4: Provincial and Territorial Annual Rate of Occurrences of Harm per 100 Acute-Care Hospital Discharges, 2014/15–2016/17

Source of data: Canadian Institute for Health Information



* Patient harm data is not available for Nunavut for 2016/17.

evaluation requirements for the health services that it provides. On February 26, 2019, the Ontario Minister of Health announced the creation of a central agency called Ontario Health to oversee the province's health-care system. The 14 Local Health Integration Networks and six provincial health agencies, including Cancer Care Ontario and eHealth Ontario, will be integrated into Ontario Health. Transition to Ontario Health began in spring 2019 and will continue until full integration is reached. In this report, our recommendations are addressed to the Ministry of Health. Ontario Health may take on responsibility for implementation of these recommendations in the near future.

2.1.3 Patient Safety Standards and Best Practices

To support the overall objective of promoting patient safety and preventing patient harm, hospitals follow patient safety standards and best practices developed by several different federal, provincial and not-for-profit organizations. Some standards and best practices pertain to specific areas of care, such as surgery, or to specific departments within the hospital, such as the hospital pharmacy. Other risk areas pertain to the hospital as a whole, such as infection prevention and control. These risk-specific standards and best practices are shown in **Appendix 2**. Other legislated requirements apply to the hospital as a whole, such as establishing a quality committee to monitor the overall quality of services provided, and surveying staff and patients with respect to the quality of care. These organization-wide requirements are shown in **Appendix 3**.

One of the main organizations that promotes patient safety best practices is Accreditation Canada. Every four years, this non-governmental, not-for-profit organization visits and accredits all 141 (123 acute-care) hospitals in Ontario, as well as other health-care facilities, against national standards. The visits are conducted to assess hospitals' compliance with all applicable standards and the required practices in six patient safety areas. The required practices in these six patient safety areas are summarized in **Appendix 4**.

Depending on the size and complexity of the hospital, Accreditation Canada's on-site visit at an Ontario hospital may last from two to six days, with an average visit of four days. During the visit, surveyors use direct observation and interaction with patients, families and health-care providers to gather evidence about the quality and safety of care and services.

In **Appendix 5,** we list other key organizations involved in setting and promoting patient safety best practices and standards.

2.1.4 Reporting on Hospital Patient Harm

Hospitals report various patient safety statistics to different organizations, both government and not-for-profit. Some of the reporting is mandatory, whereas other information is reported voluntarily. **Figure 5** lists the mandatory reporting of patient safety information by hospitals. **Figure 6** lists the voluntary reporting of patient safety information by hospitals.

2.1.5 Nurses Deliver Most Hospital Patient Care

About 182,000 nurses provide care in Ontario, of whom about 89,000 work in hospitals (74,000 in acute-care hospitals). Nurses comprise the largest single component of hospital staff and provide hands-on care to patients at their bedside by administering medications, managing intravenous lines, observing and monitoring patients' conditions and behaviour, maintaining patient records and communicating with other members of the health-care team.

Most nurses are employees of the hospital. However, at times of nurse shortages, some hospitals recruit additional temporary nurses from external agencies. These nurses are not employees of the hospital, and the hospital pays the agencies for the

Figure 5: Mandatory Reporting of Patient Safety Information by Hospitals

Prepared by the Office of the Auditor General of Ontario

Reported To	Required By	Information Reported
Ministry of Health/Health Quality Ontario	*Public Hospitals Act, 1990* (Regulation 965)	**Publicly Reportable Patient Safety Indicators** • Hospital-acquired *Clostridium difficile* rate • Rate of ventilator-associated pneumonia • Central-line infection rate • Rate of hospital-acquired Methicillin-resistant *Staphylococcus aureus* bacteremia • Vancomycin-resistant *Enterococci* infection rate • Hospital Standardized Mortality Ratio: actual deaths compared to expected deaths • Surgical Site Infection Prevention for hip and knee joint replacement surgeries • Hand Hygiene Compliance • Surgical Checklist Compliance
Local Health Integration Network/ Ministry of Health	Hospital Service Accountability Agreement	**Contractual Performance Obligations** • Hospital-acquired *Clostridium difficile* rate • Hospital Standardized Mortality Ratio • Rate of ventilator-associated pneumonia • Central-line infection rate • Rate of hospital-acquired Methicillin-resistant *Staphylococcus aureus* bacteremia
Health Quality Ontario	*Excellent Care for All Act, 2010*	**Quality Improvement Plans (QIPs)** Annual plans include mandatory, recommended and other indicators, including: • workplace violence incidents • medication reconciliation at discharge • medication reconciliation at admission • physical restraints in mental health • antimicrobial-free days
Local Health Integration Network/ Ministry of Health	Hospital Service Accountability Agreement	**Quality-Based Procedures** • Cataract surgery complications • Mortality rate from chronic obstructive pulmonary disease • Mortality rate and hospital readmission associated with congestive heart failure • Post–hip fracture surgery re-fractures and mortality rate • Post–hip/knee replacement readmission and morality rate • Stroke patient rate of readmission
Public Health Ontario	*Health Protection and Promotion Act, 1990*	**Hospital Infections** Statistics on various infections
Health Canada	Bill C-17, Protecting Canadians from *Unsafe Drugs Act* (Vanessa's Law)	**Drug Reactions** Serious adverse drug reaction (e.g., allergies) that involves a therapeutic product, or a medical device incident that involves a therapeutic product
Canadian Institute for Health Information	Ministry of Health directive	**Critical Incident Reporting** Medication and intravenous errors that result in death or serious harm
Canadian Institute for Health Information	*Public Hospitals Act, 1990*	**Hospital Harm** Reported as part of Discharge Abstract Database. Number of occurrences of patient harm—31 types of harm (infections, bed sores, objects left inside patients, etc.)

Figure 6: Voluntary Reporting of Patient Safety Information by Hospitals
Prepared by the Office of the Auditor General of Ontario

Report To	Description (Current Reporting)
American College of Surgeons and Health Quality Ontario	**National Surgical Quality Improvement Program—Ontario*** Surgical safety: Statistics on surgical problems such as site infections, leaving items inside the patient, post-operative complications and death and other surgery-related incidents
Institute for Safe Medication Practices Canada	**Canadian Medication Incident Reporting and Prevention System** Medication incidents
Canadian Institute for Health Information	**National System for Incident Reporting** Medication and radiation treatment incidents
Healthcare Insurance Reciprocal of Canada	**Incidents Resulting in Litigation** As hospital's insurance provider, has access to incident cases. Develops and distributes risk mitigation strategy plans
Canadian Patient Safety Institute (CPSI)	**Patient Safety Incidents** Hospitals may share patient safety incident information with the CPSI so they can develop best practices and other documents

* The program is made up of 46 Ontario hospital sites representing up to 80% of all adult surgeries in the province.

hours worked by the agency nurses. Nursing agencies are unregulated, and many agencies operate in Ontario. In 2017 (the latest available information), they employed about 4,600 nurses.

Personal support workers also provide hands-on care to hospital patients; however, this care is restricted to assisting patients with activities of daily living such as feeding, changing, bathing and mobility assistance. Under specific conditions, personal support workers are allowed to administer medications, but the procedure must be delegated and overseen by a nurse and/or be a routine activity for the patient.

2.1.6 College of Nurses of Ontario

Nurses working in Ontario must be registered by the College of Nurses of Ontario. The College regulates the nursing profession in Ontario and is responsible for disciplining nurses who are found to have committed an act of professional misconduct. Between 2014 and 2018, the College revoked the licences of 37 nurses. The College maintains a publicly available database that contains disciplinary decisions posted by the College and information self-reported by nurses, such as their place of employment.

2.1.7 Physicians

There are about 37,000 physicians in Ontario. To practise medicine in Ontario, physicians must be members of the College of Physicians and Surgeons of Ontario, which regulates the practice of medicine to protect and serve the public interest. In a hospital, physicians are generally responsible for diagnosing diseases and health conditions, prescribing medication, performing medical procedures, including surgeries, and monitoring patients' health. Physicians report to the hospital's Chief of Staff. Hospitals consider physicians to be independent contractors, and grant them hospital privileges that give them the right to use hospital facilities and equipment to treat patients, without being hospital employees. A hospital's Board of Directors is responsible for appointing, disciplining and terminating physicians.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether acute-care hospitals achieve patient safety by:

- ensuring that staff have processes in place that support the safe and appropriate use of equipment, procedures and medication in delivering medical care to patients;
- implementing effective processes and systems to identify and reduce the risk of patient harm; and
- identifying, reporting and responding to incidents of patient harm (including learning from past incidents and taking steps to prevent them from recurring).

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry of Health and the hospitals we visited reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and September 2019. We obtained written representation from the Ministry of Health (Ministry) and hospital management that, effective November 14, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusions of this report.

Our audit work was conducted at hospitals of various sizes in regions across the province. See **Appendix 7** for a list of the hospitals we visited as part of the audit, and the areas of the hospitals we focused on during the visits.

To gain a fuller perspective of patient safety, we also consulted with many stakeholders, and reviewed relevant journals, reports and other related documentation. In addition to visiting the hospitals described above, our audit team:

- interviewed relevant stakeholder groups, including Public Health Ontario, Health Quality Ontario, the Canadian Patient Safety Institute, the Institute for Safe Medication Practices Canada, the Ontario Nurses Association, the Ontario Hospital Association, the Patient Ombudsman and Accreditation Canada;
- met with Dr. Ross Baker, lead researcher of the landmark 2004 *Canadian Adverse Events Study: the incidence of adverse events among hospital patients in Canada*;
- met with the Deputy Chief Coroner of Ontario, Dr. Reuven Jhirad, to discuss provincial perspectives and statistics on deaths resulting from patient harm incidents;
- performed multiple walkthroughs at one Toronto-area hospital and at two Peel-area hospitals to gain an understanding of relevant hospital departments and processes in advance of our fieldwork;
- reviewed many patient safety journal articles and research papers from several jurisdictions, including Canada, the United States and the United Kingdom;
- reviewed all publicly available statistics on patient harm in Ontario and co-ordinated a request through the Canadian Institute for Health Information for additional non-public statistics; and
- obtained and reviewed the most recent safety reports from all Ontario hospitals, including:
  - hospital accreditation (assessment against required patient safety practices);
  - patient safety staff survey (staff feedback on how safe the care is at their hospital);
  - risk assessment (high-risk areas based on liability claims against the hospital);
  - hospital pharmacy inspection (annual assessment against standards); and
  - other third-party assessments of hospital laboratories, medical testing facilities and medical equipment sterilization facilities.

During our hospitals visits, we reviewed patient files, medication documentation, hospital policies, incident investigation files, human resource files, and board and committee meeting minutes. Our audit work on nurses related to only the nine hospitals we visited with respect to human resources. We also engaged a consultant with expertise in the field of medication safety and nursing patient safety best practices to assist us on this audit.

4.0 Detailed Audit Observations

Our audit focused on five areas relating to patient safety, as shown in **Figure 7**. Our findings address these areas.

4.1 Focus on Patient Safety Not Consistent between Hospitals

As defined by the World Health Organization, "quality of care" is "the extent to which health-care services provided to individuals and patient populations improve desired health outcomes. In order to achieve this, health care must be safe, effective, timely, efficient, equitable and people-centred." Patient safety is therefore included as a dimension in quality of care.

We found that "patient safety" is not explicitly stated in the mission, vision and core values for most hospitals that we visited in a way that would foreground the phrase as the foundation for the organizational culture of these hospitals.

We expected that patient safety and quality of care would be one of the key priorities that would be clearly stated in each hospital's mission, vision and core values. However, when we reviewed the mission, vision and core values of the 13 hospitals we audited, we found that not all of them made a clear and direct reference to patient safety and quality of care. The other hospitals mention quality, excellence and compassion—but not specifically patient safety.

We also found that Ontario hospital survey results show that staff ratings on overall patient safety at hospitals vary significantly, from excellent to poor and failing.

4.1.1 Staff Survey Results Show Patient Safety Culture at Different Hospitals Varies from Excellent to Poor

According to the Canadian Patient Safety Institute, workplace culture influences patient safety both directly by determining accepted practice and indirectly by acting as a barrier or enabler to the adoption of behaviours that promote patient safety.

Under the *Excellent Care for All Act, 2010*, hospitals are required to survey staff and patients with respect to the quality and safety of care provided at the hospital. As part of their four-year accreditation cycle, hospitals use the mandatory patient safety culture survey provided by Accreditation Canada.

We obtained the most recent surveys results from all 123 acute-care hospitals in Ontario, completed between 2014 and 2019, and found that as many as nine in 10 staff at some hospitals graded their hospital as "very good" or "excellent" with respect to patient safety. However, at other hospitals, as many as one in three staff graded their hospital as "poor" or "failing."

Figure 8 lists the five hospitals where staff gave the best overall assessment of patient safety culture at their hospital and the five hospitals with the highest proportion of surveyed staff who graded their hospital as poor or failing with respect to patient safety. The five hospitals with the best overall patient safety culture were all smaller hospitals with less than 250 surveyed staff. **Figure 9** shows five large hospitals (those with 499 or more surveyed staff) with the best overall staff assessment of patient safety. In **Appendix 9,** we include the survey results for all 123 acute-care hospitals.

Figure 7: Five Patient Safety Areas of Audit Focus

Prepared by the Office of the Auditor General of Ontario

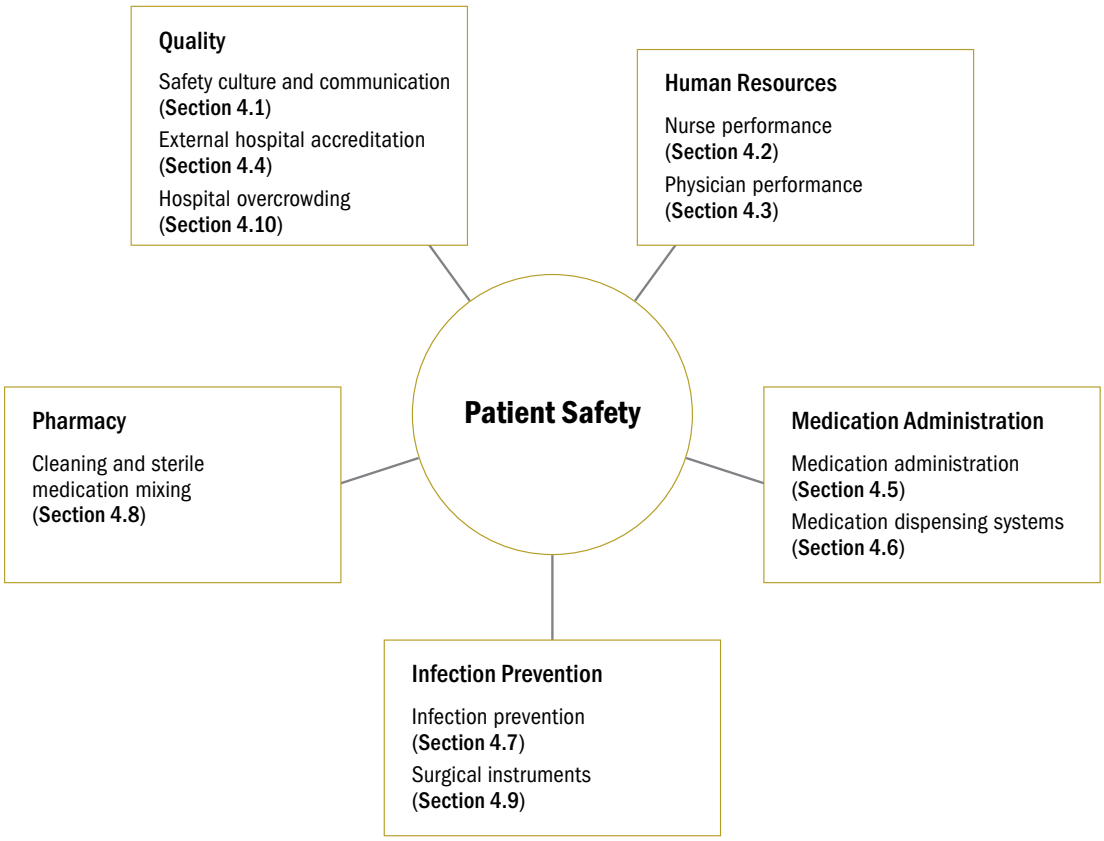


Figure 8: Five Acute-Care Hospitals with Best Overall and Worst Overall Patient Safety Culture Staff Survey Results, 2014–2019

Source of data: Ontario Hospitals

Hospital	Survey Year	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
Best						
Services de Santé de Chapleau Health Services	2016	74	89	8	3	**100**
Hanover and District Hospital	2017	113	81	16	3	**100**
St. Francis Memorial Hospital	2016	82	84	14	2	**100**
Renfrew Victoria Hospital	2017	228	80	18	2	**100**
Hôpital Notre-Dame Hospital	2017	60	82	15	3	**100**
Worst						
Brant Community Healthcare System	2017	462	28	39	33	**100**
London Health Sciences Centre	2016	502	38	38	24	**100**
Southlake Regional Health Centre	2014	503	42	34	24	**100**
Joseph Brant Hospital	2018	530	36	42	22	**100**
Humber River Hospital	2016	995	41	38	21	**100**

Note: Survey results based on staff perceptions at a point in time.

Figure 9: Five Large Acute-Care Hospitals with Best Overall Patient Safety Culture Staff Survey Results, 2014–2019

Source of data: Ontario Hospitals

Hospital	Survey Year	#of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
Woodstock Hospital	2016	499	70	26	4	**100**
The Hospital For Sick Children	2016	2,014	70	27	3	**100**
Sinai Health System	2015	751	68	29	3	**100**
University of Ottawa Heart Institute	2017	658	66	30	4	**100**
Sunnybrook Health Sciences Centre	2016	1,434	66	30	4	**100**

Note: Survey results based on staff perceptions at a point in time.

RECOMMENDATION 1

To further emphasize patient safety as a foundation for hospitals' organizational culture, we recommend that hospitals explicitly incorporate the words "patient safety" in their mission, vision, and/or as one of their core values, and communicate this to their staff, ensuring that related actions demonstrate this emphasis.

RESPONSE FROM OHA

Ontario hospitals are governed by independent hospital boards, which provide guidance on an organization's mission, vision and values. Ontario hospitals will review this recommendation at the board level to determine whether improvements are needed to elevate the culture of safety within their organization.

4.1.2 Patient Safety "Never-Events" Occurred at Six Hospitals We Visited

In 2015, Health Quality Ontario (HQO) and the Canadian Patient Safety Institute identified 15 patient safety "never-events," which are defined as patient safety incidents that result in serious patient harm or death and that are preventable using organizational checks and balances. Identifying and preventing these safety events was identified as a priority by a patient safety consortium of more than 50 Canadian health-care organizations in 2014. According to broad stakeholder consensus, "never events" are preventable and should never occur in hospitals. An organizational culture that minimizes or eliminates never-events could foster a reduction in other preventable patient harms.

Between the 2015/16 and 2018/19 fiscal years, 10 out of the 15 never-events occurred a total of 214 times in six of the 13 hospitals we visited that tracked these incidents. **Figure 10** describes the never-events and their overall frequency of occurrence at these six hospitals. Data was not available or never-events did not occur at the other seven hospitals we visited. **Figure 11** shows our compilation and summary of the number of never-events that occurred at each of the six hospitals we visited where never-events occurred between 2015/16 and 2018/19.

4.1.3 Patient Safety Never-Events Not Included in Quality Improvement Plans and Hospitals Have Not Set Targets to Eliminate Them

Preventing never-events has been identified by Health Quality Ontario and the Canadian Patient Safety Institute as a patient safety priority because these incidents are preventable and can have serious consequences for patients. For instance, at one

Figure 10: Never-Events and Their Frequency of Occurrence at Six Visited Acute-Care Hospitals, 2015/16–2018/19

Source of data: Ontario Hospitals

	Patient Safety Never-Events	Frequency
1.	Serious pressure ulcer acquired after admission to hospital	111
2.	Patient under strict observation leaves a secured area without the knowledge of staff	26
3.	Unintended foreign object left in a patient following a procedure	26
4.	Wrong tissue, biological implant or blood product given to a patient	24
5.	Patient suicide, or attempted suicide that resulted in serious harm, while a patient was under suicide-prevention watch	11
6.	Surgery on the wrong body part or the wrong patient, or conducting the wrong surgical procedure	10
7.	Patient death or serious harm due to a failure to inquire whether a patient has a known allergy to medication, or due to administration of a medication where a patient's allergy was known	2
8.	Patient death or serious harm as a result of failure to identify and treat metabolic disturbances[1]	2
9.	Patient death or serious harm as a result of one of five pharmaceutical events[2]	1
10.	Patient death or serious harm as a result of transport of a frail patient, or patient with dementia, where patient was left in an unsafe environment	1
Total		**214**

Note: The hospitals visited did not report any of these five never-events:
- patient death or serious harm arising from the use of improperly sterilized instruments or equipment provided by the health care facility;
- patient death or serious harm due to the administration of the wrong inhalation or insufflation gas;
- patient death or serious harm due to uncontrolled movement of a ferromagnetic object in an MRI area;
- patient death or serious harm due to an accidental burn; or
- infant abducted, or discharged to the wrong person.

1. Metabolic disturbances are changes in the body's chemical processes that can cause serious life-threatening health problems.
2. The five pharmaceutical never-events:
   - wrong-route administration of chemotherapy agents;
   - intravenous administration of a concentrated potassium solution;
   - inadvertent injection of epinephrine intended for topical use;
   - overdose of hydromorphone by administration of a higher-concentration solution than intended; and
   - neuromuscular blockage without sedation, airway control and ventilation capability (this was the type of event which occurred at one of the hospitals we visited (Hamilton); the patient was given the wrong drug and needed to be resuscitated).

hospital, a surgery was performed on the wrong knee, and in another hospital, a sponge was left inside the patient after a surgery.

We found that none of the six hospitals set targets in their Quality Improvement Plans to minimize or eliminate the occurrence of these events. Two other hospitals we visited included one of the never-events—serious pressure ulcer acquired after admission to hospital—in their Quality Improvement Plans for 2018/19. No never-events were reported at these hospitals.

Figure 11: Occurrence of Never-Events at Six Visited Acute-Care Hospitals, 2015/16–2018/19

Source of data: Ontario Hospitals

Hospital	# of Never-Events
Hospital 1	71
Hospital 2	66
Hospital 3	37
Hospital 4	18
Hospital 5	17
Hospital 6	5
Total	**214**

4.1.4 Hospitals Not Required to Track and Report Patient Safety Never-Events

We found that hospitals are not required to track or report never-events to Health Quality Ontario or the Ministry of Health. Such information could be analyzed to determine the reasons for these events in Ontario, the cost that these events add to the health-care system and the systemic best practices to adopt to avoid these events. For instance, one hospital we audited (Humber River Hospital) estimated that by reducing the occurrence of pressure ulcers—including serious pressure ulcers, one of the most common never-events—by about half, the hospital could save between $1.8 million to $3.7 million over two years.

We noted that hospitals in Saskatchewan and Nova Scotia are required to track and report never-events to their respective health ministries.

RECOMMENDATION 2

To determine and reduce the impact of never-events on patient safety and the health-care system, we recommend that the Ministry of Health:

- work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data;
- upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and
- partner with hospitals and best practice organizations/stakeholder groups to develop a plan to prevent them from happening.

MINISTRY RESPONSE

The Ministry welcomes this recommendation as it supports patient safety across the health system. The Ministry will assess opportunities to leverage existing data collection tools to support the capture of hospital never-events and identify evidence-based approaches to address frequency of never events and assess the health-care system cost impacts.

RECOMMENDATION 3

To minimize the occurrence of serious preventable patient safety incidents, we recommend that hospitals:

- enhance patient safety practices to eliminate the occurrence of never-events;
- set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans; and
- track and report never-events to the Ministry of Health.

RESPONSE FROM OHA

Ontario hospitals are committed to enhancing patient safety practices and will work with their boards to determine whether never-events should be added to future Quality Improvement Plans.

4.1.5 Lessons Learned from Patient Safety Incidents Are Not Shared between Hospitals

Under the P*ublic Hospitals Act, 1990*, hospitals are required to investigate patient safety incidents and take steps to prevent similar incidents from occurring in the future. Overall, we found that the hospitals we visited were committed to the objective of learning from incidents occurring at their own sites and improving the safety and quality of patient care.

We noted that the Ontario Hospital Association provides patient safety resources and facilitates peer learning among its members, and that stakeholder groups, such as the Institute for Safe Medication Practices Canada, issue safety bulletins to flag new risk areas and identified best practices.

Currently, hospitals do not share lessons learned from investigating specific patient safety incidents. This increases the risk that a patient could experience an incident at Hospital A, and another patient could subsequently experience a similar incident

at a neighbouring Hospital B. Hospital A does not share lessons learned with Hospital B in order to help prevent the same type of incident.

RECOMMENDATION 4

To better enable hospitals to prevent similar patient safety incidents, including never-events from recurring at different hospitals, we recommend that the Ministry of Health work with the Ontario Hospital Association and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.

MINISTRY RESPONSE

All health-care providers have a role in improving patient safety. The Ministry of Health supports this recommendation and will work with the Ontario Hospital Association and other health system partners like Ontario Health, the Canadian Patient Safety Institute, and the Canadian Medical Protective Association to examine the feasibility of having a shared knowledge platform for patient safety incident investigations.

4.2 Some Nurses Found by Hospitals to Lack Competence Pose an Ongoing Risk to Patient Safety

Nursing is a profession that requires a high level of trust. For most hospital patients, the nursing staff are the main providers of direct care. Although the vast majority of nurses provide safe care to their patients, there are rare exceptions that can impact patient safety. As nurses are the hospitals' front-line caregivers, with responsibility for vulnerable patients, including the old and the very young, a lack of competence in nurses can lead to serious harm. Yet the laws and regulations that protect nurses' professional status in these instances could limit hospitals' ability to know when they are hiring a nurse with a history of serious professional incompetence and/or misconduct. These limitations are discussed further in **Section 4.2.2**.

Recent events in Ontario demonstrate the risk to patient safety when a health-care facility hires a nurse without having access to their relevant work history. A former nurse who between 2007 and 2014 killed eight of her long-term care patients was terminated twice for poor performance, but long-term-care facilities and nursing agencies kept rehiring her. She was enabled to keep working and harming her patients because the current system, a combination of laws, institutional practices and employer-employee arrangements, protects the personal and professional interests of health-care professionals.

If a hospital finds that a nurse's lack of competence has caused a patient harm, as part of the progressive disciplinary process the nurse would first be provided with an opportunity to address the competence issues by completing and passing a learning plan. Only if the nurse fails to complete the plan would the hospital then consider termination. In some cases, the nurse would have more than one chance to successfully complete the learning plan. Hospitals and other organizations that employ nurses are required to report all terminated nurses to the College of Nurses of Ontario when the termination is for reasons of professional misconduct, incompetence or incapacity (for example, intoxication).

We noted that some nurses found to lack competence and who have been terminated by hospitals have been associated with repeated incidents impacting patient safety. Hospitals that rehire them are limited in the information regarding past poor performance that they can obtain from the College of Nurses of Ontario and from past employers.

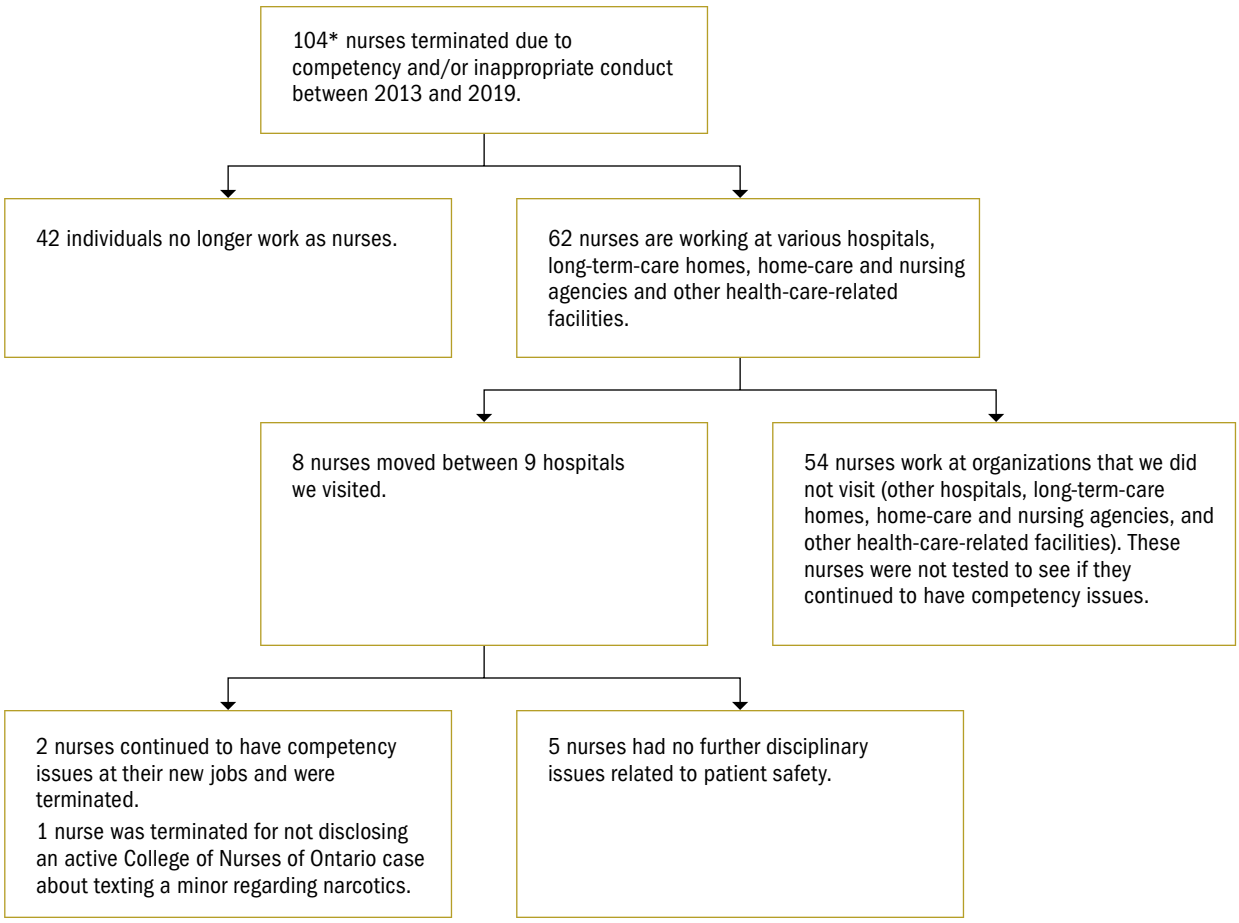
4.2.1 Hospitals We Visited Rehired Nurses Terminated Elsewhere Who Continued to Show Incompetence

Although the great majority of nurses at the hospitals that we visited have not faced any disciplinary actions, the hospitals have terminated some nurses for lack of competence and/or misconduct. As mentioned in **Section 2.1.5**, there are about 74,000 nurses working in acute-care hospitals in Ontario. Of more than 17,000 nurses employed at the nine hospitals where we conducted our work, we found that 104 nurses were terminated for lack of competence and/or inappropriate conduct over the past seven years. Of these 104 nurses, we found 62 who are still active and working (see **Figure 12**). The remaining 42 no longer practise as nurses, are not employed, have retired, work in another industry or have let their licences lapse. We also obtained from the three hospitals we visited that use agency nurses the names of 82 agency nurses who were banned from these hospitals.

We cross-referenced the names of the 62 terminated nurses between the hospitals that we visited. Eight of these nurses were subsequently rehired or worked through an agency at one of the hospitals we visited. The other 54 nurses continue to work as nurses elsewhere. We found that two of the eight nurses continued to harm patients and were again terminated or banned for lack of competence. For instance, one nurse made multiple errors, and a hospital terminated her after finding that she

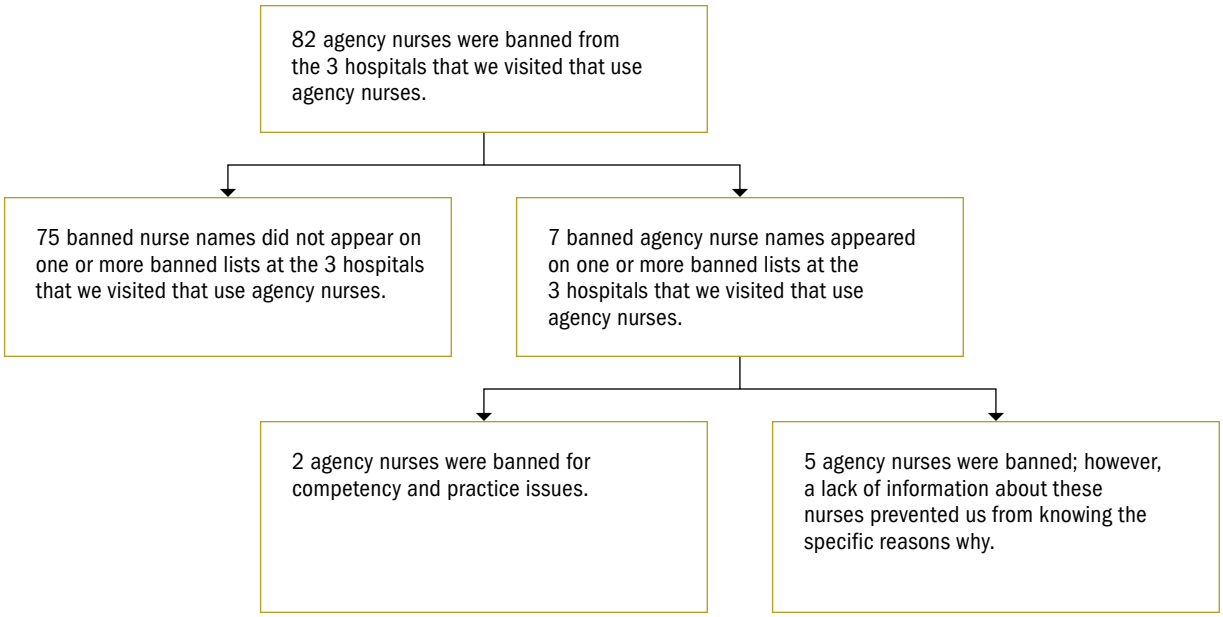
Figure 12: Testing of Nurse Termination Cases Related to Competency and Practice Issues

Prepared by the Office of the Auditor General of Ontario



* The number of cases may be incomplete due to lack of tracking of these cases—most hospitals rely on manual processes and store information in hard copies, some of which are archived.

Figure 13: Testing of Banned Agency Nurse Cases
Prepared by the Office of the Auditor General of Ontario



lacked basic nursing skills and knowledge, as well as critical thinking. This nurse then was hired by another hospital after not disclosing that she was terminated from the first hospital. The hospital then noted that this nurse lacked critical thinking skills, failed to recognize unsafe practices, failed to recognize or respond appropriately to a serious change in a patient's condition and lacked understanding of medication administration (including insulin). This nurse was then terminated by the second hospital. Currently, this nurse works as a nurse at a long-term-care home.

We also cross-referenced the names of the 82 banned agency nurses (see **Figure 13**) from the three hospitals that we visited that use agency nurses. We found that the names of seven banned agency nurses appeared on multiple lists or were terminated by the hospitals we visited. We found that two of the seven banned agency nurses were banned for lack of competence at multiple hospitals. This illustrates that when one hospital banned an agency nurse, this did not prevent the nurse from working at other hospitals, and this information was not shared by the agencies or the hospitals involved.

Figure 14 presents our observations on the work history of four nurses working at agencies or in a long-term-care home who have been terminated or banned by hospitals more than two times for lack of competence but continue to work.

4.2.2 Limited Information Available to Prospective Employers of Nurses Impacts Their Ability to be Aware of Past Performance Issues

We inquired why terminated nurses who continued to show incompetence were able to be rehired, either as employees or as agency nurses, by some of the hospitals we visited. The College of Nurses of Ontario informed us that the *Regulated Health Professions Act* limits the information it is able to share with hospitals and any member of the public with respect to nurses terminated and reported by other hospitals to the College. Hospitals also informed us that if they contact the College to obtain information about a prospective nurse employee, they are usually referred to the nurse's public profile, which does not have information on ongoing investigations

Figure 14: Work History Examples of Nurses Terminated or Banned by Acute-Care Hospitals for Lack of Competence Who Were Still Working in Hospitals

Prepared by the Office of the Auditor General of Ontario

Nurse (Current Employer)	Disciplinary Action (Employer)	Date	Cause for Termination/Banning
Nurse 1 (Agency)	Fired (Hospital)	May 2016	Medication administration and clinical decision-making errors. Over four months, failed to complete and pass a learning plan.
	Banned (Agency)	Dec 2018	Lack of critical thinking and knowledge gaps.
	Fired (Hospital)	Mar 2019	Medication administration errors. Lack of critical thinking and knowledge gaps. Over three months, failed to complete a learning plan.
Nurse 2 (Long-term-care home)	Fired (Hospital)	May 2016	Unsafe delivery of care and lack of basic nursing skills.
	Fired (Hospital)	Sep 2016	Unsafe delivery of care and lack of basic nursing skills.
Nurse 3* (Agency)	Banned (Agency)	Aug 2018	Medication administration errors.
	Banned (Agency)	Jan 2019	Medication administration errors.
Nurse 4* (Agency)	Banned (Agency)	Sep 2015	Medication administration errors.
	Banned (Agency)	Aug 2018	Practice issues (refused to help surgical patients resulting in understaffing of the surgical unit, which could lead to unsafe delivery of care for surgical patient).

Note: Agency nurses are not hospital employees, and therefore hospitals cannot discipline them. Instead, hospitals request that agencies not send them specific nurses. The names of these nurses are tracked on informal lists that hospitals refer to as "banned lists." Hospitals do not share these lists among themselves, and therefore a nurse banned in one hospital could work in other hospitals.

Hospitals store very limited information on agency nurses, as most of the information, including formal documents, is kept at the staffing agency. As a result, we reviewed only a list of agency nurses banned from the three hospitals that actively use agency nurses and the reasons for which these agency nurses were placed on the banned lists. We did not review agency records.

* These nurses were banned by two different hospitals.

and may have incomplete information. Therefore, when hospitals or agencies hire these nurses they do not have access to a complete record of their poor past employment history.

The College informed us that over the past five years, on average, organizations that employ nurses in Ontario have submitted to the College each year about 730 reports about nurses' professional misconduct, incompetence or incapacity (for example, intoxication). About 350 of the reports submitted each year (48%) pertain to nurses employed by hospitals. The other 52% have been submitted by other organizations that employ nurses, such as long-term-care homes.

Reports received by the College are individually screened for risk and are responded to in one or more ways, including meeting with the nurse, providing a written notice directing the nurse to take remedial action and, in some cases, initiating a formal investigation. From 2014 to 2018, between 26% and 47% of all reports received in the year resulted in a formal investigation. Depending on the nature and/or public risk of the reported issue, some investigations can take months or even years to resolve.

We found that the hospitals we visited reported all of the 62 terminated nurses in our sample to the College. As of July 31, 2019, there were no records publicly posted by the College relating to these nurses. There are several reasons why issues reported to the College do not appear on a nurse's public profile. For example, there may be an ongoing investigation, as was the case for Nurse 1 in **Figure 14**, or the College may take another corrective action, such as meeting with the nurse to arrange remedial steps, as occurred with Nurse 2.

In another example, one of the fired nurses failed on three separate occasions to complete and pass a learning plan; this nurse was found by the hospital to be unfit to practise and lacking the ability to perform a nurse's responsibilities, after the nurses was found to not know how to provide competent care during childbirth. This nurse currently works through an agency. The College of Nurses informed us that it is investigating this incident and assessing this nurse's competency gaps. However, none of this information is available online for prospective employers, and throughout the process, this nurse is able to continue working. We checked this individual's College profile, and it only indicated the timeline of their employment with no mention of termination or any performance issues.

RECOMMENDATION 5

To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, we recommend that the Ministry of Health have the Ontario Hospital Association work with the College of Nurses of Ontario and other regulatory stakeholders to:

- identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and
- take steps to address gaps identified.

MINISTRY RESPONSE

The Ministry of Health is working with the health sector to address gaps in information-sharing between colleges and health system partners.

As part of continuing to improve transparency and increase information-sharing between employers and the health regulatory colleges, the College of Nurses of Ontario (College) and the Ministry have worked to add information about a nurse's employers from the past three years on the College's public register so that employers have a reliable way to obtain employment information about nurses.

The College has also worked to include all current employers on the public register. Since many nurses have more than one employer, this will provide a more accurate picture of a nurse's employment.

Work is currently under way to link information in better ways. The College has proactively partnered with nurse employers to establish an Employer Reference Group to identify areas to support employers' needs relating to nursing regulation.

4.2.3 Nurses' Self-Reported Employment History on the College of Nurses of Ontario Public Database Not Complete

Nurses can be licensed and can practise in multiple jurisdictions. However, we found that in Canada, there is currently no centralized system to which all provincial nursing regulatory bodies like the College of Nurses of Ontario can report their disciplinary actions. In the United States, regulatory bodies from each state are required to report all their disciplinary actions within 30 days to the National Practitioner Data Bank, a hospital-accessible database operated by the federal government. Hospitals in the United States can check whether nurses they hire are listed in this database for disciplinary actions. There is also a second public database operated by the National Council of State Boards of Nursing (NCSBN), which tracks disciplinary actions from every state (except Michigan) and also shows the jurisdictions where each nurse holds or has held a licence. Hospitals from around the world can check whether nurses they hire are listed in this database for disciplinary action.

In Ontario, nurses are required to self-report to the College of Nurses of Ontario any nursing licence they hold in any other jurisdiction, other professional designations they hold, their place(s) of employment, whether they have been investigated by a regulatory body for any misconduct in other

jurisdictions and whether they have been convicted of (or charged with) a crime.

We took a sample of 200 nurses from the 182,000 registered in Ontario and matched the information found in the College database with the US National Council of State Boards of Nursing database and the Michigan Board of Nursing. Five of the 200 nurses reported that Ontario was the only place where they held a licence; however, we found that these five nurses were also licensed in other jurisdictions, such as Michigan. Another four nurses reported that they held a licence in Ontario and one US state, but we found that these four nurses also held licences in at least one additional state. The College's public profile for these nurses therefore is incomplete.

For example, one Ontario hospital was unaware of the work history of one nurse who we found was involved in a number of errors relating to medication administration and delivery of patient care, and who, on April 2, 2019, resigned in the midst of disciplinary proceedings at the hospital. This nurse previously had a licence revoked in 2018 in Texas after the hospital filed a report to the nursing board that the nurse was "lacking fitness to practice nursing with reasonable skill and safety." This same nurse was arrested in 2015 in Texas and pleaded guilty to charges in January 2017. When the Ontario hospital hired this nurse, it was unaware of any of these things. Disclosure to the college of registration of disciplinary actions in other jurisdictions remains a self-reporting duty for nurses.

Hospital and agency hiring decisions are mostly based on information found in resumés. The Long-Term Care Homes Public Inquiry found that nurse Elizabeth Wettlaufer, who subsequently confessed and was convicted in the deaths of eight patients, did not include in her resumé her employment at Geraldton District Hospital in 1995, from which she was fired for stealing narcotics for herself. Her College of Nurses of Ontario public record was also clean when on April 21, 2014, another employer, a long-term-care home, conducted a search. This employer found her acceptable and hired her. In 2014, the College of Nurses would post only current employer information on the nurse's profile. So, even though the long-term-care home checked the profile for the employee it was considering, it could locate only the current employer: there was no employment history to be seen.

We have noted that the College tried to resolve this issue before the public inquiry into the safety of long-term-care residents in Ontario published its report on July 31, 2019. In March 2019, the College changed the nurse profile template to show not only a nurse's current employer, but a nurse's employment history as well. However, the College left it up to each individual nurse to update their own employment history. Despite these changes, we have noted that there are nurses in our sample whose self-reported employment history on their College profile omits hospitals where they were terminated for patient safety reasons.

RECOMMENDATION 6

In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, we recommend that hospitals:

- use the National Council of State Boards of Nursing public database to determine whether nurses they hire and employ have faced disciplinary actions in the United States; and
- if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.

RESPONSE FROM OHA

Ontario hospitals will review this recommendation and are committed to working with the Ontario Hospital Association and the College of Nurses of Ontario to identify opportunities to enhance the information available to employers in making hiring decisions.

RECOMMENDATION 7

To help ensure that when hospitals hire nurses they have access to their full disciplinary record, we recommend that the Ministry of Health request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to:

- explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and
- put in place an effective process that will ensure that all places of past employment and disciplinary records from other jurisdictions for each nurse are in its database, including records from US nursing databases.

MINISTRY RESPONSE

The *Regulated Health Professions Act, 1991*, requires every Ontario nurse to file a report in writing with the Executive Director of the College of Nurses of Ontario if there has been a finding of professional misconduct or incompetence made against the nurse by another body that governs a profession *inside or outside of Ontario* unless doing so would violate a publication ban. The report must be filed as soon as reasonably practical after the nurse receives notice of the finding made against her or him. The Ministry will work with the College of Nurses of Ontario to ensure that this requirement is communicated to nurses and will work with the College to explore best practices involving the sharing of information between provincial and territorial nursing regulators.

4.2.4 Nurses' Past Poor Performance Not Shared with Potential New Employers

We found that the potential risk of civil legal actions could prevent hospitals from disclosing a complete employment history record of a nurse to their potential new employer. As a result, during an employment reference check, hospitals may not freely share with potential employers a nurse's detailed work history record—for instance, that a nurse lacked competence and failed to complete a learning plan on several attempts. Only information about employment dates, hours worked and the role the employee held or holds in the hospital is usually shared with potential employers. Other important performance information remains confidential.

We found that jurisdictions in the United States, such as New Jersey, have specific legislation in place that protects hospitals and other health-care providers from liability associated with any civil legal action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.

This legislation was enacted after these jurisdictions faced a similar situation to Elizabeth Wettlaufer's murders. After Charles Cullen was convicted of murdering at least 29 patients in multiple facilities, lack of transparency and information-sharing between health-care providers was identified as a weakness in the system. As a response, in 2005, New Jersey enacted this law to protect hospitals from liability for providing honest job evaluations and work histories to prospective employers.

Similar legislation does not exist in any Canadian jurisdiction. We have noted as well that other US states, such as Pennsylvania, North Carolina and Texas, have similar laws that extend legal protection to all employers and not just health-care providers.

RECOMMENDATION 8

To better inform employers in their hiring decisions and protect patients from the risk of harm, we recommend that the Ministry of Health assess for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.

MINISTRY RESPONSE

The Ministry will assess the actions taken by US states and Canadian provinces to protect hospitals and other health-care providers from any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer for applicability in Ontario.

4.2.5 Non-disclosure Arrangements Can Conceal Nurses' Poor Performance Records from Potential Employers

Almost all Ontario nurses are unionized, although agency nurses are not unionized. A nurse facing disciplinary action can approach his or her union for help. The union would then represent the nurse and try to negotiate with the hospital the most favourable disciplinary outcome for the nurse. For instance, the union could ask the hospital to treat the termination as a resignation or negotiate a non-disclosure arrangement; the nurse's disciplinary history would then be kept hidden in the confidential records of the hospital the nurse has departed from until the College of Nurses of Ontario completes its disciplinary investigation, if the College chooses to undertake one.

We found that this practice can prevent hospitals from knowing about a nurse's past performance to use in their hiring decisions in order to minimize potential harm to patients.

For instance, on October 16, 2018, one hospital fired a nurse for a very serious breach of mandatory patient care standards, which resulted in a patient death. The union negotiated that the firing be treated as a resignation, and this nurse currently works for another hospital. The hospital that fired this nurse reported the termination a few days later to the College. However, as of July 31, 2019, this nurse's College public record was clean. As explained in **Section 4.2.2**, there could be several reasons why a reported nurse may have a clean College public record.

In another case in October 2015, another hospital terminated a nurse for texting a young patient, treated by the nurse in the emergency department, about illegal substances, and reported the nurse to the College. The union, however, negotiated that the termination be treated as a resignation. In January 2017, after working for just over a year through a nursing agency, the nurse was hired by another hospital. Had the hospital that terminated the nurse provided a truthful reference, the second hospital, which hired the nurse, would have known that the nurse falsely stated on the job application that they had never been reported to the College and that there was not a pending College investigation. The second hospital terminated the nurse in December 2017, about 11 months later, when it found out that the College had suspended the nurse's licence for three months after completing its disciplinary process. This disciplinary process took just over two years while the nurse continued to work.

RECOMMENDATION 9

In the interest of patient safety and in order for hospitals and agencies to hire nurses fully aware of their past employment and performance history, we recommend that the Ministry of Health explore means to:

- enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and
- require these organizations to disclose such information when it is requested by a prospective employer.

MINISTRY RESPONSE

While the recommendation pertains to labour relations between the employer and unions, the *Regulated Health Professions Act, 1991*, may have a supportive role in enabling sharing of information between the College of Nurses of Ontario and employers. The Act provides a regulation that permits the government to prescribe purposes

for which disclosures can be made under clauses 36(1)(d.1) and (d.2) from the College of Nurses of Ontario to public hospitals or other named/described persons of certain information stemming from its investigations. The Ministry will examine this opportunity.

4.2.6 In Most Cases Hospitals Do Not Conduct Periodic Criminal Record Checks of Currently Employed Nurses

Our 2018 follow-up report found that only three hospitals that we audited as part of our 2016 Large Community Hospital Operations audit (Trillium Health Partners, Windsor Regional Hospital and Rouge Valley Health System) currently conduct, or will soon start conducting, periodic criminal record checks of their nurses. The other hospitals that we visited as part of this audit do not. Our 2016 audit of Large Community Hospital Operations found that some hospitals did not conduct initial and/or periodic background checks. We noted that the Ontario Hospital Association produced a document in July 2017 to guide hospitals when developing a criminal reference check program or enhancing an existing program.

RECOMMENDATION 10

So that hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to:

- perform criminal record checks before hiring nurses and other health-care employees; and
- periodically update checks for existing staff.

MINISTRY RESPONSE

Under the *Long-Term Care Homes Act* and its regulations, the Ministry outlines criminal record check requirements for long-term-care home employees. The Ministry will explore the possibility of similar requirements for hospital employees.

4.3 Disciplining Physicians Is Difficult and Costly—Legal Costs Are Indirectly Subsidized by Taxpayers

The *Public Hospitals Act, 1990* (Act) governs important elements of the physician-hospital relationship. In our 2016 audit of Large Community Hospital Operations, we reported that hospitals were not able to resolve human resources issues with physicians quickly because of the comprehensive legal process that the hospitals are required to follow under the Act. We recommended that the Ministry evaluate this problem. However, we found that hospitals still are not able to quickly and cost-effectively deal with physicians that hospitals find may have practice issues, lack competence and may pose patient safety concerns.

Once a competency and/or practice issue has been identified, hospitals must work through a lengthy process to determine whether the physician's privileges can be revoked, restricted or not renewed. While the disciplinary process is ongoing, physicians can continue to work, even at multiple hospitals, unless the hospital puts an emergency stop to a physician's work due to an immediate risk to patient safety. As part of our audit, we reviewed a sample of disciplinary proceedings to determine their duration and cost to the hospitals. We present our findings in **Figure 15**.

In defending themselves, physicians mostly do not personally incur legal fees; rather, their legal costs are indirectly paid by taxpayers through a liability insurance reimbursement program. Through this program, the Ministry reimburses physicians for enrolling either in the Canadian Medical Protective Association, a not-for-profit association that provides lawyers to represent physicians, or in any other organization they choose to purchase medical liability protection from. Disciplinary cases can take several years and cost hospitals hundreds of thousands of dollars in their own legal fees and other costs.

Figure 15: Costs Incurred by Hospitals to Discipline Physicians and Duration of Process
Prepared by the Office of the Auditor General of Ontario

Physician	Duration of Disciplinary Process (Years)	Cost Incurred by Hospital ($)	Outcome	Cause
Physician 1*	3.5	567,000	Privileges not renewed	Multiple complaints about patient treatment and misdiagnosis.
	3	901,000	Ongoing	Failed to disclose privileges not renewed at another hospital. Numerous staff and patient complaints about patient treatment including patients in critical condition within the emergency department.
	1	145,000	Ongoing	Between 2009 and 2019, numerous complaints about patient treatment including refusal to treat a patient; delayed diagnosis led to patient paralysis.
Physician 2	4	310,000	Privileges revoked	Interacted with patients in an inappropriate manner. Concerns due to prolonged absence from clinical work.
Physician 3	4.5	202,000	Privileges restricted	Hospital concerns that there were quality of care and patient safety issues related to physician performing complex surgical procedures. A review identified that the physician committed serious errors in judgment during three surgeries.

* One hospital did not renew Physician 1's privileges. Physician 1 is also involved in two separate ongoing disciplinary proceedings at two other hospitals.

We noted that in 2016/17, the Ministry of Health reimbursed physicians $256 million for costs of the Medical Liability Protection Reimbursement Program. In 2017/18, the amount was $326.4 million, an increase of $70.4 million, or 27.5%.

RECOMMENDATION 11

To enable hospitals to take timely action to improve patient safety, we recommend that the Ministry of Health explore means to make it easier and less costly for hospitals and ultimately the taxpayer to address physician human resources issues, especially in cases when doctors may have harmed patients.

MINISTRY RESPONSE

When harm to a patient occurs, hospitals, employers and health regulatory colleges have mechanisms in place to address concerns and to take action in a timely manner. Disciplinary action against health-care providers is but one way of preventing reoccurrence and is often an extreme measure that is linked to risk of harm. There are other less costly and more timely ways of addressing concerns, which may include mediation and alternative dispute mechanisms among others.

Following the release of the 2019 Arbitration Award regarding the dispute over physician compensation between the provincial government and the Ontario Medical Association (OMA), the Ministry is committed to investigating the recommendation from the Auditor General of Ontario's 2016 Large Community Hospital Operations audit to review the physician appointment and appeal processes for hospitals and physicians under the *Public Hospitals Act*.

As part of this review, the Ministry will also explore opportunities to make it easier and less costly for hospitals to address physician human resource issues, especially in cases when doctors may have harmed patients.

4.4 Hospital Accreditation Reports Highlight Gaps in Compliance

4.4.1 Eighteen Hospitals Did Not Fully Comply with Five or More Required Patient Safety Practices

We obtained the most recent Accreditation Canada report from 114 acute-care hospitals. Some of these reports include the inspection and accreditation results for more than one hospital. We found that, between 2014 and 2019, 18 hospitals did not comply with five or more required practices that are central to quality and patient safety. The required six practice areas against which Accreditation Canada assesses each hospital are listed in **Appendix 4**. As shown in **Figure 16**, 148 practices in the six practice areas deemed central to the quality and safety of care were not complied with at 18 out of 114 hospitals. For example, in the area of risk assessment, some hospitals did not have strategies in place to help prevent patient falls and pressure injuries, which increases the risk of these types of patient harm. Other hospitals did not meet the communication area required practice to ensure that information is transferred when patients move between care units within the hospital, increasing the risk of unsafe transitions of care. If these practices are not complied with, a hospital is required to submit evidence of corrective actions to Accreditation Canada. We noted that Accreditation Canada conducts its visits every four years, so it is unknown for how long prior to the visit hospitals did not have these required practices in place.

4.4.2 13 Hospitals Did Not Meet between 5% and 11% of High-Priority Patient Safety Criteria

We found that 13 out of the 114 hospitals did not meet between 5% and 11% of their high-priority patient safety criteria when assessed. Accreditation Canada assesses each hospital against a number of criteria that it uses to measure the hospital's compliance with standards that contribute to high-quality, safe and effectively managed care.

The number of applicable criteria varies according to the size of the hospital and the range and complexity of health services it provides. For instance, about 700 high-priority criteria in total could be used to assess a small rural hospital, whereas 1,200 or more could be used to assess a large hospital.

Figure 16: Unmet Required Practices in Six Patient Safety Areas at 18 Acute-Care Hospitals, 2014–2018
Source of data: Ontario Hospitals

Patient Safety Area	Examples of Required Practices	Instances of Required Practices Unmet
Safety Culture	• Patient safety incident management • Reporting and analysis of patient safety	4
Effective Communication	• Medication reconciliation as a strategic priority • Use of two identifiers to identify patients	78
Safe Use and Storage of Medication	• Infusion pumps training and safety • Monitoring and responsible usage of antibiotic medication	16
Safe Environment	• Management of patient flow to help prevent overcrowding in emergency department • Preventative maintenance program	5
Infection Prevention	• Hand hygiene compliance	3
Assessment of Patient Safety Risks	• Falls prevention strategy • Pressure ulcer prevention strategy	42
Total		**148**

High-priority criteria relate to safety, ethics, risk management and quality improvement, and have an impact on patient safety. These criteria weigh heavily in determining whether a hospital meets the accreditation standards.

Figure 17 shows the number of unmet criteria at each of the 13 hospitals, as well as some of the key patient safety concerns identified by Accreditation Canada. If high-priority criteria are not met, a hospital is required to submit evidence of corrective actions to Accreditation Canada.

4.4.3 Highest Rate of Patient Safety Concerns with Medication Management and Emergency Services

Accreditation Canada groups the various criteria into two main categories of patient safety standards against which it assesses hospitals' compliance:

- hospital-wide standards, which address patient safety throughout the hospital—these include governance, leadership, infection-prevention-and-control medication management; and
- service-specific standards, which apply to specific services provided, such as the emergency department and diagnostic imaging.

We found that as a group, the 114 hospitals did not meet 1,707 high-priority criteria relating to patient safety standards in the above two categories. **Figure 18** shows the instances when the 114 hospitals did not comply with the hospital-wide and service-specific standards that make up the high-priority criteria. Most of the instances when the 114 hospitals did not meet the criteria were in the areas of medication management, leadership, emergency department operations and reprocessing of reusable medical devices, which are also referred to in this report as "reusable surgical tools and medical devices."

4.4.4 Prevention of Falls an Ongoing Patient Safety Concern

We found that all of the 13 hospitals we visited had processes in place to assess patients who are admitted to hospital for their risk of falling. Assessing this risk is an important patient safety practice, since a patient fall could result in a hip fracture, a head injury, and in some cases, death.

Depending on a patient's identified risk of falling while in hospital, staff use additional measures to reduce this risk, such as bed exit alarms, which notify the nurse when a patient leaves the bed. Hospitals informed us that although these additional measures reduce the risk of patient falls, patient falls can still occur. For example, even when a hospital has a falls prevention process in place, a patient could still choose to leave their bed without notifying their nurse and be at increased risk of falling.

RECOMMENDATION 12

To improve patient safety, we recommend that the Ministry of Health:

- review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and
- follow up with hospitals in respect of problem areas to confirm that actions are taken to correct deficiencies.

MINISTRY RESPONSE

Patient safety is an important dimension of quality. Ontario Health's mandate includes holding health-care providers accountable for health system performance and quality. Moving forward, the Ministry will request that Ontario Health address this recommendation as part of its mandate.

Figure 17: Unmet High-Priority Accreditation Criteria at 13 Acute Ontario Hospitals

Source of data: Ontario Hospitals

Hospital	# of Unmet High-Priority Criteria	% of All High-Priority Criteria	Accreditation Date	Patient Safety Concerns
Hôpital Notre-Dame Hospital	76	11	Dec 10, 2015	• Medication storage and administration, including chemotherapy storage and preparation • Medical equipment stored in dirty areas
Haliburton Highlands Health Services	39	10	May 28, 2015	• No analysis or trends of patient safety incidents • No action plans to prevent/reduce patient safety incidents
Hornepayne Community Hospital	45	7	Nov 29, 2018	• No Quality Committee • Outdated safety plan • Private rooms not secure and unsafe
Kirkland and District Hospital	51	7	Jul 20, 2016	• Separation of similar-sounding medication names not consistently done
Lady Dunn Health Centre	41	6	Nov 30, 2017	• Pressure ulcers (bedsores) prevention not formalized and not tracked • Lessons learned from patient safety investigations not shared with front-line staff
St. Joseph's General Hospital Elliot Lake	60	6	Oct 23, 2017	• Lack of integrated Quality Improvement Plan
The Alexandra Hospital	35	5	Sep 30, 2015	• High risk of contamination of sterilized medical instruments: decontamination area not sufficiently isolated from clean storage area • No quality management program in place for cleaning and sterilization of medical and surgical tools
Riverside Health Care Facilities	41	5	Oct 23, 2015	• Chemotherapeutic intravenous medication storage and preparation concerns
North Shore Health Network	36	5	Jul 5, 2018	• No patient safety benchmarks and set goals to measure success toward targets
Englehart and District Hospital	26	5	Jun 26, 2015	• Unsafe storage of medical supplies
Campbellford Memorial Hospital	37	5	Dec 20, 2017	• Lack of proper area to clean medical equipment, dirty equipment is washed next to sterile and clean area • Quality Improvement Plan initiatives not communicated to front-line staff
North of Superior Healthcare Group	42	5	Oct 4, 2016	• No proactive approach to identify risks to patient safety in emergency department • No falls prevention strategy in place
MICs Group of Health Services	41	5	Mar 16, 2018	• Quality Improvement Plan initiatives not communicated to front-line staff • No monitoring of patients who are receiving a new dosage of narcotics or sedatives

Figure 18: Total Instances of Unmet High-Priority Criteria at 114 Ontario Acute-Care Hospitals, 2014–2019

Source of data: Ontario Hospitals

	Unmet Instances
Hospital-Wide Standards	
Medication management	181
Leadership	127
Infection prevention and control	51
Governance	120
Service-Specific Standards*	
Emergency department	209
Reprocessing of reusable medical devices	173
Perioperative services and invasive procedures	169
Medicine services	115
Diagnostic imaging services	110
Ambulatory care services	59
Obstetric services	72
Mental health services	50
In-patient services	62
Critical care	45
Community-based mental health services and supports	29
21 other service categories	135
Total	**1,707**

* Not all services are provided by every hospital.

4.5 Best Practices Not Always Followed for Medication Administration

4.5.1 Hospitals Not Always Following Best Practices to Prevent Medication-Related Patient Safety Incidents

According to the Canadian Patient Safety Institute, more than 50% of hospital patients have at least one discrepancy between the medications they take at home and those ordered for them on admission to the hospital. Many of these discrepancies in the medications patients are given have the potential to harm them.

Medication reconciliation is a patient safety best practice, to ensure that medications that were added, changed or discontinued while a patient was in a hospital are carefully evaluated against the medication that the patient was already taking at home. This reduces the possibility that medications the patient is on will be omitted, duplicated or ordered incorrectly when the patient is admitted or discharged from a hospital.

For instance, two weeks before being admitted to a hospital, a patient received from a family doctor a prescription for a narcotic pain medication. On discharge, the hospital prescribed the same narcotic, but the patient now had access to and started to take more than what was required. Shortly after that, the patient was readmitted to the hospital for a narcotic overdose.

Research by the Canadian Patient Safety Institute indicates that medication reconciliation is the most cost-effective way to prevent potential medication-related patient safety incidents, which, if not prevented, result in an average of $4,000 in additional health-care costs per incident and endanger lives.

For 2018/19, Health Quality Ontario recommended that hospitals focus on conducting medication reconciliation for patients that they discharge and add this to their Quality Improvement Plans. This is not a mandatory requirement, and only 78 hospitals included it in their 2018/19 Quality Improvement Plans. Based on information reported by these 78 hospitals to Health Quality Ontario, on average they completed medication reconciliation for only 76 out of every 100 patients where reconciliation at discharge was required. This means that, on average, about 24 out of every 100 patients discharged from the hospital did not have a medication reconciliation completed at discharge.

Hospitals that we visited informed us that medication reconciliation is a labour-intensive process and that is why sometimes they are not able to complete all the required reconciliations. Reconciling medication for patients who take a large number of medications and purchase them from several

pharmacies can take more than 24 hours, as the hospital has to contact each pharmacy to compile the patient's medication history.

We also found that some important information was not recorded during the medication reconciliation process at each of the five hospitals we visited, and that some hospitals do not report their compliance rate because they have outdated computer systems that do not allow them to track the compliance rate.

We visited five hospitals to review their medication reconciliation process. Three of the hospitals report their compliance rate to Health Quality Ontario and two do not. The compliance rates at discharge for the three reporting hospitals were 100%, 95% and only 20%.

At each of the five hospitals, we reviewed 10 completed medication reconciliations to assess how they are performed and documented. We found that each hospital documents the reconciliations differently, and at four of the five hospitals we found at least one reconciliation that was missing some important information. In total, 20 out of the 50 completed medication reconciliations we reviewed were missing information such as patients' medication history, medication dosage and quantity prescribed on discharge, and the time of the last dose taken. Without this information, on release from hospital patients may not be instructed to take their medication appropriately in order to prevent harm.

RECOMMENDATION 13

So that hospitals fully complete medication reconciliation to reduce the risk to discharged patients and that they have all the necessary patient information to properly investigate any incidents with patients' dosages or drug interactions that might occur and trigger hospital readmission, we recommend that hospitals reinforce with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented.

RESPONSE FROM OHA

Ontario hospitals support documentation of medication reconciliation being consistently more complete, comprehensive and accurate.

RECOMMENDATION 14

To reduce the risk of medication errors and readmissions to hospital, we recommend that the Ministry of Health:

- require hospitals to complete medication reconciliation for all patients;
- require hospitals to include medication reconciliation in their Quality Improvement Plans; and
- in conjunction with relevant hospitals, review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed.

MINISTRY RESPONSE

The Ministry of Health supports this recommendation and will support:

- Ontario Health in reviewing and assessing how medication errors are reported in hospitals and explore ways to strengthen reporting mechanisms;
- Ontario Health in evaluating how to make medication incident reporting within hospitals part of their Quality Improvement Plans; and
- hospitals with their review of their IT systems and help explore opportunities to enhance tracking systems for medication reconciliation.

4.5.2 Best Practices for Safe Administration of Medication Not Consistently Followed at Some Hospitals

We found that some hospitals do not always comply with policies and best practices for the administration of high-risk medications, such as using an

Figure 19: Reported Critical Patient Safety Incidents Involving Medication in All Ontario Hospitals Occurring between October 2011 and December 2018

Source of data: Canadian Institute for Healthcare Information National System for Incident Reporting

Category	2012[1]	2013	2014	2015	2016	2017	2018	Total	% Total
Severe Harm	27	23	24	10	12	6	13	**115**	75
Death	10	7	4	7	5	0	6	**39**	25
Total	**37**	**30**	**28**	**17**	**17**	**6**	**19[2]**	**154**	**100**

1. Year 2012 includes data hospitals started to report in October 2011.
2. The rise in incidents in 2018 is due to an increase both in incidents occurring in 2018 and in incidents that occurred earlier but were not reported until 2018.

independent double-check to verify medication and dosage; witnessing patients taking and swallowing medications; or confirming the identities of patients.

According to the Canadian Institute for Health Information, events associated with medication are among the most frequent of all harmful events possible in a hospital. Medication errors can be classified into prescribing errors; dispensing errors; and administration errors, when what the patient actually received differs from what was intended. Medication errors that are discovered only after the patient has taken the medication are typically the most serious of the three types of errors. The 2004 Canadian patient safety study estimated that one out of nine adults will potentially be given the wrong medication or wrong medication dosage in hospitals.

In 2011, the Ministry of Health began requiring hospitals to report patient safety incidents causing serious harm or death involving medications to the Canadian Institute for Health Information. **Figure 19** shows the list of these incidents compiled from late 2011 through to the end of 2018.

Our expert told us that it is leading practice (and an Accreditation Canada requirement) for hospitals to implement a policy where designated high-risk medications require an independent double-check before they are administered to the patient, as errors involving high-risk medications increase the likelihood of patient harm or death.

At three hospitals, we observed nine instances where nurses did not comply with medication administration best practices in 15 situations observed. There are usually four times during the day when patients could receive their scheduled medication: morning, afternoon, evening/dinner and bedtime. At each hospital we visited, we observed a nurse administering medication to five patients during one of the scheduled times. At two hospitals on five occasions, the nurses did not request another nurse to double-check the name and amount of high-risk medication given to the patients. At one hospital, in two instances, the nurse did not wait to witness the patients actually take and swallow their medications. In one of those instances, the medication was a narcotic that could be pocketed in the mouth to be then taken out, stored and used later to overdose. At another hospital, the nurse did not confirm the identification of two patients before administering medications to them.

RECOMMENDATION 15

To improve patient safety, we recommend that hospitals reinforce with nurses necessary medication administration processes to ensure that:

- independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered;
- nurses witness patients taking and swallowing high-risk medications; and
- nurses use two unique identifiers to confirm the identity of patients before administering medication to them.

RESPONSE FROM OHA

Ontario hospitals will review existing policies and processes for the administration of all medications to determine whether best practices are being followed to improve patient safety.

4.5.3 Best Practices Not Always Followed for Nursing Shift Changes

We found that six out of the 13 hospitals we visited did not always follow patient safety best practices for nursing shift changes at the patient's bedside. Nursing shift changes were not assessed at Women's College Hospital, as it is an ambulatory care facility that does not provide in-patient care, so nurses work day shifts only at this hospital.

Nurses usually work 12-hour shifts, although shifts can also be shorter. During shift changes, which usually occur at 7 a.m. and 7 p.m., the nurse whose shift is ending provides the incoming nurse with an update on the patient's condition, medication and/or treatment, as well as other patient-care specifics.

According to our expert, the best practice, if possible—based on the patient's condition—is to conduct nurse shift changes at the patient's bedside and involve the patient and the family, with the consent of the patient, in the process, rather than completing the shift change away from the patient at the nurses' station. In this way, the patient and possibly family are engaged in the care process and can identify any missing information or miscommunication between the nurses during shift change that could lead to patient safety incidents. We found, however, that this practice was followed by only six out of the 13 hospitals we observed for nursing shift changes.

RECOMMENDATION 16

To minimize patient safety incidents due to missing information or miscommunication, we recommend hospitals adopt, based on patient condition, the practice of making nursing shift changes at the patients' bedside and where possible involving the patients and their families, with the consent of the patients, in the process.

RESPONSE FROM OHA

Ontario hospitals support the review of current practices to ensure safe transfer of information between care providers. Ontario hospitals will determine what supports are needed to engage patients, where possible, to enhance nursing shift changes.

4.6 Hospital Systems for Dispensing Medication Vary from Fully Manual to Fully Automated

After a medication is prescribed for a patient, the order must be reviewed by a pharmacist, prepared and dispensed at the pharmacy, and then delivered to the patient's unit to be administered by a nurse. While all hospitals we visited have controls in place over this process, we noted that hospitals vary widely in the level of automation in this process. See **Appendix 10** for elements of automation that can impact medication dispensing and administration.

We noted that hospitals in Ontario are moving toward automating medication management but are at different stages of implementation, from fully manual to fully automated systems.

Two of the hospitals we visited have fully manual systems in at least one of their hospital sites. Two other hospitals we visited had fully automated systems. The remaining hospitals are at varying stages of implementation between manual and automated systems.

Pharmacy Staff Performing Manual Processes Could Be Better Utilized

One hospital we visited was facing a shortage of pharmacy technicians, and its pharmacy department operated with manual processes. This hospital

informed us that its pharmacy technicians were doing manual tasks that could be automated such as labelling and packaging medication and drawing medication into syringes for a single use.

With pharmacy technicians occupied by these tasks, this hospital assigned medication reconciliation to nurses, who are already busy with patient assignments. Best practice confirms that medication reconciliation can be safely and effectively performed by pharmacy technicians and pharmacists in collaboration with the prescriber. This hospital reported that in 2016, as many as 20% of all reported medication incidents in a month were due to medication reconciliation errors.

RECOMMENDATION 17

To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, we recommend that the Ministry work with hospitals toward the automation of pharmacy-related tasks.

MINISTRY RESPONSE

The Ministry acknowledges that there may be opportunities to improve how hospitals use automation to drive efficiency and safety in their local pharmacy operations. The Ministry will encourage hospitals, as part of their annual capital planning process, to consider the cost-effectiveness of moving toward the automation of pharmacy-related tasks.

4.7 Some Hospitals Have Poor Compliance with Infection Prevention Best Practices and Standards

4.7.1 Infection Outbreak Investigations Found Key Prevention Practices Lacking at 10 Hospitals

We found that some hospitals have not consistently followed infection prevention best practices and standards. Ten hospitals contacted Public Health Ontario to help them deal with recent or recurring infection outbreaks. We obtained the resulting Public Health Ontario reports, for 2016 to 2018, from each hospital detailing the type and extent of each outbreak.

Outbreaks ranged from a large-scale outbreak affecting over 100 patients at one hospital, to repeated smaller outbreaks at another hospital with a consistently higher infection rate than peer hospitals.

In reports prepared for each hospital between 2016 and 2018, Public Health Ontario identified that the 10 hospitals had low compliance with a number of infection prevention best practices established by the Provincial Infectious Diseases Advisory Committee described in **Appendix 5**. For example:

- Eight of the 10 hospitals had either cluttered rooms, making them more difficult to clean; damaged furniture that served as a reservoir for microorganisms; or damaged equipment that was corroded, leaking fluids and visibly soiled.
- Eight of the 10 hospitals had limited screening of patients for specific resistant bacteria.
- Five of the 10 hospitals did not have sufficient processes in place to monitor and prevent the spread of infections or did not have enough dedicated staff to support infection prevention processes according to best practices.
- Common observations in the affected areas at all 10 hospitals included poor hand hygiene, use of incorrect cleaning solutions and inadequate protective equipment.

Two of the 10 hospitals had outbreaks of *Clostridium difficile* (*C. difficile*), a bacterium that can cause diarrhea, severe abdominal pain and potentially life-threatening infections.

In two studies on *C. difficile*, The Ottawa Hospital found that the average length of stay for patients who acquired *C. difficile* while in hospital was 34 days, more than four times longer than for patients who did not acquire this infection (eight days). The hospital also estimated that patients who acquired *C. difficile* while in hospital required additional treatment costing an average of $9,000 per patient. In the past five years, 12,208 hospital-acquired *C. difficile* infections were reported in Ontario, an average of about 2,440 people each year.

This suggests the additional treatment costs to the provincial health-care system as a result of these infections are substantial.

In its reports to the 10 hospitals, Public Health Ontario made recommendations on how to improve infection prevention processes. We followed up with these 10 hospitals and found that these hospitals have not yet fully implemented all of the recommendations.

As of May 31, 2019, 191 (73%) of the 263 recommendations to the hospitals had been fully implemented. The hospitals are still working toward implementing the remaining 71 (27%) recommendations such as to update their policies and procedures, provide training to staff, evaluate processes for infection prevention, and allocate resources (money and staffing) more effectively.

4.7.2 Reported Frequency of Handwashing by Hospital Staff Could Be Overstated

As previously discussed, Public Health Ontario identified poor hand hygiene compliance as a contributing factor when reviewing infection outbreaks. Hospital-acquired infections such as *C. difficile* are commonly spread by the contact route via the hands of health-care workers. Therefore, hand hygiene, either through the use of alcohol-based hand rub or soap and water, is one of the main preventive measures used to prevent and control the spread of these infections. As handwashing is a simple, quick and low-cost action to do, the prevalence of handwashing in a hospital speaks to the strength of the patient safety culture in that hospital.

Best practices developed by the Provincial Infectious Diseases Advisory Committee require hospital staff to wash their hands at several key moments when caring for patients, including before initial contact with the patient and the patient's environment; before putting on gloves when performing an invasive procedure; before administering medication to a patient; immediately after removing gloves; and after contact with a patient and the patient's environment.

As part of our special audit report *Prevention and Control of Hospital-acquired Infections* (2008), we examined the Ministry's hand hygiene pilot program. The objective of this program was to observe hospital staff to assess how often they followed hand hygiene best practices by washing their hands before and after patient contact.

In our 2008 audit we found that handwashing compliance of hospital staff ranged from only 40% to 75% at the 10 participating hospitals. Physician compliance increased from only 18% at the start of the pilot to 28% by the end. Nurse compliance rose from only 44% to 60%.

Since 2008, as reported by Health Quality Ontario, hospitals have reported improvement in hand hygiene compliance rates. Hand hygiene compliance before patient contact rose from 53.3% in 2008/09 to 89.7% in 2018/19. Hand hygiene compliance after patient contact rose from 69.0% to 92.8% over the same period.

Although reported rates have increased over this period, some hospitals have indicated that reported hand hygiene compliance is likely overstated, due to the method used to assess compliance. Since hospital staff are physically observed by a hand hygiene auditor who records whether or not they wash their hands, staff are often aware they are being observed and wash their hands more often when the auditor is present. For example:

- In 2014, the University Health Network published a study that found that hospital staff washed their hands 2.5 times more often when an auditor was visible (3.75 times per hour) than when an auditor was not visible (1.48 times per hour). The study found that the compliance rate increased after the auditor's arrival, suggesting that the presence of the auditor triggered the increase in hand hygiene.
- In 2016, Sunnybrook Hospital published a study and found that while the hand hygiene compliance rate as observed by the auditor was 84%, the rate as observed by covert observation auditors was actually 50%. The study also found that handwashing by medical residents (trainees) dropped from 79.5% to 18.9% when their supervising physician did not wash his or her hands.

The Sunnybrook residents' study, in particular, demonstrates how modelling desirable behaviour can encourage and sustain patient safety culture down the line among the people working at a hospital.

We note that some hospitals have introduced additional methods of assessing and encouraging hand hygiene compliance:

- Sunnybrook Hospital has started using electronically monitored hand hygiene pumps in some units. These pumps are equipped with a sensor that counts hand hygiene events and gives each unit a compliance rate against a predetermined number of hand hygiene opportunities based on the type of unit, and the number of care providers, visitors and patients.
- University Health Network has introduced electronic monitoring systems in some units, which use electronic badges worn by staff to produce real-time prompts for staff to use soap or alcohol-based hand rub dispensers when they move in and out of rooms in the hospital.
- Women's College Hospital has distributed survey cards to patients and asked them to observe and record the hand hygiene compliance of their health-care providers. The results are forwarded to providers on a regular basis; this process allowed patients to play a more active role in their own health care.

RECOMMENDATION 18

To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, we recommend that the Ontario Hospital Association work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as electronically monitored hand hygiene pumps and monitoring systems, and asking patients to observe and record the hand hygiene compliance of their health-care providers.

RESPONSE FROM OHA

Ontario hospitals take hand hygiene compliance very seriously as it is the single most effective way to reduce the risk of health care–associated infections. Ontario hospitals agree with enhancing observation and monitoring methods and will examine strategies to improve hand hygiene compliance within their organizations.

4.8 Some Hospital Pharmacies Did Not Fully Comply with Training and Cleaning Standards for Sterile-Rooms

Some patients receive their medications, such as antibiotics, chemotherapeutic agents and pain medication, by injection directly into their veins. Hospital pharmacies have restricted access areas, called "sterile-rooms," where intravenous medication is prepared and mixed using clean and disinfected equipment.

Air in sterile-rooms is continuously filtered to remove particles. Pharmacy staff who work in sterile-rooms must wear masks, gloves and gowns. Cleaning and disinfecting personnel are responsible for cleaning the equipment used in the mixing and preparation of intravenous medications, and for cleaning floors and walls in sterile-rooms.

4.8.1 Sterile Preparation and Mixing of Hazardous (Chemotherapy) and Non-hazardous Intravenous Medications

We found that hospital pharmacies do not always fully comply with standards pertaining to the sterile preparation and mixing of hazardous (chemotherapy) and non-hazardous intravenous medications.

The Ontario College of Pharmacists is the registering and regulatory body for the profession of pharmacy in Ontario. In 2013, 1,202 hospital patients at four hospitals in Ontario (Windsor, London, Lakeridge and Peterborough) were infused with the wrong concentration of chemotherapy medication. Following this chemotherapy underdosing incident, in 2014 the College started annual inspections of hospital pharmacies to assess their compliance with 102 standards aimed at ensuring patient safety. Fifty of the 102 standards relate directly to the sterile preparation of injectable medications such as for chemotherapy and antibiotics.

The National Association of Pharmacy Regulatory Authorities, a voluntary association of provincial and territorial pharmacy regulatory bodies, developed these standards, which were adopted by the Ontario College of Pharmacists.

We analyzed all 163 inspections completed by the College in 2018, including 122 inspections of sterile preparation and mixing of medications, and found that hospital pharmacies on average fully met less than half of the 50 standards relating to the sterile preparation and mixing of intravenous medications such as for chemotherapy and antibiotics. On average, hospital pharmacies did not comply at all with about 10% of the 50 standards. For instance, 10% of the 122 hospital pharmacies did not train staff on how to prepare and mix intravenous medications correctly, and 26% of the 122 hospitals did not train their staff on how to clean and disinfect the sterile-room and the equipment used in preparing and mixing intravenous medications. **Figure 20** shows how many of the 102 standards relate to the eight main hospital pharmacy operating areas, and the pharmacies' 2018 average compliance rate with the standards pertaining to each area.

Our expert told us that sterile preparation and mixing of intravenous medications is a high-risk activity. For instance, patients can be harmed or even die if their intravenous medication has been contaminated with bacteria during mixing and preparation or if the medication has been mixed incorrectly and,

Figure 20: Hospital Pharmacies, Average Compliance Rate with Standards, 2018

Source of data: Ontario College of Pharmacists

Standard Categories	# of Standards (Out of 102)	Average Compliance Rate of All 163 Hospital Pharmacies* (%)		
		Met	Partially Met	Not Met
Sterile preparation and mixing of hazardous intravenous medications (chemotherapy)	25	43	45	12
Sterile preparation and mixing of non-hazardous intravenous medications (antibiotics, narcotics, etc.)	25	48	43	9
Safe and secure medication storage (including narcotics) throughout the hospital	10	80.3	19.2	0.5
Safe packaging handling, storage, distribution and monitoring of medications	17	79	21	–
Medication physician prescription review and processing	8	85	15	–
Safe and secure storage of narcotics within the pharmacy	5	68	32	–
Non-sterile preparation and mixing of medication	4	61	39	–
Other areas (record retention, auditability and traceability)	8	57	43	–
Total	**102**			

* Ontario hospitals may have more than one site; however, not all sites have a pharmacy.

for example, is the wrong dose or has the wrong ingredients.

In September 2016, the College mandated that by January 1, 2019, hospital pharmacies must be in full compliance with all 50 standards pertaining to the sterile preparation and mixing of intravenous medications. Inspection results from 91 hospital pharmacies completed by July 1, 2019, shared with us by the College, showed that pharmacies' compliance with the standards has improved. Sixty-four percent of the 91 inspected pharmacies met the standards pertaining to the sterile preparation and mixing of intravenous hazardous medications, such as for chemotherapy, and 70% of the 91 pharmacies met the standards pertaining to the sterile preparation and mixing of intravenous non-hazardous medications, such as antibiotics.

4.8.2 Sterile-Rooms Are Not Cleaned in Accordance with Best Practices

As mentioned, hospital pharmacies have restricted access areas, called "sterile-rooms," where intravenous medications are prepared and mixed using clean and disinfected equipment.

We visited five hospitals between May and July 2019 and observed that in four hospitals, pharmacy and housekeeping staff did not follow standards and best practices when cleaning sterile-rooms and the equipment used in the preparation of intravenous medications. For example, one hospital was using the wrong cleaning agent to disinfect the equipment. At another hospital, housekeeping staff did not properly gown prior to entering the sterile restricted area, and they cleaned the floors using the same mops used to clean other areas. (Mops should be for restricted use in only the sterile-room.) By January 1, 2019, hospitals were supposed to have trained all of their cleaning and disinfecting personnel on how to properly clean sterile-rooms. However, we found that two hospitals we visited had not yet conducted the required training.

RECOMMENDATION 19

So that sterile-rooms and the equipment used in the mixing and preparation of intravenous medications are cleaned according to required standards, we recommend that hospitals:

- provide their pharmacy and housekeeping staff with proper training on how to conduct the cleaning; and
- monitor the cleaning to ensure proper processes are being followed.

RESPONSE FROM OHA

Ontario hospitals will continue to work with the Ontario College of Pharmacists to implement strategies to ensure proper practices are put in place for cleaning of sterile-rooms and equipment.

4.9 Inspection Process for Cleaning Reusable Surgical Tools Not Optimal

4.9.1 Improper Cleaning of Reusable Surgical Tools Can Delay Surgeries and Impact Patients

Hospitals commonly reuse surgical tools, such as scalpels, and medical equipment, such as colonoscopy scopes, on patients, after they have been thoroughly washed and sterilized. When cleaning and sterilizing reusable surgical tools and medical equipment, hospitals are required to follow standards developed by the Canadian Standards Association (CSA) and Manufacturer's Instructions for USE (MIFU). Proper washing and sterilization of surgical tools and medical equipment ensures that they can be safely reused on other patients.

As shown in **Figure 18**, washing and sterilization of reusable surgical tools and medical devices is the second-highest service area of hospitals' non-compliance with high-priority criteria for patient safety, according to Accreditation Canada.

Improper cleaning and sterilization can potentially result in surgical-site infections for patients. It can also cause delays or cancellations of surgeries, as the surgical team waits for a complete set of properly washed and sterilized surgical tools to arrive. For example, in spring 2019, over a two-month period, one hospital cancelled and rescheduled 62 surgeries (elective complex orthopedic surgeries) after becoming aware that specialized surgical tools that are used for some complex orthopedic surgeries may not have achieved sterilization.

Approximately every four years, as part of its hospital visits, Accreditation Canada reviews the processes hospitals have in place to clean and sterilize reusable surgical tools and equipment. Hospitals' compliance with patient safety best practices or the CSA standards in this area is not verified by any other organization. In contrast, the Ontario College of Pharmacists inspects hospital pharmacies annually to assess compliance with relevant standards from the National Association of Pharmacy Regulatory Authorities.

Each hospital is therefore responsible to monitor its own compliance with cleaning and sterilization standards. Some hospitals hire experts to do this work. We compared the expert reports from three hospitals with Accreditation Canada reports and found that the experts identified more instances of non-compliance with Accreditation Canada criteria.

For example, between April 30 and May 5, 2017, Accreditation Canada identified that one hospital did not comply with four criteria. Nine months later, the expert found that this hospital did not comply with 10 Accreditation Canada criteria and two CSA standards. We noted that during hospital visits Accreditation Canada assesses hospitals' policies and procedures in many areas, including cleaning and sterilization, but it does not perform detailed checks for compliance with CSA standards.

RECOMMENDATION 20

To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.

RESPONSE FROM OHA

Ontario hospitals will review strategies to improve compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment.

4.9.2 Management of Outsourcing Contracts for Sterilization of Reusable Surgical Tools and Medical Equipment Has Improved

Most hospitals in Ontario wash and sterilize their own reusable surgical tools and medical equipment in-house. Four hospitals have outsourced this work to a private company, SteriPro. The company is the only private company in Canada that offers washing and sterilization services of this kind.

Three hospitals we visited contracted with this third-party provider for sterilizing medical equipment. We found that the three hospitals did not have processes in place to ensure the contract was managed effectively. Specifically, the lack of key performance indicators prevented the hospitals from reliably assessing the third-party provider's performance. For example:

- One hospital entered into a contract with the third-party provider in 2011. The contract included key performance indicators such as requirements for availability of instruments and timely delivery. These indicators were not enforced until 2014.

- Another hospital entered into an agreement in 2012, although the key performance indicators were not put in place until 2015.
- The third hospital entered into a contract with the third-party provider in 2015. The hospital has informally used key performance indicators to track performance and quality issues; however, we noted that the agreement does not include specific indicators. This hospital informed us that it will negotiate indicators to be included in the next contract, due as a renewal in 2020.

A fourth hospital that entered into an agreement with a third-party provider in 2011 decided in 2015 to bring sterilization back in-house. This hospital noted that due to the lack of published key performance measures and industry benchmarks, it is difficult to evaluate sterilization practices and drive improvement. The hospital developed a framework that built on established guidelines and included service standards, key performance indicators and targets to evaluate surgical tools and medical device cleaning and sterilization processes. The framework, published in a health-related journal, includes 25 service standards and 10 key performance indicators.

RECOMMENDATION 21

In order for contracts with private providers of sterilization services to be managed effectively by hospitals, we recommend that hospitals:

- include all the necessary service standards and performance indicators in these contracts; and
- on a regular basis, assess the private service provider's compliance with all contract terms.

RESPONSE FROM OHA

Where the use of external providers for sterilization services exists, Ontario hospitals will closely review existing processes and contracts to ensure that the quality and safety of care is not compromised.

4.10 Hospital Overcrowding Limits Availability of Beds to Critically Ill Patients

Overall, between April 2003 and the end of March 2018, according to Statistics Canada and Ministry data, the number of acute-care hospital beds in Ontario decreased from 1.5 beds to 1.3 beds per 1,000 people.

We obtained data from the Ministry for the 25 acute-care hospitals with the highest overcrowding over the 12-month period ending February 2019. Over the year, these hospitals were at 110% of capacity on average, while on some days in winter months one hospital exceeded 120% of capacity.

Critically ill patients depend on receiving timely and appropriate care. In 2013, the Ministry issued a policy statement directing emergency medical services, hospitals and other stakeholders to work together to ensure that "no patient with a life or limb threatening condition shall be refused care."

CritiCall, a Ministry-funded organization, is a 24-hour medical emergency referral service that Ontario's hospital-based physicians can call when a critically ill patient requires an assessment and/or transfer to a more specialized facility with resources beyond what is available at their hospital to care for a life-or-limb patient. CritiCall, on behalf of the referring hospitals, co-ordinates inter-facility transport of a life-or-limb patient.

According to CritiCall, from April 2016 to the end of March 2019, 784 life-or-limb patients were denied inter-facility transfer to the closest hospital that could provide the appropriate level of care, because the hospital had no bed available to receive the patient. Some of these patients were denied inter-facility transfer more than once. Ten of these patients died while CritiCall was trying to facilitate inter-facility transfer to another hospital that could provide appropriate care, after at least one hospital had denied the patient's transfer because no beds were available.

In addition to these critically ill patients, we found that in the same period about 5,356 non-critically ill

patients were denied inter-facility transfers due to a lack of available beds (some multiple times). Given that these patients were not critically ill, there was less urgency for them to transfer to another hospital; however, these denied transfers further illustrate instances where available beds were lacking in the hospital system.

In August 2019, CritiCall issued a proposal for a province-wide "command centre" initiative, which would collect and analyze, in real-time, the patient bed flow of each acute-care hospital in Ontario. This would help CritiCall identify hospitals with free beds so that it could manage the transfer of life-or-limb, urgent and emergency patients more effectively. In recent years, hospitals such as Humber River Hospital have begun to create hospital-based command centres. Humber River Hospital feeds real-time data to artificial intelligence that analyzes the data and provides the command centre staff with information that they can use to monitor and manage patient flow in the hospital. In June 2018, Humber River Hospital found that since implementing the command centre, the information provided to staff has enabled rooms to be cleaned more quickly and beds to be managed more efficiently. As a result, the time a patient in the emergency department waits for a hospital bed had been reduced by 33%.

RECOMMENDATION 22

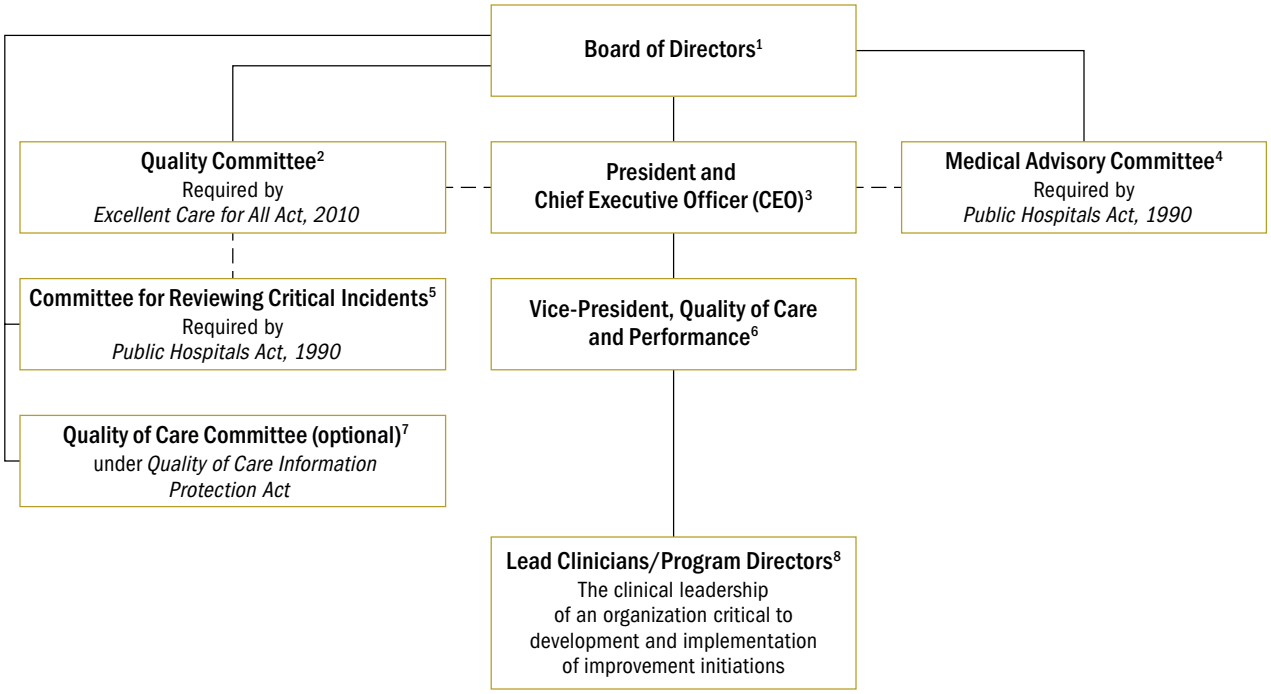
So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, we recommend that the Ministry of Health leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.

MINISTRY RESPONSE

The Ministry will work with CritiCall to explore the potential of a provincial bed command centre, including lessons learned from Humber River Hospital Command Centre.

Appendix 1: Acute-Care Hospital Governance Structure for Patient Safety

Prepared by the Office of the Auditor General of Ontario



Note: This governance and reporting structure specifically pertains to the hospitals' patient safety responsibilities under the *Excellent Care for All Act, 2010*.

1. Board of Directors: Has the ultimate authority and responsibility for the administration of the hospital and is also responsible for overseeing quality of care within the hospital.
2. Quality Committee: Oversees preparation of the Hospital's annual Quality Improvement Plan (QIP), reports to the Board on quality of care issues at the hospital and on the implementation progress of the Quality Improvement Plan.
3. President and CEO: Responsible for putting in place systems to improve quality of care in the hospital. Must establish a system for reviewing and disclosing critical incidents in the hospital, for implementing measures to avoid or reduce the risk of recurrence and for providing aggregated critical incident data to the hospital's Quality Committee at least twice a year. The CEO is also responsible for reporting to the College of Physicians and Surgeons of Ontario any disciplinary action taken with respect to physicians. Ensures the Board has the information required to understand the QIP and develops and provides progress reports to the Board on QIP.
4. Medical Advisory Committee: Monitors and approves initiatives for improving the quality of care provided to patients and promotes the standards of medical care in the hospital. Assists and advises the Board and the CEO in appointment and granting of hospital privileges to the professional staff (physicians, dentistry and midwifery), and provides general supervision over the practice of professional staff. Reports to the Board and Quality Committee any systemic or recurring quality of care issues it identifies to the Board and the Quality Committee.
5. Committee for Reviewing Critical Incidents: Investigates critical incidents, and develops recommendations on how to improve and prevent future incidents.
6. Vice-President, of Quality of Care and Performance (VP of Quality): Responsible for the planning, development and implementation of programs and initiatives to enhance patient experience in the hospital.
7. Quality of Care Committee: A special committee established to evaluate the provision of health care, which may include conducting reviews of critical incidents and which includes restrictions on disclosures from legal proceedings and most other disclosures.
8. Lead Clinicians/Clinical Directors/Program Directors: Act as the link between front-line staff, Quality Committees and the VP of Quality by reporting on progress on quality and patient safety initiatives in the organization. Involved in QIP development and implementation.

Appendix 2: Risk-Specific Patient Safety Standards and Best Practices

Prepared by the Office of the Auditor General of Ontario

Hospital Department/ Risk Area	Patient Safety Standards and Best Practices	Organizations Following Standards/Practices
Medication administration	Best practices to guide nurses on how to safely administer medication to patients	College of Nurses of Ontario
	Best practices to prevent medication errors	Institute for Safe Medication Practices Canada
Cleaning and sterilizing surgical tools	To ensure the sterilization of surgical tools and medical equipment is done according to standards	Canadian Standards Association Provincial Infectious Disease Advisory Committee
	The sterilization department should meet certain standards for employees' safety	ISO9001 (facility standards)
Hospital pharmacy	Various standards to ensure the pharmacy department operates in a safe manner	Ontario College of Pharmacists
Housekeeping	Follow provincial standards on cleaning and disinfecting health-care facilities	Provincial Infectious Disease Advisory Committee
Infection prevention and control	Follow provincial standards on screening of, isolation of and surveillance processes for micro-organisms	Provincial Infectious Disease Advisory Committee Public Health Ontario
Surgical safety	Various best practices to prevent complications from surgeries, e.g., foreign body left inside patients and surgical site infections.	National Surgical Quality Improvement Program

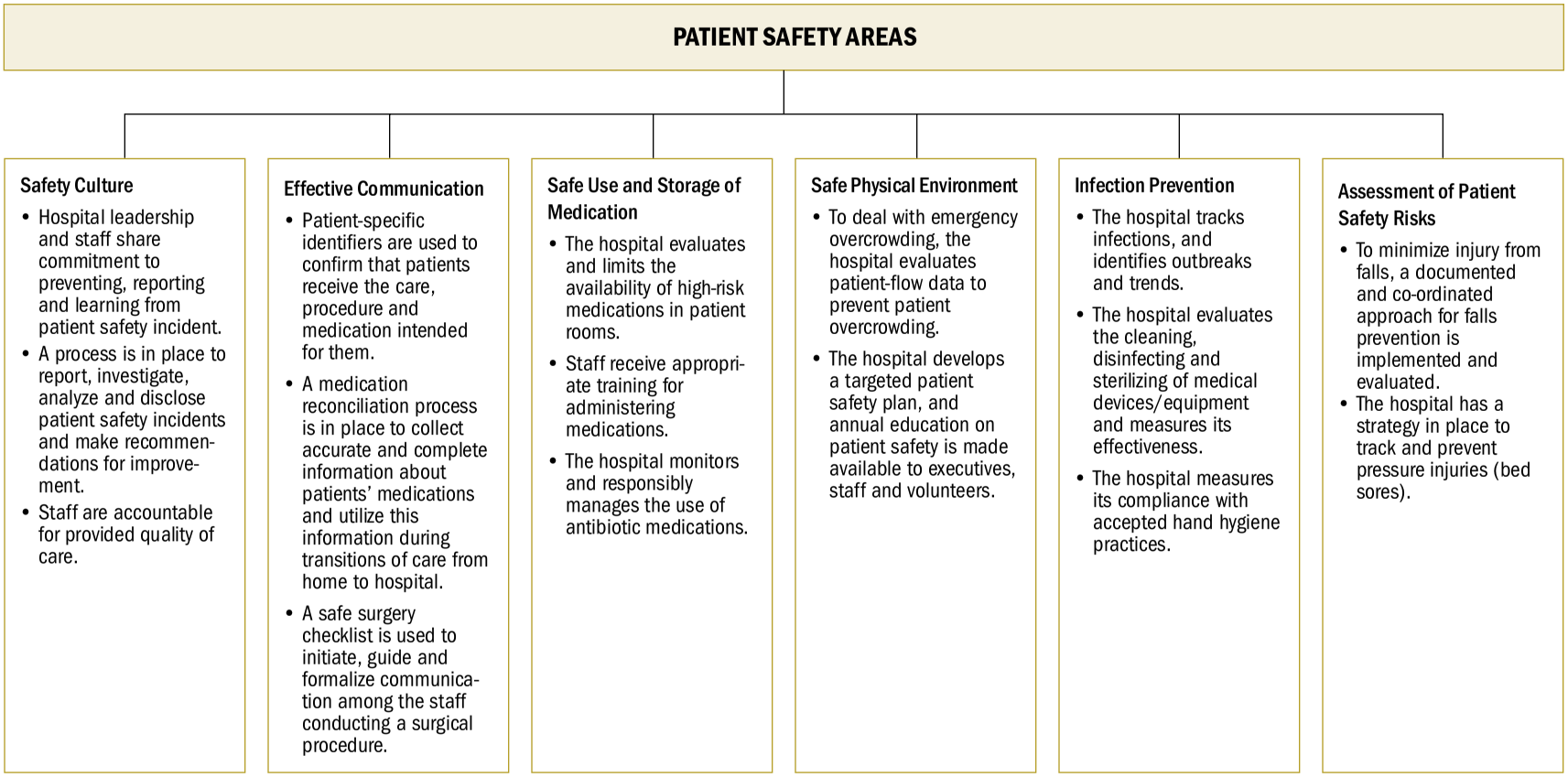
Appendix 3: Organization-Wide Patient Safety Requirements

Prepared by the Office of the Auditor General of Ontario

Organizational Focus	Patient Safety Requirements
Oversight of patient safety	The board of governors is required to have a Quality Committee, responsible for overseeing the quality and safety of care provided to patients.
Reporting patient safety incidents	Hospital staff are expected to report patient safety incidents so that they can be appropriately addressed, investigated and prevented in the future.
Survey of hospital staff and patients	Hospitals are required to survey patients and staff regularly to assess the quality and safety of care, and to incorporate survey results in annual Quality Improvement Plans.

Appendix 4: Key Required Practices for Hospital Patient Safety Reviewed for Compliance by Accreditation Canada

Source of data: Accreditation Canada



Note: Each required practice is assessed by Accreditation Canada using applicable standards.

Appendix 5: Other Patient Safety Stakeholder Organizations

Prepared by the Office of the Auditor General of Ontario

Organization	Function
Canadian Institute for Health Information	An independent not-for-profit organization that provides essential information on Canada's health systems and the health of Canadians.
Canadian Patient Safety Institute	A not-for-profit organization established by Health Canada in 2003. The Institute works with hospitals, governments and health-care providers to improve patient safety.
College of Nurses of Ontario	A regulating body for Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Nurse Practitioners (NPs) in Ontario.
College of Physicians and Surgeons of Ontario	Registering and regulating body for physicians and surgeons practicing medicine in Ontario
Health Quality Ontario	A government of Ontario agency that advises the government and health-care providers on the evidence to support high-quality care and improvements in quality, and monitors and reports to the public on the quality of health care provided in Ontario.
Institute for Safe Medication Practices Canada	A national not-for-profit organization committed to the advancement of medication safety in all health-care settings.
Ontario College of Pharmacists	Registering and regulating body for the profession of pharmacy in Ontario. It ensures that pharmacies within the province meet certain standards of operation and are accredited by the College.
Ontario Hospital Association	A not-for-profit organization serving Ontario's hospitals to build a better health system.
Ontario Medical Association	A not-for-profit organization representing the political, clinical and economic interests of the province's medical profession.
Ontario Nurses Association	The union representing registered nurses and health-care professionals, as well as nursing student affiliates, across the province.
Provincial Infectious Disease Advisory Committee	A multidisciplinary committee of health-care professionals with expertise and experience in infection prevention and control.
Public Health Ontario	A government of Ontario agency that provides scientific evidence and technical advice on infection surveillance, prevention and controls in hospitals.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Effective and cost-efficient hiring and disciplinary processes are in place to ensure that safe, competent care is delivered by doctors, nurses and hospital staff.
2.	Effective processes are in place to prevent, report, investigate, disclose and learn from patient safety incidents, including patient falls, medication errors, procedure-related errors and hospital-acquired infections.
3.	Effective and cost-efficient processes are in place to ensure that surgical tools and medical devices are properly cleaned, sterilized and handled, and are available when needed.
4.	Effective processes are in place to ensure that hospital areas are cleaned and disinfected properly.
5.	Effective processes are in place to ensure that patients receive the right dose of the right medication at the right time and by the right method.
6.	Effective processes are in place to ensure that high-risk medications are securely stored and accounted for, and safely administered to patients.

Appendix 7: Hospitals Visited and Patient Safety Areas Examined

Prepared by the Office of the Auditor General of Ontario

Hospital Name (Type)*	Patient Safety Area Examined				
	Human Resources	Infection Prevention	Medication Administration	Pharmacy	Quality
Halton Healthcare (large community)	✓	✓	✓	✓	✓
Hamilton Health Sciences (acute teaching)	✓	✓	✓	✓	✓
Humber River Hospital (large community)	✓	✓	✓	✓	✓
Nipigon Memorial Hospital (small community)	✓	✓	✓	✓	✓
Pembroke Regional (medium community)	✓	✓	✓	✓	✓
Thunder Bay Regional Health Sciences Centre (acute teaching)	✓	✓	✓	✓	✓
The Ottawa Hospital (acute teaching)	✓	✓	✓	✓	✓
Women's College Hospital – Ambulatory Care	✓	✓		✓	✓
Chatham-Kent Health Alliance (medium community)			✓	✓	
Grand River Hospital (large community)			✓	✓	
Northumberland Hills Hospital (medium community)			✓	✓	
Stratford General Hospital (medium community)			✓	✓	
St. Thomas Elgin General Hospital (medium community)			✓	✓	

Note: During the audit planning stage, we conducted walkthroughs at Trillium Health Partners (THP), which was one of the hospitals audited in our 2016 report on Large Hospital Operations. In this audit, we limited our audit work at Trillium to Human Resources.

* These are the funding categories for hospitals we visited:
- Acute teaching: Approved as a teaching hospital by the Ministry.
- Small community: Acute inpatient/day surgery activity <4,000 weighted cases per year. Weighted cases based on five years of data.
- Medium community: Acute inpatient/day surgery activity between 4,000 and 12,000 weighted cases per year.
- Large community: Acute inpatient/day surgery activity >12,000 weighted cases per year.

Appendix 8: Recommendations and Responsible Organizations

Prepared by the Office of the Auditor General of Ontario

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
1. To further emphasize patient safety as a foundation for hospitals' organizational culture, we recommend that hospitals explicitly incorporate the words "patient safety" in their mission, vision, and/or as one of their core values, and communicate this to their staff, ensuring that related actions demonstrate this emphasis.	✓	✓ (lead)		
2. To determine and reduce the impact of never-events on patient safety and the health-care system, we recommend that the Ministry of Health: • work with internal and external partners to leverage an existing system that can accumulate and track hospital never-event data; • upon implementation and rollout completion of this system, analyze the frequency of never-events occurring at Ontario hospitals, estimating their cost to the health-care system; and • partner with hospitals and best practice organizations/ stakeholder groups to develop a plan to prevent them from happening.	✓	✓		✓ (lead)
3. To minimize the occurrence of serious preventable patient safety incidents, we recommend that hospitals: • enhance patient safety practices to eliminate the occurrence of never-events; • set a formal target to eliminate the occurrence of never-events and include this target in their Quality Improvement Plans; and • track and report never-events to the Ministry of Health.	✓	✓ (lead)		✓
4. To better enable hospitals to prevent similar patient safety incidents, including never-events, from recurring at different hospitals, we recommend that the Ministry of Health work with the Ontario Hospital Association and applicable stakeholder groups to establish a forum where hospitals can share their knowledge and lessons learned from patient safety incident investigations.	✓	✓		✓ (lead)
5. To enable nurses' prospective employers to obtain a more complete record of nurses' employment history and performance and make well-informed hiring decisions, we recommend that the Ministry of Health have the Ontario Hospital Association work with the College of Nurses of Ontario and other regulatory stakeholders to: • identify gaps in the current information available to prospective employers regarding past performance issues and terminations; and • take steps to address gaps identified.	✓	✓	✓	✓ (lead)

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
6. In order for hospitals that hire nurses to have access to the complete record of nurses' past places of employment and disciplinary history, we recommend that hospitals: • use the National Council of State Boards of Nursing public database to determine whether nurses they hire and employ have faced disciplinary actions in the United States; and • if the hospital uses agency nurses, require nursing agencies to confirm these nurses have been screened through this database.	✓	✓ (lead)		
7. To help ensure that when hospitals hire nurses they have access to their full disciplinary record, we recommend that the Ministry of Health request that the Ontario Hospital Association and the College of Nurses of Ontario work together with their provincial and territorial counterparts to: • explore a national system for provincial and territorial nursing regulatory bodies to report their disciplinary actions; and • put in place an effective process that will ensure that all places of past employment and disciplinary records from other jurisdictions for each nurse are in its database, including records from US nursing databases.	✓	✓	✓	✓ (lead)
8. To better inform employers in their hiring decisions and protect patients from the risk of harm, we recommend that the Ministry of Health assess for applicability in Ontario the actions taken by US states to protect hospitals and other health-care providers from liability associated with any civil action for disclosing a complete and truthful record about a current or former nurse to a prospective employer.				✓ (lead)
9. In the interest of patient safety and in order for hospitals and agencies to hire nurses fully aware of their past employment and performance history, we recommend that the Ministry of Health explore means to: • enable hospitals and agencies to provide and receive truthful references and information to make informed nursing hiring decisions; and • require these organizations to disclose such information when it is requested by a prospective employer.	✓	✓		✓ (lead)
10. So that hospitals can make optimally informed hiring and staffing decisions, we recommend that the Ministry of Health require all hospitals in Ontario to: • perform criminal record checks before hiring nurses and other health-care employees; and • periodically update checks for existing staff.	✓	✓		✓ (lead)

Recommendation	Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
11. To enable hospitals to take timely action to improve patient safety, we recommend that the Ministry of Health explore means to make it easier and less costly for hospitals and ultimately the taxpayer to address physician human resources issues, especially in cases when doctors may have harmed patients.	✓	✓		✓ (lead)
12. To improve patient safety, we recommend that the Ministry of Health: • review the Accreditation Canada hospital reports and identify areas where hospitals may consistently not be meeting required patient safety practices and high-priority criteria; and • follow up with hospitals in respect of problem areas to confirm that actions are taken to correct deficiencies.	✓	✓		✓ (lead)
13. So that hospitals fully complete medication reconciliation to reduce the risk to discharged patients and that they have all the necessary patient information to properly investigate any incidents with patients' dosages or drug interactions that might occur and trigger hospital readmission, we recommend that hospitals reinforce with staff the importance of the medication reconciliation documentation processes so that all the necessary information is consistently documented.	✓	✓ (lead)		
14. To reduce the risk of medication errors and readmissions to hospital, we recommend that the Ministry of Health: • require hospitals to complete medication reconciliation for all patients; • require hospitals to include medication reconciliation in their Quality Improvement Plans; and • in conjunction with relevant hospitals, review their IT system needs to be able to track necessary medication reconciliation information and take action for improvement where needed.	✓	✓		✓ (lead)
15. To improve patient safety, we recommend that hospitals reinforce with nurses necessary medication administration processes to ensure that: • independent double-checks of high-risk medications are done to verify that correct medication and dosage are administered; • nurses witness patients taking and swallowing high-risk medications; and • nurses use two unique identifiers to confirm the identity of patients before administering medication to them.	✓	✓ (lead)		
16. To minimize patient safety incidents due to missing information or miscommunication, we recommend hospitals adopt, based on patient condition, the practice of making nursing shift changes at the patients' bedside and where possible involving the patients and their families, with the consent of the patients, in the process.	✓	✓ (lead)		

Recommendation		Ontario Hospitals	Ontario Hospital Association	College of Nurses of Ontario	Ministry of Health
17.	To improve patient safety with respect to medication administration and where a compelling business case for cost-effectiveness can be made, we recommend that the Ministry work with hospitals toward the automation of pharmacy-related tasks.	✓	✓		✓ (lead)
18.	To improve the accuracy of reported hand hygiene compliance, while at the same time encouraging hand hygiene, we recommend that the Ontario Hospital Association work with hospitals to evaluate and further the adoption of additional methods to assess and monitor hand hygiene, such as electronically monitored hand hygiene pumps and monitoring systems, and asking patients to observe and record the hand hygiene compliance of their health-care providers.	✓	✓ (lead)		
19.	So that sterile-rooms and the equipment used in the mixing and preparation of intravenous medications are cleaned according to required standards, we recommend that hospitals: • provide their pharmacy and housekeeping staff with proper training on how to conduct the cleaning; and • monitor the cleaning to ensure proper processes are being followed.	✓	✓ (lead)		
20.	To improve hospitals' compliance with the Canadian Standards Association's standards pertaining to the washing and sterilization of surgical tools and medical equipment, we recommend that hospitals have their washing and sterilization of surgical tools and medical equipment inspected internally on an annual basis.	✓	✓ (lead)		
21.	In order for contracts with private providers of sterilization services to be managed effectively by hospitals, we recommend that hospitals: • include all the necessary service standards and performance indicators in these contracts; and • on a regular basis, assess the private service provider's compliance with all contract terms.	✓	✓ (lead)		
22.	So that patients with a life- or limb-threatening condition receive timely care from the closest hospital, we recommend the Ministry of Health leverage learned lessons from hospitals that utilize "command centres" and work with CritiCall toward the development of a provincial bed command centre.	✓	✓		✓ (lead)

Appendix 9: Overall Patient Safety Culture Staff Survey Results at 123 Acute-Care Hospitals, 2014–2019

Source of data: Ontario Hospitals

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
Hamilton Health Sciences	Teaching	1,744	54	33	13	**100**
Health Sciences North	Teaching	580	41	39	20	**100**
Kingston Health Sciences Centre	Teaching	810	47	39	15	**100**
London Health Sciences Centre	Teaching	502	38	38	24	**100**
Montfort Hospital	Teaching	339	70	23	7	**100**
Sinai Health System	Teaching	751	68	29	3	**100**
St. Joseph's Health Care London	Teaching	n/a	n/a	n/a	n/a	**n/a**
St. Joseph's Healthcare Hamilton	Teaching	2,244	58	34	9	**100**
Sunnybrook Health Sciences Centre	Teaching	1,434	66	30	4	**100**
The Ottawa Hospital	Teaching	2,584	58	35	7	**100**
Thunder Bay Regional Health Sciences Centre	Teaching	461	48	39	13	**100**
Unity Health Toronto	Teaching	n/a	n/a	n/a	n/a	**n/a**
University Health Network	Teaching	n/a	n/a	n/a	n/a	**n/a**
University of Ottawa Heart Institute	Teaching	658	66	30	4	**100**
Bluewater Health	Large community	296	56	34	10	**100**
Brant Community Healthcare System	Large community	462	28	39	33	**100**
Grand River Hospital	Large community	968	56	35	10	**100**
Grey Bruce Health Services	Large community	503	63	31	6	**100**
Guelph General Hospital	Large community	474	56	34	10	**100**
Halton Healthcare Services	Large community	628	53	34	13	**100**
Humber River Hospital	Large community	995	41	38	21	**100**
Joseph Brant Hospital	Large community	530	36	42	22	**100**
Lakeridge Health	Large community	519	55	35	11	**100**
Mackenzie Health	Large community	359	52	35	13	**100**
Markham-Stouffville Hospital	Large community	515	58	34	8	**100**
Niagara Health System	Large community	883	53	34	13	**100**
North Bay Regional Health Centre	Large community	307	41	44	16	**100**
North York General Hospital	Large community	477	65	28	6	**100**
Peterborough Regional Health Centre	Large community	552	44	44	13	**100**
Queensway-Carleton Hospital	Large community	439	51	39	10	**100**
Quinte Healthcare Corporation	Large community	433	47	38	15	**100**
Royal Victoria Regional Health Centre	Large community	1,949	46	39	15	**100**
Sault Area Hospital	Large community	449	52	35	14	**100**
Southlake Regional Health Centre	Large community	503	42	34	24	**100**
St. Mary's General Hospital	Large community	295	42	31	27	**100**

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Failing	Total
The Scarborough Network	Large community	n/a	n/a	n/a	n/a	**n/a**
Toronto East Health Network	Large community	578	53	30	17	**100**
Trillium Health Partners	Large community	3,392	61	34	5	**100**
William Osler Health System	Large community	715	52	38	10	**100**
Windsor Regional Hospital	Large community	589	61	33	5	**100**
Brockville General Hospital	Medium community	233	42	41	17	**100**
Cambridge Memorial Hospital	Medium community	364	49	40	11	**100**
Chatham-Kent Health Alliance	Medium community	364	37	46	17	**100**
Collingwood General and Marine Hospital	Medium community	203	49	37	14	**100**
Cornwall Community Hospital	Medium community	343	54	34	12	**100**
Georgian Bay General Hospital	Medium community	197	42	42	17	**100**
Headwaters Health Care Centre	Medium community	239	53	35	13	**100**
Muskoka Algonquin Healthcare	Medium community	224	49	38	13	**100**
Norfolk General Hospital	Medium community	181	46	39	14	**100**
Northumberland Hills Hospital	Medium community	252	59	33	9	**100**
Orillia Soldiers' Memorial Hospital	Medium community	n/a	n/a	n/a	n/a	**n/a**
Pembroke Regional Hospital	Medium community	223	52	40	9	**100**
Perth and Smiths Falls District Hospital	Medium community	219	79	20	1	**100**
Ross Memorial Hospital	Medium community	251	49	38	13	**100**
St Thomas-Elgin General Hospital	Medium community	203	59	28	13	**100**
Stratford General Hospital	Medium community	214	59	37	4	**100**
Strathroy Middlesex General Hospital	Medium community	146	64	31	5	**100**
Timmins and District Hospital	Medium community	352	49	39	12	**100**
West Parry Sound Health Centre	Medium community	165	60	30	10	**100**
Woodstock General Hospital Trust	Medium community	499	70	26	4	**100**
Alexandra Hospital	Small	29	79	17	3	**100**
Alexandra Marine and General Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Almonte General Hospital	Small	150	67	26	7	**100**
Anson General Hospital	Small	56	52	36	13	**100**
Arnprior Regional Health	Small	63	48	44	8	**100**
Atikokan General Hospital	Small	74	70	27	3	**100**
Bingham Memorial Hospital	Small	61	56	39	5	**100**
Campbellford Memorial Hospital	Small	74	59	31	10	**100**
Carleton Place and District Memorial Hospital	Small	65	63	29	8	**100**
Casey House Hospice	Small	n/a	n/a	n/a	n/a	**n/a**
Clinton Public Hospital	Small	28	50	43	7	**100**
Deep River and District Hospital	Small	49	51	16	33	**100**
Dryden Regional Health Centre	Small	93	68	27	5	**100**
Englehart and District Hospital	Small	31	77	19	3	**100**

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Falling	Total
Erie Shores HealthCare	Small	196	50	31	11	**100**
Espanola General Hospital	Small	42	83	17	0	**100**
Four Counties Health Services Corporation	Small	37	57	35	8	**100**
Geraldton District Hospital	Small	84	70	25	5	**100**
Glengarry Memorial Hospital	Small	105	72	21	7	**100**
Groves Memorial Community Hospital	Small	129	43	44	13	**100**
Haldimand War Memorial Hospital	Small	122	76	20	4	**100**
Haliburton Highlands Health Services Corporation	Small	149	57	34	9	**100**
Hanover and District Hospital	Small	113	81	16	3	**100**
Hawkesbury and District General Hospital	Small	234	45	42	13	**100**
Hornepayne Community Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Kemptville District Hospital	Small	100	64	31	5	**100**
Kirkland and District Hospital	Small	73	77	22	1	**100**
Lady Dunn Health Centre	Small	43	60	33	7	**100**
Lady Minto Hospital	Small	88	48	43	9	**100**
Lake-of-the-Woods District Hospital	Small	153	40	45	15	**100**
Lennox and Addington County General Hospital	Small	110	77	16	6	**100**
Listowel Memorial Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Manitoulin Health Centre	Small	87	74	24	2	**100**
Mattawa General Hospital	Small	121	74	24	2	**100**
Nipigon District Memorial Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
North of Superior Healthcare Group	Small	77	73	15	12	**100**
North Shore Health Network	Small	88	77	15	8	**100**
North Wellington Health Care	Small	111	67	31	3	**100**
Notre Dame Hospital	Small	60	82	15	3	**100**
Red Lake Margaret Cochenour Memorial Hospital	Small	50	72	26	2	**100**
Renfrew Victoria Hospital	Small	228	80	18	2	**100**
Riverside Health Care Facilities Inc	Small	107	47	43	10	**100**
Santé Manitouwadge Health	Small	n/a	n/a	n/a	n/a	**n/a**
Seaforth Community Hospital	Small	29	72	28	0	**100**
Sensenbrenner Hospital	Small	117	47	38	15	**100**
Services de Santé de Chapleau Health Services	Small	74	89	8	3	**100**
Sioux Lookout Meno Ya Win Health Centre	Small	174	66	29	5	**100**
Smooth Rock Falls Hospital	Small	54	80	19	2	**100**
South Bruce Grey Health Centre	Small	161	53	34	14	**100**

Hospital	Funding Category*	# of Staff Surveyed	Overall Grade on Patient Safety (%)			
			Excellent or Very Good	Acceptable	Poor or Falling	Total
South Huron Hospital	Small	61	39	41	20	**100**
St. Francis Memorial Hospital	Small	82	84	14	2	**100**
St. Joseph's General Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
St. Marys Memorial Hospital	Small	29	62	31	7	**100**
Stevenson Memorial Hospital	Small	117	44	44	12	**100**
Temiskaming Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Tillsonburg District Memorial Hospital	Small	80	66	29	5	**100**
Weeneebayko Area Health Authority	Small	n/a	n/a	n/a	n/a	**n/a**
West Haldimand General Hospital	Small	95	43	43	14	**100**
West Nipissing General Hospital	Small	115	74	25	1	**100**
Winchester District Memorial Hospital	Small	163	67	24	9	**100**
Wingham and District Hospital	Small	n/a	n/a	n/a	n/a	**n/a**
Children's Hospital of Eastern Ontario – Ottawa Children's Treatment Centre	Specialty child	n/a	n/a	n/a	n/a	**n/a**
The Hospital For Sick Children	Specialty child	2,014	70	27	3	**100**
Average		**385**	**59**	**32**	**9**	**100**

Notes: Survey results based on staff perceptions at a point in time.
n/a—survey was provided in a format that was not comparable with other hospitals' survey format.

* Funding Category: This categorization applies to the hospital corporation and is used for the purposes of funding:
- Teaching: Approved as a teaching hospital by the Ministry.
- Small: Acute inpatient/day surgery activity <4,000 weighted cases per year. Weighted cases based on five years of data.
- Medium community: Acute inpatient/day surgery activity between 4,000 and 12,000 weighted cases per year.
- Large community: Acute inpatient/day surgery activity >12,000 weighted cases per year.
- Specialty child: Standalone hospital that primarily treats children.

Appendix 10: Elements of Automation in Hospitals and Impact on Medication Dispensing and Administration

Prepared by the Office of the Auditor General of Ontario

Element of Automation	Impact on Medication Dispensing and Administration
Computerized physician order entry	Allows prescribers to order medication electronically that is automatically sent to the patient's file and to the hospital pharmacy. This can prevent errors such as missing physician orders from patient files, allergy and drug interactions, because the system has warnings, and a transcription error when trying to decipher a physician's handwriting.
Electronic medication administration record	Provides an electronic record of a patient's medications, including dose and time of delivery. This reduces manual errors due to transcribing and/or re-copying this information.
Automated single dose packaging of medication	Provides an automated process for preparing and packaging medications by each single dose. This improves the accuracy of medication preparation and allows pharmacists/pharmacy technicians to focus on tasks such as medication reconciliation.
Automated dispensing cabinet	Password-protected medication cabinet that nurses use to dispense single-dose medication. The cabinet stores patient information and warns the nurse if the dispensing is not consistent with a patient's prescription. The cabinet also tracks narcotic dispensing and helps hospitals to identify whether narcotics are being diverted by health-care professionals.
Barcoded patient identifier bracelet and medication label	Provides a mechanism for health-care staff administering medication to match the medication and dose with the correct patient. The health-care staff is automatically warned if the patient or medication does not match.

Ministry of Health

Addictions Treatment Programs

1.0 Summary

Addictions are complex conditions in which problematic patterns of substance use or behaviours can interfere with a person's life. Addictions can be broadly defined as conditions that lead to a compulsive engagement with a substance or behaviour, despite negative consequences.

According to the Canadian Mental Health Association, it is estimated that approximately 10% of the population in Ontario uses substances problematically. A 2018 study published by the Canadian Centre on Substance Use and Addiction estimated that the overall costs and harms of substance use in Ontario was over $14.6 billion in 2014. Overall, the rates of problematic substance use and gambling in Ontario are fairly close to the rest of Canada based on our review of various studies.

The Ministry of Health (Ministry) is the primary funder and overseer of addictions services in Ontario. In 2018/19, about $212 million was spent by about 200 addictions treatment service providers to treat over 76,700 clients largely through three main types of programs:

- non-residential treatment programs, where clients do not stay at a facility in the community overnight but generally receive weekly or twice weekly treatment services during the day;
- residential treatment programs, where clients stay at a facility in the community for treatment services; and
- withdrawal management or detox programs, where clients receive medical and non-medical support to deal with symptoms related to the withdrawal from one or more substances either in the community or in a residential setting.

Between 2014/15 and 2018/19, spending on addictions treatment programs grew almost 25% or $42 million, rising from $170 million to $212 million. Since August 2017, an additional $134 million was spent on the Ministry's Opioid Strategy. Despite this increased spending, we found that wait times for addictions treatment, repeat emergency department visits for substance-use conditions, as well as opioid-related emergency department visits, hospitalizations and deaths continue to increase.

We found that the Ministry does not allocate funding to addictions treatment programs based on need. We also noted that the Ministry requires service providers to follow just a single set of standards, relating to withdrawal management programs only, resulting in significant variability in the operations and services for other addictions treatment programs. The Ministry also does not measure the effectiveness of addictions treatment service providers, which results in funding being given to service providers without consideration of whether their programs are effective. Funding

decisions are historically based or driven by allocations in prior years rather than program effectiveness or outcomes. In addition, we found that the Ministry does not proactively and regularly share with health-care providers and regulatory colleges information on opioid prescriptions dispensed to ensure that opioids are prescribed and dispensed appropriately.

As Ontario has committed to investing $3.8 billion over 10 years (from 2017/18 to 2026/27) for mental health and addictions services, it is important that going forward, funding for addictions services is allocated appropriately to meet the needs of Ontarians.

The following are some of our significant observations.

- **Longer wait times for addictions treatment leads to people being hospitalized or dying before receiving treatment.** Between 2014/15 and 2018/19, wait times for all addictions treatment programs increased. For example, the average wait time for residential treatment programs increased from 43 days to 50 days, with about 58% of programs having wait times of 30 days or greater, and in one case, over a year. Service providers informed us that they were aware of their clients dropping off wait lists for treatment programs because they were hospitalized, incarcerated, attempted suicide or even died while waiting for treatment.
- **Insufficient community-based addictions services causes more people to seek treatment from emergency departments.** Between 2014/15 and 2018/19, all types of emergency department visits grew by 6%, but visits to emergency departments for substance-use conditions increased by almost 40% and repeat unscheduled visits to emergency departments within 30 days for substance-use conditions increased almost 50%. While it is appropriate for emergency departments to provide emergency medical care to people with urgent substance-use issues (such as alcohol poisoning), people should obtain treatment for their addictions from community-based service providers as opposed to visiting emergency departments repeatedly. We estimated that over $5 million was spent in 2018/19 on providing care to frequent visitors of emergency departments for substance-use conditions. This same money could have been spent on addictions treatment programs delivered by service providers; for example, this amount would have funded 19 days of non-residential treatment for each of the frequent visitors.
- **The Ministry allocates funding for addictions treatment services without determining the need for each type of service across the province.** While a model exists that enables the Ministry to identify the need for addictions treatment services, the Ministry has not set a timetable for its implementation. Between 2014/15 and 2018/19, funding for addictions treatment programs grew by about 25%, (from $191 million to $239 million). Over half of the new funding was allocated to new service providers or programs and was primarily reported as being spent on non-residential counselling services, even though the majority of people seeking treatment presented with increasingly complex issues and may have required more intensive services, such as case management, as opposed to counselling services alone. We also noted that funding for the majority of ongoing addictions treatment programs only increased by 3.6% or less, which was half the inflation rate, making it challenging for some service providers to maintain the current program's service level.
- **The Ministry funds addictions treatment service providers without evaluating the effectiveness of their programs.** The Ministry only requires that service providers submit information on their spending and service activity, but has not collected any information

on their operations and performance to assess the effectiveness of their programs. While some service providers identified ways to assess the effectiveness of their programs (such as interviewing clients or conducting client surveys before and after clients receive treatment to assess their outcomes), the Ministry has never asked for this information.

- **Lack of provincial standards results in inconsistent delivery for most addictions treatment programs.** Of the three main types of addictions treatment programs (non-residential, residential and withdrawal management), the Ministry requires service providers to follow a set of standards that applies only to withdrawal management programs. In the absence of standards for non-residential and residential programs, service providers determine on their own how to deliver their programs, resulting in significant differences among service providers for the same types of programs. For residential treatment programs, the expected length of the program ranged from 19 to 175 days, and the client-to-staff ratio ranged from two to 12 clients per staff. For non-residential treatment programs offered by the community-based service providers, about 30% did not offer any services during weeknights and 76% did not offer any weekend services.
- **Integration and co-ordination is lacking among ministries that provide addictions services.** Since more than half of individuals in correctional institutions in Ontario suffer from substance-use conditions, it is important to better integrate and co-ordinate addictions services for individuals within these institutions (currently the responsibility of the Ministry of the Solicitor General) and upon their discharge. In 2018, the Office of the Chief Coroner identified 31 deaths where individuals died from opioid overdoses within four weeks of discharge from a provincial correctional institution.
- **Emerging issues, including cannabis legalization and vaping, need further monitoring:** The impacts of recent changes in legislation and consumer habits need to be monitored to identify whether additional addictions prevention and treatment services are necessary. In September 2019, three incidences of vaping-related severe lung disease were under review in Ontario. In October 2019, the U.S. Centers for Disease Control and Prevention also reported over 30 deaths and more than 1,400 cases of lung injury associated with the use of e-cigarettes or vaping. Amid such growing concern, the US government announced a plan to remove unauthorized flavoured e-cigarettes (except "tobacco" flavour) from the market and several states have enacted legislation to ban the sale of e-cigarettes. In Canada, none of the provinces have banned the sale of vaping products. In September 2019, the Minister of Health in Ontario issued an order that requires public hospitals to provide the Chief Medical Officer of Health with information related to incidences of vaping-related severe lung disease.

Another set of significant findings relates to the Ministry's Opioid Strategy (Strategy), which was launched in August 2017 to address the opioid crisis as evidenced by the significant growth of opioid-related deaths from more than one death a day in 2007 to about two deaths a day in 2016. A 2018 study by the Institute for Clinical Evaluative Sciences found a significant rise in opioid-related deaths in Ontario among young adults and youths. One out of six deaths among Ontarians aged 25 to 34 was related to opioids in 2015. Meanwhile, one of nine deaths among those aged 15 to 24 was related to opioids, which is nearly double the rate of 2010 when one in 16 deaths in the age group was opioid-related.

- **Despite spending about $134 million on the Strategy between August 2017 and March 2019, opioid-related deaths,**

emergency department visits and hospitalizations continue to increase. Opioid-related deaths grew by about 70% (from 867 to 1,473), from over two deaths a day in 2016 to more than four deaths a day in 2018. Over the same period, opioid-related emergency department visits more than doubled (from 4,427 to 9,154); and opioid-related hospitalizations also grew over 10% (from 1,908 to 2,106).

- **Most of the Strategy's funding for treating opioid addictions is not allocated to the regions with highest need.** Of the over $58 million the Ministry allocated to Local Health Integration Networks (LHINs) for opioid addictions treatment as part of its Strategy, only one-third was allocated based on factors that reflect regional needs (such as population size, opioid-related deaths, emergency department visits and hospitalizations), with the remainder being equally distributed among the LHINs. For example, in comparison with the South East LHIN, the Central East LHIN's population was over three times larger, its opioid-related deaths were more than double, and it had more than triple the number of opioid-related emergency department visits. However, in 2017, funding for opioid-addiction treatment to the Central East LHIN was only about 1.6 times higher than the South East LHIN.
- **Opioids appear to be inappropriately dispensed as prescribers do not have access to the Ministry's system that identifies the history of opioid prescriptions dispensed to a patient**. Ontario does not provide all health-care providers who can prescribe opioids, including physicians and dentists, with access to a provincial system containing the history of opioid prescriptions dispensed to patients. Therefore, prescribers may have to rely on information self-disclosed by their patients, who may intentionally or mistakenly provide wrong or incomplete information. This can lead to inappropriate or excessive opioid prescriptions, because prescribers are unable to verify if their patients have already received opioids prescribed and dispensed by others. We identified cases where patients received multiple opioids prescribed by different health-care providers. For example, in 2018/19, there were almost 1,500 instances where an individual received at least an eight-day supply of opioids prescribed by a physician and within one week received additional opioids prescribed by a dentist.
- **Information on unusual or suspicious instances where opioids were dispensed, such as opioids prescribed by physicians and dentists with inactive licences, is not shared with regulatory colleges for investigation.** The Ministry does not proactively monitor and share information on opioid dispensing events that appear to be unusual or suspicious with regulatory colleges on a regular basis, even though such information can assist the regulatory colleges to identify inappropriate practices, perform investigations and take corrective actions on a timely basis. Based on our review of information reported by pharmacy staff on opioids dispensed between 2014/15 and 2018/19, we identified cases that would have been appropriate for the Ministry to proactively bring to the attention of regulatory colleges. For example:
  - **Instances where opioids were prescribed and dispensed in large dosages:** In 2018/19, a physician prescribed opioids to 58 patients where the average daily dosage dispensed was over 17 times higher than the average daily dose dispensed based on prescriptions by all physicians. Another physician prescribed an 840-day supply of opioids within one year that was dispensed to a patient.
  - **Instances where pharmacists dispensed opioids associated with physicians**

and dentists with inactive licences: From 2014/15 to 2018/19, there were about 88,000 instances where opioids were dispensed that were associated with approximately 3,500 prescribers (2,900 physicians and 600 dentists) with inactive licences. The licences, dating back to at least 2012, were inactive for various reasons: about 400 prescribers were deceased (including two physicians who died in 1989 and a dentist who died in 2002), 10 prescribers had had their licences revoked for disciplinary reasons (including one physician whose licence was revoked in 2000), and 3,100 prescribers were no longer maintaining an active licence (for reasons such as retirement). A number of pharmacists and pharmacies had multiple instances where dispensing events for opioids were associated with prescribers with inactive licences. In one case, at a pharmacy in Belleville, 18 pharmacists collectively dispensed opioids 230 times based on prescriptions that were associated with 15 different prescribers, all of whose licences were inactive. Subsequent to our audit field work, the Ministry investigated about 15% of the instances we identified and informed us that those cases were attributable to data entry errors.

- **The guideline for opioid agonist therapy is not followed consistently.** In 2018, Health Quality Ontario developed a guideline for treatment of opioid addiction. Despite the guideline identifying that opioid agonist therapy—using replacement drugs such as methadone or buprenorphine-naloxone to help individuals deal with the cravings and withdrawal symptoms, stabilize their lives and reduce the harms related to their opioid use—is a first-line treatment for opioid addiction and should be accepted by all addictions treatment service providers, we noted that about 40% of service providers do not admit individuals who are on methadone. While the guideline also recommends that individuals on opioid agonist therapy should have their additional addictions treatment needs met, service providers reported that only about 17% of the individuals on opioid agonist therapy received addictions treatment services, such as counselling services, from them in 2018/19.
- **No actions have been taken to achieve cost savings in the distribution of naloxone through pharmacies.** The distribution of naloxone (a medication that can temporarily reverse an opioid overdose to prevent death) by organizations such as public health units and pharmacies is the largest program within the Opioid Strategy and accounts for over $71 million, or about 27%, of the Strategy's cost. The Ministry buys injectable naloxone in bulk for public health units, but not for pharmacies. If the Ministry had done group buying for pharmacies (similar to British Columbia's practice and what is done by the Ministry for flu shots in the Greater Toronto Area) and had not reimbursed pharmacies for distributing naloxone and training people on how to use naloxone (similar to British Columbia), we estimated that the Ministry could have saved up to about $7 million between 2017/18 and 2018/19.
- **The Ministry has neither determined whether the number or capacity of Consumption Treatment Services sites is appropriate nor ensured each site operates consistently.** The sites provide a safe environment where their clients can consume substances they possess under supervision of health-care professionals, who help identify and respond to overdoses on site. The sites can also connect clients to other addictions, health and social services. The Ministry has not determined whether the capacity and locations of the existing sites align with regional needs. For example, in 2018,

although the number of opioid-related deaths in Hamilton was 50% higher than in Ottawa, the capacity of Ministry-funded sites in Hamilton is about eight times less than Ottawa (serving three people in Hamilton versus 25 in Ottawa). Additionally, while the Ministry has established some provincial standards for the sites, we identified differences in their operations, including the type of medical staff on site and procedures for contacting paramedic services or for taking people to the emergency department.

Overall Conclusion

Our audit concluded that the Ministry does not have effective processes and procedures in place to measure and report to the public about the results and cost-effectiveness of addictions services in meeting their intended objectives. We found that the Ministry has not collected enough information from addictions treatment service providers to assess the effectiveness of their services.

As well, the Ministry does not have effective processes and procedures in place to oversee and monitor addictions service providers, and its funding for them, to ensure that appropriate legislation, agreements and/or relevant policies are followed. We noted that the Ministry has not established sufficient relevant treatment and care standards to ensure consistent operations and service delivery by addictions treatment service providers.

In addition, the Ministry does not have fully effective processes and procedures in place to coordinate and deliver addictions services in a timely and cost-effective manner that meets the needs of Ontarians requiring these services because there are long wait times for addictions treatment and increasing repeat emergency department visits for substance-use conditions.

This report contains 13 recommendations, consisting of 37 actions, to address our audit findings.

OVERALL MINISTRY RESPONSE

The Ministry of Health (Ministry) appreciates the Auditor General's observations and agrees with the recommendations regarding Ontario's Addictions Treatment Programs. The recommendations included in the report will support improvements to strengthen accountability and investments that will expand access to quality supports and services for Ontarians.

To build a comprehensive and connected mental health and addictions service system, the government has committed to investing $3.8 billion over ten years for mental health, addictions (MHA) and housing supports, which is a combination of federal and provincial investments. This investment includes a plan to improve and expand access to addictions treatment programs as well as the broader continuum of services that support people with addiction and prevent addiction issues before they begin.

The Ministry is embarking on a significant change initiative to improve the overall healthcare delivery system through the creation of Ontario Health and Ontario Health Teams. At full maturity, it is expected that Ontario Health Teams will be responsible for delivering MHA services across the lifespan with Ontario Health monitoring and reporting on system performance, quality and accountability. The Ministry looks forward to leveraging this new opportunity in health system planning to deliver better supports and services across our health system. Within Ontario Health, the Ministry is proposing to create an MHA Centre of Excellence that would drive a provincial quality agenda for the MHA sector.

The Ministry recognizes that the challenges facing mental health and addictions services have an impact on all Ontarians, including clients and service providers in other public service sectors (e.g., schools, policing, first responders, social housing). This understanding

drives the Ministry's commitment to invest more in the sector to expand capacity, scale-up evidence-informed programs and work closely with our partners to deliver a whole-of-government approach to mental health and addictions.

2.0 Background

2.1 Overview of Addictions

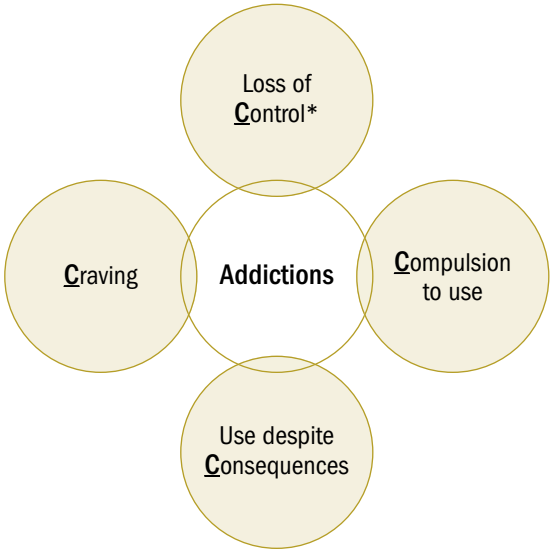
According to the Centre for Addiction and Mental Health, Canada's largest psychiatric hospital, a simple way of describing an addiction is the presence of the "four Cs" (see **Figure 1**). Addictions are caused by a combination of factors, including genetics and environment (see **Figure 2**). **Appendix 1** provides a glossary of terms used in this report.

An addiction is present only when use of a substance (such as alcohol, cannabis or nicotine) or engagement in a behaviour (such as gambling, Internet use or gaming) becomes habitual and compulsive, and results in negative health or social consequences. That is, experiencing enjoyment from the substance use or behaviour is not by itself an evidence of addiction:

- A 2017 survey conducted by the government of Canada identified that more than 75% of Ontarians consumed alcohol, but only about 21% of these individuals' alcohol use exceeded Canada's Low-Risk Alcohol Drinking Guidelines, developed by a national group of experts.

Figure 1: The Presence of the "Four Cs" in Addictions

Source of data: Centre for Addiction and Mental Health



* Specifically, loss of control of amount or frequency of use.

Figure 2: Causes of Addictions

Prepared by the Office of the Auditor General of Ontario

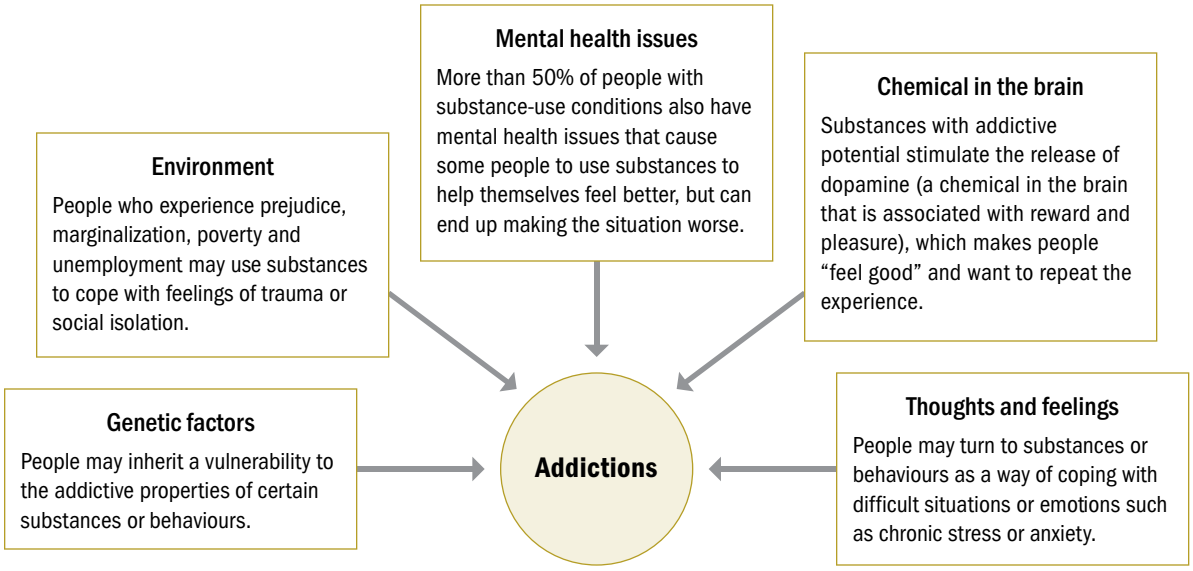
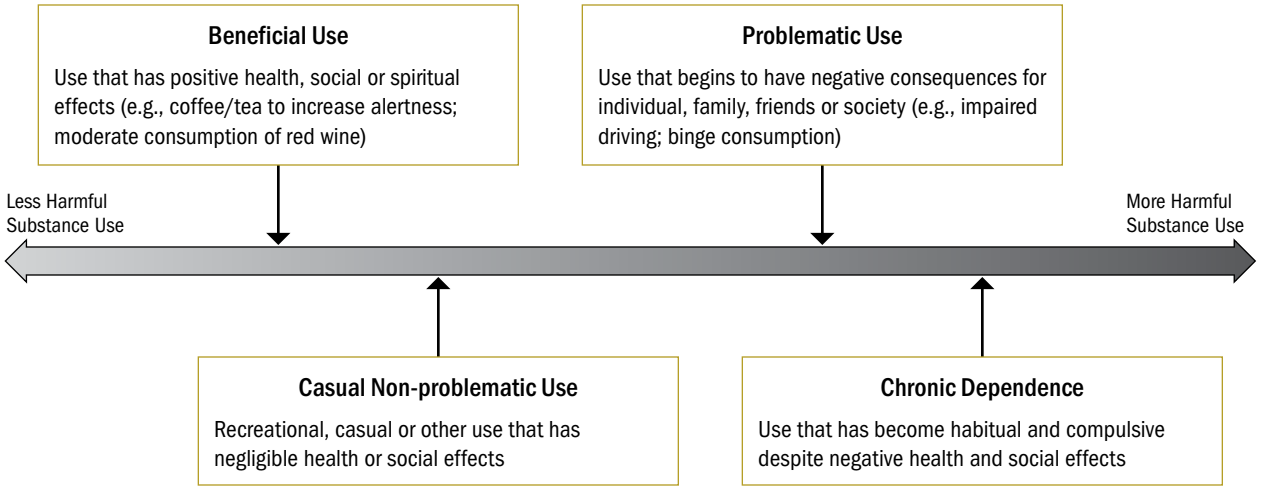


Figure 3: Spectrum of Substance Use

Source of data: Canadian Mental Health Association



- A report published by the Canadian Partnership for Responsible Gambling in 2016/17 noted that over 80% of Ontarians participated in gambling activity, but only about 1% of them were considered to be "problem gamblers."

Figure 3 shows the spectrum of substance use.

2.2 Addictions in Ontario

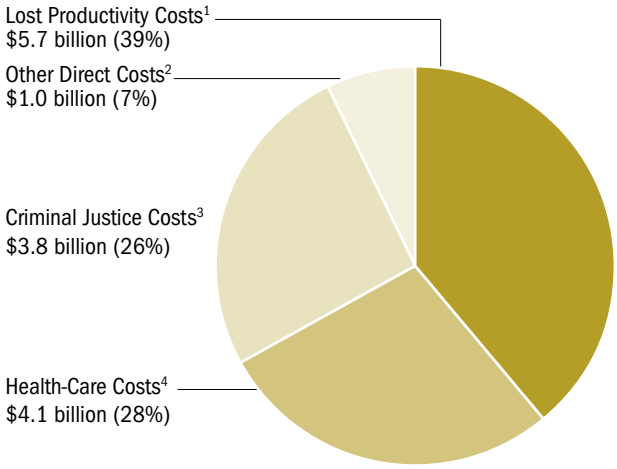
2.2.1 Prevalence and Cost of Addictions in Ontario

According to the Canadian Mental Health Association, it is estimated that approximately 10% of the population in Ontario uses substances problematically. Overall, based on our review of various studies, the rates of substance use and problem gambling in Ontario are fairly close to the rest of Canada.

A 2018 study published by the Canadian Centre on Substance Use and Addiction estimated that the overall costs and harms of substance use in Ontario was over $14.6 billion in 2014. **Figure 4** provides a category breakdown of this overall cost. Given the breakdown shown, government spending on addictions treatment to help reduce problematic substance use can achieve savings in areas ranging from health care to criminal justice and more.

Figure 4: Breakdown of the Overall Estimated Costs and Harms of Substance Use in Ontario, 2014

Source of data: Canadian Centre on Substance Use and Addiction



1. Examples of lost productivity costs include costs related to disability and premature death.
2. Examples of other direct costs include costs associated with damages to motor vehicles and other properties as a result of an individual's substance abuse.
3. Examples of criminal justice costs include costs related to police work, courts and correctional services.
4. Examples of health-care costs include costs associated with emergency department visits, hospitalizations and physician time.

2.2.2 Impact of Addictions on People and Society

Depending on its type and severity, addiction has adverse consequences not only for people with addictions, but also for their family members, friends and society. Specifically:

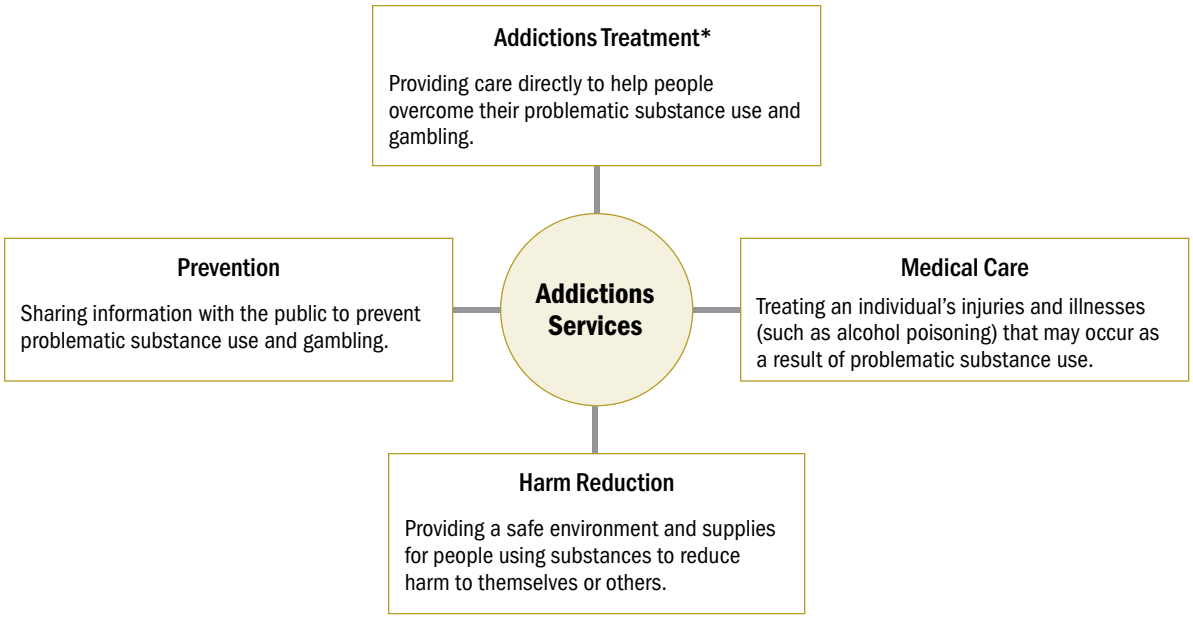
- In addition to harmful social consequences (such as losing a job or experiencing negative relationships with friends and family), problematic substance use can have health effects (such as decreased co-ordination or damage to organs) and even prematurely end a person's life. According to the death investigations performed by the Office of the Chief Coroner, between 2014 and 2018 the number of investigations that involved individuals with a history of problematic alcohol and/or drug use increased by 25% (from about 2,000 to about 2,500). Of these investigations, individuals who were confirmed to have died from alcohol and/or drug toxicity grew over 50% (from about almost 630 to about 970). **Appendix 2** provides examples of death investigations related to addictions conducted by the Office of the Chief Coroner.
- Behavioural addictions such as problem gambling can also harm individuals. Beyond financial concerns, research has shown that problem gamblers can have higher rates of depression, stress, anxiety, violence against intimate partners, divorce and thoughts of suicide. Between 2014 and 2018, over 20 individuals who had a known history of problem gambling, died as a result of suicide in Ontario.

2.3 Addictions Services in Ontario

2.3.1 Access to Addictions Services

Addictions services can be broadly grouped into four main categories: (1) addictions treatment; (2) prevention; (3) harm reduction; and (4) medical care (see **Figure 5**). Since most of these addictions services do not require a referral, individuals can refer themselves or can be referred by other

Figure 5: Four Main Categories of Addictions Services
Prepared by the Office of the Auditor General of Ontario

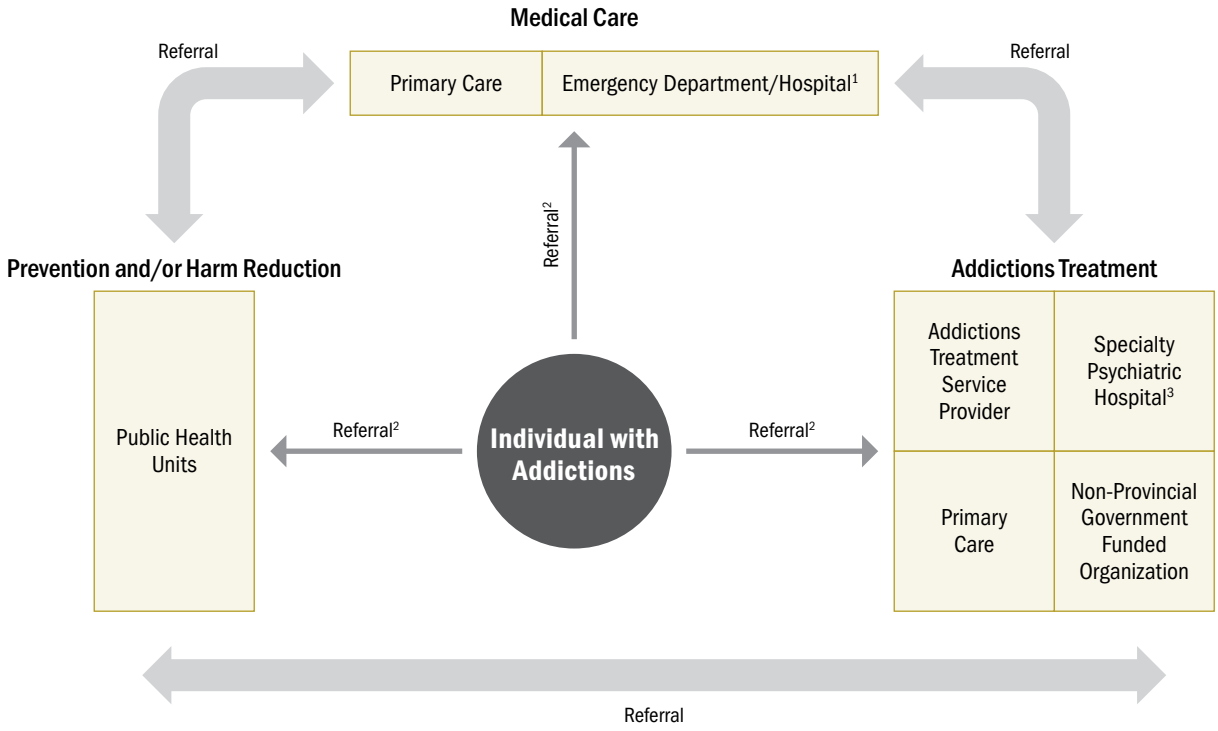


Note: One or more of these addictions services may be provided by the same provider.

* Subject of this audit.

Figure 6: Common Ways to Access Addictions Services

Prepared by the Office of the Auditor General of Ontario



1. Emergency departments provide immediate treatment for medical injuries and illnesses caused by addictions (such as intoxication).
2. Initial referral can be self-referral or by another party (such as the police or paramedic services).
3. Specialty psychiatric hospitals provide treatment to people with complex or severe addictions (including those who have other mental health conditions).

providers. **Figure 6** shows how people can connect to these addictions services.

Typically, an individual can access addictions services through various channels, which include addictions treatment service providers, public health units, primary care providers, emergency departments and specialty psychiatric hospitals. They can also contact ConnexOntario, which is an organization funded by the Ministry to provide information (through various methods, including by phone, by email and on a website) on publicly funded addictions and mental health resources available to Ontarians.

Addictions services are primarily community-based (located outside of hospitals) and focus on treating clients with mild to moderate addictions. Emergency departments and specialty psychiatric hospitals also provide addictions services: emergency departments focus on providing immediate treatment for medical injuries or illnesses caused by addictions (such as intoxication), while specialty psychiatric hospitals focus on providing treatment to clients with complex or severe addictions (including those with other mental health conditions).

2.3.2 Funding and Spending on Addictions Services

Parties providing addictions services include both those funded by the provincial government and those funded by other means. Unlike government funding for hospital services, including emergency departments and inpatient services, and physician services, which are mandated under the *Canada Health Act*, government funding for all other health services, including addictions services, are at the government's discretion.

Services Funded by Ministry of Health

In Ontario, the Ministry of Health (Ministry) oversees and funds health-care services, which include addictions services. In 2018/19, the Ministry allocated or spent over $490 million to be spent on community-based addictions services, generally to treat people with mild to moderate forms of addictions. These services were mainly delivered by the following types of service providers funded by the Ministry (see **Figure 7**):

- **Addictions treatment service providers:** There are about 200 of these providers. They are generally independently incorporated not-for-profit organizations that operate in the community (through over 450 locations) and receive their funding from the Ministry through 14 Local Health Integration Networks (LHINs). **Figure 8** shows the spending by these services providers between 2014/15 and 2018/19. **Appendix 3** lists all addictions treatment service providers funded by the Ministry and their programs.
- **Primary-care providers:** These include physicians who provide assessment, monitoring and medical management, such as prescription services, to people with substance-use issues. Physicians bill their services to the Ontario Health Insurance Plan (OHIP). Prescription drugs may be paid by the Ministry through the Ontario Drug Benefit Program.

Figure 7: Description of Key Providers of Addictions Services Funded by the Ministry of Health

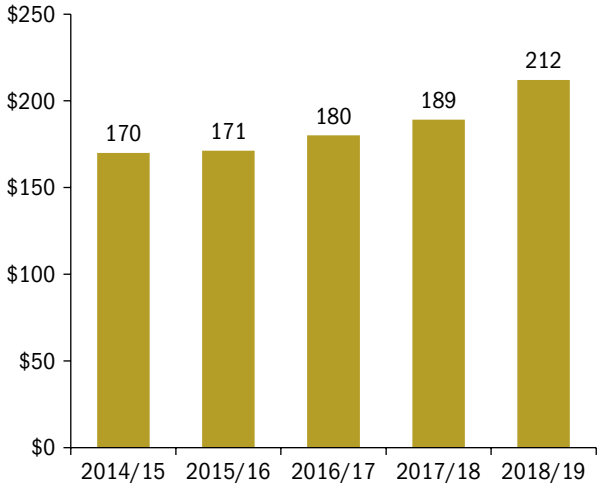
Prepared by the Office of the Auditor General of Ontario

Service Provider	Main Type of Service			Description of Services	Spending in 2018/19 ($ million)
	Addictions Treatment	Prevention and Harm Reduction	Medical Care		
Addictions treatment service providers	✓			• Provide treatment to people suffering primarily from mild to moderate addictions (over 76,700 people in 2018/19). See **Figure 10** for common treatment approaches and **Figure 11** for different types of treatment programs.	212
Primary care providers	✓		✓	• Treat medical injuries as a result of an individual's problematic substance use (such as minor injuries associated with a fall while intoxicated). • Perform an assessment to determine if an individual has an addiction. • Provide counselling services. • Prescribe medication (such as methadone) to help people manage the symptoms of opioid withdrawal. • Monitor patients who deal with withdrawal symptoms.	182[1]
Public health units and various organizations[2]		✓		• Share materials with the public to prevent problematic substance use.	44
Others[3]	✓	✓		• Offer services funded by the Ministry's Opioid Strategy (see **Section 2.4** and **Section 4.6**).	56
Total					**494**

1. $182 million includes about $100 million through OHIP billings (related to assessing individuals with addiction concerns and the monitoring of prescribed medications) and about $82 million through the Ontario Drug Benefit Program (related to prescriptions such as buprenorphine-naloxone and methadone). The OHIP billings amount is based on 2017/18 data (2018/19 data will not be available until at least six months after March 31, 2019, since physicians have a window of up to six months after rendering a service to submit billings).
2. The Ministry of Health provides funding to 35 public health units and various organizations, such as municipalities, universities and not-for-profit organizations, to provide services
3. Examples of other service providers include community health centres and pharmacists.

Figure 8: Spending by Addictions Treatment Service Providers, 2014/15–2018/19 ($ million)

Source of data: Ministry of Health



- **Public health units and various organizations:** The Ministry provides funding to 35 public health units (that have been established by municipalities to administer health promotion and disease-prevention programs) and other parties, including municipalities, universities and not-for-profit organizations, to share materials with the public to prevent problematic substance use.
- **Others:** These are community health centres and pharmacists. They provide services funded by the Ministry's Opioid Strategy (see **Section 2.4** and **Section 4.6**)

Services Funded by Other Ministries and Agencies

Other ministries and agencies apart from the Ministry of Health also fund and provide addictions services in Ontario. However, the Ministry does not have any details on the funding of addictions services provided by these other parties. We therefore contacted these other ministries and agencies ourselves. We noted that they spent a total of at least $42 million annually on mental health and addictions services, such as the Ministry of Education for development of educator training relating to addictions (see **Figure 9**).

Services Funded by For-Profit and Not-for-Profit Sectors

Service providers that do not receive provincial government funding also offer addictions treatment. Examples of these providers include not-for-profit organizations (such as Alcoholics Anonymous) that are funded by donations and/or fees from clients; and for-profit businesses that operate clinics and residential facilities that charge their clients fees for their services that are paid out of pocket by clients or through their insurance. Since the Ministry does not fund these service providers, it does not oversee their services and does not collect information from them.

2.3.3 Approaches and Types of Addictions Treatment

As discussed in **Section 2.1**, addictions are caused by a combination of factors. Therefore, two clients with the same addictions may require different treatment approaches. The two most common treatment approaches are: (1) counselling; and (2) medication. Depending on their needs, clients can be treated using just one of the methods or a combination of the two (see **Figure 10**).

Counselling is generally offered through three main types of programs: (1) non-residential treatment; (2) residential treatment; and (3) withdrawal management services or detox (see **Figure 11**). Medication is generally offered by physicians, such as those in solo or group practices, or by hospitals as emergency or inpatient services.

2.3.4 Initiatives for Addictions Services

Ontario has introduced initiatives in recent years to address problematic substance use and gambling. It has committed to investing $3.8 billion in total ($1.9 billion received from Health Canada and $1.9 billion of its own funds) "to develop and implement a comprehensive and connected mental health and addictions strategy" over 10 years (from 2017/18 to 2026/27). At the time of this audit, the

Figure 9: Summary of Mental Health and Addictions Services Funded by Other Ministries and Agencies

Sources of data: Ontario Lottery and Gaming Corporation, Ministry of the Solicitor General, Ministry of Children, Community and Social Services, Ministry of Education, and Ministry of Training, Colleges and Universities

Ministry/Agency	Description of Service	Spending in 2018/19 ($ million)
Ministry of the Solicitor General[1]	• Funds and provides health-care services, including for mental health and addictions, to individuals in provincial correctional facilities.	74[2]
Ontario Lottery and Gaming Corporation	• Funds and delivers responsible gaming program to prevent gambling problems from occurring and to minimize harm for those who experience problems, by referring to services such as counselling.	17
Ministry of Training, Colleges and Universities	• Funds campus-based mental health workers for 45 publicly assisted post-secondary institutions. • Funds development of campus-based services or programs (such as counselling, peer-to-peer support programs and awareness programs) for students with mental health and addictions issues.	16
Ministry of Education	• Funds and develops evidence-based training and practice guides related to mental health and addictions for educators and school-based mental health clinicians in all 72 district school boards. • Provides training to educators related to the legalization of recreational cannabis.	7
Ministry of Children, Community and Social Services	• Funds problematic substance use programs for certain youth in detention and those serving sentences in custody or in the community.	2
Total (excluding Ministry of the Solicitor General)[2]		**42**

1. Formerly known as Ministry of Community Safety and Correctional Services.
2. The Ministry of the Solicitor General does not separate its health-care spending by program area (such as for addictions services). $74 million is the amount spent on all health-care services for individuals within provincial correctional facilities. As a result, the total spending on addictions services of $42 million does not include $74 million of spending by the Ministry of the Solicitor General.

government had not determined exactly how the money would be allocated.

In May 2019, the Ministry announced new legislation, which, if passed, would establish a Mental Health and Addictions Centre of Excellence within Ontario Health (see **Section 3.0**) to oversee mental health and addictions services.

2.4 Opioid Crisis

Opioids are a class of drugs (including morphine, heroin, and codeine) that are commonly prescribed for pain relief, but which, for various reasons, can lead to physical dependence and addiction. The strength or potency varies from one type of opioid to another. For example, oxycodone (an opioid for moderate to severe pain) is 1.5 times stronger than morphine, while fentanyl (an opioid for long-term stable pain) is 50 to 100 times stronger than morphine. Depending on the quantity or strength of the opioids they take, an individual may experience drowsiness or respiratory depression, go into a coma or even die.

The studies and data we reviewed showed that the growth of opioid use and its harmful consequences have become a significant concern in Ontario. For example:

- A research study of opioid prescription trends in Ontario found that "from 1991 to 2007, annual prescriptions for opioids increased from 458 to 591 per 1000 individuals" and "prescriptions of oxycodone increased by 850%." This increase was in part due to the manufacturer marketing a form of oxycodone as having minimal risk of addictions.

Figure 10: The Two Most Common Addictions Treatment Approaches

Prepared by the Office of the Auditor General of Ontario

	Counselling	Medication
Purpose	• Helps individuals to understand why they have addictions and assists them in developing strategies to prevent or reduce their engagement with a substance or behaviour.	• Helps individuals deal with withdrawal symptoms and reduce drug cravings when they stop using a substance to which they are addicted.
Description	• This approach is provided by different professionals with diverse experiences and educational backgrounds through individual counselling (which is more comprehensive and personalized) or in a group setting (which provides a support network for learning and sharing of experience).	• This approach requires a prescription from a health-care practitioner, such as a physician or nurse practitioner.
Targeted at	• Addictions related to problematic substance use and behaviours (such as problem gambling).	• Addictions related to problematic substance use.
Example	• Counselling can be provided by a psychologist with a Ph.D, social worker with a Master's degree or addiction counsellor with a college diploma.	• Medication (such as methadone and buprenorphine-naloxone) can be prescribed to help people deal with their withdrawal symptoms when they stop their use of opioids.

Note: Studies have shown that providing an individual with both counselling and medication can be more effective than just providing counselling or medication alone.

Figure 11: The Three Main Types of Addictions Treatment Programs

Prepared by the Office of the Auditor General of Ontario

	Non-Residential[1]	Residential[1]	Withdrawal Management (or Detox)[2]
Description	Clients do not stay at a treatment facility overnight but only attend programs (such as individual or group counselling) during the day (ranging from one hour to all-day) and receive additional services (such as case management, whereby a case manager meets regularly with an individual to provide other health and social services).	Clients live at a treatment facility for a period of time (at least a couple of weeks) and attend daily structured programs such as individual or group counselling.	Clients stay at a treatment facility for a short-term period (generally less than five days) where they can receive medical care as well as individual or group counselling, and are monitored while dealing with their withdrawal symptoms from stopping their substance use. Clients can also access these services while staying at home.
Targeted at	Problematic substance use and behavioural addictions such as problem gambling.	Problematic substance use and behavioural addictions, such as problem gambling.	Problematic substance use.
Number of Service Providers[3]	170	73[4]	49
Spending in 2018/19 ($ million)	104	64	45

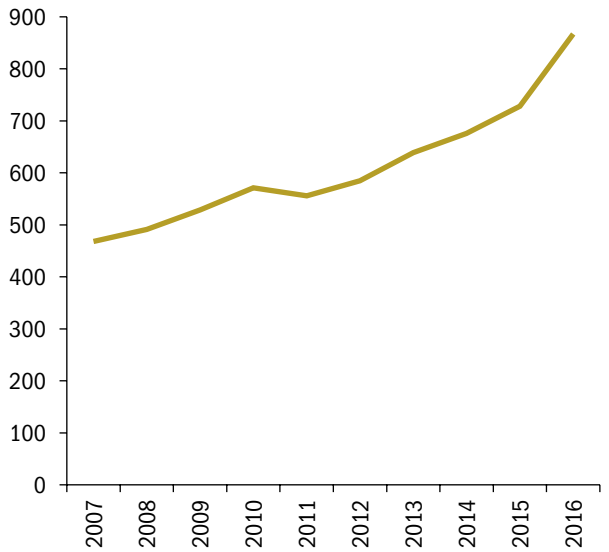
1. Whether a client obtains addictions services through a non-residential program or a residential program will depend on a number of factors. These factors include a client's preference (for example, a non-residential program may be more appropriate for a client who has work or family commitments) and the severity of the addictions, as residential treatment is generally more appropriate for people with more serious or complex addictions.
2. Generally, to effectively treat a client's addictions, withdrawal management should be followed by other non-residential or residential addictions treatment.
3. Some addictions treatment service providers offer more than one type of program.
4. Collectively, these service providers have 1,394 beds to provide clients residential addictions treatment.

- Between 2007 and 2016, opioid-related deaths, hospitalizations and emergency department visits increased significantly. In particular, opioid-related deaths grew from more than one per day in 2007 (468 deaths) to more than two per day in 2016 (867 deaths) as shown in **Figure 12**.
- A 2018 study by the Institute for Clinical Evaluative Sciences, a not-for-profit research institute that conducts research on Ontario's health data, found a significant rise in opioid-related deaths in Ontario among young adults and youths. One out of six deaths among Ontarians aged 25 to 34 was related to opioids in 2015. Meanwhile, one of nine deaths among those aged 15 to 24 was related to opioids, nearly double the rate of 2010 when one in 16 deaths in the age group was opioid-related.
- The Office of the Chief Coroner collects data on opioid-related deaths. Based on the most recent data available, about half of opioid-related deaths involved males aged 25 to 54, and fentanyl (or fentanyl analogues, which are similar but chemically different than fentanyl), was a direct cause in the majority of all opioid-related deaths (about 70%). While the Office of the Chief Coroner was unable at the time of our audit to determine in all cases how the individuals obtained the opioids that resulted in their deaths, reports show that fentanyl has become more widely circulated illegally across Canada.

In response to the growing concern and crisis related to opioids, in August 2017, the Ministry announced an investment of more than $222 million over three years to "enhance Ontario's Strategy to Prevent Opioid Addiction and Overdose." **Appendix 4** provides background and key events related to Ontario's opioid crisis. **Appendix 5** lists key initiatives of the Opioid Strategy. **Section 4.6** provides details on the issues related to the Opioid Strategy.

Our Office conducted a value-for-money audit on Ontario Drug Program Benefits in 2017 when

Figure 12: Opioid-Related Deaths, 2007–2016
Source of data: Public Health Ontario



the Ministry initiated the Opioid Strategy. As part of the 2017 audit, we recommended that the Ministry work with hospitals and the Office of the Chief Coroner for Ontario to link reported overdoses and deaths to the Ministry's system (containing data on controlled substances and other monitored drugs, including opioids) in order to identify whether the opioids were from legal or illicit sources. In 2019, our Office followed up on this recommendation and found that the Ministry was in the process of implementing this recommendation (see our *2019 Annual Report: Follow-Up Volume,* **Chapter 1 Section 1.09**).

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Health (Ministry) in partnership with other ministries, agencies and addictions treatment service providers, together have effective processes and procedures in place to:

- co-ordinate and deliver addictions treatment services in a timely and cost-effective manner that meets the needs of Ontarians requiring these services;

- oversee and monitor addictions treatment services, including Ministry funding, to ensure that appropriate legislation, agreements and/or relevant policies are followed; and
- measure and report publicly on the results and effectiveness of addictions treatment services in meeting their intended objectives.

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and June 2019. We obtained written representation from Ministry management that, effective November 8, 2019, the Ministry had provided us with all the information it was aware of that could significantly affect the findings or the conclusion of this report.

Our audit work was conducted primarily at the Ministry's Mental Health and Addictions Policy, Accountability and Provincial Partnership Branch, as well as at addictions treatment service providers' offices.

Our audit work at the Ministry included a review of relevant documentation and data related to its oversight of addictions treatment service providers, including data on funding to and spending by addictions treatment service providers, as well as data on emergency department visits related to substance-use conditions and opioid prescriptions between 2014/15 and 2018/19.

We visited or spoke with 29 addictions treatment service providers located in 11 of the 14 Local Health Integration Networks (LHINs). **Appendix 7** provides a listing of the addictions treatment service providers we contacted. We selected these service providers based on geography (to obtain representation across Ontario) and on demand for addictions treatment services (to reflect LHINs with a larger number of people seeking addictions treatment services and/or making visits to emergency departments for substance-use conditions). Our audit work with the addictions treatment service providers included the following:

- meeting with senior management and staff to understand their services and challenges; and
- reviewing program policies, procedures and other relevant documentation to understand their services and operations.

For addictions treatment service providers we did not meet or speak with, we conducted a survey to obtain information on their operations and challenges.

Appendix 8 contains information on additional work we performed and stakeholders we contacted as part of this audit.

Furthermore, we engaged an external advisor who had previous experience at a senior level of government with oversight over addictions services.

During the course of our audit, on April 18, 2019, Bill 74, the *People's Health Care Act, 2019*, received royal assent. It will come into force on a date to be proclaimed by the Lieutenant Governor. This legislation is designed to integrate multiple provincial agencies, including the LHINs, Cancer Care Ontario and Health Quality Ontario, into a single agency called Ontario Health.

4.0 Detailed Audit Observations

4.1 Increased Spending on Addictions Treatment Services Has Not Reduced Wait Times and Emergency Department Visits

As shown in **Figure 8**, between 2014/15 and 2018/19 spending on addictions treatment services increased almost 25%, rising from $170 million to $212 million. Despite increased spending, wait times for addictions treatment became longer.

Longer wait times not only result in more people seeking treatment at emergency departments (which are not designed to provide addictions treatment services) but can also cause people to forgo treatment altogether, and in some cases, this has led to hospitalization, incarceration, suicide attempts and even death.

4.1.1 Wait Times Increasing for People Seeking Treatment in Most Regions across the Province

Wait times for addictions treatment (from the time when an appropriate treatment option for a client has been determined through an eligibility assessment to the time when treatment starts) increased over the past five years.

Our review of wait time information reported by addictions treatment service providers and collected by ConnexOntario (an organization funded by the Ministry that maintains a centralized database of addictions and mental health treatment service providers and programs) noted that between 2014/15 and 2018/19, the average wait times reported for all addictions programs increased in 11 of the 14 Local Health Integration Networks (LHINs), as shown in **Figure 13**. During the same period, the average wait times for all three types of treatment programs increased (see **Figure 14**). Specifically:

- **Non-residential programs:** The average wait times grew from 18 days to 23 days, with about 14% of programs having wait times of 30 days or greater.
- **Residential programs:** The average wait times increased from 43 days to 50 days, with almost 58% of programs having wait times of 30 days or greater. We also noted instances where wait times were 143 days, 147 days, and even 235 days. While wait times for

Figure 13: Average Wait Times for Addictions Treatment Programs by Local Health Integration Network, 2014/15 and 2018/19 (Days)

Source of data: ConnexOntario

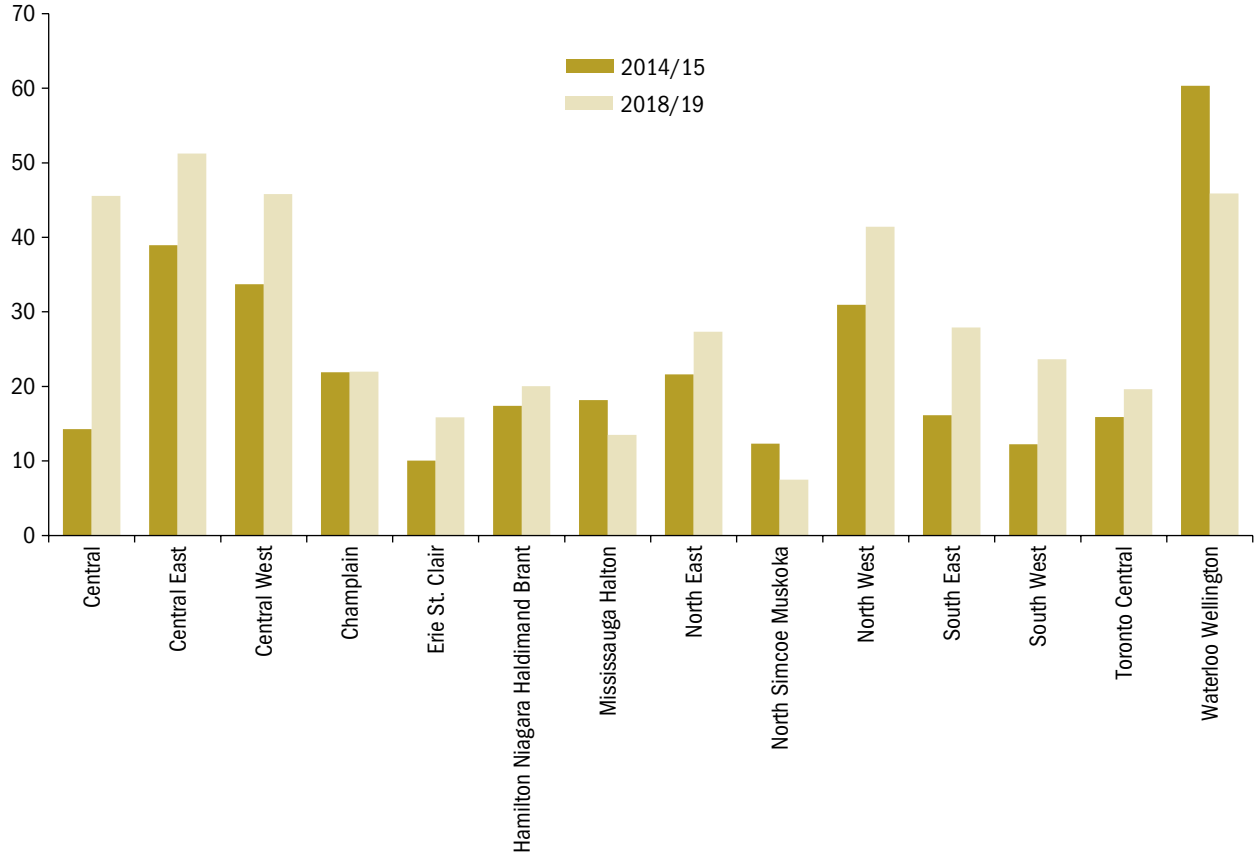
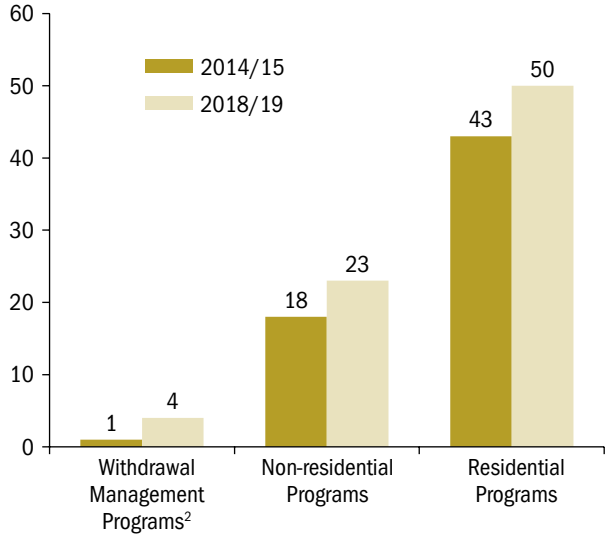


Figure 14: Average Wait Times for Addictions Treatment[1] by Type of Program, 2014/15 and 2018/19 (Days)

Source of data: ConnexOntario



1. These wait times do not include wait times for an eligibility assessment, which is performed by service providers to identify and place each of their clients into an appropriate treatment program. The average wait time for an eligibility assessment was almost nine days in 2018/19, up from 7.5 days in 2017/18, which was the first year that wait times for assessment were collected.
2. ConnexOntario collects information only on wait times for non-residential withdrawal management programs (where people can access services without staying overnight at a treatment facility). Service providers generally do not maintain a wait list for residential withdrawal management programs—residential withdrawal management services are expected to be available as soon as a client seeks them, without waits.

youth programs remained steady, they were on average longer than adult programs at about 65 days. One youth addictions program had a wait time of 413 days.

- **Withdrawal management programs:** The average wait times increased from about one day to four days.

Figure 15 shows timeline and average wait times by type of program in 2018/19. When clients are put on a wait list for addictions treatment, they will continue to struggle with their addictions, which can put themselves and/or others at risk. Our survey of 27 (or about 37%) of the 73 service providers of residential treatment programs found that they were aware of cases where their clients dropped off the wait lists before obtaining treatment. The majority of them indicated that they were aware of clients dropping off because they were waiting too long, were hospitalized or incarcerated and in some cases they attempted suicide or even died while waiting for treatment (see **Figure 16**).

4.1.2 Insufficient Access to Addictions Treatment Services Results in More Repeat Emergency Department Visits

Increased spending on addictions treatment programs has not effectively reduced the number of people with addictions seeking treatment from emergency departments repeatedly and frequently. More people visiting emergency departments for substance-use conditions indicated that community-based addictions services are not sufficiently available to meet people's needs.

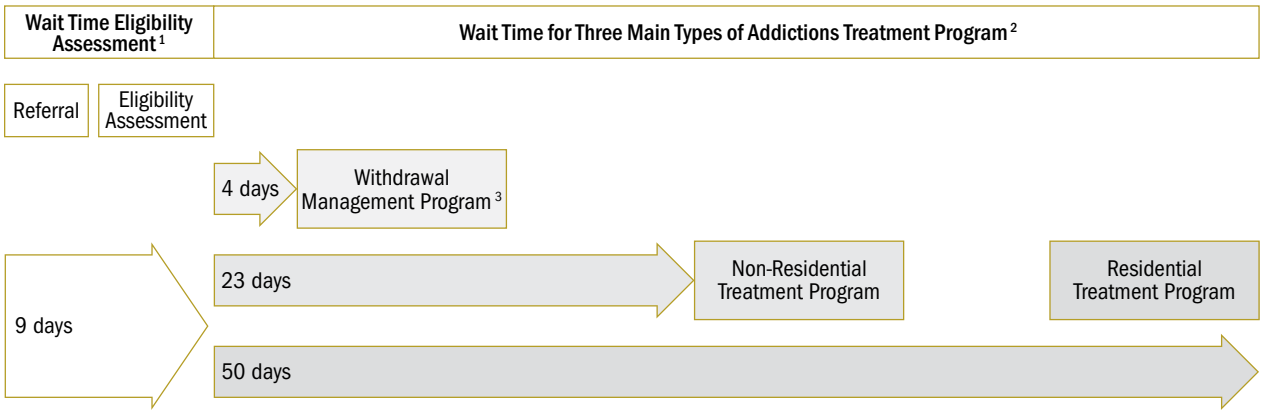
While an emergency department can provide immediate medical care for people with addictions (such as for alcohol poisoning), it does not provide ongoing treatment that helps people to overcome their addictions. For example, unlike withdrawal management programs offered by addictions treatment service providers, emergency departments are generally not staffed with addictions counsellors, who can make referrals and develop treatment plans for clients. Clients obtaining services from addictions treatment service providers on a regular basis are likely to make fewer repeat visits to emergency departments.

Based on our analysis of data on emergency department visits between 2014/15 and 2018/19, we noted that while all types of emergency department visits grew about 6% (from about 6.1 million visits to almost 6.5 million visits), visits relating to substance-use conditions (primarily alcohol and opioid use by males between the ages of 25 and 44) increased significantly. Specifically:

- Emergency department visits for substance-use conditions increased by almost 40% (from about 68,000 visits to 95,000 visits).
- Repeat unscheduled visits to emergency departments within 30 days for substance-use

Figure 15: Timeline and Average Wait Times by Type of Addictions Treatment Program, 2018/19 (Days)

Prepared by the Office of the Auditor General of Ontario



1. Wait time for eligibility assessment measures the time from when an individual contacts an addictions treatment service provider to when the service provider performs an eligibility assessment. Service providers perform eligibility assessments to identify appropriate treatment programs for their clients and place them into those programs.
2. Wait time for addictions treatment program measures the time from when the eligibility assessment is completed to when treatment starts.
3. An eligibility assessment is not always required for withdrawal management programs. ConnexOntario collects information only on wait times for non-residential withdrawal management programs.

conditions increased almost 50% (from about 20,000 visits to almost 29,800 visits).

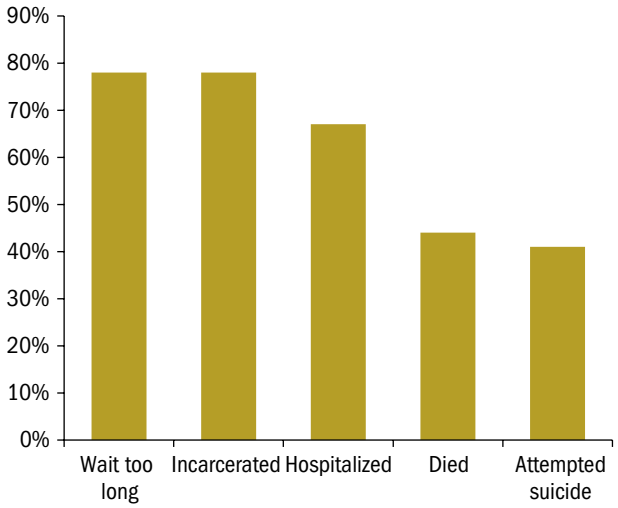
- Frequent visitors of emergency departments (six times or more within a fiscal year) for substance-use conditions increased by 60% (from about 1,250 visitors to about 2,000 visitors).

We also analyzed the cost associated with providing care to about 2,000 frequent visitors of emergency departments for substance-use conditions in 2018/19. We estimated that over $5 million was spent on these frequent visitors. This same money could have been spent on programs delivered by addictions treatment service providers; for example, this amount would fund 19 days of non-residential treatment for each of these frequent visitors.

More repeat and frequent emergency department visits for substance-use conditions indicates that people do not have access to effective and prompt community-based addictions treatment; for example, because of lack of awareness or wait times. However, the Ministry has not performed any analysis to determine what addictions services need to be expanded to reduce emergency department visits.

Figure 16: Reasons Clients Dropped off Wait Lists for Residential Addictions Treatment Programs

Prepared by the Office of the Auditor General of Ontario



Note: The percentage is calculated based on 27 (or about 37%) of the 73 residential addictions treatment service providers we contacted that are aware of instances of clients being dropped off wait lists and the reasons for those instances. As one provider may be aware of multiple reasons, the sum of all bars equals more than 100%.

RECOMMENDATION 1

To reduce wait times for addictions treatment and repeat emergency department visits for substance-use conditions, we recommend that the Ministry of Health:

- analyze wait times for addictions treatment to identify regions or programs with long wait times and work with those service providers to take corrective actions; and
- further analyze frequent and repeat emergency department visits for substance use across the province to determine what addictions services need to be expanded to reduce the number of these visits.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and recognizes that long wait times for addictions services can pose a setback to those seeking help. To address this recommendation, the government is committed to addressing capacity issues to these necessary services, across the whole spectrum of supports. In 2019/20, Ontario invested over $33 million in new funds for community addictions services with this aim.

To ensure new investments are optimal, the Ministry is exploring options to improve data quality and performance measurements. With better data quality and a performance measurement system in place, the Ministry will then analyze wait times to identify regions or programs with long wait times, which is one of multiple factors that may be used for capacity planning and resource allocation.

The Ministry also acknowledges that frequent and repeat emergency department visits are an indicator that services in the community are not reaching people in a timely fashion. The Ministry will continue to monitor this indicator to determine if additional addictions services in the community are needed. The Ministry is currently working on a co-ordinated access framework that would make it easier for people to access community services, which will help reduce frequent and repeat emergency department visits for substance use.

The Ministry will also work closely with Ontario Health, Ontario's new health agency, to ensure that the capacity for evidence-informed system planning continues to evolve.

4.2 Funding for Addictions Treatment Programs Not Tied to Clients' Needs and Programs' Effectiveness

Between 2014/15 and 2018/19, funding for addictions treatment programs increased about 25%, from about $191 million to $239 million. However, since the Ministry has not studied and determined the level of addictions treatment needed across the province and has not assessed the effectiveness of funded programs, it does not allocate funding based on clients' needs and on the effectiveness of these programs.

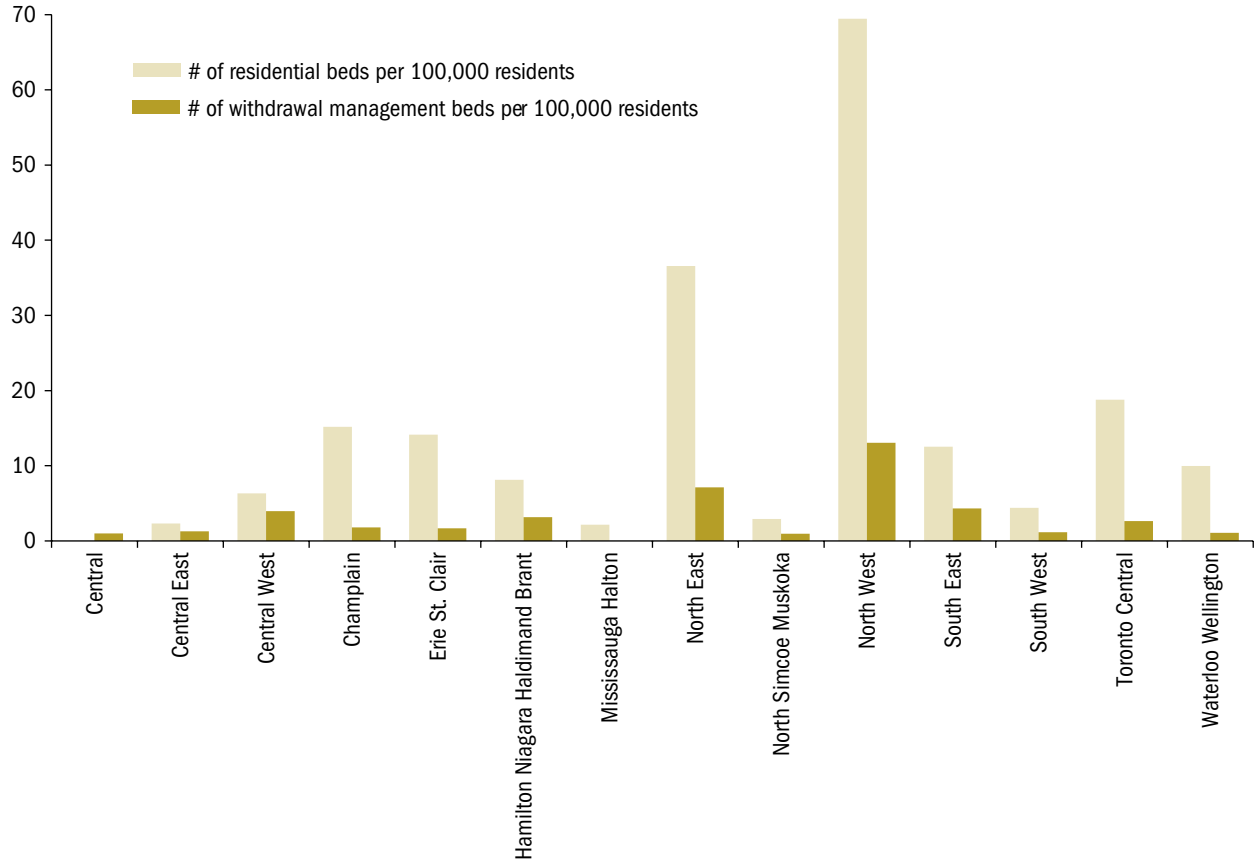
4.2.1 Method to Determine Needs for Addictions Treatment Programs Exists, But Not Used by Ministry

The Ministry does not know which specific addictions treatment programs and resources, such as withdrawal management or residential treatment beds, are needed across the province—even though there is a method that could be used to estimate this.

This method was identified by researchers in 1990 and updated based on 2012 information taken from the Canadian Community Health Survey conducted by Statistics Canada to estimate the severity of substance-use addictions and the type of addictions treatment programs, such as non-residential, residential and withdrawal management, that should be available to meet the province's needs. However, we found that the Ministry was still reviewing this model at the time of our audit and has not set a timetable for its implementation.

Figure 17: Number of Residential Treatment Beds and Withdrawal Management Beds per 100,000 Residents by Local Health Integration Network (LHIN)

Prepared by the Office of the Auditor General of Ontario



We also noted that no assessment of regional needs by the Ministry has contributed to differences in the availability of addictions treatment across the province. **Figure 17** identifies the number of withdrawal management beds and residential treatment beds for every 100,000 residents by LHIN. Specifically:

- The number of withdrawal management beds varies by LHIN, ranging from no such bed in the Mississauga Halton LHIN to 13 beds per 100,000 residents in the North West LHIN.
- The number of residential treatment beds differs by LHIN, ranging from no such bed in the Central LHIN to 69 beds per 100,000 residents in the North West LHIN.

4.2.2 Funding Not Allocated to Addictions Treatment Programs Based on Clients' Needs

Since the Ministry has not used a model to determine needs for addictions treatment services as discussed in **Section 4.2.1**, it did not allocate new funding to the service providers and programs based on where needs were highest.

Most of the new funding between 2014/15 and 2018/19 was allocated to ongoing programs (as opposed to one-time funding that is generally given to a service provider for a single fiscal year). The majority of the funding increase for ongoing programs was allocated to new service providers, and was primarily reported as being used to provide non-residential counselling services, which are generally less intensive and more appropriate for clients

with a mild form of addiction. Yet during the same period, the majority of clients obtaining addictions treatment presented with increasingly complex issues. For example, the percentage of clients obtaining addictions treatment who also had mental health conditions increased from 46% to 51%, and the percentage of clients obtaining addictions treatment due to problematic use of multiple substances remained high at 82%. These factors indicated that they may have required more intensive services, such as residential programs and case management, as opposed to counselling services alone.

As most of the new funding for ongoing programs went to new addictions treatment service providers, between 2014/15 and 2018/19, the majority of the ongoing programs delivered by the existing service providers received a funding increase of 3.6% or less, much lower than the inflation rate of about 7.2%. Service providers informed us that this has made it challenging to maintain the current programs' service levels. For example, a service provider indicated that it cut one staff member from its case management program, resulting in about an 8% reduction in the number of staff contacts made with clients enrolled in the program between 2017/18 and 2018/19.

4.2.3 Funding Allocated to Existing Addictions Treatment Programs without Evaluating Program Effectiveness

The Ministry has not collected any information from addictions treatment service providers about their operations to assess the effectiveness of their programs. Without this information, the Ministry continues to fund service providers without considering and determining whether their programs meet clients' needs effectively and contribute to a reduction in addictions.

The Ministry and the LHINs require service providers to submit information on spending and service activity (number of clients treated) by their programs. This enables them to compare this information to service activity targets set by the LHINs. However, the Ministry and the LHINs do not collect any information from the service providers to assess the effectiveness of the addictions treatment services. While what effectiveness means can differ depending on the specific goals of a client, it generally refers to improvements in a client's health, function and quality of life.

We noted that some service providers have identified ways to evaluate the effectiveness of their addictions treatment programs. For example:

- One service provider we visited evaluates its clients' outcomes through tracking a number of measures that include change in substance use and in the number of hospital visits and police interactions before and after treatment. Between 2010 and 2016, it noted that 75% of the 192 individuals who entered its program identified their substance use as consistent and problematic. Two years later, when contact was made with 18 clients who completed the program, only 17% identified their substance use as consistent and problematic.
- Another service provider offering residential addictions treatment has worked with a research institute since 2015 to survey its clients. Of those who completed the surveys, 61% reported not using any substances over a one-year follow-up period. Regarding alcohol use specifically, the percentage of clients who were abstaining from alcohol increased from 48% prior to admission to 87% one-year after treatment.

While these examples are based on survey results from only a sample of clients, they demonstrate that it is possible to assess the effectiveness of addictions treatment programs in various ways, which the Ministry and/or LHINs could have done by requiring program evaluation performed by the service providers or conducting their own work in this area.

4.2.4 Needs of Vulnerable Population Groups for Addictions Services Not Fully Met

While certain population groups, such as children and youth, as well as Indigenous people, have additional or special needs for addictions treatment services, the services available and the Ministry's funding does not appear to be sufficient to meet their needs.

Children and Youth

The average wait time for youth residential treatment programs between 2014/15 and 2018/19 has remained long at about 65 days. However the total number of residential beds designated for youth has been reduced from 116 to 113.

According to Statistics Canada, young people aged 15 to 24 are more likely to experience mental health conditions and/or substance-use disorders than any other age group in Canada. In 2018/19, Children's Mental Health Ontario, an association representing nearly 100 publicly funded child and youth mental health agencies, conducted a survey and found that 67% of respondents indicated that there are not enough addictions services available for children and youth in their regions.

Studies also showed that youth with untreated addictions can develop more serious addictions later in life that can result in other adverse consequences, including the aggravation or development of depression or anxiety, increased risk of being arrested, or involved in motor vehicle accidents and other violent events. Therefore, it is important that youth can obtain appropriate addictions treatment services in a timely manner.

In addition, we noted that one of the barriers to providing addictions treatment for children and youth is that consent is required from children and youth themselves for the majority of addictions services in Ontario, as well as across Canada. This differs from other regions, such as parts of the United States, where medical consent begins at age 18, meaning that a parent or guardian can consent to addictions treatment on behalf of a child. Stakeholders we met with also raised concerns that children and youth with addictions often lack the capacity to make decisions in their own best interests, but laws in Ontario give priority to the rights of children and youth to refuse treatment, which allows their addictions to progress and puts them at risk.

Indigenous Peoples

The needs of Indigenous peoples for addictions services are not fully met despite the Ministry's dedicated funding.

A 2016 report published by the province, *The Journey Together: Ontario's Commitment to Reconciliation with Indigenous Peoples*, showed that throughout Ontario, 82% of on-reserve First Nations (a subset of Indigenous peoples) adults and 76% of First Nations youth identified problematic alcohol and drug use as the main challenge facing their community. While Indigenous peoples can access addictions treatment from any addictions treatment service providers, some service providers focus their programs on culturally appropriate treatment services, such as the use of sweat lodge ceremonies and traditional healing for Indigenous peoples both on-reserve and off-reserve.

The Ministry dedicated over $100 million in new funding for mental health and addictions initiatives for Indigenous peoples to be allocated between 2018/19 and 2022/23. In 2017, the Ministry asked Indigenous communities, organizations and service providers to submit potential programs that could be considered for new funding. The Ministry received 114 proposals and ranked 60 as highly able to meet the needs of Indigenous peoples. However, the Ministry's dedicated funding was sufficient to fund only 44 of the 60 proposals.

4.2.5 Funding Provided for Addictions Services Late in Fiscal Year Not Spent

We noted that between 2014/15 and 2018/19 the amount of funding received by a number of addictions treatment service providers was more

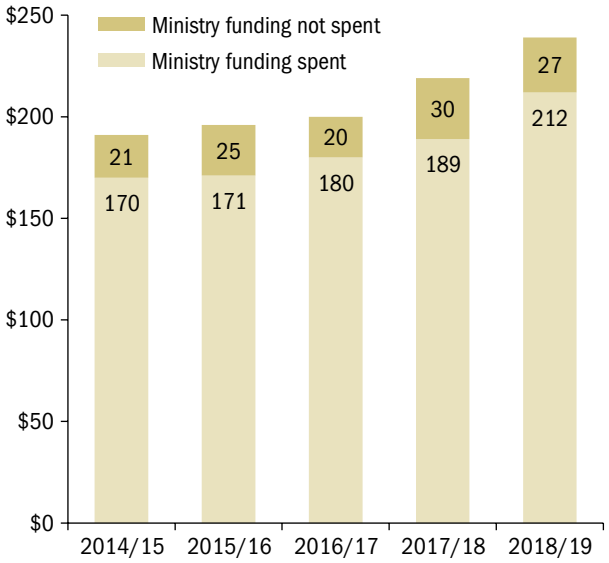
than the amount they spent on their addictions treatment programs. As shown in **Figure 18**, the difference between funding received and spent by service providers on their programs amounted to $123 million or almost $25 million on average annually, representing 12% of the total funding. While the Ministry informed us that the difference can be attributed to administration costs incurred by the service providers that they would not report as spending on addictions treatment programs, we found that this is also because service providers receive funding late in the fiscal year.

While the Ministry has increased funding for addictions treatment services since 2014/15, service providers have been unable to use all funding effectively within the designated fiscal year because they received new funding late in their fiscal year and did not have time to plan for its use. As such, they returned unspent annual funds to the Ministry.

There were instances where the Ministry did not allocate new funding to the LHINs until late in the fiscal year for distribution to the service providers. For example, in 2018/19, the Ministry had over $1.6 million in one-time funding available for one of the LHINs for community mental health and/or addictions programs. However, the Ministry did not inform the LHIN until January 11, 2019, about this funding, which had to be spent by March 31, 2019, and required the LHIN to submit a plan to the Ministry indicating how it intended to spend this money. While the LHIN was able to submit the plan to the Ministry on January 18, 2019, and allocate about $1.1 million to service providers, it was unable to allocate the remaining $500,000 due to the short time frame. In addition, the LHIN was unable to guarantee service providers as to the availability of this funding in future fiscal years due to its one-time nature, which made it difficult for the service providers to effectively plan how these funds could be used.

Figure 18: Funding Spent and Not Spent by Service Providers on Addictions Treatment Programs, 2014/15–2018/19 ($ million)

Source of data: Ministry of Health



RECOMMENDATION 2

To better meet clients' needs by providing them with timely access to appropriate and effective addictions treatment services, we recommend that the Ministry of Health:

- implement a needs-based funding model for existing and new programs;
- develop a standard approach to collect information (such as client outcomes) from service providers to assess the effectiveness of their treatment programs and take this into consideration when making future funding decisions;
- monitor the needs of children and youth as well as Indigenous peoples for addictions services to determine whether additional investment is necessary;
- work with stakeholders and peer deputy ministers of health from other provinces in Canada to discuss and identify ways of providing parents with a voice to positively guide addictions treatment for their children and youth; and
- develop a process to communicate one-time and ongoing funding decisions sooner to addictions treatment service providers to enable them to properly plan and use funding effectively for treatment services.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to provide people with timely access to appropriate and effective addictions treatment services by building a comprehensive and connected mental health and addictions system. The Ministry is exploring ways of assessing need and applying evidence of need to future funding decisions, including a core services framework. The Ministry is also working to identify opportunities to enhance quality throughout the mental health and addictions service system including robust data collection and analysis as well as quality assurance and improvement.

To further ensure that funding for addictions treatment services meets clients' needs, the government has committed to investing $3.8 billion over ten years for mental health, addictions and supportive housing. Of this investment, more than $25 million has flowed to build capacity and reduce wait times for community mental health programs, including services targeted to areas with the highest needs and priority populations, such as Indigenous people and communities.

Through these investments, the Ministry will improve access to front-line services and build a modern system focused on core services, and a robust data and digital strategy as well as a performance measurement framework to more effectively assess the effectiveness of addictions treatment service providers' programs.

The Ministry acknowledges the importance of addictions treatments for children and youth and will continue to identify ways to address the recommendation with respect to the consent to treatment for children and youth. Currently, there is no age specified in the *Health Care Consent Act* that governs an individual's ability to consent to treatment. A child may be capable of consenting to treatment, depending on the treatment proposed. Rather than age-based consent, the ability to consent is based on the person's capacity to understand the treatment being proposed and the reasonably foreseeable consequences of accepting, or not accepting, the treatment proposed.

The Ministry's current funding process exists within the broader government financial planning processes and is subject to the constraints of those processes. The Ministry will continue to communicate funding decisions as promptly as possible to all health service providers. Health service providers seeking assistance with their financial planning are encouraged to work directly with the health authority in their area (i.e., the Local Health Integration Network or Ontario Health).

4.3 Lack of Provincial Standards Can Contribute to Variability in Addictions Treatment Services across the Province

The Ministry has not established provincial standards for most types of addictions treatment programs to ensure consistency of the services these programs provide.

4.3.1 No Provincial Standards for Residential and Non-Residential Addictions Treatment Programs in Place in Ontario

While the Ministry has identified withdrawal management program standards that service providers are required to follow, it has not mandated standards for residential and non-residential addictions treatment programs. As a result, there are differences between addictions treatment service providers' operations and programs, because service providers are responsible for determining how to structure and deliver their programs (see **Sections 4.3.2, 4.3.3**, and **4.3.4**).

Currently, there is only a set of standards that the Ministry requires service providers to comply with, and it is for withdrawal management programs—no standards have been imposed on

service providers of residential and non-residential programs. Specifically:

- **Residential programs:** In 2017, Addictions and Mental Health Ontario released a standard for residential programs. This standard stipulates that staff in residential programs should use evidence-based treatment, such as cognitive behaviour therapy, peer mentoring or support for clients with addictions (or counselling services for family members of clients with addictions). However, at the time of our audit the Ministry informed us that it was not planning to require service providers to follow this standard.
- **Non-residential programs:** The Ministry informed us that it has not identified nor developed any standard for non-residential programs for addictions treatment service providers to follow.

4.3.2 Addictions Treatment Programs are Delivered Inconsistently across the Province

As discussed in **Section 4.3.1**, limited provincial standards are in place for addictions treatment programs to follow. Therefore, service providers are responsible for determining how to structure and deliver their programs, resulting in significant differences between service providers for the same type of program.

For residential treatment programs, our review of information from 28 service providers identified differences such as the expected length of program, duration of treatment and client-to-staff ratio. Specifically, we noted that:

- The expected length of programs ranged from 19 to 175 days.
- The duration of treatment ranged from three to four hours a day to eight or more hours a day.
- The client-to-staff ratio ranged from two clients per staff to 12 clients per staff.
- The staff who delivered group counselling sessions had credentials ranging from college diplomas (such as addictions service workers) to post-graduate degrees (such as psychologists).

For non-residential programs (primarily counselling and case management), our review of information from 38 service providers identified variability in their service availability during weeknights and weekends. Limited weeknight or weekend programs can make it challenging for some clients (such as those who go to school or work during the day) to access addictions treatment. Specifically, we noted that:

- Approximately 30% of programs did not offer any services during weeknights, with about 50% of programs offering services one to two weeknights a week and only 20% of programs offering services three or more nights a week; and
- 76% of programs did not offer any weekend services, with only 21% of programs offering services at least three weekends a month.

RECOMMENDATION 3

To provide people with consistent and evidence-based addictions treatment services, we recommend that the Ministry of Health:

- collect information on addictions treatment service provider programs (withdrawal management, non-residential and residential) to understand differences in their operations and service delivery (such as program length and duration, client-to-staff ratio and staff qualifications);
- review the hours of operation of non-residential service providers to determine whether services are being offered at times to meet the needs of those requiring addictions treatment counselling and case management services; and
- use the information collected and work with the service providers, stakeholders and clinical experts to implement standards for the programs.

MINISTRY RESPONSE

The Ministry agrees with the Auditor General that having better data on addiction programs is an important part of improving service quality and access. This means improving the collection, analysis, and reporting of data in the mental health and addictions sector for Ontarians of all ages.

To support the development, implementation and monitoring of evidence-based core service standards, the government has introduced legislation for the Centre of Excellence for Mental Health and Addictions, housed at Ontario Health, to take on these core responsibilities.

The Ministry has also been working to enhance its data collection capacity through the development of key performance measurement indicators and data collection alignment, and for addictions specifically, implementation of the Staged Screening and Assessment tools.

To support better quality of addictions services and access to those services, the Ministry has been working on the development of a set of evidence-based service standards, along with the implementation and monitoring of those standards. Standards could address hours of service to improve access to services, though greater access may be achieved by a variety of methods, particularly in rural and remote communities. Implementation of standards based on best practices would be a key component and could include developing communities of practice and providing on-the-ground support to individual programs.

As part of monitoring service provider performance, the Ministry will work on developing high-level performance indicators, outcome measures and program-specific assessment tools that assess key components of the standards.

4.3.3 Operation of Centralized Access Centres for Addictions Treatment Differs Across the Province

While some regions of the province have set up centralized access centres where individuals can obtain assessments and referrals to the appropriate service provider from one source, the services offered by these centralized access centres vary.

As discussed in **Section 2.3.1**, people with addictions can refer themselves by directly contacting an addictions treatment service provider to arrange for an eligibility assessment and work with the service provider to determine which program will best meet their needs. However, given that there are about 200 service providers operating at over 450 locations across Ontario that can offer different addictions services, it can be challenging for an individual to research them and figure out which service provider at which location would be the most helpful and appropriate for their needs.

The Ministry informed us that, apart from ConnexOntario (from which, as explained in **Section 2.3.1**, people can obtain information on the addictions services available in their local area), six of the 14 LHINs have established access centres to help people identify and be referred to addictions services available in the region. However, we noted significant differences in the operations of these six access centres (see **Figure 19**).

RECOMMENDATION 4

To allow people across the province to easily identify addictions treatment services that will meet their needs, we recommend that the Ministry of Health:

- develop and implement a centralized access centre model for addictions services that minimizes variations in accessibility across the province; and
- evaluate the costs and benefits of consolidating the existing addictions treatment service providers to identify potential efficiencies by integrating their operations and programs.

Figure 19: Differences in Operations between Access Centres of Six Local Health Integration Networks (LHINs)

Prepared by the Office of the Auditor General of Ontario

LHIN	Provides Services Related to Youth Less than 16 Years Old	Performs Eligibility Assessment for People[1]	Has One Common Referral Form for All Programs[2]	Can Schedule Appointments Directly with Service Providers	Hours of Operation
Mississauga Halton	×	×	✓	×[3]	Monday–Saturday, 8:30a.m.–8:00p.m.
Waterloo Wellington	✓	✓	×	✓[4]	24 hours a day, seven days a week
Champlain	×	✓	×	✓	Monday–Friday, 8:00a.m.–8:00p.m.
South West	✓	×	×	✓	24 hours a day, seven days a week
Toronto Central[5]	Varies	Varies	Varies	Varies	Varies
Central	×	✓	✓	×[3]	Monday–Friday, 8:30a.m.–4:30p.m.

Note: The Ministry informed us that while some form of centralized access for service providers exists in other LHINs, the models used there were generally less developed than the six more established centralized access centres identified above.

1. This ensures that an individual is being referred to the appropriate addictions treatment service provider and program.
2. This ensures a more efficient process by collecting the same information and giving it to each relevant addictions treatment service provider.
3. This functionality is being explored.
4. Only for four of the 11 addictions treatment service providers in the region.
5. Toronto Central has four centralized access centres (St. Michael's Coordinated Access to Addictions, Access CAMH, Central Access and the MHA Access Point) that provide different services in the region. The population served, ability to perform detailed assessments for people, ability to schedule appointments directly with service providers and hours of operation differ among these access centres. Each of these centralized access centres uses a common referral form for all programs it refers to.

MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes the need to improve access to addictions services. The Ministry is currently exploring a model that would seek to streamline access to mental health and addictions (MHA) services by building a co-ordinated access and navigation system that would include a single phone number and website (with texting and chat capability).

This access system would provide online programs/supports, general MHA information, and screening and referral using common MHA screening tools to refer people to the appropriate type of service and level of care, enabling better navigation and increased consistency in access across the province.

In addition to a provincial access system, Ontario Health Teams, mandated to provide health care across the continuum including MHA, will drive MHA providers to be more integrated with each other and with the rest of the health services within their Ontario Health Teams, improving access to services.

4.3.4 Behavioural Addictions Not Treated or Reported Consistently by Addictions Treatment Service Providers

The Ministry has not established a consistent provincial approach for treating and reporting behavioural addictions. This results in differences between addictions treatment service providers, both in terms of how they treat clients with behavioural addictions and in the way they report such services to the Ministry.

Since service providers do not accurately and consistently report the types of behavioural addictions that they actually treat, the Ministry does not know the extent of provincial behavioural addictions (other than problem gambling) being treated. In addition, the Ministry does not have the information needed to determine whether the services available to treat behavioural addictions are sufficient and effective to meet people's needs.

Apart from problem gambling, which is a well-established diagnosable addiction, there are other types of behavioural addictions, such as Internet, gaming and sex. The standard published by the American Psychiatric Association in 2013 does not include a diagnosis for any behavioural addictions other than problem gambling; it identifies Internet gaming disorder as a "condition for further study." A more recent standard, produced by the World Health Organization in 2018, identifies gambling and gaming disorders as "disorders due to substance abuse or addictive behaviours" and compulsive sexual behaviour disorder under "impulse control disorders."

The Ministry funds addictions treatment service providers to treat either problematic substance use or gambling and asks them to report back on how many clients they treated for either one or the other addiction. In other words, problem gambling is the only type of behavioural addiction funded and tracked by the Ministry. We identified differences in how service providers treat behavioural addictions other than problem gambling.

We collected information from 41 service providers and noted that the majority of them (about 73%) did provide treatment for behavioural addictions other than problem gambling. (Gaming and Internet were the main addictions treated, but treatment was also provided for pornography, sex and shopping addictions.) However, they reported such treatment to the Ministry in various ways: about 54% of them reported it as problematic substance use, 23% reported it as problem gambling and the remaining 23% reported it as either problematic substance use or gambling. For example:

- One service provider treated 62 clients in 2018/19 with different types of behavioural addictions, but reported them all to the Ministry as treatment for problem gambling.
- Another service provider treated 89 clients in 2017/18 with different types of behavioural addictions, but reported some services as problematic substance use and others as problem gambling.

For the remaining (about 27%) service providers who did not treat behavioural addictions, most of them indicated that they would like to treat behavioural addictions. However, since their funding was for treating problematic substance use and gambling only, they could not provide treatment to individuals with any other types of behavioural addictions and could only direct these individuals to other addictions or mental health service providers for treatment.

RECOMMENDATION 5

To provide Ontarians with treatment for behaviour addictions in a consistent manner, we recommend that the Ministry of Health develop reporting standards for behavioural addictions and require addictions treatment service providers to report the types of behavioural addictions they actually treat separately from problematic substance use and gambling.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and will review avenues for incorporating behavioural addictions more formally in reporting standards and processes as research and understanding matures. The Ministry will also explore how behavioural addictions could fit within a core services model should this be included in the Ministry's policy agenda moving forward.

The Ministry generally does not fund community mental health and addictions services by diagnosis. The Ministry funds services through

three streams: mental health, addictions/substance use and addictions/problem gambling. Financial reporting is aligned to these three streams by functional centre. The Ministry is aware of people with problematic behaviours, such as Internet gaming addiction and problematic technology use, receiving treatment in our publicly funded system. We have found that currently funded programs are often helpful as they are, currently structured or with minor adjustments, and are responsive to a wide range of behavioural addiction.

4.4 Programs or Practices to Reduce the Number and Frequency of Emergency Department Visits for Addictions Services Are Not Widely Adopted

As discussed in **Section 4.1.2**, more people are visiting emergency departments to obtain services related to substance-use conditions, even though emergency departments are not designed to treat addictions. While a number of programs or practices offered by addictions treatment service providers can help to reduce emergency department visits and therefore result in more effective or, in some cases, less costly, addictions treatment, they are not widely adopted and not available consistently throughout the province.

Examples of these programs and practices include the following:

- **Rapid Access Addiction Medicine clinics (clinics)**, primarily located in hospitals, community health centres and physicians' offices, provide walk-in access where people can obtain addictions treatment (such as counselling, prescriptions for medications and referral to appropriate treatment programs). A 2015 evaluation of a clinic in one hospital identified that, when comparing client outcomes 90 days before and 90 days after using the clinic, emergency department visits dropped 60%, days admitted into hospital dropped 80%, and there was an approximately 80% (or $5,000) savings in health-care costs to treat the client. Despite the benefits of the clinic, we noted that the existing 54 clinics in Ontario funded by the Ministry are, on average, open only about four hours at a time, and more than half of them are open three or fewer days a week. Based on our discussion with the clinics, this was often due to a lack of funding for staffing and resources. The Ministry has not conducted any review of the overall cost-effectiveness of the clinics to identify if the operating hours and days of the existing ones should be expanded or if additional clinics should be opened to meet people's needs.
- **Case management** is a program where case managers meet regularly with clients to ensure that apart from addictions treatment, they also obtain the other health and social services they need. In other words, case management offers clients a single point of contact to replace a haphazard process of referrals. Since 2010, an addictions treatment service provider in Toronto has operated a case management program that focuses on supporting clients who frequently visit emergency departments. This program has been proven to successfully reduce emergency department visits. In 2018/19, emergency department visits by the 167 program participants was reduced by almost 80%, dropping from 2,886 visits before participating in the program to 607 visits after joining the program. Based on our 2018/19 analysis of data of frequent visitors to emergency departments, considered as 10 or more visits within a fiscal year, for substance-use conditions, we estimated that if this same case management program had been implemented by other service providers province-wide, it could have reduced almost 22,000 emergency department visits during the fiscal year.

- **Nursing care on-site for withdrawal management programs** can help to reduce the need for emergency department visits by people with addictions. However, we noted that withdrawal management programs are primarily delivered by non-medical staff, including addictions counsellors. Our review of information from 15 withdrawal management programs noted that over 40% did not have nursing staff in their programs, and only one had access to nursing staff 24 hours a day, seven days a week. Service providers with nursing on site could admit more people into their withdrawal management programs (as they did not need to turn away people who required basic medical care), and they did not need to send clients to emergency departments to obtain basic medical care (for example, to have wounds treated or be prescribed antibiotics). For example, one service provider informed us that after adding nursing to its withdrawal management program, the number of its clients increased by more than 80%. Another service provider informed us that after adding nursing staff to its withdrawal management program, the number of its clients going to the emergency department was reduced by more than 10%.
- **Protocols for transporting people from police and paramedics to addictions treatment service providers** can provide a number of benefits (such as saving the time spent by police and paramedics waiting in an emergency department, as well as avoiding the costs of treating people in an emergency department or incarcerating them overnight) and better addictions treatment (since the service provider has trained staff who can begin expert treatment right away). However, we noted that Thunder Bay is the only region with a protocol for police and paramedic services to bring people experiencing the effects of problematic substance use directly to a local withdrawal management program. This protocol has been in operation with local police for over 20 years and with local paramedic services since 2014.

RECOMMENDATION 6

To provide Ontarians with more effective addictions treatment, we recommend that the Ministry of Health:

- evaluate the effectiveness of the existing Rapid Access Addiction Medicine clinics (clinics) to determine the costs and benefits of expanding the clinic hours or establishing additional clinics;
- evaluate the costs and benefits of expanding the case management program to regions where emergency departments have a large number of frequent visitors;
- identify withdrawal management programs with no nursing staff and evaluate the costs and benefits of adding nursing staff to these programs; and
- work with addictions treatment service providers, police and paramedic services to develop protocols for taking individuals directly to service providers versus emergency departments in appropriate circumstances.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to ensuring effective delivery and ongoing assessment of mental health and addictions services in Ontario. As the Ministry works to build a comprehensive and connected mental health and addictions system, we, along with Ontario Health, will continue to evaluate the benefits of various programs, including Rapid Access Addiction Medicine (RAAM) clinics and case management services, and explore opportunities to expand effective evidence-based mental health and addictions services and supports across the province.

The Ministry is currently working with the Mentoring, Education, and Clinical Tools for

Addiction: Primary Care-Hospital Integration (META:PHI) team at Women's College Hospital, the organization that first designed and piloted RAAM sites in Ontario, to gather information on RAAMs across the province including opportunities to address emerging issues, identify service gaps, and implement a consistent model of care. The Ministry will continue to engage with stakeholders across the mental health and addictions sector to inform ongoing policy work and address emerging needs across the province.

The Ministry recognizes the need for increased capacity for the medical management of clients, such as by nursing staff, at residential withdrawal management centres and will explore opportunities to fill this gap.

The Ministry is also committed to working across the whole of government, including with police and correctional officers, to address the mental health and addictions needs of Ontarians. The Ministry will continue to work with the Ministry of the Attorney General and the Ministry of the Solicitor General to ensure Ontarians with mental health and addictions needs who have contact with justice or correctional services are better supported.

4.5 Integration and Co-ordination is Lacking Among Ministries that Provide Addictions Services

Apart from the Ministry of Health (Ministry), other ministries and agencies also fund and provide addictions and/or mental health (which is closely related to addictions) services in Ontario. As identified in **Section 2.3.2**, at least $42 million was spent annually by other ministries and agencies on mental health and addictions services. We identified instances where integration and co-ordination is lacking (both between different ministries and between different divisions and branches within the Ministry).

4.5.1 Despite Expert Recommendation, Addictions Treatment for Individuals in Correctional Institutions Remains Outside the Ministry of Health's Responsibility

The Ministry of the Solicitor General oversees health care, including mental health and addictions, for individuals in provincial correctional institutions. From March 2015 to March 2019, the number and overall percentage of individuals in provincial correctional institutions identified as currently or previously experiencing problematic substance use increased. The number went from about 3,680 to 4,370 (up about 18%) and the overall percentage rose from 46% to 54%.

In 2018, an expert advisory committee prepared a report for the Ministry of the Solicitor General and the Ministry of Health. The committee identified that when compared to the general population, Ontario's correctional population is two to three times more likely to have mental health conditions or experience problematic substance use. The committee also raised a number of concerns, including lack of integrated and consistent correctional health care across the province; poor linkages and co-ordination between correctional health and the broader health system; and gaps in continuity of care and funding of services. To address these concerns, the committee recommended transferring the responsibility of health care for those in correctional institutions from the Ministry of the Solicitor General to the Ministry of Health.

However, both the Ministry of Health and the Ministry of the Solicitor General informed us that they do not have plans to implement this recommendation at this time. Instead, the Ministry of the Solicitor General is working on a new health-care strategy in 2019/20 to standardize treatment for problematic substance use at correctional institutions.

A number of provinces (British Columbia, Alberta, Quebec and Nova Scotia) have already transferred health-care service responsibility in correctional institutions from their justice or correctional sector to their health-care sector. Newfoundland has also committed to such a transfer by 2021.

We also found that more work still needs to be done to better integrate and co-ordinate addictions services for individuals, not only within correctional institutions, but also upon their discharge from institutions. In 2018, the Office of the Chief Coroner identified 31 individuals who died from opioid overdoses within four weeks of discharge from a provincial correctional facility. This indicates that better integration and co-ordination between correctional health and the broader health system could have facilitated these individuals' access to addictions treatment services in the community upon discharge. (See our Adult Correctional Institutions value-for-money audit report for additional details.)

4.5.2 Children and Youth Could Benefit from Better Integrated Mental Health and Addictions Services

Since April 1, 2019, the Ministry of Health has been responsible for both mental health and addictions treatment services for children and youth. However, it has not co-ordinated the two services effectively, even though a significant portion of children and youth with addictions issues also have mental health conditions.

In 2017, the Mental Health and Addictions Leadership Advisory Council recommended that the Ministry "implement a single set of core services for mental health and addictions for children and youth 0–25, to be delivered in a concurrent-disorder capable way" and "increase capacity in youth addictions services." In response to this recommendation, as of April 1, 2019, the Ministry of Health took over full responsibility for the oversight of children and youth mental health agencies from the Ministry of Children, Community and Social Services.

In 2019, an addictions residential treatment program for youth in Ontario published a survey of parents of clients admitted into this program between 2010 and 2017. The survey showed that 69% of admitted youth had at least one mental health issue, in addition to the addictions for which they were seeking treatment.

However, the Ministry has identified that only seven (or 3%) of 247 children and youth mental health agencies provide addictions services. Due to the lack of service providers capable of treating youth with both mental health conditions and addictions, people seeking treatment are forced to spend more time on identifying service providers, going through separate assessments to determine what addictions and mental health service they need, and travelling to different sites to obtain services.

RECOMMENDATION 7

To better integrate and co-ordinate the addictions services provided by different ministries and agencies in an efficient and effective manner, we recommend that the Ministry of Health:

- work with the Ministry of the Solicitor General to develop procedures to improve access to addictions treatment services for individuals in correctional institutions and after being discharged;
- formally reassess the costs and benefits of transferring the responsibility of health care for those in correctional institutions from the Ministry of the Solicitor General to the Ministry of Health; and
- evaluate the need for additional co-ordination of mental health and addictions treatment services for youth, and assess whether the existing service providers have the capacity and skill set to meet their needs or whether new service providers are needed.

MINISTRY RESPONSE

The Ministry of Health supports the Ministry of the Solicitor General with their plan to enhance addictions support in institutions, and is exploring opportunities to invest in addictions workers, etc., and expand training on the Global Appraisal of Individual Need (GAIN) assessment tool to correctional workers and/or Release From Custody Workers, to improve access to addictions treatment for incarcerated and discharged individuals.

The Ministry of the Solicitor General created a Corporate Health Care and Wellness branch in November 2018 that provides strategic oversight and health-care expertise within correctional services and centralizes all health-related roles and responsibilities. The Ministry of Health continues to support the Ministry of the Solicitor General with its implementation of a correctional health-care strategy that is focused on improving the quality of care provided to inmates and offenders, in alignment with the broader health-care system.

In June 2018, the Ontario government announced that funding and accountability for child and youth mental health programs would transfer from the Ministry of Children, Community and Social Services to the Ministry of Health to support the vision of a mental health and addictions system that reaches Ontarians of all ages and is co-ordinated with other health services to better support Ontarians.

The Ministry of Health continues to evaluate and be responsive to identified gaps in Ontario's health system, including service gaps for children and youth in addictions treatment. In 2018/19, the Ministry invested $51 million in youth residential treatment, youth withdrawal management, and child and youth mental health services. The Ministry of Health is also piloting an integrated youth services model known as 'Youth Wellness Hubs Ontario' where young people aged 12 to 25 can receive walk-in, one-stop access to mental health and addictions services, as well as other health, social and employment supports under one roof.

4.6 Opioid Strategy Needs Improvements to Address Ontario's Opioid Crisis

As discussed in **Section 2.4**, in August 2017, the Ministry of Health announced an investment of over $222 million for an Opioid Strategy (Strategy). This was in response to what was being recognized as an opioid crisis, evidenced by the significant increase in opioid-related deaths from more than one per day in 2007 to more than two per day in 2016. While many of the initiatives of the Strategy (see **Appendix 5**) are supported by evidence that they can have a positive impact on people addicted to opioids, the opioid crisis in Ontario continues, indicating that more needs to be done to end the crisis.

4.6.1 Opioid-Related Emergency Department Visits, Hospitalizations and Deaths Increased Despite Spending about $134 Million between August 2017 and March 2019 on the Opioid Strategy

While the Ministry spent approximately $134 million on the Strategy between August 2017 and March 2019, opioid-related deaths continued to grow from more than two deaths per day to four deaths per day, and opioid-related emergency department visits and hospitalizations also increased.

Figure 20 shows the trend of opioid-related emergency department visits, hospitalizations and deaths in Ontario between 2009 and 2018. We noted that between 2016 and 2018 (during the period shortly before and after the Strategy was launched):

- Opioid-related deaths grew almost 70% (from 867 to 1,473).
- Opioid-related emergency department visits more than doubled (from 4,427 to 9,154).
- Opioid-related hospitalizations increased by more than 10% (from 1,908 to 2,106).

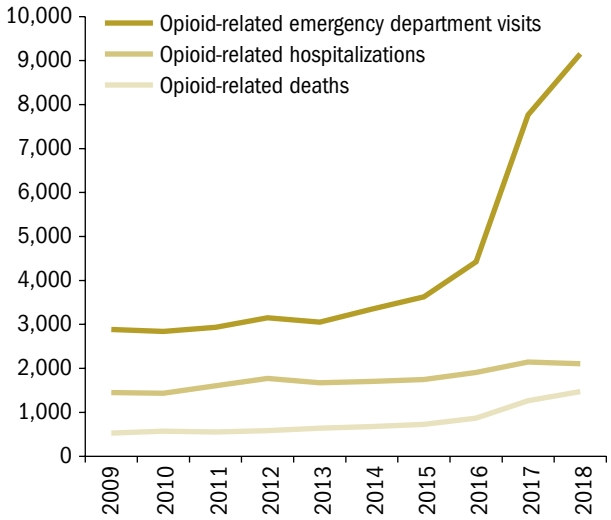
Figure 21 shows opioid-related deaths, by LHIN, in 2018.

These opioid-related trends and regional data indicate that the effectiveness of the Strategy has yet to be seen. We identified a number of areas where improvements are necessary to reduce the burden of the opioid crisis on the province as follows:

- No specific funding goals and specific performance targets were set for the Strategy (see **Section 4.6.2**).

Figure 20: Opioid-Related Deaths, Emergency Department Visits and Hospitalizations in Ontario, 2009–2018

Source of data: Public Health Ontario



Note: The significant increase between 2015 and 2017 was related to the use of fentanyl, which became more widely circulated and sold either as an opioid itself or mixed with other drugs (such as heroin or cocaine) to make them more potent. Fentanyl is much stronger than most other opioids—up to 100 times stronger than morphine. Beyond fentanyl, fentanyl analogues (compounds that are similar to fentanyl) have also started to be sold illegally or are being added to other illegal drugs sold by drug dealers. One example of this is carfentanil, which is 100 times stronger than fentanyl. Even a small amount of fentanyl or fentanyl analogues can cause an overdose, resulting in more emergency department visits, hospitalizations and even deaths.

- The Opioid Emergency Task Force is not used effectively by the Ministry to implement the Strategy (see **Section 4.6.3**).
- Funding for the Strategy is not targeted at treatment or highest need (see **Section 4.6.4**).
- Information on unusual or suspicious dispensing events related to opioids is not regularly shared with prescribers and regulatory colleges (see **Section 4.6.5**).
- Guidelines for opioid agonist therapy are not consistently followed by service providers (see **Section 4.6.6**).
- No actions have been taken to achieve cost savings and insufficient information has been collected to assess the effectiveness of naloxone distribution through pharmacies (see **Section 4.6.7**).
- Consumption and Treatment Services sites are not set up in all regions with a need and not operated consistently (see **Section 4.6.8**).

4.6.2 No Specific Goals and Targets Were Set for the Opioid Strategy

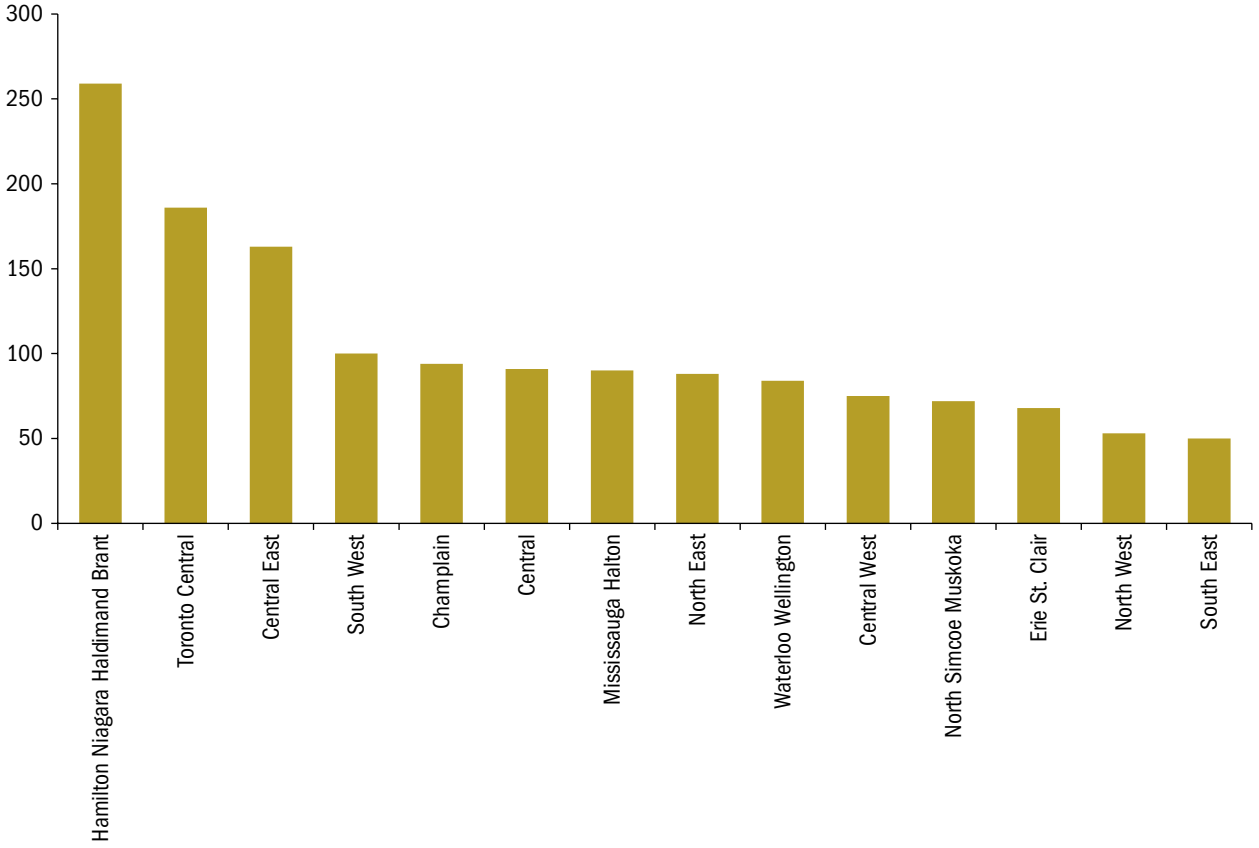
When the Opioid Strategy was developed in 2017, the Ministry did not establish any specific measurable goals and targets to determine if its funding for the Strategy was sufficient and allocated appropriately to various initiatives. The Ministry set broad and vague goals and desired outcomes, such as "enhance care for opioid use disorder" and "expand harm reduction services for all individuals using prescription or illicit drugs."

The Ministry informed us that for the first two years of the Strategy, it used initial outcome measures (including opioid-related deaths, emergency department visits and hospitalizations) to broadly assess the effectiveness of the Strategy and worked on developing more detailed performance indicators. **Appendix 9** provides a listing of the 20 indicators that the Ministry plans to measure. At the end of our fieldwork, the Ministry indicated that it had not finalized the performance report to measure performance and outcomes of the Strategy's initiatives. The Ministry has not determined when it will begin setting targets for the indicators or when regular reporting will commence.

4.6.3 Ministry Not Using Opioid Emergency Task Force Effectively to Implement the Strategy

In October 2017, the Ministry established the Opioid Emergency Task Force. The Task Force is composed of over 40 representatives from sectors that include emergency response, frontline community mental health and addictions, addictions medicine and people with lived experience. The Task Force's responsibilities included providing the Ministry with information on barriers to implementing the

Figure 21: Opioid-Related Deaths by Local Health Integration Network, 2018
Source of data: Office of the Chief Coroner



Strategy effectively, feedback on proposed measures to address the opioid crisis and potential solutions to deal with the opioid crisis.

The Ministry has not met with the Task Force since August 2018 and, at the time of our audit, had no plans to do so even though the Strategy is still under way and the opioid crisis continues, as shown by the increase of opioid-related emergency department visits, hospitalizations and deaths (see **Section 4.6.1**).

A December 2018 inquest verdict released by the Office of the Chief Coroner (regarding a Toronto man who died from an opioid overdose in 2015) recommended the Ministry reinstate the task force, stating that it "performed an important role."

4.6.4 Majority of Funding for the Strategy is Not Targeted at Treatment or Highest Need

We identified instances where the Ministry has not targeted its Strategy's funding at treatment or at areas with the highest need. Specifically:

- Over half of the funding for the Strategy is targeted at harm reduction, with only about 35% (or about $93.5 million) of the funding going toward actual treatment for opioid addictions (see **Appendix 5**). A 2019 study in British Columbia estimated that over 1,800 deaths were prevented in the province as a result of harm-reduction activities. While harm reduction is a set of strategies and ideas aimed at reducing the harmful consequences and preventing deaths associated with opioid use (such as providing an environment where people have access to sterile supplies, which can reduce

the risk of Human Immunodeficiency Virus and Hepatitis C Virus infection), it does not directly help stop people's problematic opioid use and treat their underlying addiction.

- The Ministry has allocated over $58 million to the LHINs for opioid addiction treatment in their regions. However, only one-third of the funding was allocated based on factors that reflect regional needs (such as population size, opioid-related deaths, emergency department visits and hospitalizations), with the remainder of the funding equally distributed amongst the LHINs with no consideration of local needs. For example, in comparison with the South East LHIN, the Central East LHIN's population was over three times larger, its opioid-related deaths were more than double, and its opioid-related emergency department visits were triple that of the South East LHIN. However, the Central East LHIN's funding in 2017 was only about 1.6 times higher than the South East LHIN's funding.

RECOMMENDATION 8

To implement the Opioid Strategy (Strategy) cost-effectively and address the opioid crisis in Ontario more effectively, we recommend that the Ministry of Health:

- establish targets for the Strategy's performance indicators to achieve, measure achieved results against the targets on a regular (such as quarterly) basis and take corrective action where targets are not met;
- direct the Opioid Emergency Task Force to meet and report regularly; and
- collect information on the need for opioid addiction treatment across the province and modify the funding and/or initiatives of the Strategy based on the needs information.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to monitoring the effectiveness of its opioids response and has developed an internal performance measurement report for opioids-related investments. The Ministry will continue to update the report periodically and to share with partners within the Ministry. The Ministry will further examine the feasibility of establishing targets to enhance performance monitoring.

The Ministry is also committed to listening to diverse voices and working together with stakeholders to address the opioid crisis. For example, a range of stakeholders, including members of the Opioid Emergency Task Force, were consulted as part of the 2018 review of Supervised Consumption Services and Overdose Prevention Sites. The Ministry has indicated that it will continue to communicate with the Opioid Emergency Task Force. The Ministry will take this recommendation under advisement.

In addition, the Ministry is committed to directing health-care funding to where it is needed most, and that strong accountability mechanisms are in place for all funding agreements. To help address the opioid crisis in Ontario, the Ministry is working to develop a core services framework that will identify a consistent set of core mental health and addictions services, including services for opioid addiction in Ontario, and provide an evidence-based approach to making targeted investments across the province.

As part of the health system transformation, the Ministry has created a new Crown agency, Ontario Health, as a central point of accountability and oversight for the health-care system. The Ministry will explore opportunities to work with Ontario Health to allocate funding in a way that is both accountable and reflective of local and regional needs for opioid addictions treatment.

4.6.5 Information on Opioid Prescriptions is Not Regularly Shared with Prescribers and Regulatory Colleges

Over the last five fiscal years (2014/15–2018/19), there was an average of about 9 million instances where opioids were dispensed to about 1.9 million patients each year. This amount does not include opioids dispensed in hospitals and correctional institutions or for opioid agonist therapy. These opioids were prescribed by over 48,000 health-care providers, who were primarily (about 90%) physicians and dentists.

While opioids can treat pain effectively, the Canadian Medical Association indicated that "opioid dispensing levels are strongly correlated with increased mortality, morbidity and treatment admissions for substance use." It is important to share information on dispensed opioids among prescribers and regulatory colleges to ensure that opioids are being prescribed and dispensed appropriately. However, regular information-sharing with these parties is lacking.

Prescribers Do Not Have Real-Time Access to the History of Opioids Dispensed to Patients

The Ministry has not provided all health-care providers who can prescribe opioids, including physicians and dentists, with access to information on the history of opioids dispensed to their patients, even though this information is readily available from an existing system. Therefore, prescribers may have to rely on information self-disclosed by their patients, who may intentionally or mistakenly provide wrong or incomplete information, leading to inappropriate or excessive prescriptions of opioids by health-care providers.

According to the College of Physicians and Surgeons of Ontario, while the majority of physicians are prescribing appropriately, "in order to support the safest and most effective care possible, it is essential that physicians have real-time access to information about the drugs their patients have been dispensed, particularly opioids and other controlled drugs." Since 2006 or earlier, other provinces such as Alberta and British Columbia have allowed physicians to access a provincial database that contains details on each patient's history of dispensed opioids. In contrast, Ontario still had not made patient information on opioids dispensed available to all physicians and other prescribers even though this information is already stored in an existing system (Narcotics Monitoring System) and is available for viewing through an existing computer application (Digital Health Drug Repository), as shown in **Figure 22**.

Access to the Digital Health Drug Repository is limited to some physicians and dentists. We noted that as of June 30, 2019:

- While about 360 primary care settings (such as family physicians and family health teams) have access to the repository, this is significantly lower than the number of family physician practices in Ontario (over 12,300).
- Dentists generally do not have access to the repository. (Some may if, for example, they work in one of the approximately 220 hospital sites with access to it.) Unlike Ontario, dentists in other provinces, such as Alberta and Nova Scotia, are given access to their provincial databases and are able to access details about their patients' history of opioids dispensed.

Without having access to a patient's history of opioids dispensed, prescribers are unable to verify if their patients have already received opioids dispensed by others. Based on our review of data of opioid dispensing events, we found that there were cases where patients received multiple opioids prescribed by different physicians and/or dentists, creating the risk of overdose. For example, in 2018/19:

- There were almost 1,500 instances where an individual received at least an eight-day supply of opioids prescribed by a physician and within one week subsequently received more opioids prescribed by a dentist. In one case, a patient received a 30-day supply of opioids prescribed by a dentist after receiving a 28-day supply of opioids prescribed by a physician.

Figure 22: Systems Containing Details on Opioids Prescribed and Dispensed
Prepared by the Office of the Auditor General of Ontario

	Narcotics Monitoring System	Digital Health Drug Repository
Developed in which year	2012	2016
Developed by whom	Ministry of Health	Ministry of Health, in collaboration with eHealth Ontario
Type of data available	• Data on all narcotics, controlled substances and other monitored drugs (including opioids) dispensed by pharmacists, irrespective of whether the prescription is paid for under a publicly funded drug program, through private insurance or by cash. • Examples of data include type of opioid prescribed, dispensed date, quantity, strength, prescriber's information (such as licence number), pharmacy information, and patient's information (such as health card number).	• Data from the Narcotics Monitoring System • Data on publicly funded drugs dispensed and pharmacy services (including service date and service description) under the Ontario Drug Benefit Program
Purpose of the system	• Gives notifications to pharmacists at the time of dispensing regarding situations that warrant further review or action, such as contacting the prescriber to confirm the accuracy of a prescription, before the prescription should be dispensed. For example, this could include an individual being dispensed opioids prescribed by three or more health-care providers within 28 days.	• Allows health-care providers to view data from the Narcotics Monitoring System, as well as data on publicly funded drugs dispensed and pharmacy services under the Ontario Drug Benefit Program

- There were nearly 1,000 instances where an individual received opioids prescribed by a dentist, but also received methadone or buprenorphine-naloxone (which are replacement drugs used in opioid agonist therapy) prescribed by a physician less than a week before receiving the opioids.
- More than 5,000 individuals received opioids within a week after receiving methadone or buprenorphine-naloxone. In each case, the physician who prescribed the opioid was not the one who prescribed the methadone or buprenorphine-naloxone.

While our review of data is based on information reported by pharmacy staff dispensing the opioids, the Narcotics Monitoring System does not contain patients' clinical information for why opioids were prescribed and dispensed. The Ministry informed us that to determine the appropriateness of prescriptions, a review would need to be performed of the patient clinical information at the practice level (such as the physician, dentist or pharmacist) in addition to reviewing the details of the individual prescriptions.

Regulatory Colleges Do Not Have Real-Time or Regular Access to Information on Opioids Dispensed to Identify and Investigate Inappropriate Practices by Their Members

While regulatory colleges are responsible for investigating inappropriate practices by their members and for taking corrective actions, they do not have real-time or regular access to information on the opioids prescribed and dispensed by their members on which to base their investigations.

Regulatory colleges generally have to rely on information reported by other parties, such as members of the public, to identify prescribers, dispensers and situations that may require further investigation. The Ministry provides regulatory colleges with information on the prescribing or dispensing activities of their members only if it

receives a request, but does not share such information proactively and regularly—even though the information may assist the regulatory colleges to identify inappropriate practices, perform investigations and take corrective actions on a timely basis. Specifically, we noted that:

- In 2015 and 2016, in response to a request from the College of Physicians and Surgeons of Ontario, the Ministry passed information about 125 physicians with potentially problematic opioid prescribing practices to the College of Physicians and Surgeons of Ontario for further investigation. It also passed information about 17 pharmacies with potentially problematic opioid dispensing practices to the Ontario College of Pharmacists. This has not happened since, as there have not been any further requests like this from the regulatory colleges.
- The College of Physicians and Surgeons of Ontario conducted investigations of physicians in 2017 based on information received from the Ministry in 2016. As a result of these investigations, we identified that two physicians were required to engage in continuing education and one of the physicians was required to have their prescriptions of opioids and other controlled substances monitored by another physician for six months. We noted that, subsequent to the investigation, both physicians reduced the average dosage of the opioids they prescribed per day. This indicated that the sharing of information with the regulatory colleges can be and was effective in correcting and deterring inappropriate practices by prescribers.

Figure 23 shows unusual or suspicious cases that we identified where opioids might have been prescribed or dispensed inappropriately. The Ministry could have proactively flagged these cases to the regulatory colleges for further investigation. The cases we identified can be classified into two categories:

- instances where large dosages of opioids were prescribed and dispensed; and
- instances where pharmacists dispensed opioids that were associated with physicians and dentists with inactive licences.

The Ministry indicated that the approach we used to identify these instances and reach our overall conclusion was valid and that it does not know for certain why they happened. Subsequent to our audit fieldwork, the Ministry investigated about 15% of these instances we identified and informed us that the instances were due to data entry errors, such as entering the wrong prescriber licence number or attributing a licence to the wrong regulatory college. The Ministry informed us that they will continue to investigate these incidents to identify appropriate next steps to take.

We spoke with several regulatory colleges whose members can prescribe or dispense opioids, including the College of Physicians and Surgeons of Ontario, the Ontario College of Pharmacists, and the Royal College of Dental Surgeons of Ontario. They informed us that it is important for the regulatory colleges to have real-time access to information on instances of opioids dispensed or at least to receive regular reports on opioids dispensed that appear unusual or suspicious, so they can be proactive in identifying irregular or inappropriate activity that warrants investigation.

RECOMMENDATION 9

To better prevent and deter inappropriate prescribing and dispensing of opioids, we recommend that the Ministry of Health:

- provide access to data on patients' history of dispensed opioids to all health-care providers who can prescribe opioids;
- implement additional controls in its health information system to validate the prescriber's licensing status before allowing pharmacists to dispense;
- review the unusual or suspicious cases we identified and share appropriate information

Figure 23: Examples of Unusual or Suspicious Instances Where Opioids Were Dispensed

Prepared by the Office of the Auditor General of Ontario

Opioids Dispensed in Large Quantity or Dosage[1]

- The average strength of a daily dosage of dispensed opioids is about 53 morphine milligram equivalents (MMEs) (this is based on all prescriptions from all physicians except prescriptions dispensed for opioid agonist therapy). However, one physician wrote prescriptions to 58 individuals that resulted in 283 opioid dispensing events; the average daily dosage was 924 MMEs, which is over 17 times higher than the average of 53 MMEs. Another physician wrote prescriptions to 11 individuals that resulted in 90 opioid dispensing events; the average daily dosage was 731 MMEs, almost 14 times higher than the average of 53 MMEs.
- A patient received an 840-day supply of opioids within one year, prescribed by one physician and intended for use over two years. Another patient received a 100-day supply of opioids and subsequently received another 100-day supply of opioids one month later at the same pharmacy (these were dispensed based on prescriptions made by the same physician).

Pharmacists Dispensed Opioids Associated with Physicians and Dentists with Inactive Licences[2]

- About 88,000 instances of opioids dispensed between 2014/15 and 2018/19 were prescribed by approximately 3,500 prescribers (2,900 physicians and 600 dentists) with inactive licences. The licences had been inactive since at least 2012, for different reasons (including because the prescribers were deceased, had their licences revoked or were retired):
  - About 9,000 instances of dispensed opioids were associated with about 400 prescribers who died in 2012 or earlier. For example, between 2014/15 and 2018/19, two physicians who died in 1989 were associated with 519 instances of dispensed opioids, and a dentist who died in 2002 was associated with 54 instances of dispensed opioids.
  - About 375 instances of dispensed opioids were associated with approximately 10 prescribers whose licences were revoked for disciplinary reasons in 2012 or earlier. For example, one physician whose licence was revoked in 2000 was associated with 195 instances of opioids dispensed from 2014/15 to 2018/19.
  - Almost 79,000 instances of dispensed opioids were associated with about 3,100 prescribers whose licences became inactive in 2012 or earlier for reasons such as retirement.
- A number of pharmacists and pharmacies had multiple (10 or more) instances where they dispensed opioids associated with prescribers with inactive licences. For example:
  - One pharmacist in Hamilton dispensed opioids 125 times associated with 22 different prescribers (14 physicians and eight dentists) whose licences became inactive in 2012 or earlier (including a dentist who died in 2006).
  - At one pharmacy in Belleville, 18 pharmacists dispensed opioids 230 times associated with 15 prescribers (14 physicians and one dentist) with inactive licences.

Note: Our review was based on information on dispensed opioids reported by pharmacy staff in the Narcotics Monitoring System (see **Figure 22**).

1. Examples are based on 2018/19 data.
2. We identified these cases by comparing licence numbers of physicians and dentists who prescribed opioids that were dispensed between 2014/15 and 2018/19 to active licence numbers provided by the College of Physicians and Surgeons of Ontario and the Royal College of Dental Surgeons of Ontario.

with the regulatory colleges as necessary; and

- work with the regulatory colleges to provide them with direct or real-time access to information contained in the Narcotics Monitoring System or regular reports on unusual and/or suspicious prescribers and dispensers.

MINISTRY RESPONSE

The Ministry supports this recommendation and recognizes the importance of improving provider access to information that is needed to support care. The Ministry will continue efforts to expand provider access to provincially held data, such as the drug and pharmacy services information in the Digital Health Drug Repository (Repository), by supporting the continued deployment and adoption of clinical viewers, particularly in Ontario Health Teams, and by supporting interoperability standards that will allow Repository information to be integrated with point-of-care systems.

The Ministry acknowledges the analysis and observations by the Auditor General regarding unusual cases and notes that the appropriateness of prescriptions cannot be

determined without review of the patient's clinical information at the practice level for all health-care providers involved (for example, physicians, dentists, pharmacists). Investigative work performed by the regulatory colleges in the past has demonstrated that the prescribing patterns observed by the Auditor General would have been clinically appropriate in most circumstances. In other cases, further review has revealed data entry errors, as opposed to inappropriate prescribing or dispensing.

The responsibility for practice-level assessment resides with the regulatory colleges. The Ministry worked with the regulatory colleges and Health Quality Ontario to collectively consider how the Narcotics Monitoring System data could be used in a consistent and evidence-based manner to support health-care providers, including potential responses to prescribing issues and identifying inappropriate dispensing practices. The Ministry will continue to work with the regulatory colleges to explore opportunities to ensure they are provided timely access to information contained in the Narcotics Monitoring System.

4.6.6 Guidelines for Opioid Agonist Therapy Are Not Consistently Followed by Service Providers

As part of the Strategy, the Ministry funded Health Quality Ontario to develop a guideline for caring for people (aged 16 and over) with opioid addiction. The guideline identified opioid agonist therapy as the first-line treatment for individuals addicted to opioids. Opioid agonist therapy uses replacement drugs (such as methadone or buprenorphine-naloxone) to help individuals deal with the cravings and withdrawal symptoms, to stabilize their lives and to reduce the harms related to their opioid use. Various studies have identified that people on opioid agonist therapy were less likely to engage in criminal activity compared with when they were not on opioid agonist therapy. From 2014/15 to 2018/19, the number of individuals on opioid agonist therapy increased by 26%, rising from about 54,000 to 68,000.

We identified that not all addictions treatment service providers and prescribers of opioid agonist therapy follow this guideline. For example:

- The guideline identifies that "if a person receiving opioid agonist therapy enters an inpatient facility (e.g., a hospital or residential addiction treatment program) or a correctional facility, their opioid agonist therapy should be continued without disruption." However, many addictions treatment service providers do not admit people who are taking methadone or buprenorphine-naloxone as part of opioid agonist therapy. We noted that about 40% of providers do not admit individuals who are on methadone. About 20% of providers do not admit individuals who are on buprenorphine-naloxone. Some service providers informed us that they do not follow this guideline because they have been following an abstinence-based approach whereby individuals are encouraged to stop taking all drugs, including methadone and buprenorphine-naloxone. Other service providers indicated that they do not have enough staff to monitor and take care of people who are on opioid agonist therapy.
- The guideline also recommends that "people receiving opioid agonist therapy also have their physical health, mental health, additional addiction treatment needs, and social needs addressed concurrently either in the specialized clinic or via other care providers." However, not all service providers ensure that people on opioid agonist therapy also receive other addictions treatment services. In 2018/19, about 68,000 individuals received opioid agonist therapy, but addictions treatment service providers reported that only about 11,600 (or about 17%) of these individuals received addiction treatment services (such as counselling services) from them in

2018/19. While it is possible that these clients may have received addictions treatment services from someone other than an addictions treatment service provider, such as by paying out of pocket or through insurance for private counselling, it appears that many people on opioid agonist therapy are not receiving other addiction treatment services. Some individuals receive opioid agonist therapy from clinics operated by physicians specializing in providing this therapy. The Ministry does not have information on the number of these clinics, but we identified, using ConnexOntario, over 120 of them (see **Section 2.3.2**). Our review of information from 69 of these clinics noted that about half do not offer counselling services to their clients, primarily because they are not funded to do so.

RECOMMENDATION 10

To provide appropriate and effective treatment based on guidelines for people addicted to opioids, we recommend that the Ministry of Health work with addictions treatment service providers to:

- develop a process that allows individuals on opioid agonist therapy to be admitted to treatment programs; and
- incorporate other addictions treatment services (such as counselling services) into the opioid agonist therapy.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to supporting people with opioid addiction to get the help that they need. The Ministry has been working to improve access to comprehensive addictions treatment, including opioid agonist therapy, in keeping with best practice guidelines. For example, the Ministry has supported initiatives to increase the capacity of primary-care physicians to treat opioid addiction. It has also funded Rapid Access to Addiction Medicine clinics that provide immediate access to short-term, comprehensive addictions care.

To help incorporate other addictions treatment services into the opioid agonist therapy, the Ministry is working to develop a core services framework that will identify a consistent set of core mental health and addictions services in Ontario and provide an evidence-based approach to making targeted investments across the province. Service standards for core services will be developed.

In May 2019, the government introduced legislation that would create a central driver of system quality, the Mental Health and Addictions Centre of Excellence within Ontario Health. If passed, this new partnership will also help address this recommendation by:

- supporting consistent, high-quality mental health and addictions services across the province;
- building a robust data system to inform ongoing performance measurement and monitoring of the system; and
- building a knowledge base that will support continuous improvement across the sector.

4.6.7 No Actions Have Been Taken to Achieve Cost Savings and Insufficient Information Collected to Assess Effectiveness of Naloxone Distribution Through Pharmacies

Naloxone distribution is the Strategy's largest funded program, accounting for over $71 million, or about 27%, of the Strategy's cost. However, the Ministry has not taken action to achieve potential cost savings for the naloxone program and has not assessed its effectiveness.

Naloxone is a drug that can be sprayed into the nose or injected into muscle to temporarily reverse an opioid overdose. It helps the individual to breathe and regain consciousness. The Ministry's naloxone program distributes naloxone kits to

individuals free of charge through three separate initiatives under the Strategy:

- an initiative that distributes naloxone kits through public health units and other eligible community-based service providers;
- an initiative that distributes naloxone kits through pharmacies; and
- an initiative operated by the Ministry of the Solicitor General to distribute naloxone kits to individuals in provincial correctional facilities at risk of an opioid overdose and those who would like to receive one when they are released from custody.

Ministry Has Not Achieved Potential Cost Savings from Distributing Naloxone Through Pharmacies

The Ministry could have achieved potential cost savings of up to about $7 million if it had administered its naloxone distribution initiative through pharmacies as British Columbia does. Specifically:

- Unlike British Columbia, the Ministry does not buy injectable naloxone kits for pharmacies in bulk. Instead, the Ministry pays pharmacies to purchase their own kits at $35 each. This is about $24 more per kit than the Ministry pays when bulk buying the kits for public health units and other eligible community-based service providers. While distribution costs would be incurred, up to about $2.8 million could have been saved with bulk buying given that pharmacies billed the Ministry for about 118,000 injectable naloxone kits purchased between 2017/18 and 2018/19. The Ministry also bulk buys flu shots for public health units, pharmacies, community health centres and hospitals in the Greater Toronto Area.
- Unlike British Columbia, the Ministry reimburses participating pharmacies for dispensing naloxone kits to individuals ($10 per naloxone kit dispensed) as well as for, training individuals, upon request, on how to use injectable naloxone kits ($25 per person trained). The Ministry spent about $4.3 million on these payments between 2017/18 and 2018/19.

Ministry Has Not Collected Sufficient Information to Assess Effectiveness of Naloxone Distribution Through Pharmacies

The Ministry has collected limited information to assess the effectiveness of the naloxone program, even though about 339,000 naloxone kits have been distributed since 2017/18 and the program cost about $35 million between August 2017 and March 31, 2019.

While the Ministry requires public health units to report details of their naloxone distribution, reporting these details is voluntary for participating pharmacies. The details public health units must report include the number of people they train to administer naloxone, the number of kits they distribute and the number of people that receive naloxone.

Although pharmacies have accounted for over 60% of the distributed naloxone kits since the launch of the program in 2017, only about 36% of the approximately 1,575 pharmacies participating in the program have voluntarily reported details of their distributions to the Ministry on a quarterly basis.

While the Ministry is aware of the number of naloxone kits distributed by pharmacies based on their billings, it is unable to fully assess the effectiveness of the naloxone distribution program without collecting complete information from the pharmacies. Such information, where possible, should include the number of people who receive naloxone injections and the number of times paramedic services are called when naloxone is administered.

RECOMMENDATION 11

To achieve savings and assess the effectiveness of its naloxone distribution through pharmacies as part of the Opioid Strategy, we recommend that the Ministry of Health:

- evaluate the costs and benefits of bulk buying injectable naloxone kits for pharmacies and implement bulk buying if it results in cost savings; and
- collect detailed information from all participating pharmacies about their naloxone distribution, such as how many people are trained to use naloxone kits to assess the effectiveness of this initiative in order to identify whether any changes are needed.

MINISTRY RESPONSE

The Ministry appreciates the Auditor General's suggestions regarding naloxone distribution in the province and will revisit the appropriateness of bulk buying naloxone kits for pharmacies. Although the Ministry currently pays pharmacies $35 for each injectable naloxone kit distributed through the Ontario Naloxone Program for Pharmacies (ONPP), this includes the cost of procuring the supplies and assembling the kits. Bulk buying of naloxone will need to consider the operating and distribution costs as well.

The Ministry will review and evaluate the possibility of a centralized distribution system for supplying naloxone kits to the province under all of the Ministry's publicly funded naloxone programs. The logistics of potentially supplying naloxone to approximately 4,500 pharmacies, in addition to the current public health units, were previously examined when the programs were launched but can be further explored at this time.

The Ministry is in the process of updating the Quarterly Report Back Form that pharmacies participating in the ONPP complete for the purpose of gathering outcome information and experiences on the ONPP. This automated and user-friendly form will decrease the administrative burden for pharmacies and will likely encourage higher response rates. More relevant and higher quality data to assist with evaluating the ONPP will be obtained.

4.6.8 Consumption and Treatment Services Sites Not Set Up in All Regions with a Need and Not Operated Consistently

As of April 1, 2019, a new program, Consumption and Treatment Services sites (sites), replaced the previous Supervised Consumption Services and Overdose Prevention Sites that had been in operation since August 2017 and February 2018, respectively. While the Ministry has developed some provincial standards, such as required staffing levels and the range of services to be offered, it has not developed other standards to ensure consistent operations of the sites. Additionally, the Ministry has not determined whether the existing sites are adequate and in appropriate locations.

The sites are considered a harm-reduction initiative, as they are not primarily operated to treat an individual's addictions. Rather, the sites can provide a safe environment where people can:

- consume substances they possess under supervision of health-care professionals (who identify and respond to overdoses);
- access sterile needles and other drug supplies (which reduces the risk of disease transmission from sharing supplies); and
- connect to addictions treatment and other health or social services on-site or off-site (such as primary care and rehabilitation, and mental health and social supports).

The Ministry requires each site to get support from its community, including its local municipal government and local businesses, as part of the application process to establish and run a site.

The sites are mainly located within public health units or community health centres. As of October 15, 2019, the Ministry was funding 16 sites and reviewing the applications from three others. From August 1, 2017 to March 31, 2019, about 157,000 visits had been made to these 16 sites. In this same period, opioid-related deaths had been prevented—none of the over 2,400 overdoses resulted in death, and over 34,200 referrals to other services were made (the equivalent of about one referral for every five visits).

Capacity and Locations of Consumption and Treatment Services Sites Do Not Fully Reflect Community Needs

Not all regions with a need for sites have them. The Ministry approves sites through an application process, but not all regions with a need have applied to establish sites. The Ministry continues to review and accept applications for the establishment of sites. As for the existing sites, the Ministry has not determined whether their capacity and location align with the needs of the region or should be changed.

In 2018, the Ministry assessed the regions showing the greatest need for sites, using information on opioid-related emergency department visits, hospitalizations and deaths between 2013 and 2017. The assessment identified that of the 10 regions with the highest need for a site, eight had sites in place. As of fall 2019, two regions still had no site set up, despite the need. While the Ministry informed us that one region was preparing its site application, the other region had no plans for a site at the time of our audit—even though in 2017, the opioid-related death rate in that region was over double the provincial average and the opioid-related hospitalization in that region was nearly triple the provincial average.

We also noted that the Ministry has not determined what capacity each site should have based on the region's need. For example, although the number of opioid-related deaths in Hamilton in 2018 was 50% higher than that of Ottawa (123 compared with 82), the capacity of Ministry-funded sites in Hamilton is about eight times less than Ottawa. (The Hamilton site currently has three consumption booths versus 25 in Ottawa's sites.)

Lack of Provincial Standards for Consumption and Treatment Services Sites Results in Inconsistent Operations

While the Ministry has established some provincial guidelines for sites, such as staffing levels and services the sites should offer, it has not established provincial standards for how services should be provided at the sites to ensure that they operate as effectively and efficiently as possible and in a consistent way.

The sites are required to fulfill a number of criteria as part of their application to the Ministry. For example, a health-care professional must be present during operating hours, and used supplies must be discarded using appropriate equipment, such as tamper-proof bins.

Our review of information from five of the 16 Ministry-funded sites identified that their operating policies and procedures differed with respect to the type of medical staff on site, the administration of naloxone, contacting paramedic services and taking people to emergency departments, and whether drugs could be checked for the presence of fentanyl (see **Figure 24**).

RECOMMENDATION 12

To provide people addicted to opioids with sufficient and consistent services at Consumption and Treatment Services sites (sites), we recommend that the Ministry of Health:

- analyze data from the existing sites and work with service providers (such as public health units and community health centres) to identify appropriate locations for the sites and what each site's capacity or size should be; and
- work with the existing sites to develop standard policies and procedures for operations (such as the type of health-care provider on site and when to contact paramedic services).

MINISTRY RESPONSE

The Ministry acknowledges that monitoring and evaluating program outcomes are important components of the Ministry's Consumption and Treatment Services (CTS) funding program. The Ministry agrees with the recommendation to analyze data from CTS sites and to work with service providers to monitor performance of the

Figure 24: Differences in Operations between a Sample of Consumption and Treatment Services Sites

Prepared by the Office of the Auditor General of Ontario

Site Location	Type of Medical Staff On-Site	Quantity of Naloxone Administered During an Overdose	Procedure for Contacting Paramedic Services/Taking Client to Emergency Department	Availability of Drug-Checking for Fentanyl[1]
Kingston	Paramedic	Decided by paramedic	Decided by paramedic	No
Guelph	Nurse	One dose or titration method[2]	As naloxone is administered	No
Ottawa	Nurse	One dose or titration method[2]	If two doses of naloxone are not effective	Yes
Middlesex-London	Nurse or paramedic	One dose	If client is not breathing/has no pulse or if other medical complications are present	Yes
Niagara	Paramedic	Titration method[2]	Decided by paramedic	Yes

1. The purpose of drug-checking for fentanyl, an opioid which is much stronger than most other opioids such as morphine, is to reduce the chance of overdose. Drug-checking services help people find out what is in their drug, including if the drug contains toxic substances like fentanyl. Drug-checking is done using fentanyl test strips. For sites to receive fentanyl test strips from the Ministry, they must obtain approval from Health Canada as part of their exempted services under the *Controlled Drugs and Substances Act*.
2. The titration method is a process that more slowly releases a dose of naloxone to an individual. This decreases the risk of providing excessive naloxone, which can result in an individual experiencing withdrawal symptoms from opioids and desiring to immediately use them again.

CTS funding program in order to assess whether any changes to CTS site capacity are required. A monitoring and reporting process is already in place and the Ministry will continue this process.

Based on monitoring and evaluation results, and taking into consideration the need for site-specific operational flexibility, the Ministry will work with existing sites to develop standard policies and procedures where appropriate.

The Ministry's CTS funding program is a new application-based program where communities determine whether to apply for a CTS. The Ministry has established funding criteria for CTS, which is publicly available. All approved CTS went through a rigorous application screening process, and sites that met the Ministry's CTS funding program requirements were approved. This includes local or neighbourhood data to support the location of the proposed CTS site, and how the proposed service delivery model is best suited to local conditions. CTS applications continue to be accepted.

4.7 Recent Changes and Emerging Trends Relating to Addictions Need To Be Monitored

Changes in government policy, regulations and consumer habits can impact the types and trends of addictions as well as Ontarians' need for addictions treatment. We identified a number of recent changes and emerging issues relating to addictions that warrant close monitoring by the Ministry (see **Appendix 10**). For example:

- The legalization of cannabis may increase cannabis use in Ontario.
- The use of electronic cigarettes (also known as e-cigarettes or vaping) has resulted in cases of severe lung illnesses.
- The provincial government's policy decisions will increase the availability of alcohol across Ontario, which research has shown can increase alcohol consumption as well as acute and chronic health harms.

RECOMMENDATION 13

To address emerging addictions issues related to recent government initiatives and consumer

habits, we recommend that the Ministry of Health:

- monitor the use of cannabis by Ontarians of different age groups to determine whether there is a need for additional prevention and addictions treatment services;
- monitor the use of electronic cigarettes (or vaping products) by Ontarians of different age groups to determine whether there is a need for additional prevention and addictions treatment services;
- study the long-term health effects associated with vaping and investigate cases of vaping-related illness to determine whether there is a need to strengthen the monitoring and applicable regulation on the manufacture, labelling, sale and promotion of vaping products; and
- perform an assessment on the impacts of increased alcohol availability to the health system (including impact on emergency department visits and need for addictions treatment services) and use this assessment as part of future addictions treatment funding decisions.

MINISTRY RESPONSE

The Ministry agrees with the Auditor General that protecting the health and well-being of all Ontarians, especially children, youth and young adults, is of the utmost importance. Therefore, the Ministry invests in programs that:

- protect the public, especially children and youth, from the harmful effects of tobacco use and vaping;
- raise awareness of the responsible consumption of cannabis (e.g., Lower-Risk Cannabis Use Guidelines);
- promote the safe consumption of alcohol (e.g., Low-Risk Alcohol Drinking Guidelines);
- prevent alcohol, cannabis and nicotine addiction; and
- provide addiction treatment services, including smoking/vaping cessation services, community and residential withdrawal management, community counselling services, residential treatment and support, and supports within housing.

The Ministry also collaborates with the federal government on issues within their legislative requirements (e.g., manufacturing, labelling).

The Ministry agrees that continued monitoring of the health impact of substance use—cannabis, e-cigarettes and vaping products, and alcohol—on Ontarians is a priority. The government is taking urgent action to address the issue of youth vaping. Starting January 1, 2020, the promotion of vapour products will only be permitted in specialty vape stores and cannabis retail stores (not in convenience stores, gas stations or grocery stores) to which entry is restricted to adults aged 19 and over.

Building on its existing monitoring and surveillance plans, the Ministry is committed to continue monitoring the use of cannabis, e-cigarettes and instances of vaping and vaping-related illness in order to assess the impact that consumption of these products has on addiction in Ontario, including specific age groups. In September 2019, a Minister's Order was issued under section 77.7.1 of the *Health Protection and Promotion Act*, which requires public hospitals in Ontario to provide the Chief Medical Officer of Health with statistical, non-identifying information related to incidences of vaping-related severe pulmonary disease.

The Ministry will also monitor and assess any health impacts that result from the increased alcohol sales (availability) in Ontario. The Ministry will do this once the regulatory changes pertaining to increased alcohol sales availability have been fully implemented and data becomes available.

Appendix 1: Glossary of Terms

Prepared by the Office of the Auditor General of Ontario

Addiction: A chronic, complex condition that is characterized by an individual having cravings, compulsive, uncontrollable use, and use despite harmful consequences. Addictions are classified as either substance (e.g., alcohol, tobacco) or behavioural addictions (e.g., gambling).

Addictions Treatment: Care that helps an individual overcome their addictions. Counselling is the most commonly used form of treatment. Medications are often an important part of treatment, especially when combined with counselling.

Addiction Severity (Mild/Moderate/Severe): Substance use disorders are classified as mild, moderate, or severe, depending on how many diagnostic criteria are met. The Diagnostic and Statistical Manual of Mental Disorders lists 11 Criteria: 1) Hazardous use; 2) Social or interpersonal problems related to use; 3) Neglected major roles to use; 4) Withdrawal; 5) Tolerance; 6) Used larger amounts/longer; 7) Repeated attempts to control use or quit; 8) Much time spent using; 9) Physical or psychological problems related to use; 10) Activities given up to use; and 11) Craving. To be diagnosed with a substance use disorder, individuals must meet two or more of these criteria within a 12 month period. Two or three is considered a mild addiction. Four to five is considered moderate. Six or more criteria is considered severe.

Behavioural addiction: Also known as process addictions, behavioural addictions are not a result of ingesting substances like drugs or alcohol. Behavioural addiction is the compulsion to continually engage in an activity or behavior despite it being a significant disruption to a person's life, relationships and mental and/or physical health and functioning. Problem gambling is the most widely accepted behavioural addiction that is commonly treated.

Case Management: A service where a case manager meets regularly with an individual to assist them in obtaining all health and social services they require.

Counselling: This involves helping people understand why they have an addiction and assisting them in developing strategies to prevent or reduce their engagement with a substance or behaviour. This can be done with a professional in an individual or group setting.

Harm Reduction: An evidence-based, client-centered approach that seeks to reduce health and social harms associated with problematic substance use, without necessarily requiring people who use substances from abstaining or stopping. Essential to a harm reduction approach is that it provides people who use substances a choice of how they will minimize harms through non-judgemental and non-coercive strategies. Interventions may include promoting physical safety, preventing overdose/infection or consequential health issues. Specific practices may include Consumption and Treatment Services sites and supplies as well as housing and shelters that permit substance use.

Non-Residential Treatment Program: Services are offered to individuals while they reside in their home or community. Services may range from an hour-long session to all-day programs and include counselling and case management.

Office of the Chief Coroner for Ontario: Office conducts death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances.

Opioids: Opioids are drugs such as oxycodone, morphine or codeine that are used primarily to treat pain from conditions such as injuries, surgery, dental procedures or long-term chronic pain. Opioids can also induce euphoria (feeling high), which gives them the potential to be used improperly. Opioids are an effective medication when used properly. When being misused, opioids have serious side effects and risks such as the potential for developing an addiction, overdose and death.

Opioid Crisis: The Opioid Crisis is a complex public health issue and can be linked to the rapid rise in overdoses and deaths involving both legally prescribed opioids and illegally produced opioids such as fentanyl, a drug 50-100 times more potent than morphine.

Opioid Agonist Therapy: This is also called opioid substitution therapy, which is a treatment for addiction to opioids. The therapy involves prescribing replacement drugs (such as methadone or buprenorphine-naloxone) to help individuals deal with cravings and withdrawal symptoms, to stabilize their lives and to reduce the harms related to their opioid use.

Rapid Access Addiction Medicine Clinics: They are walk-in clinics where people can obtain addictions treatment (such as opioid agonist therapy, counselling and referral for longer-term addictions treatment programs). They are often located in hospitals, community-health centres and physicians' offices.

Residential Treatment Program: Individuals live at a treatment facility for a set period (often at least a couple of weeks) and receive daily structured programs such as individual or group counselling.

Withdrawal Management Program: Also known as detox programs, these programs provide medical and non-medical assistance to help individual to withdraw from substances. Individuals may attend a program in a residential setting (often for a period of five days or less) or non-residential setting.

Appendix 2: Examples of Death Investigations Related to Addictions Conducted by the Office of the Chief Coroner

Prepared by the Office of the Auditor General of Ontario

A 27-year-old female's accidental death due to fentanyl toxicity

The deceased had a history of opioid addiction (using both prescription and non-prescription opioids) related to a chronic pain disorder resulting from traumatic brain and thoracic spine injuries suffered from a motor vehicle collision. She had never been on an opioid agonist therapy, but was reportedly working with a physician to taper her opioid doses at the time of her death.

A 28-year-old female's accidental death due to toxicity from multiple substances

The deceased had a history of complex medical and psychosocial issues, including problematic substance use, resulting in more than 100 hospital visits dating back to 2005. She was last seen in hospital six weeks prior to her death due to problematic use of multiple substances (fentanyl and methadone), at which time she requested treatment.

A 31-year-old male's accidental death due to life-threatening allergic reaction after use of multiple substances

The deceased had a long history of asthma and problematic substance use (both opioids and non-opioids). He began using prescription drugs about 10 years ago and started using street drugs during the last five years. He made multiple attempts to treat his addictions by enrolling in programs offered by rehabilitation centres and by seeing psychiatrists. His last rehabilitation attendance was about one year prior to his death. He was also treated in hospital for several overdoses over the years. The last overdose treatment took place during the morning of the day he died in hospital.

Appendix 3: List of Addictions Treatment Service Providers by Local Health Integration Network (LHIN) and Type of Treatment Programs for Problematic Substance Use and Gambling, 2018/19

Source of data: Ministry of Health

LHIN	Addictions Treatment Service Provider		Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
Central	1.	Across Boundaries	✓			
	2.	Addiction Services of York Region	✓		✓	✓
	3.	Black Creek Community Health	✓			
	4.	Canadian Mental Health Association – York Region	✓			
	5.	Caritas School of Life	✓			
	6.	Humber River Hospital	✓		✓	
	7.	North York General Hospital	✓			
	8.	Vitanova Foundation	✓			
Central East	9.	Chinese Family Services of Ontario				✓
	10.	Four Counties Addiction Services Team Inc	✓		✓	✓
	11.	Lakeridge Health	✓	✓	✓	✓
	12.	Peterborough Regional Health Centre	✓			
	13.	Scarborough Health Network	✓			
	14.	Senior Persons Living Connected	✓			
Central West	15.	Canadian Mental Health Association – Peel Branch	✓		✓	
	16.	Family Transition Place	✓			
	17.	Governing Council of the Salvation Army in Canada	✓	✓		
	18.	Punjabi Community Health Services	✓			
	19.	Services and Housing in the Province	✓			
	20.	William Osler Health System	✓		✓	✓
Champlain	21.	Amethyst Women's Addiction Centre	✓			✓
	22.	Canadian Mental Health Association Ottawa-Carleton Branch	✓			
	23.	Centretown Community Health Centre	✓			✓
	24.	Cornwall Community Hospital	✓	✓	✓	✓
	25.	David Smith Youth Treatment Centre	✓	✓		
	26.	Empathy House of Recovery	✓	✓		
	27.	Governing Council of the Salvation Army in Canada		✓		
	28.	Hopital General de Hawkesbury & District General Hospital Inc	✓		✓	✓
	29.	Mackay Manor Inc	✓	✓	✓	
	30.	Maison Fraternite – Fraternity House	✓	✓		
	31.	Montfort Hospital	✓			
	32.	Montfort Renaissance Inc	✓	✓	✓	
	33.	Ottawa Inner City Health Inc	✓		✓	
	34.	Pathways Alcohol & Drug Treatment Services	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
	35.	Renfrew Victoria Hospital	✓			✓
	36.	Rideauwood Addiction & Family Services	✓			✓
	37.	Royal Ottawa Health Care Group	✓	✓	✓	
	38.	Sandy Hill Community Health Centre	✓			✓
	39.	Serenity House Inc	✓	✓		
	40.	Sobriety House		✓		
	41.	Vesta Recovery Program for Women Inc	✓	✓		
	42.	Wabano Centre for Aboriginal Health Inc	✓			
Erie St. Clair	43.	Bluewater Health	✓		✓	✓
	44.	Canadian Mental Health Association Lambton Kent Branch	✓		✓	
	45.	Charity House (Windsor)	✓	✓		
	46.	Chatham-Kent Community Health Centres	✓			
	47.	Chatham-Kent Health Alliance	✓		✓	✓
	48.	Hotel-Dieu Grace Healthcare[2]	✓		✓	✓
	49.	House of Sophrosyne	✓	✓		
	50.	Victorian Order of Nurses for Canada — Ontario Branch	✓			
	51.	Westover Treatment Centre	✓	✓	✓	
	52.	Windsor Essex Community Health Centre	✓			
Hamilton Niagara Haldimand Brant	53.	A Y Alternatives for Youth Hamilton	✓			
	54.	ARID Group Homes	✓	✓		
	55.	Centre de Sante Communautaire Hamilton-Niagara Inc	✓			
	56.	City of Hamilton	✓			✓
	57.	Community Addiction and Mental Health Services of Haldimand and Norfolk	✓			✓
	58.	Community Addiction Services of Niagara	✓			✓
	59.	Good Shepherd Centre Hamilton	✓			
	60.	Good Shepherd Non-Profit Homes Inc	✓			
	61.	Hamilton Health Sciences Corp	✓			
	62.	Hamilton Urban Core Community Health Centre	✓			
	63.	Joseph Brant Hospital	✓			
	64.	Mission Services of Hamilton Inc	✓			
	65.	Native Horizons Treatment Centre	✓	✓		
	66.	Niagara Health System	✓	✓	✓	
	67.	Norfolk General Hospital	✓	✓	✓	
	68.	Quest Community Health Centre	✓			
	69.	Six Nations of the Grand River	✓			
	70.	St Joseph's Healthcare Hamilton	✓	✓	✓	
	71.	St Leonard's Community Services Inc	✓	✓		✓

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			
			Non-Residential	Residential	Withdrawal Management	Problem Gambling[1]
	72.	Wayside House of Hamilton	✓	✓		
	73.	Wayside House of St Catharines		✓		
	74.	Wesley Urban Ministries Inc	✓			
Mississauga Halton	75.	Halton Alcohol Drug and Gambling Assessment Prevention Treatment – ADAPT	✓		✓	✓
	76.	Hope Place Centres	✓	✓		
	77.	Peel Addiction Assessment and Referral Centre (PAARC)	✓		✓	✓
North East	78.	Algoma Family Services	✓			
	79.	Algoma Substance Abuse Rehabilitation Centre	✓	✓		
	80.	Anishnabie Naadmaagi Gamig Substance Abuse Treatment Centre	✓	✓		
	81.	Canadian Mental Health Association–Cochrane Timiskaming Branch	✓			✓
	82.	Centre de Reeducation Cor Jesu De Timmins Inc	✓	✓		
	83.	Community Counselling Centre of Nipissing	✓		✓	✓
	84.	Counselling Centre of East Algoma	✓			
	85.	District of Algoma Health Unit	✓			
	86.	Health Sciences North	✓		✓	✓
	87.	La Maison Arc-En-Ciel Inc		✓		
	88.	La Maison Renaissance Inc	✓	✓		
	89.	Maamwesying North Shore Community Health Services			✓	
	90.	Monarch Recovery Services	✓	✓		
	91.	Noojmowin Teg Health Centre	✓		✓	
	92.	North Bay Recovery Home	✓	✓		
	93.	North Bay Regional Health Centre	✓	✓	✓	
	94.	North Cochrane Addiction Services Inc	✓			✓
	95.	N'Swakamok Native Friendship Centre	✓			
	96.	Sagamok Anishnawbek	✓			
	97.	Sault Area Hospital	✓		✓	✓
	98.	Sault Ste Marie Alcohol Recovery Home Inc		✓		
	99.	Services de Sante de Chapleau Health Services	✓			
	100.	Shkagamik-Kwe Health Centre	✓			
	101.	Smooth Rock Falls Hospital		✓	✓	
	102.	South Cochrane Addiction Services Inc	✓		✓	✓
	103.	St Josephs General Hospital		✓	✓	
	104.	Weeneebayko Area Health Authority	✓			✓
	105.	West Nipissing General Hospital	✓			
	106.	Wikwemikong Unceded Indian Reserve (WUIR)	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
North Simcoe Muskoka	107.	Canadian Mental Health Association—Muskoka-Parry Sound Branch	✓			✓
	108.	Canadian Mental Health Association—Simcoe County Branch	✓		✓	✓
	109.	Royal Victoria Regional Health Centre	✓	✓	✓	
	110.	Seven South Street Treatment Centre		✓		
North West	111.	Alpha Court Non-Profit Housing Corp	✓			
	112.	Atikokan General Hospital	✓			✓
	113.	Canadian Mental Health Association—Fort Frances Branch	✓			
	114.	Changes Recovery Homes		✓		
	115.	Children's Centre Thunder Bay	✓			
	116.	Crossroads Centre Inc		✓		
	117.	Dilico Anishinabek Family Care	✓	✓	✓	
	118.	Dryden Regional Health Centre	✓	✓	✓	✓
	119.	Fort Frances Tribal Area Health Services Inc	✓	✓	✓	
	120.	Kenora Chiefs Advisory Inc	✓			
	121.	Lac Seul Band	✓			
	122.	Lake of the Woods District Hospital (LWDH)	✓	✓	✓	✓
	123.	Matawa Health Co-Operative Inc	✓			
	124.	Mishkeegogamang First Nation		✓		
	125.	North of Superior Community Mental Health Program Corp	✓			✓
	126.	North of Superior Healthcare Group	✓			✓
	127.	Northern Chiefs Council	✓			
	128.	Norwest Community Health Centre	✓			
	129.	Red Lake Margaret Cochenour Memorial Hospital Corp	✓			✓
	130.	Riverside Health Care Facilities Inc	✓			✓
	131.	Sioux Lookout First Nations Health Authority	✓			
	132.	Sioux Lookout Meno-Ya-Win Health Centre	✓		✓	✓
	133.	St Joseph's Care Group Corp[2]	✓	✓	✓	✓
	134.	The Reverend Tommy Beardy Memorial Wee Che He Wayo-Gamik Family Treatment Centre		✓		
	135.	Three C's Reintroduction Centre Inc		✓		
	136.	Thunder Bay Counselling Centre	✓			
	137.	Thunder Bay Seaway Non-Profit Apartments		✓		
	138.	Weechi-It-Te-Win Family Services Inc	✓			
South East	139.	Addiction and Mental Health Services—KFLA	✓			✓
	140.	Addictions and Mental Health Services—Hastings Prince Edward	✓	✓		✓

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			
			Non-Residential	Residential	Withdrawal Management	Problem Gambling[1]
	141.	Belleville and Quinte West Community Health Centre	✓			
	142.	Brockville General Hospital	✓			
	143.	Governing Council of the Salvation Army in Canada		✓		
	144.	Kingston Community Health Centres (KCHC)	✓			
	145.	Kingston Health Sciences Centre			✓	
	146.	Lanark Leeds and Grenville Addictions and Mental Health	✓	✓		✓
	147.	Peer Support South East Ontario	✓			
South West	148.	Addiction Services of Thames Valley	✓		✓	✓
	149.	Alexandra Hospital			✓	
	150.	Canadian Mental Health Association Grey Bruce	✓	✓		✓
	151.	Chippewas of the Thames First Nation	✓			
	152.	Choices for Change Alcohol Drug and Gambling Counselling Centre	✓		✓	✓
	153.	G&B House		✓		
	154.	Grey Bruce Health Services	✓		✓	
	155.	HopeGreyBruce Mental Health and Addictions Services	✓	✓		✓
	156.	Mission Services of London		✓		
	157.	Oneida Nation of the Thames	✓			
	158.	Southwest Ontario Aboriginal Health Access Centre (SOAHAC)	✓			
	159.	Turning Point Inc		✓		
Toronto Central	160.	Alpha House		✓		
	161.	Anishnawbe Health Toronto	✓			
	162.	Breakaway	✓			
	163.	Centre for Addiction & Mental Health (CAMH)	✓		✓	✓
	164.	City of Toronto	✓			
	165.	COSTI Immigrant Services				✓
	166.	Fred Victor Centre	✓			
	167.	Good Shepherd Non-Profit Homes Inc	✓			
	168.	Good Shepherd Refuge Social Ministries		✓		
	169.	Governing Council of the Salvation Army in Canada	✓	✓		
	170.	Hospital for Sick Children (HSC)	✓			
	171.	Jean Tweed Treatment Centre[2]	✓	✓		✓
	172.	Lakeshore Area Multi-Services Project Inc (LAMP)	✓			
	173.	Loft Community Services	✓	✓		
	174.	Parkdale Queen West Community Health Centre	✓			
	175.	Pine River Institute		✓		
	176.	Reconnect Community Health Services	✓			

LHIN		Addictions Treatment Service Provider	Problematic Substance Use			Problem Gambling[1]
			Non-Residential	Residential	Withdrawal Management	
	177.	Regent Park Community Health Centre	✓			
	178.	Renascent Foundation Inc		✓		
	179.	South Riverdale Community Health Centre	✓			
	180.	St Michael's Homes	✓	✓		
	181.	St Stephen's Community House	✓			
	182.	St Vincent de Paul Ozanam		✓		
	183.	Street Haven at the Crossroads	✓	✓		
	184.	The Four Villages Community Health Centre	✓			
	185.	Toronto East Health Network	✓		✓	
	186.	Transition House		✓		
	187.	Unison Health & Community Services	✓			
	188.	Unity Health Toronto (O/A Providence St Josephs & St Michaels Healthcare)	✓		✓	
	189.	University Health Network	✓		✓	
	190.	YMCA of Greater Toronto	✓			
	191.	Young Women's Christian Association of Greater Toronto (YWCA)	✓			
Waterloo Wellington	192.	Grand River Hospital Corporation	✓		✓	
	193.	Guelph Community Health Centre	✓			
	194.	Homewood Health Centre Inc	✓	✓		✓
	195.	House of Friendship	✓	✓		✓
	196	Portage Program for Drug Dependencies Inc	✓	✓		
	197.	Ray of Hope Inc	✓	✓		
	198.	St Mary's General Hospital	✓			✓
	199.	Stonehenge Therapeutic Community	✓	✓		
Total			**170**	**73**	**49**	**52**

Note: This lists the names and locations of addictions treatment service providers the Ministry of Health funded in 2018/19. Information on the services provided generally came from the Ministry of Health and ConnexOntario's database. The locations and the actual services offered may differ from what is shown above. About 50 of these addictions treatment service providers are hospitals. Hospitals generally use funding to provide addictions services to hospital outpatients or residential services to individuals at dedicated sites (as opposed to their primary hospital location).

1. All problem gambling treatment programs are non-residential.
2. Provides residential problem gambling programs in addition to the non-residential problem gambling programs indicated.

Appendix 4: Background and Key Events related to Ontario's Opioid Crisis

Prepared by the Office of the Auditor General of Ontario

Year	Description
1996	Opioid prescriptions increased after a form of oxycodone (an opioid to treat pain) was approved in 1996 and the manufacturer marketed the opioid as having minimal risk of addictions.
2000	In 2000, the Ontario government added oxycodone to the public drug formulary, which allowed it to be obtained free of charge by people who qualified for the Ontario Drug Benefit Program.
2003–2012	Fentanyl is a very strong opioid that can be obtained through a prescription or illicitly and is profitable to sell (according to various sources, fentanyl powder can be ordered from overseas for as little as $12,500 to make 500,000 or more fentanyl pills, which can result in a profit of about $10 million or more). Opioid deaths related to fentanyl increased from 34 in 2003 (responsible for about 9% of all opioid-related deaths) to 151 in 2012 (responsible for over 25% of all opioid-related deaths).
2006	In 2006, the Ministry of Health (Ministry) established the Methadone Maintenance Treatment Practices Task Force, which published a report in 2007 with recommendations for improving patients' access to methadone, implementing best practices and training for health-care providers, and implementing appropriate payment models. As a result of this report, the Ministry reduced the amount that physicians could bill for urine drug screening through the Ontario Health Insurance Plan.
2012	In 2012, as the risks associated with opioid addiction and overdoses became better understood, the Ontario government removed the previously mentioned form of oxycodone from its public drug formulary. Since they could not obtain this form of oxycodone funded by the province, some individuals began to turn to illicit forms of opioids sold by drug dealers. The Ministry started to require community pharmacies to report data on all narcotics, controlled substances and other monitored drugs (including opioids) into the Ministry's Narcotics Monitoring System (see **Section 4.6.5** and **Figure 22**). As well, the Ministry established the Expert Working Group on Narcotic Addiction, which published a report with recommendations for reducing the impact of removing oxycodone from the formulary and improving the addictions treatment system in Ontario.
2016	In 2016, as the number of opioid-related emergency department visits, hospitalizations and deaths continued to rise (see **Figure 20**), a Methadone Treatment and Services Advisory Committee was established to prepare a report with recommendations on how to improve treatment for those addicted to opioids. The report was used as a basis for the Opioid Strategy announced by the Ministry of Health in August 2017.

Appendix 5: Key Initiatives of the Opioid Strategy in Ontario

Prepared by the Office of the Auditor General of Ontario

Program Area	Key Initiatives	Funding ($ million)*
Appropriate opioid prescribing and reporting	• Improving data collection and reporting in an existing system to make more information available to opioid prescribers at the point of care about medications that have been dispensed to patients in the past. • Providing education and professional development for health-care providers about opioid prescribing. • Launching a web-based tool on the Public Health Ontario website that publishes data on opioid-related deaths, hospitalizations and emergency department visits over the last 10 or more years.	15.8
Treatment	• Expanding the number of Rapid Access Addiction Medicine clinics. These walk-in clinics provide immediate and short-term addictions care to patients (such as medication, brief counselling, referral to other services and primary care for long-term follow-up). • Providing funding to addictions treatment service providers through Local Health Integration Networks for new and existing services, such as withdrawal management.	93.5
Harm reduction	• Adding Consumption and Treatment Services sites, which replaced the former Supervised Consumption Services and Overdose Prevention sites models by offering on-site or defined pathways off-site to addictions treatment services, primary care, mental health and other social supports. • Expanding the distribution of naloxone, a drug that can temporarily reverse an opioid overdose. • Expanding the distribution of harm-reduction supplies, such as sterile needles, to people who use drugs through the Ontario Harm Reduction Distribution Program.	150.8
Total		**260.1***

* Funding for the Opioid Strategy has been allocated from 2017/18 to 2019/20. Specifically, in August 2017, the Ministry of Health announced an investment of over $222 million. In 2018/19, the total amount of funding for the Opioid Strategy was revised upward to over $260 million as a result of a decision to increase the amount of naloxone that would be distributed through its naloxone distribution initiatives, as well as to make additional investments in treatment services.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Effective procedures and co-ordination among service providers are in place to ensure Ontarians have timely and equitable access to safe, evidence-based addictions services that meet their needs regardless of where they live.
2.	Funding is allocated in an outcome-based, timely and equitable manner to service providers, used for the purposes intended, and administered with due regard for economy and efficiency.
3.	Adequate co-ordination is in place to facilitate the provision of addictions services. The roles, responsibilities and expectations for the delivery of services are clearly defined, and best practices are shared.
4.	Appropriate accountability requirements, performance measures and targets are established and continuously monitored against actual results to help guide decision-making, and ensure that intended outcomes are achieved and corrective actions are taken on a timely basis when issues are identified.
5.	Relevant, accurate, and timely information on addictions services is regularly collected and publicly reported to assist Ontarians in finding the services they need.

Appendix 7: List of Addictions Treatment Service Providers Contacted for Our Audit

Prepared by the Office of the Auditor General of Ontario

Local Health Integration Network (LHIN)	Name	
Central	1.	Addiction Services of York Region
Central East	2.	Four Counties Addiction Services Team Inc.
Central East	3.	Lakeridge Health
Central West	4.	William Osler Health System
Champlain	5.	David Smith Youth Treatment Centre
Champlain	6.	Maison Fraternite – Fraternity House
Champlain	7.	Montfort Renaissance Inc.
Champlain	8.	Royal Ottawa Health Care Group
Champlain	9.	Sandy Hill Community Health Centre
Erie St. Clair	10.	Chatham-Kent Health Alliance
Erie St. Clair	11.	Westover Treatment Centre
Hamilton Niagara Haldimand Brant	12.	St. Joseph's Healthcare Hamilton
Hamilton Niagara Haldimand Brant	13.	St. Leonard's Community Services Inc.
Hamilton Niagara Haldimand Brant	14.	Wayside House Of Hamilton
Mississauga Halton	15.	Halton Alcohol Drug & Gambling Assessment Prevention Treatment (ADAPT)
Mississauga Halton	16.	Peel Addiction Assessment & Referral Centre (PAARC)
North West	17.	Children's Centre Thunder Bay
North West	18.	Dilico Anishinabek Family Care
North West	19.	Riverside Health Care Facilities Inc.
North West	20.	St. Joseph's Care Group Corp
South West	21.	Addiction Services of Thames Valley
Toronto Central	22.	Jean Tweed Treatment Centre
Toronto Central	23.	Pine River Institute
Toronto Central	24.	Renascent Foundation Inc.
Toronto Central	25.	St. Michael's Homes
Toronto Central	26.	St. Stephen's Community House
Toronto Central	27.	Unity Health Toronto
Toronto Central	28.	University Health Network
Waterloo Wellington	29.	Homewood Health Centre Inc.

Appendix 8: Additional Audit Work Performed

Prepared by the Office of the Auditor General of Ontario

During our audit, in addition to the activities described in Section 3.0, we obtained information from the following parties:

- ConnexOntario (an organization funded by the Ministry to provide information on addictions and mental health resources available to Ontarians) for information about addictions treatment service providers and wait times; and
- Centre for Addiction and Mental Health for information on the number of people treated by addictions treatment service providers between 2014/15 and 2018/19 as well as their socio-demographic information.

In addition, we met or spoke with various parties, including:

- staff from all 14 Local Health Integration Networks (LHINs) to understand how they distribute Ministry funding to addictions treatment service providers and their challenges of integrating and co-ordinating addictions treatment services in their regions;
- staff from 11 hospitals in eight LHINs to understand their challenges and how their emergency departments co-ordinate with addictions treatment service providers;
- staff from five Consumption and Treatment Services sites that provide a safe environment where people can consume substances they possess under the supervision of health-care professionals and receive referrals for other services to understand their policies, procedures and operations;
- representatives from regulatory colleges (including the College of Physicians and Surgeons of Ontario, Ontario College of Pharmacists and Royal College of Dental Surgeons of Ontario) to understand their roles and challenges regarding opioids prescribed and dispensed by their members;
- representatives from local police and paramedic services (including the Ontario Provincial Police, Ottawa Police Service, Thunder Bay Police Service and the Ontario Association of Paramedic Chiefs) to understand their roles and challenges when dealing with the opioid crisis and people with addictions;
- representatives from other ministries and agencies (including the Ontario Lottery and Gaming Corporation, the Ministry of the Solicitor General, the Ministry of Children, Community and Social Services, the Ministry of Education, and the Ministry of Training, Colleges and Universities) to understand the addictions services they perform and fund;
- staff from the Office of the Chief Coroner to obtain and review information on its investigations of people who died due to substance use;
- representatives from research and advisory groups (including Gambling Research Exchange Ontario, Homewood Research Institute, Ontario Drug Policy Research Network, Mentoring, Education, and Clinical Tools for Addiction: Primary Care–Hospital Integration, Public Health Ontario and Health Quality Ontario) to understand current research on addictions treatment;
- representatives from stakeholder groups (including Addictions and Mental Health Ontario, Canadian Mental Health Association, Children's Mental Health Ontario and Families for Addiction Recovery) to understand the needs and challenges of both addictions and mental health service providers and individuals seeking addictions treatment; and
- other jurisdictions (including Alberta Health Services, British Columbia's Ministry of Mental Health and Addictions and British Columbia's Ministry of Health) to understand their oversight and funding of addictions treatment services as well as their actions in response to the opioid crisis.

Appendix 9: Ministry of Health's Planned Indicators to Assess Its Opioid Strategy Initiatives

Prepared by the Office of the Auditor General of Ontario

Response-Wide Indicators	
1.	Number and rate of emergency department visits for opioid overdose
2.	Number and rate of hospitalizations for opioid overdose
3.	Number and rate of opioid-related deaths
Appropriate Prescribing and Pain Management	
4.	Milligram morphine equivalents (MMEs) per population
5.	Percentage of people who are prescribed opioids and subsequently develop an opioid addiction
6.	Proportion of opioid-related deaths where the patient was dispensed an opioid in the previous seven days
7.	Number and rate of patients newly started on opioids (within six months)
8.	Number and rate of patients newly started on opioid dosages of over 50 and 90 MMEs daily*
Treatment for Opioid-Use Disorder	
9.	Number and proportion of patients who were referred from Rapid Access to Addiction Medicine clinics to primary care
10.	Wait time for access to Rapid Access to Addiction Medicine clinics
11.	Proportion of emergency department visits for opioid overdose where the patient was dispensed an opioid agonist therapy medication in the previous seven days
12.	Proportion of opioid-related deaths where the patient was dispensed an opioid agonist therapy medication in the previous seven days
Harm Reduction	
13.	Number of naloxone kits and refills distributed per naloxone program site
14.	Number of Consumption and Treatment Services site client visits
15.	Number of referrals to treatment, health and social services provided to clients at Consumption and Treatment Services sites
16.	Number of (self) reports of naloxone administration
17.	Number of overdoses reversed/treated with (a) oxygen/rescue breathing (b) naloxone at Consumption and Treatment Services sites
18.	Number of public health units and public health unit regions with opioid response plans
Surveillance	
19.	Number of public health units and public health unit regions with early warning systems
20.	Number of warnings issued by public health units and public health unit region partners

* Patients beginning long-term opioid therapy for chronic non-cancer pain should not be prescribed more than 50 MMEs a day. This is according to the 2017 Canadian Guideline for Opioids for Non-Cancer Pain. If more than this is prescribed, there is a risk of overdose. The Guideline also recommends that, before a health-care provider prescribes a beginning dosage of greater than 90 MMEs a day (because, for example, the patient's pain is extreme), they get a second opinion from another health-care provider.

Appendix 10: Examples of Recent Changes and Emerging Issues Related to Addictions

Prepared by the Office of the Auditor General of Ontario

Recent Change and Emerging Issue	Description
Cannabis Legalization	• In April 2017, the federal government introduced the *Cannabis Act, 2017*, to legalize recreational cannabis. This Act came into force on October 17, 2018, allowing persons 18 or older to possess up to 30 grams of cannabis in public. The provincial governments are responsible for enacting further regulations related to sales, distribution and use of cannabis. On October 17, 2018, Ontario passed the (provincial) *Cannabis Act, 2017*, which increases the age to buy, use, possess and grow recreational cannabis to 19 to be on par with alcohol and tobacco. • While the Ministry of Health (Ministry) has not performed any studies after cannabis legalization in October 2018, studies from other jurisdictions that have legalized cannabis (such as Colorado and Washington State) have shown mixed results. In some cases, cannabis use among specific populations increased or cannabis use temporarily increased and returned back to pre-legalization levels; in other cases, there was no significant increase in cannabis use pre- or post-legalization. • Statistics Canada, through the use of a survey, has compared cannabis use across Canada each quarter. In the most recent survey, it noted that the prevalence of cannabis use in Ontario has remained stable (16.8% in the second quarter of 2019 compared to 17.8% in the second quarter of 2018); it is still higher than the quarter directly before cannabis legalization (15.1% in the third quarter of 2018).
Electronic Cigarette Usage	• While tobacco usage dropped in Ontario from around 23% of Ontarians over the age of 15 in 1999 to about 13% in 2017, the usage of electronic cigarettes (also known as e-cigarettes or vaping) has increased, especially among youth. In 2019, Health Canada released the results of the Canadian Student Tobacco, Alcohol and Drugs survey, which indicated a growth in Ontario's students (in Grade 7 to Grade 12) who used e-cigarettes between 2014/15 and 2016/17. The percentage of students who tried e-cigarettes increased from 16% to 18% and the percentage of those who used e-cigarettes within the past 30 days grew from 5% to 7%. • E-cigarettes generally contain fewer harmful chemicals than burned tobacco products, but they can still pose health risks. For example, they contain nicotine, which is highly addictive and can harm adolescent brain development. An Ontario study in 2018 assessing vaping products at retail outlets found that it was common for products to be mislabeled—27% of products labeled as "with nicotine" had concentrations above the amount indicated. • In September 2019, three incidences of vaping-related severe lung disease were under review in Ontario. In October 2019, the Centers for Disease Control and Prevention in the United States also reported over 30 deaths and more than 1,400 cases of lung injury associated with the use of e-cigarettes or vaping. In light of this, the US government announced a plan to remove unauthorized flavoured e-cigarettes from the market (i.e., only the "tobacco" flavor was to remain available). While waiting for a federal plan to be finalized, some US states (including Michigan, New York, Massachusetts and Rhode Island) have enacted legislation to ban the sale of vaping products and a number of other states (including Illinois, New Jersey and Delaware) are considering similar legislation. In Canada, none of the provinces have banned the sale of vaping products. In September 2019, the Ontario Minister of Health issued a Minister's Order requiring that public hospitals in Ontario provide the Chief Medical Officer of Health with information on incidences of vaping-related severe lung disease, so that the potential scope of this issue may be understood.

Recent Change and Emerging Issue	Description
Increased Availability of Alcohol	• As part of its 2019 budget, the Ontario government identified various plans to expand the availability of alcohol, such as by expanding the sale of alcohol to corner, grocery and big box stores as well as extending alcohol service at licensed establishments (such as bars and restaurants) to earlier in the day (9:00 a.m.). • In April 2019, the Centre for Addiction and Mental Health released a response to the proposed changes on alcohol policy in Ontario. It identified that as alcohol availability increases, alcohol consumption increases, as does both acute (such as emergency department visits) and chronic health harms related to alcohol use. It also referred to the World Health Organization's stance on alcohol availability, which was updated in September 2018 and identified actions governments could take to reduce the harmful use of alcohol and strengthen restrictions on alcohol availability. • The Ministry informed us that it has not performed any analysis to identify the impact of changes to increasing the availability of alcohol in Ontario, including the potential increased need for more addictions treatment services for alcohol.

Cancer Care Ontario (Ontario Renal Network)

Chronic Kidney Disease Management

1.0 Summary

Chronic kidney disease has been referred to as a "silent killer" because it often goes undetected or undiagnosed over several years and, in most cases, has no cure. The prevalence of chronic kidney disease is on the rise in Ontario, leading to a higher need for dialysis treatment and a greater demand for kidney transplants. Over the last decade, the number of Ontarians with end-stage renal (kidney) disease has grown over 37% (from about 14,800 people to about 20,300 people).

There are numerous risk factors that increase the likelihood of developing chronic kidney disease, including diabetes, high blood pressure, age and family history. While chronic kidney disease is prevalent among the elderly population, it is also common among the middle-aged group. Of all people with end-stage renal disease in Ontario, the senior population (aged 65 or older) accounts for 47% and middle-aged adults (aged 45 to 64) account for about 39%. Although some risk factors such as age and family history are unavoidable, individuals can prevent or delay chronic kidney disease by having a healthy lifestyle that includes maintaining a balanced diet, living an active lifestyle, and avoiding tobacco consumption.

The Ontario Renal Network (Renal Network), established in 2009 as a division of Cancer Care Ontario (CCO), is responsible for advising the Ministry of Health (Ministry) on chronic kidney disease management, determining funding to each of the 27 Regional Renal Programs in Ontario, and leading the organization of chronic kidney disease services (excluding transplants, which fall under the responsibility of the Ministry, Trillium Gift of Life Network [Trillium Network] and six adult kidney transplant centres). In 2018/19, the Renal Network's expenditures on chronic kidney disease services was approximately $662 million, and the Ministry provided approximately $20 million to transplant centres for funding of about 700 kidney transplants.

Our audit found that the funding allocation for most chronic kidney disease services in Ontario has not been reviewed and adjusted for many years, and may not reflect the actual costs of providing specific services to patients. In addition, lack of integration and co-ordination between the Ministry, Renal Network and Trillium Network has contributed to a fragmented renal care system that creates difficulties in planning, monitoring and evaluating the services provided. As the Ontario government has planned to integrate multiple provincial agencies, including the Renal Network within CCO and Trillium Network, into a single agency called Ontario Health, it is important that going forward, renal services are better co-ordinated to meet the needs of Ontarians.

The following are some of our other significant findings.

Primary Care and Multi-Care Kidney Clinics

- **Patients are not always referred by primary care providers to nephrologists on a timely basis even though referral criteria have been met.** In 2017/18, over 40% (or about 8,700) of patients in Ontario who met the Renal Network's referral criteria did not have a visit with a nephrologist (a physician with a specialization in kidney care) even though these patients' lab test results indicated that they would benefit from a nephrology visit. The Renal Network has not followed up on these patients or with their primary care or health-care providers and the Regional Renal Programs do not receive enough information to identify and follow up on these patients. Late referrals to a nephrologist result in late referrals to a Multi-Care Kidney Clinic (Clinic), which is designed to help patients manage their chronic kidney disease and educate patients on the treatment options available.
- **Most patients do not receive the recommended amount of care from Multi-Care Kidney Clinics.** The Renal Network and Regional Renal Programs indicated that patients should receive at least 12 months of multidisciplinary care in the Clinics before starting dialysis in order to slow down the progression of the disease, delay dialysis starts and educate patients on the treatment options available. However, we found that almost 60% of patients did not receive at least 12 months of multidisciplinary care in the Clinics. Of the approximately 3,350 patients who started dialysis in 2018/19, about 25% received less than 12 months of care in a Clinic while 33% did not receive any care in a Clinic prior to starting dialysis.

Dialysis

- **Capacity for in-centre dialysis in a hospital or clinic setting does not align with regional needs.** Twenty-seven Regional Renal Programs have a total of 94 in-centre dialysis locations across Ontario with a capacity to serve about 10,200 patients. While the occupancy rate of all locations is about 80% on average, it ranges from 26% to 128% depending on location. About 35% of these locations have an occupancy rate of at least 90%, with some at or near full occupancy. Meanwhile, about 18% of these locations have an occupancy rate below 70%, meaning their dialysis stations are not being consistently used. We found that the mismatch between dialysis capacity and regional need can be the result of patients not always receiving dialysis at the locations closest to them. For example, a Regional Renal Program with an occupancy rate of approximately 90% at most of its locations has about 22% of its patients coming from outside of its catchment area.
- **Home dialysis usage rate has improved, but remains low and does not meet targets.** Compared with in-centre dialysis, home dialysis costs significantly less, improves patient quality of life, and allows for more treatment flexibility. While promoting and increasing the use of home dialysis has been part of the Renal Network's strategic direction since 2012, the home dialysis usage rate still has not met the Renal Network's target. We noted that the home dialysis usage rate varies significantly (16% to 41%) among the 27 Regional Renal Programs, and only six met the current target of 28%.
- **Initiatives to increase the rate of home dialysis usage have limited coverage and unclear cost effectiveness.** The Ministry and the Renal Network have implemented several initiatives aimed at increasing the use of home dialysis, but they have not evaluated their cost-effectiveness and potential for expansion. For example, the Ministry has been funding supports for patients on peritoneal dialysis in long-term-care homes since 2009, but only 4%

of long-term-care homes in Ontario provide these supports. Meanwhile, the Ministry has spent about $10.5 million between 2017/18 and 2018/19 to transport approximately 450 patients each year from long-term-care homes to in-centre dialysis for treatment. However, it is not clear whether this initiative should be expanded to save the costs of transporting patients between long-term-care homes and dialysis facilities because neither the Ministry nor the Renal Network has collected information on the number of dialysis patients living in long-term-care homes. As another example, in 2015, the Renal Network introduced an initiative at eight Regional Renal Programs to provide patients with a personal support worker to assist with their home hemodialysis, but no fulsome evaluation has been done to determine whether it is cost-effective and should be expanded.

Kidney Transplants

- **Long wait times for deceased-donor kidney transplants have created a burden on patients and costs to the health-care system.** While kidney transplants are considered the best clinical treatment option for patients with end-stage renal disease, wait lists and wait times for deceased-donor kidney transplants remain long. In each of the last five years, approximately 1,200 patients on average were waiting for a deceased-donor kidney transplant and the average wait time was approximately four years, resulting in some patients becoming too ill for a transplant or dying before receiving a transplant. Patients waiting for a kidney transplant have to undergo dialysis as well as continuous testing and evaluation to stay on the wait list, creating mental and physical burdens on patients and resulting in significant costs to the health-care system.

- **Barriers to living-donor kidney transplants have not been fully addressed.** While a living-donor kidney transplant has a much shorter wait time (approximately one year), its growth has remained static since 2008 for several reasons, such as a lack of consistent information, education and public awareness on living-donor transplants, as well as the financial burden to living donors. While Ontario has a reimbursement program to compensate donors for eligible costs (such as travel, accommodation and lost income), the Ministry and Trillium Network have not updated the reimbursement rates since the program was introduced in 2008.

Funding

- **Funding for chronic kidney disease services does not align with the actual cost of providing services to patients.** The Renal Network has not reviewed its funding amounts for most chronic kidney disease services since implementing them between 2012/13 and 2014/15, even though they were meant to be a starting point given the limited evidence available at the time. We noted that the Renal Network does not collect actual expenditures incurred by the Regional Renal Programs to ensure that funding allocated to each of them aligned with costs of providing renal care. Through our review of expenditures of the five Regional Renal Programs we visited, we found possible surpluses of $37 million over the last five years. As well, for Multi-Care Kidney Clinic (Clinic) patients, the Renal Network provides $1,400 per year for each eligible patient registered with the Clinic, based on a patient making at least six visits to the Clinic in the year. However, the average number of visits by patients in 2018/19 was four, indicating that funding allocations may not align with the level of services being provided.

- **Base funding for kidney transplants is unchanged since 1988 and does not align with the actual cost.** The current funding rate per kidney transplant is approximately $25,000, with a top-up amount of $5,800 (introduced in 2004) for living-donor transplants to help offset additional costs (such as testing and retrieving a kidney from a living donor). Our review of information at the transplant centres we visited showed that the cost of a kidney transplant varies and that the current funding rate does not align with the actual cost incurred by the centres. For example, the average cost reported for a deceased-donor kidney transplant, including pre-transplant and pre-operative care provided by the transplant centre, was $40,000, ranging from about $32,000 at one centre to $57,000 at another.
- **Further work is needed to identify potential savings related to peritoneal dialysis supplies.** The Renal Network has reviewed the cost of hemodialysis equipment and supplies and achieved a savings of approximately $30 million through a provincial procurement initiative. While the Renal Network has not established a similar initiative for peritoneal dialysis supplies, it began reviewing the pricing of peritoneal dialysis supplies at the time of our audit to determine if additional savings are available. We reviewed a sample of invoices for peritoneal dialysis supplies across the Regional Renal Programs and found price differences ranging from 8% to 20%, indicating opportunities for cost savings.

Co-ordination of Renal Care

- **Variability in oversight, funding and reporting of dialysis has created challenges for planning and measuring renal care.** Apart from the 27 Regional Renal Programs funded and overseen by the Renal Network, the Ministry also funds and oversees seven Independent Health Facilities (Facilities) that provide dialysis to patients. Unlike the Regional Renal Programs that also provide dialysis, these Facilities are not required to report the same data to the Renal Network. Because of this, the Renal Network does not have complete oversight of and information on dialysis across the province. This makes it difficult for the Renal Network to effectively plan and measure renal care in Ontario.
- **Inaccurate and incomplete transplant data have caused difficulty in measuring and reporting transplant activities.** The Renal Network has no oversight of kidney transplants, which fall under Trillium Network's responsibility. While Trillium Network and the Renal Network established a data-sharing agreement in September 2017 to capture patients' complete transplant journeys, concerns about the data's accuracy and completeness have made it difficult for the Renal Network to determine whether the Regional Renal Programs refer patients who are eligible for a transplant to a transplant centre on a timely basis. As well, while patients on dialysis may eventually receive a transplant and patients with failed transplants would go back on dialysis, there is limited co-ordination between the Renal Network and Trillium Network in terms of tracking the performance of transplant activities (such as post-transplant care) and patient outcomes.

Data Reporting and Performance Measures

- **Information on the performance of chronic kidney disease services is incomplete and not fully reported to the public.** The Renal Network has developed performance measures to assess and benchmark chronic kidney disease services provided by the Regional Renal Programs in Ontario. However, we noted that many Regional Renal

Programs do not report optional but useful information (such as primary nephrologist's name and home dialysis eligibility) to the Renal Network for planning and oversight responsibilities. For example, of the almost 8,600 patients that spent time in the Multi-Care Kidney Clinics and began dialysis between 2015/16 and 2018/19, more than 2,850 (33%) were missing data in the Renal Network's system that indicated their eligibility for home dialysis. The Renal Network acknowledged that the completeness of optional data varies. Meanwhile, we noted that the Renal Network has identified 39 performance measures over its last two strategic plans up to 2019, but it provides very limited public reporting as only the results of eight measures were made publicly available.

Overall Conclusion

Our audit concluded that the Ontario Renal Network, in conjunction with the Trillium Gift of Life Network and the Ministry of Health, does not have fully effective systems and procedures in place to ensure that chronic kidney disease services are provided in a timely, equitable and cost-efficient manner to meet Ontarians' needs and in accordance with applicable standards, guidelines and legislation. Specifically, patients who would benefit from visiting a nephrologist are not always being referred on a timely basis by their primary care provider, resulting in some patients going straight to dialysis without receiving enough multidisciplinary care to help delay or prepare for treatment.

In addition, the mismatch between dialysis capacity and patient needs results in some dialysis locations operating at maximum capacity and being unable to take more patients while other locations are not being fully utilized. We also found that funding amounts for multidisciplinary care, dialysis and kidney transplants do not align with the actual costs of providing these services.

Further, while a kidney transplant is the best clinical and cost-effective treatment for patients with end-stage renal disease, patients must wait about four years on average for a deceased-donor kidney transplant, resulting in some patients becoming too ill for a transplant or dying before a transplant can be done. While a living-donor kidney transplant has much shorter wait times, its growth has remained static because of various barriers. As well, there is a lack of integration and co-ordination between the Ministry, Renal Network and Trillium Network, because the Renal Network has no oversight over dialysis services provided by the Independent Health Facilities and kidney transplants co-ordinated by Trillium Network.

We also concluded that the Renal Network needs to do more to measure and report on the effectiveness of chronic kidney disease services and initiatives in meeting their intended objectives. While the Renal Network develops measures to evaluate the performance of goals set out in its public strategic plan, it does not release the results of all measures to the public on a regular basis.

This report contains 14 recommendations, consisting of 27 actions, to address our audit findings.

OVERALL RESPONSE FROM THE ONTARIO RENAL NETWORK

The Ontario Renal Network appreciates the Auditor General's comprehensive audit of chronic kidney disease management in Ontario. We welcome opportunities to work together with our partners, including the Ministry of Health, Trillium Gift of Life Network, patients and families, to improve these services in Ontario. In time, Ontario Health will take on the work of the Ontario Renal Network and Trillium Gift of Life Network. As a single agency, Ontario Health will have the opportunity to improve the oversight, integration and co-ordination of kidney care services in this province.

The Ontario Renal Network was launched in 2009 and—for the first time in this province's history—began to systemically address the detection, diagnosis and treatment of chronic kidney disease. Transformational change takes time to realize, but in just 10 years there have been significant improvements in the way kidney care services are delivered and managed in Ontario. For example, there has been increased engagement with nephrologists, patients and families, as well as improved access to multidisciplinary clinics for high-risk patients.

The Ontario Renal Network has enabled these improvements through strong partnerships, a robust performance management and accountability model, data infrastructure, and clinical expertise.

The recommendations within this report build upon the work that has been done to date by the Ontario Renal Network, the Ministry of Health, Trillium Gift of Life Network and many other partners. The report also identifies further opportunities to drive improvements in a number of areas, many of which echo the goals and objectives of the Ontario Renal Plan 2019–2023.

The Ontario Renal Network is committed to working with the Ministry of Health and our many partners, in particular renal patients and their families, to create a system that delivers person-centred, safe and effective kidney care services in an efficient, equitable and timely manner.

OVERALL RESPONSE FROM THE TRILLIUM GIFT OF LIFE NETWORK

Over the past five years, the Trillium Gift of Life Network has advanced the Ontario transplant system for chronic kidney disease patients with increasing rates of registration and increasing referrals for donation resulting in more patients in Ontario with healthy kidney transplants. We look forward to working with our partners to provide more options, more kidney transplants and high-quality care for all renal patients and we are excited for the opportunity to collaborate with the Ministry and other stakeholders to increase and enhance living donation in Ontario.

Current and future initiatives at the Trillium Gift of Life Network, such as reviewing and comparing data, policies and best practices with other jurisdictions and reviewing and updating current funding models, will help to ensure that key services are appropriately resourced and reimbursed and that the best possible care is provided to chronic kidney disease patients.

The Trillium Gift of Life Network welcomes the recommendations from the Auditor General and knows that with the continued and ongoing support from the Ministry of Health and its stakeholders these recommendations can be achieved for a better quality and integrated health-care system.

OVERALL RESPONSE FROM THE MINSTRY OF HEALTH

The Ministry of Health (Ministry) agrees with the recommendations made by the Auditor General of Ontario directed to the Ministry and thanks her for conducting this timely audit. The Ministry is committed to the development and implementation of innovative initiatives and solutions that address the impact of chronic kidney disease on the lives of Ontarians. We welcome any insights and recommendations provided by the Auditor General.

In 2018/19, Ontario provided approximately $662 million for renal services in Ontario. This funded the delivery of chronic kidney disease services, such as pre-dialysis services, dialysis (home and in-facility) and patient support. In addition, this funding developed and implemented various quality initiatives that provide specialized and person-centered care, and that promote early detection and prevention of progression of chronic kidney disease. In 2018/19, Ontario provided over $14 million in new

funding for renal services, most of which was for volume funding for chronic kidney disease services. As Ontario continues to invest in renal services, the Ministry will aim to ensure there is continuous system improvement to renal services, including co-ordination of care, removal of barriers to treatment, appropriate capacity development, efficient funding, and measurement and evaluation.

The audit identifies areas of consideration that the Ministry is already taking measures to address and reinforces the Ministry's commitment to continuous improvement. The Ministry is confident that Cancer Care Ontario and the Trillium Gift of Life Network deliver high-quality care to Ontarians with chronic kidney disease, and that they will make full use of the audit's recommendations to further improve that care.

The Ministry will continue to work closely with Cancer Care Ontario and the Trillium Gift of Life Network (and, once the agencies have integrated, with Ontario Health) to ensure that Ontarians have access to equitable, integrated, cost-efficient renal services.

2.0 Background

2.1 Overview of Chronic Kidney Disease

2.1.1 Causes of Chronic Kidney Disease

Kidneys form an important filtering system for the body by removing extra water and waste from the blood, balancing salts and minerals in the blood, and creating hormones for producing red blood cells. Chronic kidney disease is the presence of kidney damage, or a decreased level of kidney function, for a period of three months or more.

Chronic kidney disease can be caused by many factors, but is often a result of diabetes and/or high blood pressure. **Figure 1** shows the major risk factors for chronic kidney disease. While some factors (such as family history and age) are unavoidable, individuals can prevent or delay chronic kidney disease by making healthy lifestyle choices (such as maintaining a balanced diet, living an active lifestyle, and avoiding tobacco consumption).

2.1.2 Diagnostic Tests and Stages of Chronic Kidney Disease

The two primary measures of kidney function are the estimated glomerular filtration rate (GFR) and the albumin to creatinine ratio (ACR). The GFR is determined based on a blood test of creatinine (a waste product that is normally removed by kidneys), while the ACR is determined through a urine test of albumin (a protein that is found in blood but should not be present in urine). The GFR test is often included as part of routine blood work, but the ACR is less commonly tested and is often used for patients with diabetes.

There are five stages of chronic kidney disease, ranging from mild to severe, and each stage is represented by a range of GFR and ACR. **Figure 2** shows the percentage of kidney function by stage of chronic kidney disease.

When a patient is diagnosed with Stage 5 (or end-stage renal disease), the kidneys are approaching or at the point where they can no longer filter blood effectively, which can result in kidney failure and death if not treated.

While not all individuals with chronic kidney disease require medical intervention, those with more severe kidney disease require treatment to slow down the progression of kidney damage and stay alive. **Section 2.3** provides details on each treatment option.

2.2 Importance of Chronic Kidney Disease Management

2.2.1 Prevalence of Chronic Kidney Disease in Ontario

Chronic kidney disease is much more widespread than people realize and could be a "silent killer"

Figure 1: Major Risk Factors for Chronic Kidney Disease

Prepared by the Office of the Auditor General of Ontario

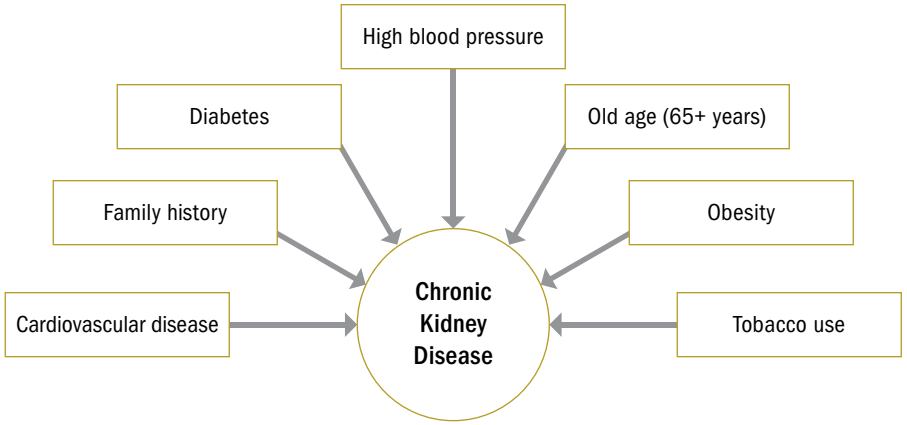
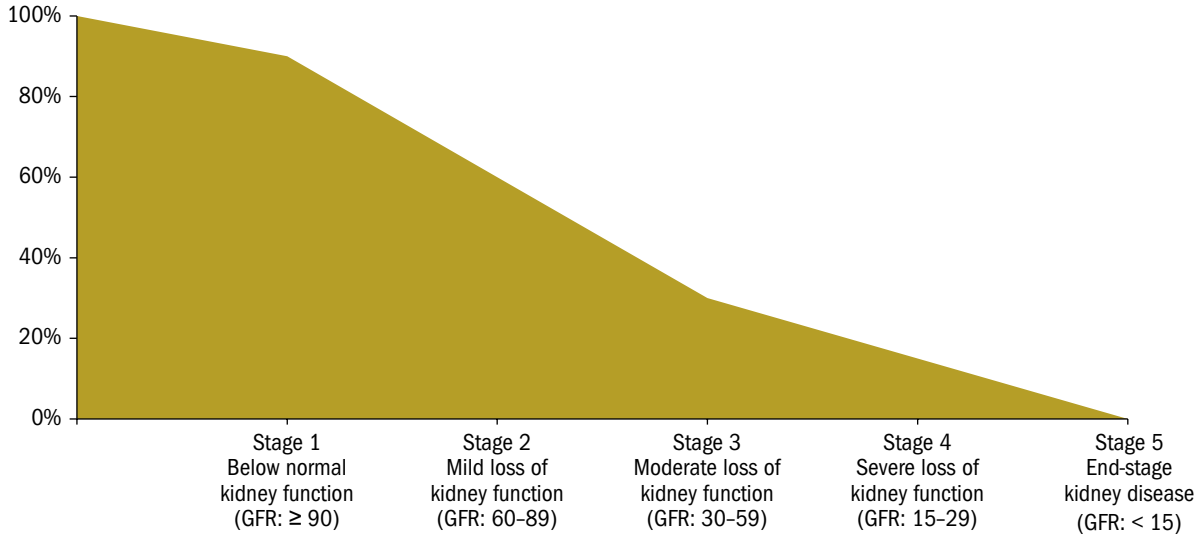


Figure 2: Percentage of Kidney Function by Stage of Chronic Kidney Disease

Prepared by the Office of the Auditor General of Ontario

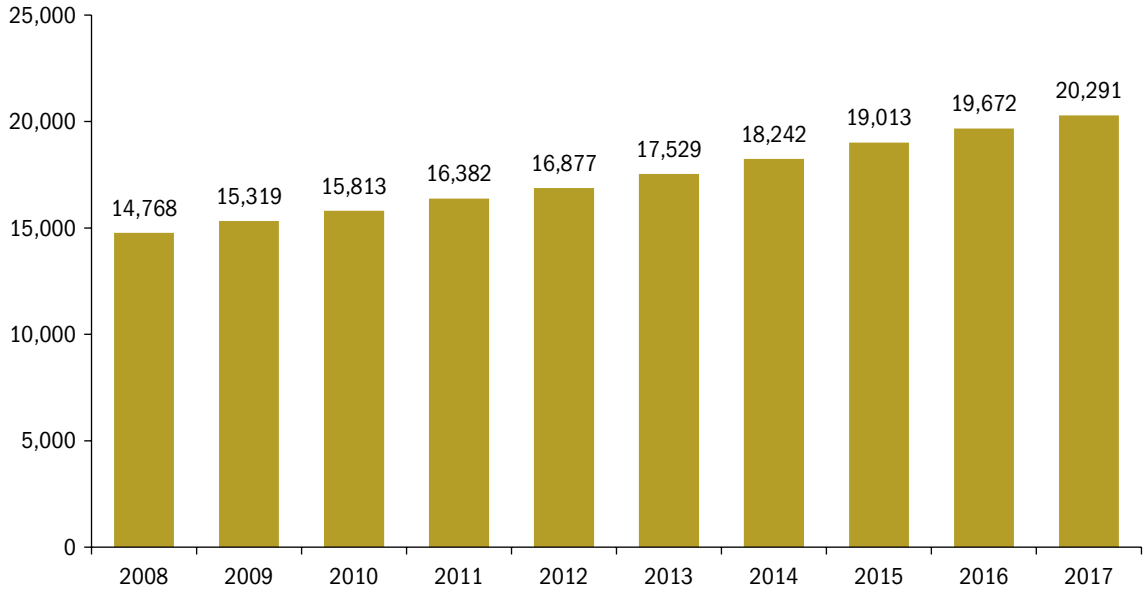


Note: Estimated glomerular filtration rate (GFR) measures the level of kidney function and determines the stage of kidney disease. GFR is calculated using a blood test of creatinine (a waste product that is normally removed by the kidneys), and albumin is calculated using urine to measure the excretion of protein in the urine.

because it often starts slowly and goes undetected or undiagnosed over several years. Although symptoms of chronic kidney disease are silent in the early stages and a person could lose more than 50% of kidney function before symptoms appear, individuals can prevent or delay the need for treatment by making healthy lifestyle choices such as maintaining a balanced diet and getting regular exercise. As well, in most cases there is no cure for chronic kidney disease, which means treatment is focused on controlling symptoms, reducing complications, and slowing down progression of the disease.

Statistics from various sources (such as the Canadian Institute of Health Information and Kidney Foundation of Canada) showed that the number of patients with chronic kidney disease and kidney failure is on the rise in Canada and Ontario, leading to a greater need for dialysis treatment and higher demand for kidney transplants. As shown in **Figure 3**, the number of people with end-stage renal

Figure 3: Number of People with End-Stage Kidney Disease in Ontario, 2008–2017
Source of data: Canadian Institute for Health Information

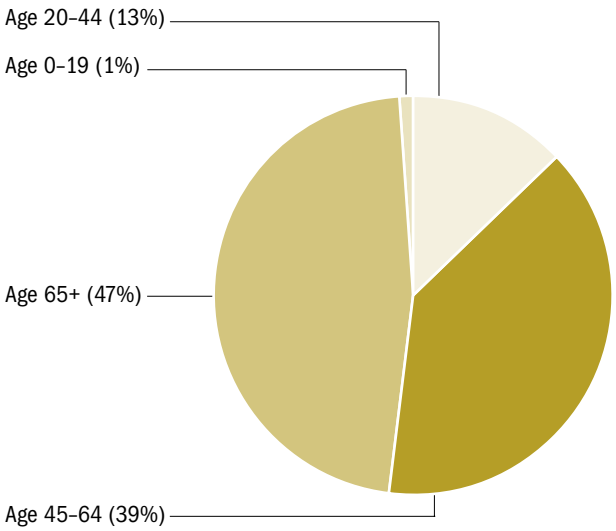


disease (Stage 5) in Ontario has grown over 37% between 2008 and 2017 (from about 14,800 people to about 20,300 people).

The increasing prevalence of chronic kidney disease can be attributed in part to an aging population and higher rates of high blood pressure and diabetes. Our analysis of data on Ontarians who started dialysis in 2018/19 found that about 88% had high blood pressure and about 57% had diabetes.

While old age is a risk factor, chronic kidney disease also affects those in middle adulthood. As shown in **Figure 4**, of all people with end-stage renal disease in Ontario in 2017, the senior population (aged 65 or older) accounted for 47% and adults in middle age (aged 45 to 64) accounted for about 39%. According to the Kidney Foundation of Canada, about 46% of new patients with kidney failure across Canada are under the age of 65.

Figure 4: Breakdown of Patients with End-Stage Kidney Disease by Age Group in Ontario, 2017
Source of data: Canadian Institute for Health Information



2.2.2 Impacts of Chronic Kidney Disease on Patients and the Health-Care System

Chronic kidney disease and its treatments not only take a great physical, psychological and financial toll on patients, they also create a significant burden and cost to the health-care system. Patients with kidney failure often must undergo dialysis (which is the most common treatment for Stage 5 or end-stage renal disease) multiple times per day or week, depending on the type of dialysis (see **Section 2.3**).

Transportation to and from dialysis can also be a significant and costly challenge for patients. A 2018 survey administered by the Kidney Foundation of Canada and the Canadian Association of Nephrology Social Workers found that out-of-pocket costs associated with dialysis can range from $1,400 to $2,500 per year and can amount to 12.5% of some patients' income.

Dialysis is also costly to the health-care system. For example:

- According to a 2017 study published in the *Canadian Journal of Kidney Health and Disease*, dialysis costs the health-care system nearly $100,000 per patient per year and the total cost to the Canadian health-care system for patients on dialysis is nearly $2.5 billion annually.
- According to another study in 2018 conducted by researchers from various hospitals and universities based on data in Ontario, the mean direct health-care cost for a dialysis patient in a hospital or clinic setting in the first year is about $140,000, which is more than 30 times the average Ontario per capita public health expenditure ($4,362), and is substantially higher than for adults with cancer ($26,000), heart failure ($28,000) or late-stage liver disease ($11,000).

2.3 Patient Journey and Treatment Options for Chronic Kidney Disease

2.3.1 Journey of Patient with Chronic Kidney Disease

The journey of a patient with chronic kidney disease typically begins with a primary care provider (such as a family physician). Primary care providers are responsible for managing the day-to-day health of their patients and are often involved in providing care during the early stages of a patient's chronic kidney disease. If a primary care provider notes that a patient is showing signs of high-risk chronic kidney disease according to the Kidneywise Clinical Toolkit (see **Section 4.1.1**), they are encouraged to refer the patient to a nephrologist (a physician specializing in kidney care), who is responsible for diagnosing the patient based on a blood and/or urine test, determining the patient's stage of chronic kidney disease (see **Section 2.1.2**), and providing the patient with recommendations to slow progression of their kidney disease. If a patient shows a high risk of progression toward end-stage renal disease, a nephrologist will refer the patient to a Multi-Care Kidney Clinic, which provides active management for a patient's chronic kidney disease as well as education on the different end-stage renal disease treatment options (see **Section 2.3.2**). **Appendix 1** provides an illustration of the ideal journey of a patient with chronic kidney disease.

2.3.2 Treatment Options for Chronic Kidney Disease

As discussed in **Section 2.1.2**, there are five stages of chronic kidney disease. When a patient is diagnosed with early chronic kidney disease, he or she can typically be managed by a primary care provider with common treatment options, including prescription medication (which can vary from patient to patient depending on a patient's symptoms and/or other illnesses) and lifestyle changes (such as healthy eating and regular exercise). If a patient with high-risk chronic kidney disease has been seen by a nephrologist and is assessed as progressing toward end-stage renal disease, the nephrologist refers the patient to a Multi-Care Kidney Clinic (see **Section 4.1**), which provides multidisciplinary care to help patients manage the disease.

As shown in **Figure 5**, if a patient is diagnosed with end-stage (Stage 5) chronic kidney disease, three treatment options are available: (1) dialysis; (2) transplant; and (3) conservative care. **Figure 6** provides a summary of each of these treatment options.

Figure 5: Treatment Options by Stage of Chronic Kidney Disease

Prepared by the Office of the Auditor General of Ontario

	Treatment Options
Early Stages[1]	• Prescription medication[2]
Progressing Stages	• Lifestyle changes (e.g., healthy eating, regular exercise)
	• Referral to a Multi-Care Kidney Clinic[3]
End Stage[4]	• Dialysis
	• Transplant
	• Conservative Care[5]

1. Generally, patients with early stage chronic kidney disease do not require significant treatment for their disease.
2. There is no medicine specifically for chronic kidney disease, but medication can help stop or slow down its progression by targeting an underlying health condition, or it can prevent consequences or complications that can occur as a result of the disease. Examples include medications that control high blood pressure and diabetes, reduce cholesterol and treat anemia. The medication options will be influenced by other medical conditions of the patients.
3. A Multi-Care Kidney Clinic consists of a team of multidisciplinary health professionals within a regional renal program that provides care for a patient including active management of chronic kidney disease and education on end-stage renal disease treatment options (see **Section 4.1.2**).
4. See **Figure 6** for details on each treatment option for patients with end-stage kidney disease.
5. Conservative care is like palliative care, which aims to delay progression of the disease and reduce any pain and suffering a patient is experiencing until death.

Figure 6: Treatment Options for a Patient with End-Stage Renal Disease or Kidney Failure

Prepared by the Office of the Auditor General of Ontario

Treatment Options	Type of Treatment	Description
1. Dialysis	Hemodialysis	• This involves extracting a patient's blood and passing it through a machine that replicates kidney function and then delivering the filtered blood back into the patient. • This can be done in-centre (in a hospital or clinic setting) or at home with appropriate training and resources. • This is usually done three to four times a week, for approximately four hours per treatment, but it can also be done overnight and/or daily.
	Peritoneal Dialysis	• This involves inserting a liquid into the lining of a patient's abdomen, which acts as a filter to absorb toxins, and draining the waste-filled liquid out. • This is primarily done at home and is commonly used by those who prefer home dialysis because it does not require the large equipment necessary for hemodialysis. • This must be done daily, approximately three to five times a day for about 30 minutes each (if done manually) or once overnight (if using a machine).
2. Transplant	Living-Donor Kidney Transplant	• This involves removing a kidney from a living donor (who is often a biological family member such as a parent, sibling or child but can also be a distant relative, spouse, friend or even stranger) and transplanting it into a patient.
	Deceased-Donor Kidney Transplant	• This involves removing a kidney from a deceased donor (who has consented to be an organ donor directly or indirectly through family) and transplanting it into a patient.
3. Conservative Care		• This includes palliative care and treatment to delay progression of the disease and reduce any pain and suffering a patient is experiencing until death. • This treatment option is generally selected by patients who are severely ill and prefer not to go through frequent dialysis treatments and who are not medically eligible for a transplant.

2.4 Management and Delivery of Chronic Kidney Disease Services

2.4.1 Roles and Responsibilities of Key Parties Involved

Figure 7 outlines the key parties involved in the management and delivery of chronic kidney disease services in Ontario and their working relationships. The major parties include the Ministry of Health (Ministry), Ontario Renal Network (Renal Network), Trillium Gift of Life Network (Trillium Network), hospitals (27 Regional Renal Programs and six adult kidney transplant centres) and independent health facilities. **Appendix 2** provides a summary of each party's roles and responsibilities.

The Renal Network was created as a division of Cancer Care Ontario (CCO) in 2009 to use CCO's experience with clinical engagement and quality improvement through its oversight of cancer services. It is responsible for advising the Ministry on chronic kidney disease management, determining funding for each of the 27 Regional Renal Programs in Ontario, and organizing chronic kidney disease services (excluding transplants, which fall under the responsibility of the Ministry, Trillium Network and six adult kidney transplant centres).

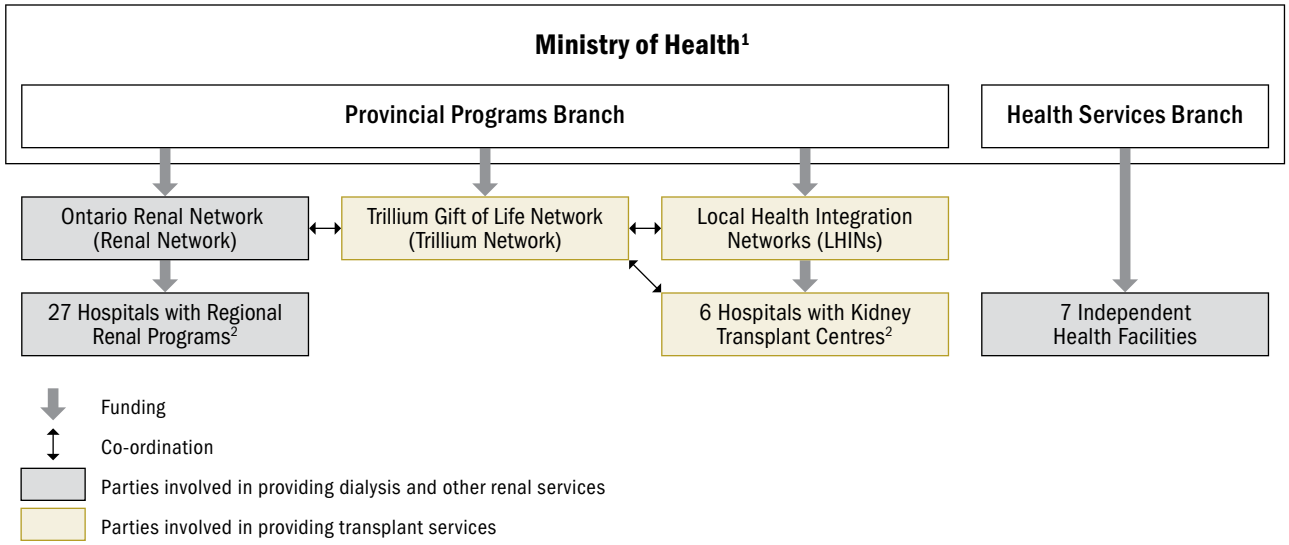
2.4.2 Funding for Chronic Kidney Disease Services

The Ministry provides funding to the Renal Network, which manages and allocates the funding to the 27 Regional Renal Programs that deliver chronic kidney disease services. Over the last five fiscal years (2014/15–2018/19), the Renal Network's expenditures on chronic kidney disease services (excluding transplants) grew by about 8% (from about $612 million to $662 million), as shown in **Figure 8.**

In 2018/19, almost 93% (or about $617 million) of the Renal Network's funding was for direct services (such as Multi-Care Kidney Clinics and dialysis) delivered by the 27 Regional Renal Programs to patients with chronic kidney disease, with the remaining 7% primarily for capital and administration (such as dialysis equipment and initiatives related to quality improvement, staffing and information technology). **Appendix 3** shows the

Figure 7: Key Parties Involved in the Management and Delivery of Chronic Kidney Disease Care in Ontario

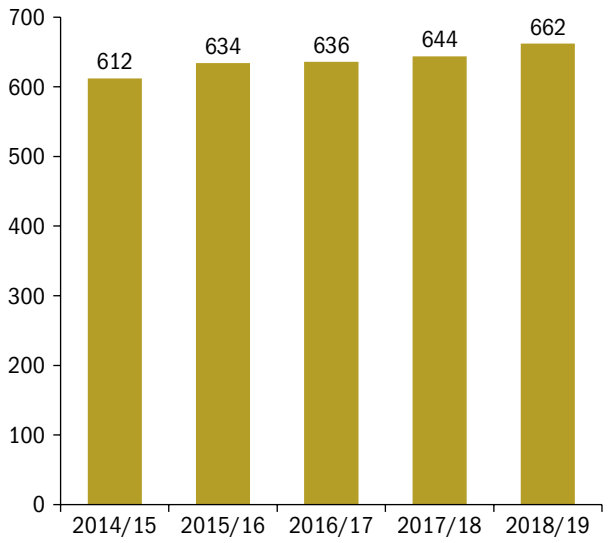
Prepared by the Office of the Auditor General of Ontario



1. Other parties involved are the Ministry of Long-Term Care and the Health Capital Branch within the Ministry of Health.
2. In total, the 27 hospitals with Regional Renal Programs have a combined 94 dialysis locations across the province, including 42 satellite hospitals. Each Regional Renal Program has a Multi-Care Kidney Clinic. Six of these 27 hospitals are also kidney transplant centres. There are seven kidney transplant centres in Ontario. Our audit focused on six adult kidney transplant centres.

Figure 8: Ontario Renal Network's Expenditure on Chronic Kidney Disease Services, 2014/15–2018/19 ($ million)

Source of data: Ontario Renal Network



Quality-Based Procedure funding for direct services (see **Section 4.1.1**) and the average number of dialysis patients for each Regional Renal Program in 2018/19.

The Ministry also provides funding to the Trillium Network and hospitals for kidney transplants. In 2018/19, the Ministry provided approximately $20 million in funding for about 700 kidney transplants.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ontario Renal Network (Renal Network) within Cancer Care Ontario (CCO), in association with the Ministry of Health (Ministry), the Trillium Gift of Life Network (Trillium Network) and Regional Renal Programs, has effective systems and procedures in place to:

- ensure that chronic kidney disease services are provided in a timely, equitable and cost-efficient manner to meet Ontarians' needs and in accordance with applicable standards, guidelines and legislation; and
- measure and report periodically on the results and effectiveness of chronic kidney disease services and initiatives in meeting their intended objectives.

In planning for our work, we identified the audit criteria (see **Appendix 4**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Renal Network, Ministry and Trillium Network reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and June 2019. We obtained written representation from the Renal Network, the Ministry and Trillium Network management that, effective October 30, 2019, it had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

We conducted our audit work at the Renal Network within CCO where we:

- interviewed senior management and staff responsible for managing and overseeing the delivery of chronic kidney disease services in Ontario;
- reviewed applicable policy and procedure manuals, reports and briefing notes related to chronic kidney disease services in Ontario;
- collected and analyzed data to identify trends, gaps and outcomes of chronic kidney disease services in Ontario; and
- reviewed strategic plans and targets and related performance of all 27 Regional Renal Programs in delivering chronic kidney disease services in Ontario.

We conducted site visits at five of the 27 Regional Renal Programs located in different Local Health Integration Networks (LHINs), three of which are also kidney transplant centres (see **Appendix 3**). We selected the following five sites based on geography

(to obtain representation across Ontario), demand for chronic kidney disease services (to reflect the number of people served in the region), and types of services provided (to cover both dialysis and transplants).

1. **Kingston Health Sciences Centre (South East LHIN):** Large catchment geography and a transplant centre.
2. **London Health Sciences Centre (South West LHIN):** Research and academic affiliation and a transplant centre.
3. **Scarborough Health Network (Central East LHIN):** Highest funding from Renal Network and largest number of dialysis patients.
4. **Thunder Bay Regional Health Sciences Centre (North West LHIN):** Largest catchment geography and patient population that includes First Nations, Inuit and Metis.
5. **University Health Network (Toronto Central LHIN):** Highest home dialysis rate and number of kidney transplants over the last five years.

Our audit work at each of the five Regional Renal Programs included the following:

- interviewing management and front-line staff, including physicians involved with the program;
- reviewing program policies, procedures and other relevant documentation to understand their services and operations;
- reviewing measures and indicators being used to evaluate program performance; and
- reviewing patient files for details on the services provided by the Regional Renal Programs, patient journey, and patient experience with various treatment options including dialysis and kidney transplants (such as how often patients visited Regional Renal Programs for services and why patients selected specific treatment options).

We also conducted a survey of all 27 Regional Renal Programs to get a better understanding of the renal care system in Ontario. We received responses from 21 Regional Renal Programs, representing a 78% response rate.

As well, we conducted audit work at Trillium Network, including collecting and reviewing transplant policies and data. We contacted and obtained documentation from the Ministry related to kidney transplants and independent health facilities that provide dialysis.

In addition, we met with and obtained feedback from stakeholders, including the Kidney Foundation of Canada as well as members of provincial and regional patient and family advisory groups.

Further, we reviewed relevant research and studies in Ontario and other jurisdictions. We contacted other jurisdictions and compared their eligibility criteria, funding and delivery methods for renal services, and performance measures with those of Ontario.

We engaged an independent advisor with expertise in the field of chronic kidney disease services to assist us on this audit.

At the time of our audit, Bill 74, *The People's Health Care Act, 2019*, received royal assent on April 18, 2019. It will come into force on a date to be proclaimed by the Lieutenant Governor. The legislation is designed to integrate multiple provincial agencies, including the LHINs, CCO and Trillium Network, into a single agency called Ontario Health. It has implications for our recommendations presented herein. All recommendations to the Renal Network within CCO and Trillium Network in this report have been addressed directly to Ontario Health and/or to the Ministry of Health.

4.0 Detailed Audit Observations

4.1 Patients Do Not Always Receive Sufficient and Consistent Specialty and Multidisciplinary Care on a Timely Basis

As discussed in **Section 2.3** and **Appendix 1**, the typical journey of a patient with chronic kidney

disease begins with a primary care provider, who refers a patient with signs of chronic kidney disease to a nephrologist. If the nephrologist determines that the patient is at high risk of progressing to end-stage renal disease, the patient will be referred to a Multi-Care Kidney Clinic (Clinic) within a Regional Renal Program for follow-up and monitoring. However, we found that patients do not receive sufficient and consistent services on a timely basis because of late referrals and that not all Clinics provide equitable access to multidisciplinary care.

4.1.1 Patients Are Not Always Referred to Nephrologists on a Timely Basis Despite Meeting Referral Criteria

Most patients diagnosed with early-stage chronic kidney disease can be managed by a primary care provider (such as a family physician or a nurse practitioner) who monitors and treats their health conditions and risk factors (such as diabetes and high blood pressure) to ideally slow down or delay the disease's progression. In 2015, the Ontario Renal Network (Renal Network) developed, as part of its Kidneywise Clinical Toolkit, criteria to help primary care providers identify patients who are at high risk of progressing to advanced stages of chronic kidney disease and should be referred to a nephrologist. However, we found that such referrals are not always done on a timely basis.

The Ontario Laboratories Information System (OLIS) is an information repository that gives authorized health-care providers access to lab test data from hospitals, community labs and public health labs. The Renal Network uses data from the OLIS and other sources to measure the percentage of patients who visited a nephrologist within 12 months of meeting the referral criteria outlined in the Kidneywise Clinical Toolkit.

Our review of the Renal Network's most recent (2017/18) results on this measure noted that over 40% of patients (or about 8,700) had not been referred to a nephrologist even though they met the referral criteria. We also noted that about 2,200 patients who initially met referral criteria in 2015/16 and continued to meet criteria in subsequent years were never referred to a nephrologist.

However, the Renal Network has not followed up on these cases, and it does not provide the Regional Renal Programs with adequate and complete lab data that would enable them to identify and follow up on these patients. Instead, the Regional Renal Programs only receive high-level regional information on the percentage of people who have met the criteria and have already been referred. As a result, the Regional Renal Programs must wait until patients are referred to them or until patients arrive at the Regional Renal Program needing to start dialysis urgently without having received sufficient care in a Multi-Care Kidney Clinic, as discussed further in **Section 4.1.3**.

Our review of statistics from the Kidney Foundation of Canada also noted that:

- 1 in 4 patients starting dialysis had never seen a nephrologist; and
- nearly 25% of patients in Canada had late referrals, which means they started dialysis only 90 days after first seeing a nephrologist.

According to a 2012 study of Kaiser Permanente Hawaii (a region of Kaiser Permanente, which is one of the United States' leading health-care providers), a care model with an integrated electronic health record helps reduce late referrals by enabling nephrologists and primary care providers to collaborate and share information on chronic kidney disease patients. While this study focused on the population and care model in Hawaii, we noted that something similar could be implemented in Ontario by proactively providing nephrologists and/or Regional Renal Programs with details of patients who meet the referral criteria according to the Kidneywise Clinical Toolkit so that they can reach out to these patients or their primary care providers.

As discussed in **Section 4.1.2**, the Multi-Care Kidney Clinics (Clinics) are staffed and connected with nephrologists. Therefore, referring patients to nephrologists in a timely manner is important to

ensure that patients have timely access to the multidisciplinary care at the Clinics, which help patients manage their chronic kidney disease and educate them on the treatment options available.

RECOMMENDATION 1

To help patients receive timely referrals to a nephrologist and slow down the progression of their chronic kidney disease, we recommend that the Ontario Renal Network:

- work with the Ministry of Health to share lab data from the Ontario Laboratory Information System with the Regional Renal Programs to help them identify and follow up on patients who are eligible for referral to a nephrologist; and
- work with the Regional Renal Programs to investigate cases where patients are not being referred to see nephrologists on a timely basis to ensure these patients are referred for assessment.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees that timely referral to nephrology is important to slow and delay the progression of chronic kidney disease.

Currently, the Ontario Renal Network reports to the Regional Renal Programs the early chronic kidney disease referral rate to nephrology on an annual basis. In order to better understand the trends and opportunities for improved referrals, the Ontario Renal Network is conducting an in-depth analysis of the available information. The analysis explores regional variation and identifies potential barriers and reasons for no or late referrals, including demographic variances and primary care patient enrolment models. The results of this analysis will be shared with the Regional Renal Programs to ensure that local initiatives are focused on these patients and their physicians.

In collaboration with the Ministry of Health and other partners, the Ontario Renal Network will explore mechanisms to use the Ontario Laboratories Information System database to identify eligible patients so that Regional Renal Programs and primary care physicians can ensure timely and appropriate referrals. This exploration would include privacy considerations related to personal health information for direct communication with patients and primary care providers.

The Ontario Renal Network will continue to work with the Regional Renal Programs to increase awareness among primary care providers of the KidneyWise Clinical Toolkit, which includes guidelines on how to identify patients at high risk of chronic kidney disease, diagnose and manage patients with chronic kidney disease in a primary care setting and refer patients at high risk of progression to nephrology.

MINISTRY RESPONSE

The Ministry recognizes the potential for Ontario Laboratories Information System data to inform important clinical care pathways to improve outcomes for renal patients. The Ministry is prepared to work with the Ontario Renal Network (and/or Ontario Health) to explore the potential for Ontario Laboratories Information System data sharing and how that might be achieved.

4.1.2 Patients Do Not Receive Equitable and Consistent Services from Multi-Care Kidney Clinics across the Province

In 2013/14, the Renal Network introduced a Multi-Care Kidney Clinic (Clinic) within each Regional Renal Program in Ontario. Each Clinic (previously known as a predialysis clinic) is staffed by a multidisciplinary team (which includes nephrologists, nurses, dietitians, social workers and pharmacists). While the Renal Network requires each Clinic to have a multidisciplinary team and provides best practices for team composition, we found that it does not track

nor specify the staffing level or staff-to-patient ratio for each discipline to ensure that Clinics provide consistent services across the province.

A Clinic focuses on helping patients manage their chronic kidney disease, educating patients on end-stage treatment options and preparing patients for transition to the treatment option selected. As of 2018/19, over 16,000 patients received care at the Clinics across the province. Most of these patients had advanced chronic kidney disease and are at high risk of kidney failure. Our review of various studies noted that multidisciplinary care is associated with improved clinical outcomes such as fewer urgent dialysis starts and improved survival when on dialysis.

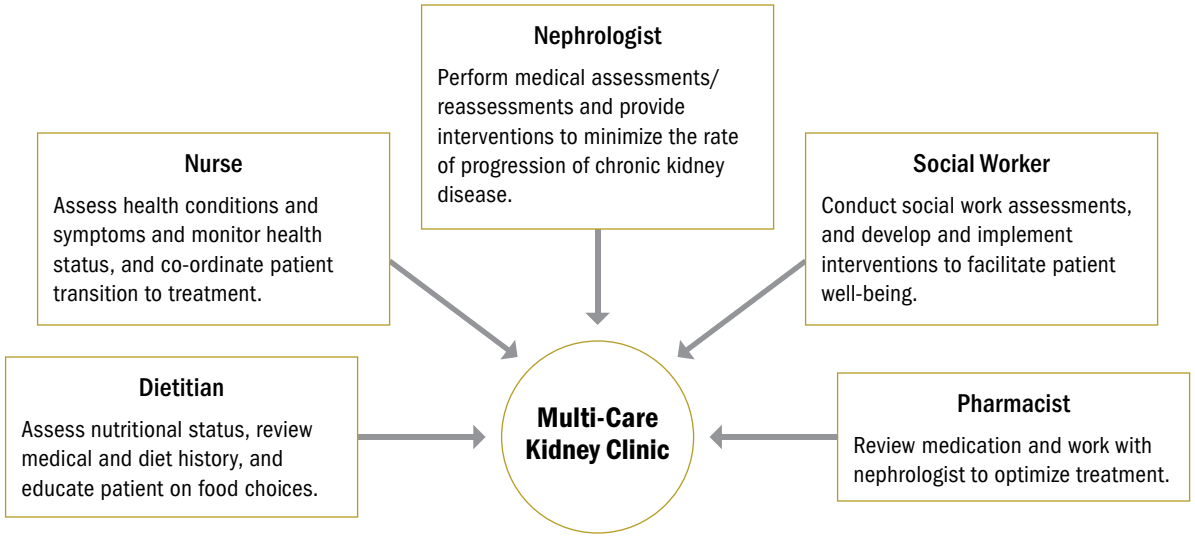
In January 2019, the Renal Network released a document that outlines best practices for the Clinics. One of the best practices is related to the composition and responsibilities of the multidisciplinary team. Specifically, apart from the patient and caregiver, the team should include at a minimum a nephrologist, nurse, pharmacist, dietitian and social worker. **Figure 9** summarizes the roles and responsibilities of staff in the multidisciplinary team.

Despite the Renal Network's best practices, through our survey we found that staffing levels vary from one Clinic to another. For example, one Regional Renal Program with approximately 500 Clinic patients had access to two full-time pharmacists, while another with a similar patient volume only had access to one part-time pharmacist. Our survey also found that approximately 50% of Regional Renal Programs that responded indicated having gaps in their Clinic as a result of either not having a specific discipline of staff (for example, a pharmacist) or not having enough access to a specific discipline. Therefore, patients' access to care at the Clinics varies depending on which Regional Renal Program they are connected to, creating an inequity in the availability of services across the province.

Unlike Ontario, we noted that the best practice guide in British Columbia specifies and provides examples of staffing levels for each discipline based on the size of the clinic and the estimated hours of service that will be provided by each clinic. For example, it provides an estimate on the number of hours per year a social worker provides services for new cases and discharged cases based on patient volumes and the size of the clinic. This estimate is then converted into the number of full-time equivalents for social workers required.

Figure 9: Roles and Responsibilities of Staff in the Multidisciplinary Team of the Multi-Care Kidney Clinics in the 27 Hospitals with Regional Renal Programs

Prepared by the Office of the Auditor General of Ontario



RECOMMENDATION 2

To help patients with advanced stages of chronic kidney disease obtain access to equitable and consistent services across the province, we recommend that the Ontario Renal Network:

- collect information on the composition and staffing level of the multidisciplinary team at each Multi-Care Kidney Clinic from the Regional Renal Programs on an annual basis to identify teams that do not meet best practices and make changes accordingly; and
- review the composition and practices of each multidisciplinary team to identify whether to implement minimum patient-to-staff ratios.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees that access to equitable and consistent services within Multi-Care Kidney Clinics is a key service for patients with high-risk chronic kidney disease. In 2019, the Ontario Renal Network released a best practices document that establishes the quality and type of care to be delivered in Multi-Care Kidney Clinics.

The Ontario Renal Network will continue to monitor access and quality indicators related to Multi-Care Kidney Clinics. The Ontario Renal Network will regularly conduct on-site quality-focused assessments of Regional Renal Programs and also continue to request annual reporting from all Regional Renal Programs to ensure compliance with the Multi-Care Kidney Clinic best practices, including collecting information on access and composition of multidisciplinary teams.

4.1.3 Most Patients Do Not Receive the Recommended Amount of Care from Multi-Care Kidney Clinics Based on Best Practice

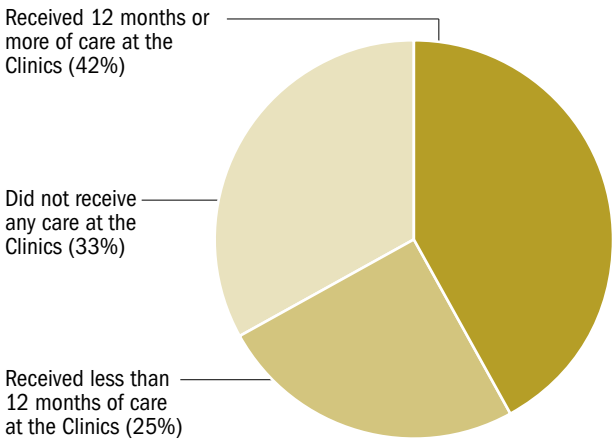
While the Renal Network has identified a best practice for the length of time spent in a Clinic prior to starting dialysis, we found that most patients had not received this recommended amount of multidisciplinary care.

Through expert consultation, the Renal Network has identified that at least 12 months of multidisciplinary care is associated with improved patient outcomes when compared to less than three months. Our survey of Regional Renal Programs also found that approximately 90% of them agreed that patients should ideally be in a Clinic for at least 12 months in order to receive adequate care from the multidisciplinary team and enough information to understand and make a decision on the treatment options available.

The Renal Network measures the percentage of patients who had at least 12 months of multidisciplinary care at the Clinics prior to starting dialysis. Our review of data on about 3,350 patients who started dialysis in 2018/19 found that more than half of these patients had not received the recommended amount of multidisciplinary care in the Clinics (see **Figure 10**). Specifically:

Figure 10: Length of Time Spent by Patients in the Multi-Care Kidney Clinics (Clinics) Prior to Starting Dialysis, 2018/19

Source of data: Ontario Renal Network



- about 25% of patients received an insufficient amount (less than 12 months) of care in the Clinics prior to starting dialysis; and
- about 33% of patients did not receive any care in the Clinics at all prior to starting dialysis.

People receiving less than 12 months or no multidisciplinary care in a Clinic in accordance with best practice means that they likely did not receive sufficient care to help manage their chronic kidney disease prior to requiring dialysis or did not receive enough information or time to learn about the treatment options available.

While neither the Renal Network nor Regional Renal Programs have tracked why patients received insufficient or no multidisciplinary care before starting dialysis, they cited several potential reasons, including:

- lack of access to a primary care provider, who helps monitor a patient's health conditions and risks for chronic kidney disease;
- late referral by a primary care provider to a nephrologist;
- late referral by a nephrologist to a Clinic;
- a significant change in a patient's health condition that triggered a kidney-related disease; and
- patient's preference and choice.

Regarding access to primary care, our review of data from the Renal Network noted that about 34% of patients were not registered with a primary care provider. This means patients may not have received an adequate level of chronic disease management and preventive care, which is usually provided by a primary care provider, and could contribute to late referrals to the Clinic.

Our review of patient files confirmed instances where patients were not referred to a Clinic on a timely basis. We also noted cases where patients had visited a hospital in prior years for conditions related to chronic kidney disease (such as diabetes) and were referred back to their regular health-care provider, only to return to hospital when their condition worsened to the point where they needed urgent dialysis and spent little to no time in a Clinic beforehand. If these patients had been referred to a Clinic earlier and had spent more time at a Clinic, their need for starting dialysis could potentially have been deferred or avoided altogether.

Additionally, we found that most patients (61%) that started home dialysis (which costs less than in-centre dialysis) in 2018/19 received at least 12 months of multidisciplinary care at the Clinics. This suggests that patients who are referred to and receive at least 12 months of care from a Clinic are more likely to choose home dialysis as their treatment option, which helps save costs and time for patients, and lowers the cost to Ontario's health-care system (see **Section 4.2.3**).

RECOMMENDATION 3

To provide enough multidisciplinary care to patients with advanced stages of chronic kidney disease, we recommend that the Ontario Renal Network work with the Regional Renal Programs to fully investigate the reasons for late referrals to the Multi-Care Kidney Clinics and implement practices to allow for timely referral.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation and will continue to work with Regional Renal Programs to investigate the reasons for late referral to Multi-Care Kidney Clinics and implement initiatives as appropriate.

The Ontario Renal Network reviews Regional Renal Program performance on a quarterly basis; indicators include the proportion of Multi-Care Kidney Clinic referrals and time spent in Multi-Care Kidney Clinic prior to dialysis. The Ontario Renal Network will set provincial targets for both and will continue to monitor Regional Renal Program performance against these targets.

The Ontario Renal Network has developed criteria to provide guidance to nephrologists on timing of referral. Ultimately, however,

nephrologists, who may or may not be affiliated with a Regional Renal Program, use clinical judgment to determine if or when it is appropriate for a patient to be referred to a Multi-Care Kidney Clinic, considering patient preference and patient prognosis.

4.1.4 New Eligibility Criteria for Multi-Care Kidney Clinics Getting Mixed Feedback

One of the main goals for the Renal Network is to ensure that the right patients receive the right care in the right place at the right time. In order to identify the right patients, in 2016 the Renal Network revised the eligibility criteria for admission into the Clinics to ensure that only patients with a high risk of kidney failure are admitted. However, we noted that the Regional Renal Programs expressed mixed opinions on the new criteria and some raised concerns that warrant further review by the Renal Network.

In 2016, the Renal Network revised the eligibility criteria for admission to the Clinic because the original criteria (established in 2013) had resulted in many patients with a lower risk of kidney failure being referred to the Clinics unnecessarily. Subsequent to the criteria changes, the number of patients admitted to the Clinics fell about 39% between 2015/16 and 2018/19, which resulted in cost savings of about $8 million per year for the Renal Network to use for other initiatives.

In 2016/17 and 2017/18, the Renal Network evaluated the impact of revised eligibility criteria and found no negative impact on patient outcomes. However, the Renal Network received mixed feedback from a survey it conducted during the first year of implementation. For example:

- Staff at the Clinics indicated that patient feedback about the change of criteria varied (positive, negative or neutral).
- Administrators, nephrologists and health-care providers wanted more information about the evidence and rationale for changing the criteria.

We also noted that 73% of Regional Renal Programs that responded to our survey indicated they provided Clinic care to patients using other sources of funding even though these patients did not meet the new eligibility criteria. The survey result aligns with what we found during our site visits.

RECOMMENDATION 4

To help the Multi-Care Kidney Clinics (Clinics) admit the right patients who would benefit from multidisciplinary care at the right time, we recommend that the Ontario Renal Network:

- collect further information and feedback regarding the revised eligibility criteria for Clinics from health-care providers at the Regional Renal Programs as well as experts in the field of renal care; and
- update the revised eligibility criteria if needed, based on information and feedback.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees it is important for patients who would benefit from multidisciplinary care to access Multi-Care Kidney Clinics at the right time.

The Ontario Renal Network completed an evaluation of the new funding eligibility criteria. Responses from Multi-Care Kidney Clinic staff indicated: patients had a neutral or positive response to the change; most administrators and health-care providers believed the primary driver of the criteria change was to focus care on the right patients; and, critically, the change in criteria resulted in no negative outcomes for patients.

The Ontario Renal Network will continue to review relevant clinical literature and will update the Multi-Care Kidney Clinic Best Practices document, including the Multi-Care Kidney Clinic eligibility criteria, to reflect the latest evidence as needed. The Ontario Renal Network will continue to evaluate any changes that are implemented.

4.2 Dialysis Services Do Not Fully Meet People's Needs or Provincial Target

Dialysis, which is the most common treatment for people with end-stage renal disease, can be done in a hospital or clinic setting (referred to as in-centre dialysis) or at home. We identified areas for improvements for both in-centre dialysis and home dialysis. For example, in the case of in-centre dialysis, capacity does not align with regional needs, and inconsistent oversight and funding has caused hardship for some patients. Meanwhile, the usage rate of home dialysis (which has added benefits for patients who are medically suitable) does not meet the province's overall target and varies significantly across the province, and more needs to be done to increase it.

As discussed in **Section 2.3** and **Figure 6**, there are two types of dialysis:

1. **Hemodialysis** (using a machine to filter waste and fluid from the blood) can be delivered in a hospital or clinic setting (also referred to as in-centre) or at home.
2. **Peritoneal dialysis** (using the lining of the abdomen to clean the blood) is primarily delivered at home.

Patients can choose the type of dialysis they want depending on, for example, the severity and stability of their medical conditions and the available space in their homes. **Figure 11** provides a breakdown of about 11,800 dialysis patients in Ontario by type of dialysis in 2018/19. Specifically, 79% of patients are on hemodialysis and the remaining 21% are on peritoneal dialysis. Regarding dialysis location, 74% of patients received dialysis in a hospital or clinic setting while 26% received dialysis at home (hemodialysis or peritoneal dialysis).

4.2.1 Capacity for In-Centre Dialysis Does Not Align with Regional Needs

The 27 Regional Renal Programs have a total of 94 in-centre dialysis locations across Ontario. These locations have almost 1,800 dialysis stations, with an estimated capacity to serve approximately 10,200 patients in Ontario if each location is running three dialysis shifts per day. However, we found that many locations are operating at or near full capacity while other locations have excess capacity.

Our review of data on these locations found that the occupancy of in-centre dialysis stations varies across the province and does not align with regional needs. Specifically, at the end of 2018/19:

- The occupancy rate was about 80% on average, but varied significantly from one dialysis facility to another, ranging from 26% to 128%. According to the Renal Network, it is possible that in situations where demand for dialysis increases at a faster rate than the physical capacity available, the Regional Renal Programs may need to create additional dialysis stations within their existing space, leading to a less-than-ideal environment for receiving dialysis treatment.
- 33 dialysis locations (or 35% of all locations) had an occupancy rate of at least 90%. For example, one Regional Renal Program in the Greater Toronto Area had an occupancy rate of approximately 90% at most of its locations and noted difficulties in keeping up with demand.
- 16 dialysis locations (or 18% of all locations) had an occupancy rate lower than 70%, meaning that they had dialysis stations that were not being used consistently.

A contributing factor to this capacity issue is that patients do not always receive in-centre dialysis at the location that is closest to them. For example, a patient living in Mississauga may choose to receive in-centre dialysis in Toronto. When a patient does not receive dialysis at the facility closest to them, it can result in a mismatch between dialysis capacity and regional demand.

Our review of data and documents from the Renal Network and Regional Renal Programs noted that approximately 49% of patients were not receiving in-centre dialysis at the location closest to them. This primarily happens in larger urban locations where patients have more options as to where to receive treatment. For example:

- At one Regional Renal Program in Toronto, 83% of its dialysis patients lived closer to another Regional Renal Program.
- At another Regional Renal Program (with an approximately 90% occupancy rate at most of its locations in the Greater Toronto Area), almost 22% of its dialysis patients came from outside of its catchment area and 81% of dialysis patients did not receive treatment at the facility closest to them. An external review of this Regional Renal Program in 2017 also raised concerns about patients coming from outside of the region for care. For instance, a patient lived in the Durham Region, but commuted to the Greater Toronto Area for dialysis.

While the Renal Network and Regional Renal Programs have not collected information on why patients received dialysis from sites other than the ones closest to them, they informed us that this is usually due to a patient's preference based on factors such as proximity to employment, family members and other health-care providers; referral by a patient's primary care provider or nephrologist; and availability of transportation for patients.

RECOMMENDATION 5

To better align the capacity for in-centre dialysis with regional needs, we recommend that the Ontario Renal Network conduct a province-wide capacity analysis and realign the supply of in-centre dialysis spots to alleviate high-demand situations in some Regional Renal Programs and reduce the amount of under-used capacity at others.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation. Recognizing that patient choice is a critical factor in where people receive dialysis, the Ontario Renal Network will continue its efforts to optimize system capacity to support the efficient use of resources.

Since 2011, the Ontario Renal Network has conducted biannual provincial in-centre Dialysis Capacity Assessments, which forecast the capacity required to meet patients' needs over the next 10 years. The 2019 assessment is being finalized and will be used to work with the Regional Renal Programs to develop a multi-year provincial Dialysis Capital Investment Strategy that reflects regional and local needs. This strategy will be used to inform the prioritization, location, size and timing of investments required to create additional capacity where necessary, and to optimize the utilization of existing resources. This strategy will be updated regularly, based on changes in demand over time.

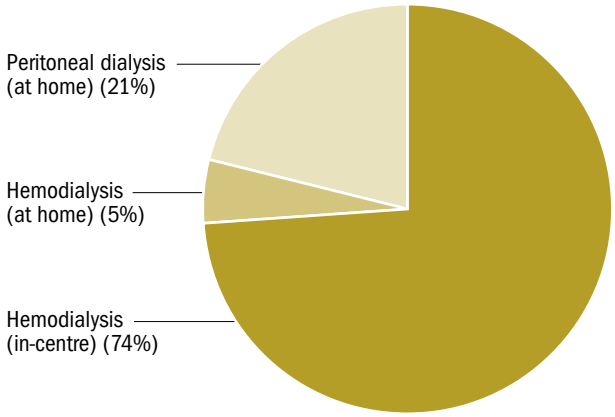
As part of this work, the Ontario Renal Network will work with Regional Renal Programs to conduct collaborative capacity planning across regions and to monitor patient referral patterns to ensure alignment with future planned capacity, making adjustments to these plans where necessary.

4.2.2 Home Dialysis Usage Rate of Most Regional Renal Programs Has Not Met Target and Varies Significantly across the Province

Home dialysis is when patients with end-stage kidney disease undergo dialysis in their homes, either on their own or with help from care providers or family members. Compared with dialysis in a hospital or clinic setting, evidence indicates that the possible benefits of dialysis at home include better quality of life and greater independence

Figure 11: Breakdown of Dialysis Patients by Type of Dialysis, 2018/19

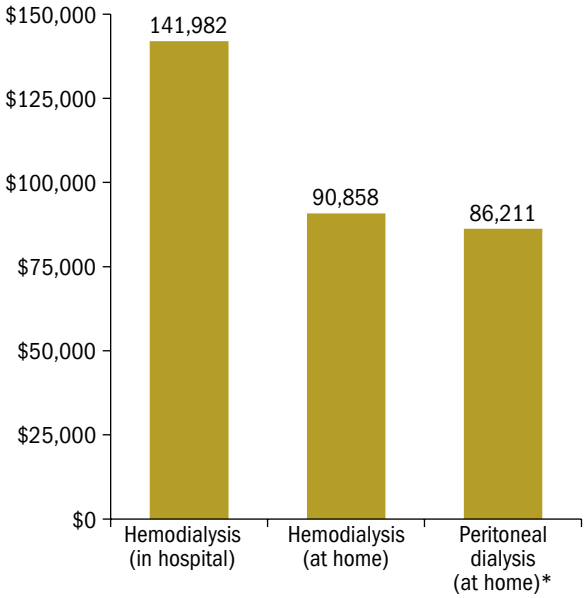
Source of data: Ontario Renal Network



Note: Hemodialysis can be delivered in a hospital setting (also referred to as in-centre) and at home, while peritoneal dialysis is primarily delivered at home.

Figure 12: Average Total Direct Health-Care Costs by Type of Dialysis

Prepared by the Office of the Auditor General of Ontario



Note: Cost data is provided by the Ontario Renal Network based on a research study published in 2019.

* Peritoneal dialysis is primarily done at home.

for patients, and lower costs for the health-care system. Despite these benefits, Ontario's home dialysis usage rate of 26% does not meet the Renal Network's target (which is currently 28%) and rates across the province vary significantly.

While both types of dialysis (hemodialysis and peritoneal dialysis) can be done at home, **Figure 11** shows that most patients (about 74%) still receive their dialysis treatments in a hospital or clinic setting (also known as in-centre), which is the most expensive form of dialysis. The direct health-care cost for in-centre hemodialysis is almost $142,000 per year per patient, about 1.6 times higher than home hemodialysis and peritoneal dialysis (see **Figure 12**). Based on the Renal Network's Quality-Based Procedure funding allocation method (see **Section 4.4.1**) and the number of dialysis patients in 2018/19, a 1% increase in home dialysis usage in Ontario could result in savings of approximately $1.8 million per year.

Increasing the percentage of patients receiving home dialysis has been one of the Renal Network's main priorities since 2012. Although close overall, the home dialysis usage rate in Ontario still has not met the Renal Network's current target of 28% (measuring the percentage of patients on home dialysis out of all patients on dialysis). Our analysis of home dialysis usage rates in 2018/19 at each of the 27 Regional Renal Programs found that (see **Figure 13**):

- the rate across the province is 26% on average, but it varies significantly, ranging from approximately 16% at one Regional Renal Program to about 41% at another; and
- only six (or 22%) of the 27 Regional Renal Programs met the current home dialysis target of 28%.

Through discussion with the Regional Renal Programs as well as our review of patient files and documents submitted by the Regional Renal Programs to the Renal Network, we noted that increasing and maintaining home dialysis usage rates has been challenging for many reasons, mainly related to patients' choices or medical conditions and staffing or resource issues (see **Figure 14**).

Additionally, our review of the most recent data available for home dialysis usage rates in

Figure 13: Home Dialysis Rate by Regional Renal Program, 2018/19

Source of data: Ontario Renal Network

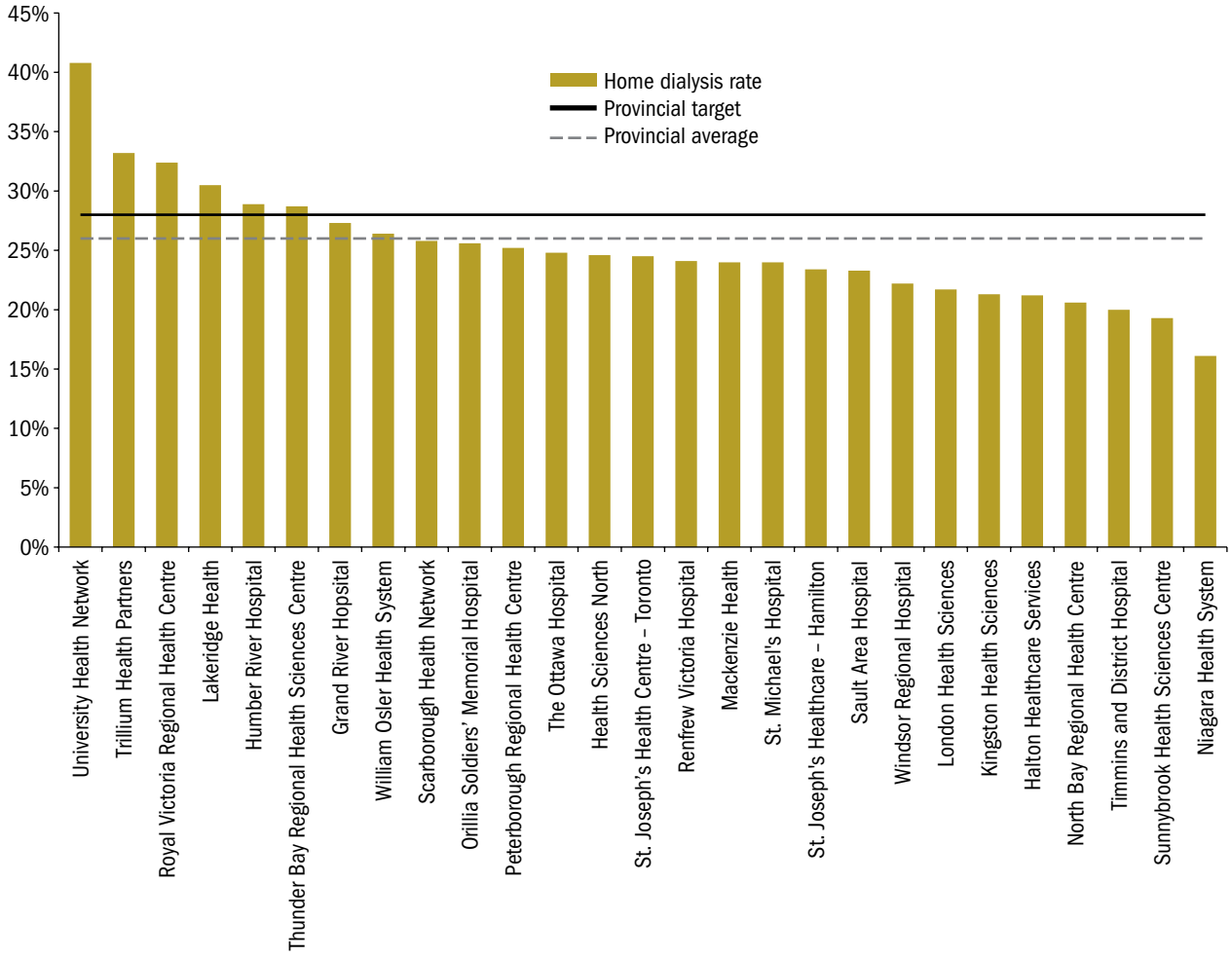


Figure 14: Why Increasing Home Dialysis Usage Rates Can Be Challenging

Prepared by the Office of the Auditor General of Ontario

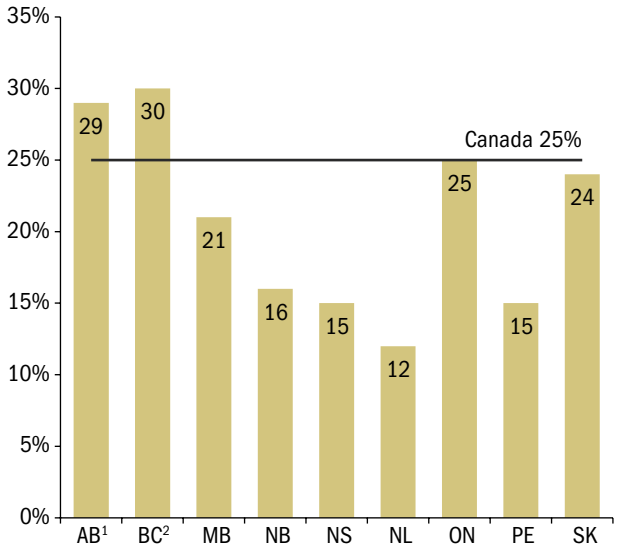
Patients' choice or medical condition
• Patients may have clinical factors (such as comorbidities, frailty and obesity) that make them unsuitable for home dialysis.
• Patients often prefer to receive care in a hospital or clinic setting even if they are suitable for home dialysis because they feel uncomfortable doing their own treatment.
• Patients are less likely to choose home dialysis if they live near a facility that provides in-centre dialysis.
• Patients may be too ill to be able to dialyze on their own and do not have the necessary supports (such as family members) to assist them at home.
• Patients do not always attend their scheduled home dialysis education and information sessions.
• Patients going straight into the system without enough previous multidisciplinary care require immediate dialysis, which must be done in a hospital or clinic setting.
Staffing or resource issues
• Some Regional Renal Programs and/or nephrologists promote home dialysis more than others, and this can influence patient choice.
• Regional and community-based agencies, such as Local Health Integration Networks and long-term-care homes, do not have enough resources to support patients who require assistance with home dialysis.
• Not all Regional Renal Programs have the same staffing and capacity resources to dedicate to home dialysis.

Canada and other countries noted that the rate in Ontario has remained steady (around 25% to 26% in recent years), but is lower than some provinces and other countries:

- According to the most recent (2017) data from the Canadian Institute for Health Information, Ontario's home dialysis usage rate was about 25%, the same as the rate in Canada but lower than the rates in Alberta (29%) and British Columbia (30%), as shown in **Figure 1**5.
- According to the 2018 United States Renal Data System Annual Data Report, home dialysis rates vary worldwide, ranging from less than 5% in some countries (such as Japan) to over 40% and 70% in New Zealand and Hong Kong, respectively. The rate in Canada is about 25%, which is higher than 12% in the United States and is about the same as Ontario's current average rate of 26%. The rates are high in some jurisdictions for various reasons, including a longstanding culture and history of promoting home dialysis as well as a reimbursement system that reimburses patients for home dialysis, but requires patients to pay out of pocket for in-centre dialysis.

Figure 15: Home Dialysis Usage Rates Across Canada, 2017

Source of data: Canadian Institute for Health Information



Note: This figure excludes data from Quebec because of under-reporting.

1. Data from Alberta includes Northwest Territories and Nunavut.
2. Data from British Columbia includes Yukon Territory.

4.2.3 Home Dialysis Training Does Not Always Meet Patients' Needs

Providing patients with enough training on home dialysis can help prevent patients from returning to in-centre dialysis after starting home dialysis. The Renal Network funds Regional Renal Programs to provide 21 days of training to patients choosing home hemodialysis and five days of training to patients choosing home peritoneal dialysis. The Renal Network also funds retraining for patients as required. Some Regional Renal Programs informed us that while five days of training for peritoneal dialysis is usually sufficient, 21 days of training for home hemodialysis is often not enough to ensure that a patient is adequately trained. This means that patients may have to go back to in-centre dialysis.

We found that home dialysis attrition to in-centre dialysis (patients who tried home dialysis, but returned to in-centre dialysis within 12 months of beginning home dialysis) varies across the province. Our review of home attrition to in-centre dialysis noted that while the average attrition rate was approximately 13% province-wide in 2018, the rate varied significantly between the Regional Renal Programs, ranging from 0% to over 20% for peritoneal dialysis and approximately 0% to 45% for home hemodialysis.

Some Regional Renal Programs informed us that they have provided training for longer than the length of training funded by the Renal Network. For example, a Regional Renal Program that has one of the highest home dialysis rates in Ontario indicated that in 2018/19, the average length of training required for its home hemodialysis patients was 46 days, over two times longer than the 21-day training funded by the Renal Network. After the 21-day training term was up, the Regional Renal Program would continue providing training while classifying the patients as in-centre dialysis patients

to recoup some of the costs of training. Our survey of Regional Renal Programs also found that the average number of training days for home hemodialysis was 31 days.

4.2.4 Initiatives to Increase Home Dialysis Have Limited Coverage, Unclear Effectiveness and Mixed Outcomes

Promoting the appropriate use of home dialysis is a major strategic direction in Ontario that is supported by a number of initiatives collectively known as the "Home First" Strategy. With limited home and community supports, however, patients are more likely to choose in-centre dialysis even if they are eligible for or prefer home dialysis. For example, our analysis of Renal Network data noted that of the approximately 3,350 patients beginning dialysis in 2018/19, more than 1,300 were assessed as eligible for home dialysis but only 780 (or about 60%) of these patients intended to go on home dialysis.

While the Renal Network has introduced initiatives to help patients who prefer to receive home dialysis but are unable to manage treatment by themselves, they have had mixed results. Through discussion with patient representatives and our survey of Regional Renal Programs, we found that the following initiatives, for example, have generally been received positively.

- In 2018/19, the Renal Network provided approximately $9.2 million to the 14 Local Health Integration Networks (LHINs) for arranging community nurses or personal support workers to visit and help patients perform peritoneal dialysis at their homes. We noted that additional work on this initiative is needed, as our survey found that 64% of Regional Renal Programs noted that there are not enough LHIN and community resources available to help patients with home dialysis, and 73% of Regional Renal Programs indicated that the quality and consistency of care provided is not always adequate.
- In 2017, the Renal Network introduced a grant to help offset patients' utility costs (electricity and water) when conducting hemodialysis independently at home. The amount of the grant varies by patient as it is calculated based on, for example, municipal water and electricity rates, as well as treatment frequency and duration. In 2018/19, a total of about $295,000 was paid to approximately 650 patients on home hemodialysis.

However, we found that other initiatives have limited coverage, unclear effectiveness and mixed outcomes. For example:

- In 2009, the Ministry began funding supports for patients on peritoneal dialysis in long-term-care homes so that patients would not have to travel to in-centre dialysis sites for treatment. Since then, the Ministry has spent about $5.7 million on funding these supports. However, neither the Ministry nor the Renal Network has collected information on the number of dialysis patients living in long-term-care homes. Without this information, it is not clear whether the Ministry's funding is sufficient to meet the dialysis needs in long-term-care homes or how much can be saved on transporting patients between long-term-care homes and dialysis facilities. In 2018/19, the Ministry's funding for supporting patients on peritoneal dialysis in long-term-care homes was approximately $324,000, but only 27 (or 4%) of 630 long-term-care-homes offered these supports to 38 patients on peritoneal dialysis. The Ministry also spent a total of about $10.5 million between 2017/18 and 2018/19 to transport approximately 450 patients each year from long-term-care homes to in-centre dialysis facilities for treatment.
- In 2015, the Renal Network began funding a personal support worker for home hemodialysis patients at eight of the 27 Regional Renal Programs to assist with their dialysis treatments. This initiative targeted patients who would not have been able to

do home hemodialysis without this support. Since 2015, the Renal Network has spent approximately $5.4 million to provide home hemodialysis and support to approximately 74 patients through this initiative. A recent review of this initiative found that by 2018, 29 patients were receiving this support and more than half of the personal support workers (39 out of 75 workers) either resigned for personal reasons (such as unstable hours or stress from work) or were asked to leave for various reasons (such as not meeting clinical requirements). Although the Renal Network estimated this initiative would be more costly than in-centre dialysis during the first year given upfront training costs for personal support workers, it expected savings in subsequent years as more patients chose to go on home dialysis. However, we found that no costing analysis or fulsome evaluation on this initiative have been completed. Without this information, it is unclear whether this initiative is cost-effective and should be expanded to other Regional Renal Programs.

RECOMMENDATION 6

To further increase the rate of home dialysis in Ontario and meet the target, we recommend that the Ontario Renal Network work with the Ministry of Health to:

- assess and address the challenges (such as staffing and resources issues) of increasing the home dialysis usage rate and take corrective action;
- collect information on home dialysis training from the Regional Renal Programs to determine the appropriate funding for training and adjust the current funding allocation if needed; and
- conduct a province-wide and cross-jurisdictional analysis to identify best practices for increasing home dialysis usage rates and implement those practices across the province.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees that home dialysis is a priority and will continue to work with the Ministry of Health and Regional Renal Programs on this area.

The Ontario Renal Network has made significant efforts to increase and sustain the home dialysis rate. The rate has increased from 22.2% to 25.8% since 2012, with the number of home dialysis patients increasing from 2,260 to 3,060. Since 2014, kidney transplantation has also increased by about 40%. Since patient demographics and medical characteristics of transplant and home dialysis candidates tend to be similar, the increase in kidney transplantation has influenced the ability to further improve home dialysis rates.

As challenges to home dialysis vary based on unique program factors, the Ontario Renal Network has worked with individual Regional Renal Programs to identify areas of opportunity. Additionally, applicable practices have been identified from comparable jurisdictions, including British Columbia and Australia. Despite continuing efforts to address challenges to home dialysis, patient choice remains a critical factor.

The Ontario Renal Network will continue to focus on inadequate assistance for peritoneal dialysis patients and catheter complications associated with peritoneal dialysis, two common barriers. A home dialysis mentorship model will further support sharing best practices among Regional Renal Programs. It is recognized that training is a key enabler for patients to successfully conduct home dialysis. The Ontario Renal Network will collect and analyze data on home dialysis training from Regional Renal Programs to determine whether adjustments to the funding model for home dialysis training and retraining are needed.

MINISTRY RESPONSE

The Ministry supports this recommendation and agrees that it is important to understand and address the challenges inherent in increasing the usage rate of home dialysis, and to take corrective action where possible. The Ministry will work with the Ontario Renal Network to provide chronic kidney disease patients with access to the right type of treatment.

The Ministry will also collaborate with the Ontario Renal Network to ensure that training for home dialysis is appropriately funded in the light of the information that the Ontario Renal Network gathers from the Regional Renal Programs. The Ministry will work with the Ontario Renal Network to determine how best to implement best practices from the cross-jurisdictional analysis.

4.3 Despite Benefits of Kidney Transplants, Wait Times Remain Long

Despite the benefits of kidney transplants (such as better quality of life and improved survival rates for patients and lower costs for the health-care system), the increasing number of people in need of a new kidney and the shortage of organ donors means that some patients will still never receive a transplant. Since barriers to kidney transplants have not been fully addressed, wait times for kidney transplants remain long, creating hardship on patients and higher costs for the health-care system.

As discussed in **Section 2.3**, there are two types of kidney transplants: (1) deceased-donor transplant; and (2) living-donor transplant. Kidney transplants make up the majority of organ transplants in Ontario. In 2018/19, approximately 700 (or 57%) of 1,221 organ transplants in Ontario involved a kidney. **Appendix 5** provides the patient journey for a kidney transplant.

A kidney transplant is the best clinical treatment for patients who have end-stage renal disease and are eligible to receive a transplant. There are additional benefits to a living-donor kidney transplant compared to a deceased-donor transplant, including longer patient and organ survival rates and shorter wait times to receive a kidney (see **Section 4.3.2**). As well, multiple studies we reviewed found that when compared to dialysis, a kidney transplant is more cost-effective in the long run and is associated with better patient outcomes and lower costs to the health-care system. For example, these studies noted that kidney transplants result in:

- **Better quality of life:** Patients have renewed freedom and productivity.
- **Improved survival:** A 2018 study by the Canadian Institutes for Health Information found that up to 74% of Canadians with a kidney transplant still have a functioning kidney after 10 years, but only 16% of Canadians on dialysis survive past 10 years.
- **Lower health-care system costs:** A 2018 study published by the National Institute of Health in the U.S. noted that over a five-year period, every 100 kidney transplants save the Canadian health-care system about $20 million in averted hospital-based dialysis costs.

4.3.1 Long Wait Times for Kidney Transplants Create Hardship on Patients and Costs to Health-Care System

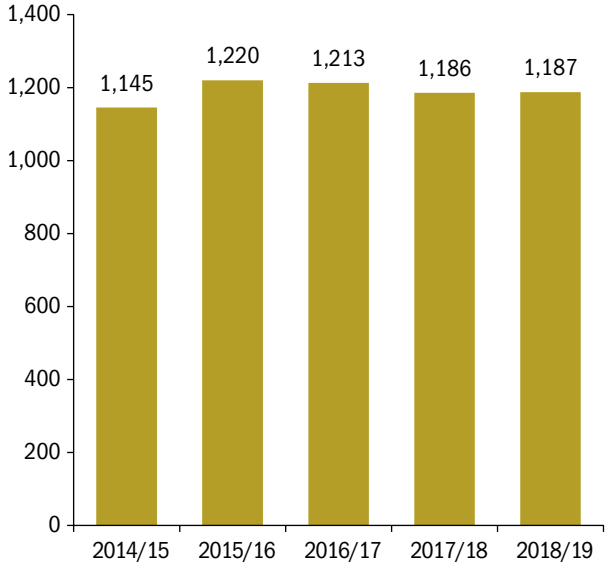
Patients are often on dialysis while waiting for a kidney transplant, and wait times for kidney transplants in Ontario have remained long. Besides the ongoing costs of dialysis, patients must also undergo an assessment every year in order to stay on the wait list, which creates further burdens for patients and additional costs for the health-care system. We noted that the current pre-transplant assessment process could be resulting in unnecessary costs in many cases.

Of all Ontarians on the wait list for an organ donation, more than 70% on average were waiting for a kidney. Over the last five fiscal years (2014/15–2018/19), the number of people waiting

for a kidney transplant remained high, on average about 1,200 in each fiscal year (see **Figure 16**). During the same period, the number of people being added to the wait list for a kidney transplant each year increased by 26% (from about 600 to over 750) (see **Figure 17**).

Figure 16: Number of People on Wait List for Kidney Transplant in Ontario, 2014/15–2018/19

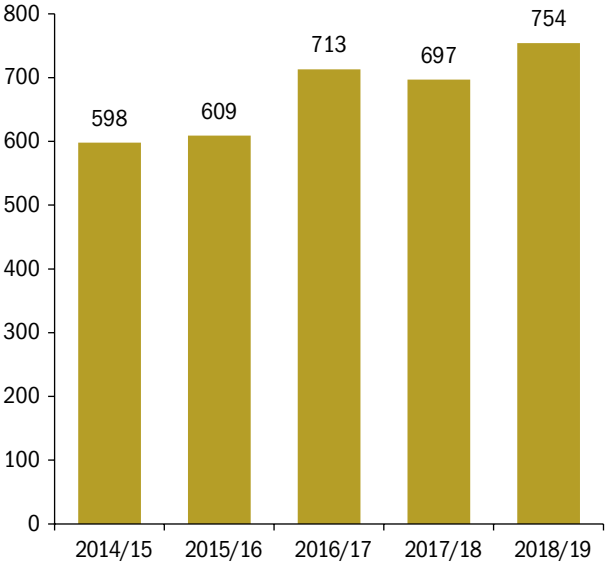
Source of data: Trillium Gift of Life Network



Note: Data is point-in-time or snapshot based on the number of people waiting as of April 1 of the fiscal year.

Figure 17: Number of People Added to Wait List for Kidney Transplant in Ontario, 2014/15–2018/19

Source of data: Trillium Gift of Life Network



Most patients who choose the option of a deceased-donor transplant receive dialysis while they wait. According to the Kidney Foundation of Canada, the median wait time for a deceased-donor transplant in Canada is approximately four years, with the longest wait time in Manitoba (six years) and the shortest in Nova Scotia (three years). The average wait time for a deceased-donor kidney transplant in Ontario is about four years.

As a result of the long waits, we noted that a number of people were taken off the wait list and were unable to receive kidney transplants because they were either no longer medically eligible or they passed away. Specifically:

- Over the last five fiscal years (2014/15–2018/19), almost 300 people were removed from the wait list either because they were too ill and no longer medically suitable for a kidney transplant or because they died while waiting for a transplant, which could have been for reasons other than chronic kidney disease, such as other health complications.
- In 2018/19, over 50 people were taken off the wait list because they were too ill or had died. The average wait time for these patients was about three and a half years, almost 30% of them had been waiting for longer than four years, and the longest wait time was almost 13 years. Some patients may face a longer-than-average wait if they require a medically unique kidney or if they have medical complications that take a long time to resolve.

As well, patients waiting for a kidney transplant must undergo continuous work-ups (including blood work, ongoing testing and evaluation) to reconfirm their eligibility and stay on the deceased-donor transplant wait list. However, some of the Regional Renal Programs informed us that this work-up not only creates a burden on patients, but also results in significant costs to the health-care system. Our review of costing submissions by the six adult kidney transplant centres in Ontario noted that the average cost of this work-up for a deceased-donor kidney transplant is approximately $8,000 per patient per

year. Based on the average wait time of approximately four years for a deceased-donor kidney, the health-care system could save up to $24,000 per patient by delaying the annual work-up until a patient is a year away from receiving a deceased-donor kidney.

A 2019 study conducted by the European Renal Association—European Dialysis and Transplant Association also identified considerable agreement among experts that the work-up for a kidney transplant for low-risk patients should only include a limited number of tests. Yet, the existing work-up process for a kidney transplant in Ontario aims to cover all patients and circumstances, even though complicating factors (such as age and presence of other health conditions) can vary significantly between kidney transplant candidates.

One of the transplant centres in Ontario informed us that it will pilot a new initiative to defer transplant work-ups until a patient is closer to receiving a suitable kidney. It will use transplant and organ donation data to predict how long it would take for a suitable kidney to become available and use that information to determine when the work-up for each patient is needed. This could eliminate years of unnecessary work-ups and assessments and reduce the burden on patients and the health-care system.

RECOMMENDATION 7

To provide eligible patients with timely access to kidney transplants in Ontario and appropriate pre-transplant care, we recommend that the Trillium Gift of Life Network, in collaboration with the Ministry of Health and the Ontario Renal Network:

- study transplant policies and initiatives in other jurisdictions to identify best practices that would help increase organ donations and shorten wait times in Ontario; and
- work with kidney transplant centres and Regional Renal Programs to review the transplant eligibility and annual pre-transplant assessment or work-up process in order to identify efficiencies and cost savings.

TRILLIUM GIFT OF LIFE NETWORK RESPONSE

The Trillium Gift of Life Network supports this recommendation and will continue to work with the Ministry and Ontario Renal Network to improve timely and efficient access to kidney transplants and provide appropriate pre-transplant care for all Ontarians.

The Trillium Gift of Life Network will continue to collaborate with the Ontario Renal Network to further advance the Access to Kidney Transplantation strategy, which is aimed at enhancing access to, and improve patients' experience of, kidney transplantation with a focus on increasing living kidney donation. The Trillium Gift of Life Network will also continue to collaborate with the Ministry and other partners to review policies and initiatives in other jurisdictions to increase kidney transplants from organ donors, which may help to shorten wait times for kidney transplantation.

The Trillium Gift of Life Network will also continue to work with the Ontario Renal Network, transplant programs and other stakeholders to review transplant eligibility and annual assessment requirements while on the kidney wait list. These criteria are reviewed every two years and, in collaboration with the Ontario Renal Network, result in materials produced for patients and referring centres. In addition, the Trillium Gift of Life Network will continue with renewing the organ wait list and allocation IT system that will allow for integration with referring programs to track the patient's journey from referral to post transplant.

This will also enhance the ability to measure and evaluate the process to identify efficiencies and new improvement opportunities such as deferring transplant work-ups until a patient is

closer to transplant and supporting pre-transplant evaluation closer to patients' homes.

MINISTRY RESPONSE

The Ministry is supportive of the Trillium Gift of Life Network's ongoing work to increase organ donations in Ontario. The Ministry agrees with the recommendation to review transplant eligibility and the annual pre-transplant assessment and work up process in order to identify efficiencies. The Ministry anticipates that the Kidney Transplant Working Group, which is responsible for establishing Ontario's referral and listing criteria for kidney transplantations, would participate in this review.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation and will continue to work with Regional Renal Programs to optimize pre-transplant care for patients with chronic kidney disease.

The Ontario Renal Network is partnered with Trillium Gift of Life Network to implement a provincial Access to Kidney Transplant and Living Donation Strategy based on practices in place in other jurisdictions. As part of this strategy, Regional Renal Programs have introduced several initiatives to promote and improve the rate of kidney transplantation, including quality improvement, education for health-care providers, patients and potential living donors, and the development of peer support networks focused on kidney transplantation. In 2021, this strategy will be expanded to all 27 Regional Renal Programs.

The Ontario Renal Network will continue to work with Trillium Gift of Life Network, Transplant Centres and Regional Renal Programs to identify how to improve the transplant work-up process, recognizing that there are opportunities to make the process more efficient for the benefit of both patients and the health-care system. The Ontario Renal Network is currently collecting information from Regional Renal Programs on their local models for supporting transplant work-up, and understanding their local barriers and challenges. This information will be used to identify and promote more timely and efficient work-up processes within Regional Renal Programs.

4.3.2 Various Barriers to Kidney Transplants Remain

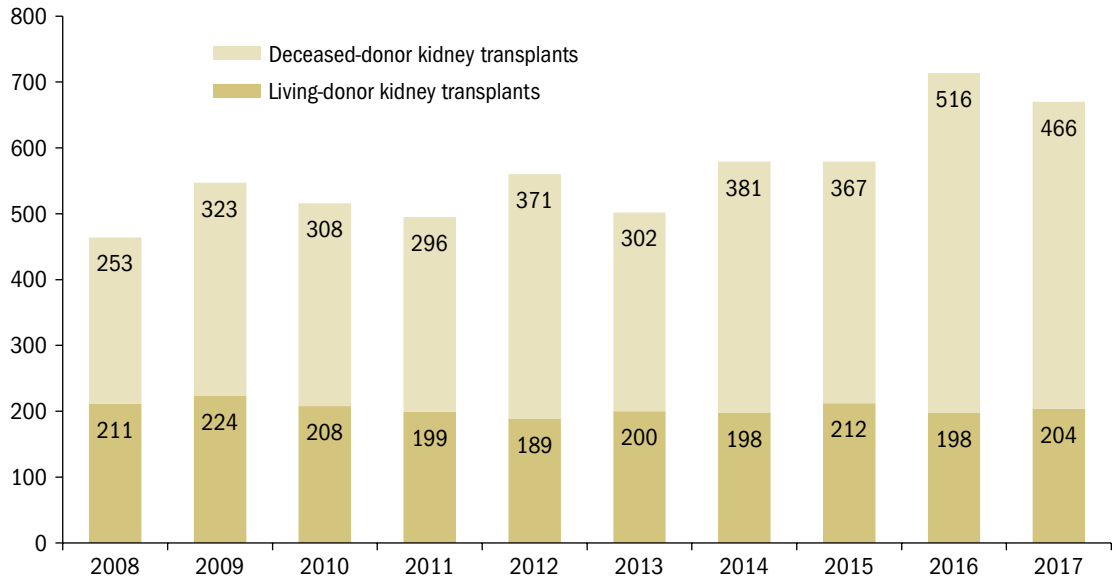
As discussed in **Section 4.3.1**, wait lists and wait times for a kidney transplant have remained long, but the number of people in need of a kidney transplant continues to rise. This is due to various barriers that limit the growth of kidney transplants, including living-donor transplants (including costs to potential donors and a lack of consistent information, education and public awareness).

Growth of Living-Donor Transplants in Ontario Remains Static

While the number of deceased-donor transplants per year has increased in Ontario, it is not enough to keep up with the pace of growing needs. The alternative is a living-donor transplant, and while anyone can be assessed to become a living donor, it is often a family member who donates a kidney to a patient. A living-donor transplant has a much shorter wait time and a higher transplant success rate. For example, the wait time for a living-donor transplant is about one year (once a living-donor candidate is identified), while the wait time for a deceased-donor transplant is on average four years but could be longer depending on the unique needs of the patient (such as blood type). The five-year survival rate for adults with transplanted kidneys is 92% from living donors and 82% from deceased donors.

Over the last 10 years, the number of living-donor transplants has remained static even though a living-donor transplant presents an opportunity

Figure 18: Number of Living-Donor and Deceased-Donor Kidney Transplants in Ontario, 2008–2017
Source of data: Canadian Institute for Health Information



to improve a patient's survival and quality of life. **Figure 18** shows that the overall number of kidney transplants has been increasing in Ontario, but this growth was due to an increase in deceased-donor transplants while living-donor transplants have remained almost unchanged since 2008. Specifically, living-donor transplants accounted for about 45% of all kidney transplants in 2008, but dropped to 30% in 2017. This is much lower than the world average, as a 2018 study published by the American Society of Nephrology noted that approximately 40% of the kidneys for transplant worldwide come from living donors.

In comparison with other provinces, as shown in **Figure 19**, while the rate per million population for a deceased-donor kidney transplant in Ontario (30.9) was higher than other provinces, except British Columbia (41.4), the rate for a living-donor kidney transplant in Ontario (13.5) was lower than Alberta (13.7), British Columbia (17.5) and Manitoba (20.9).

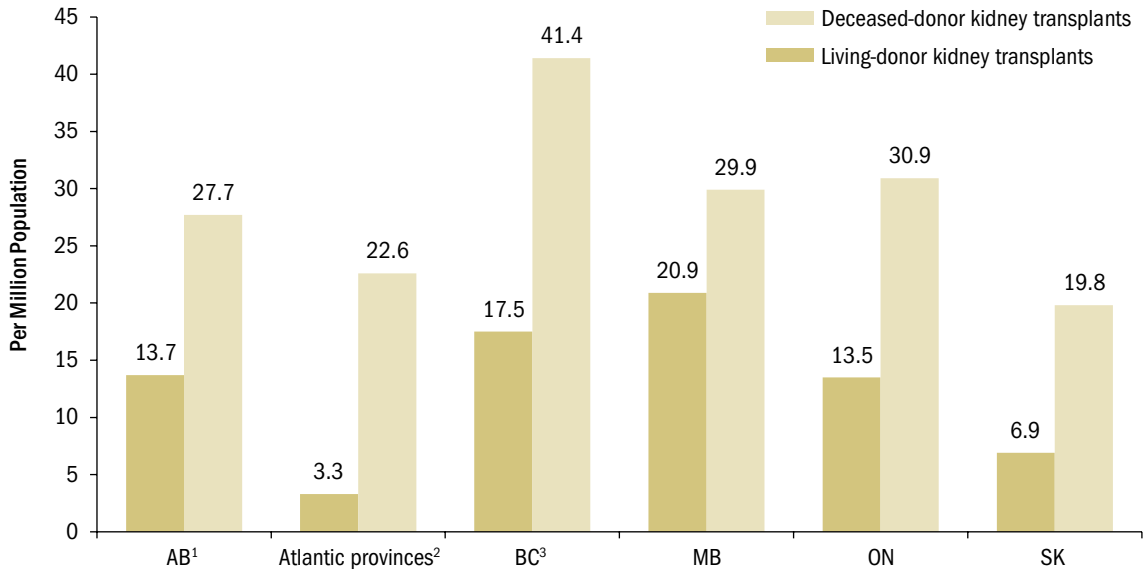
Various Barriers Hinder the Increase of Kidney Transplants, Especially Living-Donor Transplants

One of the barriers to a living-donor transplant is the costs that potential donors may incur during the kidney donation process. While Ontario has a program called Program for Reimbursing Expenses of Living Organ Donors (PRELOD) to reimburse living organ donors for eligible expenses, the reimbursement rate has not been changed since April 2008 when PRELOD was first introduced.

The purpose of PRELOD is to reduce the financial burden of living-organ donors by reimbursing actual out-of-pocket expenses and lost income associated with living-organ donation. Trillium Gift of Life Network (Trillium Network) administers PRELOD on behalf of the Ministry. PRELOD reimburses travel, parking, accommodation, meals and loss of income up to a maximum of $5,500. Over the last five fiscal years (2013/14–2017/18), a total of $930,000 was paid to over 920 applicants through PRELOD. However, we noted that despite completing a review of PRELOD in 2009 and 2012 that showed donors were still experiencing financial hardship, the reimbursement rate of $5,500 has remained unchanged.

Figure 19: Living-Donor and Deceased-Donor Kidney Transplants by Province in Canada, 2017

Source of data: Canadian Institute for Health Information



Note: This figure excludes data from Quebec because of under-reporting.

1. Data from Alberta includes Northwest Territories and Nunavut.
2. Data from the Atlantic Provinces (including New Brunswick, Newfoundland and Labrador, Nova Scotia and Prince Edward Island) was combined because of small numbers.
3. Data from British Columbia includes Yukon Territory.

Several recent studies noted financial costs incurred by donors as one of the barriers for a living-donor kidney transplant. For example, two studies in 2018 and 2019 (published by the National Institutes of Health in the United States) identified gaps between costs incurred by living-kidney donors and costs reimbursed through living-donor reimbursement programs. Another study of living-kidney donors and recipients in Ontario in 2017 (published in the *Canadian Journal of Kidney Health and Disease*) also identified financial costs incurred by donors as one of the barriers to living-kidney donations. It noted that nearly all kidney donors (96%) incur out-of-pocket costs as a result of donor evaluation and surgery (including expenses related to travel, accommodation, lost wages, medications and child care) and that the current system still has limitations and cannot yet support the total financial costs incurred by most donor candidates. It went on to identify other barriers, which we also noted as part of our audit, including:

- **Lack of consistent information and education:** Patients and their families find that it is difficult to obtain direct access to clear, timely and consistent information because multiple parties (including the Regional Renal Programs, Renal Network and Trillium Network) provide transplant-related education with an unco-ordinated approach.
- **Lack of integration between Regional Renal Programs and transplant centres:** There are communication gaps during patient transitions between the Regional Renal Programs and transplant centres, and during long-term follow-ups for donors. For example, after Regional Renal Programs perform an initial work-up and a patient is seen by a transplant centre, there are often gaps in information and communication.
- **Lack of public awareness:** There is uncertainty within various religious and cultural groups regarding the ability to donate and,

among the general public, there are gaps in knowledge and understanding about the need for and benefits of living-donor donation. These barriers can cause confusion, delay and even dismissal of the donation process altogether.

We also found that financial burden is not only a barrier to living-kidney donation, but also an obstacle for patients who are eligible for a kidney transplant. In particular, costs can be a financial barrier for any patient who must pay for travel and accommodation to be close to the transplant centre for their work-up, surgery and recovery period, which can also result in lost income for patients who are currently working. Patient-borne cost is especially pronounced for patients from rural and remote regions such as Northern Ontario (where there is no transplant centre) given the greater travel distances involved. One of the Regional Renal Programs in Northern Ontario (Health Sciences North) estimated that more than 50% of its patients that are eligible for a kidney transplant do not pursue it because of the travel and accommodation costs. Our review of patient files also identified a case where a patient in Thunder Bay was eligible for a kidney transplant in 2018, but did not have the financial resources to cover the travel and accommodation costs (as there is no transplant centre near Thunder Bay). This patient has continued to undergo dialysis since October 2017. Over 80% of Regional Renal Programs that responded to our survey indicated that additional financial support for patients and donors could increase the number of patients willing to pursue transplants, which are much more cost-effective than dialysis.

RECOMMENDATION 8

To improve patient access to living-donor transplants in Ontario, we recommend that the Trillium Gift of Life Network, in collaboration with the Ministry of Health and the Ontario Renal Network:

- conduct a review of the Program for Reimbursing Expenses of Living Organ Donors to determine if the reimbursement rate is reasonable and if any adjustment is needed; and
- study living-donor transplant policies and initiatives in other jurisdictions to identify best practices that would help increase the rate of living-donor transplants in Ontario.

TRILLIUM GIFT OF LIFE NETWORK RESPONSE

The Trillium Gift of Life Network supports this recommendation and commits to continue to work with its partners to improve patient access to living-donor transplants in Ontario with the appropriate Ministry support and directives.

The Trillium Gift of Life Network is currently undertaking a review to assess gaps and limitations of the Program for Reimbursing Expenses of Living Organ Donors. The details of the review along with recommendations to support changes to the policy will be shared with the Ministry.

The Trillium Gift of Life Network will continue to collaborate with the Ontario Renal Network to further advance the Access to Kidney Transplantation strategy. The Trillium Gift of Life Network will also work with the Ministry to determine a value-added role to support living donation in Ontario and review living-donor transplant practices in other jurisdictions to identify best practices to be implemented in Ontario.

MINISTRY RESPONSE

The Ministry is in agreement with the recommendation to review the Program for Reimbursing Expenses of Living Organ Donors. The Ministry is supportive of the Trillium Gift of Life Network's continued collaboration with the Ontario Renal Network to increase living kidney donations in Ontario. Additionally, the Ministry and the Trillium Gift of Life Network are participating in Health Canada's Organ Donation and

Transplantation Collaborative (ODTC), which has the goal to develop concrete and actionable options to improve organ donation and transplantation performance that meet Canadians' needs and improve patient outcomes. The Ministry is part of an ODTC working group dedicated to increasing living donation.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation. Consultations with Regional Renal Programs, patients and family members consistently highlight patient-borne costs as a barrier to kidney transplantation.

Many of the initiatives that have been introduced in Ontario as part of the Access to Kidney Transplant and Living Donation Strategy were based on studies completed in other jurisdictions. The Ontario Renal Network will continue to investigate and monitor how other jurisdictions have successfully implemented policy or program changes to improve the rate of living-donor kidney transplantation. The Access to Kidney Transplant and Living Donation Strategy has focused on improving access to living kidney donation through education, quality improvement, peer support and data. A suite of resources to support and promote living-donor kidney transplant will be available to all Regional Renal Programs by 2021, after which a comprehensive evaluation will be completed to inform future interventions.

4.4 Funding Needs to Be Reviewed to Match Actual Costs and Identify Potential Savings

Funding amounts for most chronic kidney disease services (including Multi-Care Kidney Clinics, dialysis and kidney transplants) may not reflect the actual costs of providing services to patients. As well, the pricing of peritoneal dialysis supplies has not been reviewed to identify potential savings.

4.4.1 Funding for Chronic Kidney Disease Services Does Not Align with Actual Cost of Providing Services to Patients

Beginning in 2012/13 and phased in over a three-year period, the Renal Network's funding for most chronic kidney disease services (including Multi-Care Kidney Clinics and dialysis treatments) was standardized across the province using the Quality-Based Procedure (QBP) method, which bases funding on the needs of the population, number of patients seen, types of services delivered and quality of care. Under the QBP method, the Renal Network bundles the cost of most services based on several factors (such as the types and volumes of patients treated at Regional Renal Programs) to arrive at a fixed amount of funding per service. However, we found that the current funding may not reflect the current actual cost of providing services as the QBP funding has not been changed since it was implemented.

In 2017, the Renal Network engaged an external consultant to study the QBP funding. The study noted that the initial volumes used to calculate the fixed amounts of funding per service was meant to be a starting point given the limited evidence available at the time. While the Renal Network planned to adjust the service volumes when additional evidence became available, it has not yet done so, but began reviewing the QBP in 2019.

Funding Allocated for Chronic Kidney Disease Services Exceeds Expenditures Reported by Hospitals

Our review of the Regional Renal Programs' budget submissions and their annual reporting to the Renal Network found that their budget submissions were based on the QBP funding model, but their report back to the Renal Network did not include the actual expenditures they incurred to provide services. Therefore, the Renal Network does not know if the allocated funding to Regional Renal Programs reflects the cost of providing renal services.

In order to gather the actual expenditures incurred by the Regional Renal Programs, we reviewed expenditure information over the last five years (2013/14–2017/18) at the five Regional Renal Programs we visited. These expenditures are neither reported to nor reviewed by the Renal Network. We found that funding received by the Regional Renal Programs from the Renal Network was higher than the expenditures incurred, resulting in a possible surplus of about $37 million. This indicates that the current funding allocation, which is primarily based on the QBP method, may not reflect the actual costs incurred by the Regional Renal Programs to provide services to patients.

Funding for Chronic Kidney Disease Services Does Not Align with Actual Amount of Services Provided

For each patient that meets the eligibility criteria for and is registered with a Multi-Care Kidney Clinic (Clinic) for a full fiscal year, a Regional Renal Program receives about $1,400. When this amount was determined using the QBP method, it was based on a patient making six visits on average per year to the Clinic. In 2018/19, the total funding for the Clinics was about $13 million.

In order for a Clinic to qualify for funding, each of its patients has to meet specific medical criteria; make at least two visits a year to the Clinic (one visit during the first half of the fiscal year and another visit during the rest of the fiscal year); and has to be seen by at least three health professionals at each visit (which may include a nephrologist, nurse, dietitian, pharmacist or social worker). Although not tracked, we noted that Clinics sometimes provide care between visits through phone calls.

Based on a data analysis of all patients who met the criteria above in 2018/19, we noted that patients on average made four visits per year, which does not align with the number of visits (six per year) that was used when setting the funding amount.

Apart from funding for the Clinics, we also noted that in 2016/17, Cancer Care Ontario (CCO) conducted an analysis of the funding for in-centre hemodialysis (the most common and costly form of dialysis) and found possible surpluses when comparing the number of dialysis sessions funded through the Renal Network's QBP method to the number of dialysis sessions reported by hospitals through other data sources. We requested CCO to re-perform this analysis using 2017/18 data and noted similar results. Specifically, the financial impact of presumed missed sessions was at least $7.4 million (which could be higher given differences in the data sources used for the analysis). CCO had to use various data sources to calculate the number of missed sessions and the financial impact because the Renal Network does not collect data on the number of dialysis sessions attended by patients.

RECOMMENDATION 9

To better reflect the volume and costs of services actually provided to patients in the funding amounts that are set based on the Quality-Based Procedure (QBP) method, we recommend that the Ontario Renal Network:

- conduct a review of the QBP funding per service to determine if the amount is reasonable and adjust if needed based on costing information from the Regional Renal Programs and best practices; and
- collect renal expenditures from Regional Renal Programs on an annual basis and use the information to inform changes in future funding allocation.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with the need to review the Chronic Kidney Disease Quality-Based Procedure (QBP) funding model and has begun work to refresh this model. Detailed costing information from Regional Renal Programs and current best practices will be used to review funding rates as well as the type and volume of services provided, and adjustments will be made where necessary. The

QBP refresh will be conducted so that future changes to costs or to best practices can be readily incorporated into the funding model.

The Ontario Renal Network also agrees with the recommendation to collect information on renal expenditures from Regional Renal Programs on an annual basis. The QBP funding model is complex and includes patient-care services provided within the dialysis unit as well as those provided by other hospital departments. The Ontario Renal Network will work with Regional Renal Programs to develop a reporting methodology to capture all appropriate expenses as accurately as possible.

4.4.2 Base Funding for Each Kidney Transplant Unchanged Since 1988

Each of the six adult kidney transplant centres in Ontario receives a fixed amount of funding from the Ministry for each kidney transplant performed. The current funding rate per kidney transplant is approximately $25,000 and this rate has not been updated since it was implemented in 1988. The only change made since then was in 2004 when a top-up amount of $5,800 was introduced to help offset additional costs when performing a living-donor transplant (such as the costs of testing and retrieving a kidney from a living donor).

In 2018, Trillium Gift of Life Network (Trillium Network) began assessing the cost information from the kidney transplant centres to determine if the funding amount is still reasonable. While this funding review was still under way at the end of our audit, our review of preliminary costing information from the six adult kidney transplant centres in Ontario noted that the cost of a kidney transplant varies from one transplant centre to another and the current funding rate for a kidney transplant does not reflect the actual costs incurred by the centres. For example:

- For each deceased-donor transplant, the actual costs reported by the transplant centres ranged from about $32,000 at one centre to $57,000 at another. On average, the cost was approximately $40,000, compared to the current funding rate of about $25,000.
- For each living-donor transplant, the actual costs reported by the transplant centres ranged from about $26,000 at one centre to $52,000 at another. On average, the cost was approximately $35,000, compared with the current funding rate of approximately $30,800 ($25,000 plus the $5,800 top-up).

The transplant centres we visited raised additional concerns. For example, the time and resources involved in managing patients waiting for transplants are significant given the ongoing testing and evaluation required (see **Section 4.3.1**). The current funding rate of $25,000 only covers the cost of the transplant procedure during the surgical phase. Therefore, if the patient dies while waiting for a transplant, the transplant centres do not receive any funding for providing pre-transplant care to the patient and maintaining the patient on the wait list. As well, some transplant centres indicated that the top-up of $5,800 for each living-donor transplant is not enough to cover the additional costs of evaluating donors, as multiple donors typically have to be evaluated for suitability in each kidney transplant case.

The Renal Network and the Regional Renal Programs we visited raised similar concerns. Regional Renal Programs are responsible for educating patients and their families on kidney transplants and, in some cases, are also involved in assisting transplant centres with pre-transplant testing and evaluation. However, there is currently no direct funding provided for this work.

RECOMMENDATION 10

To better reflect the actual costs incurred by the transplant centres for kidney transplants, we recommend that the Trillium Gift of Life Network, in collaboration with the Ministry of Health:

- continue to collect and review cost information from the transplant centres; and
- conduct a review of the current funding rates for both deceased-donor and living-donor transplants to confirm what adjustments are needed.

TRILLIUM GIFT OF LIFE NETWORK RESPONSE

The Trillium Gift of Life Network supports this recommendation and commits to review the costs of kidney transplant in Ontario and explore opportunities to continue and expand on this work with the appropriate Ministry support and directives. The Trillium Gift of Life Network will also review the living-donor transplant funding rate as part of the overall funding evaluation for transplantation.

The Trillium Gift of Life Network will continue to work with the Ministry, Ontario Renal Network and other provincial agencies and partners to finalize the costing and funding model, which includes pre-transplant, transplant and post-transplant related activities that are performed at transplant centres and Regional Renal Programs. Determining the costs across the patient continuum will help to identify the types of funding adjustments that are needed to develop innovative care models that will aim to enhance patient-centred care.

MINISTRY RESPONSE

The Ministry continues to support the efforts of the Trillium Gift of Life Network and the transplant program stakeholders in their work to evaluate the current transplant funding model. The current model includes incremental volume-based funding, which may be augmented by the hospital global budgets and activity-based funding.

4.4.3 Pricing of Peritoneal Dialysis Supplies Has Not Been Reviewed to Identify Potential Savings

While the Renal Network has a procurement initiative in place to reduce the costs of hemodialysis equipment and supplies, it has not reviewed the pricing of peritoneal dialysis supplies to identify potential savings.

Prior to 2016, each Regional Renal Program was responsible for its own procurement of hemodialysis equipment and supplies. The Renal Network's policy did specify the maximum funding rate for each item, but the actual costs varied across Regional Renal Programs, as some of them were able to secure better pricing than others. In December 2017, the Renal Network secured fixed-price agreements with major vendors of hemodialysis equipment and supplies, reducing the maximum funding rates outlined in the Renal Network's policy. For example, the maximum funding rate for one specific hemodialysis machine went down from $30,000 to $17,000, resulting in savings of up to $13,000 per machine. This was the first-ever provincial procurement for hemodialysis machines and supplies.

Overall, the Renal Network estimated that this procurement initiative would result in cost savings of approximately $30 million over the terms of the agreements based on the number of hemodialysis machines and supplies that will need to be purchased. In order to verify whether the Regional Renal Programs have benefited from this initiative, we reviewed a sample of invoices and found that this initiative has resulted in savings. For example, one Regional Renal Program's cost per hemodialysis machine went from just over $26,000 to about $17,000, resulting in savings of $9,000.

While cost savings have been achieved through fixed-price agreements for hemodialysis equipment and supplies, the Renal Network has not yet established similar agreements for peritoneal dialysis supplies, although at the time of our audit, it began work on an initiative that is expected to

result in additional cost savings. Our review of a sample of invoices for peritoneal dialysis supplies found a wide range of prices paid by Regional Renal Programs, indicating opportunities for cost savings. For example:

- The price for a peritoneal dialysis cycler drainage set ranged from $207.40 to $248.19 per unit, representing an almost 20% difference.
- The price for a peritoneal dialysis solution bag ranged from $56.74 to $68.10 per bag, representing about a 20% difference.
- The price for a peritoneal dialysis cycler ranged from $740.40 to $802.93 per unit, representing about an 8% difference.

The Renal Network informed us that it has conducted a preliminary analysis based on a limited sample of pricing data for peritoneal dialysis supplies. It was in the process of obtaining a larger sample of data from the Regional Renal Programs in order to confirm whether similar fixed-price agreements for peritoneal dialysis supplies would provide additional savings. Without setting standard provincial pricing through these agreements, there is a risk that vendors may increase their prices of peritoneal dialysis supplies for individual Regional Renal Programs.

RECOMMENDATION 11

To help identify and achieve potential savings from the procurement of peritoneal dialysis equipment and supplies, we recommend that the Ontario Renal Network:

- collect cost information on peritoneal dialysis equipment and supplies from the Regional Renal Programs; and
- analyze whether a provincial procurement initiative (similar to the fixed-price agreements for hemodialysis equipment and supplies) would provide additional savings.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation and appreciates the Auditor General's acknowledgment of the savings realized from the implementation of the Ontario Renal Network's provincial procurement strategy for hemodialysis-related equipment, supplies and services.

As the next phase of work in this domain, the Ontario Renal Network has identified the supplies and service offerings related to peritoneal dialysis as an opportunity to achieve additional savings and improve services for patients, and has begun planning for a provincial procurement. As one of the early steps of this initiative, the Ontario Renal Network is developing an approach to obtaining detailed information on the costs of peritoneal dialysis equipment and supplies from Regional Renal Programs. This information will be used to analyze variances in current pricing and to estimate the potential savings from a provincial procurement. Any savings realized may allow for reinvestment in the renal system for the benefit of patients.

4.5 Lack of Co-ordination Creates Challenges for Planning and Managing Renal Care

While the Renal Network is responsible for managing the delivery of chronic kidney disease care in Ontario, it has no oversight on dialysis services provided by the Independent Health Facilities (which are overseen by the Ministry) and kidney transplants (which fall under the responsibility of the Ministry and Trillium Gift of Life Network). Lack of co-ordination and integration between the Ministry, Renal Network and Trillium Network results in a fragmented renal care system in Ontario.

4.5.1 Ontario Renal Network Does Not Have Complete Oversight of and Information on Dialysis across the Province

In addition to the 27 Regional Renal Programs funded and overseen by the Renal Network, the Ministry also funds and oversees seven Independent Health Facilities (Facilities) that provide dialysis to patients. In 2018/19, the Facilities provided dialysis to approximately 250 patients. However, we noted that variability in oversight, funding and reporting of dialysis services by the Regional Renal Programs and the Facilities has created challenges for the Renal Network to adequately plan and measure renal care across the province. Since the Facilities are under the oversight of the Ministry, the Renal Network neither collects complete information from these Facilities nor measures the performance of them in the delivery of dialysis.

The Renal Network indicates that its "Ontario Renal Reporting System (ORRS) identifies all people receiving care for chronic kidney disease in Ontario. All kidney care service providers in Ontario submit data to [it] through this reporting system. The data they provide supports [its] reporting, planning and system management activities." However, we noted that the Facilities are not required to submit data in ORRS, although they do submit optional data on the services they provide.

We identified the following gaps in information-sharing and co-ordination between the Ministry and Renal Network with respect to the dialysis services provided by the Facilities:

- While the Facilities are required to report certain information directly to the Ministry, they are not required to report data to the Renal Network similar to what is being reported by Regional Renal Programs that provide dialysis.
- The Ministry does not proactively and regularly share information related to the Facilities with the Renal Network.
- The information collected by the Ministry is very limited, at a high level, and does not contain the patient-level details that the Renal Network collects from the Regional Renal Programs.
- While both Facilities and Regional Renal Programs provide dialysis to patients, the performance measures used by the Ministry to evaluate the performance of the Facilities are different from the measures used by the Renal Network to evaluate the Regional Renal Programs. For example, the Renal Network cannot assess the results of patient-reported experience measures at the Facilities as it does for Regional Renal Programs because the Ministry does not collect this information.

Since the Facilities are not subject to the same reporting requirements and performance measures as the Regional Renal Programs, the Renal Network cannot assess whether the dialysis services provided by the Facilities are effective, efficient and consistent with the Regional Renal Programs and whether the operations of the Facilities align with the goals outlined in the Renal Network's strategic plans.

RECOMMENDATION 12

To provide patients with equal access to quality dialysis services across the province, we recommend that the Ontario Renal Network (Renal Network) work with the Ministry of Health (Ministry) to:

- conduct a review of the oversight and funding of dialysis services provided at the Independent Health Facilities (Facilities) to identify opportunities to improve the co-ordination between the Facilities and the Regional Renal Programs and evaluate the benefits of transferring the Ministry's responsibility for the Facilities to the Renal Network; and
- begin collecting information from the Facilities that is consistent with the information collected from Regional Renal Programs so that the data on all dialysis patients is complete for planning and performance measurement purposes.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation and the importance of providing patients with equal access to quality dialysis services across the province.

The Ontario Renal Network will work with the Ministry of Health to identify opportunities for improved co-ordination between the Regional Renal Programs and Independent Health Facilities that provide dialysis services. This will include an investigation of the benefits and legislative considerations of transferring the responsibility for funding, quality improvement, as well as performance measurement and management, of these Independent Health Facilities from the Ministry of Health to the Ontario Renal Network.

Currently, Independent Health Facilities that provide dialysis services are not required to report data to the Ontario Renal Network; however, most do submit certain data elements to the Ontario Renal Reporting System on a voluntary basis. The Ontario Renal Network will work with the Ministry of Health to evaluate options for collecting data from these Independent Health Facilities that is further aligned with the information collected from Regional Renal Programs, where this is appropriate and applicable, based on the services provided to patients.

MINISTRY RESPONSE

The Ministry supports this recommendation and will work with the Ontario Renal Network to explore opportunities to improve co-ordination between the Independent Health Facilities and the Regional Renal Programs and explore the benefits of transferring the Ministry's responsibility for the Independent Health Facilities to the Ontario Renal Network/Cancer Care Ontario.

As part of new agreements recently executed, the Independent Health Facilities are required to collect data on key performance indicators. The Ontario Renal Network was consulted in the development of these indicators and further alignment will be considered through the initiatives noted above.

4.5.2 Ontario Renal Network Does Not Obtain Accurate and Complete Transplant Data and Has Limited Co-ordination with Trillium Network

Apart from the dialysis services provided by the Facilities (see **Section 4.5.1**), the Renal Network also does not have oversight of kidney transplants, which fall under the responsibility of the Ministry and Trillium Gift of Life Network (Trillium Network). A kidney transplant is the best treatment option for people with advanced chronic kidney disease (see **Section 4.3**).

Effective September 6, 2017, Trillium Network and the Renal Network established a data-sharing agreement to exchange renal and transplant data between their systems. This link was meant to provide both parties with a view of each patient's complete transplant journey from the time the patient begins receiving renal care within a Regional Renal Program to the time the patient receives a kidney transplant at one of Ontario's six adult kidney transplant centres.

However, inaccurate and incomplete data transfers from Trillium Network to the Renal Network, as well as limited co-ordination between the Renal Network and Trillium Network on tracking the performance of kidney transplant activities and patient outcomes, have made it difficult for either party to measure and report on the effectiveness of kidney transplants and activities.

Inaccurate and Incomplete Transplant Data Have Caused Difficulty and Challenge in Measuring and Reporting Transplant Activities

Trillium collects data from transplant centres and then shares this data with the Renal Network. However, some files have had data-quality issues that

had not been fully resolved at the time of our audit. Specifically:

- Two data files that contained data on transplant recipient referrals and consultations as well as potential living-donor candidates were not accurately and consistently reported by transplant centres and/or not adequately validated by transplant centres and the Trillium Network before sharing with the Renal Network. Therefore, the Renal Network has faced challenges in generating any performance measurement indicators based on these data sets.
- Inability to link data from Trillium Network's system to the Renal Network's system has made it difficult for the Renal Network to determine whether a patient has been referred for a kidney transplant and whether a potential living donor has come forward.
- The Renal Network also indicated that the data-quality issues have made it challenging to determine whether the Regional Renal Programs refer eligible patients to a transplant centre on a timely basis.

We noted that the Renal Network presented proposals to Trillium Network in May 2019 on how to improve data quality. These proposals included several short- and medium-term solutions for Trillium Network and the Renal Network to work together to resolve data issues, but no formal process has been identified and confirmed by both the Renal Network and Trillium Network at the end of our audit fieldwork. Trillium Network informed us that it is working with a vendor to create a new system that will allow data to be collected and shared more quickly and accurately.

Effectiveness of Kidney Transplants Is Unknown Because of Limited Co-ordination between the Renal Network and Trillium Network

Although patients on dialysis may eventually receive a kidney transplant and patients with failed kidney transplants would need to go back on dialysis, there is limited co-ordination between the Renal Network and Trillium Network in terms of tracking the performance of kidney transplant activities and patient outcomes.

While the Renal Network can identify when patients are referred to or receive a kidney transplant, it has no information on whether the transplant is successful. Patients who have a kidney transplant will only show up in the Renal Network's system if their transplants begin failing and the patients end up in a Multi-Care Kidney Clinic or start dialysis again.

Staff from the transplant centres we visited indicated that there is a gap in clearly defining the responsibility for post-transplant care, which could be done either by the transplant centres or Regional Renal Programs, or a combination of both. Our review of data collected by the Renal Network and Trillium Network noted that while Trillium Network tracks post-transplant care activity such as follow-up visits and lab test results, this data is not shared with the Renal Network for the purpose of monitoring patients who may need additional renal care if their transplant fails. Without sharing this data and the related patient outcomes, neither the Renal Network nor Trillium Network can fully report on the effectiveness of kidney transplants.

RECOMMENDATION 13

To collect accurate and complete transplant data for performance measurement and reporting purposes, we recommend that the Trillium Gift of Life Network, in collaboration with the Ontario Renal Network:

- continue to work with kidney transplant centres and Regional Renal Programs to identify and address the data issues, understand the underlying data flow, and explore potential options to support the data-validation process; and
- continue to develop and improve performance measures related to post-transplant activities (such as transplant failure rate and frequency of follow-up visits).

TRILLIUM GIFT OF LIFE NETWORK RESPONSE

The Trillium Gift of Life Network supports this recommendation and commits to continue to work with the Ontario Renal Network, Regional Renal Programs and kidney transplant centres to enhance data quality for performance measurement and reporting purposes.

The Trillium Gift of Life Network will continue to work with the Ontario Renal Network, Regional Renal Programs and Kidney Transplant Centres to improve and enhance data quality and to leverage the new IT system to reduce data entry redundancy, support data validation and accuracy and to share and exchange relevant patient data.

The Trillium Gift of Life Network is currently working with transplant programs to further define, enhance and develop transplant performance indicators. The Trillium Gift of Life Network will leverage this work and collaborate with the Ontario Renal Network and Regional Renal Programs to further develop and improve post-transplant kidney performance measures, and to support system monitoring, reporting and quality improvement.

ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation and will continue to work with Trillium Gift of Life Network to improve data quality for kidney transplantation.

Consultations are under way with Regional Renal Programs and Transplant Centres to investigate the barriers to submitting timely and accurate transplant data. These consultations will be used to inform the implementation of short- and long-term solutions to improve data quality, which will improve the Ontario Renal Network's ability to monitor and evaluate the impact of interventions to improve access to kidney transplantation.

The Ontario Renal Network, in partnership with Trillium Gift of Life Network, will consult with Transplant Centres, Regional Renal Programs, patients and living donors to gather a more complete understanding of where post-transplant care can most appropriately be provided, taking into consideration clinical best practice, funding, patient preferences and Regional Renal Program and Transplant Centre capacity. The Ontario Renal Network will explore models of care for post-transplant patients and, with stakeholder consensus, define and implement performance indicators to monitor and evaluate post-transplant care activities. The Ontario Renal Network will work with partners to develop and report key process and outcome measures to monitor the effectiveness of the full kidney care system, including transplant, which is the optimal treatment option for chronic kidney disease patients.

4.6 Information on the Performance of Chronic Kidney Disease Services Is Incomplete and Not Fully Reported to the Public

The Renal Network does not have complete data on renal care from the Regional Renal Programs, because the Regional Renal Programs have faced a significant burden related to data collection and reporting. The Renal Network also does not publicly report the results of most of the performance indicators for measuring chronic kidney disease services.

4.6.1 Regional Renal Programs Do Not Report Optional but Useful Information to Ontario Renal Network

Although the Renal Network's Ontario Renal Reporting System (ORRS) allows the Regional Renal Programs to submit additional information on patients (such as primary nephrologist's name and home dialysis eligibility), the submission of this

information is voluntary. Even though this information is helpful for the Renal Network to plan and oversee chronic kidney disease services, we found that many Regional Renal Programs do not typically report such optional information. For example, of the almost 8,600 patients that spent time in the Multi-Care Kidney Clinics and began dialysis between 2015/16 and 2018/19, more than 2,850 (33%) were missing data in ORRS that indicated their eligibility for home dialysis.

The Renal Network determines what information must be reported by Regional Renal Programs in ORRS and what information can be optionally reported, and it has acknowledged that the completeness of the optional data varies. Its preliminary review identified significant missing data in certain areas (such as a patient's eligibility for home dialysis or education on treatment options available), but more complete data in other areas (such as the presence of more than one health condition in a patient).

Through our discussion with Regional Renal Programs, some of them agreed that such optional information would be helpful to the Renal Network for its planning and oversight responsibilities. However, all Regional Renal Programs we visited raised concerns about the increasing data burden and lack of resources provided by the Renal Network to collect and report data. Our survey also found that 95% of Regional Renal Programs noted that their data required a significant amount of customization to report into ORRS.

4.6.2 Public Reporting on the Performance of Chronic Kidney Disease Services Is Limited

The Renal Network developed performance measures for each of its past strategic plans—Ontario Renal Plan 1 (2012–15) and Ontario Renal Plan 2 (2015–19)—to assess and benchmark the performance of Regional Renal Programs, identify opportunities for growth and improvement, and ensure that dialysis services are provided effectively, efficiently and consistently across Ontario. However, the Renal Network provides very limited public reporting on the results of these performance measures.

Our review of all performance measures (39 in total) established by the Renal Network over the last two strategic plans covering 2012 to 2019 found that the Renal Network only publicly released the results of eight of these measures, including the proportion of dialysis patients receiving home dialysis (see **Appendix 6**). However, we noted that the results of other important measures that specifically involve educating patients and assisting patients in decision-making were not made public. For example, results for the following measures were not publicly released:

- the proportion of patients/families who are informed about treatment options including dialysis modality (in-centre or at home), transplant and conservative care;
- the proportion of patients within the Multi-Care Kidney Clinics referred for a kidney transplant within a year of meeting eligible laboratory referral criteria; and
- the proportion of patients who had the opportunity to participate in the development of their plan of care.

RECOMMENDATION 14

To better oversee and report on chronic kidney disease services across Ontario, we recommend that the Ontario Renal Network:

- conduct a comprehensive review of all data fields and determine what data must be reported by the Regional Renal Programs to effectively plan and measure the delivery of renal care; and
- publish the results of all performance measures related to the goals outlined in its strategic plans regularly (such as quarterly or annually).

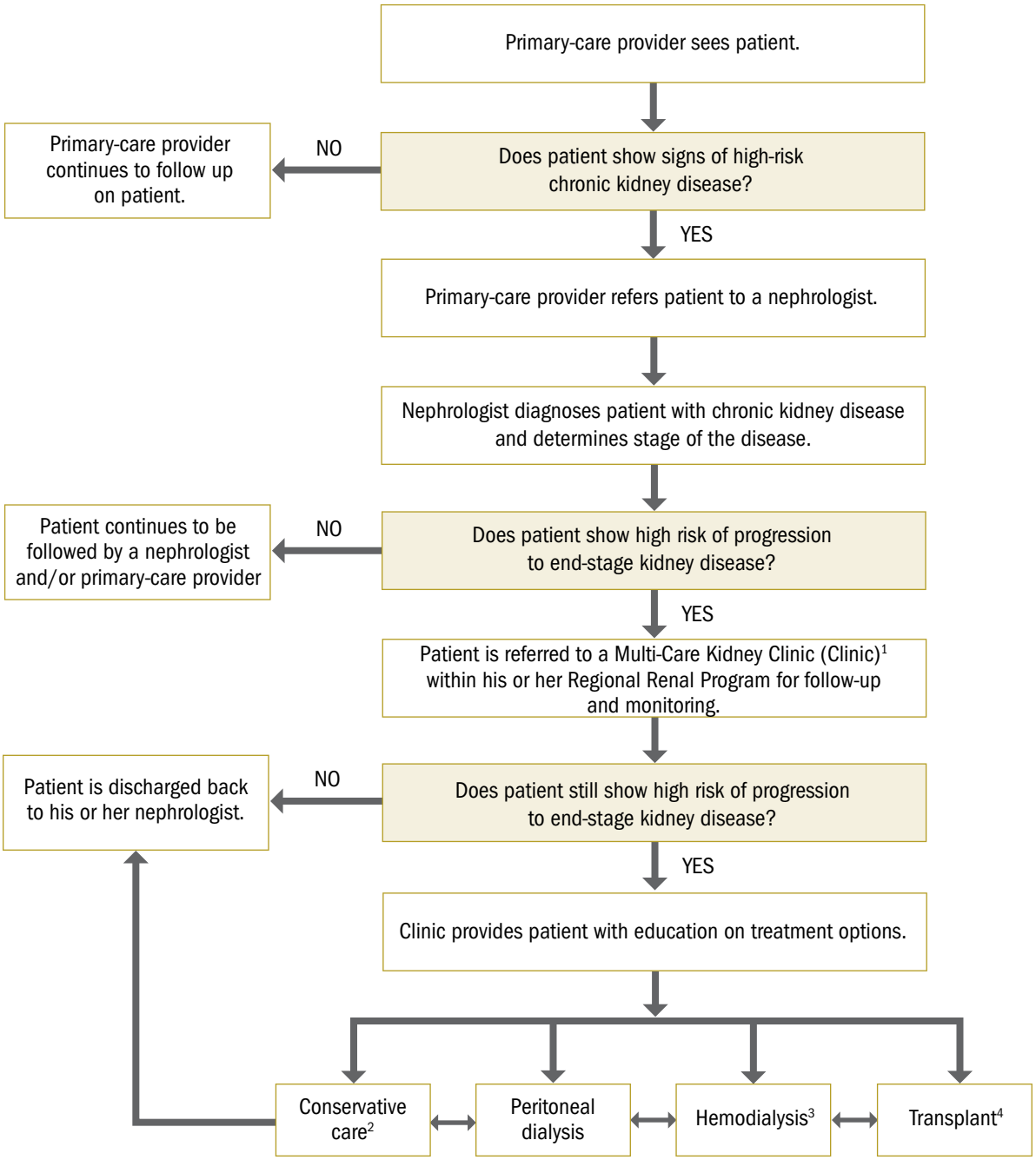
ONTARIO RENAL NETWORK RESPONSE

The Ontario Renal Network agrees with this recommendation. The Ontario Renal Network recognizes that all data collected from the Regional Renal Programs should have a clear purpose and use, and has completed work to map all data elements in the Ontario Renal Reporting System to their current uses for reporting and disclosure. Building upon this work, the Ontario Renal Network will work with the Regional Renal Programs to conduct a review of all data elements to determine where items should be removed or modified to optimize data collection for the planning, funding and improvement of renal care, and to reduce the overall burden of reporting for the Regional Renal Programs.

The Ontario Renal Network will review its suite of performance measures and develop a plan to expand its public reporting. This will include a comprehensive set of measures that reflect the priorities outlined in the Ontario Renal Plan as well as the impact of the Ontario Renal Network's initiatives on the provincial renal system in order to deliver meaningful improvements in care for people affected by chronic kidney disease.

Appendix 1: Journey of a Patient with Chronic Kidney Disease

Prepared by the Office of the Auditor General of Ontario



1. At a Multi-Care Kidney Clinic, a team of multidisciplinary health professionals provide care to help patients manage their chronic kidney disease.
2. Similarly to palliative care, conservative care aims to reduce the pain and suffering a patient experiences in the time before they die.
3. Hemodialysis is provided either in a medical facility or at home.
4. See **Appendix 5** for the journey of a patient undergoing a kidney transplant.

Appendix 2: Roles and Responsibilities of Key Parties Involved in the Delivery of Chronic Kidney Disease Care in Ontario

Prepared by the Office of the Auditor General of Ontario

Key Party	Role/Responsibility
Ministry of Health (Ministry)	Responsible for overseeing all services relating to chronic kidney disease in Ontario. This includes providing strategic direction and funding to the Ontario Renal Network and Trillium Gift of Life Network, as well as determining funding approaches. The Ministry, through the Local Health Integration Networks (LHINs), also funds transplant centres that perform kidney transplants and directly funds seven independent health facilities that provide dialysis services.
Ontario Renal Network (Renal Network)	Responsible for advising the provincial government on chronic kidney disease management. The Renal Network was created in 2009 as a division of Cancer Care Ontario (CCO). The Renal Network also leads the organization of chronic kidney disease services (excluding transplants, which fall under the responsibility of the Ministry and the Trillium Gift of Life Network). This includes determining how much funding to provide to each of the 27 Regional Renal Programs in the province.
27 Regional Renal Programs	Responsible for delivering services (including dialysis, nephrology clinics and a multi-care kidney clinic) in their regions, either directly or in collaboration with satellite sites (which may include other hospitals and health organizations). Each Regional Renal Program is run by a hospital or hospital network. **Appendix 3** lists the 27 Regional Renal Programs, which are funded by, and report directly to, the Renal Network. Each of the 14 LHINs has at least one Regional Renal Program.
6 Transplant Centres	Responsible for performing adult kidney transplants. Each transplant centre is located in a hospital with a Regional Renal Program. Six of the 27 hospitals with a Regional Renal Program are also transplant centres, and patients are referred to one of these centres when they opt for a transplant.
Trillium Gift of Life Network (Trillium Network)	Responsible for policy on, and co-ordination of, the donation of organs and tissue (including kidneys), as well as some transplantation activities (such as wait-list management). Trillium Network is a government agency that began operations in 2002. Trillium Network's role includes promoting consent for organ and tissue donation, and co-ordinating kidney donations with Ontario's six transplant centres. Trillium Network also works with Canadian Blood Services to co-ordinate national organ donations. This includes sharing organs with other Canadian jurisdictions.
7 Independent Health Facilities (Facilities)	Responsible under the Independent Health Facilities Act for providing dialysis and other health services. Each Facility is independently owned and run, mainly by physicians. Ontario's seven Facilities are funded by, and report directly to, the Ministry.

Appendix 3: The Regional Renal Programs in Ontario

Prepared by the Office of the Auditor General of Ontario

	Provider	LHIN	Associated Transplant Centre?	Funding 2018/19 ($ million)[1]	Average # of Dialysis Patients 2018/19
1.	Grand River Hospital	Waterloo Wellington		28.1	540
2.	Halton Healthcare Services	Mississauga Halton		16.6	322
3.	Health Sciences North	North East		15.5	290
4.	Humber River Hospital	Central		31.1	580
5.	Kingston Health Sciences Centre[2]	South East	✓	25.7	527
6.	Lakeridge Health	Central East		20.9	428
7.	London Health Sciences Centre—University Hospital[2]	South West	✓	43.8	805
8.	Mackenzie Health	Central		30.0	542
9.	Niagara Health System	Hamilton Niagara Haldimand Brant		25.0	478
10.	North Bay Regional Health Centre	North East		3.3	65
11.	Orillia Soldiers' Memorial Hospital	North Simcoe Muskoka		13.1	255
12.	Peterborough Regional Health Centre	Central East		15.3	310
13.	Renfrew Victoria Hospital[3]	Champlain		–	89
14.	Royal Victoria Regional Health Centre	North Simcoe Muskoka		9.0	178
15.	Sault Area Hospital	North East		5.9	116
16.	Scarborough Health Network—Scarborough and Rouge Hospital[2]	Central East		47.2	934
17.	St. Joseph's Health Centre Toronto	Toronto Central		13.2	252
18.	St. Joseph's Healthcare Hamilton	Hamilton Niagara Haldimand Brant	✓	36.1	603
19.	St. Michael's Hospital	Toronto Central	✓	27.4	500
20.	Sunnybrook Health Sciences Centre	Toronto Central		20.0	357
21.	The Ottawa Hospital	Champlain	✓	42.4	882
22.	Thunder Bay Regional Health Sciences Centre[2]	North West		18.2	353
23.	Timmins and District Hospital	North East		1.9	36
24.	Trillium Health Partners	Mississauga Halton		35.7	704
25.	University Health Network—Toronto General Hospital[2]	Toronto Central	✓	39.6	625
26.	William Osler Health System	Central West		34.1	663
27.	Windsor Regional Hospital	Erie St. Clair		18.0	351
Total				**617.1**	**11,785**

1. Funding is based on Quality-Based Procedures (QBP) method and covers the majority of direct services, including dialysis and Multi-Care Kidney Clinics.
2. One of the five Regional Renal Programs we visited as part of our audit.
3. Renfrew Victoria Hospital, due to its small size, does not receive QBP funding; instead, its chronic kidney disease services are funded through its global hospital funding.

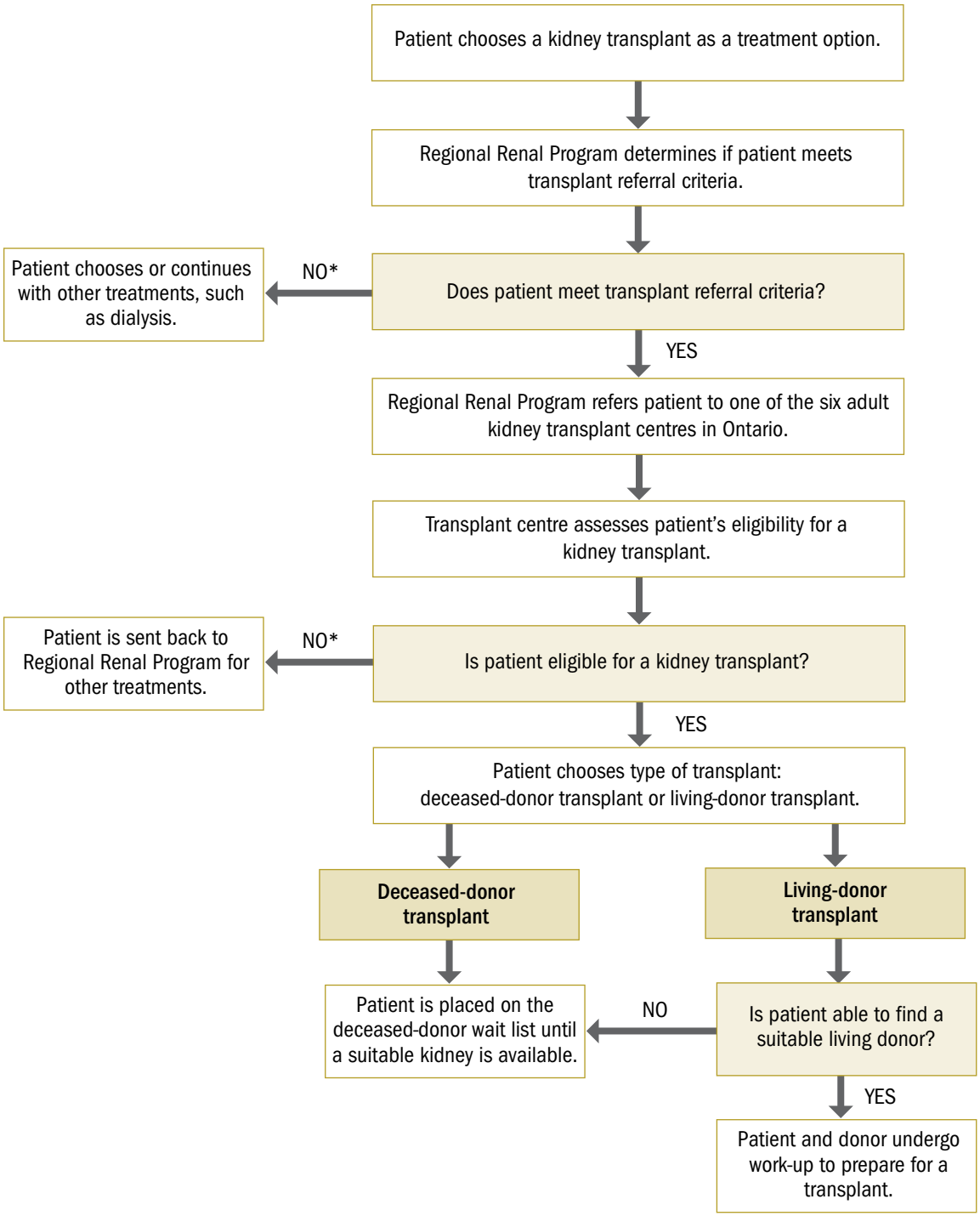
Appendix 4: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Effective procedures and co-ordination among service providers are in place to ensure patients have timely and equitable access to safe and evidence-based chronic kidney disease services that meet their needs regardless of where they live.
2.	Effective procedures and controls are in place to ensure patients are assessed on a timely and consistent basis in accordance with eligibility and prioritization criteria.
3.	Roles and responsibilities of all parties involved in the delivery of chronic kidney disease services are clearly defined, and accountability requirements are established, to ensure effective service delivery, co-ordination and oversight.
4.	Funding and resources are allocated in a timely and equitable manner to service providers based on patient needs, used for the purposes intended, and administered with due regard for economy and efficiency.
5.	Sufficient, accurate and timely financial and operational data across all chronic kidney disease services is regularly collected and assessed to help guide management decision-making.
6.	Appropriate performance measures and targets are established and continuously monitored against actual results to ensure that intended outcomes are achieved, and corrective actions are taken on a timely basis when issues are identified.

Appendix 5: Journey of a Patient Choosing a Kidney Transplant

Prepared by the Office of the Auditor General of Ontario



* A patient may be reassessed in the future and become eligible for a transplant referral and/or a kidney transplant.

Appendix 6: List of Performance Measures Not Publicly Reported

Prepared by the Office of the Auditor General of Ontario

	Performance Measure	Publicly Reported?
Ontario Renal Plan 1 (2012–2015)		
1.	Proportion of complex predialysis patients having a comprehensive care plan (education)	
2.	Proportion of complex predialysis patients having a comprehensive care plan (patient decision)	
3.	Proportion of Stage 5 chronic kidney disease patients that received education on home dialysis	
4.	Proportion of Stage 5 chronic kidney disease patients that received education on access type	
5.	Proportion of patients receiving care in their modality and location of choice (initiation)	
6.	Proportion of patients receiving care in their modality and location of choice (3 months following initiation)	
7.	Proportion of patients receiving care in their modality and location of choice (6 months following initiation)	
8.	Minimum educational resources/materials made available to patients and families	
9.	Proportion of chronic kidney disease programs that have a patient engagement plan in place	
10.	Percent decrease in patients that initiated dialysis as a sub-optimal start	
11.	Percent decrease in patients that initiated dialysis as crash start	
12.	Proportion of predialysis patients receiving multidisciplinary care	
13.	Proportion of chronic kidney disease programs that have a mentorship program with primary care providers	
14.	Proportion of predialysis patients assessed for access type prior to starting dialysis	
15.	Percent decrease in prevalent patients with catheter	✓
16.	Establish a target for improvement in access wait times	
17.	Proportion of patients that started on independent dialysis within 6 months of initiation	✓
18.	Proportion of dialysis patients assessed for independent dialysis prior to starting dialysis	
19.	Proportion of facility-based dialysis patients who travel less than 30 minutes	✓
20.	Proportion of facility-based dialysis patients who travel more than 60 minutes	✓
21.	Capacity planning analysis	
22.	Expand Dialysis Outcomes and Practice Patterns Study (DOPPS)[1] to include a sample of patients and facilities from at least 50% of chronic kidney disease programs	
23.	Implement a report from two field evaluations on emerging drugs and technology	
24.	Establish a patient-based funding framework in Ontario with associated accountability	
25.	Extend patient-based funding beyond the hospital sector, including Community Care Access Centres (CCACs)[2] and long-term care	
Ontario Renal Plan 2 (2015–2019)		
26.	Proportion of programs that have structures or standardized tools in place (e.g., patient passport and/or patient portal) to regularly document a plan of care (including modality choice, access choice, goals of care)	
27.	Proportion of patients/families who are informed about treatment options including dialysis modality, conservative care, access and transplant	
28.	Proportion of patients who had the opportunity to participate in the development of their plan of care	
29.	Proportion of incident chronic dialysis patients with at least 12 months of Multi-Care Kidney Clinics follow-up prior to dialysis start	
30.	Proportion of chronic kidney disease patients who had a nephrology visit and met at least one KidneyWise Clinical Toolkit referral criterion	

	Performance Measure	Publicly Reported?
31.	Proportion of dialysis patients referred for a kidney transplant within the first year of starting chronic dialysis	
32.	Proportion of patients within the Multi-Care Kidney Clinics referred for kidney transplant within one year of an eligible laboratory value for referral	
33.	Proportion of incident chronic dialysis patients with whom a Goals of Care Conversation has been documented	
34.	Proportion of patients receiving access creation surgery within recommended time frame – Priority 2 Cases	✓
35.	Proportion of patients receiving access creation surgery within recommended time frame – Priority 3 Cases	✓
36.	Proportion of patients receiving access creation surgery within recommended time frame – Priority 4 Cases	
37.	Proportion of prevalent chronic dialysis patients on a home dialysis modality	✓
38.	Proportion of incident chronic dialysis patients with deferred elective dialysis start	✓
39.	Proportion of Multi-Care Kidney Care–eligible patients referred from general nephrology to Multi-Care Kidney Clinics	

1. The Dialysis Outcomes and Practice Patterns Study (DOPPS) is a prospective, observational study of hemodialysis practices based on the collection of data for a random sample of patients from dialysis facilities in a representative and random sample of units in 20 countries.
2. The term Community Care Access Centre (CCAC) is no longer in use. In May 2017, the Ontario government transferred the responsibility for home-care services from CCAC to the Local Health Integration Networks.

Ministry of Transportation

Commercial Vehicle Safety and Enforcement

1.0 Summary

The Ministry of Transportation (Ministry) has estimated that Ontario's truck traffic increased 10% from 2009 to 2018. Truck traffic is daily truck volumes on Ontario roads, including trucks not registered in Ontario. This rise in commercial vehicle traffic means Ontarians are increasingly sharing the road with large vehicles. Collisions involving commercial vehicles have a higher risk of injury and death due to the size of the vehicles involved.

According to the Ministry, the direct social cost of large truck collisions in Ontario for the five-year period from 2011 to 2015 (the most recent data available) was $2 billion. This includes costs related to property damage, health care, police, courts, fire and ambulance services, tow trucks and traffic delays.

In the ten years from 2008 to 2017, commercial vehicles (large trucks and buses) were involved in over 182,000 collisions in Ontario. The collisions resulted in almost 44,000 injuries and 1,180 fatalities. Commercial vehicles were at-fault in 46% of these collisions, including 33% of collisions that resulted in a fatality, whether due to the driver's actions or the vehicle's condition.

We found that Ontario consistently ranks among the safest provinces in Canada and compares favourably to the United States for overall road safety when measured based on fatalities and injuries per registered motor vehicle and vehicle kilometres travelled. However, Ontario maintained higher fatality and injury rates than Canada as a whole and the United States in the majority of years between 2008 and 2017 when evaluating only commercial vehicles. Commercial vehicles include trucks and trailers with a gross weight over 4,500 kilograms, tow trucks—regardless of weight—and buses with a seating capacity of 10 or more passengers.

From 2014/15 to 2018/19, the Ministry spent over $200 million on commercial vehicle enforcement, including $39.4 million in the 2018/19 fiscal year. In 2018, about 60,000 carriers were registered to operate in the province and over 290,000 registered commercial vehicles.

Our audit found that there are many opportunities for the Ministry to improve overall safety through its commercial vehicle safety and enforcement program. One of the most important activities the Ministry performs to ensure safety on Ontario roads is its roadside inspections of commercial vehicles. However, we found that between 2014 and 2018, the number of inspections the Ministry conducted decreased by 22%, from over 113,000 in 2014 to fewer than 89,000 in 2018, because the Ministry was unable to fill enforcement officer vacancies, and because the majority of enforcement officers did not meet their individual annual productivity targets for the number of inspections

to complete. As a result, the Ministry missed the opportunity to remove thousands of additional unsafe commercial vehicles and drivers from Ontario's roads. To conduct roadside inspections, the Ministry employs about 230 enforcement officers in 18 Ministry districts across the province. In addition to the Ministry's enforcement officers, about 50 police officers at 15 municipal police forces, and 81 Ontario Provincial Police (OPP) officers, conducted roadside inspections in 2018.

We also found that driver training is not mandatory for some of the highest risk commercial driver's licence classes, and that Ontario allows commercial vehicle driver licensing practices that are uncommon in other jurisdictions, such as allowing commercial vehicle carriers (businesses that operate commercial vehicles) with a poor collision history to test their own drivers for commercial vehicle driver's licences.

In addition, the Ministry does not effectively monitor and consistently take action to address high-risk Motor Vehicle Inspection Station (MVIS) garages, which issue safety certificates for commercial vehicles.

The following are some of our specific concerns about the Ministry's commercial vehicle safety and enforcement program:

- **More unsafe commercial vehicles and drivers could have been removed from the roads with more inspections.** We noted that between 2014 and 2018, the Ministry removed 22% of all the commercial vehicles it inspected from the road for driver violations and mechanical defects. If the Ministry had continued to conduct as many inspections between 2015 and 2018 as it did in 2014, it could have removed as many as 10,000 additional unsafe commercial vehicles or drivers from Ontario's roads.
- **Roadside inspection enforcement is not consistent across the province, impacting the effectiveness of roadside inspections in preventing collisions.** Although the Ministry introduced a framework in 2015 to increase the consistency of the decisions its officers make, we found significant differences across the province in the rate at which officers lay charges and remove unsafe vehicles from the road. For example, in 2018, one district laid charges in over 30% of roadside inspections, while another laid charges in fewer than 8% despite finding violations in over 40% of inspections. The Ministry has not performed an analysis of why different regions seem to lay fewer charges given similar opportunities. Ministry research indicates that laying charges during a roadside inspection prevents collisions, preventing a minimum of 25%, and possibly up to half the collisions that inspected carriers may otherwise be involved in.
- **The majority of carriers have not had a vehicle inspected in the past two years, including carriers with a poor collision history.** Our audit found that the Ministry had not inspected any of the commercial vehicles of 56% of Ontario's 60,000 carriers in the last two years. This included many carriers at the highest risk of future collision. We analyzed the carriers with the highest collision violation rates and found that nearly 20% (of 870 highest risk carriers) had not had any of their commercial vehicles inspected in the two years preceding May 2019.
- **Most roadside inspections are performed on provincial highways, allowing "local haulers" to avoid inspection.** Although the Ministry collects data on commercial vehicle traffic on provincial highways, it has limited data on commercial vehicles operating on municipal (including urban) roads. Using collision data as a proxy for traffic, we found that from 2014 to 2018 approximately 68% of collisions involving trucks belonging to Ontario-registered carriers occurred on municipal roads. However, over 90% of roadside inspections are conducted by Ministry enforcement officers, usually at truck inspection stations

on provincial highways. This indicates that "local haulers," who operate primarily on municipal and urban roads, are unlikely to be subject to roadside inspection, and drivers and carriers could purposely avoid roadside inspection by driving on municipal roads.

- **Despite a high risk of collisions, the Ministry does not sanction municipalities.** We analyzed the 50 largest Ontario municipalities that operate commercial vehicles and found that on average, the collision violation rate for these municipalities was almost 250% higher than the average collision violation rate for all carriers travelling a similar amount of kilometres. The rate measures collisions where the driver or a vehicle defect was listed at-fault in the collision. Of the 50 municipalities reviewed, 28% had exceeded 100% of their collision points' threshold at the time of our audit. Though the Ministry issues warning letters, carries out facility audits and conducts interviews in response to high violation rates, we found that the Ministry does not impose sanctions on municipalities—such as suspending or cancelling the registration of municipalities, regardless of how poor their safety record is. Municipalities, therefore, can operate under poor safety ratings with few consequences and little incentive to improve.
- **The Ministry does not assess the reasonableness of kilometres travelled reported by carriers that are used to calculate safety ratings.** Both our own analysis and a 2013 analysis conducted by a consultant hired by the Ministry identified that many carriers reported kilometres travelled per truck that were in excess of what is reasonable. Although carrier kilometres travelled is a key variable for calculating the Ministry's carrier safety rating, we found that the Ministry does not have a process to ensure that carrier kilometres travelled reported to the Ministry are reasonable and accurate. As a result, the Ministry cannot ensure the accuracy of carrier safety ratings.
- **Mandatory Entry-Level Training (MELT) has not been extended to other commercial class driver's licences.** All drivers must complete MELT before they can apply for a Class A licence, required to drive a tractor-trailer, but the Ministry has not extended this requirement to other licence classes. We found that drivers of large trucks that do not require a Class A licence—for example, a dump truck—were involved in more collisions and injuries per registered truck than drivers of tractor trailers.
- **The Ministry allows some carriers with a poor history of collisions to test their own employees for commercial vehicle driver licences.** The Ministry approves colleges, government organizations, safety organizations and private businesses, including carriers, to train and test drivers under the Driver Certification Program. Carriers approved under the program can deliver and grade knowledge and road tests for their own drivers. We analyzed carriers that test their own drivers and found that drivers who took their road test with carriers between 2014/15 and 2018/19 had a pass rate of 95% compared with just 69% at DriveTest centres. However, the Ministry has not analyzed this difference to assess whether it is reasonable. We found that 25% of the 106 carriers testing their own drivers under the program ranked among the worst 1% of all carriers for at-fault collision performance. A jurisdictional scan by the Ministry found that with the exception of a handful of carriers in two provinces, other Canadian provinces do not allow carriers to test their employees for commercial driver's licences.
- **There is no mandatory drug and alcohol testing for commercial vehicle drivers.** In Ontario there is no requirement for commercial vehicle drivers to be subject to

mandatory testing either before or during their employment, unlike in the United States. In addition, Ontario drivers who hold a prescription for medical marijuana may operate a commercial vehicle with marijuana present in their system as long as they are not legally impaired, unlike those who use it recreationally. In contrast, Metrolinx has banned all marijuana use, including medical use, for its train and bus operators and Transport Canada has also banned all marijuana use, including medical use, for flight crews and flight controllers. There is no exception for commercial vehicle drivers using medical marijuana in the United States. From 2014 to 2018, 244 collisions involving commercial vehicle carriers listed the driver as under the influence of drugs or alcohol, 21% of which resulted in injury or a fatality.

- **Commercial vehicle licence plates are renewed annually by Service Ontario without proof the vehicle has passed an inspection.** We found that the Ministry does not require Service Ontario to ask for proof of a valid annual or semi-annual inspection certificate when renewing commercial vehicle licence plates. Therefore, the Ministry does not know how many commercial vehicles are operating without an up-to-date annual or semi-annual inspection certificate. The only way to catch these vehicles is for police or enforcement officers to review the certificate during a roadside inspection. During roadside inspections in 2017 and 2018—the first full years this information was tracked—officers found almost 7,500 instances where commercial vehicles did not have a valid annual or semi-annual inspection certificate.
- **Many MVIS garages are ordering excessive quantities of inspection certificates without investigation by the Ministry.** The MVIS inspection certificate ordering system has no automated controls to flag excessive ordering of inspection certificates. Excessive ordering creates the risk that garages could be distributing or selling inspection certificates they order but do not need, or are issuing certificates without actually inspecting vehicles. Our analysis of orders made by MVIS garages revealed that many seem to be ordering far more than they could be issuing based on the number of registered mechanics they have. For instance, 211 garages ordered over 528 certificates per licensed mechanic during 2018, which is 10 times the amount ordered by the average garage.

Overall Conclusion

Our audit concluded that the Ministry of Transportation does not have fully effective and efficient processes and systems to consistently carry out safety programs that promote and enforce the operation of commercial vehicles in compliance with legislative and policy requirements that protect the safety of Ontario's road users.

We found that Ministry enforcement officers collectively did not complete the Ministry's targeted number of inspections per officer in each of the last five years and that there were significant inconsistencies in the rates that officers laid charges for road safety violations between Ministry districts.

We also found that the number of roadside inspections conducted by the Ministry declined by 22% between 2014 and 2018, and that over this same period of time the Ministry removed fewer unsafe vehicles and drivers from Ontario's roads. The Ministry also laid fewer charges against carriers and drivers for road safety violations, even though the Ministry's research indicates that laying charges during roadside inspections can prevent 25% or more of the collisions that inspected carriers may otherwise have been involved in. In addition, we found that carrier safety ratings calculated by the Ministry are not always accurate, and that Ministry enforcement actions, such as carrier facility audits, are not always focused on the riskiest carriers. Furthermore, we found that the Ministry

does not effectively monitor and consistently take action to address high-risk MVIS garages.

Our audit also concluded that the Ministry does not have efficient and effective processes to measure and report on the effectiveness of commercial vehicle safety programs. For example, the Ministry has just two performance indicators that measure road safety in Ontario and only one of these indicators is specific to commercial vehicles—an indicator that measures inspection compliance during an annual three-day inspection initiative.

This report contains 19 recommendations, consisting of 51 action items, to address our audit findings.

OVERALL MINISTRY RESPONSE

The Ministry of Transportation appreciates the work of the Auditor General and welcomes the recommendations on how to improve the Commercial Vehicle Safety and Enforcement Program (Program). We agree with all the recommendations and are committed to implementing them as quickly as possible and will report back regularly on our progress.

The recommendations within this report build upon the continuous improvement the Ministry has been focused on with industry and enforcement partners to act on internal research of truck safety and oversight.

We are also considering the important role technology will play as we develop tools and data to drive efficiencies in operational delivery such as the subscription-based Drivewyze program to increase officer focus on underperforming and unknown carriers.

In addition, the Program is piloting risk-based screening tools at four truck inspection stations to improve the effectiveness and efficiency of existing commercial vehicle enforcement operations. We have begun work consistent with many of the recommendations, including transformation of our Motor Vehicle Inspection Station (MVIS) program, a comprehensive review of the Commercial Vehicle Operators Registration (CVOR) program as well as a program review of our commercial vehicle enforcement operations.

Ontario represents in excess of 40% of Canada's trucking activities; to help improve Ontario's safety record the Ministry has also introduced new safety initiatives such as Entry Level Training for new truck drivers, in place in Ontario since 2017 and being leveraged to develop a Canada-wide model.

The Ministry recognizes there are further opportunities to increase value for the Program by building on current efforts to review, monitor and update programs; detect and deter unsafe practices; and leverage the development of strong performance measures to ensure the Program is achieving its objectives.

2.0 Background

2.1 Overview

The Ministry of Transportation (Ministry) is responsible for administering Ontario's *Highway Traffic Act* (Act), which regulates all drivers, vehicles and roadways in Ontario. The Ministry has a mandate to move people and goods safely, efficiently and sustainably to improve Ontarians' quality of life and support a globally competitive economy. Its Road User Safety Division (Division) focuses on improving safety and security for all road users. The Division's activities include the regulation and enforcement of safety standards for commercial vehicles (trucks and buses) operating in Ontario (see **Section 2.2.1**).

In the five years from 2014/15 to 2018/19, the Ministry spent over $200 million on commercial vehicle enforcement, including $39.4 million in the 2018/19 fiscal year.

Individuals and businesses that operate commercial vehicles in Ontario, known as "operators" or "carriers," are required to register with the

Ministry and to renew their registration annually or bi-annually, depending on their safety record. This requirement also applies to out-of-country carriers, such as from the United States and Mexico, whose commercial vehicles travel into Ontario. In 2018, there were about 60,000 carriers registered to operate in the province, and over 290,000 registered commercial vehicles.

2.2 Role of the Ministry

The Ministry maintains 32 fixed roadside inspection stations along Ontario highways. It also utilizes approximately 70 temporary roadside inspection stations—paved areas on the side of provincial highways—where officers set up temporary inspection checkpoints. Ministry enforcement officers perform inspections of commercial vehicles and their drivers at these roadside inspection stations. In addition to potential roadside inspections, all large trucks registered in Ontario must be inspected and safety-certified annually (semi-annually in the case of buses), by a licensed mechanic at one of almost 13,000 Ministry-licensed Motor Vehicle Inspection Stations.

The Ministry also has a rating system for monitoring the safety performance of registered carriers. The system uses a formula based on roadside inspection results, collisions, convictions, and audits of the carrier's place of business. A number of intervention options are available to the Ministry when carriers have a poor safety rating, including warning letters, in-person interviews, facility audits, and sanctions up to and including revocation of the carrier's right to operate in Ontario.

2.2.1 Road User Safety Division

The key objective of the Ministry's Road User Safety Division (Division) is to reduce death and injury on Ontario roads by developing, promoting and participating in road user safety programs. The Division's programs to regulate commercial vehicles operating in Ontario and to enforce applicable safety standards include the following activities:

- conduct roadside inspections of commercial vehicles and driver records in accordance with North American Commercial Vehicle Safety Alliance (CVSA) standards (see **Section 2.5.1**);
- monitor the safety ratings of commercial vehicle carriers and take action to improve them (see **Section 2.5.2** and **Section 2.5.3**);
- perform risk-based facility audits of carriers that can include an examination of the carrier's vehicle maintenance records, driver log books and trip documentation (see **Section 2.5.4**);
- develop safety education for commercial vehicle drivers, including mandatory training for new drivers applying for a Class A licence (see **Section 2.6.2**);
- monitor and investigate Motor Vehicle Inspection Stations, which inspect and safety certify commercial vehicles (see **Section 2.7**); and
- conduct performance measurement and reporting (see **Section 2.8**).

2.3 Commercial Vehicle Collision Statistics and Trends

2.3.1 Commercial Vehicle Collision Statistics

In the ten years from 2008 to 2017, commercial vehicles (large trucks and buses) were involved in over 182,000 collisions in Ontario. The collisions resulted in almost 44,000 injuries and 1,180 fatalities, with no obvious year-over-year trend. Commercial vehicles were at-fault in 46% of these collisions, including 33% of collisions that resulted in a fatality, whether due to the driver's actions or the vehicle's condition. **Appendix 1** provides detailed commercial vehicle collision statistics.

Compared with an average motor vehicle accident, collisions involving commercial vehicles are more likely to result in a fatality. From 2008 to

2017, 1,033 collisions involving commercial vehicles resulted in at least one fatality, representing 0.57% of all commercial vehicle collisions. That rate rises to 0.65% if only large trucks are included and buses are excluded. In comparison, 0.23% of passenger vehicle collisions resulted in at least one fatality, indicating that collisions involving large trucks were almost three times more likely to result in a death. It is also noteworthy that the majority of people killed in collisions involving commercial trucks are occupants of other vehicles.

2.3.2 Overall Road Safety and Commercial Vehicle Safety Trends

Transport Canada data indicates that, on average, between 2013 and 2017 Ontario had the lowest annual fatality rate per billion vehicle-kilometres for all motor vehicles among Canadian provinces, and had a lower injury rate per billion vehicle-kilometres than the country as a whole (see **Figure 1** and **Figure 2**). Ontario's fatality rate of 4.0 and injury rate of 406 per billion vehicle-kilometres was below the national fatality rate and injury rate of 5.1 and 435 respectively. In addition, Ontario consistently maintained a lower fatality and injury rate per 10,000 registered motor vehicles than each of Canada and the United States in the ten years from 2008 to 2017 as illustrated in **Figure 3** and **Figure 4**.

However, when examining commercial vehicles only, **Figure 5** and **Figure 6** show that in the majority of the ten years from 2008 to 2017, Ontario maintained higher fatality and injury rates than each of Canada and the United States in collisions per 10,000 registered commercial vehicles.

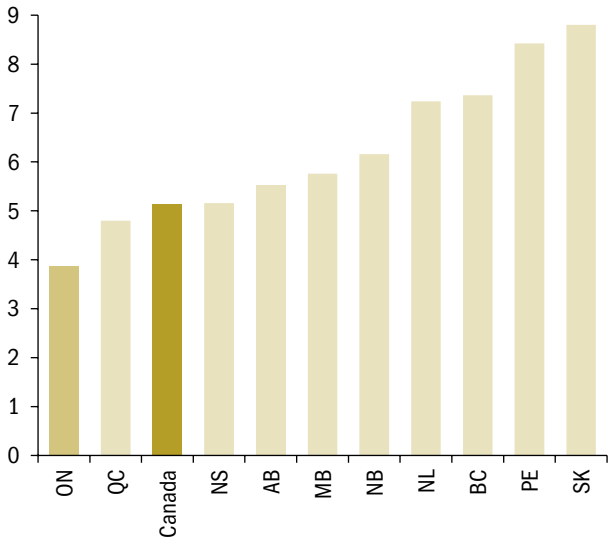
2.4 Commercial Vehicles and Operators

2.4.1 Commercial Vehicles

The *Highway Traffic Act* (Act) uses gross vehicle weight to classify trucks as commercial. Gross

Figure 1: Average Annual Fatalities per Billion Vehicle-Kilometres[1] by Province (All Motor Vehicles), 2013–2017[2]

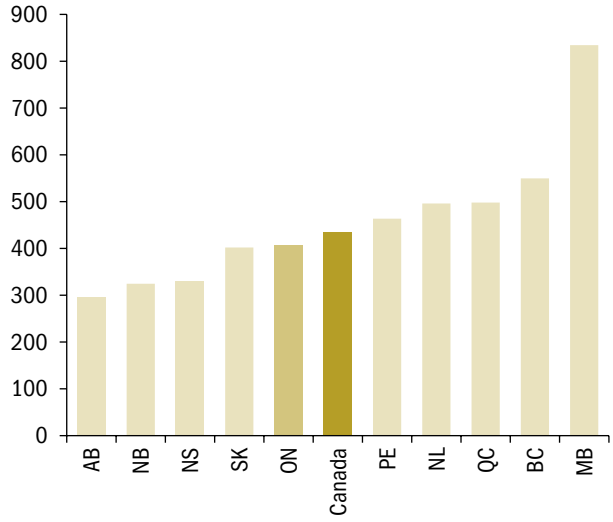
Source of data: Transport Canada



1. Vehicle-kilometres in Transport Canada's data are estimates.
2. 2017 data included in the average is preliminary for Ontario and Alberta. 2017 data included in the average is estimated for New Brunswick.

Figure 2: Average Annual Injuries per Billion Vehicle-Kilometres[1] by Province (All Motor Vehicles), 2013–2017[2]

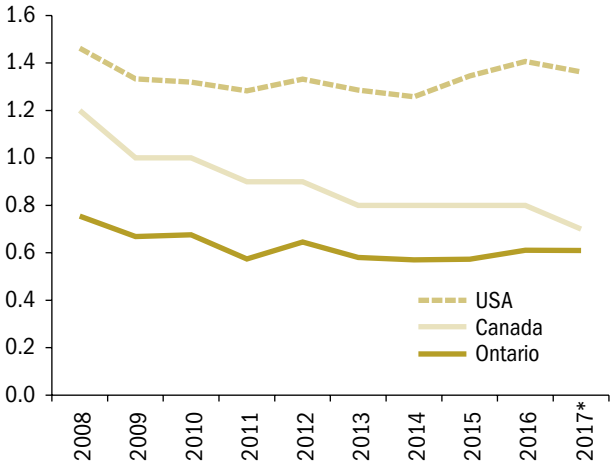
Source of data: Transport Canada



1. Vehicle-kilometres in Transport Canada's data are estimates.
2. 2017 data included in the average is preliminary for Ontario and Alberta. 2017 data included in the average is estimated for New Brunswick and Nova Scotia.

Figure 3: Fatalities per 10,000 Registered Vehicles (All Motor Vehicles), 2008–2017

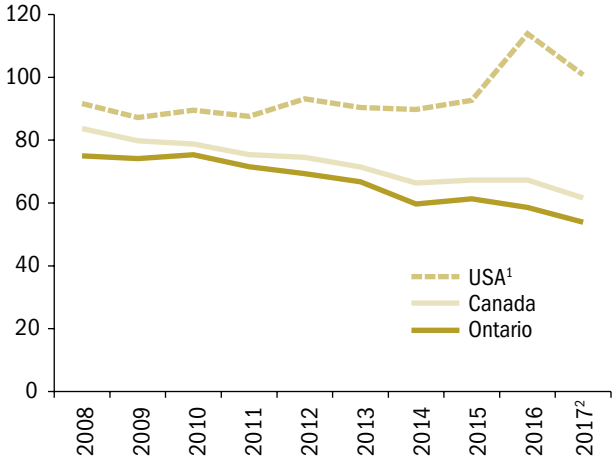
Sources of data: Ministry of Transportation, Transport Canada and Federal Motor Carrier Safety Administration (USA)



* 2017 data for Ontario and Canada is preliminary.

Figure 4: Injuries per 10,000 Registered Vehicles (All Motor Vehicles), 2008–2017

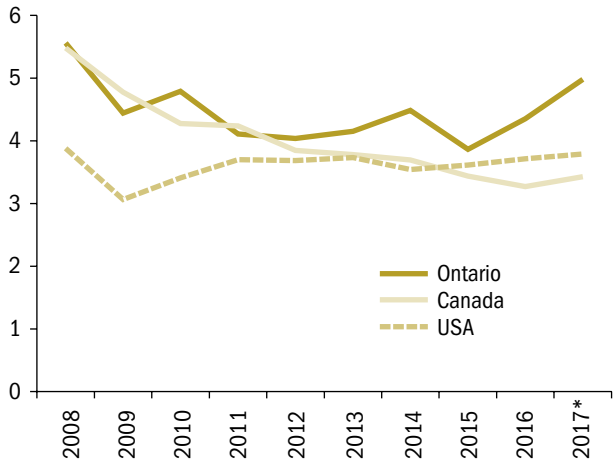
Sources of data: Ministry of Transportation, Transport Canada and Federal Motor Carrier Safety Administration (USA)



1. U.S. collision injury statistics are an estimate based on sampling performed by the National Highway Traffic Safety Administration. Due to a system change in 2016, the Federal Motor Carrier Safety Administration cautions that analysis of this data before and after the system change should be performed with caution.
2. 2017 data for Ontario and Canada is preliminary.

Figure 5: Fatalities in Collisions Involving Commercial Vehicles per 10,000 Registered Commercial Vehicles, 2008–2017

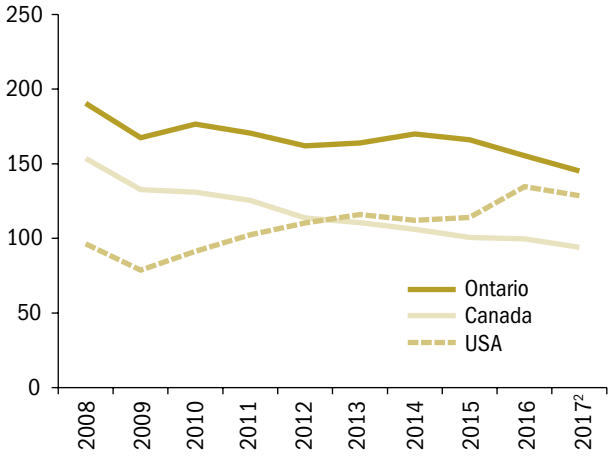
Sources of data: Ministry of Transportation, Transport Canada and Federal Motor Carrier Safety Administration (USA)



* 2017 data for Ontario and Canada is preliminary. 2017 Canada data includes estimates for New Brunswick.

Figure 6: Injuries in Collisions Involving Commercial Vehicles per 10,000 Registered Commercial Vehicles, 2008–2017

Sources of data: Ministry of Transportation, Transport Canada and Federal Motor Carrier Safety Administration (USA)



1. U.S. collision injury statistics are an estimate based on sampling performed by the National Highway Traffic Safety Administration. Due to a system change in 2016, the Federal Motor Carrier Safety Administration cautions that analysis of this data before and after the system change should be performed with caution.
2. 2017 data for Ontario and Canada is preliminary. 2017 Canada data includes estimates for New Brunswick and Nova Scotia.

weight is the weight of the loaded truck and any trailers that the truck is towing. The following are considered commercial vehicles under the Act:

- trucks and trailers with a gross weight over 4,500 kg;
- buses with a seating capacity of 10 or more passengers; and
- tow trucks—regardless of weight.

There are exceptions under the Act for some vehicles that meet the above definition but are not commercial in nature, including ambulances, fire trucks, hearses and motor homes used for personal purposes.

Between 2008 and 2018, the average age of commercial trucks registered in Ontario ranged from a high of 10.0 years in 2010 to a low of 8.6 years in 2018.

2.4.2 Commercial Vehicle Operator Registration

An operator is the individual or business responsible for the operation of a commercial motor vehicle under the Act. Operators are more commonly referred to as "carriers." Carriers that operate vehicles in Ontario that meet the definition of a commercial motor vehicle must register with the Ministry and obtain a valid Commercial Vehicle Operator's Registration (CVOR) certificate. This includes vehicles plated in Ontario, the United States and Mexico. Each carrier is responsible for the operation of their commercial vehicle fleet, including the conduct of drivers and the mechanical fitness of vehicles. About 60,000 carriers are registered in Ontario in the CVOR system.

Trucks or buses plated in another Canadian province or territory that meet the definition of a commercial vehicle must comply with all provincial standards for commercial vehicles when operating in Ontario. However, they do not need to obtain a CVOR certificate. Instead, each province shares information on collisions, convictions and inspections for use in the registration system of the carrier's home province.

2.5 Carrier Oversight and Enforcement

2.5.1 Roadside Inspections

One of the Ministry's most important enforcement activities for ensuring commercial vehicle safety is roadside inspections. Inspections of both commercial vehicles and driver records are conducted at the Ministry's 32 fixed roadside inspection stations, as well as at approximately 70 temporary roadside inspection stations—paved areas on the side of provincial highways where officers set up temporary inspection checkpoints. In addition, enforcement officers can conduct roadside inspections while on patrol. The Ministry divides roadside inspections and other enforcement activities into five regions across the province. See **Appendix 2** for a map of the Ministry's regions and 32 fixed inspection stations.

Roadside inspections are conducted in accordance with North American Commercial Vehicle Safety Alliance (CVSA) standards. These standards pertain to vehicle weight, load security, and mechanical and driver fitness. Vehicles with critical defects may be impounded, and unsafe drivers may have their licence suspended. Enforcement officers complete training delivered by the Ministry on inspecting commercial vehicles in accordance with CVSA standards.

To conduct roadside inspections, the Ministry employs about 230 enforcement officers, in 18 Ministry districts across the province. See **Appendix 3** for a list of districts, regions, and the number of officers and inspections performed in each. In addition to the Ministry's enforcement officers, 50 police officers at 15 municipal police forces, and 81 Ontario Provincial Police (OPP) officers also completed CVSA training and conducted roadside inspections in 2018. **Figure 7** provides a breakdown of inspections conducted by Ministry enforcement officers, the OPP, and municipal police in 2018.

Commercial vehicles selected for inspection are typically subject to one of the following three levels of CVSA inspection:

Figure 7: 2018 Roadside Commercial Vehicle Inspections by Agency

Source of data: Ministry of Transportation

Enforcement Agency	% of Inspections	Inspections
Ministry of Transportation*	91.1	88,670
Ontario Provincial Police	4.5	4,420
Municipal Police Services	4.4	4,250
Total	**100.0**	**97,340**

* From 2014 to 2018 the proportion of inspections completed by the Ministry ranged from a high of 94.5% in 2015 to a low of 91.1% in 2018.

- **Level 1** – Otherwise referred to as the "North American Standard" inspection, is the most comprehensive and time-consuming inspection. The vehicle, load and driver are all thoroughly examined for violations or out-of-service defects.
- **Level 2** – Otherwise referred to as a "Walk Around" inspection, is the most commonly performed inspection type in Ontario. It involves an inspection of the driver's documentation (such as driver's licence and hours of service) and a walk-around inspection of the vehicle and load to observe any obvious safety violations (without physically getting under the vehicle). A Level 2 inspection is escalated to a Level 1 inspection if mechanical defects are discovered or suspected.
- **Level 3** – Is a document-focused inspection and involves an inspection of the driver's licence, hours of service, annual vehicle inspection certificate, vehicle permits and seat belts. A Level 3 inspection can occur when there are no concerns about the vehicle.

Vehicles with defects and drivers who have committed violations that pose an immediate safety risk may be taken off the road and placed out-of-service until the violation or defect is corrected. These out-of-service defects and violations found during an inspection are recorded and included on the carrier's safety record (discussed in **Section 2.5.2**). In cases where an inspection detects violations, enforcement officers may issue a warning or charge the driver or the carrier based on their judgment. If a defect is considered critical, licence plates may be seized and the vehicle may be impounded. **Figure 8** provides examples of defects and violations that should result in vehicles being placed out-of-service or impounded.

2.5.2 Carrier Safety Ratings

The Ministry's Registration and Licensing System Ontario automatically assesses each carrier's safety rating using Commercial Vehicle Operator Registration (CVOR) record data. This includes collisions, convictions (against the carrier or someone driving for the carrier), and out-of-service violations and defects discovered during roadside inspection. These events result in violation points against the carrier's safety rating.

Collision violation points are assigned only if the carrier or the carrier's driver is determined to be at-fault. The points consider the severity of the collision, increasing the violation points assigned to the carrier if a collision resulted in an injury, and assigning further points if the collision resulted in fatality. Similarly, conviction violation points consider the severity of the charge for which the carrier and its driver is convicted.

The Ministry calculates a violation rate for each carrier by comparing the carrier's violation points over the previous 24 months to a carrier-specific threshold for violation points that is based on the number of kilometres travelled (the threshold increases as kilometres travelled increase). Carrier safety ratings can be obtained free of charge on a Ministry website. Additional information, such as detailed carrier safety records, can be obtained from the Ministry for a fee by interested parties. According to the Ministry, users of this information include insurance companies, financial institutions and shippers to make informed decisions when choosing a carrier.

Figure 8: Vehicle Defects and Results
Source of data: Ministry of Transportation

Severity of Defect	Result	Example
Out-of-service defect	Driver, vehicle and/or cargo placed out of service until the condition(s) or defect(s) are corrected or fixed.	• Leaking, flat, or worn-out tires. • Insecure loads or cargo. • Invalid driver's licence.
Critical defect	Licence plates and inspection stickers removed from vehicle. Up to a $20,000 fine. Vehicle is impounded: • 15 days for first offence • 30 days for second offence • 60 days for third offence	• Brake fluid leaking combined with a brake drum or rotor cracked, broken or missing. • Frame of vehicle broken or bent and is improperly contacting another part of the vehicle.

2.5.3 Carrier Interventions and Sanctions

Based on a carrier's violation rate, the Ministry can undertake the following interventions:

- **Warning letters** – The most common and least serious type of carrier intervention.
- **Facility audits** – Audits conducted at the carrier's premises by Ministry enforcement officers.
- **Interviews** – The carrier is invited to attend an interview with the Ministry to discuss their non-compliance. The Ministry may require the carrier to develop an action plan for improvement.
- **Sanctions** – Sanctions available to the Ministry include restrictions on the number of commercial vehicles the carrier may operate, plate seizure, suspension of the carrier's operating privileges and permanent cancellation of the carrier's Commercial Vehicle Operator Registration certificate. A carrier can receive a Notice of Sanction, typically when exceeding 100% of their overall violation rate. The corporate officer or senior official of the company is given the opportunity to show cause to the Ministry as to why sanctions should not be imposed.

Figure 9 illustrates the interventions and sanctions the Ministry may undertake when a carrier's violation rate meets a predetermined level.

Figure 9: Carrier Violation Rates and Ministry Interventions
Source of data: Ministry of Transportation

Violation Rate (%)	Carrier Safety Rating[1]	Intervention/ Sanction
<15	Excellent	None
15–35	Satisfactory	None
35–50	Satisfactory	Warning letter
50–70	Satisfactory	Facility audit
70–85	Conditional	Facility audit
85–100	Conditional	Interview
>100[2]	Unsatisfactory	Sanctions

1. If a carrier has had a facility audit, their safety rating is also dependent on audit results as described in **Appendix 4**.
2. Violation rate is calculated as violation points for collisions, convictions and inspections as a percentage of a threshold calculated by the Ministry of Transportation for each carrier as described in **Section 2.5.2**. It is therefore possible to exceed 100%.

2.5.4 Facility Audits

The Ministry has the authority under the Act to initiate a facility audit of a carrier at any time. In 2018, 25 Ministry enforcement officers completed 476 facility audits. Typically, a facility audit is triggered when a carrier's violation rate (discussed in **Section 2.5.2**) exceeds 50%. The Ministry may also undertake a facility audit at the request of a carrier that wants to improve its safety rating, or in response to complaints it has received about a carrier.
See **Appendix 4** for a description of the standard procedures performed during a facility audit and a

description of the scores that can be assigned to a carrier at their conclusion.

If a carrier fails its facility audit, the carrier's safety rating will be changed to conditional. The carrier safety rating remains as conditional until it passes a subsequent audit.

2.6 Driver Regulations and Training

2.6.1 Driver Licensing

The *Highway Traffic Act* (Act) governs Ontario's commercial vehicle driver licensing. The type of licence required to drive a commercial vehicle in Ontario depends on the weight of the vehicle driven, the weight of a towed vehicle and the type of vehicle driven; for example, freight versus passenger. Generally, a Class A licence is required for tractor-trailer combinations, Class D for other large trucks, and a regular passenger vehicle Class G licence is sufficient for smaller commercial vehicles. **Figure 10** outlines the different classes of licences needed to operate commercial vehicles.

Individuals in Ontario who already hold a Class G licence can obtain an A, C, D or F commercial class driver's licence by completing a written knowledge test and a road test at DriveTest centres. Drivers must pass a separate knowledge and practical test in order to operate a vehicle with air brakes, in addition to holding the appropriate driver's licence. This separate certification is known as a "Z" endorsement. For example, a Class A licence holder who is certified to operate vehicles with air brakes holds an AZ licence. The Ministry licenses a private-sector organization to operate 95 DriveTest centres across Ontario. In addition, the Ministry approves colleges, government organizations, safety organizations and private businesses, including carriers, to provide training and deliver road and knowledge tests to drivers under the Driver Certification Program.

2.6.2 Mandatory Entry-Level Training

The Ministry has developed a driver education and training program called Mandatory Entry-Level Training (MELT), which came into effect July 1, 2017. It must be completed by all drivers applying for a Class A licence before they take their road test.

MELT is delivered by two types of organizations:

Figure 10: Commercial Vehicle Driver's Licences

Source of data: Ministry of Transportation

Driver's Licence Class	Vehicle Type	Mandatory Entry-Level Training	Commercial Vehicle Example	Can Also Operate
A	Tractor–trailer combination with towed trailers >4,600 kg	✓	Tractor-trailer 	Class D and G
C	Bus >24 passenger capacity	×	Coach bus 	Class D, F, and G
D	Vehicle >11,000 kg gross weight provided the towed vehicle is not >4,600 kg	×	Dump truck 	Class G
F	Bus with up to 24-passenger capacity	×	Small bus 	Class G
G	Any car, van or small truck or combination of vehicle and towed vehicle up to 11,000 kg provided the vehicle towed is not >4,600 kg	×	20ft Cube truck 	None

Note: Classes B and E relate to school-purpose vehicles and are not the focus of this audit. The Office of the Auditor General of Ontario audited student transportation in 2015.

- **Private career colleges**: 91 private career colleges deliver MELT at 130 campuses in the province under the oversight of the Ministry of Colleges and Universities; and
- **Driver Certification Program:** 38 organizations are approved by the Ministry of Transportation to deliver MELT. The organizations include colleges, government bodies, safety groups and private businesses, including carriers.

The training consists of 36.5 in-class hours, 50 behind-the-wheel hours and 17 in-yard hours covering topics such as pre-trip inspection of the truck, for a total of 103.5 hours. Approximately 18,100 students had completed MELT as of August 1, 2019.

Ontario was the first Canadian jurisdiction with a mandatory training program for new tractor-trailer drivers. Alberta and Saskatchewan also have a program and Manitoba was establishing one at the time of our audit. The federal government announced in January 2019 that a Canada-wide national standard for entry-level training would be developed by 2020. The Ministry indicated it would update MELT to ensure alignment with the national standard where required.

2.7 Motor Vehicle Inspection Stations

The Ministry licenses qualified garage operators as Motor Vehicle Inspection Stations (MVIS). MVIS garages inspect vehicles and issue inspection certificates. In order to obtain a licence to operate an MVIS garage, an applicant must complete and submit an application to the Ministry and pass a site inspection by the Ministry.

MVIS garages that provide inspection certificates for commercial vehicles operate under the same licence as those that inspect regular passenger cars and must renew their licence annually. Almost 13,000 MVIS garages operate in Ontario, most of which are privately owned. MVIS garages must employ certified technicians (mechanics) in order to issue inspection certificates.

2.7.1 Inspection Certificates

MVIS garages purchase inspection certificates directly from the Ministry. Three types of certificates can be required for a commercial vehicle:

1. **Safety Standard Certificate** – Required when transferring a used vehicle to a new owner. Applies to both passenger and commercial vehicles.
2. **Annual Inspection Certificate** – Required for all commercial vehicles. Includes a sticker, which is affixed to the vehicle and can be inspected by enforcement officers during roadside inspections.
3. **Semi-Annual Inspection Certificate** – Required for all commercial buses. Includes a sticker, which is affixed to the bus and can be inspected by enforcement officers during roadside inspections.

In order to inspect a commercial vehicle, the mechanic must hold a certificate of qualification in the appropriate trade based on the particulars of the vehicle, such as weight and whether the vehicle has air brakes. For example, automotive service technicians, the same mechanics who work on passenger cars, can inspect smaller commercial vehicles without air brakes. A breakdown of technician types and the commercial vehicles they can inspect is in **Appendix 5**.

2.7.2 Monitoring of MVIS Garages

As of August 2019, the Ministry employed 31 enforcement officers who hold a mechanic's licence and are responsible for enforcing MVIS requirements. Ministry enforcement officers typically take enforcement action against MVIS garages in response to public complaints or if a problem is brought to their attention. Enforcement actions take the form of investigations and audits of MVIS garages, which are defined as follows:

- **Investigations** – Enforcement officers investigate a specific compliance issue. The findings of an investigation may trigger an audit.

- **Audits** – Enforcement officers visit the MVIS operating location and perform an audit to assess compliance with specific requirements under the Act.

Where the Ministry's enforcement officers find the MVIS garage to be non-compliant with requirements, the Ministry can issue warnings and lay charges. Where significant non-compliance is found, the Ministry has the power to revoke an MVIS garage's licence. When a licence is revoked, the MVIS garage has the opportunity to appeal to the Licence Appeal Tribunal, an independent, quasi-judicial provincial agency that resolves disputes concerning licensing activities regulated by the provincial government.

2.8 Performance Measurement

The Ministry uses two performance indicators to measure road safety performance. The description, results and our review of these indicators are discussed in **Section 4.7.**

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Transportation (Ministry), has efficient and effective processes and systems to:

- carry out safety programs that promote and enforce the operation of commercial vehicles in compliance with legislative and policy requirements established to protect the safety of Ontario's roads and users; and
- measure and report on the effectiveness of commercial vehicle safety programs designed to enhance public road safety.

In planning for our work, we identified the audit criteria (see **Appendix 6**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. The Ministry's senior management reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between January 2019 and August 2019. We obtained written representation from Ministry management that, effective November 12, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

We conducted the majority of our work at the Ministry's Road User Safety Division's Toronto head office and at its St. Catharines branch. We also visited and conducted audit work at three district offices: London, Kingston and North Bay. We selected them based on traffic rates, geographical coverage and inspection results. As well, we visited three roadside inspection stations and observed roadside inspections of commercial vehicles.

In addition, we met with stakeholders, including the Ontario Trucking Association, the Private Motor Truck Council of Canada, the Ontario Police Commercial Vehicle Committee and the Truck Training Schools Association of Ontario, to discuss their role in the industry and any concerns regarding commercial vehicle safety.

The scope of our audit included an analysis of policies and procedures, and relevant documents and reports, as well as detailed discussions with staff at the Division's head offices involved in the design, oversight and performance measurement of the Commercial Vehicle Safety and program. We also met with the Ministry's regional and district managers and supervisors responsible for overseeing enforcement officers in the districts we visited.

Although we reviewed and analyzed policies and procedures for the licensing and training of commercial vehicle drivers, we did not audit DriveTest, the Ministry-licensed, private-sector organization that conducts the majority of driver's licence testing in Ontario. We also did not audit the Ministry of Colleges and Universities, which is responsible for regulating private career colleges that deliver many driver-training programs.

At the time of our audit, Ministry collision data for the 2017 and 2018 calendar years was considered

preliminary. The Ministry explained that 2017 and 2018 collision data has not yet undergone full validation, including thorough review of fatality files from the Office of the Chief Coroner of Ontario, which the Ministry advised us can take up to two years to finalize. The use of preliminary collision data is consistent with Transport Canada practices. The most recent data available in Transport Canada's National Collision Database, which is publicly available, includes preliminary 2017 Ontario data provided by the Ministry. Therefore, we have included 2017 collision data throughout this report for the province as a whole. Where we use 2017 collision data, we note that it is preliminary.

4.0 Detailed Audit Observations

4.1 Roadside and Bus Terminal Inspections

4.1.1 Fewer Charges Laid and Fewer Unsafe Vehicles Taken Off the Road Due to Declining Roadside Inspections

As illustrated in **Figure 11**, we found that the number of roadside inspections conducted by the Ministry steadily dropped by 22% from over 113,000 in 2014 to less than 89,000 in 2018. Over this same period, we also found that there had been an unplanned reduction of 19% in the total number of enforcement officers from 287 in 2014 to 233 in 2018 due to vacancies not being filled, despite the Ministry's efforts to recruit new officers.

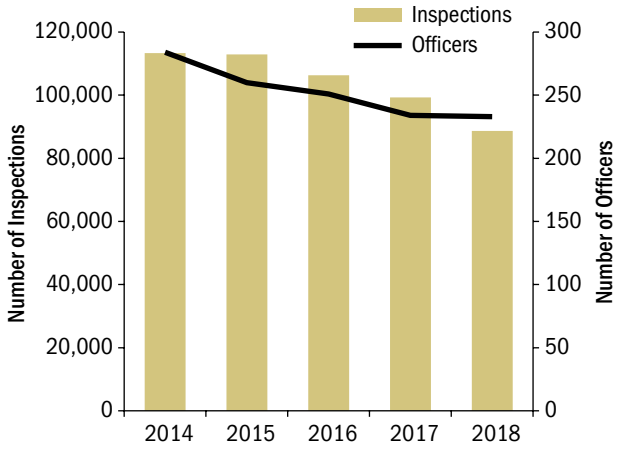
We also noted that between 2014 and 2018, the Ministry removed 22% of all the commercial vehicles it inspected from the road for mechanical defects or driver violations. We calculated that if the Ministry had continued to conduct as many inspections between 2015 and 2018 as it had in 2014 (113,000), it would have performed over 46,000 additional inspections. With 22% of commercial vehicles removed from the road for mechanical defects or driver violations, it could therefore have removed as many as 10,000 more unsafe commercial vehicles and drivers from Ontario's roads.

The decrease in Ministry-conducted roadside inspections over the last five years is concerning because Ministry studies and safety models from other jurisdictions show that there is a correlation between conducting roadside inspections and reducing commercial vehicle collisions, injuries and fatalities.

For example, the Roadside Intervention Effectiveness Model developed by the US Federal Motor Carrier Safety Administration consistently demonstrates the effectiveness of roadside inspections in preventing collisions by detecting and correcting violations. For 2013 (the most recent data available), the model estimated that roadside inspections prevented almost 10,000 crashes, over 6,000 injuries and 319 fatalities in the United States due to violations found and corrected. In addition, a draft Ministry study on commercial truck safety oversight concluded that mechanical defects detected during roadside inspections were predictive of a carrier's collision involvement in future periods and that the presence of defects at inspection may be indicative of a carrier's overall safety culture. The Ministry study stated consideration

Figure 11: Number of Enforcement Officers and Roadside Inspections, 2014–2018

Source of data: Ministry of Transportation



should be given to ensuring as many carriers as possible are subject to unplanned roadside inspections.

Ministry Does Not Have a Strategy to Address Shortfall in Number of Enforcement Officers

The Ministry produced a draft internal report in 2012 that it presented to its senior management, titled *Enforcement Gaps in Ontario*. The report highlighted that the Ministry had an insufficient number of enforcement officers to deliver roadside inspections, MVIS garage investigations, facility audits and bus terminal inspections. The Ministry informed us that, despite efforts to hire additional enforcement officers in 2015, 2017 and 2018, it had been unsuccessful in filling enough positions to offset retirements and officers leaving for other opportunities. Some reasons included that positions in some geographical areas were difficult to fill, there had been more retirements than anticipated, and one recruitment campaign was deferred to later a date. In the fall of 2018, the Ministry also identified that an additional 21 enforcement officers will be reaching their retirement date by March 2020. However, we found that the Ministry has not updated its 2012 report and does not have a long-term strategic plan to identify and hire the number of enforcement officers that may be needed to conduct a sufficient number of roadside inspections.

Based on 2011 traffic data, the Ministry's report calculated that 264 enforcement officers were required full-time to perform strictly roadside and bus terminal inspections and MVIS audits. We compared this target with the actual number of enforcement officers who were assigned to those duties between 2014 and 2018. We found that the number of such enforcement officers actually decreased (see **Figure 12**). For 2018, we found that the Ministry employed approximately 34% fewer enforcement officers (175), excluding supervisors, facility auditors and trainees, than the target in the report (264).

The Ministry's report was presented to its senior leadership in 2013. Highlights included:

- enforcement officer staffing in the majority of districts was below minimum levels (as calculated in the report);
- targets for the percentage of commercial vehicle traffic inspected were not being achieved in the majority of districts; and
- enforcement officers in most districts were not able to adequately patrol areas and roads away from fixed inspection stations.

The report's target is based on 2011 traffic data, and since 2011, the Ministry estimates truck traffic on Ontario highways has increased by 9%, suggesting that an even larger number of enforcement officers may be needed.

Ministry Does Not Have Provincial Target for Total Roadside Inspections, Enforcement Officers Not Meeting Individual Productivity Targets

Our audit found that the Ministry has not established a formal target for the total annual number of roadside inspections needed to address commercial vehicle safety in Ontario. Although the Ministry did establish productivity targets in 2012 for the number and type of roadside inspections it expects its enforcement officers to individually conduct each year, we found that most enforcement officers have not met these targets in any of the last five years. However, the Ministry had not analyzed the impact that missing productivity targets had on the safety of commercial vehicles and Ontario's road users, and it had not identified the specific steps needed for officers to meet them.

In 2012, the Ministry set targets for enforcement officers who perform roadside inspections in all regions to complete at least 600 inspections per year, based on allocating 60% of their available time to completing inspections. The Ministry set a target for at least 500 of these inspections to be a combination of Level 1 and Level 2 inspection, and at least 120 of the 500 inspections to be Level 1 (described in **Section 2.5.1**). The remaining 100 inspections can be of any level.

Figure 12: Enforcement Officer Staffing Vacancies (Excluding Supervisors, Facility Auditors and Trainees) 2014–2018

Source of data: Ministry of Transportation

	2014	2015	2016	2017	2018
Actual # of officers	217	197	182	175	175
Target # of officers (based on 2011 traffic)	264	264	264	264	264
Vacancies	**(47)**	**(67)**	**(82)**	**(89)**	**(89)**

Figure 13: Percentage of Enforcement Officers Meeting Annual Individual Roadside Inspection Targets, 2014–2018

Source of data: Ministry of Transportation

Annual Target	2014	2015	2016	2017	2018
>600 inspections [1] Levels 1, 2 and 3	28	43	52	47	36
>120 Level 1 [2]	40	51	55	51	45
>500 Level 1 and 2 [3]	49	59	60	54	41

1. The target of 600 inspections includes all inspection types.
2. Level 1: Otherwise referred to as the "North American Standard" inspection, is the most comprehensive and time-consuming inspection. The vehicle, load and driver are all thoroughly examined for violations or out-of-service defects.
3. Level 2: Otherwise referred to as a "Walk Around" inspection, is the most commonly performed inspection type in Ontario.

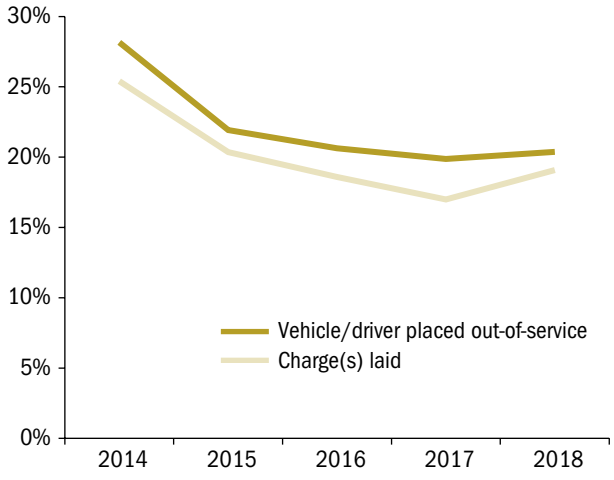
As illustrated in **Figure 13**, during the five-year period from 2014 to 2018, enforcement officers did not meet these targets. In 2018, productivity was particularly low as only 36% of enforcement officers achieved the 600-inspection target, and only 45% completed at least 120 Level 1 inspections.

The Ministry told us that failing to meet targets is considered during an individual enforcement officer's annual performance evaluation and that in many cases the reason that an individual enforcement officer missed targets was due to a medical leave or medical accommodations. The Ministry also noted that some of these officers had other responsibilities, including MVIS garage enforcement, limiting their available time for inspections. However, the Ministry had not analyzed the impact that missing its targets had on the safety of commercial vehicles and Ontario's road users, and it had not identified the specific steps needed to meet its overall inspection targets.

We also found that in the inspections that enforcement officers were conducting, they were laying fewer charges and placing fewer vehicles

Figure 14: Percentage of Inspections Resulting in a Charge or Vehicle Out-of-Service, 2014–2018

Sources of data: Ministry of Transportation



and drivers out-of-service. **Figure 14** shows the percentage of inspections that resulted in a charge or vehicle/driver placed out-of-service from 2014 to 2018. When enforcement officers find violations during roadside inspections, they have the opportunity to lay a charge. **Figure 15** shows that officers

Figure 15: Roadside Inspection, Violation and Charge Counts, 2014–2018
Source of data: Ministry of Transportation

	Inspections	Inspections with Violations	Inspections with Charges	Charge Rate per Inspection with Violation (%)
2014	113,400	62,800	28,800	46
2015	112,900	53,000	23,000	43
2016	106,300	49,400	19,800	40
2017	99,300	44,500	16,900	38
2018	88,700	41,700	16,900	41

continued to find a significant number of violations in the inspections they performed from 2014 to 2018, but the proportion of instances where they laid charges decreased from 46% in 2014 to 41% in 2018.

The Ministry's draft truck safety oversight study concluded that the collision prevention associated with laying charges during a roadside inspection is substantial, preventing a minimum of 25%, and possibly up to half the collisions that inspected carriers would otherwise be involved in. The study stated the Ministry should consider encouraging officers to lay charges during inspection wherever warranted.

RECOMMENDATION 1

To increase the effectiveness of roadside inspections in preventing future collisions and improving commercial vehicle safety, we recommend that the Ministry of Transportation:

- study and determine the optimal number of total annual roadside inspections needed to address commercial vehicle safety in Ontario and establish a target;
- create a province-wide staffing plan for enforcement officers based on a target sample size of commercial vehicle traffic to be inspected;
- evaluate options and implement actions to improve enforcement officer recruitment;
- regularly review whether enforcement officers are meeting productivity targets for roadside inspections and take corrective action when they are not; and
- implement the recommendations of its truck safety oversight study by formally encouraging enforcement officers to lay charges during inspections where possible and warranted.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and it will be incorporated into the work we currently do to ensure that roadside inspections are done effectively.

The Ministry is undertaking a Commercial Vehicle Enforcement Program review to fully consider and implement all functions that drive safety improvements, including post intervention charges, setting targets for inspection volumes and distribution throughout the province, which can then be used to develop long-term staffing plans.

The enforcement review is designed to undertake an assessment of the Program mandate, deliverables and outcomes and those results will be considered, along with the introduction of new technology, in determining the optimal delivery strategy of the program. The review will lead to the development of a provincial staffing plan that considers officer retention, along with appropriate staff levels and geographic officer distribution.

While this work is under way, the enforcement program will review current recruitment

strategies seeking opportunities to streamline the hiring processes that maintain required staffing levels and enhance management oversight and documentation related to enforcement officer productivity. Management practices will ensure officers have the support, training and tools needed to meet performance expectations, and will take corrective action when necessary to effectively and efficiently meet the program output requirements that deliver safety improvements.

The Ministry is continuously looking to modernize and improve public safety. The Ministry has recently undertaken internal research to develop a Truck Safety and Oversight Study. Once completed, this study will provide us with a guideline for improvements. The Ministry will work toward implementing the study recommendations, including formally encouraging enforcement officers to lay charges during inspections where possible and warranted.

4.1.2 Roadside Inspection Enforcement is Not Consistent across the Province, Impacting Effectiveness of Inspections in Reducing Collisions

We found significant differences across the province on the rate at which officers lay charges and place vehicles out-of-service during roadside inspections. For example, in 2018, one district laid charges in over 30% of the roadside inspections they conducted, while another laid charges in fewer than 8%. Ministry research indicates that laying charges during a roadside inspection can prevent collisions, and can possibly prevent half the collisions in which inspected carriers may be involved. **Figure 16** illustrates the differences in the percentage of inspections where a charge was laid compared with the percentage of inspections where a violation was found, by district.

Differences in types of commercial vehicle traffic, such as long haul, cross-border, or local, could affect the amount of infractions that officers see in different districts. However, we found the districts that laid the fewest charges per inspection had many opportunities to lay more charges. Officers in the five districts with the lowest percentage of inspections where a charge was laid identified violations in 43% of their inspections, near the average for all districts of 46%. However, these five districts collectively laid charges in just 12% of roadside inspections.

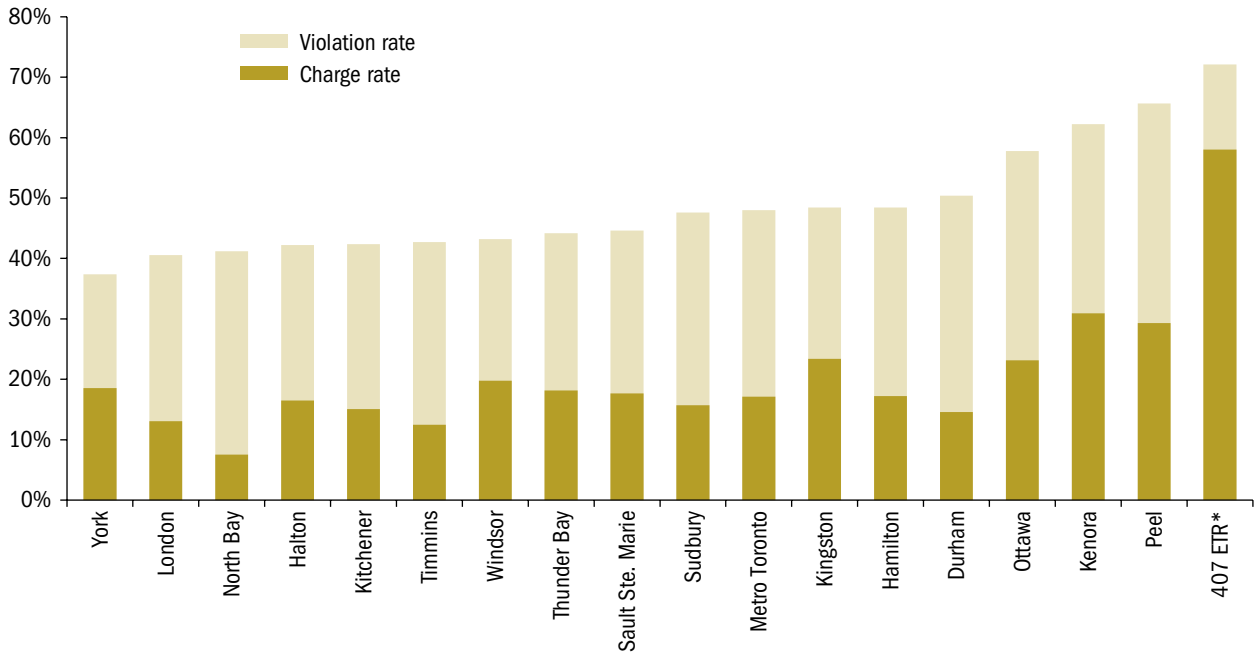
Where vehicle defects and driver violations were discovered at inspection that led to a vehicle being taken off the road and placed out-of-service, we found that the variance between districts was smaller though still significant, ranging from 13% to 28%. However, we found that there were very large differences between districts and individual officers in the rates that they impounded vehicles for critical defects. For example, in 2018 three officers in one district (London) performed 1,876 inspections and impounded 143 commercial vehicles. The vehicles impounded by these three officers accounted for 59% of the 243 vehicles impounded across the entire province.

In contrast, officers in the entire Northern region who performed over 12,000 inspections in 2018, impounded just one vehicle. Management in the Northern region explained that though many additional vehicles met impoundment criteria, they often only place those vehicles out-of-service due to a lack of impound facilities at inspection stations and not having enough enforcement officers staff to carry out impoundments. We also noted that only 16 of 32 fixed roadside inspection stations had the facilities required to impound a vehicle.

The performance of roadside inspections is largely at the discretion of each individual enforcement officer who conducts them. Although enforcement officers are to conduct inspections in accordance with North American Commercial Vehicle Safety Alliance (CVSA) standards (described in **Section 2.5.1**), enforcement officers do not complete a checklist during an inspection that indicates they examined all of the required vehicle and driver components. In addition, which

Figure 16: Percentage of Inspections Resulting in a Violation and Charge by District, 2018

Source of data: Ministry of Transportation



* Ministry enforcement officers working the 407 Express Toll Route district have the additional responsibility of enforcing 407 ETR toll/transponder regulations, which leads to higher violations and charges being issued. Toll and transponder charges are not safety-related violations and have no impact on a carrier's safety rating. 32% of 407 ETR violations reported are for not having a transponder, and the Ministry estimates approximately 51% of 407 ETR charges are transponder related.

vehicles are inspected, the level of inspection and enforcement action taken is up to the judgment of each enforcement officer.

For greater consistency in roadside inspections, the Ministry developed an Informed Judgment Matrix framework in 2015 that provides guidance for when officers should lay charges based on criteria such as the type of violation and history of the carrier and driver. However, the rates at which districts lay charges have become no more consistent since the matrix was developed. For example, in 2014 the difference between the districts with the lowest and highest percentage of inspections with charges laid was 22% (ranging from 14% to 36%). However, by 2018, the difference had actually risen slightly to 23% (ranging from 8% to 31%).

The Ministry has not performed an analysis of why different regions seem to lay fewer charges given similar opportunities and to determine whether corrective action is needed. It also has not used roadside inspection, carrier and driver data to evaluate whether enforcement officers are following the informed judgment matrix.

RECOMMENDATION 2

To ensure that roadside inspections are consistent throughout the province, we recommend that the Ministry of Transportation (Ministry):

- develop a checklist for all key steps to be undertaken during each inspection and require enforcement officers to complete it;
- evaluate why enforcement action differs among districts and take corrective action where such differences are not reasonable; and
- analyze whether enforcement officers are laying charges, placing vehicles out-of-service and impounding vehicles in accordance with the Ministry's informed judgment matrix guidelines.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. We recognize the importance of a uniform, province-wide program delivery.

The Ministry will evaluate variation in enforcement actions among districts and will take corrective action where that variation is not driven by reasonable geographical factors.

Through the enforcement program review, a variety of tools, including checklists and the informed judgment matrix, will be assessed against officer efficiency, outcome consistency and value in producing improved safety outcomes. Once analyzed, the Ministry will act on the findings of the review and implement changes that maximize program delivery and safety results.

4.1.3 Majority of Carriers Have Not Had a Vehicle Inspected in Past Two Years, Including Those with Poor Collision History

Our audit found that the Ministry has not inspected any of the commercial vehicles of more than 56% of Ontario's 60,000 carriers in the last two years (as described in **Section 2.5.2**, violations found during an inspection affect a carrier's safety rating for a period of two years). This included many carriers at the highest risk of future collision.

We analyzed the 870 carriers in the Ministry's database with the highest collision violation rates from May 2017 to May 2019 and found that nearly 20% had not had any of their commercial vehicles inspected in the previous two years.

While it is expected that many small carriers, such as those that are owner-operators with only one truck, would often go long periods of time without being stopped for inspection, we also found that none of the commercial vehicles of many large carriers had been inspected in the last two years. Among the top 25% largest carriers (based on kilometres travelled), 22% (over 3,200) had not had a vehicle inspected in the prior two years. This includes one US-based carrier that reported over three million kilometres travelled per year and 84 trucks operating in Ontario. It also includes another carrier, an Ontario government ministry, that reported over 3.4 million kilometres travelled per year and 131 commercial vehicles. This carrier was also involved in 40 collisions during the same two-year period.

4.1.4 Majority of Roadside Inspections Random and Proportion of Truck Traffic Stopped Decreasing

Our audit found that in the five years from 2014 to 2018 the proportion of truck traffic that was subject to a roadside inspection decreased by 25% from 20 of every 10,000 trucks to 15 of every 10,000 trucks. Truck traffic is daily truck volumes on Ontario roads, including trucks not registered in Ontario. Given the small proportion of traffic the Ministry is able to inspect at roadside, it is important that roadside inspections focus on the riskiest vehicles and carriers. However, we found that, despite new technology to assess risk (discussed in the section that follows), the vast majority of vehicles inspected at roadside are still selected at random at one of the Ministry's 32 fixed inspection stations on Ontario's highways.

Inspection stations signal to trucks to enter the station for possible inspection by turning on signal lights along the highway that indicate the station is open. At many stations, truck traffic is so heavy that the queue of trucks is full in minutes and the lights must be turned off, allowing for only a small sample of the truck traffic passing by to be inspected. Therefore, the trucks that enter the queue do so at random rather than based on the risk posed by a specific carrier because of past collisions or convictions.

When trucks are in the inspection station queue, enforcement officers use their judgment to select which trucks from the queue to inspect and which to allow to pass through. Based on our discussion

with enforcement officers, the factors each officer considers varies. Common considerations included:

- vehicle weight (if the station is equipped with a scale);
- visual condition of the vehicle; and
- inspection history or safety rating pulled from the Commercial Vehicle Operator Registration system.

4.1.5 New Technology Introduced Risk-Based Inspections but Remains Voluntary for Carriers

In 2018, the Ministry implemented two major technology systems—Drivewyze and Pre-screening—to enable officers working at inspection stations to concentrate on high-risk carriers, trucks and drivers.

Drivewyze is a voluntary GPS-based application that transmits information about a carrier ahead of entering the inspection station. The Drivewyze system determines whether a vehicle is eligible to bypass the inspection station using risk-based rules designed by the Ministry. For example, if the truck has had a recent clear inspection, it might be eligible to bypass the station. The Ministry completed testing and implementation of Drivewyze at all inspection stations at the end of 2018, and officially announced the program's availability in January of 2019. The supplier has provided the Drivewyze system at no cost to the Ministry. Instead, it charges participating carriers a monthly fee. We noted that Alberta implemented Drivewyze in 2017, while British Columbia introduced a similar system in 2009. At the time of our audit, according to Drivewyze's website, 44 US states were using Drivewyze.

Because Drivewyze is voluntary, only 71 carriers as of September 2019, representing 1,600 trucks actively operating in Ontario, had enrolled. The Ministry had not set targets for enrollment and had not evaluated the possibility of making Drivewyze mandatory, but did indicate the program would be evaluated at a time that had yet to be determined.

In 2018, the Ministry also selected four inspection stations based on traffic volume to pilot pre-screening technology. The technology began being used at three of the four stations between January and March 2019, and the fourth station was expected to be using the technology by January 2020. The technology is activated once a truck pulls into the inspection station and automatically examines safety elements such as tires, brakes and weight. For example, the technology uses thermal imaging to scan the vehicle for hot spots associated with unsafe and defective equipment such as inoperative brakes, failed bearings and underinflated or damaged tires. The technology also scans the licence plate of the vehicle and retrieves safety record information, such as previous inspections, from the CVOR system.

The capital cost of the pre-screening technology for the four stations was $3.7 million. The Ministry indicated a formal plan to evaluate the pilot and consideration of any expansion will be developed in 2020.

RECOMMENDATION 3

To maximize the effectiveness of its inspection resources and move toward risk-based inspections, we recommend the Ministry of Transportation:

- perform a cost-benefit analysis on making the Drivewyze program mandatory for all carriers; and
- evaluate the results of inspections at the four stations piloting pre-screening technology after one year, and compare results to other stations.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. The Ministry is currently monitoring the effectiveness of technology.

The Ministry recognizes the potential road safety benefit of increased enrolment of Drivewyze and has been actively communicating the

potential benefits to industry while the impact the technology has on resource effectiveness and safety is monitored. Analysis of how this program builds on the risk-based approach in targeting high-risk carriers in our compliance activities remains part of our ongoing assessment of the newly implemented technology. As part of this assessment, the Ministry will perform a cost-benefit analysis of making Drivewyze mandatory for all carriers.

With the implementation of the safety prescreening technologies at the last pilot location planned for early 2020, the Ministry is committed to undertaking an assessment of the results of the pilot locations to measure the effectiveness of the technology to ensure it provides good value for the financial investment prior to consideration of expanding the use of the technology to additional locations.

4.1.6 Carriers are Subject to Few Inspections While Operating on Municipal Roads

Our audit found that while most commercial vehicle collisions occur on municipal roads, the vast majority of roadside inspections are conducted on provincial highways. In addition, we found that the Ministry does not regularly co-ordinate or have a strategy with police services to inspect commercial vehicles that operate on high-traffic municipal and urban roads.

As discussed in **Section 4.1.3**, the chance of being inspected at roadside by the Ministry is small. Given this fact, it is important to ensure that the inspection system does not inadvertently provide opportunities for carriers or drivers to bypass inspections altogether.

Though the Ministry collects data on commercial vehicle traffic on provincial highways, it has limited data on commercial vehicles operating on municipal (including urban) roads. Using collision data as a proxy for traffic, we found that from 2014 to 2018 approximately 68% of collisions involving trucks belonging to Ontario registered carriers occurred on municipal roads, including 69% of collisions resulting in injury or fatality. This indicates municipal roads see a significant amount of commercial vehicle traffic. However, over 90% of roadside inspections are conducted by Ministry enforcement officers, usually at truck inspection stations on provincial highways. This indicates that "local haulers" who operate primarily on municipal and urban roads are unlikely to be subject to roadside inspection, and drivers and carriers could purposely avoid roadside inspection by operating on municipal roads.

The Ministry's enforcement officers and the Ontario Provincial Police conduct their roadside inspections primarily on provincial highways. The small portion of roadside inspections on municipal roads are primarily conducted by the various municipal police services with North American Commercial Vehicle Safety Alliance (CVSA)-trained officers. We found the number of CVSA-trained officers and roadside inspections conducted by each police service varied significantly. For instance, five CVSA officers with Halton Regional Police conducted over 1,400 roadside inspections in 2018, and seven officers with Waterloo Regional Police conducted 283 inspections. In contrast, Hamilton and Windsor police services have no CVSA-trained officers to conduct roadside inspections. This is despite significant truck traffic in those regions due to their proximity to the border and major routes flowing in and out of the Greater Toronto and Hamilton Area.

RECOMMENDATION 4

To increase the effectiveness of roadside inspections in preventing collisions and improving commercial vehicle safety, we recommend that the Ministry of Transportation:

- analyze carriers that avoid roadside inspection, whether purposely or inadvertently, and develop a strategy for targeting these carriers for inspection; and

- work with police services to develop a coordinated area patrol strategy that covers municipal and urban roads with high commercial vehicle traffic.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and supports a multi-pronged approach to addressing safety risks presented by carriers, including roadside inspections. The Ministry is continuously looking to modernize and improve public safety.

The Ministry will undertake a review of high-risk municipal locations to assess the best approach to improve safety outcomes and will work with the local police services to examine the need for added Ministry supports. In addition, the Ministry's review of the Commercial Vehicle Operator Registration program's effectiveness will assess the risks of carriers exposed to infrequent inspections and act on opportunities to support Ontario's trucking industry through risk-focused enforcement initiatives, including inspections.

4.1.7 Almost One-Quarter of Bus Terminals Overdue for Inspections Because of Backlog

At the time of our audit, 394 (21%) of 1,863 bus terminals in the province were overdue for an inspection by the Ministry. On average, these terminals were 86 days overdue, with some terminals being over one year overdue, including two bus operators that had never been inspected. We also noted that 30 of these overdue bus operators had been in at-fault collisions in the last five years.

The Ministry primarily inspects buses during bus terminal inspections. The Ministry uses its Bus Information Tracking System, implemented in 2002, to automatically track buses registered in the province as well as bus terminals. Bus terminals are to be inspected at least once per year. These inspections include selecting a sample of buses from each terminal to be inspected based on their prior inspection history.

The Ministry explained that the backlog of inspections was due to a large increase in the number of terminals and buses being tracked after the Ministry updated the bus tracking system in 2018. The update resulted in the addition of over 14,000 buses and hundreds of bus terminals.

We also found that the inspection backlog was longer than Ministry backlog reports indicated because in some cases Ministry employees were manually changing inspection due dates in the tracking system. According to the Ministry's bus tracking system manual, due dates are only to be changed if the due date does not match the seasonal operating schedule of a particular bus operator; for example, school boards, which do not typically operate in the summer months. However, since the system update in 2018, we found that 55 terminal inspections had been changed without proper justification, including 41 inspections where the date was changed after the inspection was already overdue.

RECOMMENDATION 5

To reduce the risk to road safety posed by the backlog in Ministry of Transportation (Ministry) bus terminal inspections, and to ensure buses and bus terminals are inspected at least annually as required, we recommend that the Ministry:

- prioritize high-risk bus operators when clearing the inspection backlog, such as those with a history of collisions and those that have never been inspected;
- implement controls to prevent the alteration of bus inspection terminal due dates; and
- ensure employees only change bus terminal inspection due dates for legitimate reasons.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. The Ministry is taking action to address

the identified backlog and is making progress toward reducing it.

The Ministry continues to address the bus inspection backlog by actively targeting those most overdue and will review the current system to ensure inspections at higher risk bus companies take priority. The Ministry will also develop and monitor enhanced controls over the inspection due dates to ensure changes are only made to appropriately align inspections to match seasonal operation schedules of bus operators.

4.2 Carrier Oversight and Monitoring

4.2.1 Ministry Does Not Assess the Reasonableness of Carrier-Reported Kilometres Travelled That Are Used to Calculate Safety Ratings

The Ministry's carrier oversight activities, including when it undertakes specific interventions, are based on a carrier's safety rating (described in **Section 2.5.2**). The safety rating depends on carriers reporting accurate kilometres travelled. However, we found that the Ministry does not have a process in place to ensure kilometres reported by carriers are reasonable. As a result, the accuracy of carrier safety ratings are subject to error. It also creates the opportunity for carriers to over report kilometres travelled to avoid reaching violation thresholds that would trigger Ministry enforcement action, such as a facility audit of the carrier's premises, or sanctions.

The Ministry advised us that a carrier reporting annual travel in excess of 250,000 kilometres per vehicle in its fleet was likely to be unreasonable. We examined a sample of 30 carriers that reported more than 250,000 kilometres per vehicle and shared our results with Ministry staff who confirmed that 70% had reported unreasonably high kilometres.

We found 767 instances of carriers reporting annual travel in excess of 250,000 kilometres per vehicle from 2014 to 2018. In addition, a 2013 report to the Ministry by an external consultant identified over 380 carriers that appeared to have reported kilometres per truck that were in excess of what was possible.

The 2013 consultant's report made recommendations to the Ministry to validate kilometres travelled. However, we found that the Ministry could not demonstrate that it had taken specific action to address these recommendations.

In addition, we noted that the Ministry could work with Service Ontario to verify and record information from annual inspection certificates when carriers renew commercial vehicle licence plates. Inspection certificates include odometer readings that are recorded by the mechanic who performed the inspection.

4.2.2 More than Half of Carrier Violation Rates Could Be Inaccurate

Based on the design of the Ministry's formula for calculating carrier safety ratings, we found that there is a risk that more than half of carrier violation rates could be inaccurate.

The Ministry's formula for calculating carrier violation rates uses Commercial Vehicle Operator Registration (CVOR) data on collisions, convictions and the results of roadside inspections. Out-of-service violations and vehicle defects discovered during roadside inspection account for 20% of the carrier's overall violation rate. However, we found that rather than omitting carrier inspection results from the calculation when there have been no inspections, the Ministry's formula assigns the carrier a perfect score for results from roadside inspections.

As noted in **Section 4.1.3**, 56% of carriers have not had any of their vehicles inspected at roadside in the last two years. Therefore, there is a risk that the violation rates of these carriers are understated. We recalculated violation rates at the time of our audit for all carriers that had not received an inspection in the previous two years and adjusted the calculation to exclude the inspection component. We found that by doing so:

- 94 carriers moved into a range that would trigger a warning letter;
- 38 carriers would trigger a facility audit;
- 10 carriers would move to a conditional safety rating;
- four carriers would trigger an interview; and
- three carriers would potentially trigger a sanction, such as suspension or cancellation of their CVOR.

Carrier violation rates are re-calculated daily over a rolling two-year period. The above examples only represent safety rating changes that would have occurred on the date we performed our analysis. Thus, over a two-year period, the safety ratings of many more carriers would likely be affected if they were recalculated by excluding perfect inspection scores where no inspection had been conducted.

RECOMMENDATION 6

To improve the accuracy of carrier violation rates and the effectiveness of Ministry of Transportation (Ministry) enforcement efforts, we recommend that the Ministry:

- implement controls that identify potentially unreasonable kilometres travelled for follow up;
- explore options to validate carrier-reported kilometres in cases where kilometres travelled do not appear reasonable; and
- review and revise how it calculates carrier violation rates when a carrier has not been subject to a roadside inspection.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is committed to examining opportunities to enhance data and safety rating accuracy.

The Ministry has initiated steps to make improvements including an assessment of the effectiveness of the Commercial Vehicle Operator Registration program by reviewing data inputs, such as kilometric travel and safety risks to consider program updates that will drive efficient and effective compliance efforts. The Ministry will develop controls that identify unreasonable kilometres travelled for follow-up, and explore options to validate kilometres travelled.

The Ministry will review how it calculates carrier violation rates where a carrier has not been subject to roadside inspection, and revise the calculation based on this review.

4.2.3 Ministry Policy Significantly Shortens Time that Convictions Affect Carrier Safety Records

Convictions are intended to remain on a carrier's safety record for a period of two years. However, the Ministry uses the date the offence occurred as the starting point for the two-year period instead of the conviction date, thus making the actual monitoring period shorter than intended, and in many cases, of almost no value.

Our analysis of 2017 and 2018 convictions found that on average, convictions remained on a carrier's record for 20 months, meaning delays in obtaining convictions and adding them to the carrier's safety rating reduced the time carriers were affected by those convictions by four months. In addition, over 4,500 convictions over this two-year period, or 7%, took more than a year to add to the carrier's safety record. We also found that more serious offences took longer to obtain convictions, and consequently affected carrier safety ratings for a shorter period of time than less serious convictions. Offences accompanied by five violation points (the most serious) against the carrier's safety rating took almost one-and-a-half months longer than those accompanied by zero violation points.

In addition to the time it takes to obtain a conviction in court, the Ministry is slow to add many offences to a carrier's record after a conviction is obtained. Though the Ministry informed us that new convictions are added overnight or the next day to the carrier's record, we found that on average it actually took 12 days. In 375 cases in 2017

and 2018, the Ministry took over a year to add the conviction to the carrier's safety record, including 30 cases where it took over two years. Many of these convictions were for serious offences including operating without insurance, unsafe driving and driving with an improper class of driver's licence.

By measuring the time from the offence date but adding the event to the carrier's record after the conviction date, the Ministry may be providing incentive for carriers to fight and delay convictions. We analyzed carriers with more than 10 convictions for five points (the most serious) against their carrier safety rating in 2018 and found a wide range of average times between offence date and conviction date. Carriers can therefore receive a significant advantage by delaying convictions. For example, in 2018 Carrier A was convicted of 22 offences carrying the maximum violation points, including operating an unsafe vehicle and providing false information on daily logs. However, because on average it took over 18 months for this carrier to be convicted of theses offences, the convictions affected its safety rating for less than six months. In contrast, Carrier B was convicted for similarly serious offences in less than two months on average, and the convictions affected its safety rating for over 22 months.

If an offence takes longer than two years to result in a conviction and be added to the carrier's safety record, it will not count against a carrier's violation rate at all. From 2017 to 2018, over 425 convictions took longer than two years and were not included as violations against the carrier's safety rating. For example, in 2017 and 2018, one carrier had seven charges that took longer than two years to result in a conviction; all related to separate instances of falsifying driver logs, and driving more than the allowable hours in a day (14 hours in Ontario).

The Ministry informed us that the CVOR system automatically flags some convictions added over two years from the offence date for review by an analyst if it is determined they could have had a significant impact on the carrier's violation rate. However, we noted these convictions do not formally count against the carrier's violation rate.

RECOMMENDATION 7

So that convictions are fully reflected in carrier safety records, we recommend that the Ministry of Transportation:

- include convictions in the calculation of carrier safety records from the date of conviction rather than the date of the offence; and
- evaluate why some convictions are significantly delayed in being added to the Commercial Vehicle Operator Registration and take action to correct the delays.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. As part of modernization, the Ministry will review ways to address risks associated with convictions as part of our multi-year Commercial Vehicle Operator Registration (CVOR) review.

The Ministry's treatment of convictions is aligned with the National Safety Code Standards, a set of nationally agreed-upon standards covering a number of vehicle- and driver-related areas. Ontario will continue to raise the concern with data entry delays with its national safety partners to see if there is a willingness to review the National Safety Code Standard, including reflecting events in the CVOR rating for a full 24 months.

The Ministry will evaluate why in some cases there is a delay in convictions being added to the CVOR system, and take corrective action to address these delays.

4.3 Carrier Enforcement

4.3.1 Ministry Conducting Fewer High-Risk Facility Audits Due to Limited Resources

Our audit found that the number of enforcement officers who are trained for and spend the majority of their time conducting facility audits decreased from 30 in 2014 to 24 by the end of 2018, a reduction of 20%. This is consistent with the drop in the

Figure 17: Facility Audits and Staffing, 2014–2018
Source of data: Ministry of Transportation

	2014	2015	2016	2017	2018	% Change 2014–2018
Facility auditors	30	29	29	26	24	(20)
Facility audits	649	597	391	387	476	(27)
Voluntary audits	44	54	35	53	95	116
Proportion voluntary (%)	**7**	**9**	**9**	**14**	**20**	**196**

total number of enforcement officers discussed in **Section 4.1.1** due to the Ministry being unable to fill vacancies. It also coincides with a reduction in facility audits of 27% as shown in **Figure 17**. The Ministry expects to perform a minimum of 600 facility audits per year—both voluntary and non-voluntary—but has not reached this mark since 2014. The Ministry informed us that the drop in the number of facility auditors also has contributed significantly to facility audit wait times and an overall backlog.

Over the same five-year period, the number of these audits that are voluntary and conducted at the request of a carrier that wishes to improve its safety rating increased by 116%. In 2018, voluntary audits represented 20% of all audits that enforcement officers performed, compared with 7% in 2014.

We found that between 2014 and 2018, 92% of carriers that had a voluntary audit had been audited previously, and the pass rate for voluntary audits was 82%, compared with 50% for non-voluntary audits. Enforcement staff we spoke to at district offices agreed that audit resources were increasingly being over-directed toward voluntary audits.

As of April 2019, the Ministry had a backlog of 142 audits in its system, including voluntary audits requested by carriers, 87 of which were triggered by a carrier exceeding 50% of the violation rate for its carrier safety rating. The Ministry has set a target for completing facility audits within 60 days of being assigned, but at the time of our audit the average wait time for facility audits exceeded 150 days, including one audit where the wait time was over 400 days.

RECOMMENDATION 8

To improve the effectiveness of its carrier oversight, and the accuracy and completeness of carrier safety ratings, we recommend that the Ministry of Transportation:

- evaluate why wait-time targets for the completion of facility audits are not being met and take corrective action;
- assess whether it has a sufficient number of enforcement officers who perform facility audits to meet its wait-time targets and take corrective action if it determines that it does not; and
- focus and prioritize the use of its resources on completing facility audits of the carriers that pose the greatest risk to road safety in Ontario.

MINISTRY RESPONSE

The Ministry agrees with the recommendation.

The Ministry is undertaking a multi-year review of facility audit volumes to better quantify anticipated audits required annually. In addition, the distribution of resources and required staffing levels against program demands and targets, such as inspection and facility audit, will be considered as part of the Ministry's Commercial Vehicle Enforcement Program review.

To address the noted 161% increase in voluntary audits, and focus the Ministry's resources on carriers that pose the greatest risk to road safety, the Ministry has implemented a one-year

pilot to reduce the number of low-risk, voluntary audits and address them through alternative approaches.

4.3.2 Failed Facility Audits Do Not Always Lead to Consequences for Carrier to Encourage Improved Road Safety

We found that failed facility audits often lacked consequences for carriers, such as charges being laid, or follow-up by the Ministry to ensure improvements were made. The Ministry also does not have a process to demonstrate that facility audits are performed consistently, including decisions to lay charges against carriers when safety violations are found.

A carrier needs to achieve an overall score of 55% on its facility audit to pass, despite the fact that most facility audits are conducted in response to a carrier having a poor safety rating. The Ministry could not demonstrate its justification for setting 55% as the passing score. We noted British Columbia requires a score of 70% to pass an audit and Manitoba requires 85%. In addition, the Ministry does not have a policy of following up with carriers in regard to violations and issues discovered during a facility audit. Because a failed audit does not count against the carrier's violation rate, carriers can potentially continue to operate indefinitely without consequence, especially if the enforcement officer conducting the audit does not lay charges.

The Ministry's draft truck safety oversight study found that similar to roadside inspections of commercial vehicles, facility audits, specifically failed facility audits, were significantly more effective at preventing future collisions when they were accompanied by charges. However, our analysis found that 37% of non-voluntary failed audits between 2014 and 2018 did not result in charges against the carrier, despite the fact that many violations, and therefore opportunities to charge, must be present in order for a carrier to fail. For example:

- In one failed audit in 2015 with an overall score of 8%, the carrier could provide no maintenance records for the previous two years, did not monitor driver qualifications, and had no systems in place to document and perform driver safety training, collision reporting, or preventative maintenance. The officer conducting the audit laid no charges.

As noted in **Section 4.1.2**, the Ministry developed an Informed Judgment Matrix framework in 2015 that provides guidance for when enforcement officers should lay charges, including in the case of facility audits. Nevertheless, we noted significant variances between districts subsequent to the framework's implementation. For instance, in 2018 one district laid charges in 83% of failed audits, while another laid charges in just 29%.

We were also informed that where reviews of facility audits are performed by supervisory staff, they are informal, and the Ministry confirmed it has no quality assurance process that ensures audits are conducted consistently and that appropriate charges are laid.

RECOMMENDATION 9

To improve the effectiveness of facility audits in improving carrier safety, we recommend that the Ministry of Transportation (Ministry):

- evaluate and establish a score that carriers must pass during a facility audit that supports improving commercial vehicle safety;
- evaluate why differences exist between districts in charges laid during facility audits and take corrective action where such differences are not reasonable; and
- assess whether enforcement officers are laying charges during facility audits in accordance with the Ministry's Informed Judgment Matrix guidelines and take corrective action where they are not.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and strives to ensure all compliance activities, including facility audits, include appropriate consequences.

The Commercial Vehicle Operator Registration effectiveness review will consider necessary updates and enhancements to the program, including analysis of the current facility audit pass score.

The Ministry's Enforcement Program review will examine strategies to improve province-wide consistency in compliance and enforcement delivery, including within our facility audits. The review will also assess the current tools, such as the Informed Judgment Matrix, for applicability with the audit program while exploring additional methods of corrective action for achieving consistent audit results focused on driving carrier behaviour changes to achieve compliance and promote greater safety outcomes.

4.3.3 Despite High Risk of Collisions, Ministry Does Not Sanction Municipalities

A carrier's collision violation rate measures collisions where the driver or a vehicle defect was listed at-fault in the collision. We found that, on average, the collision violation rate at the time of our audit for the 50 largest Ontario municipalities that operate commercial vehicles was almost 250% higher than the average rate for all carriers travelling a similar amount of kilometres. As well, of the 50 municipalities we reviewed, 28% had exceeded 100% of their collision points threshold at the time of our audit. Though the Ministry issues warning letters, carries out facility audits and conducts interviews in response to high violation rates, we found that the Ministry does not impose sanctions on municipalities—such as suspending or cancelling the registration of municipalities, regardless of how poor their safety record is.

Of the 50 municipalities we reviewed, 18% had not had a vehicle inspected at roadside in the previous two years. Municipalities tend to operate primarily on municipal roads and within urban centres, not provincial highways where the vast majority of roadside inspections are undertaken.

Regardless of their violation rates, the Ministry informed us that it does not suspend or cancel the registration of municipalities because of the essential nature of the services they provide to their local communities. Municipalities, therefore, can operate under poor safety ratings with few consequences and have little incentive to improve.

RECOMMENDATION 10

So that municipalities are held to the same standards as other carriers, and have incentive to improve poor safety performance, we recommend that the Ministry of Transportation:

- study the causes for the increased collision risk associated with municipalities; and
- develop alternative options that encourage safety improvement where sanctions, such as cancellation and suspension of municipal carrier registration certificates, is not feasible.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and has incorporated municipal collisions analysis in our Commercial Vehicle Operator Registration effectiveness review.

The Ministry will take action to develop alternative options to encourage safety improvements for municipalities where current available sanctions are warranted but not feasible due to the essential nature of the services municipalities provide to local populations.

4.4 Driver Licensing and Training

4.4.1 Ministry Does Not Monitor if Mandatory Entry-Level Training for Drivers is Delivered Consistently

Mandatory Entry-Level Training (MELT) is delivered by two different types of organizations: private career colleges and the Driver Certification Program (discussed in **Section 2.6.2**). We noted that the two are subject to different delivery and oversight standards (see **Figure 18**). This could affect the consistency and effectiveness of MELT in preparing new commercial drivers to operate vehicles safely on Ontario roads. As of July 1, 2017, all drivers applying for a Class A licence must complete MELT before they can take their road test.

Although the Ministry of Transportation developed the MELT program and standard, including a curriculum framework, course structure, course hours and facility requirements, the majority of students complete MELT at private career colleges, which are regulated by the Ministry of Colleges and Universities. We found that the Ministry of Transportation did not have a memorandum of understanding with the Ministry of Colleges and Universities to deliver MELT or to share information on the program. As a result, the Ministry of Transportation knew little about how MELT was being delivered at career colleges.

Near the end of our audit, the Ministry informed us that in September 2019 it began to evaluate the effectiveness of MELT. The evaluation was still in progress at the end of our fieldwork, and a final conclusion had yet to be reached.

Ministry Has No Standards for Teaching Qualifications or for Granting Students Advanced Standing

We also found that neither the Ministry of Colleges and Universities nor the Ministry of Transportation has a certification program for MELT instructors,

Figure 18: Policy Comparison between Organizations that Deliver Mandatory Entry-Level Training
Source of data: Ministry of Transportation

Mandatory Entry-Level Training (MELT) Policy Area	Ministry of Colleges and Universities Requirement for Private Career Colleges*	Ministry of Transportation (Ministry) Requirements for Organizations Licensed under the Driver Certification Program (Certification Program)
Responsibility for oversight and monitoring	Ministry of Colleges and Universities	Ministry of Transportation
Program and curriculum approval	Career colleges must engage an adult education specialist and a subject matter expert to review its MELT curriculum for compliance with Ministry of Transportation standards.	Organizations submit their training and testing curriculum directly to the Ministry for approval.
Inspection/audit policy	Career colleges are typically inspected once every two to three years based on risk by Ministry of Colleges and Universities staff.	Certification Program organizations are audited by external auditors every one to three years, depending on the results of the previous audit.
Instructor training or certification required	No	No
Students can be given advanced standing in the program	Yes	No
Knowledge and road tests	Students complete testing at DriveTest centres after completing MELT.	Students can complete testing at the Certification Program organization after completing MELT (see **Section 4.6.1**)

* Based on policies and descriptions provided by the Ministry of Colleges and Universities.

nor do they require any formal education or training in teaching. Multiple stakeholders we spoke to expressed their concern that the quality of MELT was not consistent, due in part to a lack of required training or certification for instructors.

We also noted that while private career colleges can grant students advanced standing, Driver Certification Program organizations cannot. Advanced standing allows students with previous recognized training or acquired skills to skip some of the 103.5 hours required in MELT. Some stakeholders we spoke with expressed concern that advanced standing might be granted too easily at some schools. Without a well-defined policy from the Ministry of Transportation on how to evaluate prior experience and how much advanced standing should be granted, there is a risk that career colleges will grant advanced standing in order to attract students who want the quickest path to their Class A licence.

RECOMMENDATION 11

To improve the consistency with which Mandatory Entry-Level Training (MELT) is delivered across the province, we recommend that the Ministry of Transportation work with the Ministry of Colleges and Universities to:

- review and standardize curriculum approval and audit policies for organizations delivering MELT;
- develop an instructor certification process for all instructors delivering commercial vehicle training;
- evaluate whether offering advanced standing at private career colleges and not at organizations operating under the Driver Certification Program is fair and justified; and
- periodically review the effectiveness of MELT in improving the safety of drivers who complete it.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. The Ministry is continuously looking to modernize and improve public safety.

The Ministry, in partnership with the Ministry of Colleges and Universities, will undertake a review of the curriculum approval process and audit policies for those organizations delivering Entry-Level Training for commercial Class A truck drivers. Based on this review, steps to standardize curriculum approval and audit policies will be determined.

The Ministry has initiated a review of Entry-Level Training for Commercial Class A truck drivers, including exploring options relating to the introduction of instructor certification requirements and the elimination of advanced standing altogether to ensure that applicants for a Class A licence are properly trained before they are tested and licensed. The Ministry will periodically review the effectiveness of MELT in improving driver safety.

4.4.2 MELT Not Extended to Other Commercial Class Licences that Pose Significant Safety Risks

Although the introduction of Mandatory Entry-Level Training (MELT) is a step toward ensuring professional drivers in Ontario are trained for the vehicles they operate, MELT only applies to obtaining a Class A licence. Some of the industry stakeholders we spoke to believe MELT should be extended to all commercial class licences, some of which pose a comparable safety risk as the tractor-trailers typically operated under a Class A licence.

Figure 10 summarizes the different types of commercial vehicle licences and illustrates the types of vehicles that the licence holder can operate. Class D licence holders are able to operate vehicles greater than 11,000 kg, meaning they can drive vehicles that are as heavy as some tractor-trailers. The only restriction on a Class D licence, other

Figure 19: Truck Driver-At-Fault Collision Statistics per 10,000 Registered Vehicles for Tractor-Trailers and All Other Trucks,[1] 2017[2]

Source of data: Ministry of Transportation

	Licence Class Generally Required	Per 10,000 Registered Vehicles		
		Fatalities	Injuries	Collisions
Tractor-trailer	A	2.4	50.0	213.0
Other commercial trucks	D or G	0.9	87.2	393.4

1. Other commercial trucks include tow trucks, open trucks, closed trucks, tank trucks, car-carriers and dump trucks.
2. 2017 data is preliminary.

than the "Z" endorsement required for all licence classes for vehicles with air brakes (described in **Section 2.6.1**), is that any towed trailer must not exceed 4,600 kg. In the example of a dump truck, which can be operated with a Class D licence, the dump bucket of the truck is not considered a trailer because it is fixed to the truck's frame.

Because licence restrictions are based on the weight of a vehicle and the load it is towing for trucks, and passenger capacity for buses, it is not always easy to determine what commercial vehicles require what type of licence. However, we can compare tractor-trailers, which in most cases require a Class A licence, and therefore the completion of MELT, to all other types of large trucks (such as dump trucks or trucks where the cargo box is fixed to the frame), which in most cases requires a Class D or G licence. **Figure 19** provides collision statistics for tractor-trailer combinations and all other types of large trucks for 2017.

As the figure shows, though driver at-fault collisions involving tractor-trailers produce more fatalities per registered tractor-trailer, driver at-fault collisions involving other trucks produce more injuries and collisions in general per registered truck. Overall, drivers of large trucks that do not require the completion of MELT appear to pose a significant risk to road users.

RECOMMENDATION 12

To help improve commercial driver safety on Ontario roads, we recommend that the Ministry of Transportation (Ministry):

- evaluate the benefits of requiring additional classes of new commercial drivers to take Mandatory Entry-Level Training (MELT); and
- extend MELT to the classes of new commercial drivers where the Ministry determines it would be beneficial.

MINISTRY RESPONSE

The Ministry agrees with this recommendation.

The Ministry has met with a number of stakeholders since the introduction of the current Mandatory Entry-Level Training and will continue to work with them as we analyze data, continue to conduct further research and review policies.

The Ministry is also undertaking a formal evaluation of the currently implemented Entry-Level Training for Class A drivers. The results of this evaluation will provide the Ministry with a greater understanding of the impact of Entry-Level Training on collision involvement for Class A drivers and will be critical in guiding discussions to determine whether the Ministry proceeds with Entry-Level Training for other commercial driver licence classes.

4.5 Commercial Driver Testing and Drug and Alcohol Regulations

4.5.1 95% of Student Drivers Passed by Carriers Compared with 69% at DriveTest

As described in **Section 2.6.1**, individuals in Ontario can obtain a commercial class driver's licence at DriveTest centres or through organizations that include private carriers under the Driver Certification Program (Certification Program). Drivers who take their road test with carriers can also be trained and employed by the carrier—even those with a poor collision history. We found that carriers had a significantly higher pass rate of 95% compared with just 69% at DriveTest centres. A jurisdictional scan by the Ministry found that British Columbia allows four carriers to test employees for commercial driver's licences and Alberta allows one carrier. No other provinces were found to allow carriers to test their own employees for commercial driver's licences. There were 106 carriers registered to test employees for commercial driver licences in Ontario at the time of our audit.

We found several instances of carriers with a poor collision history that were allowed to continue testing drivers under the Certification Program. For example, one municipal transit operator had been involved in enough collisions to exceed 100% of its collision points threshold at the time of our audit. The carrier's drivers had been involved in over 220 collisions between 2014 and the completion of our fieldwork in July 2019, in which their actions or inattentiveness had contributed to the collision; 32 of these collisions resulted in injury. Despite this, the carrier was still testing employees for commercial vehicle licences.

We analyzed all 106 registered carriers approved under the Certification Program at the time of our audit and found that 27, or 25%, ranked among the worst 1% of carriers for at-fault collisions. These 27 carriers performed over 7,800 road tests for commercial vehicle licences between 2014/15 and 2018/19 and failed just 9% of drivers tested.

Multiple stakeholders we spoke to indicated that there is currently a shortage of qualified drivers for carriers to hire. Because carriers are allowed to test their own drivers, there could be incentive to pass drivers who otherwise would have failed in order to get trucks and commercial vehicles on the road.

The Ministry also indicated it is not uncommon for the same instructors who deliver training programs to then administer their students' knowledge and road tests for licensing, posing a potential conflict of interest.

We compared road tests performed by carriers between 2014/15 and 2018/19 under the Certification Program against those performed by DriveTest and found the following:

- Over 22,600 road tests were performed by carriers for commercial vehicle licences under the Certification Program, which represented approximately 17% of all road tests.
- Carriers failed just 11 of almost 1,500 drivers they road tested for Class D licences during the period. **Figure 20** shows commercial road test pass rates by licence class. (See **Figure 10** for what types of commercial vehicles are associated with each class.)
- Carriers passed 97% of drivers they road tested for Class B licences during the period, compared with 73% at DriveTest. This includes a school bus line ranked among the

Figure 20: Commercial Class Licence Road Tests by Testing Authority, 2014/15–2018/19

Source of data: Ministry of Transportation

Driver Licence Class	Pass Rates (%)	
	Carriers Driver Certification Program	DriveTest
A	85	64
B	97	73
C	89	78
D	99	77
E	97	66
F	97	73
Total	**95**	**69**

worst 1% of carriers for at-fault collisions that road tested 61 drivers with no failures.

We also found that Ontario is the only jurisdiction in Canada that currently allows drivers to obtain a Class A equivalent licence by performing their road test in a vehicle with an automatic transmission and does not restrict those drivers from operating trucks with manual transmissions. The United States and all Canadian provinces except Ontario do not allow drivers who obtain their licence using a vehicle with an automatic transmission to operate a tractor-trailer with a manual transmission. This means that in Ontario, a driver can obtain a Class A licence and operate a manual transmission truck with a gross weight as high as 63,500 kg with as many as 18 gears without any experience driving with a manual transmission. We noted that in 2019 both Alberta and Manitoba changed their Class A licence equivalent to require the use of a manual transmission truck when performing the test.

RECOMMENDATION 13

So that only drivers who demonstrate the required skills and knowledge to operate commercial vehicles are able to obtain a commercial vehicle driver's licence, we recommend that the Ministry of Transportation:

- analyze the difference in pass rates between the Driver Certification Program and DriveTest to determine whether they are reasonable and identify instances that require follow up or corrective action;
- review whether allowing carriers to administer driver's licence testing through the Driver Certification Program constitutes a conflict of interest; and
- obtain data on drivers testing and driving different transmission types, and study any related safety implications to inform policy decisions on driver licensing.

MINISTRY RESPONSE

The Ministry agrees with this recommendation.

The Ministry will analyze the pass rates between the Driver Certification Program and DriveTest to determine whether they are reasonable and take corrective action as required. The Ministry will also review whether allowing carriers to administer driver's licence testing through the Driver Certification Program constitutes a conflict of interest.

The Ministry is committed to address the situation of testing in vehicles with different transmission types. The Ministry is exploring these, including placing a restriction to the driver's licence to prohibit the operation of a Class A manual transmission vehicle if the road test was passed in a vehicle with an automatic transmission.

4.5.2 Ontario Truck Drivers Not Subject to Mandatory Drug and Alcohol Testing and Strict Medical Cannabis Regulations

In Ontario, drivers operating a vehicle that requires a commercial licence are prohibited from having any presence of alcohol, marijuana, or any other prohibited drugs in their system. However, there is no requirement in Ontario for commercial vehicle drivers to be subject to mandatory testing either before or during their employment. The Ministry informed us that testing is completed at roadside if police suspect that a driver is impaired. In addition, employers may require preliminary and ongoing testing as a condition of employment, although the Ministry did not know how many carriers had such policies. Our research did not find any Canadian provinces enforcing mandatory testing of commercial vehicle drivers.

In contrast, federal regulations in the United States require mandatory pre-employment drug testing, as well as random drug and alcohol testing for commercial drivers throughout the year by the carriers that employ them, or by a consortium

in the case of owner-drivers. Ontario drivers who operate in the United States are also subject to these regulations and random tests. Multiple stakeholder groups we spoke to were in favour of mandatory pre-employment and randomized drug and alcohol testing for commercial vehicle drivers.

From 2014 to 2018, 244 collisions involving commercial vehicle carriers listed the driver as under the influence of drugs or alcohol, 21% of which resulted in injury or a fatality. From 2014 to 2016 (the most recent year with finalized fatality statistics) 6.8% of collisions involving commercial vehicles where a carrier's driver was under the influence of drugs or alcohol resulted in a death. This made them over twelve times more likely to result in death than the average commercial vehicle collision, which has a 0.57% chance of fatality (described in **Section 2.3.1**).

4.5.3 Despite Risks, Commercial Drivers with Prescriptions Allowed to Drive under the Influence of Marijuana

Ontario drivers who hold a prescription for medical marijuana may operate a commercial vehicle with marijuana present in their system as long as they are not legally impaired, unlike those who use it recreationally. We found the distinction between medical and recreational use concerning given that the negative effect on a driver's ability to operate a large commercial vehicle may be similar. The Ministry does not track information on the number of commercial vehicle drivers using medical marijuana.

Some transportation organizations in Canada have come out against the use of medical marijuana for operators of vehicles such as buses, trains and airplanes. For instance, Metrolinx, an agency of the government of Ontario that oversees the operation of intercity bus and train transportation in Greater Toronto and its surrounding areas, has banned all marijuana use, including medical, for its train and bus operators. Transport Canada has also banned all marijuana use, including medical, for flight crews and flight controllers (aviation is a federally regulated industry). In addition, there is no exception for commercial vehicle drivers using medical marijuana in the United States. Multiple industry stakeholders we spoke to were in favour of adopting similar regulations for Ontario's commercial vehicle drivers.

RECOMMENDATION 14

To reduce the risk of collisions involving commercial vehicle drivers under the influence of drugs and alcohol, we recommend the Ministry of Transportation:

- study and report on the potential road safety benefits of mandatory pre-employment and random drug and alcohol testing for commercial vehicle drivers;
- where road safety benefits are identified in the study, work with federal and provincial governments to establish pre-employment and random drug and alcohol testing guidelines for commercial vehicle drivers; and
- study the risks to road safety of exempting commercial vehicle drivers with medical prescriptions for marijuana from the same standards applied to recreational users, and develop a strategy to mitigate these risks.

MINISTRY RESPONSE

The Ministry agrees with the recommendation. The Ministry is always looking for ways to reduce the risk of collisions involving commercial vehicle drivers under the influence of drugs and alcohol.

The Ministry will study potential road safety benefits of mandatory pre-employment and random drug and alcohol testing for commercial vehicle drivers. Where significant benefits are identified, the Ministry will work with provincial and federal partners on the establishment of testing guidelines.

The Ministry will study potential risks to road safety of exempting commercial vehicle drivers with medical prescriptions for marijuana from the same standards applied to recreational

users, and develop a strategy to mitigate these risks. In the meantime, workplace-testing policies can be established by employers in Ontario, but are not mandatory. The Ministry of Labour, Training and Skill Development has established guidance on its website to help workplace parties understand impairment and workplace health and safety obligations under the law.

4.6 Motor Vehicle Inspection Stations

4.6.1 Commercial Vehicle Licence Plates Renewed Annually by Service Ontario without Proof Vehicle Has Passed an Inspection

As noted in **Section 2.7**, the Ministry licenses qualified MVIS garages that inspect commercial vehicles in order to issue inspection certificates certifying a particular vehicle mechanically safe to operate. MVIS garages order and purchase booklets of paper-based inspection certificates directly from the Ministry. In this regard, the program has remained largely unchanged since its creation in 1974.

We found that the Ministry does not require Service Ontario to ask for proof of a valid annual or semi-annual inspection certificate when renewing commercial vehicle licence plates. Therefore, the Ministry does not know how many commercial vehicles are operating without an up-to-date annual or semi-annual inspection certificate. The only way to catch these vehicles is for police or enforcement officers to review the certificate during a roadside inspection. During roadside inspections in 2017 and 2018—the first full years this information was tracked—officers found almost 7,500 instances where commercial vehicles did not have a valid annual or semi-annual inspection certificate.

Providing proof of an inspection certificate at plate renewal would be an opportunity for the Ministry to collect data on the MVIS garage, mechanic and vehicle that the certificate was issued to.

Ministry Does Not Track Inspection Certificates to Ensure They Are Used Appropriately by MVIS Garages

The Ministry is unable to track annual and semi-annual inspection certificates because they are a paper-based. With the exception of tracking which blank certificates were purchased by each MVIS garage, the Ministry has no information on the annual inspection of commercial vehicles performed by MVIS garages or the certificates they issued. For example:

- Although the Ministry knows which annual and semi-annual inspection certificate numbers were sold to specific MVIS garages, it does not know if or when these certificates were issued to vehicles, or if the garage that ordered the certificates is the same garage that performed the inspection.
- The Ministry cannot link a particular annual or semi-annual inspection certificate number to the vehicle it was issued to, or the mechanic who performed the inspection. The only way to obtain this information would be to review a paper copy of the inspection certificate at the MVIS garage.

An inspection program with significantly stronger controls and data capture exists in the province's Drive Clean program. **Figure 21** outlines key process and control differences between the MVIS and Drive Clean programs.

Up until April 2019, Drive Clean tested all vehicle emissions. Since April 2019, it no longer tests passenger vehicles but does continue to test heavy-duty diesel commercial vehicles for acceptable emissions levels. The Drive Clean program contracts private facilities, many of which are MVIS garages, to perform emissions inspections. The Ministry of Transportation, the Ministry of the Environment and Service Ontario jointly administer the program.

Figure 21: Comparison of Drive Clean and Motor Vehicle Inspection Station Processes and Controls

Source of data: Ministry of Transportation

Process or Control	Drive Clean	Motor Vehicle Inspection Station (MVIS) Garages
Inspection reports/ certificates	Completed electronically on the Drive Clean inspection system. All details of inspections are uploaded to a central database immediately after the inspection except for mobile facilities, which have up to three days to upload. Inspection facilities are also required to keep inspection records for two years.	Paper-based. Inspection details can only be accessed by physically reviewing them at the MVIS.
Inventory control	Cancelled/suspended/expired inspection facilities can be locked out of the Drive Clean inspection system, and are then unable to issue inspection reports.	The Ministry of Transportation (Ministry) system will not process orders for inspection certificates made by cancelled/ suspended/expired MVISs. However, the MVIS may still hold significant stock of paper inspection certificates.
Data available to the Ministry for analysis	• Inspection number • Inspection facility • Inspector name, licence number • Vehicle inspected • Vehicle specifications such as make, model, year, weight and engine size • Date and time of inspection • Odometer reading • Vehicle computer module readings, such as RPM, during inspection • Photos of the vehicle for verification and auditing purposes • Test results (emission readings, pass/fail)	Inspection certificate numbers that the Ministry sold to each MVIS.
Service Ontario renewal requirements	Service Ontario requires proof of a passed Drive Clean inspection prior to renewing licence plates.	Service Ontario only requires proof of an inspection certificate when there is a change of ownership of the vehicle.
Audits and/or investigations	Inspection facilities can be audited over the phone, in real time through the Drive Clean system, or through a site visit.	MVISs are typically investigated or audited only in response to complaints from the public, and enforcement officers must visit their place of business.

RECOMMENDATION 15

To support the licence renewal of only commercial vehicles that have passed an annual or semi-annual inspection and to improve the efficiency and effectiveness of its oversight of Motor Vehicle Inspection Stations (MVIS), we recommend that the Ministry of Transportation:

- work with Service Ontario to include proof of inspection certificates as a requirement when licence plates are renewed for commercial vehicles; and
- implement electronic inspection certificates to be issued by MVIS garages using a central system, using the Drive Clean program and its controls as an example.

MINISTRY RESPONSE

The Ministry agrees with this recommendation.

The Ministry is currently reviewing system connectivity between mechanical inspections and vehicle registration (plate) renewal. The Ministry is in discussions with Service Ontario to develop policies linking registration and annual and semi-annual inspection results.

The Ministry is analyzing the introduction of electronic inspection certificates, which would be issued by MVIS stations to a central system administered and managed by a third-party service provider. The Ministry would have full access and ownership of all data, including individual vehicle inspection results, which will be relied on for program monitoring, investigation and enforcement purposes.

4.6.2 Ministry Does Not Consistently Identify and Take Action against High-Risk MVIS Garages

Our audit found that the Ministry only conducts investigations at MVIS garages if it receives complaints from the public, or if a problem comes to the attention of the Ministry's enforcement staff. The Ministry also does not have criteria to determine when MVIS garages should be subject to Ministry interventions such as investigations and audits (see **Section 2.7.2**), or be subject to sanctions, including revoking their licence. And the Ministry does not follow up on MVIS garages that have had serious violations to ensure improvements have been made.

When the Ministry does have reason to investigate garages, it often finds serious violations and sometimes fraudulent activity. Examples of investigation findings over the past five years include:

- MVIS issuing inspection certificates for defective vehicles;
- MVIS issuing inspection certificates without inspecting the vehicle;
- inspections performed by unlicensed mechanics; and
- failure to notify the Ministry of lost, stolen or destroyed inspection certificate stock.

In one 2019 case under investigation at the time of our audit, an enforcement officer found an individual, who was not a mechanic or MVIS operator, selling inspection certificates over Facebook for cash.

We found that in most cases, MVIS garages with a significant number of convictions resulting from an audit or investigation continued to be licensed by the Ministry without the Ministry taking steps to follow up and ensure the garage made improvements.

For example, one MVIS had 100 charges and subsequent convictions due to a Ministry investigation that was completed in July 2016, including "obstructing an inspector or refusing to provide information to an inspector." At the time of our audit, the MVIS was still operating and had not undergone a follow-up visit from the Ministry. The Ministry stated that it had not revisited the MVIS because it had not received another complaint about the station from the public.

The Ministry attempted to revoke only 14 MVIS licences from 2014 to 2018. At the time of our audit, three of the 14 were still licensed after a successful appeal to the Licence Appeal Tribunal (described in **Section 2.7.2**), and two were still licensed while awaiting their appeal hearing, leaving only nine garages successfully revoked by the Ministry.

In our 1997 audit *Commercial Vehicle Safety and Regulations*, we expressed concern about the absence of an inspection process for MVIS garages, and the Ministry committed to developing criteria for choosing high-risk MVIS garages for inspection audits. However, by our 2008 audit the Ministry had made no progress in developing guidelines or a process for identifying high-risk MVIS garages, or for taking any enforcement action against them. During our current audit, we found that the Ministry had still made no progress toward implementing a process to identify high-risk MVIS garages.

We also found that the Ministry was not utilizing roadside inspections to record inspection certificate information or identify high-risk MVIS garages. Part of a standard roadside inspection is checking for a

valid inspection certificate. However, enforcement officers do not record details of the certificate, such as the issuing MVIS garage, signing mechanic, or when the certificate was issued. In addition, the Ministry also has no formal process that allows officers to flag a vehicle with a recently issued inspection certificate that they find to have significant mechanical defects. Such a process could identify and allow for the investigation of MVIS garages that are potentially inspecting commercial vehicles improperly or the fraudulent signing of inspection certificates.

RECOMMENDATION 16

To help identify and take enforcement action on high-risk Motor Vehicle Inspection Station (MVIS) garages, we recommend that the Ministry of Transportation:

- add inspection certificate information to the data captured during roadside inspections;
- create a process that allows enforcement officers to easily flag concerning inspection certificates for follow up with the MVIS garage; and
- develop a system for assigning risk levels or scores to MVIS garages and use this information to drive investigations and audits.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and has initiated work on modernizing oversight of the MVIS network to identify and act on high-risk stations.

As part of planned program modernization, the Ministry is analyzing a risk-based monitoring and compliance solution. This information could be used to inform station investigations and audits. Furthermore, program modernization will improve opportunities for collaboration between on-road enforcement officers and the MVIS oversight function, including the opportunity to flag concerning inspection certificates for follow up with the MVIS garage. The Ministry is also analyzing ways to examine whether the roadside capture of inspection information will add value to the improved oversight of the inspection regime and act if warranted.

4.6.3 Many MVIS Garages Ordering Excessive Number of Inspection Certificates without Investigation by the Ministry

Our analysis of orders made by MVIS garages in 2018 revealed that many seem to be ordering far more than they could be issuing based on the number of registered mechanics they have. Excessive ordering creates the risk that garages could be distributing or selling inspection certificates they order but do not need, or are issuing certificates without actually inspecting vehicles.

For instance, 211 garages ordered over 528 certificates per licensed mechanic during 2018, which is 10 times the amount ordered by the average garage. Despite this, Ministry order processors requested only 18 investigations related to excessive certificate ordering in 2018. At the time of our audit, six of the 18 requests were open while 12 had been investigated. Seven of the 12 investigations led to failed site inspections and charges. Three of the 12 investigations led to the officer proposing revoking the garage's licence.

The MVIS inspection certificate ordering system has no automated controls to flag excessive ordering of inspection certificates. It is up to order processors employed at the Ministry to identify what seems like excessive or unusual ordering based on their own judgment and flag such ordering for investigation by an enforcement officer. However, the Ministry informed us that there is no benchmark or guideline to assist order processors in identifying these orders, nor is there any requirement for them to report any anomalies in ordering.

Many of the MVIS garages ordering the highest number of inspection certificates per mechanic have received no investigation at all. For example:

- An MVIS garage with one mechanic ordered 7,300 certificates from 2016 to 2018, or 46 times the average per mechanic across all

MVIS garages. Order processors did not create any requests for investigation into the garage's ordering practices, and the Ministry has not conducted an investigation of the garage.

- An MVIS garage employed only one mechanic and was sent 4,000 inspection certificates in 2018 alone, which is 76 times the average per mechanic. When we asked the Ministry about the orders, it began investigating and found that the station had actually only ordered 2,000 certificates, which is still 38 times the average per mechanic. An error in the Ministry's system caused a duplicate order to be filled at no charge to the MVIS garage. Therefore, the garage and its single mechanic received 4,000 safety certificates, 2,000 of them for free, without the system flagging the transaction or Ministry staff noticing until we brought the case to their attention. The Ministry indicated it was initiating the process to collect payment for the additional 2,000 certificates.

RECOMMENDATION 17

So that Motor Vehicle Inspection Station (MVIS) garages are not ordering excessive inspection certificate stock that could be sold, distributed, or issued inappropriately, we recommend that the Ministry of Transportation:

- create automated controls in the inspection certificate ordering system that flag excessive ordering based on factors such as registered mechanics and prior order history; and
- create guidelines and train order processors to identify excessive ordering, and follow up when investigation requests are submitted by these processors.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and has initiated work on modernizing oversight of the MVIS network to identify and act on high-risk stations.

As part of the Ministry's modernization efforts, the Ministry is reviewing its current paper-based stock ordering process to replace it with the issuance of on-demand electronic certificates. These electronic certificates would then be monitored to flag instances of potentially excessive issuance, and to take compliance action against the associated technician and/or station where warranted. The new program will include streamlined processes for removing stations unable to maintain safety and reporting compliance.

4.6.4 MVIS Inspectors Lack Standardized Training and Oversight, Leading to Inconsistent Results

Enforcement officers who conduct audits and investigations are known as vehicle inspectors. Though vehicle inspectors must be licensed mechanics, we found that there was no standardized training instructing these officers how to effectively audit or investigate an MVIS garage. Instead, they learn simply by observing more experienced vehicle inspectors performing their duties. Managers we spoke to expressed their concern over the lack of training for vehicle inspectors. They indicated that being licensed mechanics gives inspectors the required automotive knowledge for the job, but when hired they have no experience in investigations, gathering evidence, or laying charges against MVIS garages.

In addition to a lack of standardized training, the Ministry has not updated the MVIS Policy Manual or its MVIS audit reports and checklists since 2009. This is problematic given that changes have occurred since, and the manual refers to information systems no longer used by the Ministry. We reviewed MVIS audit files at all three district offices we visited and found audit requirements were not being met consistently. For example:

- inspectors did not check for all required tools in 47% of the files we tested;

- inspectors did not complete the audit checklist in 53% of files, and 20% of audit files we tested had no checklist at all;
- in 37% of audit files, mechanic trade certificates were not reviewed to ensure mechanics were registered, in good standing and qualified to sign inspection certificates for the types of vehicles being inspected; and
- in two cases, audit files we requested as part of our sample could not be found at all, in paper or digital form.

RECOMMENDATION 18

So that audits and investigations of Motor Vehicle Inspection Station (MVIS) garages are performed consistently, we recommend that the Ministry of Transportation (Ministry):

- provide vehicle inspectors with standardized training on conducting audits and investigations; and
- update its MVIS policy manual, audit reports and checklists to reflect current practices and Ministry systems.

MINISTRY RESPONSE

The Ministry agrees with this recommendation.

As part of MVIS modernization, the Ministry will develop standardized training for vehicle inspectors conducting audits and investigations, and update the MVIS policy manual, audit reports and relevant checklists to reflect the most current practices.

4.7 Performance Measurement

Ministry Performance Indicators Insufficient to Effectively Monitor Commercial Vehicle Safety Performance

Our 2008 audit on commercial vehicle safety noted that the Ministry had not developed meaningful performance indicators and targets to assess the effectiveness of its activities in improving commercial vehicle safety. We found that the Ministry has since developed two performance indicators with associated targets that measure road safety. However, we noted that only one of these indicators is specific to commercial vehicles. The indicators and Ontario's performance over the last five years are presented in **Figure 22**.

The Ministry publicly reports fatalities per 10,000 licensed drivers in the *Ontario Road Safety Annual Report*. This is a standard indicator used across North America as a measure of overall road safety. In 2016 (the most recent year a comparison is possible), Ontario's fatality rate of 0.58 per 10,000 licensed drivers was the second lowest in all of North America, behind only the District of Columbia in the United States.

The only commercial vehicle specific performance indicator currently in place is the indicator on Commercial Vehicle Compliance Rates during RoadCheck, which is not publicly reported. RoadCheck is an annual three-day inspection initiative benchmarking truck safety in Canada, the United States and Mexico. The indicator measures the percentage of vehicles and drivers inspected without violation. Carriers and drivers are aware of when RoadCheck occurs because the dates are announced months in advance. Compliance rates are typically much higher than during regular roadside inspections, calling into question the usefulness of the indicator for measuring the effectiveness of the Ministry's commercial vehicle enforcement activities.

We noted that the Ministry tracks extensive data on carriers, commercial vehicles and drivers that could be used to establish performance indicators that would help measure the effectiveness of the Ministry's commercial vehicle enforcement activities. As well, we noted that the province's road safety annual report provides extensive road safety statistics for Ontario that could also be used to measure performance, including commercial vehicle specific statistics such as:

- number and rate of fatalities in large truck collisions;

Figure 22: Road User Safety Division Performance Indicators, 2014–2018

Source of data: Ministry of Transportation

Indicator	2014	2015	2016	2017	2018	Target
# of fatalities per 10,000 licensed drivers [1]	0.53	0.54	0.58	0.58[2]	0.56[2]	**0.82**
Commercial vehicle compliance rates (%) — RoadCheck	79	85	84	84	83	**80**

1. This performance indicator relates to all licensed drivers, not just those with a licence to drive a commercial vehicle.
2. 2017 and 2018 are based on preliminary data.

- selected factors relevant to fatal large truck collisions (for example, involvement of alcohol and vehicle defects); and
- commercial vehicles as a percentage of the total population of vehicles.

We did, however, note that there is usually a significant delay in publishing the annual report. The most recent publicly available annual report is for the 2016 calendar year, and the Ministry did not release the 2015 and 2016 reports until August 2019. The Ministry explained that production of finalized statistics cannot occur until the completion of necessary police and coroner investigations, in relation to serious collisions.

RECOMMENDATION 19

To more effectively assess Ontario's performance in commercial vehicle safety and allow for informed decision-making in regard to commercial vehicle safety policy, we recommend that the Ministry of Transportation:

- develop relevant commercial vehicle safety-specific performance indicators and associated targets and take steps toward meeting those targets; and
- report these performance measures to the public.

MINISTRY RESPONSE

The Ministry agrees with this recommendation and is actively developing key performance measures that leverage currently available data to support evidence-informed decision-making. This work will progressively develop measures, baselines and performance targets that enable continuous improvement in commercial vehicle safety programs. With the completion of this work, the Ministry will begin publicly reporting relevant performance measures to the public.

Appendix 1: Commercial Vehicle Collision Statistics, 2008–2017

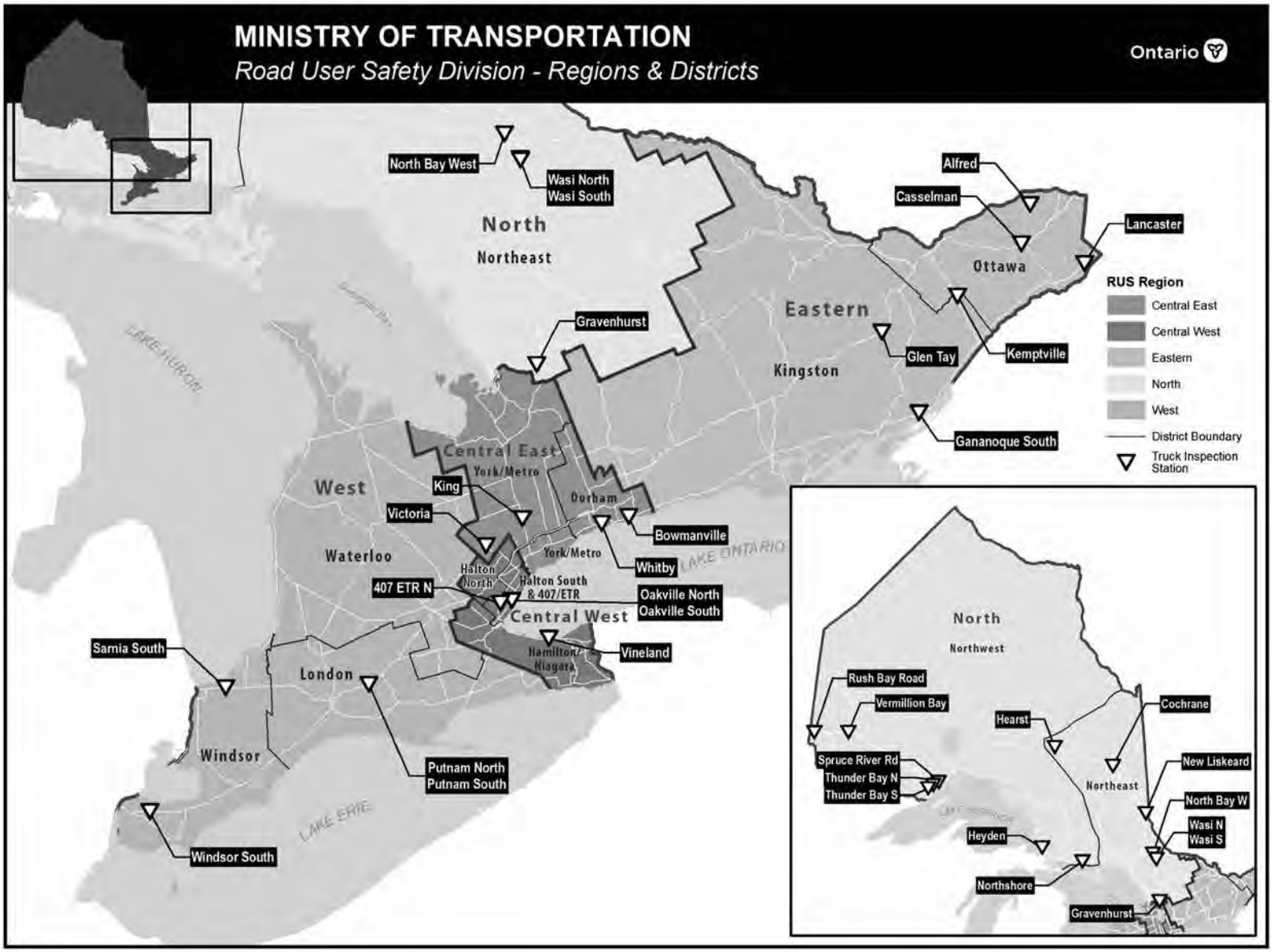
Source of data: Ministry of Transportation

	Registered	Collisions	Injuries	Fatalities
Large Trucks[1]				
2008	221,555	16,416	3,666	130
2009	217,116	13,226	2,948	99
2010	221,445	13,981	3,213	109
2011	226,731	13,932	3,175	101
2012	230,738	13,491	3,091	100
2013	233,478	14,738	3,287	96
2014	237,435	16,306	3,615	109
2015	236,904	15,155	3,368	95
2016	244,773	14,259	3,145	113
2017[2]	249,786	14,391	3,156	137
Total		**145,895**	**32,664**	**1,089**
Buses[3]				
2008	30,462	3,926	1,176	10
2009	30,372	3,691	1,224	12
2010	31,072	3,824	1,301	14
2011	31,211	3,825	1,282	7
2012	31,806	3,792	1,226	6
2013	31,888	4,051	1,098	15
2014	32,291	4,176	1,009	12
2015	32,285	4,112	1,176	9
2016	33,415	3,573	1,205	8
2017[2]	33,367	3,341	1,000	6
Total		**38,311**	**11,697**	**99**

1. Large trucks include tow trucks, open trucks, closed trucks, tanker trucks, car-carriers, dump trucks and tractor-trailers. Note: The types of truck in the Ministry's registration data does not align with the types of truck indicated by police on collision reports. The Ministry indicated an accurate comparison between all types of trucks registered in Ontario and those involved in collisions is not possible.
2. 2017 data is preliminary.
3. Buses include municipal, intercity and school buses.

Appendix 2: Regions and Roadside Inspection Stations

Source of data: Ministry of Transportation



Appendix 3: Roadside Inspections by District and Region, 2018

Source of data: Ministry of Transportation

Region	District	Roadside Inspection	% of Total Inspections	Enforcement Officers[1]	% of Total Officers
West	Kitchener	3,484	4	7	4
	London	11,117	13	18	10
	Windsor	12,957	15	22	13
	Total	**27,558**	**31[2]**	**47**	**27**
Central West	407 ETR	2,358	3	4	2
	Halton	7,904	9	19	11
	Hamilton	7,911	9	15	9
	Total	**18,173**	**20[2]**	**38**	**22**
Central East	Durham	5,027	6	12	7
	Metro Toronto[3]	2,728	3		
	Peel	1,375	2	17	10
	York	4,693	5		
	Total	**13,823**	**16**	**29**	**16[2]**
East	Kingston	7,221	8	15	9
	Ottawa	9,745	11	18	10
	Total	**16,966**	**19**	**33**	**19**
Northern	North Bay[4]	3,218	4		
	Sudbury	1,263	1	14	8
	Timmins	1,807	2		
	Kenora[5]	1,653	2		
	Sault Ste. Marie	2,627	3	14	8
	Thunder Bay	1,577	2		
	Total	**12,145**	**14**	**28**	**16**
Province Total		**88,665**	**100**	**175**	**100**

1. Excludes supervisors, facility auditors and trainees.
2. Some percentages have been rounded.
3. Metro Toronto, Peel and York share these 17 enforcement officers.
4. North Bay, Sudbury and Timmins share these 14 enforcement officers.
5. Kenora, Sault Ste. Marie and Thunder Bay share these 14 enforcement officers.

Appendix 4: A Facility Audit Evaluation and Audit Scores

Prepared by the Office of the Auditor General of Ontario

A facility standard audit includes an evaluation of the following:

- **Vehicle maintenance –** Examination of vehicle maintenance records including repairs, preventative maintenance, and annual and semi-annual inspections.
- **Hours of service –** Examination of driver logs and on-duty hours for compliance with the requirements of the Act, and comparison to supporting documentation such as receipts for bridge tolls, fuel, accommodations and meals, telephone, and GPS records.
- **Qualifications, records and reporting –** Review of conviction and collision records, driver qualifications, and driver abstracts. Driver abstracts are a five-year record of the driver's collisions, safety-related offence convictions and inspection defects relating to the driver.

The audit produces a percentage compliance score for each of the above categories evaluated. Violations found during facility audits can result in charges against the carrier. If the carrier is convicted, the convictions are included on the carrier's safety record (discussed in **Section 2.5.2**).

After an audit, carriers receive one of the following three facility audit scores:

- **Excellent –** If the overall audit score is 80% or greater and all categories examined receive a score of 70% or greater. Carriers that receive an excellent score may receive an "excellent" carrier safety rating, depending on their on-road safety performance.
- **Pass –** If the overall audit score is 55% or greater and no category examined receives a score below 50%. Carriers that receive a passing score receive at most a "satisfactory" carrier safety rating, but no higher, depending on their on-road safety performance.
- **Fail –** If the overall audit score is below 55% or any category examined receives a score below 50%. Carriers that receive a failing score are eligible for at most a "conditional" carrier safety rating. A carrier that receives a conditional safety rating cannot improve its rating unless it passes a subsequent audit. The Ministry may initiate a partial audit if only some categories of the audit need to be re-evaluated.

Appendix 5: Commercial Vehicles that Motor Vehicle Inspection Station Mechanics Can Inspect, by Certification

Source of data: Ministry of Transportation

Vehicle Type	Restrictions	Certification		
		Automotive Service Technician	Truck and Coach Technician	Trailer Service Technician
Trucks	4,500 to 9,000 kg GVWR* – no air brakes	✓	✓	
	>9,000 kg GVWR – including air brakes		✓	
Buses	3,400 kg to 9,000 kg GVWR – no air brakes	✓	✓	
	≥3,400 kg GVWR – with air brakes		✓	
Trailers	<4,500 kg GVWR – no air brakes	✓	✓	✓
	≥4,500 kg GVWR – with air brakes		✓	✓

* Gross vehicle weight rating.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Roadside inspections of commercial vehicles and drivers are carried out in accordance with standards and are effective in detecting and deterring vehicle defects, and carrier and driver infractions.
2.	Effective processes are in place for monitoring commercial vehicle carrier safety performance. Appropriate interventions and corrective actions are taken on a timely basis when carriers have poor safety records or pose a safety risk.
3.	Effective monitoring—including audits, investigations, and where necessary, steps to facilitate corrective action—is taken to ensure motor vehicle inspection stations comply with legislative and Ministry of Transportation policy requirements concerning the inspection and certification of commercial vehicles.
4.	Effective processes are in place to ensure commercial vehicle drivers have sufficient training, experience and knowledge to safely operate commercial vehicles. The public are made aware of how to effectively reduce their own risk when encountering commercial vehicles on Ontario's roads.
5.	Human and physical resources, including inspection stations, are used efficiently and effectively to fulfill mandated responsibilities.
6.	Accurate, timely and complete information is regularly collected to allow management to assess the performance of safety programs and to make informed decisions.
7.	Meaningful performance indicators and targets to enhance commercial vehicle safety are established, monitored and compared against actual results to ensure intended safety outcomes are achieved. Results are publicly reported and corrective action is taken on a timely basis.

Ministry of Long-Term Care

Food and Nutrition in Long-Term-Care Homes

1.0 Summary

More than 77,000 adults live in Ontario's 626 long-term-care homes. The Ministry of Long-Term Care (Ministry) funds the homes to provide residents with 24-hour nursing care and help with daily living activities in a protective and supportive environment.

The legislation governing long-term-care homes in Ontario states that the homes are a place where residents may live with dignity and in security, safety and comfort. Long-term-care homes also provide more assistance than either retirement homes or supportive housing.

At the time of our audit, the average age of residents in Ontario's long-term-care homes was 83. However, compared with 2009, the current cohort of residents are more cognitively impaired and require more assistance with daily living. The percentage of residents with a form of dementia has increased from 56% in 2009 to 64% in 2019. In essence, as the population in Ontario has increased, the number of long-term-care home beds has not risen proportionately, meaning that people with dementia are proportionately filling more of the beds. As noted in **Appendix 1**, the overall state of residents admitted into long-term-care homes has declined since 2009. People with dementia require more help with basic daily activities, including eating and drinking. It was estimated that in 2016, there were 228,000 people living with dementia and this number was expected to grow to over 430,000 by 2038. Providing food and nutrition services to residents will become more challenging for long-term-care homes with the expected increase in the prevalence of dementia. As of March 31, 2019, the occupancy rate of long-term-care homes was 98%. In about 25 years, it is expected that the number of people aged 65 and over in Ontario will almost double and account for 25% of the province's population.

A basic and frequent activity in long-term-care homes is eating, with the dining experience being one of the most social times of day. Not only do families of the residents count on long-term-care homes to care for their vulnerable loved ones, the residents themselves depend on receiving nutritious food to sustain their well-being in a comfortable environment. We observed throughout the audit that residents rarely had family or friends present during mealtimes and relied on personal support workers to provide appropriate food and nutrition.

The Ministry inspects long-term-care homes on aspects related to food, such as dining room observation, menu planning, and evaluating nutritional and hydration risks to residents. As well, Ontario's 35 public health units, which are co-funded by the Ministry of Health and municipalities, inspect the homes for food-safety

concerns such as food temperature control, food-area sanitation, pest control and food-preparation practices.

The consequences of improper food and nutrition care are significant. In the 17 months between January 2018 and May 2019, long-term-care homes reported over 660 incidents involving food and nutrition issues. These included residents choking, missed meals, staff feeding residents food with the wrong texture, and gastroenteritis outbreaks. These outbreaks may be caused by contaminated food or drink, or spread through contact with infected persons or contaminated items for reasons such as poor handwashing practices. This represents about 1.3 incidents a day and includes 27 cases of unexpected deaths for reasons such as choking or aspiration and about 100 cases of abuse, neglect or improper treatment of a resident by home staff related to food that resulted in harm or risk of harm to the resident. Choking occurs when a foreign object obstructs a person's airway and aspiration occurs when a person accidentally inhales an object or fluid into their windpipe or lungs.

Further, according to the Ministry of Health's database on avoidable emergency department visits based on data reported by hospitals, in 2018 long-term-care home residents made 1,121 food-related emergency room visits that might have been avoided. This includes 454 avoidable emergency department visits in 2018 due to dehydration, representing about one in every 175 residents. According to Dietitians of Canada, "dehydration is estimated to be present in almost half of the long-term-care residents. Inadequate fluid intake may lead to increased risk of: constipation, falls, longer time for wound healing, acute confusion, decreased kidney function, and increased hospitalization."

Our audit found that the long-term-care homes were not consistently providing residents with sufficient and high-quality food and nutrition care. Further, the Ministry could do more through its inspection program to help confirm that long-term-care homes are providing a safe and comfortable eating environment and good quality food to help residents enjoy a more home-like dining experience at the long-term-care homes. In some cases, residents were subject to unnecessary risks that made them ill, simply by eating and drinking.

Our more significant audit findings include:

Dining Room Experience

- **Mealtime service is affected when personal support workers tend to other responsibilities or do not report to work.** Some residents are dependent on long-term-care home staff during mealtimes as they require assistance and encouragement eating and drinking. Residents typically wait longer during breakfast to receive their food, an average of 43 minutes compared to 29 minutes during lunch and 24 minutes during dinner, because personal support workers have other responsibilities in the morning to help residents get ready for the day. For example, at one home we observed that a resident only had two bites of food and needed to wait for staff to come back to feed them because the staff had been called away to help another resident. We also observed a resident was not encouraged to eat their meal despite having stayed in the dining room for over an hour and only ate a third of the main course. As well, over a two-week period in February 2019, one in eight or 13% of meals served at the long-term-care homes at which we conducted detailed work did not have a full complement of staff reporting to work on those days. These staff would typically work in the dining room. At one home, the absence rate was much higher, with 39% of meals not having the expected number of staff. We surveyed a sample of personal support workers in the 59 long-term-care homes we visited across Ontario. Of those personal support workers who responded to our survey, 46% said that they could provide sufficient care to meet nutritional needs of residents at the current

staffing levels, 24% said that they could not and 30% had no opinion.

- **Residents in older long-term-care homes can be less likely to enjoy meals in a home-like environment.** The Ministry requires dining rooms in long-term-care homes built after 1998 to have no more than 32 residents, but homes built before then are not subject to this design standard. We observed at two older homes that some residents were eating in a hallway outside the dining room, close to linen carts and to people moving through the hallway.

Nutritional Care Needs

- **Long-term-care staff do not consistently follow the residents' plan of care, increasing the risk that residents may be eating the wrong food.** Plans of care define the level of care residents require for various aspects of their living activities, including eating. Between January 2017 and May 2019, the Ministry noted 56 homes that failed to follow a resident's plan of care, with 29% of these homes having repeated non-compliance issues in this same area. Staff at a home where we conducted detailed work informed us that they knew the residents well enough to have memorized the residents' diet requirements and did not refer to the dietary requirement lists. Dietary requirement lists have selected information from the current plan of care for residents including updates. Direct-care staff therefore could not be readily aware of changes to plans of care as documented in the system, increasing the risk that the residents in the dining room received inappropriate meals.
- **Long-term-care homes' registered dietitians do not spend sufficient time proactively monitoring residents.** Although registered dietitians spend at least 30 minutes per resident per month to carry out clinical and nutrition care duties as required by regulation, they estimate that they spend most of this time performing clinical assessments and creating or updating plans of care, as opposed to activities such as proactively observing residents eating in the dining room to help identify residents who may be struggling to eat or feed themselves. Early recognition of nutritional intervention could avoid putting residents' health at risk.

Food Quality and Safety

- **Menus do not have recommended nutrients for residents compared to the recommendations in the Dietary Reference Intakes.** While we found that homes' menus had sufficient protein, they contained too much sugar (40% to 93% above recommended amount); too much sodium (32% to 59% above recommended amount); and not enough fibre (19% to 34% below recommended amount). This is contrary to the regulatory requirement for these menus to provide residents with adequate nutrients, fibre and energy based on the current Dietary Reference Intakes. Some homes' registered dietitians have highlighted exceptions to the recommendations in their assessments but still approved these menus. At the five homes where we conducted detailed work, registered dietitians and nutrition managers informed us that in the last three years, Ministry inspectors never asked them for the nutrient analysis of the home's menu.
- **Long-term-care homes are offering residents food and drinks high in sugar; high sugar intake can contribute to heart disease, stroke, obesity, diabetes, high blood cholesterol, cancer and poor dental health.** The 2019 Canada's Food Guide recommends water as the drink of choice, but juice is the most purchased item in three of the five homes where we obtained detailed food-purchase information. As well, we observed

that juice was consistently on the menus at all of the homes we visited during this audit, and staff seldom encouraged water over juice. Further, snacks served at homes consisted mainly of different types of cookies, loaves or pastries.

- **In three of the five long-term-care homes where we conducted detailed work, some food used to make meals was past its best-before date.** Two of these homes served that food to its residents; one of the food items was three months beyond the best-before date. Food past its best-before date may still be safe but can lose some of its freshness, flavour and nutritional value, and undergo a change in texture.
- **Only 19% of residents observed to have washed their hands to proactively prevent and control infections.** We also observed that 76% of staff practised proper hand hygiene directly before or after the meal. According to the Ministry of Health and Long-Term Care, which is now the Ministry of Health, long-term-care homes could prevent 20% of these infections through adherence to an infection prevention and control program that includes proper hand hygiene. Of the five homes where we conducted detailed work, four had experienced gastroenteritis outbreaks between January 2018 and May 2019. The home that did not have a gastroenteritis outbreak had the highest handwashing rate, at 69%, compared to a range of 0% to 35% in the other four homes. Of these four homes, one experienced a gastroenteritis outbreak in spring of 2019 over a 19-day period. This incident affected over 20 staff and over 100 residents—five residents subsequently died as a result. In the 17-month period of January 2018 to May 2019, over 510 cases of gastroenteritis outbreaks at 325 homes were reported affecting multiple residents.

Food Purchasing

- **Group purchasing has not been fully explored to help long-term-care homes realize higher savings to allocate to potentially higher-quality food.** Each long-term-care home is responsible for securing its own food suppliers. Ontario Health, an agency established under the *Connecting Care Act, 2019*, will eventually be responsible for co-ordinating with long-term-care homes and other health-service providers to realize the benefits of group purchasing. Widespread group purchasing was not in place at the completion of our audit.

Performance Measurement

- **The Ministry does not require long-term-care homes to report on performance indicators related to food and nutrition.** Such indicators could include the percentage of residents at high nutritional risk, ratio of staff to residents who need help eating and satisfaction of residents and families with respect to food and dining. As a result, the Ministry cannot fully measure whether residents are receiving sufficient and high-quality food, or identify areas of improvement to increase residents' satisfaction with food and nutrition intake, which would improve their overall quality of life.

This report contains 19 recommendations, with 31 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry of Long-Term Care (Ministry) and the long-term-care homes do not have sufficient procedures in place to confirm that residents are receiving sufficient mealtime assistance and that they receive food and nutrition services in accordance with their individual plans of care.

Menus that long-term-care home registered dietitians approved did not always meet nutritional requirements in accordance with Canada's Food Guide and the Dietary Reference Intakes. Some residents who require help to eat and drink have to wait longer when personal support workers tend to other responsibilities. Staffing is not consistently allocated optimally to provide residents with resident-centred care that meets their dietary and nutritional needs including feeding assistance requirements.

Further, the Ministry does not require long-term-care homes to report on performance indicators related to food and nutrition, such as the percentage of residents at high nutritional risk. As a result, the Ministry cannot confirm that all long-term-care home residents are receiving sufficient food and nutrition care.

OVERALL RESPONSE FROM ADVANTAGE ONTARIO AND ONTARIO LONG TERM CARE ASSOCIATION (ASSOCIATIONS)

We agree with the Office of the Auditor General that more supports are needed to improve the food and nutrition care of those living in long-term-care homes. The issues outlined in the report are a symptom of a systemic shortfall of funding and other supports that have contributed to a severe staffing shortage.

As the report recognizes, people who live in long-term care have increasingly complex needs. In the last decade, there has been a significant increase in acuity and the number of people who need support with daily activities such as eating and drinking. Yet funding and other supports have not kept pace. Improving the dining experience for residents is also dependent on a massive infrastructure program to rebuild and modernize Ontario's long-term-care homes.

Another important consideration for the findings in this report is resident choice. Long-term-care homes are rapidly adopting the people-centred approach to care that honours personal preferences and habits, rather than an institutional model. Many people in long-term care prefer to eat a diet they find familiar, even if it is "less nutritious." Many are also near the end of life when the desire to eat and drink naturally diminishes. The rights of seniors living in long-term-care homes, including those with dementia, to decide what they wish to eat or drink must be respected. The *Long-Term Care Homes Act, 2007* and its dietary requirements are based on the old institutional model of care.

We recommend government work with the sector to move forward on the development of a health human resources strategy to address the staffing crisis and nutrition issues in long-term-care homes.

OVERALL MINISTRY RESPONSE

The fundamental principle of the *Long-Term Care Homes Act, 2007* (Act) is to provide a place for residents to live with dignity and in security, safety and comfort. Dietary services, nutritional care and hydration programs are central to maintaining the well-being of over 78,000 long-term-care home residents in Ontario.

The government understands that nutritious food is critical to overall care and as such, the Ministry of Long-Term Care (Ministry) appreciates the comprehensive audit conducted by the Auditor General on Food and Nutrition in Long-Term-Care Homes.

The Act and Ontario Regulation 79/10 require that every licensee of a long-term-care home ensures that there are organized programs of nutrition care and dietary services to meet the daily nutrition needs of the residents.

Each day, there are over 234,000 meals served in long-term-care homes, which is over 85 million meals per year. Reported food-related incidents represent less than 1% of these daily interactions. The Auditor General made

a recommendation to the Ministry in the 2015 audit of Long-Term-Care Home Quality Inspection Program to put the safety of residents first by focusing on high-risk areas. As a result, in fall of 2018, the Ministry shifted to a risk-based compliance program to prioritize inspections and resources for situations that put the residents at highest risk.

The Ministry has made a combination of investment and policy changes over the past few years to ensure that residents' nutritional requirements are met. Since 2011/12, the Raw Food per diem has increased by more than 28%. In 2019/20, the Ministry provided a global per diem increase of 1% to the Level of Care funding.

We are investing $72 million more into long-term care this year. This is in addition to $1.75 billion invested to create 15,000 new long-term care beds and redevelop 15,000 older long-term care beds over five years.

We actively engage with partners to support innovation in the delivery of long-term-care services and infrastructure, including ensuring that proposed long-term-care home development and infrastructure projects serve the needs of their communities.

2.0 Background

2.1 Overview of Long-Term-Care Homes

Ontario's 626 long-term-care homes provide residential accommodations to over 77,000 adults who need 24-hour nursing care or help with daily living activities such as eating in a protective and supportive environment. According to the *Long-Term Care Homes Act, 2007* (Act), a long-term-care home is "primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met."

The Ministry of Long-Term Care (Ministry), formerly part of the Ministry of Health and Long-Term Care, funds, licenses and regulates the homes under the Act. Long-term-care homes are supposed to offer more personal care and support than typically offered by either retirement homes or supportive housing.

Homes are operated by either for-profit or not-for-profit entities, including municipalities. All homes, regardless of their ownership or governance model, must comply with the legislative requirements under the Act.

As shown in **Figure 1**, the average age of long-term-care home residents was 83 as of March 2019, the same as in 2009. However, compared to 2009, the current cohort of residents are more cognitively impaired and require more assistance with daily living. In essence, as the population in Ontario has increased, the number of long-term-care beds has not risen proportionately, meaning that people with dementia (discussed in **Section 2.2.4**) are proportionately filling more of the beds. According to the Ministry, each resident stays on average two years and seven months, and the most typical reason for leaving a long-term-care home is death. As of March 2019, the occupancy rate of long-term-care home beds was 98%. The state and abilities of long-term-care home residents in 2009 and 2019 are illustrated in **Appendix 1**.

In addition to the Ministry, several other key organizations and stakeholders are involved in various aspects of homes. Each of them plays a key role in providing and/or supporting quality of care and quality of life for residents. **Appendix 2** provides more detail on the key players and their roles in the long-term-care home sector.

Figure 1: Profile of Long-Term-Care Residents in Ontario, March 2009 and 2019

Source of data: Ministry of Long-Term Care, Ministry of Health, the Canadian Institute for Health Information and Statistics Canada

	As of March 31, 2009	As of March 31, 2019	% Change
Total # of residents	75,960	77,391	2
# of residents per 1,000 population	5.8	5.3	(9)
# of residents per 1,000 population aged 65 and over[1]	43	31	(28)
Average age of resident	83 years	83 years	–
% of residents aged 85 years or older	50	55	10
% of residents under 65 years	6	6	–
% of female	69	67	(3)
% of male	31	33	6
% of residents with a form of dementia such as Alzheimer's disease	56	64	14
Average cognitive performance of residents[2]	2.8	3.1	n/a
Average assistance required for daily activities of residents[3]	3.5	3.9	n/a
Average duration of stay	2 years, 7 months[4]	2 years, 7 months[4]	–

1. As of July 1.
2. Based on a scale from 0 to 6, with 0 being cognitively intact and 6 being very severely impaired, as per aggregate assessment scores recorded by long-term-care homes and collected by the Canadian Institute for Health Information.
3. Based on a scale from 0 to 6, with 0 being independent and 6 being totally dependent, as per aggregate assessment scores recorded by long-term-care homes and collected by the Canadian Institute for Health Information.
4. As of December 31, 2011, the earliest available data and December 31, 2018, the latest available data.

2.2 Overview of Food and Nutrition in Long-Term-Care Homes

2.2.1 Impact of Food on Resident Health

Nutrition care and dietary services in long-term-care homes are among the key programs that enhance residents' quality of life. Each day, homes provide residents with three meals, as well as two snacks and three drinks between meals. Many residents consider dining times to be one of the most social times of the day.

A long-term-care-home resident can also use food and nutrition to restore health or prevent its deterioration. For example, an increase in calcium and vitamin D intake can reduce serious risks of bone fractures from falls. As well, for some residents, appropriate quantity and quality of food intake can help control diseases related to the heart, blood pressure, strokes, dementia and blood-sugar levels. In contrast, inadequate or improper nutrition and dietary intake increases the risk of health consequences such as malnutrition, dehydration, delayed healing of wounds, and food-borne illnesses.

Various staff in and outside of homes are involved in providing food and nutrition services to residents, as shown in **Appendix 3**. For example, the registered dietitian at a home is responsible for assessing residents to identify the level of help they require to eat and the consistency of food they need, such as regular versus puree.

2.2.2 Canada's Food Guide

A regulation made under the *Long-Term Care Homes Act, 2007*, requires that long-term-care homes provide a variety of foods each day from all food groups in keeping with Canada's Food Guide. In January 2019, Health Canada released a new version of the Food Guide, 12 years after the last update. Unlike the previous Food Guide, the current Food Guide no longer classifies food into

different groups or provides serving counts for recommended intake. Instead, it provides guidelines and advice intended to help Canadians make healthy food choices and adopt healthy eating habits. Another significant change is that Health Canada recommends that fruit and vegetables make up half of the plate, with whole grains and protein foods each making up the remaining quarters (see **Figure 2**).

In late 2019, Health Canada planned to release additional resources directed at health professionals and policy-makers for use in different institutional settings.

During our audit in 2019, homes were still following the old Canada's Food Guide when delivering food and nutrition services. Although the Ministry expects homes to comply with the Act and as such the current Canada's Food Guide, at the time of our audit, there was an understanding with the Ministry that homes were in a period of transition.

2.2.3 Dietary Reference Intakes

A regulation made under the *Long-Term Care Homes Act, 2007*, requires that a long-term-care-home operator provide adequate nutrients, fibre and energy for residents based on the current Dietary Reference Intakes values established by a scientific body commissioned by both the Canadian and the US governments. These values specify the intake level required of healthy populations in specific sex and age groups. An example of a standard from the Dietary Reference Intakes is that people over the age of 70 years have a recommended dietary allowance of 1,200 mg of calcium per day.

Health Canada recommends using these values for assessing and planning diets, and expects professionals such as registered dietitians in healthcare settings to tailor these values to accommodate health requirements of different individuals.

Figure 2: Key Aspects of Canada's Food Guide, January 2019

Source: Health Canada

Guideline 1

Nutritious foods are the foundation for healthy eating.

- Vegetables, fruit, whole grains and protein foods should be consumed regularly. Among protein foods, consume plant-based more often.
  - Protein foods include legumes, nuts, seeds, tofu, fortified soy beverage, fish, shellfish, eggs, poultry, lean red meat including wild game, lower fat milk, lower fat yogurts, lower fat kefir, and cheeses lower in fat and sodium.
- Foods that contain mostly unsaturated fat should replace foods that contain mostly saturated fat.
- Water should be the beverage of choice.

Guideline 2

Processed or prepared foods and beverages that contribute to excess sodium, free sugars, or saturated fat undermine healthy eating and should not be consumed regularly.

- For example, sugary drinks and confectioneries should not be consumed regularly.

Guideline 3

Food skills are needed to navigate the complex food environment and support healthy eating.

- Cooking and food preparation using nutritious foods should be promoted as a practical way to support healthy eating.
- Food labels should be promoted as a tool to help Canadians make informed food choices.

2.2.4 Impact of Dementia on Food Intake and Assistance Required

The percentage of long-term-care home residents with dementia has increased in the last 10 years, from 56% in 2009 to 64% in 2019, as shown in **Figure 1**. People with dementia require more assistance with daily living needs such as eating and drinking.

Dementia is not a part of normal aging; it is a group of conditions that affect the brain and causes problems with memory, thinking, speaking or performing familiar tasks such as eating and drinking. Poor appetite, cognitive impairment, physical disabilities, and hearing or eyesight loss can all cause a resident with dementia to have problems eating and drinking. As dementia progresses, residents need more assistance with eating and drinking. Residents with severe dementia or other end-stage diseases eat and drink less as part of the natural progression of their disease.

The incidence of dementia is expected to rise in the coming years; the increase will likely result in a corresponding increase in the demand for more assistance with eating and drinking in homes. The Premier's Council first interim report, *Hallway Health Care: A System Under Strain*, issued in January 2019, noted that an estimated 228,000 people in Ontario lived with dementia as of 2016, and that this number is expected to grow to over 430,000 by 2038. The report also noted that "some long-term-care homes cannot care for additional residents with dementia since the numbers are already so high—which can delay admission and cause additional strain on families looking for support."

2.3 Food and Nutrition Standards and Related Inspections in Long-Term-Care Homes

Two primary pieces of legislation and their regulations govern the requirements of long-term-care homes in their provision of food and nutrition services, as shown in **Figure 3**. The Long-Term Care Homes Quality Inspections and the Food Premises Inspections, conducted by Ministry of Long-Term Care staff and public health unit staff, respectively, serve to confirm compliance with these legislative and regulatory requirements. There was little overlap between the procedures of these two types of inspections.

2.3.1 Long-Term Care Homes Quality Inspection Program

The Ministry implemented the Long-Term Care Homes Quality Inspection Program in July 2010, after the *Long-Term Care Homes Act, 2007* (Act) came into effect. This inspection program focuses on residents' quality of care and quality of life. Through inspections and inquiries, the Ministry checks for compliance with the Act and its regulation to protect the rights, safety, security and quality of life of residents.

The Ministry conducts four types of unannounced inspections—quality of residents' experience, complaints, critical incidents and follow-ups—and publishes the results on its website. The Act requires that the Ministry inspect each home annually. In some cases, the Ministry combines several different types of inspections to allow for addressing higher-priority inspections in a streamlined fashion. For example, the Ministry may address other issues simultaneously with a quality-of-residents'-experience inspection—the only form of inspection that is proactive—during inspection visits to homes. In 2018, the Ministry conducted 1,662 inspections, 329 of which, or 20%, were proactive quality-of-residents'-experience inspections.

The Ministry establishes inspection protocols to assist inspectors in determining whether a home complies with legislative and regulatory requirements. These protocols contain instructions, guidance, probes and questions for use during inspections. The Ministry also makes these protocols available to all homes for self-inspection.

Some protocols relate directly to food and nutrition in homes, as shown in **Appendix 4**. In 2018,

Figure 3: Relevant Legislation and Regulations Governing Delivery of Food and Nutrition Services in Long-Term-Care Homes

Prepared by the Office of the Auditor General of Ontario

Legislation and Regulation	Details

Long-Term Care Homes Act, 2007 and Ontario Regulation 79/10	• designed to provide residents with safe, consistent, high-quality, resident-centred care in accordance with their plans of care
	• regulates admissions, operations, funding, licensing, compliance and enforcement through inspections at long-term-care homes
	• governs residents' rights, care, and service, specifically, every resident has the right to be properly fed through an organized program for dietary services, nutrition care, and hydration services
	• outlines requirements such as menu planning, food production, dining and snack services, and proper qualifications of staff involved with food management
	• requires menus:
	  ◦ to be approved by the long-term-care home's registered dietitian;
	  ◦ to provide for adequate nutrients, fibre and energy for residents based on the current Dietary Reference Intakes; and
	  ◦ to provide for a variety of foods, including fresh seasonal foods, each day, in keeping with Canada's Food Guide
	• requires registered dietitians spend at least 30 minutes per resident per month to carry out clinical and nutrition care for residents
	• requires long-term-care homes to have a full breakfast available before 8:30 a.m. and serve dinner after 5:00 p.m.

Health Protection and Promotion Act and Ontario Regulation 493/17	• aimed at preventing the spread of diseases and promoting and protecting the health of the people in Ontario • sets out the requirements for the operation of food premises, such as long-term-care homes, in Ontario to assist in the prevention and reduction of foodborne illnesses, and the enforcement of the regulation through public health inspections • sets out the requirements for operation and maintenance of the food premises, cleaning and sanitizing of equipment, and food handling

105 or 6% of the Ministry's inspections covered aspects of food or nutrition. Since 2015, inspections that related to food or nutrition have steadily declined from 13% to 6%.

Our Office last audited the Long-Term Care Homes Quality Inspection Program in 2015.

2.3.2 Food Premises Inspection Program

The *Health Protection and Promotion Act* stipulates the province's 35 public health units, funded jointly by the Ministry of Health and municipalities, have the power to inspect any place where food is prepared, stored, or served, including long-term-care homes. Public health units classify homes as "high-risk food establishments" because they serve a vulnerable population consisting mainly of seniors. As such, the Ministry of Health requires public health units to inspect homes a minimum of three times a year.

To assist in the prevention and reduction of foodborne illnesses, the Ministry of Health has provided local public health units with direction through public health standards, food safety protocols and guidelines. These specify that local public health units through inspections must:

- assess risk of food safety practices and determine if homes comply with the Food Premises regulation under the Act; and
- provide consultation and education on food handling practices to homes.

During routine inspections, public health inspectors observe whether homes maintain food safety practices, such as keeping the correct temperature for food safety from the preparation to serving process and keeping raw food separate from ready-to-eat food, as shown in **Appendix 4**.

2.4 Funding

2.4.1 Ministry Funding and Resident Co-payments to Long-Term-Care Homes

The Ministry, along with residents, co-fund long-term-care homes operations.

Residents pay their "room and board" or co-payment to the home at a rate set by the Ministry. For example, as of July 2019, the rate for a long-stay basic room, which accommodates between one and four residents, is about $1,900 per month. Residents in a basic room may apply for a government subsidy should they require income assistance to pay for the room and board fee.

Homes also receive Ministry funding through the Local Health Integration Networks (LHINs) in the following four broad areas: nursing and personal care; program and support services; raw food; and other accommodations, as shown in **Figure 4**. Raw food funding includes both "raw" and other products such as processed or frozen food to make meals. Other accommodations funding covers other areas such as salaries for food service workers and

Figure 4: Breakdown of Ministry of Long-Term Care per-Diem Funding to Long-Term-Care Homes for Each Resident by Funding Categories, August 2019

Source of data: Ministry of Long-Term Care

Funding Category	Details	Amount ($)	Allocation (%)
Nursing and Personal Care	• Includes wages, benefits, and training for direct-care staff, as well as any equipment or supplies used by direct-care staff to provide nursing and personal care to the residents. • Staff in this category include registered nurses, registered practical nurses, and personal support workers who, beyond clinical duties, provide eating assistance to residents.	102.34	56
Program and Support Services	• Includes staff, equipment, and supplies used to provide services and programs to residents. • Staff in this category include Registered Dietitians, physiotherapists, occupational therapists, social workers, recreational staff and others that provide support services to the residents.	12.06	7
Raw Food[1]	• Strictly for the purchase of raw food materials, including food supplements ordered by a physician, a nurse, or a Registered Dietitian. • Includes the resident portion of food for special events (like Christmas dinners), but does not include any non-resident guests like family.	9.54	5
Other Accommodations[1]	• Includes other eligible expenditures defined in the Ministry's policy that are not included in the above categories, such as dietary services (i.e., food service workers, cooks), housekeeping services, property operations and maintenance, and general and administration services.	56.52	31
Total[2]		**180.46**	
2019/20 Global Increase	• For 2019/20, the Ministry provided an overall increase on top of the above four funding categories. The purpose of this additional funding was to enhance direct-care services as well as to support other operating costs within any of the four categories.	1.77	1
2019/20 Total		**182.23**	**100**

1. Ministry funds up to this amount after the long-term-care home applies the residents' co-payments to these two categories.
2. This per diem amount is the standard rate for residents with the lowest complexity of needs. The Ministry uses a formula to adjust this base per diem rate according to the overall complexity score of the residents in the long-term-care home.

Figure 5: Ministry of Long-Term Care Funding for Raw Food and Total per Diem per Resident, 2015/16–2019/20
Source of data: Ministry of Long-Term Care

Fiscal Year	Raw Food per Diem Funding ($)	Raw Food as a % of Total per Diem (%)	Total per Diem Funding ($)
2015/16	8.03	4.9	163.71
2016/17	8.33	5.0	166.63
2017/18	9.00	5.3	170.78
2018/19	9.54	5.4	176.76
2019/20	9.54[1]	5.2	182.23[2]
% increase from 2015/16–2019/20	**19[3]**	**6.7**	**11**

1. For 2019/20, the Ministry provided an overall increase of $1.77 per resident per day on top of four funding categories, including the raw food category, as described in **Figure 4**. The purpose of this additional funding was to enhance direct-care services as well as to support other operating costs within any of the four categories.
2. The per diem rate for the period April 1 to July 31, 2019 was $180.80. The Ministry increased this rate to $182.23 effective August 1, 2019.
3. In comparison, the cost of Canadian food inflated by 10% between June 2014 and June 2019 as per Statistics Canada. We discuss the reasonableness of the raw food and food production costs in **Section 4.8.1**.

cooks. The LHINs generally do not adjust Ministry-determined funding to homes.

Homes report actual spending in these four areas to the Ministry annually. The Ministry allows homes to make a profit from the resident-paid "room and board" amount, and from any savings achieved in the "other accommodations" category. However, the Ministry expects homes to return any unspent funds if there are any in raw food, nursing and personal care, and program and support services, at the end of each calendar year.

Homes may receive additional funding beyond what they receive from the Ministry and their residents. For instance, not-for-profit homes may receive additional funding through fundraising efforts and municipal homes may receive additional funding from their municipality.

2.4.2 Funding and Spending Related to Food

For 2019/20, the Ministry's funding on raw food was $9.54 per day per resident, representing a 19% increase from 2015/16, as shown in **Figure 5**. This increase is above the increase in the cost of food in Canada over the same period. This funding includes a portion of resident co-payment with top-up from the Ministry to the per diem amount.

The Ministry maintained the per diem funding rate of $9.54 per resident for raw food used in 2018/19 for 2019/20, but increased the overall daily rate from $176.76 to $182.23 per resident per day over these two years.

The Ministry and resident co-payment together fund long-term-care homes' spending on food, food service workers and cooks, with the residents paying the majority of these costs:

- On raw food alone, the split between residents and the Ministry is about 73/27—based on data from 2017/18, the most recent available financial data obtained from the Ministry. In that year, residents paid about $184 million and the Ministry spent about $68 million on the food used to make meals.
- After including food production costs such as the salary of cooks and food service workers, using data from a sample of homes we visited, the split between residents and the Ministry is about 73/27 based on data from 2018/19, as shown in **Figure 6**.

Figure 6: Estimated Spending per Resident per Day on Food (2018/19) and Food Production Cost (2017)

Source of data: Ministry of Long-Term Care and selected long-term-care homes in Ontario

Food-Related Expenditure	Average Resident Co-payment ($)	Average Ministry Top-Up Amount ($)	Total ($)
Food[1]	6.47	2.39	8.86
Supplements[1]	0.50	0.18	0.68
Subtotal using "raw food" funding	**6.96**	**2.58**	**9.54**
Cost of food production using "other accommodations" funding[1,2]	11.51	4.26	15.77
Total food-related expenditures	**18.47**	**6.84**	**25.31**
Percent of total food-related expenditures	73%	27%	100%

1. Data is based on 2018/19 actual spending reported by five selected long-term-care homes in Ontario, excludes top-up from sources other than the Ministry and resident co-payment such as municipal top-up.
2. Data is based on 2017 (the most recent information available at the time of the audit) average dietary service costs as reported to the Ministry by all long-term-care homes in Ontario; these costs include salaries and wages of food service workers and cooks in the "other accommodations" funding category.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Long-Term Care (Ministry), in conjunction with long-term-care homes and public health units, has effective systems and procedures in place to ensure that:

- food and nutrition services are delivered to residents in long-term-care homes in accordance with relevant legislation, regulations and policies;
- resources are appropriately managed to provide safe and nutritious meals to long-term-care home residents; and
- results on the efficiency and effectiveness of food and nutrition services provided to long-term-care home residents are measured and publicly reported.

In planning for our work, we identified the audit criteria we would use to address our audit objective. We established these criteria based on a review of applicable legislation, policies and procedures, internal and external studies and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our objectives and associated criteria as listed in **Appendix 5**.

We conducted our audit between December 2018 and August 2019. We obtained written representation from Ministry management that, effective November 8, 2019, it has provided us with all the information it was aware of that could significantly affect the findings or the conclusion of this report.

Our audit focused on activities of the Ministry, public health units and long-term-care homes in the three-year period between 2016/17 and 2018/19 and considered relevant data and events in the last 10 years. In conducting our work, we reviewed applicable legislation, agreements, reports, and program guidelines and policies.

Overall, we visited 62 of the province's 626 homes across 60 municipalities, with the majority of our work conducted at 59 homes. **Appendix 6** shows the list of the homes we visited during this audit.

We conducted detailed audit procedures in five homes in Mississauga, Oshawa, Ottawa, Thunder Bay and Toronto. We selected these homes to visit based on a variety of factors such as geography, amount of funding provided, governance type of the home and number of residents. At these five homes, we conducted the following work:

- interviewed senior management, residents and family councils;

- interviewed and shadowed staff including registered dietitians, registered nurses and registered practical nurses (nurses), personal support workers, chefs and food service workers;
- observed inventory control at the home's kitchen, dining services and snack services;
- reviewed client files, homes' policies, records of gastroenteritis infections and outbreaks, inspection reports prepared by the Ministry and public health, complaints, resident council minutes, surveys and other relevant documents related to food and nutrition; and
- obtained and analyzed relevant data.

Further, we conducted unannounced visits at another 54 homes to observe meal service at either breakfast, lunch, or dinner, with some visits conducted on the weekend or on a statutory holiday when staffing level may differ from the regular workday.

At another two homes, we observed dining and kitchen operations and interviewed senior management as well as selected food and nutrition services staff to better understand their perspectives on food and nutrition services for home residents and their day-to-day work.

We surveyed 218 personal support workers at the homes we visited—personal support workers assist residents with their dining needs—to obtain their perspective on their workload and opinions on food at the home. The response rate for the survey was 97%.

At the Ministry, we obtained, reviewed and analyzed data on inspections, critical incidents, and financial information related to food and nutrition services at homes and interviewed relevant Ministry staff. To observe how the Ministry conducts its inspections, we accompanied its inspectors on the food-and-nutrition-related portion of a home complaint inspection in North York.

At five public health units located in Ottawa, Peel, Simcoe Muskoka, Toronto and York, we obtained and analyzed food-safety-inspection data and interviewed relevant public health unit staff. We co-ordinated with the audit team of the Food Safety Inspection Programs audit (see **Chapter 3, Section 3.06**) in selecting these five public health units, which were selected based on the number of food premises, especially high-risk premises including long-term-care homes, population of the region and total expenditures on food safety programs.

We met with the Ministry of Health and reviewed ministry documents to understand the province's food safety requirements in long-term-care homes. As well, we spoke with the Ministry of the Environment, Conservation and Parks to understand the province's waste diversion policy on food and organic waste in long-term-care homes.

At two Local Health Integration Networks (Central West and Hamilton Niagara Haldimand Brant), we interviewed senior management and reviewed relevant documents to understand their roles and responsibilities related to food and nutrition. We also met with Public Health Ontario and Health Shared Services Ontario to understand how their organization uses the data obtained from homes.

We met with several associations and advocacy groups that represent or work with long-term-care-home operators, residents and families across the province, including AdvantAge Ontario, Advocacy Centre for the Elderly, Family Councils Ontario and the Ontario Long Term Care Association.

Regarding the design and application of nutrition policy, we met with and reviewed documents prepared by Dietitians of Canada and its Ontario Long Term Care Action Group (Dietitians of Canada), a professional association representing dietitians at the local, provincial/territorial and national levels. As well, we met with Ontario Society of Nutrition Management. We spoke with the Office of Nutrition Policy and Promotion in Health Canada to understand the federal government's efforts to support healthy eating. We also engaged an independent registered dietitian to provide advice on information on best practices and evaluate a sample of menus used in homes to determine whether they meet regulatory requirements.

We researched how other provinces operate their food services in long-term-care homes and spoke with other large provinces including Alberta, British Columbia and Manitoba to identify areas for improvement in Ontario.

In determining the scope and extent of our audit work, we reviewed relevant audit reports issued by the Ontario Internal Audit Division and complaints data received by the Ontario Patient Ombudsman in the last two years.

4.0 Detailed Audit Observations

4.1 Poor Food and Nutrition Care Provided to Long-Term-Care Home Residents Could Lead to Significant Consequences

4.1.1 Average of at Least One Critical Food-Related Incident per Day Reported by Long-Term-Care Homes

Homes prepare over 231,000 meals each day. In the 17 months between January 2018 and May 2019, almost all of the province's 626 long-term-care homes reported critical incidents to the Ministry. Overall, 662 incident reports, representing about 1.3 incidents a day, contained issues on food and nutrition, such as choking, missed meals, staff feeding residents wrong texture food, and gastroenteritis outbreaks. These outbreaks may be caused by contaminated food or drink, or spread from person to person through contact with infected persons or contaminated items for reasons such as poor handwashing practices from staff, residents and visitors. These incidents include:

- 27 cases at 26 homes of unexpected deaths that related to choking or aspiration;
- about 100 cases at 70 homes of abuse, neglect or improper treatment of a resident by home staff related to food that resulted in harm or risk of harm to the resident—for instance, residents were given the wrong diet, force-fed, missed meals or did not receive staff assistance to eat;
- about 20 cases at 17 homes where the residents were taken to a hospital resulting in a significant change in their health status due to food-related issues such as choking and falls involving low food and drink intake;
- nine cases at eight homes where drinking water was contaminated; and
- over 510 cases at 325 homes of gastroenteritis outbreaks. Outbreaks always affect multiple residents each time they occur. We obtained outbreak data from five of the 35 public health units. For 84 gastroenteritis outbreaks that occurred in 2018, almost 2,000 residents were affected over the course of 15 days on average; 16 residents died as a result.

The Advocacy Centre for the Elderly—a legal clinic funded by Legal Aid Ontario that specializes in providing legal services to low-income seniors—informed us that the most common food-related concerns they receive from home residents and their families also relate to residents receiving the wrong diet or texture, being force-fed, missing meals, not receiving proper assistance in eating from staff and experiencing avoidable emergency department visits due to dehydration or malnourishment.

Factors such as home staff not following residents' plans of care and not providing sufficient quality of food to residents can contribute to these incidents. We discuss these factors in **Sections 4.2** and **4.3**.

4.1.2 Poor Food and Nutrition Can Contribute to Avoidable Emergency Department Visits

Food and nutrition intake can affect the well-being of anybody, including long-term-care residents who are often living with health conditions. We found that some residents experienced poor health

Figure 7: Number of Avoidable Emergency Department Visits of Long-Term-Care Home Residents from Conditions That Can Be Affected by Food and Nutrition, 2014 and 2018

Source of data: Ministry of Health

Types of Avoidable[1] Emergency Department Visits	2014	2018	% Change
Dehydration[2]	644	454	(30)[2]
Diabetes[3]	430	454	6
Hypertension[4]	183	195	7
Hypoglycemia[5]	18	18	–
Total conditions that may be prevented by eating and drinking well	**1,275**	**1,121**	**(12)**
Total avoidable emergency department visits made by long-term-care residents in Ontario	23,392	23,856	2

1. Avoidable according to the Ministry of Health based on consultations with researchers, clinicians and the long-term-care sector.
2. Dehydration is a condition that occurs when the body does not have enough fluids to carry out its functions; it may be prevented or managed by regularly consuming adequate fluids throughout the day. Some long-term-care homes attribute this 30% decrease in avoidable emergency department visits between 2014 and 2018 to measures that homes have introduced to address this condition. Such measures include more timely communication of resident's food and fluid intake from personal support workers to registered staff for appropriate interventions (as discussed in **Section 4.2.2**) and increased use of hypodermoclysis treatments on residents (as discussed in **Section 4.9.2**).
3. Diabetes is a condition that occurs when there are high glucose levels in the bloodstream over a prolonged period; it may be managed by adjusting a person's diet to control fluctuation in blood glucose levels or with insulin injections.
4. Hypertension is a condition that occurs when the force of blood within the arteries is at a level that can cause future health complications; it may be managed by adjusting a person's diet to control sodium intake levels; commonly known as high blood pressure.
5. Hypoglycemia is a condition that occurs when very low levels of glucose are in the bloodstream; it is an acute complication of diabetes; that may occur when a person has not eaten and can be managed by adjusting a person's diet to ensure nutritious meals are consumed at regular intervals. It may also be managed using food, drink or supplements high in glucose.

outcomes because of insufficient quantity and quality food and fluid intake.

According to the Ministry of Health's database on avoidable emergency department visits based on data reported by hospitals, in 2018 long-term-care-home residents made 1,121 emergency department visits that may have been managed or controlled by eating and drinking well, as shown in **Figure 7**. These visits were made for conditions such as dehydration and hypertension.

With respect to dehydration, we found that 443 residents across all 626 homes in Ontario made 454 avoidable emergency department visits in 2018—that is about one in every 175 residents, a decrease compared to 644 visits in 2014. According to Dietitians of Canada's February 2019 report on best practices in homes for providing high-quality nutrition and food services, "dehydration is estimated to be present in almost half of long term care residents. Inadequate fluid intake may lead to increased risk of: constipation, falls, longer time for wound healing, acute confusion, decreased kidney function, and increased hospitalizations."

Factors such as home staff not following residents' plans of care and not providing sufficient quality of food to residents can contribute to these visits. We discuss these factors in **Sections 4.2** and **4.3**.

4.2 Plans of Care Not Always Followed or Updated to Meet Residents' Needs for Food and Nutrition

The *Long-Term Care Homes Act, 2007* (Act) states that every resident is to have a plan of care, which should set out the planned care for a resident, the goals the care is intended to achieve and clear directions to staff and others who provide direct care to the resident. This includes level of eating assistance required, diet plan, food sensitivities and necessary food textures, and is identified by a registered dietitian through a nutritional assessment.

A resident's nutritional and dietary needs can change from time to time, such as switching from

a regular-textured diet to a pureed-textured diet, because the resident has decreased oral functioning. When a change to a resident's plan of care occurs, the registered dietitian needs to communicate the change to nurses, personal support workers, and food service workers in order to ensure a resident will consume the meal safely or reach their nutrition goals.

Between January 2017 and May 2019, the Ministry noted 56 homes that failed to follow a resident's plan of care, with 29% of these homes having repeated non-compliance issues in this same area.

4.2.1 Current Dietary Requirements in Resident's Plan of Care Not Always Followed

We found that personal support workers at the homes we visited did not always have timely access to the most current plan of care, and home management did not consistently ensure that they had access. Being aware of the most current plan of care is important because not all residents can voice their concerns if staff do not follow their plan of care—posing potentially serious risks to the residents' health such as choking or malnourishment.

For example, a resident choked and died in July 2018 at a long-term-care home where we conducted detailed work. In that incident as noted in the Ministry's inspection report, a nurse had initially noted in the resident's plan of care that food needed to be cut up, but this information was not consequently communicated to either the registered dietitian or other staff who were involved in the resident's care. With no direct intent, staff incorrectly gave the resident regular-textured food instead of cut-up food, resulting in the death of this resident. Since then, management at this home monitor staff's communication of changes to the plan of care more rigorously.

Similarly, family representatives at three homes where we conducted detailed work informed us that they were aware of staff almost serving residents regular-textured meals instead of the pureed-textured meal required by the resident's plan of care. In these cases, family members or other staff were able to intervene before the residents consumed the meals. However, had the resident consumed the meal, they would have been at a greater risk for choking.

Our review of a sample of Ministry inspection reports also showed that Ministry inspectors have observed similar concerns at homes they have inspected. For instance, in 2017, a Ministry inspector noted that staff at one home took away a resident's unfinished plate, with about 75% of the food remaining, despite the plan of care of that resident stating that the resident is a high nutritional risk and requires encouragement during meals. Further, home staff did not serve this resident a specialized drink as required by the resident's plan of care. Not following the plan of care in this case could contribute to the resident becoming malnourished.

A regulation under the Act states that long-term-care homes shall ensure staff and others who provide direct care to a resident have convenient and immediate access to the resident's plan of care. We noted the following issues at the homes we visited:

- Staff at a home where we conducted detailed work informed us that they knew the residents well enough to have memorized the resident's diet requirements, and did not refer to the dietary requirement lists. Dietary requirement lists have selected dietary information to assist personal support workers and food service workers in the dining rooms and could include updates to residents' plans of care. This practice is contrary to the home's policy to refer to these lists before plating. Management at this home informed us that they continually needed to remind staff of this policy in order to watch for changes to plans of care. Similarly, at another home we visited, food service workers informed us that the home recently switched its information system and while the residents' dietary requirements were on the information system, staff could not access this information for at least two weeks.

- At two of the five homes where we conducted detailed work, we found the dietary requirement lists were up to three weeks outdated. Further, the dietary requirement list at one of these homes did not include any information for three new residents who arrived during the three-week period at the time of our audit.

One best practice we observed at a home we visited involved using place cards at the resident's dining table listing dietary requirements. This process allowed personal support workers to confirm they are serving the meal in accordance with the resident's plan of care.

AdvantAge Ontario informed us that long-term-care home staff find it challenging to manage mealtimes because they are required to read the dietary requirement lists to confirm individual dietary needs while also performing other tasks. These include going to each resident to offer meal choices, recording what they prefer, serving meals to everyone at the table at the same time, assisting to feed residents where needed, serving and topping up drinks, and serving each subsequent course once each resident at the table is finished.

In February 2019, Dietitians of Canada released a report for best practices in homes for providing high-quality nutrition and food services. The report emphasized the importance of effective communication, documentation, and collaboration between departments and disciplines at the home to provide the maximum benefit of nutrition, hydration and dining programs for residents.

RECOMMENDATION 1

To provide residents with safe and appropriate food and nutrition services that are in accordance with their plans of care and reduce the risk of food-related harm to residents, we recommend that long-term-care homes develop ways to ensure that all direct-care staff have timely access to the most current plans of care of the residents for food and nutrition before serving food.

ASSOCIATIONS RESPONSE

We agree with the recommendation to ensure residents are provided with safe and appropriate nutrition services prior to being served any food.

Meal times in long-term-care homes are a starting point for enhancing social interaction and resident quality of life. This requires building on the existing relationships between residents and care staff as a guide to the individualized assistance for each resident. Long-term-care homes are trying to find innovative ways to free up staff time for resident care, including leveraging technologies such as the Meal Suite software that provides individual nutritional care plans at point of service.

In addition to using technological solutions for plans of care, we will assist long-term-care homes to develop ways to give direct-care staff more timely access to the most current plans of care of residents for food and nutrition, and to more widely use visual cues such as coloured placemats, wrist bands and place cards to help reach the goal of safe and pleasurable dining experience for residents.

Three times a day, care staff are tasked with promoting individualized safe food intake while offering support and promoting the dignity of each resident they are assisting. In addition to improving timely communication of care needs, system measures are required to address the many factors contributing to the possibility of food safety errors in the dynamic long-term-care home dining environment.

We look forward to collaborating with the Ministry of Long-Term Care to expeditiously move forward with:

- developing a provincial human resources strategy, particularly for personal support workers who are the main providers of mealtime assistance;

- enabling the redevelopment of older long-term-care homes to modern design standards that recognize the complex needs of those living in long-term care today, including smaller dining rooms where residents can receive meals in a more appealing environment and that eliminate risks associated with dining rooms accommodating up to 100 residents at each sitting;
- adopting and spreading innovation in relationship-centred care; and
- funding and introducing technology that can enhance care for residents, improve efficiency and effectiveness, and alleviate staff workload.

RECOMMENDATION 2

To remind long-term-care homes of the importance of providing residents with safe and appropriate food and nutrition services that are in accordance with their plans of care and reduce the risk of food-related harm to residents, we recommend that the Ministry of Long-Term Care confirm during its inspection process that all direct-care staff are able to know the residents' plans of care for food and nutrition before serving food.

MINISTRY RESPONSE

The Ministry already adheres to this recommendation and will continue to confirm during its inspections' process that all direct-care staff have access to the residents' plan of care for food and nutrition before serving food. The Ministry will be communicating with the long-term-care sector to remind them of the importance of knowing a residents' plans of care for food and nutrition before serving food.

4.2.2 Plans of Care Not Assessed for Food and Nutrition Updates When Referrals to Registered Dietitians Are Not Made

Registered dietitians rely on direct-care staff such as nurses and personal support workers to identify and refer to them residents who require a change to their plan of care, so the resident's health does not deteriorate. We found that direct-care staff of long-term-care homes do not always follow their home's internal referral policy to refer residents for a registered dietitian assessment. As well, the consumption data to help identify residents who require dietary intervention was not always reliable.

At two homes where we conducted detailed work, nurses did not follow the home's documented policy for referring residents to the registered dietitian and instead had been relying on their professional judgment, which varied from residents having poor food intake for two meals to a week of meals. At one of these homes, for a sample of 10 residents who met the home-referral criteria, we found evidence that the direct-care staff referred only one resident for a nutritional assessment. The home could not provide evidence to demonstrate that nurses had also referred the remaining nine residents. Some direct-care staff at this home informed us that they are not responsible for monitoring a resident's food-consumption level. Instead, they believed it should be part of the registered dietitian's responsibility. This is contrary to that home's policy of requiring direct-care staff to refer residents for a nutritional assessment.

Direct-care staff need to record accurate food consumption data to identify residents who may need a referral to a registered dietitian to enable appropriate dietary interventions, such as supplements or assistance eating, to be made. In the five homes where we conducted detailed work, we found no food consumption records for up to 15% of the residents' meals in a sampled two-week span in February 2019. As well, at two of the homes, personal support workers relied on memory to recall how much food and fluid each resident had

consumed. Each personal-support worker recorded consumption data for eight to 15 residents, in some cases 90 minutes after the completion of the meal. The personal-support workers we observed recording data long after the meal had ended informed us the delay was because resident care takes priority over documentation and/or the information system into which staff enter this data is located outside of the dining area.

While the regulation requires homes to have a system to monitor food and fluid intake of residents, Ministry inspectors only look at food and fluid consumption records if the inspection was related to a resident at a nutrition or hydration risk. Ministry inspectors would only review completeness and accuracy of records related to the inspection they are doing and not for all residents. Reviewing the home's system for monitoring resident food and fluid intake as a whole could help proactively minimize the nutrition and hydration risk posed to other residents.

4.2.3 Registered Dietitians' Time is Mostly Spent on Clinical Assessments; Not Enough to Proactively Monitor Residents

Registered dietitians are required under a regulation of the Act to spend at least 30 minutes per resident per month to carry out clinical and nutrition care duties. At the five homes where we conducted detailed work, we found that registered dietitians met this requirement. However, based on their estimated time spent on their tasks, which they did not document, they allocated more time to conduct clinical assessments and create or update plans of care, as opposed to proactively monitoring residents' dietary needs. Dietitians of Canada states that a registered dietitian can spend up to 30 minutes per resident to conduct an assessment and develop a plan of care.

Registered dietitians did not spend much time on the following proactive care:

- proactively observing residents eating in the dining room to help identify residents who may be struggling to eat or feed themselves and therefore potentially avoid weight loss;
- attending all resident-care conferences with the home's health-care team to see if the resident and family are satisfied with the food, dietary interventions and to ensure homes are meeting the resident's needs; and
- providing education to residents, staff and family members, such as reminding and teaching staff about different diets and educating family members on the risks associated with consuming the wrong texture food. For example, a home reported that a resident choked on a chocolate bar provided by a family member, two days after admission; the family member knew that the resident required a pureed diet but may not be aware of the risk associated with inappropriate textured food.

In the five long-term-care homes where we conducted detailed work, we examined whether registered dietitians assessed recently admitted residents and regularly re-assessed residents within prescribed timelines to contribute or update the resident's plan of care. Based on our review of a sample of resident's plans of care, we found that registered dietitians assessed residents on time.

RECOMMENDATION 3

To better meet the dietary needs of their residents, as assessed in their plans of care and proactively mitigate nutritional risks to residents, we recommend that long-term-care homes:

- communicate to their staff the importance of complying with internal policies to refer residents for registered dietitian assessment and maintain complete and accurate food and fluid consumption records; and
- allocate more time for the registered dietitians to proactively monitor the nutrition and hydration risk posed to all residents such as observing residents eating at mealtimes, attending resident-care conferences and

providing education to residents, staff and family members.

ASSOCIATIONS RESPONSE

We agree with the recommendation to better meet the dietary needs of residents.

Long-term-care homes will periodically communicate to their staff to emphasize the importance of complying with internal policies on referring residents for dietitian assessments and maintaining accurate food and fluid consumption records.

The current workload associated with registered dietitian assessments for all new admissions, quarterly and annual assessments, review of high-risk situations, along with menu approval is extremely time intensive. We look forward to continuing to work in partnership with the Ministry of Long-Term Care to identify opportunities to decrease the administrative burden that limits time to care and for greater flexibility in roles and expanded scopes of practice to support interdisciplinary-care teams in the sector.

RECOMMENDATION 4

To confirm that long-term-care homes are meeting the residents' dietary needs as assessed in their plans of care and proactively mitigate nutritional risks to residents, we recommend that the Ministry of Long-Term Care:

- monitor whether long-term-care homes' staff are complying with internal policies to refer residents for registered dietitian assessment and maintain complete and accurate resident food and fluid consumption records;
- establish protocols for registered dietitians to allocate more time for observing residents eating at mealtimes, attending resident-care conferences and providing education to residents, staff and family members; and
- during their inspections, review long-term-care homes' system for monitoring resident food and fluid consumption as a whole to see how they proactively minimize the nutrition and hydration risk posed to other residents.

MINISTRY RESPONSE

The content of this recommendation currently exists within legislation and we will continue to work within the inspection framework to ensure long-term-care homes staff are complying with legislation. The Ministry will also continue to monitor the home's internal policies related to registered dietitians' assessments and referrals and support long-term-care homes by informing them about the importance of allocating appropriate resources to support residents during mealtimes, care conferences and education opportunities. The ministry will work with the long-term-care sector to examine what appropriate protocols for registered dietitians could look like.

4.3 Residents Not Consistently Consuming Sufficient Quality of Food and Fluid

4.3.1 Menus Approved by Registered Dietitians Do Not Have Recommended Nutrients for Residents

Our review of menus and recipes from a sample of long-term-care homes showed that residents were not provided with food that had adequate nutrients, fibre and energy based on the current Dietary Reference Intakes values. With the assistance of an independent registered dietitian, we found that food on the homes' menus contained sufficient protein and energy as measured in calories, but excessive or insufficient nutrients as compared to recommendations made in the Dietary Reference Intakes (see **Section 2.2.3**), such as:

- too much sugar (40% to 93% above recommended amount), mainly in juice, fruit drinks and bakery items, which increases the risk of

obesity and type 2 diabetes; see **Section 4.3.2** for further discussion;

- too much sodium (32% to 59% above recommended amount), mainly in entrees and soups, which increases the risk of high blood pressure, stroke and heart failure;
- too much saturated fat (19% to 69% above recommended amount), mainly in entrees, which increases the risk of heart disease;
- not enough fibre (19% to 34% below recommended amount), which increases the risk of constipation;
- not enough potassium (14% to 42% below recommended amount), usually found in fresh fruit and vegetables that help lower blood pressure; and
- not enough magnesium (5% to 35% below recommended amount), usually found in fresh beans, nuts, seeds, fish and whole grains that promote healthy bones, muscles and nerves.

In 2017/18, according to the Canadian Institute for Health Information, 28% of assessed residents had a diagnosis of diabetes and 65% had a diagnosis of hypertension. We found that a significant number of menu items were pre-packaged and processed. These items included meats, soups, mashed potatoes and desserts. The majority of the packaged items were the main contributors of sodium, saturated fat and sugar in the menus.

Serving food that contains insufficient nutrients may contribute to poor health outcomes. At the time of our audit, in the five homes where we conducted detailed work, registered dietitians assessed that 39% of residents were at a "high nutritional risk." Statistics Canada defines people with high nutritional risk as those who need further assessment and intervention to prevent or reverse the consequences of chronic under-nutrition.

Regulation requires that the home's registered dietitian approve the menu, which should be in accordance with Canada's Food Guide and the Dietary Reference Intakes. Of the five homes where we conducted detailed work, two could not provide evidence that their registered dietitian analyzed the home's menu, two performed minimal analysis and instead relied on the corporate dietitian to perform the analysis, and one performed analysis as required. Even though some registered dietitians have noted exceptions such as high sodium, they still approved the menus with certain nutrients being over or below the recommended values. For example, the registered dietitian at one home who had concerns with the menu's sodium content did not change the current menu cycle but, instead, made recommendations to decrease the sodium in the next menu cycle. We could not verify whether the next menu had sodium adjusted because the menu was not finalized when we completed the audit. As well, two of the five homes did not even have data on the sugar content in their menus and were therefore unable to demonstrate they meet Dietary Reference Intakes recommendations for sugar.

While Ministry inspectors have protocols to review nutrition levels of menus, the Ministry informed us that it would be unlikely an inspection would require a review of the entire menu cycle. An inspector would likely only review nutrition levels of a particular day if there were complaints about the nutrients provided or if the inspector observed unusual meals in the dining room. At the five homes where we conducted detailed work, registered dietitians and nutrition managers informed us that in the last three years Ministry inspectors never asked them for the nutrient analysis of the home's menu.

4.3.2 Residents Provided Food and Fluid High in Sugar

Overall, we found that long-term-care homes provide residents with food and fluid that contain sugar beyond the recommended limit as discussed in **Section 4.3.1**. According to the Heart and Stroke Foundation of Canada, consuming too much sugar is associated with heart disease, stroke, obesity, diabetes, high blood cholesterol, certain cancers and poor dental health.

Canada's Food Guide states that publicly funded institutions should offer healthier options that limit the availability of highly processed foods and beverages, such as sugary drinks and confectioneries.

Too much sugar does not directly cause weight gain. However, Health Canada notes that intake of sugar-sweetened drinks has been associated with an increased risk of weight gain, obesity and diabetes. About 36% of residents whose files we tested at the five homes where we conducted detailed work were either above or below their target goal weight range. Of these residents, 78% were above their target goal weight and had gained an average of 7 kg since admission.

We noted the following concerning sugar intake at the homes we visited during the audit:

- Despite the 2019 Canada's Food Guide recommending water as the drink of choice to replace sugary drinks, each of the 59 homes we visited had "assorted juice" on the menu for all meals each day. We observed that during mealtimes, juice is the most popular drink choice and staff seldom encourage water over juice as residents have the right to choose. For three of the five homes from which we obtained detailed food purchase information, juice was among the top five purchased items in terms of quantity.
- In all of the menus we reviewed from the five long-term-care home visits where we conducted detailed audit work, snacks consisted mainly of different types of cookies, loaves or pastries.

Some registered dietitians informed us that quality of life is the primary goal in homes and sometimes this can take priority over nutrition. As well, keeping residents hydrated is important, even with juice, since old age increases the risk that residents lose their ability to recognize thirst. Since many residents can no longer taste more subtle flavours, they rely on their sense of sweet or salty for enjoyment of food. Residents who have the mental capacity to make decisions on their own can make food and fluid choices, even when they may not be healthy or in their best interest. This further supports the importance of proper education and communication to residents and families about healthy food choices, as discussed in **Section 4.2.3**.

4.3.3 Residents Provided Limited Fresh Fruit

As required by regulation, long-term-care-home menus are to provide for a variety of foods, including fresh seasonal foods, each day in keeping with Canada's Food Guide.

Homes usually offer residents fruit during breakfast and lunch. Nutrition managers in the five homes where we conducted detailed work informed us that that they try to include fresh seasonal fruits. We found that 39% of the fruits on the menus at the five homes where we conducted detailed work were fresh; the remaining 61% were either frozen, prepackaged or canned, such as bottled applesauce, canned fruit cocktail or frozen cantaloupe chunks in water, sugar, and preservatives.

We also noted that a family member of a resident complained to the Patient Ombudsman in February 2018 that they observed four residents sharing one banana and the home administrator informed this family member that there was not enough fruit available for all residents.

The Advocacy Centre for the Elderly informed us that, based on their work with families and residents, they generally want better quality of food. However, rather than serving fresh food, homes tend to provide processed foods high in sugar and fat, because they are easy to mass-produce at a low cost, and fresh food requires more preparation such as washing, peeling and cutting prior to consumption.

Management and food service workers at the homes where we conducted detailed work estimated that 25% to 60% of each day's meals are thrown away because residents do not finish their meal. Based on our observation of a sample of meals at one home and using food-cost data (excluding supplements) in **Figure 6**, we estimated that the cost of thrown-out food is about $2.48 or

26% of the $9.54 per diem funding on average for each resident. Management at these homes attributed some of the waste to having to provide portion sizes as recommended in the 2007 Canada's Food Guide. If long-term-care homes made adjustments, they could potentially use some funds to provide food that is of higher quality or fresher to residents versus an excess quantity provided to some residents who do not eat as much.

We surveyed a sample of personal support workers in the 59 long-term-care homes we visited across Ontario. Of those personal support workers who responded to our survey, 14% rated the overall quality of food at the home they worked at as poor, 33% had no opinion and 53% rated the food as good quality. Further, 19% said they would not want their loved ones eating the food at the home they worked at, 31% had no opinion and 51% would want their loved ones eating the food. As well, the five homes where we conducted detailed audit work conducted their satisfaction surveys to residents and families either in 2018 or in 2019. Each home asked different questions about different aspects of food—such as quantity, quality and temperature. For the questions on the quality or taste of food, the satisfaction score ranged from 30% (with a response rate of 57%) to 90% (with a response rate of 22%).

At the time of our audit, the five homes where we conducted detailed work were still following the 2007 Canada's Food Guide. As noted in **Section 2.2.2**, Health Canada released a new version of the Food Guide in January 2019 recommending that people include plenty of vegetables and fruit in their meals as they contain important nutrients such as fibre, vitamins and minerals. At the completion of our audit, the Ministry did not have a transition plan to set out when homes need to fully adopt the current Canada's Food Guide.

RECOMMENDATION 5

To increase the likelihood that residents receive food and fluids with adequate nutrients, fibre and energy, we recommend that long-term-care homes':

- registered dietitians make appropriate menu changes to achieve compliance with the current Canada's Food Guide and Dietary Reference Intakes requirements; and
- management monitor their menus for compliance with the current Canada's Food Guide and Dietary Reference Intakes requirements.

ASSOCIATIONS RESPONSE

We agree that Dietary Reference Intakes requirements and the new Canada's Food Guide should be followed where possible. However, we suggest that these resources be used as guides for health professionals to use in care planning, weighed carefully against discussions with residents and families regarding their wishes and desires. Nutritional requirements in the elderly change over time and are influenced by health status. There is evidence to suggest that malnutrition is among the first effects of disability and other age-related problems and is a generalized response to approaching end of life. The current population of residents in Ontario's long-term-care homes are experiencing progressive life-limiting illness and approaching the end of their natural life expectancy.

The homes' dietitians and management are responsible for meeting legislative requirements that call for the menus to meet nutrient, fibre and energy requirements. We will work with long-term-care homes to offer nutritional food and drinks to all residents, and look forward to continuing to work in partnership with residents and families, health professions and academics, as well as the Ministry of Long-Term Care, to identify best practices and implement models of nutritional care that support best nutritional outcomes for the unique, vulnerable population residing in long-term-care homes.

RECOMMENDATION 6

To increase positive health outcomes and assist residents in receiving food and fluid with adequate nutrients, fibre and energy, we recommend that the Ministry of Long-Term Care:

- support long-term-care homes to develop and implement a transition plan setting out when long-term-care homes need to fully adopt the 2019 Canada's Food Guide; and
- instruct its inspectors to regularly verify that long-term-care-home menus are meeting the current Canada's Food Guide and Dietary Reference Intakes requirements as part of their inspection protocol and review the long-term-care home's nutrient analysis of its menus.

MINISTRY RESPONSE

The Ministry supports this recommendation. The Ministry will support long-term-care homes to develop and implement a transition plan to adopt the 2019 Canada's Food Guide, and will instruct its inspectors to verify that menus are meeting nutritional requirements during food-related inspections.

4.3.4 Poor Food Inventory Management at Some Long-Term-Care Homes Can Result in Some Residents Eating Lower Quality Food

We observed overall cleanliness at the five long-term-care homes where we conducted detailed work, and found that overall, kitchens and food-serving areas were clean and home management adequately maintained proper pest control.

However, in three of the five homes, we discovered food items past their best-before date still in the fridge or dry-storage area. Management at these homes explained that staff did not always use food inventory according to the home's policy of first-in-first-out. After we informed the homes of these items:

- One home immediately discarded the mango chutney, which had not yet been served to residents.
- One home immediately discarded the liquid whole eggs, which were three months beyond the best-before date, but staff had already served some of it to residents before we notified them.
- One home kept the cantaloupe chunks and served them to residents three days later. By then the food was six days beyond the best-before date. Upon our discovery of its practice, staff at the home informed us that they served the food past its best-before date to residents because the food still looked edible. This is contrary to the home's policy of discarding food when the best-before date is past.

According to the Canadian Food Inspection Agency, a best-before date is not always an indicator of food safety, but indicates to consumers that if the product has been properly stored and unopened, it will be of high quality until the specified date, meaning it will retain its freshness, taste, or nutritional value. Consumers can eat foods after the best-before date has passed. However, when this date has passed, the food may lose some of its freshness and flavour, its texture may have changed, or some of its nutritional value may be lost.

Ministry inspectors and public health inspectors have protocols to observe whether homes store food and fluid in a manner that preserves taste, nutritional value, appearance and food quality. However, Ministry inspectors only perform this when an incident or complaint related to food storage occurs.

4.3.5 Public Health Inspections Mostly Conducted at Least Three Times a Year as Required

We examined whether five of the province's 35 public health units had appropriately inspected

long-term-care homes within their jurisdictions at the frequency prescribed by the Ministry of Health. We found that while four of the five units had met the Ministry requirement of inspecting homes three times a year, one did not. In that public health unit, five (or 6%) of the homes in 2017 and nine (or 11%) of the homes in 2018 were not inspected at least three times per year because of staff turnover. This increases the risk of harm to residents with unsafe food practices.

At the five homes where we conducted detailed work, food-premises inspections occurred at the prescribed time intervals from January 2017 to March 2019. During these inspections, public-health inspectors identified issues that increase the risk of residents getting ill from consuming unsafe food. For example,

- fridge temperature was too high to hold certain food;
- fruit flies around living and kitchen areas;
- dust, mould, rust or other debris found in the kitchen;
- food items improperly stored together;
- no paper towels and liquid soap at handwashing stations; and
- dishwasher did not have sufficient cleaning detergents or water temperature.

RECOMMENDATION 7

To minimize the risk of residents consuming low-quality food, we recommend that long-term-care homes require and monitor that their staff abide by the internal food storage policy, including not storing food beyond their best-before date.

ASSOCIATIONS RESPONSE

The health of long-term-care home residents takes top priority. We agree with the recommendation to minimize the risk of residents consuming low-quality food.

While we believe that long-term-care homes largely comply with their internal food storage policy, improvements can still be made. We look forward to working with the Ministry of Long-Term Care to share best practices on food inventory management with the sector to help achieve resident nutritional health outcomes.

RECOMMENDATION 8

To minimize the risk of residents consuming low-quality food, we recommend that the Ministry of Long-Term Care require its inspectors to regularly verify that food items in refrigeration and storage in long-term-care homes are not beyond their best-before date.

MINISTRY RESPONSE

The Ministry will continue to monitor during its inspection process whether long-term-care homes staff are ensuring that foods and fluids are stored using methods to preserve food quality.

4.4 Wait Times for Meals and Level of Service Vary Across the Province

4.4.1 Some Residents Experience Longer Wait Times During Breakfast

We found that some residents either had to wait a long time for breakfast, or did not eat until after the scheduled mealtime, because personal support workers typically need to assist residents in getting ready for the dining room.

In our observations at 59 long-term-care homes, we found that residents waited in the dining room on average 43 minutes during breakfast, compared to 29 minutes during lunch and 24 minutes during dinner, before they received their food. Personal support workers have additional responsibilities in the morning, such as helping residents to dress, use the washroom, and assisting residents with mobility limitations to get to the breakfast dining area. We found that most homes do not stagger breakfast times as doing so would require assistance from additional personal support workers.

Consistent with our review of complaint logs and our discussions with home staff, we observed the following at breakfast time at the homes we visited:

- A resident arrived at the dining room for breakfast 40 minutes after the scheduled mealtime because the resident's morning routine needed two personal support workers as required by the home's lift and transfer policy, but only one was available because of a staffing shortage that day.
- A resident had to wait 30 minutes on the toilet before staff were able to respond because they were helping in the dining area and did not hear the call bell. When residents are in their room during a mealtime, response to call bells may take longer as most of the staff are assisting with the meal service.

4.4.2 Some Residents Do Not Receive Timely Assistance for Eating

In our observations at 59 long-term-care homes, we found that residents who require assistance eating—for instance, when they do not have the motor skills to feed themselves, or require their food first be cut up and then fed to them—took an average of 29 minutes to finish a meal, but as much as 64 minutes. Further, we observed that residents rarely had family or friends present during mealtimes and relied on personal support workers to help them eat or feed them. We observed that the attentiveness to care varied from home to home, with some personal support workers demonstrating affectionate care such as handholding or genuine interest in what the resident was saying while others provided more basic clinical care.

Overall, we observed that home staff including personal support workers were assisting no more than two residents at a time, as required by regulation. However, when staff need to assist more than two residents during a meal, they typically serve two at a time and one course at a time. As a result, those residents beyond the two being assisted still have to wait to be fed.

We observed 16 examples where residents needed to wait for assistance or did not receive encouragement from staff to eat their food, with notable examples shown in **Figure 8**. Conversely, at one home, we also observed a resident throw their breakfast and spill an entire cup of milk on a personal support worker. Despite this occurrence, we observed that the personal support worker remained calm and continued to encourage the resident to keep eating. The resident ended up consuming 100% of their meal.

Management at one home where we conducted detailed work informed us that when personal support workers spend more time assisting residents at mealtimes, residents are more likely to consume more food. We observed that in a sample of over 470 plates of food served in 16 homes as they were being disposed of at the end of the meal, 24% of the residents finished less than half of those meals. This could be due to either the resident not wanting to eat or not receiving the needed assistance to eat.

4.4.3 Staffing Shortfall Affects on Average 13% of Mealtimes at Selected Long-Term-Care Homes

Our audit found that residents at long-term-care homes do not receive needed assistance with eating when personal support workers call in sick or the homes have staffing vacancies. When certain personal support workers do not report to work, the ones that do would inevitably face increased workload on those shifts, which affects their ability to deliver adequate care to residents.

At the five homes where we conducted detailed work, we obtained staffing schedules over a two-week period in February 2019, and found that staff did not report to work despite being scheduled to work. This resulted in an average of 13% of meals not having enough staff on the floor, and as many as 39% of meals in one home.

The Ministry's inspection in March 2019 at another home noted that staffing shortages caused eight residents to miss their meal in the dining

Figure 8: Examples of Observations Made at Certain Long-Term-Care Homes During Audit

Prepared by the Office of the Auditor General of Ontario

Concern	Details
Plan of care not followed	One resident ate only one banana during breakfast and was not offered any other courses, despite the dietary requirement list (which includes plan of care instructions) indicating that this resident eats "double egg" at breakfast and staff should "serve all courses at one time."
Little or no encouragement to eat	A resident was not encouraged to eat their meal despite having stayed in the dining room for over an hour. This resident ate only a third of the main course and none of the dessert or appetizer that were also served.
	A resident fell asleep upon arrival in the dining room and was not woken up until the personal support worker was ready to feed this resident, an hour after the breakfast had started. The dining room was short-staffed on this particular day.
No assistance to receive food in the proper texture	A resident needed their food cut up and another resident helped because staff were unavailable.
Wait for assistance to eat	A personal support worker came to help one resident after already spending time with two other residents. The personal support worker initially helped the resident. However, after the resident ate two bites of food, the personal support worker had to leave to help another resident in their room. This resident tried to reach up to feed themself, but was unable to reach their spoon and had to wait for this personal support worker to come back to help them. No other staff were available to assist this resident while the personal support worker was helping the second resident in their room.
	One resident was slumping in their wheelchair in the hallway until the end of the mealtime, at which point staff were finally available to help feed the resident.
Unavailable pureed texture food listed on menu	Residents on pureed or minced diet only ate pureed toast and pureed pineapple, while other residents ate banana, muffin and eggs. Food service workers informed us that these foods were not available in pureed format.
	Residents on pureed or minced diet were not provided with the breaded fish on the menu and ate pureed or minced pork and beef instead. Staff informed us that the chef did not have enough time to take off breading from the fish to puree or mince.
Items listed on menu unavailable	Residents were not offered yogurt and prunes even though these were on the menu and available.
	Residents were not offered tomato juice even though it was on the menu.
Delay in receiving food	On a statutory holiday, during breakfast, one resident complained to us that they did not receive their first course despite the scheduled mealtime starting 45 minutes prior. This particular dining room seated about 90 residents.
Poor hand hygiene practices	We observed no sink in the dining room for handwashing of residents.
	A resident had visible grime on their hands and black dirt under their fingernails, yet staff only provided hand sanitizer to clean the resident's hands. The resident's hands should have been washed with soap and running water as per hand hygiene best practices.

room or in their own room. The inspector identified five of the eight residents who were at a nutritional risk, which increased their risk of malnutrition.

In 2018, the Ontario Long Term Care Association conducted a survey of long-term-care homes. About 200 homes responded to the survey, with about 80% of respondents indicating they had difficulty filling shifts and 90% experiencing recruiting challenges.

At the five homes where we conducted detailed work, we found that when these homes were fully staffed, residents on average received between 2.4 hours and 2.9 hours per day of direct nursing and personal support worker care. Each personal support worker assists between seven and 15 residents per shift.

We surveyed a sample of personal support workers in the 59 long-term-care homes we visited

across Ontario. Of those personal support workers who responded to our survey, 46% said that they could provide sufficient care to meet nutritional needs of residents at the current staffing levels, 24% said that they could not, and 30% had no opinion.

RECOMMENDATION 9

To promote quality of life and provide timely assistance during mealtimes to residents, we recommend that long-term-care homes evaluate alternative staffing options to provide assistance to residents during peak demand times such as mealtimes; for example, volunteer or students trained in feeding residents with dementia.

ASSOCIATIONS RESPONSE

We agree with the recommendation and have been actively advocating for changes to regulation that would enable long-term-care operators greater flexibility in staffing, especially to support assistance at mealtimes. In the past, homes have been able to address peak times such as mornings with part-time staff working four-hour shifts. Most employees, however, prefer full-time work and often leave when they find it elsewhere.

Up to 40% of residents require assistance with meals. Many long-term-care homes have been integrating other care staff and volunteers to assist in meeting the growing demand. Personal support workers provide the most help to residents during meals, but all available staff including nurses, activity staff and dietary aides often assist as well.

The *Long-Term Care Homes Act, 2007* specifies that assistance with activities of daily living to residents be provided by qualified personal support workers. This may be interpreted as including helping residents to eat at mealtimes. While this requirement is open to interpretation, clarification by the Ministry of Long-Term Care would help remove a barrier to ensuring sufficient support for residents during mealtimes in light of the severe shortage of qualified personal support workers and growing demand. We believe that homes should have the ability to hire a greater spectrum of staff to deliver direct care.

We look forward to working in partnership with the Ministry of Long-Term Care to ensure long-term-care homes are able to expand support for flexible and alternative staffing models to provide timely and compassionate assistance to residents during mealtimes.

RECOMMENDATION 10

To promote quality of life and provide timely assistance during mealtimes to residents, we recommend that the Ministry of Long-Term Care:

- clarify to long-term-care homes that alternative staffing options exist that can be used to provide assistance to residents during peak demand times such as mealtimes; for example, part-time staff, volunteers or students trained in feeding residents with dementia; and
- develop and implement an updated staffing strategy for the long-term-care home sector that considers the varying needs of residents throughout the day.

MINISTRY RESPONSE

The Ministry will explore how it can work with the long-term-care sector to better meet the needs of residents during peak demand times. The government also announced on September 20, 2019, that it will be developing a staffing strategy that will address this recommendation.

4.5 Design of Dining Areas Impacts Residents' Dining Experience

Overall, we found that almost all of the dining rooms we visited during the audit had a pleasant or neutral odour. However, we found across the 59 homes we visited that residents in older homes

that are not subject to current Ministry dining-room design requirements were less likely to dine in a pleasurable environment. Specifically:

- Staff working in larger dining rooms on average assisted 6.5 residents, compared to an average of 5.0 residents in smaller dining rooms. The Ministry requires dining rooms in long-term-care homes built after 1998 to have no more than 32 residents, but homes built before then are not subject to the same design standard. We found the number of residents varied from nine to 98 residents in the dining rooms we visited.
- We observed that larger dining rooms were louder as more people talked over each other and staff cleared more plates. Some residents and staff indicated to us that the additional noise made the overall dining experience less home-like.

Further, we observed in older homes that residents, especially those in wheelchairs, eat in a less comfortable environment because of the design of the home. Home management informed us that more residents today have mobility limitations than in previous years, and use either wheelchairs or walkers. Although these homes met Ministry requirements on home design, we found that:

- At some older homes, staff had to transport residents—primarily those in wheelchairs—by elevator from the floor where their bedrooms are to another floor where the dining room is, adding to the time these residents had to wait before sitting down to their meal. At one home we visited, residents who were unable to come to the dining room on their own arrived at the dining room on average 14 minutes before the scheduled mealtime, with one resident even coming 45 minutes prior to the scheduled mealtime.
- The Ministry allows homes built before 2009 to have dining areas outside of dining rooms; however, this does not provide residents with a home-like environment, which the government committed to in the *Long-Term Care Homes Act, 2007*. We observed at two older homes for instance that some residents were eating in the hallway outside of the dining room, close to linen carts and close to people moving through the hallway (see **Figure 9**).
- At one home where we observed residents having limited space to move in the dining room, we saw that 16 residents—many of them in wheelchairs—were seated in a small dining room along with three staff and family members who were assisting with feeding. Residents who had mobility devices were not able to move through the dining room unless staff moved other residents. This is contrary to Ministry's best practice as noted in its 2015 home design manual, which says that dining room layouts should consider wheelchair access to tables as well as staff accessibility as they serve meals.

Figure 9: Residents of a Long-Term-Care Home Ate in the Hallway Instead of a Proper Dining Room

Source: A long-term-care home in Ontario

RECOMMENDATION 11

To allow more long-term-care home residents to eat in a safe and home-like environment, we recommend that the Ministry of Long-Term Care:

- re-evaluate whether its home design requirements for homes constructed before 2009 continue to be reasonable given the

increased use of mobility devices in long-term-care homes today; and
- determine what measures to put in place for homes that do not have dining spaces under the current design manual to increase the comfort of their residents during mealtimes.

MINISTRY RESPONSE

The Ministry supports this recommendation. Homes that do not meet current standards are eligible to apply for redevelopment funding and the Ministry is targeting that all older homes substantially not meeting current standards are redeveloped. The Ministry is also launching consultations on what a new minor capital program could look like to address deficiencies in the near term.

4.6 Only 19% of Residents Observed to Have Washed Their Hands to Prevent Infections

At the 59 homes that we visited across Ontario during this audit, we observed that only 19% of residents practised proper hand hygiene directly before or after a meal. Proper hand hygiene consists primarily of handwashing or hand sanitizing. Management and personal support workers from some long-term-care homes informed us one of the reasons that they did not perform proper hand hygiene with residents was due to the lack of available time. We also observed that 76% of staff practised proper hand hygiene directly before or after a meal.

All of the five homes where we conducted detailed work had policies to support proper hand hygiene, including requiring both staff and residents to wash their hands with running water or to use hand sanitizer. As well, we observed that home management displayed reminders on proper hand hygiene throughout the homes. Further, the Ministry in its inspections monitors whether home staff and residents practise proper hand hygiene during mealtimes. Despite these efforts, we still observed improper hand hygiene directly before or after the meals.

In a March 2018 document, *Recommendations for the Control of Gastroenteritis Outbreaks in Long-Term Care Homes*, the Ministry of Health and Long-Term Care—now the Ministry of Health and the Ministry of Long-Term Care—noted that proper hand hygiene is the single most important practice in preventing the transmission of infections. It further noted that although not all gastroenteritis infections and outbreaks in homes are preventable, homes could prevent 20% of these infections through adherence to an infection prevention and control program that includes proper hand hygiene. Gastroenteritis infections, such as norovirus, may result from person-to-person spread or ingestion of contaminated food or water, and symptoms usually consist of diarrhea and/or vomiting.

Of the five homes where we conducted detailed work, four had experienced gastroenteritis outbreaks between January 2018 and May 2019 and one had not. The home that had no outbreak had the highest handwashing rate of residents, 69%, compared with rates in the four other homes varying between 0% and 35%. Of these four homes, one experienced a gastroenteritis outbreak in spring of 2019 over a 19-day period. This incident affected over 20 staff and over 100 residents—five residents subsequently died as a result of the illness.

RECOMMENDATION 12

To minimize the risk of gastroenteritis outbreaks in long-term-care homes, we recommend that long-term-care homes regularly assess compliance with the Ministry of Health's policy on hand hygiene around mealtimes and correct on a timely basis any weaknesses that they identify through these reviews.

ASSOCIATION RESPONSE

We agree with the recommendation to improve hand hygiene around mealtimes.

Improving rates of hand hygiene compliance among residents is an important health and safety outcome that requires a multi-faceted and systemic approach. The long-term-care home is an interactional setting where there is verbal and non-verbal interaction among residents, staff, families and visitors.

Nearly half of all 76,000 long-term-care residents exhibit some form of aggressive behaviour, most often through resisting care, such as bathing and hand washing. As a result of government investment in specialized staff, long-term-care homes have implemented behaviour management strategies to work sensitively with residents and create supportive environments that are less institutional. Continued success depends to a large degree on both the availability of staff and flexibility to hire compassionate staff to fill the necessary support and care roles.

We will work with long-term-care homes to put in measures to improve hand hygiene practices around mealtimes for both staff and residents.

We look forward to working with the Ministry of Long-Term Care to continue to advance specialized dementia and mental health care for residents of long-term-care homes and to initiate and support a provincial human resources strategy.

RECOMMENDATION 13

To minimize the risk of gastroenteritis outbreaks in long-term-care homes, we recommend that the Ministry of Long-Term Care monitor to ensure that long-term-care homes regularly assess compliance with the Ministry of Health's policy on hand hygiene around mealtimes, and correct on a timely basis any weaknesses that they identify through these reviews.

MINISTRY RESPONSE

The Ministry supports this recommendation and through its risk-based inspection framework, the Ministry will continue to ensure long-term-care homes regularly assess compliance with the Ministry of Health's policy on hand hygiene around mealtimes, and support long-term-care homes to focus on any areas for improvement identified through these reviews. The Ministry will be communicating with the long-term-care sector to communicate the importance of compliance with the Ministry of Health policy on hand hygiene around mealtimes.

4.7 Long-Term-Care Homes Can Do More to Divert Food Waste from Landfills

There are currently no legislative or regulatory requirements for the diversion of food and organic waste from long-term-care homes. However, as set out in the March 2019 *Reducing Litter and Waste in our Communities: Discussion Paper*, keeping food and organic waste out of the disposal stream is a high priority for the province. This could help Ontario fight climate change and effectively benefit Ontarians, the environment and the economy.

Food and other organic waste, when they decompose in landfills, emit methane, a potent greenhouse gas. According to the province's *Strategy for a Waste-Free Ontario*, when food and other organic waste is sent to the landfill, Ontarians lose valuable resources that could be used to support healthy soils and miss opportunities to reduce greenhouse gas emissions.

The province's Food and Organic Waste Policy Statement of April 2018 sets goals, for both the public and private sectors, to reduce and divert food and organic waste. For example, the goal of diverting food and organic waste in certain hospitals is 70% by 2025, and the goal of diverting food and organic waste generated in multi-unit residential buildings is 50% by 2025. The policy statement does not apply to long-term-care homes. The Ministry of the Environment, Conservation and Parks informed us that it plans to review whether these goals will apply to other types of establishments and waste materials; this work had not yet begun when we completed the audit.

Only one of the five homes where we conducted detailed work had procedures to divert food waste from landfills; specifically, this home donates leftover food to a local soup kitchen and composts the remaining organic waste. From January to March 2019, this home donated an average of 862 portions of uneaten food per month and composted on average 94% of its total waste or 42 kg per resident per month. Composting food and organic waste for about 200 residents at this home helped avoid about 110 tonnes in greenhouse gas emissions (carbon dioxide equivalents) per year. This is equivalent to the amount of emissions that about nine Ontarians would typically produce each year. One of the homes informed us that they do not compost because they do not have enough physical space to store a compost bin.

Nova Scotia and parts of British Columbia, through its legislation and city bylaws, respectively, require long-term-care homes to divert food and organic waste from landfills.

RECOMMENDATION 14

To limit the impact of food waste on the environment, we recommend that the Ministry of Long-Term Care:

- work with the Ministry of the Environment, Conservation and Parks to establish a goal of diverting food and organic waste generated in long-term-care homes; and
- work with the associations that represent the long-term-care home sector to develop guidelines to help long-term-care homes meet this goal.

MINISTRY RESPONSE

The Ministry will work with the Ministry of the Environment, Conservation and Parks to establish a goal for diverting food and organic wastes generated in long-term-care homes.

In addition, the Ministry will consult with the long-term-care sector on what guidelines could look like to limit the impact of food waste on the environment.

4.8 Opportunities Exist to Improve Allocation of Resources Related to Food and Nutrition

4.8.1 Spending on Food and Food Production Similar to Other Provinces

As shown in **Figure 6**, we estimated that homes in Ontario spend an average of $25.31 per resident each day on raw food and food production costs such as labour costs for chefs and food service workers. This is similar to Manitoba and Alberta, which budget an average of $25.25 and $25.74 per resident each day, respectively.

In comparison with the Ministry's per diem raw food funding of $8.18 per resident per day in 2016:

- each home spent an average of $8.74 per resident per day on food, ranging from $5.79 to $14.98, based on financial information the Ministry received from almost all of the homes across Ontario. The Ministry reviews food spending and other financial data—audited by the homes' independent auditors—from all homes and performs reconciliation on the data to determine whether the Ministry requires repayment from or payments to the long-term-care homes based on the funding provided. As of September 2019, the most complete and reliable reconciled financial data was from 2016;
- municipal government-operated homes on average spent the most on raw food, at $9.24 per resident per day, and up to $14.98 per resident per day. A nutrition manager at a municipal home informed us that the municipal government had provided an additional amount to top up the Ministry's raw food funding; the additional funding was used to procure fresher and locally grown food; and
- for-profit homes on average spent the least on raw food, at $8.44 per resident per day.

Further, compensation for personal support workers, food service workers and nutrition managers in 2018 was on average 9% higher in the municipal homes compared with the for-profit and not-for-profit homes where we conducted detailed work.

At the five homes where we conducted detailed audit work, we compared the homes' spending on food with three other factors—resident satisfaction with food according to internal surveys, improvement in resident health as measured by weight within goal range and purchases of fresh over frozen or processed fruit. Based on the data from these five homes, we found little correlation between spending on food and these factors.

4.8.2 Group Purchasing Not Fully Explored Province-Wide

Each of the long-term-care homes where we conducted detailed work was responsible for securing its own bulk-purchase discounts from food suppliers. These homes each achieved this by being part of a group-purchasing organization that leveraged collective buying power to obtain discounts from food suppliers.

A 2012 report funded by a number of organizations, including the University of Guelph and the Ministry of Agriculture, Food and Rural Affairs, reported on food provision in Ontario's hospitals and long-term-care homes. The report noted that 72% of the 61 homes that responded to its survey were part of a group-purchase organization. The Ontario Long Term Care Association informed us that about 80% of long-term-care homes participated in group purchasing as of fall 2019, according to its own research.

Even so, there were notable price variations for some of the most common food items at all of the five homes where we conducted detailed work, such as:

- Four litres of 2% milk cost between $5.92 and $6.80, with the average at $6.43. Homes purchased on average 1,445 bags of milk per week.
- A loaf of bread cost anywhere between $1.12 and $2.39, with the average at $1.45. Homes purchased on average 232 loaves of bread per week.

While the Local Health Integration Networks (LHINs) purchase nursing services, personal support services and medical equipment and supplies for the home and community care sector, they do not play a role in group purchasing for long-term-care homes, hospitals, and mental health and addiction agencies. These health service providers are funded by the LHINs and some have established their own group purchasing organizations. Under the *Connecting Care Act, 2019*, passed in June 2019, LHINs and other provincial health agencies will transition into Ontario Health. Ontario Health is responsible for, among other things, providing support to health service providers and ensuring financial accountability. At the completion of our audit, Ontario Health's mandate regarding long-term-care homes was not yet established and long-term-care homes were arranging their own purchases of food products.

RECOMMENDATION 15

To achieve further cost savings in purchasing food for the long-term-care-home sector, we recommend that Ministry of Long-Term Care, in conjunction with the Ministry of Health:

- identify the organization(s) responsible for co-ordinating group purchasing for long-term-care homes;
- determine how best to group the long-term-care homes, such as by region or by ownership type, in future food-buying arrangements, until the organization(s) responsible for co-ordinating group purchasing is identified; and
- assist in the establishment of group-buying contracts where needed, until the organization(s) responsible for co-ordinating group purchasing is identified.

MINISTRY RESPONSE

The Ministry supports this recommendation. The Ministry will continue to consult on what supply chain centralization would look like for the long-term-care sector.

4.9 Measurement and Reporting of Food and Nutrition Services

4.9.1 Performance Measurement and Inspection Result Reporting on Food and Nutrition Services in Long-Term-Care Homes Could be Improved

The Ministry does not have performance indicators that measure how homes manage residents who are of high nutritional risk, and are under or over their goal weight range. None of the homes where we conducted detailed work have established a target for these measures.

In February 2019, Dietitians of Canada released a report for best practices in long-term-care homes that outlined food and nutrition services quality and performance indicators. Indicators shown in **Appendix 7** can help measure whether homes are providing high-quality nutrition and food services.

Although the Ministry requires homes to survey residents and families on the homes' services, including food and nutrition, it does not set any targets related to the satisfaction scores of these surveys, which can help a home drive improvement to increase residents' satisfaction and quality of life. See **Section 4.3.3** for results of the satisfaction survey conducted at the five homes where we conducted detailed work.

RECOMMENDATION 16

To demonstrate that residents receive the best possible nutritional care, we recommend that the Ministry of Long-Term Care, in conjunction with long-term-care homes:

- identify appropriate meaningful performance indicators that measure how effective a long-term-care home is at meeting residents' food and nutrition needs;
- set performance targets and regularly assess actual results against these targets; and
- report publicly on the results.

MINISTRY RESPONSE

The Ministry will work with long-term-care partners and stakeholders to identify meaningful indicators around residents' food and nutrition needs and share the results.

4.9.2 Ministry Does Not Analyze Long-Term Care Homes Quality Inspection Results to Identify and Share Best Practices

The Ministry does not analyze food-related compliance data from inspection reports to support quality improvement in long-term-care homes and improve decision-making such as training and guidance provided to homes.

The Ministry informed us that it works with stakeholders in the sector to identify their needs and provide education on these topics identified, which is not limited to food and nutrition. As shown in **Figure 10**, we reviewed food and nutrition-related Ministry inspections conducted in 2017, 2018 and the first five months of 2019. While the number of non-compliance incidents related to food and nutrition had gone down over time, homes consistently did not comply with certain food and nutrition-related areas—such as not following residents' plans of care and insufficient monitoring of residents during mealtime—year over year.

Although long-term-care homes share best practices through their associations, Ministry inspectors can objectively identify differences between the homes and help identify and share best practices to support continuous improvement. Administrators from the long-term-care homes we visited said they would benefit from an advisory function within the Ministry for clarification and guidance on the Act. Justice Eileen E. Gillese's report, *The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*, released in July 2019, also recommended that the Ministry establish a dedicated unit to, among other things, support homes in achieving regulatory compliance and identify, recognize, and share best practices leading to excellence in the provision of care in homes.

Figure 10: Number of Long-Term Care Homes Quality Inspection Report Compliance Issues Related to Food and Nutrition, January 2017–May 2019

Source of data: Ministry of Long-Term Care

Food and Nutrition-Related Non-compliance	2017	2018	2019 (Jan–May)	Total
Failure to follow resident's plans of care	57	13	10	**80**
Menu-related issues	37	25	12	**74**
Insufficient food consumption monitoring	47	20	2	**69**
Failure to refer resident to a registered dietitian	57	8	–	**65**
Failure to offer meal or choices	33	17	3	**53**
Failure to provide assistance eating	20	24	6	**50**
Insufficient registered dietitian staffing	9	4	2	**15**
Improper hand hygiene during mealtime	8	3	–	**11**
Other[1]	124	41	13	**178**
Total	**392**	**155[2]**	**48[2]**	**595**

1. Includes issues such as kitchen equipment in poor condition, insufficient food services monitoring, poor meal timing, poor staff behaviour in the dining room, and unsafe feeding positions.
2. Not all inspections conducted between January 2018 and May 2019 resulted in non-compliances being identified. Therefore, totals are less than the number of food-related critical incidents in **Figure 10**.

We observed the following practices in some of the homes we visited during this audit that were worth sharing among homes but were not widespread:

- Registered dietitians informed us a best practice in long-term care is to have a "food first" mentality with the intent to reduce resident intake of supplements, commonly in the form of a drink with the consistency of a milkshake. This is consistent with Dietitians of Canada's February 2019 report on best practices. At one home we visited, as an alternative to supplements, the registered dietitian used fortified milk, milkshakes, pudding and hot cereal to provide additional calories and protein to residents. Residents informed us that that they enjoyed these foods. At this home, 28% of residents were on supplements at the time of our visit, which is lower than the average of 34% in the five homes where we conducted detailed work.
- Home staff displayed important food-related information, such as food texture and allergies, directly on the resident's table to decrease the risk of not following a resident's plan of care, especially when there is part-time staff in the dining area. We observed that this process allowed personal support workers to confirm they are serving the meal in accordance with the resident's plan of care.
- Four of the five homes where we conducted detailed work used a hydration process on residents called hypodermoclysis to avoid the need for emergency-room care. Hypodermoclysis treats residents with mild-to-moderate dehydration and is a less invasive process than intravenous therapy because it injects fluid under the skin of the resident instead of directly to the vein. Further, AdvantAge Ontario informed us that another home implemented a "Sip & Go" program where home staff frequently offer a drink of water to residents who are at high risk for dehydration. This includes home staff education to monitor and encourage fluid intake through visual cues and reminders such as labelling residents' water tumblers or wheelchairs.

RECOMMENDATION 17

To improve the well-being and safety of long-term-care home residents, we recommend that

long-term-care homes formally share best practices related to food and nutrition with each other.

ASSOCIATIONS RESPONSE

The long-term-care sector has a long and demonstrated history of collaboration and innovation, which includes the sharing and dissemination of best practices, but more can be done. We agree with the recommendation and look forward to working with residents and families, health professions, academics, as well as the Ministry of Long-Term Care, to identify best practices, innovative models of care and the required pathways to build sector capacity through knowledge exchange, education and member support.

RECOMMENDATION 18

To improve the well-being and safety of long-term-care home residents, we recommend that the Ministry of Long-Term Care identify commonly occurring issues related to food and nutrition from data collected through critical incidents and inspections, and provide information and recommend best practices to long-term-care homes.

MINISTRY RESPONSE

The Ministry supports this recommendation. The Ministry will be communicating with the long-term-care sector to share commonly occurring issues and best practices in dealing with those incidents.

4.10 Ministry Not Always Inspecting Food-Related Critical Incidents in a Timely Manner

While the Ministry inspected each long-term-care home at least once a year in 2018 as is required by legislation and its internal policy, it did not respond to 47 (or 64%) of the food-related critical incidents reported by homes between January 2018 and May 2019 within the timeline required in its internal policy, as shown in **Figure 11**. We discuss examples of these incidents in **Section 4.1**.

The Ministry's internal policy states that inspectors must immediately examine incidents that the Ministry classifies as "serious harm or immediate risk," and inspect the homes within 30 days to 90 days for incidents of other risk levels. About 83% of the cases where inspection delays occurred were those involving alleged violations of the Act that resulted in "significant actual" and "actual" harm or risk to residents.

The Ministry explained that since fall of 2018, it shifted its focus to a risk-based inspection program. This means that it had prioritized inspections for higher-risk issues and concerns, some of which may not be related to food and nutrition. As a result, some food-related incidents may not be inspected within prescribed timelines.

RECOMMENDATION 19

To decrease long-term-care home residents' harm or the risk of harm, we recommend that the Ministry of Long-Term Care respond to all critical incidents reported by long-term-care homes within prescribed timelines.

MINISTRY RESPONSE

The Ministry will continue to respond to all critical incidents reported by long-term-care homes within target timelines to ensure risk to residents is promptly mitigated. Since the Auditor General's 2015 audit on Long-Term Care Home Quality Inspection Program, the Ministry has been actively responding to all critical incidents reported by long-term-care homes and has established monitoring mechanisms and corrective actions to ensure that target timelines are met.

Figure 11: Long-Term Care Homes Quality Inspectors Response Time to Food-Related Critical Incidents, January 2018–May 2019

Source of data: Ministry of Long-Term Care

Risk level	# of Cases with Risk Levels Assigned	Required Response Time as per Internal Policy	Average Response Time (# of Business Days)	# of Cases Not in Line with Internal Policy	% of Cases Not in Line with Internal Policy
Level 4: Serious harm or immediate risk[1]	–	Immediate inspection	n/a	–	n/a
Level 3+: Significant actual harm or risk[2]	9	Within 30 business days	10	2	22
Level 3: Actual harm or risk[3]	57	Within 60 business days	79	37	65
Level 2: Minimal harm or risk[4]	8	Within 90 business days	170	8	100
Level 1: Low harm or risk[4]	–	Within 90 business days	n/a	–	n/a
Total food-related critical incidents with risk levels assigned	**74**	**n/a**	**77**	**47**	**64**
Food-related critical incidents with no risk level assigned[5]	588	n/a	n/a	n/a	n/a
Subtotal[6]	**662**	**n/a**	**n/a**	**n/a**	**n/a**
Other reported critical incidents that do not potentially relate to food	22,571	n/a	n/a	n/a	n/a
Total	**23,233**	**n/a**	**n/a**	**n/a**	**n/a**

1. Cases involving any alleged violation of the *Long-Term Care Homes Act, 2007* (Act) that places resident(s) in immediate jeopardy if the Ministry or the home fails to intervene as it has caused (or is likely to cause) serious consequences, injury, harm, and/or could result in death.
2. Cases involving any alleged violation of the Act that result in a serious negative impact on resident(s) health, quality of life and/or safety.
3. Cases involving any alleged violation of the Act that result in harm that will not resolve without Ministry or home intervention or when there is a pattern of incidents contributing to harm or risk.
4. Cases involving any alleged violation of the Act that result in minimal discomfort or risk of harm to the resident(s).
5. Includes cases where no action was required, only inquiries to the homes were needed, or the Ministry was still awaiting further information. For example, the Ministry does not go to the long-term-care home and perform an inspection if it determines that legislative and regulatory requirements were not contravened, or when the incident was not indicative of a trend.
6. Our audit focused on long-term-care home reported critical incidents that could most likely relate to food in the following categories: abuse, contamination of water, disease outbreak, incompetent/improper treatment of resident, incident/injury resulting in hospitalization, or unexpected death.

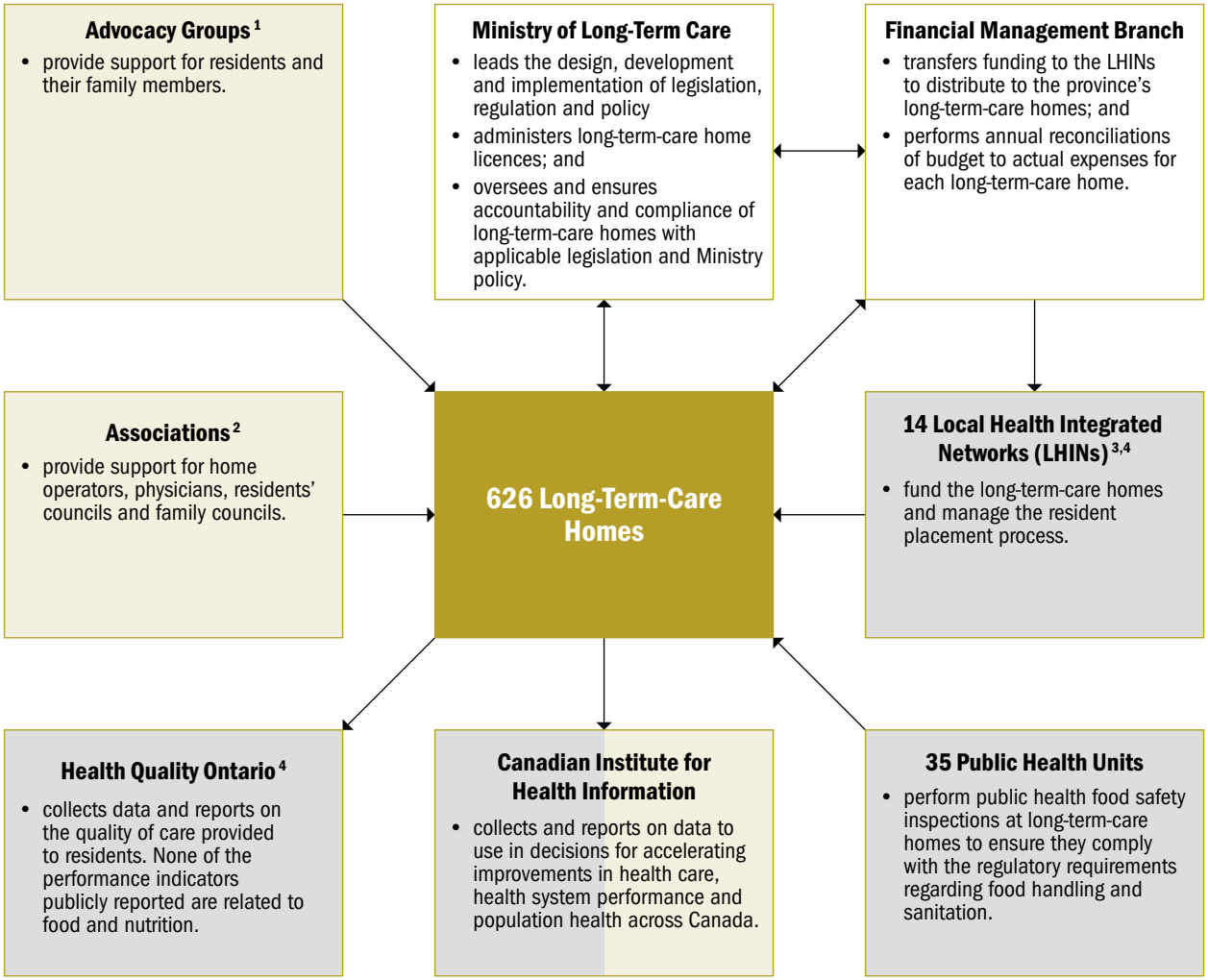
Appendix 1: Overall State of Residents in Long-Term-Care Homes, 2009 and 2019

Prepared by the Office of the Auditor General of Ontario, based on information from the Ontario Long Term Care Association and AdvantAge Ontario

	2009	2019
Use of mobility devices such as wheelchairs and walkers	A larger proportion of residents were able to move around on their own without the use of wheelchairs or walkers.	The majority of residents in long-term care require wheelchairs or walkers and are dependent on personal support workers to move around the home.
Ability to independently eat	A larger proportion of residents were able to feed themselves with little to no assistance from personal support workers.	Over 85% of long-term-care home residents need extensive or complete daily assistance. For example, the majority of residents need the assistance of a personal support worker to help them with eating.
Cognitive abilities	A larger proportion of residents were cognitively intact and able to understand communication. Fewer people required extensive assistance to take care of their daily activities such as toileting or eating within the long-term-care home.	About one in three residents' cognitive abilities are severely impaired. Sixty-four percent of residents have dementia, a progressive disease that affects all aspects of functioning. The rising rates of dementia are a major contributor to the increased need for support.
Health status of residents upon admission	Fewer residents entered long-term-care homes with advanced mental and chronic illnesses and complications.	More people are entering long-term-care homes at a later stage of their conditions. They have more complex health issues and are more physically frail. A larger proportion have dementia and many more have psychiatric diagnoses along with dementia.
Long-term-care homes' staff approach to care	Residents admitted to long-term-care homes were seeking a safe, comfortable place where they could receive 24-hour nursing care and supervision beyond the levels available through home care. A larger proportion of residents in 2009 fit the profile of someone who today would more likely be in a retirement home.	More residents now have unstable physical health requiring monitoring by direct care staff and more trips to the hospital for care. Nearly half of all residents exhibit some form of behaviours related to dementia, such as pacing, vocalizing and irritability. Staff are not able to spend as much time to provide residents with the individual attention that they need. In addition to supporting and planning daily care, a large proportion of direct care time is spent completing required documentation, reporting and responding to families' concerns and expectations.

Appendix 2: Support and Information Flow from Key Players in the Long-Term-Care Sector

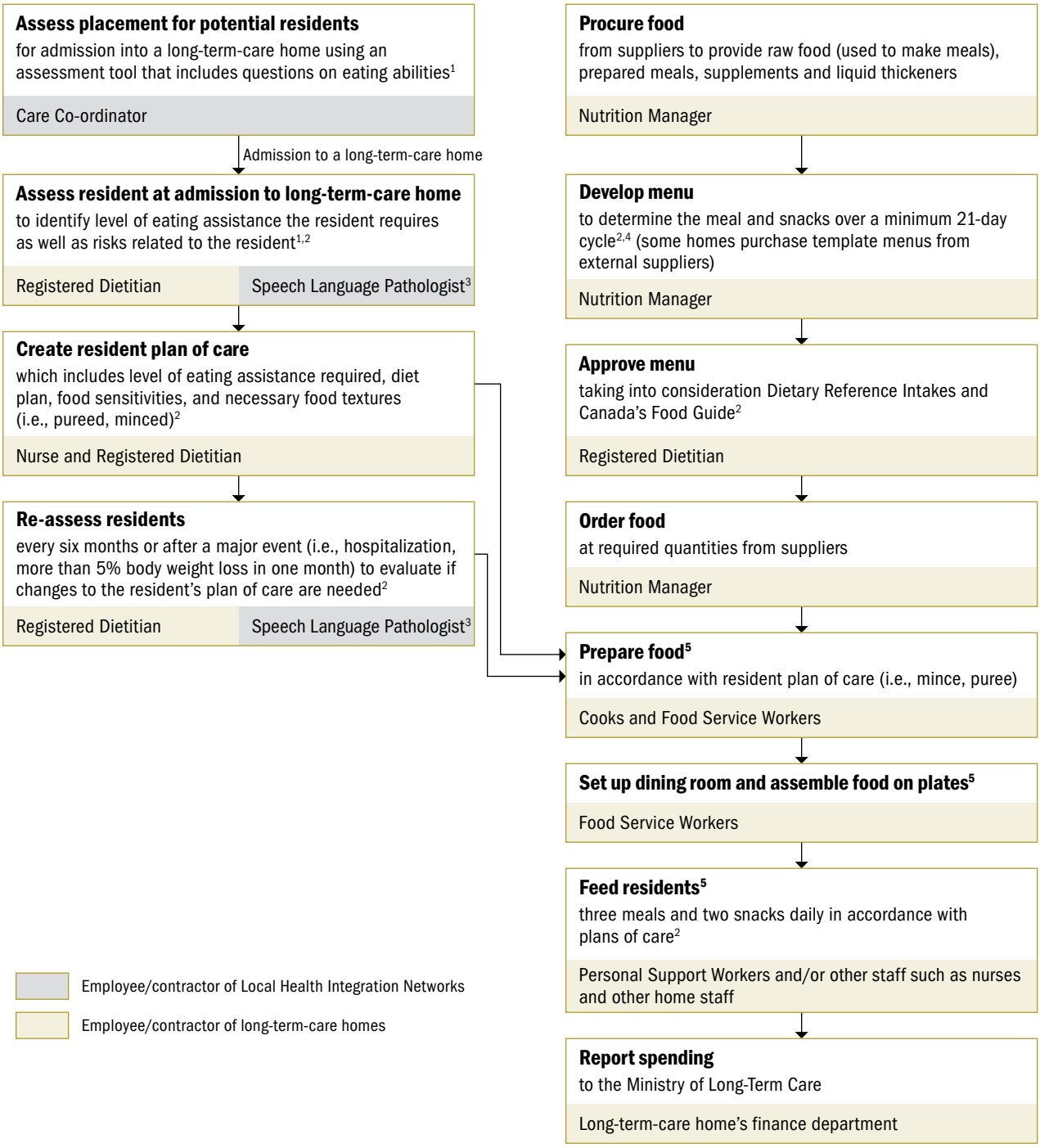
Prepared by the Office of the Auditor General of Ontario



1. Such as Advocacy Centre for the Elderly.
2. Such as the Ontario Long Term Care Association, AdvantAge Ontario, Ontario Association of Residents' Councils and the Family Councils of Ontario.
3. Although the Ministry flows funding through the Local Health Integration Networks, ultimately, the Ministry through its Quality Inspection Program is accountable to the public to ensure that long-term-care homes provide adequate care to residents.
4. On June 6, 2019, the *Connecting Care Act, 2019*, came into force. Provisions of this legislation allow for the integration of multiple existing provincial agencies, including the LHINs and Health Quality Ontario, into a single agency, called Ontario Health. At the time of our audit, transition of LHINs and Health Quality Ontario operations to the new single agency had not yet begun.

Appendix 3: Key Activities and Staff Involved in Food and Nutrition at Long-Term-Care Homes

Prepared by the Office of the Auditor General of Ontario



1. Care co-ordinators at the Local Health Integration Networks (LHINs) and long-term-care home staff are required to use a standardized resident assessment form to assess a resident's needs.
2. As required by the *Long-Term Care Homes Act, 2007* or its regulation and inspected by the Ministry's Long-Term Care Homes Quality Inspection Program.
3. A long-term-care home usually refers residents with complex cases (i.e., throat cancer) to LHIN-funded speech language pathologists for swallowing assessments. Otherwise, the long-term-care home's own registered dietitians can complete routine swallowing assessments.
4. Menu planning takes into consideration Canada's Food Guide and Dietary Reference Intakes.
5. These activities are inspected by Ministry of Long-Term Care inspectors or public health inspectors. See **Appendix 4** and **Section 2.3** for further details.

Appendix 4: Selected Inspection Protocols Used by Inspectors from the Ministry of Long-Term Care and Public Health Units Relating to Food and Nutrition at Long-Term-Care Homes

Prepared by the Office of the Auditor General of Ontario

Protocol Used by Inspector	Details
Long-Term Care Homes Quality Inspection Program[1] used by Ministry Inspectors	
Dining Observation	The protocol contains two parts: 1. Resident risk and care outcomes 2. Contributing factors (to be completed if non-compliance found in part 1 or if inspector deems necessary) • used in every proactive intensive resident quality inspection The inspector may: • observe a full meal service (any meal) in at least one dining area; • conduct interviews of residents or staff (as deemed necessary); and • document observations and evidence to support any non-compliance (i.e., if a resident is not receiving the correct menu item or is not eating their meal, a nutrition and hydration inspection may be initiated).
Food Quality	The protocol contains two parts: 1. Menu planning, food production, supplies and equipment 2. Contributing factors (to be completed if non-compliance found in part 1 or if inspector deems necessary) • used only when warranted by ministry inspector; focuses on entire home The inspector may: • observe, interview staff, and/or review records relating to dietary services and nutrition delivery (i.e., inspector will observe or assess the menu cycle in relation to the nutritional needs of residents, food appearance, taste, temperature); and • document all observations and provide evidence to support any non-compliance.
Snack Observation	Used to review snack service of a long-term-care home. • used only when warranted by ministry inspector; focuses on entire home The inspector may interview the residents and staff and must document all observations and support non-compliance with evidence.
Nutrition and Hydration	The protocol contains two parts: 1. Resident risk and care outcomes 2. Contributing factors (to be completed if non-compliance found in part 1 or if inspector deems necessary) • complete an inspection for each selected resident • document all observations and evidence must be provided to support any non-compliance • used only when warranted by ministry inspector; focuses on specific residents The inspector may: • interview the resident and staff; • review the resident's assessment as well as weight history, physical assessment and plan of care among other things; and • assess whether staff accurately or consistently assess the resident's nutrition and hydration status upon admission and as needed thereafter.

Protocol Used by Inspector	Details
Food Premises Inspection Program[2] used by Public Health Inspectors	
Food Temperature Control	• Food that is potentially hazardous should be held at an internal temperature of 4°C (40°F) and lower, or 60°C (140°F) or higher. Thermometers should be used to measure temperature. • Food should be held in frozen state. • Food should be safe to eat.
Food Handler Hygiene and Handwashing	• Food Handlers must wash their hands as required to promote food safety. • Food Handlers should keep hygiene as a priority.
Food Protected From Contamination and Adulteration	• Raw food should be kept separate from ready-to-eat foods. • Food must be protected from contamination. • Food must be purchased through federally and provincially inspected sources.
Maintenance/Sanitation of Food Contact Surfaces	• Equipment and other food contact surfaces must be properly maintained, designed, constructed and installed.
Maintenance/Sanitation of Non-Food Contact Surfaces	• Equipment and other non-food contact surfaces must be properly maintained, designed, constructed and installed.
Pest Control	• Adequate protections/safeguards against the entrances of insects and pests.

1. Ministry of Long-Term Care inspectors follow these protocols to assess long-term-care homes' compliance with the requirements outlined in the *Long-Term Care Homes Act, 2007* and Ontario Regulation 79/10 made under the Act.
2. Public health unit inspectors follow these protocols to assess long-term-care homes' compliance with the requirements outlined under the *Health Protection and Promotion Act* and Ontario Regulation 493/17 made under the Act.

Appendix 5: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

Long-Term-Care Homes	
1.	Long-term-care home residents have nutritious food and drinks that are safely prepared to meet their assessed needs and in accordance with legislative and regulatory requirements.
2.	Best practices on food and nutrition in long-term-care homes are collected and shared on an ongoing basis for continuous improvement of resident care.
3.	Food and nutrition-related complaints and incidents in long-term-care homes are documented and reviewed, and timely corrective action is taken when required.
4.	Resources related to food and nutrition are allocated with due regard for economy and efficiency to properly meet residents' needs.
Ministry of Long-Term Care and Public Health Units	
5.	Ministry and public health inspections of food and nutrition services at long-term-care homes do not overlap with each other and are conducted at prescribed time intervals.
6.	Meaningful performance measures and targets related to food and nutrition in long-term-care homes are established, monitored, and publicly reported to ensure that the intended outcomes are achieved and that corrective actions are taken on a timely basis when issues are identified.

Appendix 6: Long-Term-Care Homes Visited During the Audit

Prepared by the Office of the Auditor General of Ontario

#	Location	Long-Term-Care Home Name	Governance Type		
			For Profit	Non-Profit	Municipal
1.	Ajax	Chartwell Ballycliffe Long Term Care Residence	✓		
2.	Atikokan	Atikokan General Hospital		✓	
3.	Aurora	The Willows Estate Nursing Home	✓		
4.	Bolton	Vera M. Davis Community Care Centre		✓	
5.	Bowmanville	Glen Hill Strathaven		✓	
6.	Bradford	Bradford Valley Care Community	✓		
7.	Brampton	Maple Grove Care Community	✓		
8.	Brantford	St. Joseph's Lifecare Centre		✓	
9.	Burlington	The Village of Tansley Woods	✓		
10.	Cambridge	Golden Years Nursing Home	✓		
11.	Chatham-Kent	Riverview Gardens			✓
12.	Deseronto	Friendly Manor Nursing Home	✓		
13.	Dunnville	Edgewater Gardens Long Term Care Centre		✓	
14.	East York	St. Clair O'Connor Community Nursing Home		✓	
15.	Etobicoke	Humber Valley Terrace	✓		
16.	Georgetown	Bennett Health Care Centre		✓	
17.	Guelph	LaPointe-Fisher Nursing Home	✓		
18.	Hamilton	St. Peter's Residence at Chedoke[1]		✓	
19.	Jasper	Rosebridge Manor	✓		
20.	King City	King City Lodge Nursing Home	✓		
21.	Kingston	Providence Manor		✓	
22.	Limoges	Foyer St-Viateur Nursing Home	✓		
23.	London	Earls Court Village	✓		
24.	Maple	York Region Maple Health Centre			✓
25.	Markham	Bethany Lodge		✓	
26.	Metcalfe	Township of Osgoode Care Centre		✓	
27.	Milton	Allendale			✓
28.	Mississauga	Malton Village Long Term Care Centre[1]			✓
29.	Mississauga	Tyndall Nursing Home[2]	✓		
30.	Napanee	The John M. Parrott Centre			✓
31.	Newmarket	Eagle Terrace	✓		
32.	North York	Downsview Long Term Care Centre	✓		
33.	North York	Hawthorne Place Care Centre[1]	✓		
34.	Oakville	West Oak Village	✓		
35.	Orangeville	Avalon Retirement Centre	✓		
36.	Oshawa	Hillsdale Terraces[2]			✓

#	Location	Long-Term-Care Home Name	Governance Type		
			For Profit	Non-Profit	Municipal
37.	Ottawa	Extendicare West End Villa[2]	✓		
38.	Perth	Perth Community Care Centre	✓		
39.	Peterborough	Springdale Country Manor	✓		
40.	Petrolia	Lambton Meadowview Villa			✓
41.	Port Hope	Regency Long Term Care Home	✓		
42.	Port Perry	Port Perry Place	✓		
43.	Puslinch	Morriston Park Nursing Home	✓		
44.	Richmond Hill	MacKenzie Health Long Term Care Facility		✓	
45.	Scarborough	Seven Oaks			✓
46.	St. Catharines	Niagara Ina Grafton Gage Village		✓	
47.	St. Jacob's	Derbecker's Heritage House	✓		
48.	St. Thomas	Caressant Care on Mary Bucke	✓		
49.	Stoney Creek	Heritage Green Nursing Home		✓	
50.	Stouffville	Bloomington Cove Care Community	✓		
51.	Terrace Bay	Wilkes Terrace		✓	
52.	Thunder Bay	Hogarth Riverview Manor[2]		✓	
53.	Toronto	Weston Terrace Care Community[2]	✓		
54.	Uxbridge	ReachView Village	✓		
55.	Vaughan	Villa Colombo Seniors Centre		✓	
56.	Waterdown	Alexander Place	✓		
57.	Waterloo	The Village at University Gates	✓		
58.	Whitby	Fairview Lodge			✓
59.	Winchester	Dundas Manor Nursing Home		✓	
60.	Windsor	Riverside Place	✓		
61.	Woodbridge	Kristus Darzs Latvian Home		✓	
62.	Woodstock	Caressant Care Woodstock Nursing Home	✓		

1. We conducted minimal work in these three homes.
2. We conducted detailed work in these five homes.

Appendix 7: Food and Nutrition Services Quality and Performance Indicators Examples

Source of data: Dietitians of Canada

Quality and Performance Indicator	Description of Quality and Performance Indicator
Number of nutrition referrals received monthly	• to identify trends in referrals and assess registered dietitian workload impact
Average number of days to complete nutrition referrals received monthly	• to set realistic goal target according to registered dietitian days on-site weekly
Percent of residents at high nutritional risk	• to determine acuity trends
Percent completion of residents with significant weight change assessed	• to ensure timely nutritional assessment for significant weight changes • goal to have 100% of significant weight changes assessed monthly
Percent completion of registered dietitian skin wound reviews	• to ensure regular assessment of residents with wounds • goal to have 90% of skin wounds assessed monthly until healed
Percent completion of registered dietitian high nutrition risk reviews	• to ensure regular assessment of residents at high nutritional risk • goal 90% of high nutritional risk residents assessed monthly
Number of residents requiring partial and total feeding assistance	• to identify staff impact of residents requiring partial or total feeding assistance
Satisfaction of residents and families with respect to food and dining	• to identify areas of improvement to increase satisfaction and quality of life

Ministry of Agriculture, Food and Rural Affairs;
Ministry of Health; and Public Health Units

Food Safety Inspection Programs

1.0 Summary

Foodborne illnesses in this province already account for 41,000 visits to hospital emergency rooms and 137,000 more to physicians' offices each year. Contaminated food kills about 70 people in Ontario annually and sends another 6,600 to hospital.

Symptoms of foodborne illnesses range from mild nausea and stomach pains to, in rare cases, long-term health problems, and even death. Most people have had a mild case of food poisoning at one time or another without being aware of it—according to 2014 Public Health Ontario statistics, an estimated 96% of cases go unreported.

Contamination of food can happen at any point in the food-supply chain, from the farm to transport to preparation and packaging.

Meat, for example, can be rendered unfit by unclean conditions at slaughterhouses, or by contamination at meat-processing plants. Water runoff and sprays containing bacteria, pesticides, and other chemicals can affect the purity of farm produce.

In addition, food at "food premises," which Ontario law defines as any "premises where food or milk is manufactured, processed, prepared, stored, handled, displayed, distributed, transported, sold or offered for sale," can be contaminated with bacteria from the use of unsanitary utensils and improper cooking methods.

In Ontario, prevention of foodborne illness is the responsibility of all three levels of government, which license and inspect food producers and food premises as follows:

- Meat, produce, fish and dairy produced, processed and consumed only in Ontario are generally the responsibility of the Ontario Ministry of Agriculture, Food and Rural Affairs (Ministry of Agriculture).
- Food premises are inspected by 35 Public Health Units in municipalities across Ontario that are funded by the Ontario Ministry of Health and by the municipalities in which they are based.
- Food imported into Ontario from other provinces or countries, or produced in Ontario for export outside the province, is inspected by the federal Canadian Food Inspection Agency (CFIA).

Forty-five percent of agriculture food products sold in Ontario are produced or processed within the province; the remaining half is imported from other provinces and countries, which means it is licensed and inspected by the federal CFIA.

It is important that the Ministry of Agriculture do an effective job of licensing and inspecting producers to ensure that food produced in this province for sale to Ontarians is free of any contamination that might affect their health. Similarly, the Public Health Units have an important responsibility to make sure that

food is handled hygienically and prepared correctly to protect consumers.

The Ministry of Agriculture spent about $39.5 million in the 2018/19 fiscal year on food-safety licensing, inspections and other related services, while the Ministry of Health and municipalities spent about $63.1 million the same year to fund the Public Health Units. Total average annual spending by the two ministries and municipalities over the last five years on food safety was about $105.7 million.

While the risk of a mass foodborne-illness outbreak in Ontario is likely low, small-scale food incidents could have the potential to occur because it would take only one diseased animal or one unclean restaurant. Our audit identified several areas where improvements could further minimize food-safety risks to Ontarians. We noted, for example, the following issues with respect to Ministry of Agriculture licensing and inspection of Ontario producers:

- **Ninety-eight percent of meat tested negative for harmful drug residue, but in the 2% of cases of positive drug-residue test results, there was no follow-up with the farmers who raised the animals to prevent repeat occurrences.** Since April 2015, about 300 meat samples (representing about 2% of the meat tested) taken from provincially inspected slaughterhouses were found to contain drug residues above prescribed standards. The lack of an appropriate process to follow up and educate farmers whose animals have tested positive increases the risk of such meat entering the food chain.
- **Some pesticides banned for use in groundskeeping for health and safety reasons are found in Ontario-grown produce in levels exceeding Health Canada's allowable limits.** The *Cosmetic Pesticides Ban Act* lists 131 pesticides that cannot be used for cosmetic groundskeeping, in parks and yards, for example, because of potential health and environmental concerns. However, their use is allowed in agriculture for operational and economic reasons. Between 2014 and 2018, the Ministry of Agriculture tested about 1,200 Ontario-grown produce samples and found residues of 14 banned pesticides that exceeded Health Canada limits a total of 76 times.
- **Current legislation provides limited enforcement tools to compel fish processors to address food-safety infractions, resulting in repeat offences.** Fish processors who sell only in Ontario do not require a licence to operate. The Ministry of Agriculture, therefore, may not be able to close them because there is no licence to revoke if inspectors identify serious food-safety deficiencies. The Ministry also has no legal power to issue fines or compliance orders. Our sample review of 182 inspection reports on fish-processing plants found that two-thirds of the infractions noted in 2018/19 were repeat offences that had also been observed in each of the two previous years.
- **The Ministry of Agriculture did not receive sufficient information to provide sufficient oversight of the Dairy Farmers of Ontario (DFO).** The Ministry delegated inspection of cow-milk producers to the DFO in 1998. However, the Ministry did not consistently receive sufficient information from DFO to provide adequate oversight of the organization. We found that DFO's reports to the Ministry were high-level summaries that did not specifically identify non-compliant producers whose test samples repeatedly exceeded regulatory bacteria limits. In addition, the reports did not say what actions DFO took to address the issue of repeat offenders.
- **The Ministry of Agriculture did not have complete details about the activities of produce farmers in Ontario to select appropriate producers for sample-testing.** The Ministry's inventory of farmers did not contain complete information on production volumes, type of crops grown, and where the produce

was sold. Such data would be useful to determine a risk-based food-sample-testing plan.

We noted the following issues with Public Health Units, which are responsible to inspect food premises:

- **Public Health Units did not investigate complaints of foodborne illnesses on a timely basis.** Based on our review of inspection reports from 2016 to 2018 at five Public Health Units, we found that for those foodborne-illness complaints that required food premises inspections, the Public Health Units consistently did not inspect 20% of food premises within two days of receiving the complaint. The Public Health Units we visited informed us that a two-day timeline is considered a best practice.
- **Different inspection-grading systems for food premises among Public Health Units provided inconsistent information to the public across Ontario.** The degree of public disclosure of inspection results for food premises, along with the inspection-grading systems used by the 35 Health Units, varied across the province. The variations can be confusing to the public.
- **While not all special events require inspections, only about 12% of them within the jurisdictions of the five Public Health Units we visited were inspected in 2018, and only about 15% in 2017.** Public Health Units are required to assess food safety risks at temporary food premises, which include special events such as summer fairs and festivals, to determine if these premises require an inspection. However, we found that there are currently no minimum provincial requirements for the frequency of inspections of special events as there are for fixed food premises, such as restaurants. According to the US Centers for Disease Control and Prevention, special events can be high risk because the usual safety features of a kitchen, such as the ability to monitor food temperatures and washing facilities, may not be available at outdoor events.
- **Some food premises were never inspected until Public Health Units received complaints from the public.** The lists of food premises kept by the five Health Units were not up to date. At the five Health Units we visited, we found 253 complaints received between 2016 and 2018 relating to food premises whose existence the Health Units were unaware of until they received the complaints.

There were also several areas where current regulations and standards may be insufficient. For example:

- **Businesses operating solely within Ontario can market their products as "organic" even if they are not certified to the Canadian Organic Standards.** The CFIA requires certification for products labelled as organic when they are sold across provincial or international borders—but Ontario allows the sale of non-certified products labelled as organic within the province. In comparison, Quebec, Manitoba, Alberta, British Columbia, New Brunswick and Nova Scotia all have laws requiring that organic food be certified to the Canadian Organic Standards even when it is sold only within their borders. Based on our research, there are at least 34 organic producers in Ontario that are not certified to the Canadian Organic Standards but are advertising their products as "organic." The majority of these organic growers sell their products through farmers' markets. We also noted that routine sample testing of produce for pesticides residue is not required for the CFIA organic certification process.
- **Sheep milk and non-chicken eggs are not subject to mandatory regulation or inspection for quality assurance.** Milk from cows and goats, along with eggs from chickens, is regulated and inspected by the federal or Ontario governments, or both. However,

there is no mandatory regulation or inspection of milk from sheep and water-buffalo, or of eggs from other fowl. In comparison, Manitoba and Alberta regulate all animals kept for the purpose of producing milk.

Finally, we noted gaps in the inspections carried out by the different government entities responsible for food safety. We found, for example, that although the Ministry of Agriculture and the CFIA check for federal food-labelling requirements regarding allergens in provincial food-processing plants, they do not verify other labelling requirements, such as place of origin and nutritional value.

Overall Conclusion

We found overall that efficient systems and procedures are in place to keep the Ontario food supply safe, but that more could be done to improve the Ministry of Agriculture's licensing and inspection programs.

With respect to the Ministry of Health, we determined that the five Public Health Units we visited had effective systems and procedures in place to inspect food premises and conduct foodborne-illness surveillance and outbreak management in accordance with applicable legislation and regulations. However, we also noted several areas where improvements could be made, including inspection of online and home-based food businesses and special events. We also found inconsistencies between Public Health Units with respect to inspection policies and procedures, and public disclosure of inspection results both online and on-site at the food premises.

This report contains 21 recommendations, with 36 action items, to address our audit findings.

OVERALL MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs thanks the Office of the Auditor General for recognizing that we have efficient systems and procedures in place to keep Ontario's food supply safe.

The report demonstrates that Ontario's food safety system is a network of government and industry partners, which relies upon robust science, laboratory and analytical capacity to protect the public. Ontario has enabling legislation that provides the foundation for oversight through a modern licensing, permitting and inspection program. Like other regulators, we use a progressive compliance approach, one that includes education, advisory services and enforcement. The Ministry appreciates the areas that the Auditor General has highlighted and is committed to using all tools available to support continuous improvement. We will carefully review the Auditor General's report and, where identified, work with our food safety partners to implement the report recommendations.

OVERALL MINISTRY OF HEALTH RESPONSE

The Ministry of Health welcomes the Auditor's recommendations on how the Ministry can ensure that the Ministry and Public Health Units are delivering on their mandate of providing safe food to the people of Ontario. We agree with the recommendations made to the Ministry and are committed to ensuring that the actions we take in response ensure strengthened accountability and value for money, and lead to continued improvements in food safety in Ontario.

The Ministry acknowledges the province's 35 Public Health Units' and municipalities' role as leaders and champions of evidence-based food safety program delivery, measuring and reporting on public health outcomes and supporting continuous quality improvements within an increasingly complex public health sector.

The Ministry also recognizes that there are further opportunities to increase the value for money and impact of the food-safety program and delivery in Ontario, as well as opportunities

to work with food-safety stakeholders to build on current efforts. While many of these can be realized through the Ministry's existing mandate to, among other things, support quality improvement, the Ministry recognizes that strengthening consistency across system partners would be beneficial for an even safer food system. The Ministry will continue to work with Public Health Units and municipalities to assess those opportunities going forward.

Currently, the government is taking a comprehensive approach to modernize Ontario's health-care system, which includes a coordinated public health sector that is nimble, resilient, efficient and responsive to the province's evolving health needs and priorities. The modernization will yield opportunities to better leverage existing frameworks for information-sharing, data collection and accountability to further support improvements to food safety.

2.0 Background

2.1 Overview

Public Health Ontario, a Crown agency, estimates that foodborne illness kills approximately 70 people in Ontario each year and sends another 6,600 to hospital. It also accounts for 41,000 visits to hospital emergency rooms and at least 137,000 visits to physicians.

Most people who have had a foodborne illness experience symptoms that are mild enough to pass unnoticed, such as nausea, stomach pain, vomiting and diarrhoea. In rare instances, they can trigger longer-term health issues such as chronic bowel and gastrointestinal problems, autoimmune disorders, neurological dysfunction and kidney failure. In rarer instances, they can lead to death, with the elderly and individuals with underlying health issues most at risk.

Food can become contaminated at various points in the supply chain, from feed and medication administered to animals, to processing, storage, handling and preparation of food.

A 2017 survey of 1,509 Canadians conducted by the Canadian Centre for Food Integrity, a not-for-profit organization dedicated to help the Canadian food system earn public trust through research and training, found that the number of Canadians who trust the food system is on the rise, but 54% still had concerns about food safety.

In Canada, regulatory responsibility for food safety is shared among all levels of government, with some interconnection of roles. **Figure 1** provides a high-level overview of the jurisdictional oversight of food safety in Ontario. **Appendix 1** provides a more detailed description of the roles and responsibilities of key stakeholders in food safety.

In the 2018/19 fiscal year, the province, through the Ministry of Agriculture and the Ministry of Health and the 35 Public Health Units, spent over $102 million on food safety inspection programs and services. **Figure 2** provides a breakdown of this cost.

Appendix 2 provides an overview of the federal Canadian Food Inspection Agency (CFIA), Health Canada, the provincial Ministry of Agriculture and the Public Health Units' oversight of meat, fruits and vegetables, fish, dairy, eggs and organic foods in Ontario.

2.2 Legislation and Regulations

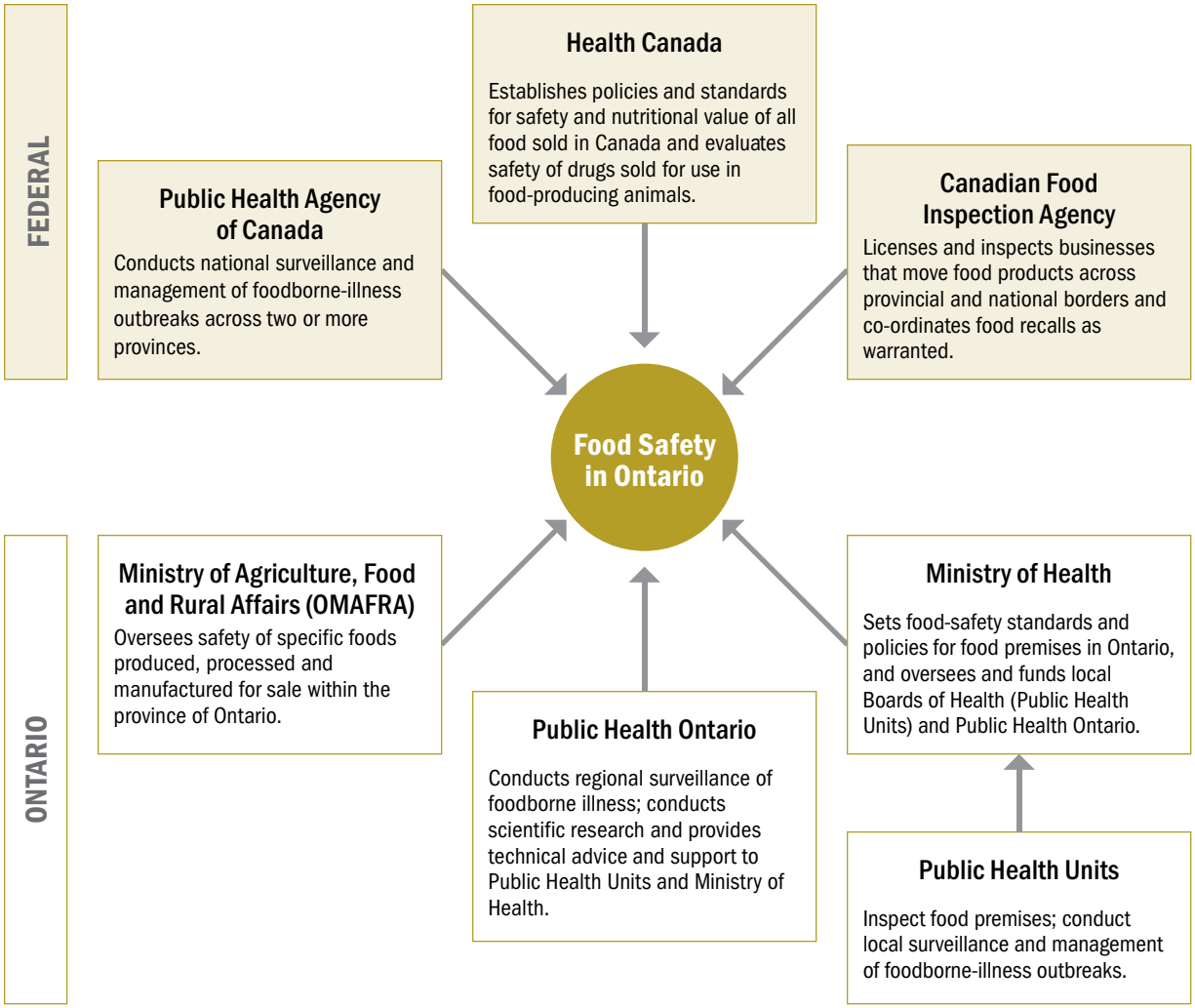
Provincial

Ontario's jurisdiction over food safety is governed primarily by four provincial laws:

- The *Food Safety and Quality Act, 2001* (Act) outlines the Ministry's role in food safety. Under the Act, the Ministry of Agriculture has the authority to:
  - establish food-safety standards with respect to meat, eggs, foods of plant origins (such as fruits, vegetables, culinary herbs, nuts, edible fungi, maple syrup and

Figure 1: Overview of Food Safety Responsibilities by Jurisdiction

Source of data: Ministry of Agriculture, Food and Rural Affairs, and Ministry of Health



Note: This audit focused on the food-safety programs and services delivered by OMAFRA and by Public Health Units, which are overseen and partly funded by the Ministry of Health.

honey) that are produced and consumed within Ontario;

- license, suspend or revoke licences of food processors; and
- inspect and detain food products and other relevant items such as records and equipment, issue orders, and/or lay charges.

- The *Fish Inspection Act* regulates the standards for fish processing and the sale of fish that is processed and consumed within Ontario.
- The *Milk Act* outlines the Ministry of Agriculture's role with respect to the inspection and testing of raw milk from cows and goats, as well as the licensing and inspection of dairy plants.
- The *Health Protection and Promotion Act* requires Public Health Units to inspect food premises for the purpose of preventing, eliminating and decreasing the effects of health hazards. Examples of food premises are restaurants, food courts, grocery stores, butcher shops, mobile food carts, banquet halls and catering facilities.

Figure 2: Breakdown of Ministry of Agriculture, Food and Rural Affairs, Ministry of Health and Municipal Food Safety Costs, 2014/15–2018/19 ($ million)

Source of data: Ministry of Agriculture, Food and Rural Affairs, and Ministry of Health

Costs	2014/15	2015/16	2016/17	2017/18	2018/19
Ministry of Agriculture, Food and Rural Affairs					
Salaries and benefits	23.1	24.9	25.1	24.9	25.2
Services	5.8	6.4	5.9	5.7	3.8
Transportation and communications	1.3	1.4	1.4	1.3	1.2
Supplies and equipment	0.4	0.3	0.4	0.3	0.2
Laboratory testing	5.5	5.5	5.5	5.5	5.6
Other direct costs*	2.7	2.7	2.7	2.8	2.7
Transfer payments	1.3	1.4	0.9	2.5	0.9
Less: Revenue from licences	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)
Subtotal of Ministry of Agriculture Costs	**40.0**	**42.5**	**41.8**	**42.9**	**39.5**
Ministry of Health Food-Safety Expense	**45.5**	**47.4**	**46.8**	**47.1**	**45.7**
Municipal Food-Safety Expense	**17.5**	**17.6**	**18.2**	**18.5**	**17.4**
Total Ontario Food-Safety Costs	**103.0**	**107.5**	**106.8**	**108.5**	**102.6**

* Other direct costs include bad-debt expenses and occupancy-cost allocation.

Federal

The federal *Food and Drugs Act* and Regulations establish standards for the safety and nutritional quality of all foods sold in Canada.

The federal *Safe Food for Canadians Act* and Regulations generally apply to food that crosses provincial borders. However, some of the food labelling and advertising, and grading provisions, also apply to foods produced, processed and sold within the province.

In addition, the federal Safe Food for Canadians Regulations, 2019, outline the organic certification system known as the Canadian Organic Regime. Under the Regulation, organic food products must be certified according to the Canadian Organic Standards (see **Section 2.4** for details) if they:

- have an organic claim on the label and are sold between provinces or territories or imported; or
- display the Canadian Organic Logo on the label and are sold within or outside of Canada.

2.3 Food-Safety Programs of the Ministry of Agriculture

The Ministry of Agriculture licenses, inspects, performs ongoing laboratory testing of food products and engages in compliance and enforcement activities for meat, foods of plant origin, seafood, dairy and eggs. **Figure 3** provides a summary of key food-safety programs delivered by the Ministry of Agriculture in 2019. **Appendix 3** summarizes the Ministry of Agriculture's food-safety inspection and audit reports, while **Appendix 4** contains a summary of the Ministry of Agriculture's food-sample test results from 2014/15 to 2018/19.

Meat

To help ensure a safe meat supply and reduce the potential for foodborne illnesses, the Meat Regulations of the *Food Safety and Quality Act* states that no one may sell, transport, deliver or distribute meat unless:

- the animal was inspected prior to slaughter and approved for slaughter, and the carcass was inspected following slaughter and

Figure 3: Food-Safety Programs under the Ontario Ministry of Agriculture, Food and Rural Affairs, 2019

Prepared by the Office of the Auditor General of Ontario

	Meat	Fruits and Vegetables	Fish and Seafood	Dairy
Licensing/ Registration	• Licenses 122 slaughterhouses and 362 meat-processing plants • Renewal of licences every 3 years	• No licensing requirements for the 1,871 produce farmers[1]	• No licensing requirements for the 100 processors	• Oversees third-party licensing of 3,452 cow-milk farms • Registers 268 dairy goat farms • Licenses 141 dairy-processing plants (includes 48 provincial plants and 93 dual-licence plants[2])
Inspection/ Audits	• Inspects slaughterhouses and all animals slaughtered for food[3] • Inspects high-risk and high-volume processing plants every 2–6 weeks • Conducts annual audits of slaughterhouses[4] • Contracts with third parties to perform annual audits of processing plants	• Performs inspections as a result of complaints or adverse sample results	• Oversees third-party inspections of fish-processing plants twice a year	• Oversees third-party inspection of cow-milk farms at least every 2 years • Inspects goat-milk farms and provincial dairy-processing plants annually
Sampling	• Risk-based sample testing of carcasses and ready-to-eat meats for bacteria and chemical residue	• Risk-based sample testing for bacteria and chemical residue	• Performs bacterial swabs of equipment and food-contact surfaces at processing plants	• Oversees third-party sample testing of cow-milk farms for bacteria and inhibitors • Regulatory sample testing of goat-milk farms for bacteria and inhibitors • Risk-based sample testing of provincial dairy plants
Compliance Tools	• Warning letters • Compliance orders • Suspend production • Detain or dispose of carcasses and/or meat products • Withdraw inspection services • Suspend or revoke licence • Prosecution	• Warning letters • Compliance orders • Detention, seizure or disposal of produce	• Warning letters • Detain products, make arrests	• Goat and Cow Farms: warning letters, disposal of milk, production shutdown, financial penalties (cow farms only) • Dairy Processors: warning letters, detention or disposal (after a hearing) of product, issue a licence with conditions (e.g., shortened licence), revoke or suspend a licence (after a hearing)
Other food-safety services	• Provides education, outreach and advice to producers and processors • Maintains online food-safety-reporting tool for public use • Research and supports regulatory efforts, food-safety research (e.g., post-secondary institutions) and co-ordinates with other agencies to address foodborne-illness outbreaks • Administers cost-sharing program for farmers and food processors (OAGO audited in 2017)			

1. Number of fruit and vegetable farmers in Ministry of Agriculture, Food and Rural Affairs database as of August 2019.
2. Dairy-processing plants that export outside Ontario require dual licensing from both the provincial and federal governments.
3. An inspection is the routine monitoring and review at food premises of employee hygiene and operational standards, collection of samples and verification of adherence to written programs for such areas as sanitation and pest control.
4. An audit is an annual comprehensive review of plant operations to verify and ensure compliance with legislation and regulations.

approved for use as food in accordance with the Meat Regulations;
- the animal was slaughtered in a plant that is licensed provincially or federally; and
- the meat is stamped, labelled or tagged with an inspection legend.

At slaughterhouses supplying the Ontario market only, every single animal must be examined pre- and post-slaughter by Ministry of Agriculture inspectors to ensure animal health and welfare standards are met and it is disease-free and fit for human consumption. Inspectors also take product and environmental samples for laboratory testing for bacteria and chemical residues. Slaughterhouses are also audited by a Ministry of Agriculture veterinarian yearly to ensure compliance with food-safety and animal-welfare legislation.

The Ministry of Agriculture also performs a risk assessment at each Ontario meat-processing plant under its jurisdiction to determine the frequency of inspections. The risk assessment is done annually or whenever major changes that could affect the food safety of the plant occur—when alterations are made, for example, that impact the production flow or implementation of a food-safety program. High-risk plants are to be inspected every two weeks, moderate-risk ones every three weeks and low-risk plants every six weeks. The Ministry of Agriculture also conducts annual audits of all meat-processing plants for compliance with food-safety legislation and policies.

In Canada, growth hormones are approved for use in beef cattle but not in dairy cattle, chicken, pork or any other animal raised for food. Growth hormones are used in beef cattle to increase the weight of animals while using less feed. The federal government regulates the use of growth hormones.

Foods of Plant Origin (Such as Fruits and Vegetables)

Producers of foods of plant origin who export a portion of their produce outside Ontario are licensed and inspected by the CFIA. There are no licensing requirements for producers of fruits, vegetables, sprouts, herbs, edible fungi, nuts, maple syrup and honey that are sold only in Ontario.

The Ministry of Agriculture does not routinely inspect farms but it regularly tests produce samples from farmers' markets, retail stores and wholesalers for chemical residues and bacteria, and for compliance with labelling requirements such as the origin of the produce or the grade of maple syrup. The Ministry of Agriculture will conduct inspections when an issue such as a complaint or an adverse test result has been brought to its attention.

The Ministry of Agriculture's sample-testing selection is based on analysis of a number of risk factors such as the physical characteristics of the product and susceptibility to contamination, how often the produce is consumed by Ontarians, whether it is eaten raw, and the compliance history of a producer, including past sample test results and any foodborne-illness outbreaks.

Pesticide contamination is typically a result of improper use of a chemical, including its use on a crop for which it was not intended, incorrect dilution of the concentrate before spraying, wind carrying the spray to nearby fields, and harvesting produce too soon after spraying.

Since pesticides may be harmful to humans or the environment, they must be registered with Health Canada's Pest Management Regulatory Agency before use. The federal *Pest Control Products Act* sets the maximum allowable levels of residue that may be found in food in Canada. The Ministry of Agriculture must observe these limits when it monitors chemical contamination of locally grown foods.

Fish and Seafood

There are about 170 fish- and seafood-processing plants in Ontario, along with 22 fish farms.

There are no licensing requirements for 100 of the plants because they sell only in Ontario, but they are inspected by the Ministry of Agriculture at least twice a year. The Ministry of Agriculture's

inspections include checking for proper controls over sanitation, hygiene, equipment maintenance, water source, waste disposal, receiving, transportation and storage of food.

It also routinely takes environmental samples such as swabs of surfaces that come into contact with food at fish-processing facilities to test for pathogens (bacteria, viruses or other microorganisms that can cause disease) to verify the effectiveness of cleaning and sanitation procedures.

The CFIA licenses, inspects and does sample testing at the other 70 fish- and seafood-processing plants that export outside the province. It also sample-tests processed fish and seafood sold to the Ontario public that may include imports and Ontario-processed fish and seafood products.

Of the 22 fish farms, 12 export their products and 10 produce only for the Ontario market. Of the 10 that sell only in Ontario, nine produce rainbow trout and one produces tilapia and barramundi.

The Ministry of Agriculture does not inspect fish farms because the *Fish Inspection Act* does not give the Ministry authority over the 10 farms that produce solely for the Ontario market. The Act provides authority for fish products only when they enter the food system through handling, processing, sorting, grading, packaging, marketing or transporting. These farms are licensed by the Ministry of Natural Resources and Forestry, which conducts regular water quality and sediment monitoring on six cage aquaculture sites in Ontario to assess their impact on the aquatic environment.

The CFIA only licenses operators of farms that produce, process, treat, preserve, grade, package or label fish and seafood for export outside the province. The CFIA inspects only licensed farms and tests samples of fish and seafood sold to the Ontario public that may include imports and Ontario-raised fish. The CFIA's sample testing looks for heavy metals (such as mercury), bacteria and chemical residues (such as antibiotics).

Dairy

The Ministry of Agriculture oversees the registration and inspection of all 3,504 cow-milk farms and 268 goat-milk farms that supply milk for processing in Ontario dairy plants. The Ministry of Agriculture also licenses all 141 dairy-processing plants in Ontario, including 48 Ontario-licensed plants and 93 plants licensed by both the federal and provincial governments (dual-licensed) that export outside the province.

For raw cow milk, the Ministry of Agriculture has delegated the responsibility for administering and enforcing various quality and safety provisions under the *Milk Act* to the Dairy Farmers of Ontario (DFO). DFO inspects dairy farms at least once every two years, and oversees the monthly collection and testing of milk samples for bacteria and inhibitors such as antibiotics or other chemicals at each farm. DFO is also responsible for training, certifying and inspecting Bulk Tank Milk Graders (Graders) of raw cow milk, who are responsible for grading and sampling milk, and ensuring the quality is acceptable, before loading it into trucks at the farms and delivering it to dairy processors. DFO is also responsible for inspecting milk tank-trucks used to pick up and deliver milk.

The use of growth hormones to increase milk production for animals kept for the purpose of milking is illegal in Canada. In Ontario, dairy farmers are to produce milk volumes according to their quota allotment set by the Dairy Farmers of Ontario. If dairy farmers produce more milk than their quota allows, they will not be paid for it and the excess milk will be disposed of.

For raw goat milk, the Ministry of Agriculture inspects all registered dairy goat farms at least once annually and trains, certifies and inspects Graders of raw goat milk. The Ministry of Agriculture also inspects the tank-trucks used to pick up and deliver milk. Graders collect monthly milk samples for bacteria and inhibitor testing.

At dairy-processing plants, raw milk is processed into fluid milk (that is, homogenized, 2%, and so on) and other dairy products such as butter,

cheese, yogurt and ice cream. The Ministry of Agriculture is responsible for the inspection of the 48 provincially licensed dairy-processing plants, and conducts sample testing for bacteria and inhibitors on finished dairy products, and environment testing in each plant up to four times per year based on a risk assessment.

Eggs

Grading of chicken eggs fall under the jurisdiction of the CFIA, which requires that all chicken eggs be graded at federally registered grading stations. The stations wash, candle, weigh and pack the eggs into containers with the applicable federal grade. (In the candling process, a light is used to inspect eggs for any interior defects and cracks in the shell.) In addition, the CFIA also collects egg samples for bacteria and chemical-residue testing.

Ungraded eggs may only be sold to an egg dealer or egg-grading station, although farmers may sell directly to consumers on the farm. Egg dealers are operators licensed by Egg Farmers of Ontario, which is responsible for transporting ungraded eggs from farmers to grading stations.

2.4 Organic Foods

According to regulations under federal legislation, the *Safe Food for Canadians Act, 2012*, food products must be certified as organic according to the Canadian Organic Standards if they are sold between provinces or territories, or imported, or display the Canadian Organic Logo.

The use of the organic logo is permitted only on products that have an organic content greater than or equal to 95%, and that have been certified according to the Canadian Organic Standards, developed by the federal Canadian Food Inspection Agency (CFIA). The CFIA is responsible for monitoring and enforcing standards for organic products across the country in accordance with the Canadian Organic Standards.

The Standards include a detailed set of principles, guidelines and permitted substances that apply to the organic certification process. According to the Standards, organic livestock must have access to more space, natural light, the outdoors and habitats that encourage roosting, rooting and grazing. **Appendixes 5** and **6** summarize the farming standards for organic livestock in Canada. Organic produce farmers are not allowed to use synthetic fertilizers and pesticides. **Appendix 7** summarizes the farming standards for organic produce.

There are several certification bodies in Ontario, all accredited by the CFIA, that certify organic farms and food-processing operations. Organic certifications are renewed annually after an on-farm inspection to check for compliance with the organic standards. When a producer fails to correct any issues of non-compliance, certification bodies have the power to revoke or suspend certification.

Imported organic products must also meet the requirements of the Canada Organic Standards and may be certified either by a CFIA-accredited certification body or by a certification body accredited by that foreign country and recognized by Canada through an equivalency arrangement—a trade agreement made with another country after assessing and comparing the two regulatory systems, including the organic standards, to ensure they are consistent. Currently, Canada has established organic equivalency arrangements with the US, the European Union, Costa Rica, Japan and Switzerland. Organic products from countries that do not have organic equivalency arrangements with Canada and do not meet the Canadian Organic Standards cannot be imported into Canada as organic products.

2.5 Food-Safety Programs of the Public Health Units

The Ministry of Health sets food-safety standards and policies through the Ontario Public Health Standards. The Standards identify the minimum expectations for public health programs and

Figure 4: Food Safety Oversight by Public Health Units

Prepared by the Office of the Auditor General of Ontario

Public Health Units		
Inspections of Food Premises	**Investigations of Foodborne Illneses**	**Education, Training and Other Services**
Inspect restaurants, grocery stores, mobile food trucks, special events, banquet halls and other food premises, and provide education and consultation to owners and operators	Conduct investigations/inspections of local foodborne-illness outbreaks in food premises, and reporting diseases of public-health significance	Provide training for food-handler certification, respond to food-related complaints and provide public with food-safety information

services to be delivered by Ontario's 35 Boards of Health (Public Health Units). One of those programs is food safety. **Appendix 8** provides information on the 35 Public Health Units as of December 31, 2018.

The Ministry of Health also has oversight of legislation and regulations such as the Food Premises Regulation under the *Health Protection and Promotion Act*, which establishes the food safety requirements for food premises.

As shown in **Figure 4**, Ontario's 35 Public Health Units are responsible for implementing public health programs and services, which include inspecting food premises to ensure compliance with food handling and sanitation requirements under the Food Premises Regulation and *Health Protection and Promotion Act*. Each Public Health Unit is governed by a local independent Board of Health, which is accountable to the Ministry of Health for meeting provincial standards, including delivering the food safety programs and services specified in the Ontario Public Health Standards.

The Ministry of Health's Foods Safety Protocol requires Public Health Units to maintain a list of all food premises in their jurisdiction. In 2018, Ontario had over 73,000 food premises that were open year-round and over 7,500 seasonal food premises.

The Public Health Units must conduct an annual risk assessment using the Ministry's risk categorization tool and the Food Safety Protocol to determine the level of risk and minimum inspection frequency associated with each of the fixed food premises in their region. Factors that may indicate high risk include:

- food premises serving vulnerable populations, such as hospital patients, seniors and children, or those performing extensive food handling (three or more preparation steps);
- full-service banquet halls as well as premises that primarily serve catered meals off-site; and
- food premises with a previous history of a confirmed foodborne illness or outbreak as well as previous infractions.

Based on the assessed risk, as shown in **Figure 5**, Public Health Units inspect each food premises anywhere from every four months for high-risk facilities to every 12 months for low-risk ones. Food premises that offer only low-risk pre-packed food are inspected every 24 months.

Public Health inspectors can issue tickets for non-compliance with regulations, issue summons for court appearances, destroy unsafe food, and close the food premises as long as a health hazard exists.

According to the Ministry's Public Health Standards, Public Health Units must maintain 24/7 access for the public to report foodborne illnesses, unsafe food-handling practices, consumer complaints and other food-related issues. The Public Health Units, in collaboration with the Ministry of Health and Public Health Ontario, also conduct surveillance by recording, tracking and investigating all suspected and confirmed foodborne-illness cases, and managing outbreaks.

Figure 5: Risk Categories and Frequency of Inspections of Food Premises

Source of data: Ministry of Health and Public Health Units

Risk Category	Frequency of Inspection
High – Food premises represent high likelihood of foodborne-illness outbreak (e.g., banquet halls with food preparation, smoked meat restaurants)	At least once every 4 months
Moderate – Food premises represent moderate likelihood of foodborne-illness outbreak (e.g., sushi restaurants, grocery stores)	At least once every 6 months
Low – Food premises represent low likelihood of foodborne-illness outbreak (e.g., convenience stores, cafés serving tea, coffee and prepackaged foods)	At least once every 24 months for food premises that sell only pre-packaged non-hazardous food, and at least once every 12 months for all other low-risk food premises

Note: The risk categorization of food premises is based on multiple factors such as food preparation steps, history of inspection results, length of time in business, population served and any links to confirmed foodborne illness. The same type of restaurant can be categorized in different categories based on these factors. Therefore, the restaurant types listed under each category are used here only as examples.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether the Ontario Ministry of Agriculture, Food and Rural Affairs (Ministry of Agriculture) has effective systems and procedures in place to:

- ensure licensing, inspection and sampling programs are delivered economically and efficiently in accordance with applicable legislation, regulations, agreements and policies such that food-safety risks for commodities farmed, processed and marketed within Ontario are managed to protect the health of Ontarians; and
- measure and publicly report periodically on the results and effectiveness of food-safety programs and services.

In addition, we assessed whether the Ministry of Health (Ministry) through the Public Health Units, has effective systems and procedures in place to:

- inspect food premises and conduct foodborne-illness surveillance and outbreak management economically and efficiently to prevent the effects of foodborne illnesses, in accordance with applicable legislation, regulations, agreements and policies; and
- measure and publicly report periodically on the results and effectiveness of food premises inspection programs.

We identified the audit criteria we would use to address our audit objective. These are listed in **Appendix 9**. These criteria were established based on a review of applicable legislation, policies and procedures, and internal and external studies. Senior management at the Ministry of Agriculture and the Ministry of Health reviewed and agreed with our audit objectives and associated criteria.

Our audit work, conducted at the Ministry of Agriculture's office in Guelph between January 2019 and August 2019, examined its oversight of food-safety programs including licensing, inspections and laboratory testing of food producers and processors.

We also visited and performed audit fieldwork at five of the 35 Public Health Units—specifically, in Toronto, York, Peel, Simcoe Muskoka and Ottawa—from April 2019 to August 2019. Our selection of Public Health Units was based on their number of food premises, especially high-risk premises, population of the region and total expenditures on food-safety programs. Overall, the five Public Health Units are responsible for about 49% of all food premises and 50% of the total Ministry of Health food-safety expenditures in Ontario.

At the Public Health Units, we examined their food-safety programs, including food-premises

inspections, food-handling certifications and food-safety public education and outreach. Our audit also assessed whether there is timely communication, information-sharing and collaboration between the Ministry of Agriculture, the Public Health Units and other system partners such as the federal Canadian Food Inspection Agency (CFIA) and Public Health Ontario (PHO) in the event of outbreaks of foodborne illness or food recalls.

We interviewed senior management and staff, and examined related data and other documents from the Ministry of Agriculture, Public Health Units, the CFIA, Health Canada, PHO and the Ministry of Health to obtain an understanding of each entity's involvement with food safety in Ontario. We also shadowed inspections of producers, processors and food premises, and visited a number of farms with inspectors from the Ministry of Agriculture and Public Health. We also commissioned the University of Guelph to test a sample of fish, and of organic and regular produce, locally grown and imported, for chemical residue and bacteria count.

We also interviewed stakeholders such as the Dairy Farmers of Ontario, Ontario Dairy Council, Ontario Sheep Farmers, Canadian Sheep Federation, Ontario Independent Meat Processors, College of Veterinarians of Ontario, Ontario Food Terminal, Canadian Produce Marketing Association, Ontario Fruit and Vegetable Growers' Association, Agricorp, Ministry of the Environment, Conservation and Parks, Health Canada's Pesticide Management Regulatory Agency, Ontario Aquaculture Association, Ministry of Natural Resources and Forestry, Organic Council of Ontario, Ontario Restaurant Hotel and Motel Association, Cancer Care Ontario and the Ontario Public Health Association.

In addition, we reviewed relevant research and best practices of food safety in Canada and other jurisdictions. We also engaged an independent advisor with expertise in food microbiology and food safety to assist us on this audit.

4.0 Detailed Audit Observations: Inspections of Food Producers and Processors

4.1 Meat

For the 2018/19 fiscal year, 84% of all red-meat slaughters (e.g., pork, beef, lamb) and 92% of all white-meat slaughters (e.g., poultry) carried out by 29 slaughterhouses in Ontario were under the oversight of the Canadian Food Inspection Agency (CFIA) because these plants also export outside the province. There is no information on how much meat slaughtered in these plants is consumed in Ontario. The remaining 16% of red meat and 8% white meat is slaughtered strictly for consumption in Ontario through 122 slaughterhouses licensed by the Ministry of Agriculture.

There were 362 meat-processing plants that supply meat exclusively for Ontario consumption inspected by the Ministry of Agriculture during the 2018/19 fiscal year. Another 186 meat-processing plants in Ontario export outside the province and are licensed and inspected by the CFIA. However, there is no data on the percentage of meat processed in Ontario that comes from facilities inspected by the Ministry of Agriculture and the percentage that comes from facilities inspected by the CFIA.

4.1.1 Ninety-Eight Percent of Inspected Slaughterhouse Meat Tested Negative for Harmful Drug Residue

Ninety-eight percent of meat at provincially inspected slaughterhouses that the Ministry of Agriculture randomly tested between April 2015 and March 2019 tested negative for harmful drug residues. This means that any potential drug residues that may have existed were at levels below the allowable limit set by Health Canada. However, no

follow-up was done by the CFIA nor the Ministry of Agriculture at the farms that raised the animals for the 2% that did test positive for drug residues.

As of April 2015, the CFIA no longer follows up with the farmer on positive drug-residue results in meat originating from provincially inspected slaughterhouses. Since then, the Ministry of Agriculture has had about 300 positive drug-residue results (meaning that about 2% of all slaughterhouse meat tested has tested positive), all shared with the CFIA, but there has been no follow-up with the farms.

Prior to April 2015, the Ministry of Agriculture had a process in place to send all positive test results to the CFIA, which would then follow up with the farmers to confirm the level of antibiotics and drugs used and to educate them about Health Canada's prescribed standards.

The Ministry of Agriculture's meat-sampling program at provincially inspected slaughterhouses tests animal organs and muscle tissue for antibiotics and other drug residue in slaughtered animals. For this testing, the Ministry of Agriculture uses Health Canada's prescribed standards on allowable limits for antibiotics and other chemical compounds. If the Ministry of Agriculture's sample tests show a presence of antibiotics and other drug residues above allowable limits, it can condemn the entire carcass to ensure meat with residue does not enter the food chain.

However, the lack of an appropriate process to follow up with and educate farmers whose animals have tested positive for drug residues above prescribed standards increases the risk of such meat entering the food chain because the Ministry only tests animals on a sample basis. Since it is not reasonable to test every animal, the Ministry must ensure that farmers do not produce animals with drug residues above prescribed standards. If these farmers are not aware that their animals have drug residues above allowable limits, they will not be able to take corrective action on their remaining and future animal stocks.

Neither the Ministry of Agriculture nor the CFIA has the authority to follow up with farmers who originally sold the animals with antibiotics and drug levels above the allowable limits to slaughterhouses. The federal *Food and Drugs Act* does not regulate the use of antibiotics and drugs on farms. The federal *Feeds Act* provides regulatory authority only for the mixing and selling of livestock feed and does not provide authority in the use of the feed. As a result, the Ministry of Agriculture can only encourage provincially inspected slaughterhouse operators to follow up positive drug test results with their suppliers.

Antibiotics are commonly given to cows, hogs and poultry to treat infections, to prevent and control diseases from spreading, and to enhance growth. While harmful bacteria can be killed by cooking to the correct temperature, cooking does not remove antibiotic and drug residues in meat.

RECOMMENDATION 1

To reduce the risk of meat with drug-residue levels above prescribed standards from entering the food chain, we recommend that the Ontario Ministry of Agriculture, Food and Rural Affairs, in collaboration with the Canadian Food Inspection Agency:

- establish clear roles and responsibilities in the areas of reviewing positive drug-residue results with the farmers who raised the animals; and
- formally penalize farmers who continue to sell animals with drug-residue levels above the allowable limit.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that unsafe drug residues should not enter the food system. As part of the Ministry's food safety oversight role, we have a strong surveillance and monitoring program in place at provincially inspected slaughter facilities. Since April 2015, we have tested over

17,000 meat samples for antibiotics and other drug residues, and found adverse levels in the about 300 cases you have mentioned.

We follow up by taking all necessary actions at the meat plant, including condemning unsafe meat products. We take strong compliance actions for plants with repeat infractions, using compliance orders, imposing licensing conditions and implementing increased surveillance where necessary. We also implement more stringent testing programs for livestock groups that show a higher incidence of adverse results.

Of the 1,359 samples tested through the random monitoring program in 2018/19, less than 0.6% tested above the prescribed limits, showing that while most farmers in Ontario are using livestock medicines responsibly, regulatory oversight is needed. We will continue targeted outreach to meat plant operators about the risks of drug residues and effective traceability so they can be selective about their source of animals.

We immediately forward any adverse test results to the Canadian Food Inspection Agency (CFIA) for risk assessment and follow-up, including product recall under the federal *Food and Drugs Act*. To ensure effective follow-up with farmers, we will ask the CFIA to share its follow-up plan from Ministry referrals and report back on actions taken. We will continue to support the CFIA in its compliance response.

We will work with the CFIA over the next 12 months to clarify roles and responsibilities for reviewing positive drug-residue results with farmers.

We will also work jointly with the CFIA over the next 18 months to raise awareness across the supply chain through an outreach/education campaign about the responsible use of livestock medicines.

4.1.2 Different Criteria Used by Ministry of Agriculture and Public Health Units to Inspect Meat-Processing Facilities

We found that the Ministry of Agriculture and the Public Health Units used different criteria when inspecting high-risk meat processors, such as butchers and restaurants that smoke or cure meat. Ministry of Agriculture inspectors enforce the Meat Regulations for such premises while Public Health Inspectors enforce the Food Premises Regulation.

The Ministry of Agriculture's Meat Regulations define high-risk meat activities as the canning, curing, dehydrating, sausage-making, fermenting, or smoking of meat. These activities are considered to be of higher risk because there is more room to introduce biological, physical or chemical hazards. Specific time and temperature combinations, water activity or pH levels must be met during processing to prevent pathogen growth. This is particularly critical for ready-to-eat meat, as there is no further cooking prior to consumption. Therefore, all premises conducting such meat processes require licensing and inspection by the Ministry of Agriculture, except for:

- businesses such as restaurants and caterers that mostly do food service such as preparing and serving meals;
- food processors that make products containing less than 25% meat such as pizza, sandwiches or soups; or
- meat-processing plants that produce less than 20,000 kg of meat annually and engage in lower-risk activities such as cutting and packaging.

Therefore, a restaurant or a butcher conducting high-risk meat-processing activities is exempt from Ministry of Agriculture licensing but is inspected by a Public Health Unit if it mainly operates as a food-service premises. While the Ministry of Health, in partnership with the Ministry of Agriculture, provided training to Public Health Inspectors on high-risk meat processing, there is no requirement for Public Health Inspectors to inspect these

facilities in accordance with the criteria outlined in the Meat Regulations.

We found that the Public Health Units neither track the number of food premises that fall under this category nor have a formal inspection checklist specifically used for high-risk meat processing. For example:

- While Ministry of Agriculture inspections have specific guidelines and procedures for checking cooling rate, nitrate and nitrite levels and humidity conditions, Public Health Units are not required to check for these items under the Food Premises Regulation.
- The Ministry of Agriculture guidelines also address specific risk materials such as brain tissue and spinal cords, and inedible by-products in meat processing, but these materials are not part of the Public Health Units' required inspection.

RECOMMENDATION 2

To ensure more consistent inspections of facilities that engage in high-risk meat processing such as smoking and curing, we recommend that the Ministry of Agriculture, Food and Rural Affairs (Ministry), in collaboration with the Public Health Units, develop Ministry-approved inspection guidelines for Public Health Unit inspectors to follow when inspecting such facilities.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that we can help public health inspectors be more consistent by providing them with expert technical advice related to the production of smoked or cured meat products, and support them in their development and delivery of inspection resources tailored to their needs, including enhancing training materials and guidance documents.

To produce safe food, critical steps must be taken during processing. The production of higher-risk meat products, especially ready-to-eat meat products, requires additional safeguards to prevent microbial growth and ensure food safety.

The Ministry has a comprehensive inspection system for meat plant operators conducting higher-risk meat processing that includes licensing, compliance verification, product testing and environmental swabbing. The Ministry provides technical resources and guidance for meat plant operators to ensure safe production of these types of meat products.

The Ministry will continue to provide information to Public Health Units to identify facilities producing higher-risk meat products such as smoked and cured meats that meet the regulatory exemption for provincial licensing.

The Ministry will engage immediately on this recommendation. We will collaborate with the Ministry of Health and Public Health Ontario in their oversight of these higher-risk activities in food premises by developing additional guidelines and providing support to their training and education requirements for public health inspectors. We will target completion of the materials in the next 12 months.

4.2 Fruits and Vegetables

The Ministry of Agriculture regularly tests Ontario-grown produce samples from farmers' markets, retail stores and wholesalers for chemical residues and bacteria. According to the latest 2015 data from Statistics Canada, about 30% of produce sold in Ontario was grown in the province, about 3% came from other provinces and the remaining 67% was imported from other countries. The Ministry of Agriculture has oversight of the 30% that was grown in Ontario while CFIA is responsible for the remaining 70% that came from other provinces and countries.

Based on our review, the food-safety risk of Ontario-grown produce is low. Between 2014 and 2018, the Ministry of Agriculture found that 54 in about 3,900 samples of Ontario-grown produce, or 1.4%, tested positive for illness-causing bacteria, and 54 in about 1,200 samples of Ontario-grown produce, or 4.5%, contained pesticides in concentrations higher than those allowed by Health Canada. Generally, the level of contamination was low and the affected volume of produce was small.

We also found that where contamination was detected through sample testing, the Ministry of Agriculture would immediately notify the farmer, then follow up with a visit to the farm to investigate and advise the farmer regarding potential causes of contamination that it observed on the farm. The Ministry of Agriculture also immediately notifies the Ministry of Health, relevant Public Health Units and the CFIA of an adverse bacteria or chemical residue testing result in case a recall of the produce is required. The CFIA communicates recall decisions and assists companies to implement the recall.

We commissioned the University of Guelph to test 40 samples of Ontario-grown and 40 samples of imported produce, including peaches, grapes, lettuce and spinach from retail grocery stores and the Ontario Food Terminal, which is the largest wholesale fruit and produce distribution centre in Canada. Of the 80 samples, we found three imported peach samples and one Ontario-grown spinach sample that tested positive for *Listeria*. No produce sample tested positive for *E. coli* and *Salmonella*. The tests also did not identify health concerns regarding the pesticide residues detected in the produce we tested since the pesticide levels were all below Health Canada's allowable limit.

4.2.1 Pesticides Banned for Groundskeeping Are Found on Ontario Produce in Levels Exceeding Health Canada's Allowable Limit

We noted that some of the 131 pesticides banned in Ontario for cosmetic purposes such as general groundskeeping—on lawns and parks, for example—are found on Ontario produce in levels exceeding Health Canada's allowable limit.

The *Cosmetic Pesticides Ban Act* (Act) came into effect in 2009 to protect against the unnecessary health and environmental risks of pesticides and prevent a patchwork of varied municipal bans. The Act lists 131 pesticides that cannot be used for general groundskeeping on lawns, vegetable and ornamental gardens, patios, driveways, cemeteries, parks and school yards. There are lower-risk pesticides, biopesticides and alternatives to pesticides that can be used instead.

However, the 131 pesticides banned for general groundskeeping are allowed in agricultural farming because the Ministry of the Environment, Conservation and Parks deemed it necessary from an operational and economic perspective. Health Canada has established allowable maximum residue levels for the majority of the 131 pesticides—a safe concentration of residue expected to remain on food products when a pesticide is used according to label instructions.

Between 2014 and 2018, the Ministry of Agriculture sample-tested about 1,200 Ontario-grown produce items and found residues of 14 banned pesticides in excess of Health Canada's allowable maximum levels a total of 76 times. However, the CFIA assessed that a food recall was not required because the risk to the public was low, based on the affected volume of produce, the residue concentration and other factors such as the toxicity of the pesticide found.

The Ministry of the Environment, Conservation and Parks is responsible for regulating the sale, use, transportation, storage and disposal of pesticides in Ontario. All farmers in Ontario must be certified before they are allowed to buy and use certain pesticides on their farms.

The Ministry of Agriculture, in collaboration with the Ministry of the Environment, Conservation and Parks, delivers an education and training program for farmers, including a formal certification

course that covers the proper use of pesticides and alternatives to the use of pesticides.

However, our review of a sample of 30 cases of Ontario-grown produce that tested positive between 2014 and 2018 for pesticides in concentrations higher than those allowed by Health Canada found that the causes of pesticide contamination of produce were:

- pesticide spray drifting from adjacent crops in 13 cases;
- farmers unaware of which pesticides were approved for use on which crops in 12 cases, meaning that they may be using a pesticide that has been approved for one kind of crop on another kind of crop for which the same pesticide has not been approved;
- produce harvested too soon after pesticides were applied in two cases; and
- cross-contamination from other crops during packaging in the remaining three cases.

RECOMMENDATION 3

To improve the safety of Ontario produce, we recommend that the Ministry of Agriculture, Food and Rural Affairs, in collaboration with the Ministry of the Environment, Conservation and Parks, assess the education and training it provides to farmers to ensure that it fully addresses:

- the use of lower-risk pesticides, biopesticides and alternatives to pesticides in agricultural farming; and
- which pesticides are approved for use on which crops, and how long to wait after applying pesticides to harvest crops.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that farmer education about the proper use of pesticides is part of ensuring safe produce in Ontario.

The Ministry has a comprehensive suite of programs and tools to educate farmers in the proper use of pesticides, and data from the Ministry's fruit and vegetable pesticide testing program demonstrates that most Ontario farmers are applying pesticides responsibly.

Should adverse levels be detected through product testing, we review applicator certification and application records, confirm the use of pesticides according to label instructions, and provide targeted instruction to farmers.

There is a current regulated requirement for Ontario farmers to complete training and certification for the use of most, but not all, restricted and commercial pesticides. The provincial government, through the Ministry of the Environment, Conservation and Parks, has recently introduced proposed amendments to the *Pesticides Act*, to align provincial pesticide classes to the federal system, regulated through Health Canada's Pest Management Regulatory Agency. If the amendments are passed, all Ontario farmers will require training and certification for the use of all restricted and commercial agricultural pesticides.

Within the next 18 months, the Ministry will work with the Ministry of the Environment, Conservation and Parks and industry to review and improve training material to ensure it addresses the use of the correct pesticides for each crop, harvest timing after application, and the use of lower-risk pesticides, biopesticides and alternatives.

4.2.2 Glyphosate, Banned in Some Countries, Commonly Used on Ontario Soybean and Corn Farms

We noted that glyphosate, a herbicide linked to cancer, was commonly used on the two highest-volume crops in the province—corn (including sweet corn) and soybeans. According to the Ministry of Agriculture's most recent 2013/14 survey of Ontario farmers, glyphosate was the most widely used herbicide in Ontario, accounting for 54% of total pesticide use.

At the time of our audit, the Ministry of Agriculture confirmed that this herbicide continues to be used.

In 2015, the World Health Organization's International Agency for Research on Cancer classified it as "probably carcinogenic" (or probably cancer-causing) in humans, based on sufficient evidence of carcinogenicity in experimental animals. On the other hand, the European Food Safety Authority concluded in November 2015 that glyphosate "is unlikely to pose a carcinogenic threat to humans." In December 2017, the US Environmental Protection Agency, a government agency responsible for research, monitoring, standard-setting and enforcement activities to ensure environmental protection, arrived at the same conclusion as the European Food Safety Authority.

In 2017, Health Canada re-evaluated its assessment of glyphosate and concluded that food and drinking water exposure associated with the use of glyphosate is not expected to pose a risk to human health. As such, Health Canada has continued to allow the use of glyphosate in Canada and has established maximum residue levels. It is also commonly used in corn and soybean farming in other Canadian provinces.

Since 2017, there have been more studies on glyphosate use and its link to cancer. The April 2019 "Toxicological Profile for Glyphosate" by the US Agency for Toxic Substances and Disease Registry referenced three meta-analyses and a number of epidemiology studies that reported positive association between glyphosate use and non-Hodgkin's lymphoma, a cancer originating in the lymphatic system. A 2019 study published by the University of Washington also found that people with high exposures to glyphosate have a 41% increased risk of developing non-Hodgkin's lymphoma. We also noted that California courts ruled in 2019 that non-Hodgkin's lymphoma had been caused in people who applied products containing glyphosate.

While Canada, the United States and the European Union still allow the use of glyphosate, some countries have banned the substance, including Germany (effective 2020), France (2021) and Austria (2023).

The Ministry of Agriculture does not regularly monitor or sample-test sweet corn and soybeans for residues of glyphosate.

RECOMMENDATION 4

In order to protect consumers, we recommend that the Ministry of Agriculture, Food and Rural Affairs, in collaboration with Health Canada:

- add glyphosate to the list of chemicals to be monitored and tested as part of the regular pesticide-residue sample testing; and
- use the results of the testing to reassess whether glyphosate should be approved for use in farming and the appropriate maximum residues allowed in produce.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that a strong monitoring and enforcement regime is necessary to ensure responsible use of all pesticides.

The Health Canada Pest Management Regulatory Agency is responsible for pesticide regulation in Canada, including glyphosate. Health Canada registers pesticides after a stringent, science-based evaluation that ensures risks are within acceptable limits. Pesticides on the market are re-evaluated on a 15-year cycle to ensure the products meet scientific standards. Health Canada also promotes and verifies compliance of pesticide use and enforces situations of non-compliance warranting action.

Glyphosate was recently re-evaluated by Health Canada, and its continued use for agricultural purposes has been allowed for specific applications, with a maximum residue level for food products. As part of this recent re-evaluation, label requirements were changed to protect applicators, workers and bystanders,

and spray buffer zones are now required so as to protect land and water habitats.

The Ministry will implement a new two-year baseline sampling study to better understand the prevalence of glyphosate residues in produce starting in April 2020. Once the study is completed, the Ministry will share the results with the Pest Management Regulatory Agency to be included as part of any planned reassessments of the use of glyphosate.

4.2.3 Inventory of Produce Farmers Contains Insufficient Information

We noted that the Ministry of Agriculture's inventory of fruit and vegetable producers does not contain sufficient information to inform its sampling.

The Ministry of Agriculture collects samples of fruits and vegetables grown and consumed in Ontario from farmers' markets, sales at farms, retail stores and wholesalers to test for chemical residues such as pesticides and for bacterial contamination such as *E. coli* and *Salmonella*. It is therefore important for the Ministry of Agriculture to maintain an up-to-date list of farms and producers, along with producer information such as type of crops grown, production volumes and where the produce is sold, to ensure that produce from all suppliers, especially the larger ones, is considered when selecting samples for testing.

For example, between 2014 and 2018, the Ministry of Agriculture found 54 of about 1,200 samples of Ontario-grown produce, or 4.5%, contained pesticides in concentrations higher than those allowed by Health Canada. We reviewed 30 of these files and noted that the contaminated produce was determined to be of low risk to the public because the affected volume of produce was small and the residue concentration was low.

However, we found that the Ministry of Agriculture's current inventory of producers lacks specific information on the type of crops grown, how much is grown and where the produce is sold. The listing mainly contains the location of the farm, contact information and a general description of the type of crops grown (for example, fruits and vegetables) and the operation's sampling history, including any past adverse results. This limited information makes it difficult for the Ministry of Agriculture to select appropriate producers for sample-testing.

The Ministry of Agriculture does have access to the registry of Ontario farms with gross sales of $7,000 or more annually maintained by Agricorp, an agency of the Ministry. This registry contains information on the top three grossing crops grown. However, the Ministry of Agriculture was not using Agricorp's registry to update its inventory listing because, according to the Ministry, the crop information in the registry is updated at most every five years, with information self-reported by farmers. Agricorp does not validate this information.

RECOMMENDATION 5

To help the Ministry of Agriculture, Food and Rural Affairs develop a risk-based approach to sampling produce suppliers, we recommend that it:

- obtain access to the Agricorp database to provide it with additional produce information; and
- update its database of producer information that includes types of crops grown, production volumes, where the produce is sold and other data as available.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that there are opportunities to enhance the information we have about producers to improve our sampling program.

The Ministry's sampling program aims to detect microbiological and chemical contaminants in Ontario produce, honey and maple products. Through this program, the Ministry gathers valuable information that supports Ontario's agri-food industry in producing safe

food so that consumers can purchase Ontario products with confidence.

During the 2019/20 inspection cycle, the Ministry began compiling business information, including location, commodities, acreage grown and marketing volumes, into the business profiles for produce, honey and maple producers. The Ministry uses this information to identify potential trends, develop education and training tools, and inform future sampling plans.

The Ministry will continue to update its Ontario producer business profile inventory and make improvements by including any relevant data from the Farm Business Registration Database held by Agricorp in our 2020 sampling plan.

4.3 Fish and Seafood

There are about 170 fish- and seafood-processing plants in Ontario. CFIA licenses and inspects about 70 of these plants that export while the Ministry of Agriculture inspects the remaining 100, which sell only in Ontario. In 2018/19, the Ministry of Agriculture inspected facilities that processed about 5.1 tonnes of fish and seafood products. However, neither the Ministry of Agriculture, CFIA nor Statistics Canada had any data as to what percentage of the total processed fish and seafood products sold in Ontario came from the Ministry of Agriculture-inspected facilities.

4.3.1 Ministry of Agriculture Does not Inspect Fish Farms

There are 22 fish farms in Ontario producing trout, lake whitefish, tilapia, barramundi and shrimp. Of the 22 farms, 12 export their products outside Ontario. The remaining 10, producing rainbow trout, tilapia and barramundi for Ontario consumption, are licensed by the Ministry of Natural Resources and Forestry. The Ministry of Natural Resources and Forestry only conducts regular water quality and sediment monitoring on six cage aquaculture sites in Ontario to assess their impacts on the aquatic environment. The Ministry of Agriculture does not inspect these farms.

We commissioned the University of Guelph to test 10 samples each of Ontario-grown and imported fish from retail stores in Ontario. The tests found levels of boron were higher in the imported samples and concentrations of thallium were higher in the Ontario fish. However, the test results overall showed that the heavy-metal levels found in the fish did not represent a health concern based on CFIA guidelines for chemical contaminants and toxins in fish and fish products.

We also tested 20 samples of fish sushi from restaurants in Ontario and found that these products contained generally acceptable microbial levels. However, one of the 20 sushi samples tested positive for *Listeria*.

4.3.2 No Licensing Requirement for Fish Processors

While the Ministry inspects the 100 fish-processing plants in the province, there is no licensing requirement for them. The province has not enacted the regulatory changes under the *Fish Inspection Act* (Act) that the Ministry of Agriculture had anticipated in 2014, after responsibility for administering the fish inspection program was transferred to the Ministry of Agriculture from the Ministry of Natural Resources and Forestry.

We noted that the current Act has only limited enforcement tools that the Ministry of Agriculture can use to compel fish processors to address infractions. Processors who do not sell outside the province, for example, require no licence to operate. This means the Ministry of Agriculture may not be able to close them if there are problems because there is no licence to revoke in the event that inspectors identify serious food-safety deficiencies.

In comparison, provincial meat-processing plants require a licence to operate, and the Ministry of Agriculture can suspend or revoke licences if significant food-safety infractions are found during inspections.

In addition, the Ministry of Agriculture has no authority to issue tickets, fines or compliance orders. Ministry of Agriculture inspectors only have the authority to detain and dispose of unsafe fish products.

In 2017, the Ministry of Agriculture drafted an updated regulation to make licensing mandatory for fish processors. Staff at fish processors would also be required to complete training in food handling, and develop plans for managing potential food recalls. However, this draft regulation had not yet been enacted at the time of our audit.

We noted that almost 20% of the Ministry of Agriculture's environmental testing done in 2018/19 at fish-processing plants showed high bacterial counts on food-contact surfaces and food-handling equipment. As shown in **Appendix 4**, the Ministry of Agriculture's fish sampling has one of the highest percentage of adverse microbial test results when compared to other sample-testing results for meat, dairy and produce. In addition, we reviewed 182 inspection reports on fish-processing plants between 2016/17 and 2018/19 found that two-thirds, or 588 of 896 infractions observed in 2018/19, were repeat offences that had also been observed in the 2016/17 and 2017/18 inspections. Had some of the repeat infractions noted below been observed at meat-processing plants, they would have led to the suspension of operations. The infractions included:

- no records showing that water and ice used in processing fish was from municipal water systems and therefore is safe to use for food preparation;
- no evidence that staff were properly trained on handling and segregating unacceptable fish;
- no evidence that minimum required temperatures were used in the smoking process; and
- ingredients used in fish products not being recorded on packaging materials.

In one of the cases we reviewed, the inspector noted in January 2018 that a processor was not using safe oxygen-permeable packaging for refrigerated smoked fish. The Ministry of Agriculture did not have the authority to recall products so it referred the matter to the CFIA, the only agency with the authority to issue food recalls in Canada, which later issued a recall of this product after it found the inappropriate packaging could support the growth of botulism-causing bacteria.

RECOMMENDATION 6

To improve the food safety of fish processed in Ontario, we recommend that the Ministry of Agriculture, Food and Rural Affairs implement a licensing requirement for fish processors and allow inspectors to suspend or revoke licences if significant infractions are found during inspections.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that fish processors should be licensed to strengthen its compliance tools to improve food safety.

The oversight of Ontario fish processors requires co-ordination with government partners, including Public Health and the Canadian Food Inspection Agency, to have effective food safety oversight.

The Ministry has inspected non-federally licensed fish processors since 2014. Comprehensive annual audits (or more frequent audits for repeated non-compliance and to address complaints) assess a broad range of food safety risks and outline specific areas for improvement or corrective action. A number of compliance tools can be used in the event of non-compliance. The Ministry has the authority to detain and destroy non-compliant fish products, and when food safety risks are identified, the Ministry will refer these situations to Public Health, which has the authority to suspend operations or close food premises where required.

The Ministry is proposing a new modernized fish regulation within the *Food Safety and Quality Act* that would align with our regulatory oversight for other commodities. The provincial government recently introduced legislation that, if passed, will allow replacement of the *Fish Inspection Act* with the new regulation.

The regulation proposes the use of licensing for high-risk activities, inspection authorities for processing facilities and products, detention and seizure authorities for non-compliant fish products, compliance orders to require food safety improvements and the authority to suspend or revoke a licence to operate when necessary.

The Ministry will immediately work with our regulatory partners to strengthen protocols for responding to food safety issues in fish-processing facilities and enhance information-sharing to include outcomes and follow-up under the current legislative framework. We will implement improvements within 12 months.

4.3.3 Gap Exists between the Ministry of Agriculture and Public Health Regarding Inspections of "Dual" Fish-Processing Premises

We found that the authority of the Ministry of Agriculture and the Public Health Units differed with respect to "dual" premises—operators involved in both processing fish and selling it at retail, all from a single location. This difference can sometimes lead to such operators not being held accountable for failing to meet food safety standards.

The Ministry of Agriculture is responsible for inspecting the fish-processing areas of dual premises. Public Health Units also have the authority to inspect the premises, including the processing areas, but we observed that, reasonably, the Public Health Units only inspect retail areas in order to avoid duplicating the Ministry of Agriculture's inspection scope.

As noted in **Section 4.3.2**, under the *Fish Inspection Act*, the Ministry of Agriculture does not have the authority to shut down a fish-processing facility if an investigation uncovers significant deficiencies—it can only detain unsafe products. However, it can dispose of detained products after a court hearing.

On the other hand, Public Health Units can temporarily shut the entire facility down and dispose of products without a court hearing if they find significant deficiencies. We observed that one of the Public Health Units we visited inspected only the retail portion of a dual fish operation. We also noted that some of these dual fish operators with repeat infractions on the processing side continued to operate because the operator was found upon inspection to be in compliance with the requirements under the *Health Protection and Promotion Act*.

In May 2019, for example, the Ministry of Agriculture inspected a facility that processed fish in the back of the premises and had a retail counter at the front. The Ministry of Agriculture only had jurisdiction to inspect the processing operation at the back. The retail operation in the front was inspected by the Public Health Unit.

The Ministry of Agriculture inspection reports for this facility for the past three years noted a history of poor performance, including risk of cross-contamination between cooked and raw food, unacceptable operating condition of cooking utensils and equipment, and no evidence of regular cleaning and pest control.

We shadowed the Ministry of Agriculture's May 2019 inspection of this facility and observed a general lack of hygiene, along with negligence toward cleanliness, food handling, storage and equipment maintenance. We also observed staff defrosting fish in hot water at room temperature, and using the same knives and gloves when handling cooked and raw fish.

Immediately after the inspection, the Ministry of Agriculture emailed and called the Public Health Unit to inform it of the deficiencies that had been observed and request that it conduct its own inspection, since the Public Health Unit has additional enforcement tools, such as the ability to suspend operations under its regulatory authority. The

Ministry also shared with Public Health a copy of the inspection report detailing all the infractions identified during the visit. The following day, Public Health inspected the facility—but only the retail area—and also observed sanitation problems for which it issued a ticket. However, the Public Health Unit gave the premises a green pass solely based on its inspection of the retail area.

Since 2015, we noted 13 other instances where the Ministry of Agriculture made similar referrals to Public Health Units about food safety concerns at seven food premises that also process fish on-site.

RECOMMENDATION 7

To appropriately address food safety concerns in dual facilities that both process fish and sell it at retail, we recommend that the Ministry of Agriculture, Food and Rural Affairs, in collaboration with Public Health Units, conduct joint inspections of these facilities.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees there are opportunities to conduct joint inspections with Public Health Units in dual facilities.

A current Memorandum of Understanding (MOU) between the Ministry and the Ministry of Health streamlines the inspection process of meat plants under the jurisdiction of both the Ministry and public health. The MOU clarifies responsibilities, and increases inspection efficiencies while minimizing duplication and providing guidelines for joint inspection, and also improves the communication and co-operation between both parties.

We will immediately engage with the Ministry of Health to renew the MOU and update it to include fish-processing facilities to improve our regulatory response to food-safety concerns and to confirm required processes for implementing joint inspection activities. The Ministry will ensure its inspection staff are trained on any new protocols or procedures within the next 18 months.

4.4 Dairy

The Ministry of Agriculture oversees the registration and inspection of all 3,504 cow-milk farms and 268 goat-milk farms that supply raw milk in Ontario. Almost all of this raw milk goes to Ontario dairy-processing plants to be pasteurized to make fluid milk, cream, cheese, yogurt and other dairy products.

All dairy produced from the 48 Ministry of Agriculture-licensed dairy-processing plants is sold in Ontario. As of 2019, the Ministry estimated that these plants processed over 12 million litres of cow milk and over two million litres of goat milk.

In addition, the Ministry of Agriculture estimated that there are 75 sheep-milk producers and three water buffalo-milk farms in Ontario. However, no data is kept on the production volumes of sheep and water buffalo milk in Ontario. There are no requirements for sheep- and buffalo-milk producers to be registered with or inspected by the Ministry of Agriculture.

All dairy-processing plants in Ontario require a provincial licence to operate. In addition, dairy-processing plants in Ontario that export their products outside of the province also require a federal licence from the CFIA to operate. There are another 93 dairy-processing plants in Ontario licensed by both the Ministry of Agriculture and CFIA because they also export outside the province. However, no production data is collected by the Ministry of Agriculture, Dairy Farmers of Ontario, Ontario Dairy Council or the Canadian Dairy Commission to determine what percentage of dairy products processed in these dually licensed dairy plants are sold in Ontario.

4.4.1 Raw Goat Milk Sampled Has High Bacterial Count

As seen in **Appendix 4**, the Ministry of Agriculture's raw goat-milk test results between the 2014/15 and 2018/19 fiscal years indicated a significantly larger percentage of samples tested with high bacterial count or presence of inhibitors (antibiotics and other chemicals) compared to cow milk.

When we reviewed Ministry of Agriculture inspections in the past five years, we noted that about 18%, or 46, of the goat-milk producers repeatedly had the same infractions for the last three annual inspections. Infractions included issues surrounding cleanliness and sanitation of the cooling and milking equipment, milking area and milk house.

The Ministry of Agriculture has the authority to issue warning letters to dairy producers, dispose of raw milk and order production shutdowns. However, we found that the Ministry had not developed clear policies on which compliance tools should be used, and when, for goat-milk producers with frequent infractions. The Ministry of Agriculture's goat-milk producer inspection program also did not have policies that prioritize the significance of infractions or set due dates for correcting infractions.

For example, in one case we reviewed, a goat-milk producer repeatedly did not receive a pass rating in each of the past five annual inspections and the same infractions related to the cleanliness of the milking equipment were noted during these inspections. This producer received the list of deficiencies from the Ministry of Agriculture subsequent to the annual inspections, and took an average of 121 days to correct them. However, the Ministry never issued any warning letters with respect to production shutdowns in light of the producer's repeated history of non-compliance.

RECOMMENDATION 8

To improve the safety of goat-milk products in Ontario, we recommend that the Ministry of Agriculture, Food and Rural Affairs:

- develop policies that prioritize the significance of infractions and establish deadlines for correcting infractions; and
- develop policies regarding which compliance tools should be used, and when, for goat-milk producers with frequent infractions.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees there are opportunities to improve our compliance policies to provide clearer and more consistent direction to inspectors.

The Ministry conducts an annual compliance inspection of all goat-milk farms in the province. When corrective action is required, the Ministry ensures the producer adheres to a corrective action plan and conducts follow-up inspections. As part of each pick-up, the Ministry tests milk samples, and assesses milk quality, the condition of the animals and the cleanliness of the facility to determine whether the premises meet the regulated standard. If the premises do not meet the standard, the milk will not enter the food system and no further milk will be collected until standards are met.

The Ministry has been improving its dairy goat compliance policies as part of a broader review of all inspection programs. This review will allow us to immediately place additional inspection emphasis on frequent or repeated non-compliance.

Within the next 12 months, the Ministry will prioritize the significance of infractions and establish deadlines for goat-milk producers to take corrective action.

Within 18 months, these enhancements will be included in written compliance policies, and training will be provided to inspection staff.

4.4.2 Sheep and Buffalo Milk Production Unregulated in Ontario

The Ontario *Milk Act* specifically defines "milk" as milk from cows or goats. As a result, the Act regulates only milk and milk products from cows and goats. It does not regulate the production of milk from other species such as sheep and water buffalo.

There are an estimated 75 sheep-milk producers and three water-buffalo-milk farms in Ontario. These producers, unlike those producing cow and goat milk, do not have to comply with regulations under the *Milk Act* related to quality, sanitation of farms or testing for bacteria and inhibitors such as antibiotics and other chemicals.

While Public Health Units have the authority to inspect milk from sheep and water-buffalo in food premises, Public Health Inspectors do not inspect the farms or sample test raw sheep and water-buffalo milk.

In comparison, all animals kept for the purpose of milking are regulated in other Canadian provinces such as Manitoba and Alberta. Manitoba regulates the production, transportation, processing and distribution of sheep milk while Alberta's regulations also include requirements for licensing, inspections and product sampling.

The Ministry of Agriculture has been asked by sheep-milk producers to visit their farms and provide input and note issues such as poor sanitation of premises and equipment, and inappropriate milk-handing practices. In one such visit, the Ministry of Agriculture discovered hair and dirt in sheep milk used to make cheese. In another visit, in 2014, the Ministry of Agriculture noted a major cleaning failure in one section of the milk pipeline.

In a 2006 survey of Ontario sheep-milk producers by the Ministry of Agriculture, respondents indicated that they were interested in government doing more to assist in the development of the dairy sheep industry by providing information and testing milk.

Subsequently, in 2011, the Ministry of Agriculture conducted a study to determine the quality and safety of raw sheep milk produced in Ontario. The study found that most producers needed to improve milk-handling procedures and equipment sanitation, with over 50% of samples exceeding the dairy industry's suggested guidelines for bacteria in cow milk.

RECOMMENDATION 9

To improve the safety of all milk products in Ontario, we recommend that the Ministry of Agriculture, Food and Rural Affairs include inspection oversight of milk from species such as sheep and water buffalo in its dairy food-safety program.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that there are opportunities to improve food-safety oversight for dairy products not currently covered by the *Milk Act*.

Public Health provides regulatory oversight and inspection of the processing of milk products from species such as sheep and water buffalo. The Ministry supports our public health partners in their food-safety oversight of sheep and water buffalo milk processors by providing technical and scientific expertise related to the safe production of milk products.

The Ministry will engage with industry and our regulatory partners to propose options to improve oversight for milk from all dairy species.

4.4.3 Incomplete Oversight of Dairy Farmers of Ontario

In 1998, the Ministry of Agriculture signed an initial agreement with Dairy Farmers of Ontario (DFO) to delegate specific provisions of the *Milk Act* regarding cow milk to DFO. The organization became responsible for inspecting milk producers' premises, overseeing grading of milk, collecting

samples to test for bacteria, and overseeing transport of milk to dairy-processing plants.

The Ministry of Agriculture is responsible for overseeing DFO's administration of the Raw Cow Milk Quality Program. A 2010 agreement between the Ministry of Agriculture and DFO, which did not replace the 1998 agreement, was added to outline the DFO's new responsibilities for sampling and testing of raw cow milk.

However, the Ministry of Agriculture does not receive the information that it needs from DFO to demonstrate sufficient oversight of DFO.

We found that the reports the Ministry of Agriculture received from DFO did not contain detailed information but, instead, high-level summaries on those producers who had consistently failed inspections, received high bacteria-count results on sample testing, or had to be suspended by DFO for unsanitary conditions.

The Ministry of Agriculture cannot, using just the reports, identify non-compliant milk producers who repeatedly committed the same infractions, those whose sample tests exceeded regulatory bacteria limits and, most importantly, what actions DFO took to address repeated non-compliance by producers.

According to the 2010 agreement, DFO is required to provide the Ministry of Agriculture with monthly reports showing the total number of milk samples collected, type of sample testing performed and an explanation for any shortfalls between the required and actual sampling. However, it does not provide these reports.

It is also unclear in the agreements with the DFO what other information the Ministry of Agriculture has access to. In 2018, for example, the Ministry requested data on oversight of milk transporters since the Ministry is responsible for the certification of transporters. Both the DFO and the Ministry of Agriculture had to engage their legal teams to determine just what information the DFO could share with the Ministry under this agreement, especially when it comes to information about individual producers. The DFO ultimately provided the Ministry with the information that it had requested.

We reviewed inspection reports, sample-testing results and producer shutdown data for the past five years that we requested from the DFO, and noted repeat offenders. Thirty-one cow-milk producers, for example, consistently received inspection ratings of "fail." We reviewed the inspection data of these 31 producers and noted problems with cleanliness and maintenance of milk houses, animal housing, and milking and cooling equipment. We also found 20 producers were repeatedly penalized at least four times in the last five years for having sample-testing results with high bacteria counts. The Ministry of Agriculture was unaware of these repeat offenders and had not followed up with the DFO on actions taken against them.

RECOMMENDATION 10

To improve oversight of Ontario cow-milk producers, we recommend the Ministry of Agriculture, Food and Rural Affairs (Ministry) to work with the Dairy Farmers of Ontario (DFO) to update their 2010 agreement to clarify the Ministry's right of access to all information it needs given that the province in its own right has the authority to delegate and retract authority from the DFO.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees we can improve oversight of the Dairy Farmers of Ontario (DFO) to ensure their effective oversight of raw cow milk safety.

The DFO has a comprehensive compliance program as part of its responsibilities for oversight of raw milk safety. This includes on-farm inspections to verify that the premises meet regulatory requirements. The DFO performs testing, grading and sampling to assess the quality of cow milk in relation to regulatory

requirements. Non-compliance is addressed through a suite of comprehensive compliance tools, including disposing of non-compliant milk, administrative penalties and issuing orders requiring corrective actions.

The Ministry will immediately work with the DFO to update the 2010 Administrative Agreement and clarify our right of access to information. More information will enhance the Ministry's ability to verify that the DFO is meeting the requirements of the Agreement. The information will include, but may not be limited to, inspection results, response to non-compliance and the approach taken to address incidents of repeat non-compliance. A new draft agreement will be completed within 18 months.

To align with the new agreement, the Ministry will develop training for staff to support effective oversight of the DFO.

4.5 Non-Chicken Eggs Not Graded or Inspected For Quality Assurance

The grading of all chicken eggs in Canada falls under the jurisdiction of the federal CFIA. However, we are concerned that non-chicken eggs are not subject to any grading or inspection process in Canada.

The CFIA's grading requirements for chicken eggs are intended to protect the public from certain risk factors involving quality, weight, cleanliness and shell construction that affect safety, quality and wholesomeness of eggs. However, there are no similar CFIA regulated grading requirements in Ontario for non-chicken eggs such as those from quails or ducks.

Like Canada, the UK does not regulate non-chicken eggs. We noted that in 2010, the UK had a *Salmonella* outbreak of 66 cases, all relating to duck eggs, that resulted in one death and two hospitalizations.

In the US, eggs from domesticated chickens, turkeys, ducks, geese and guinea fowl are all regulated, and inspections of hatcheries and plants are mandatory.

While there are no regulated grading requirements for non-chicken eggs, Public Health Inspectors are required to check during their inspections of grocery stores and other food premises whether non-chicken eggs are clean, free of visible cracks and stored at 4 degrees Celsius or lower. However, Public Health Inspectors would not provide the same rigorous degree of inspection as a federally registered grading station for chicken eggs.

RECOMMENDATION 11

To improve the food safety of non-chicken eggs, we recommend that the Ministry of Agriculture, Food and Rural Affairs, in collaboration with the Canadian Food Inspection Agency, assess the risks and benefits of extending the chicken-egg inspection and grading requirements to non-chicken eggs.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs will immediately engage with the Canadian Food Inspection Agency to determine if there is an opportunity to collaborate on assessing the risks and benefits of adding non-chicken eggs to federal grading requirements and offer any information, including insights from our public health partners, on food safety risks associated with non-chicken eggs.

4.6 Organic Foods

According to the latest 2017 Canadian Organic Market Report by the Canada Organic Trade Association, the total organic market in Canada is estimated to be $5.4 billion, up from $3.5 billion in 2012. The Canada Organic Trade Association is an association for organic agriculture and products in Canada and its members include growers, shippers, processors, certifiers, farmers' associations,

distributors, importers, exporters, retailers and other organic stakeholders.

The Canada Organic Trade Association also reported that 66% of Canadian shoppers are purchasing organic items weekly. Eighty percent of these shoppers make their organic purchases at regular grocery stores. The study also reported that less than half, 48%, of Canadians rate the Canada Organic logo as trustworthy.

4.6.1 No Certification Required for Organic Foods Produced and Sold Only in Ontario

Food produced and sold only in Ontario and claiming to be organic does not have to be certified to the federal Canadian Organic Standards; no provincial law requires such certification. Certification to the federal Canadian Organic Standards is required only for organic foods sold across provincial or international borders.

In comparison, Quebec, Manitoba, Alberta, British Columbia, New Brunswick and Nova Scotia all have laws requiring that organic food be certified to the Canadian Organic Standards even when it is sold only within their province.

Due to the lack of provincial regulations on organic food, businesses that operate solely within Ontario are allowed to market their products as "organic" even if they are not certified. Based on our research, there are at least 34 organic producers in Ontario that are not certified to the Canadian Organic Standards but are advertising their products as "organic." The majority of these organic growers sell their products through farmers' markets. According to the Canada Organic Trade Association, 23% of organic shoppers, in addition to making purchases at regular grocery stores, also make their organic purchases through farmer-direct channels such as farmers' markets.

4.6.2 Pesticide Testing Not Required for Organic Certification of Produce

We found that the organic certification process does not require testing of fruits and vegetables for pesticide residues.

Under the Canadian Organic Standards, producers of organic fruits and vegetables are not permitted to use synthetic pesticides or fertilizers on their crops, and are encouraged, instead, to use alternative pest-control methods such as crop rotation, mulching, traps and animal grazing. They may also use biopesticides, which can be derived from natural substances like plants, bacteria or minerals, but only after field monitoring indicates a need and as a last resort. Organic producers may also use fertilizer composed of organic and non-organic manure, and compost from plant and animal matter.

However, according to the CFIA, organic produce may still be exposed to pesticide residues from airborne drifts and water runoffs originating at neighbouring farms, or from cross-contamination during transport or packaging. Such produce is still labelled organic as long as the farm from which it was harvested complies with the Canadian Organic Standards.

As part of the Ministry of Agriculture's routine food-safety monitoring programs, Ontario organic and conventionally grown produce is tested for pesticide residues against the same Health Canada maximum residue limits. There are no maximum pesticide residue limits that apply specifically to organic produce.

Organic farms in Canada certified to the Canadian Organic Standards are inspected by one of the CFIA-accredited organic certification bodies once a year to ensure ongoing compliance with organic standards. However, organic certification bodies do not, and are not required to, perform routine sample-testing of organic produce for pesticide residue.

We commissioned the University of Guelph to test 20 samples each of Ontario-grown and imported organic produce, including grapes,

peaches, lettuce and spinach. Of the 20 samples of Ontario-grown organic produce, pesticide residues were found in 14. Of the 20 samples of imported produce, pesticide residues were detected in 15. However, the pesticide residue levels were low, and below Health Canada's allowable limit.

4.6.3 No Provincial or National Certification for Other Food Claims

We found that there was no federal or provincial government certification in place for some of the more common methods of production claims such as "free run," "free range," and "grass fed." **Appendix 10** lists common food claims made on labels of food products.

Under the federal *Safe Food for Canadians Act* and the *Food and Drugs Act*, no food can be advertised in a way that is false, misleading or deceptive. The CFIA investigates food-packaging claims to confirm they are consistent with the public's general understanding of the terms in question.

According to the Chicken Farmers of Canada, "free run" (or "cage free") chickens are kept outside cages in open-concept barns. Chickens are allowed to run free indoors and, ideally, have access to nests and roosting spaces.

We found that CFIA does not regulate the use of the term "free run" eggs. Therefore, there is no specific standard as to the maximum density of the barns. As long as hens are not kept in cages in an open-concept barn, eggs produced by these hens are considered "free run." Depending on practices of individual farms, some "free run" eggs come from hens that have more space in which to run than other hens raised in a more crowded barn.

According to the Chicken Farmers of Canada, "free range" refers to chickens having access to the outdoors. However, since CFIA does not regulate the use of the term "free range," there are no specific requirements, such as the length of time spent outdoors, that qualifies for the use of the claim "free range."

In contrast, BC Egg, that province's egg marketing board, requires that all free-range eggs must be from chickens that access the outdoors for at least 120 days a year, with each day outdoors lasting at least six hours. Free-range egg farmers in BC are also required to keep a record of the number of days and hours that chickens spend outdoors. Ontario has no comparable standards or certification processes for free-range and free-run eggs. So whether it's 10 minutes per week or 10 hours per day, as long as the livestock have access to the outdoors, the requirement is considered met. According to the Chicken Farmers of Canada, "free-range" practices vary from farm to farm.

"Grass-fed" meat suggests there are requirements for the minimum proportion of grass in an animal's diet. However, there are currently no provincial or national standards for grass-fed claims in Canada.

Various Ontario entities, such as the DFO and Pro-Cert, one of the CFIA-accredited organic certification bodies, have developed individual grass-fed standards, but these vary. For example, Pro-Cert states that grass and other roughage should be the sole diet of grass-fed livestock, whereas DFO requires only 75% of a cow's dry-food diet be grass or forage.

In comparison, the US Department of Agriculture worked directly with the American Grassfed Association (AGA) to develop and implement a national certification program and standards for grass-fed animal producers. AGA's standards require that animals are fed only grass and forage from weaning until harvest. In addition, AGA standards require that animals are raised on pasture without confinement, are never treated with antibiotics or added growth hormones, and are born and raised on American farms.

4.6.4 No Verification of Food Labelling Relating to Health Claims

"Natural" does not mean "organic" in food labelling—CFIA defines the term to mean the product

contains no added vitamins, nutrients, artificial flavours or other food additives. In addition, it cannot have been significantly processed (except for the removal of water) and may only be subject to such less invasive procedures as freezing and cutting, for example. Since there are currently no certification systems in place for the term "natural," producers of natural products are not subject to any independent inspections or product-testing to ensure that no preservatives, artificial flavours or other food additives are used in the production process.

CFIA defines "raised without antibiotics" and "raised without hormones" to mean that neither the animal nor its mother was raised with either substance. In Canada, growth hormones are allowed only for beef cattle, and banned from use in all other animals. Since meat contains naturally occurring hormones, there is currently no lab test available to test for "added hormones" to verify the "raised without hormones" claim.

In Ontario-licensed slaughterhouses, the Ministry of Agriculture selects a statistically representative number of meat samples to test for chemical residues, including antibiotics. In addition, if an animal is suspected of having been subjected to antibiotics (e.g., inspectors observe needle marks or other abnormalities) they are also tested for residues.

Testing of both organic and conventional meat is done to the same Ministry of Agriculture standards because checking for compliance to organic standards is the responsibility of the CFIA-approved organic certification bodies. If residues above the maximum limits established by Health Canada are detected, the meat will be discarded. If the animal underwent a sufficiently long withdrawal period after antibiotics were injected (depending on the substance), there will be no traces of antibiotic remaining in the meat to be detected on a residue test, so a negative drug residue test does not necessarily mean no antibiotics were used on the animal. There is currently no lab test available to determine if antibiotics have ever been used on animals to verify the "raised without antibiotics" claim.

RECOMMENDATION 12

To promote consistent standards for organic foods, we recommend that the Ministry of Agriculture, Food and Rural Affairs collaborate with the Canadian Food Inspection Agency to:

- consider having organic food produced and consumed in Ontario certified to the federal Canadian Organic Standards;
- develop more specific requirements for farming of livestock, such as maximum density of barns for "free run" egg-laying chickens and minimum length of time spent outdoors for "free range" animals;
- require sample monitoring and testing for pesticide residues in produce as part of an organic certification process;
- develop a system of certification for food claims such as "free run," "free range," and "grass fed" to ensure consistency in standards; and
- develop public-education materials on food labelling and marketing claims.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that accurate food claims on product labels allow consumers to make informed choices about the food they consume. Food is produced safely under many different production regimes, including organic and conventional systems.

The Canadian Food Inspection Agency (CFIA) is responsible for monitoring and enforcing organic product regulations across the country. Organic products crossing provincial/territorial or Canadian borders, or those using the Canadian Certified Organic logo, must meet Canadian Organic Standards. In Ontario, many of the large organic producers are certified to allow for access to trade. Providing false or misleading information on any food label is an offence under federal

food safety laws, and the Ministry currently refers incidents of suspected non-compliant food claims to the CFIA for action.

Ontario has developed a Foodland Ontario Organic brand to support Ontario producers, processors and retailers to connect consumers to local organic food. Products must meet the Foodland Ontario standards and be certified to the Canadian Organic Standard to use the Foodland Ontario Organic branding.

The Ministry will immediately engage with the CFIA to identify opportunities to clarify federal requirements for food claims such as those included in **Appendix 10** of the report.

The Ministry will immediately work with the CFIA and industry partners to improve distribution of existing guidance on food labelling and marketing claims.

Within the next six months, the Ministry will re-engage with industry and regulatory partners through the Food Integrity Initiative and other opportunities to promote awareness of food integrity issues and pursue improvements to the reliability of food claims.

4.7 Federal Labelling Requirements Not Enforced in Provincial Food-Processing Plants

We found a lack of co-ordination between the Ministry of Agriculture and the CFIA that created a gap in the inspection and enforcement of federal labelling requirements in Ontario food-processing plants.

The CFIA does not routinely inspect plants that process food for consumption solely within Ontario, even though it has the authority to do so, because these plants are under the jurisdiction of the Ministry of Agriculture. However, Ministry of Agriculture inspectors do not check for federal food-labelling requirements (for example, place of origin, nutritional value, etc.) in provincial plants, except for allergens. For example, while the Ministry of Agriculture's *Meat Inspector Policy and Procedures Manual* included guidance specifically on allergens, we noted that the labelling section of the manual offers no guidance on inspecting for other food-labelling requirements.

One Ontario plant, for example, previously used cooked chicken in its microwavable product but then changed over to raw chicken—without updating the cooking instructions on labels to reflect that the product contained uncooked chicken. This was discovered after a complaint was received.

Raw poultry often contains harmful bacteria such as *Salmonella* and *Listeria*, which can only be killed by cooking at the proper temperature. Although the Ministry of Agriculture inspected the plant three times after it had changed over to raw chicken, inspectors did not notice the mislabelling.

After CFIA received the complaint, CFIA and the Ministry of Agriculture jointly investigated and found improper labelling for seven other products, and detained 2,000 packages on-site. These products also had undeclared allergens. Subsequently, the CFIA issued a recall for an estimated 10,000 packages of these mislabelled products.

In addition, between 2014 and 2018, over half of food recalls (238 of 441) issued by the CFIA were due to undeclared allergens on food labels. Mislabelled products with undeclared allergens may have life-threatening consequences for some consumers with severe food allergies.

In 2018, for example, the CFIA received a complaint about illness from improperly declared eggs in frozen dumplings processed and packaged in a provincial meat plant. About 58,000 bags of the dumplings were subsequently recalled. The plant had been inspected by the Ministry of Agriculture 17 times during the year of the complaint and recall, but the undeclared allergens had not been noted in any of the 17 inspections.

RECOMMENDATION 13

To help reduce gaps and overlaps in inspections of food producers by the Ontario Ministry of Agriculture, Food and Rural Affairs (Ministry)

and the federal Canadian Food Inspection Agency (CFIA), we recommend that the Ministry collaborate with the CFIA to:

- update the Ministry's *Meat Inspection Policy and Procedure Manual* to include guidance on the inspection of federal and provincial labelling requirements; and
- ensure the Ministry checks for allergens and labelling more thoroughly during inspections.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (the Ministry) agrees that reducing gaps and overlaps in the inspection of food producers will improve the food safety system.

The Ministry has procedures in place to assess recipes, including a review of ingredient lists in meat products produced in provincially licensed meat plants, and validate that meat products are labelled accurately.

The Ministry has already started to update our policy and procedure manuals to provide clearer direction for inspection staff on assessing compliance with federal labeling requirements for meat products from the provincial system, including those for allergens. We will complete our update within 12 months and validate the updated procedures with the Canadian Food Inspection Agency (CFIA) to ensure we have reduced gaps and overlaps.

The Ministry will train inspection staff on any updated procedures and protocols and implement updates within 18 months.

The Ministry will report on the effectiveness of these procedures within 24 months. The Ministry will then engage with the CFIA to enhance existing protocols for follow-up when corrective action is required under federal legislation.

4.8 Lack of Public Disclosure of the Ministry of Agriculture Inspection Results

We found that the inspection results of producers and processors were not disclosed on the Ministry of Agriculture's public website. This would give institutional buyers such as retail stores and wholesalers food-safety performance information about producers and processors that they could take into account in making purchasing decisions.

For example, the Ministry of Agriculture does not publicly disclose:

- names of farms and types of produce that tested positive for pesticides and bacteria in excess of Health Canada's allowable limits;
- inspection results of slaughterhouses, farms and processing plants (see **Appendix 3**); and
- microbial and chemical testing results of food samples and environmental testing results of processing facilities (see **Appendix 4**).

In comparison, Saskatchewan and Newfoundland and Labrador publicly report on the inspection results of their slaughterhouses. British Columbia also publicly posts fish-processing plant audit inspection results.

We also noted that the inspection results of food premises, whether pass or fail, are disclosed on the Public Health Units' websites, along with details of infractions or deficiencies found during the inspection.

A May 2017 study by the US Department of Agriculture found that publicly disclosing details about chicken-slaughtering plants with poor performance on *Salmonella* tests significantly decreased levels of *Salmonella* in subsequent tests because the market demanded better performance from the slaughterhouses.

RECOMMENDATION 14

To improve transparency about food safety, we recommend that the Ministry of Agriculture, Food and Rural Affairs publicly disclose

the results of its food-safety inspections and sample testing.

MINISTRY OF AGRICULTURE RESPONSE

The Ministry of Agriculture, Food and Rural Affairs (Ministry) agrees that there are opportunities to improve transparency of food-safety compliance in Ontario.

The Ministry currently posts the names of food-related businesses that hold a licence with the Ministry. As well, the Ministry follows a disclosure protocol used by other provincial regulatory bodies to make public convictions and penalties for offences under our mandate.

To further improve transparency, the Ministry will include notice of any changes to licences, such as a revocation or a suspension, within six months.

To further enhance our public disclosure of compliance information, the Ministry will work with industry and government partners over the next 12 to 18 months to review best practices used by other regulators and identify potential enhancements to improve transparency of our food safety compliance actions.

We will immediately engage with the Ministry of Health and Public Health Ontario to work towards a disclosure system that uses consistent principles across the provincial food-safety system.

5.0 Detailed Audit Observations: Inspections of Food Premises

5.1 Inventory of Food Premises

5.1.1 List of Food Premises Not Up to Date

The five Public Health Units we visited did not have a process in place to receive regular notifications about the opening of new food premises. The *Health Protection and Promotion Act* requires all food premises operators to notify their Public Health Unit when opening new premises, but some did not follow this requirement.

In addition to receiving notification from new food premises operators, the five Public Health Units we visited relied on their working relationships with, for example, issuers of municipal business licences and provincial liquor licences to maintain up-to-date lists of food premises. However, there are no agreements in place that outline the responsibilities of the municipalities and the Public Health Units. In addition, not all municipalities have the same licensing requirements for businesses. Public Health Units also conduct ongoing surveillance by monitoring social media, business directories and complaints. While Public Health Units advised us that these activities captured a majority of new food premises, there was no guarantee that they captured all of them.

We noted in our review of data from 2016 to 2018 at the five Public Health Units we visited that there had been 253 complaints relating to food premises that were not on the Public Health Units' lists at the time of the complaints. This means the Public Health Units had never inspected these premises because they did not know of their existence until they received complaints about them. We also noted that in 15%, or 39, of these complaints, customers suspected that they got sick from food consumed at the food premises.

5.1.2 Inconsistent Monitoring and Inspection of Online and Home-Based Food Businesses

The recent growth of online and home-based food businesses has made it difficult for Public Health Units to keep track of and inspect these food premises.

According to a 2018 amendment to the *Health Protection and Promotion Act*, a food premises is "a room where food is prepared, processed, packaged, served,

transported, manufactured, handled, sold, offered for sale, but does not include a room actually used for dwelling in a private residence." The amendment provided clarity that the definition of food premises includes home-based businesses. The Ministry of Health has also clarified with the Public Health Units that a Public Health Inspector has the legal authority to inspect a private home where there is an enterprise that fits the definition of a food premises.

However, we noted the processes for tracking and inspecting home-based and online food businesses varied among the five Public Health Units we visited. Only one was proactively reaching out to home-based and online food businesses to add them to its inventory and conducting inspections. Three inspected home-based and online food businesses only when they became aware of them. And the fifth Public Health Unit provided food-safety education materials to home-based business owners but would not enter premises to complete an inspection because this Public Health Unit's legal opinion was that inspectors do not have the legal authority to enter a room used as a dwelling without the consent of the occupant.

Our research of online food businesses found 74 online and home-based businesses that were not part of the Public Health Units' food premises inventory. For example, one online food business, which provided customers with an online choice of meal options to order in advance, was linked to four confirmed cases of salmonellosis in 2016. The Public Health Unit was unable to inspect this food premises prior to the outbreak due to a lack of information about the operator, such as the location of the food preparation site and the operator's contact information.

RECOMMENDATION 15

To provide every Public Health Unit with access to current lists of food premises in its jurisdiction, we recommend that the Ministry of Health collaborate with the Ministry of Municipal Affairs and Housing and municipalities to put in place agreements to have regular access to a current inventory of food premises.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the importance of Ontario's 35 Public Health Units having access to a comprehensive inventory of food premises within their jurisdictions. The Ministry recognizes that municipalities do not have the same bylaws in place for the licensing of businesses and, as a result, some food premises may not be captured. As well, the Ministry notes that the Food Safety Protocol, 2018, requires Public Health Units to have a procedure in place to access the contact information and locations for all food premises and a current inventory of all food premises within their jurisdictions.

Accordingly, the Ministry will collaborate with the Ministry of Municipal Affairs and Housing and municipalities on the development of appropriate protocols to enhance inventories of food premises.

The Ministry will also leverage the existing training delivered to Public Health Units to provide further guidance for the inspection of home-based businesses.

5.2 Public Health Units' Inspection and Enforcement Practices

5.2.1 Public Health Units Inspecting Average of Fewer than 20% of Special Events

We found that, unlike with fixed food premises such as restaurants, there are currently no minimum provincial requirements for the frequency of inspections of temporary food premises at special events, such as summer fairs and festivals. While not all special events require inspections, we found that only about 12% of all special events in 2018 within the jurisdictions of the five Public Health Units we visited were inspected based on their assessed risk. Only about 15% were inspected based on assessed risk in 2017.

While the vast majority of foodborne illnesses are associated with food safety in restaurants and residential homes, special events present unique risks. The US Centers for Disease Control and Prevention states that special events can be high risk because the usual safety controls that a kitchen provides, such as monitoring of food temperatures and washing facilities, may not be available when cooking and dining at outdoor special events. In 2013, for example, 146 people got sick after eating the cronut burger contaminated with *Staphylococcus aureus* toxin at the Canadian National Exhibition in Toronto. Sample tests run by the Public Health Ontario Laboratory after the outbreak isolated the bacon jam topping on the burger as the source of the pathogen. The Public Health Unit was not able to isolate the identical pathogen from affected patients and the facility where the jam was prepared. However, the Public Health Unit found food-handling and storage issues both at the CNE food premises and at the offsite jam-preparation facility.

More recently, our review of foodborne-illness records at the five Public Health Units we visited found four separate individual cases of confirmed foodborne illnesses between 2016 and 2018 where the Public Health Unit recorded food consumed at a special event as the most likely source of the pathogen causing the illness.

Inspections of special events can be difficult because many are held on weekends, when Public Health Units lack the required staffing to inspect them all. Of the Public Health Units we visited, only one had a formal agreement in place where inspectors are scheduled to work weekends as part of their regular work week, permitting the inspection of premises, including special events, outside traditional core business hours.

Also, while the Ministry of Health requires Public Health Units to establish and implement procedures to monitor or inspect temporary food premises, including those operating at special events, it has not yet developed a standard template that Public Health Units can use to assess the risk of special events. Although the Ministry of Health provides direction to Public Health Units on factors that need to be considered at a minimum, Public Health Units have developed their own forms and protocols to assess the risk of a special event to determine whether it should be inspected.

As a result, we noted significant differences in the inspection rates of special events among the Public Health Units we visited. In 2018, for example, one Public Health Unit inspected about 35% of all special events in its jurisdiction after completing the risk assessments according to its own protocols, while another inspected only about 3% based on its risk assessments. Similarly, in 2017, we found one Public Health Unit inspected about 41% of all special events while another inspected only about 4%, again using their own forms and protocols to assess the risk of all special events and inspecting only those that were assessed to be of high risk. **Figure 6** summarizes the number of special events in 2017 and 2018 for each of the five Public Health Units we visited and the number of special events that were inspected by each of them.

RECOMMENDATION 16

To improve the consistency of inspections for special events among Public Health Units, we recommend that the Ministry of Health establish clear protocols and minimum standards for inspection requirements at special events based on a consistent risk assessment, which includes relevant factors such as event size, expected attendance and types of food preparation.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the recommendation to develop minimum inspection requirements for special events. Currently, the Operational Approaches for Food Safety Guideline under the Ontario Public Health Standards outline evidence-informed factors (for example, event size and type of food being served) to enable the risk assessment of special events and determine appropriate public health action

(that is, whether operator education or further inspection is warranted).

Municipalities will need to establish parameters at the local level to further define and account for different types of special events, which in turn would enable appropriate allocation of public health resources and action. This would also ensure that public special events are inspected and assessed appropriately based on the risk to public health and safety. The Ministry of Health, in consultation with the Public Health Unit and municipalities, will further clarify the role of Public Health Units with respect to all special events.

5.2.2 Inconsistencies in Inspections

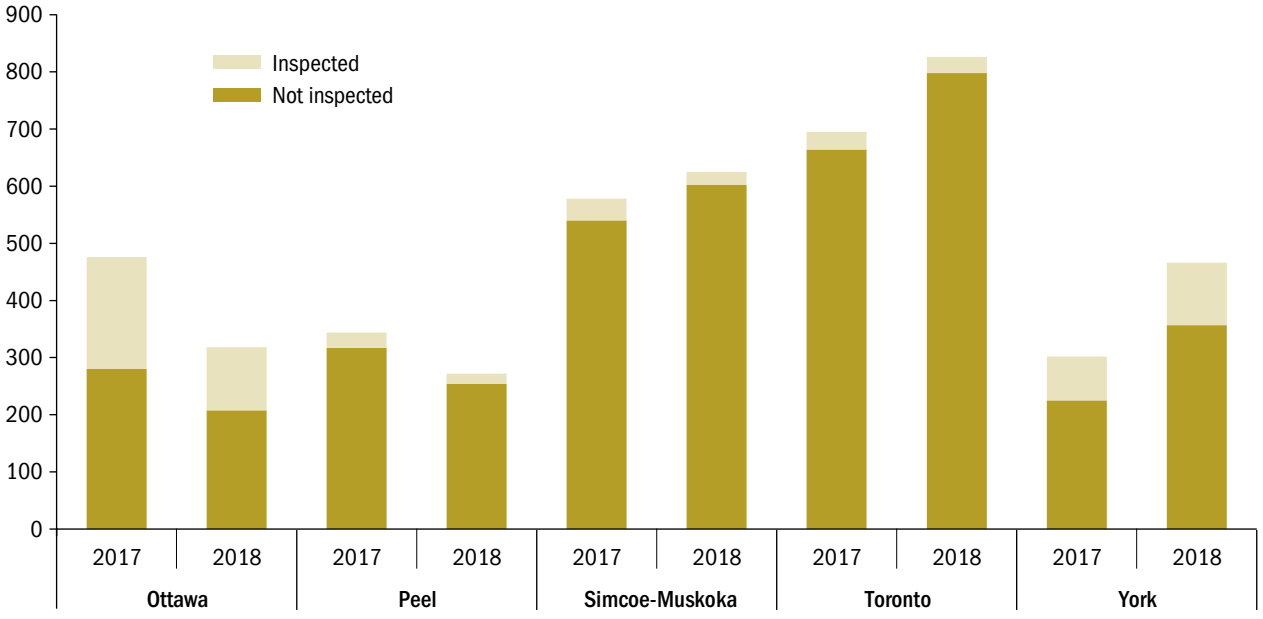
The Ministry of Health's Food Safety Protocol under the Ontario Public Health Standards requires that Public Health Units implement an inspection process for food premises. This includes assessing safe food-handling practices, inspecting for compliance with regulations and consulting with food premises operators about food-safety practices. The intent of this protocol is to minimize food-safety hazards and promote on-site food-safety education and training. The protocol does not prescribe the content of the inspection reports, the details that an inspector needs to include in the inspection report and what actions the Public Health Unit will take when there is non-compliance.

Public Health Units have developed inspection forms and protocols based on the requirements under the Food Safety Standard and Food Safety Protocol. While these forms and protocols reflect the requirements of the regulation, we noted that they were not standardized across the province. For example:

- **The process for completing annual risk assessments.** Public Health Units are required to complete an annual on-site risk assessment for each of the food premises in their region to determine the frequency of inspections. Higher-risk premises are inspected more frequently than lower-risk ones, as explained in **Figure 5**. While four of the five Public Health Units we visited complete the risk assessment physically at the premises while conducting the first compliance inspection of the year, one does not

Figure 6: Inspections of Special Events by Selected Public Health Units, 2017 and 2018

Source of data: Ministry of Health and Public Health Units



follow the Ministry of Health's annual risk assessment protocol, instead completing the risk assessment in the Public Health Unit's own offices before the inspector has even visited the premises. Risk assessments made without an on-site visit means inspectors cannot learn if any risk factors have changed, such as the addition of high-risk cooking processes. This could lead to high-risk food premises incorrectly assessed as moderate or low-risk.

- **The level of detail recorded in terms of infractions and observations during the inspection.** Public Health Units have policies and procedures in place to ensure details recorded on infractions and observations during an inspection are consistent within each Public Health Unit. Despite the policies and procedures each Public Health Unit have in place, there were still inconsistencies across inspection reports that we reviewed at the five Public Health Units we visited. This also made it difficult for inspectors to get a clear and complete history of a food premises during investigations of complaints of foodborne illnesses.
- **Enforcement actions taken by Public Health Units for not having a certified food handler present.** The 2018 amendments to the Ontario Food Premises Regulation require that every operator of a food premises must have at least one certified food handler or supervisor on the premises who has completed food-handler training during every hour that the premises is operating. Public Health Inspectors can issue tickets to operators in non-compliance. However, at the completion of our fieldwork, we found that two of the five Public Health Units we visited were not enforcing this new requirement under the regulation. One was only educating food operators about the new requirement and monitoring progress, while the other gave operators a 12-month compliance period and only began enforcing the new regulation subsequent to our fieldwork in July 2019. The three other Public Health Units we visited were already issuing tickets for not having at least one certified food handler on-site or having expired food-handler certification.

In addition, while the Ontario Public Health Standards require Public Health Units to have quality improvement plans in place for their programs and services, there is no requirement to have a formal quality assurance process in place. The quality assurance departments at the five Public Health Units that we visited did not have formal consistent procedures and protocols in place to audit the quality of work done by their inspectors. Only one of the five Public Health Units completed an audit of inspectors in 2018, while another only audited new inspectors and summer students to ensure that they were conducting field inspections properly once their in-house training was completed. Two of the five had completed reports to identify input errors from inspectors in their database to improve inspection accuracy.

RECOMMENDATION 17

To ensure consistency across Ontario's 35 Public Health Units, we recommend the Ministry of Health work with the Public Health Units to:

- establish a consistent set of inspection and quality-assurance procedures, protocols and tools for conducting consistent food-premises inspections that all Public Health Units can use; and
- require consistent enforcement of the 2018 amendments to the Ontario Food Premises Regulation regarding not having at least one certified food handler or supervisor on the premises who has completed food-handler training during every hour that the premises is operating.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the recommendation to enhance continuous quality improvement. The Ontario Public Health Standards require Public Health Units to ensure continuous quality improvement. The Public Health Units are accountable to the Ministry to identify and use tools, structures, processes and priorities to measure and improve the quality of programs and services based on local need. The work to modernize public health may provide additional opportunities to enhance food safety, including in the area of continuous quality improvement and food safety inspections.

Amendments to the *Health Protection and Promotion Act* Food Premises Regulation in July 2018 led to consistency of multiple food-safety requirements across the province. The food service industry has been given time to achieve compliance with the new requirements. Public Health Units are working in collaboration with food-premises operators toward compliance in meeting this regulatory requirement. The Ministry will also collaborate with Public Health Units to establish a deadline for the food service industry to achieve compliance with the new requirements.

Currently, the Ministry is proposing further amendments to the Ontario Food Premises Regulation for premises that are serving low-risk and/or pre-packaged ready-to-eat foods to further enhance consistency across the province and reduce barriers for operators.

5.2.3 Inconsistent Disclosure by Public Health Units of Inspection Results

There is no requirement for Public Health Units to post the results of their inspections on-site. At the time of our audit, only 15 of the 35 Public Health Units posted the results on-site. The Ministry of Health requires Public Health Units only to have an online disclosure system on which to post inspection reports within two weeks of a completed inspection. However, we found that four of the 35 Public Health Units (Huron, Perth, Porcupine and Thunder Bay) did not post their inspection results on their respective websites as required by the Ministry of Health. The inspection results for these Public Health Units are available only upon request, meaning that the public must contact them directly to request a copy of the inspection results.

We also noted a number of different inspection-grading systems in use across the province in the Public Health Units' online disclosures, as seen in **Appendix 11**. For example:

- Eight used a three-colour traffic light system: red for closed (immediate health hazard), yellow for conditional pass (pass but has critical infractions that need to be corrected before a re-inspection) and green for pass (zero or minor infractions).
- One Public Health Unit used a two-colour system (red for closed and green for pass).
- Twenty-two Public Health Units only disclosed infractions but used no colour grading scheme.

These variations in inspection grading systems can be confusing and may not give the public consistent and comparable information about food-premises inspection results across different regions of Ontario.

RECOMMENDATION 18

To make inspection results clear for Ontarians, we recommend that the Ministry of Health work with the Public Health Units to establish a single consistent and comparable food premises grading system. Subsequent to establishing the system, we recommend that the Ministry of Health work with the Public Health Units to:

- ensure that all Public Health Units publicly report their inspection results through a single provincial website; and
- ensure that the latest inspection results are posted on-site at food premises.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the recommendation to make inspection results clear for Ontarians. The Ministry is committed to exploring the effectiveness of various disclosure grading systems of food premises in contributing to better public health outcomes. New and emerging technology can increase ways for consumers to access the information.

In 2018, the Ministry improved public disclosure of inspection results through the modernized Ontario Public Health Standards. The Ministry requires all Public Health Units to post their inspection results on their websites. To increase convenience for the public to access inspection reports, the Ministry will assess the development of an online consolidated list of province-wide inspection results.

The Ministry agrees with public access to the latest inspection results of the food premises on site. The Ministry will work with Public Health Units and food premises operators to ensure the latest inspection results are available at the food premises for the public to make informed dining choices.

5.3 Tracking and Monitoring of Foodborne-Illness Outbreaks

Between January 2016 and June 2019, Public Health Ontario recorded nearly 33,000 laboratory-confirmed cases of gastrointestinal illnesses. In 2014, Public Health Ontario reported that about 96% of the top five reportable foodborne illness cases were estimated to go unreported because individuals with symptoms do not always seek medical attention, or lab tests were not performed to confirm the illness.

5.3.1 Public Health Unit Policies on Foodborne-Illness Investigations Differ

There was no consistency in the processes in place to investigate foodborne illnesses connected to food premises at the five Public Health Units we visited.

According to the Ontario Public Health Standards, one of the goals of Public Health Units is the timely and effective detection and identification of, and response to, foodborne illnesses, their associated risks, emerging trends, and unsafe food offered for public consumption. This includes timely monitoring, surveillance and investigation of cases of suspected or confirmed illnesses connected to food premises.

The Ministry of Health's 2018 Food Safety Protocol requires Public Health Units to determine and initiate a response within 24 hours of receiving a food-related complaint. Responding to a complaint can mean contacting the complainant to obtain food history, requesting a stool sample or conducting an inspection of the suspected food premises.

Although the Ministry does not require an inspection within a specified time period, all of the Public Health Units we visited informed us that it is a best practice to perform an inspection, if needed, within 48 hours of receiving the complaint. Delays in completing the inspection within the first two days can mean that the suspect food item may have already been depleted or discarded, and likely food-safety concerns may have already been corrected prior to the inspection. This means the loss of evidence of the cause of the illness.

Our review of the five Public Health Units we visited showed that, once the Public Health Unit determined that a food premises inspection was required, 80% of foodborne-illness complaints connected to a food premises were inspected within two days of the complaint being received, 10% were inspected between three to five days after the complaint, and the other 10% more than five days later.

While the Ministry of Health has established protocols that set out the operating guidelines for co-ordinating with other health agencies during a

foodborne illness outbreak, there are no standardized procedures on how to investigate foodborne illness complaints within each Public Health Unit. Our review showed that the investigation procedures of the five Public Health Units we visited varied.

In one Public Health Unit we visited, for example, we found that someone calling to complain about having gastrointestinal symptoms as a result of eating at a food premises is first spoken to by the infectious disease department, which collects such information as the caller's 72-hour food history. The department also requests a stool sample to help identify the pathogen that caused the illness. Once that work is completed, the case is referred to the food-premises inspection department, which then sends an inspector to investigate the premises and gather samples.

Our review of this Public Health Unit's 2016–2018 inspection records showed that when an inspection resulting from a complaint is needed as per the Ministry's Food Safety Protocol, it conducted 63% of the food premises inspections within two days of receiving the complaint.

In comparison, another Public Health Unit we visited had a process in which a caller's complaint was handled by the food-premises inspection department to receive detailed information from the complainant. The complaint was then assigned to the food-premises inspection department for an inspection. The complainant was not referred to the Public Health Unit's infectious disease department unless there were two or more calls regarding the same food premises; in that case, stool samples would be collected by the infectious disease department.

Our review of this Public Health Unit's 2016–2018 inspection records showed that when an inspection resulting from a complaint is needed as per the Ministry's Food Safety Protocol, it conducted 90% of the food premises inspections within two days of receiving the complaint.

The other three Public Health Units we visited each also had a different protocol in place, and the time each took to investigate complaints connected to a food premises varied.

RECOMMENDATION 19

To improve the effectiveness and consistency of the complaints investigations relating to potential exposures to foodborne hazards, we recommend that the Ministry of Health work with Public Health Units to:

- establish consistent protocols and procedures for the investigation of complaints of potential foodborne illness connected to food premises; and
- require Public Health Units to conduct food premises inspections connected to a potential foodborne illness within two days of receiving the complaint, if an inspection is needed as per the Ministry's Food Safety Protocol.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the recommendation and will include additional information on foodborne hazard exposures as part of the ongoing updates of the Ontario Public Health Standards and Protocols with respect to the investigation of complaints for potential foodborne illness and hazard exposures in connection to a food premises.

The Ontario Public Health Standards are evergreen documents and are continuously updated. As the Ontario Public Health Standards are reviewed and updated, the Ministry will consult with Public Health Units and Public Health Ontario on the evidence-informed best practices to ensure that food premises with foodborne hazards are risk-assessed and investigated in a timely and consistent manner.

5.3.2 Inconsistent Foodborne-Illness Data in Public Health Unit Databases

Data from Public Health Units' investigations and inspections of food premises in response to public complaints of foodborne illnesses must be recorded in each Public Health Unit's database.

In addition, the Public Health Units are also required to record instances of foodborne illnesses

in the Ministry of Health's integrated Public Health Information System (iPHIS). Public Health Ontario uses the data entered into iPHIS by Public Health Units to monitor and do surveillance of disease trends, and to co-ordinate efforts between Public Health Units and the Ministry of Health during an outbreak of a foodborne illness in Ontario.

We noted, however, that the level of detail recorded in iPHIS varied among the individual Public Health Units, and that the accuracy of data recorded in iPHIS relied on manual inputting by staff of the individual Public Health Units.

In addition, the databases operated by individual Public Health Units and iPHIS were not integrated, meaning it was not possible to do easy information uploading, sharing and cross-database searching.

RECOMMENDATION 20

To improve the consistency in the recording of foodborne-illness information data by Public Health Units, we recommend that the Ministry of Health, in collaboration with the Public Health Units and Public Health Ontario, review current guidelines for data entry reporting into the integrated Public Health Information System and make any necessary revisions.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees foodborne-illness data quality can be further improved to ensure public health and safety. Public Health Ontario, in collaboration with the Ministry, develops standardized questionnaires for enteric illnesses to ensure consistent reporting. With advances in technology, food preparation and social activities, enhanced surveillance directives are given to Public Health Units to expand the scope of questions and data collection in a consistent manner. The Ministry is committed to reviewing, in collaboration with Public Health Ontario and Public Health Units, the current guidelines for data entry reporting into the integrated Public Health Information System to identify areas for refinement.

5.3.3 Public Health Units Could Further Educate the Public on Food Safety

We reviewed the Ontario data for exposure to gastrointestinal illness between 2016 and 2019. As shown in **Figure 7**, while 9% of all gastrointestinal illness exposure originated from food premises inspected by the Public Health Units, a larger percentage, about 12%, originated at home. These exposures represent a possible source of illness.

The Food Safety Protocol outlines a Public Health Unit's responsibility in distributing food-safety information and educational material to the general public that includes foodborne-illness prevention, seasonal food safety, new and emerging food safety risks and the safe preparation and handling of food at home.

We reviewed educational and marketing materials on food safety that have been developed by the five Public Health Units we visited and found that

Figure 7: Gastrointestinal Illness Exposures in Ontario Reported by Public Health Units, January 2016–August 2019

Source of data: Integrated Public Health Information System

Exposure Settings and Setting Types	# of Exposures Reported	% of Total
Unknown[1]	16,422	50
Travel	7,752	24
Private homes	4,086	12
Food premises[2]	2,883	9
Other settings[3]	1,755	5
Total[4]	**32,908**	**100**

1. Public Health Units investigated and determined that the exposure setting was unknown or undetermined.
2. Food premises include restaurants, delis, banquet halls, long-term-care homes, daycare centres, hospitals, schools, shelters and other settings as defined as a food premise under the Food Premise Regulation. These facilities are inspected by Public Health Units.
3. Other settings including, but not limited to, petting zoos, workplaces and laboratories.
4. This represents the total number of gastrointestinal illness exposures associated with the 27,776 cases that reported exposures. The number of reported exposures is greater than the total number of cases because some cases reported multiple exposures.

these Units were taking steps to ensure that the public is educated about food safety at home. Some of the education materials distributed to the public by the five Units we visited included:

- tips on safe thawing and cooking temperatures and procedures for meat and poultry;
- tips on safe food preparation and serving for outdoor picnics and safe grilling during summer barbeque season;
- brochures on washing fruits and vegetables, proper handwashing technique, and how to use a probe thermometer; and
- information on how to prevent foodborne illnesses.

A 2018 Health Canada survey of Canadians' knowledge and behaviours related to food safety showed that Canadians are generally conducting themselves appropriately when it comes to handling and preparing foods. However, the survey also identified some improper preparation, handling and storage of food by ordinary citizens at home.

For example, 62% of survey respondents rinsed poultry before cooking it, which can increase the risk of food poisoning as splashing water from washing chicken under a tap spreads bacteria onto hands, work surfaces, clothing and cooking equipment.

In addition, 51% of consumers did not use a food thermometer to check whether food is cooked to the recommended temperature, and 43% did not store raw meat, poultry and seafood on the bottom shelf of the fridge to prevent juices from dripping onto other foods and causing cross-contamination. Twenty-two percent of consumers were still defrosting frozen meat on the countertop at room temperature, which promotes bacteria growth on the outside while the inside is still frozen.

RECOMMENDATION 21

To reduce the number of foodborne-illness cases due to improper preparation, handling, cooking and storage of food at home, we recommend that the Public Health Units:

- regularly survey Ontarians to monitor areas of poor food-safety knowledge and behaviours; and
- develop specific educational materials to address those weaknesses.

MINISTRY OF HEALTH RESPONSE

The Ministry of Health agrees with the recommendation and is committed to ensuring public awareness of safe food-handling practices through a variety of means. For example:

- In 2018, the Ministry of Health modernized the Ontario Public Health Standards to require Public Health Units to conduct a local needs assessment as part of their Annual Service Plans. These assessments will take into consideration geographical regions and carry out evidence reviews and research, which includes surveys for populations in their communities to help identify and implement programs and services.
- As part of his role, Ontario's Chief Medical Officer of Health disseminates emerging evidence and information for public awareness on food safety and safe food-handling practices.
- Along with Public Health Units, the Ministry also promotes food safety through seasonal social media campaigns (including, for example, campaigns for Thanksgiving and summer BBQs).

The Ministry will leverage local and federal public education and awareness opportunities in collaboration with public health stakeholders to enhance public awareness and understanding of safe food-handling practices at home. This will include utilizing information from federal surveys and food-safety campaigns to reinforce key messaging for food safety in Ontario.

Appendix 1: Key Public Sector Players in Food Safety

Source of data: Canadian Food Inspection Agency, Ministry of Health and Ministry of Agriculture, Food and Rural Affairs

Federal Government

Health Canada

- Develops federal food-safety regulations and policies
- Develops nationwide mandatory nutrition and allergen-labelling policies
- Performs research and surveillance on foodborne pathogens
- Supports the Canadian Food Inspection Agency (CFIA) on foodborne-illness investigations
- Assesses the effectiveness of CFIA food-safety activities

Canadian Food Inspection Agency (CFIA)

- Provides food-safety oversight of all food sold in Canada (import and export)
- Has the power to enter and inspect any non-federal food facilities
- Co-ordinates food recalls and informs the public
- Participates in ad hoc joint investigations of foodborne illness

Public Health Agency of Canada (PHAC)

- Performs national public-health surveillance
- Co-ordinates foodborne-illness outbreak investigations when two or more provinces are involved
- Maintains national databases of foodborne illnesses
- Provides lab services and sampling to support federal agencies and public-health research

Ontario Government

Ministry of Health (MOH)

- Sets food-safety standards and policies for food premises
- Provides food-safety oversight of food premises and food handling in Ontario
- Co-ordinates investigations of foodborne-illness outbreaks within Ontario
- Oversees and funds local Public Health Units and Public Health Ontario
- Collaborates with OMAFRA on overlaps in regulatory authority for certain food premises such as dairy and meat

Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA)

- Provides food-safety oversight of food produced and sold within Ontario
- Has no authority to order food recalls; supports outbreak co-ordination/investigation, and scientific and analytical work
- Provides industry with food-safety promotion and education

Public Health Ontario (PHO)

- Performs public-health surveillance in Ontario
- Provides lab services, sampling, and scientific and technical advice to MOH and Public Health Units
- Reports to federal PHAC during national outbreaks

Public Health Units in Municipalities

35 Public Health Units

- Inspect local food premises where food is manufactured, prepared, processed, stored, handled, displayed, distributed, transported, sold or offered for sale to consumers
- Responsible for inspecting:
  - retail portion of provincially licensed dairy and meat-processing plants;
  - small-volume and low-risk meat-processing plants producing such items as frozen pizza, beef broth and sandwiches;
  - facilities that produce minimally processed vegetables such as bagged salads and sliced vegetables; and
  - manufacturing plants that process milk not from cows and goats (e.g., sheep)
- Investigate and report foodborne illness to PHO and MOH and manage local outbreaks
- Conduct surveillance of foodborne illnesses and monitor trends over time
- Provide training, education and awareness to food handlers and the public

Appendix 2: Federal and Provincial Oversight of Meat, Fruits and Vegetables, Fish and Seafood, Dairy, Eggs and Organics

Prepared by the Office of the Auditor General of Ontario

	Canadian Food Inspection Agency and Health Canada	Ontario Ministry of Agriculture, Food and Rural Affairs	Public Health Units
Meat	• Farms: regulate the sale of drugs and feed to livestock, as well as their transport • Slaughterhouses: license and regulate slaughterhouses that sell to other provinces and countries[1] • Meat-processing plants: license and regulate plants that sell to other provinces and countries[2]	• Slaughterhouses: licenses and regulates slaughterhouses that sell only within Ontario[1] • Meat-processing plants: licenses and regulates plants that sell only within Ontario and those conducting high-volume processing activities[2]	• Regulate and inspect meat processors that mostly do food services or low-volume meat processing such as butchers and restaurants that smoke or cure their own meat
Fruits and Vegetables	• Inspect importers and exporters of produce • Sample produce from grocery stores for bacteria and chemical residue	• Samples Ontario grown produce for bacteria and chemical residue from produce farms, farmers' markets, wholesalers, roadside stalls and retail	• Inspect farmers' markets • Regulate and inspect produce processor and retail stores
Fish and Seafood	• Inspect importers and exporters of wild-caught and farmed fish and seafood • Sample imported fish and seafood from retail for heavy metals, bacteria and chemical residue	• Inspects provincial fish- and seafood-processing plants • Regulates and inspects dual fish (retail and processing) premises	• Regulate and inspect dual fish (retail and processing) premises
Dairy	• License and inspect federal dairy-processing plants that sell to other provinces and countries	• Inspects goat-milk farms (Ministry of Agriculture) and cow-milk farms (Dairy Farmers of Ontario) • Certifies graders who have the authority to accept or reject raw milk at the farm and the processing plant • Inspects tank trucks that transport raw milk to processing plants • Samples goat and cow raw milk and finished products for bacteria and inhibitors[3] • Inspects provincial dairy-processing plants that sell only within Ontario • Licenses all dairy-processing plants in Ontario (both federal and provincial)	• Regulate and inspect retail stores where milk products are sold
Eggs	• Grade all hen eggs in Canada	• Responds to information requests and complaints related to hen eggs	• Regulate and inspect retail stores where egg products are sold or used
Organics	• Regulate, establish and enforce organic standards • Approve certification bodies that inspect organic producers • Respond to and investigate organic complaints	• No Ministry of Agriculture oversight	• No Public Health Unit oversight

1. Slaughterhouses slaughter livestock for further processing on-site or for distribution.
2. Meat-processing plants process and/or package meat.
3. Inhibitors are antibiotics, medicines or chemicals that can be detected in milk.

Appendix 3: OMAFRA's Food Safety Inspection and Audit Results, 2014/15–2018/19

Source of data: Ministry of Agriculture, Food and Rural Affairs

Facilities	Inspections and Audits				
	2015[1]	2016[1]	2017[1]	2018[1]	2019[1]
Meat – slaughterhouses[1]	• 123 audits • Audit pass: 77.2% • Conditional pass: 22.8% • Fail: 0%	• 120 audits • Audit pass: 80% • Conditional pass: 16.7% • Fail: 3.3%	• 117 audits • Audit pass: 65.8% • Conditional pass: 29.9% • Fail: 4.3%	• 119 audits • Audit pass: 70.6% • Conditional pass: 23.5% • Fail: 5.9%	• 114 audits • Audit Pass: 60.5% • Conditional pass: 34.2% • Fail: 5.3%
Meat – processing plants[2]	• 335 audits • Audit pass: 98.3% • Conditional pass: 1.7% • Fail: 0.0%	• 374 audits • Audit pass: 98% • Conditional pass: 1.4% • Fail: 0.6%	• 347 audits • Audit pass: 95.6% • Conditional pass: 3.2% • Fail: 1.2%	• 334 audits • Audit pass: 96% • Conditional pass: 2.9% • Fail: 1.1%	• 349 audits • Audit pass: 89.1% • Conditional pass: 10.6% • Fail: 0.3%
Dairy – cow milk on farm[3]	• 2,833 inspections • Inspection pass (Grade A): 83.1% • Conditional pass: 10.6% • Non-Grade A[4]: 5.9% • Unsanitary: 0.4%	• 3,066 inspections • Inspection pass (Grade A): 85.1% • Conditional pass: 6.9% • Non-Grade A[4]: 7.9% • Unsanitary: 0.1%	• 3,211 inspections • Inspection pass (Grade A): 87.4% • Conditional pass: 4.2% • Non-Grade A[4]: 8.4% • Unsanitary: 0.0%	• 3.323 inspections • Inspection pass (Grade A): 89.8% • Conditional pass: 4.3% • Non-Grade A[4]: 5.9% • Unsanitary: 0.0%	• 3,391 inspections • Inspection pass (Grade A): 91.5% • Conditional pass: 4.2% • Non-Grade A[4]: 4.2% • Unsanitary: 0.1%
Dairy – goat milk on farm[5]	• 155 inspections • Inspection pass: 60.0% • Conditional pass: 38.1% • Non-Grade A[4]: 0.6% • No results: 1.3%	• 203 inspections • Inspection pass: 52.2% • Conditional pass: 44.8%[6] • Non-Grade A[4]: 0.5% • No results: 2.5%	• 237 inspections • Inspection pass: 49.0% • Conditional pass: 50.6%[7] • No results: 0.4%	• 262 inspections • Inspection pass: 63.4% • Conditional pass: 34.7% • No results: 1.9%	• 170 inspections • Inspection pass: 71.2% • Conditional pass: 24.7% • No results: 4.1%
Dairy processing	• 37 in-depth inspections provincial plants • Licences renewed: 100%	• 36 in-depth inspections provincial plants • Licences renewed: 100%	• 40 in-depth inspections provincial plants • Licences renewed: 100%	• 48 in-depth inspections provincial plants • Licences renewed: 98% • Conditional licence renewals: 2%	• 49 in-depth inspections • Licences renewed: 100%
Fish processing	• 266 inspections • n/a[8]	• 250 inspections • Inspection pass: 66.8% • Conditional pass: 14.0% • Fail: 18.4% • No results: 0.8%	• 239 inspections • Inspection pass: 76.6% • Conditional pass: 12.6% • Fail: 10.5% • No results: 0.3%	• 239 inspections • Inspection pass: 71.1% • Conditional pass: 20.5% • Fail: 8.4%	• 201 inspections • Inspection pass: 77.9% • Conditional pass: 12.6% • Fail: 9.5%

1. Inspections are also conducted, but do not result in pass, conditional pass, or fail. Inspections result in infractions that require corrective action plans. The number of inspections from 2015 to 2019 range from 8,431 to 9,787.
2. The number of inspections from 2015 to 2019 range from 5,428 to 5,563.
3. As of July 2019.
4. Non-Grade A means that the farm has an item or items that are not in compliance with regulations and that may adversely impact milk quality or animal welfare.
5. As of August 2019. Goat inspections take place throughout the year.
6. Number of conditional passes in 2016 correlate to growth in number of new goat-milk producers.
7. Downturn in goat-milk market led many producers to seek off-farm jobs, leading to a higher-than-usual number of deficiencies noted during farm inspections.
8. The Ministry did not assign ratings for fish processors during the 2014/15 fiscal year.

Appendix 4: OMAFRA's Food Safety Sample Testing Results, 2014/15 to 2018/19

Source of data: Ministry of Agriculture, Food and Rural Affairs

Commodity and Test[1]	% of Samples with Adverse Results/Positive Swabs				
	2014/15	2015/16	2016/17	2017/18	2018/19
Meat – raw: microbial (trichina parasite and BSE only)	0	0	0	0	0
Meat – raw: chemical	2.1	1.4	2.1	1.8	1.0
Meat – ready-to-eat: microbial	5.8	7.3	5.9	3.7	4.7
Meat – water testing: microbial	1.2	1.4	0.8	1.0	1.0
Dairy – cow milk (on farm)[2]: microbial, chemical	3.2	3.0	2.9	2.5	2.2[3]
Dairy – goat milk (on farm): microbial, chemical	11.4	14.7	14.2	13.7	31.2[4]
Dairy processing (finished product): microbial	4.1	3.4	5.6	4.0	3.2
Produce: microbial, chemical	1.2	0.9	1.1	3.2	3.7
Fish processing: microbial, environment	n/a	17.7	11.4	11.9	19.4

1. "Microbial" tests for bacteria such as *Listeria* and *Salmonella*. "Chemical" tests for drugs and antibiotics. "Environment" swabs surfaces that come into contact with food to test for bacteria.
2. Data for 2015 through 2018 from December monthly reports by Dairy Farmers of Ontario. Data from 2019 is as of July 2019.
3. Somatic cell count adverse level established in October 2018 and so not included in prior years' adverse results.
4. Starting in 2018/19, adverse results include bacteria, somatic cell counts and inhibitors.

Appendix 5: Comparison of Farming Standards for Organic and Conventional Livestock

Source of data: Canadian Food Inspection Agency, Organic Council of Ontario

Item	Organic Farming	Conventional Farming
Antibiotics	• Dairy cows can be treated with antibiotics in medical emergencies, and can continue to produce organic milk after 30 days or twice the withdrawal period as prescribed, whichever is longer. • There is zero tolerance for all meat; any antibiotic treatment results in the loss of the meat's organic designation.	• The withdrawal period for antibiotic treatment is as prescribed. • All Canadian milk must be free of drug residue such as antibiotics. • All Canadian meat is sample tested at the slaughterhouse to ensure it is free of drug residue such as antibiotics.
Hormones	• Growth hormones are not allowed in any livestock.	• Growth hormones may be used in beef cattle. • Growth hormones are not allowed in poultry, pork or any milk-producing dairy cattle.
Feed	• Feed must be certified organic or from non-synthetic sources occurring in nature, such as marine products. Mineral substances are permitted only if they are of natural origin.	• Feed does not have to be certified organic.
Lighting	• Livestock should not be exposed to continuous lighting or kept in permanent darkness.	• No specific requirements or guidelines.
Climate control	• While in transit and before slaughter, animals shall have shelter against inclement weather such as wind, rain and excessive heat or cold.	• No specific requirements or guidelines.

Transportation	• Physical segregation or other methods shall be used to avoid commingling or substitution with non-organic ingredients and products.
	• Organic products in transit must include the following information:
	  ◦ name and address of producer;
	  ◦ name of the product;
	  ◦ organic status of the product; and
	  ◦ traceability information such as a lot number.
		• No specific requirements or guidelines.

Appendix 6: Additional Farming Standards for Specific Organic Livestock

Source of data: Canadian Food Inspection Agency, Organic Council of Ontario

Livestock	Standards
Poultry	• Poultry shall not be kept in cages. • Poultry must be raised in a free-range environment and have access to pasture, open-air runs, and other exercise areas, weather permitting. • Laying flock must have outdoor access for a minimum of one-third of their laying life. • Meat chickens raised outdoors in shelters without indoor access shall have access to pasture on a daily basis by the age of four weeks. • Poultry must be fed daily; "skip a day" feeding regime is prohibited. • Poultry barns shall have sufficient exits (popholes) to ensure that all birds have outdoor access, and these exits must allow for passage of more than one bird at a time, and be evenly distributed along the line of access to the outdoor range. • Barns must contain natural light, bright enough to read a newspaper in the room. If the length of day is artificially prolonged, the total duration of light shall not exceed 16 hours, and shall be terminated by gradual reduction of light intensity followed by eight hours of continuous darkness.
Cattle, sheep, goats	• Herbivores shall have access to pasture during the grazing season. • At other times, they shall have access to the open air or an outdoor exercise area, weather permitting. • Exceptions can be made for breeding males and cattle confined to outdoor lots during the final finishing phase, and young animals if their health/well-being is threatened and documented.

Hogs	• Hogs shall have access to outdoor exercise areas, which should allow for rooting. Outdoor areas may include woodlands or other natural environments; access to pasture is recommended but not mandatory.
	• Piglets shall not be kept on flat decks or in cages.
	• Nose rings are prohibited.
	• Sows and gilts shall be kept in groups, with the following exceptions:
	  ◦ females in estrus may be placed in individual pens for up to 5 days; and
	  ◦ sows in the suckling phase can be placed in a pen.

Appendix 7: General Requirements for Organic Produce

Preapred by the Office of the Auditor General of Ontario

Topic	Organic
Pesticides	• Only approved substances found in the Canadian General Standards Board[1] document, "Organic Production Systems – Permitted Substances Lists"[2] can be used on organic farmland • Any substance not on this list is considered a prohibited substance
Transition Period	• No prohibited substances can be used on the land for at least 36 months before produce can be certified organic • If there are new crops added to the existing organic operations, the operator must provide evidence that the land is in compliance with the 36-month requirement
Parallel Production	• Parallel production is defined as the same crop being produced organically and non-organically at the same time • This practice is banned under the organic standards; exceptions may be made for processing plants using separate lines as well as perennial plants (plants that do not need to be replanted each year)
Split Production	• Split production is the production of different crops, some produced organically and some non-organically • This practice is allowed under the organic standards, as long as the split operation is entirely separate and identified separately
Cross-Contamination	• Distinct buffer zones (i.e., at least 8 m wide) or other barriers (e.g., hedgerows, windbreaks, permanent roads or other physical obstructions) are required to prevent cross-contamination with prohibited substances • Crops grown in a buffer zone are not considered organic
Crop Management	• The soil fertility should be maintained or increased through crop rotations that are as varied as possible and include plough-down, legumes, catch crops, deep-rooting plants and compost when necessary
Crop pest, disease and weed management	• Producers are encouraged to use alternative pest control methods such as crop rotation, mulching, traps and animal grazing • The use of permitted organic pesticides is allowed when organic management practices and alternative pest control methods alone cannot prevent or control crop pests, disease or weeds
Irrigation	• Irrigation is permitted provided that the operator documents precautions taken to prevent contamination of land and products with prohibited substances

1. The Canadian General Standards Board is a federal government organization that develops standards for products and services in Canada.
2. http://publications.gc.ca/collections/collection_2018/ongc-cgsb/P29-32-311-2018-eng.pdf

Appendix 8: Data on Ontario Public Health Units as of December 31, 2018

Prepared by the Office of the Auditor General of Ontario

Public Health Unit	Population Served[1]	# of Food Premises[2]	Expenditures Funded by the Ministry ($)	Expenditures Funded by the Municipalities ($)[3]	Total Expenditures ($)[3]	# of Food Safety Staff[4]
Algoma	113,084	608	1,305,741	379,414	1,685,155	13
Brant	134,943	621	427,440	202,132	629,572	4
Chatham-Kent	102,042	595	472,100	150,400	622,500	5
Durham	645,862	3,031	1,881,047	768,385	2,649,432	17
Eastern Ontario	202,762	1,197	1,020,749	328,250	1,348,999	7
Grey Bruce	161,977	1,002	834,000	262,133	1,096,133	8
Haldimand Norfolk	109,652	510	335,526	109,915	445,441	4
Haliburton, Kawartha, Pine Ridge	179,083	955	838,035	266,178	1,104,213	7
Halton	548,430	2,643	1,470,112	945,647	2,415,759	17
Hamilton	536,917	3,183	1,369,125	489,013	1,858,138	16
Hastings Prince Edward	161,180	996	665,432	215,374	880,806	8
Huron County	59,297	379	238,696	76,896	315,592	2
Kingston	193,363	1,265	586,159	324,819	910,978	7
Lambton	126,638	607	370,021	150,039	520,060	4
Leeds	169,244	921	532,201	238,741	770,942	6
Middlesex-London	455,526	2,491	1,224,251	458,377	1,682,628	13
Niagara	447,888	2,633	1,533,302	553,897	2,087,199	17
North Bay Parry Sound	123,820	654	881,215	260,870	1,142,085	8
Northwestern	76,455	419	298,017	82,341	380,358	3
Ottawa[5]	934,243	4,914	2,788,226	1,011,084	3,799,310	32
Peel[5]	1,381,744	5,512	3,174,908	1,689,521	4,864,429	38
Perth	76,796	503	278,241	89,272	367,513	3
Peterborough	138,236	910	434,996	136,665	571,661	4
Porcupine	84,201	512	468,740	135,126	603,866	4
Renfrew	103,593	600	543,776	181,259	725,035	6
Simcoe Muskoka[5]	540,249	2,987	1,596,983	562,957	2,159,940	14
Southwestern	199,840	1,306	599,246	228,959	828,205	6
Sudbury	196,448	1,302	1,057,035	352,058	1,409,093	11
Thunder Bay	151,884	941	832,967	141,903	974,870	8
Timiskaming	33,049	324	229,718	66,360	296,078	2
Toronto[5]	2,731,571	16,879	10,681,327	3,451,855	14,133,182	108
Waterloo	535,154	2,773	1,181,138	374,013	1,555,151	12
Wellington-Dufferin-Guelph	284,461	1,448	1,119,568	691,829	1,811,397	10
Windsor-Essex County	398,953	2,243	1,120,752	382,514	1,503,266	12
York[5]	1,109,909	5,408	3,333,420	1,648,434	4,981,854	36
Total	**13,448,494**	**73,272**	**45,724,210**	**17,406,630**	**63,130,840**	**472**

1. Based on the 2016 Census population prepared by Statistics Canada.
2. Number of food premises (high-, moderate-, low-risk) within Public Health Units' jurisdiction (excludes facilities under CFIA or OMAFRA oversight).
3. This information is self-reported by the Public Health Units.
4. Measured in full-time equivalents (FTEs).
5. Public Health Units where OAGO visited and performed audit field work.

Appendix 9: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA)
1. Food-safety licensing, inspection and sampling programs are delivered across the province in a consistent and timely manner, are effective in managing food-safety risks, and take into account best practices from other jurisdictions.
2. Processes are in place to ensure that resources, including human and financial, are managed economically and efficiently. Staff also have sufficient and appropriate training, regulatory tools and resources to identify and correct food-safety deficiencies and enforce food-safety legislation and regulations.
3. OMAFRA collects and maintains timely, accurate and complete information on licensing, inspection and sampling programs, as well as information about food producers and food processors to inform program policies and staffing decisions.
4. OMAFRA measures and publicly reports on the effectiveness of its food-safety licensing and inspection programs. Corrective actions are taken on a timely basis when issues are identified.

Ministry of Health and Public Health Units
1. Public Health Units inspect food premises such as restaurants and food retailers using a risk-based approach in a consistent and timely manner taking into account best practices from other jurisdictions to prevent food safety risks.
2. Food-premises inspections are managed economically, efficiently and are performed by appropriately trained Public Health Unit inspectors to identify and correct food safety deficiencies in food premises.
3. Public Health Units measure and publicly report periodically on the effectiveness of their food premises inspections and food handler training programs. Corrective actions are taken on a timely basis when issues are identified.
4. Foodborne-illness outbreaks are accurately recorded, monitored, investigated and resolved on a timely basis to minimize the impact on public health.

OMAFRA and Public Health Units
1. Roles and responsibilities between the OMAFRA, Public Health Units through the Ministry of Health, and the federal government for food safety in the province are clearly defined and accountability requirements are established.
2. OMAFRA and the Public Health Units through the Ministry of Health have efficient and effective systems in place to co-ordinate their efforts and share information on a timely basis and with other government stakeholders in the delivery of food-safety programs and during foodborne-illness outbreaks and food recalls.
3. OMAFRA educates food producers and processors, and the Public Health Units through the Ministry of Health educate food premises operators and the public about food-safety best practices.

Appendix 10: Common Labels on Food Products

Prepared by the Office of the Auditor General of Ontario

Label	Notes
Allergens	• Allergen labelling is required if packaged food contains any priority[1] food allergens, gluten sources or added sulphites. • Allergens can be declared through the ingredients list, or a "contains" statement detailing all allergens present in the food. • Cross-contamination or precautionary statements (e.g., "may contain ...") may be declared by food manufacturers and importers when, despite all reasonable measures, there is the unintended presence of food allergens in the food.
Free of Pesticides	• Use of the claim "free of pesticide residues" on fresh fruits and vegetables can be misleading as produce may have been exposed to pesticide residues from neighbouring farms, chemical drift or runoff. • Producer is responsible to demonstrate that product is free of pesticide residue when making such a claim. • Applies to fruits and vegetables.
Free Range	• Ability to regularly roam outdoors. • No specific requirements for the outdoor space and time spend outdoors. • CFIA does not have a definition for this claim and there is no formal certification process. • Applies to egg-laying chickens and to meat.
Free Run	• Ability to roam inside the barn. • In egg production, "free run" (or "cage free") refers to eggs produced by hens kept outside cages in open-concept barns. Egg-laying chickens are allowed to run free indoors and, ideally, have access to nests and roosting spaces. • CFIA does not have a legal definition for this claim and there is no formal certification process. • Applies to egg-laying chickens and to meat.
Gluten Free	• Voluntary certification provided by the Canadian Celiac Association (CCA). • Certification requires the use of independent third-party inspectors to verify that manufacturers meet the program's requirements on an annual basis.
Grain Fed	• Minimum percentages of feed made up of grains and grain by-products over animal's entire life. For red meat animals (beef, veal, pork, lamb, mutton, goat, rabbit, horse, venison and bison) the minimum is 75%. For turkey, it is 80%, and for chicken, 85%. • Applies to meat.
Grass Fed	• Currently no provincial or national standards in Canada. • Various entities, including Pro-Cert and Dairy Farmers of Ontario, have developed individual grass-fed standards. • Applies to meat and dairy.
Halal	• Foods certified as "halal" must include the full name of the certifying organization. • Federal regulations do not specify how organizations qualify to certify foods as halal, and the CFIA does not oversee such organizations.
Kosher	• Foods certified as "kosher" must include the full name of the certifying organization. • Federal regulations do not specify how organizations qualify to certify foods as kosher, and the CFIA does not oversee such organizations.
Natural	• Product contains no artificially added vitamins, nutrients, artificial flavours or other additives. • Cannot be significantly processed or have anything removed except water. • Natural meat may not be raised using antibiotics, hormones or other drugs. • Applies to eggs, meat,[2] dairy, fruits and vegetables, and seafood.

Label	Notes
Non-GMO (Non-Genetically Modified Organism) Project Verified	• Voluntary certification provided by the Non-GMO Project, a US organization dedicated to building and protecting a non-GMO food supply. • Certification involves sample testing according to a risk-assessed sampling plan, as well as annual inspections by third-party inspectors commissioned by the Non-GMO Project. • Applies to meat, fruits and vegetables, seafood and eggs.
Omega-3	• Nutrient content claims are not permitted for total polyunsaturates, monounsaturates or individual fatty acids. • The only claims permitted are: "Source of/contains/provides omega-3 polyunsaturated fatty acids." • The amount of each fatty acid is disclosed on the nutritional label of each product. • Applies to eggs.
Organic	• Use of Canada Organic Logo permitted only on products with organic content of 95% or more, and those certified according to requirements of the Canada Organic Regime. • Organic farms certified by a CFIA-accredited certification body. • Organic foods produced without growth hormones or antibiotics, and animal feed must also be organic. • Products with 70–95% organic ingredients may not use Canada Organic Logo and can only declare percentage of organic ingredients. Products with less than 70% organic content may identify the organic ingredients. • Applies to eggs, meat (all organic poultry is free-range and free-run), dairy,[3] fruits and vegetables, and seafood.[4]
Raised without Antibiotics	• Animal was not treated with antibiotics. • Vaccinations and other preventive drugs are allowed for dairy cattle and livestock marked for consumption. • All Canadian milk is free of antibiotics. • Applies to eggs, meat and fish.
Raised without Hormones	• Animal or mother not treated with hormones. • Label not allowed for dairy, poultry and pork products without an additional qualifying statement such as "like other similar products" because growth hormones are already banned for these commodities. • Applies to meat, dairy and fish.
Simulated meat and poultry products (commonly referred to as plant-based meat)	• Products contain no meat, but are represented as having physical and nutritional characteristics of meat or poultry. • The words "Simulated (meat/poultry)" must appear on labels and ads for all simulated meat or poultry foods. • The phrase "contains no meat" or "contains no poultry" is required on the principal display panel of the label, close to the product name. • Applies to fruits and vegetables.

Vegetarian/Vegan	• Vegetarian can be used to describe the following foods:
	  ◦ lacto-ovo- (or ovo-lacto)-vegetarian, which permits plant foods plus dairy and eggs;
	  ◦ lacto-vegetarian, which permits plant foods plus dairy, but not eggs;
	  ◦ ovo-vegetarian, which permits plant foods plus eggs, but no dairy; and
	  ◦ vegan, which permits plant foods only.
	• Applies to eggs, dairy, and fruits and vegetables.

1. Priority allergens are the 12 most common food allergens: gluten, eggs, milk, mustard, peanuts, crustaceans and mollusks, fish, sesame seeds, soy, sulphites, tree nuts, wheat and triticale.
2. To be considered natural, the animal must have been raised with minimal human intervention (i.e., not raised on a farm).
3. Same level of inhibitors (e.g., antibiotics) and testing applies to both conventional and organic cow farms.
4. Organic regulations apply only to farmed aquaculture products; products from fishing of wild animals are not covered.

Appendix 11: Inspection Grading Systems of Ontario's 35 Public Health Units as of November 7, 2019

Prepared by the Office of the Auditor General of Ontario

	Online Disclosure				On-Site (At Food Premises) Disclosure		
Public Health Unit	• Green (Pass) • Red (Closed)	• Green (Pass) • Yellow (Conditional Pass) • Red (Closed)	Only Infractions Disclosed	No Online Disclosure	Inspection Results Posted as Summary, Colour-Coding or Grading System	Inspection Signage with Website or QR Code to Access Results	No On-Site Posting at Food Premises
Algoma			✓				✓
Brant			✓		✓		
Chatham-Kent			✓			✓	
Durham		✓			✓		
Eastern Ontario		✓			✓		
Grey Bruce			✓			✓	
Haldimand Norfolk			✓			✓	
Haliburton, Kawartha, Pine Ridge	✓				✓		
Halton			✓		✓		
Hamilton		✓			✓		
Hastings Prince Edward			✓			✓	
Huron County				✓			✓
Kingston			✓			✓	
Lambton		✓			✓		
Leeds			✓			✓	
Middlesex-London		✓			✓		
Niagara			✓			✓	
North Bay Parry Sound			✓		✓		
Northwestern			✓				✓

Public Health Unit	Online Disclosure				On-Site (At Food Premises) Disclosure		
	• Green (Pass) • Red (Closed)	• Green (Pass) • Yellow (Conditional Pass) • Red (Closed)	Only Infractions Disclosed	No Online Disclosure	Inspection Results Posted as Summary, Colour-Coding or Grading System	Inspection Signage with Website or QR Code to Access Results	No On-Site Posting at Food Premises
Ottawa		✓				✓	
Peel		✓			✓		
Perth				✓			✓
Peterborough			✓			✓	
Porcupine				✓			✓
Renfrew			✓			✓	
Simcoe Muskoka			✓		✓		
Southwestern			✓			✓	
Sudbury			✓			✓	
Thunder Bay				✓	✓		
Timiskaming			✓				✓
Toronto		✓			✓		
Waterloo			✓			✓	
Wellington-Dufferin-Guelph			✓			✓	
Windsor-Essex County			✓			✓	
York			✓		✓		
Total	**1**	**8**	**22**	**4**	**14**	**15**	**6**

Appendix 12: Glossary of Terms

Source of data: Canadian Food Inspection Agency, Organic Council of Ontario

Antibiotics: drugs used to treat bacterial infections in animals or to build up bacterial resistance.
Audit (specific to meat-processing plants): an annual comprehensive review of plant operations to verify and ensure compliance with legislation and regulations (plant operators are given advance notice of audits).
Bulk tank milk grader: responsible for grading and sampling milk, and ensuring quality is acceptable, before loading milk at farms and delivering it to dairy processors
Candling: a process by which chicken eggs are inspected against a light to check for interior defects.
Environmental sampling: taking swabs from surfaces that come into contact with food.
Food handler certification: an educational program offered by Ontario's public health units, other educational institutions, and commercial entities to improve the knowledge of food-premises staff about food-safety practices to minimize the risk of foodborne illnesses (as of July 2018, food premises in Ontario must have at least one certified food handler on site during operating hours).
Food premises: a place where food or milk is manufactured, prepared, processed, stored, handled, displayed, distributed, transported, sold or offered for sale.
Foraged foods: food items gathered from plants growing in the wild (e.g., pinecones, berries, tree bark, etc.)
Free-range chickens: chickens raised with access to the outdoors (certification bodies for free-range chickens are self-governing and not subject to regulatory oversight).
Free-run chickens: chickens raised with the freedom to move within the barn (certification bodies are self-governing and not subject to regulatory oversight).
Glyphosate: herbicide more commonly known as Roundup and widely used to kill weeds in crops, commonly found on corn and soybeans.
Grain-fed chickens: chickens raised on a grain-based diet.
Health hazard: the *Health Protection and Promotion Act* defines a health hazard as a condition of a food premises, a substance, thing, plant or animal, or a solid, liquid, gas or any combination of them that has or is likely to have an adverse effect on the health of any person.
Hormone: substance occurring naturally in animals that regulates bodily functions and behaviour (in Canada, hormones can be administered to beef cattle to enhance muscle growth so an animal can gain weight on less feed).
Inhibitors: antibiotic, medicine or chemical that can be detected in milk.
Inspection: routine monitoring and review at food premises of employee hygiene and operational standards, collection of samples, and verification of adherence to written programs for sanitation, pest control, etc. (inspection frequency is based on the premises' level of risk, with the exception of abattoirs, for which an inspector must be present at all times of slaughter to inspect every animal before and after the slaughter).
Maximum residue limit: limits established by Health Canada to minimize health risks to consumers from excessive exposure to chemical residues and contaminants in foods.
Mobile food premises: a trailer, cart, vehicle, or other itinerant food premises that can be readily moved and in which food is prepared and offered for sale to the public.
Outbreak: an incident in which two or more unconnected persons experience similar illness and there is epidemiologic evidence of an association between them.
Pathogen: a bacterium, virus or other microorganism that can cause disease.
Withdrawal period: minimum time between the administration of a drug and the production of meat or other animal-derived products for food such that the level of drug residue would not likely cause injury to human health.

Ministry of Labour, Training and Skills Development

Health and Safety in the Workplace

1.0 Summary

The *Occupational Health and Safety Act* (Act) is intended to protect workers from workplace health and safety hazards. It sets out the rights and duties of all parties in the workplace, establishes procedures for dealing with hazards, requires compliance with minimum standards, and provides for enforcement of the laws where compliance is not met. The Act applies to all workplaces in Ontario, except for workplaces regulated by the federal government. As a result, the Act covers approximately 6.6 million workers of the 7.4 million workers employed in Ontario. In 2018, 85 people in Ontario died at work and an additional 62,000 were absent from work because of a work-related injury. In addition, another 143 people died from an occupational disease. The Ministry of Labour, Training and Skills Development's Occupational Health and Safety Program is responsible for administering the Act, and it spent about $200 million in 2018/19 for prevention and enforcement activities. Almost half of this funding goes to six external health and safety associations to consult with and train businesses and workers on how to maintain a safe workplace. The Ministry recovers its costs to administer the Act from the Workplace Safety and Insurance Board (WSIB), which derives its revenue primarily from premiums paid by employers to insure their workers.

Over the last five years (2014–2018), the number of employers, supervisors or workers prosecuted and convicted for violating the *Occupational Health and Safety Act* totalled 1,382, or about 276 annually. Financial penalties imposed totalled $62.1 million.

Aside from the impact on a worker's health, livelihood and productivity, work-related deaths and injuries have a financial impact on employers. The Workplace Safety and Insurance Board pays about $2.6 billion annually to claimants and their families in compensation for workplace deaths, injuries and illnesses.

Compared to other Canadian jurisdictions, Ontario has consistently had one of the lowest lost-time injury rates over the 10-year period from 2008 to 2017 (the most recent year for which data is available). In fact, it has had the lowest rate of any province since 2009. On a sector basis, we calculated that Ontario had either the lowest or second-lowest lost-time injury rates in the construction, health-care, and industrial sectors, in each year from 2014 to 2017. In the mining sector, Ontario's ranking among Canadian provinces improved each year from seventh place in 2014 to second-best in 2017.

With regard to fatalities from workplace injuries or occupational diseases, we calculated that Ontario had the second-lowest fatality rate in Canada on average from 2013 to 2017 (the most recent year for which data is available).

Although Ontario has consistently performed well compared to other provinces with regard to worker fatality and injury rates, Ontario should not become complacent when it comes to occupational health and safety. This is because within Ontario, injury rates for workers who lost time from work as a result of a workplace injury began to decrease from 2009, but have increased since 2016. Also, injury rates for workers who did not lose any time from work initially began to decrease following 2009, but have levelled off since 2016. The rate of traumatic workplace fatalities has not improved noticeably over the last decade and has also increased since 2017. Additionally, the rate of death from occupational diseases overall has trended downward but still far exceeds the number of traumatic workplace fatalities (that is, deaths due to accidents in the workplace). Further, the number of injuries in the industrial and health-care sectors has increased over the last five years by 21% and 29%, respectively.

Some of our significant audit findings include:

Enforcement

- **The Ministry's enforcement efforts are not preventing many employers from continuing the same unsafe practices.** We reviewed companies inspected at least three times during the past six fiscal years, and found that many of these companies have been issued orders for violations and contraventions relating to the same type of hazard in multiple years. For example, in the construction sector, 65% of companies we reviewed had repeatedly been issued orders relating to fall protection hazards. Furthermore, although under the Act the employer bears the most responsibility for ensuring the health and safety of its workers, almost all fines were issued to individuals such as workers and supervisors, rather than employers.
- **Ministry inspectors confirming employer's subsequent compliance with orders.** We reviewed 100 inspection files across the four Ministry sectors at the three regional offices we visited and noted that inspectors confirmed that employers had corrected the health and safety hazards and contraventions in 92% of 470 orders sampled.

Inspections

- **The Ministry's information system contains only 28% of all businesses in Ontario, leaving many workplaces uninspected.** The Ministry does not maintain an inventory of all businesses that are subject to inspection under the *Occupational Health and Safety Act*. This is because there is no requirement for businesses to register with or notify the Ministry when they start operating or close down. Instead, the inventory is updated only when the Ministry's contact centre receives a complaint or an incident report, or if an inspector happens to notice a new, unrecorded workplace in their area of inspection. We estimated that the Ministry's system contains only 28% of all businesses in Ontario and that it proactively inspects about 1% of Ontario businesses each year and investigates an additional 1% of businesses for incidents that have occurred. We reviewed a sample of fatalities and critical injuries reported to and investigated by the Ministry, and found that although all companies with critical injuries were in the system, in 40% of fatality cases there was no prior record of the associated business in the Ministry's system. Three-quarters of the cases not previously in the Ministry's system were in the construction sector.
- **The Ministry does not identify workplaces for inspection where workers are more likely to get injured, often leaving companies with the highest injury rates uninspected.** The Ministry uses WSIB injury data and its own compliance data to identify

high-risk hazards or workplace/worker characteristics for developing enforcement strategies. The data includes known incidents of worker injuries and the compliance history of firms in the same sector. However, the Ministry does not use this data to identify, rank and select specific higher-risk workplaces for inspection. Instead, inspectors select workplaces based largely on their own judgment and familiarity with activities within their assigned geographical areas. Along with the use of judgment and field intelligence, using compliance and injury-claims data could further refine the inspection-selection process. Also, the Ministry cannot identify affiliates of businesses found to have unsafe workplace practices because it does not consistently record ownership details.

- **The Ministry has made very little progress on preventative inspection initiatives for the mining sector.** In 2015, the Ministry began a comprehensive inspection program to assess all mining operations for health and safety purposes. In 2016, it also began an engineering review of all mining operations that focused on the top three hazards for underground and surface mines. However, as of July 2019, comprehensive inspections had been completed for only 23 of over 550 mining operations, and only one out of 39 underground mines had undergone an engineering review for all top three hazards.

Strategy

- **The Ministry has not measured the effectiveness of its 2013 *Healthy and Safe Ontario Workplaces Strategy*.** Although the Ministry established performance indicators to measure the effectiveness of the strategy's activities, it has not measured them. The Ministry determined that it lacked sufficient sources of data and the quality of its data was low, and this prevented it from being able to measure the effectiveness of the strategy in a meaningful way.

Health and Safety Associations

- **Although the Ministry provides health and safety associations with about $90 million in funding per year, it does not know how effective the associations have been at helping to prevent occupational injury or disease.** The Ministry provides about $90 million annually to six health and safety associations, five that consult and train workers on occupational health and safety, and one that provides clinical services to treat workers' illnesses (see **Appendix 1**). The Ministry assesses the associations' performance using measures that are focused solely on outputs (for example, number of training hours provided) rather than measuring the impact or effectiveness of their prevention efforts (for example, changes in the rates of injuries and fatalities in businesses that received their consulting and training services).
- **The Ministry does not require health and safety associations to account for or repay surplus funding owed to the government.** Under the transfer-payment agreements with the Ministry, the associations are not allowed to retain any portion of unused funding at year's end. In addition to government funding, all five training associations also generate revenue from private sources. None of the associations, however, track what portion of expenses relate to activities funded by the government, and the Ministry does not require them to do so. Using the average percentage of revenue the Ministry's funding represented for each association over the last five-year period ending in 2018, we estimated the Ministry's share of the associations' total recoverable surplus to be approximately $13.7 million. At the time of our audit, the Ministry had not recovered any surplus funds.

In January 2019, the Ministry reduced the fourth-quarter payment to health and safety associations by $2.9 million and directed the associations to use accumulated surplus to cover any operational shortfalls that may arise from the reduction. In April 2019, a further reduction ($12 million) in transfer payments was announced and again the health and safety associations were allowed to use their accumulated surplus to offset this.

- **The Ministry has not tried to recover interest income generated on funds it provided to the health and safety associations, even though this is required by the government's Transfer Payment Accountability Directive.** We noted that the health and safety associations were reporting total interest income on their audited financial statements, but not identifying what portion of interest income was generated from Ministry-provided funding versus self-generated income. Using the average percentage of revenue the Ministry's funding represented for each association over the last five-year period ending in 2018, we estimated the portion of interest income generated on Ministry-provided funding to be approximately $3.1 million.

This report contains 13 recommendations, with 26 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry has been successful at consistently maintaining the lowest lost-time injury rate in comparison to other provinces. Further, the rates of injury in each sector are among the lowest in the country. However, the Ministry should not become complacent with these results, as Ontario's rates have either levelled off or begun to climb in recent years. As well, the Workplace Safety and Insurance Board still pays about $2.6 billion annually to claimants and their families for work-related deaths, injuries and illnesses.

The audit also concluded that the Ministry does not have assurance that it is identifying and inspecting all workplaces with a high risk for worker injury or illness. In addition, the Ministry's enforcement and prosecution efforts are allowing some companies to continue their poor health and safety practices. Specifically, as evidenced by the number of repeat offenders, the Ministry needs to improve its efforts for ensuring workplaces take corrective action to achieve compliance with orders issued.

In 2013, the Ministry developed an overall strategy called *Healthy and Safe Ontario Workplaces* to help it set priorities for preventing injuries and illness and create a culture where health and safety is at the centre of all workplaces. However, six years on, the Ministry has not yet assessed whether the strategy is having an impact on workplace safety. The Ministry has also since developed four sector-specific action plans (in 2015, 2016 and 2017), and while it has made progress implementing some of the recommendations of its action plans, it is too early to assess their effectiveness.

The training and consulting services provided by the health and safety associations, which represent almost half of all Ministry costs for the Occupational Health and Safety Program, are not evaluated for their effectiveness. Therefore, the Ministry cannot ensure that it is receiving value for money from the funding it provides to the associations for prevention activities.

We noted that the Ministry publicly reports on the number of work-related deaths and injuries and the rate of their occurrence. Further, the Ministry has established targets for four key performance measures relating to occupational health and safety. However, the targets and accompanying results are only reported internally through the budgeting process to Cabinet, but not in the Ministry's published Annual Report.

OVERALL MINISTRY RESPONSE

The Ministry of Labour, Training and Skills Development would like to thank the Auditor General and her staff with respect to their diligence in auditing the Ministry's business processes and oversight of Ontario's occupational health and safety system performance. We welcome feedback on how we are performing as a Ministry and recommendations for change that strengthen our ability to continue as a leader in workplace safety.

The Ministry takes oversight of its health and safety system partners seriously. We are committed to examining areas where oversight processes can be enhanced and to provide the public with greater assurances that these health and safety organizations are fulfilling their mandates in the interests of the employers and workers of Ontario.

The Ministry will continue to work closely with our health and safety organizations, Workplace Safety and Insurance Board and Ministry of Municipal Affairs and Housing to improve worker health and safety across the province.

The Ministry will develop an implementation plan that outlines specific steps it will take to improve oversight processes. The Ministry is currently in the process of replacing outdated information-technology applications and restructuring business systems to increase compliance, enhance evidence-based/risk-based decision-making, improve data collection and analytics, while enabling better customer service and transparency.

2.0 Background

2.1 Overview

The Ministry of Labour, Training and Skills Development (Ministry) administers the Occupational Health and Safety Program (Program), in collaboration with the Workplace Safety and Insurance Board and six external Health and Safety Associations (described in **Appendix 1**) that receive funding from the Ministry. The Program aims to prevent fatalities, injuries and illnesses in Ontario workplaces.

The size of the workforce in Ontario as of March 31, 2019, was 7.4 million. In 2018, 85 people in Ontario died at work and an additional 62,067 missed time at work because of a work-related injury. Of those who died or were injured, 57% were males and 43% were females. Also, 13% were under the age of 25, which the Ministry defines as a young worker. In addition, another 143 people died in 2018 from diseases caused by their exposure to workplace hazards (occupational diseases). Many workplace injuries and deaths result from unsafe practices that are in violation of the *Occupational Health and Safety Act*. In 2018/19, 34% of 32,245 investigations conducted by the Ministry resulted in orders for corrective action being issued for violations of the Act. See **Appendix 2** for the top types and causes of workplace injuries.

In addition to the impact on a worker's health, livelihood and productivity, work-related deaths and injuries have a financial impact on employers. According to the Workplace Safety and Insurance Board (WSIB), over the last five years (2014–2018), there have been almost 1,500 claims for work-related deaths and over 900,000 claims for work-related injuries or illness, as shown in **Figure 1**. On an annual basis, the WSIB pays about $2.6 billion to claimants or their families.

The Ministry checks for compliance with the *Occupational Health and Safety Act* and its regulations by inspecting workplaces and investigating workplace fatalities, critical injuries, employee work refusals and employer reprisals. In the 2018/19 fiscal year, the Ministry conducted over 70,000 inspections and investigations. See **Appendix 3** for a five-year trend of the number of inspections, investigations and consultations conducted by sector. The Ministry is also responsible for monitoring, evaluating and reporting on workplace

Figure 1: Number of Claims for Workplace Injuries and Occupational Disease, 2014–2018

Source of data: Workers Safety and Insurance Board

Type of Claims	2014	2015	2016	2017	2018	Total
Fatalities						
Traumatic[1]	65	61	64	72	74	**336**
Occupational Disease[2]	209	212	231	215	260	**1,127**
Total Fatalities	**274**	**273**	**295**	**287**	**334**	**1,463**
Lost Time						
Injury[3]	51,204	48,922	54,734	57,141	62,067	**274,068**
Occupational Disease[4]	2,584	2,794	2,668	2,413	2,946	**13,405**
Total Lost Time	**53,788**	**51,716**	**57,402**	**59,554**	**65,013**	**287,473**
Non-Lost Time						
Injury[3]	116,192	112,838	112,092	115,839	118,403	**575,364**
Occupational Disease[4]	10,270	10,238	10,124	11,506	12,673	**54,811**
Total Non-Lost Time	**126,462**	**123,076**	**122,216**	**127,345**	**131,076**	**630,175**
Total	**180,524**	**175,065**	**179,913**	**187,186**	**196,423**	**919,111**

1. Based on year of death.
2. Based on year claim approved by WSIB.
3. Based on year injury occured.
4. Based on year claim registered with WSIB.

safety in Ontario, and advising the Minister on the strategic direction and government priorities in this area. There are four occupational health and safety sector programs comprising 81 sectors. See **Figure 2** for a description of each program. In addition, the Ministry reviews and proposes amendments to the *Occupational Health and Safety Act* and regulations made under the Act.

2.1.1 Occupational Health and Safety Act

The *Occupational Health and Safety Act* (Act) forms the basis of the Occupational Health and Safety Program. The Act protects workers from workplace health and safety hazards; sets out the rights and duties of all workplace parties and rights for workers; establishes procedures for dealing with hazards; requires compliance with minimum standards to protect the health and safety of Ontario workers; and provides for enforcement of the laws where compliance is not met. See **Figure 3** for the duties of employers and the rights of workers under the Act.

The underlying philosophy of the *Occupational Health and Safety Act* and the Occupational Health and Safety Program is that each workplace has a well-functioning Internal Responsibility System. That is, all parties in the workplace (employers, workers, supervisors, etc.) share the responsibility for health and safety to the extent that each party has control over it.

The Act applies to all workplaces in Ontario, except for workplaces regulated by the federal government or work done in a private residence by an owner, occupant or servant. Federally regulated workplaces include post offices, airlines and airports, banks, some grain elevators, telecommunication companies, and interprovincial trucking, shipping, railway and bus companies. As of March 31, 2019, the Act covered approximately 6.6 million workers of the 7.4 million workers employed in Ontario.

There are 26 regulations under the Act that address hazards by sector (e.g., mining, construction, industrial establishment, health care facilities), by the type of work (e.g., window cleaning

Figure 2: Ministry of Labour, Training and Skills Development Occupational Health and Safety Sector Programs
Prepared by the Office of the Auditor General of Ontario

Sector Program	# of Sectors	Description
Construction	32	Applies to the construction, alteration, repair, demolition, installation of any machinery or plant, and any other work or undertaking in connection with a construction project.
Mining	12	Applies to underground mines, open pit mines and quarries, sand and gravel pit operations, mineral exploration sites, and oil and gas extraction sites and facilities (both onshore and offshore locations).
Health Care	7	Applies to workplaces that provide health or community care services, such as hospitals, long-term care homes, retirement homes, nursing services, medical laboratories, and professional offices and agencies.
Industrial	30	The largest and most diverse of the programs as it applies to all other sectors, such as automotive, restaurants, government, police service, and retail.

Figure 3: Employers' Duties and Workers' Rights under the *Occupational Health and Safety Act, 1990*
Source: *Occupational Health and Safety Act, 1990*

Duties of Employers
• Take every reasonable precaution under the circumstances for the protection of a worker.
• Provide, maintain and ensure proper use of equipment, materials and protective devices.
• Ensure required measures and procedures are carried out, such as ensuring employees are using personal protective equipment when working with or around hazards.
• Provide information, instruction and supervision to workers. For example, Occupational Health and Safety Awareness and Training for every worker and supervisor, and Working at Heights Training for all employees in the construction sector.
• Acquaint workers and supervisors with workplace hazards.
Rights of Workers
• Know about any hazard to which they may be exposed.
• Participate in identifying and resolving health and safety concerns, for instance through membership on a joint health and safety committee.
• Refuse unsafe work.

and diving operations), and by the type of hazard (e.g., needle safety, x-rays, toxic substances, and noise). See **Appendix 4** for a list of the regulations and the sectors to which they apply.

2.1.2 Parties Involved in Occupational Health and Safety in Ontario

The Occupational Health and Safety Program is delivered through the Ministry's head office, five regional offices and 17 district offices. There are 843 Ministry employees working in the Occupational Health and Safety Program. A total of 373 frontline staff are involved in inspection and enforcement activity, made up of 321 inspectors, 22 engineers, 20 hygienists, nine ergonomists and one medical consultant. Other staff include management and support staff at the five regional offices (176); a policy division (38); a prevention office (67); and other support functions (86). About 100 other employees work partly on other Ministry programs such as Employment Standards and Labour Relations. See **Appendix 5** for an organizational chart of the Ministry of Labour, Training and Skills Development's Occupational Health and Safety Program.

Other outside parties assist the Ministry with its workplace health and safety activities, including health and safety associations, advisory committees, the WSIB, and a prevention council. See **Figure 4**

Figure 4: Key Parties Responsible for Occupational Health and Safety

Prepared by the Office of the Auditor General of Ontario

Ministry of Labour, Training and Skills Development

- Sets strategic direction for the occupational health and safety system.
- Administers and enforces the *Occupational Health and Safety Act* and regulations through inspections and investigations.
- Develops legislation and regulation under the *Occupational Health and Safety Act*.

Advisory Committees

Appointed by the Minister of Labour, there are 11 committees, each related to a specific industry, such as firefighters, police, film and television, mining and health care. Members of the committees include representatives from the Ministry, Health and Safety Associations, industry, and employee associations. There are 181 members in total on all committees combined.

Key responsibilities include:

- inquire into and report on workplace health and safety matters as requested by the Ministry and considered advisable by the committees.

Prevention Office–Chief Prevention Officer

A division of the Ministry of Labour responsible for carrying out prevention activities related to occupational health and safety.

Key responsibilities include:

- establish a provincial occupational health and safety strategy;
- set province-wide training and safety programs standards and oversee training providers;
- report to the Minister of Labour on the performance of Ontario's occupational health and safety system;
- provide funding and oversight through transfer-payment agreements to Health and Safety Associations; and
- provide funding for occupational health and safety research to universities and other associations with a focus on occupational health and safety.

Prevention Council

Composed of nine members appointed by the Minister with equal representation from trade unions and provincial labour organizations. This group typically meets four times a year.

Key responsibilities include advising the Minister of Labour and the Chief Prevention Officer on occupational health and safety issues, including:

- prevention of workplace injuries and illnesses;
- development of the provincial occupational health and safety strategy; and
- any significant proposed changes to funding and delivery of services under the Act.

Health and Safety Associations

Funded by the Ministry of Labour, there are six not-for-profit Health and Safety Associations (four sector-based associations, a medical clinic, and a designated training centre).

Key responsibilities include:

- provide occupational health and safety training, education and awareness to workers and businesses; and
- provide specialized clinic services to identify and treat work-related illnesses.

See **Appendix 1** for further descriptions and information for each Health and Safety Association.

Research and Program Grant Recipients

Funded through transfer payment agreements from the Ministry of Labour.

Key responsibilities include:

- conduct research projects that focus on identified occupational health and safety system priorities set by the Ministry.

Workplace Safety and Insurance Board

An agency of the Ministry of Labour.

Key responsibilities include:

- administer compensation and no-fault insurance to 75% of Ontario workplaces; and
- promote occupational health and safety (OHS) in alignment with the provincial OHS Strategy.

for the key parties involved in the Ministry's administration of the occupational health and safety system. Also, see **Appendix 6** for a jurisdictional comparison of who is accountable for Occupational Health and Safety regulations and related functions in other provinces and territories in Canada.

Up to March 2012, prevention activities for occupational health and safety were the responsibility of the Workplace Safety and Insurance Board. Effective April 1, 2012, the Ministry accepted the recommendations of the Expert Advisory Panel on Occupational Health and Safety and assumed all prevention responsibilities from the Workplace Safety and Insurance Board, including funding responsibility for Health and Safety Associations and prevention grants.

2.1.3 Provincial Occupational Health and Safety Strategy and Other Action Plans

On December 16, 2013, the Ministry released the province's first integrated strategy to prevent injuries and improve workplace health and safety. Called *Healthy and Safe Ontario Workplaces*, the strategy is to guide the Ministry and its safety-system partners—including the Workplace Safety and Insurance Board, and Ontario's six health and safety associations—toward setting priorities to prevent injuries and illnesses, and to create a culture where health and safety is at the centre of every workplace. The strategy outlines two major goals, each with three specific priorities, as seen in **Figure 5**.

The Ministry has also developed four separate action plans. The implementation status of recommendations contained in the action plans is listed in **Appendix 7.** The action plans are as follows:

- ***Mining Health, Safety and Prevention Review (March 2015)***—The goal of this plan was to ensure that those who work in Ontario's mines come home healthy and safe at the end of every shift and to maintain a productive and innovative mining industry. The plan focused on six key health and safety issues in underground mining, namely: health and safety hazards; the impact of new technology; emergency preparedness and mine rescue; training, skills and labour-supply issues; the capacity of the occupational health and safety system; and the Internal Responsibility System (which puts in place an employee-employer partnership where everyone in an organization has direct responsibility for health and safety as an essential part of his or her job). The plan made 18 recommendations,

Figure 5: Goals and Priorities of the Provincial Health and Safety Strategy

Source of data: Ministry of Labour, Training and Skills Development

Goal	Priorities	Performance Measure
Target the areas of greatest need	Assist the most vulnerable workers	• Number of occupational injuries, illnesses and fatalities among young workers
	Support occupational health and safety improvements in small businesses	• Number of small businesses engaged • Number of occupational injuries, illnesses and fatalities among workers in small businesses
	Address the greatest hazards that resulting in workplace injuries, illnesses or fatalities	• Number of occupational injuries, illnesses and fatalities associated with the conditions of work with the highest rates of injuries, illnesses and fatalities
Enhance service delivery	Integrate service delivery and system-wide planning	• Budget allocated to cross-sector priorities (e.g., supporting vulnerable workers, supporting small businesses)
	Build collaborative partnerships between occupational health and safety service delivery partners	• Activities to increase stakeholder reach and foster partnerships
	Promote a culture of health and safety	• Number of requests for information made to service delivery providers

of which eight, or 44%, had been implemented at the time of our audit.

- ***Preventing Workplace Violence in Health Care (December 2016)***—The goal of this plan was to reduce the risk of violence towards nurses in hospitals. The plan provided 23 recommendations across four areas: leadership and accountability; hazard prevention and control; communications and knowledge translations; and indicators, evaluations and reporting directed to the then Ministry of Labour and the then Ministry of Health and Long-Term Care, hospitals, and other partners in the health-care sector. At the time of our audit, 10 or 43% of the recommendations had been implemented.
- ***Occupational Disease Action Plan (January 2017)***—The goal of this plan was to reduce illnesses and fatalities associated with occupational diseases in Ontario workplaces. The plan focused on general occupational disease awareness, noise, allergens and irritants leading to skin and lung disease, diesel exhaust emissions, and emerging exposures where knowledge exchange and research may not be fully developed. The plan outlines 28 specific activities to be undertaken of which 14, or 50%, had been implemented.
- ***Construction Health and Safety Action Plan (May 2017)***—The goal of this plan was to increase the construction sector's compliance with occupational health and safety regulations, by focusing on developing a more knowledgeable and skilled system and sector. The plan recommended 41 actions, of which 36, or 88%, were implemented.

2.1.4 Enforcement Activities

The Ministry's enforcement activities are delivered through its five regional offices (Central East, Central West, Northern, Eastern, and Western), primarily through field visits to workplaces to conduct inspections or investigations.

Inspectors are appointed under the *Provincial Offences Act* and have the power to conduct inspections and investigations of workplaces, order compliance with the Act and its regulations, and commence a prosecution, when warranted.

The Ministry's enforcement strategy, called *Safe at Work Ontario*, consists of the following activities:

- creating annual sector enforcement plans, including inspection initiatives (based on areas of focus) conducted by occupational health and safety inspectors in workplaces;
- consulting and collaborating with other health and safety program partners;
- engaging stakeholders to help shape Ontario's occupational health and safety compliance strategy; and
- publicly reporting inspection and enforcement results.

There are three types of field visits:

- **Consultations** may occur before an actual workplace inspection, most often at the request of the business. An inspector discusses with the employer and/or joint health and safety committee member the purpose of their visit and may request information for the workplace parties to prepare for their next visit.
- **Unannounced inspections** are intended to ensure compliance with the *Occupational Health and Safety Act* and its regulations, particularly in workplaces where greater hazards exist (such as high levels of noise or working from heights), and to ensure parties in the workplace maintain an effective Internal Responsibility System.
- **Investigations** look into fatalities, critical injuries, work refusals, complaints of a hazardous situation, or other health and safety events in the workplace. These are brought to the attention of the Ministry through its Health and Safety Contact Centre, a 24/7 hotline where workplace incidents are to be reported and complaints involving unsafe work practices or conditions can be made.

Investigations take priority over proactive inspections planned or under way. The Ministry does not typically receive referrals from WSIB.

Annually over the last five fiscal years (2014/15–2018/19), the Ministry has conducted on average about 67,400 field visits at approximately 36,000 workplaces or 25,000 companies. The majority of visits are inspections (54%), followed by investigations (44%). As well, the majority of field visits have been carried out in the industrial (54%) and construction (37%) sectors. See **Appendix 3** for the number of field visits by program sector and type between 2014/15 and 2018/19.

2.1.5 Enforcement Tools and Penalties

Enforcement tools available to an occupational health and safety inspector include issuing an order, issuing a fine (through a ticket or summons to appear in court), and recommending cases for prosecution.

When a contravention to the Act is found, the inspector is required to record the contravention and issue an order that explains the contravention and the corrective action required, or issue a fine or pursue prosecution if warranted. An order can be issued to an owner, employer, contractor, supervisor or worker. See **Appendix 8** for a description of the types of orders an inspector can issue, and the number of orders issued by sector program and type in the last five fiscal years.

Between 2014/15 and 2018/19, on average the Ministry issued 126,000 orders per year. More than 90% of the orders were in the industrial and construction sectors, similar to the proportion of inspections conducted. See **Appendix 8** for the number of orders issued by sector program and type. The Ministry may initiate prosecutions when there have been serious contraventions, including gross disregard of the legislation, failure to comply with orders, and obstruction of an inspector.

For serious violations, such as those that result in a worker's death or critical injury, individuals and/or corporations are prosecuted by the Ontario courts under the *Provincial Offences Act*. These prosecutions can result in lengthy, complex trials. If convicted of an offence, an individual employer, supervisor or worker can be fined up to $100,000 and/or imprisoned for up to 12 months. The maximum fine for a corporation is $1.5 million. As shown in **Figure 6**, over the last five years (2014–2018), the number of employers, supervisors or workers prosecuted and convicted under the *Provincial Offences Act* totalled 1,382, or about 276 annually, and the financial penalties imposed totalled $62.1 million. In cases where an inspector, in consultation with their superiors, recommends prosecution, the Ministry's legal staff review the investigation report to determine if prosecution is warranted. Legal staff assess whether there is a reasonable prospect of conviction and, if so, whether it is in the public interest to proceed with prosecution.

Figure 6: Prosecutions with Convictions and Financial Penalties Imposed under the *Occupational Health and Safety Act* and Regulations, 2014–2018
Source of data: Ministry of Labour, Training and Skills Development

Year	# of Convictions	Financial Penalties Imposed ($ million)
2014	261	9.9
2015	283	12.8
2016	288	13.2
2017	296	13.1
2018	254	13.1
Total	**1,382**	**62.1**

For other lesser violations, individuals are fined up to a maximum of $1,000. Municipalities collect and retain amounts resulting from all fines and prosecutions.

Over the last five calendar years (2014-2018), about 9,100 fines were issued. As seen in **Figure 7**, 95% of all fines were issued in the construction sector.

Figure 7: Fines Charged Under the *Provincial Offences Act*, by Sector Program, 2014–2018
Source of data: Ministry of Labour, Training and Skills Development

Sector Program	2014	2015	2016	2017	2018	Total	% of Total	Total Fines Issued ($ 000)
Construction	1,397	1,350	1,921	1,798	2,178	**8,644**	95.1	2,481.2
Industrial/Health Care	47	68	91	47	150	**403**	4.5	142.6
Mining	–	–	–	11	5	**16**	0.2	7.0
Uncategorized	6	12	2	–	2	**22**	0.2	1.4
Total	**1,450**	**1,430**	**2,014**	**1,856**	**2,335**	**9,085**	**100.0**	**2,632.2**

2.1.6 Inspector Training and Qualifications

All newly hired inspectors complete a nine-month training program that involves alternating classroom training and in-the-field training shadowing an experienced inspector. The initial training is mandatory for all new recruits and includes common components for all inspectors on the Act and Regulations, use of the Ministry database (ICE—Inspection, Compliance, Enforcement), writing orders, each section of the policy and procedures manual, overviews of each health and safety program, investigations and prosecutions, and employee health and safety.

Following training on the common elements, inspectors branch off into specific training tailored to the health and safety program for which they were hired, where the Industrial including Health Care, Construction and Mining programs have specific training based on applicable regulations.

2.2 Funding and Financial Information

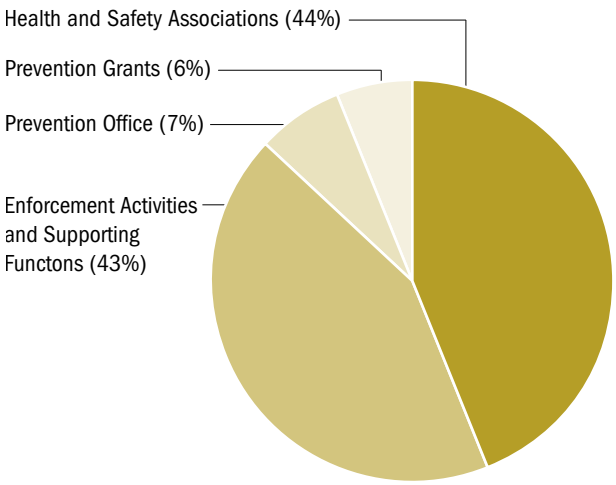
The Occupational Health and Safety Program cost an average of $204 million per year over the period 2014/15 to 2018/19. About 60% is for prevention activities through the Prevention Office and the other 40% is for enforcement and its supporting functions.

Almost 90% of the prevention expenditures ($100 million) is funding provided to transfer payment recipients, most notably the six Health and Safety Associations. Of the $113 million allocated to the Prevention Office in 2018/19, about 80% or $90 million was used to fund the Health and Safety Associations. See **Figure 8** for expenditures of the Occupational Health and Safety Program.

The *Occupational Health and Safety Act* (Act) allows the Ontario Government to recover the full cost of administering the Act from the Workplace Safety and Insurance Board (WSIB). The repayment arrangements are noted in a Memorandum of Understanding between the Ministry and the WSIB. The WSIB derives its revenue primarily from premiums paid by employers to insure their workers and survivors.

For fiscal 2019/20, the government mandated a $16-million reduction in funding to the occupational health and safety program. The Ministry

Figure 8: Expenditures of the Occupational Health and Safety Program, 2018/19
Source of data: Ministry of Labour, Training and Skills Development



determined that $12 million would be a reduction in funding to the Health and Safety Associations because the associations had accumulated surpluses and have the ability to generate revenue from other sources. The other $4-million reduction would be in the area of grants for other prevention activities.

3.0 Audit Objective & Scope

The objective of the audit is to assess whether the Ministry of Labour, Training and Skills Development (Ministry) has effective systems and procedures in place to:

- ensure regulated workplaces are operating in accordance with the *Occupational Health and Safety Act* and Ministry policies, in order to prevent or reduce workplace injuries, fatalities and illnesses;
- provide awareness and prevention activities that prevent or reduce workplace health and safety incidents; and
- measure and publicly report periodically on the results and effectiveness of its workplace health and safety initiatives.

Before starting our work, we identified the audit criteria we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Ministry reviewed and agreed with the suitability of our audit objective and related criteria as listed in **Appendix 9**.

We conducted our audit from January to July 2019, and obtained written representation from the Ministry that, effective November 8, 2019, it has provided us with all the information it was aware of that could significantly affect the findings or the conclusion of this report.

The focus of the audit was on assessing the adequacy of the Ministry's procedures to enforce the *Occupational Health and Safety Act*, in accordance with its applicable regulations, and key Ministry policies. Focus was also placed on whether the prevention activities conducted by the Ministry and its transfer-payment agencies are measured and effective in reducing poor workplace health and safety.

Specifically, we reviewed inspection files to determine whether workplace inspections and investigations were conducted in a thorough and consistent manner and that enforcement tools were appropriately applied. This included an assessment of the inspections being done through the Ministry's regional and district offices, as well as analysis of data maintained by the Ministry. Data analysis included examining both Ministry and Workplace Safety and Insurance Board (WSIB) data to determine the types and causes of fatalities, critical injuries and contraventions to the Act taking place, by industry sector, geographic region, and employer.

We also assessed whether the Ministry had appropriate procedures in place—through both its own initiatives and those it funds through associations that deliver training—to reduce the risk and incidents of workplace injury or abuse. This included an examination of the measures in place to assess the effectiveness of prevention activities conducted by six Health and Safety Associations funded by the Ministry, and the impact of initiatives conducted by the Ministry outlined in its sector enforcement plans.

We reviewed whether the Ministry had a risk-based process in selecting workplaces to inspect on a proactive basis and the efficiency and effectiveness of its inspections process. We also reviewed similarities and differences between Ontario and other provinces in conducting both prevention and enforcement activities.

We conducted our work primarily at the Ministry's head office in Toronto and three regional offices, namely Central East Region (Toronto), Western Region (Hamilton) and Northern Region (Sudbury). We accompanied inspectors on inspections in each of the Ministry's programs. We also met with and discussed prevention initiatives with those responsible at all six Health and Safety Associations

(see **Appendix 1**) to understand the value they add to the system and examined how funding is spent. We reviewed coroners' inquest reports relating to workplace deaths and reviewed the Ministry's response to injury recommendations.

4.0 Detailed Audit Observations

4.1 Performance of the Worker Occupational Health and Safety Program

4.1.1 Ontario Is Performing Well Overall Compared to Other Provinces

Based on information we obtained from the Association of Workers' Compensation Boards of Canada, compared to other Canadian jurisdictions, Ontario has consistently had one of the lowest lost-time injury rates over the 10-year period between 2008 and 2017 (the latest period for which information was available), as shown in **Figure 9**.

On a sector-program basis, we calculated the injury rate per 100,000 workers across Canada using the number of lost-time injuries from the Association of Workers' Compensation Boards of Canada and labour-force data from Statistics Canada for each province. We found that Ontario had the lowest or second-lowest lost-time injury rates in the construction, health-care, and industrial sectors, in each year from 2014 to 2017. With regards to the mining sector, Ontario's ranking improved each year from seventh place in 2014 to second in 2017 (the most recent year for which data was available).

Additionally, although no comparison across Canada was available, we calculated the provincial fatality rates per 100,000 workers using the number of fatalities in each jurisdiction reported by the Association of Workers' Compensation Boards of Canada in relation to labour-force data from Statistics Canada. Over the five-year period from 2013 to 2017 (the latest period for which information was available), on average Ontario had the second lowest annual fatality rate in Canada. See **Figure 10**.

Figure 9: Allowed Lost-Time Injury Rates per 100 Workers, by Province and Territory of Canada, 2008–2017
Source of data: Association of Workers Compensation Boards of Canada

	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	Average Annual Ranking (Best to Worst)
ON	1.51	1.27	1.15	1.05	1.01	0.95	0.92	0.85	0.94	0.95	1
NB	1.36	1.29	1.35	1.26	1.18	1.13	1.15	1.15	1.33	1.46	2
PE	1.35	1.33	1.21	1.28	1.35	1.22	1.39	1.28	1.44	1.47	3
AB	1.73	1.51	1.42	1.49	1.39	1.34	1.31	1.25	1.25	1.39	4
NL	2.15	2.07	2.03	1.99	1.76	1.78	1.73	1.70	1.58	1.54	5
QC	2.32	2.02	1.97	1.93	1.85	1.82	1.80	1.74	1.80	1.89	6
NS	2.59	2.33	2.21	2.08	2.01	1.92	1.90	1.94	1.81	1.83	7
YK	2.73	2.38	2.12	2.28	2.14	1.87	2.07	2.00	2.10	2.05	8
NT/NU	2.51	2.17	2.45	2.37	2.13	2.21	2.33	2.02	2.03	2.21	9
BC	2.96	2.35	2.27	2.33	2.34	2.30	2.27	2.22	2.20	2.18	10
SK	3.57	3.33	3.15	2.90	2.81	2.57	2.24	2.04	2.11	2.00	11
MB	4.08	3.54	3.37	3.27	3.33	3.12	3.17	2.99	2.91	2.82	12
Canada	2.12	1.82	1.76	1.72	1.65	1.60	1.56	1.51	1.54	1.58	n/a

Note: Areas shaded in grey denote the province with the lowest (best) lost-time injury rate for the year.

Figure 10: Fatality[1] Rates per 100,000 Workers, Canadian Provinces, 2013–2017

Prepared by the Office of the Auditor General using injury data from the Association of Workers Compensation Boards of Canada and labour-force data from Statistics Canada.

Province[2]	2013	2014	2015	2016	2017	5-Year Average Rate	Ranking Based on Average Rate
Manitoba	3.6	2.3	2.8	2.4	2.5	2.7	1
Ontario	3.6	3.9	3.8	3.9	3.8	3.8	2
New Brunswick	3.0	3.3	4.9	5.1	3.9	4.1	3
Quebec	4.2	3.7	4.4	4.9	5.1	4.5	4
Nova Scotia	5.2	3.7	5.7	4.9	2.9	4.5	5
Saskatchewan	5.9	6.6	5.3	5.1	4.5	5.5	6
British Columbia	5.3	7.1	5.0	5.7	6.1	5.8	7
Alberta	8.1	7.1	5.1	5.8	6.7	6.6	8
Newfoundland	10.9	10.7	8.9	4.8	9.5	9.0	9

1. Fatality is defined as a death resulting from a work-related incident (including contracting a disease) that has been accepted for compensation by a Board or Commission.
2. Prince Edward Island and the Yukon and Northwest Territories did not provide the data needed to calculate the fatality rate. The reason is that the actual number of deaths in a year is usually three or less, and providing the data could breach the privacy of the individuals and families involved.

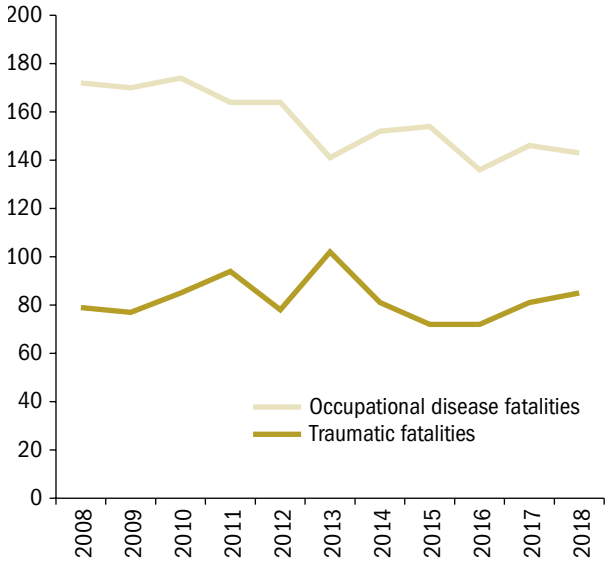
4.1.2 Overall Rates of Occupational-Related Deaths and Injuries Have Improved from a Decade Ago, but Have Either Levelled Off or Begun to Climb in Recent Years

On an annual basis, the Ministry publicly reports on the number of work-related deaths and injuries and the rate of their occurrence. Results for the last 10 years are shown in **Figure 11** and **Figure 12** (with detailed data in **Appendix 10**). There has been no noticeable improvement in the rate of traumatic workplace fatalities in the last decade, and it has been increasing each year since 2017. For occupational diseases, the rate of death has fluctuated, but overall it has shown a downward trend and has started to level off since 2017. Similarly, the rate of injuries has improved from a decade ago, although the rate has levelled off since 2016 for injuries that did not result in time off work, and the rate has increased each year since 2016 for injuries that did result in time off work.

Despite Ontario having one of the lowest lost-time injury rates in Canada, the number of injuries in the industrial and health-care sectors, as seen in **Figure 13**, has generally increased over the last five years by 21% and 29%, respectively. The types of

Figure 11: Trend in Traumatic Workplace Fatalities and Deaths from Occupational Diseases

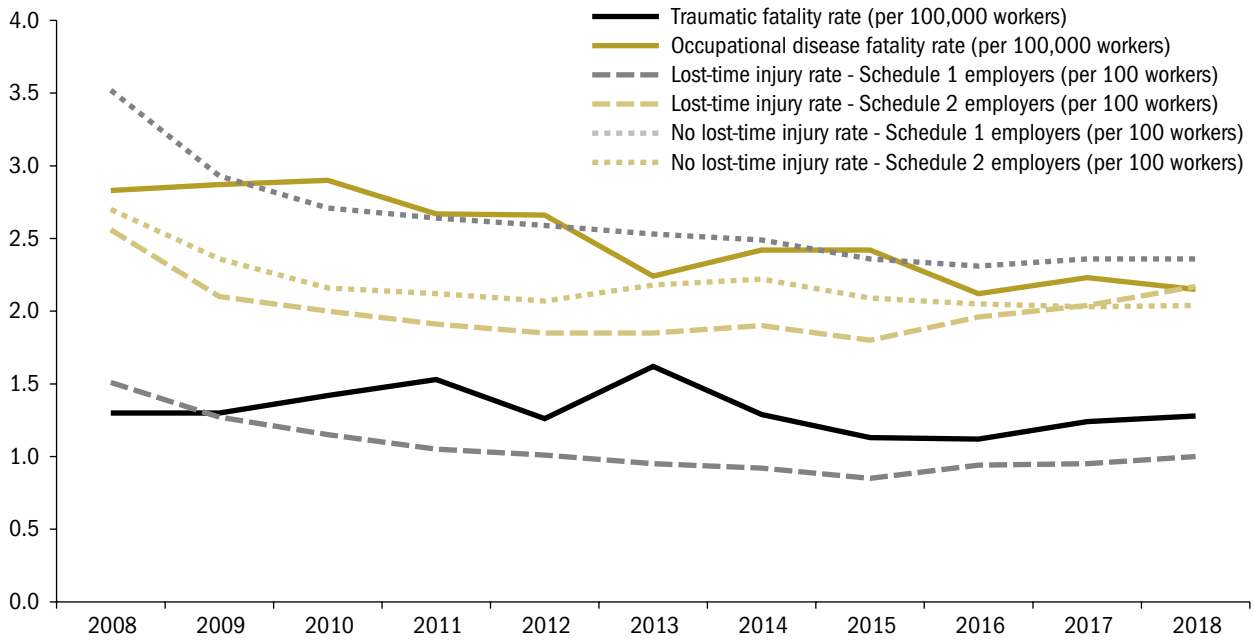
Source of data: Workplace Safety and Insurance Board and Ministry of Labour, Training and Skills Development



entities within the industrial sector that have seen the largest increase in lost-time injuries include provincial ministries and related government organizations (40%), education (35%), retail services (27%) and municipal governments (21%).

Figure 12: Trend in Occupational-Related Fatality and Injury Rates

Source of data: Workplace Safety and Insurance Board and Ministry of Labour, Training and Skills Development



1. Schedule 1 employers refer to those that pay premiums to the WSIB and, in return, the WSIB pays benefits to injured workers out of money pooled in the insurance fund.
2. Schedule 2 employers refer to those that self-insure the payment of compensation benefits for workers' claims, and are individually responsible for the full cost of the accident claims filed by their workers; for example, large municipalities and the provincial government.

Figure 13: Lost-Time Injuries* by Sector Program, 2014–2018

Source of data: Workplace Safety and Insurance Board

Program Sector	2014	2015	2016	2017	2018	Total	% Change
Industrial	**41,345**	**39,311**	**44,225**	**46,042**	**50,173**	**221,096**	**21**
Retail and Services	12,252	12,181	13,735	14,295	15,536	**67,999**	27
Manufacturing	5,880	5,485	6,224	6,282	6,964	**30,835**	18
Municipal	5,136	4,929	5,296	5,719	6,201	**27,281**	21
Education	4,324	4,159	4,886	5,346	5,857	**24,572**	35
Transportation	4,594	4,040	4,516	4,622	5,095	**22,867**	11
Federal Government	1,952	1,733	1,881	1,789	1,822	**9,177**	(7)
Automotive	1,577	1,390	1,655	1,621	1,798	**8,041**	14
Other Provincial Ministries and Government Organizations	1,350	1,316	1,495	1,749	1,891	**7,801**	40
Other	4,280	4,078	4,537	4,619	5,009	**22,523**	17
Health Care	**5,434**	**5,262**	**5,837**	**6,098**	**7,028**	**29,659**	**29**
Construction	**4,249**	**4,180**	**4,511**	**4,810**	**4,695**	**22,445**	**10**
Mining	**176**	**169**	**161**	**191**	**171**	**868**	**(3)**
Total	**51,204**	**48,922**	**54,734**	**57,141**	**62,067**	**274,068**	**21**

* Based on the year injury occurred. Data does not include illness related to occupational disease.

Figure 14: Ministry of Labour's Internal Key Performance Indicators for the Occupational Health and Safety Program

Source of data: Ministry of Labour, Training and Skills Development

Expected Outcome/Goal	Baseline[1]		Target Rate	Target Met			
	Established	Rate		2015	2016	2017	2018
Reduce the rate of fatalities by 2% over five years[2]	2014	1.44	1.41	Yes	Yes	Yes	Yes
Reduce the rate of allowed lost-time injuries by 10% over five years[3]	2014	0.92	0.83	No	No	No	No
Reduce the rate of fatalities due to falls from heights by 10% over five years[4]	2015	2.20	1.98	n/a	Yes	—[5]	—[5]
Reduce the rate of lost-time injuries in small businesses by 10%[3]	2015	1.03	0.92	n/a	No	—[5]	—[5]

1. The baseline rates used for key performance indicators are based on WSIB reported fatalities among schedule 1 employers divided by estimates of the number of schedule 1 employees. This rate will not agree to the fatality rate seen on **Figure 11** which is based on fatalities of all employers divided by Statistics Canada provincial employment numbers.
2. Per 100,000 workers.
3. Per 100 workers.
4. Per 1 million workers.
5. Not measured.

4.1.3 Limited Public Reporting of Performance Results

We noted that the Ministry has established outcome-based targets for four key performance measures relating to occupational health and safety. These targets for improvement were established using baseline data in either 2014 or 2015, depending on the measure, as shown in **Figure 14**. Only two of these measures are reported publicly in the Ministry's annual report. However, the Ministry does not report any targets in its annual report. The targets and accompanying results are only reported internally through the government budgeting process.

Provincial Occupational Health and Safety Strategy

In the Ministry's provincial strategy developed in 2013, *Healthy and Safe Ontario Workplaces Strategy* (see **Section 2.1.3**), the Ministry originally included 13 performance indicators to measure the effectiveness of the strategy's activities. These indicators were based on six strategic priority areas. However, the Ministry determined that it could not effectively measure the indicators because of insufficient data sources and low data quality. As a result, the Ministry reduced the number of indicators to seven, but it still has not reported on them. See **Figure 5** for a listing of the priority areas and related performance measures.

Enforcement Initiatives

We noted that for each focus area in its annual enforcement plans, the Ministry publicly reports the number of inspections conducted and the number and type of orders issued. However, it does not indicate whether the orders that were issued were in connection with the focus areas or whether they addressed other areas of concern.

RECOMMENDATION 1

In working toward a continuous reduction in worker injuries and fatalities, we recommend that the Ministry of Labour, Training and Skills Development set meaningful targets, and track and publicly report performance measures that demonstrate the impact of its prevention efforts and strategies.

MINISTRY RESPONSE

The Ministry agrees that a strengthened performance measurement framework that includes tracking and public reporting on performance measures will allow for improved measurement and the ability to better demonstrate the impact of its health and safety programs. This will be given increased focus by the Ministry.

The Ministry makes a range of occupational health and safety performance data available to the public on the open-data catalogue on Ontario.ca. This data includes the number of inspections and field visits conducted, the number of orders issued, as well as fatality rates and critical-injury rates.

The Ministry is currently developing Ontario's next five-year Occupational Health and Safety Strategy. It will include the introduction of an evidence-based and outcomes-focused approach and a commitment to developing and tracking performance indicators. The Ministry will also set appropriate targets for the implementation of the strategy.

4.2 Ministry Oversight of Health and Safety Associations

4.2.1 Health and Safety Associations Not Consistently Meeting Their Performance Measures, and Effectiveness of Activities Is Unclear

From our review of the reporting provided by the Health and Safety Associations to the Ministry, we noted the Ministry does not know how effective the associations have been at helping to prevent occupational injury or disease. The transfer-payment agreements outline performance measures that focus solely on outputs (for example, the number of training and consulting hours provided, the number of in-person and online training courses held, and the number of materials distributed), and not on the impact or effectiveness of prevention efforts provided by the Health and Safety Associations.

Nevertheless, when we reviewed their performance against their targeted service levels, we noted that two associations (Infrastructure Health and Safety Association, and Public Services Health and Safety Association) had not been able to meet all their targets in any of the last five years (see **Figure 15**), as they did not consistently provide the contracted amount of services agreed to for training, consulting and providing resource products. The Ministry informed us that it has never reduced an association's funding when performance targets were not met.

Tracking only the number of training hours provided, consulting sessions held, and training materials produced, does not help the Ministry assess whether the associations are having an impact on health and safety in their targeted sectors. While the Ministry has access to data such as WSIB claims information or orders issued by inspectors to workplaces, it does not use it to determine if the associations' activities are succeeding in preventing workplace injuries and ensuring compliance with the Act for businesses that received their consulting and training services.

We attempted to assess the correlation between services provided by the Health and Safety Associations and the change in occupational health and safety incidents. For each of the four associations that provide consulting services, we analyzed the number of WSIB claims submitted by the five businesses they consulted with most frequently. There was no clear downward trend in WSIB claims for the period 2013/14–2017/18 and no correlation between the number of times a business received consulting services from a Health and Safety Association and the number of WSIB claims submitted by that business. The Ministry indicated that rather than the frequency of consultation, a better measure would be the type and level of consulting received, for example, conducting a risk assessment for a business rather than an email or phone call.

Figure 15: Achievement of Key Performance Measures, by Health and Safety Association, 2013/14–2017/18
Prepared by the Office of the Auditor General of Ontario

	2013/14 (%)	2014/15 (%)	2015/16 (%)	2016/17 (%)	2017/18 (%)
Infrastructure Health and Safety Association					
Training [1]	69	67	83	57	33
Consulting [2]	67	50	90	91	57
Products [3]	100	50	100	50	50
Public Services Health and Safety Association					
Training [1]	60	33	29	71	0
Consulting [2]	100	50	0	36	71
Products [3]	80	50	50	0	0
Workplace Safety and Prevention Services					
Training [1]	0	100	80	100	100
Consulting [2]	40	100	100	100	100
Products [3]	71	100	100	100	100
Workplace Safety North					
Training [1]	n/a	100	71	56	60
Consulting [2]	50	100	64	36	43
Products [3]	n/a	100	100	100	0
Occuupational Health Clinics for Ontario Workers					
Clinical [4]	n/a	75	100	100	100
Consulting [2]	100	n/a	100	100	100
Products [3]	n/a	n/a	100	100	100
Workers Health and Safety Centre					
Training [1]	n/a	100	100	100	100

1. Develop, deliver, measure and evaluate safety education for work environment, for example in the number of in-person training sessions provided, and the number of participant hours.
2. Provide consulting services that help firms evaluate and implement controls for workplace hazards, in addition to engaging safety partners/stakeholders, for example in the number of firms consulted and consulting hours provided.
3. Provide occupational health and safety products that promote exposure to hazards, for example in the number of materials distributed, and the number of products developed.
4. Provide resources to front-line health-care providers on development of prevention, for example in the number of written articles for discussion, and the number of responses to enquiries.

However, the Ministry does not require the associations to track the nature of consulting provided.

We reviewed how other provinces measure performance and noted that many are moving toward more outcome-driven targets. For example, health and safety associations in British Columbia are required to define the safe-work behaviours or practices they are trying to create or change and set target objectives linked to these goals. At the end of the year, they are then required to provide evidence that the objectives were accomplished. This can be done, for example, through a survey or a focus group, or by visiting the workplaces that the health and safety association worked closely with to observe their work practices for safety.

RECOMMENDATION 2

To better measure the effectiveness of the Health and Safety Associations' prevention activities, we recommend that the Ministry of Labour, Training and Skills Development develop a well-documented, outcome-focused performance measurement model including

relevant, quantitative metrics that Health and Safety Associations must be accountable for meeting as demonstrated through annual performance measurement.

MINISTRY RESPONSE

The Ministry accepts the recommendation and agrees that evidence-based, outcome-focused performance measurement is ideal for effective program management. To implement such an approach will require improved data requirements and system-wide collaboration.

The Ministry has begun revising the management of funding Health and Safety Associations to ensure the relevance and effectiveness of their initiatives and accountability to the Ministry of Labour, Training and Skills Development. This is anticipated to occur over a three-year period (2019–2022) with incremental changes in reporting requirements year over year.

All modernization efforts will require collaborative inputs from other ministries and ministry stakeholders, and will align with the new Occupational Health and Safety Strategy currently under development.

4.2.2 Health and Safety Associations Allowed to Retain Surpluses and Interest Income Earned on Government Funds

Our audit identified concerns with the Ministry's practice of not recovering surplus government funding, as stipulated under the funding agreement with the health and safety associations, and interest income generated on these government funds.

Surpluses

Prior to April 2013, when agreements with the Health and Safety Associations were administered through the WSIB, associations were allowed to retain their excess revenue over expenses, to a limit of 6% of total prior-year revenue. Under the transfer-payment agreements with the Ministry, the associations are not allowed to retain any portion of unused funding at year-end, in accordance with the provincial Transfer Payment Accountability Directive. However, the Ministry has not recovered any surplus funding since it began to administer these agreements in 2013.

In addition to government funding, all five training associations also generate revenue from private sources. The associations co-mingle all their revenue regardless of the revenue source, and none have mechanisms in place for tracking what portion of expenses relates to activities funded by the government. This limits the Ministry's ability to track and recover government funding that is not used by the associations for prevention activities.

At March 31, 2018, the accumulated surplus for all health and safety associations combined was $17.9 million. Using the average percentage of revenue the Ministry's funding represented for each association over the five-year period ending 2018, we estimated that the recoverable surplus to the Ministry could be approximately $13.7 million. In January 2019, however, the Ministry announced it would not pursue the recovery of prior surplus amounts, and instead reduced the fourth-quarter payment to health and safety associations by $2.9 million and directed the associations to use accumulated surplus to cover any operational shortfalls that may arise from the reduction. In April 2019, the Ministry announced a further $12-million reduction in transfer payments and again allowed the health and safety associations to use their accumulated surplus to offset the funding cuts to begin in 2019/20.

Interest Income Generated with Government Funding

In addition to surplus funding, interest income generated on Ministry-provided funds is to either be returned to the Ministry or used to reduce future funding instalments to the Association, according to the government's Transfer Payment Accountability Directive and the transfer-payment agreements in

place between the Ministry and Health and Safety Associations. At the time of our audit, we noted that associations were reporting total interest income on their audited financial statements, but the associations were not identifying what portion of interest income is generated from Ministry-provided funding versus self-generated income, because they co-mingled their funding from all sources. Furthermore, the associations were not expecting to repay the Ministry, as there was no payable to the province recorded on their financial statements.

Using the average percentage of revenue the Ministry's funding represented for each association over the last five-year period ending 2018, we estimated that the portion of interest income generated on Ministry-provided funding from 2013/14 to 2017/18 could be approximately $3.3 million.

Operating Grant Being Used for Capital Purposes

Two of the associations (Workplace Safety and Prevention Services and Infrastructure Health and Safety Association) jointly and wholly own the Centre for Health and Safety Innovation (Centre), which provides facilities for occupational health and safety training. In 2012, the Centre commissioned a reserve-funding study, which laid out an annual-reserve contribution that would be required to maintain the building it leases according to a maintenance schedule. As of the fiscal year ending in 2018, the two associations have collectively transferred $3.1 million of unrestricted funds to the Centre's restricted capital-improvement fund. Although a majority of the Centre's funding is indirectly received from the Ministry through the associations, the Centre does not need to comply with the government's Transfer Payment Accountability Directive when it uses these funds.

The Ontario Internal Audit Division completed a review in 2016 and found that the Ministry had not approved this restricted fund or any of the subsequent funds transferred.

At the time of our audit, the Workplace Safety and Prevention Services had not responded to the Ministry's request to conduct a full reconciliation of the amount of transferred funds attributable to Ministry funding and to self-generated revenue, and has continued transferring funds to the reserve fund. For this reason, the Ministry does not know if government funding was used for the reserve fund. Non-Ministry approved expenditure on capital improvements rather than prevention efforts goes against the spirit of the transfer-payment agreements between the Ministry and the Health and Safety Associations, which state that the funds are only to be used for prevention activities.

RECOMMENDATION 3

So that government funding is both used and recovered in accordance with the Transfer Payment Accountability Directive, we recommend that the Ministry of Labour, Training and Skills Development:

- require Health and Safety Associations to track government funding and how that money is used, separately from other revenue and expenses;
- recover any surplus funding not used by year-end;
- collect interest income earned by associations on government funds; and
- follow up and recover any Ministry funding that may have been inappropriately transferred to the Centre for Health and Safety Innovation.

MINISTRY RESPONSE

The Ministry agrees with and accepts the recommendations. The Ministry will work toward improving accountability and oversight of the health and safety associations.

The Ministry has already begun addressing the issue of co-mingling of funds and this will continue to be a Ministry priority. The Ministry recognizes that addressing this issue is paramount to the recovery of surplus funding.

The Ministry will recover its portion of surplus funding, recover its portion of interest income, and follow up to recover any Ministry funding that may be inappropriately transferred to the Centre for Health and Safety Innovation.

4.3 Identifying Workplaces for Inspection

4.3.1 Ministry Does Not Have a Complete Inventory of Workplaces from Which to Select Sites for Inspection

The Ministry does not have a complete inventory of workplaces because there is no requirement for businesses to register with or notify the Ministry when they start operating or close down (only construction projects costing $50,000 or more are required to register a Notice of Project). Instead, the inventory is updated when the Ministry's contact centre receives a complaint or an incident report, or if an inspector happens to notice a new, unrecorded workplace in their area of inspection. Therefore, the Ministry's information system contains information primarily on workplaces that have already been visited, either through an inspection or investigation.

In comparison, the provinces of British Columbia, Manitoba, and New Brunswick maintain a database of all companies registered with their respective workers' compensation boards to assist with the selection of workplaces for inspection.

Using 2018 data from Statistics Canada, we estimated that the Ministry's system contains only 28% of businesses in Ontario. We compared the average number of workplaces in the Ministry's system inspected in each of the last six years, 2013/14–2018/19, with the number of businesses in Ontario according to Statistics Canada data. We estimated that the Ministry proactively inspects about 1% of Ontario businesses each year, and investigates an additional 1% of businesses.

Further, we reviewed a sample of fatalities and critical injuries reported to and investigated by the Ministry between 2014 and 2018, and found that although all companies with critical injuries were in the Ministry's system, there had been no previous record of businesses in the system for 40% of fatalities reviewed. As they were not in the Ministry's system, these companies had never been inspected.

Lack of Co-ordination across the Government

It may be difficult to maintain a real-time up-to-date inventory of all workplaces, but there are ways for the Ministry to identify new businesses and workplaces in the province in order to maintain a more complete inventory. For example, businesses are required to register with the Ontario Business Registry through Service Ontario, and with the Workplace Safety and Insurance Board.

At the time of our audit, the Ministry told us that for fixed-site workplaces (that is, excluding temporary workplaces like construction and mining sites), it was working on a strategy to use information from the Ontario Business Registry and the WSIB's firm-registration system to develop a more complete list of businesses that could be used for planning purposes. The Ministry had also developed a draft plan of the needed IT changes to allow systems to interface with one another. The new design is expected to combine information about employers from multiple sources, such as employer profile information from the Ontario Business Registry, injury claims data from the WSIB and inspection results from the Ministry.

Ministry Unaware of All Construction Projects (a High-Risk Sector)

Prior to starting a construction project with an expected total cost of at least $50,000 (labour and materials), or that meets other specific conditions, the general contractor (or, in the absence of a contractor, the owner of the building under construction) must provide a Notice of Project to the Ministry.

Municipalities require that a building permit be filed for the construction of any new building and

have inspectors who are responsible for ensuring these permits are in place. However, the Ministry has noted that contractors are applying for building permits with municipalities, but not always filing a Notice of Project with the Ministry. For example, the Ministry's Western regional office analyzed data from the municipality of Oakville for the period 2016 to 2018, and found that approximately 30% of sites or projects that filed a building permit with the municipality had failed to provide a Notice of Project to the Ministry. The Ministry told us this was due to a lack of awareness by contractors of the requirement to file a Notice of Project.

Municipal building permits would be a good source of information for the Ministry to identify where and what type of construction projects are planned or under way. In fact, we noted that four of the five Ministry regional offices were receiving building permits on an informal basis from some municipalities in their regions. Permits were usually received monthly through inspectors or other regional staff who have well-developed relationships with local municipalities, but these were not used to update the inventory of workplaces, unless the inspector ended up visiting it to conduct an inspection. The Ministry has not formalized an official arrangement to capture this building permit information consistently across all regions.

We reviewed building permits from various municipalities (Oakville, Burlington and Sudbury) and noted that they required much of the same information as the Ministry's Notice of Project, including the name of the contractor. It would therefore be useful for municipalities to send information on new permits to the Ministry on a regular basis in lieu of a separate Notice of Project being filed.

Furthermore, we found that having only a financial threshold, like the $50,000 reporting threshold for construction companies, as a measure of risk may not capture worksites that pose a risk for workers. For example, the Ministry has identified roofing as high-risk given the hazard posed by falling from heights. In the five years ending 2018, there have been 21 deaths as a result of falling while working on a roof. This represents 8% of all workplace deaths over this period. Moreover, 5% of all WSIB lost-time injury claims in the construction sector were from roofing companies. Yet, since most roofing projects do not usually meet the $50,000 threshold, a Notice of Project is not typically filed with the Ministry, with the result that these types of high-risk work sites are not proactively inspected.

Another gap in identifying construction work sites and the businesses associated with them comes from the Ministry's reporting system itself. The Notice of Project that must be filed for a construction project identifies the general contractor as the employer; however, this is not the case where portions of the work are sub-contracted out to other companies that are not identified.

RECOMMENDATION 4

To maintain a more complete inventory of businesses in areas demonstrating a high risk of worker injuries or fatalities, including construction projects, from which to assess risk and prioritize inspections, we recommend the Ministry of Labour, Training and Skills Development:

- review business registration information captured by Ministry of Government and Consumer Services and the Workplace Safety and Insurance Board to determine the most useful source of information for the program's needs, and develop an information-sharing agreement with the appropriate party that could include use of their IT systems;
- develop, in collaboration with the Ministry of Municipal Affairs and Housing, an information-sharing agreement for municipalities to provide a listing of building permits on a regular basis, such as weekly or monthly;
- assess whether the $50,000 reporting threshold is reasonable and whether other factors should be considered for construction work in order to sufficiently capture all worksites that pose a high risk for workers; and

- amend the threshold and add any other criteria needed based on the results of the assessment.

MINISTRY RESPONSE

The Ministry will work with our partners at the Ministry of Government and Consumer Services and the Workplace Safety and Insurance Board to establish information-sharing agreements to ensure the Ministry is provided with relevant business information digitally for inspection-planning purposes.

The Ministry will work with the Ministry of Municipal Affairs and Housing to formalize arrangements to obtain permit information from municipalities that inform enforcement efforts.

The Ministry is planning to consult publicly on the threshold and potential changes to the Notice of Project form to ensure high hazards are appropriately captured regardless of dollar value.

In the interim, the Ministry will continue to use our enforcement data, local field intelligence and sector plans to identify workplaces for proactive inspection.

4.3.2 Not All Companies with the Highest Number of Injuries Were Selected for Inspection

Each fiscal year, the Ministry identifies high-risk areas of focus when it develops enforcement initiatives for each of its sector programs. However, the Ministry does not use a similar risk-based approach to identify, rank and select specific higher-risk workplaces or businesses that should be visited for inspection.

The Ministry identifies its enforcement initiatives based on various sources of information, including WSIB lost-time injury data, feedback from stakeholders, the Ministry's own non-compliance data (orders issued), input from field staff, and the Ministry's strategic priorities. Initiatives could focus, for example, on a particular hazard inherent to the operation of businesses in a particular sector, such as falling from heights or being injured by improperly guarded machinery. Or they could focus on a particular type of worker or workplace, such as new or small businesses or new and young workers. Once the Ministry sets the initiatives for the year, inspectors are responsible for selecting which specific workplaces or businesses to inspect based on the initiatives.

However, the Ministry does not have a risk-based approach to identify, rank and select other higher-risk workplaces or businesses that may not be otherwise inspected under the Ministry's enforcement initiatives. At the regional offices visited, we found that inspectors selected other workplaces largely based on their own judgment and field intelligence (that is, their knowledge of local workplaces and familiarity with activities within their assigned geographical areas). We noted that the Ministry's current IT system does not allow inspectors to generate reports showing the hazard type, severity, or frequency of violations by workplace. In addition, although the WSIB provides the Ministry with access to its claims data, the Ministry has not yet been able to link this data to its own inspection and compliance data so that inspectors can select workplaces based on their compliance history and employee-claims history, or the history of other businesses in the same sector. Along with the use of judgment and field intelligence, using compliance and injury-claims data could further refine the inspector selection process.

A better risk-based approach to selecting workplaces for inspection could help identify workplaces that would otherwise not appear on an inspector's radar. For example, in our audit, we reviewed a sample of 100 companies (25 companies with 50 or more employees with the highest number of lost-time claims per full-time-equivalent for each of the four sector programs), and found that 14% had never been inspected or investigated.

We also noted some cases where the Ministry only became aware of a workplace after a worker

was fatally injured on the job. These workplaces had never been inspected by the Ministry. In one case, a worker fell nine feet inside an elevator shaft when the supporting platform they were on collapsed. The inspector determined that the platform being used did not meet the requirements under the Act, resulting in the worker's death.

RECOMMENDATION 5

To help prevent and minimize future injuries to workers, we recommend that the Ministry of Labour, Training and Skills Development:

- improve its case-management system to allow inspectors to extract compliance data from the system so that they can analyze trends and compare workplaces;
- link and compare compliance data in its case-management system with claims data from the Workplace Safety and Insurance Board; and
- select workplaces for inspection across all sectors based on their compliance history and employee-claims history.

MINISTRY RESPONSE

The Ministry is developing a work-planning model to combine enforcement data from our case-management system and claims information from the Workplace Safety and Insurance Board. This will result in work-planning tools that can be used by inspectors to identify workplaces for proactive planning purposes.

The work planning will be further informed using compliance information from other ministries to improve risk-based planning.

The Ministry is currently gathering requirements for a new software application to replace its ageing system and will ensure the system links and compares data across sectors and compliance histories.

4.3.3 Ministry Cannot Identify and Inspect Affiliated Businesses with Unsafe Work Practices

While the Ministry's system records the names of businesses, information identifying owners or boards of directors is not consistently recorded, even though the Ministry's system has a data field for this information. Because an individual or corporation could own several businesses with different names, the Ministry cannot always identify and inspect affiliates with common ownership that might be using the same unsafe practices. We reviewed a sample of businesses in the Ministry's system and found that 44% of records did not contain details about the owner(s) or board of directors.

For example, a news publication reported in July 2019 that a company had a fatality at one of its plants in October 2018. The newspaper reported that, previous to this death, there had been three fatalities at companies affiliated with this company in 1999, 2011, and 2016. Had the Ministry been able to identify the affiliated companies and taken action to inspect all affiliates, health-and-safety concerns may potentially have been identified and proactively addressed. Following this newspaper report, an additional fatality occurred at this company in September 2019.

The Ministry told us this is even more problematic in the high-risk construction sector. As noted in **Section 4.3.1**, contractors are required to file a Notice of Project with the Ministry for projects costing $50,000 or more. For these projects, the Ministry typically registers in its system the name of the business, but not the owner, to track inspection results relating to the project. If the contractor operates under different business names, it is difficult to follow the inspection results and records of the same contractor over time, given the short-term and temporary nature of construction projects.

RECOMMENDATION 6

In order to identify risks of poor health-and-safety practices that may extend to organizations and associated companies under common ownership, we recommend that the Ministry of Labour, Training and Skills Development:

- consistently record the names of business owners in its system and analyze reported incidents and inspection results by common ownership, in addition to the business name; and
- inspect affiliates with common ownership that might be using the same or similar unsafe practices.

MINISTRY RESPONSE

The Ministry will implement a data-sharing arrangement with the Ontario Business Information System to collect corporate information about Ontario businesses and corporations.

Efforts are being made to merge organizational information from multiple systems to allow for potential analysis based on common corporate directors.

4.3.4 Not All Critical Injuries Are Being Reported to the Ministry

In September 2016, the Ministry clarified its interpretation of the definition of critical injury to include fractures of the wrist, hand, ankle, foot, and multiple fingers and toes. According to the Ministry, it did so based on case law and decisions of the Ontario Labour Relations Board and stakeholder feedback.

In 2017, the Ministry conducted a pilot project because it was concerned that critical injuries were being underreported to the Ministry. In order to verify if underreporting had occurred, the Ministry reviewed a sample of WSIB claims from three different regions submitted between January and August 2017 and contacted workplaces where necessary. The Ministry concluded that out of this sample of 69 critical-injury claims, 33, or 48%, had not been reported to the Ministry as required.

According to the Ministry, the most common reasons why employers failed to notify the Ministry were because they:

- were not aware of the new interpretation of the critical-injury definition;
- were not aware of their obligations under the Act; and
- thought that by submitting their claims forms to the WSIB they had let the Ministry know of the incident and had fulfilled their obligations.

At the time of our audit, the Ministry had not taken any specific actions to address the reasons employers failed to notify the Ministry of critical injuries, following the exercise it undertook in 2017.

RECOMMENDATION 7

To obtain more complete information on critical injuries for investigation that could contribute to preventing future incidents, we recommend that the Ministry of Labour, Training and Skills Development (Ministry) develop a process with the Workplace Safety and Insurance Board to inform the Ministry of claims that meet the Ministry's definition of a critical injury.

MINISTRY RESPONSE

While not all injuries that are reportable to the Workplace Safety and Insurance Board would meet the definition of a critical injury under the Occupational Health and Safety Act, the Ministry recognizes that there is some underreporting that occurs. The Ministry will work with the Workplace Safety and Insurance Board on technology or process to improve injury reporting, to both simplify the reporting process for stakeholders and to ensure that the Ministry receives all required reports.

4.4 Recording of Field Visit Reports and Orders

4.4.1 No Formal Checklist of Items to Be Reviewed and Documented by Inspectors during Inspections

The Ministry's policy and procedure manual provides guidance on how to plan for inspections, which key personnel to talk to on site, and which records to review to verify workers' occupational health-and-safety training. The guidance for planning for inspections includes reviewing results of prior inspections and investigations. Although the Ministry has checklists for inspection of specific equipment (such as mobile cranes and material hoists), the manual does not provide a checklist of specific criteria that inspectors should assess when conducting field visits for all health-and-safety areas (for example, assessing certain electrical hazards in construction sites, ensuring protective equipment is worn by employees or proper procedures are being followed for heavy-equipment handling).

We reviewed a sample of inspection reports, and noted inconsistencies in the level of detail documented. Some documented in detail what areas were inspected, what the inspector was looking for, and what they found. Others had much less detail, such that it was unclear which relevant areas were inspected, which made it difficult for the reviewing manager to ensure that all relevant areas of the inspection were actually covered by the inspector. The use of a checklist could lead to a more efficient documentation process with consistent information on inspections collected.

RECOMMENDATION 8

To assist inspectors in efficiently assessing and documenting all health and safety hazards in a workplace, we recommend the Ministry of Labour, Training and Skills Development develop checklists specific to each sector and require that inspectors use and include the checklists in their inspection reports.

MINISTRY RESPONSE

The Ministry has developed detailed checklists for "technical" inspections of tower cranes, and man and material hoists. We will conduct a review of the sectors and our processes to determine the feasibility and appropriateness of developing additional checklists.

4.4.2 Inspectors Confirming Employer's Subsequent Compliance with Orders Issued

We reviewed 100 inspection files across the four sectors at the three regional offices we visited. The inspections occurred between 2013/14 and 2018/19, and resulted in 470 orders. We found that inspectors confirmed that employers had corrected the health and safety hazards and contraventions in 92% of these orders.

We further reviewed whether workers suffered critical injuries subsequent to the initial inspection for the 8% where compliance was not confirmed. We noted injuries at four workplaces; however, the injuries were not related to the initial violation that gave rise to the orders.

4.4.3 Quality-Assurance Process Not Assessing Quality of Inspections

We reviewed the Ministry's quality-assurance process, which is intended to assess whether inspections are done consistently and effectively, including whether inspection results are communicated to workplaces in a consistent manner. We found that the quality-assurance process itself focused on administrative accuracy rather than whether an inspection covered all relevant areas of the Act and regulations, and the hazards present at the workplace.

The Ministry's quality-assurance process involves reviewing the notebook an inspector uses while conducting inspections, reviewing a sample of two to four inspection reports for each inspector, and having a senior staff member accompany inspectors on an inspection, all on an annual basis.

More significantly, we found that the inspection reports were not assessed for quality. Instead, the reviewer looked at whether the inspector noted the purpose of the field visit; whether the inspector recorded the location within the workplace where the inspection was carried out; and whether an order issued was referenced to the appropriate section of the Act and its regulations. The reviewer was not, however, required to assess the content of the reports, for example whether the inspector included information necessary to understand what was looked at and what was found during an inspection. This could include the types of hazards the inspector looked for, a full account of observations, and relevant discussions with workplace parties.

Ministry policy also requires that each inspector be accompanied by senior staff on an inspection at least once a year to ensure inspections are being conducted adequately and consistently. The senior staff member marks the inspector on seven metrics of performance. All of these metrics, however, are based on whether an inspector had completed an element of an inspection, rather than how well they had completed the task. For example, did the inspector request to be accompanied by management and worker representatives, or a worker, in carrying out the field visit? Or did the inspector record information in their notebook? The assessment does not, for example, evaluate whether the inspection covered all applicable hazards and legislative requirements. Such overly simple assessments limit the Ministry in more critically assessing inspectors' capabilities to identify their training needs.

RECOMMENDATION 9

To improve the quality-assurance process for inspections, we recommend that the Ministry of Labour, Training and Skills Development develop and implement metrics to use when assessing whether an inspection has covered applicable hazards and legislative requirements.

MINISTRY RESPONSE

The Ministry will review the current quality-assurance processes and add metrics and new tools to evaluate whether applicable hazards and legislative requirements have been thoroughly addressed.

The Ministry will reinforce direction to inspectors to review sector plans and blitz materials to identify highest-risk hazards prior to proactive inspections. The Ministry will ensure any available data on violations that give rise to most non-administrative orders in each sector are included in sector materials for inspectors.

4.5 Ministry Enforcement of Occupational Health and Safety

4.5.1 High Rate of Repeat Offenders Issued Stop-Work Orders

For each of the Ministry's four sector programs, we reviewed companies that were inspected or investigated at least three times during the past six fiscal years (2013/14–2018/19), and found that many of these companies had been issued orders for violations and contraventions relating to the same type of hazard at least twice in the six-year period. Our review focused on five areas of hazards for each sector program where multiple violations were noted to have occurred (see **Appendix 11**). Many of these violations and hazards have been identified in Ministry action plans and sector enforcement plans as being high-risk for causing injury to workers or as important to a well-functioning Internal Responsibility System. For example, in the construction sector, 65% of 4,165 companies had repeatedly been issued orders relating to fall-protection hazards.

We also reviewed stop-work orders separately, and similarly found that many companies had contraventions for the same type of hazard multiple times. For example, in the mining sector, 31% of 95 companies had repeatedly been issued stop-work

orders relating to a lack of protective guarding on machinery or equipment. These offenders are of more concern, because stop-work orders are only issued by an inspector when there is an immediate danger or risk to the health or safety of workers.

There are no consequences to a company or individual if they do not comply with an order, or if they comply temporarily, unless the Ministry considers issuing the company a fine or pursuing prosecution.

Ministry policy requires inspectors to consider issuing fines or recommending prosecution where stop-work orders have been issued, or orders have been issued to repeat offenders. We attempted to analyze fines and prosecution data for each sector program over the six calendar years 2013–2018, to assess whether the Ministry was effective in deterring repeat offenders. However, we could not determine if the companies with repeat offences were issued fines or prosecuted for those repeat offences we identified in **Appendix 11**, as both the Ministry's database of fines issued and information received from the Ministry of the Attorney General regarding prosecutions did not contain the required information, including a common identifier such as a business registration number to link the information and perform this analysis.

According to the Ministry, the employer should bear most of the responsibility with respect to health and safety in the workplace, and under the Act the employer is responsible for taking every precaution reasonable in the circumstances for the protection of its workers. However, we found that almost all fines were issued to individual workers, including supervisors, rather than employers. For example, in the construction sector, 95% of fines were issued to workers or supervisors, while 5% were issued to employers.

The following cases illustrate the importance of deterring repeat offences:

- In 2018, a worker died when they fell from a damaged scaffold that was in poor condition and did not have adequate guarding to prevent the worker from falling. The inspector found the scaffold from which the worker fell was not safe and the employer did not meet the requirements under the Act for using scaffolds. The employer was ordered to immediately stop using the scaffold until a scaffold that met the requirements in the Act was put in place. The employer had previously been issued four orders for similar safety concerns relating to scaffolding, but the Ministry did not pursue prosecution against this employer to deter the continued safety violations until this latest incident in 2018, for which the supervisor in charge of the work was convicted in July 2019.
- In March 2017, a worker fell, hit his head and lost consciousness because the platform he was working on did not have a guardrail to prevent him from falling. The investigation into this incident found that the contractor had violated the Act and the inspector issued a stop-work order on the platform until a guardrail system was put in place to protect workers. In February 2018, the Ministry began prosecution proceedings for this incident. However, prior to this incident, the contractor had twice been issued orders for the same violation, beginning in October 2015, but the Ministry had not pursued prosecution. After this incident, the same contractor was again found to have improper guardrails in place on another occasion and was issued an order to correct the contravention.
- In December 2018, a worker broke his arm when it was caught in a piece of equipment. The inspector determined that the equipment was not adequately guarded to prevent access to moving parts, which contributed to the worker's injury. The employer was ordered to stop using the machine until it was equipped with a proper guard and could provide the Ministry with a report by a professional engineer stating that the equipment was not likely to endanger a worker again. In the five years prior to this incident, the employer had been issued orders for inadequate guarding of equipment three times.

However, prosecution relating to guard equipment has not been pursued.

In comparison to other jurisdictions in Canada, Ontario, along with Saskatchewan, impose the highest maximum fine on corporations, at $1.5 million. However, the maximum fine for individuals in Ontario is $100,000, which is much lower than many provinces. For example, both Newfoundland and Manitoba can fine an individual up to $250,000.

We also noted inconsistencies in the number of orders issued during an inspection and fines charged to employers or individuals. We found that in 2018/19, 25% of inspectors were responsible for almost 50% of all the orders issued. As well, we noted that 61% of inspectors did not issue any fines during 2018/19. Ten inspectors alone were responsible for issuing 35% of all fines. One-third of those inspectors who did not issue any fines in 2018/19 were working in the Western Region.

RECOMMENDATION 10

To increase the accountability of employers that have continued violations of the same hazard and to deter future infractions, we recommend that the Ministry of Labour, Training and Skills Development:

- analyze enforcement data to determine which employers or individuals are repeatedly in contravention of the Occupational Health and Safety Act (Act) for the same hazard;
- for employers or individuals who are responsible for repeat offences, use escalating measures to deter future infractions, such as issuing more fines through tickets and summonses or recommending prosecution; and
- analyze the effectiveness of the various measures used to deter violations of the Act.

MINISTRY RESPONSE

The Ministry agrees with this recommendation. The Ministry will review and revise our policies and procedures and inspector training related to:

- reviewing compliance history before proactive inspections;
- repeat contraventions; and
- when to consider prosecution.

The Ministry plans to undertake a compliance project, which reinforces the Ministry's commitment that enforcement action be proportionate to the health-and-safety risks and to the seriousness of any contraventions of the Act and its accompanying regulations. Inspectors will receive refresher training on the enforcement tools available and receive direction on using escalating measures where there is a history of non-compliance or higher-risk contraventions.

The Ministry will develop a formal "repeat violator strategy" to identify high-risk organizations and conduct proactive inspections.

The Ministry actively promotes achievement of results through evidence-based reporting and will commit to developing a review plan for enforcement initiatives, including the development of measures to assess their effectiveness.

The Ministry will engage with research partners to evaluate the effectiveness of the various measures (orders, tickets, prosecutions) used to deter violations.

4.5.2 Occupational Diseases Taking the Lives of More People than Traumatic Workplace Events

According to WSIB data, in 2018, there were 143 deaths from occupational diseases, compared to 85 deaths from traumatic injuries at work. Deaths from occupational diseases have outnumbered traumatic workplace-fatality claims for at least the past decade (see **Figure 11**). This illustrates that the impact from continued exposure to health-and-safety hazards, although not immediate, is greater.

Occupational illness that may contribute to death or disability normally develops over a period of time because of workplace conditions, and can occur in all sectors across various workplaces and occupations

(see **Appendix 12** for occupational-disease claims by sector). Such conditions might include exposure to disease-causing agents, such as particles, fumes, gases or smoke. Under the *Occupational Health and Safety Act*, occupational illness is defined as a condition that results from exposure in a workplace to a physical, chemical or biological agent to the extent that the normal physiological mechanisms are affected and the health of the worker is impaired.

Close to half of all WSIB claims relating to occupational diseases that affect health, but did not necessarily contribute to death, for the five years ending in 2018 were because of exposure to noise-induced hearing loss or communicable-disease such as hepatitis and tuberculosis. For a list of the top 10 causes of occupational disease, see **Figure 16**. Accounting for a quarter of occupational-disease claims with WSIB over the five years 2014–2018 were nurse aides, orderlies and registered nurses, as shown in **Figure 17**.

The Occupational Disease Action Plan (Plan) was developed in 2016 by various parties including the then Ministry of Labour (Prevention, Operations and Policy divisions), Health and Safety Associations, Specialized Research Centres (such as the Centre for Research Expertise in Occupational Disease and the Occupational Cancer Research Centre) and the Workplace Safety and Insurance Board, as well as the Ontario Lung Association, Public Health Ontario and the Ministry of Health and Long-Term Care. The objective of the plan is to prevent hazardous exposures in Ontario workplaces in order to reduce the incidence and burden of occupational disease. The plan outlines 28 specific activities to be undertaken in eight focus areas (for example, research and data management, and raising awareness). See **Appendix 7** for the implementation status of the Plan's activities.

The Plan noted that its effectiveness and priorities would be reviewed annually starting in fall 2017 and adjustments may be made. At the time of our audit, the Ministry had not yet evaluated the plan's effectiveness. One of the Ministry's funded health-and-safety associations, the Occupational Health Clinic for Ontario Workers Inc., references the Occupational Disease Action Plan in its annual report and mainly reports on the actions taken by the five working groups established under the Plan.

We followed up with the Ministry on the status of activities that were to be undertaken under the Plan, and noted that as of July 2019, half (50%) had been completed, including those recommendations that have to occur on an ongoing basis. The other 50% had either not been started, were on hold, or were in progress. Those actions still in progress were typically in focus areas relating to

Figure 16: Top 10 Types of Occupational Disease WSIB Claims, 2014–2018

Source of data: Workplace Safety and Insurance Board

Types of Occupational Disease Claims	2014	2015	2016	2017	2018	Total	%
Contact/exposure to communicable diseases	3,787	3,803	3,625	3,947	2,803	**17,965**	26
Noise-induced hearing loss	2,988	2,955	2,962	3,343	3,785	**16,033**	23
Toxic effects of venom (e.g., bees or wasp sting)	821	871	812	983	580	**4,067**	6
Effect of exposure to a chemical agent	493	508	680	1,004	596	**3,281**	5
Colitis, enteritis, and gastroenteritis	480	878	764	572	577	**3,271**	5
Allergic reactions	268	350	351	482	486	**1,937**	3
Rash and other skin eruptions	215	212	292	231	236	**1,186**	2
Heat exhaustion	62	127	266	98	222	**775**	1
Toxic effect of gases, fumes, and vapours	4	46	15	65	594	**724**	1
Dyspnoea and respiratory abnormalities	149	158	158	120	89	**674**	1
Other (includes 584 other types of illness and disease)	3,587	3,124	2,867	3,074	5,651	**18,303**	27

Note: Based on year claim registered with WSIB.

Figure 17: Top 10 Occupations for Occupational Disease Loss-Time WSIB Claims, 2014-2018

Source of data: Workplace Safety and Insurance Board

Occupation	2014	2015	2016	2017	2018	Total	%
Nurse Aides, Orderlies and Other Health Services Support Workers	495	503	532	417	427	**2,374**	18
Nurse Supervisors and Registered Nurses	207	212	155	158	225	**957**	7
Other Technical Occupations in Health Care (except Dental)	165	200	165	135	75	**740**	6
Cleaners	149	146	123	135	108	**661**	5
Police Officers and Firefighters	123	132	128	120	141	**644**	5
Motor Vehicle and Transit Drivers	70	89	103	81	128	**471**	4
Childcare and Home-Support Workers	82	84	98	90	108	**462**	3
Paralegals, Social Service Workers, and Occupations in Education	75	84	101	88	81	**429**	3
Other Occupations in Protective Service	43	69	76	101	115	**404**	3
Labourers in Processing, Manufacturing and Utilities	63	64	67	60	80	**334**	2
Other (includes 122 other occupations)	1,112	1,211	1,120	1,028	1,458	**5,929**	44

obtaining information on which to base decisions. Examples of these are developing and using existing exposure and disease-surveillance data (such as WSIB data, or the Occupational Cancer Research Centre's Occupational Disease Surveillance System Project) to inform priorities, better target prevention efforts and generate research questions; identifying what the current research reveals regarding emerging exposures to inform the health-and-safety prevention system; and exploring and evaluating workplace-exposure assessment tools (for all priority exposures).

Regarding data collected for occupational diseases, we found that WSIB data was not entirely useful because it had incomplete information on the occupation and employer of affected workers. Steps to be taken under the Plan may address this shortfall, including embedding a patient's occupation in the Electronic Medical Record maintained by their doctor to improve data on the relationship between work and health.

The ministries of Labour, Health, and Long-Term Care, jointly with the Public Health Agency of Canada, funded the Occupational Cancer Research Centre to develop a system to monitor patterns and trends in occupational disease in Ontario. The Ministry of Labour, Training and Skills Development's annual contribution is $475,000. The Occupation Disease Surveillance System, which was developed in 2016, is being used to study the link between occupation and certain types of cancer and non-cancerous diseases. The system combines data from the following sources: WSIB lost-time claims to identify persons with occupational illness; the Ontario Cancer Registry to identify persons diagnosed with malignant disease; and the OHIP database and the National Ambulatory Care Reporting System (which contains data for all outpatient medical services) to identify cases of non-malignant disease.

RECOMMENDATION 11

To continue to gain knowledge about and limit hazardous exposures in Ontario workplaces, and in order to reduce the incidence and burden of occupational disease, we recommend that the Ministry of Labour, Training and Skills Development continue completing the activities outlined in the Occupational Disease Action Plan (as listed in **Appendix 7** of this report), assess

the Plan's effectiveness periodically, and make adjustments if necessary.

MINISTRY RESPONSE

The Ministry agrees with the recommendation. The Ministry plans to continue to implement the Occupational Disease Action Plan. The Ministry will also use findings from the review being conducted by a consultant affiliated with the Occupational Cancer Research Centre to inform the Occupational Disease Action Plan.

The Ministry is currently developing Ontario's next five-year Occupational Health and Safety Strategy. The Ministry will incorporate the Occupational Disease Action Plan into the Strategy.

It is expected that in aligning with the objectives of the next strategy, the Ministry will be able to measure and report on effectiveness achieved.

4.6 Very Little Progress on Newer Initiatives Aimed at Reducing Health and Safety Risks at Mines in Ontario

In September 2014, the Ministry, in collaboration with employers, conducted a formal risk assessment to identify and rank the top areas posing health and safety hazards in underground mining operations in Ontario. The top three areas identified were ground-control stability (that is, avoiding a cave-in), occupational disease resulting from inadequate ventilation, and water management (that is, minimizing water accumulation to avoid ground erosion). In 2016, the Ministry conducted a similar risk assessment of surface-mining operations (which includes open-pit mines and quarries) and identified ground-control stability, water management, and traffic control as the hazard areas that pose the greatest risk to the health and safety of workers.

Following the initial review, the Ministry introduced two initiatives for the mining sector:

- **Comprehensive inspections:** In 2015, the Ministry began a large-scale inspection program to assess all mines for health-and-safety purposes. Whereas a regular inspection involves an inspector showing up unannounced and usually focusing on one area of the mine in a single day, this more comprehensive inspection involves a team of at least two mining inspectors and other technical-resource staff (such as hygienists, ergonomists, engineers, or electrical mechanical inspectors) inspecting the entire mining property over several days. Mine officials are notified six to eight weeks in advance of a comprehensive inspection.
- **Engineering reviews:** In 2016, the Ministry began an initiative to have all mining operations in the province undergo a mining engineering review focused on the top three hazards identified for underground mines and surface mines. Ministry engineers, accompanied by Ministry inspectors, were to conduct these reviews. The purpose of the reviews was to confirm that:
  - appropriate engineering studies and analyses were carried out at the design stage;
  - mitigating controls were in place to effectively address identified risks; and
  - operations were compliant with the mining regulation.

While both initiatives are valuable in assessing the health and safety of mining operations in the province, we noted that few comprehensive inspections and engineering reviews had been done in the three and four years since they began. The Ministry told us this was because it did not have the complement of mining inspectors available to complete these in addition to other inspections and investigations.

As of July 2019, the Ministry had completed comprehensive inspections for 15 of the 39 underground mines operating in the province and for eight surface mines. The Ministry does not know

the exact number of surface-mining operations in the province; however, we noted that the Ministry's information system identifies 548 open-pit and quarry sites. Meanwhile, the Ministry had completed engineering reviews of all three top hazards for only one of 39 underground mines and none of the surface-mining operations. The Ministry's plan was to complete all engineering reviews by July 2020. The Ministry confirmed that this plan was too ambitious to complete by that date.

For the engineering reviews that were done, we noted inconsistencies in the level of detail in reports completed by different engineers, even though the Ministry had developed a reporting template. Some reports ranged from a few pages with very little details while other reports gave a more comprehensive description of the review.

With respect to comprehensive inspections, we noted that there was no standard template for reporting results or checklists that clearly directed inspectors and other technical staff on what they should be evaluating. The Ministry told us that it is in the process of developing formal procedures for comprehensive inspections.

RECOMMENDATION 12

To help identify and correct health-and-safety risks to workers at mining operations, we recommend that the Ministry of Labour, Training and Skills Development:

- reassess the benefits of conducting further engineering reviews and comprehensive inspections and if these are determined to be beneficial, prioritize resources to conduct engineering reviews and/or comprehensive inspections for all underground mining operations and high-risk surface mining operations; and
- develop procedures for conducting engineering reviews and documenting results in a consistent manner.

MINISTRY RESPONSE

The Ministry will reassess the benefits of engineering reviews and comprehensive inspections from the lenses of benefit to employers; impact on reducing health-and-safety risks to workers; review of the volume and nature of orders issued (administrative orders versus high-risk hazard-related orders); and value with respect to informing ongoing enforcement activities.

The Ministry is currently developing procedures for conducting comprehensive inspections and plans to do the same for engineering reviews, with a view to maximize efficiency, standardize reporting, incorporate peer review and reduce the demand on resources.

4.7 Work Needed to Address Recommendations of Ministry's Action Plans to Reduce Workplace Health-and-Safety Incidents

As noted in **Section 2.1.3**, the Ministry has developed action plans for three of the sector programs—construction (2017), mining (2015) and health care (2016) regarding workplace-violence prevention). At the time of our audit, none of the plans had been fully implemented. Implementation rates ranged from 43% to 88%. See **Appendix 7** for the implementation status of each recommendation in the various plans.

We reviewed WSIB claims data for the period since each plan's implementation to determine whether the plans have had an impact on their respective sectors:

- With respect to the mining sector, from 2014 to 2018, the number of injury claims from workers decreased by 5% for lost-time injuries and non-lost injuries combined.
- In the health-care sector, the number of injury claims due to violence or harassment for nursing staff increased by 29% from 2016 to 2018. Most incidents occurred in hospitals, followed by long-term-care homes. In 2018,

90% of injuries resulted in lost-time claims. In the health-care sector overall, only 43% of the recommendations have been implemented.

- The impact of the other two plans was too early to assess. Given that both plans were released in 2017, only one year of claims data was available to assess impact. Furthermore, in the case of the occupational-disease plan, more time is necessary to assess the impact between the time of exposure to a workplace hazard and the time an illness appears.

RECOMMENDATION 13

To help prevent and reduce the occurrence of occupational-related fatalities and injuries in workplaces across the province, we recommend that the Ministry of Labour, Training and Skills Development:

- continue to implement the recommendations outlined in the various sector-specific action plans;
- measure the impact each plan has had toward achieving its objective; and
- based on the results of the impact achieved, assess a future course of action.

MINISTRY RESPONSE

The Ministry agrees and will work with our partners to implement recommendations from the sector-specific Action Plans.

The Ministry is currently developing Ontario's next five-year Occupational Health and Safety Strategy, and where appropriate, will incorporate the recommendations outlined in the various sector-specific Actions Plans.

It is expected that in aligning with the objectives of the next Strategy, the Ministry will be able to measure and report on effectiveness achieved.

Appendix 1: Health and Safety Associations Funded by the Ministry

Prepared by the Office of the Auditor General of Ontario

Health and Safety Association	Sector Served	Services Provided	Representation of the Oversight Board	Ministry Funding ($ million)					2017/18 Ministry Funding as % of Associations' Total Revenue
				2014/15	2015/16	2016/17	2017/18	2018/19*	
Designated Safe Workplace Associations									
Infrastructure Health and Safety Association (2010) 179 staff	Construction, electrical, utilities, aggregates, natural gas, ready-mix concrete, and transportation sectors.	Training, consulting, and information products. Only Ontario provider of the Certificate of Recognition (COR) accreditation program, which verifies that a construction-related company's health and safety program has reached a national standard.	57% union 43% private sector	25.1	23.9	23.9	24.1	24.9	73
Public Services Health and Safety Association (2010) 75 staff	Education, culture, community, health care, municipal and provincial government, and emergency services sectors.	Training, consulting, and information products.	47% private 33% public 20% union	8.2	8.3	8.8	9.5	8.5	75
Workplace Safety and Prevention Services (2009) 267 staff	Agricultural, industrial, manufacturing, and services sectors.	Training, consulting, and information products.	75% private 17% public 8% union	32.0	30.4	30.6	30.5	30.5	72
Workplace Safety North (2009) 77 staff	Mining and forest products industries, as well as businesses across northern Ontario.	Training, consulting, and information products. Ontario Mine Rescue Program: staffs, equips and maintains a network of mine rescue stations across the province to provide emergency response capability.	84% private 8% public 8% union	11.0	11.5	11.8	12.4	11.6	76

Health and Safety Association	Sector Served	Services Provided	Representation of the Oversight Board	Ministry Funding ($ million)					2017/18 Ministry Funding as % of Associations' Total Revenue
				2014/15	2015/16	2016/17	2017/18	2018/19*	
Designated Medical Clinic									
Occupational Health Clinics for Ontario Workers (1989) 46 staff	All workers and employers in Ontario	Clinical services to determine and treat work-related illnesses. Provide research information and online resources for outreach and education.	100% union	7.1	7.5	7.9	8.8	7.8	100
Designated Training Centre									
Workers Health and Safety Centre (1989) 56 staff	All workers and employers in Ontario	Training.	100% union	9.9	9.2	9.2	9.2	9.2	79

* Based on amounts in transfer payment agreements.

Appendix 2: Top 10 Lost-Time Injuries by Type, Cause, and Occupation of Worker, 2014–2018

Source of data: Workplace Safety and Insurance Board

Top 10		# of Injuries[1]	% of All Injuries 2014–2018
Type of Injury			
1.	Sprains and strains	121,761	44
2.	Bruises, contusions	25,432	9
3.	Fractures	23,720	9
4.	Cuts, lacerations, punctures	19,414	7
5.	Traumatic injuries, disorders, complications	18,206	7
6.	Concussions	15,006	6
7.	Multiple traumatic injuries	6,496	2
8.	Mental disorders or syndromes	5,943	2
9.	Abrasions, scratches and other superficial injuries	5,162	2
10.	Burn or scald (heat)	4,180	2
	Other (45 other types of injuries)	28,748	10
Total		**274,068**	**100**
Causes of Injury			
1.	Bodily reaction and exertion[2]	50,758	19
2.	Overexertion[3]	48,310	18
3.	Fall on same level	43,324	16
4.	Struck by objects or equipment	40,443	15
5.	Struck against objects or equipment	17,360	6
6.	Fall/jump to lower level	16,275	6
7.	Assaults, violent acts, harassment	13,338	5
8.	Caught in or compressed by equipment or objects	9,459	3
9.	Repetitive motion	7,962	3
10.	Highway accidents	6,243	2
	Other (17 other causes of injuries)	20,596	7
Total		**274,068**	**100**
Occupation			
1.	Motor Vehicle and Transit Drivers	20,320	7
2.	Labourers in Processing, Manufacturing and Utilities	13,787	5
3.	Cleaners	12,941	5
4.	Assisting Occupations in Support of Health Services	12,916	5
5.	Longshore Workers and Material Handlers	9,596	4
6.	Trades Helpers and Labourers	9,463	3
7.	Childcare and Home Support Workers	9,238	3
8.	Retail Salespersons and Sales Clerks	9,237	3
9.	Secondary and Elementary School Teachers and Counsellors	8,430	3
10.	Police Officers and Firefighters	7,109	3
	Other (131 other occupations)	161,031	59
Total		**274,068**	**100**

1. Based on the year injury occurred. Data does not include illnesses related to occupational disease.
2. Non-impact injuries resulting from assuming an unnatural position, whether from voluntary movements like climbing or twisiting or from involuntary motions induced by sudden noise, fright, or efforts to recover from slips or loss of balance (but not resulting in falls).
3. Injuries that occur when an employee pulls, lifts, pushes, or throws something, and the joint is forced to move beyond its normal range of motion or a muscle is pulled.

Appendix 3: Number of Field Visits by Sector Program and Type, 2014/15–2018/19

Source of data: Ministry of Labour, Training and Skills Development

Type of Field Visit	2014/15	2015/16	2016/17	2017/18	2018/19	Total	%
Consultations	**844**	**895**	**901**	**1,045**	**4,726***	**8,411**	**2**
Industrial Health and Safety Program	434	496	454	577	3,896	**5,857**	
Construction Health and Safety Program	269	267	303	325	658	**1,822**	
Mining Health and Safety Program	80	90	91	86	53	**400**	
Health Care Unit	61	42	53	57	119	**332**	
Inspections	**36,557**	**36,256**	**34,877**	**35,527**	**37,825**	**181,042**	**54**
Construction Health and Safety Program	17,391	15,282	17,443	17,426	17,614	**85,156**	
Industrial Health and Safety Program	15,984	17,939	14,784	15,077	16,886	**80,670**	
Mining Health and Safety Program	1,775	1,472	1,218	1,807	1,991	**8,263**	
Health Care Unit	1,407	1,563	1,432	1,217	1,334	**6,953**	
Investigations	**25,449**	**27,960**	**30,422**	**31,264**	**32,245**	**147,340**	**44**
Construction Health and Safety Program	6,326	7,275	8,610	8,521	8,035	**38,767**	
Industrial Health and Safety Program	16,878	18,404	19,230	20,080	21,348	**95,940**	
Health Care Unit	1,810	1,793	1,966	2,126	2,283	**9,978**	
Mining Health and Safety Program	435	488	616	537	579	**2,655**	
Total Field Visits	**62,850**	**65,111**	**66,200**	**67,836**	**74,796**	**336,793**	**100**

* Increase in consultations in 2018/19 compared to prior years is the result of a project by the Ministry to offer consultation and resources to small businesses newly registered with WSIB. To conduct this project, the WSIB provided the Ministry with a list of over 20,000 newly registered businesses.

Appendix 4: List of Regulations and Applicable Sectors under the *Occupational Health and Safety Act*

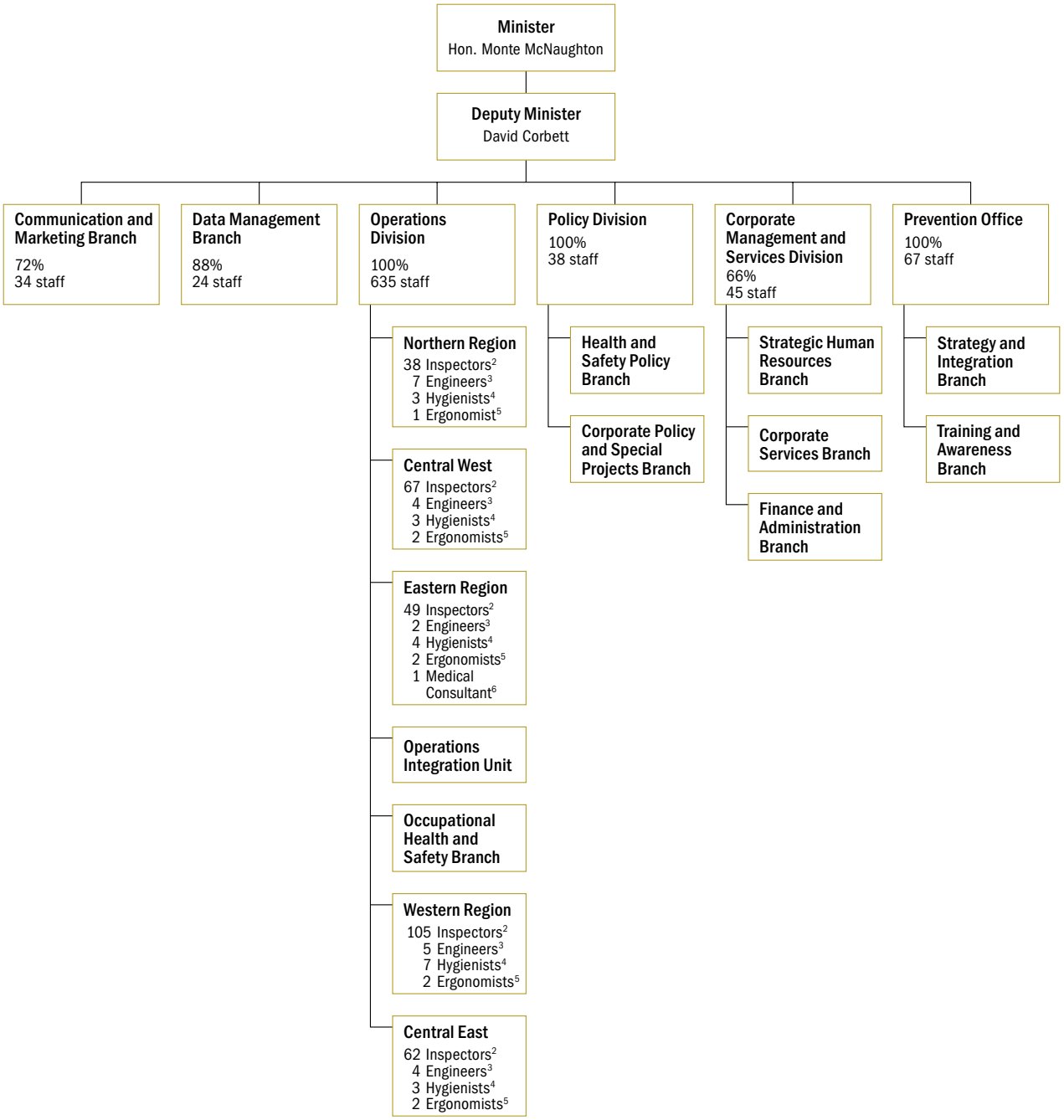
Source of data: Ministry of Labour, Training and Skills Development

Regulation	Last Update	Applicable Sector					
		Construction Projects	Industrial Establishments	Health Care and Residential Facilities	Mines and Mining Plants	Farming Operations	Other Workplaces
Sector-Based							
1. Construction Projects (O. Reg. 213/91)	Jul 1, 2019	✓					
2. Farming Operations (O. Reg. 424/05)	Jul 1, 2016					✓	
3. Firefighters – Protective Equipment (O. Reg. 714/91)	Mar 2, 2018						✓
4. Health Care and Residential Facilities (O. Reg. 67/93)	Apr 30, 2018			✓			
5. Industrial Establishments (Reg. 851)	Jul 1, 2019		✓				
6. Mines and Mining Plants (Reg. 854)	Jul 1, 2019				✓		
7. Oil and Gas Offshore (Reg. 855)	Jul 1, 2019						✓
Hazard-Based							
8. Confined Spaces (O. Reg. 632/05)	Jul 1, 2016	✓	✓	✓	✓		✓
9. Control of Exposure to Biological or Chemical Agents (Reg. 833)	Jan 1, 2018	✓	✓	✓	✓		✓
10. Designated Substance – Asbestos on Construction Projects and in Buildings and Repair Operations (O. Reg. 278/05)	Mar 2, 2018	✓	✓	✓	✓		✓
11. Designated Substances (O. Reg. 490/09)	Jan 1, 2018	✓	✓	✓	✓		✓
12. Needle Safety (O. Reg. 474/07)	Jul 1, 2010		✓	✓			✓
13. Noise Regulation (O. Reg. 381/15)	Jul 1, 2016	✓	✓	✓	✓	✓	✓
14. Roll-Over Protective Structures (Reg. 856)	Jun 28, 1991	✓	✓	✓	✓		✓
15. Workplace Hazardous Materials Information System (WHMIS) (Reg. 860)	Jan 21, 2019	✓	✓	✓	✓		✓

Regulation	Last Update	Applicable Sector					
		Construction Projects	Industrial Establishments	Health Care and Residential Facilities	Mines and Mining Plants	Farming Operations	Other Workplaces
Activity-Based							
16. X-Ray Safety (O. Reg. 861)	Mar 15, 2018	✓	✓	✓	✓		✓
17. Diving Operations (O. Reg. 629/94)	Mar 1, 2014						✓
18. Window Cleaning (O. Reg. 859)	Aug 28, 1992						✓
Administrative							
19. Criteria to be Used and Other Matters to Be Considered by the Board Under Subsection 46(6) of the Act (O. Reg. 243/95)	Jan 26, 2009	✓	✓	✓	✓	✓	✓
20. Critical Injury – Defined (O. Reg. 834)	Jun 28, 1991	✓	✓	✓	✓	✓	✓
21. Joint Health and Safety Committees – Exemption from Requirements (O. Reg. 385/96)	Jan 26, 2009	✓	✓	✓	✓		✓
22. Inventory of Agents or Combinations of Agents for the Purpose of Section 34 of the Act (O. Reg. 852)	Aug 28, 1992	✓	✓	✓	✓	✓	✓
23. Offices of the Worker and Employer Advisors (O. Reg. 33/12)	Apr 1, 2012	✓	✓	✓	✓	✓	✓
24. OHS Awareness and Training (O. Reg. 297/13)	Jul 1, 2019	✓	✓	✓	✓	✓	✓
25. Teachers (Reg. 857)	Jun 28, 1991						✓
26. University Academic and Teaching Assistants (Reg. 858)	Jun 28, 1991						✓

Appendix 5: Organizational Structure of Ministry of Labour - Occupational Health and Safety Staff

Source of data: Ministry of Labour, Training and Skills Development, data as of September 30, 2019



1. Total Staff – 843
2. Inspectors – 321
3. Engineers – 22
4. Hygienists[7] – 20
5. Ergonomists[8] – 9
6. Medical Consultant – 1
7. An occupational hygienist evaluates worker exposure to health hazards to help workers avoid sickness, impairment or discomfort.
8. An occupational ergonomist assesses whether the designs of systems, equipment and facilities provide the best levels of efficiency, comfort and health and safety for workers using them.

Appendix 6: Jurisdictional Comparison of Accountability for Occupational Health and Safety Functions

Source: Ministry of Labour, Training and Skills Development

	Regulation-Making	Prevention	Investigations	Enforcement	Prosecution	Insurance
British Columbia	WorkSafe British Columbia	WorkSafe British Columbia	WorkSafe British Columbia	WorkSafe British Columbia	Government	WorkSafe British Columbia
Alberta	Government	Government	Government	Government	Government	Workers Compensation Board
Saskatchewan	Government	WorkSafe Saskatchewan	Government	Government	Government	Workers Compensation Board
Manitoba	Government	SAFE Manitoba (Government/ WCB Partnership)	Government	Government	Government	Workers Compensation Board
Ontario	Government	Government	Government	Government	Government	Workplace Safety and Insurance Board
Quebec	Committee on Standards, Equity, Health and Safety	Committee on Standards, Equity, Health and Safety	Committee on Standards, Equity, Health and Safety	Committee on Standards, Equity, Health and Safety	Government	Committee on Standards, Equity, Health and Safety
Newfoundland and Labrador	Government	Workplace Health, Safety and Compensation Commission	Government	Government	Government	Workplace Health, Safety and Compensation Commission
New Brunswick	WorkSafe New Brunswick	WorkSafe New Brunswick	WorkSafe New Brunswick	WorkSafe New Brunswick	Government	WorkSafe New Brunswick
Prince Edward Island	Workers Compensation Board	Workers Compensation Board	Workers Compensation Board	Workers Compensation Board	Government	Workers Compensation Board
Nova Scotia	Government	Workers Compensation Board	Government	Government	Government	Workers Compensation Board
Yukon	Workers Compensation Board	Workers Compensation Board	Workers Compensation Board	Workers Compensation Board	Government	Workers Compensation Board
Northwest Territories/ Nunavut	Workers' Safety and Compensation Commission	Workers' Safety and Compensation Commission	Workers' Safety and Compensation Commission	Workers' Safety and Compensation Commission	Government	Workers' Safety and Compensation Commission

Note: Functions performed outside the respective ministry are shaded. These organizations are all government agencies.

Appendix 7: Implementation Status of Ministry Action Plans

Source: Ministry of Labour, Training and Skills Development

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
Preventing Workplace Violence in Health Care							
1.	Create transition teams – sustainable groups of experts that can assist and provide advice with the implementation of workplace violence prevention (WVP) tools and leading to improve a hospital's WVP journey to excellence.			✓			
2.	Create a workplace safety environmental standard for healthcare workplaces.	✓					
3.	Develop resources and supports to help hospitals create a psychologically safe and healthy workplace based on the CSA standard.			✓			
4.	Amend the Occupational Health and Safety Act to allow a designated worker member of the Joint Health and Safety Committee to be included in workplace violence investigations under certain circumstances.	✓					
5.	Amend the Occupational Health and Safety Act to create a requirement about the information to be provided to a worker who experienced a violent incident.	✓					
6.	Include more details on legislative compliance and requirements in the workplace violence section of the Ministry of Labour's (MOL) health-care sector plan.					✓	
7.	Strengthen workplace-violence language in Accreditation Canada's Required Organizational Practice.					✓	
8.	Strengthen workplace-violence language in Accreditation Canada's Standard.					✓	
9.	Amend the Ministry of Labour Policy and Procedure manual to ensure all risk assessments conducted by hospitals are adequate.					✓	
10.	Promote the use of all existing and future Public Service Health and Safety Association (PSHSA) Violence, Aggression and Responsive Behaviour tools in all Ontario hospitals.					✓	
11.	Ask the PSHSA, in collaboration with stakeholders, to develop additional tools to support: a. incident reporting and investigation (root-cause analysis); b. a code white (violent person); c. patient transit (inside the facility) and transfer (outside of the facility); and d. work-refusal procedures.			✓			
12.	Develop specific supplementary tools through the Leadership Table in the second phase and out-years of the project.					✓	

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
13.	Provide more supports for patients with known aggressive or violent behaviour within health-care facilities and in the community.	✓					
14.	Create and implement a standard provincial form/process to engage a patient and/or family/caregiver in developing a patient's care plan that includes safety for workers.	✓					
15.	Work with the College of Nurses of Ontario to provide more clarity related to nurses' right to refuse to provide care to patients in hazardous situations, where the hazard is workplace violence.					✓	
16.	Require post-secondary institutions to provide students with enhanced training in workplace violence and prevention before entering the workforce.					✓	
17.	Develop and implement a consistent minimum provincial training standard for those performing the role or function of providing security in hospitals.					✓	
18.	Address issues related to workplace-violence incident reporting systems.			✓			
19.	Include workplace-violence prevention in Quality Improvement Plans.					✓	
20.	Create consistent communication protocols between hospitals and external care environments to limit the risk of violence to health-care workers and patients.			✓			
21.	Expand an existing communication protocol to prepare a health-care facility to receive an incoming patient for a psychiatric assessment.			✓			
22.	Implement a joint ministry public campaign regarding the Workplace Violence Prevention in Health Care project.			✓			
23.	Post information about all MOL fines against employers in health care under $50,000.		✓				
Total		**5**	**1**	**7**	**0**	**10**	**0**
Construction Health and Safety Action Plan							
1.	Infrastructure Health and Safety Association (IHSA) to develop an advanced training program – Communications Skills for Supervising Health and Safety.						✓
2.	IHSAs Keep Your Promise campaign.						✓
3.	Occurrence information on fatality incidents, and relevant prevention resources, posted on the MOL website post-event.						✓
4.	MOL to develop annual enforcement plans that focus on workplace hazards and health-and-safety issues for different sectors, including construction.						✓
5.	Construction supervisors added as a topic in Canadian Centre for Occupational Health and Safety (CCOHS)/IHSA web tool.					✓	
6.	System partners prioritize noise in the workplace, including year-long campaign.					✓	

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
7.	Working at Heights (WAH) communications campaign to raise awareness about WAH training requirements.					✓	
8.	IHSA initiative to communicate health-and-safety information to consumers and contractors throughout the supply chain.						✓
9.	Creation of resources that can be used by supervisors.					✓	
10.	MOL and partners to promote Foundations of Safety Leadership Module.					✓	
11.	MOL to help build a knowledge base through Prevention Office's Research Opportunities Program.				✓		
12.	Leadership and worker participation toolkit for small construction companies.					✓	
13.	MOL to promote employee recognition programs that encourage workers to report unsafe work practices.		✓				
14.	Partner with construction associations and labour groups to distribute resources to construction employers, supervisors and workers.						✓
15.	Translate IHSA's Working at Heights material into 10 different languages, and pilot the delivery of WAH in those languages using translators.					✓	
16.	Partner with the City of Toronto to promote health-and-safety resources and information.					✓	
17.	MOL to work with other municipalities to expand relationships based on the model with the City of Toronto.		✓				
18.	MOL to explore partnering with approved training providers to utilize existing registries of learners as a means to distribute health-and-safety resources.					✓	
19.	MOL to work with system partners to complete a scan of existing system resources in priority areas and create resources where needed.					✓	
20.	Develop a small-business tool-kit based upon small construction employers' priorities.					✓	
21.	The MOL to partner with the Ontario Cooperative Education Association (OCEA), IHSA and PSHSA to gather occupational health-and-safety resources for teachers.						✓
22.	The MOL to work with Ministry of Education regarding training requirements under the Occupational Health and Safety Act and the Regulation for Construction projects.						✓
23.	The MOL to create a strategy for career-long health-and-safety learning for the construction sector.					✓	
24.	The MOL to work with the Ministry of Advanced Education and Skills Development and the Ontario College of Trades to develop opportunities to include more health-and-safety training into apprenticeship training.				✓		

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
25.	MOL to develop guidance information when proposing regulatory changes and work with partners and stakeholders to ensure its development as needed.						✓
26.	MOL will work with CCOHS and IHSA to ensure that topics included in the H&S mobile app are updated should there be amendments or new requirements.						✓
27.	University-level engineering students will collaborate with residential construction and roofing-industry stakeholders and fall-protection-system experts to find innovative approaches to the use of existing equipment.						✓
28.	CCOHS and IHSA to develop a web tool to include health-and-safety resources to assist employers and workers in understanding what the law requires.					✓	
29.	The MOL has focused on working at heights and residential roofing through WAH training, enforcement initiatives and the Underground Economy Residential Roofing Pilot Project.					✓	
30.	The MOL to work with partners to create plain-language resource materials to assist in the interpretation of existing legislative and regulatory requirements.					✓	
31.	The Chief Prevention Officer (CPO) to work with stakeholders and the Ministry of Municipal Affairs to explore opportunities and implementation challenges to enhance health and safety in the residential-construction sector.						✓
32.	The MOL to develop a resource kit on key construction OHS issues for small employers that can be provided by Ministry Inspectors at time of inspection.						✓
33.	The MOL to review the current schedule of offences for tickets related to contraventions of the construction regulations and set fine amounts.					✓	
34.	The MOL to explore the use of Administrative Monetary Penalties (AMPs) and consider the penalty amounts that would be recommended under such a system and to which contraventions they would apply.					✓	
35.	The CPO to consult with stakeholders regarding the implementation of an “Accreditation” program.					✓	
36.	MOL to initiate partnerships with municipalities to pilot a web-based application that allows municipal building inspectors to report unsafe work practices.					✓	
37.	The MOL Central West Region to partner with the IHSA, the OMCA, and the MCAT to run their Falls from Elevation: Scaffolding and Platform Initiative.					✓	
38.	The MOL to partner with the IHSA and ESA to deliver orientation sessions for inspectors on specific electrical hazards that will be the focus of inspections.					✓	
39.	Safe At Work Ontario consultations have identified possible inspection initiatives for the construction program in 2017-18.					✓	

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
40.	Ministry of Labour to develop inspection priorities and strategies based upon the risk assessments that were conducted for construction and residential renovations with worker and employer representatives.						✓
41.	The MOL to explore opportunities to include additional notification requirements of high-risk construction activities, such as residential roofing.				✓		
Total		**0**	**2**	**0**	**3**	**22**	**14**
Mining Health, Safety and Prevention Review							
1.	The Ministry of Labour supported by all relevant health-and-safety system partners and subject matter experts, to undertake a Mining Sector Risk Assessment with employers and labour every 3 years.					✓	
2.	The Ministry of Labour to require employers in the mining sector to conduct risk assessments, which would include measures and procedures to control the risks identified in the assessment as likely to expose a worker to injury and illness. The joint health and safety committee, health and safety representative or workers, are to be consulted on the risk assessment. Employer risk reassessments are to be done as often as necessary to ensure programs that result from the assessment continue to protect workers.					✓	
3.	The Ministry of Labour to work with its Research Advisory Council to focus its grants and research on topics that address the priority hazards identified in the Mining Sector Risk Assessment, and disseminate and act upon the findings where appropriate.			✓			
4.	The Mining Legislative Review Committee to align the majority of its work with the major hazards identified in the sector level risk assessment exercise.					✓	
5.	The Ministry of Labour to require that mining employers address the priority hazards identified in the risk-ranking exercise.			✓			
6.	The Ministry of Labour to review existing occupational exposure limits for a number of key airborne and chemical hazardous substances in underground mines with a view to giving further consideration to the limits for those substances and, if appropriate and advisable, amend Regulation 833. Priority to be given to a review of the occupational exposure limits for silica, nitrogen dioxide and diesel particulate matter (DPM). Other hazards to be considered include sulfur dioxide and radon.			✓			
7.	The Ministry of Labour to require mine operators to establish and implement a written management of change procedure, to include workers and the joint health and safety committee or health and safety representative.			✓			

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
8.	The Ministry of Labour to require mining companies to conduct risk assessments to establish Emergency Response Plans for exploration sites, new mines, surface mines and mining plants.			✓			
9.	Workplace Safety North to revise the Mine Rescue Handbook to include guidelines for fitness of crew members, critical-incident stress management and acclimatization of emergency responders.			✓			
10.	The Ministry of Labour to work with stakeholders to develop proposed recommendations regarding the responsibilities of mine rescue crew members and mine owners/employers, with respect to mine-rescue operations.	✓					
11.	Requiring the Mining Tripartite Committee, which supports the development of Common Core training, to present to the ministries of Labour and Training, Colleges and Universities options and recommendations to enhance supervisor and management health-and-safety training. Requesting the Mining Tripartite Committee to review the pre-requisites for Supervisor Common Core training and determine the best format for this training (e.g., classroom learning, hands-on experience).			✓			
12.	The Ministry of Labour to engage in discussions with the Ministry of Training, Colleges and Universities about the quality and consistency of Common Core training in the underground mining sector, evaluate the current state of that training delivery and identify circumstances where refresher training may be appropriate.			✓			
13.	The Ministry of Labour and the relevant Health and Safety Associations to increase their capacity to ensure the health-and-safety system has the resources to address mining hazards effectively – particularly the priority hazards identified in the risk-ranking exercise.					✓	
14.	The Ministry of Labour to review its policies and procedures that apply to mining inspectors related to unannounced field visits, reprisals, repeat orders, the training of inspectors and the provision of information to workplace parties and how those policies and procedures are implemented. Take appropriate actions based on the findings of that review.					✓	
15.	The Ministry of Labour and its partners to review the health-and-safety system's ability to meet the needs of the mining sector, especially related to providing services to remote communities, training small numbers of trainees, and aligning their training activities to the priority hazards. Take appropriate actions based upon the findings of that review.			✓			

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
16.	The Ministry of Labour to work with the Ministry of Community Safety and Correctional Services to enhance the information supplied to the Chief Coroner's Office and build better linkages between both ministries.					✓	
17.	The Ontario Mining Association to work with labour representatives to develop an Internal Responsibility System best practice guideline as an industry benchmark and to be endorsed by the Ontario Mining Association for implementation by its members.					✓	
18.	The health-and-safety system to share information both on emerging injury and illness trends, and information on incidents causing serious injury across the industry to trigger preventative actions by workplace parties.					✓	
Total		**1**	**0**	**9**	**0**	**8**	**0**
Occupational Disease Action Plan							
1.	Develop a strategy to embed "Occupation" and potentially other links to work into the Electronic Medical Record being led by e-Health Ontario and OntarioMD, to improve data on the relationship between work and health.			✓			
2.	Develop a plan for obtaining occupational-exposure baseline data from Ontario workplaces to focus and support action to prevent occupational disease.			✓			
3.	Develop and use existing exposure- and disease-surveillance data (e.g., WSIB data, OCRC Occupational Disease Surveillance System Project) to inform priorities, better target prevention efforts and generate research questions.			✓			
4.	Conduct a jurisdictional scan to review occupational-disease legislation, regulations and guidelines in other jurisdictions.						✓
5.	Conduct a jurisdictional scan of prevention initiatives aimed at reducing workplace exposure to hazardous levels of noise, to explore potential prevention initiatives for Ontario.			✓			
6.	Identify priority irritants and allergens for skin and lung disease to focus action-plan activities.					✓	
7.	Identify what the current research reveals regarding emerging exposures to inform the health-and-safety prevention system; and develop future research questions (to fill knowledge gaps).			✓			
8.	Explore and evaluate workplace-exposure assessment tools (for all priority exposures).			✓			
9.	Assess worker knowledge of allergens and irritants (skin and lung) to target awareness efforts (e.g., survey tool).	✓					

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
10.	Integrate Action Plan priorities into MOL Research Programs (e.g., Research Opportunities Program).				✓		
11.	Develop and implement a communications and marketing plan focusing on raising awareness of harm and prevention with respect to the priority exposures: noise and/or allergens and irritants and/or diesel hazards in the workplace, with an underlying theme of general occupational-disease prevention.					✓	
12.	Target specific sectors to raise awareness of priority allergens and irritants (potential for focus on employers).					✓	
13.	Deliver educational opportunities and resources to increase the health-and-safety knowledge of individuals within the health-and-safety system on priority exposures (noise, allergens and irritants, and diesel) and general occupational-disease incidence and prevention (e.g., Occ-tober).					✓	
14.	Target advisory and support services to workplaces falling under the expanded noise regulation.					✓	
15.	Target advisory and support services to the action plan priority exposures for specific sectors.						✓
16.	Inventory and align system educational resources to promote occupational-disease prevention. Initially focusing on the priorities of noise, allergens/irritants, diesel and general occupational-disease awareness.					✓	
17.	Identify any gaps and a process to develop new resources to address them and/or support ODAP and system partners' ongoing occupational-disease efforts.			✓			
18.	Review mandatory training initiatives and standards to identify opportunities to add or strengthen occupational-disease prevention content.			✓			
19.	Inventory and align existing system-training initiatives to promote occupational-disease prevention, initially focusing on the priorities of noise, allergens/irritants, diesel and general occupational-disease awareness.					✓	
20.	Identify any gaps and a process to develop new training initiatives or standards to address them and/or support ODAP and system partners' ongoing occupational-disease efforts.					✓	
21.	Develop and deliver health-care practitioner education on general and specific occupational-disease topics (e.g., work-related asthma).			✓			
22.	Integrate awareness of occupational-disease exposures (irritants and allergens- skin and lung) into career counselling and vocational services.			✓			
23.	Provide/recommend tools to JHSC for health-hazard identification and management.					✓	

Action Item #	Recommendation	No Work Begun	Planning	In Progress	On Hold	Complete	Ongoing
24.	Develop enforcement strategies for occupational-disease priorities.						✓
25.	Explore the National Institute for Occupational Health and Safety's "Buy Quiet" program and potential applicability for Ontario.			✓			
26.	Explore the integration of occupational-disease and priority exposures with WSIB on premium or prevention program projects (e.g., Workwell).						✓
27.	Explore opportunities to incorporate occupational-disease elements into accreditation programs (e.g., assurance of controls, proper equipment/ventilation).			✓			
28.	Review and consider opportunities for regulatory changes.						✓
Total		**1**	**0**	**12**	**1**	**9**	**5**
Total # for all plans combined		**7**	**3**	**28**	**4**	**49**	**19**
Total % for all plans combined		**6**	**3**	**25**	**4**	**45**	**17**

Appendix 8: Types of Compliance Orders and the Number Issued by Program Sector and Type

Source of data: Ministry of Labour, Training and Skills Development

Types of Compliance Orders	
Type of Orders (by severity)	**Description of Order**
Stop-work order	Stops work or the use of any place, equipment, machine, device or thing or any process or material until the related contravention order is complied with.
Forthwith order	Issued to comply immediately with a provision of the Act, or a Regulation. Compliance must be achieved by the time the inspector leaves the workplace.
Time-based order	Specifies the period of time within which compliance must be achieved. The length of time given to comply is at the discretion of the inspector.
Time-unknown order	Does not specify a date for completion. This order must be accompanied by a stop-work or compliance plan order.
Compliance-plan order	Specifies the date by which a compliance plan must be received by the Ministry. The compliance plan must specify how the workplace plans to comply with the order and the date by which compliance will be achieved. The inspector is to make a field visit to verify compliance has been achieved.
Requirement	Issued to gather further information, or to determine/verify compliance, e.g., conduct a noise assessment and provide documentation.

Orders Issued by Sector, 2014/15–2018/19							
Sector Program	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**	**Average**	**%**
Industrial	65,465	70,151	54,839	60,894	63,119	62,894	50
Construction	55,967	47,291	55,372	55,348	57,100	54,216	43
Mining	4,804	4,248	3,773	5,749	5,854	4,886	4
Health Care	4,259	4,885	4,086	3,186	3,527	3,989	3
Total	**130,495**	**126,575**	**118,070**	**125,177**	**129,600**	**125,983**	**100**

Orders Issued by Type, 2014/15–2018/19					
Order Type (in order of severity)	**2014/15**	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Stop-use/Stop-work order	7,908	6,923	6,923	7,179	7,384
Forthwith order	35,764	27,006	29,443	31,209	31,241
Time-based order	70,269	76,993	66,124	70,505	74,611
Time-unknown order	10,679	9,588	9,188	9,834	9,911
Compliance-plan order	932	1,036	874	857	784
Requirements	4,943	5,029	5,518	5,593	5,669
Total	**130,495**	**126,575**	**118,070**	**125,177**	**129,600**

Type of Orders Issued by Sector, 2018/19					
Order Type (in order of severity)	**Construction**	**Industrial**	**Health Care**	**Mining**	**Total**
Stop-use/Stop-work order	5,071	1,858	23	432	**7,384**
Forthwith order	25,799	4,605	198	639	**31,241**
Time based order	16,575	51,435	3,024	3,577	**74,611**
Time-unknown order	6,970	2,138	28	775	**9,911**
Compliance-plan order	61	507	44	172	**784**
Requirements	2,624	2,576	210	259	**5,669**
Total	**57,100**	**63,119**	**3,527**	**5,854**	**129,600**

Appendix 9: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Processes are in place to identify regulated workplaces and a risk-based approach is used to identify from these workplaces candidates for proactive inspections.
2.	Inspections and investigations are conducted by qualified and well-trained staff. There is effective oversight of the inspection process to ensure efficient and quality occupational health and safety inspections are conducted consistently and on a timely basis across the province.
3.	Processes are in place to promptly investigate all workplace fatalities and critical injuries, and to effectively prioritize inspections of less serious work-related incidents and complaints based on the level of urgency.
4.	Inspections are completed in accordance with ministry policy and key regulatory requirements, and issues identified during inspections are documented and followed up to ensure corrective action is taken on a timely basis. Enforcement tools and penalties are applied consistently and in accordance with legislation to deter future occurrences.
5.	Procedures are in place to ensure that funding to health and safety associations and other transfer payment recipients for prevention activities is being used as intended with due regard for economy and efficiency, and that unspent funding is recovered.
6.	Appropriate measures are in place to monitor the performance of the Occupational Health and Safety Program against established expectations and to assess the effectiveness of the program in achieving legislated and stated goals. Performance results are publicly reported.
7.	Systems are in place to collect and maintain timely, accurate and complete information for decision making on occupational health and safety programs and enforcement.

Appendix 10: Publicly Reported Occupational Health and Safety Performance Measures

Source of data: Ministry of Labour, Training and Skills Development, Annual Reports

Performance Measures	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Measures Relating to Worker Deaths										
Traumatic Fatalities[1]	77	85	94	78	102	81	72	72	81	85
Traumatic Fatality Rate (per 100,000 workers)	1.32	1.43	1.55	1.28	1.64	1.29	1.13	1.12	1.24	1.28
Occupational-Disease Fatalities[2]	170	174	164	164	141	152	154	136	146	1.43
Occupational-Disease Fatality Rate (per 100,000 workers)	2.91	2.93	2.70	2.68	2.26	2.42	2.43	2.12	2.23	2.15
Measures Relating to Worker Injuries										
Critical Injuries[3] Reported	1,166	1,104	966	1,147	1,130	1,095	873	938	1,898	2,115
Critical-Injury Rate (per 100,000 workers)	19.94	18.57	15.91	18.77	18.13	17.41	13.75	14.62	28.97[4]	31.78
Lost-time Injury Claims[5]	64,843	60,200	56,672	55,525	54,430	53,688	51,570	57,368	59,529	64,855
Lost-time Injury Rate – Schedule 1 Employers[6] (per 100 workers)	1.27	1.15	1.05	1.01	0.95	0.92	0.85	0.94	0.95	1.00
Lost-time Injury Rate – Schedule 2 Employers[7] (per 100 workers)	2.10	2.00	1.91	1.85	1.85	1.90	1.80	1.96	2.04	2.17
No Lost-time Injury Claims[8]	131,843	123,852	123,675	124,019	125,328	125,524	122,133	121,500	126,251	129,759
No Lost-time Injury Rate – Schedule 1 Employers[6] (per 100 workers)	2.93	2.71	2.64	2.59	2.53	2.49	2.36	2.31	2.36	2.36
No Lost-time Injury Rate – Schedule 2 Employers[7] (per 100 workers)	2.36	2.16	2.12	2.07	2.18	2.22	2.09	2.05	2.03	2.04

1. Traumatic Fatalities—Workers who died of a work-related traumatic incident in the year specified. Excludes claims from workers who died while in receipt of 100% permanent disability benefits granted under a pre-1990 legislative framework.
2. Occupational-Disease Fatalities—Death of a worker due to a health problem caused by exposure to a workplace health hazard, in the year specified.
3. Critical Injuries Reported—Injuries include only those that have been reported to the Ministry and not necessarily critical injuries as defined by the Occupational Health and Safety Act. The Ministry investigates workers covered by the Occupational Health and Safety Act. Critical injuries in the Ministry's data systems may include non-workers who were injured at a workplace because the hazard that injured the non-worker may also pose a threat to workers.
4. According to the Ministry, the increase in critical injuries in 2017/18 was due to the Ministry expanding the definition of a "critical injury" in September 2016 to include fractures of the wrist, hand, ankle, foot, multiple fingers and toes. Legislation defines a critical injury as an "injury of a serious nature" that "involves the fracture of a leg or arm but not a finger or toe." The Ministry decided to interpret the definition to include fractures to the above-named body parts. The Ministry's data does not allow for isolation of the variance due to the definition change.
5. Lost-Time Injury Claims—Created when a worker suffers a work-related injury/disease that results in one of the following: being off work past the day of accident, loss of wages/earnings or a permanent disability/impairment.
6. Schedule 1 Employer—These employers pay premiums to WSIB and in return WSIB is liable to pay benefit compensation for workers' claims.
7. Schedule 2 Employer—These employers self-insure the payment of compensation benefits for workers' claims.
8. No Lost-Time Injury Claim—Results from a work-related injury where no time is lost from work other than on the day of accident, but where health-care is required. The health-care costs resulting from the injury are paid by the Workplace Safety and Insurance Board.

Appendix 11: Number and Percentage of Companies with the Same Contravention on at Least Two Occasions, 2013/14–2018/19

Source of data: Ministry of Labour, Training and Skills Development

	Total # of Businesses Issued Orders	# of Business Issued Orders for the Same Type of Offence on Multiple Occasions	% of Total Businesses with Repeat Offences
Construction Sector			
Orders Issued (excluding stop-work orders)			
Falls Protection	4,165	2,698	65
Lack of Personal Protective Equipment	4,314	2,502	58
Improper Access and Egress	3,499	1,923	55
Improper Use and Handling of Ladders and Scaffolding	2,592	1,044	40
Electrical Hazards	2,267	926	41
Stop-Work Orders Issued			
Falls Protection	1,986	651	33
Improper Access and Egress	1,165	332	28
Improper Use and Handling of Ladders and Scaffolding	710	125	18
Other Equipment Contraventions	504	80	16
Electrical Hazards	405	43	11
Industrial Sector			
Orders Issued (excluding stop-work orders)			
Workplace Violence and Harassment	4,011	1,413	35
Health and Safety Representative and Joint Health and Safety Committee Contraventions	3,881	1,383	36
Lack of Equipment, Material, and Protective Device Maintenance	3,453	1,099	32
Lack of Machine and Equipment Guarding	2,575	813	32
Improper Material Handling	2,633	754	29
Stop-Work Orders Issued			
Lack of Equipment, Material, and Protective Device Maintenance	801	101	13
Lack of Machine and Equipment Guarding	668	83	12
Other Equipment	251	8	3
Improper Material Handling	206	9	4
Lack of Training	157	10	6
Health-Care Sector			
Orders Issued (excluding stop-work orders)			
Workplace Violence and Harassment	462	184	40
Lack of Measures and Procedures	332	169	51
Equipment, Materials, Protective Devices not Maintained in Good Condition	270	100	37
Health and Safety Representative and JHSC Contraventions	272	81	30
Housekeeping and Work Surfaces	203	54	27

	Total # of Businesses Issued Orders	# of Business Issued Orders for the Same Type of Offence on Multiple Occasions	% of Total Businesses with Repeat Offences
Stop-Work Orders Issued			
Equipment, Materials, Protective Devices not Maintained in Good Condition	15	2	13
Lack of Machine and Equipment Guarding	14	2	14
Improper Use and Handling of Ladders and Scaffolding	8	0	0
Mining Sector			
Orders Issued (excluding stop-work orders)			
Poorly Maintained or Unguarded Conveyors	301	162	54
Lack of Equipment, Material, and Protective Device Maintenance	290	159	55
Traffic Management	377	201	53
Electrical Hazards	205	98	48
Lack of Machine/Equipment Guarding	260	129	50
Stop-Work Orders Issued			
Poorly Maintained or Unguarded Conveyors	130	34	26
Lack of Equipment, Material, and Protective Device Maintenance	113	31	27
Lack of Machine/Equipment Guarding	95	29	31
Electrical Hazards	56	11	20
Improper Access and Egress	58	15	26

Appendix 12: Occupational-Disease Claims by Sector Program, 2014-2018*

Source of data: Workplace Safety and Insurance Board and Statistics Canada

Program Sector	2014	2015	2016	2017	2018	Total
Industrial	**8,025**	**8,336**	**8,421**	**9,282**	**10,636**	**44,700**
Municipal	1,749	1,817	1,947	2,017	2,215	**9,745**
Manufacturing	1,464	1,534	1,474	1,470	1,790	**7,732**
Retail and Services	1,127	1,203	1,201	1,417	1,586	**6,534**
Education	770	772	760	896	1,063	**4,261**
Other Provincial Ministries and Government Organizations	455	535	599	753	844	**3,186**
Transportation	515	536	498	558	675	**2,782**
Automotive	336	291	331	406	446	**1,810**
Food	244	278	267	269	343	**1,401**
Other	1,365	1,370	1,344	1,496	1,674	**7,249**
Health Care	**3,600**	**3,396**	**2,971**	**3,199**	**3,382**	**16,548**
Construction	**1,002**	**1,056**	**1,184**	**1,208**	**1,343**	**5,793**
Mining	**227**	**244**	**216**	**230**	**258**	**1,175**
Total	**12,854**	**13,032**	**12,792**	**13,919**	**15,619**	**68,216**

* Based on year claim was registered with WSIB

Ministry of the Solicitor General

Office of the Chief Coroner and Ontario Forensic Pathology Service

1.0 Summary

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) that operates within the Ministry of the Solicitor General has a broad mission to conduct high-quality death investigations that support the administration of justice and the prevention of premature death. The Office conducts investigations and inquests to ensure that no death will be overlooked, concealed or ignored, and establishes death review committees that have specialized expertise in certain types of deaths to support death investigations. Recommendations made through these processes help improve public safety and prevent death in similar circumstances.

Since 2009, the Office has been led by both a Chief Coroner, responsible for death investigations and the work of coroners and inquests, and a Chief Forensic Pathologist, responsible for the work of forensic pathologists and pathologists who perform autopsies. The Office's total expenditures for both coroner and pathology services in 2018/19 were about $47 million. It employs about 131 permanent, full-time staff, and through fee-for-service arrangements, about 350 licensed physicians who work as coroners and about 100 pathologists and forensic pathologists. In 2018, the Office conducted about 17,000 death investigations. In almost half of these cases, an autopsy was performed.

Coroners perform death investigations for types of deaths defined by the *Coroners Act* (Act)—mostly those that are sudden and unexpected. Coroners in Ontario are physicians, or medical doctors, who usually have a medical practice in addition to their fee-for-service work as coroners. Currently about 70% of the about 350 licensed physicians who work as coroners have a background in family medicine.

Coroners investigate to answer five key questions: who is the deceased, when did the death occur, where did the death occur, how did the person die, and by what means (also called "manner of death"), such as whether the death will be classified as natural, accidental, a homicide or a suicide. When a manner of death cannot be determined based on available facts, the coroner will determine the manner of death to be undetermined. In almost half of all death investigations, coroners ordered additional tests, most often an autopsy, because they could not answer these five questions after an initial assessment. The 117 pathologists and forensic pathologists in Ontario who perform autopsies are physicians who specialize in disease and injury. The police, the criminal justice system and the family of the deceased rely on the findings of the Office, particularly death investigation reports after a sudden or unexpected death occurs.

In some cases, most of which are defined in the Act, the Office holds an inquest. Cases may also be forwarded to a death review committee for additional review. The Office has five specialized

committees—for example, for deaths of children and youth and deaths that result from domestic violence. The Death Investigation Oversight Council oversees the Office. It provides non-binding recommendations to the Office on a wide range of areas including finance, strategy and quality assurance.

Overall, our audit found that the Office does not have effective processes to demonstrate that its coroners and pathologists consistently conduct high-quality death investigations, and does not sufficiently analyze data or follow up on the implementation of its recommendations to improve public safety and to help prevent further deaths.

We found that coroners perform death investigations with little supervision and many deficiencies have gone undetected. Coroners have performed death investigations on 132 of their former patients, billed for more than 24 hours of coroner and physician services in one day, and conducted death investigations while under practice restrictions by the College of Physicians and Surgeons of Ontario (College). The Office was unaware of some of these issues before we brought them to its attention. These cases involve about 11% of the province's coroners, and they highlight risks to the integrity of the death investigation system.

Pathologists' work is also a critical component of the death investigation process because coroners often rely on autopsy reports. Autopsy findings can indicate if a death was natural or caused by something or someone else. The Office made improvements to autopsy quality assurance after a 2008 provincial inquiry made recommendations to improve the integrity and reliability of the province's death investigation system. A key improvement was the creation of a pathologist register to help ensure the assigned pathologists could, in each case, competently conduct the autopsy. For example, only pathologists with training and experience in pediatric autopsies are permitted to perform them.

However, our review of quality assurance processes on pathologists' work noted deficiencies. For example, the Office's policy requires autopsy reports of criminally suspicious cases to be peer-reviewed by a centrally assigned reviewer on a rotation list. However, some forensic pathologists do not follow this process and instead choose their reviewer. Choosing a reviewer can lead to bias in the review process and unintended consequences in the criminal justice system. As well, while the Office's policy requires 10% of each pathologist's autopsy cases on non-criminally suspicious deaths to be reviewed, only 5% in some cases were reviewed, leading to a risk that errors were not identified and corrected.

We found that the Office did not centrally track the errors of pathologists and forensic pathologists. Some of these errors required intervention, such as additional training or even removal from the register. As well, the Office does not have policies to guide its actions when performance issues are identified with a pathologist or forensic pathologist. As a result, the Office cannot ensure that it applies consistent interventions for performance concerns of all the forensic pathologists and pathologists working across the province and determine whether actions taken are effective.

Our other observations include:

Quality Assurance on Coroner Reports

- **Regional supervising coroners did not always identify coroners' errors through their review of coroner reports.** The only structured training required for a physician to work as a coroner is a five-day course, with neither a check to ensure course completion nor a competency examination. Refresher training is only required after the initial course if quality issues are identified. However, the Office's quality assurance unit identified significant errors in 18% of the 2017 coroner reports. The reports were incorrect, incomplete, or did not meet the standards of the Office—even after the regional supervising coroners had reviewed them.

- **There is no policy on suspending or removing coroners.** The Office does not have a documented policy for suspension or removal of coroner appointments for those under practice restrictions by the College of Physicians and Surgeons of Ontario. We found that 16 coroners had performed death investigations while under practice restrictions by the College. One of these coroners was restricted by the College from prescribing narcotics in 2012 but had investigated 19 cases since then where the death was as a result of drug toxicity.

Body Storage Weaknesses

- **Weaknesses exist in body storage practices in hospital-based regional forensic pathology units.** Bodies that need autopsies are often stored with other bodies in the hospital morgue. In 2019, one regional unit conducted an autopsy on the wrong body. Due to limited capacity, regional units have stored bodies in hospital hallways and other rooms.

Data on Death

- **The Office misses the opportunity to make more effective use of its death investigation data to identify actions to improve public safety and reduce preventable deaths.** The Office has a significant amount of data, such as circumstances of death, and age and gender of deceased persons, that it does not use to study and to then recommend ways to reduce further deaths. Most often, the Office uses its data to respond only to current, high-profile issues.
- **Deaths are not always reported to the Office as required by law.** In 2018, about 2,000 deaths, including those that resulted from pregnancy, fractures, dislocations or other trauma, were under-reported to the Office and so not investigated.
- **Coroners are not required to document reasons for deciding that a death investigation was not necessary.** The Office does not require its coroners to provide it with documented reasons when they conclude a death investigation is not needed. While the Office does not track how frequently coroners do not provide reasons, our audit found that in about 56% of the cases we sampled, the coroner did not do so.

Governance and Recommendations Not Sufficiently Addressed

- **The Death Investigation Oversight Council is not effectively fulfilling its legislative mandate to oversee the Office due to its limited authority.** The Council is the primary oversight for the Office's activities, but its recommendations are non-binding. As well, it was not informed of key decisions such as the closure of a hospital-based regional forensic pathology unit.
- **The Office has not fully ensured it delivers death investigations and related services cost-effectively.** For example, the Office has not analyzed whether its new service delivery model of using different health care professionals as coroners in place of the current part-time physician coroners would help improve efficiencies of death investigations. Also, it has not evaluated whether its transfer payments to regional hospital-based forensic pathology units were reasonable, based on the actual cost to operate these units.
- **The Office does not publicly report responses to hundreds of recommendations made by inquest and death review committees.** The Office published about 600 recommendations made by inquests and death review committees in 2018 but did not report information to help the public evaluate whether recommendations were properly implemented.

This report contains 14 recommendations, consisting of 38 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) did not demonstrate that it has effective systems and procedures in place to have consistent, high-quality death investigations that improve public safety and prevent or reduce the risk of preventable deaths.

The Office can do more to measure and report on the effectiveness of its activities. Unlike other Canadian provinces that publish government and other organizations' responses to inquest and death review committee recommendations, Ontario does not do this, limiting their usefulness in learning from the past to minimize the occurrence of future preventable deaths.

OVERALL RESPONSE

Recognizing the importance that death investigation plays in health and safety in Ontario, the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) is committed to working with its partners toward continuous improvement of cost-effective, efficient, equitable and high-quality death investigation services.

The Office welcomes and accepts the insights and recommendations provided by the Auditor General. As indicated to the audit team throughout the process, there are some key initiatives already under way that, when fully implemented, will satisfy the recommendations and greatly improve efficiencies, effectiveness and documented performance of the organization. Several of the recommendations are in keeping with those recently provided by Justice Gillese in her report: *The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System*. The Office has committed to implementing an action plan with our Ministry of Health partners that includes key themes also provided by the audit team: training and education; improved data surveillance, analysis and tracking; a new service delivery model for death investigation; and quality assurance.

Ontario has the largest death investigation system in the country and one of the largest in North America, both geographically and by investigation numbers. While the Office is recognized worldwide for its expertise in areas such as forensic pathology and international training programs, we recognize and share the audit team's view that our work in modernizing death investigation is not yet complete. The audit rightly identified several areas of consideration where the Office will build on existing efforts and initiatives to evaluate, address and improve. We will continue to take strides to strengthen the death investigation system to support our health and justice sector partners in contributing to the health and safety of Ontarians.

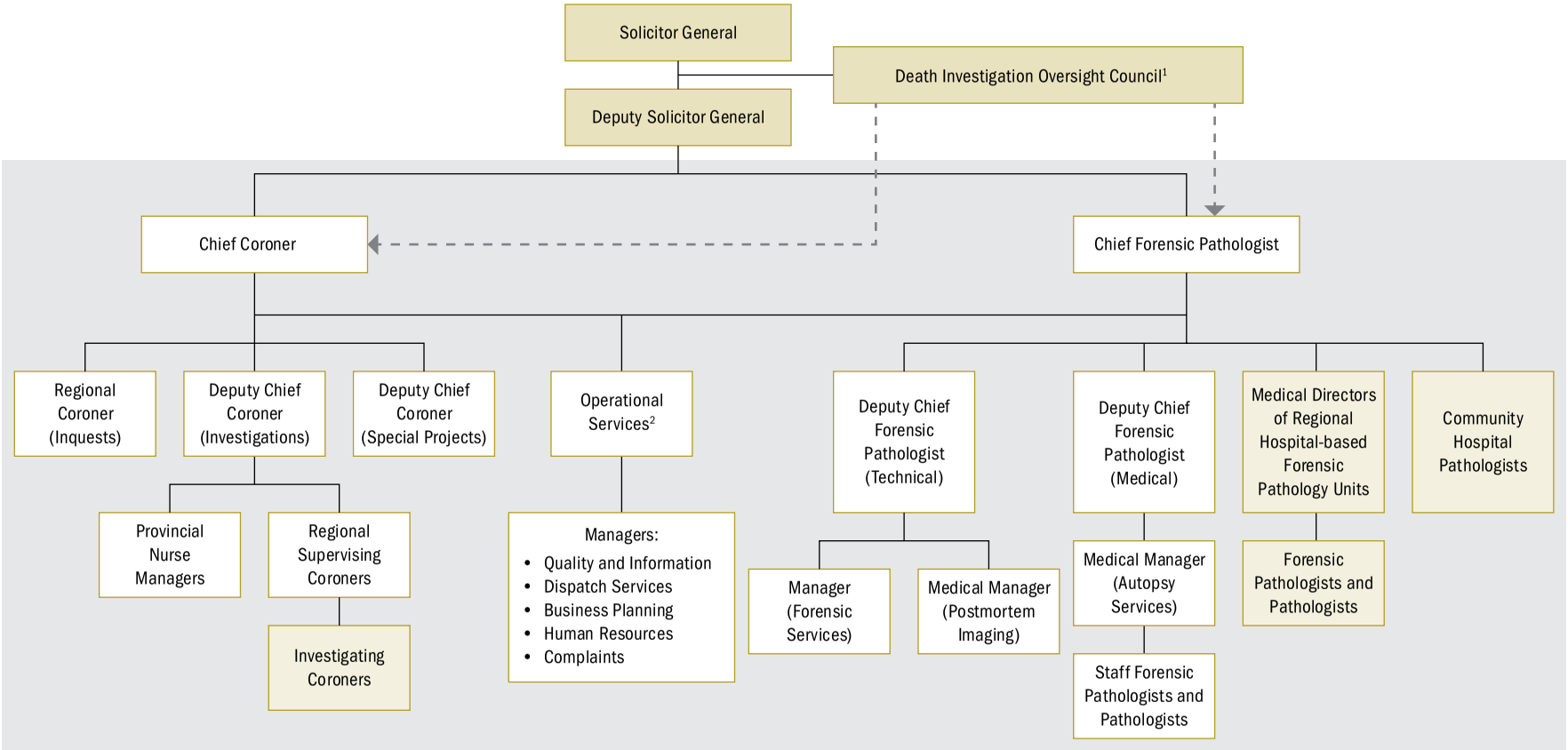
2.0 Background

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) reports to the Ministry of the Solicitor General (Ministry), and is responsible for conducting death investigations required by the *Coroners Act* (Act). Under the Act, death investigations must be conducted for all deaths that are not natural, as well as deaths that are natural but sudden and unexpected. **Figure 1** shows the organizational structure of the Office as of July 2019.

According to the Ministry, death investigations strengthen public safety and security, and are also intended to help ensure that public safety systems are effective, efficient, accountable and responsive to the needs of Ontario's diverse communities. According to its 2015–2020 Strategic Plan, the Office aspires to improve the health and safety

Figure 1: Organizational Structure of the Office of the Chief Coroner and Ontario Forensic Pathology Service as of July 2019

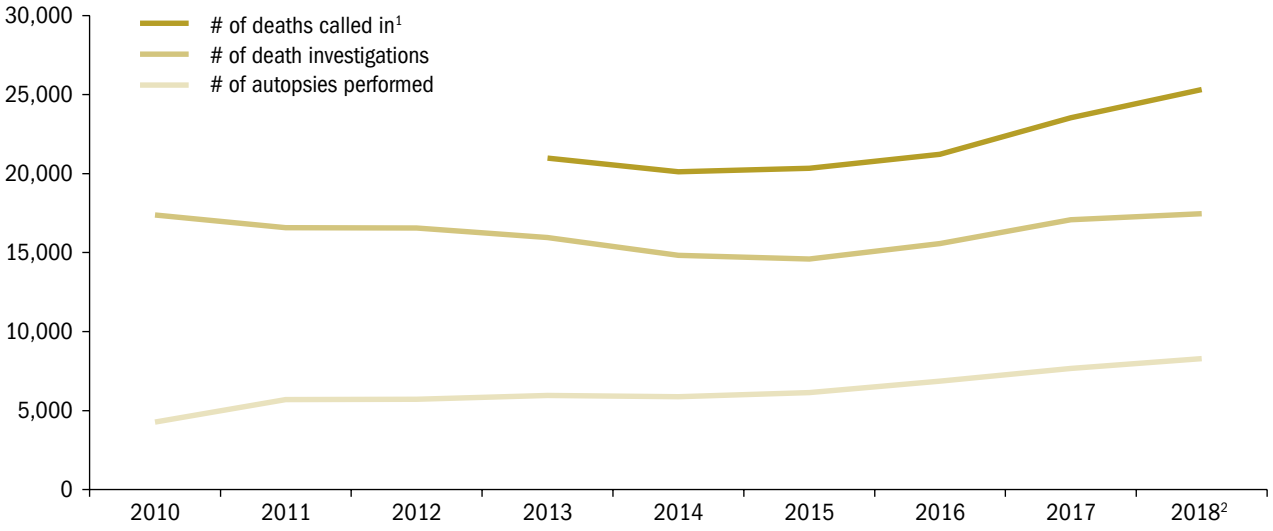
Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service



1. The Death Investigation Oversight Council provides advice and makes non-binding recommendations to the Chief Coroner and the Chief Forensic Pathologist on matters that include quality assurance and compliance with the *Coroners Act*. Members are appointed through the Public Appointments Secretariat.
2. The Director of Operational Services reports to both the Chief Coroner and the Chief Forensic Pathologist.

Figure 2: Number of Deaths Called In, Death Investigations and Autopsies, 2010–2018

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)



1. Dispatchers at the Office assign cases to coroners (explained in **Figure 5**). Dispatch data is less reliable prior to 2013. No total-calls-received amount is available because there was no central provincial dispatch system at that time, and call-recording processes were inconsistent across the regions.
2. 2018 data was still being finalized when we completed the audit. Data is current as of September 2019.

of Ontarians and prevent future and sudden unexpected deaths, and:

- support the needs of families by providing answers and information after sudden and unexpected deaths;
- search for the truth and provide evidence and data to support the administration of justice; and
- advance forensic medicine and public safety through knowledge and capacity development.

The Office has two primary functions:

- **coroner services**, including overall responsibility for death investigations, fall under the authority of the Chief Coroner; death investigations are led by physician coroners; and
- **post-mortem examinations or autopsies**, are the responsibility of the Ontario Forensic Pathology Service, led by the Chief Forensic Pathologist; pathologists and forensic pathologists conduct autopsies when coroners request them.

Refer to **Appendix 1** for a glossary of terms.

The Operational Services Branch of the Office provides support to both the coroner and forensic pathology service areas.

The Office employs about 131 staff and is headquartered in the Forensic Services and Coroners Complex in Toronto.

In 2018, the Office conducted about 17,000 death investigations. In almost half of these cases, an autopsy was performed. While the total number of deaths in Ontario in 2018 was not available at the time of our audit, we noted that between 2009 and 2017, the Office performed death investigations on between 15% and 20% of all deaths in Ontario. The Office's overall expenditures have increased from $43 million in 2016/17 to about $47 million in 2018/19. The increase in expenditures is consistent with the increase in death investigations. The number of death investigations rose from about 15,600 in 2016 to about 17,500 in 2018. **Figure 2** shows the trend of death investigations and autopsies between 2010 and 2018. **Figure 3** shows the steady increase in death investigations, and death investigations with autopsies over the same period.

Figure 3: Proportion of Death Investigations With Autopsy, 2010–2018

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

	Total # of Death Investigations (Coroners)	Total # of Autopsies (Pathologists)	% of Death Investigations With Autopsy
2010	17,378	4,270	25
2011	16,579	5,703	34
2012	16,549	5,708	34
2013	15,946	5,874	37
2014	14,817	5,955	40
2015	14,592	6,138	42
2016	15,567	6,858	44
2017	17,078	7,657	45
2018*	17,461	8,287	47

* 2018 data was still being finalized when we completed the audit. Data valid as of September 2019.

2.1 Coroners

Coroners in Ontario are physicians and members of the College of the Physicians and Surgeons of Ontario. As of December 2018, about 350 licensed physicians were appointed to the coroners' service by the Chief Coroner. Most have their own medical practices as well. The Office expects coroners to attend a five-day training course before they assume coroner responsibilities. **Appendix 2** provides further details on the appointment process for coroners. **Appendix 3** describes key topics covered in the coroners training course.

The coroners' service is divided into 10 regions across the province, including two in the Toronto area. Each region is led by a regional supervising coroner. Regional supervising coroners are full-time, salaried staff of the Office.

In the 2018/19 fiscal year, the Office paid a total of $8 million, which is included in the Office's overall expenditures of $47 million, to about 330 coroners for death investigations. All coroners in Ontario are paid on a fee-for-service basis, and the Office pays them a base rate of $450 for a death investigation. The Office expects coroners to complete death investigation reports within 30 days of accepting a case–this deadline is generally achieved.

2.1.1 Reporting Deaths and Dispatching Coroners to Death Scenes

According to the Act, certain deaths must be reported to a coroner. Listed in **Appendix 1**, these include deaths where there is reason to believe the death is a result of violence, misadventure, negligence, misconduct or malpractice, and deaths that are sudden or unexpected.

Figure 4 shows the process for death investigations in Ontario. **Figure 5** shows the key parties at the Office that are involved in the process.

2.1.2 Documentation and Quality Assurance for Coroners' Death Investigations

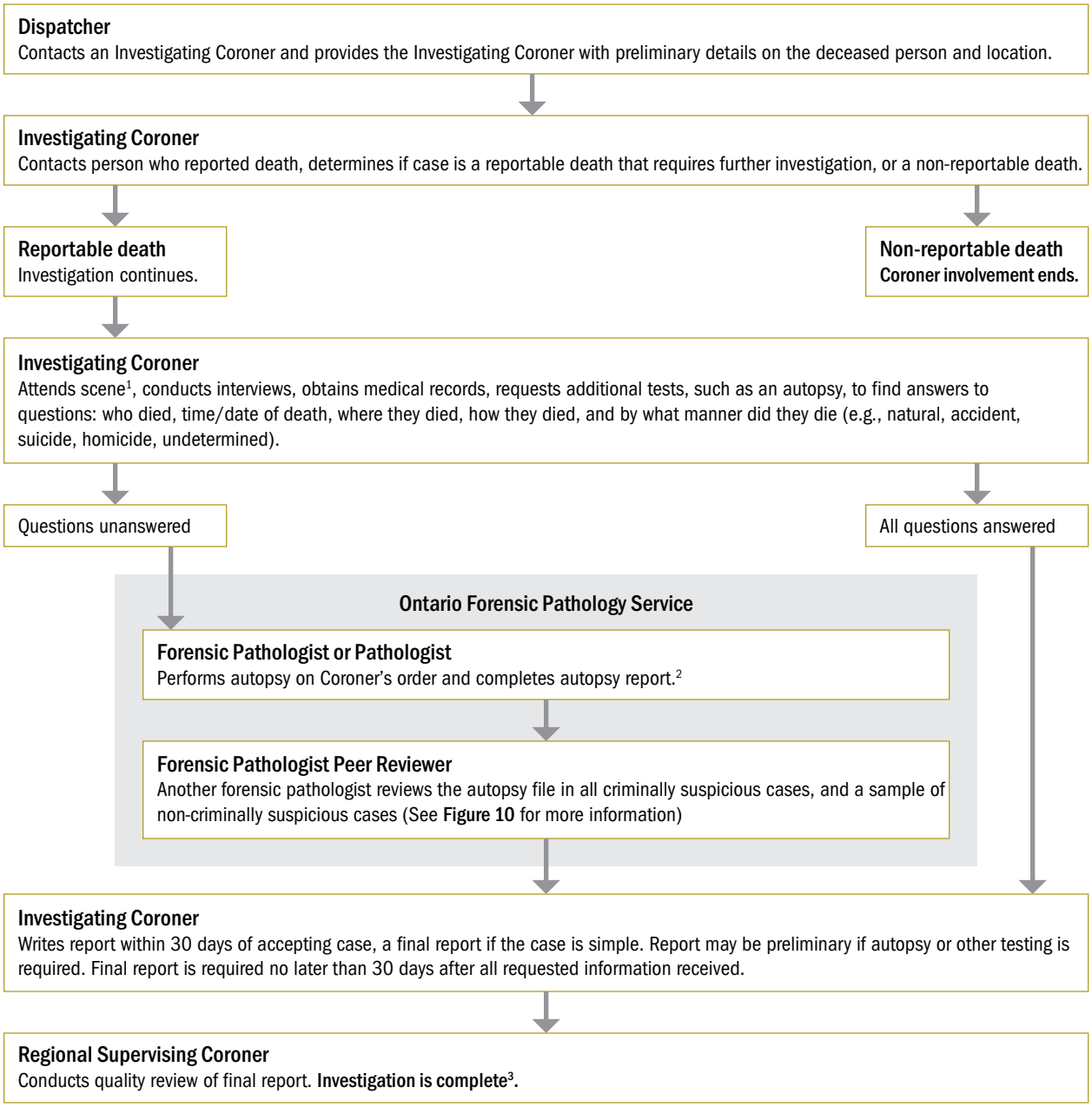
The coroner's investigation report provides a summary of the death investigation with all the relevant observations made by the investigating coroner. These reports are used by police, lawyers in the criminal justice system and the family of the deceased person to help understand why and how someone died.

These reports include answers to five questions about the deceased and the death—who, when, where, how, and by what means. Some of the specific information includes:

Figure 4: Death Investigation Process Map

Prepared by Office of the Auditor General of Ontario

When someone dies in most community settings in Ontario, the person who discovers the death usually calls 911. When emergency service personnel dispatched by 911 attend, they contact the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) through its Central Provincial Dispatch. When someone dies in a health-care facility, like a hospital or long-term-care home, a facility representative will report the death directly to Dispatch if it meets the requirements for a reportable death (see **Appendix 1**). The Forensic Pathology Service group within the Office becomes involved only in some cases. (For more on who does what in reporting deaths, see **Figure 5**.)



1. The *Coroners Act* allows a coroner to delegate a death scene investigation to a police officer or a physician who is at scene. The delegate is to communicate relevant details about the death scene and the body by phone or video to the investigating coroner.
2. May involve Centre of Forensic Sciences (part of the Ministry of the Solicitor General, for toxicology testing, for example).
3. Inquest, death review committee or re-opening of death investigation is possible in some cases (see **Section 2.3** for more information).

Figure 5: Responsibilities of Various Parties Involved in Death Investigations

Prepared by Office of the Auditor General of Ontario

Responsible Party	Key Activities
General public, police or health-care worker	• contacts Dispatch at the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) after becoming aware that a death has occurred in the community or an institution
Dispatcher	• contacts investigating coroner on duty • relays information to the investigating coroner regarding basic details on the deceased and location of the death scene • opens a case upon confirming with investigating coroner that a death investigation is warranted; enters preliminary information into the Coroners Information System

Investigating Coroner	• accepts or returns calls from dispatcher
	• contacts person who reported the death; makes initial inquiries
	• accepts the investigation if coroner determines the death constitutes a reportable death under the *Coroners Act* (see **Section 2.1.1**) or if the deceased does not have a regular physician; for such reported deaths, a coroner may be sent to the scene, but an increasing number of these calls are expected to be referred to coroner investigators—see **Section 4.6.2**
	• declines the investigation if coroner determines death is not-reportable and if the deceased has a physician—the physician is expected to go to the scene to complete the death certificate; the coroner receives a small fee ($30 or $60) for documenting the rationale for declining the case
	• for death investigations accepted, attends and assesses death scene; conducts death investigation (such as by examining the body, interviewing family and police and obtaining medical records) to determine answers to the five questions
	  ◦ may complete a case remotely by relying on information provided by police or others on scene, and not attend death scene if no local coroner is available
	• contacts dispatcher within five hours of accepting case to update whether a cause of death can be readily determined
	  ◦ orders an autopsy or other tests if a cause of death cannot be readily determined
	• concludes on cause and manner of death, considering the autopsy results where applicable; and completes death investigation report
	  ◦ if the five questions can be readily answered, coroners are to submit a final report within 30 days of accepting the death investigation; otherwise, coroners can submit a preliminary report and order additional testing, such as an autopsy, dental comparisons or toxicology tests; once sufficient information is available, a final report is to be submitted within 30 days of receiving the results from the additional testing
	  ◦ cases can be re-opened at a later date for reasons such as the discovery of new evidence not available during the initial investigation; the Coroners Information System tracks the number of open cases but not the number of cases re-opened after they are completed

Regional Supervising Coroner	• conducts quality review of death investigation report to ensure that investigating coroner conducted the death investigation appropriately
Forensic Pathologist/Pathologist	• performs autopsy at coroner's order • completes autopsy report • performs peer reviews on all autopsies of criminally suspicious cases and quality assurance reviews on a sample of other autopsy cases (see **Figure 10**)
Inquests or Death Review Committees	• review certain deaths (see **Section 2.3**)

- basic information regarding the deceased, including date of birth and gender;
- relevant aspects of the medical history of the deceased;
- a description of the known circumstances leading up to the death, the body at the scene and results of the body examination;
- a narrative that supports and expands upon the investigation, and refers to relevant autopsy findings or toxicology tests; and
- additional details, including the location type of where the death occurred, such as a long-term-care home or the home of the deceased, and in what manner the death occurred—whether it was natural, accidental, suicide, homicide or undetermined.

Figure 6 shows that between 2014 and 2018, about half of the deaths investigated resulted from natural causes such as heart or lung disease, and almost a third were due to accidents such as opioid overdose.

Coroners complete their reports using a standard form that is submitted to the Office and downloaded into the Coroners Information System. Regional supervising coroners must review the reports and identify any areas requiring changes. The Coroners Information System, now 17 years old, is being replaced. The Office contracted a third-party vendor in March 2018 to create a new system for about $2 million following a competitive process. The new information system will be web-based, allowing investigating coroners to access and submit their investigation reports directly to the Office. The Office expects the new system to be available by the end of 2020.

2.2 Pathologists and Forensic Pathologists

The Office's forensic pathology service performs autopsies on deceased individuals when coroners request them. Autopsies provide more detailed information about the deceased and details of the death, informing the death investigation and any subsequent law enforcement activities.

Under the Act, the Chief Forensic Pathologist supervises and directs pathologists and forensic pathologists on the provincial register in providing these services, including their education and training. Pathologists are licensed physicians who study the cause and development of disease, and perform autopsies in cases with no suspicion of criminal wrongdoing. In comparison, *forensic* pathologists need additional education and training, as well as certification in forensic pathology. Forensic pathology is a sub-specialty of pathology that focuses on determining the cause of death through the examination of a deceased person.

Figure 6: Number and Percentage of Deaths Investigated by Coroner Based on Manner of Death, 2014–2018[1]

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

Manner of Death	2014	2015	2016	2017	2018[2]
Natural	8,374	8,145	8,582	9,186	9,021
Accident	4,598	4,494	4,715	5,381	5,697
Suicide	1,334	1,404	1,623	1,745	1,556
Undetermined[3]	166	183	217	208	266
Homicide	345	357	401	475	623
Open cases still under investigation	0	9	29	83	298
Total # of cases with death investigations	**14,817**	**14,592**	**15,567**	**17,078**	**17,461**

1. Data valid as of September 2019.
2. Some cases in 2018 may have cause and manner of death determined, but are still open as they have not been officially closed by the regions (e.g., awaiting further reports—such as police and ambulance reports—to come in).
3. A death is classified as "undetermined" if the death investigation concludes without sufficient evidence to determine manner of death.

2.2.1 Specialization Areas and Work Locations of Forensic Pathologists and Pathologists

The Chief Forensic Pathologist maintains a register of pathologists who may conduct autopsies under the Act. Each pathologist is assigned a category that defines what types of autopsies can be assigned, based on credentials and medical experience. A Credentialing Committee was created at the same time as the register to assist the Chief Forensic Pathologist in deciding on pathologists to add to or remove from the register. This committee consists of three senior forensic pathologists who make recommendations to the Chief after considering a pathologist's body of work, including performance, peer review history, and any issues related to professionalism, such as complaints.

As of March 31, 2019, the register included 117 pathologists, 96 of whom performed autopsies in 2018/19. **Figure 7** shows where these 96 pathologists worked, and their autopsy categories. These pathologists conduct autopsies in three types of settings:

- **The Toronto Forensic Pathology Unit** is located in the Forensic Services and Coroners Complex in Toronto. This unit is responsible for all autopsies in the Greater Toronto Area, and across the province when pathologists with the required skills are not available locally. This unit is also the headquarters for forensic pathology. In 2018/19, 44% of all autopsies were conducted at this unit.
- **Regional Hospital-Based Forensic Pathology Units** are located in six cities: Hamilton, Kingston, London, Ottawa, Sudbury, and Sault Ste. Marie. These units, located in teaching hospitals, are responsible for autopsies in their own regions and the surrounding areas. Each unit is led by a medical director who is a forensic pathologist. In 2018/19, these units conducted 42% of all autopsies.
- **Community Hospitals** employ pathologists who conduct autopsies for the Office's forensic pathology service. These pathologists worked out of 16 community hospitals,

Figure 7: Category of Pathologists on the Provincial Register as of March 31, 2019, by Location

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

Autopsy Location	Category per Pathology Register[1]			Total
	A[2]	B[3]	C[4]	
Toronto Forensic Pathology Unit	15	0	1	**16**[5]
Regional Hospital-Based Forensic Pathology Units				
Hamilton	4	1	0	**5**
Ottawa	5	0	0	**5**
London	4	8	0	**12**
Sudbury	3	0	0	**3**
Kingston	1	14	0	**15**
Sault Ste. Marie	1	1	0	**2**
Community Hospitals	4	29	5	**38**
Total	**37**	**53**	**6**	**96**[6]

1. The register reflects the availability of pathologists in different parts of the province. Anyone who is qualified can be added to the register; consequently, staffing levels vary across the province.
2. Category A pathologists can perform all autopsies, including pediatric, homicide and criminally suspicious cases. All category A pathologists are forensic pathologists.
3. Category B pathologists can only perform non-criminally-suspicious adult cases.
4. Category C pathologists can only perform non-criminally-suspicious pediatric cases.
5. During 2018/19, 13 of these pathologists worked on a full-time basis and three worked on a part-time basis.
6. These active pathologists, together with 21 other pathologists that did not work on cases in 2018/19, formed the entire provincial register of 117 pathologists.

Figure 8: Caseload per Autopsy Location, 2014/15–2018/19

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)

Autopsy Location	2014/15	2015/16	2016/17	2017/18	2018/19
Toronto Forensic Pathology Unit	2,350	2,577	3,044	3,224	3,742
Regional Hospital-Based Forensic Pathology Units					
Hamilton*	815	891	999	1,276	1,386
Ottawa	633	669	709	786	763
London	471	455	521	528	566
Sudbury	197	283	356	380	402
Kingston	227	188	233	244	355
Sault Ste. Marie	62	85	103	118	127
Community Hospitals	1,168	1,051	1,126	1,241	1,233
Total	**5,923**	**6,199**	**7,091**	**7,797**	**8,574**

* In July 2019, the Office decided to close the Hamilton hospital-based regional forensic pathology unit due to staffing and other operational difficulties. Current plans include transferring all Hamilton autopsy cases to the Toronto Forensic Pathology Unit by July 2020. The Office estimated that the closure could result in $750,000 annual savings after two years of decommissioning and would increase efficiencies since the Toronto Forensic Pathology Unit has unused facilities for performing autopsies; in particular, the Unit usually has six autopsy bays that are not in use.

typically located in more remote areas, and conducted 14% of all autopsies in 2018/19.

Figure 8 shows the caseloads of these autopsy locations between 2014/15 and 2018/19.

2.2.2 Payment to Forensic Pathologists and Pathologists

Of the 117 forensic pathologists and pathologists on the provincial register, 12% are full-time, salaried staff of the Office. These full-time staff all work out of the Toronto Forensic Pathology Unit. Three additional forensic pathologists work at the Toronto unit on a part-time, fee-for-service basis. All other pathologists—those who work at regional hospital-based forensic pathology units or community hospitals—either work as full-time employees of the hospitals, or provide autopsy services on a fee-for-service basis, as shown in **Figure 9**.

2.2.3 Quality Assurance for Pathologists and Forensic Pathologists

Figure 10 outlines the Office's three different quality assurance processes for autopsy reports, including:

- criminally suspicious deaths;
- non-criminally suspicious deaths; and
- transcripts of court proceedings where the forensic pathologist testifies and the related autopsy report is presented in court.

2.2.4 Morgue Management

Bodies for autopsies ordered by investigating coroners in the Greater Toronto Area are transferred to the Toronto Forensic Pathology Unit by either dedicated body transfer services or funeral homes. The Unit also receives bodies from other parts of the province to reduce local backlogs.

In addition to dispatching coroners to death scenes, dispatchers in the Office's Central Provincial Dispatch unit at the Toronto headquarters also act as morgue attendants. Their morgue-related duties include receiving and releasing bodies, checking the identities of deceased persons, and managing body storage. Staff conduct body inventories to monitor morgue capacity, and to confirm bodies are in the correct location.

In regional hospital-based forensic pathology units and community hospitals, hospital staff are responsible for managing the morgue. The intake

Figure 9: Pathologist and Forensic Pathologist Fees across Ontario, April 2018

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

Pathologists Working In	Remuneration Type
Toronto Forensic Pathology Unit	Salaried employees[1]
Regional Hospital-Based Forensic Pathology Units	Transfer payment agreement (annual) • each regional unit receives a transfer payment ranging from $100,000 to $570,000 to be a Provincial Centre of Excellence for Forensic Pathology[2] Professional fees (per case)[3] • $300 for external autopsy (i.e., no dissection) • $1,200 for standard autopsy • $1,650 for complex autopsy (i.e., criminally suspicious, homicide or pediatric) Facility fees (per case) • $400 to reimburse each regional unit for costs incurred by the regional unit to perform autopsies
Community Hospitals	Same professional fee rate and facility fee rate per case as regional hospital-based forensic pathology units; no centre of excellence transfer payments

1. Another three forensic pathologists performing cases at this unit work on a fee-for-service basis, and receive the same professional fees as pathologists who work in regional forensic pathology units and community hospitals.
2. The agreement indicates that the hospital will conduct all autopsies required as part of death investigations, including homicide and criminally suspicious and pediatric autopsies, and these will be overseen by a medical director. The agreement also outlines the specific responsibilities of the Medical Director.
3. Depending on the contractual arrangements between regional units and pathologists, professional fees may be paid to the hospital, the pathologist or an organization that receives these payments on behalf of its members (for example the Eastern Ontario Regional Laboratory Association). These fees are set out in O.Reg 19/15 under the *Coroners Act*.

and release of bodies from the morgue are the responsibility of hospital security.

2.3 Inquests, Death Review Committees and Expert Panels

Inquests and death review committees operate under the authority and supervision of the Office. While they are both tasked with considering the circumstances of deaths, and suggesting recommendations to help reduce the risk of further deaths, **Figure 11** shows the key differences between them. The Office held 186 inquests from 2014 to 2018; 170 inquests were mandatory and 16 were discretionary. In 2018 alone, there were 35 inquests, 31 of which were mandatory and four were discretionary.

In addition, the Chief Coroner may establish expert panels to inform the investigation of certain types of deaths. **Appendix 4** shows a list of five death review committees active at the time of our audit, as well as three expert panels established by the Chief Coroner since 2013 that have issued reports. In 2019, the Chief Coroner initiated an expert panel to review the deaths of nine police officers by suicide during 2018. This panel had not completed its report at the time of our audit.

2.4 Death Investigation Oversight Council

The Death Investigation Oversight Council was created in 2010. It is an oversight body for the Office that provides advice. Its 12 voting members have mostly legal, policing and health care backgrounds, and members are appointed through the Public Appointments Secretariat. The Council has a mandate to support the provision of effective and accountable death investigation services. The Chief Coroner and the Chief Forensic Pathologist also sit on the Council as non-voting members.

The Council was created by an amendment to the *Coroners Act* following a recommendation from the Inquiry into Pediatric Forensic Pathology in

Ontario led by Commissioner Stephen T. Goudge (Goudge Inquiry). This inquiry was established by the government to provide improved oversight for forensic pathologists and coroners and specifically, to address systemic weaknesses in the oversight of forensic pathology services. These weaknesses ultimately resulted in miscarriages of justice after faulty forensic pathology work led to innocent people being charged with manslaughter.

Figure 10: Quality Assurance Processes for Pathologists and Forensic Pathologists

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)

Type of Review	Type of Cases and Coverage	Scope of Review	# of Reviews Conducted		Review Completed By
			2017/18	2018/19	
Peer Review[1]	100% of autopsy reports of criminally suspicious cases before they are released to the coroner and police.	Reports are evaluated regarding: • completeness, consistency, and ease for another forensic pathologist to review and reach the same conclusion; • reasonableness of cause of death stated in the autopsy report given the evidence available; and • an unbiased expert opinion on content of autopsy report.	282	391	Category A pathologists (i.e., pathologists who perform all autopsies including homicide and criminally suspicious cases) on a rotation basis
Quality Reviews[2]	Non-criminally suspicious autopsies: • 10% of all autopsies; • 100% of autopsies involving undetermined cause of death; • 100% of autopsies involving natural death of individuals under age 40; and • 100% of autopsies conducted by pathologists who perform fewer than 20 autopsies a year.	Reports are evaluated regarding: • completeness and consistency; • reasonableness of cause of death stated in the autopsy report given the evidence available; and • turnaround times from autopsy conducted to report issued and from toxicology sampling to report issued.	1,300	1,251	Deputy Chief Forensic Pathologists, Medical Directors, category A pathologists
Court Transcripts	Forensic pathologists are sometimes called to court to provide expert opinions based on their autopsy findings. All forensic pathologists who testify in court are to have the courtroom transcript of at least one case peer reviewed by another forensic pathologist each calendar year.	Forensic pathologists are evaluated regarding whether they: • are prepared to testify; • only provide opinions on areas of expertise; • demonstrate general knowledge, interpret evidence properly and draw conclusions and form opinions that are credible, objective and scientifically sound.	6[3]	19[3]	Category A pathologists randomly assigned

1. Refer to **Section 4.3.1** for details.
2. Refer to **Section 4.3.2** for details.
3. The Office does not maintain records of court cases attended by forensic pathologists; therefore we are unable to confirm whether the number of reviews conducted met Office requirements.

Appendix 5 provides further details on the Goudge Inquiry.

The Inquiry recommended the creation of the Council to address the gap in oversight, and to ensure more objective and independent governance. The Council has oversight regarding the work of both the Chief Coroner and the Chief Forensic Pathologist and staff of the coroner and forensic pathology services.

The Council is supported by three staff members from the Ministry of the Solicitor General. The total cost of the Council has been about $500,000 for the last several years. About 70% of this cost is salaries for support staff.

The Council also administers a public complaints process. As set out in the Act, the Council does not review a complaint unless it has been addressed first by the Office for response. The only exception is a complaint about the Chief Coroner or Chief Forensic Pathologist, which the Council would review directly.

Figure 11: Overview of Inquests and Death Review Committees

Prepared by the Office of the Auditor General of Ontario

Description	Authorization and Responsibility	Deliberations and Reporting
Mandatory inquest – held after a coroner has completed work on a death investigation. Required when a death occurs: • by accident on the job at a construction site, mine, pit or quarry; • in custody or while being detained except if a natural death occurs in a correctional facility; • due to an injury sustained or other event that occurred while in custody, or when the use of force by police, special constables, or a First Nations Constable is the cause of death; • while a person is being physically restrained and detained in a psychiatric facility, hospital, or secure treatment program. Also required when a child dies as a result of a criminal act of a person who has custody of the child.	*Coroners Act* **Regional supervising coroner** responsible for determining when a mandatory inquest is required.	**Public forum**, case specific and time-limited **Citizen jurors** deliver a verdict answering the five questions regarding a death and determine recommendations[1]
Discretionary inquest – held after a coroner has completed work on a death investigation May be held when: • the coroner determines that enough information is known from a death investigation to support an inquest; • the coroner decides that it is desirable for the public to have an open and full hearing of the circumstance of a death; and • if the coroner believes a jury could make useful recommendations to prevent further deaths.	*Coroners Act* **Regional supervising coroner**, with input from the Inquest Advisory Committee,[2] responsible for determining when a mandatory inquest is required.	**Public forum**, case specific and time-limited **Citizen jurors** deliver a verdict answering the five questions regarding a death and determine recommendations
Death Review Committee – can be established by the Chief Coroner at any time to assist coroners in conducting death investigations with specialized expertise. May be established for types of deaths that are of critical concern to Ontarians.	At the discretion of the **Chief Coroner**.	**Private forum**, deliberations continue at the discretion of the Chief Coroner **Stakeholders and experts** in related fields

1. Responses from parties receiving these recommendations, which are received by the Office of the Chief Coroner and Ontario Forensic Pathology Service, are available to members of the public upon request.
2. The Inquest Advisory Committee members are appointed by the Chief Coroner and include both Deputy Chief Coroners, three regional supervising coroners, and the Chief Counsel to the Chief Coroner and is chaired by a Deputy Chief Coroner.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) has effective systems and procedures in place to:

- conduct high-quality death investigations and prevent premature deaths, according to legislative requirements, internal policies and best practices;
- deliver death investigation and related services cost-effectively; and
- measure and report on the effectiveness of its activities.

Before starting our work, we identified the audit criteria we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at the Office reviewed and agreed with the suitability of our audit objective and related criteria as listed in **Appendix 6**.

Our audit focused on activities of the Office in the three-year period ending March 31, 2019, and considered relevant data and events in the last 10 years. We conducted our audit from January to September 2019, and obtained written representation from the Office that effective November 5, 2019, it has provided us with all the information it was aware of that could significantly affect the findings or the conclusions of this report.

In conducting our work, we reviewed applicable legislation, agreements, reports, program guidelines and policies. We also examined documents and relevant files, analyzed data, reviewed information technology controls and assessed risks, and observed the processes involved in death investigations, including activities within the Forensic Services and Coroners Complex located in Toronto, and selected regions outside of Toronto.

Regarding forensic pathology services, we interviewed 45 management, pathology and support staff including:

- senior management, including Deputy Chief Forensic Pathologists and the Chief Forensic Pathologist, forensic pathologists, pathologists and other forensic pathology and support services staff in the Provincial Forensic Pathology Unit in Toronto;
- medical directors at all regional forensic pathology units including Kingston, London, Ottawa, Sault Ste. Marie and Sudbury—since the position of medical director was vacant in Hamilton during much of our audit—and other forensic pathologists and pathologists in Hamilton, Ottawa and Sudbury; and
- pathologists and forensic pathologists at two community hospitals.

To compare how these functions are performed across the province, we reviewed quality assurance processes in all autopsy locations including Toronto and the six regional hospital-based forensic pathology units, and observed morgue management practices in Ottawa, Sudbury and Toronto; we visited the Ottawa and Sudbury regional units and also visited two community hospitals in Ottawa and Toronto. In addition, we engaged an expert with experience in death investigation practices in other provinces and in the United States. Our expert reviewed a sample of death investigation reports and autopsy reports to ensure sufficient evidence was gathered and reasonable conclusions were reached based on the evidence obtained. As well, we conducted a survey of pathologists and forensic pathologists across Ontario and received a 34% response rate overall—25% of pathologists and 49% of forensic pathologists who had a valid email address responded.

Regarding coroner services, we interviewed the Deputy Chief Coroners and the Chief Coroner, and interviewed and obtained information from regional supervising coroners, including their review of coroners' work, in all 10 regions across the province. We also analyzed the Office's death

investigation data against data we obtained directly from the Ministry of Health. As well, we conducted surveys of active and recently resigned coroners and regional supervising coroners; 41% of the coroners who had a valid email address responded and 100% of the regional supervising coroners responded.

We sat in on the hearings of two inquests conducted in Toronto to better understand the purpose of inquests and the parties that participate in them. We met with and obtained relevant information from the Death Investigation Oversight Council to better understand its role and mandate as an oversight body for the Office. As well, we reviewed the work of the Office's death review committees and interviewed select chairs from these committees to better understand how their work assists in the Office's death investigations.

In addition, we met with the Registrar of the College of Physicians and Surgeons of Ontario, two representatives from municipal police forces, one of whom also represented the Ontario Association of Chiefs of Police and four lawyers—current and former Crown attorneys and defence lawyers—who have experience working with the Office, to understand their perspectives on the Office in conducting death investigations.

We researched how other Canadian provinces operate their death investigations systems and spoke to or otherwise communicated with representatives from all nine provinces to identify areas for improvement in Ontario.

In determining the scope and extent of our audit work, we reviewed relevant audit reports issued by the Ontario Internal Audit Division.

3.1 Outstanding Issues

During our audit, we identified instances of certain coroners investigating deaths of individuals to whom the coroners had provided patient care in the years prior to their deaths. These coroners provide medical care to living patients when not performing coroner work. We discuss this in **Section 4.1**. The Office began investigating these cases as soon as we brought them to its attention; senior management at the Office informed us that they would need to thoroughly evaluate these cases to determine whether the circumstances constitute inappropriate actions by the coroners. At the completion of our audit, the Office had developed a plan to review and analyze the case information for the instances we identified. The plan includes an assessment of whether the coroners:

- should reasonably have known about the conflicts at the time they accepted and conducted the death investigation;
- should have considered the cases as being possible conflicts of interest; for example, given the nature and timing of the care the physician had provided; and
- should have informed their regional supervising coroner about the potential conflicts of interest since they oversee the coroners' work.

When we completed our audit, the Office's investigation process was still ongoing.

As well, during our audit, two forensic pathologists—one currently employed and one formerly employed in the Hamilton regional hospital-based forensic pathology unit—filed separate complaints with the Death Investigation Oversight Council against the Chief Coroner and the Chief Forensic Pathologist. Among other concerns, the complainants alleged that the two Chiefs abused their power in reaching the Office's decision to decommission the Hamilton unit. The Council was still finalizing the complaint investigation reports when we completed the audit.

4.0 Detailed Audit Observations

4.1 Some Coroners Suspected to Be Engaging in Unethical Practices and Professional Misconduct

Overall, we found that 36, or 11% of the coroners who worked for the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) in 2018, have potentially engaged in unethical practices or violated either the Office's policies or professional practice rules. Some coroners investigated the deaths of former patients without declaring conflicts of interest. Others conducted death investigations while under practice restrictions by their regulatory college, such as restrictions from prescribing narcotics in their medical practices. Others were no longer licensed to practise medicine. The Office was not aware of some of these restrictions. We also found that some coroners had double-billed for their work.

Coroners are expected to abide by the Office's Coroners Code of Ethics. Coroners, as physicians, are also expected to follow the College of Physicians and Surgeons of Ontario's (College) policies and guidelines on medical professionalism because the College regulates the medical profession. However, neither the Code of Ethics nor the *Coroners Act* requires coroners to be physicians in good standing with the College. Since the primary subject of the investigation does not have a voice, and coroners typically work independently, it is critical that the Office ensures its coroners are held to a high standard of conduct.

4.1.1 Some Coroners Investigated Their Former Patients' Deaths

We found that 19 of the 23 top-billing coroners of 2018 conducted death investigations on 132 people whom they had provided care for between April 1, 2013, and December 31, 2018. If this analysis is reduced to patients seen within one year by the physicians who later investigated their deaths, we found 15 of these 23 coroners conducted death investigations on 54 of their former patients. This practice constitutes a potential conflict of interest under the Office's policy. These cases are concerning because there is a risk that the truth about a death will not come to light if the physician's treatment decisions while the patient was alive could have contributed to the patient's death. Of the 132 cases, 64 did not have autopsies.

The majority of coroners in Ontario are physicians with their own medical practices. More than 70% have family medicine backgrounds, while the rest specialize in areas including cardiology, psychiatry and internal medicine. Of the 19 physician-coroners, at least two practised addiction medicine, at least six practised in emergency departments and at least one in long-term-care homes.

The Office requires coroners to declare and discuss a potential conflict of interest if they are asked to perform a death investigation on former patients to ensure they are free of bias when conducting death investigations. **Appendix 7** outlines the Office's policy on conflict of interest. The Chief Coroner and Deputy Chief Coroners were not aware of any of the cases we found because the Office does not monitor whether coroners are abiding by the Office's policy. The Ministry of Health, which tracks physician billings, does not review the work of coroners.

Of these 19 coroners, we found no documentation that 14 declared a conflict of interest with their regional supervising coroners, contrary to the Office's policy; five documented declaring a conflict of interest with their regional supervising coroners but did so only in 12% of their cases. Overall, these 19 coroners did not document their declaration of conflicts of interest in 95% of their cases.

Moreover, for five of the patients of these coroners, we used Ministry of Health data on dispensed opioid prescriptions and found that the investigating coroner had prescribed methadone to the patient within one month of the death.

Investigating the death of a former patient could influence a coroner's judgment in the death investigation. For example, as highlighted in **Figure 12**, one coroner saw his patient 143 times in the four years prior to the patient's death, and last saw the patient 10 days prior to the patient's death. Another coroner saw a patient 43 times in the three years prior to the patient's death and last saw the patient four days before death. Both coroners practised addiction medicine and prescribed methadone to these patients. Both patients died from drug toxicity. As the coroners were actively managing their patients' care and addictions, it would be difficult for the coroner to impartially evaluate the circumstances leading up to death, which is central to the role of coroner.

However, the Office does not have access to any information on the identities of the patients that coroners care for in their medical practices and so cannot exclude certain coroners from being

Figure 12: Examples[1] of Coroners Who Investigated Their Own Patients' Deaths and Did Not Declare Conflict of Interest[2]

Prepared by the Office of the Auditor General of Ontario

Coroner/Specialty/ Primary Location of Practice	Case Description
Coroner A Addiction Medicine Toronto	Coroner A had seen the patient 10 days prior to the patient's death. In the last four years prior to the patient's death, the coroner saw the patient 143 times (the patient was seen on a weekly basis). The coroner wrote in the death investigation report the exact dosages of methadone that the deceased was taking and what dose was last dispensed. The coroner did not document or report that he was the prescribing physician for the methadone[3]. The cause of death was drug toxicity. Coroner A had seen the patient 32 days prior to the patient's death. The coroner found that the patient died as a result of multiple gunshot wounds; the coroner was informed of the death by the Special Investigations Unit—a civilian law enforcement agency that investigates incidents where deaths involving the police have occurred. The deceased tested positive for methadone and cocaine, as well as other drugs. The coroner and another physician had prescribed methadone to the patient in the month before death.[3]
Coroner B Addiction Medicine Brampton	Coroner B had seen the patient four days prior to the patient's death. In the three years before the patient's death, the coroner saw the patient 43 times. The coroner noted in the death investigation report the exact dosage of methadone that had been prescribed to the patient, and that methadone was found in the patient's home; however, the coroner did not report that it was he who had prescribed the methadone[3]. The cause of death was drug toxicity.
Coroner C Family Medicine Toronto	Coroner C had seen the patient the day before the patient's death. The coroner indicated a death investigation was warranted because the patient had sustained an accidental fall almost a week prior to death (and deaths caused by accident are required to be investigated). The coroner did not document in the death investigation report that she assessed the patient the day before the patient died. The cause of death was complications from a rib fracture.
Coroner D Orthopedic Surgery Oshawa	Coroner D, who practised as an orthopaedic surgeon at a hospital, had overseen the surgery to repair a hip fracture of a patient. After surgery, the patient was transferred to an intensive care unit where the patient continued to deteriorate. The patient died a week later. The coroner's report indicated that there were "no care concerns" and a decision was made not to conduct an autopsy. The cause of death was complications from a hip fracture.

1. We reviewed all coroners who conducted more than 119 death investigations in 2018 (i.e., the 90th percentile caseload, explained in **Figure 13**) to identify instances where they billed the Ontario Health Insurance Plan (OHIP) for providing patient care to people between April 1, 2013, and December 31, 2018 and also later investigated their deaths as a coroner. This test did not include 11 of these high-volume coroners who receive compensation outside of OHIP, such as through a hospital salary or payments through a group practice such as a family health organization or group.
2. The documentation of any conflict of interest declaration was determined by reviewing the narrative of the death investigation report.
3. Methadone is a replacement drug that helps individuals deal with opioid cravings and withdrawal symptoms. It can also be prescribed for pain management. For cases where methadone was found to be the cause or factor that led to the patient's death, we used the Ministry of Health's data to confirm that the coroner who investigated that patient's death was also the physician who prescribed the methadone.

assigned to death investigations where they are likely to have a conflict of interest. Furthermore, contrary to the spirit of the conflict of interest policy, the Office does not require a coroner to confirm that the coroner has not provided care to the deceased, either when accepting the death investigation or when reports are submitted, and dispatchers do not ask coroners if the deceased was a patient prior to death. The Office policy defines and restricts coroners from performing death investigations that constitute a conflict of interest but does not specify the time lapse needed between treating a living patient and performing a death investigation that would be considered appropriate and not a conflict situation.

The Office has never obtained physician fee claims of its coroners from the Ministry of Health. This Ontario Health Insurance Plan information could help to identify coroners who had conducted death investigations on former patients.

We met with the Registrar of the College of Physicians and Surgeons of Ontario, who informed us that the College would be concerned about a potential conflict of interest for coroners who investigate their own patients' deaths. Although the College has no specific policies prohibiting this, because it does not routinely review the work of coroners, it informed us that it would review any concern about potential conflict and evaluate it based on the circumstances of the situation. The availability of coroners to do an investigation can vary across the province, particularly in more isolated areas, and coroners who find themselves in those circumstances can discuss the matter with a regional supervising coroner. However, if an issue of apparent conflict of interest were to present itself, the College would still review the matter.

We informed the Office in May and September of 2019 about the cases we found. For cases where there were reasonable grounds to believe that the physicians had committed acts of professional misconduct, a regulation under the *Coroners Act* requires the Office to report the physicians to the College. If the cases were reported immediately, the College could undertake an unannounced investigation, requiring the physicians to provide their records of both coroner and physician work without any advance warning. However, the Office chose instead to discuss the cases with their coroners first. They indicated to us that these discussions will inform the Office's decision on whether or not to contact the College. These discussions were still ongoing when we completed the audit.

RECOMMENDATION 1

To strengthen the objectivity and quality of death investigations, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- update its conflict of interest policy to be more specific about the time lapse required by a coroner between treating a living patient and performing a death investigation on that patient;
- communicate to coroners and regional supervising coroners the policy prohibiting coroners from investigating the deaths of former patients clearly and periodically;
- require coroners to formally confirm the absence of conflict of interest when they accept a death investigation, or complete a death investigation report;
- track the workplaces of coroners, for example addiction medicine or long-term-care homes, and take this information into consideration when assigning death investigations; and
- monitor compliance with this policy routinely and, for instances where the policy has been violated, suspend or terminate coroner appointments, and report coroners to the appropriate party, such as the College of Physicians and Surgeons of Ontario.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and will take subsequent actions aimed at strengthening the objectivity and quality of death investigations. The Office will:

- revise, review and update its conflict of interest policy to reflect learnings from the findings of the Office of the Auditor General, including ensuring specific guidance about the time interval between treating a living patient and performing a death investigation. This will include explanations regarding what constitutes a correlation between "treatment" and the death investigation, such as when a coroner who is also a rural family physician treats a patient for a sprained ankle, then two months later, this patient dies in a local car crash;
- clearly communicate the policy to coroners and regional supervising coroners through regular reminders in the all coroner updates and annual course;
- require investigating coroners to complete the new Coroner Investigation Template in QuinC (a coroner investigation database under development and expected to be complete by the end of 2020) that includes a mandatory field to indicate whether the coroner has treated the deceased person and if so, when and under what circumstances. If "yes" is indicated, the case will prompt immediate review by the responsible regional supervising coroner;
- expand the existing coroner database to include fields that identify the type of practice and expertise of each coroner. This will include affiliated treatment facilities and hospitals. Regional offices will send annual requests to confirm whether there are changes to a physician's place(s) of employment or specialty of practice. The Office will consider mechanisms to integrate this data into the case assignment process; and
- identify approaches to monitor and evaluate for compliance, including but not limited to the use of the conflict of interest mandatory field on the electronic investigation template, to ensure timely review and response. If non-compliance is identified, potential responses may include: performance management, suspension, termination or notification of the appropriate regulatory body, such as the College of Physicians and Surgeons of Ontario, if required.

4.1.2 Some Coroners Investigating Deaths While under Practice Restrictions Imposed by Regulatory College

A regulation under the *Coroners Act* requires both the Chief Coroner and the Registrar of the College of Physicians and Surgeons of Ontario to provide notification to each other about instances where a physician who is also a coroner has committed an act of professional misconduct, or is found to be incompetent. The Act does not require the College to provide details of the circumstances leading up to the investigation and the results.

By reviewing information available on the College's public website for coroners who were permitted to perform death investigations in 2018, we found that the Ontario College and another province's regulatory college had concerns with 16 coroners.

For six of these coroners, the Office was not aware that the College had imposed practice restrictions on the coroners' practice of medicine.

For seven of these coroners, the Office was aware that the colleges—including another province's regulatory college—had imposed practice restrictions following investigations of these coroners' practice of medicine. However, the Office did not restrict the coroners' work following the regulatory college's notification that these coroners

had been found to be incompetent or engaged in professional misconduct.

For three of these coroners, the Office restricted the coroners' work by placing one on a leave of absence for 13 months, and requiring regional supervising coroners to provide closer supervision for the other two coroners. Consequently, all conducted death investigations while under practice restrictions by the College because the Chief Coroner did not consider their infractions to impact their work as coroners.

We reviewed the work of these coroners and in some cases, we were able to identify quality concerns regarding their work, as described below. However, neither we nor the Office were able to assess whether there were any significant performance concerns, such as insufficient depth of investigation at the death scene, or not interviewing all appropriate witnesses, because coroner work is largely unsupervised.

Office Was Not Aware of Regulatory College's Notifications of Coroners' Practice Restrictions

The College makes public, by posting on its website, cases where it has imposed terms, conditions or limitations on a physician's ability to practice. We identified cases where the Office was unaware of such issues, mainly because it does not periodically check the College's website for such information. Instead the Office expected the College to provide this information through direct communications, since this is required under the *Coroners Act*. The College informed us that it had provided this information to the Office. However, because the College also sends the Office notices about every public sanctioning action of any Ontario physician—about 650 emails annually, and less than 1% are coroners or forensic pathologists—the Office did not consistently identify communications about coroners until we brought this to their attention.

The Office was not aware that six practising coroners collectively performed 104 death investigations while under the College's medical practice restrictions. One of these coroners signed an agreement with the College in October 2017 to cease practising due to concerns about the way he had practised medicine. This coroner was subsequently involved in 52 death investigation requests—accepting and investigating 28, and deciding that 24 did not require an investigation. In June 2018, the coroner resigned from the College but still took on another six death investigations the following month, and resigned from being a coroner July 1, 2018.

We reviewed a sample of the death investigation reports of these coroners and found obvious deficiencies, and ethical concerns:

- One coroner investigated the deaths of nine individuals who were either his patients or were treated at the hospital where he was the chief of staff—both constitute a potential conflict of interest. Further, in two of these cases, the family of the deceased expressed concerns regarding the care their relative had received at the hospital in the period leading up to the death. As chief of staff, it would be especially inappropriate for the coroner to investigate these deaths, since poor quality of care at a hospital could reflect negatively on both the hospital and the chief of staff. The Office informed us that these death investigations were acceptable because the deaths occurred in a small community and there were limited options for another coroner to attend the death. However, there was no documentation of the conflict, and how the risk of a biased death investigation was managed.
- With another coroner, the College identified deficiencies with record-keeping. All 2018 death investigation reports completed by the coroner either lacked details required by policy, or were not submitted to the regional supervising coroner by the time our audit concluded, making some reports almost one year overdue.

4.1.3 Policy Not Addressing When to Suspend or Terminate Coroners

The Office policy sets out the responsibilities of a coroner and the Office when a coroner is under investigation by the College, or for civil or criminal matters. Under this policy, the Office relies on coroners to notify their regional supervising coroners when they are under investigation. The policy does not provide guidance or criteria on when to suspend or terminate a coroner.

Since his 2013 appointment, the Chief Coroner had identified two cases where, in his judgment, a coroner's behaviour warranted being reported to the College and the Chief Coroner reported these cases to the College. He has not revoked any coroner's appointment, however. One coroner voluntarily resigned during an investigation by the Office and another coroner was suspended from working on coroner cases. In the latter case, the regional supervising coroner had raised concerns about the coroner's work in 2017, causing the Chief Coroner to initiate a review, which was ongoing when we completed our audit. The Chief Coroner also notified the College in 2017 that it was performing this review.

In another case, the Chief Coroner, who was then relatively new to the role, dismissed a regional supervising coroner due to concerns raised about this supervising coroner's workplace behaviour, which led to a revocation of his appointment as a coroner. This action warranted notification to the College but the Chief Coroner did not notify the College because the Office did not have a formal process in place to notify the College at that time.

However, we noted other cases where the regulatory colleges cited practice concerns related to prescribing narcotics, poor record-keeping, and failing to properly dispose of patient records, as well as concerns about the care and management of falls of elderly patients, communication and professionalism. The Chief Coroner did not restrict the work of any of these coroners because in his view these concerns did not affect the coroner's ability to perform death investigations. Restricting the work of these coroners would be prudent since weaknesses in judgment in the above areas could contribute to poor decisions being made in a death investigation. For example, one coroner who was restricted by the College from prescribing narcotics in 2012 has investigated 19 cases since then where the death was as a result of drug toxicity.

RECOMMENDATION 2

To improve its communication with the College of Physicians and Surgeons (College) regarding coroners who have practice concerns and properly address performance concerns of coroners, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- work with the College to develop more effective ways of sharing information about physicians appointed as coroners who already have or may have serious performance issues;
- update its policy to address when to suspend or terminate coroners with identified cases of professional misconduct, incompetence, other quality issues or ethical concerns; and
- report instances of professional misconduct, incompetence or other quality issues or ethical concerns to the College on a timely basis.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and will take the recommended steps to improve communication with the College of Physicians and Surgeons of Ontario (College) regarding coroners who have practice concerns and will properly address performance concerns of coroners.

In addition to working with the College to develop more effective ways to share information about physicians appointed as coroners with performance concerns, the Office is

developing a new service delivery model that will include a defined contractual relationship, which will outline clear performance, service and conduct expectations. The service-level agreements will encompass all aspects of the terms of service including, but not limited to: availability; remuneration; conflict of interest attestation; continuing education requirements; defined reappointment periods and adherence to quality standards.

The Office will involve the College in developing the contractual agreements to ensure a seamless approach to reporting instances of potential professional misconduct, incompetence or other quality issues that is acceptable and workable with the College.

The Office will also work with the College to update its policy to address when to suspend or terminate coroners with identified cases of professional misconduct, incompetence, other quality issues or ethical concerns. One of the defined components of the revised policy will be to set clear expectations about when and how reporting of potential concerns of professional misconduct, incompetence or other quality issues or ethical concerns to the College will occur. One of the components of the Office's quality management approach will be to track the timeliness of these reports.

4.2 Minimal Oversight of Coroners' Work

4.2.1 Coroners New to the Role Provided Five Days of In-Class Training

When physicians are appointed as coroners, they are required to take a five-day training course on death investigations run by the Office each year as explained in **Section 2.1**. The course is also sometimes used to improve the skills of coroners where regional supervising coroners identify deficiencies in their work. However, coroners are not required to pass a competency examination at course completion. Further, the Office does not verify that coroners actually attend all of the sessions and senior staff acknowledged to us that they did not know who had actually attended the training or whether they achieved the desired learning goals.

The Death Investigation Oversight Council in 2014 recommended to the Minister at the time, who accepted the recommendation, that the Office make ongoing training a requirement to continue to be a coroner. However, at the time of our audit, not all coroners were required to undergo ongoing training.

4.2.2 Office Did Not Consistently Establish Reasonable Coroner Caseload or Detect Questionable Billing Practices

Most of the regional supervising coroners and other senior coroner staff agree that conducting a minimum number of death investigations helps to ensure coroners are competent, and support high-quality death investigations. Senior staff at the Office agreed that low investigation numbers present a risk for poor quality death investigations. They also agree that an excessive caseload could lead to poor quality investigations. However, the Office had not established minimum or maximum investigation numbers for coroners. Our communications with other Canadian provinces indicated that British Columbia expects its coroners to complete a minimum of 160 reports per year; both Manitoba and Saskatchewan, similar to Ontario, do not have a standard for minimum coroner cases.

With respect to coroners who conducted few death investigations, we found that in 2018, 113 (or 33%) of the coroners conducted 20 or fewer death investigations in the year, with 30 (or 9%) conducting fewer than five investigations. In analyzing caseload data, we included only those coroners who were active—that is, investigated at least one case during that year—and excluded those coroners who had been appointed for less than a year. One coroner who conducted fewer than 20 death investigations in 2018 did not provide sufficient detail in the

reports and failed to complete some investigations on time, as discussed in **Section 4.1.2**.

With respect to coroners who had a heavy caseload of death investigations in 2018, we found that, while the average caseload for a coroner in 2018 was 52 cases, 34 coroners carried about 90% of the total caseload. One coroner performed 16 times the average number of death investigations in 2018—872 in total, the highest of any coroner in 2018. The same coroner investigated the most deaths in each year from 2014 to 2018. In 2018, a coroner with 52 cases would be paid about $23,000. In contrast, the coroner who performed the 872 investigations was paid about $440,000—this coroner incurred additional premiums such as for travel. **Figure 13** shows the average and highest coroner caseloads between 2009 and 2018.

We examined how reasonable the workloads were for the five coroners with the highest numbers of death investigations in 2018. These coroners also provide patient care as physicians in their medical practices when they are not performing death investigations. While coroners have some flexibility in conducting much of the work of death investigations—for example, requesting the deceased's health records—death scene work must be conducted on the same day as the death investigation is accepted.

In performing this analysis, we compared coroner billings with Ontario Health Insurance Plan (OHIP) billings to assess how much work—both as coroners and as physicians—these coroners were performing in a single day. Using the Office's estimate, we assumed each death investigation takes 90 minutes. While this analysis did not highlight any concerns regarding the majority of coroners who bill OHIP, we found that on one day in 2018, the top billing coroner, in addition to the time spent on investigating deaths, saw 82 living patients. The doctor would have had only about five minutes to see each patient—if this doctor worked around the clock for 24 hours.

We also found other questionable billing practices, including:

- Twelve coroners who billed twice for the same service from 2014 to 2018. These coroners billed and received both the $450 case fee from the Office, and OHIP fees for pronouncing and certifying deaths. The coroners should have billed only the $450 coroner fees. These inappropriate billings were not identified because the Office and the Ministry of Health do not share billing data. While the total amount inappropriately billed to OHIP was less than $1,000 in total, the

Figure 13: Coroner Caseloads Statistics, 2009–2018

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

	Total # of Cases	# of Coroners with at Least One Case Commenced During the Year	Average Caseload per Coroner	90th Percentile Caseload[1]	Highest # of Cases per Coroner
2009	17,058	313	54	127	605
2010	17,378	321	54	125	587
2011	16,579	311	53	127	616
2012	16,549	314	53	123	601
2013	15,946	327	49	111	602
2014	14,817	323	46	106	662[2]
2015	14,592	309	47	108	792[2]
2016	15,567	325	48	110	1,111[2]
2017	17,078	339	50	115	985[2]
2018	17,461	337	52	119	872[2]

1. Nine out of 10 coroners carried a caseload at or below this amount in the year specified.
2. The same coroner completed the highest number of death investigations in 2014 through 2018.

Office informed us that it assumed physicians would understand that double billing was unethical. Therefore, it did not have a policy that prohibits charging both fees.

- One coroner conducted two death investigations and performed post-mortem eye donations on the individuals. The coroner double-billed after-hours and travel premiums to both OHIP (over $200) and the Office (over $100) for these two cases.
- One coroner billed the Office the full death investigation fee of $450 for a death investigation that was transferred to another coroner because of a conflict of interest. The Office policy, again, does not include this situation. However, senior management indicated that billing for a case in which a conflict of interest has been identified indicates poor coroner judgment.

RECOMMENDATION 3

To improve the quality of coroners' death investigations and quality of care to their living patients, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- require all coroners to attend ongoing training as a requirement to continue to be a coroner, in accordance with the recommendation from the Death Investigation Oversight Council in 2014;
- establish minimum and maximum caseload guidelines for coroners' work;
- assess the reasonableness of coroners' caseloads periodically by analyzing caseload and total workload using Ontario Health Insurance Plan (OHIP) claims data;
- establish a policy prohibiting coroners billing OHIP for the same services as the Office, and monitor compliance with this policy; and
- report any trends of billing violations or concerns to the Ministry of Health.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and will take steps to improve the quality of coroners' death investigations and quality of care to their living patients. This will be achieved by:

- Working together with experts in medical education development to prepare an evidence-informed, competency-based training and continuing education program. As part of the Office's service delivery contractual relationship, all coroners will be required to attend ongoing training to allow reappointment as a coroner. The Office will continue its engagement with a university continuing medical education department to build on the foundational work recently completed to replace the current new coroners' course.
- The new service delivery model will establish both minimum and maximum caseload guidelines for coroners' work clearly outlined in the service-level agreements. For example, some coroners may be "full time" whereas some may work on a per diem basis. Remuneration is expected to be based on per diem as opposed to per case.
- Case numbers will be evaluated as part of performance reviews that will be integral to the new service delivery model contractual relationship. The Office will work with the Ministry of Health to determine potential methods of claim data access to support contractual compliance oversight.
- Service level agreements will clearly indicate that coroners are prohibited from billing OHIP for the same services as the Office.
- While the Office does not have direct access to OHIP billing information, we will work with the Ministry of Health to establish an

approach to information sharing, monitoring compliance and anticipated Office action arising from discovery of billing violations.

4.2.3 Opportunities to Improve Quality of Death Investigation Reports Lost Due to Inconsistent Supervisor Reviews

Since coroners perform their work with little or no direct supervision, regional supervising coroners sign off on each death investigation report to confirm the coroner has conducted a thorough death investigation, completed the report properly and arrived at a reasonable conclusion.

However, the Office's policy is silent on how regional supervising coroners should communicate changes needed to the coroner who authored the report, or how to document and track deficiencies identified. We surveyed all of the regional supervising coroners and found that their review practices varied. For example, they usually do not consistently document evidence of their review, making it difficult to assess the depth and extent of review. Consequently, the Office cannot confirm that the reviews consistently identify and correct quality concerns in death investigation reports. Specifically, we found that:

- only one of the 10 regional supervising coroners used the checklist the Office developed to help guide their reviews of death investigation reports. The one regional supervising coroner who did use the checklist said it was used only for new coroners' work. Our survey of the regional supervising coroners indicated that they did not use the checklist because it was not required, and a few said it was too time-consuming. Further, one regional supervising coroner did not know it existed. However, most of the regional supervising coroners indicated that the checklist could be useful and were considering using it in the future;
- when the cause and manner of death provided does not flow logically from the evidence obtained in the investigation, all regional supervising coroners indicated they would contact the coroner to discuss this situation because they considered this type of error to be most significant. However, for other errors, such as coding, report-writing style or derogatory comments—that could unnecessarily distress the family of the deceased and undermine the professional reputation of the Office—some regional supervising coroners would correct the reports, while others would direct coroners to revise and resubmit the reports. This informal process made it difficult for us to confirm whether certain coroners' reports required more revisions than others; and
- no regional supervising coroners kept records of issues they had identified in their reviews to determine whether certain coroners were repeating the same errors, making it difficult to identify coroners who require additional support or training.

With the assistance of an experienced expert who has a death investigation and medical background, we reviewed a sample of 15 death investigation reports to assess whether the Office's conclusions were reasonable given the evidence in the file. While we found no issues in five of the 15 reports, the remaining 10 contained various concerns with either the coroner's death investigation report or the pathologist's autopsy report. The concerns we had on the coroner reports—all of which would have been reviewed by a supervisor—mainly relate to the accuracy of the report and the completeness of evidence considered. For example, in one case, the name of the deceased was inconsistent throughout the report, which could have upset the family. In another case, we found no evidence that the coroner reviewed photos taken by police at the death scene, which could have assisted the coroner in assessing the fatal injury. We discuss concerns with pathologist's autopsy report from this work in **Section 4.3.1**.

4.2.4 Quality Assurance Unit Identified Errors in Coroners' Reports Even after Supervisor Reviews

The Office requires that quality assurance staff at the Operational Services Branch's quality assurance unit review a sample of coroners' final investigation reports after the supervisor has reviewed them. Our audit found that quality assurance staff did not review all death investigation reports of new coroners in their first year as required. As well, the Office did not have procedures for performing additional reviews on the work of coroners at higher risk of completing erroneous death investigation reports.

In 2017, quality assurance staff found that 18% of the death investigation reports reviewed contained information that was incorrect, incomplete, or did not meet the Office's standards, even after the supervisor reviews. Because quality assurance reviews are conducted after death investigation reports are finalized and issued to external parties, undetected errors in death investigation reports could affect policy development that relied on the data, and could have legal or medical ramifications. For example, the Domestic Violence Death Review Committee chair indicated there are difficulties in identifying which deaths that are included in the Committee's review involved victims in Indigenous communities, thereby making it difficult to develop recommendations to address their unique concerns.

The quality assurance unit reviews its sample, chosen according to the risk attached to the manner of death, to identify whether conclusions are documented clearly and flow from the investigation. Unit staff do not question whether the investigation was done properly because they do not have the expertise to do so. They instead review the report and identify incorrect information by comparing the death investigation report to other documents in the file, such as autopsy reports, toxicology reports and reports from the police and ambulance services.

We have the following concerns regarding the Office's quality assurance reviews:

- **The quality assurance unit did not review reports of all new coroners in their first year as required in the Office's policy:** In 2017, the most recent year for which sufficient data was available, unit staff reviewed only 19% of cases performed by new coroners in their first year because the regional supervising coroners did not send in all new coroners' death investigation reports for review, and quality assurance unit staff had not followed up to obtain them. In contrast, the Office's policy requires all such cases to be reviewed. In comparison, the unit reviewed beyond the required amounts for other types of death investigation reports—the unit reviewed 63% for accidents (25% required), 55% for natural deaths (10% required), 79% for suicides (50% required), and 77% for undetermined deaths (50% required). The unit reviewed all homicide cases as required.
- **The Office does not have additional target coverage rates aimed at testing the quality of other higher-risk death investigation reports:** Coroners who had a higher rate of major errors identified by quality assurance reviews are not subject to further reviews. We reviewed error rates as identified by the quality assurance process by coroner and found that 23 coroners who had at least five cases reviewed in 2017 had a major error rate of between 40% and 80%, but the Office did not require additional quality assurance reviews for these coroners. As well, the Office does not require each coroner to have at least one death investigation report reviewed each year. We found that 36 coroners did not have any cases reviewed in 2017.
- **Quality assurance reviews are conducted after death investigation reports are issued externally; undetected major errors could have an impact on the family of the deceased, other investigating partners and the justice system:** Quality assurance reviewers categorize errors as major when

they could potentially affect the justice system or the Office's investigative partners, such as the police, investigators from the Office of the Fire Marshal and the Ministry of Labour. For example, major errors include first and/or last name of the deceased spelled wrong, cause of death not logical or consistent with the details of the investigation, the absence of body examination details, and the inclusion of any findings or conclusions of legal responsibility, which are not to be made by coroners.

- **No analysis on what common major errors are trending year over year:** We found that the major error rate found in coroner reports has increased to 18% in 2017 from 6% in 2013, as indicated by an operational review of the Office of the Chief Coroner conducted by the Ministry's internal audit in 2013. At our request, the Office compiled data on the type of errors coroners had made. According to this information, the top major errors found in the Office's 2017 quality assurance reviews included improperly recording factors that contributed to the death, such as drug or alcohol abuse, and not correctly recording the location of death.

We also reviewed the quality assurance results of coroners who are currently or have been a regional supervising coroner. Several regional supervising coroners were recently promoted and some regional supervising coroners elected to take on cases to keep their skills current. Our analysis of quality assurance unit data indicated that seven out of 14 regional supervising coroners who performed death investigations had higher error rates, ranging between 20% and 63% in 2017—as compared with the 18% error rate over all reviewed cases. These regional supervising coroners had between two and 71 death investigation reports reviewed by the quality assurance unit.

4.2.5 Coroner Decisions to Not Investigate Certain Deaths Often Not Documented

As noted in **Figure 5**, a coroner's acceptance of a case from a coroner dispatcher is always preliminary. The coroner must make inquiries of police or medical staff at the death scene to determine if the case warrants a death investigation. According to the Coroners' Investigation Manual, a coroner should only accept the investigation if there is reason to believe the death is not from natural causes, or is a natural death that is sudden and unexpected.

It is important for the coroner to document the rationale for not investigating a death for the Office to be assured that all deaths required by the *Coroners Act* are investigated. However, the Office does not require coroners to provide documentation to support their rationale for deciding death investigations are not warranted. The Office pays coroners $30 for documenting and providing them with the reasons in a daytime case, and $60 for a case at night; however, coroners still sometimes choose not to do so. We reviewed a sample of dispatcher records of incoming and assigned death investigation cases in the month of June 2018 and found that, for cases the dispatchers had coded as not warranting a death investigation according to the coroner, coroners did not submit documentation of their rationale in 56% of the cases.

The Office has never estimated how frequently coroners indicate that a death investigation is not warranted, and does not provide reports to regional supervising coroners on the rate their coroners accept death investigations versus informing dispatch that an investigation is not warranted. The risk of not documenting these reasons was highlighted in the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, which focused on the actions of one nurse who administered lethal doses of insulin to eight long-term-care home residents and attempted to kill six other victims. In one of the deaths, a nurse at the long-term-care home reported the death to the Office to investigate, as physicians at the

hospital flagged the patient's symptoms preceding death—a sudden drop in blood sugar—as suspicious. However, the coroner who was assigned informed dispatch that a death investigation was not warranted because, in his opinion, the death appeared to be from natural causes. Because this coroner did not document the rationale supporting his opinion, neither the Office nor the Inquiry was able to review the reasonableness of the coroner's rationale. Over the next two-and-a-half years, the nurse went on to murder one additional victim and attempted to murder two more victims. The final July 2019 report of the Inquiry recommended that the Office require a coroner who decides not to perform a death investigation to complete a standard document setting out the reasons for the decision. This document should then be submitted electronically to both the regional supervising coroner and the Office within specified timelines.

4.2.6 Lack of Data Available to Supervisors to Help Monitor Coroners' Work Performance

The Office does not track certain data that could help inform the regional supervising coroners' assessments of their coroners' decision-making in managing deaths reported to the Office. This assessment includes whether coroners responded to requests to perform death investigations on a timely basis, and whether they performed high-quality work. Without this information, regional supervising coroners cannot determine whether their coroners have met legislative requirements in investigating deaths.

Figure 14 lists a number of indicators that would help the Office monitor and assess whether its coroners are producing high-quality work.

RECOMMENDATION 4

To strengthen the objectivity and accuracy of death investigations and to support informed decision-making, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- require regional supervising coroners to fully document their reviews of death investigations;
- track coroner errors to identify systemic issues through both the regional supervising coroner reviews and the quality assurance unit, and take appropriate actions such as providing more training to help reduce errors, and performing more reviews of reports from coroners with higher error rates;
- provide reports to regional supervising coroners on the rate their coroners indicate a death investigation is not warranted;
- require all coroners to provide documented rationale to the Office when they determine a death investigation is not warranted;
- require regional supervising coroners to review such cases to ensure the rationale documented was reasonable; and
- identify all significant areas of coroners' work that require their judgment and timely response, including the rate at which they order autopsies and collect and critically review this information regularly.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and will take steps to strengthen the objectivity and accuracy of death investigations, and support informed decision-making. The Office's new information technology system, QuinC, and the Coroner Investigator program will be key in satisfying this recommendation.

- With the new QuinC system, coroners will submit their reports for review electronically to their respective regional supervising

Figure 14: Data Not Tracked and Provided to Regional Supervising Coroners to Manage Quality of Work of Coroners

Prepared by the Office of the Auditor General of Ontario

Indicator	Why This is Important
How often each coroner answers or returns phone call requests from the dispatchers to conduct death investigations	This would allow the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) to monitor whether coroners are making themselves reasonably available during their on-call period. A high refusal rate might indicate that they should be taken off of the on-call roster.
How often each coroner applies sound judgment in accepting a case for investigation	This would allow the Office to monitor whether death investigation resources are used only on cases that warrant investigation—for example, coroners would be expected to decline obvious natural death cases. An unusual ratio may indicate that poor decisions are being made. The Ontario Internal Audit Division noted in its 2013 operational review of the Office that there is a risk that coroners "may accept a case outside of the mandatory legislated cases in order to increase their income" when undertaking death investigations that do not meet the criteria established in the *Coroners Act*.
How often each coroner orders an autopsy for a death investigation	While unnecessary autopsies incur unnecessary expense (from $700 to $2,000 per autopsy), a low percentage of autopsies may indicate coroners are coming to conclusions about cause and manner of death without sufficient evidence. A high or low ratio could help the regional supervising coroner identify possible trends that indicate poor death investigation practices. For example, we noted that the percentage of death investigations for which coroners determined an autopsy was necessary has gradually increased from 37% of 15,946 death investigations in 2013 to 47% of 17,461 death investigations in 2018, as shown in **Figure 3**.
The amount of time that elapses after a coroner has agreed to conduct a death investigation until arrival at the death scene*	This would allow the Office to determine whether coroners arrived at the scene within reasonable amount of time to limit wait times by external parties such as the police or health-service providers. While significant time elapses before a coroner's arrival on scene could result in a complaint being received at dispatch, such complaints are not tracked.
How often death scenes are not visited by a coroner and instead are managed remotely; when coroners do not attend the death scene in person, but instead delegate the investigation to police or other health-care professionals	According to the Office's guidelines for coroners, coroners should attend the death scenes whenever possible to examine the body; the coroner's attendance at the death scene can provide valuable information that other people may miss, such as examining the position of the body to determine whether it was moved after the person died, and the relevance of how the death may have been caused by objects in the deceased person's proximity. The June 2019 report *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* had identified coroners not attending scenes as an example of the difficulty Indigenous people have in accessing justice. The report recommended that, "In order to ensure consistency in all sudden death investigations, wherever possible, and taking into account the resources available in a community, coroners on call should coordinate their schedules to avoid other responsibilities that would prevent them from attending a scene."
How frequently coroners make errors in completing death investigation reports	This would help identify whether certain coroners had repeated errors in the same areas, as described in **Section 4.2.3**.

* The Ministry's internal audit performed an operational review of the Office of the Chief Coroner in 2013 and also noted this information was not tracked.

coroner. The system will have version tracking so the supervising coroner's changes will be fully documented and available for review directly by the coroner. The report will not be finalized until the coroner accepts the changes and returns the revised report to the supervisor for further review.

- The QuinC system will allow tracking of coroner errors and will identify systemic issues when a quality review is conducted. This provides a roadmap for systemic change organizationally and individually for the supervising coroner to inform the need for remediation and training that may be required for a coroner to improve performance.
- The QuinC system will require documentation of all contacts requesting involvement of the Office. Case selection decisions, including rationale for not accepting a case for investigation, will be mandatory and will be reviewed for reasonableness by the regional supervising coroner on a case-by-case basis. Reports will be able to be generated to illustrate individual coroner actions and comparable regional or provincial data.
- The Office's Coroner Investigator program should greatly reduce the investigating coroner's need to assess whether a case will be accepted. Coroner Investigators complete a vigorous, documented screening of apparent natural death calls from Provincial Dispatch (the ones most commonly rejected by coroners) and only refer cases to coroners that clearly meet the criteria outlined in the *Coroners Act*. Up until now, these calls were sent from dispatchers to the coroners directly, as Provincial Dispatch does not have the legislative authority to perform any investigative function. Coroner Investigators will be documenting all calls in the coroner investigator module in QuinC.
- Performance expectations will be clearly defined in the new service delivery contractual relationships. Key performance indicators will be developed with reporting facilitated by the QuinC system to allow individual coroner review.

4.3 Gaps Identified in Oversight of Pathologists' Autopsy Work

The quality of autopsies is key to two of the core priorities of the Office—to provide answers and information to families after sudden and unexpected deaths, and to search for the truth and provide evidence in support of the administration of justice.

4.3.1 Established Process to Support Objective Review of Autopsy Cases for Criminally Suspicious Deaths Not Consistently Followed

The Office completed 391 peer reviews of autopsy reports of criminally suspicious deaths in 2018/19, the most recent year for which data was available. However, over six and a half years, between January 2013 and June 2019, about 185 cases or 11% of such autopsy cases were not assigned to reviewers in the manner prescribed by policy. The Office policy requires cases to be centrally assigned by pathology administrators, by rotating through all forensic pathologist reviewers. These reviews can help confirm that the opinions stated by the original forensic pathologist are reasonable, given the available evidence, and that the autopsy report is clear to other forensic pathologists. This is important if the autopsy report is presented as evidence in court, and those without medical training are required to understand it.

We found that:

- For the cases where forensic pathologists did not follow the established peer review policy, forensic pathologists either directly requested that another forensic pathologist review their work, or requested the pathology administrator in charge of the peer review process assign it to a particular forensic pathologist. For example, a pathologist requested a

specific peer reviewer because they had previously discussed the case, and the requested reviewer was more familiar with the details. However, we question how objectively a reviewer could evaluate a report in these circumstances, particularly for clarity. While it may be reasonable for the rotation to be set aside if a forensic pathologist has expertise with a particular type of case, such exceptions should be described in the Office quality assurance policy, and centrally assigned with the rationale documented.

- The Chief Forensic Pathologist can override the rotation policy if he determines this to be appropriate. This practice was not formalized in the Office's policy until May 2019. Even so, the Office still does not require the rationale for overriding the rotation policy to be documented and does not track when this occurs.

In our survey of forensic pathologists, half of the respondents indicated that the peer review process was effective, while the other half indicated that some improvements could be made to increase its effectiveness—they responded it was only "usually effective" in identifying significant errors. Effective peer review of criminally suspicious cases is important because even one undetected error can have legal ramifications.

With the assistance of an experienced expert who has a death investigation and medical background, we reviewed a sample of 15 death investigation reports to assess whether the Office's conclusions were reasonable given the evidence in the file. While we found no issues in five of the 15 reports, the remaining 10 contained various concerns—some of which could have legal ramifications, the most significant of which are described in this report—with either the coroner's death investigation report or the pathologist's autopsy report.

These cases were previously peer reviewed. In one case, the autopsy report was not signed by all responsible pathologists who conducted and oversaw the autopsy, which could be questioned in court. In another case, a peer reviewer did not document his rationale for accepting the autopsy pathologist's opinion that a prior assault of the deceased was not an influence on the death. Significant unanswered questions remained regarding the cause of death in this case.

4.3.2 Weaknesses in Review Process of Autopsy Cases for Non-criminally Suspicious Deaths

We found that the Office does not monitor whether the various locations where autopsies are conducted consistently review autopsies of non-criminally suspicious cases in an objective manner, and in accordance with its policy. It also does not track the concerns raised in these reviews to identify systemic issues or concerns with individual pathologists. Knowing the quality of pathologist work is important; such information must be documented in personnel files to help inform the senior forensic pathologists on the Credentialing Committee. This Committee advises on adding or removing pathologists from the register of approved forensic pathologists and pathologists and may also make recommendations to the Chief Forensic Pathologist to help inform his supervisory decision on particular pathologists.

The policy does not indicate how to choose cases for quality assurance review—for example, self-selection or random selection—or how a reviewer is chosen. Senior staff informed us that they expect 10% of each pathologist's reports to be reviewed. We found the following:

- Regarding the selection of cases to be reviewed, different units across the province used different approaches. One regional unit selected cases randomly; another regional unit allowed its pathologists to self-select the cases to be reviewed; and the Toronto unit pulled every tenth case from each pathologist, which allowed pathologists to predict which of their cases would be selected for review.
- Regarding the selection of reviewers, similar to the review process for criminally suspicious

cases, for one of the regional units we visited, pathologists would select the reviewer, thereby introducing bias into the review process. In this unit, two married forensic pathologists reviewed each other's cases. While the Chief Forensic Pathologist informed us that he did not have any concerns with this arrangement since no concerns had been raised about the quality of the work of these forensic pathologists, the expert we engaged noted that this practice should not be considered acceptable as a general rule since it introduces the possibility of bias.

We also found that for the 2013/14 to 2018/19 fiscal years, regional units did not always submit quarterly summary reports of their reviews to the Office as required and various units did not review the required number of non-criminally suspicious cases, as shown in **Figure 15**. In one regional unit, nine quarterly reports noted that between 3% and 17% of autopsy reports it reviewed contained significant errors. As well, four of the six units informed us that the medical director would review and correct errors and not count them in the reports that were forwarded to the Office.

Regarding community hospitals where no direct supervision of the quality of autopsies is available onsite, the Office provides the oversight. In 2016/17, 12 pathologists who conducted fewer than 20 cases per year had only 39% to 93% of cases reviewed. In 2017/18, 11 pathologists had only 29% to 95% of cases reviewed. Policy requires all such cases to be reviewed.

4.3.3 No Policies on When Pathologists Require More Training, Suspension or Removal from the Register

Under the *Coroners Act*, the Chief Forensic Pathologist is responsible for the supervision and direction of pathologists in the provision of services. The Office does not have policies that

Figure 15: Weaknesses of Quality Review Practice for Autopsies of Non-Criminally Suspicious Cases by Location
Prepared by the Office of the Auditor General of Ontario

Regional Hospital-Based Forensic Pathology Units	Policy Requirement	
	All Quarterly Summary Reports Submitted to Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)	**Reviews Done for 10% of Non-criminally Suspicious Cases in Fiscal Year per Pathologist**
Hamilton	Missing one quarterly report from 2014/15 and one from 2015/16; Office sent an email to follow up: • For 2014/15 quarter, the Medical Director informed the Office that the Unit had not retained the results of the review and the Office decided to assign a 100% compliance rate. • For 2015/16 quarter, the regional unit did not provide a response and the Office did not follow up further.	Reviews 10% of unit cases, not per pathologist
Ottawa	No concern	Only 5%-9% of cases were reviewed between 2016/17 and 2018/19, except for one quarterly report that met 10% requirement.
London	No concern	Reviewed all cases of Category B pathologists and minimal Category A pathologists; that is, not meeting 10% per pathologist requirement.
Sudbury	No quarterly reports submitted since 2013/14	Reviewed minimal cases.
Kingston	No concern	No concern
Sault Ste. Marie	No concern	No concern

describe circumstances that warrant interventions such as training, suspension or removal from the register. As well, when the Office requires pathologists or forensic pathologists to undergo supplementary training, it does not consistently document the reasons for training, or its objectives and results. Furthermore, while the Goudge Inquiry recommended that the regional directors at hospital-based forensic pathology units conduct performance appraisals of the forensic pathologists that report to them, the Office does not obtain copies of these and cannot consider this information when making decisions on whether to retain or remove the physician from the register. Without this information, the Office cannot ensure that pathologists' performance issues are being addressed and actions to improve performance are effective.

The Office typically requires pathologists with performance concerns to undergo training, or supervision while completing cases. We were informed that when the Office's quality assurance processes, peers, or stakeholders such as Crown or defence attorneys identify a pattern of deficient performance with a pathologist, the Chief Forensic Pathologist determines if it is necessary for the pathologist to undergo performance intervention.

The Office does not centrally track which pathologists the Chief Forensic Pathologist has required to undergo performance intervention. We reviewed the personnel files of all pathologists on the register since 2014 to identify performance concerns, and the actions taken to address these concerns. Our review found that performance issues were noted with 10 pathologists. In six cases, we found one or more of the following issues:

- the Office did not consistently document the rationale for supplementary training;
- the Office lacked clear policies on the risks posed by deficiencies of the pathologists' work on living patients that might affect their autopsy work; and
- the policies were silent on situations that warrant removal of a pathologist from the register.

In another case, the Chief Forensic Pathologist did not remove a forensic pathologist from the register despite repeated performance concerns since 2011, and the Office's Credentialing Committee's advice recommending removal from the register in 2014. The Chief Forensic Pathologist did not notify the College of Physicians and Surgeons of Ontario about the concerns that led to this 2014 recommendation, but required this forensic pathologist to undergo supplementary training in 2017 and 2019—which was still ongoing when we completed the audit—and notified the College about the concerns that led to these later actions. The Chief Forensic Pathologist did not remove this forensic pathologist from the register because in his view, "boundaries of professionalism are not well-defined" in forensic pathology, the forensic pathologist was showing improvement, technical expertise was not an issue, and de-registration would end this forensic pathologist's career.

RECOMMENDATION 5

To support the provision of consistent, high-quality autopsies across Ontario, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- define in policy the situations where the rotation process does not need to be observed for autopsies of criminally suspicious cases, and document in the peer review report when these exceptions apply;
- monitor that autopsy cases of criminally suspicious deaths are assigned on a rotation basis as per Office policy;
- define in policy the situations that warrant performance interventions, such as training, direct supervision or removal from the register of pathologists and forensic pathologists, and communicate this policy to staff;
- revise the transfer payment agreement with regional hospital-based forensic pathology units to allow the Office to obtain more detailed quality assurance data, particularly

on the types of errors made by forensic pathologists and pathologists, and follow up on any missed reports; and
- track all errors by pathologists and forensic pathologists and use this information to inform appropriate intervention of staff, such as training.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts the recommendation and will implement procedural improvements to increase the level of documentation on decisions made pertaining to the registration of pathologists and forensic pathologists. The Office will:
- define circumstances for non-random assignment of peer reviewers for autopsy reports;
- create standards for the continuing professional development of registered pathologists and forensic pathologists including defining circumstances for suspension or removal from the register;
- update transfer payment agreements to include key quality indicators; and
- improve tracking of errors by registered pathologists and forensic pathologists.

4.4 Weaknesses in Body Storage Practices

4.4.1 Minimal Safeguards in Hospital Morgues Increase Risk of Body Misidentification and Degradation

Proper body storage practices are crucial to maintaining the integrity of a death investigation and for maintaining public trust with grieving families by ensuring that their loved ones will be handled with dignity and respect. As discussed in **Section 2.2.4**, while the Toronto Forensic Pathology Unit has dedicated storage spaces for bodies before and after autopsies, regional hospital-based forensic pathology units and community hospitals store bodies for coroners along with other bodies. Morgues in these settings store bodies that do not warrant death investigations, such as natural deaths at the hospital, and unclaimed bodies that municipalities are ultimately responsible for burying. Typically, hospital porters and nurses are responsible for bringing the bodies of those who die in hospital to these storage areas, and hospital security is responsible for both receiving the bodies of those who die in the community, and releasing bodies from the morgue. We visited two regional hospital-based forensic pathology units and two community hospitals, observing in some cases that hospitals had three to nine lockable spaces for homicide victims, but no assigned spaces for other coroner cases.

The Office does not have agreements with or information on community hospital policies and procedures for body storage, and does not receive reports from these hospitals about their ability to store bodies for death investigations. While the Office has transfer payment agreements with each regional hospital-based forensic pathology unit in the area of morgue management, the agreements merely require that the unit be "equipped and up-to-date." Cold storage rooms where bodies are kept are under the authority of the hospital, not the regional unit.

The Goudge Inquiry also recommended that, "with the support of the Ministry of Health and Long-Term Care and the Ministry of Community Safety and Correctional Services, the Ontario Forensic Pathology Service and each hospital with which a regional unit is associated should create protocols to clearly define the areas and limits of the hospital's responsibilities, to avoid confusion about the oversight roles of the Chief Forensic Pathologist and the hospital." While the Office introduced transfer payment agreements to define these limits, they do not address the operation and security of the cold storage rooms, where bodies may be held while in the custody of the coroner and pathologist. The expert we engaged informed

us that coroners and pathologists—regardless of where they work—should be expected to consistently demonstrate care and respect until the body is released from the coroner's custody.

The absence of arrangements for body storage has resulted in misidentification or degradation of bodies at three regional hospital-based forensic pathology units.

- At one regional unit in 2019, a forensic pathologist autopsied the wrong body. The hospital incident report noted that contributing factors were "a lack of appropriate numbered storage spaces within the morgue cold storage room and secondary checks to prevent inadvertent mix-ups; and high volume of bodies on stretchers in the cold storage room."
- Senior management at another regional unit reported that due to limited storage space, bodies have been moved out of cold storage into the hallway, and bodies in body bags are sometimes stored side by side or on top of each other in storage spaces. This regional unit did not document these instances but indicated that they occurred during 2019 and did not know if any of these bodies were coroner cases.
- A bag containing personal effects of a deceased person went missing in 2019 in another regional unit. The regional unit investigated but could not locate the bag. It informed us that it subsequently paid the next-of-kin for the lost items. In this regional unit, there are no cameras in the morgue or in the cooler area, and the unit cannot track who has accessed the morgue given that hospital porters, nurses and security use a key, not a security card, to access it.

RECOMMENDATION 6

To safeguard evidence needed for death investigations and maintain the dignity of the deceased, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- develop minimum standards for both community hospitals and regional hospital-based forensic pathology units to apply to bodies that form part of a death investigation performed at these locations that require them to secure and maintain bodies at appropriate temperatures; and
- revise transfer payment agreements with the regional hospital-based forensic pathology units to include standards on body management and monitor compliance.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts the recommendation and will develop minimum standards for securing and maintaining bodies in community hospitals and forensic pathology units. The Office will share these standards with hospitals and include them in the transfer payment agreements.

4.4.2 Lack of Body Storage Procedures in the Office's Headquarters Results in Errors in Release of Bodies

Proper quality assurance measures for the storage of bodies is important to ensure that bodies are treated in a respectful way, and released only with proper authorization. Between December 2015 and January 2018, the Toronto Forensic Pathology Unit released the wrong body to a funeral home or cremation service on three separate occasions. In all three cases, the cause was a combination of human error and the lack of proper controls to identify and locate bodies in the morgue at the Toronto Forensic Pathology Unit. Families impacted by these incidents were notified after the errors were discovered.

At the beginning of 2018, the Office introduced policies to guide the release of bodies to families or funeral homes to reduce the risk of inappropriate

release at the Toronto Forensic Pathology Unit. However, no standard operating procedures exist for performing an inventory of bodies.

While morgue staff informed us that they performed body inventories periodically, they saved only body count results, so we could not review any errors that were identified. We performed a body inventory in the Toronto Unit in May 2019, and identified 10 errors in body location—a body was found in the wrong cooler twice, and bodies were located on the wrong tray or gurney eight times. These errors increase the risk of a body being released incorrectly for burial or cremation. It also creates inefficiencies for the morgue attendant, who might need to check many locations to find the correct body. Management informed us that they could not conclusively say why these errors had occurred. They suggested that the errors were likely due to typos in logging bodies, morgue staff errors in locating or releasing bodies, or their electronic logging system, which does not prevent the same location from being entered twice. The risk of the lack of controls for body storage is likely to increase as caseloads increase at the Toronto Forensic Pathology Unit when it takes on an additional 1,300 cases each year by July 2020 as a result of the decommissioning of the Hamilton unit.

RECOMMENDATION 7

To reduce the risk of inappropriately releasing bodies in the Toronto Forensic Pathology Unit, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service develop policies to describe the proper and systematic storage of bodies and for performing inventories of bodies, and to monitor compliance.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service accepts this recommendation and will develop internal policies for the acceptance, storage and discharge of bodies from the cold storage facility, including the regular inventory of bodies and compliance monitoring.

4.5 Thousands of Deaths Under-reported to the Office

While police and health-care workers report the majority of deaths reported to the Office, everyone is required under the *Coroners Act* to contact the police or a coroner when certain types of deaths occur. (See **Section 2.1.1**). Coroners may investigate a death when a family member or health-care provider raises concerns about the care provided to an individual prior to death.

To examine whether the Office was informed of all reportable deaths as defined by the Act, we reviewed the cause of death that physicians included in their Ontario Health Insurance Plan billings in 2018 for certification of death, and identified those that appeared to meet the reporting requirements under the Act.

We identified about 2,300 deaths in 2018 that appeared to meet the criteria of reportable deaths but were not reported to the Office. These include sudden deaths with unknown causes; deaths resulting from fractures, dislocations, or other traumas; adverse effects of drugs and medications; and deaths during pregnancies. Senior medical staff at the Office confirmed that these deaths should have been reported. The Office does not electronically track the identity or details about the person reporting a death. The lack of such information makes it difficult for the Office to know how to develop a public education campaigns to improve understanding about reporting deaths.

The Office informed us that generally, death investigations are more difficult after significant time has passed since bodies may have been cremated, witnesses may not recall details and death scenes may no longer be available.

According to the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System, as discussed in **Section 4.2.5**, six of the eight deaths were not reported to the Office and so were not investigated until these cases came to light after the confession of the individual who committed these crimes.

RECOMMENDATION 8

To strengthen its ability to investigate all deaths defined as reportable under the *Coroners Act*, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- track and assess the groups of people—for example whether police, hospital staff or members of the public—reporting deaths into the Office; and
- develop a communication strategy (with a public education component) to educate relevant parties from the medical community and law enforcement on the legislative requirement to report deaths for investigation.
- build on its response to recommendations arising from The Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System to develop an education curriculum for all members of the health-care sector to include specific education about the legislative requirement, purpose and benefit of reporting deaths to the Office in a timely manner; and
- revisit its current death investigation training programs delivered to law enforcement to ensure clarity in detailing the legislative requirements for reporting deaths for investigation.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts the recommendation to strengthen its ability to investigate all deaths defined as reportable under the *Coroners Act*. To achieve this, the Office will:

- ensure that QuinC has the capacity to track the categories of people, such as police, hospital or member of the public reporting deaths to the Office, to help inform strategies to enhance notification of reportable deaths to the Office. This would be a required field that is completed upon intake of the initial call to Provincial Dispatch;

4.6 Review of Service Delivery Model Needed

4.6.1 Pilot Project of Forensic Pathologist-Led Death Investigation Not Evaluated

Over the last decade, the Ontario government has commissioned various studies, as well as a pilot project, to review the benefits of having forensic pathologists attend death scenes. Although some forensic pathologists attend death scenes, the reasons for and benefits of doing so have not been examined. For example, the Office terminated the pilot project in 2018 without evaluating whether it had helped improve death investigations. Conducting such an assessment would help guide when it is cost-beneficial to use this valuable resource in such a manner. See **Appendix 8** for details on the events that led to the scene attendance practices that are followed by forensic pathologists who provide autopsy services for the Office.

In May 2018, the Office noted that prior to the pilot project "forensic pathologists did attend scenes but this was done ad hoc and not tracked." At the time of our audit, the Toronto Forensic Pathology Unit was not tracking scene attendance by forensic pathologists. In contrast, outside of Toronto, we found that in 2017/18, forensic pathologists at six regional hospital-based forensic pathology units

made 41 scene visits. Our review of this data indicated the majority (almost 70%) of these visits were made in one regional unit but the Office had not assessed whether this higher attendance rate was because the scene visits were found to provide valuable insights to these death investigations in that area. We surveyed other Canadian provinces and found that forensic pathologists either do not attend death scenes or do so only in rare circumstances.

4.6.2 Alternative Coroner Staffing Models Not Evaluated

The Ministry's internal audit noted in its 2013 operational review of the Office of the Chief Coroner that regional supervising coroners have difficulty managing coroners because of the lack of contractual relationships. The Chief Coroner responded by acknowledging that a "more robust framework (was) needed for engaging and managing the performance parameters and expectations of our coroners." He informed us that the absence of time-limited appointments for coroners makes it more difficult to remove coroners with quality concerns since there is no mechanism established to prompt a review. In comparison, pathologist appointments are periodically revisited through the time-limited appointment process set out in the pathologist register. In 2014, the Death Investigation Oversight Council recommended that coroners be appointed for a specified time period and that the reappointment be contingent on the recommendation of the Chief Coroner.

The Office began a pilot in early 2018 to reduce the instances of coroners investigating natural deaths. A registered nurse, acting as a "coroner investigator," makes an initial judgment about whether a death requires an investigation, which primarily consists of determining whether it is likely from natural causes. The Office expects this approach to reduce the number of deaths a coroner investigates by about 3,400 cases per year, with annual net savings estimated at about $1 million. Further, the Chief Coroner informed us that his long-term plan is to introduce a new service delivery model composed of trained health-care professionals who will dedicate a portion of their time to death investigations and will be engaged to work for the Office through a contractual relationship. The health-care providers will likely include doctors, nurses and paramedics. This is expected to improve efficiencies and develop the competence of these coroners through experience in death investigations. However, the Office has not performed an analysis of this model. Such an analysis could include comparing the salaries of the non-physician coroners and the time needed to conduct a death investigation for a full-time staff person, against the current $450 fee for a part-time physician coroner. According to our research, death investigation conclusions are made by those with a medical background in the majority of other Canadian provinces (see **Appendix 9**).

RECOMMENDATION 9

To improve the accountability and cost-efficiency of Ontario's death investigation services, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service:

- develop a process to track forensic pathologists' scene attendance and the impact of such attendance on the death investigation;
- assess the costs and benefits of including forensic pathologists at death scenes, and the types of scenes that their expertise helps improve the quality of the death investigation; and
- evaluate staffing model alternatives such as changing the current workforce of coroners with other non-physician professionals or forensic pathologists when autopsies are involved, and making coroner positions full time, and implement changes required.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service accepts this recommendation and will develop tools to implement improvements in accountability and cost-efficiency of Ontario's death investigation services, including:

- tracking the frequency, investigative effectiveness and cost-efficiency of scene attendance by forensic pathologists;
- establishing guidelines for caseload and workload for professional contributors to the death investigation system to ensure a sustainable workforce; and
- ensuring effective analysis of the proposed new coroner service delivery model to ensure a cost-effective service model, as compared with other possible models.

4.6.3 Transfer Payments to Regional Forensic Pathology Units Not Reviewed Based on Workload and Cost-Effectiveness

The Office makes annual transfer payments to six hospital-based regional forensic pathology units, but does not ensure the funding is used for autopsies, staff or any other measurable factor. In fact, in the 2018/19 fiscal year, the Office's overall cost for each autopsy varied from $1,569 at the Sault Ste. Marie unit to $2,610 at the Ottawa unit—a 66% difference.

The Office has not assessed the actual costs needed to operate the forensic pathology service program. As noted in **Figure 9**, each regional unit receives from $100,000 to $570,000 per year. These amounts were determined about a decade ago and have not changed. The Ministry's internal audit also reported in June 2018 that funding to regional units did not align with autopsy workload.

RECOMMENDATION 10

To demonstrate that it is receiving value-for-money from regional hospital-based forensic pathology units, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service review its funding to these units for workload and cost-effectiveness and revise as necessary.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and will endeavour to review funding of the units based upon workload and cost-effectiveness. The Office requires approval from Treasury Board and the Ministry of the Solicitor General to increase transfer payment amounts to forensic pathology units.

4.7 Public Reporting on Office's Activities Not Timely or Not Available

4.7.1 Published Reports at Least Four Years Old

When information is not shared with the public in a timely way, the public's confidence in the work of an organization may be diminished. Although the *Coroners Act* does not require the Office to publish an annual report, the Chief Coroner and the Ontario Forensic Pathology Service have published separate reports for the public. While the Ontario Forensic Pathology Service informed us that it has shared its annual results ending July 26, 2017 and July 26, 2016 with stakeholder groups such as police, Crown Attorneys and coroners, at the time of our audit, the most recent reports published online for the general public included only a report from the Ontario Forensic Pathology Service for the period ended July 26, 2015, and from the Chief

Coroner for the four-year period from 2012 to 2015. In comparison, we noted that Newfoundland and Labrador and Quebec had published more recent results, from 2017 and 2018, respectively.

For the year 2017, the Office took about 21 months—from January 2018 to September 2019—to complete about 98% of that year's 17,078 death investigations, about half of which (7,657) included autopsies. Senior management at the Office explained that the delay in publishing these results was partially due to a significant turnover of five of 10 regional supervising coroners since January 2017. The Chief Coroner informed us that the Office does not have an annual reporting cycle and that other operational matters had been focused on such as the day-to-day requirements of conducting death investigations as well as providing data to stakeholder groups when requested.

RECOMMENDATION 11

To increase its transparency and be more accountable to the public for its death investigation work, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service annually report on performance and provide updates in future years if statistics pertaining to a particular year are revised.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation. To increase transparency and be more accountable to the public for its death investigation work, the Office will:

- annually report on performance and provide updates if statistics pertaining to a particular year are revised, such as changes arising from finalizing conclusions when investigations are completed; and
- work with the Ministry of the Solicitor General's Research, Analytics and Innovation Branch, and Communications Branch, to develop an innovative approach to annual reporting that can provide more real-time data, such as publishing links to Public Health Ontario's Opioid tracker with the Office's most recent data.

4.7.2 No Public Status Updates on Recommendations to Reduce the Risk of Further Deaths

One of the Office's goals is to prevent further deaths. Senior staff informed us, however, that measuring the Office's impact in this area is inherently difficult because multiple parties are involved in making changes to help improve safety in Ontario. Inquests involve legal counsel and other parties presenting evidence on the processes within government organizations to help develop recommendations to prevent further deaths. The Chief Coroner informed us that the Office does not have specific insights to know whether these recommendations are fully implementable. Consequently, he indicated that the recommendations made under the Office's authority should not be considered binding. Death review committees and inquests, together with one expert panel, produced about 600 written recommendations that were published in 2018, as shown in **Figure 16**.

The Office has never publicly indicated that it does not validate whether these recommendations can be implemented. Yet the public would view coroner recommendations made through inquests and death review committees to be fully supported by the Office.

The Office requests that ministries and other organizations that receive recommendations from death review committees or inquests respond within six months. The Office rarely reports the responses that it receives publicly. According to the Chief Coroner, the rationale for not publishing responses is the concern that the number of requests may not justify the time and cost of formatting responses for their website from hard copy, and translating them

into French. Without responses to inquest and death review committee recommendations, the public cannot determine whether organizations or ministries have addressed deficient areas that could still contribute to further deaths.

We noted that both the governments of British Columbia and Saskatchewan make responses to inquests public. British Columbia publicly posts responses to its death review units, which are similar to Ontario's death review committees.

RECOMMENDATION 12

To better serve and be transparent to the public in its role in preventing further deaths and protecting the living, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office):

- make the current status of implementation and responses to recommendations made by inquests and death review committees publicly available online; and
- communicate to the public the Office's position regarding the usefulness and practicality of these recommendations.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation. To better serve and be more transparent to the public about our role in preventing further deaths and protecting the living, the Office will:

Figure 16: Recommendations Made by Inquests, Death Review Committees and an Expert Panel in 2018
Prepared by the Office of the Auditor General of Ontario

Source of Recommendation	Description	# of Recommendations Published in Reports
Inquests		
35 inquests held during 2018 for 47 deaths	Five Ontarians appointed as jurors hear testimony from witnesses, experts and other parties such as ministries and are presented with information from these parties. Jurors may choose from presented recommendations and/or develop some of their own. Each inquest is self-contained, a one-off, that produces a formal report containing recommendations.	536
Death Review Committees		
Domestic Violence Death Review Committee	Five death review committees that each review specific types of deaths, usually those that are considered to be of more critical concern to Ontarians, in order to: • help ensure consistent review processes over each type of death • support coroners in conducting death investigations as needed by providing expertise in the subject area Death review committees meet on an ongoing basis, provide case-specific recommendations and produce formal reports. Only three of the committees published reports in 2018.	33
Paediatric Death Review Committee		23
Maternal and Perinatal Death Review Committee		22
Expert Panel		
Deaths of Children and Youth in Residential Placement	Consist of a group of experts who evaluate deaths that meet a certain criteria (for example, deaths of youth in residential placements) and create recommendations to reduce future deaths. Expert panels meet for a limited time and produce a formal report containing recommendations.	5

- work with the Ministry of the Solicitor General's Communications Branch to provide more immediate access to the current status of the implementation of and responses to recommendations made at inquests and death review committees publicly available online; and
- develop a communications strategy that facilitates communicating to the public the value, benefit and potential concerns about recommendations following death reviews and inquests. Any immediate public health and safety improvements should be highlighted.

4.7.3 Death Data Not Systematically and Periodically Analyzed to Identify Death Trends to Protect the Living

Although the motto of the Office is "we speak for the dead to protect the living," we found that the Office performs limited analysis on the data it collects to identify death patterns or trends. Performing more systematic analysis could identify areas of risk that could be addressed to help prevent further deaths and improve public safety. Data collected by the Office includes the circumstances of death, age and gender of the deceased, location of death, and manner of death, such as accident or suicide. Without regularly analyzing this data, the Office is missing an opportunity to use its information to prevent or reduce the risk of further deaths.

The Office acknowledges the importance of data analysis. The *Coroners Act* notes that a coroner's work involves collecting and analyzing information about deaths in order to prevent further deaths. In the Office's 2015–2020 Strategic Plan, the Office intended to implement a data management plan to capture, track and analyze information to make meaningful and measurable contributions to health and public safety. The plan also included an intention to have the "capacity for dynamic analysis to assess for emerging trends and areas of interest across the broader public safety and health sectors."

In recent years, the Office has analyzed its death investigation data to inform a 2018 expert panel on the deaths of children and youth in the care of Children's Aid Societies and Indigenous Wellbeing Societies in residential placements. The expert panel evaluated this systemic issue further to the Office's analysis of deaths as reported by stakeholder groups.

In December 2017, the Office initiated a pilot project to evaluate and prevent the deaths of children and youth between the ages of 10 and 25. (See **Appendix 4** for more on expert panels.) The project uses data from five ministries, as well as community child and youth agencies in four municipalities, to create a risk model to learn more about the circumstances leading up to the death of a child or youth, and evaluate trends. The intent is to evaluate intervention points for future recommendations. The Office may consider the possibility of reviewing all child and youth deaths in Ontario after the pilot is completed in March 2020.

4.7.4 Data on Deaths in Correctional Facilities to Inform Intervention Policies Not Publicly Released

While death review committees publish statistics on specific types of deaths, such as pediatric and domestic violence-related deaths, the Office does not publish the number and nature of deaths of inmates in correctional facilities. This includes whether a death is by suicide, accident, or natural causes. This information could help inform intervention policies. In comparison, the British Columbia Coroners Service tracks and publishes the number of inmate deaths by nature of death, and by federal or provincial correctional facility. The British Columbia Coroners Service informed us this data can help those who manage or provide oversight of correctional facilities to make changes for the better. Similarly, Saskatchewan's Ministry of Justice and the Attorney General tracks and publishes the number of suicides by year, gender and age group. For example, we noted that this data

indicates that suicides by males in Saskatchewan have generally been increasing since 2005, and that 2018 had the most suicides of any year.

4.7.5 Lack of Information Collected to Inform Intervention Policies and Public Health Concerns

The information coroners typically collect in death investigations is not always complete enough to address public health concerns. To enhance the Office's ability to support the reduction of opioid-related deaths, beginning in 2017 the Office initiated a form to be used for coroners to complete in this type of death investigation. The Office started requiring coroners to gather additional information from hospitals, family members, bystanders and emergency responders to build data on deaths that may be related to opioid use. This information included demographics, mental health and substance use history. While the Chief Coroner informed us that he has from time to time conducted media interviews where he has provided information on deaths resulting from high temperatures, the Office has not released any formal reports to the public on the extent to which heat has resulted or contributed to deaths to Ontarians. The Chief Coroner informed us that given current data limitations, he could not perform such an analysis. We noted that heat-related deaths related to climate change have been an issue of growing public concern.

Similarly, the Public Inquiry into the Safety and Security of Residents in the Long-Term Care Homes System report, released in July 2019, recommended that the Office redesign its form for institutional patient deaths to collect additional information. This information could include clinical observations from staff, or concerns raised by family or other care providers about the resident's care in the period leading up to and including the death.

RECOMMENDATION 13

To reduce the occurrences of preventable premature deaths and improve public safety, we recommend that the Office of the Chief Coroner and Ontario Forensic Pathology Service collect relevant information to analyze deaths, identify trends and provide the information to government and other organizations that can use this information in policy development.

OFFICE OF THE CHIEF CORONER AND ONTARIO FORENSIC PATHOLOGY SERVICE RESPONSE

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) accepts this recommendation and agrees that to reduce the occurrences of preventable premature deaths and improve public safety, that we collect relevant information to analyze deaths, identify trends and provide the information to government and other organizations to inform policy development to enhance the health and safety of Ontarians.

The QuinC system will implement case-specific templates to guide the investigation and collection of defined data elements in multiple death types, such as motor vehicle crashes, deaths of children, gunshot-related deaths, and drownings.

The general and specific investigative approaches were developed to capture information about the determinants of health with a view to inform a public health approach to intervention, and to inform prevention of further deaths. Each of the case specific approaches were informed by those with expertise in the case type, for instance, the Lifesaving Society for the drowning template.

In addition, in 2018 there were amendments to the *Coroners Act* that provide clarity, framework and privacy processes to support the

sharing of mortality data with other entities for data analysis and research.

4.8 Oversight Role of Death Investigation Oversight Council Cannot be Effectively Executed

As noted in **Section 2.4**, the Death Investigation Oversight Council (Council) was established in 2010 to provide independent oversight for the Office, following recommendations by the 2008 Goudge Inquiry. The Council was established to improve the oversight of forensic pathologists working on death investigations, as well as coroners, and to ensure that the Office of the Chief Coroner is independent of government.

The Council is unique to Canada. Ontario is the only province that has established an oversight body for death investigation services. Its function is to provide advice and recommendations to the Chief Coroner and Chief Forensic Pathologist, as outlined in the **Appendix 10**.

Our audit identified many areas where the Council was not effectively supporting and overseeing the effective operation of the Office:

- The Council made about 60 recommendations to the Office in the last five years that the Office committed to implement. The Council does not have the authority to require the Office to implement these recommendations.
- The Council does not review the work of the Chief Coroner or Chief Forensic Pathologist. The Goudge Inquiry recommended in 2008 that a forensic pathologist from outside Ontario be appointed as a member of the Council. A forensic pathologist still had not been appointed to the Council by the time of our audit.
- The *Coroners Act* sets out the broad responsibilities of the Council, which include financial management, strategic planning, quality assurance and accountability. However, when the Office proposed closing one of its regional hospital-based forensic pathology units in 2019, it requested and obtained Ministry approval to do so without informing the Council; the Office informed us that they did not inform the Council because the Ministry of the Solicitor General directed them to keep this confidential. The Office did not engage with the Council on this decision until the government's confidential annual budget planning cycle was complete. The Ministry informed us that it acknowledges the importance of the Council's financial and strategic planning role and commits to engaging with Council on Office plans before entering into any future confidential budget planning cycles.
- Despite the Council having a specific mandate—over its nine years of operations—to make recommendations to the Office on its performance measures, it informed us that it had recently begun, during the course our audit, to more regularly inquire about the Office's specific key indicators. The Council informed us this is partly because it has been waiting for the new coroner information system to be rolled out; the Council expected this system to form the basis of a new performance framework. The Council has been receiving regular updates on the new system and the expectations of it. While we found that the Office had certain performance indicators that measure the timeliness of completing death investigation reports, as noted in **Section 4.2.6**, the Office did not track data to measure the quality of individual coroners' work.

RECOMMENDATION 14

To improve the effectiveness of oversight of the Office of the Chief Coroner and Ontario Forensic Pathology Service, we recommend that the Ministry of the Solicitor General revisit the terms of reference and authority of the Death Investigation Oversight Council.

MINISTRY RESPONSE

The Death Investigation Oversight Council (Council) was established in December 2010 as an independent advisory body, which generally aligns with the recommendations of the Goudge Inquiry related to the province's forensic pathology system. The legislative framework for the Council is set out in the *Coroners Act*. The government's Agency Review Task Force recently reviewed the Council and determined that it should be maintained, while exploring improvements to its complaints and appointments processes. The Ministry will consider this recommendation as part of its work identified by the Agency Review Task Force related to the Council.

Appendix 1: Glossary of Terms

Prepared by the Office of the Auditor General of Ontario

Autopsy: Also known as a post-mortem examination, a pathologist or forensic pathologist examines a deceased person's body to help determine cause of death. An autopsy could include an external examination, full dissection (examination of internal organs), or targeted dissection (examination of specific organs based on findings from a computerized tomography (CT) scan).

Coroner: A medical doctor, appointed by the Chief Coroner to conduct death investigations as mandated by the *Coroners Act*. About 70% of active coroners have a background in family medicine.

Death Investigation: A coroner, with the assistance of a forensic pathologist (when required) conducts analysis of available evidence to understand how and why a person died. A coroner must answer five questions when investigating a death:

- Who (identity of the deceased)
- When (date of death)
- Where (location of death)
- How (medical cause of death) and
- By what means (natural causes, accident, homicide, suicide or undetermined).

Information may be obtained from several sources including, but not limited to, family, co-workers, neighbours, doctors, hospital records, police and other emergency service workers.

Death Review Committees: Five committees established between 1989 and 2014 that offer specialized knowledge and expertise in complex death investigations within the specific subject matter areas of patient safety, domestic violence, maternal and perinatal, geriatric and long-term care, and pediatric. Refer to **Appendix 4** for further details.

Expert Panels: Established by the Office of the Chief Coroner to inform the investigation of certain deaths, such as children and youth who die in residential placements, and those who die from participating in winter sports, to identify any commonalities and/or trends, systemic issues or concerns, and make recommendations that may assist in preventing further deaths in specific areas.

Forensic Pathologist: A physician who performs autopsies and is expert in disease and injury that result in sudden death; has about one year of additional schooling/training compared to a pathologist. By definition, all Category A pathologists on the Ontario register of pathologists are forensic pathologists and can perform all autopsies, including homicide, pediatric and criminally suspicious cases.

Forensic Pathology: A sub-specialty of pathology that focuses on determining the cause of death through the examination of a deceased person.

Inquest: A public hearing designed to focus public attention on the circumstances of a death through an objective examination of facts. At the conclusion of an inquest, the five-person jury makes recommendations that are intended to prevent further deaths. There are two types of inquests: mandatory (required by law) and discretionary (at the discretion of the coroner). (See **Figure 11** for more information.)

Pathologist: A physician who performs autopsies and is expert in disease and injury, requiring about four to five years of additional schooling/training in general pathology or anatomical pathology after becoming a physician. All pathologists on the Ontario register of pathologists are categorized by the types of autopsies they can perform. Category A pathologists can perform all autopsies, including pediatric, homicide and criminally suspicious cases. All Category A pathologists are forensic pathologists. Category B pathologists can perform autopsies on non-criminally-suspicious adult cases. Category C pathologists can perform non-criminally-suspicious pediatric cases.

Pathology: A branch of medical science that involves the study and diagnosis of disease through the examination of surgically removed organs and tissues, and in some cases the whole body (i.e., an autopsy).

Reportable Death: The *Coroners Act* requires that every person in Ontario must report certain types of deaths to a coroner. Reportable deaths are defined as:

- Deaths as a result of violence, misadventure, negligence, misconduct, or malpractice;
- Deaths during pregnancy or following pregnancy in circumstances that might reasonably be attributable to pregnancy;
- Deaths that are sudden and unexpected;
- Deaths from disease or sickness for which he or she was not treated by a legally qualified medical practitioner;
- Deaths from any cause other than disease;
- Deaths where a person dies while resident or an in-patient in the following settings:
  - a children's residence as defined under Part IX (Residential Licensing) of the *Child, Youth and Family Services Act, 2017* or premises that had been approved under subsection 9(1) of Part I (Flexible Services) of the *Child and Family Service Act*, as it read before its repeal;
  - a supported group living residence or an intensive support residence under the S*ervices and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008*;
  - a psychiatric facility designated under the *Mental Health Act*;
  - a public or private hospital to which the person was transferred from a facility, institution or home referred to in this list;
- Deaths in long-term care homes;
- Deaths off premises of psychiatric facilities, correctional institutions, youth and custody facilities (the person was a patient or committed to the facilities; however, death occurred while not on premises or in actual custody of the facilities);
- Deaths of individuals while detained in and on the premises of a lock-up;
- Deaths of individuals while committed to or on the premises of a place of temporary detention under the *Youth Criminal Justice Act* (Canada);
- Deaths of individuals while committed to and on the premises of a place or facility designated as a place of secure custody under section 24.1 of the *Young Offenders Act* (Canada);
- Deaths of individuals while committed to or on the premises of a correctional institution, or off premises of the institution but in the actual custody of a person employed at the institution; or at a hospital after having been transferred to the hospital by the correctional institution;
- Deaths of individuals while detained by or in the actual custody of peace officers, or an injury sustained or other event that occurred while the individual was detained by or in the actual custody of peace officers is a cause of the death;
- Deaths of individuals as a result of the use of force by a police officer, auxiliary member of a police force, special constable or First Nations Constable;
- Deaths of individuals where the Special Investigations Unit Director causes an investigation to be conducted;
- Deaths of individuals while being restrained and while detained in and on the premises of a psychiatric facility within the meaning of the *Mental Health Act* or a hospital within the meaning of Part XX.1 (Mental Disorder) of the *Criminal Code* (Canada);
- Deaths of individuals while being restrained and while committed or admitted to a secure treatment program within the meaning of Part VII of the *Child, Youth and Family Services Act, 2017*;
- Deaths of workers as a result of an accident occurring in the course of the worker's employment at or in a construction project, mining plant or mine, including a pit or quarry.

Appendix 2: Appointment Process for Investigating Coroners

Prepared by the Office of the Auditor General of Ontario

The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) follows Ontario Public Service (OPS) guidelines for appointing new coroners by posting an annual recruitment advertisement on the OPS website. Prospective coroners submit their applications and the Office's human resources department performs an initial screening by eliminating all applicants who are not physicians. The remaining applications are usually forwarded to a deputy chief coroner who creates a short list of applicants to be invited to interview after eliminating applicants in regions that have a sufficient number of coroners.

Regional supervising coroners conduct the interviews of people applying within their regions. The regional supervising coroners are to score the applicants based on the interview and then make a recommendation to the Chief Coroner on whether to accept an application. Ultimately, the Chief Coroner makes the final decision on appointments. In 2018 and 2019, 71% and 58% of coroners who applied and were recommended were accepted, respectively. Reasons for not accepting applicants included concerns about their living patient workload, and whether new physicians would be licensed in time to take the annual coroner's course.

Appendix 3: Topics Covered in New Coroners Course Offered by the Office of the Chief Coroner and Ontario Forensic Pathology Service

Prepared by the Office of the Auditor General of Ontario

- An overview of a death investigation: the purpose of the investigation, which answers the five questions for each death (who, when, where, how, by what means);
- Duties and powers of coroners, including the circumstances of deaths that need to be investigated (non-natural deaths, etc.) as set out under the *Coroners Act*;
- Receiving calls from the Office's Central Provincial Dispatch Unit: how to decide whether a case should be investigated, which generally requires an evaluation of whether a death was natural based on preliminary information available;
- Scene attendance: the requirement to dress appropriately for the scene (for example, wearing boots, jackets, and personal protective equipment based on location and weather), documents (such as warrants to take possession of the body, and brochures for families), ways to gain access to death scenes, initial questions for police (e.g., do they have any reason to believe there are criminal concerns, whether they have identified the deceased person), speaking with family, examination of the body, and completion of warrants;
- Case studies on all manners of deaths: natural, accident, suicide, homicide, and undetermined;
- Process for communicating high-profile cases (i.e., deaths with significant potential risk to the Office and/or criminal justice system if not managed optimally) so that preliminary information can be shared between coroners and pathology service;
- Introduction to autopsy and forensic pathology: how forensic pathologists determine cause of death, describing an autopsy, duties of forensic pathologists, post-mortem changes (pathways to decomposition), and introduction to injuries (e.g., blunt force, sharp force, firearm, strangulation) that may be factors to consider in concluding on deaths;
- Inquests: their purpose, how and when an inquest is called, and when to consider making a suggestion for an inquest to a regional supervising coroner;
- Protocols on identification of unidentified bodies including checking dental records;
- Introduction to toxicology: different types of tests and analyses as well as how to read toxicology reports and results;
- Additional considerations for investigating certain types of deaths such as maternal and pediatric;
- Case documentation requirements, entering death investigation information and generating reports, and submission of reports to the Office; and
- Certifying death.

Appendix 4: Death Review Committees and Expert Panels Supporting the Chief Coroner

Source of data: Office of the Chief Coroner and Ontario Forensic Pathology Service

Committee/Panel	Year Established	Types of Deaths Reviewed
Death Review Committees		
Patient Safety Review Committee	2005	Health-care-related deaths where system-based errors or issues appear to be a major factor
Domestic Violence Death Review Committee	2003	Deaths of persons that occur as a result of domestic violence
Maternal and Perinatal Death Review Committee	1994	Deaths relating to maternal, stillbirths, and neonatal
Geriatric and Long-Term Care Review Committee	1989	Deaths involving geriatric and elderly individuals and others receiving services within long-term care homes
Paediatric Death Review Committee[1]	1989 2014	Deaths of children and youth where care-related concerns have arisen or when a children's aid society has been involved within 12 months of the death.
Expert Panels		
Expert Panel on the Deaths of Children and Youth in Residential Placements	2018	Children and youth under care of children's aid societies or the Indigenous Child Wellbeing Society and died in residential placement.
Winter Sports Death Review	2015	All accidental skiing, snowboarding and tobogganing deaths
Ornge Air Ambulance Transport Related Deaths	2013	Death with concerns related to air ambulance transport identified
Other		
Construction Fatality Review Committee[2]	2012	Identifying potential, urgent public safety hazard that may not have already been acted upon by other individuals or organizations (investigating coroner, Ministry of Labour investigation, police investigation, etc.) and suggest recommendations and areas where questions could be asked at inquest

1. This committee was formed in November 2018 after the Deaths Under Five Committee and the previous Pediatric Death Review Committee were merged.
2. Neither a death review committee nor an expert panel, but functions similarly to both.

Appendix 5: Inquiry into Pediatric Forensic Pathology in Ontario, 2008

Prepared by the Office of the Auditor General of Ontario

The Inquiry into Pediatric Forensic Pathology in Ontario, commonly known as the Goudge Inquiry, was a public inquiry ordered by the Government of Ontario following various discoveries of the inaccurate post-mortem pediatric work of Dr. Charles Smith. Dr. Smith performed such work on behalf of the Office of the Chief Coroner, and was then the Director of the Ontario Pediatric Forensic Pathology Unit at the Hospital for Sick Children. From 1981 to 2005, due to systemic weaknesses regarding the oversight of forensic pathology services, Dr. Smith performed pediatric forensic pathology despite having no formal training or certification in forensic pathology.

Concerns were being raised at a growing rate about Dr. Smith's competency by court officials, family members of those affected by his work, and the Association in Defence of the Wrongly Convicted. The then-Chief Coroner called a formal review of Dr. Smith's work in 2005, using the services of five international forensic pathologists. They examined all 45 criminally suspicious cases for which Dr. Smith had conducted an autopsy or provided a consultation opinion since 1991. In nine of 45 cases, the reviewers did not agree with "significant facts" that appeared in Dr. Smith's report or his testimony. In 20 of 45 cases, the reviewers had concerns with the opinions expressed in Dr. Smith's reports and/or his testimony, and in 12 of these cases, the legal proceedings had resulted in a guilty verdict (the Inquiry did not indicate how many of Dr. Smith's opinions were used as the basis for a guilty verdict). This report was released on April 19, 2007.

Later in April 2007, a commission was established by the Government of Ontario to review the way pediatric forensic pathology was being practised and overseen in Ontario. The Honourable Stephen T. Goudge was chosen to lead this commission. Justice Goudge was directed to focus on the 20 cases flagged by the formal review, and to make recommendations to correct the system's potential for error and absence of oversight. The Inquiry into Pediatric Forensic Pathology in Ontario released its report on October 1, 2008.

The Inquiry made 169 recommendations with five lead ministries assuming reporting responsibility; 127, or about three quarters of the recommendations were directed to the Ministry of Community Safety and Correctional Services (Ministry)—now the Ministry of the Solicitor General. The Ministry established a project team to act as the co-ordinating body for the recommendations. The implementation of the recommendations from the Inquiry resulted in a general strengthening of the quality assurance processes over autopsies through the *Coroners Amendment Act* (2009). Changes included the introduction of the register for forensic pathologists and pathologists authorized to conduct autopsies that would form part of a death investigation, and the position of Chief Forensic Pathologist to oversee the work of pathologists. The Death Investigation Oversight Council was also created to oversee the operations of the Office of the Chief Coroner and Ontario Forensic Pathology Service.

Appendix 6: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	The Office of the Chief Coroner and Ontario Forensic Pathology Service (Office) performs death investigations where required by legislation.
2.	All coroners and pathologists used by the Office are competent.
3.	Death investigations are completed in a timely manner.
4.	Adequate information to support the rationale for decisions made is documented for all deaths reported to the Office, including those that did not result in a death investigation. The conclusions of death investigations are accurate and evidence-based.
5.	The value of performing additional death investigation processes, such as autopsies and inquests, is demonstrated.
6.	Ontario's death investigation model is assessed to determine its cost-effectiveness, for example, by comparing it with other jurisdictions. The resource requirements for coroners and pathologists are assessed and appropriate actions are taken where necessary.
7.	Recommendations made by the Office are tracked and followed up to help prevent further deaths.
8.	Meaningful performance measures and targets related to death investigations are established, monitored, and publicly reported.

Appendix 7: Excerpts from the Coroners Investigation Manual on Conflict of Interest

Source: Office of the Chief Coroner and Ontario Forensic Pathology Service

"In most circumstances, a coroner should not accept for investigation a case where there exists, or may be a perception of a conflict of interest. If a conflict becomes apparent during an investigation already started, the coroner should not continue with the investigation, and seek guidance from the RSC [regional supervising coroner].

It is recognized that physician coroners in most communities may have medical staff appointments at their local hospital. Although the potential for a relative conflict of interest may exist, in most situations where there are no serious care concerns, the coroner can conduct an objective and unbiased investigation provided he/she was not involved in the care.

Examples of where conflict of interest may exist include:

1. The coroner has had a professional relationship with the deceased or family of the deceased (e.g. as attending physician);
2. The deceased was a relative, friend or business associate of the coroner;
3. There appear to be questions of quality of care provided to the deceased and the health care professionals in question have a professional affiliation with the coroner (e.g. work in same clinic);
4. The coroner is on the professional staff of the hospital or other institution and there are serious questions of the quality of care provided in the institution.

In some circumstances where another coroner is not immediately available, it may be reasonable for the coroner originally contacted to initiate the investigation, to order the post mortem examination (if indicated) and to notify the RSC [regional supervising coroner] for transfer of the case to another coroner for the remainder of the investigation."

Appendix 8: Key Events That Led to Scene Attendance by Forensic Pathologists in Ontario, 2005–2018

Prepared by the Office of the Auditor General of Ontario based on information provided by the Office of the Chief Coroner and Ontario Forensic Pathology Service (Office)

June 2005	Chief Coroner and Medical Director of the Toronto Forensic Pathology Unit (later made the Chief Forensic Pathologist) send memo to all investigating coroners, forensic pathologists and police services in Toronto specifying the types of death scenes that forensic pathologists should attend, wherever possible. Such death scenes include those related to sexual violence, dismembered or buried bodies and homicides in a concealed location.
October 2008	As noted in **Appendix 5**, the Goudge Inquiry is released and makes a recommendation that addresses scene attendance by forensic pathologists. Justice Goudge recommends that the Office identify the circumstances in which scene attendance by forensic pathologists would be valuable and outline a protocol to be followed at the scene when forensic pathologists are in attendance.
November 2012	Ministry of Community Safety and Correctional Services (now the Ministry of the Solicitor General) engages a consulting firm to conduct a review of different death investigation systems in and outside of Canada to improve and enhance the death investigation system in Ontario. The report recommends forensic pathologists take over all coroner duties whenever a coroner orders an autopsy.
April 2013	The Death Investigation Oversight Council (Council), established in 2010, approves several recommendations from the 2012 review, including appointing forensic pathologists as coroners and having them act as coroners in all criminally suspicious deaths.
July 2014	The Office implements a pilot project, appointing 19 forensic pathologists to act as coroners in criminally suspicious deaths. They start to attend death scenes with experienced coroners.
March 2018	The Council finalizes a review and provides a final report on the pilot project to the Office that includes surveys and interviews. The Council finds that 46% of coroners, 85% of forensic pathologist-coroners, and 85% of police have favourable views of the project. Positive comments include an increased opportunity for collaboration and learning, and better case continuity from the start of the death investigation to the presentation of its findings in court. Police view the forensic pathologist-coroner as an asset who helps them examine the scene. However, the Council review does not assess whether the pilot has helped improve the quality of death investigations.
May 2018	The Office terminates the pilot project without assessing the costs and benefits of including forensic pathologists at death scenes. The Office reaffirms the memo that was sent in June 2005, and further notes “there are specific homicide or criminally suspicious scenes where attendance by the forensic pathologist is extremely useful to the death investigation,” and extends this memo province-wide, indicating that a method of tracking scene attendance and a key performance indicator for scene attendance will be developed.

Appendix 9: Comparison of Death Investigation System across Canada and Selected Regions in the United States and Australia

Prepared by the Office of the Auditor General of Ontario

	Death Investigation Conclusion Made by[1]		Organization Headed by			Annual Funding or Budget ($ million)[2] *Actual **Budgeted Amount	# of Death Investigations Performed Annually[3] (Year)
	Medical	Non-Medical	Chief Coroner	Chief Medical Examiner	Chief Forensic Pathologist		
ON	✓		✓		✓	47.1 (2018/19*)	17,900 (2018)
BC		✓	✓			16.9 (2018/19**)	5,700 (2017)
AB	✓			✓		13.6 (2018/19*)	5,700[4] (2018)
SK		✓	✓			3.0 (2018/19*)	2,200 (2018)
MB	✓			✓		3.7 (2017/18*)	1,800 (2017)
QC	✓	✓	✓			9.0 (2017/18**)	5,500 (2018)
NB		✓	✓			2.6 (2017/18*)	1,700 (2017)
PE	✓		✓			0.6 (2018/19**)	300 (2018)
NS	✓			✓		4.6 (2017/18*)	1,200 (2017)
NL	✓			✓		1.4 (2018/19*)	600 (2018)
Harris County (Houston)	✓			✓		35.7 (USD) (2018/19*)	4,600 (2018)
Maricopa County (Phoenix)	✓			✓		Information is not available[5]	6,100 (2018)
Queensland (Australia)	✓	✓	✓		✓	25.6 (AUD)[6] annual average	5,800 (2017/18)

	Remuneration[7]		Inquest/Inquiry Recommendations Made By[8]		
	Coroner or Medical Examiner (performs death investigation)	Forensic Pathologist/Pathologist (performs autopsies)	Jurors	Judge	Coroner
ON	$450 per case	$300–$1,650 per autopsy	✓		
BC	Part-time coroners: $32 per hour plus mileage Full-time coroner annual salary: $75,000–$85,000	$1,000 per autopsy (non-complex) $1,850 per autopsy (complex)	✓		
AB	Medical Examiner annual salary: $145,000 to $383,000	Fee-for-service		✓	
SK	Lay Coroners:[9] $135 base fee; $25 per additional hour Full-time coroner annual salary: $88,500 plus on-call pay or shift differentials	Annual salary: $299,000 to $345,000	✓		
MB	Medical Examiners: $72.50 per case	Annual salary[5]		✓	

	Remuneration[7]		Inquest/Inquiry Recommendations Made By[8]		
	Coroner or Medical Examiner (performs death investigation)	**Forensic Pathologist/Pathologist (performs autopsies)**	**Jurors**	**Judge**	**Coroner**
QC	Medical Coroner: $347–$756 per case Legal Coroner: $336–$631 per case	Annual salary or fee-for-service[5]			✓
NB	Coroners: $25 per hour plus expenses	Annual salary plus fee-for-service: $1,200 (forensic)	✓		✓
PE	Coroners: Fee-for-service[5]	Fee-for-service[5]	✓		
NS	Information is not available[5]	Annual salary plus fee-for-service: $850 per autopsy (for each additional autopsy, if the pathologist performs more than 200 autopsies per year)		✓	
NL	Annual salary[5]	Annual salary plus fee-for-service: $200 (external examinations) $335 (non-complicated autopsies)		✓	
Harris County (Houston)	Information is not available[5]	Annual salary[5]	n/a[10]	n/a[10]	n/a[10]
Maricopa County (Phoenix)	Medical examiner annual salary: $175,000 and above (USD)	Information is not available[5]	n/a[11]	n/a[11]	n/a[11]
Queensland (Australia)	Coroner annual salary: $361,000 (AUD)	Annual salary: Up to $335,000 (AUD)			✓

1. In non-medical systems, coroners may be physicians but can also be lawyers, retired law enforcement, other health-care professionals, and in smaller communities, well-known members of the community such as a respected business leader. British Columbia, Saskatchewan, Quebec and New Brunswick supplement the lack of medical expertise with other medical staff.
2. In Canadian dollars, unless otherwise specified.
3. Rounded to the nearest hundredth.
4. The organization indicated it conducted 5,700 death investigations in 2018, taking into consideration comparable types of death investigations conducted in Ontario. Taken together with other unnatural and non-suspicious death cases that it was involved in and its processes to facilitate approvals for cremation, the organization investigated about 20,000 cases in 2018.
5. Details are not publicly available and the organization informed us it was confidential and so could not be shared.
6. Between 2012/13 and 2016/17, the total cost of the coronial system in this jurisdiction was $128 million (AUD).
7. In some provinces, senior staff, such as the Chief Coroner, Chief Forensic Pathologist and their deputy chiefs, also perform death investigations and autopsies. Their salaries are not included.
8. The term inquest or inquiry is used depending on the jurisdiction.
9. A lay coroner system is a death investigation system that uses individuals from a variety of backgrounds; for example, nurses, retired police and bankers.
10. The organization informed us that it does conduct inquiries/inquests and therefore, this column does not apply.
11. The organization referred us to the Arizona Revised Statutes (ARS). There is no reference to inquiries/inquest in the ARS and therefore, this column does not apply.

Appendix 10: Excerpts from the Coroners Act on the Functions of the Death Investigation Oversight Council

Prepared by the Office of the Auditor General of Ontario

Functions of Oversight Council

Advice and recommendations to Chief Coroner and Chief Forensic Pathologist

8.1 (1) The Oversight Council shall oversee the Chief Coroner and the Chief Forensic Pathologist by advising and making recommendations to them on the following matters:

1. Financial resource management.
2. Strategic planning.
3. Quality assurance, performance measures and accountability mechanisms.
4. Appointment and dismissal of senior personnel.
5. The exercise of the power to refuse to review complaints under subsection 8.4 (10).
6. Compliance with this Act and the regulations.
7. Any other matter that is prescribed. 2009, c. 15, s. 4.

Reports to Oversight Council

(2) The Chief Coroner and the Chief Forensic Pathologist shall report to the Oversight Council on the matters set out in subsection (1), as may be requested by the Oversight Council. 2009, c. 15, s. 4.

Advice and recommendations to Minister

(3) The Oversight Council shall advise and make recommendations to the Minister on the appointment and dismissal of the Chief Coroner and the Chief Forensic Pathologist. 2009, c. 15, s. 4.

...

8.4 (10) Despite subsections (4) and (5), the Chief Coroner and the Chief Forensic Pathologist may refuse to review a complaint referred to him or her if, in his or her opinion,

(a) the complaint is trivial or vexatious or not made in good faith;

(b) the complaint does not relate to a power or duty of a coroner or a pathologist under this Act; or

(c) the complainant was not directly affected by the exercise or performance of, or the failure to exercise or perform, the power or duty to which the complaint relates. 2009, c. 15, s. 4.

Ministry of Children, Community and Social Services

Ontario Disability Support Program

1.0 Summary

The Ontario Disability Support Program (ODSP) is a social assistance program under the Ministry of Children, Community and Social Services (Ministry) created to meet the unique needs of people with disabilities. The program provides income support, including health and other benefits, for Ontarians with disabilities who are in financial need. An employment-support program is also available to ODSP recipients to help them prepare for, obtain, or maintain a job so that they can live as independently as possible. In 2018/19, the Ministry provided ODSP income support to more than 510,000 individuals comprising recipients and their qualifying family members.

To be eligible for ODSP income support, applicants must first demonstrate financial need by providing evidence that their assets and income levels do not exceed specified amounts. Applicants whose income and assets do not exceed these limits are then assessed to determine whether they have a medical condition that meets the definition of a disability under the *Ontario Disability Support Program Act, 1997* (ODSP Act). As of March 2019, the most prevalent primary disabilities among ODSP recipients were mental illnesses (psychoses or neuroses) and developmental disabilities, which accounted for 39% and 18% of all disabilities, respectively. The proportion of Ontarians on ODSP is 2.5% of the population, which is the highest rate among all Canadian provinces' disability programs.

The Ministry delivers ODSP directly through its front-line staff in 47 local offices. The Ministry also contracts with approximately 150 service providers to deliver ODSP employment supports across the province.

Since our last audit of ODSP in 2009, the cost of the program has increased by approximately 75% from $3.1 billion to approximately $5.4 billion in 2018/19. A significant contributing factor to the program's rising cost is the increase in the number of individuals and families receiving ODSP. Since 2008/09, the average monthly number of ODSP cases—a single individual or a family unit—has increased by 50%; in contrast, the population in Ontario has increased by just 12% over this same time frame. However, despite this significant increase to the caseload and program cost, we found that the Ministry has not investigated or studied the key reasons for caseload growth to identify whether corrective action in its delivery and administration of the program is needed.

Overall, our audit found that the Ministry's systems and processes are not effective to ensure that only eligible applicants qualify for the program and receive income support. In addition, the Ministry lacks processes to review recipients' continued eligibility for the program. The financial eligibility of most recipients is not periodically reassessed

to determine whether recipients continue to be eligible for ODSP benefits, which can lead to overpayments. We found that most of the overpayments made to ODSP recipients that we reviewed occurred because recipients had not reported changes in their circumstances that affect their eligibility. Since the time of our last audit, the Ministry has overpaid recipients nearly $1.1 billion and written off approximately $400 million in overpayments. Providing funding to ineligible individuals limits the province's ability to better support the needs of those who are eligible.

In addition, we found that in 2018/19 over 40% of ODSP applicants were confirmed as disabled by the Ministry after a cursory review of their application, a 56% increase from the time of our last audit. As well, 80% of applicants found to be disabled were approved for benefits for life without setting a future medical review to confirm they still meet the definition of a person with a disability, compared with 51% at the time of our last audit. In particular, the increase was sharpest from 2015/16 onward as illustrated in **Figure 18**. Despite the impact on program costs associated with these increases, the Ministry does not currently have a quality assurance process to assess the appropriateness of disability approval decisions, and decisions on whether to assign a medical review date. We also found, based on our own review, that the rationales for these decisions were not always sufficiently detailed or clear. Given that people with disabilities experience a wide range of challenges, it makes sense that ODSP should be simple and accessible, but it does not make sense to abdicate common sense reviews to ensure that only those that require assistance from this program receive it.

We also found that the employment outcomes of individuals on the program are not improving. Fewer than 2% of disabled adults are referred annually to the Ministry's employment supports, and most dependent family members who are not disabled are not participating in mandatory employment assistance activities. This reduces the likelihood of these individuals obtaining employment and reducing their family's financial dependence on ODSP.

The following are some of our specific concerns about the Ministry's delivery and administration of ODSP:

- **Caseworkers often do not complete required third-party checks to confirm applicants are financially eligible for ODSP**. At three of the four local ODSP offices we visited, we found that caseworkers frequently did not use information from third-party sources, such as tax return information from the Canada Revenue Agency (CRA), and credit information from Equifax Canada Inc. (Equifax), to confirm that financial information declared by ODSP applicants was complete and accurate. Caseworkers did not carry out one or more of the mandatory Equifax and CRA checks in the majority of the files we reviewed.
- **Financially ineligible recipients may transfer from Ontario Works to ODSP.** In 2018/19, approximately 62% of all financial eligibility applications granted ODSP were processed by Ontario Works offices. Our audit found that Ontario Works caseworkers did not carry out the required third-party verification checks with both Equifax and the CRA in between 23% and 100% of the files we reviewed to verify applicant income and assets prior to transferring the file to ODSP. In addition, at all four ODSP offices visited, the ODSP caseworkers did not subsequently carry out at least one of these two required third-party checks to make sure that the individual or family unit was financially eligible for ODSP prior to issuing income support payments.
- **Over 40% of ODSP applicants are confirmed to be disabled after a cursory review of their application, representing a 56% increase from the time of our last audit.** The Ministry determined these applicants to be disabled and to qualify for ODSP

through its triage process, which is an expedited process intended to be a cursory review of a completed application to determine whether the medical evidence clearly identifies that an applicant is disabled. Despite the significance of this increase, the Ministry has not analyzed the reasons for the increase to ensure these decisions are appropriate and made in accordance with the ODSP Act.

- **The Ministry has no process to assess the appropriateness of disability approval decisions, despite significant differences between adjudicators.** We found that while one adjudicator who reviewed almost 4,200 applications in 2018/19 through the triage process approved just 20% of ODSP applications, two adjudicators, including an adjudicator who reviewed over 500 applications, approved all of them. These differences are concerning because the Ministry does not have a process to review the appropriateness and consistency of decisions between adjudicators and to take corrective action where these differences are not reasonable. In 2014, the Ministry stopped completing adjudication file reviews to ensure adjudicator decisions are appropriate and in line with the ODSP Act and Ministry policies.
- **Adjudicators' rationale for disabled decisions are not always clear, resulting in a lack of transparency and accountability for the taxpayer.** We reviewed a sample of applications confirmed to be disabled and found that in almost 20% of the approved applications we reviewed it was not clear from the application and the adjudicator's rationale how the applicant met the definition of a person with a disability. One such example included an applicant with two listed conditions: fibromyalgia and vertigo. The documentation in the application did not support that the applicant had substantial impairments, and included documentation from a health-care professional that concluded there was no diagnosis of vertigo. The adjudicator's rationale did not explain why the applicant was approved in the absence of substantial impairments.
- **The Ministry rarely sets medical reviews that are required by legislation, which has resulted in the majority of approved applicants confirmed as disabled for life.** Across all stages of adjudication, the number of approved disability applications that were not assigned a medical review date and, instead, approved as disabled for life, increased from 51% at the time of our last audit in 2009 to 80% in 2018/19.
- **Adjudication decisions without medical review dates are not always fully supported.** Our review of a sample of adjudication decisions made at the triage and regular stage of adjudication identified that in over 40% of the cases we reviewed it was not clear how the adjudicator made the decision that no medical review was required.
- **Ministry guidelines for setting medical reviews are not consistent with the regulations under the ODSP Act.** We found that the Ministry's adjudication framework in relation to setting medical reviews is not consistent with regulations under the ODSP Act and requires the adjudicator to do more to conclude that a medical review is required than it is to conclude that one is not.
- **Similar to our last audit of ODSP 10 years ago, the Social Benefits Tribunal (Tribunal) continues to overturn about 60% of the Ministry's not-disabled decisions appealed to the Tribunal.** We also found that the rate of overturning Ministry decisions at the Tribunal varied from as low as 28% for one member to 93% in the case of another member. Senior representatives from Tribunals Ontario, which oversees the Tribunal, informed us that the decision whether to uphold or overturn the Ministry's decision on disability lies solely with the

Tribunal member who conducted the hearing, and there is no internal review of decisions for quality or consistency.

- **Ineligible recipients likely remain on ODSP because caseworkers rarely assess recipients' ongoing eligibility.** At the four ODSP offices we visited, we reviewed a sample of recipient cases that had been on the ODSP caseload for several years. We found that in 58% to 100% of the files we reviewed, the recipient's information had not been reviewed for at least five years to confirm their continued financial eligibility for ODSP. In addition, we found that caseworkers had not been in touch with recipients for over two years in 22% to 50% of the files we reviewed. As of September 2019, caseworkers had suspended or terminated six of the cases we reviewed after they looked into the recipients' circumstances and established overpayments in these cases totalling approximately $107,000.
- **The Ministry did not carry out eligibility verifications required by its directives to identify overpayments and remove ineligible recipients from the program.** Between April 2015 and March 2019, the Ministry carried out only about 8,300 eligibility verifications instead of the over 508,000 it should have performed according to its directives. Based on the level of overpayments identified in the cases it completed in 2017/18 (which were selected at random) we calculated that the Ministry might have identified a further $375 million in overpayments and terminated a further 11,700 cases, leading to annual savings of approximately $165 million.
- **Approximately 42,000 fraud allegations have not been investigated on time, and caseworkers are not trained to investigate fraud to ensure only eligible recipients are receiving income support.** We also found that 60% of the allegations were over one year old. Timely reviews of these allegations are critical to identifying and minimizing overpayments. We found that it had been nearly 10 years since the last time the Ministry had provided training to caseworkers on how to investigate fraud.
- **About 19,000 medical reviews of recipients are overdue, increasing the risk that income support payments are being made to individuals who no longer medically qualify for ODSP.** According to Ministry data, more than half of the 19,000 medical reviews are more than two years overdue.
- **Non-disabled adults are not participating in required Ontario Works employment assistance activities to progress toward obtaining employment.** As of March 2019, approximately 57,000 non-disabled adults in family units were on the ODSP caseload. According to Ministry data, 75% were not participating in employment assistance activities as required. We reviewed a sample of these adults and found that the primary reason they were not participating was because the ODSP caseworker had not referred them to Ontario Works for employment assistance activities.
- **The Ministry has little information on whether employment support service providers help ODSP recipients to obtain long-term employment.** We found that the Ministry does not track whether recipients who have participated in employment support services and obtained a job have maintained employment consecutively, or in the same job to assess whether recipients are obtaining sustainable, long-term employment. In addition, we noted that an evaluation commissioned by the Ministry in 2012 highlighted that just 1.5% of ODSP recipients who participated in the employment supports program were able to exit from ODSP because their employment earnings were high enough that they no longer qualified financially for assistance. The Ministry report also found that just over 20% who participated in employment support

services worked for more than 12 months over a 33-month period.

This report contains 19 recommendations, with 52 action items, to address our audit findings.

Overall Conclusion

Our audit concluded that the Ministry of Children, Community and Social Services does not have effective systems and procedures in place to ensure that only eligible recipients receive income support and that recipients are receiving the employment supports they need. We found that the Ministry was not taking sufficient steps to ensure that all recipients continue to be eligible for the program and that non-disabled adults are participating in required Ontario Works employment assistance activities. Our audit also concluded that the Ministry does not have effective processes and systems in place to measure, evaluate and publicly report on the effectiveness of the Ontario Disability Support Program.

OVERALL MINISTRY RESPONSE

The Ministry of Community, Children and Social Services (Ministry) welcomes the observations and recommendations of the Auditor General.

Through the Ontario Disability Support Program (ODSP), the Ministry provides income and employment supports to people experiencing significant health and disability challenges. The Ministry recognizes the need for improvements to program delivery, which includes addressing the recommendations of the Auditor General to ensure the effective stewardship of public funds, while striving to provide service that is respectful, responsive and person-centred.

In response to the long-term trend of increasing caseloads, the Ministry intends to focus on the reduction of its administrative workload through process improvements and digital solutions, along with the implementation of risk-based approaches, to maximize the effectiveness of available resources in delivering the program in a way that respects recipients and ensures program integrity.

The Ministry has recently created the Social Assistance Performance and Accountability Branch in order to provide the Ministry and our partners with a central focal point for program accountability and to help ensure that the design and delivery of social assistance meets program objectives, achieves performance expectations and is accountable to Ontario's taxpayers.

To help ODSP recipients to increase their economic independence, a concern also raised by the Auditor General, the government is introducing a new employment services system that is locally responsive and easy to use, and helps all job seekers, including people with disabilities, find and keep work. The Employment Services Transformation will integrate Ontario Works and ODSP employment programs into the Ministry of Labour, Training and Skills Development—Employment Ontario to create one efficient system that is easy to use and supports all job seekers.

2.0 Background

In Ontario, social assistance is provided by the Ministry of Children, Community and Social Services (Ministry) under two programs:

- Ontario Works—for unemployed or underemployed people in temporary financial need; and
- Ontario Disability Support Program—intended to help people with eligible disabilities live as independently as possible and to reduce or eliminate disability-related barriers to employment.

In 2018/19, these two programs provided social assistance to approximately 615,000 individuals as well as to their qualifying family members for a total of 960,000 people a month, on average.

Approximately 60% of these individuals received assistance through the Ontario Disability Support Program (ODSP) and 40% from Ontario Works. Total provincial transfer payments for these two programs totalled $8.4 billion in 2018/19, which accounted for 5.2% of total provincial expenditures. Transfer payments for ODSP, the subject of this audit, were approximately $5.4 billion in 2018/19.

2.1 Overview of ODSP

ODSP is governed by the *Ontario Disability Support Program Act, 1997* (ODSP Act) and its regulations. Under the ODSP Act, the purpose of the program is to provide income support and employment support to eligible persons with disabilities, effectively serve people with disabilities who need assistance and to be accountable to the taxpayers of Ontario.

To be eligible for assistance, applicants must demonstrate financial need by providing evidence that their income and asset levels are below specified amounts (see **Section 2.2.1**). Applicants whose income and assets do not exceed these limits are then assessed to determine whether they have a medical condition that meets the definition of a disability under the ODSP Act (see **Section 2.2.2**), or qualify as a member of a prescribed class, such as individuals who are 65 years old or over and ineligible for Old Age Security.

If an applicant qualifies for ODSP and becomes a recipient, they become eligible to receive ODSP income supports (see **Section 2.3**) and employment supports (see **Section 2.4**).

2.1.1 Roles and Responsibilities for ODSP

Approximately 2,200 staff within the Ministry's Social Assistance Program Division, Business Intelligence and Practice Division and Strategic Policy Division are involved in the administration and the delivery of ODSP through 47 Ministry local offices. **Appendix 1** shows the ODSP organizational structure and **Appendix 2** lists the Ministry's local offices by region.

The Ministry's role and responsibilities in the administration and delivery of ODSP include:

- developing options for any changes to the legislative and regulatory framework;
- setting policy directives, guidelines and standards for service quality and delivery to support the delivery of ODSP in accordance with legislation and its regulations;
- determining initial and ongoing eligibility for the program;
- providing eligible recipients with income, and employment supports;
- detecting fraud, and identifying and recovering overpayments;
- program oversight and monitoring; and
- performance measurement and reporting.

2.1.2 Number of Ontarians Receiving Income Support

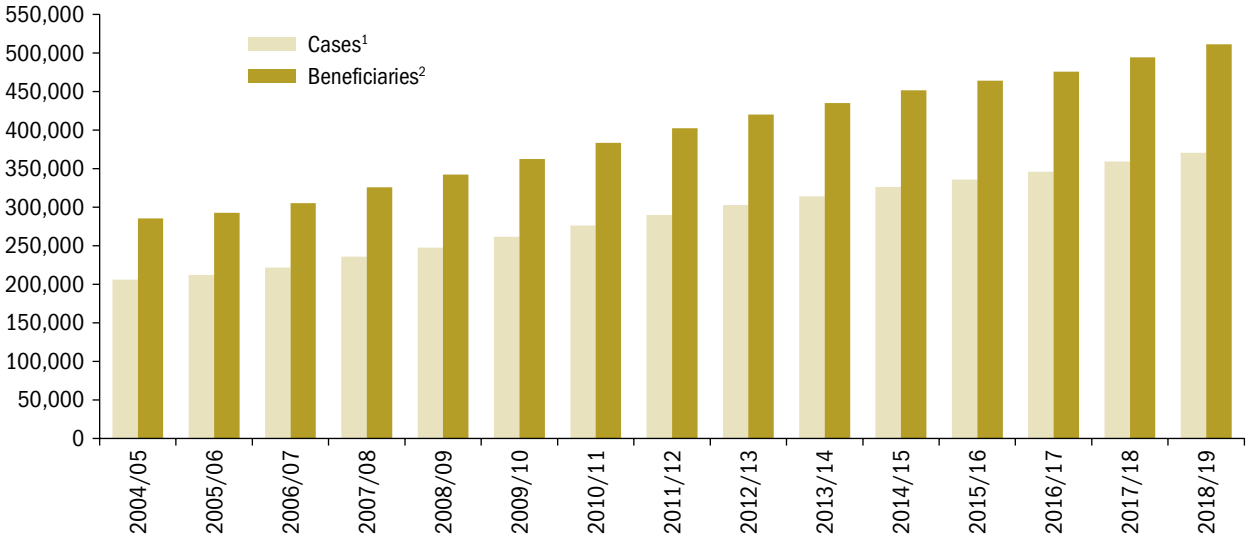
Since our last audit of the program in 2009, the average number of ODSP cases has increased by 50% from approximately 247,500 in 2008/09 to 370,700 in 2018/19. Similarly, the number of beneficiaries (recipients and their dependents) has also increased by about 50% from approximately 342,100 in 2008/09 to 511,200 in 2018/19. Over this same period, the population in Ontario increased by approximately 12%. **Figure 1** illustrates the average number of ODSP cases and beneficiaries between 2004/05 and 2018/19.

Figure 2 compares the rate by which ODSP cases and beneficiaries have increased relative to the rate that Ontario's population increased by between 2004/05 and 2018/19.

Since 2008/09, the average monthly caseload has been growing by about 4% per year on average. **Appendix 3** shows the local offices with the highest and lowest caseload growth relative to provincial growth rate. Caseload growth occurs when the number of cases receiving ODSP income support exceeds the number of cases exiting the program. In addition, many people on ODSP do not leave until they become eligible for federal seniors' benefits. As

Figure 1: Average Monthly Cases and Beneficiaries, 2004/05–2018/19

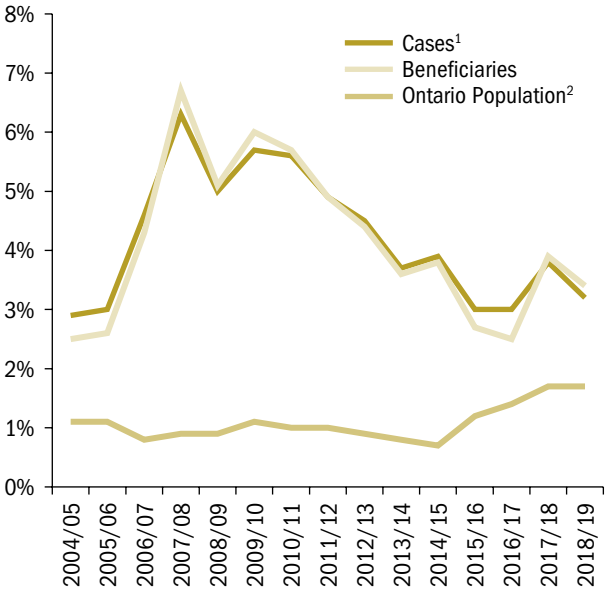
Source of data: Ministry of Children, Community and Social Services



1. A case refers to a single disabled recipient or a single family unit on the Ontario Disability Support Program.
2. The number of beneficiaries refers to the total number of disabled recipients plus their dependents (for example, spouse, children under age 18 and dependent adult children).

Figure 2: Yearly Percentage Change in Caseload, Beneficiaries and Ontario Population, 2004/05–2018/19

Sources of data: Ministry of Children, Community and Social Services and Statistics Canada



1. The Ministry advised us that the Ontario Disability Support Program caseload experienced a steep increase in fiscal year 2006/07 as the Ministry implemented operational initiatives to reduce the backlog of 14,000 applications awaiting adjudication as of the end of fiscal 2005/06. This resulted in applications granted at a faster pace than normal, causing the spike in the year-over-year caseload growth.
2. Ontario population data is based on July 1 population estimates (most recent data available) from Statistics Canada.

of March 2019, the average length of time a single individual or family unit has been in receipt of ODSP income support is 10 years.

2.1.3 Provincial Cost of ODSP

The total provincial cost of the program has increased by 75% (excluding administration) from $3.1 billion in 2008/09 to $5.4 billion in 2018/19, as illustrated in **Figure 3**. Key reasons for the increase include:

- a 50% increase in the number of recipients and beneficiaries, as described in **Section 2.1.2**;
- income support rate increases over this period of time; and
- an increase in the percentage of income support costs payable solely by the province from 80% in 2008 to 100% in 2011 (the change was already identified and set to take place at the time of our last audit; previously, municipalities covered a percentage of the program costs).

Figure 3: Provincial Cost of Ontario Disability Support Program (ODSP), 2008/09–2018/19 ($ billion)
Source of data: Ministry of Children, Community and Social Services

	Income Support	Employment Supports[1,2]	Administration[3]	Total	Annual Increase (%)
2008/09	3.025	0.033	0.247	**3.305**	–
2009/10	3.294	0.031	0.246	**3.571**	8
2010/11	3.536	0.031	0.264	**3.831**	7
2011/12	3.795	0.031	0.270	**4.096**	7
2012/13	4.029	0.029	0.259	**4.317**	5
2013/14	4.166	0.031	0.274	**4.471**	4
2014/15	4.383	0.034	0.284	**4.701**	5
2015/16	4.591	0.036	0.327	**4.954**	5
2016/17	4.809	0.037	0.287	**5.133**	4
2017/18	5.070	0.039	0.300	**5.409**	5
2018/19	5.325	0.039	0.294	**5.658**	5

1. The Ministry of Children, Community and Social Services (Ministry) negotiates annual contracts with approximately 150 individual service providers that provide employment supports to ODSP recipients. These contracts include targets for job placement and job retention, and the Ministry compensates service providers according to the achievement of these targets. See **Section 2.4** for further details.
2. Between April 2014 and March 2018, ODSP employment supports, employment benefits, and the costs associated with allowing recipients an employment earnings exemption under ODSP income support were cost-shared with the federal government under the Canada-Ontario Labour Market Agreement for Persons with Disabilities (LMAPD). The maximum annual contribution by the federal government was $76.4 million, which is not limited to ODSP. Beginning in April 2018, the LMAPD was replaced by the Canada-Ontario Workforce Development Agreement (WDA). Under the WDA, the federal government's maximum contribution for persons with disabilities continues to be $76.4 million.
3. Costs reflect administration costs for both Ontario Works and ODSP. Although the Ministry advised us that the vast majority of these costs relate to ODSP, it does not track the costs of administering each program separately.

2.2 Eligibility for ODSP

An applicant's eligibility for ODSP income support is determined in accordance with the eligibility criteria set out in the *Ontario Disability Support Program Act, 1997* (ODSP Act) and its regulations.

To be eligible for ODSP, an applicant must:

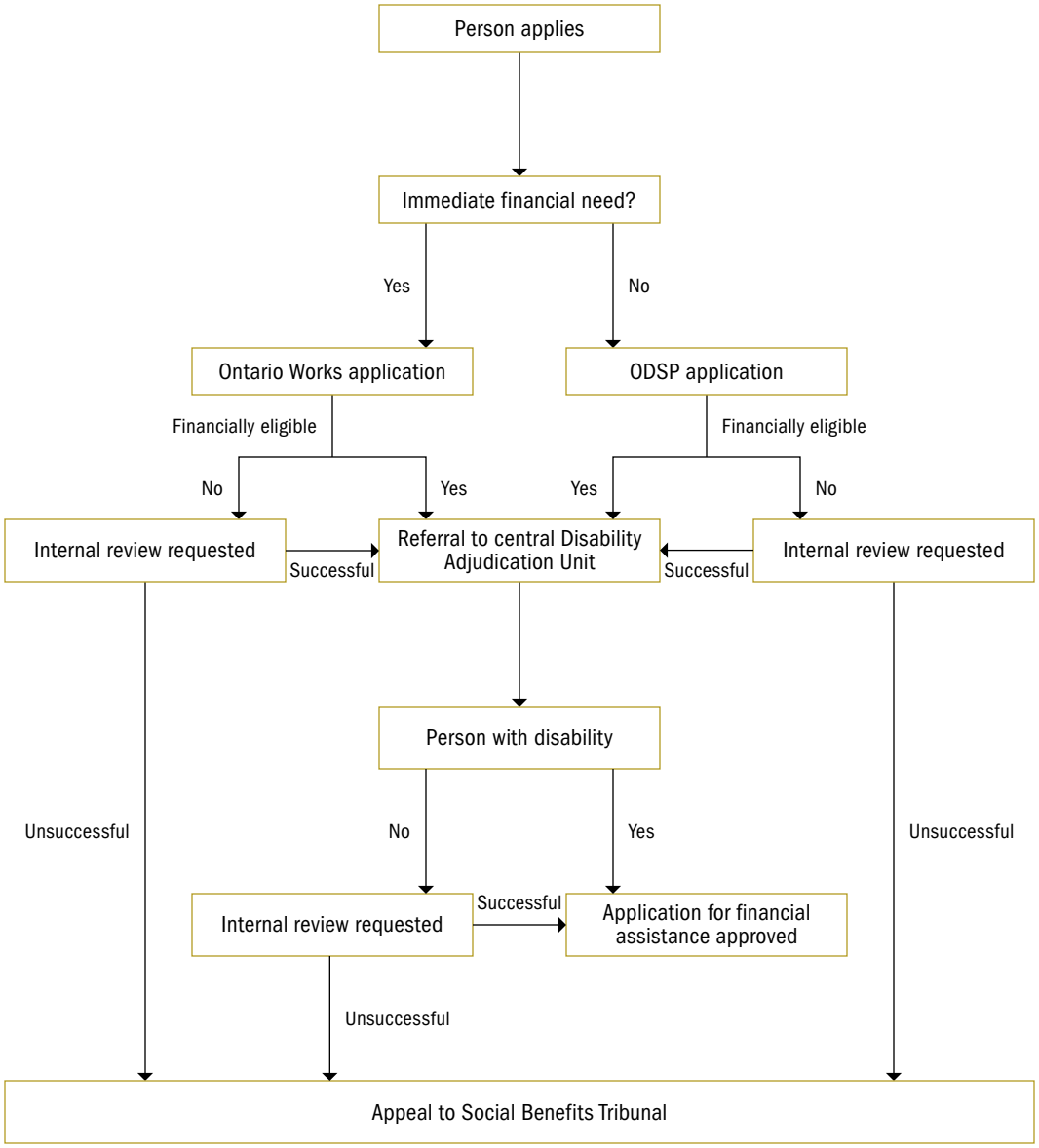
- live in Ontario, and be a Canadian citizen or be legally entitled to reside in Canada permanently;
- be in financial need, with assets no greater than the limits set out in regulations under the ODSP Act (see **Section 2.2.1**); and
- be assessed as a "person with a disability" under the ODSP Act (see **Section 2.2.2**), or qualify as a member of a prescribed class.

An applicant's financial eligibility for the program must be confirmed before they can apply to be assessed as a person with a disability under the ODSP Act. **Figure 4** shows the steps in the ODSP application process, including the appeal of applications rejected by the Ministry. ODSP caseworkers based in Ministry local offices across Ontario are responsible for assessing the financial eligibility of applicants (see **Section 2.2.1**). Disability Determination Adjudicators (adjudicators) that are located in the Ministry's corporate office are responsible for assessing whether applicants meet the definition of a person with a disability under the ODSP Act (see **Section 2.2.2**). **Appendix 4** includes the number of caseworkers and adjudicators, as well as their key responsibilities and required experience.

2.2.1 Financial Eligibility

Individuals can begin the process of applying for ODSP online, or by contacting one of the 47 local ODSP offices across the province by telephone or in person. As illustrated in **Figure 4**, people who deem themselves to be in immediate financial need can apply to Ontario Works for financial assistance,

Figure 4: Ontario Disability Support Program (ODSP) Application Process
Source of data: Ministry of Children, Community and Social Services



which is granted more quickly than ODSP. These individuals can then transfer to ODSP once it is established that they have an eligible disability under the ODSP Act.

If the applicant is not in immediate financial need, a caseworker at the applicant's local ODSP office will start their application by assessing their financial eligibility. The assessment of financial eligibility takes into account an applicant's as well as their dependent family members' assets and income from all sources. See **Appendix 5** for asset and income limits and exemptions.

To verify the accuracy and completeness of eligibility-related information provided by applicants, the Ministry has a policy that requires caseworkers to carry out Canada Revenue Agency income verification and an Equifax asset verification checks (see **Figure 5**). Caseworkers also complete other third-party checks if these are relevant to the applicant's circumstances.

Figure 5: Third-Party Verification Checks

Source of data: Ministry of Children, Community and Social Services

Third-Party Organization	Reason for Verification
Canada Revenue Agency (CRA)	Income verification[1]
Equifax Canada	Asset verification[2]
Ministry of Transportation	Vehicle ownership verification (where there has been a history of vehicle ownership or changes in address).
Employment Insurance	Identification of employment insurance benefits (where there has been a history of employment).
Ontario Student Assistance Program (OSAP)	Identification of OSAP assistance (where a member of the benefit unit is attending or has attended post-secondary school).

1. An income verification with CRA compares the income an applicant declares with their tax return information.
2. An asset verification with Equifax identifies any inconsistencies in the information an applicant declares by reviewing credit information.

2.2.2 Medical Eligibility

As illustrated in **Figure 4**, once an applicant's financial eligibility for ODSP has been established, the local ODSP or Ontario Works office provides the applicant with an application form called a disability determination package. The package contains the forms used to verify information related to an applicant's disability, including the medical condition and related impairments, restrictions, the likely duration, and the impact the medical condition and impairments have on the applicant's daily living activities. The application also includes an optional self-report form that gives the applicant the opportunity to describe how their disability affects their daily life. The package must be completed by a health-care professional, such as a physician, psychologist or registered nurse, and returned to the Ministry's centralized Disability Adjudication Unit (Adjudication Unit) for review within 90 days.

Disability Determination Adjudicators (adjudicators) in the Adjudication Unit are responsible for determining if, based on the information provided in the disability determination package, the applicant meets the definition of a "person with a disability" under the ODSP Act.

Under the ODSP Act, a person is disabled if:

- the person has a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more;
- the direct and cumulative effect of the impairment on the person's ability to attend to his or her personal care, function in the community and function in a workplace, results in substantial restriction in one or more of these activities of daily living; and
- the impairment and its likely duration and the restriction in the person's activities of daily living have been verified by a person with the prescribed qualifications.

The definition of disability for similar programs in other Canadian provinces is shown in **Appendix 6**. **Figure 6** summarizes the Adjudication Unit's process for assessing new applications and appeals.

If the adjudicator determines that the applicant is a person with a disability, the Adjudication Unit notifies the local office and the applicant of the decision. The local office is responsible for issuing ODSP income support to the applicant. If the applicant applied through an Ontario Works office, that office must provide the appropriate ODSP office with electronic access to the applicant's file, and transfer the hard copy within five business days. The Ministry's internal target is for the first payment of income support to be issued within 15 business days of the disability determination decision.

Figure 6: Adjudication Unit Processes for Assessing Applications and Appeals

Prepared by the Office of the Auditor General of Ontario

Stage	Process	Description
Application	Triage	• Ministry has a target for its Disability Determination Adjudicators to complete an initial review of all new applications within 10 business days. • Adjudicators perform this expedited cursory review to assess if the applicant can be immediately determined to be disabled.
	Regular Medical Adjudication	• Applications that require a more detailed review as determined through the triage process are assessed by a different Ministry adjudicator. • Ministry has a target to complete medical adjudication reviews within 90 business days.
Appeal	Internal Review	• Unsuccessful applicants can appeal the decision and request an internal review within 30 calendar days. • A different adjudicator than the one who made the original decision reassesses the application. • The review and the adjudicator's decision is communicated to the applicant within 30 calendar days of the request.
	Pre-tribunal Review	• Applicants whose appeal is rejected during an internal review can appeal to the external (and independent) Social Benefits Tribunal within 30 calendar days of the Ministry's internal review decision. • New medical information received by the Adjudication Unit at least 30 calendar days before the Tribunal hearing is assessed by a different adjudicator prior to the Tribunal hearing. • The adjudicator must have a decision related to the new medical information communicated to the Tribunal, appellant and their legal representative 10 calendar days before the hearing. • If the adjudicator determines the applicant is disabled, the Tribunal hearing is withdrawn.

2.2.3 Ongoing Eligibility

Reporting Changes and Application Updates

Recipients are responsible for reporting changes in their circumstances, such as a change in living arrangements or family composition, so that their caseworker can reassess their financial eligibility for the program or their income support rates and entitlements. As part of managing their recipient cases, caseworkers decide whether to complete a file review and an application update report. Their decision is based on their knowledge of the recipient and assessing eligibility risk factors, such as duration since last review, date of granting assistance and previous eligibility-related issues. The file review should include updating third-party checks to verify the recipient's income and assets and may include a visit to a recipient's home.

Medical Reviews

Regulations under the ODSP Act require that a medical review date be assigned to applicants unless there is no likelihood of improvement in the person's impairments. In these cases, a medical review date of two or five years after the disability decision may be assigned by the adjudicator, at which time the adjudicator is required to reassess whether the recipient continues to be medically eligible for ODSP. Recipients who are due for a medical review are issued a medical review package that must be completed by a health-care professional. Recipients are required to submit their completed medical review package within 90 days to remain eligible for income support and benefits. The adjudicator reviews the completed package and assesses whether the recipient's condition continues to meet the definition of disability under the ODSP Act.

2.2.4 Demographics of Recipients

As of March 2019, male recipients accounted for 53% of all ODSP cases, and female recipients accounted for 47%. Approximately 80% of ODSP cases were single recipients without children or adult dependents, and the majority (57%) of ODSP recipients were older than 45 years of age, as shown in **Figure 7**.

Figure 8 shows the primary disability of recipients—mental health disabilities classified as psychoses (21%) or neuroses (18%), and developmental disabilities (18%), account for 57% of all disabilities.

Mental health and developmental disabilities account for 75% of the disabilities of recipients under the age of 35. Developmental delay is the most common disability for those aged 18–21 (45%), 22–24 (50%) and 25–34 (33%).

Figure 9 compares the primary disabilities of ODSP recipients in March 2019 and March 2009, when we last audited the ODSP program. The two primary conditions that saw the largest increases in ODSP recipients were related to mental health conditions (psychoses and neuroses) that saw combined increases of over 60,000 recipients during this period. The most common conditions diagnosed for these recipients over this period included anxiety, post-traumatic stress disorder, various phobias, depressive disorders and mood disorders.

Figure 10 shows the education level of adult beneficiaries: almost half (44%) have an education level of Grade 11 or less and only 20% have completed post-secondary education. Among the 20%, only 4% of adult recipients with developmental delays have post-secondary education. In contrast, according to 2016 Statistics Canada census information, approximately 65% of all adults in Ontario have a post-secondary education.

Figure 11 shows the living arrangements for ODSP recipients as of March 2019. The majority of recipients were renting accommodations in either the private market (68%) or subsidized market (9%). As well, approximately 1% of ODSP recipients were either homeless or transient.

Among all ODSP cases that received income support in March 2019, approximately 91% were Canadian citizens, 7% were permanent residents and 2% were convention refugees or refugee claimants.

Figure 7: Composition of Recipients by Age, March 2019

Source of data: Ministry of Children, Community and Social Services

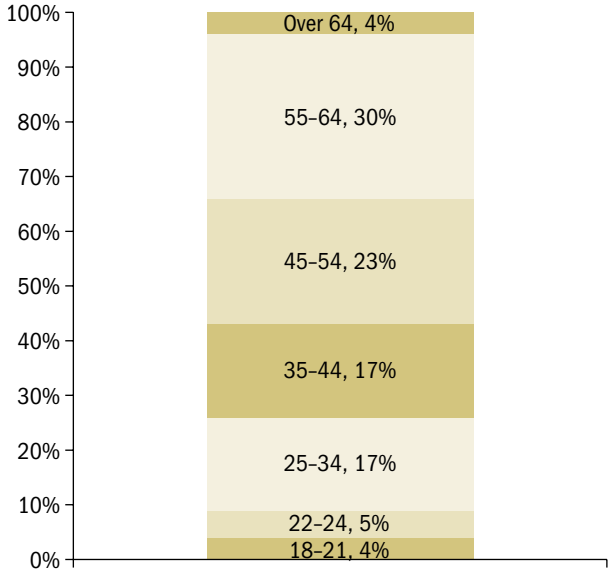
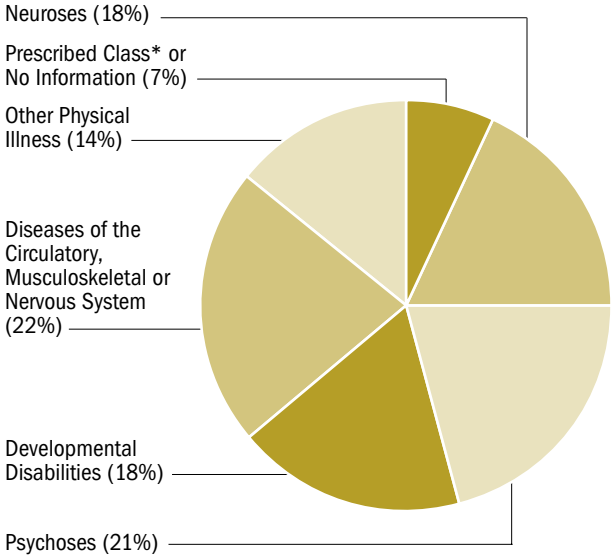


Figure 8: Primary Disability of Recipients, March 2019

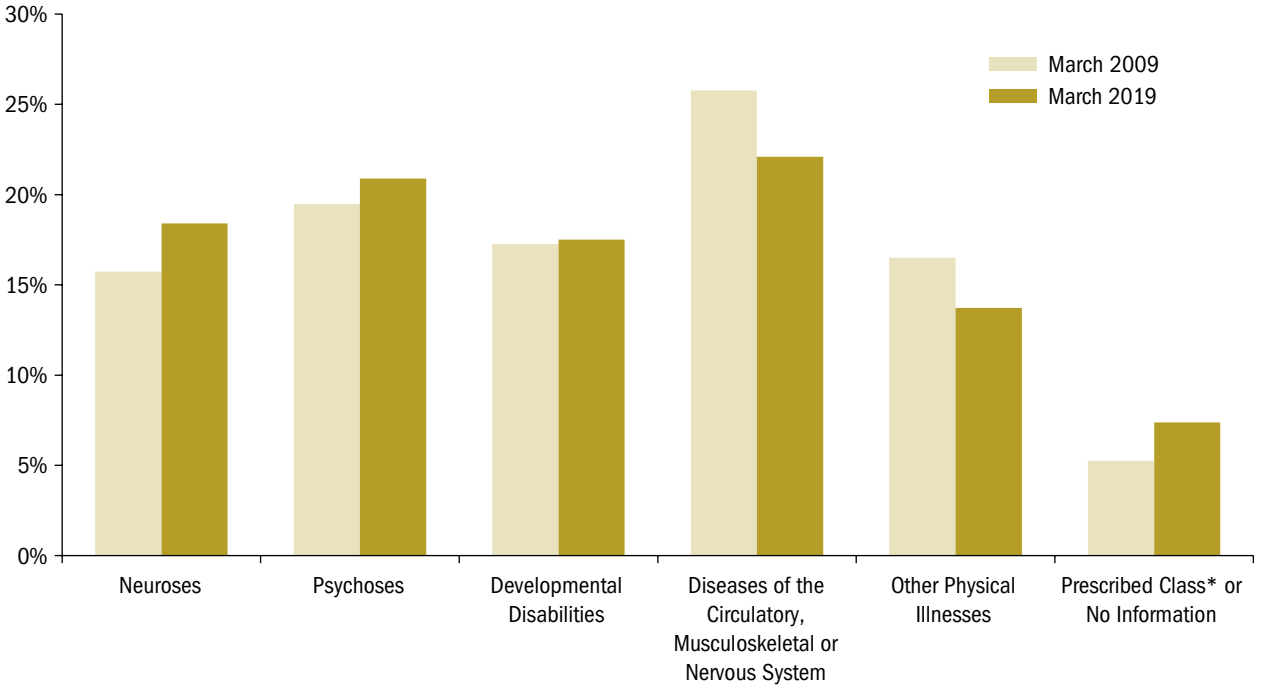
Source of data: Ministry of Children, Community and Social Services



* Members of a prescribed class only need to establish financial eligibility for Ontario Disability Support Program. Prescribed class members can include, but are not limited to, recipients of federal Canada Pension Plan Disability Benefits, former recipients (or spouse) who received income support from the Family Benefits Program up until May 31, 1998, and individuals who are 65 years old or over and not eligible for Old Age Security.

Figure 9: Comparison of Primary Disability of Recipients, March 2009 and March 2019

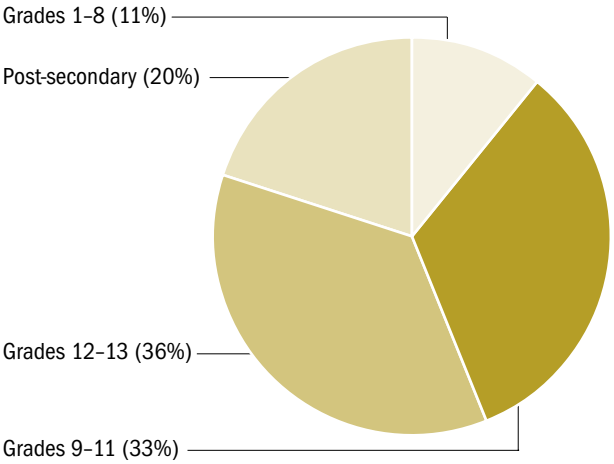
Source of data: Ministry of Children, Community and Social Services



* Members of a prescribed class only need to establish financial eligibility for the Ontario Disability Support Program. Prescribed class members can include, but are not limited to, recipients of federal Canada Pension Plan Disability Benefits, former recipients (or spouse) who received income support from the Family Benefits Program up until May 31, 1998, and individuals who are 65 years old or over and not eligible for Old Age Security.

Figure 10: Education Level of Adult Beneficiaries,* March 2019

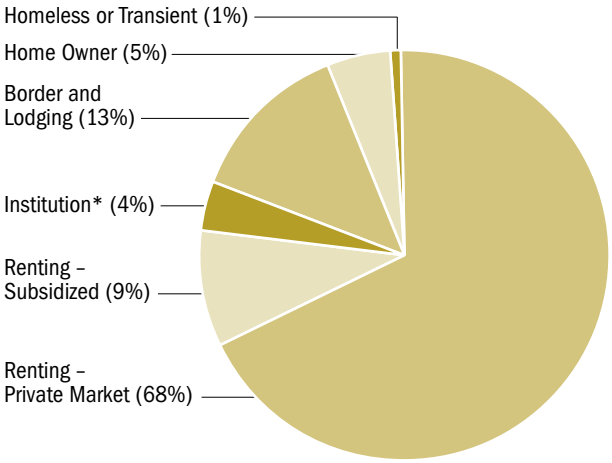
Source of data: Ministry of Children, Community and Social Services



* Adult beneficiaries include the total number of disabled recipients plus their adult dependents.

Figure 11: Recipient Living Arrangements, March 2019

Source of data: Ministry of Children, Community and Social Services



* Recipients living in residences providing specialized care; for example, a psychiatric facility or a long-term-care home.

2.3 Provision of Income Support

The Ministry provides income support to eligible ODSP recipients to help cover the costs of their shelter and basic needs including food, clothing and other necessary personal items. While recipients are provided a flat rate for basic needs, funding for shelter is paid based on the expenditures incurred, such as rent, utilities and mortgage payments, up to the maximum shelter allowance available. The amount of financial assistance is based on family size and composition. **Figure 12** illustrates the current rates for basic needs and shelter, and the rates at the time of our last audit in 2008/09.

In addition to income support for basic needs and shelter, eligible applicants may also qualify for additional assistance including the following:

- special purposes allowances such as a special diet allowance, pregnancy or breast-feeding nutritional allowance, and a remote communities allowance if a resident lives north of the 50th parallel and is without year-round access; and
- employment, health and disability-related benefits as outlined in **Appendix 7**.

In March 2019, 39% of recipient cases received a special diet allowance, 15% of recipient cases were receiving medical transportation benefits and 7% of recipient cases received funding for diabetic supplies.

2.4 Employment Supports

The purpose of the ODSP employment supports program is to help people with disabilities increase their economic independence through competitive (remuneration equal to at least minimum wage) and sustainable jobs. Legislation requires that the Ministry provide employment supports, such as employment preparation and training, job coaching and any necessary mobility devices, to recipients who intend and are able to accept and maintain employment. The Ministry has contracts with approximately 150 service providers across the province to work with ODSP recipients to help them achieve their employment goals. These service providers include a range of organizations including for-profit and non-profit, large and small, and urban and rural. Some serve individuals with all disability types while others are niche service providers specializing in specific disabilities. In addition to providing employment supports to ODSP recipients, some service providers also have contracts with Ontario Works and Employment Ontario.

Unlike employment assistance activities in the Ontario Works program, participation in ODSP employment supports is voluntary for ODSP recipients with disabilities. Caseworkers are expected to discuss employment supports with recipients to explain how ODSP employment supports work, and help recipients decide whether they are ready for employment. If so, their caseworker provides the recipient with a list of employment support service providers and information about the services they

Figure 12: Maximum Monthly Basic Needs and Shelter Rates

Sources of data: Ministry of Children, Community and Social Services; Statistics Canada

	Single Person			Single Person with One Child			Couple with One Spouse Disabled and One Child		
	Basic Needs	Shelter	Total	Basic Needs	Shelter	Total	Basic Needs	Shelter	Total
2008/09	566	454	**1,020**	709	714	**1,423**	838	775	**1,613**
2018/19 (actual)	672	497	**1,169**	815	781	**1,596**	969	846	**1,815**
2018/19 (adjusted for inflation*)	668	536	**1,204**	837	843	**1,680**	989	915	**1,904**

* Adjusted based on the rate of inflation per Statistics Canada.

Figure 13: Employment Outcome Payments to Service Providers

Source of data: Ministry of Children, Community and Social Services

Milestone	Amount	Description
Six-Week Job Start	$1,000	Service providers earn $1,000 when a client has been placed in competitive[1] employment earning minimum wage or better for six cumulative weeks.
13-Week Job Placement	$6,000	Service providers earn $6,000 when a client has been placed in competitive[1] employment earning minimum wage or better for 13 cumulative weeks (including the six weeks that qualify for the six-week job placement milestone payment).
Job Retention	For the first 15 months retention payments are equal to the greater of: • 60% of the client's chargeable earnings[2] per month, or • $250 per month where the client receives employment earnings. For the remaining 18 months, retention payments are equal to: • 60% of the client's chargeable earnings.[2]	Following 13 cumulative weeks of job placement, service providers earn a job retention payment for each month that the client is competitively[1] employed and has earnings for up to 33 consecutive months. The total number of job retention payments cannot exceed 33.

1. Competitive employment refers to any employment that remunerates the individual an amount equal to at least minimum wage.
2. For the purposes of calculating retention payments in Ontario Disability Support Program employment supports, chargeable earnings are determined by applying a 50% earnings exemption to net earnings (gross earnings less mandatory payroll deductions) and deducting eligible child-care and disability-related expenses.

offer—such as experience with the recipient's type of disability—to help the recipient make their selection.

After recipients contact a service provider, the service provider assesses whether they are ready to prepare for, accept and maintain competitive employment, and whether the needs of the recipient will be best served by the service provider or another agency. Upon accepting a recipient's application, the service provider must develop an employment plan with the recipient, prepare the recipient for a job and find a suitable placement. **Figure 13** illustrates the compensation that service providers receive for achieving specific employment outcomes.

As shown in **Figure 3**, the Ministry spent $39 million on ODSP employment supports in 2018/19 ($33 million in 2008/09), which represented less than 1% of total ODSP expenditures. The Ministry's regional program managers and supervisors oversee contracted service providers, which includes conducting compliance reviews to determine whether service providers are delivering the program and maintaining recipient files according to program requirements.

2.4.1 Participation Requirement for Non-disabled Adults in Ontario Works Employment Assistance

If an adult who does not have a disability is part of a family unit that receives ODSP income support, such as a non-disabled spouse or dependent adult child, that non-disabled individual is required to participate in Ontario Works employment assistance activities. These activities include looking for a job, participating in basic education or job-specific training, and development of employment-related skills, which are designed to increase the individual's likelihood of obtaining employment. ODSP caseworkers must refer all non-disabled adults to Ontario Works employment assistance unless they waive an individual's requirement to do so. Waivers can only be approved in certain circumstances, such as caregiving responsibilities for a family member,

or attending school on a full-time basis. If a non-disabled adult does not comply with Ontario Works participation requirements, the ODSP caseworker may reduce the income support issued to the family unit by the additional amount received for the non-disabled adult.

2.5 Monitoring and Oversight

One of the Ministry's key processes to monitor and oversee the delivery of ODSP is its Eligibility Verification Process (eligibility verification). This process involves reviewing ODSP recipient cases on a sample basis based on risk to ensure recipients are eligible for the income support they are receiving. ODSP directives require that 3% of cases are selected for review each month. Each month, recipients' information stored in the Ministry's Social Assistance Management System (SAMS), and external information from Equifax (consumer credit and other proprietary information) and the Canada Revenue Agency (CRA) are analyzed to prioritize cases for review. During eligibility verification reviews, staff analyze financial information such as income and assets, conduct additional third-party verification checks, and interview recipients to determine if a change is required to the amount of income support the recipient is receiving and if a referral for a fraud investigation is required. Equifax credit checks and CRA income checks are mandatory checks for each review. Other third-party checks, such as with Employment Insurance and the Ministry of Transportation, can also be performed based on the specifics of each case.

In addition to eligibility verification, the Ministry also operates a welfare fraud hotline that the public can contact to anonymously report suspected cases of social assistance fraud. All fraud allegations with a positive social assistance match are referred to local social assistance offices for assessment and investigation.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ministry of Children, Community and Social Services (Ministry) had effective systems and processes in place to:

- ensure only eligible recipients receive income support in accordance with legislative and policy requirements;
- provide recipients with employment supports that are commensurate to their needs; and
- measure, evaluate and publicly report on the effectiveness of the Ontario Disability Support Program (ODSP).

In planning for our work, we identified the audit criteria (see **Appendix 8**) we would use to address our audit objective. These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies and best practices. Senior management reviewed and agreed with the suitability of our objectives and associated criteria.

The Ontario government announced in November 2018 that it planned to reform the delivery of social assistance in Ontario. Throughout the course of our audit, the Ministry developed proposals for the government to reform social assistance, including ODSP. At the completion of our audit, the Ministry advised us that a range of service delivery improvements, along with the transformation of ODSP employment supports through integration with Employment Ontario, are under way and that the Ministry is continuing to work with the government on developing policy options to reform and improve ODSP.

We conducted our audit between January 2019 and September 2019. We obtained written representation from Ministry management that, effective November 13, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

Our audit work was conducted at the Ministry's corporate offices in Toronto and four of the 47 local offices across Ontario: Hamilton, Ottawa, Sudbury and Willowdale (Toronto). Collectively, the four local offices we visited represented approximately 18% of the total ODSP caseload. We focused on the Ministry's activities in the three-year period ending March 2019.

Our work at the Ministry's corporate offices included a review of policies and procedures, analysis of program and performance data and discussions with key Ministry staff. We also performed data analysis and sample testing of disability adjudication decisions to determine whether legislative and policy requirements were met.

Our audit work at the four local offices we visited included an analysis of local policies and procedures and discussions with front-line staff responsible for delivering ODSP. We also conducted data analysis and sample testing of recipient case files to determine whether legislative and policy requirements were met concerning financial eligibility, case management and fraud. In each region of the local offices we visited, we also met with a number of employment support service providers responsible for providing employment supports to ODSP recipients. We visited thirteen service providers to gain an understanding of the types of services they provide and their methods for delivering these services. These thirteen service providers served approximately 1,200 recipients and represented 16% of the total contracted expenditure for employment supports in 2018/19.

As well, we conducted a survey of all 1,400 ODSP caseworkers and administrative support clerks (56% response rate). They are the front-line staff who deliver the program and whose primary functions include determining initial and ongoing eligibility of recipients and providing eligible recipients with income support. We also conducted a survey of all 74 disability determination adjudicators (78% response rate) who determine whether applicants meet the definition of a person with a disability under the ODSP Act.

In addition, we spoke with senior representatives of stakeholder groups to obtain their perspective on issues related to the delivery of ODSP, as well as issues and concerns related to recipients of the program.

4.0 Detailed Audit Observations

4.1 Ministry Has Not Assessed Why ODSP Caseload Has Grown by 50% in Last Decade

Since our last audit of the Ontario Disability Support Program (ODSP) in 2009, the average number of cases has increased by 50% from approximately 247,500 in 2008/09 to 370,700 in 2018/19. In contrast, the population of Ontario has grown by 12% over the same period. Our research into other jurisdictions also identified a 2019 study that identified the caseloads in Canadian provinces' disability programs in 2017/18. We calculated that the proportion of Ontarians on ODSP was 2.5% of the population in 2017/18 (2.5% in 2018/19). This was the highest rate among all Canadian provinces' disability programs. The rate in other provinces ranged from as little as 0.8% of the population in New Brunswick to between 1.3% and 1.5% in larger provinces, such as Alberta, Saskatchewan and Quebec. The closest to Ontario was British Columbia at 2.0%.

As highlighted in **Section 2.1.2**, the substantial increase to the caseload since the time of our last audit is one of the key contributing factors to the 75% increase in program costs over the past decade. Despite the impact to the program's overall cost, we noted that since 2011, the Ministry has not investigated or studied the key reasons for caseload growth to assess whether the growth is reasonable, whether it reflects the changing needs of Ontarians, or whether, and by how much, it is related to the Ministry's administration of the program.

We noted several areas in the Ministry's administration and delivery of ODSP that can be

improved and may have contributed to the increase in the program's caseload and costs, such as the following:

- Third-party checks of financial information were not performed in many cases to verify the assets and income declared by applicants, increasing the risk of providing benefits to ineligible individuals (**Section 4.2**).
- The proportion of ODSP applicants approved as disabled after a cursory review increased by 56% since our last audit in 2009, with virtually all approved for life without the requirement for a medical review in the future to confirm that they continue to have an eligible disability (**Section 4.3** and **Section 4.4**).
- Over the last five years, recipient ongoing financial eligibility was almost never reassessed by caseworkers in order to confirm continued eligibility for ODSP benefits (**Section 4.6.1**).
- Fraud allegations were not reviewed within the time frame required by the Ministry and investigations were not always thoroughly conducted to ensure ineligible individuals are terminated from ODSP (**Section 4.6.4**).

RECOMMENDATION 1

We recommend that the Ministry of Children, Community and Social Services investigate and identify the extent that either its policies and procedures to administer and deliver the Ontario Disability Support Program and/or its non-compliance with these policies and procedures have contributed to caseload growth, and take corrective action so that only individuals who are eligible for ODSP receive benefits from the program.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation. The Ministry recognizes that the ODSP caseload has been increasing and that there are a number of factors that have contributed to its growth.

The Ministry will undertake a comprehensive analysis of the factors driving caseload growth, including any impact that policy and business process changes have had on this growth. The analysis will consider what additional steps can be taken to manage caseload growth. The Ministry expects to complete its analysis by March 2021. Based on this analysis, the Ministry will take action to ensure that only eligible individuals receive assistance from the ODSP.

4.2 Caseworkers Do Not Verify Completeness, Accuracy of Applicant-Declared Income and Assets to Verify Financial Eligibility

4.2.1 ODSP Caseworkers Often Do Not Complete Required Third-Party Verification Checks to Confirm Applicants Are Eligible

ODSP caseworkers are required to check whether the information provided by applicants regarding their assets and income is accurate and complete by using outside sources such as the Canada Revenue Agency (CRA) and Equifax Canada Inc. (Equifax). However, we found that caseworkers frequently do not undertake these third-party verifications.

Our review of a sample of files at three of the four local offices we visited found that caseworkers did not carry out one or more of the mandatory Equifax or CRA checks in the majority of the files we reviewed.

These third-party checks are essential to confirm that information provided by applicants is complete and accurate because verifying an individual's income and assets from personal representations and applicant-provided supporting documents, such as a monthly bank statement, is not sufficient. For example, there is no assurance that an individual has provided a bank statement for all of his or

her accounts. Furthermore, an applicant could have withdrawn most of the money in the account before the bank issued the monthly statement.

CRA Income Check Not Possible for Thousands of Applicants Because Caseworkers Did Not Obtain SIN

At two of the local offices we visited, we found that in approximately 20% of the files we tested, a Social Insurance Number (SIN) had not been obtained as required for at least one of the adults in the family unit. Therefore, for these cases, no CRA third-party verification could be performed because the Ministry requires the SIN number to obtain the tax information from the CRA.

We analyzed data from the Ministry's Social Assistance Management System for ODSP recipients across all local offices in the province to determine whether SIN information had been consistently obtained. We found that as of March 2019, there was no SIN information for approximately 19,400 adults, equivalent to approximately 4% of the adults on the ODSP caseload. As a result, for these individuals, the Ministry would not be able to carry out a third-party verification check with CRA as its policy requires.

4.2.2 Third-Party Verification Checks Not Always Completed Thoroughly

We found that in instances where caseworkers had carried out mandatory third-party verification checks, they did not always identify and follow up on significant discrepancies that could affect an applicant's eligibility. Specifically, we found such discrepancies that warranted further investigation by the caseworker in 11% to 38% of the files where verifications had been carried out. One instance included the following case:

- A family of three applied for ODSP in December 2018 at which time the caseworker performed an Equifax check on both the applicant and their spouse to assess financial eligibility for ODSP. Our review of these Equifax reports identified that the sum of the primary applicant and spouse's minimum monthly payments for their credit cards ($2,515) and rent ($750) exceeded the income ($2,218) that the family had reported at the time. Nevertheless, the Equifax reports showed no past due amounts in either the applicant or spouse's credit cards. Because the family appeared to be making their required minimum payments, there is a risk that they under-reported their income. However, we found that the caseworker did not identify this issue, or take steps to obtain additional information to determine whether the applicant was eligible for ODSP.

Although the Ministry expects its caseworkers to review Equifax reports, it is unclear what steps caseworkers are expected to perform to identify discrepancies that may affect recipients' financial eligibility and to follow up on such discrepancies. When we discussed the example with management at the local ODSP office concerned, they told us that although caseworkers have been provided instructions to use their judgment to manage risk, there is no requirement to request additional information. We were also told that caseworkers would require additional training to be able to identify and follow up on such discrepancies.

RECOMMENDATION 2

To better identify and prevent applicants who are not financially eligible for the Ontario Disability Support Program (ODSP) from receiving benefits, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- implement a process to monitor and to take corrective action in instances where local ODSP offices and their caseworkers are not complying with the requirement to verify the accuracy and completeness of each applicant's declared income and assets using the third-party information sharing agreements the Ministry has in place;

- provide mandatory, relevant and comprehensive training for caseworkers on how to interpret the results of third-party checks, and to identify and investigate discrepancies between the information applicants have declared and the information obtained from third-party checks; and
- review the information held in the Social Assistance Management System to identify and collect all missing information, such as a Social Insurance Number, required to carry out third-party checks.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation. Third-party checks are an effective mechanism for assessing financial eligibility.

The Ministry is currently exploring opportunities to automate third-party checks as part of the application process in the 2021/22 fiscal year. While the Ministry is exploring opportunities to automate third-party checks at application, the Ministry will in the interim develop and implement an ongoing monitoring strategy to ensure mandatory third-party checks are being completed by September 2020.

The Ministry will build on improvements made to the usability of third-party reports and review its training curriculum to identify opportunities to support and enhance caseworker ability to understand third-party information reports and use the information to assess financial eligibility by December 2021.

In addition to the steps the Ministry is taking to ensure the verification of applicant-declared assets and income, the Ministry is also working with Service Canada on a Benefit Income Data Exchange that will ensure that ODSP clients are receiving all available federal pension income. The first exchange is scheduled to occur by March 2020. The Ministry will continue to work with Service Canada to explore how the exchange can further strengthen program accountability. Work is under way to obtain Social Insurance Numbers for the portion of the ODSP caseload when they are not recorded in the Social Assistance Management System.

4.2.3 Lack of Checks Creates Risk of Financially Ineligible Applicants Transferring from Ontario Works to ODSP

As shown in **Figure 4**, applicants who are in immediate financial need can apply to Ontario Works first to receive Ontario Works financial assistance while they go through the medical application and assessment process to assess medical eligibility for ODSP. In these cases, an Ontario Works office will check the applicant's residency and financial eligibility for Ontario Works and ODSP. Our audit found that Ontario Works caseworkers often do not to carry out mandatory CRA and Equifax third-party checks to verify applicant income and assets, to determine financial eligibility for ODSP. In addition, ODSP caseworkers did not subsequently carry out one or more of these required third-party checks once the file was transferred to ODSP. Therefore, there is a risk financially ineligible applicants are transferring from Ontario Works to ODSP.

At the four local offices visited, Ontario Works caseworkers did not complete one or more of the required CRA and Equifax checks in between 23% and 100% of files we reviewed of individuals transferring to ODSP. **Figure 14** shows the results at all four of the local offices visited.

The findings are concerning because in 2018/19 approximately 62% of all financial eligibility applications granted ODSP were processed by Ontario Works offices. The Ministry's reliance on Ontario Works caseworkers is also concerning as our audit of Ontario Works in our *2018 Annual Report* identified issues with Ontario Works service managers' assessment of applicant financial eligibility. We found that Ontario Works caseworkers were not always carrying out third-party checks in their

Figure 14: Percentage of Files We Reviewed Where One or More Third-Party Verifications Not Performed by Ontario Works Offices Prior to Transferring the Case to Ontario Disability Support Program Offices
Prepared by the Office of the Auditor General of Ontario

Offices Visited	Canada Revenue Agency and/or Equifax
Hamilton	23
Ottawa	38
Sudbury	79
Willowdale	100

initial application, or on an ongoing basis. Caseworkers also often did not investigate red flags in applications, leading to potential mistakes in determining eligibility for the program.

At the time of our current audit, the Ministry informed us that ODSP caseworkers are not required to review whether Ontario Works caseworkers performed third-party checks. However, ODSP staff could at any time conduct financial reviews, including third-party checks, if they determine that action is necessary. We found that where an Ontario Works caseworker had not performed the required third-party checks, in all cases at all four ODSP offices we visited, ODSP caseworkers did not subsequently carry out one or more of these required third-party checks to make sure that the individual or family unit was still financially eligible for ODSP prior to issuing income support payments.

RECOMMENDATION 3

To prevent financially ineligible Ontario Works recipients from transferring to the Ontario Disability Support Program (ODSP) and receiving income support that they are not entitled to, we recommend that the Ministry of Children, Community and Social Services:

- update its directives, policies and business procedures to clearly define and communicate Ontario Works responsibilities for performing third-party checks prior to transferring recipients to ODSP, and ODSP caseworker responsibilities in instances where these checks have not been performed;
- implement a process to monitor compliance with these requirements; and
- put in place mechanisms to hold Ontario Works service managers accountable in instances of non-compliance with ODSP requirements.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and recognizes that further action can be taken to improve the financial eligibility information of a case being transferred from Ontario Works to the Ontario Disability Support Program (ODSP).

The Ministry has established a working group to assess and implement standard processes and tools related to the transfer of recipients from Ontario Works to ODSP. These activities will also set out requirements for ODSP caseworkers receiving transferred clients from Ontario Works. This work will be completed by September 2020. A standard process for monitoring compliance with these requirements will also be implemented by September 2020.

To strengthen the accountability with these requirements, the Ministry will communicate that the completion of third-party checks is required prior to transferring cases to ODSP as an Ontario Works service planning priority for the 2020/21 fiscal year, and monitor performance. The Ministry will also assess, by June 2021, other mechanisms that can be used to strengthen accountability in this area and take steps to implement them thereafter.

4.3 Despite Increasing Approval Rates, Ministry Does Not Review Disability Decisions for Appropriateness

4.3.1 Over 40% of New ODSP Applicants in 2018/19 Determined to Be Disabled at Triage after Cursory Review

We found that the percentage of new ODSP applications approved as meeting the definition of a person with a disability increased from 48% in 2008/09, when we last audited the ODSP program, to 59% in 2018/19 (see **Figure 15**). The rise was primarily related to a 56% increase in the percentage of new applications approved after a cursory review, at what is referred to as the triage stage of adjudication, from 27% in 2008/09 to 42% in 2018/19.

We found that the Ministry had not analyzed the reasons for the increase to ensure decisions regarding disability are made in accordance with the ODSP Act and Ministry policies.

The Ministry has a target to perform a review at triage of all new applications within 10 business days of receiving them. This expedited cursory review determines whether the medical evidence clearly identifies that applicants can be immediately determined as disabled, or whether they require a detailed review through the regular medical adjudication process.

4.3.2 Triage Adjudicators Each Expected to Make between 20 and 25 Disability Decisions per Day

While the Ministry has a target for its adjudicators to review between 20 and 25 ODSP applications in the triage stage each day, we found that the Ministry could not demonstrate how it determined that the target could be achieved while making appropriate decisions on whether applicants are disabled.

As noted in **Section 2.2.2**, in addition to the forms included in the Disability Determination Package, based on our review of ODSP applications approved at the triage stage, we found that about 90% of them also contained additional medical

Figure 15: Percentage of Applications Received Found Disabled at Triage[1] and Regular[2] Adjudication Stages, 2008/09–2018/19

Prepared by the Office of the Auditor General of Ontario with data from the Ministry of Children, Community and Social Services

	# of New Applications	# of Applications Found Disabled at Triage	% of Applications Found Disabled at Triage	# of Applications Found Disabled at Regular Adjudication	% of Applications Found Disabled at Regular Adjudication	% of Applications Found Disabled at Triage and Regular Adjudication
2008/09	33,946	9,056	27	7,096	21	48
2009/10	38,045	11,568	30	8,874	23	54
2010/11	39,958	10,853	27	6,766	17	44
2011/12	40,879	10,861	27	8,105	20	46
2012/13	40,219	11,312	28	7,260	18	46
2013/14	39,483	9,967	25	7,753	20	45
2014/15	35,049	9,942	28	6,651	19	47
2015/16	34,512	10,948	32	7,408	21	53
2016/17	37,576	13,380	36	7,841	21	56
2017/18	37,689	15,479	41	6,689	18	59
2018/19	37,250	15,740	42	6,163	17	59

1. Triage is the first stage of adjudication where adjudicators perform a cursory review of applications to assess if the applicant can be immediately determined to be disabled.
2. Regular adjudication is the second stage of adjudication. Applications that require a more detailed review as determined through the triage process are assessed by a different Ministry adjudicator.

reports that would have to be reviewed, including psychiatrist reports and x-rays.

Due to the volume of information in ODSP applications and the targeted number of applications adjudicators are expected to review, there is a risk that adjudicators do not always have time to reach decisions based on the good judgment and clinical expertise expected by Ministry adjudication policies. We found that the Ministry has never carried out a study to obtain and analyze data to determine the average time needed to effectively assess ODSP applications at any of its adjudication stages in order to set appropriate targets.

4.3.3 Ministry Has No Process to Assess Appropriateness of Disability Approval Decisions Despite Significant Differences Among Adjudicators

We found the percentage of ODSP disability applications approved by different adjudicators differed drastically but the Ministry does not review the reasonableness of these differences or assess whether adjudicator decisions are appropriate.

In our 2011 follow-up to our 2009 ODSP audit, the Ministry informed us that it established a formal adjudication file review process in 2010. A sample of approximately 40 adjudicator files were reviewed each week to determine the appropriateness of the decisions and to identify any training needs. The Ministry advised us that a file feedback form was to be completed for each review and provided to the applicable adjudicator. In addition, we were told that for any file reviewed where it was recommended that the original decision be overturned, the file was further reviewed by a panel of three individuals who then made a final determination. However, during our current audit, the Ministry advised us that it stopped these reviews to focus on other adjudication priorities in 2014 and did not have a substitute process to ensure adjudicator disability decisions are appropriate and in line with the ODSP Act and Ministry policies.

Figure 16: Adjudicator Approval Percentage at Each Stage of Adjudication, 2018/19

Source of data: Ministry of Children, Community and Social Services

	Highest	Lowest	Adjudicator Average
Triage	100	20	57
Regular Medical Adjudication	73	8	30
Internal Review	20	5	10
Pre-Tribunal Review	65	14	31

We also reviewed Ministry data and found that there are vast differences among adjudicators in the percentage of ODSP applications that they approve at each stage of the adjudication process (see **Figure 16**). For example, in the triage stage where all new applications undergo a cursory review, we found that in 2018/19 while one adjudicator who reviewed almost 4,200 applications approved just 20% of them, two adjudicators, including an adjudicator who reviewed over 500 applications, approved all of them.

We also found large differences in adjudicator application approval rates in the regular medical adjudication stage. In 2018/19, 17% of applications that underwent a regular medical adjudication were approved by the Ministry as illustrated in **Figure 15**. However, we found that adjudicators' approval rates ranged from as low as 8% to as high as 73% of applications reviewed.

Although the Ministry advised that some adjudicators with high approval rates are responsible for adjudicating cases that involve critical or terminal conditions, differences in approval rates are not analyzed to determine if they are reasonable, or if follow-up action is needed to ensure that adjudicator decisions are consistent and made in accordance with the ODSP Act and Ministry policies.

Ministry Management's Feedback Not Always Focused on Making Right Decision

We reviewed feedback from Ministry adjudication managers to adjudicators that was particularly

concerning given the lack of a process to review the appropriateness of disability decisions. Our review of a sample of email feedback to adjudicators showed that it is heavily focused on productivity. We noted examples where adjudication managers focused on increasing the number of disability decisions without regard to the complexity of the applications reviewed. Feedback also included managers asking adjudicators to explain why their disabled decision rate, or pass rate, was low. In addition, several of the adjudicators who responded to our survey raised concerns about Ministry management's focus on the number of files reviewed rather than the appropriateness of decisions made. Concerns expressed in the survey included that management was focused on meeting quotas to increase the number of applications processed rather than focusing on making the right decision.

4.3.4 Adjudicators' Rationale for Disabled Decisions Not Clear, Resulting in Lack of Transparency and Accountability for Taxpayers

We reviewed a sample of ODSP applications approved at the triage and regular medical adjudication stages, as well as a sample of rejected applications. We found that in the rejected applications we reviewed, the Ministry's rationale for rejecting the application was clear, referencing the medical documentation and why it did not illustrate that the applicant had a substantial impairment or restriction to their daily living activities.

Conversely, we found that the Ministry's rationale for approving an application was less detailed. We found that in almost 20% of the approved applications we reviewed it was not clear from the application and the adjudicator's rationale how the applicant met the definition of a person with a disability. For example:

- One application involved an applicant with three listed conditions: a mild intellectual disability, a learning disability and attention deficit hyperactivity disorder. The application did not list substantial restrictions to activities of daily living and the adjudicator's rationale did not explain why the applicant was approved in the absence of substantial restrictions to activities of daily living.
- Another application involved an applicant with two listed conditions: fibromyalgia and vertigo. The documentation did not support that the applicant had substantial impairments, and included a report from a health-care professional that concluded there was no diagnosis of vertigo. The adjudicator's rationale did not explain why the applicant was approved in the absence of substantial impairments.

The Ministry informed us that unlike rejected applications where it expects that its decision may be appealed, adjudicators have been advised to keep the rationale for approved applications succinct to ensure that adjudication productivity targets are met. However, the vast majority (80% in 2018/19) of these cases result in approving the applicant with ODSP benefits for life (see **Section 4.4**), potentially costing taxpayers hundreds of thousands of dollars for each recipient. The rationale should therefore be clear—including how the adjudicator dealt with any inconsistencies in the application and supporting documents to arrive at a decision.

In addition, we reviewed a sample of disabled decisions made at the pre-Tribunal stage of adjudication. As described in **Figure 6**, if new medical information becomes available between the date of the appeal to the Social Benefits Tribunal and 30 calendar days before the date of the hearing, the Adjudication Unit will assign a different adjudicator to re-adjudicate the application prior to the hearing.

We found that in 40% of the overturned decisions we reviewed at the pre-Tribunal stage, there was no mention in the adjudicator's rationale of how the additional medical information received at this stage suggested substantial impairment or restrictions to activities of daily living and therefore supported overturning previous adjudicator decisions.

RECOMMENDATION 4

So that all applicants who meet the Ontario Disability Support Program's definition of a disabled individual receive benefits, we recommend that the Ministry of Children, Community and Social Services:

- review the reasonableness of its targets and expectations for the number of disability applications it expects its triage adjudicators to complete and to update its targets accordingly;
- implement a formal process to regularly review the appropriateness of decisions to approve and reject applicants as disabled; and
- monitor and investigate significant differences in the rates that adjudicators approve applicants as disabled and take steps to facilitate corrective actions where differences are determined to be unreasonable.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation. Effective oversight of the adjudication process is an essential component of overall program integrity. Adjudication oversight must ensure both that individuals who are not medically eligible are not found eligible, and that individuals who are eligible are determined to be so as quickly as possible.

The Ministry will review the reasonableness of its targets and expectations for the number of disability applications it expects its triage adjudicators to complete. This review will be completed by December 2020. Based on this review, the Ministry will update its targets accordingly.

The Ministry will assess options to strengthen its adjudication quality assurance framework by March 2020. Thereafter, it will implement a process to regularly review the appropriateness of its decisions.

The Ministry will implement a process to monitor and investigate significant differences in approval rates of adjudicators with comparable caseloads by June 2020. Thereafter, the Ministry will take corrective action where it determines differences to be unreasonable.

4.3.5 Adjudication Unit's Medical Information and Guidelines Outdated, Leading to Approval of Some Applicants in Contravention of ODSP Act

Adjudicators determine whether a condition and related impairments are substantial primarily by referring to the Adjudication Unit's handbook and triage guidelines. We found that because the handbook and guidelines have not been updated since their inception in 2004, some applicants are incorrectly approved as disabled even though their condition does not have a substantial impact on their activities of daily living. This is because the impairments associated with certain conditions have changed significantly. Accordingly, the handbook and guidelines require revision to reflect advancements in treatment.

In our review of a sample of ODSP applications approved as disabled, we found several instances where the medical condition and related impairments of the applicants did not result in a substantial restriction on their daily living activities, which is a requirement to establish disability under the ODSP Act. Specifically, we found the following:

- an individual was approved as disabled for life because of profound hearing loss even though the health-care professional who completed the application indicated they could function normally with hearing aids; and
- several individuals were approved as disabled for life due to contracting HIV despite having no substantial restrictions on their daily living activities. The Ministry told us that it had not updated its guidelines concerning HIV in over 15 years, and thus its policy had not taken into consideration medical advances

since that time. The Ministry's guidelines for adjudicators indicate that confirmed cases of HIV are to be deemed disabled with no requirement for a medical review. We noted that in the last five fiscal years, more than 2,000 applicants had been approved as disabled because they have HIV—steadily increasing each year from 325 in 2014/15 to 458 in 2018/19.

RECOMMENDATION 5

So that only applicants who meet the Ontario Disability Support Program's definition of a disabled individual receive benefits, we recommend that the Ministry of Children, Community and Social Services update the Adjudication Unit's handbook and triage guidelines to reflect advances in treatment associated with medical conditions where there have been significant changes that may no longer render individuals disabled, or permanently disabled.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation that current medical information and guidelines are vital to the adjudication process. A refreshed Adjudication Handbook and triage guidelines, including enhancements on infectious diseases, will be updated in consultation with medical and disability experts by December 2020 to reflect advances in treatment associated with medical conditions.

4.3.6 Ministry Does Not Track Concerns about Health-Care Professionals Who Complete Disability Applications

We found that the Ministry does not record basic information, such as the name and address, of health-care professionals who complete disability applications in its information systems. In addition, the Ministry does not have a process to track concerns about disability applications completed by specific health-care professionals. As a result, the Ministry is unable to monitor trends that may warrant further investigation, such as health-care professionals who complete a high volume of applications, or concerns about a specific health-care professional's completed applications.

We obtained data from the Ministry of Health and found that some health-care professionals complete a disproportionately high number of disability application forms. For example, we noted that over the last five years, one physician had completed an average of 240 disability applications per year, compared with an average of four per year among all physicians who completed such forms. We noted that the Ministry undertook a similar exercise during our audit and also identified that a few physicians completed a disproportionately high number of disability application forms. However, the Ministry advised us that it had yet to determine the next steps it would take in response to its analysis.

We also surveyed adjudicators who raised many concerns about the information provided by physicians who complete disability application forms. In particular, concerns were raised with the thoroughness, accuracy and consistency of information. Examples provided by adjudicators include physicians scoring applicants with high ratings for severity of impairments or restrictions arising from their medical condition without corroborating information, suspected exaggerated medical assessments, and completing disability application forms for first-time patients they may not be familiar with.

RECOMMENDATION 6

So that only applicants who meet the Ontario Disability Support Program's (ODSP) definition of a disabled individual receive benefits, we recommend that the Ministry of Children, Community and Social Services:

- record the name and address of health-care professionals who complete disability applications, as well as any concerns about these

applications identified by adjudicators in its information system, to analyze and identify trends, and take corrective action where needed; and

- review and assess the appropriateness of applications completed by physicians that complete a disproportionately high number of disability applications.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and that it is important to understand the underlying reasons behind variations in Disability Determination Package (DDP) completion rates and differences in how the DDP is completed by health-care practitioners, and to take action on any inappropriate behaviour should this be identified.

The Ministry will explore options to strengthen the data collected on health-care professionals to assist in trend analysis and take appropriate action when needed.

The Ministry has worked with the Ministry of Health to obtain data and has started an analysis of trends, including identifying those health-care professionals who complete a disproportionate number of DDPs. The Ministry will evaluate whether this variation reflects a control or quality problem in the completion of DDPs and, if so, will develop a plan to address any such problem by September 2020.

4.4 Ministry Determines 80% of Applicants It Finds Disabled to Be Disabled for Life; Rarely Assigns Medical Reviews Required by Legislation

4.4.1 92% of Applicants Approved at Triage after a Cursory Review Determined to Be Disabled for Life

The Ministry requires medical adjudicators to assign approved applicants a medical review date of either two or five years unless the adjudicator is satisfied that the individual's impairment is not likely to improve. Our review of Ministry data for decisions made at the triage stage of adjudication identified that in 2018/19, after a cursory review of the application, 92% of approved applicants were not assigned a medical review date by the adjudicator and were instead deemed disabled for life and thus eligible for ODSP benefits for life. As illustrated in **Figure 17**, this represents an increase of over 40% since the time of our last audit in 2009, when 65% of approved applicants were not assigned a medical review date. This increase is particularly concerning because, as noted in **Section 4.3.1**, the percentage of applications approved as disabled at triage has also increased by 56% since the time of our last audit.

4.4.2 Ministry Efforts to Reduce Medical Reviews Contributed to Increase in Applicants Approved for Benefits for Life without Review

Across all stages of adjudication, we noted that the number of approved disability applications that were not assigned a medical review date increased from 51% in 2008/09, at the time of our last audit, to 80% in 2018/19. This represents a 57% increase in the percentage of approved applicants who receive ODSP benefits for life. As **Figure 17** illustrates, the increase was sharpest from 2015/16 onward. Because the Ministry had not studied the reasons for this increase, we analyzed the Ministry's

Figure 17: Percentage of Disabled Decisions Not Assigned a Medical Review Date by Adjudication Stage, 2008/09–2018/19

Source of data: Ministry of Children, Community and Social Services

	Triage	Regular	Internal Review	Pre-Tribunal Review	All Stages
2008/09	65	40	42	33	51
2009/10	63	34	39	29	48
2010/11	62	36	35	30	49
2011/12	58	35	29	28	45
2012/13	57	35	36	31	46
2013/14	67	36	44	37	51
2014/15	69	34	39	40	52
2015/16	83	53	58	60	69
2016/17	94	58	63	72	79
2017/18	96	67	55	72	85
2018/19	92	60	54	59	80

decisions to not assign a medical review by type of disability. We discovered, as illustrated in **Figure 18**, that certain conditions, including neuroses, psychoses, diseases of the musculoskeletal system and diseases of the circulatory system, experienced the most significant increases. We shared this analysis with the Ministry. Although the Ministry could not identify specific reasons, it provided a list of actions taken since 2015/16 to reduce the number of medical reviews assigned that may have contributed to the increase. These actions included:

- providing a number of training sessions in 2015 that emphasized not assigning medical reviews for certain conditions such as various mental health conditions, cancers and chronic diseases;
- implementing a process where a decision to assign a medical review date to an applicant was to be reviewed by another adjudicator. If the other adjudicator could not see what would improve in relation to the applicant's disability in two or five years' time, the file would be returned to the original adjudicator to reconsider assigning a review date or to provide a fuller explanation of what was expected to improve; and
- implementing functionality in its adjudication software to alert adjudicators that a medical review may not be necessary for certain conditions that the Ministry deemed significant. The Ministry's Adjudication Unit approved this software alert and advised us that it did not seek approval from the Ministry's senior leadership to make this change.

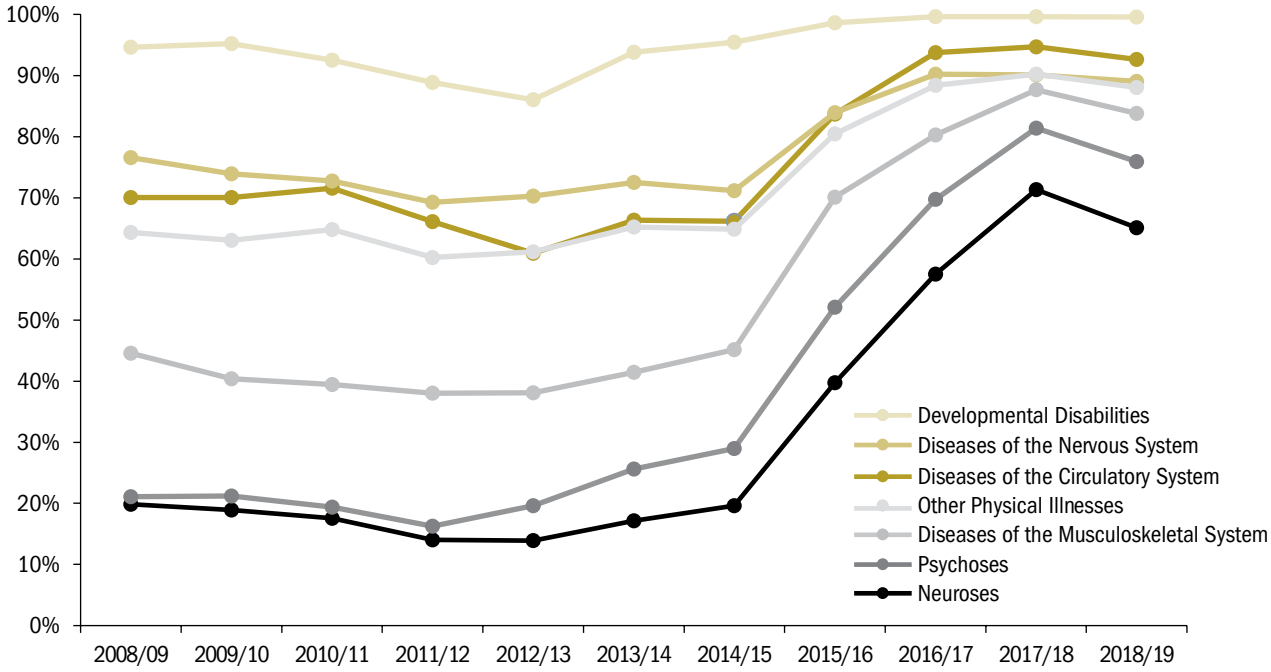
However, we were concerned with the impact of these actions because, as discussed in **Section 4.4.3**, we noted that the Ministry's guidance for adjudicators for setting all medical review dates is not consistent with the regulations under the ODSP Act. In addition, as discussed in **Section 4.4.4**, in our sample of decisions we reviewed at the triage and regular stages of adjudication, we also identified that disability decisions without medical review dates were not always fully supported.

4.4.3 Ministry Adjudication Framework Not Consistent with Legislation for Setting Medical Reviews

The regulations under the ODSP Act state that adjudicators should set a date to review decisions confirming an individual is disabled, unless the adjudicator is satisfied that the person's condition, impairment and restrictions are not likely to

Figure 18: Trend in Percentage of Decisions with No Medical Review Date Assigned by Disability Type, 2008/09–2018/19

Source of data: Ministry of Children, Community and Social Services



improve. However, we found that the Adjudication Unit's medical adjudication framework does the opposite: it puts the onus on adjudicators to determine that the condition, impairment, and restrictions are likely to improve in order to assign a medical review date. This change in interpretation relative to the regulations under the ODSP Act means that it is more difficult to conclude that a medical review is required than it is to conclude that it is not. The Ministry's documentation requirements for assigning medical reviews is also consistent with this framework. For example, the Ministry requires more documentation if an adjudicator assigns a medical review than it does for when the adjudicator decides that no medical review is required.

4.4.4 Adjudication Decisions without Medical Review Dates Not Always Fully Supported

Our review of a sample of adjudication decisions from 2017/18 and 2018/19 at the triage and regular stages of adjudication identified that in over 40% of the cases we reviewed, the file did not contain an explanation of how the adjudicator determined that the applicant's condition, impairments and restrictions were unlikely to improve and that no medical review was required in order to satisfy regulatory requirements of the ODSP Act. For example:

- A 41-year-old woman whose application identified chronic post-traumatic stress disorder with anxiety and insomnia was determined by a Ministry adjudicator to be disabled for life. The adjudicator's summary stated that various medication trials and psychotherapy intervention had failed to produce improvement and noted that no medical review was required. However, the applicant started taking medication only a couple of months before she was approved as disabled, so not enough time would have passed to conclude that treatments had failed.
- A 44-year-old woman diagnosed with obesity and knee arthritis was determined by an adjudicator to be disabled for life. Treatment

options had been proposed by a health-care professional, such as pursuing a weight loss program and undergoing a knee replacement. We did not find evidence in the file supporting that the applicant is not likely to improve.

Since adjudicator decisions to not assign a medical review result in approving applicants with ODSP benefits for life, which can cost taxpayers hundreds of thousands of dollars for each decision, the adjudicator's rationale should be sufficiently detailed to meet regulatory requirements under the ODSP Act, and clearly indicate how the adjudicator concluded that the applicant's condition is unlikely to improve.

RECOMMENDATION 7

So that only applicants who meet the Ontario Disability Support Program's definition of a disabled individual receive benefits, we recommend that the Ministry of Children, Community and Social Services:

- analyze by disability type the increase in the proportion of cases that it does not assign a medical review, and assess whether these increases are reasonable;
- revisit the actions taken since 2015/16 that contributed to the increase in cases it does not assign a medical review, and take corrective measures where these actions have led to decisions that are not consistent with the regulations under the *Ontario Disability Support Program Act, 1997* (ODSP Act);
- review and implement changes to the Adjudication Unit's policies and guidelines where they are not consistent with the principles of the ODSP Act; and
- review and update its requirements for both obtaining evidence in support of medical review decisions and documenting the rationale for such decisions so that they are clearly supported and consistent with the regulatory requirements under the ODSP Act.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation. The Ministry's approach to adjudication and the assignment of medical reviews is governed by the *Ontario Disability Support Program Act, 1997* (ODSP Act), and its regulations. The interpretation and application of the ODSP Act have evolved as a result of regulatory changes and binding court decisions that inform the Ministry's policies and delivery of ODSP.

The Ministry agrees with the value of analyzing by disability type any increase in the proportion of cases where a medical review is not assigned and assessing whether the "'disability type' assignments" are reasonable. The Ministry will target to complete a review by December 2020 and will implement a file review process by March 2021.

The Ministry will revisit actions taken since 2015/16 that may have contributed to the increase in cases it does not assign a medical review and assess if those actions require modification or updating. This assessment will be completed by June 2020. Thereafter, the Ministry will take corrective measures as needed to ensure decisions are consistent with the ODSP Act.

The Ministry recognizes that there are opportunities to review and enhance adjudicative policies and guidelines. The Disability Adjudication Framework aims to provide clarity and transparency of policy used to determine eligibility under the ODSP Act. A review of the Framework will be conducted by June 2020 and the Ministry will implement any necessary changes to adjudicative policies and guidelines in accordance with the requirements of the ODSP Act, regulations and case law.

The Ministry recognizes that there are opportunities to review and enhance adjudicative practices and will review its requirements

for both obtaining evidence to support medical review decisions and documenting the rationale for such decisions by September 2020.

4.5 Majority of Non-disabled Decisions Still Overturned by Tribunal

We found that 10 years after our last audit of ODSP in 2009, the Social Benefits Tribunal (Tribunal) continues to overturn about 60% of the Ministry's decisions appealed to the Tribunal where the Ministry has found applicants not disabled and therefore not eligible for ODSP benefits.

Our review of data relating to appeals dealt with by the Tribunal included similar findings to those we reported in our *2009 Annual Report* (see **Sections 4.5.1** and **4.5.2**).

4.5.1 Outcomes of Tribunal Hearings Vary Significantly Depending on the Tribunal Member

Senior representatives from Tribunals Ontario informed us that the decision of whether to uphold or overturn the non-disabled decision lies solely with the member who conducts the hearing. After the hearing, the presiding Tribunal member is given 60 days to submit their decision to the applicant and the Ministry. There is no internal review of decisions for quality or consistency. We also noted that Tribunal members are not required to have a medical background. In addition, we noted a high variation in Tribunal member decisions. We reviewed the decisions made from hearings in 2018/19 and found, for example, that while one member overturned 28% of Ministry decisions, a different member overturned 93% of the Ministry's decisions.

RECOMMENDATION 8

So that only eligible individuals are provided with Ontario Disability Support Program income support, we recommend that the Social Benefits Tribunal (Tribunal), while respecting Tribunal member independence:

- review the overturn and uphold rates for reasonableness between Tribunal members and determine whether any changes in training or other tools are needed to foster greater quality; and
- make improvements where needed.

SOCIAL BENEFITS TRIBUNAL RESPONSE

The Social Benefits Tribunal (Tribunal) takes its responsibilities under the legislation seriously and is committed to ensuring members receive the professional development and supports they require to make fair and just decisions, consistent with the *Ontario Disabilities Support Program Act, 1997*. The Tribunal has several internal institutional processes in place, designed to support this objective. The Tribunal will actively look for opportunities to foster and improve the quality, reasonable consistency, and coherence of Tribunal decisions, and will take steps to identify and put in place additional processes if determined needed, provided that they respect judicial independence as well as the appearance of that propriety.

4.5.2 Ministry Officers Attend Just 16% of Hearings Despite Tribunal Upholding More Ministry Decisions When Officers Attend

Although legal counsel often represent the appellant at Tribunal hearings, our review of Ministry and Tribunal data showed that the Ministry's case-presenting officers (officers) appeared in only 16% of hearings in the last 10 years, including 28% in 2018/19, to provide the Ministry's legal submissions and the rationale for denying the applicant's appeal. The Ministry explained that it does not have sufficient human resources to attend all of the Tribunal hearings. However, we found that the Tribunal upheld the Ministry's decisions to deny eligibility at a significantly higher rate when an officer was present at a hearing.

Between 2009/10 and 2018/19, 48% of Ministry decisions were upheld by the Tribunal with an officer in attendance compared with 38% when an officer did not attend. This includes a difference of nearly 20% in 2018/19, when 48% of decisions were upheld with an officer in attendance compared with 30% when an officer did not attend.

Similarly, the Ministry shared with us its analysis of all Tribunal decisions from 2017/18 that also showed the Tribunal upheld Ministry decisions at a higher rate when an officer was present than when an officer was not. However, we noted that the Ministry has not performed a cost-benefit analysis of officers attending more than 16% of Tribunal hearings to determine whether officers should attend all hearings or, if not, the optimal number of hearings that officers should attend to minimize overall program costs.

Officer Attendance at Tribunal Hearings Varies by Location, Not Based on Risk of Ministry's Decision Being Overturned

With the exception of a very small number of Tribunal hearings, the Ministry does not prioritize the cases to be heard by the Tribunal to determine which cases its officers should attend, including in which cases there is a higher risk of its decision being overturned. Instead, the Ministry encourages officers to select locations where a minimum of three hearings each day are scheduled to maximize the number of hearings that its officers attend. As a result, we found wide variations in officer attendance across locations, even among locations where a significant number of Tribunal hearings were held. Specifically, we looked at locations where at least 1,000 Tribunal hearings had been held in the last three fiscal years and found that officer attendance varied from as low as 8% to almost 40% of hearings.

RECOMMENDATION 9

So that only eligible individuals are provided with Ontario Disability Support Program income support, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- review the impact of Ministry attendance on the outcome of Tribunal hearings, to determine whether officers should attend all hearings, or if not, the optimal number of hearings to attend to minimize overall program costs, and to ensure that the Ministry's position is effectively explained and supported at hearings; and
- select Tribunal hearings to attend based on the risk of the Ministry's decision being overturned in the Ministry's absence.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and recognizes the need to determine the optimal approach to handling representation at Tribunal hearings. The Ministry will assess the impact of in-person representation at hearings along with the current approach for Ministry hearing attendance. This assessment will be completed by December 2020. Based on this assessment, the Ministry will make adjustments to its current practices accordingly.

4.5.3 Ministry Efforts to Reduce Percentage of Non-disabled Decisions Overturned by the Tribunal Have Been Ineffective

After our 2009 audit, the Ministry committed to address the high rate at which the Tribunal overturned ODSP decisions related to whether an individual is disabled. Between 2011 and 2017, the Ministry undertook four separate reviews of a sample of Tribunal decisions to identify and address the reasons the Tribunal overturned its decisions. The Ministry advised us that in an effort to reduce the number of applicant appeals to the Tribunal, and to reduce the number of its decisions overturned, it took action such as providing additional training to Ministry adjudicators, and updating its

Figure 19: Social Benefits Tribunal Decisions, 2008/09 and 2018/19
Source of data: Ministry of Children, Community and Social Services

	Decisions Overturned		Decisions Upheld		Decisions Varied		Total Appeals #
	#	% of Total	#	% of Total	#	% of Total	
2008/09 Disability Determination	4,182	59	2,517	36	341	5	**7,040**
2018/19 Disability Determination	2,789	60	1,690	37	145	3	**4,624**

adjudication framework in 2017 to increase the consistency of decision-making.

As illustrated in **Figure 19**, the number of appeals to the Tribunal declined by 34%, from over 7,000 in 2008/09 to just over 4,600 in 2018/19. Contributing to the reduction in the number of appeals to the Tribunal is the fact that the Ministry approved more applicants as disabled in 2018/19 (59%) than in 2008/09 (48%) (see **Figure 15**).

Nevertheless, the Ministry identified that the Tribunal's decisions continue to affect the Ministry's decisions on whether an applicant is disabled. While the number of appeals to the Tribunal declined, the percentage of Ministry decisions overturned by the Tribunal actually increased slightly from 59% in 2008/09 to 60% in 2018/19.

We noted that in British Columbia, its Employment and Assistance Appeal Tribunal (BC Tribunal), which hears appeals on disability decisions for social assistance, rescinded less than 5% of the appeals that it heard on disability decisions in 2017/18 (the most recent data available). We noted that unlike Ontario's Tribunal, which has broad powers and can make a different decision than the Ministry, the BC Tribunal can only confirm or rescind the decision of the Ministry—it cannot make its own decision.

RECOMMENDATION 10

So that only eligible individuals are provided with Ontario Disability Support Program (ODSP) income support, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- review whether the high overturn rate of the Ministry's decisions at the Social Benefits Tribunal has affected the Ministry's ability to reach disability decisions that are consistent with the ODSP Act; and
- assess the suitability for ODSP of models for appeals in other jurisdictions and propose alternatives to the Ontario government for an appeals framework that enhances the consistency of disability decisions between the Ministry and the appeals body with the ODSP Act.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation. While acknowledging the independence of the Social Benefits Tribunal (SBT), and the existing mechanisms that hold decisions made by the SBT accountable, the Ministry will undertake an assessment of the impact that SBT decisions have on Ministry decisions, review appeal frameworks within other jurisdictions, and propose enhancements to the appeal framework in Ontario based on this assessment by March 2021.

4.6 Ineligible Recipients Likely Remain on ODSP

4.6.1 Caseworkers Rarely Review Recipients' Continued Financial Eligibility

To ensure that recipients remain eligible for income support, the Ministry expects caseworkers to review and update recipients' application information on an ongoing basis to identify any changes in financial or other circumstances that may affect their eligibility or the amount of income support received. Caseworkers decide when it is necessary to do this based on their knowledge of the recipient case and assessing eligibility risk factors, such as the duration since the last complete review, the length of time on ODSP and any previous eligibility-related issues. We found that caseworkers rarely review and update recipient application information to confirm their continued financial eligibility and to prevent ineligible recipients from continuing to receive benefits.

At the four ODSP offices we visited, we selected a sample of recipient cases that had been on the ODSP caseload for several years. As illustrated in **Figure 20**, we found that in 58% to 100% of the files we reviewed, the recipient's application information had not been updated for at least five years. In many cases it was much longer, including one recipient whose information had not been updated since 2005.

In addition, we found that caseworkers had not been in touch with recipients for over two years in 22% to 50% of the cases we reviewed. In some cases, there was no evidence that the current caseworker had ever spoken or had any communication with the recipient. This lack of contact highlights that there is a significant risk that if recipients do not report changes in their circumstances that may affect their eligibility, caseworkers will not detect these changes.

To address our observations, some caseworkers contacted recipients related to the files we reviewed. Following a review of the recipients' circumstances, as of September 2019, caseworkers had either terminated or suspended six of the cases we reviewed and established overpayments in these cases totalling approximately $107,000. This included one case where we identified a recipient who had started to receive Old Age Security benefits in 2016. We brought this case to the attention of the Ministry who subsequently investigated it, terminated the recipient's ODSP benefits and established an overpayment totalling approximately $34,000.

The results of our survey also illustrated that caseworkers across all offices in the province rarely review recipients' ongoing financial eligibility. As highlighted in **Figure 21**, other than when recipients

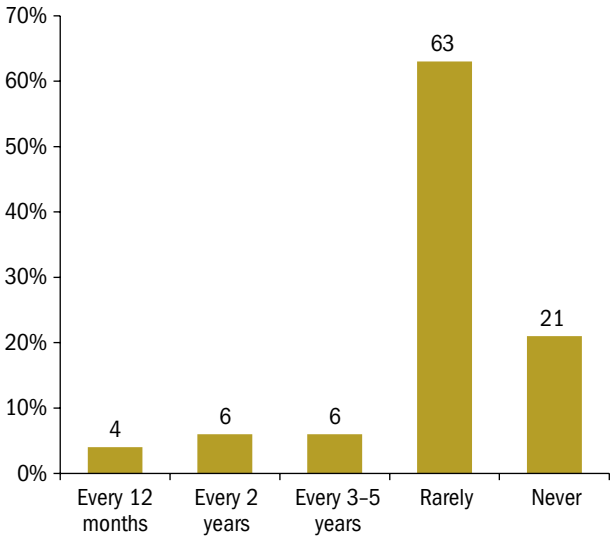
Figure 20: Percentage of Files Reviewed Where Caseworkers Had Not Updated Recipients' Application Information

Prepared by the Office of the Auditor General of Ontario

Offices Visited	Application Information Not Updated for at Least Five Years	Caseworker Had Not Been in Touch with Recipient for >Two Years
Hamilton	80	40
Ottawa	100	22
Sudbury	100	50
Willowdale	58	50

Figure 21: Frequency of Financial Eligibility Reviews as Reported by Caseworkers*

Prepared by the Office of the Auditor General of Ontario



* Caseworkers who responded to our survey.

self-report a change in their circumstances, over 80% of caseworkers who responded to our survey told us that they rarely (63%) or never (21%) review a recipient's financial eligibility.

Some Recipient Deaths Not Identified on a Timely Basis, Leading to Overpayments

We found that despite having an agreement to obtain data from the province's death registry to help identify deceased ODSP recipients who were still being paid benefits, the Ministry does not regularly use this information to identify deceased recipients on a timely basis and prevent overpayments.

We obtained death registration data from the Ministry of Government and Consumer Services that we analyzed and used to identify 110 individuals who were deceased but continued to be included in the ODSP caseload as of March 2019. Although in most of these cases the payments the Ministry issued to these individuals were cancelled, we found that as of September 2019, income support payments were issued to 26 of these individuals. As a result, we identified overpayments of approximately $540,000 relating to payments made between December 2006 and September 2019. This included overpayments to two deceased individuals of $140,000 and $104,000, respectively, where both the individuals had passed away more than 10 years ago. We also found that the Ministry had not assessed the ongoing eligibility of both of these recipients in the last five years.

In addition, we identified three people who had died but were still included as a family member when calculating the income support payments payable to their spouse—one of these individuals had been deceased since 2012. At the conclusion of our audit, the Ministry was still investigating these cases to determine the extent of the overpayments and to investigate whether fraud may have occurred.

We also identified approximately 450 additional active ODSP recipients with the same first name, last name and date of birth as an individual in the death registration data. While there was not a match on the address for these individuals, these cases warrant further investigation by the Ministry to determine and stop making payments where they are confirmed to be the same people as in the death registry.

We noted that the Ministry has had an agreement in place since April 2015 with the Ministry of Government and Consumer Services to obtain and use death registration information to identify deceased individuals that are in receipt of social assistance payments, including ODSP. However, we found that since putting this agreement in place, the Ministry has only attempted to perform a data match between the death registry and the ODSP caseload three times, including its most recent data match in January 2018. Identifying deceased recipients in a timely manner is critical to preventing overpayments.

4.6.2 Ministry Did Not Perform Planned Targeted Eligibility Verification Reviews to Terminate Ineligible Recipients or Identify Overpayments

The Ministry's key process to oversee and confirm the eligibility of ODSP recipients, and verify that they are receiving the correct amount of income support, is its eligibility verification review, which supplements the ongoing eligibility reviews (see **Section 4.6.1**) that caseworkers are expected to perform. Ministry directives state that 3% of all ODSP recipient cases will be selected for an eligibility verification review each month (see **Section 2.5**).

Based on selecting 3% of the caseload each month, we calculated that the Ministry should have performed approximately 508,300 eligibility verification reviews in the last four fiscal years (April 1, 2015, to March 31, 2019). However, we found the Ministry completed only 8,262 of these eligibility verification reviews: 6,181 in 2017/18 and 2,081 in 2018/19. That was only 1.6% of the total reviews it should have performed.

The Ministry suspended eligibility verification reviews during 2014/15 due to the implementation of the Ministry's information technology system Social Assistance Management System (SAMS). In the two years since the reviews resumed, in 2017/18 and 2018/19, the Ministry allocated only 21 staff per month on average to complete the reviews. In 2017/18, the Ministry selected cases for eligibility verification at random rather than risk. Out of the 6,181 reviews it completed, it identified overpayments in 18% of the cases totalling about $4.65 million. This is equivalent to an average overpayment of almost $4,200 in each of these cases. Based on these results, if all of the 508,300 reviews required by the Ministry's directives had been completed, the Ministry may have identified a further $375 million in additional overpayments that it could have prevented from increasing and started to recover from recipients. Even if the Ministry had been unable to perform any reviews between 2015/16 and 2016/17 due to the demands of implementing SAMS, it still could have identified a further $240 million in additional overpayments in 2017/18 and 2018/19.

In 2017/18, the eligibility verification review also resulted in terminating 2.35% of cases looked at because recipients were no longer eligible for ODSP income support. If the Ministry had completed all of the reviews, based on these results, more than 11,700 additional cases may have been terminated. The monthly rate for a single recipient on ODSP is $1,169; therefore, terminating these potentially ineligible cases could have led to annual savings to ODSP income support expenditures of at least $165 million per year, or $105 million if no reviews were done in 2015/16 and 2016/17.

RECOMMENDATION 11

So that only eligible recipients continue to receive Ontario Disability Support Program (ODSP) benefits, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- establish a risk-based timeframe for ODSP caseworkers to periodically review the eligibility of all ODSP recipients;
- implement a process to identify deceased ODSP recipients on a timely basis to prevent overpayments;
- review the backlog of cases that ODSP directives required to be subject to an eligibility verification review over the past four fiscal years, and design and execute a plan to identify and carry out reviews on these cases based on their relative risk;
- review the results of the eligibility verification reviews and carry out a cost-benefit analysis to determine the optimal percentage of eligibility verification reviews the Ministry should complete on an annual basis to maximize savings to the program; and
- put in place a plan to complete the number of eligibility verification reviews determined to be optimal to maximize savings to the program.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and acknowledges that there are opportunities to enhance its oversight of the ODSP caseload.

The Ministry will develop guidelines that include expectations for staff to make contact with their caseload on a periodic basis, and update and assess eligibility-related information according to time frames that the Ministry will set based on the risk characteristics of cases.

Starting in April 2020, the Ministry will undertake a regular data match process of social assistance recipient and death databases. The results of this data match will inform how frequently the Ministry will undertake this data matching exercise.

Currently, the Ministry applies a risk model incorporating both social assistance and third-party information to identify high-risk cases for

eligibility reviews. The risk model has proved to be effective in identifying cases where there is a high likelihood that there would be change in eligibility when the case is reviewed. The Ministry continuously works with its partners to enhance the case selection model based on the outcomes of eligibility reviews identified through the model.

The Ministry acknowledges the need to determine the optimal volume of reviews to be completed on an annual basis and put in place a plan with an appropriate resourcing strategy to ensure that the selected highest-risk cases will be reviewed within expected time frames. The determination of the optimal volume of reviews will be based on a cost-benefit analysis and will also take into consideration that reviews were suspended for several years. The plan and resourcing strategy will be included in the Ministry's 2020/21 Multi-Year Plan that it will submit to the government for approval.

4.6.3 Ministry Does Not Use Results of Eligibility Verification to Help Prevent Payments to Ineligible Recipients

The Ministry collects data on the results of the eligibility verification reviews it performs, including whether the review resulted in a recipient's termination or identifying an overpayment to the recipient. However, it does not analyze the underlying reasons, such as an undeclared spouse, that led to any of these changes. Without consolidated data to understand the most common causes of terminations and overpayments identified through the eligibility verification reviews, the Ministry is unable to use the results of the reviews to identify which of its processes it needs to improve to prevent and reduce these occurrences.

In addition, we found that results from the eligibility verification reviews were not clearly communicated to caseworkers so they could learn from the findings and apply that to their future work. Among the caseworkers who responded to our survey, approximately 55% reported that they did not receive feedback from the results of the eligibility reviews conducted. The Ministry advised us that caseworkers can view the details of eligibility reviews completed for recipients in their caseload in SAMS. However, even among the caseworkers who responded to say that they did receive feedback, approximately 20% reported that the feedback was not helpful because sometimes they were unaware when a review had been completed, or they did not find the results of the audit to be documented in enough detail or the notes to be understandable.

RECOMMENDATION 12

To maximize the benefits of the eligibility verification process, we recommend that the Ministry of Children, Community and Social Services:

- enhance its systems and processes to record and analyze the causes that led to undetected changes in recipients' financial eligibility;
- clearly communicate where such instances are occurring for review by caseworkers; and
- take action to address these causes to minimize their occurrence.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees that the information obtained through eligibility reviews can be used to inform preventative measures to ensure only eligible individuals receive assistance.

By September 2020, the Ministry will assess the enhancements needed to technology systems and business processes to record and analyze the causes that led to undetected changes in recipients' financial eligibility.

The Ministry will also analyze the information on the causes that led to undetected changes, trends and patterns, and communicate findings to staff so that preventative measures can be taken. This may include additional staff training, case management system upgrades

and enhancements, or updates to business processes and procedures. The Ministry will target March 2021 to implement actions in response to its analysis.

4.6.4 Many Fraud Allegations Not Investigated on Time and Investigations Often Ineffective

Our analysis of Ministry data found that as of March 2019, there was a backlog of approximately 42,000 fraud allegations that had not been assessed within the Ministry's required time frame of 15 business days, including approximately 6,900 at the four local offices we visited. Sixty percent of these 42,000 allegations were over a year old.

The Ministry receives fraud allegations concerning ODSP recipients from various sources such as calls to the Ministry's Welfare Fraud Hotline from the public, and through information sharing agreements such as with the Ministry of the Solicitor General to identify social assistance recipients who may be incarcerated. Local ODSP offices are required to complete a preliminary assessment of the allegations relating to clients in their caseloads within 15 business days. If the local office determines that a comprehensive investigation is required, it must be carried out within six months to establish whether it affects the recipient's eligibility for ODSP, whether there has been an overpayment and if the matter should be referred to the police.

If fraud allegations are not reviewed on a timely basis, there is a risk that ineligible recipients can continue to receive ODSP benefits for a longer period, leading to the need to recover even larger overpayments when the caseworker finally completes the investigation.

At the four local offices we visited, we reviewed a sample of fraud allegations that had not yet been preliminarily assessed and a sample of allegations that had been closed as investigated. We found that in the cases where fraud allegations had not been preliminarily assessed, in 67% to 100% of these cases the allegation appeared to be substantial and warranted further investigation by the caseworker. For example, for one recipient there was an allegation in October 2018 that the recipient was receiving social assistance from Alberta in addition to ODSP. However, at the time of our review, approximately seven months after receiving this allegation, the caseworker had yet to conduct a preliminary assessment. After bringing this outstanding allegation to the caseworker's attention, the caseworker investigated it, terminated the recipient, and determined that the recipient had received overpayments totalling approximately $17,000.

We also found that steps taken to investigate fraud allegations were not always sufficient. For example, at one office, we noted instances of closed investigations where recipients were asked to merely sign a statement denying the fraud allegation. At another office, we found instances where investigations were closed but it was not evident that caseworkers took any action at all before closing the investigation.

Caseworkers Not Trained to Investigate Fraud

The Ministry advised us that it has made available an online tutorial on controlling fraud, and that a small number of caseworkers have completed it. However, we noted that the Ministry does not periodically provide training to caseworkers on how to assess and investigate allegations of fraud. This possibly contributes to the number of fraud allegations not investigated and weaknesses in the steps taken to investigate allegations. Approximately half of the caseworkers who responded to our survey indicated that they had not received the training they need to capably review, investigate and close fraud allegations. In addition, we were informed that the Ministry has not provided such training to caseworkers since 2010.

Fraud Allegations Concerning Medical Conditions Almost Never Investigated

Although the vast majority of fraud allegations relate to financial matters, a number are also

related to allegations of disability fraud. In such cases, the Ministry expects caseworkers to forward these allegations to the Disability Adjudication Unit (Adjudication Unit) as caseworkers do not have access to an individual's medical information. However, our audit found that this process was not working effectively.

Forty-five percent of the caseworkers who responded to our survey indicated that they had received a fraud allegation relating to a recipient's medical condition. However, approximately one-third of these caseworkers reported that they either did nothing or closed the allegation without investigating or referring it to the Adjudication Unit because they did not think it was their responsibility to do so. A further one-third responded that they investigated it themselves. However, we noted that caseworkers would not have information about the recipient's medical condition to adequately investigate such allegations. Only one-third told us that they would refer the allegation to the Adjudication Unit. However, we were advised by the Adjudication Unit that they had not had any allegations forwarded to them by caseworkers in the past year or in the recent past prior to that.

RECOMMENDATION 13

So that only eligible individuals receive Ontario Disability Support Program (ODSP) benefits, and that overpayments to recipients are identified and minimized, we recommend that the Ministry of Children, Community and Social Services take steps to:

- provide training to caseworkers on how to assess and investigate allegations of fraud;
- conduct a review of its process for assessing and investigating allegations of disability fraud and clearly communicate roles and responsibilities; and
- implement a process to monitor whether allegations of fraud have been reviewed and investigated within required time frames and take corrective action where these time frames have not been met.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and acknowledges the importance of timely and effective investigations when fraud is alleged.

The Ministry is currently conducting a review of the process to investigate allegations about possible fraud, this includes both financial and disability fraud. This review will identify areas of improvement related to learning and development, roles and responsibilities, and mechanisms to increase oversight and monitoring.

Recommendations from this process review are expected by March 2020. Thereafter, the Ministry will take action to implement the necessary changes to ensure staff responsible for addressing fraud allegations are sufficiently trained, and that oversight processes are put in place to monitor whether fraud allegations are addressed in a timely manner.

4.6.5 Undetected Changes in Eligibility Led to Significant Overpayments

At the four local offices we visited, we reviewed a sample of overpayments to recipients. We found that between 70% and 90% of overpayments had occurred because clients had not reported changes in their circumstances that affected their eligibility and in many cases, at three of these offices, caseworkers had not completed steps designed to detect changes in their eligibility on a timely basis. This includes reviewing ongoing financial eligibility as described in **Section 4.6.1**. For example, in one case, a recipient and their spouse had been receiving Canada Pension Plan benefits that they had not declared to ODSP, as required, since 2011. However, seven years later, the caseworker had yet to identify this because they had not decided that an update of the recipient's application information was necessary. The Ministry only identified this case through its eligibility verification process in 2018; however,

by that point, the recipient had already been overpaid a total of approximately $104,000 and is likely not in a position to repay it.

We also compared the dates that the overpayments we sampled were detected with when they could have reasonably been detected based on program directives and policies such as for investigating fraud allegations and reporting changes to recipient income. We found that the overpayments had occurred because the change in eligibility had not been reported by the recipient or detected by the caseworker on a timely basis. For example, in one instance, a fraud allegation was received in July 2015 that a recipient had undeclared income and had not reported that a dependent adult no longer resided with them. The caseworker did not assess the allegation in the required time frame of 15 business days. Instead, the caseworker took until January 2017 to start an investigation—almost 18 months later. When the caseworker completed the investigation in March 2017, an overpayment was established totalling almost $52,000.

Identifying overpayments as early as possible is important to minimize their size and increase the Ministry's chance of recovering these amounts from recipients. In particular, identifying overpayments early can help reduce the amount of overpayments written off when recipients appeal their repayment to the Social Benefits Tribunal (Tribunal). We reviewed a sample of Tribunal decisions concerning overpayments and found that in approximately half of these cases, the Tribunal deemed the overpayments uncollectible and the debt forgiven. This is because the Tribunal determined that these overpayments could have been avoided had the Ministry carried out all its responsibilities, or the Tribunal determined that there was no intent by the recipient to withhold relevant information, or that repaying the overpayment would cause the recipient undue hardship.

This included an instance where a recipient had not informed the Ministry caseworker about increases to their federal pensions benefits, or that their spouse also started to receive federal pension benefits. The caseworker did not detect this for five years, and only discovered this after the recipient made an inquiry about accessing a new benefit. The caseworker subsequently reviewed this file and established that the recipient was overpaid approximately $44,000. Upon appeal, the Tribunal acknowledged the sustained workload in the local ODSP office but determined that had the local office followed up on the information it had the overpayment could have been avoided. In addition, the Tribunal ruled that the overpayment was not collectible because it determined that the recipient had no intention to deceive the Ministry, and that it would cause the recipient undue hardship.

Based on the Ministry's data, since 2009/10, following our last audit of the program, overpayments have been made totalling $1.067 billion. This amount excludes 2015/16, when technical issues with the implementation of the Ministry's IT system led to an increase in overpayments. Since 2009/10, the Ministry has written off a total of $409 million of uncollected overpayments.

As of March 2019, $622 million in overpayments to recipients remains uncollected; $281 million relates to current recipients of ODSP and $341 million relates to former recipients. We noted that the Ministry can recover overpayments to individuals who are receiving financial assistance through automated deductions from future monthly income support payments at a rate of between 5% and 10% until the overpayment is repaid. However, for individuals who no longer receive assistance, recovery of overpayments generally requires more effort. Therefore, identifying overpayments as early as possible while individuals are actively receiving ODSP benefits can minimize the size of overpayments and increase the proportion of overpayments recovered by the Ministry.

Underlying Causes of Overpayments Not Tracked, Limiting Ability to Prevent Them

As we reported in our audit of Ontario Works in our *2018 Annual Report*, the Ministry's Social Assistance Management System (SAMS) determines the

reason that overpayments have occurred. However, these system-generated reasons are too general for the Ministry to understand the most common systemic causes of overpayments. Without this information, the Ministry cannot analyze how they occurred to identify how to prevent or reduce future overpayments. This is the same situation with respect to ODSP overpayments.

RECOMMENDATION 14

To reduce the number and size of overpayments to recipients, we recommend that the Ministry of Children, Community and Social Services enhance its systems and processes to determine and record the cause of overpayments, to analyze the root causes and take action to reduce the length of time to identify them, and minimize their occurrence.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and that action should be taken to reduce the occurrence of overpayments where possible, and will be undertaking the following in the 2020/21 fiscal year to support enhanced efforts in the prevention and timely detection of overpayments:

- enhancing its data analytics capacity as well as third-party information sharing to identify high risk cases; and
- increasing the number of eligibility reviews completed on cases with a higher likelihood of overpayments.

In addition, the following initiatives are part of the Ministry's service delivery modernization plan that the Ministry expects will have an impact on reducing the occurrence of overpayments:

- introducing flexible and convenient service channels (e.g., online) for recipients to report earnings and changes in circumstances in a timelier manner; and
- streamlining the process for accessing federal seniors' benefit programs for recipients aged 65 and older to reduce the occurrence of overpayments as recipients transition to these programs.

The Ministry also acknowledges that information on the root causes of overpayments will help in determining appropriate actions to address their occurrence. Therefore, the Ministry will continue to identify opportunities to collect information, and will enhance its systems and processes to determine and record the cause of overpayments. This will help to reduce the number and size of overpayments, to detect them in a timely manner, and minimize their occurrence.

4.6.6 About 19,000 Medical Reviews Overdue, More Than Half by at Least Two Years

A medical review date should be assigned to applicants unless there is no likelihood of improvement in the person's condition, impairments and restrictions. In these cases, a medical review date of two or five years after the disability decision may be assigned by the Ministry, at which time the Ministry is required to reassess whether the recipient continues to be medically eligible for ODSP (see **Section 2.2.3**). As of March 2019, the Ministry had not followed up on approximately 19,000 recipients whose medical reviews were overdue, and more than half of these were overdue by at least two years or more. Because medical reviews have not been conducted, there is a possibility that these recipients' medical conditions have improved and they no longer medically qualify for ODSP.

Medical Reviews to Confirm Continued Eligibility Cancelled

In February 2015, the Ministry implemented a process to review all recipients with an outstanding medical review to determine whether their medical

review should proceed. According to the Ministry, adjudicators responsible for making these decisions consider the original decision and decide whether there is a clear need for the medical review to go ahead, taking into consideration the likely degradation of the recipient's condition and changes in medical science. Adjudicators do not request new medical information or an update to the recipient's information as part of this process.

In the past two years, based on review of the Ministry's data, we calculated that through this process, adjudicators determined that 47% (20,810) of outstanding medical reviews were not required. In all these cases, the adjudicator determined that, instead, the individual was disabled for life. We reviewed a sample of these decisions and found that for 90% of these, there was insufficient documentation to understand how the adjudicator had reached their conclusion to cancel the medical review. In these cases, a medical review may still have been appropriate based on the information in the original application.

RECOMMENDATION 15

So that the Ministry of Children, Community and Social Services (Ministry) only provides Ontario Disability Support Program (ODSP) payments to eligible recipients, and overpayments to ineligible individuals are minimized, we recommend that the Ministry carry out medical reviews on a timely basis in accordance with its requirements to determine whether recipients continue to have disabilities that meet the eligibility requirements for ODSP.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the importance of completing medical reviews on a timely basis. The Ministry will continue to complete medical reviews with the goal of eliminating the remaining backlog by March 2021.

4.7 Most Non-disabled Adults Not Participating in Required Employment Assistance Activities

Non-disabled adults in family units receiving ODSP benefits are required to participate in Ontario Works employment assistance activities, unless they have been granted a waiver by their caseworker from doing so. The intent of this policy is that if a recipient's non-disabled spouse and other dependent adults, such as adult children, find employment, the family unit may be able to reduce its financial dependence on ODSP or leave the program.

As of March 2019, approximately 57,000 non-disabled adults in family units were on the ODSP caseload. We reviewed the Ministry's data and found that approximately 43,000 (75%) of these adults were not participating in employment assistance activities even though their requirement to do so had not been waived. At the four ODSP offices we visited, we selected a sample of files with non-disabled adults who were not participating in employment assistance activities and determined that in almost all cases they either should have been participating or there was insufficient documentation to support why they were not. Specifically, we found:

- Approximately 45% of the non-disabled adults had not been referred to Ontario Works employment assistance activities by their ODSP caseworker as required. In around half of these cases, the ODSP caseworkers told us that the individuals should be waived from participating in these activities but they had not officially waived the requirement. They could not demonstrate with sufficient supporting documentation that the individuals should be waived.
- Approximately one-third of the non-disabled adults had been referred to Ontario Works but were not participating due to lack of follow-up by the Ontario Works and ODSP caseworkers. We found that the ODSP caseworkers notified the Ontario Works office

of the referral through the Ministry's Social Assistance Management System, but an Ontario Works caseworker had not followed up on the referral to meet with the adult.

- About 20% of the non-disabled adults had received a waiver from participating in employment assistance activities but the waiver had expired. We found that neither the ODSP nor the Ontario Works caseworker had followed up to see whether the adult's circumstances had changed and they could now participate.

In our survey of caseworkers, 75% of caseworkers who indicated that they did not always promptly refer non-disabled adults to Ontario Works or obtain documentation to grant them a waiver, indicated that it was because they did not have time due to their workload and other priorities.

We also asked caseworkers whether Ontario Works caseworkers were meeting with the non-disabled adults that they had referred to employment assistance activities, and whether these adults were actively participating in such activities. Approximately one-quarter responded that they were not, or that they did not know.

It was also evident from caseworkers' responses to our survey that roles and responsibilities between ODSP and Ontario Works caseworkers need to be clarified. ODSP caseworkers were unclear who is responsible for ensuring that the non-disabled adults they refer to Ontario Works employment assistance activities subsequently participate. Approximately 10% of caseworkers told us that it was the ODSP caseworker's responsibility, 30% told us that it was both the ODSP and Ontario Works caseworker's responsibility and 60% told us that it was the Ontario Works caseworker's responsibility.

Our findings highlight that the Ministry needs to review its processes, and the tools available to caseworkers, so that they can effectively monitor whether non-disabled adults in their caseload are actively participating in Ontario Works employment assistance activities, or, where they are not, whether a valid and up-to-date waiver is in place.

RECOMMENDATION 16

To improve the employment outcomes of non-disabled adults on the Ontario Disability Support Program (ODSP), we recommend that the Ministry of Children, Community and Social Services:

- review and update its process for referrals to Ontario Works employment assistance to ensure that all referrals are identified and acted upon on a timely basis;
- implement a process to monitor whether all non-disabled adults have been referred to Ontario Works employment assistance or have a valid waiver in place;
- take corrective action in instances where ODSP offices and their caseworkers are not complying with the requirement to refer non-disabled adults to Ontario Works employment assistance, or ensure that valid waivers are in place; and
- put in place mechanisms to hold Ontario Works service managers accountable in the instances of non-compliance with responsibilities in relation to participation for non-disabled adults on ODSP.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees that more can be done to ensure that all non-disabled adults are either referred to appropriate employment supports or waived from participation in employment activities for valid and documented reasons.

The government is transforming Ontario's employment services to make them more efficient, more streamlined, and outcomes-focused. As part of Employment Services Transformation, a new service delivery model will integrate ODSP and Ontario Works employment services, as well as other government employment services, into Employment Ontario to create a system that is more responsive to the needs of job seekers, businesses and local communities.

This transformation will roll out in three prototype areas beginning in April 2020, with this phase running until October 2020. During the prototype phase, the Ministry will review the assessment and referral processes for non-disabled adults to enhance their access to high-quality, appropriate employment services wherever possible by October 2020. This review will include updating mechanisms for identifying cases that require review, documenting valid waivers, and making referrals as appropriate, as well as tools to monitor results, and ensure that valid waivers or referrals are in place in all cases. Corrective action will be taken thereafter where they are not.

The Ministry will build on experiences and outcomes in the prototype areas to enhance referral processes as Employment Services Transformation is fully implemented across the province over the next few years.

To strengthen accountability in this area, the Ministry will include the requirement of Ontario Works delivery partners providing employment services to non-disabled adults as an Ontario Works service planning priority for 2020/21, as well as ongoing performance monitoring. The Ministry will also assess, by June 2021, other mechanisms that can be used to strengthen accountability in this area, and take action thereafter to implement and monitor the effectiveness of these mechanisms.

4.8 Large Caseloads Impact Ability of Caseworkers to Carry Out Roles and Responsibilities Effectively

We found that the Ministry has not established benchmarks for ODSP caseworker caseloads to ensure that caseworkers are able to meet their obligations and to execute their responsibilities efficiently and effectively.

At the time of our 2009 audit, the average caseworker's caseload was 266 recipient cases, which included either single individuals or family units. At the time of our current audit, we found that the average caseload had increased to 323 recipient cases because of the overall growth in the number of individuals and families receiving ODSP. **Figure 22** shows the average ODSP caseload per caseworker between 2015/16 and 2018/19 at the four ODSP offices we visited.

Figure 22: Average Caseload per Caseworker at Offices Visited, 2015/16–2018/19

Source of data: Ministry of Children, Community and Social Services

	2015/16	2016/17	2017/18	2018/19
Hamilton	295	307	316	321
Ottawa	304	313	322	336
Sudbury	276	301	297	307
Willowdale	286	298	319	281

Caseworkers across Ontario who responded to our survey also reported that their current caseloads were in this range, and in some cases significantly higher. Approximately 10% indicated that their caseloads were over 450 recipient cases.

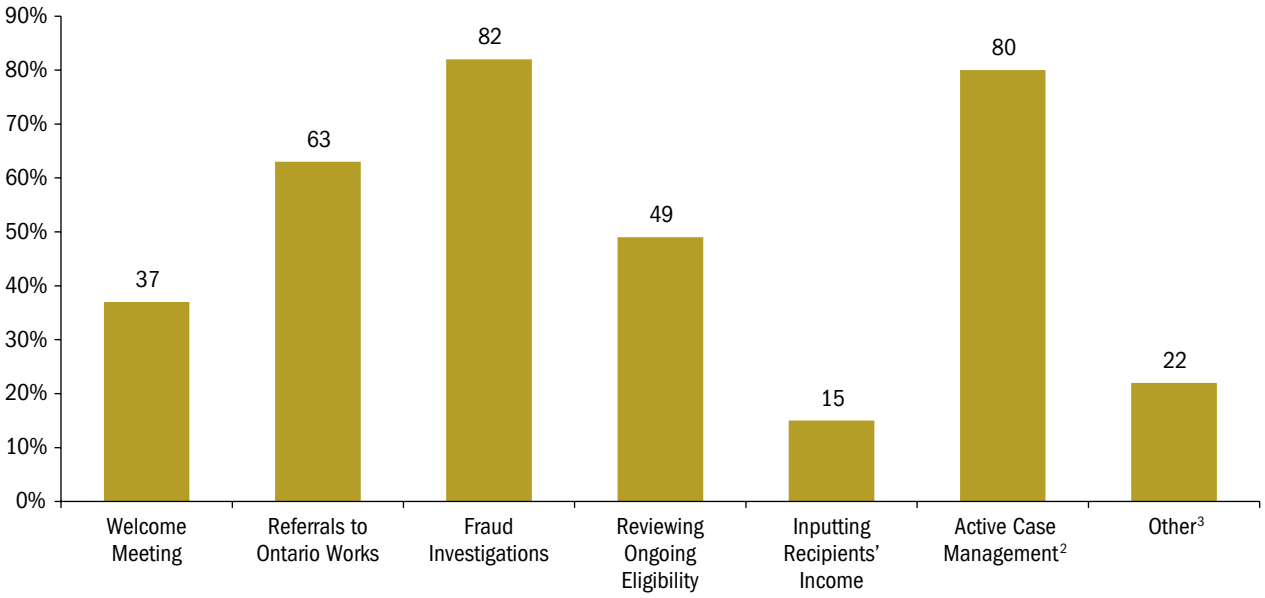
The size of caseworkers' caseloads is likely a contributing factor to several of our audit findings throughout this report related to caseworker responsibilities. However, similar to our observations in 2009, we noted that the Ministry does not have caseload benchmarks to assess whether staffing is sufficient to perform all necessary case management functions adequately.

In our survey, we asked caseworkers whether they felt they were able to manage their caseload to effectively carry out all of the duties and responsibilities expected of them; 54% reported that they were unable to do so. **Figure 23** shows the duties that these caseworkers indicated they were unable to perform.

We also asked caseworkers whether they were confident that all the recipients in their caseload met the financial eligibility requirements for ODSP—determining financial eligibility is one of the primary responsibilities of a caseworker. Over 40% of those who responded said that they were not. One of the main reasons cited included unmanageable caseloads making it impossible to complete

Figure 23: Duties Caseworkers[1] Reported Being Unable to Carry Out Effectively Due to Size of Caseload

Prepared by the Office of the Auditor General of Ontario



1. Caseworkers who responded to our survey.
2. Active case management—caseworkers are expected to maintain a case management plan for each recipient that identifies their individual goals, including employment goals, and to update the plan as the recipient progresses or their circumstances change.
3. Other includes issuing health-related benefits for clients, processing vendor payments and managing absent caseworkers' caseloads.

regular file reviews or contact clients to confirm eligibility. Many caseworkers also reported that they had not had contact with some recipients in years, or no contact at all.

Although we recommended in our *2009 Annual Report* that the Ministry establish caseworker caseload benchmarks, the Ministry had not yet reviewed caseworker caseloads to determine what an appropriate ratio of recipient cases per caseworker should be. In April 2018, the Ministry did study how much time ODSP front-line staff, including caseworkers, spend on activities in the delivery of ODSP in order to establish a baseline for the time spent on different activities. However, the Ministry has not used this study to review the appropriateness of caseloads and consider whether caseworkers can perform all the duties the Ministry requires given the current caseloads.

RECOMMENDATION 17

So that Ontario Disability Support Program (ODSP) caseworkers can effectively carry out their responsibilities designed to achieve program expectations and requirements, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- assess workloads and processes to establish a roadmap that clearly identifies the Ministry's intermediate and longer-term actions to improve the ability of caseworkers to handle ODSP cases; and
- implement the actions identified in the roadmap so that program requirements can be met.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation and by June 2020 will establish

a roadmap identifying intermediate and longer-term actions that will improve the ability of ODSP caseworkers to effectively carry out their responsibilities, including supporting clients with their employment goals. After completing the roadmap, the Ministry will begin to implement actions to ensure program requirements are met.

4.9 Ministry Refers Few ODSP Recipients to Employment Supports

4.9.1. Fewer than 2% of Disabled Adults Referred to Employment Supports Providers

The aim of ODSP employment supports is to assist people with disabilities to increase their economic independence through employment. Participation in the program is optional; even so, we identified that between 2012/13 and 2018/19, just 2% of recipients took part in the employment supports program in any given year.

Infrequent Contact with Recipients Limits Opportunities to Encourage Participation in Employment Supports

At the four offices we visited, we found that in the vast majority of cases we reviewed, caseworkers discussed employment supports with recipients when they first began to receive ODSP benefits.

In our survey of caseworkers, 75% told us that actively engaging with ODSP clients was between somewhat and very helpful in assisting them to meet their long-term goals, including employment goals. However, as described in **Section 4.6**, we found that ongoing contact with recipients was infrequent. We also found that in 2014, the Ministry suspended the requirement (in order to implement SAMS) to maintain an ongoing case management plan for each recipient. The case management plan identifies each recipient's goals, including employment goals. Prior to the suspension, caseworkers were required to update case management plans as the recipient progressed toward their goals or their circumstances changed.

4.9.2 Ministry Does Not Know How Many ODSP Recipients Would Benefit from Participating in Employment Supports

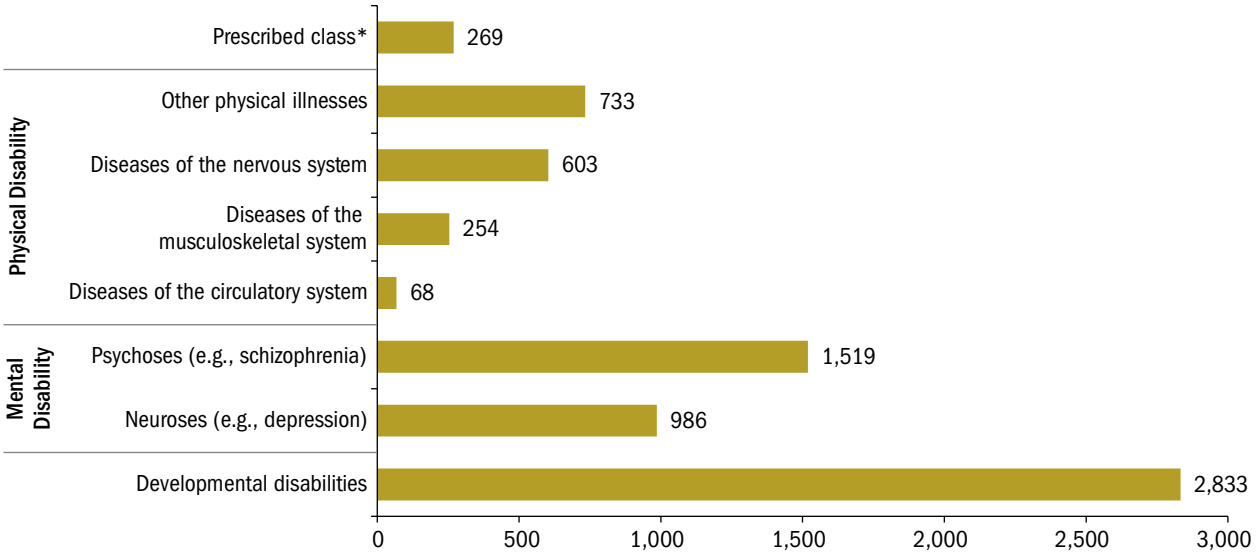
ODSP recipients can have different disabilities that pose different barriers to their ability to obtain and retain employment. We noted that the Ministry tracks the types of disabilities all ODSP recipients have (see **Figure 8**) including those participating in employment supports (see **Figure 24**), and tracks how many individuals caseworkers refer to employment supports service providers. However, we found that the Ministry has not assessed, and does not know how many individuals on the ODSP caseload could benefit from participating in employment supports activities. Such activities could help them obtain employment and increase their economic independence, and, for some, potentially earning sufficient income to no longer require ODSP income support.

4.9.3 Ministry Has Little Information on Whether Service Providers Help ODSP Recipients to Obtain Long-Term Employment

Employment support service providers are compensated based on employment outcomes. These include the number of individuals placed in a job earning at least minimum wage for six and 13 cumulative weeks, and for the number of consecutive months thereafter, up to 33 months, that an individual continues to be employed. **Figure 25** illustrates the number of placements and jobs retained between 2012/13 and 2018/19. Although the number of six- and 13-week job placements has increased by 28% and 30% respectively between 2012/13 and 2018/19, the percentage of referrals placed in six- and 13-week job placements was relatively consistent between 2012/13 and 2018/19, at around 40% and 50% respectively.

Figure 24: Number of Individuals by Disability Type Participating in Employment Supports, 2018/19

Source of data: Ministry of Children, Community and Social Services



* Members of a prescribed class can include, but are not limited to, recipients of federal Canada Pension Plan Disability Benefits, former recipients (or spouse) who received income support from the Family Benefits Program up until May 31, 1998, and individuals who are 65 years old or over and not eligible for Old Age Security. These members only need to establish financial eligibility for the Ontario Disability Support Program.

Figure 25: Number of Referrals, Job Starts, Placements and Job Retention, 2012/13–2018/19

Source of data: Ministry of Children, Community and Social Services

	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Referrals	5,772	6,254	6,646	6,604	6,735	7,160	6,722
Six-Week Job Start	2,679	2,998	3,186	3,128	3,399	3,535	3,429
13-Week Job Placement	2,264	2,406	2,649	2,548	2,818	2,914	2,949
Job Retention	4,579	4,771	5,182	5,451	5,736	5,920	6,048

We also noted that although the number of jobs retained increased by about 30% from 2012/13 to 2018/19, the Ministry nevertheless tracks little about whether ODSP recipients obtain employment in steady, long-term jobs. This is because jobs retained—per the Ministry's tracking—can relate to any period of time more than 13 weeks and up to an additional 33 months rather than consecutive months of uninterrupted employment.

In addition, although the Ministry does track the total number of individuals who leave ODSP due to employment income, the Ministry does not track the proportion of those individuals who participated in employment supports who left the program because they earned enough to no longer require ODSP support.

We noted that an evaluation of the employment supports program commissioned by the Ministry in 2012 highlighted that just 1.5% of ODSP recipients who participated in the program were able to exit ODSP due to their employment earnings. The evaluation also highlighted that just over 20% managed to work for more than one year over the course of the 33 months following a 13-week job placement.

4.9.4 Ministry Not Evaluating whether Employment Support Providers Supply Quality, Consistent Services

The Ministry compensates service providers for achieving job placements and for the number of months that recipients retain jobs over a period of time (see **Section 2.4**). However, the Ministry does not evaluate how service providers use the funding they receive for achieving job placements or retention, or what services they provide to ODSP recipients to ensure that the Ministry obtains value for money. We noted that a 2012 evaluation of employment support programs commissioned by the Ministry recommended that the Ministry consider reviewing how it funds service providers, including considering the actual cost of providing services and service quality.

We visited 13 service providers and found that the services available to participants varied considerably among providers. For example, some providers offered additional supports and services to participants beyond what was required by their ODSP contract, such as assisting participants with housing or getting access to medical care. We also found that some providers paid for some training for participants—for example, to achieve basic industry certificates—while others did not.

Some providers also had recreation facilities or wellness activities available such as a fitness centre. Some providers told us that they were able to offer these services because they are charities and can use funding from different sources, not just ODSP, to invest in their facilities and community programs that are accessed by all their clients, including ODSP recipients. In 2018/19, approximately 30% of the providers were for profit and the rest were not-for-profit.

4.9.5 ODSP May Be Paying Some Providers for Job Placements Achieved Using Other Government Employment Programs

The Ministry does not monitor how service providers achieve their job placements. Our audit identified a risk that some ODSP employment service providers may be paid for job placements achieved in part or in whole by enrolling their clients in Employment Ontario programs, which are funded by the Ministry of Labour, Training and Skills Development. Employment Ontario programs offer incentives to employers that are not available in the ODSP employment supports program, including signing bonuses, training allowances and placement incentives.

We obtained a list of participants who enrolled with Employment Ontario service providers that offer similar services to ODSP employment support service providers, such as job search, job matching, job coaching and job placement. We compared this to a list of participants enrolled with ODSP employment support service providers for the regions of Hamilton/Niagara and Eastern Ontario and identified approximately 250 individuals who may have accessed both programs in the same fiscal year.

Based on this comparison we identified concerns that some ODSP employment support providers may be achieving job placements in some cases due to the assistance of an Employment Ontario program that offers incentives to employers. Nevertheless, in these cases, the ODSP employment support provider still receives full payment for that placement through the ODSP employment supports program.

There is also a risk that these job placements are being recorded as "achieved" by both Employment Ontario service providers as well as the ODSP employment supports provider, even though they may relate to the same client and the same placement. This would mean that both the Ministry and Employment Ontario may have paid to place the same individual in employment.

RECOMMENDATION 18

To better help Ontario Disability Support Program (ODSP) recipients to increase their economic independence, we recommend that the Ministry of Children, Community and Social Services (Ministry):

- periodically provide information on employment supports to all ODSP recipients who can benefit from them;
- assess the disabilities of recipients on the ODSP caseload to determine the proportion and number of recipients who can benefit from participating in employment supports;
- explore options to increase the number of ODSP recipients referred to employment supports to help increase the proportion of recipients who become more economically independent;
- track additional information from employment support service providers on employment outcomes, monitor whether recipients obtain long-term employment and earn sufficient income to exit from ODSP, and take corrective action where outcomes do not meet Ministry expectations;
- review the services provided by employment support service providers to determine whether they are meeting recipients' needs and assess and take steps to ensure they provide value for money;
- obtain data from the Ministry of Labour, Training and Skills Development to identify individuals who have been provided similar employment support services by both Employment Ontario service providers and ODSP service providers, and take action to recover payments where two service providers have been paid for the same job placement; and
- work with the Ministry of Labour, Training and Skills Development to put in place processes that prevent payment to two different service providers for the same employment outcomes.

MINISTRY RESPONSE

The government is transforming Ontario's employment services to make them more efficient, streamlined and outcomes focused. Employment Services Transformation will establish a new service delivery model that integrates ODSP Employment Supports, Ontario Works employment services, and other government employment services. As Employment Services Transformation is implemented, employment services will be delivered under a new delivery, funding and performance management framework. The Ministry of Labour, Training and Skills Development (MLTSD) will roll out the new model in three prototype areas beginning in April 2020, with a transition phase running until October 2020.

The Ministry plans to introduce Individual Action Plans (IAPs) to support ODSP recipients by identifying barriers to achieving their goals, including their employment goals, and to help them to take steps to overcome these barriers. Under the transformed employment delivery system, ODSP caseworkers will work closely with Employment Ontario, using the information from each ODSP recipient's IAP, to provide recipients with information about employment service options that are relevant to their needs.

Caseworkers will also discuss life stabilization as it relates to employment goals both through development of Individual Action Plans and through the use of Employment Service Transformation's Common Assessment (currently under development). The Common Assessment will provide a structured method to identify client strengths and barriers to employment and life stabilization needs, and to identify what level of supports the jobseeker will need to help them find work. The Ministry will collect data from these plans and tools to determine which ODSP recipients can benefit from participating in employment supports.

MLTSD is also implementing a new performance management framework to monitor employment outcomes and work continuously to improve the performance of the system. This includes the level of referrals coming from the social assistance system. Outcomes will continue to vary by client and realistic goals that support client independence will be set.

The Ministry also agrees that ODSP employment supports service providers should provide value for money. The current, outcomes-based funding framework is designed to ensure that the Ministry pays only for results. While ODSP employment supports will be replaced by the transformed employment system over time, in the interim, Ministry staff will monitor services, outcomes, and customer satisfaction to ensure that the right services are in place, and take action where they are not.

The Ministry is developing a performance measurement framework for ODSP that will establish targets for the number of ODSP recipients that can both access these services, and obtain employment and earn sufficient income to no longer require ODSP income support. In addition, indicators will be established to help the Ministry measure whether these targets are met, and to take action where they are not.

The potential for payment duplication for the same services to one client will be addressed after the Employment Service Transformation is complete and services are integrated. In the interim, the Ministry will work with MLTSD to identify common clients and develop a process to ensure that no duplication of funding is provided to service providers, and take appropriate steps where duplicate funding has been provided.

4.10 Ministry Has Not Developed Outcome Indicators and Targets to Evaluate if ODSP Goals Achieved

Although the Ministry does track operational statistics related to ODSP, such as the average number of days to adjudicate applications, we found that it has not determined what the desired outcomes for the program and its recipients are, or developed corresponding performance indicators to track whether these outcomes are met.

The Ministry expected to finalize an outcomes framework for its social assistance programs in 2018, but work was not completed and is on hold following recent government announcements of proposed changes to social assistance programs.

The Ministry does not publicly report on any performance measures related to ODSP.

RECOMMENDATION 19

To measure and improve the efficiency and effectiveness of the Ontario Disability Support Program (ODSP) for those using its supports and services, and to increase accountability of the program to Ontario taxpayers, we recommend that the Ministry of Children, Community and Social Services:

- design and implement performance indicators and related targets for intended program and recipient outcomes;
- implement a process to monitor the performance of the program against these indicators and targets and take corrective action where targets are not being met; and
- report publicly on the effectiveness of ODSP.

MINISTRY RESPONSE

The Ministry of Children, Community and Social Services (Ministry) agrees with the recommendation, and will finalize an outcomes framework for its social assistance programs, including ODSP.

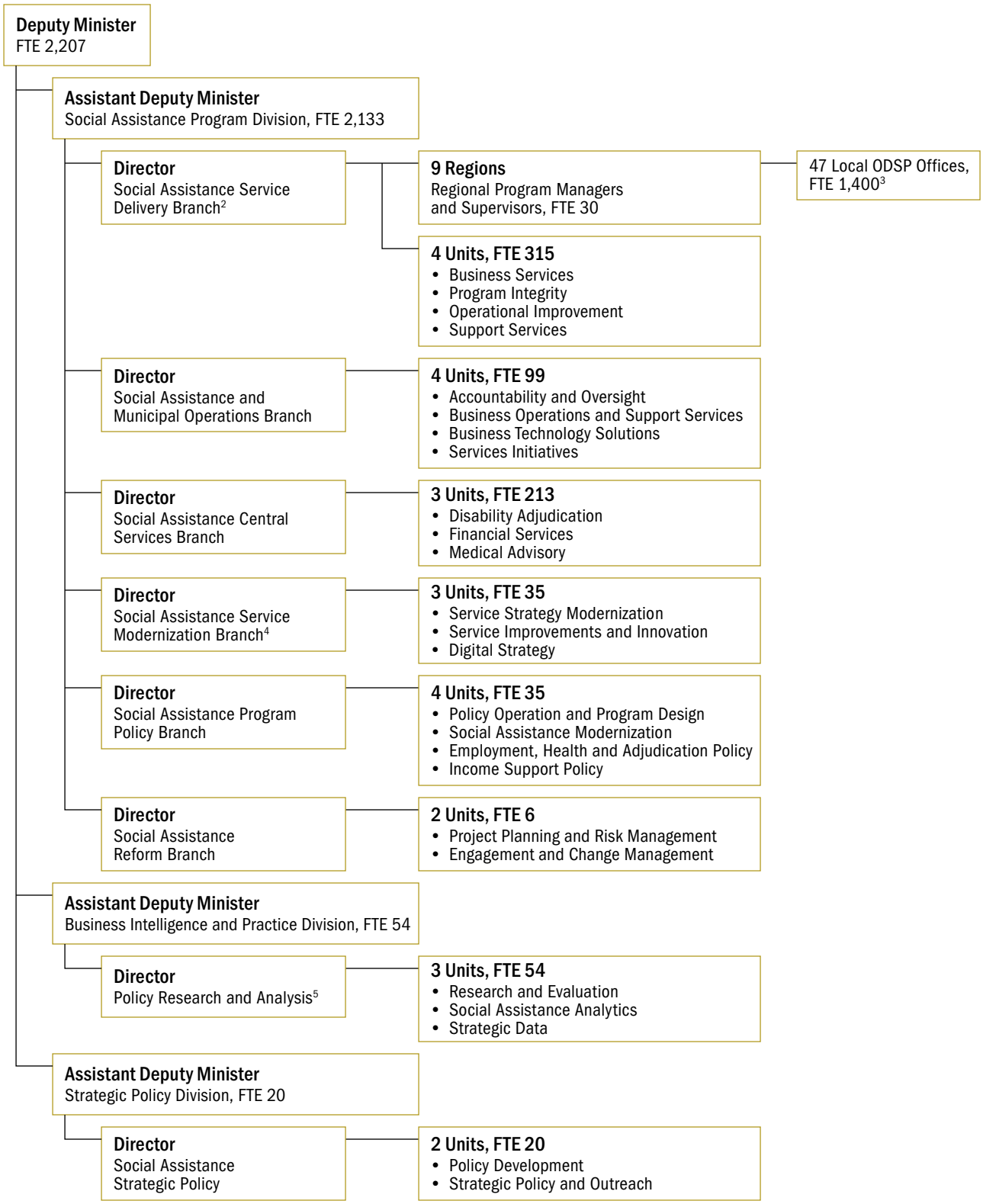
The Ministry will implement an outcomes framework that establishes clear expectations and targets for ODSP and ODSP recipients by March 2021.

In November 2019, the Ministry created the Social Assistance Performance and Accountability Branch, to bring a focused responsibility to program performance and accountability. One responsibility of this new branch will be to begin monitoring, in the 2021/22 fiscal year, the performance of the program against targets established in the Ministry's outcome framework, and take action where targets are not met.

The Ministry will also establish a timetable and process to begin to publicly report on the effectiveness of the ODSP program.

Appendix 1: Ontario Disability Support Program (ODSP) Organizational Structure,[1] June 2019

Source of data: Ministry of Children, Community and Social Services



1. The organizational structure relates to the number of full-time equivalent (FTE) positions in the administration and delivery of ODSP.
2. This branch's responsibilities include oversight, monitoring and providing advice on program delivery, enhancing program integrity through the eligibility verification process, quality assurance and investigations of fraud, identifying strategies for improvement, and managing Human Resource-related matters and other client issues.
3. The Ministry of Children, Community and Social Services (Ministry) operates 47 local offices to deliver ODSP to residents who live in the different geographical areas of the province. Approximately 1,400 caseworkers and administrative support clerks work in the offices. The offices are overseen by approximately 30 regional program managers and supervisors.
4. The branch is responsible for leading the development and implementation of projects that support a modern, responsive, efficient, cost-effective and sustainable service delivery system that is focused on recipients and supports integration across Ministry programs.
5. This branch is responsible for data governance and oversight, and improving access to data across the Ministry. It is also responsible for producing caseload and expenditure forecasts and statistical reports, developing performance measures and data collection tools, evaluating programs, and leading research activities.

Appendix 2: 2018/19 Office Caseloads and Income Support Expenditures

Source of data: Ministry of Children, Community and Social Services

	Local Office	Average Monthly Caseload	% Share of Caseload	Income Support ($ million)	% Share of Income Support
West Program Office 1	Chatham	4,473	1.2	60.8	1.1
	London	18,105	4.9	238.6	4.5
	Owen Sound	5,031	1.3	65.6	1.2
	Sarnia	3,918	1.1	51.7	1.0
	Stratford	3,587	1.0	45.9	0.9
	Windsor	13,638	3.7	187.4	3.5
	Total	**48,752**	**13.2**	**650.0**	**12.2**
West Program Office 2	Brantford	5,639	1.5	85.2	1.6
	Hamilton	20,571	5.5	289.4	5.4
	Simcoe	3,202	0.9	40.9	0.8
	St. Catharines	16,437	4.4	229.8	4.3
	Woodstock	2,761	0.7	35.6	0.7
	Total	**48,610**	**13.0**	**680.9**	**12.8**
North Program Office 1	Kenora	2,303	0.6	30.1	0.6
	Sault Ste. Marie	5,944	1.6	83.6	1.6
	Thunder Bay	5,971	1.6	78.1	1.5
	Total	**14,218**	**3.8**	**191.8**	**3.7**
North Program Office 2	Kirkland Lake	1,540	0.4	21.4	0.4
	Timmins	3,444	0.9	48.6	0.9
	Sudbury	8,069	2.2	111.7	2.1
	North Bay	4,811	1.3	70.8	1.3
	Bracebridge	3,176	0.9	45.3	0.9
	Total	**21,040**	**5.7**	**297.8**	**5.6**
East Program Office 1	Cornwall	5,167	1.4	74.2	1.4
	Hawkesbury	2,818	0.8	39.5	0.7
	Ottawa	25,094	6.8	338.9	6.4
	Pembroke	2,207	0.6	31.1	0.6
	Renfrew	1,446	0.4	19.7	0.4
	Smiths Falls	2,875	0.8	39.6	0.7
	Brockville	3,382	0.9	47.7	0.9
	Total	**42,989**	**11.7**	**590.7**	**11.1**
East Program Office 2	Belleville	10,650	2.9	153.9	2.9
	Kingston	7,618	2.1	104.5	2.0
	Lindsay	2,478	0.7	33.0	0.6
	Oshawa	14,199	3.8	195.5	3.7
	Peterborough	8,246	2.2	115.5	2.2
	Total	**43,191**	**11.7**	**602.4**	**11.4**

	Local Office	Average Monthly Caseload	% Share of Caseload	Income Support ($ million)	% Share of Income Support
Central Program Office 1	Barrie	8,396	2.2	118.3	2.2
	Guelph	5,630	1.5	72.8	1.4
	Orillia	5,127	1.4	69.3	1.3
	Newmarket	13,233	3.6	183.2	3.4
	Total	**32,386**	**8.7**	**443.6**	**8.3**
Central Program Office 2	Brampton	9,635	2.6	133.5	2.5
	Burlington	6,051	1.6	78.1	1.5
	Cambridge	3,590	1.0	46.7	0.9
	Kitchener/Waterloo	8,976	2.4	120.8	2.3
	Mississauga	10,637	2.9	146.9	2.8
	Total	**38,889**	**10.5**	**526.0**	**10.0**
Toronto Program Office	Yorkgate	11,611	3.1	175.0	3.3
	Lawrence Heights	11,301	3.0	159.0	3.0
	Parkdale	11,753	3.2	157.5	3.0
	Willowdale	11,322	3.1	169.6	3.2
	111 Wellesley Street East	11,647	3.1	153.0	2.9
	Golden Mile	11,339	3.1	164.5	3.1
	Malvern	11,626	3.1	171.2	3.2
	Total	**80,599**	**21.7**	**1,149.8**	**21.7**
Other payments and adjustments*				192.2	
Total		**370,674**	**100.0**	**5,325.2**	

* Primarily relates to payments direct to vendors for health-related benefits for recipients, such as dental care.

Appendix 3: Comparison of Local Office Caseload Growth or Reduction Compared with Provincial Average, 2008/09–2018/19 (%)

Source of data: Ministry of Children, Community and Social Services

		Local Office[1]			
		High		Low	
Fiscal Year	Province				
2008/09	5.0	8.6	Barrie[2] Cambridge[2]	0.4	North Bay
2009/10	5.7	9.7	Cambridge[2]	1.4	North Bay
2010/11	5.6	9.5	Kingston	(3.9)	Smiths Falls
2011/12	4.9	8.9	Brampton[2]	(4.1)	Smiths Falls
2012/13	4.5	14.9	London	(1.5)	Kirkland Lake
2013/14	3.7	12.5	London	(0.9)	Kirkland Lake
2014/15	3.9	8.0	Barrie[2]	0.6	Timmins
2015/16	3.0	6.7	Brampton[2]	(0.4)	Timmins
2016/17	3.0	6.0	Brampton[2]	0.7	Cornwall
2017/18	3.8	5.9	Barrie[2] Brampton[2]	1.5	Thunder Bay[3]
2018/19	3.2	13.0	Simcoe	(13.1)	Lindsay[4]

1. Excludes offices with incomplete data in specific years.
2. The Ministry of Children, Community and Social Services (Ministry) advised us that high caseload growth rates in Barrie, Brampton and Cambridge were due to proportionately more new applications in these offices compared with the number of cases that exited the Ontario Disability Support Program (ODSP).
3. The Ministry advised us that caseload growth in Thunder Bay was low in 2017/18 because that was the fiscal year that cases began to exit ODSP for the Basic Income Pilot project.
4. The Ministry advised us that the significant reduction in caseload for the Lindsay office in 2018/19 is due to a number of recipients who exited ODSP in fiscal 2017/18 to participate in the Basic Income Pilot project.

Appendix 4: Adjudicator and Caseworker Key Responsibilities and Experience

Sources of data: Ministry of Children, Community and Social Services and information obtained by the Office of the Auditor General of Ontario

	Disability Determination Adjudicators (Adjudicators)	Caseworkers
# of employees	70[1]	1,108[2]
Location and key responsibilities	Adjudicators are a centralized team within the Ministry's Disability Determination Unit, based at the Ministry's corporate office in Toronto. Adjudicators are responsible for determining and reviewing the medical eligibility of applicants for ODSP. As a centralized unit reviewing applications from across the province, adjudicators do not meet with applicants or recipients.	Caseworkers are based in local offices across the province. See **Appendix 2** for a list of local ODSP offices. Caseworkers are responsible for meeting with applicants and determining and reviewing their financial eligibility for ODSP. Caseworkers and Administrative Support Clerks at the local ODSP offices are recipients' only point of contact with ODSP and are responsible for ensuring eligible recipients receive benefits to which they are entitled. Caseworkers are also responsible for investigating allegations of recipient fraud, and identifying recipients who may be interested in obtaining employment.
Experience required	• Significant knowledge of physical or mental impairments and their impact on activities of daily living normally acquired through a recognized university program leading to a Master's degree or equivalent in nursing; occupational therapy, Health Science, clinical psychology, rehabilitation or with equivalent medical education. • Significant clinical experience in treatment settings for disabled adults • Ability to keep informed of advancements in medical research and changes in treatment practices • Analytical and problem-solving skills • Communication and interpersonal skills • Computer skills	• Knowledge of community services, resources, policies, programs and issues/barriers affecting clients with disabilities • Knowledge of labour market trends • Ability to interpret and apply legislation in order to review or determine program eligibility and identify infractions • Customer service and communication skills • Analytical, planning and organizational skills
Length of time in role (%)	<12 months: 0 1–2 years: 26 3–5 years: 26 6–10 years: 17 >10 years: 31 Average length of time in role: 8 years[1]	<12 months:[2] 12 1–2 years: 19 3–5 years: 17 6–10 years: 38 >10 years: 14 Average length of time in role: 7 years
Examples of previous work experience[3]	• Physician (trained outside of Canada) • Registered nurse • Social worker • Chiropractor • Occupational therapist	The Ministry does not maintain a listing of caseworkers' background information.

1. As of March 31, 2019.
2. As of June 19, 2019.
3. Represents the most common backgrounds reported in response to the Office of the Auditor General of Ontario's survey of adjudicators.

Appendix 5: Applicant Asset and Income Limits and Exemptions for Ontario Disability Support Program (ODSP) Eligibility

Prepared by the Office of the Auditor General of Ontario

Assets

- As of September 2018, an applicant's net assets must not be greater than $40,000 for singles, $50,000 for a couple and $500 for each dependent other than a spouse.
- Certain assets are exempt, and thus excluded when determining whether an applicant's assets are within prescribed limits.
- Exempt assets include, but are not limited to, a homeowner's principal residence, a primary motor vehicle, locked-in RRSPs, and the proceeds of a life insurance policy to a limit of $100,000.

Income

- An applicant's income must be less than their potential ODSP income support entitlement (see **Section 2.3**).
- Some sources of income are exempt and excluded in determining an applicant's income including payments from a registered disability savings plan, child support payments, and gifts from friends and family of up to $10,000 every 12 months.
- When assessing an applicant's income, a caseworker considers income from sources such as the Canada Pension Plan, the Workplace Safety and Insurance Board, Employment Insurance, and employment.
- With respect to employment income, applicants can earn up to $200 a month without a reduction to their ODSP income support entitlement. Half of all employment income in excess of $200 per month is considered in determining an applicant's ODSP income support entitlement.

Appendix 6: Comparison of Disability Income Support Programs among Canadian Provinces

Source of data: Ministry of Children, Community and Social Services

	ON	PE	NS	NB	QC	MB	SK	AB	BC
Separate income support program for people with disabilities [1]	Yes	Yes	Yes	No	Yes	No	Yes	Yes	Yes
Definition of Disability									
Degree of impairment	Substantial	Substantial	Chronic and persistent	Major	Significant	Degree of impairment not specified	Significant and enduring	Severe	Severe
Degree of restriction in daily living	Substantial	Substantial	Significant	Severe	Degree of restriction not specified	Degree of restriction not specified	Substantial and requires assistance	Degree of restriction not specified	Significant and requires assistance
Expected duration	One year or more; continuous or recurrent	One year or more; continuous or recurrent	Persistent	Indefinite	Permanent or indefinite	More than 90 days	Longstanding or permanent; continuous or periodic	Continuous and permanent	Two years or more
Employability a factor [2]	No	No	No	No	Yes	Yes	No	Yes	No
Monthly Rates (April 2019) and Statistics									
Single person with a disability ($)	1,169	904	810	663	1,061	1,012	1,114	1,685	1,183
Single parent with a disability, one child ($)	1,596	1,183	845	974	1,061	1,364	1,386	1,885	1,519
Couple (one disabled), two children ($)	1,887	1,788	1,170	1,092	1,561	1,756	1,691	1,985	1,821
Caseload (% of total population) [3]	2.5	0.9	n/a [4]	0.8	1.5	n/a [4]	1.3	1.4	2.0

	ON	PE	NS	NB	QC	MB	SK	AB	BC
Annual Income Support Expenditures, March 31, 2018									
Income support for people with disabilities ($ million)	5,120	15	338	46	n/a[4]	235	224	1,059	1,300
Income support for non-disabled people ($ million)	2,975	36	345	124	n/a[4]	245	223	870	370
Total income support expenditures ($ million)	8,095	51	683	170	3,792	480	447	1,929	1,670
Income support for people with disabilities as a % of total income support expenditures	63	29	49.5	27	n/a[4]	49	50	55	78
Total provincial expenditures ($ million)	154,266	1,913	11,750	9,272	103,489	16,890	14,322	55,318	51,719
Total provincial surplus (deficit) ($ million)	(3,700)	75	226	67	4,915	(695)	(303)	(8,023)	301
Income support expenditures as a % of total provincial expenditures	5.3	2.7	5.8	1.8	4	2.8	3.1	3.5	3.2

1. Indicates whether the province has a separate program for people with disabilities. If not, the province has a single income assistance program that includes an additional allowance for a person with a disability.
2. Eligibility requirement specifically mentions that capacity for employment or ability to earn a living is substantially impacted by the applicant's disability.
3. For this interprovincial comparison, caseload data from 2017/18 is used. Source: *Social Assistance Combined Summaries Canada Report – April 2019*, published by Maytree.
4. This information is not available.

Appendix 7: Employment, and Health and Disability-Related Benefits for Ontario Disability Support Program (ODSP)

Source of data: Ministry of Children, Community and Social Services

Health and Disability-Related Benefits	
Assistive devices	Assists with the consumer contribution for devices approved by the Assistive Devices Program (ADP) of the Ministry of Health and with an assessment to determine eligibility for an ADP device if no other funding is available.
Batteries and repairs for mobility devices	Covers the cost of batteries and repairs for mobility devices.
Dental coverage	Basic services provided by dentists and dental hygienists. Children 17 and under receive dental services through the Healthy Smiles Ontario program.
Extended health benefits	If ODSP recipients with high health costs have income that make them financially ineligible, they may receive continued assistance with the cost of various health benefits after leaving ODSP.
Hearing aids	For hearing aids, including batteries and repairs.
Mandatory special necessities	Diabetic supplies.
	Surgical supplies and dressings.
	Incontinence supplies.
	Cost of travel to medical appointments. In addition, the Northern Health Travel Grant reimburses northern Ontarians for travel over 100 kilometres one-way for specialist treatment.
Prescription drug coverage	For drugs listed in the Ontario Drug Benefit formulary.
Vision care	For prescription lenses and frames (once every three years), repairs (at caseworkers' discretion) and routine eye examinations (once every two years). Note: Ontario Health Insurance Plan covers routine eye exams for people under 20 and over 64.

Employment Benefits and Incentives		
Benefit		**What is Covered**
Employment benefits	Employment and training start-up benefit	Up to $500 annually to assist with the costs of finding or starting a job or employment training.
	Employment transition benefit	$500 benefit to assist with the transition of leaving ODSP due to paid employment.
	Up-front child care benefit	Funding for up-front child-care costs incurred to begin, change or maintain employment or an employment-related activity.
	Work-related benefit	An additional $100 per month for each month that a client reports earnings, training income or positive net income from a business.
Exemptions and deductions	Attending full-time secondary or post-secondary school	Earnings of full-time students are not deducted from ODSP income support.
	Child-care deductions	Chargeable earnings can be reduced by the actual cost of licensed child-care or by up to $600 per month for unlicensed child-care costs.
	Disability-related employment expense deductions	Chargeable earnings can be reduced by up to $1,000 per month for qualifying disability-related employment expenses.
	Earnings exemptions	Monthly $200 flat rate exemption plus 50% exemption for earnings over $200.
Other supports for employment	Transitional health benefits	If ODSP recipients have income from employment that make them ineligible, they may receive coverage for drugs, dental, vision care, and batteries and repairs for mobility devices until their employer provides comparable benefits.

Appendix 8: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Applications for Ontario Disability Support Program income support are processed and reviewed on a timely basis, and accurate and consistent decisions on initial eligibility are reached based on appropriate and supportable evidence.
2.	Payments to recipients for basic needs, shelter and benefits are correctly calculated and issued on a timely basis to eligible recipients.
3.	Timely, accessible and effective employment supports are provided to help recipients with disabilities reduce or eliminate disability-related barriers to employment and increase their economic independence through competitive and sustainable jobs.
4.	Recipients' ongoing eligibility is reviewed on a timely basis, and only those who continue to meet all eligibility criteria receive income support.
5.	Effective processes are in place to support the prevention and detection of fraud and the timely identification and recovery of overpayments.
6.	Effective oversight processes are in place to ensure the program is delivered in accordance with legislative and policy requirements.
7.	Meaningful performance measures and targets are established for the program. Results are monitored and compared against targets to ensure that the intended outcomes of the program are achieved. Corrective action is taken on a timely basis when issues are identified.

Ministry of Finance

Ontario Financing Authority

1.0 Summary

Effective borrowing, debt management and cash management by the province is important to avoid unnecessary costs to taxpayers, such as higher interest charges on debt. Effective investing balances safeguarding the province's finances while achieving the maximum return for investments.

In 1993, following the 1990 recession, the provincial government created the Ontario Financing Authority (OFA) to manage the province's debt, borrowing and investing. The OFA reports to the Ministry of Finance (Ministry). Its responsibilities also include managing the province's liquid reserve, which represents borrowed funds held as cash and short-term investments. As well, the OFA provides financial advice to the government and manages the operations of the Ontario Electricity Financial Corporation. In addition, public-sector bodies, such as hospitals, universities and agencies, can do their borrowing through the OFA.

Since 1993/94, the average annual increase in net debt—the difference between the province's total financial liabilities and assets—has been $10.3 billion. By 2018/19, net debt had risen to $338 billion from $81 billion in 1993/94. Even with historically low interest rates, in 2018/19 interest on debt was $12.4 billion, which was 8% of total provincial expenditures. This makes interest on debt the province's fourth largest expenditure area, behind health care, education, and children's and social services. Should interest rates increase, interest expenditures would increase, which could create pressure to further reduce program spending in other areas to meet the required interest payments on the debt.

We found that the OFA was effective in its investing operations and assessing short-term risks. However, the OFA has not sufficiently analyzed long-term debt sustainability—that is, the province's future ability to repay debt. Its attention has typically been short-term, focusing on a three-year period—that is, the current year and the upcoming two fiscal years. The Ministry, in turn, has not established long-term targets in conjunction with government to inform debt and expenditure decision-making by using an analysis of debt sustainability that considers the impact of and recovery steps that would be needed in response to potential economic shocks. This is a practice followed by the federal government's debt manager. The lack of long-term debt sustainability planning could contribute to and prolong the negative effects of a future economic shock. For example, Ontario's slow pace in addressing the 2008 financial crisis negatively affected the province's credit rating as late as 2017.

We found that the OFA's practices and decisions in the last five fiscal years incurred significant costs that the OFA did not formally assess to demonstrate

that the province obtained value for them. These estimated costs comprise commissions paid when issuing debt; interest paid by public bodies at rates in excess of the province's borrowing rates; foreign borrowing at costs in excess of borrowing in Canada; and the cost of maintaining liquid reserves that may be in excess of provincial needs.

Our analysis can serve as a guide to areas where the OFA should assess the potential for significant future savings, as highlighted below:

Borrowing and Short-Term Debt Management

- **Direct borrowing by public bodies instead of through the OFA cost $258 million in additional interest costs.** As of March 31, 2019, public government bodies had borrowed $7.7 billion outside of the OFA, of which $5.4 billion was outstanding. This debt results in $258 million in higher interest costs because the public bodies borrowed directly rather than through the OFA, which can get lower interest rates. As of March 31, 2019, $27 million of these additional interest costs had been paid and the remaining $231 million will be paid over the remaining life of the debt, which on average is 15 years. The public bodies acquired this debt at a higher cost primarily because they did not know they could borrow through the OFA or the OFA would not provide their desired repayment terms.
- **Expanding the use of debt auctions would save commission expenses, which were $509 million over the last five years.** The OFA spent $508.9 million on commissions to groups of banks, called syndicates, between 2014/15 and 2018/19 to issue its domestic debt. The OFA has not formally assessed whether to expand its use of debt auctions, which do not carry any significant costs to the province and are commonly used by public borrowers of its size. This means borrowers sell debt instruments, such as bonds, via auction to a broader market, with the objective of incurring lower interest costs than if they issued debt only through banks.
- **The OFA issued debt in foreign markets over the last five years that cost the province $47.2 million more in interest costs than if the debt had been issued in Canada.** We found no evidence that the OFA assessed whether these increased costs were needed for the province to manage the risk associated with issuing debt.
- **Compliance with the province's implementation of an accounting standard could result in $54 million of additional annual interest costs to avoid financial statement volatility.** An anticipated change in a key accounting standard in 2021/22 may result in the OFA using a more expensive way to manage the risks of fluctuations in the exchange rate between foreign currencies and the Canadian dollar. The change in the accounting standard will result in fluctuations appearing in the annual financial statement debt if the OFA's current approach is used but not if a more expensive approach is used. The OFA told us it was considering using the more expensive option to better align the debt in the financial statements with the provincial budget. If the OFA does this, it is expected to increase the province's interest costs by $54 million a year.

Liquid Reserve Management

- **Excess liquid reserve cost up to $761 million in interest payments over the last five years.** In 2018/19 every billion dollars held in liquid reserve cost the province $7.5 million in interest costs annually because the province earns less interest on the liquid reserve than it pays on funds borrowed to maintain the liquid reserve. Therefore, holding a liquid reserve in excess of cash management needs results in additional borrowings being needed, which then results in additional interest costs. Additional interest

costs result in lower funding available for other programs. The OFA has never had to use its liquid reserve, which was $32.6 billion on average in fiscal 2018/19, because it always has been able to borrow to meet short-term needs, even during the financial crisis in 2007/08. While maintaining a sufficient liquid reserve is important for reducing the province's risk of not meeting its short-term needs—for example, if it is unable to borrow to meet debt repayments—the OFA has not conducted a cost/benefit analysis to determine the optimal amount of liquid reserve to hold so that these needs are met without excess interest costs being incurred. The OFA sets the minimum amount of liquid reserve at one month's worth of cash requirements but has maintained an average liquid reserve of 2.8 months over the last five years. The excess liquid reserve amount above one month is estimated to have cost up to $761 million in additional interest payments over the last five years.

Investing

- **Investment return benchmark under the Ontario Nuclear Funds Agreement exceeded by 0.51% on average since 2003.** At March 31, 2019, the nuclear funds have earned a 7.29% rate of return since their inception on July 24, 2003, exceeding the market benchmark of 6.78%. The benchmark is based on the returns on comparable investments, for example, government bonds. These funds are managed by external private-sector investment management companies contracted by the OFA together with Ontario Power Generation.

OFA's Operations

- **A $32.2-million surplus from the OFA's administrative charges to public bodies has not been invested or used to reduce the province's debt.** Between 2007/08 and 2018/19, the OFA charged the public government bodies that have borrowed through it administrative costs, which are also funded by the Ministry of Finance, to administer the debt. As of October 2019, this surplus is held in a bank account and has not been invested to earn interest at a higher rate or used to reduce the province's debt.
- **The OFA lacks objective measures to monitor and report on its performance.** Most of OFA's performance measures are reporting and operating requirements, such as calculating interest on debt monthly, and meeting with credit rating agencies. In addition, the OFA does not publicly report on many of its measures and where it does report, in most cases it does not disclose its performance against its targets.

Overall Conclusion

Our audit concluded that the Ontario Financing Authority (OFA) was effective in its investing operations, assessing short-term risks and complying with legislation and regulations. However, the OFA did not formally assess its practices and decisions to determine whether the province obtained the best value for borrowing and debt management operations. For example, the OFA has not evaluated the costs associated with its borrowing methods, such as the commission fees it pays for issuing debt through syndicates and the higher interest rates it is subject to in foreign markets. Nor has it conducted a cost/benefit analysis of the optimal level of liquid reserve (excess borrowing held in the form of cash or investments) to hold.

Also, the OFA is not formally reporting to the Ministry of Finance on long-term debt sustainability or analyzing options for the recovery from potential economic shocks.

The OFA could increase transparency by identifying objective outcome measures of its performance and publicly reporting on the results achieved.

This report contains 10 recommendations, consisting of 20 action items to address our audit findings.

OVERALL MINISTRY AND OFA RESPONSE

The Ministry of Finance and the Ontario Financing Authority accept the recommendations in the report and will endeavour to implement them expeditiously. The OFA is committed to providing cost-effective borrowing and debt management. It carries out its mandate with careful attention to costs and risks. The OFA accepts that the report will serve as a guide to areas with potential for future savings. It will use the recommendations within this report to further its efforts to provide value and cost savings while ensuring effective and prudent management of the province's debt.

The Ministry and the OFA would like to thank the Office of the Auditor General of Ontario for preparing this report.

2.0 Background

2.1 Overview of Ontario Financing Authority

The Ontario Financing Authority (OFA) manages the province's debt, borrowing, investments and cash. The OFA was established as a Crown agency on November 15, 1993, by the *Capital Investment Plan Act, 1993* (Act). The Minister of Finance is responsible for the administration of the Act in respect of the OFA.

The OFA's mandate includes:

- managing the provincial debt and providing cash management and other financial services for the province;
- borrowing on behalf of the province;
- conducting investing and financial risk management activities for the province;
- advising and helping public bodies, such as ministries and Crown agencies, on how to borrow and invest money;
- issuing securities, such as Treasury Bills;
- lending to certain public bodies, when directed by the province to do so;
- investing on behalf of some public bodies;
- jointly investing, with Ontario Power Generation Inc. (OPG), OPG's Used Fuel Segregated Fund and the Decommissioning Segregated Fund established under the Ontario Nuclear Funds Agreement; and
- carrying out the day-to-day operations of Ontario Electricity Financial Corporation.

The Act defines a public body as a Crown agency, hospital, municipality, university, college, school board, and any other entity named or described as a public body in regulations made under the Act.

Before the Act, the Office of the Treasury (Office), which at the time was part of the Ministry of Treasury and Economics, managed the province's debt. The Office was responsible for developing and implementing a centralized financing policy. The Office's activities included borrowing, investing and cash management. More details around the processes of borrowing, investing and cash management are included in **Appendix 1**.

One of the reasons the OFA was initially created was because under the accounting standards in existence then, by using the OFA the government could acquire debt and not record it on the province's financial statements. But before the OFA began operating, the accounting standards were strengthened to prohibit the government from borrowing through a separate entity (for example, the OFA) without recording the debt issued on the province's consolidated financial statements.

Another reason the province created the OFA was that the province anticipated an increase in borrowing both domestically and internationally. The province expected that the growth in borrowing and debt management would require enhanced governance and expertise, which could be provided by the OFA's board of directors.

Powers given to the OFA that the Office of the Treasury did not have include the ability to:

- make loans to other public-sector bodies;
- pool funds from government and other public-sector bodies for investment; and
- take over the financial activities (if directed to do so) of any other public body in order to resolve their fiscal management problems.

The OFA also has administrative flexibility that the Office of the Treasury did not have, such as the ability to offer staff working in trading desk positions and financial management positions special compensation, for example performance pay and salaries not tied to government salary ranges.

The OFA produces an annual debt plan (Financing and Debt Management Plan) for the province and the Ontario Electricity Financial Corporation. This plan outlines the province's borrowing requirements for the upcoming fiscal year and the OFA's strategy for meeting these requirements. The OFA's strategy addresses the average term of debt instruments the OFA intends to issue, the amount it intends to issue in foreign jurisdictions, and its limits on exposure to risk factors. More details on the ranges, targets and actual performance related to various risk measures is available in **Appendix 2**.

2.1.1 Board of Directors

A Board of Directors (board) governs the OFA and is accountable to the Minister through the chair of the board. The OFA's board is composed of a chair and at least four, but not more than 12, other directors. There are currently 13 members on the board.

Under the *Capital Investment Plan Act*, the Deputy Minister of Finance is, by virtue of position, the chair of the board. The other board members are appointed by Cabinet, including the OFA's Chief Executive Officer (CEO).

Under the Act, board members are appointed for a term of three years and can be reappointed for successive terms of three years each. Board members serving as of March 31, 2019, had served on the board for five years on average, with a range of service from 10 months to 19 years (the OFA's CEO, who is also a board member, had served for 19 years). Eight of the other 12 board members have been on the board for more than one term. In April 2017, the board approved a policy limiting board members to three terms. This limitation is not applicable to the Deputy Minister or CEO of the OFA.

Board members, other than the three Ontario Public Service (OPS) employees (that is, the Chair, the CEO and the Chief Talent Officer of the OPS), currently receive $500 a day for each day they are engaged in OFA business, plus expenses, and the vice-chair receives $550 a day plus expenses. In 2018/19, members were paid a total of $91,025 ($83,200 in 2017/18).

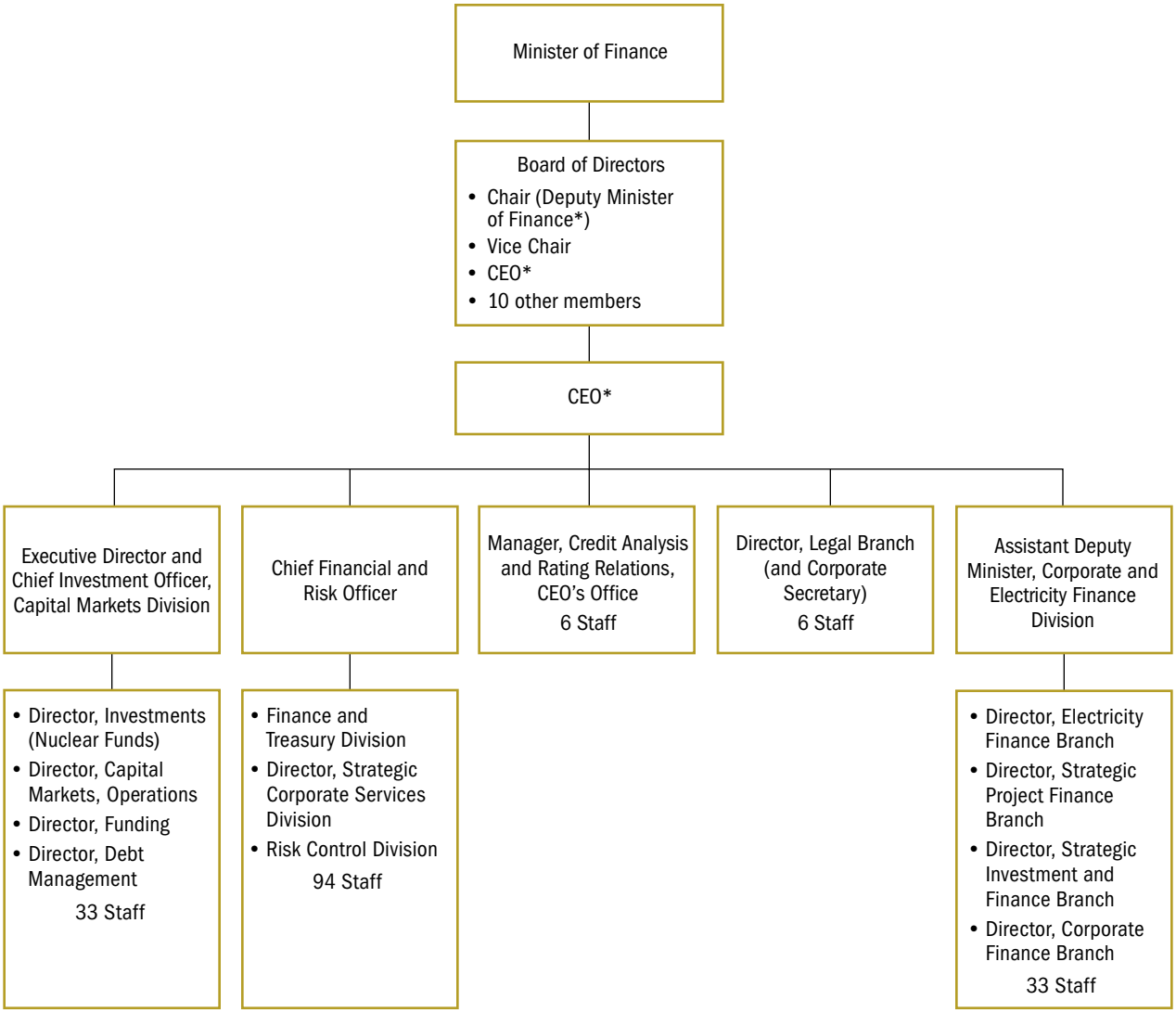
The board is responsible for the oversight of the OFA's management. The board can pass by-laws related to the management of the OFA but these must be approved by the Minister. The board approves the OFA's Annual Financing and Debt Management Plan, and the OFA's operating policies. The board has three committees that make recommendations to the board:

- the Human Resources and Governance Committee,
- Audit and Risk Management Committee, and
- Ontario Nuclear Funds Agreement Investment Committee.

The CEO has responsibility for the day-to-day operations of the OFA. Rather than the board, the Cabinet has the authority to select, hire, and dismiss the CEO. The CEO's performance is evaluated by the chair in consultation with the board.

As the Chair, the Deputy Minister of Finance is responsible for the OFA's performance in achieving its mandate and for reporting and timely communication to the Minister of Finance. The Deputy Minister of Finance is also responsible for the provision of administrative and organizational support to the OFA.

Figure 1: Ontario Financing Authority Organizational Chart (172 Staff)
Prepared by the Office of the Auditor General of Ontario



* The Chair is the Deputy Minister of Finance. The CEO reports to the Chair; the Deputy Minister of Finance reports to the Minister of Finance.

2.1.2 Organizational Structure and Operations

As of March 31, 2019, the OFA employed 172 full-time-equivalent (FTE) staff. It operates from a single location in downtown Toronto and had expenditures of $26.6 million in 2018/19.

The OFA has seven divisions: capital markets; corporate and electricity; finance and treasury; legal; risk control; strategic corporate services; and the CEO's office. See **Figure 1** for the OFA Organization Chart and **Figure 2** for the total number of staff and compensation expenditures over the last five fiscal years. See **Appendix 3** for a description of activities within each division.

2.1.3 Borrowing and Investment Authority

Ontario has two sources of borrowing authority for provincial debt:

- the *Financial Administration Act*; and
- the *Ontario Loan Act*.

The *Financial Administration Act* sets out the financial activities the OFA is authorized to direct,

Figure 2: Number of Staff and Compensation Expenditures, 1993/94, 2014/15–2018/19

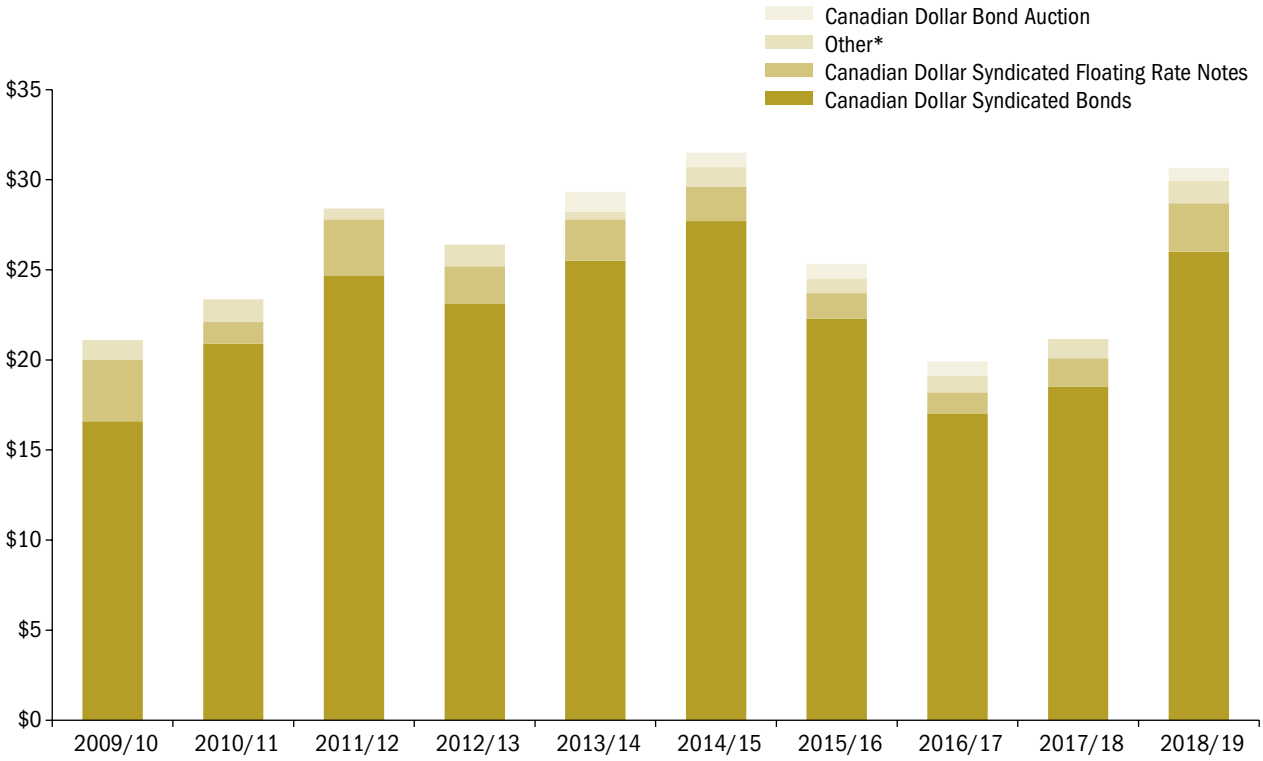
Source of data: Ontario Financing Authority

	1993/94[1]	2014/15	2015/16	2016/17	2017/18	2018/19
OFA staff	115	166	166	166	172[2]	172
Salaries, wages and benefits ($ million)	5.2	18.90	19.10	19.30	21.10	22.50

1. Number of staff when the OFA was created.
2. The staff increase from 2016/17 is due to adding full-time IT staff where roles were previously performed by consultants.

Figure 3: Domestic Borrowings Completed by Ontario, 2009/10–2018/19 ($ billion)

Source of data: Ontario Financing Authority



* Other includes Green Bonds, Medium-term Notes and Ontario Savings Bonds.

control and carry out in the name of—and on behalf of—the Minister. These include issuing bonds to borrow money and carrying out investment activities.

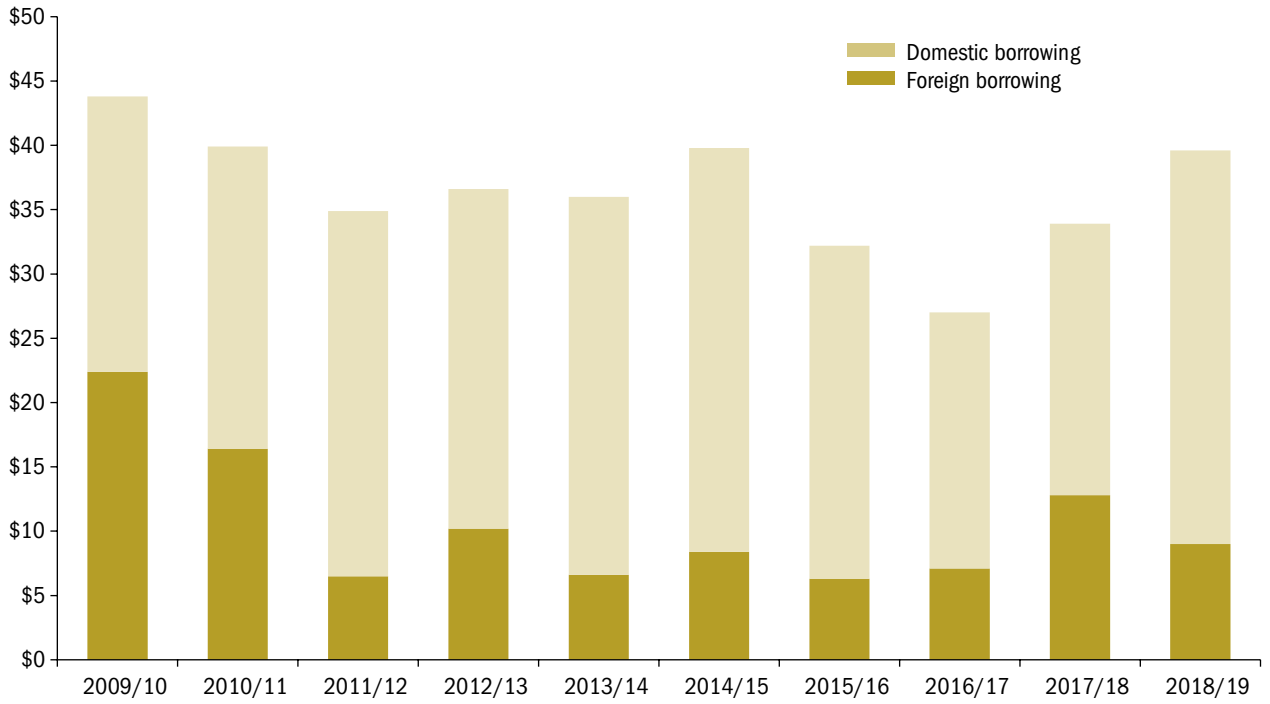
The *Ontario Loan Act* authorizes the OFA to pay the debts of the province and to make any payments from the province's Consolidated Revenue Fund as required by any act. The Consolidated Revenue Fund is the account into which taxes and other revenue the province collects are deposited.

2.1.4 Borrowing Program

Ontario's borrowing program (the total amount borrowed by the province in a given year) is the largest of the Canadian provinces. For the 2018/19 fiscal year, it was approximately 43% of the total dollars borrowed for all provinces combined.

Figure 3 shows the approximately $26 billion obtained by issuing Canadian dollar syndicated bonds. This amounted to 66% of the province's total $39.6 billion borrowed in 2018/19. These are bonds sold within Canada that are purchased by

Figure 4: Foreign Borrowing as a Proportion of Total Annual Borrowing, 2009/10–2018/19 ($ billion)
Source of data: Ontario Financing Authority



syndicates. Syndicates are groups of lenders, such as the big six banks—Bank of Montreal, Canadian Imperial Bank of Commerce, National Bank of Canada, Royal Bank, Scotiabank and Toronto Dominion Bank—and other international banks, such as Goldman Sachs and JP Morgan.

Of the $39.6 billion the province borrowed in 2018/19, 77% was done domestically. Domestic markets generally offer longer financing opportunities compared with foreign markets (for example, 30-year bonds).

Bonds are typically issued in five-, 10- or 30-year terms (the period of time over which the bond is outstanding). The minimum amount the OFA aims to raise varies depending on the term of the bonds it is issuing. Since 2010/11, the minimum it plans to raise for each bond issue is:

- Five-year bonds—$1 billion;
- 10-year bonds—$750 million; and
- 30-year bonds—$600 million.

These minimums are policies set by the OFA and approved by the board. The province does not have a regular schedule for issuing bonds and, to maintain maximum flexibility, it does not publicly commit to minimum amounts of debt to issue.

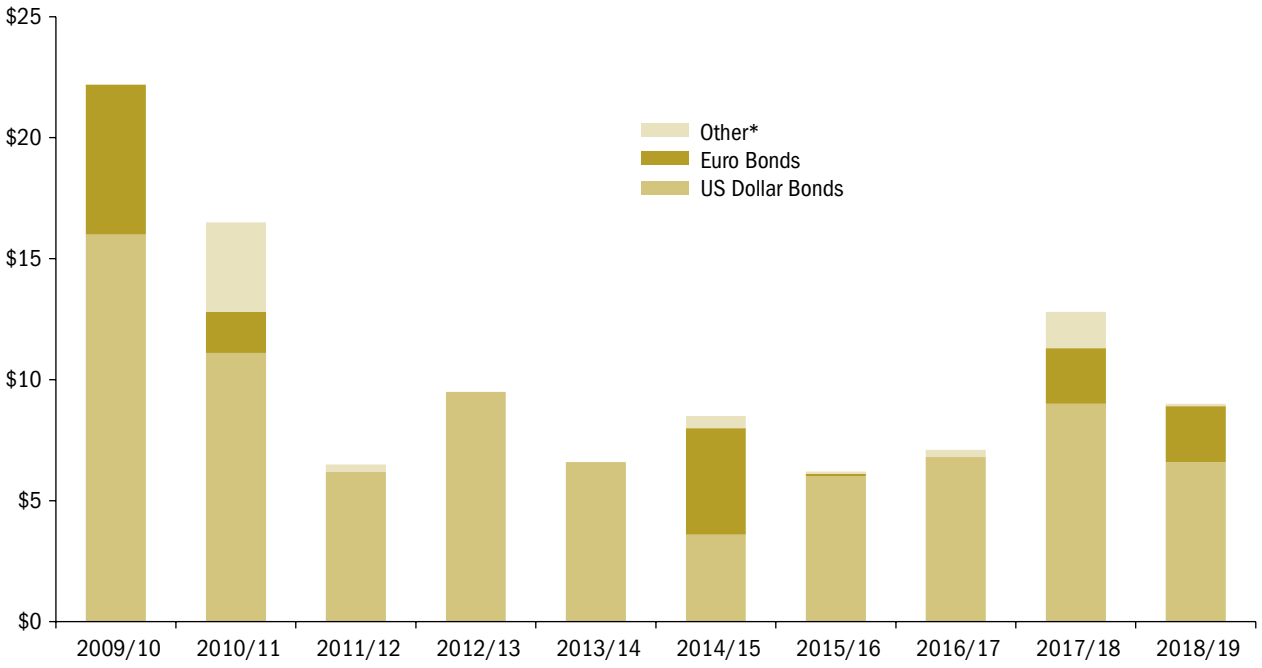
As shown in **Figure 4**, in 2018/19, the OFA raised $9 billion (23%) of the total borrowing through international bonds, which were sold in different countries' currencies. The amount of foreign debt the province issues changes on a yearly basis due to changing market conditions. For example, as little as 18% of all debt issued in 2013/14 was foreign debt, while as much as 51% of the debt was foreign debt in 2009/10, largely due to the level of domestic demand coming out of the financial crisis and the opportunities available to the OFA abroad. **Figure 5** shows the foreign debt issued by currency. The amount of debt to be issued, the terms of the debt, and the mix of foreign and domestic debt are outlined in the OFA's Financing and Debt Management Plan.

2.1.5 Investment Program

The OFA invests and manages the province's liquid reserve. As of March 31, 2019, the amount

Figure 5: Annual Foreign Borrowing by Currency, 2009/10–2018/19 ($ billion Cdn)

Source of data: Ontario Financing Authority



* Other includes Australian Dollar Bonds, Hong Kong Dollar, Japanese Yen, Norwegian Kroner, Sterling and Swiss Franc.

of the liquid reserve was $36 billion of cash and short-term investments. The goal of liquidity management is to maintain sufficient cash and short-term investments to meet the province's daily operating needs and to withstand financial stress or shock events, such as a sudden increase in interest rates or sudden volatility in the financial markets.

As of March 31, 2019, the OFA also invested a total of $2 billion on behalf of seven public entities:

- Deposit Insurance Corporation of Ontario;
- Ontario Trillium Foundation;
- Pension Benefits Guarantee Fund;
- Ontario Capital Growth Corporation;
- Ontario Infrastructure and Lands Corporation;
- Northern Ontario Heritage Fund Corporation; and
- Ontario Immigrant Investor Corporation.

The OFA and Ontario Power Generation (OPG) jointly manage the investment activities of OPG's Used Fuel Segregated Fund and the Decommissioning Segregated Fund, which were established under the Ontario Nuclear Funds Agreement (ONFA). As of March 31, 2019, the combined market value of these two funds was $22.4 billion.

2.2 Government Debt

Government debt is money borrowed from external parties that the government must pay back in the future with interest. A government acquires debt when the cost of operating its programs (for example, providing health-care and education services) and/or the cost of investing in capital (for example, land, buildings, roads) exceeds its revenue (for example, taxes collected). Ontario's debt consists primarily of bonds, treasury bills, and United States commercial paper the province issues. **Figure 6** shows the debt funding requirements due to operating expenditures and investments in capital assets.

Ontario is the most indebted sub-sovereign borrower in the world. (A sub-sovereign jurisdiction is a level of government below the national level, for example, a province, state, city or region.) See **Figure 7** for a listing of the top five most indebted

Figure 6: Debt Incurred to Fund Ontario's Operating Expenditures and Capital Assets from 1960/61 to 2018/19 ($ million)

Source of data: Public Accounts of Ontario

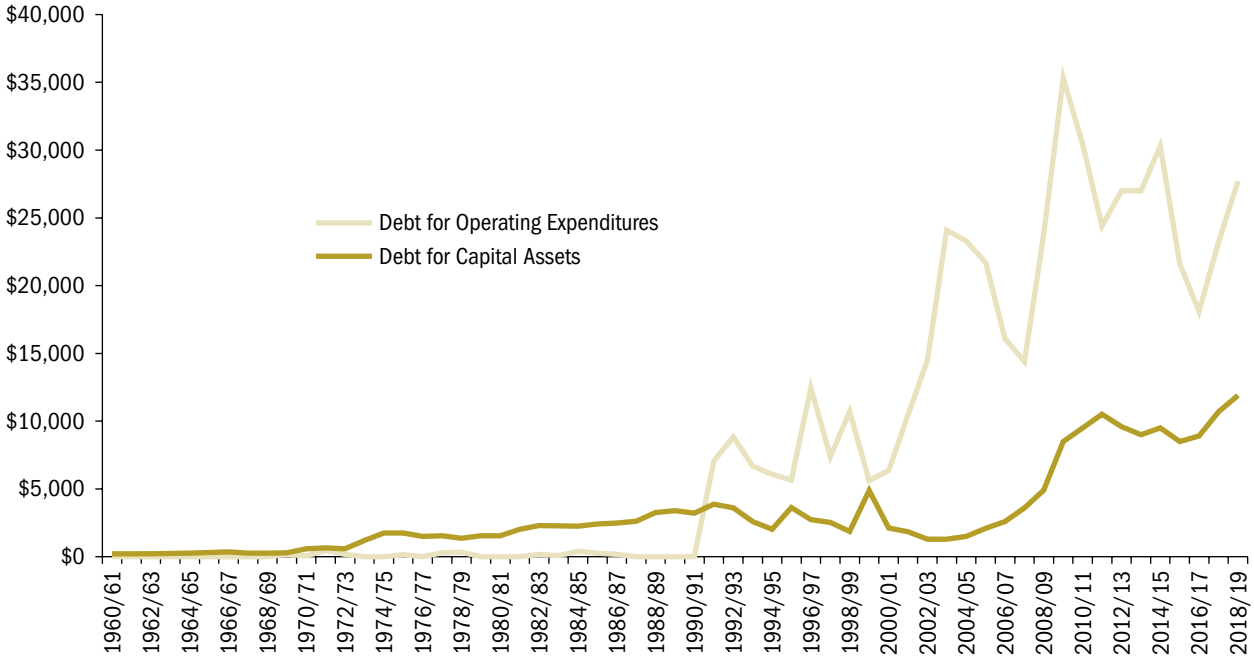


Figure 7: Highest Levels of Sub-sovereign Debt in the World, 2018/19

Sources of data: Annual Reports and Consolidated Financial Statements of other jurisdictions

Sub-sovereign Jurisdiction	Total Debt* ($ billion)
Ontario	354.3
Quebec	195.2
California	146.2
New York	79.6
Texas	70.9

* In Canadian dollars, converted using exchange rate at date of respective jurisdictions' 2018/19 financial statements.

sub-sovereign jurisdictions. Compared with other sub-sovereigns, Canadian provinces have a unique structure whereby they have responsibility over items with significant expenses, including health-care and education.

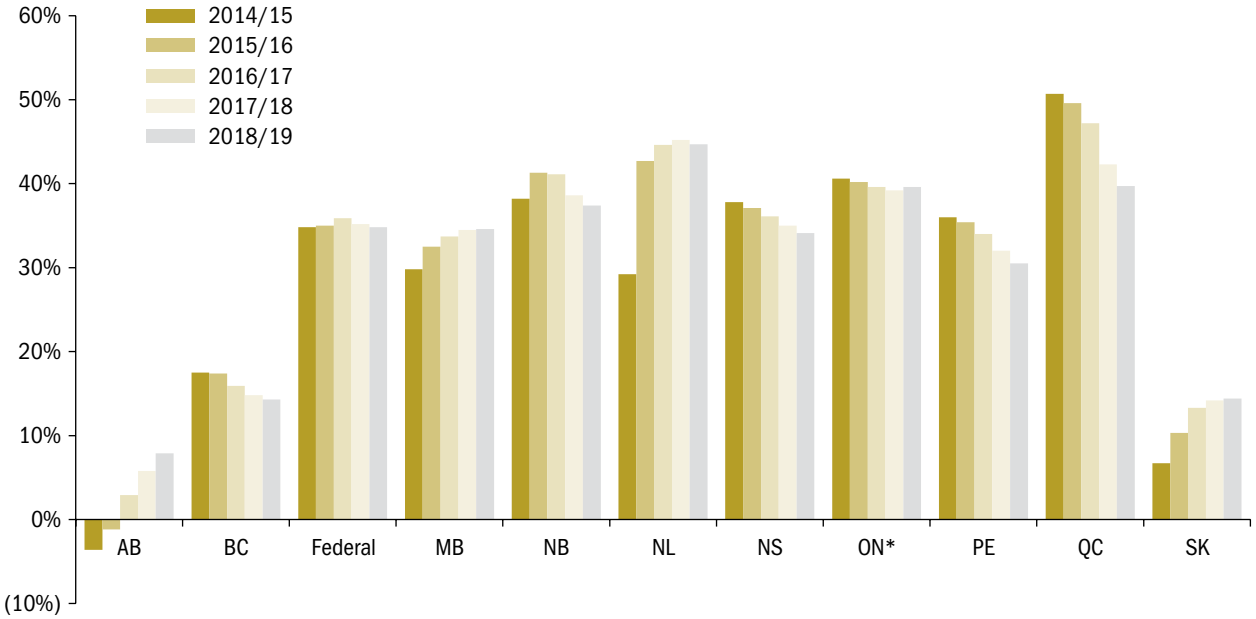
By the end of the 2018/19 fiscal year, the province of Ontario had total debt of $354 billion and net debt—the amount of total liabilities less financial assets—of $338 billion. The province borrowed $39.6 billion in fiscal 2018/19, primarily through bond markets. As of March 31, 2019, the province's net debt-to-GDP ratio was 39.6% (see **Figure 8**).

Many experts believe when a jurisdiction's net debt-to-GDP ratio rises above 60%, the jurisdiction's fiscal health is at risk and is vulnerable to unexpected economic shocks. In its report on the *Long-Term Budget Outlook 2017*, the Financial Accountability Office projected Ontario's net debt-to-GDP ratio could reach 63% by 2050/51.

Net debt-to-GDP is the ratio of net debt to the market value of goods and services produced by an economy. It measures the relationship between a government's obligations and its capacity to raise the funds needed to meet them. This ratio is an indicator of the burden of government debt on the economy. When the net debt-to-GDP ratio rises, it means the province's net debt is increasing faster than the provincial economy is growing and the net debt is becoming a growing burden.

Figure 8: Net Debt-to-GDP by Province, 2014/15–2018/19

Sources of data: Province of Ontario Annual Report and Consolidated Financial Statements; Annual Reports and Consolidated Financial Statements of other provincial jurisdictions; federal budgets and budget updates; budgets of provincial jurisdictions



Note: Jurisdictions with lower debt than Ontario may have a higher net debt-to-GDP ratio because they also have a lower GDP.

* 2015, 2016 and 2017 record the government's correction of previous accounting treatment related to Pensions and the Fair Hydro Plan.

2.2.1 Ontario's Debt Continues to Increase

The recession that started in 1990 reduced the province's tax revenues, with net debt rising as the province incurred large deficits. A later financial crisis in 2008 resulted in an economic downturn that led to increased borrowing.

In 2011, the government of Ontario established the Commission on the Reform of Ontario's Public Services (the Drummond Commission), chaired by former Toronto Dominion Bank chief economist Don Drummond. The Drummond Commission's Report—or the Drummond Report as it is often called—was released in February 2012. It provided recommendations on expense reduction and revenue raising. The last time the province assessed the implementation status of the Drummond Report recommendations was in 2015/16. That assessment showed that 14.6% of the recommendations were fully implemented and 71.2% had some action taken on the recommendations. Some actions were not acted on because the then government considered that those recommendations did not align with its mandate. For example, the Drummond Report recommended limiting annual spending growth until 2017/18. The actual growth/reductions and cost implications from 2012/13 to 2017/18 are identified in **Figure 9**. If spending had been restrained to the levels recommended in the Drummond Report, the province's total debt could potentially have been reduced by $30.3 billion by 2017/18. **Figure 10** shows the growth in net debt in Ontario from 1960/61 to 2018/19, and the growth in net debt-to-GDP over the same period.

Interest expense is the province's fourth-largest annual expenditure behind health, education, and children's and social services. In its 2019 budget, the province forecast that in the 2019/20 fiscal year, for example, if there is a 1% increase in borrowing rates the annual interest on debt would go up by $350 million. The average cost of borrowing for all debt outstanding in the fiscal 2018/19 was 3.6% and in 2019/20 is forecast to be 3.4%. This rate is low compared with historic borrowing rates, which have been as high as 13.1% in 1987/88. Increases

Figure 9: Comparison of Select Cost Constraints Recommended in Drummond Report with Actual Expenses

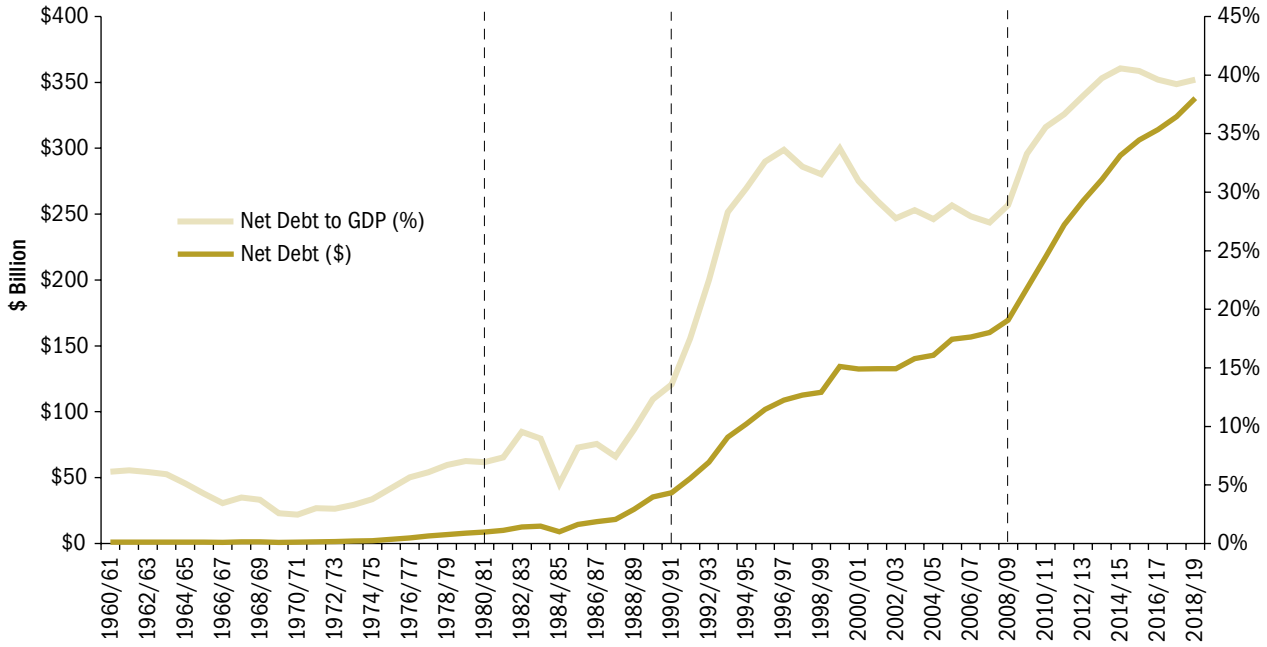
Prepared by the Office of the Auditor General of Ontario

Sector	Drummond Report's Recommended Annual Change in Expenses for 2012/13–2017/18 (%)	Actual Average Annual Change in Expenses 2012/13–2017/18 (%)	Total Cost from Actual Expenses Exceeding Drummond Recommendations 2012/13–2017/18 ($ million)
Health Care	2.5	3.4	2,286
Education	1.0	4.3	7,555
Post-secondary Education and Training*	1.5	3.4	1,136
Social Services	0.5	3.9	8,114
All other programs	(2.4)*	3.6	11,207
Total			**30,298**

* The Drummond Report excluded Training from the 1.5% limit under Post-secondary Education and Training. Such expenses would have fallen under the All Other Programs category, which the Drummond Report recommended be subject to a 2.4% reduction. Since Training was not excluded from our analysis, the cost differences are understated.

Figure 10: Net Debt and Net Debt to GDP, 1960/61–2018/19

Source of data: Public Accounts of Ontario



* The vertical lines indicate recessions in Ontario in 1981, 1990 and 2008, as identified in the *Spring 2019 Economic and Budget Outlook* issued by the Financial Accountability Office of Ontario.

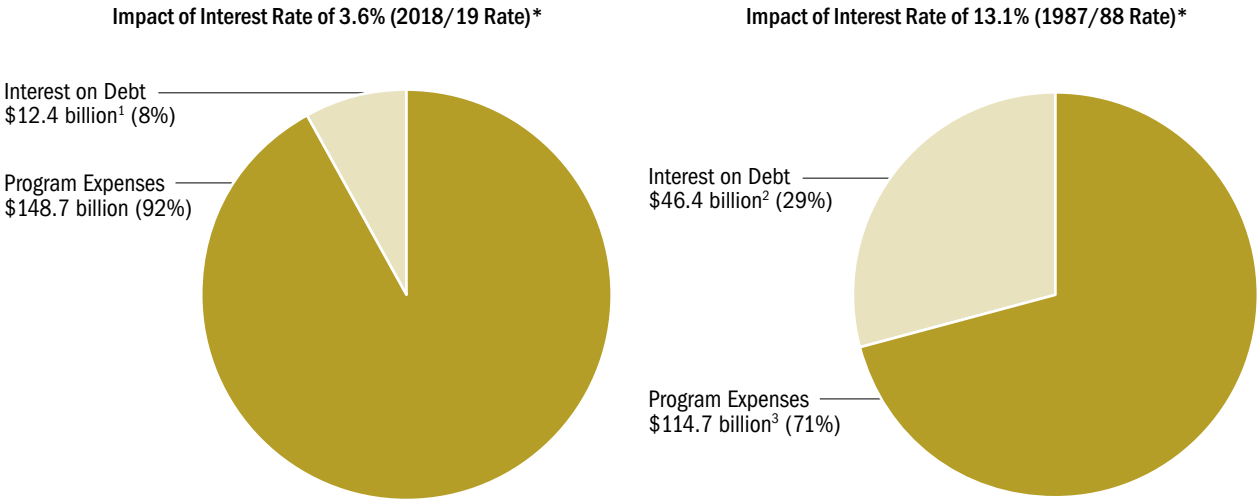
in borrowing rates would result in a growth in the province's annual interest costs. **Figure 11** shows the impact a return to historic high interest rates would have on the province's interest costs. Though the province's borrowing rates have been reducing since their peak in the late 1980's, interest costs have grown because of the increase in provincial debt, as shown in **Figure 12**.

2.3 Public Debt Management

Public debt management is the process of creating a strategy to raise the funds required for the government to meet its planned operating and capital expenditures in the short, medium, and long term and then executing the strategy. According to the International Monetary Fund (IMF), an organization made up of 189 countries

Figure 11: Impact if Interest Rates Increased to Same Level as 1987/88, as a Percentage of 2018/19 Expenses

Prepared by the Office of the Auditor General of Ontario



* Rate is the average cost of borrowing for all debt outstanding during the year.

1. Currently, interest on debt at 8% is the province's fourth largest expense after health (38%), education (19%) and children's and social services (11%).
2. With an interest rate of 13.1%, interest on debt at 29% would become the province's second largest expense, after health spending.
3. This depiction of the impact of an interest rate of 13.1% on Ontario's 2018/19 expenses assumes total expenses would not change.

working to ensure the stability of the international monetary system, "the main objective of public debt management is to ensure that the government's financing needs and its payment obligations are met at the lowest possible cost, consistent with a prudent degree of risk."

Governments make policy decisions concerning what a prudent degree of risk is. A risk policy that focuses on cost savings in the short term without giving thought to preparing for economic shocks runs a high risk of drastic increases in interest costs. Under such a policy, the government concentrates on short-term debt and floating rate debt because they generally have lower interest costs when they are issued. However, when short-term debt matures, it is generally reissued. If there is an economic shock resulting in large increases in interest rates, matured short-term debt will be reissued at much higher rates. This means interest costs on debt increase drastically. A government that is unprepared to pay this increased interest cost may default on its debt obligations.

Governments outline their risk policies through their debt structures—for example, by establishing targets or ranges for key risk indicators, such as the portion of their debt that has foreign currency exposure, the portion that will have a floating interest rate, and the duration they issue debt for. Generally, governments aim for low levels of risk, mostly accepting market interest rates as they are and not taking on additional risks to attempt to save costs. Governments do not want to be seen to be speculating on positive outcomes and thus not mitigating against risk, in case there are cost increases.

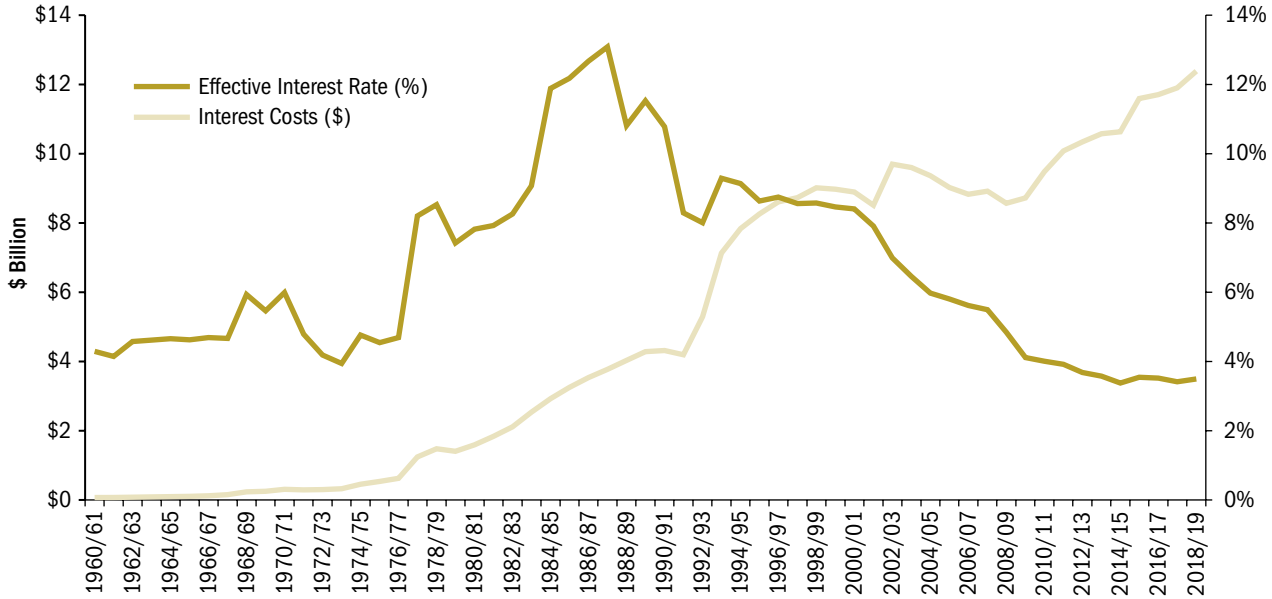
Managing debt involves creating and issuing debt instruments (for example, bonds), with an understanding of the domestic and international market, in order to raise the required amount of money when needed at the lowest interest rates possible. It also involves identifying the risks associated with this debt and applying risk-mitigation strategies to reduce or eliminate the identified risks.

Just like the financial head of a household, a public debt manager has two important jobs to ensure that it will be possible to pay the debt that has been taken on:

- keep enough cash and short-term investments (investments whose returns can easily be converted to cash) on hand to pay back debt that is due in the short term; and

Figure 12: Interest Costs and Effective Interest Rates, 1960/61–2018/19

Source of data: Public Accounts of Ontario



- figure out the best time to take on more debt (or "issue new debt") given the obligations of the existing debt (that is, when to borrow to repay existing debt and interest).

The risk of being unable to meet provincial debt obligations as they come due is referred to as liquidity risk. This risk can be mitigated by holding liquid reserves or having access to funding through market-based mechanisms such as short-, medium- or long-term bonds.

Two other key areas of risk related to debt management are:

- the risk of fluctuations in interest rates (this can happen when a debt instrument provides a variable rate of interest that can go up or down based on market factors, such as the supply and demand for credit); and
- the risk of a change in the value of foreign currencies in relation to the Canadian dollar.

These risks can be mitigated by hedging. This involves investing in financial instruments (monetary contracts) whose value changes (goes up or down) in the opposite direction of the provinces' debt instruments.

Here is an example case. The province raises funds by issuing a bond in United States (US) dollars. The bond is set up to require that the province pays $1 billion US one year from now. At today's exchange rate, that will cost $1.3 billion in Canadian (Cdn) dollars. The province wants to protect itself from the risk that one year from now, because the exchange rate will have changed, the payment will cost more—say, $1.4 billion Cdn. So it enters into a separate agreement with another party to buy $1 billion US one year from now at today's exchange rate. A year from now, even if the exchange rate has changed and the province is due to pay $1.4 billion Cdn, it buys the $1 billion US from the other party for $1.3 billion Cdn as arranged, and then uses the newly purchased $1 billion US to pay its debt. No additional cost is incurred from the change in the value of the Canadian dollar compared to the US dollar.

Another risk is credit risk, which is the risk of an economic loss due to the failure of the other party in a financial transaction to pay amounts owed to the province. This risk can be mitigated in a variety of ways, such as by setting criteria and limits for financial transactions with other parties,

Figure 13: Ontario's Credit Ratings from Four Agencies, 2015–2019
Prepared by the Office of the Auditor General of Ontario

Credit-Rating Agency	2015	2016	2017	2018	2019
DBRS Morningstar (previously DBRS)	AA (low) Stable	AA (low) Stable	AA (low) Stable	AA (low) Stable	AA (low) Stable
Fitch Ratings	AA–Stable	AA–Stable	AA–Stable	AA–Negative	AA–Stable
Moody's	Aa3 Negative	Aa3 Stable	Aa3 Negative	Aa3 Stable	Aa3 Stable
Standard & Poor's	A+ Stable	A+ Stable	A+ Stable	A+ Stable	A+ Stable

by monitoring these risks and taking appropriate actions when necessary, and by entering into collateral agreements. A collateral agreement defines and pledges the collateral each party offers to ensure any losses can be recouped.

2.4 Credit Rating Agencies

Credit rating agencies are private, for-profit companies that assign a credit rating to an entity that issues debt, such as a province. The credit rating is an assessment of the entity's credit risk and reflects the entity's ability to make interest payments, as well as the likelihood that the entity will either repay or default on the original debt. Credit ratings are based on economic and financial forecasts and assessments of future developments and risks.

Four credit agencies provide credit ratings for the province of Ontario. See **Figure 13** for the credit ratings these agencies have assigned the province as of October 2019.

3.0 Audit Objective and Scope

Our audit objective was to assess whether the Ontario Financing Authority (OFA):

- cost-effectively conducts and manages the borrowing, debt and investment needs of the province;
- mitigates the risks associated with public debt;
- complies with legislation and regulations; and
- measures and reports on the results and effectiveness of the OFA's borrowing, debt and investment performance.

In planning for our work, we identified the audit criteria (see **Appendix 4**) we would use to address our audit objective. We established these criteria based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. OFA senior management reviewed and agreed with the suitability of our objective and associated criteria.

We conducted our audit at the office of the OFA between November 2018 and October 2019. We received written representation from Ministry management that, effective November 12, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

Our audit focused on the OFA's management of the province's debt, which involves issuing debt instruments domestically and internationally, investing, assessing and hedging the risks associated with issuing debt, managing the province's liquid reserve, and reporting on the province's operations and debt.

We analyzed data provided by the OFA and the Ministry of Finance covering the last 10 years, with a primary focus on the province's borrowing, investing, cash management and debt management during the five-year period between April 1, 2014, and March 31, 2019. Where appropriate, we examined relevant information available from the creation of the OFA in 1993 through to the completion of our audit work in October 2019.

We engaged experts in government debt management to help in assessing whether the OFA's financing strategies were optimal and cost-effective to reduce interest on debt and financial risk exposure. Our experts also assessed and provided feedback on the OFA's management of risks and its use of financial instruments to hedge risks.

We interviewed staff from the Government of Canada, Alberta, British Columbia, Manitoba, New Brunswick, Newfoundland and Labrador, Prince Edward Island, and Quebec to understand how they manage debt in their respective jurisdictions. In addition, we spoke with four credit-rating agencies to discuss their views on the province's debt management.

4.0 Detailed Audit Observations

Our audit identified that the OFA was conforming with good practices in risk management and investing, as discussed in **Sections 4.3** and **4.9**. The report addresses areas for improvement in the Ministry of Finance's debt sustainability (**Sections 4.1** and **4.2**), the cost-effectiveness of borrowing done by public bodies such as hospitals, colleges and school boards (**Section 4.4**), the cost-effectiveness of the OFA's borrowing and debt management strategies (**Sections 4.6**, **4.7** and **4.8**), and the OFA's operations (**Sections 4.5**, **4.10**, **4.11** and **4.12**).

4.1 Ministry Should Formally Assess Sustainability of Province's Debt Burden and Develop Long-Term Plan to Address Debt Burden

The Ministry of Finance (Ministry) has not assessed whether the current levels of provincial debt are sustainable and whether the province will be able to withstand an economic shock such as a recession. We found that there are no targets or measures in place related to debt sustainability in any formal, long-term plan. The province currently sets its annual budget for projected revenues and expenses, and the OFA creates a plan to acquire enough debt to meet the needs of any annual projected funding shortfall. The budgeting process does not incorporate a debt-to-GDP reduction target based on an analysis of long-term sustainability.

Credit rating agencies advised us that net debt as a percentage of the province's gross domestic product (net debt-to-GDP) is an important measure for assessing the sustainability of a province's debt because it indicates the province's ability to pay back its debt.

In the province's 2017 budget, the Ministry of Finance identified the target of achieving a net-debt-to-GDP ratio of 27% by 2029/30. But this target was removed by the then government from the province's 2018 budget. Since then, the Ministry of Finance has not established an alternative long-term net debt-to-GDP reduction target.

In August 2018, the Independent Financial Commission of Inquiry (Commission), a commission established to review Ontario's past spending and accounting practices, stated that the province should take immediate steps to reduce the net debt-to-GDP ratio and the Commission recommended that an analysis be conducted to determine—and set—an appropriate target and timeline to reduce the province's ratio of net debt-to-GDP.

Ontario has the highest total debt of any province in Canada and the third-highest net debt-to-GDP ratio (see **Figure 8**). As of March 31, 2019, the province's net debt-to-GDP ratio was 39.6%. In the 2019 budget, which was released April 11, 2019, the Ministry introduced a debt-burden-reduction strategy and announced that the government's objective was to have Ontario's net debt-to-GDP ratio below 40.8% by 2022/2023.

In the Financial Accountability Office of Ontario's (FAO) report *Assessing the Impact of an Economic Downturn on Ontario's Finances*, the FAO concluded that "the government's fiscal plan is vulnerable to an economic downturn … [which] would put the government's commitments to both

balance the budget and limit increases in Ontario's [net] debt-to-GDP ratio at risk." In that report, the FAO highlights that under a reasonable recession scenario, the province could incur additional debt, which would increase the province's net debt-to-GDP ratio from 40.2% to nearly 45% by 2021/22.

Other provinces have announced specific net debt-to-GDP targets. For example, in 2013/14, Nova Scotia had a net debt-to-GDP ratio of 38%, which was nearly as high as Ontario's that year. But that year, the Nova Scotia Commission on Building Our New Economy, a group commissioned by the then premier, issued the One Nova Scotia Report recommending the province reduce its net debt-to-GDP ratio to 30% by 2024. As of March 31, 2019, Nova Scotia's net debt-to-GDP ratio was at 34.1%, and Nova Scotia was on track to meet its target. Though Ontario established an overall cap, the cap was based on current projected expenditures versus a review of future debt sustainability.

Ontario has balanced budget legislation. The *Fiscal Transparency and Accountability Act, 2004*, required that the province plan for a balance budget unless, as a result of extraordinary circumstances (which are not defined in that Act), the government determines it is necessary for the province to have a deficit. Under that Act, if the government plans a deficit, it must develop a recovery plan for achieving a balanced budget in the future. Since the time the *Fiscal Transparency and Accountability Act, 2004*, was enacted, the province has run a deficit in all years except 2006/07 and 2007/08. See **Appendix 5** for a list of the government's explanations regarding the extraordinary circumstances that resulted in a deficit for these years.

In May 2019, the *Fiscal Sustainability, Transparency and Accountability Act, 2019* (2019 Act) replaced the *Fiscal Transparency and Accountability Act, 2004*. The 2019 Act continues to require a balanced budget and allows the government to plan to run a deficit for undefined extraordinary circumstances. The 2019 Act expands on the earlier Act's requirements by requiring that the government include a recovery plan in the budget. The 2019 Act also includes new requirements for a debt-burden-reduction strategy and for introduction of Minister and Premier accountability measures.

Other provinces target debt reduction through balanced budget legislation that limits the ability of the government to run deficits that further increase their debt. These provinces include British Columbia, Manitoba and Quebec. See **Appendix 6** for a comparison of provincial balanced budget legislation.

RECOMMENDATION 1

To increase the ability of the Ministry of Finance (Ministry) to achieve long-term sustainability for the provincial debt, we recommend that the Ministry:

- clearly define "extraordinary circumstances" as set out in the *Fiscal Sustainability, Transparency and Accountability Act, 2019*;
- identify relevant measures to assess debt sustainability;
- develop formal, evidence-based long-term targets and plans to meet them; and
- monitor these measures and assess the impact on the province's current and projected financing needs, and the cost of debt.

MINISTRY RESPONSE

The Ministry agrees with the recommendation and acknowledges the importance of maintaining the long-term sustainability of the province's debt.

Consistent with the *Fiscal Sustainability, Transparency and Accountability Act, 2019*, the Ministry reports on the debt burden reduction strategy in the annual budget, specifying objectives for Ontario's projected net debt-to-GDP and plans and progress to meet those objectives. The Ministry will also identify other relevant measures to assess debt sustainability, such as interest as a percentage of revenue, and report on these measures.

4.2 The Province Lacks Plans to Respond to Impact on Debt and Operations from an Economic Shock

Though the province seeks input from OFA staff, such as asking for projected net debt-to-GDP amounts, the Ministry has not empowered the OFA to proactively advise the government on how to manage the sustainability of the provincial debt burden or respond to economic shocks. Given this limitation, we found that OFA staff, who are experts in debt management, were not being used effectively to assist the government in managing the provincial debt.

The following activities are not performed by the OFA, the Ministry, or by anyone else in the provincial government:

- assessing the sustainability of current and projected debt levels;
- formally monitoring emerging trends in debt sustainability (for example, demand for Ontario debt) and informing the Ministry;
- analyzing the impacts of potential economic shocks on the debt sustainability measures and cost of the province's debt; and
- creating mitigation strategies or actions that could be taken should an economic shock occur.

The OFA is in frequent communication with credit rating agencies that assess the province's short-term capacity to meet its financial obligations. The OFA, through its CEO, advises the Ministry on concerns credit rating agencies identify regarding sustainability assessments. These discussions are not documented, however, and so we could not review them.

The OFA told us that it has advised the Ministry that targets and measures for debt sustainability, including the assessment of probable economic shock scenarios that could have a negative impact, are critically important. But the OFA does not identify what these targets or measures should be, and it does not provide guidance on selecting the economic shock scenarios, nor does it perform any form of assessment unless directed to do so by the Ministry. The Ministry has not directed the OFA to perform an assessment on these scenarios.

In contrast, the federal government's Department of Finance assesses economic shock scenarios to identify the flexibility and robustness of the federal debt program and the relevant legislative and regulatory authorities, and the ability of the governance framework to respond to these scenarios. This involves the Department's economic forecast group working with relevant government entities, such as the Bank of Canada. This ensures that the federal government's debt programs are able to respond to changes in economic and financial circumstances and enables the Department to develop contingency plans. The expertise of the different government entities that the group works with adds value to the contingency plans. This makes it possible for a range of potential changes to fiscal and economic policy to respond to the economic shock to be included in those plans. For example, if a scenario affects credit markets and financial stability, the Bank of Canada recommends policies or other actions it could implement for the contingency plan.

The next step in the federal process is for the debt management group to develop plans to borrow the money needed for each economic shock scenario and contingency plans. Each borrowing plan is assessed for how feasible and how sustainable it is. The final step is for all the groups involved to discuss how the contingency and borrowing plans would be enacted so that each party knows its role.

One credit rating agency noted that during the 2008 financial crisis, Ontario was slow to respond (for example, it was slow to reduce expenditures and it took only very modest steps to increase revenue) and that the slow response has had a lingering impact on Ontario's credit assessment as late as the agency's 2017 rating. Having contingency plans in place to respond to economic shocks would enable the province to increase responsiveness and potentially reduce the short-,

medium- and longer-term impacts in the event of another economic shock.

In its Spring 2019 Economic and Budget Outlook, the Financial Accountability Office of Ontario (FAO) noted that Ontario has "arguably experienced three recessions over the last four decades." Recessions are associated with reduced revenues and increased expenditures because:

- governments generally provide additional fiscal stimulus (for example, tax cuts); and
- spending on government programs that support lower-income and unemployed people increase (for example, spending on employment training and social assistance).

The FAO warned that the province's budget is susceptible to an economic downturn and that a moderate recession could increase Ontario's net-debt-to-GDP ratio to nearly 45%. As shown in **Figure 10**, the province's net debt to GDP continued to rise following the 1981, 1990 and 2008 recessions, and did not drop significantly during the periods of economic expansion between recessions.

RECOMMENDATION 2

So that the Ministry of Finance (Ministry) is better informed about the province's ability to withstand potential new economic shocks and about potential scenarios to consider when faced with new significant economic impacts, we recommend that the Ministry request that the Ontario Financing Authority:

- develop and test scenarios that consider the impacts of potential economic shocks (for example, the 2008 financial crisis); and
- use the information from these tests to advise the Ministry on optimal borrowing levels and on the response strategies, such as fiscal and economic policies, it could apply in the event of economic shocks.

MINISTRY RESPONSE

The Ministry agrees with the recommendation and will enhance the development and testing of scenarios that consider the impacts of potential economic shocks as part of its forecasting and planning process. The Ministry and the OFA will work together to consider the impact of these scenarios on the province's funding and borrowing requirements, and debt and cost of debt outlook, as well as work together to develop advice for government to inform decision-making related to the annual budget and other economic and fiscal updates throughout the fiscal year.

4.3 OFA's Management of Debt Risks Aligned with Good Practices

The OFA effectively identifies and manages the risks associated with the debt management portfolio. Its primary performance measure for the cost-effectiveness of its borrowing methods, combined with risk tolerances identified in its Financing and Debt Management Plan, conforms to good public debt management practices. One of the features of good public debt management practice is keeping costs low within a prudent degree of risk.

The OFA has made a policy decision that associates prudent risk with a targeted weighted average interest rate for its bonds throughout the year. This policy decision gives the OFA the flexibility to engage in transactions that could lower the province's interest costs for issuing domestic debt. In seven of the last nine years, the OFA issued debt domestically at a cost lower than the median of the rates it could have issued at throughout the year. The OFA calculated that this saved the province $347.5 million in interest costs on debt issued between 2008/09 and 2018/19, within a reasonable degree of risk.

In its Financing and Debt Management Plan, the OFA explains its risk tolerances for fluctuations in interest rates and for changes in the value of foreign currencies in relation to the Canadian dollar. This includes hedging a majority of these risks, which is a common practice of public debt management. Our review of the financial instruments the OFA

used to mitigate the risks and its reporting on compliance with the thresholds from the Financing and Debt Management Plan indicates that the OFA's management of debt risks within its identified risk tolerance is aligned with good practices. **Appendix 2** presents various risk measures the OFA has taken over the last five years and its performance with respect to them.

4.4 Hospitals, School Boards and Colleges Acquired Over $2.7 Billion of Debt Outside of OFA, Incurring More than $204 Million in Higher Interest Costs in Five Years

Between 2014/15 and 2018/19, hospitals, school boards and colleges acquired $2.7 billion in debt directly, meaning they did so on their own and not through the OFA. This cost the province more than an additional $204 million. For simplicity, we refer to such direct borrowing as being "outside of the OFA." Such borrowing is allowed because these public bodies or broader-public-sector entities are not required to borrow through the OFA. In some cases, the entities acquired debt themselves because they were unaware the OFA was an option, while in others they found that the OFA would not meet their needs (for example, with respect to the timing of cash flows or the term of the borrowing).

The OFA, under the *Capital Investments Plan Act*, can lend money to any public body, including:

- provincial government agencies;
- hospitals and other facilities receiving capital funds from the Minister of Health;
- colleges and universities;
- municipalities; and
- school boards.

We obtained information from the ministries of Health, Education, and Training, Colleges and Universities to determine the total debt acquired by hospitals, school boards and colleges that was outstanding as of March 31, 2019. This debt was acquired from November 17, 1997, through to March 31, 2019. Our calculations show that these broader-public-sector entities borrowed $7.7 billion outside the OFA between the 1996/97 fiscal year and 2018/19. See **Figure 14** for a breakdown of this amount by entity. Total debt outstanding as of March 31, 2019, was $5.4 billion. This means that $2.3 billion was paid back to external lenders.

Figure 14: Amount of Debt Public Bodies Acquired Outside of OFA between 1996/97 and 2018/19

Source of data: Ministry of Health, Ministry of Education and Ministry of Colleges and Universities

Sector	Total Debt ($ million)	Average Term of Debt (Years)
Hospitals	3,028	14
School Boards	4,206	15
Colleges	487	20
Total	**7,721**	**16**

We calculated the amount of additional interest paid on $7.7 billion of this debt acquired outside of the OFA, where adequate information existed to perform a reasonable calculation. By borrowing outside the OFA, the province, through its public bodies, is incurring $257.8 million in additional interest costs on debt issued from November 19, 1999, through to March 31, 2019, because these entities acquire debt from financial institutions, such as a bank, at a higher rate than what the OFA could obtain from the market through its debt-issuing mechanisms. As a result, public bodies will pay additional interest costs for on average 15 years into the future, given the lengthy maturity dates of some of this debt. As shown in **Figure 15**, public bodies have paid $27.1 million in additional interest on their outstanding debt as of March 31, 2019 (which they acquired outside of the OFA). In addition, these public bodies will pay a further $230.7 million in interest over the remaining term of this debt.

Our analysis focused on the entities listed in the *Capital Investments Plan Act* because these entities' debts are consolidated into the province's financial statements. Other entities receiving funding from the government of Ontario may also be borrowing

Figure 15: Additional Interest Costs Incurred as of March 31, 2019, and Committed to Be Incurred after March 31, 2019 ($ million)

Sources of data: Ministry of Health and Ministry of Education

Sector	Nov 19, 1999–Mar 31, 2019	After Mar 31, 2019	Total
Hospitals	15.9	229.1	**245.0**
School Boards	11.2	1.6	**12.8**
Total	**27.1**	**230.7**	**257.8**

outside of the OFA at higher rates and therefore costing the province more.

Hospitals are not required to borrow through the OFA. As of May 2018, colleges are also exempt from borrowing through the OFA when either of the following occur:

- they acquire debt under $1 million; or
- the total amount of the debt is less than 25% of the college's annual revenue and the term of debt is one year or less.

We contacted hospitals, school boards, colleges and universities regarding their reasons for acquiring debt outside of the OFA. Their responses included:

- They did not know that the OFA was a financing option.
- They found the OFA's reporting requirements onerous compared to those of external financial institutions.
- They thought the terms of the OFA's agreements were too restrictive.
- To better manage their cash flow, they prefer non-amortizing debt, which is where the principal is paid in a lump sum at maturity.

One public body that did not know it could borrow through the OFA said that the OFA advised it in pricing its debt issuance, but never mentioned that it could borrow through the OFA at a lower interest rate.

Other public bodies said that the OFA's restrictive terms did not meet their financing needs. For example:

- The OFA's lending agreement may require a public body that has any debt owing to another lender to renegotiate its repayment terms with that lender to have the OFA paid back first, before the public body can obtain a loan from the OFA.
- The OFA requires public bodies to make principal and interest payments equally throughout the term of the debt, instead of permitting the principal to be repaid at the end of the term of the debt.

The OFA began providing loans to public bodies in the 2006/07 fiscal year and has loaned $6.6 billion to school boards. In 2017, school boards started receiving all of their long-term capital financing through a transfer payment from the Ministry of Education. As a result, they no longer needed to obtain long-term capital financing externally. Prior to 2017, school boards had obtained $3.4 billion in debt externally for capital additions, and they continue to make principal and interest payments on this debt.

School boards borrow externally for short-term operating and capital funding because the OFA provides only long-term financing. Since 2017, school boards have borrowed $773 million outside of the OFA (excluding lines of credit). As of March 31, 2019, school boards also had access to $458 million in lines of credit, of which $55 million was drawn. On average, the difference between the interest rates on these lines of credit and the interest rate the OFA could obtain on the market was 1.13%.

We found that it is uncommon for government entities in other jurisdictions to borrow directly rather than through their government debt manager, although it has happened in a few cases. For example, the following entities issue their own bonds:

- The Canada Housing Trust and Export Development Canada (federal government);
- The Crown Labrador Hydro (Newfoundland); and
- Hydro Québec (Quebec).

RECOMMENDATION 3

To reduce the interest cost incurred on the province's debt, we recommend that the Ministry of Finance reassess public entities' borrowing options to require public bodies to borrow through the Ontario Financing Authority where savings to the province could be achieved.

MINISTRY RESPONSE

The Ministry accepts the recommendation as it would reduce the province's interest on debt cost.

The OFA will review options with the Ministry for expanding its loan program, and work with other ministries with responsibility for broader-public-sector agencies and entities, to inform them of the potential cost advantages of borrowing through the OFA. Long-term loans that meet a minimum threshold will initially be looked at as this is where there is the greatest potential for cost savings. Short-term loans are more challenging to administer and do not yield the same level of cost savings as long-term debt.

4.5 OFA's Surplus from Loan Administration Charges to Public Bodies Not Used to Reduce Debt Costs or Earn Interest

Beginning in the 2006/07 fiscal year, when the OFA began providing loans to government bodies, it charges them a higher interest rate than what it pays in the market. These charges are intended to recover the administrative costs that the OFA incurs to manage these loans (such as OFA staff time). The Ministry of Finance provides funding to the OFA to cover all of its costs including the costs to administer loans. Therefore, these charges resulted in the OFA holding a surplus of $32.2 million as of March 31, 2019.

The OFA has not used this surplus to reduce debt or fund programs. The funds are held in a bank account because the OFA did not believe the amount was high enough to warrant investment. In 2015/16, our Office recommended that the OFA develop a policy to determine the best use of these funds, but as of October 2019, the OFA has not created one.

As of October 2019, the Ministry had not requested the OFA to remit this surplus to reduce debt. The surplus does not need to be paid into the Consolidated Revenue Fund until the Minister requests it.

RECOMMENDATION 4

To reduce the province's debt, we recommend that:

- the Ministry of Finance request that the Ontario Financing Authority provide to the province its surplus administrative fees earned to date; and
- the Ontario Financing Authority review and revise the administrative fees it charges to keep them at or below its actual administrative costs, so that public bodies do not have to borrow more money just to pay administrative fees to the Ontario Financing Authority.

MINISTRY RESPONSE

The Ministry accepts this recommendation and will work with the OFA and its Board of Directors to determine the most cost-effective approach to manage the OFA's surplus.

OFA RESPONSE

The OFA accepts the recommendation to continue to review its loan administration fees to ensure that the fees accurately reflect the cost incurred in administering loans.

4.6 Province Could Save Commission Expenses by Expanding Debt Auctions

Between 2014/15 and 2018/19, the OFA spent $508.9 million on commissions paid to syndicates to issue its domestic debt without formally considering expanding its use of debt auctions, which are less costly, to better align with common practices for large, regular issuers of debt.

The OFA issues most of its domestic debt (in the form of government securities such as bonds) through syndication (meaning to groups of banks to which it pays commissions). Investors then purchase these Ontario bonds through the banks involved in the syndicate. Between 2014/15 and 2018/19, the OFA issued syndicated domestic debt totalling $112 billion, and it paid commissions totalling $508.9 million. The OFA did not perform any analysis to determine whether, in light of these commission fees, issuing debt through syndicates achieved value for money for the province. It also did not assess the extent to which the province should issue debt through syndicates instead of through the no commission cost option of issuing through auctions.

Debt auctions involve the OFA making a public announcement outlining the quantity and type of debt to be auctioned. Banks and investors can call the OFA to place their bids (that is, the amount of debt they wish to acquire and the interest rate they are willing to pay) on the day of the auction. The winning bidders (those that bid the lowest interest rates) are notified, and the results of the auction are made public. The OFA advised us that an auction requires less than two hours of its staff time.

Ontario has the highest sub-sovereign debt in the world, equalling the debt of many countries. As **Figure 7** shows, few sub-sovereign jurisdictions manage a comparable amount of debt—Ontario's debt is more than twice that of California, the sub-sovereign with the third-highest debt. By comparison, in countries belonging to the Organization for Economic Co-operation and Development (OECD), debt auctions are the most common process for issuing debt. Some smaller countries in the Eurozone combine auctions with syndication. Countries in the Eurozone that are similar to Ontario, in that they are large, regular borrowers, use auctions for issuing debt. **Figure 16** lists the most indebted Eurozone countries and Ontario. Canada also uses auctions, while other provinces that issue smaller amounts of debt use syndication.

The OFA says a key concern with using debt auctions is the possibility of a failed auction. A failed auction results when the supply of debt the borrower attempts to issue exceeds demand in the investment community. In the worst case, the OFA is concerned that it could have to cancel an auction, which could affect its credibility with investors. Unlike most sovereign nations, Ontario does not have a central bank to purchase Ontario's debt should the auction not have adequate demand.

Between 2014/15 and 2018/19, the OFA auctioned debt only four times, issuing debt totalling $3 billion. Debt issued through auctions had an average term of three years. The OFA pays no commission fees on these auctions, and the OFA says there are no significant costs associated with the auctions. In the auctions held by the OFA, the average cost was similar to the market rate of interest that would have been obtained through syndication. Although on individual auctions the OFA had obtained interest rates both lower and higher than expected through syndication, generally there have been overall savings on the average interest costs compared with the market rate of interest that would have been paid through syndication.

RECOMMENDATION 5

To reduce the cost of issuing debt, we recommend that the Ontario Financing Authority perform a formal assessment of its domestic-debt-issuing strategy and consider the costs and benefits of increasing the amount of debt it issues through auctions.

Figure 16: Top 15 Eurozone Countries Based on Gross Debt Outstanding and Their Use of Auctions and of Syndication, as of December 2018

Source of data: Eurostat: General Government Gross Debt

	Gross Debt Outstanding ($ million Cdn)	Auctions	Syndication[1]	
			First Issuance[2]	Domestic[3]
Italy	3,553,058	✓	✓	
France	3,542,869	✓	✓	
Germany	3,157,065	✓	✓	
United Kingdom	3,143,314	✓		
Spain	1,795,088	✓	✓	
Belgium	703,357	✓		✓
Netherlands	620,386	✓		
Greece	511,964	✓	✓	
Austria	435,737	✓		✓
Portugal	374,755	✓	✓	
Poland	367,967	✓		
Ontario	**354,264**[4]	✓		✓
Ireland	315,549	✓		
Sweden	277,409	✓		✓
Finland	210,471	✓	✓	
Denmark	155,215	✓		

1. This column shows that these jurisdictions mostly use syndication when issuing a new type of bond for the first time.
2. Syndication for first time the jurisdiction issues a new type of bond in its domestic market.
3. Syndication for issuance of bonds that are already available in the domestic market.
4. Debt as of March 31, 2019.

OFA RESPONSE

The OFA agrees with the recommendation and will perform a formal evaluation of the costs and benefits of increasing the use of auctions as a method of funding.

4.7 OFA Does Not Formally Assess Cost of and Need for Issuing Debt in Foreign Markets

The OFA does not do a formal assessment of whether the increased cost of issuing debt in foreign markets benefits the province. For example, we found that between April 1, 2014, and March 31, 2019, issuing debt in international markets (instead of within Canada) resulted in obligations to pay an estimated $47.2 million in additional interest and hedging costs. The OFA told us that before issuing debt in a foreign market, OFA staff discuss the cost and consider the associated risks and benefits. But the OFA did not keep records documenting its discussions or reasons, so we were unable to review what the OFA considered before issuing debt in foreign markets.

We found that the OFA issued, on average, 25% of its debt instruments ($43.6 billion), such as bonds, in foreign markets between 2014/15 and 2018/19. The amount issued in foreign markets at a cost exceeding domestic issuances totalled $36.8 billion and ranged from $6.2 billion in 2015/16 (about 18% of total debt issued that year) to $12.8 billion in 2017/18 (about 38% of debt issued that year). Because of the higher overall cost

of issuing this foreign debt compared to debt issued in Canada, this will cost the province an estimated additional $221.8 million in interest and hedging costs from the time it was issued until all payments are made on the debt. See **Appendix 7** for an explanation of the methodology used to quantify this cost estimate for issuing debt in foreign markets. The term of debt issued in foreign markets during this period averaged 5.7 years and ranged from three to 25.4 years.

For example, on January 18, 2019, the OFA issued $2.5 billion in five-year fixed rate bonds in the United States at an interest rate of 2.7%, including the cost of mitigating the foreign exchange risks. On that same day, the interest rate on five-year bonds in Canada was 2.6%. It will cost the province an additional $20 million in interest payments over the five years of these bonds because of the premium in interest rate that applies for having the debt issued in the United States instead of Canada.

Besides the higher costs associated with issuing debt outside of Canada, there are higher risks associated with foreign debt, according to the OFA's Financing and Debt Management Plan. The risks include credit risks associated with entering into financial transactions with other parties to mitigate the foreign exchange risk (as explained in **Section 2.3**). As well, there is more administrative work (in the form of jurisdictional filings) when debt is issued outside of Canada, as well as more regulations to comply with.

Despite its preference for issuing debt in Canada, the OFA said that it issued debt in foreign markets to prevent the risk of higher debt costs in the Canadian market due to oversaturation. That is, if the demand in the domestic market does not continue to match the amount of debt the OFA intends to issue, issuing more debt domestically could result in the OFA having to pay higher interest rates. The OFA had not attempted to estimate the likelihood or extent of these higher interest rate costs or whether they would be more or less than the costs of issuing debt in foreign markets.

The OFA also said it continues to issue debt in foreign countries to maintain a presence in international markets so that it can access these markets in the future if needed. The OFA reasons that there might be costs of re-entering a market after a sustained absence. We found that the OFA has not documented any analysis demonstrating the quantity of debt it would need to issue in foreign markets, or the frequency of such issues, in order to reduce or eliminate the costs of re-entering these markets. Further, it has not done a written assessment identifying whether—and to what extent—these additional costs or barriers actually exist or whether the costs currently being incurred covers them.

From discussions with other Canadian jurisdictions, we learned the following:

- After not issuing debt in foreign markets since 1999, the federal government issued $3 billion US in debt in September 2009, and another $2 billion EUR in debt in January 2010. The federal government encountered no significant barriers to re-entering these foreign markets after absences of 10 years. Both issues were highly successful, with more demand than the quantity of bonds issued.
- Alberta, having issued very little debt in international markets for 15 years, issued $23.9 billion in debt, primarily in the United States and Europe, between April 2015 and March 2019. To do this, Alberta promoted itself internationally through investor relations-type activities and re-established proper documentation with local regulators. Alberta told us that it did not pay any additional costs due to higher interest rates, even though it was mostly absent from international markets for over a decade.

The OFA noted that the estimated costs of issuing debt in foreign markets (where it is assumed that hedging will be immediately used to eliminate the foreign exchange risk) have been higher than the actual costs historically recorded. This is because the actual costs of the hedging

instruments used were less than estimated. The OFA calculated that the use of forward contracts has resulted in reducing the cost of issuing foreign debt to $47.2 million, from their originally estimated $221.8 million. The OFA advised us that this reduction might no longer be pursued in the future, due to a change in accounting policy (see **Section 4.10** for further details).

RECOMMENDATION 6

To further minimize the interest costs of debt assuming a reasonable level of risk, we recommend that the Ontario Financing Authority:

- formally assess the amount and frequency of debt it should issue in foreign markets; and
- document its assessment of the costs and benefits of issuing debt in foreign markets instead of domestically before issuing debt, and retain this information to support current decisions and inform future ones.

OFA RESPONSE

The OFA accepts the recommendation to perform a formal assessment of the amount and frequency of debt issued in foreign markets. The OFA will formally outline the assumptions and potential costs involved in its planned use of foreign debt issues.

Since foreign borrowing tends to be more expensive than domestic borrowing, the costs and benefits are always considered and discussed prior to a foreign debt issue. The OFA agrees with the recommendation to document the rationale for foreign issuance and has started to document and retain this information based on conversations with staff from the Office of the Auditor General during the value-for-money audit.

4.8 OFA Has Not Established Optimal Amount of Costly Liquid Reserve to Hold

The province's liquid reserve, which essentially consists of cash and short-term investments, is needed to meet spending and debt payment obligations in the short term. The OFA has not performed a cost/benefit analysis to determine the optimal amount of liquid reserve to carry at any point in time. Nor does it have a policy on how much cash and short-term investments to maintain in its liquid reserve above the minimum cash requirements needed to meet the province's daily operating costs. As of March 31, 2019, the liquid reserve was $36 billion.

Liquid reserves are costly in that the interest rates they earn are less than the interest costs of the province's borrowings. In Ontario, the liquid reserve earned interest at an average annual rate of 1.67% during the 2018/19 fiscal year, while the province's average annual borrowing rate was 2.42% for new debt issued during the year. In other words, every billion dollars that the province held in liquid reserve in 2018/19 cost it $7.5 million in that year. This is because in order to maintain a liquid reserve, the province has to increase its quantity of debt issued above its requirements for operating and capital costs. On the other hand, having a sufficient liquid reserve on hand protects the province from the risk of cash shortfalls when having to meet immediate and unanticipated needs. So the cost of holding liquid assets should be minimized within an acceptable level of risk.

In its annual Financing and Debt Management Plan, the OFA considers various scenarios of cash requirements to forecast liquid reserve needs to ensure enough is maintained to meet its spending and debt payment obligations. Considerations in addition to maintaining the minimum liquid reserve level of one month's cash needs include significant debt maturities in the short and medium term, the pace of the annual borrowing program, the timing of cash flows to the province and collateral requirements.

The OFA has never performed a cost/benefit analysis to determine the optimal level of liquid reserve to hold in light of these factors, nor has it established a ceiling for these reserves. Rather, the OFA calculates the cost of the prior year's liquid reserve and provides a forecast of planned year-end levels of liquid reserve.

The OFA maintained, on average, $32.6 billion in its liquid reserve during the 2018/19 fiscal year. The province's cash requirements during that period were on average $9.6 billion each month. This meant the province was holding the equivalent in liquid reserve of about 3.4 months' worth of cash requirements. Over the last five years, the province has held on average 2.8 months' worth of liquid reserve.

The federal government has previously maintained about one month's worth of cash requirements as liquid reserve but now typically exceeds this amount, recently earning more in interest on its liquid reserve than its cost to borrow. Alberta has a target of holding cash requirements equal to the most costly three months of the year.

The liquidity coverage guideline proposed in the Third Basel Accord, commonly referred to as Basel III, a voluntary set of global banking regulations developed to promote stability in the international financial system, is a minimum of one month's worth of cash requirements. In its Financing and Debt Management Plan, the OFA identifies that it monitors one month's worth of cash needs, consistent with the Basel III recommendation. This serves as the minimum threshold for liquidity, and if the liquid reserve is reduced beyond this point the OFA is to develop a strategy to increase liquid reserve to this minimum level. The province's liquid reserve has always exceeded the one-month minimum, dropping as low as 1.6 months' worth of cash requirements in January 2017.

An entity's liquidity levels are an important consideration for both credit rating agencies and investors. This is because a liquid reserve reduces the risk of the entity being unable to make payments on its debt obligations. The amount of liquid reserve held has an influence on how much debt investors are willing to buy and the interest rates they require. One credit rating agency informed the OFA that a reduction in the province's liquid reserve to one-month's cash requirements would have a "downward pressure" on its credit rating. The OFA did not obtain a confirmation of whether this would result in a reduction in its credit score. The OFA indicated that "downward pressure" in one area may not reduce the province's credit score.

The OFA does not assess the cost impacts associated with varying levels of its liquid reserve. Therefore, these costs are not considered when determining the optimal level of liquid reserves based on the province's need to access the liquid reserve for its immediate cash requirements in the event of an economic shock.

We calculated the cost of the OFA maintaining the liquid reserve above its one-month minimum and determined that holding the level of liquid reserve cost the province about $172 million in additional interest costs in 2018/19. Applying this same logic to the last five years (that is, between 2014/15 and 2018/19) indicated that additional interest costs of $761 million were incurred to hold a liquid reserve above the OFA's one-month minimum. A standard of one month's cash requirements may not be adequate for Ontario when considering its risk tolerance and the potential impact on its credit score. These factors need to be considered in determining the optimal level of liquid reserve.

When the OFA calculates the cost of holding a liquid reserve it uses the cost of floating rate debt, instead of the average cost of all debt issued throughout the year. Floating rate debt has a lower interest cost. However, the liquid reserve does not only hold funds obtained through issuing floating rate debt. Whether the funds are obtained through floating rate debt or fixed rate debt they are held in the liquid reserve until they are used to meet the province's cash requirements. Using the OFA's metric to calculate the cost of holding a liquid reserve above the one-month minimum would result in

a $55-million cost for 2018/19, and $250 million over the last five years. Whether its metric is used or our Office's metric, there exists a potential cost savings ranging from $55 million to $172 million, for 2018/19.

The OFA informed us that it has never had to use its liquid reserve to meet spending and debt obligations as a result of an economic shock. This is because it has always had access to capital markets for its short-term borrowing, even during the financial crisis in 2008. Given this, it is reasonable to assume that the OFA could maintain a liquid reserve lower than the current level of 3.4 months while not going below its one-month minimum. Carrying an amount in excess of the OFA's one-month minimum results in additional costs to the province.

RECOMMENDATION 7

To reduce the costs of holding more liquid reserve than needed while still staying within a reasonable risk tolerance level, and enable the savings to go to paying debt and interest costs, we recommend that the Ontario Financing Authority:

- analyze the province's cash-flow requirements and establish an optimal liquid reserve target, considering the costs and benefits (such as the risk of being unable to meet immediate cash needs and the risk of impacting the province's credit rating) of holding different levels of its liquid reserve; and
- regularly monitor and report on the amount of the reserve and the costs and benefits of effectively managing it.

OFA RESPONSE

The OFA agrees with the importance of reducing the cost of holding liquid reserves. The OFA will enhance the assessment and reporting of liquid reserves consistent with the recommendations, and will look for opportunities to reduce the cost of holding liquid reserves.

Liquid reserves are an integral component of Ontario's overall liquidity management. Liquid reserves are used to meet daily operating requirements that include debt maturities, as well as providing support and flexibility for Ontario's annual borrowing programs and credit rating. Liquid reserve levels are monitored and reported daily.

On average, the province held $32.6 billion in liquid reserves in 2018/19, which represented about 3.4 months of cash requirements. The OFA views holding liquid reserves equivalent to one month of cash requirements as being much too low given the size, timing, and variability of the province's cash requirements and credit rating considerations, and may limit the OFA's ability to take advantage of favourable borrowing opportunities. The OFA accepts this recommendation and will focus on assessing the cost/benefit of liquid reserves while maintaining prudence in overall liquidity management.

4.9 OFA Meeting Requirements on Investments for Other Entities

The OFA effectively manages the investment activities for seven of its "clients" (public bodies) and for the Used Fuel Segregated Fund and the Decommissioning Segregated Fund (nuclear funds) established under the Ontario Nuclear Funds Agreement (ONFA) by consistently meeting its clients' investment objectives and by facilitating returns that exceed performance benchmarks.

The OFA managed discretionary investments totalling $1.3 billion as of March 31, 2019. Over the past five years, in the management of its clients' discretionary investments, the OFA has exceeded its performance benchmarks. For example, the Pension Benefits Guarantee Fund valued at $832 million as of March 31, 2019, earned an average return of 1.19%, exceeding the market benchmark of 0.96% over the last five years.

Together with Ontario Power Generation, the OFA is responsible for managing the assets of the nuclear funds, totalling $22.4 billion as of March 31, 2019. The primary objective is to have sufficient funds to meet the payment obligations associated with nuclear plant decommissioning and disposal costs associated with used nuclear fuel. The ONFA requires a diversified investment portfolio, which was selected to help attain returns to meet the decommissioning costs while also reducing risk to safeguard the assets to ensure they will be available when needed for decommissioning. The OFA and the OPG together engage external private-sector investment management companies to invest the funds in accordance with the ONFA objectives. As of March 31, 2019, the nuclear funds have earned a 7.29% rate of return since their inception on July 24, 2003, exceeding the market benchmark of 6.78%.

4.10 OFA Plans to Spend $54 Million More a Year for Financial Statement Debt to Better Match the Net Debt Projected in Budgets

Changes in accounting standards that are expected to take effect in 2021 may result in the OFA choosing to incur higher-than-necessary costs for its foreign currency transactions. The OFA would incur these costs in order to make the province's interest on debt and the net debt numbers shown in the province's consolidated financial statements align more closely to the interest on debt and net debt numbers projected in the provincial budgets. The OFA interprets provincial directives requiring the Ministry of Finance to operate within its budgeted allocation as requiring the OFA to match the interest on debt numbers in the province's financial statements to the numbers projected in the provincial budgets. It estimates to do so it will cost taxpayers an extra $54 million a year in higher interest costs after the new accounting standard is in effect.

Currently, the OFA uses two types of financial contracts to manage the risks of fluctuations in the exchange rate between foreign currencies and the Canadian dollar. One type—currency swaps—commonly costs more than the other type: forward contracts. Applying current accounting standards, regardless of which financial contract is used, the debt reported in the financial statements is treated as protected, or "hedged," from exchange rate fluctuations. Using either type of financial contract provides the same impact on the interest on debt, compared to the budgeted interest on debt.

Under the changes in accounting standards expected in 2021, the debt reported in financial statements will no longer be treated as protected from exchange-rate fluctuations when the OFA uses the cheaper forward contract to manage risk. While the economic substance of the debt is not affected by exchange-rate fluctuations, such fluctuations would cause the interest on debt and the net debt on the financial statements to vary from the interest on debt and the net debt projected in the budget. **Appendix 8** shows the financial statement impact of the proposed change in accounting standards.

The OFA told us that when the new accounting standards are in place, it may decide to use only the more expensive currency swap in its foreign currency transactions to ensure that its financial statement debt is protected from fluctuations and so that the interest it reports on debt will vary minimally from the interest on debt and net debt projected in the government's budget.

The OFA estimates that, if only currency swaps are used when the new accounting standards take effect, it will pay $54 million in additional interest costs every year. This money will be spent so that the province can reduce the volatility of reported results relative to budget, and to avoid needing to explain that volatility (i.e., having to explain to users of its financial statements the fluctuations in the net debt and interest expense numbers and why they appear not to align with the corresponding projected budget numbers). Incurring costs for the purpose of achieving a favourable accounting

outcome on paper is not consistent with the OFA's mandate of managing financial risk as cost effectively as possible.

Prior to 2008/09, the OFA would use interest rate swap agreements in conjunction with issuing short-term debt to, in effect, create long-term fixed-rate debt. The value of these agreements entered into totalled $7 billion between 1998/99 and 2008/09, and the OFA calculated that this saved the province $194.3 million in reduced interest costs. The OFA said that it had discontinued this practice in anticipation of the adoption of the new accounting standard (given that, once the new accounting standard comes into effect, continuing the practice may result in reported outcomes appearing to deviate from budget because of interest rate fluctuations).

RECOMMENDATION 8

To better maximize value for money in the business practices of the Ontario Financing Authority (OFA), and to follow the new accounting standard should it be effective as currently proposed in 2021, we recommend that the OFA:

- incorporate the impact of the potential volatility arising from implementing the change in accounting standards in its debt planning; and
- use the most cost-effective methods to manage the risk of fluctuations in exchange and interest rates.

OFA RESPONSE

The OFA accepts the recommendation to use the most cost-effective methods to manage the risk of fluctuations in foreign exchange and interest rates. Ontario and most other senior governments in Canada are working with the Public Sector Accounting Board (PSAB) to ensure their collective concerns on the introduction of fair-value accounting and its inherent volatility are reflected in the new standard on financial instruments.

The OFA will take steps to prepare for the implementation of the new standard and will consult with the Office of the Auditor General on best practices, including minimizing volatility for the province, strong internal controls and audit evidence required to operationalize them. As part of the implementation, the OFA will also review its borrowing strategy in light of the impact of this new standard.

4.11 No Operational Reviews of OFA's Organizational Structure and Staffing Levels

The OFA has an operating structure that is unique in Canada, being the only provincial debt management agency, and has more than twice the number of debt managers of the other provinces and the federal government. Twenty-three of the OFA's staff receive performance pay, which is not done in other provinces or the federal government, and are being paid significantly more than their comparable counterparts. The Ministry of Finance has never formally compared this operating structure to that of other provincial or federal debt managers.

The OFA has never reviewed its operations to determine whether the current structure and staffing level and mix are optimal to achieve its mandate in a cost-effective manner. **Figure 17** breaks down debt management staffing levels by jurisdiction in contrast with total debt managed. The OFA informed us its view is that it is not possible to compare its operations to debt managers in other jurisdictions because the debt-management operations and mandate of each jurisdiction vary.

Neither the Minister of Finance nor the Treasury Board has ever performed an operational review of the OFA relating to staffing levels and organizational structure.

We were told in May 2019 that 10 staff will be leaving the OFA through the Voluntary Exit Program before the end of 2019 and that these vacancies will not be filled. This will reduce the OFA's staff by 6%. The Human Resources and Govern-

Figure 17: Debt Management Staffing and Debt Management by Canadian Jurisdiction[1]

Source of data: Survey responses and consolidated financial statements from other jurisdictions

Jurisdiction	Debt Issued in 2017/18 ($ billion)	Debt Outstanding as of March 31, 2018 ($ billion)	Staff Involved in Debt Management
Federal	258.0	721.2	30
BC	2.1	65.4	25
AB	17.3	63.5	14
MB	6.4	47.0[3]	13
ON	**33.3**	**337.4**	**62[2]**
QC	17.9	201.9	18
NB	1.8	17.2	13
NL	1.2	11.7	6
PE	0.0	2.1	2

1. Data not available for Nova Scotia and Saskatchewan.
2. Ontario has 172 staff. OFA indicated that 62 of them are involved in debt management.
3. Includes $19.1 billion of debt managed on behalf of the Manitoba Hydro Electric Board.

ance Committee of the OFA's board says it has no resource concerns regarding these departures and that the OFA will continue to be able to effectively achieve its mandate.

Unlike other jurisdictions in Canada, where debt management is done by a branch of the ministry or department of finance, the OFA is set up as a separate agency. This agency structure has led to a unique compensation structure in that Ontario is the only province to provide staff involved in debt management with performance pay. We found that the compensation ranges for the 23 staff involved in debt management receiving performance pay were higher than that of other jurisdictions. The average pay for staff receiving performance pay was $223,736 as of March 31, 2019; the compensation range for staff receiving performance pay (including the performance pay) was from $118,407 to $647,347. **Figure 18** shows the compensation ranges in other jurisdictions.

Unique to the OFA, one of these debt management staff receiving performance pay is the Chief Financial and Risk Officer (CFRO). This position combines the senior management responsibilities for finance and risk into one role. This makes the CFRO responsible both for the OFA's financial and operating activities and for assessing the risk of these activities. In essence, the CFRO is in the position of assessing their own work, which is contrary to best practice. Specifically, there is the risk that the CFRO will not properly identify, for example, that operational issues may be negatively affecting financial performance because they are biased in assessing their work in managing and overseeing operations.

Figure 18: Debt Management Compensation by Canadian Jurisdiction

Source of data: Public-sector compensation disclosure from government websites in other jurisdictions and survey responses from other jurisdictions.

	High End of Compensation Range ($)	Low End of Compensation Range ($)
AB	198,000	62,000
BC	223,000	60,000
MB	138,000	60,000
ON	**647,000**	**118,000**
NB	124,000	60,000
NL	137,000	60,000

RECOMMENDATION 9

To enable operational efficiencies at the Ontario Financing Authority (OFA) that will improve value for money, we recommend that the Ministry of Finance, in conjunction with the OFA, evaluate and determine the optimal organizational structure and staffing size to cost-effectively achieve the province's debt management objectives.

MINISTRY RESPONSE

The Ministry agrees to undertake a formalized review of the OFA's organization structure and staffing, to be conducted in consultation with the OFA and its Board of Directors.

4.12 OFA Lacks Measures to Adequately Report on Performance

Of the OFA's 33 performance measures, 25 were not objective measures of performance. Instead, these 25 measures related to reporting or operating requirements that the OFA has the responsibility to perform. All that is measured is whether the OFA has or has not completed the requirement, rather than measuring how effectively the OFA is performing in these areas. For all of them, the OFA indicated that it was in compliance. For example:

- Reporting requirements:
  - "Stress testing is performed and reported on a monthly basis."
  - "Interest on debt forecasts to be provided monthly."
- Operating requirements:
  - "Provide an advisory role at Infrastructure Ontario's CRC meetings."
  - "Following the release of the Budget, senior OFA and Ministry of Finance staff will meet with the rating agencies."

Of the remaining eight measures, half lack evaluation criteria that can be applied to the measurement, or are not supported. For example:

- "Ensure that the [Ontario Savings Bond] program is cost-effective" (there is no criterion for evaluating cost-effectiveness). After always being reported to its board as meeting the cost-effective measure, the OFA said this program was discontinued in 2018/19 because it was not cost-effective.
- "Generate actual returns within ±2 basis points [0.02 percent] of the benchmark portfolio" (the OFA was not aware of how this target was selected and could not provide support for it, so we could not determine if achieving this target indicated good performance).

The Memorandum of Understanding (MOU) between the Minister of Finance and Chair of the OFA board requires that an Annual Business Plan (Plan), approved by the board, be provided to the Minister for approval. Under the MOU, the Chair of the board is responsible for ensuring that the Plan contains performance measures that include:

- goals;
- the method of achieving these goals;
- the targeted results; and
- associated time frames.

In our review of the performance measures in the Plan, we found that these elements were generally absent. Specifically, measures rarely contained assessable goals or clear timelines, and, where methods of achieving the goals were communicated, the methods were contained in other documents that were not directly referenced.

The OFA's publicly accessible business plan indicates that the OFA has performance measures that it uses internally and reports to its board. The OFA does not publicly report on many of its measures and where it does report, in most cases it does not disclose its performance against its targets, limiting Ontarians' ability to understand or gauge the OFA's performance.

RECOMMENDATION 10

To effectively measure and report on all significant activities within its mandate, we recommend that the Ontario Financing Authority:

- identify objective outcome measures of performance for all its activities;
- set reasonable targets and regularly reassess the relevance and effectiveness of these targets, updating them as needed; and
- publicly report on its targets and the results achieved.

OFA RESPONSE

The OFA agrees with this recommendation and will review its performance measures with a view to increasing objectivity. As part of this review, the OFA plans to revisit which performance measures, targets and outcomes are publicly reported, with a focus on reporting key measures.

Performance measures are set out in the OFA's Annual Business plan, which is approved by the OFA Board and affirmed by the Minister of Finance. Related performance targets are evaluated and reported to the OFA Board on a quarterly basis. Overall results for some measures are published in the OFA's Annual Report.

Appendix 1: Process Descriptions

Prepared by the Office of the Auditor General of Ontario and the Ontario Financing Authority

Borrowing and Debt Management

The OFA annually creates a Financing and Debt Management Plan (Plan) that outlines the type, amount and methods of issuing debt. The first step in determining the borrowing requirements of the province is to analyze the budget and see what the funding shortfall is. The OFA bases the borrowing requirements on the projected surplus or deficit (adjusting for non-cash items such as amortization of capital assets), the province's planned investments in capital assets, and the amount of provincial debt that is maturing. The OFA then develops a plan to meet the province's borrowing needs by creating ranges for the average term of debt and the amounts of domestic and foreign debt to be issued.

The OFA issues its debt primarily through syndicates that purchase bonds for resale to investors, guaranteeing the sale of all bonds issued at an identified interest rate. The OFA pays a commission fee for this service. Prior to issuing debt, the OFA calls the lead banks in the syndicate to inform them of the interest rate and quantity of bonds to be issued. These are determined from daily discussions with the banks, which provide the OFA with information on the demand for the province's debt among their investor base.

Risk Management

Debt management involves the mitigation of risks. The OFA works toward reducing risks to an acceptable level for the province. As outlined in the Financing and Debt Management Plan, when considering debt issuance, the OFA identifies ranges of acceptable levels of risk for fluctuations in foreign exchange, credit exposure and interest rates. The OFA Board approves these ranges.

To mitigate the risks, the OFA uses hedging—it purchases financial instruments that change in value based on interest-rate and foreign-exchange benchmarks. These financial instruments are referred to as derivatives. The main derivatives used by the OFA are swaps, forwards and futures. See **Appendix 8** for a definition of these instruments.

The OFA then regularly assesses its level of exposure to risks, in accordance to the thresholds outlined in the Financing and Debt Management Plan, and reports the results to the OFA Board and a committee of the OFA.

Liquidity/Cash Management

The objective of cash management is to ensure that the province has sufficient cash available to meet its financial obligations. Under the Financing and Debt Management Plan, the OFA has set a minimum threshold of having enough cash available to meet one month's financial requirements. To manage cash flows, the OFA tracks the amount of cash held in banks each morning and updates projected cash outflows and inflows. The Capital Markets Division receives this information daily and issues short-term Ontario Treasury Bills and US Commercial Paper as needed to meet the liquidity requirements. Liquidity is managed through issuing short-term debt if the amount of cash and short-term investments held is below the amount the OFA determines is required to meet the province's financial obligations.

Investments

The OFA provides investment services to seven public bodies (clients), see **Section 2.1.5**, and the province's Nuclear Funds Agreement (ONFA). An investment management agreement is established between the client and the OFA to outline the roles and responsibilities of the OFA.

Discretionary clients are those that have contracted with the OFA to make investment decisions on their behalf. The OFA makes investments for these clients in low-risk short-term investments such as government-issued treasury bills and commercial paper, as well as banker's acceptances that have a fixed rate of return to maturity and government bonds of different maturity dates.

Each discretionary client develops risk and return parameters in conjunction with the OFA, which include investment objectives and applicable performance benchmarks. The OFA monitors the performance of the investments and its compliance with these parameters, and reports this back to the client and the OFA board quarterly.

Non-discretionary clients make their own investment decisions based primarily on their cash flow needs. The OFA offers non-discretionary clients the opportunity to invest in Ontario treasury bills and bonds, and executes these investment transactions as directed by the client.

The OFA jointly manages the ONFA funds with Ontario Power Generation Inc. (OPG). The main objective of the ONFA is to ensure sufficient funds are available to pay for future costs of decommissioning nuclear stations and disposing of nuclear waste and used fuel. These funds have a requirement for meeting a long-term real return target. In order to meet the target, the funds are invested in a mix of equity, fixed income and real assets. Investment decisions are made jointly with staff from the OFA and OPG. The OFA, with the OPG, measures the performance of investment activities, and reports back to a joint OFA and OPG committee and the OFA board.

Appendix 2: Risk Measures

Source of data: Ontario Financing Authority

	2014/15		2015/16		2016/17		2017/18		2018/19	
	Target	Actual	Target	Actual	Target	Actual	Target	Actual	Target	Actual
GFRE[1] (%)	9.7–13.7	12.2	9.7–13.7	13.6	10.4–14.4	13.4	11.4–15.4	13.8	11.4–15.4	12.9
FEE[2] (%)	<2.5	0.3	<2.5	0.3	<2.5	0.2	<1.25	0.2	<5	0.2
NIRRE[3] (%)	<35	11	<35	10.9	<35	11.1	<35	11	<35	10.8
Term[4] (years)	7.0–14.0	13.8	6.4–15.1	17.5[5]	6.9–13	13.9[5]	6.9–13	12.9	7.9–13	12.7

1. **Gross Floating Rate Exposure (GFRE):** The portion of provincial debt that is subject to fluctuations in market changes in interest rates.
2. **Foreign Exchange Exposure (FEE):** The net exposure of provincial debt to changes in foreign exchange rates. The FEE relates to the risk that the foreign currency debt principal and interest payments and foreign currency transactions will vary in Canadian dollar terms because of fluctuations in foreign exchange rates.
3. **Net Interest Rate Resetting Exposure (NIRRE):** The amount of debt issued by the province that is subject to changes in interest rates over the next 12 months. The NIRRE includes floating rate debt and fixed rate debt maturing within the next 12 months minus the liquid reserve investments on hand.
4. **Average Term of New Borrowing (Term):** The weighted average term of debt issued by the province in the year.
5. When actual amounts exceeded the approved range, the Ontario Finance Authority went back to the board for approval to exceed the range.

Appendix 3: Ontario Financing Authority (OFA)

Source of data: OFA

As of March 31, 2019, the OFA employed 172 full-time-equivalent (FTE) staff who worked in seven divisions. Here is a description of the activities carried on by the divisions, as well as an indication of the number of FTEs in each division.

Capital Markets Division (33 FTE)
• developing and executing the province's borrowing and debt management programs;
• investing funds for the province and specific government entities;
• providing investment, borrowing, and debt services to the Ontario public sector;
• conducting investor relations activities;
• maintaining debt management-related documentation; and
• running the Ontario Savings Bond program.
Corporate and Electricity Finance Division (33 FTE)
• providing financial advice to the Minister of Finance, ministries, Crown agencies, and other public bodies on policies and projects; and
• providing financial advice on electricity reforms and supply initiatives, as well as on the financial performance of Ontario Power Generation, Hydro One, the Ontario Electricity Financial Corporation, and the Ontario Nuclear Funds Agreement.
Finance and Treasury Division (45 FTE)
• settling, accounting and reporting on the province's and the Ontario Electricity Financial Corporation's debt, interest on debt, and investments; and
• providing centralized cash management and banking services to the province.
Legal Branch (6 FTE)
• providing legal advice; and
• acting as Corporate Secretary to the board of directors.
Risk Control Division (17 FTE)
• setting risk management policies, maintaining information related to risk exposures, market values and performance measurements of capital market transactions and portfolio;
• monitoring and forecasting public debt interest;
• maintaining Ontario's relationship with credit rating agencies; and
• reporting to the board on changes to bank credit limits, exceptions to policies, and breaches of credit exposure limits.
Strategic Corporate Services Division (32 FTE)
• responsible for IT infrastructure and network management, electronic business solutions and physical security management; and
• Human Resources functions and general office administration.
Chief Executive Officer's Office (6 FTE)
• day-to-day operations and ongoing activities management of the OFA in accordance with government policies.

Appendix 4: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Effective governance structures are in place for the cost-effective and accountable operation of the OFA as required by legislation, policies and targets.
2.	A risk-based strategy is in place to address and manage the province's short- and long-term borrowing needs.
3.	Cost-effective financing and borrowing processes are applied to minimize interest on debt and effectively manage financial risks.
4.	Processes are in place to cost-effectively optimize returns on investments.
5.	The current staffing mix and compensation plan effectively and economically support the OFA's achievement of its mandate.
6.	Performance measures and targets are established, monitored and compared against actual results and reported to promote achievement of intended outcomes, and corrective actions are taken on a timely basis when issues are identified.

Appendix 5: List of Extraordinary Circumstances Resulting in a Budget Deficit

Source of data: Various Ontario government budgets and public accounts

Fiscal Year	Budget ($) Surplus/ (Deficit)	Actual ($) Surplus/ (Deficit)[1]	Government's Explanation of Extraordinary Circumstance for the Budget Deficits
2004/05	(2.2 billion)	(1.6 billion)	"But prior to the government assuming office, there were several years during which Provincial program spending grew much faster than the rate of growth in taxation revenue."
2005/06	(2.8 billion)	298 million	"The deficit was the result of a prolonged period where annual growth in Provincial spending exceeded annual growth in Provincial revenue."
2006/07	310 million	2.3 billion	Not applicable
2007/08	400 million	600 million	Not applicable
2008/09	(3.9 billion)	(6.4 billion)	"The government will continue its prudent approach to managing Ontario's finances during the current global economic downturn. To protect key public services and make the short- and long-term investments required, Ontario, like many governments across Canada and around the world, will experience a deficit. This is due to a significant deterioration in revenues and short-term measures to stimulate the economy, not to significant increases in core program spending."
2009/10	(21.3 billion)	(14.1 billion)	"In response to the economic crisis, the government took action by making short-term investments to create jobs and lessen the impact of the recession on families and businesses."
2010/11	(16.7 billion)	(14.0 billion)	"The government chose to help lessen the impact of the recession on Ontarians, through short-term stimulus investments that created and preserved jobs and helped restore growth."
2011/12	(16.3 billion)	(13.0 billion)	"When the global recession hit, the government chose to lessen the impact on Ontarians, through stimulus investments, boosting job training for laid-off workers and lowering income taxes for nine out of 10 Ontario taxpayers."
2012/13	(15.2 billion)	(9.2 billion)	Part of five-year plan to achieve balance in response to the 2008 recession to balance budget by 2017/18
2013/14	(11.3 billion)	(10.5 billion)	Part of five-year plan to achieve balance in response to the 2008 recession to balance budget by 2017/18
2014/15	(10.9 billion)	(10.3 billion)	Part of five-year plan to achieve balance in response to the 2008 recession to balance budget by 2017/18
2015/16	(5.7 billion)	(5.0 billion)	Part of five-year plan to achieve balance in response to the 2008 recession to balance budget by 2017/18
2016/17	(4.3 billion)	(1.0 billion)	Part of five-year plan to achieve balance in response to the 2008 recession to balance budget by 2017/18
2017/18	600 million	(3.7 billion)	Not applicable as surplus budgeted
2018/19	(6.7 billion) Revised (11.7 billion)	(7.4 billion)	"The government believes that the best way to deliver prosperity to more people in Ontario is by continuing to invest in the economy, and in public services that promote greater fairness and opportunity across the province."
2019/20	(10.3 billion)	n/a (10.3 billion)[2]	"The findings of the Independent Financial Commission of Inquiry (Commission) revealed that the government inherited a $15 billion dollar deficit in 2018–19 from the previous government. This was largely because of unsustainable levels of spending that resulted in structural deficits, combined with a heavy reliance on one-time revenues in recent years, which further amplified the fiscal challenge."

1. Actual surplus or deficit taken from Public Accounts from the fiscal year; only 2017/18 and 2018/19 show adjustments for Fair Hydro Plan and Pensions.
2. Forecast by province in budget.

Appendix 6: Comparison of the *Fiscal Sustainability, Transparency and Accountability Act* and Balanced Budget Legislation in British Columbia, Manitoba and Quebec

Prepared by the Office of the Auditor General of Ontario

	Ontario	British Columbia	Manitoba	Quebec
Name of Act	*Fiscal Sustainability, Transparency and Accountability Act, 2019*	*Balanced Budget and Ministerial Accountability Act, 2001*	*The Fiscal Responsibility and Taxpayer Protection Act, 2017*	*Balanced Budget Act, 2001*
Provision Regarding Deficits	For each fiscal year, the Executive Council shall plan for a balanced budget	The main estimates for a fiscal year must not contain a forecast of a deficit for that fiscal year	The government should not incur a deficit greater than a baseline amount. After the deficit is eliminated, the government is not to incur a deficit.	The government may not incur a budgetary deficit
Ability to Run Deficits	Can run a deficit if there are extraordinary circumstances	None	The following amounts are not included in calculation of deficit: • Manitoba Hydro's net income or loss • Amounts transferred to the fiscal stabilization account for that fiscal year • Expenditures required for war or unexpected disaster • Reductions in revenue from the decision of another level of government or regulatory body • One-time expenditures or revenue reductions of more than $25 million that relate to an accounting change or a change in the government reporting entity	The government may incur an overrun if it is the result of: • A disaster that has a major impact on revenue or expenditures • Significant deterioration of economic conditions • A change in federal programs of transfer payments to the provinces
Consequence of Deficits	None	Salary holdback of 10% for the Executive Council in the event of a deficit budget plus an additional 10% holdback for Ministers who allow their ministry budget to exceed budget estimates	Salary holdback of 20% for Ministers, increasing to 40% in a second consecutive year	None

Appendix 7: Methodology for Quantifying Additional Cost of Foreign Debt Issuance

Prepared by the Office of the Auditor General of Ontario and the Ontario Financing Authority

When determining the cost of issuing debt in a foreign market we start with the known interest cost on the debt instrument issued. Additional costs associated with entering into a hedge transaction, such as a foreign-exchange or interest-rate swap, are added to the known interest cost. These agreements were not always entered into immediately. We used the OFA estimate of what it would have cost to enter into these on the date the debt was issued.

We then compared this calculated cost of issuing debt in a foreign market to the estimated cost of issuing debt in the domestic market. We determined this estimated cost based on information we got from a bank about the rate the bank believes debt could have been issued at in the domestic market. Note that debt issued in the domestic market is often for lower quantities than the amount of debt issued in a foreign market. So, increased quantities of debt issued on the same day could result in increased interest costs. The OFA was not able to quantify such potential additional costs.

Appendix 8: Current and Proposed Accounting Treatments of Foreign Currency Transactions

Prepared by the Office of the Auditor General of Ontario

Transaction	Description	Current Accounting Treatment	Proposed Accounting Treatment*
Foreign exchange forward contract	A contract in which party (A) buys or sells a foreign currency at an exchange rate that is locked in until a future date. Party (A) gains or loses money depending on the difference between the locked-in exchange rate and the actual exchange rate on the day the contract matures, which is usually three months after the purchase or sale date. For example: • On April 1, 2018, the province agrees to buy $1 billion US from a US bank on July 1, 2018, at an exchange rate of $1.33 Cdn per US dollar (so for $1.33 billion Cdn). • On July 1, 2018, the actual exchange rate is $1.23 Cdn per US dollar, so purchasing $1 billion US on July 1 costs $1.23 billion Cdn. • In this case, the province incurs a loss of $100 million because the locked-in exchange rate of the contract was higher than the actual exchange rate on the date the contract matured.	The gain or loss is recognized immediately. The gain or loss is offset by the change in value of the debt. For example: • The province has US debt due seven years after it purchased the $1 billion US (i.e., on April 1, 2025). • In the fiscal year, Ontario incurred a net loss of $50 million on four consecutive contracts (that is, a loss of $12.5 million per contract). The value of the debt increases by $50 million over the fiscal year. • This would result in a nil effect on the statement of operations in the financial statements.	The gain or loss is recognized immediately while the change in value on the debt is deferred. For example: • If there is a net loss of $50 million on four forward contracts (that is, $12.5 million each), the province must show a loss of $50 million on its 2018/19 financial statements that is due to the fluctuations in the exchange rates between Canadian and US dollars. The change in value of debt is recorded in a separate statement and recorded in the statement of operations when the debt matures. • The effect on the province's financial statements may differ substantially from budget projections because of the fluctuations in exchange rates.
Foreign exchange swap	A contract in which party (A) borrows an amount of one currency from party (B) at an agreed-upon rate and repays it by selling (B) another currency at an agreed-upon rate. The contract with the agreed-upon rates usually lasts until the debts are fully repaid. For example: • On April 1, 2018, Ontario issues $1 billion US in bonds at a rate of $1.33 Cdn per US dollar (so it owes $1.33 billion Cdn). It simultaneously enters into an agreement with a bank for $1.33 billion Cdn at the same exchange rate (so it is owed $1 billion US). • Over the seven-year term of the contract, Ontario pays interest and the principal to the bank in US dollars and the bank pays interest and the principal to Ontario in Cdn dollars.	Same as for foreign exchange forward contracts: each fiscal year's gains or losses (in this case associated with the loans' interest payments) are recognized annually and are matched by the changes in value of the debt, which reduces the impact of the loss in the current year's statement of operations.	No change from current accounting treatment resulting in minimal impact on each year's statement of operations. However, there will be impacts to net debt as the swap contract and debt are fair valued at each year-end date.

* Under a proposed change in Public Sector Accounting Board accounting standards expected to take effect in 2021.

Appendix 9: Glossary of Terms

Prepared by the Office of the Auditor General of Ontario

Auctioned bonds: Bonds whose interest rates are set by a process where investors submit bids, and the lowest interest rate submitted is chosen.
Capital expenditures: Costs associated with purchasing assets whose expected life is longer than one year, such as land, buildings and roads.
Credit risk: The risk of an economic loss due to the failure of the other party in a financial transaction to pay amounts owed to the province.
Fixed rate debt: Bonds whose interest payments are set at the time they are issued and do not change.
Floating rate debt: Bonds whose interest payments vary based on a referenced market rate, such as the London Inter-bank Offered Rate (LIBOR).
Foreign exchange risk: The risk of debt and interest costs increasing due to the change in value of foreign currencies in relation to the Canadian dollar.
Forwards: A financial instrument where two parties agree to buy and sell an asset at a future date for a specified price. This is a private contract between two parties that is settled at the end of the agreement period.
Futures: A financial instrument where two parties agree to buy and sell an asset at a future date for a specified price. In contrast with forwards, this is a contract with standardized terms trading publicly on financial instrument exchanges. The change in the value of the contract is assessed daily, and the two parties exchange cash based on the change in value.
Hedging: An investment to reduce the risk that future changes in the value of one currency (e.g., the Canadian dollar) compared to a foreign currency (e.g., the US dollar) will increase the cost of an asset or liability.
Interest rate risk: The risk of interest costs increasing due to market factors such as the supply and demand for credit.
Liquid assets: Assets that are cash or can be readily converted into cash.
Liquid reserve: Liquid assets held by a bank, company or government to meet expected future payments and/or emergency needs.
Liquidity risk: The risk of being unable to meet the province's debt obligations as they come due.
Net debt: The difference between the government's total liabilities and its financial assets. Liabilities consist of all amounts the government owes to external parties, including total debt, accounts payable, pension and retirement obligations, and transfer-payment obligations. Financial assets are those that theoretically can be used to pay off liabilities or finance future operations, and include cash, accounts receivable, temporary investments and investments in government business enterprises. Net debt provides a measure of the amount of future revenues required to pay for past government transactions and events.
Net debt to GDP: A measure of the government's debt level (net debt) relative to the size of its economy (the gross domestic product, or GDP). Net debt to GDP measures the relationship between a government's obligations and its capacity to raise the funds needed to meet them. It is an indicator of the burden of government debt on the economy.
Non-amortizing debt: Debt where payments on the principal are not made until the debt matures.
Operating expenditures: Costs associated with operating government programs, such as health-care and education services.
Sovereign: The governing body of a nation, country or territory.
Sub-sovereign: The jurisdiction below a sovereign body, such as a province, region or state.
Swaps: Financial instruments where two parties agree to exchange cash flows. One party agrees to provide a steady amount while the other party provides an amount that varies based on movement in the benchmark. For the OFA's purposes, this benchmark could be the difference in the Canadian dollar from another international currency or an interest-rate benchmark such as the London Inter-bank Offered Rate (LIBOR).
Syndicated bonds: Bonds originating when a group of banks is paid to create demand from other investors. The bank group sometimes underwrites the issue of syndicated bonds, meaning that, if all of the bonds are not sold, the banks must buy what is left.
Term of bond: The amount of time between the date a bond is issued and the date the province redeems the bond by paying the principal amount.
Total debt: The total amount of borrowed money the government owes to external parties. Total debt consists of bonds issued in public capital markets, non-public debt, Treasury Bills and US commercial paper. Total debt provides the broadest measure of a government's debt load.

Treasury Board Secretariat

Oversight of Time-Limited Discretionary Grants

1.0 Summary

The province provides about $3.9 billion annually in time-limited grants to third parties to pay for activities that are intended to benefit the public and help achieve public policy objectives. These grants are discretionary, meaning the province is not required to provide funding for these activities to meet statutory obligations. The ministries are responsible for determining the level of funding for their specific grant programs in their annual budgets, based on their objectives and priorities. The Treasury Board Secretariat is responsible for reviewing the final allocation of these grants for each ministry based on government priorities, political direction and the economic climate.

The government reports all grant payments together in the Public Accounts and the Estimates of the province of Ontario, without differentiating between those for time-limited activities (funded through discretionary grants) and those for the delivery of government services (for example, to hospitals for health care or to school boards for education). Without being able to identify which grant payments are for time-limited projects and which are for ongoing programs, Members of the Provincial Parliament do not have the necessary information on which to base funding allocation decisions in times of fiscal constraint or changing government priorities.

Furthermore, the Treasury Board Secretariat has not clearly defined these grants and there is no central list of time-limited discretionary grants that would facilitate their consolidated oversight.

We found that most time-limited discretionary grant programs we tested were selecting recipients based on objective evaluation criteria, except for a few grant programs under the Ministry of Heritage, Sport, Tourism and Culture Industries (Ministry), which selected some recipients based solely on the Minister's discretion. Based on our testing, we noted that over the last few years, the Ministry has allocated about 10% of grant funding to events at the discretion of the Minister. The Transfer Payment Accountability Directive provides direction on determining a recipient's eligibility and requirements for documenting funding decisions. A ministry that wants an exemption from part or all of the directive, only for exceptional circumstances, must seek Treasury Board/Management Board of Cabinet approval. In addition, the ministry must set out the rationale for the exemption in a business case. We noted the Ministry did not request an exemption from Treasury Board for any of the grant programs we tested where grants were awarded under ministerial discretion.

We also found that for a sample of grant recipients in programs we reviewed, the amounts awarded were accurate, did not exceed the amount

requested by the applicant, and did not exceed the maximum funding allowed per recipient as established by each grant program.

We also noted that monitoring efforts to ensure grant funding was being used as intended needed improvement. Ministries mostly relied on recipients reporting their own performance results to assess progress towards the grants meeting public policy objectives. Also for seven of 15 grant programs we reviewed, granting ministries did not visit any recipients to confirm that the funded activities were taking place effectively.

In March 2016, the Treasury Board made the use of the Grants Ontario system, operated by the Ministry of Government and Consumer Services, mandatory for administering all project-based/time-limited grant programs. The system was expected to create efficiencies by standardizing the granting process, and to improve oversight and evidence-based decision-making by providing a common platform for ministries to share recipient funding and performance information. As of September 2019, the expected benefits have not yet been achieved, as only 53% of the time-limited grant programs have implemented the mandatory system. The other 47% of grants were still being managed by different systems in place across the various ministries. As a result, it is still difficult to aggregate government grant information to exercise appropriate oversight and to use in decision-making, as the data exists across different systems that are not easily accessible. These other systems used to manage grant programs cost about $45 million to operate in 2017/18 (latest data available at the time of our audit).

The following are our significant findings:

- **Public disclosure of government grants is not always consistent or transparent.** For grant recipients that are paid directly by ministries, their names and amounts received are disclosed in the Province's public accounts. However, we identified eight organizations that received $402 million in grant funding from the province in 2018/19 and then disbursed those funds to other parties, which were not disclosed in the public accounts. While some of these flow-through organizations listed the grant recipients and amounts awarded to them on their own websites, disclosure of grant recipient information was inconsistent and difficult to find. In contrast, the federal government makes the amount of funding per grant recipient available on one common platform, whether funds are provided by the government directly or through a flow-through organization.
- **Some grant recipients that did not meet evaluation criteria received funding under Ministerial discretion.** The Ministry of Heritage, Sport, Tourism and Culture Industries' Celebrate Ontario grant program has supported festivals since its inception in 2007. From 2016/17 to 2018/19, all applicants that achieved the minimum required score were approved for grant funding. However, the grant program also provided almost $6 million in funding through ministerial discretion to 132 applicants that had not achieved the minimum evaluation score required for funding approval. The explanation justifying these approvals was that these applications fell under a certain priority category, but there was no other documented justification on file explaining why the Minister chose to fund a certain applicant over another in the same category that had a higher score. An additional $2.5 million in funding was provided through ministerial discretion to 73 applicants in 2019/20. In this case there was no indication what specific priority area the selected applicants were to address.
- **Most grant programs do not consider an applicant's need for funding during the selection process.** Only two of the 15 grant programs we reviewed considered the need for grant funding as part of the selection process. We noted that the Ontario Scale-Up Vouchers Program, whose objective is to accelerate the

growth of start-up technology companies, provided $7.65 million in 2018/19 to businesses that already had a significant amount of resources available to them already. Prior to receiving support from the program, 27 recipients combined had raised $491 million dollars in capital. Similarly, under the New Relationship Fund, the Ministry of Indigenous Affairs provides First Nations and Metis communities with funding for one consultation coordinator, without considering their workload or need for funding. Over the last five years, the number of consultation requests ranged from 14 at one First Nation to 1,177 at another. Both First Nations received the same amount of funding.

- **Ministries mostly rely on self-reported information to assess whether the recipients used grant funding as intended.** Based on our review of 15 grant programs, ministries were receiving project-specific financial information to assess the use of grant funding for 13 grants. However, only three programs required recipients to provide independent verification of the use of those funds by submitting audited financial information. We selected a sample of recipients to verify their use of funds and noted some recipients had claimed ineligible expenditures. For example, under the Ontario 150—Partnerships program, the Ministry provided $75,000 in funding to an organization to promote women's engagement in politics and to host an event at Queen's Park. However, we noted that the organization claimed the majority of the expenditures for consulting work performed by its executive director at a rate of $675 per day, even though regular staff salaries were not eligible for funding under this program.
- **Ministries do not verify the performance results reported by recipients for reasonability.** For 14 of the 15 grant programs we reviewed, ministries relied on recipient-reported performance results without verifying these results. For example, the Ministry of Heritage, Sport, Tourism and Culture Industries used recipient-reported attendance and visitor expenditures information to assess the economic impact of the Celebrate Ontario grant. For 2017/18, the Ministry had to exclude 50% of performance results reported by recipients because it was deemed unreliable. For example, some recipients reported that the increase in visitors to their events exceeded the total number of visitors to their events, while some reported that new visitors spent more than all visitors combined. The Ministry did not follow up with recipients to update the information it received and did not take this into consideration in future grant-funding decisions. One recipient we spoke with informed us that they simply guessed at the number of attendees and amount spent by visitors at their event.
- **The impact of grant funding for programs and projects with long-term objectives is not being monitored after the funding period ends.** Under the Youth Skills Connections—Industry Partnerships program, the Ministry of Economic Development, Job Creation and Trade supports training and provides work placement for youth to close industry-identified skills gaps. However, the Ministry did not follow up after the completion of the funding agreement to assess whether the companies that received the grants were still employing the newly trained youth after a certain period. For the Jobs and Prosperity Fund—New Economy Stream, applicants noted that about 4,700 jobs were at risk if projects were not implemented. The Ministry of Economic Development, Job Creation and Trade invested over $270 million into these projects. However, the Ministry has no recourse if the jobs are not retained after the contract ends.
- **Most grant programs are not reporting performance results publicly.** The grant

programs we reviewed generally contained performance measures, but lacked performance targets and results were not being reported publicly. For the majority of grant programs we reviewed, the measures were primarily activity-based rather than outcome-based. Activity-based measures count actions, but not whether those actions were effective in achieving the desired outcomes. To illustrate, the Youth Skills Connection program aims to address skills gaps through industry partnerships and improve competitiveness in key sectors of Ontario's economy. The Ministry of Economic Development, Job Creation and Trade measures the number of industry partners, youth trained, work placements and jobs filled, but it does not measure and report whether the skills gap is closing in various sectors, or closing to an acceptable level.

This report contains 13 recommendations, with 24 action items, to address our audit findings.

Overall Conclusion

Discretionary, time-limited provincial grants are important for supporting activities that benefit the public and helping the government achieve its public policy objectives. However, because the Treasury Board Secretariat has not clearly defined these time-limited grants and there is no central list cataloguing all the grants available and their details, the process for managing and monitoring these funds is fragmented and ineffective. Furthermore, because time-limited grant funding is not identified or isolated in the Public Accounts and the Estimates of the Province of Ontario, it is difficult for Members of the provincial Legislature to make appropriate funding re-allocation suggestions or decisions in times of economic constraint without affecting ongoing government services.

Our audit found that ministries did establish objectives for their grant programs that aligned with their mandates. In addition, most ministries provided grants based on objective evaluations, except for the Ministry of Heritage, Sport, Tourism and Culture Industries, which provided funding to some applicants based solely on the minister's discretion. We also noted, though, that most ministries did not consider an applicant's need for funding as part of their evaluation and selection process. This raises concerns that the government is providing funding where it might not be financially needed, at the expense of programs that need the funding.

Where the grant selection and approval processes were objective and followed ministry mandates, we found that ministries did not adequately monitor grant recipients to ensure funds were spent as intended and grant activities were taking place effectively. As well, in most cases we reviewed, the performance measures established for grant programs were not sufficient to assess whether grant programs were meeting their objectives.

Furthermore, seven years after the province developed a government-wide IT system for managing grants, and three years after the system became mandatory, ministries have only transferred a little over half of all grant programs into the system, and are still not using all its functionality to full effect. Instead, they rely on a patchwork of various processes, leading to inefficiencies and an inability to share the financial and performance information of grant recipients that would be critical for making broader evidence-based decisions regarding future funding priorities and allocations.

OVERALL RESPONSE

The Treasury Board Secretariat (Secretariat) and the Ministry of Government and Consumer Services (Ministry) welcome the recommendations of the Auditor General on improving the administration and oversight of discretionary grants.

We recognize there are opportunities to enhance transparency, increase efficiencies, and help ensure that discretionary grants are meeting their desired goals and objectives. The Secretariat is leading initiatives to identify opportunities to improve implementation of and

compliance with the corporate rules (including the Transfer Payment Accountability Directive and Transfer Payment Operational Policy) and to work with ministries on implementing transfer payment programs through the centralized Transfer Payment Ontario system. This includes, enhancing the current use of key system components to ensure the adoption of best practices and reducing risk.

We welcome the insights and the recommendations in the report. Actions will be taken by the Ministry and Secretariat, in collaboration with ministries and provincial agencies, that focus on improving the efficiency, effectiveness, and value and oversight of time-limited discretionary grants. Work is already under way to address some of the recommendations, specifically those aligned with Transfer Payment Consolidation, one of the key government priorities in Smart Initiatives. This initiative is designed to strengthen accountability and oversight of transfer payments, and improve provincial services through better integrated, more effective, and efficient transfer-payment processes. As part of the work, the rules and controls for transfer payments will be reviewed and modernized, and the Secretariat will help build Ontario Public Service's transfer-payment capacity by developing a transfer-payment curriculum to promote education opportunities across government.

We are taking a sector approach to examine opportunities for transfer payment consolidation and for reducing the burden on transfer payment recipients through integrated and/or reduced agreements and reporting. Major enhancements and upgrades to the Transfer Payment Ontario system have also been completed.

Through this Smart Initiative, the Secretariat intends to reduce administrative costs and burden on the service delivery partners, improve service delivery and outcomes, and increase value for money of provincially funded programs. The observations and recommendations in this audit will be instrumental as we consider the actions required to fulfill the government commitment.

We look forward to a continued constructive relationship with the Auditor General and her staff as we move forward with implementing the recommendations in this report.

2.0 Background

2.1 Overview

The government delivers some services directly to the public, such as registering births and deaths, issuing and renewing health cards and drivers' licences, or distributing disability support payments to eligible individuals. In other cases, the government provides funding to third parties, through a transfer payment, to deliver services. Some of these third-party-provided services are non-discretionary, meaning the government is legislated to provide funding (for example, health care and education). Other services are discretionary, and while the government is not legislated to provide funding, it has chosen to do so either on an ongoing basis for years (for example, childcare and services for persons with autism), or on a time-limited basis to support new initiatives and government priorities (for example, cultural festivals and support for new businesses).

The province's public accounts and budgeting process does not distinguish between funding provided to service providers for legislated government services, ongoing government programs that are not legislated, and one-time or short-term discretionary grants. Our audit focused on one-time or short-term discretionary grants (time-limited grants).

2.2 Time-Limited Discretionary Grants Provided by the Province

As there is no central reporting of time-limited discretionary grants in the province, we worked with the Treasury Board Secretariat and all 23 ministries to assemble the list. Based on information provided by each ministry, as seen in **Figure 1**, there were 249 discretionary grant programs in 2018/19 and the province paid out $3.9 billion in grant funding.

We asked the ministries to categorize each grant program in the last five years based on its main purpose, and assembled a list of grants by category (see **Appendix 1**). Time-limited grants have increased in total by $379 million (11%) from 2014/15 to 2018/19. In the last fiscal year, approximately 50% of time-limited grants were in support of northern/rural communities, private industry and education, as shown in **Figure 2**. **Figure 3** shows the changes in grant funding by category from 2014/15 to 2018/19.

2.3 Grant Approval Process in the Province

Through the annual budgeting process, every ministry must prepare budget plans for the upcoming year, based on the ministry's objectives and priorities. These plans contain proposed changes to grant programs, including the introduction of new programs and termination of existing programs.

Figure 1: Time-Limited Grants by Ministry, 2018/19

Source of data: Ontario Ministries

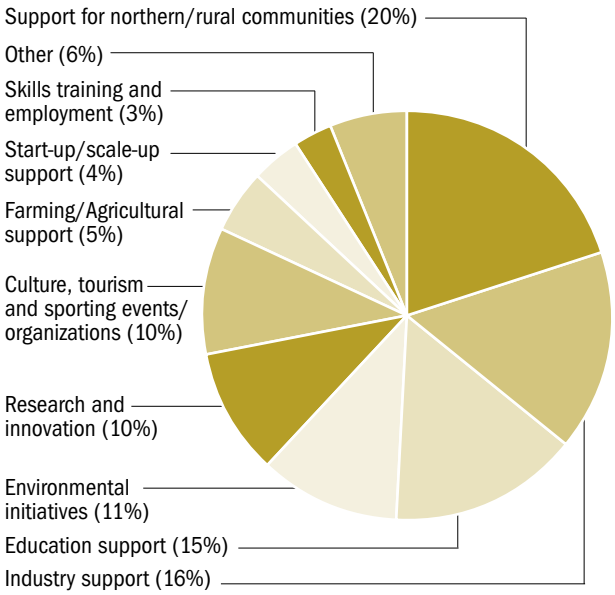
Ministry	# of Grant Programs	Total Funding Provided ($)
Economic Development, Job Creation and Trade	54	686,913,199
Finance	8	656,864,532
Education	3	426,411,096
Tourism, Culture and Sport	16	360,672,112
Agriculture, Food and Rural Affairs	22	324,389,673
Training, Colleges and Universities	15	270,795,176
Environment, Conservation and Parks	14	268,672,675
Energy, Northern Development and Mines	21	264,686,953
Municipal Affairs and Housing	3	201,512,623
Transportation	5	151,671,297
Children, Community and Social Services	2	80,997,475
Health and Long-Term Care	11	56,153,221
Attorney General	10	50,284,301
Indigenous Affairs	9	40,646,274
Seniors and Accessibility	3	19,927,186
Natural Resources and Forestry	12	14,075,057
Government and Consumer Services	25	6,637,970
Solicitor General	6	4,212,430
Labour	3	3,206,438
Francophone Affairs	2	1,041,119
Infrastructure	2	865,050
Cabinet Office	2	432,021
Treasury Board Secretariat	1	162,077
Total	**249**	**3,891,229,954**

Ministries determine the level of funding for specific grant programs based on, for example, the level of funding in the prior year, anticipated program demand, and/or performance results.

Ministry budgets require Treasury Board approval, but first these plans are reviewed by Treasury Board Secretariat analysts, who make recommendations to the board. Treasury Board approval is based on government priorities, political direction and the economic climate, and determines the final allocation for each ministry.

Figure 2: Time-Limited Grants by Category, 2018/19

Source of data: Ontario ministries



Government Imposes Freeze on Discretionary Spending

In June 2018, the provincial government imposed expenditure restrictions, which included a freeze on discretionary spending that was in place at the time of our audit. The memo from the Secretary of Cabinet announcing the expenditure restrictions described discretionary spending as follows: "Discretionary spending includes, but is not limited to, time-limited payments and programs funded through transfer payments (for example, annual call for proposals), time-limited service contracts (for example, consulting services and temporary help services), non-essential travel, events, and communications (for example, advertising, media monitoring and publications), and any expense that can be placed on hold without putting government service delivery or the public at risk (for example, matters of health, safety and security)."

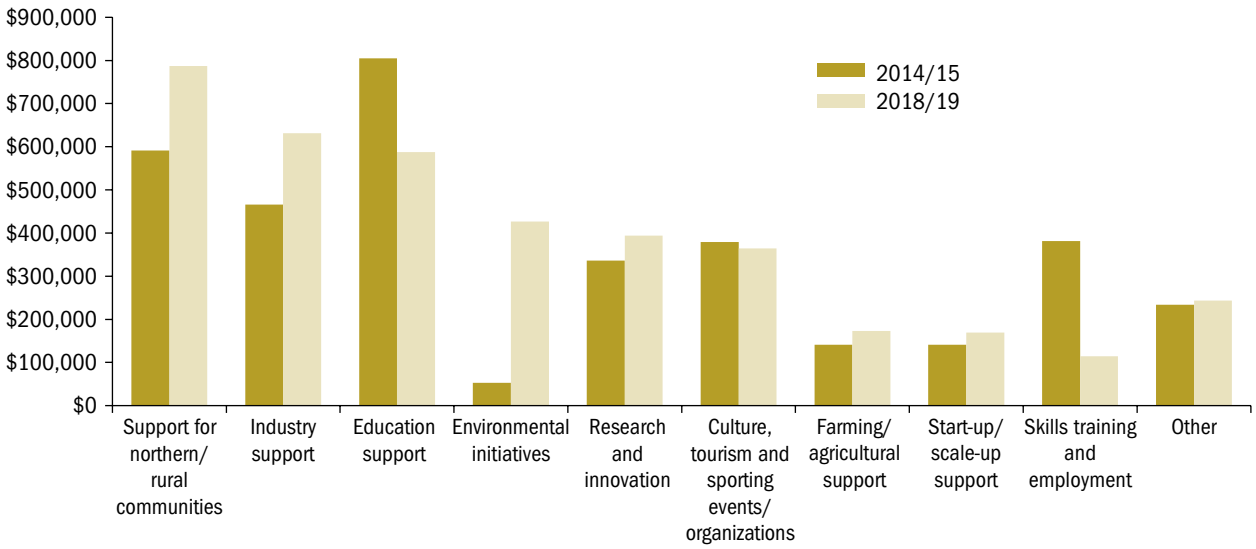
2.4 Grants Ontario System

2.4.1 Creation of Grants Ontario System

In 2008/09, multiple ministries worked collaboratively to identify common business processes related to project-based or time-limited grants in order to develop a government-wide IT system for managing such grants. This project was led by the

Figure 3: Changes in Grant Funding by Category, 2014/15–2018/19

Source of data: Ontario ministries



business teams in the Ministry of Citizenship and Immigration (now part of the Ministry of Children, Community and Social Services) and the Ministry of Tourism and Culture (now part of the Ministry of Heritage, Sport, Tourism and Culture Industries).

The project leaders looked at existing grant systems across the Ontario public sector and in other jurisdictions. However, none of the existing systems were deemed a fit for the requirements and functionalities identified for a government-wide system. The Grants Ontario system was built in 2012 at a cost of $8.3 million, with the assistance of an outside consultant. The system gives users the ability to screen grant applicants, evaluate applications, process grant payments, monitor recipient progress, and track approved funding commitments and actual payments.

2.4.2 Support to Expand the Grants Ontario System to Other Ministries

In February 2012, around the time the system was being developed, the report of the Commission on the Reform of Ontario's Public Services, commonly known as the Drummond Report, was released. The Commission, whose task was to advise the Government of Ontario on how to reduce the Province's debt levels, recommended that the Ontario Public Service should develop an integrated transfer payment operation centre and an enterprise grant management system. The report noted that the expansion of the newly developed enterprise grants management system (now known as Grants Ontario) across the Ontario Public Service would create further efficiencies in program administration and value-for-money gains.

2.4.3 Grants Ontario System Becomes Mandatory

In 2013/14, the Transfer Payment Administrative Modernization project was initiated to identify and implement efficiencies across the government by streamlining and automating administrative practices relating to transfer payments, including grants. In March 2016, Treasury Board made the use of the Grants Ontario system mandatory for administering project-based/time-limited grant programs, and all ministries were expected to be using the system by March 2019. The Information Technology Executive Leadership Council (Council) also endorsed the Grants Ontario system for all grant programs. The Council is composed of Chief Information Officers across the government and certain individuals at the Director and Assistant Deputy Minister level. Its role is to ensure that the value of the Ontario government's investment in information and information technology, both in terms of staff and money, is maximized.

2.5 Applicable Government Directives and Policies

2.5.1 Transfer Payment Accountability Directive

The Transfer Payment Accountability Directive sets out an administrative accountability framework for, among other things, discretionary grants. The directive establishes the principles, requirements and responsibilities for ministries and provincial agencies when overseeing grant activities. See **Appendix 2** for the guiding principles of the directive.

The directive lays out requirements in three areas as follows: recipient assessments, agreements and oversight.

- **Recipient Assessments:** Used to determine the level of oversight required for the recipient. The minimum risk factors that must be considered are: the recipient's capacity (that is, governance structure and controls), recipient history (including funding received and performance), and public perception (that is, how the public and media view the recipient). A higher level of monitoring and reporting is required for activities and recipients deemed to be higher risk.

- **Agreements:** Ministries should have a signed agreement in place with a recipient before a grant payment is provided. Agreements should identify the rights, responsibilities, and obligations for both the recipient and the accountable ministry. Agreements should also clearly outline the related outputs and outcomes of the grant payment and the reporting requirements for the grant recipient. Ministries must engage legal counsel when drafting or amending agreements, and follow a consistent, documented approvals process for finalizing, executing and amending agreements. The directive recommends that ministries use an agreement template, where appropriate, in order to promote consistency and reduce administrative burden for ministries and recipients.
- **Oversight:** Ministries should monitor recipients throughout the term of the agreement to ensure they are meeting the terms outlined in the agreement. Ministries are required to review all reports submitted by recipients, as required by their agreement, and document receipt and review of those reports as evidence that they have assessed a recipient's progress toward achieving the intended outputs/outcomes of the activity for which they are being funded. Also, the steps taken by the Ministry to remedy any non-compliance by the recipient should be proportionate to the non-compliance in question and documented. Any severe corrective action, such as termination of the contract, must be done by the Ministry after consulting their legal counsel.

Ministries are also required to clearly define how success is evaluated and how the outcomes/outputs of each grant program support the achievement of the associated public policy objectives. In addition, the directive states that approval from Treasury Board/Management Board of Cabinet is required for exemption from all or part of the directive.

2.5.2 Transfer Payment Operational Policy

The purpose of this policy is to set out operational requirements and best practices that support effective and proportional oversight of transfer payments, which includes time-limited grants, and support productive relationships with funding recipients. Below is a summary of some of the key requirements and best practices in selected areas outlined in the policy.

Use of government-wide systems

The government has two mandatory systems that ministries must use to manage transfer payment activities:

- **Transfer Payment Common Registration (TPCR)—**This is a central repository of grant-recipient information. It includes profile information of a grant applicant and/or recipient such as their legal name and address, as well as a unique business number issued by the Canada Revenue Agency. All recipients of time-limited and/or ongoing funds must be registered in the system. Ministries must use data from the TPCR as the authoritative source for recipients' profile information. Ministries must ensure recipient registration is completed prior to entering, renewing or amending existing agreements.
- **Grants Ontario System—**This is a case management system for managing all time-limited grant programs. In August 2019, the system was expanded to ongoing transfer payment programs, both legislated and discretionary. (The Grants Ontario system is described more fully in **Section 2.4**.)

Both systems are integrated and are administered by the Ministry of Government and Consumer Services' Transfer Payment Ontario Branch (formally, the Grants Ontario Business Office). In turn, the Grants Ontario system is integrated with the government's accounting system (the Integrated Financial Information System). This means that the payments approved in Grants Ontario generate a payment in the Integrated Financial Information System.

Agreements

The policy also sets out circumstances when an agreement must be updated or amended. As a best practice, ministries should notify grant recipients in advance of any amendments or updates to grant payment agreements. A minimum of 30 days advance notification is recommended.

Oversight

As a general rule, grant programs are required to identify opportunities to streamline and consolidate reporting for recipients. Instances where this is appropriate are as follows:

- Where a grant recipient is assessed with low risk of not meeting their obligations under the terms of the funding agreement. In this case, ministries have the option to streamline reporting requirements; streamline the agreement renewal process (that is, no need to renegotiate); and/or allow the grant recipient to re-allocate certain funds between designated expenditure categories without the Ministry's prior approval (referred to as budget flexibility). Ministries must ensure that grant recipients and their related risk assessment ratings are current.
- Where a grant recipient is funded by more than one grant program within the same Ministry. In this case, the program areas could use a standard multi-project agreement or perform a consolidated year-end reconciliation process. Where opportunities are identified, ministries must consolidate and streamline reporting.
- Where a grant recipient is funded by more than one grant program in different ministries for a similar activity. In this case, the program areas could implement common reporting requirements, set out such requirements in a common agreement, perform a consolidated year-end reconciliation process, or align the timing for recipient reporting.

3.0 Audit Objective and Scope

The objective of our audit was to assess whether ministries that provide time-limited discretionary provincial grants have effective policies and procedures in place to ensure that:

- grants are provided and used efficiently and effectively towards achieving public policy objectives and desired program goals, in accordance with government directives and respective program policies and guidelines; and
- the impact and effectiveness of grant programs is measured, evaluated and publicly reported on.

In planning our work, we identified the audit criteria (**Appendix 3**) we would use to address our audit objective. These criteria were established based on a review of applicable policies, procedures and directives, internal and external studies, and best practices. Senior management at the Treasury Board Secretariat and the Ministry of Government and Consumer Services reviewed and agreed with the suitability of our audit objective and associated criteria.

We also shared our audit objective and criteria with the following ministries from which we selected a sample of discretionary grant programs for review:

- Ministry of Economic Development, Job Creation and Trade;
- Ministry of Heritage, Sport, Tourism and Culture Industries;
- Ministry of Finance;
- Ministry of Indigenous Affairs;
- Ministry of the Environment, Conservation and Parks; and
- Ministry for Seniors and Accessibility.

We conducted our audit work mainly at the Transfer Payment Ontario Branch and the six granting ministries selected as part of our review. We focused on key areas of the grant lifecycle: selection

of grant recipient, funding, monitoring, and performance measures.

Our work included interviewing senior management at the Transfer Payment Ontario Branch and the ministries selected; reviewing applicable policies, directives and procedures; sampling and reviewing relevant grant applicants' documentation; and reviewing other relevant documents to assess the impact of grant programs, including program reviews.

We also worked closely with the Treasury Board Secretariat and all 23 ministries to create a list of all provincial discretionary grant programs and to gather five years of financial information on these grants. We also surveyed ministries that were using the Grants Ontario system to obtain their feedback on the system.

We selected 15 grant programs for detailed testing across various ministries for different purposes and to different types of recipients. The purposes we focused on were culture, tourism or sporting events/organizations, start-up/scale-up, skills training employment, support for northern/rural communities, industry support, environmental initiatives, research and innovation, Aboriginal support, social services and international disaster-relief support. The types of recipients we selected included businesses, not-for-profit organizations, post-secondary institutions, municipalities, and First Nations.

A brief description of each grant we selected for review is included in **Appendix 4**, and the results of our testing are summarized in **Appendix 5**. Based on our review of grant information available at the ministry level, we also visited five and contacted an additional 10 grant recipients to review selected source documents.

For three of the six discretionary grant programs that were funded by the Ministry of Economic Development, Job Creation and Trade but administered by the Ontario Centres of Excellence or the MaRS Discovery District, we visited the grant program administrators to complete our testing.

Our audit excluded any time-limited discretionary grants programs audited by our Office in the last five years.

4.0 Audit Observations

4.1 Discretionary Grant Information and Disclosures

4.1.1 Discretionary Grants Are Not Separately Disclosed to Allow Legislators to Make Informed Decisions

The Estimates of the Province of Ontario outlines the spending plans for each ministry, while the Public Accounts of Ontario outlines the actual revenues and expenditures for each ministry. However, both group all transfer payments to third parties together, without differentiating between those for time-limited activities and those for the delivery of government services, whether legislated or not.

For example, in the 2018/19 Public Accounts of Ontario, time-limited discretionary grants are included under the classification of "transfer payments." This classification also includes refundable income tax credits, subsidies, assistance, and other legislated grants paid to individuals, businesses, institutions and other government bodies. Therefore, it is difficult to confirm how much of the transfer payments provided in the year were for ongoing programs, such as education grants to school boards, versus time-limited discretionary grants. In 2018/19, transfer payments before consolidation with the broader public sector (including, hospitals and school boards) accounted for 80% of the Province's total expenditures or $130 billion.

Members of the legislative assembly approve the spending plans of each ministry outlined in the Estimates of the Province. Once approved by the legislature, the Estimates become the legal spending authority for each ministry. Without being able to identify which transfer payments are discretionary and which are for ongoing programs versus

time-limited programs, Members of the Legislature or the Standing Committee on Estimates, which considers Estimates of selected ministries, do not have access to the necessary information on which to base discussions, questions and later funding allocation decisions in times of fiscal constraint or changing government priorities.

There Is No Central Listing of All Time-Limited Grant Programs in Ontario

Internally, the government does not have a centralized list of time-limited discretionary grants and there is no clear or consistent understanding and reporting of discretionary grants across the ministries.

As of June 2019, only 25% of time-limited discretionary grants in the Grants Ontario system (discussed in **Section 4.2**) were listed on Grants Ontario's public website, describing the purpose of grant funding and eligibility requirements. The Transfer Payment Ontario Branch (formerly Grants Ontario Business Office) told us that the decision of whether or not to list the grants publicly was made based on input from the granting ministry. For the grants not listed on the Grants Ontario website or not yet transferred to the Grants Ontario system, it was difficult to find a description of the grants and their eligibility requirements on the respective ministries' websites. In contrast, Australia's government-wide information system (GrantConnect) provides transparency through the granting process. The system provides notification of future grant opportunities, and details on current grant opportunities as well as every grant awarded by the Australian government regardless of value.

As part of the government's annual budgeting process, all ministries are required to complete a Transfer Payment Analysis Form for each of their transfer payment programs that provide funding of more than $25 million annually. The form identifies, among other things, whether the grant program was created through legislation or whether it is at the Ministry's discretion. However, this information is not verified, accumulated or tracked centrally to allow for year over year comparative analysis of discretionary grant funding.

For the purpose of this audit, we had to contact each ministry to provide us with a list of all their time-limited discretionary grant programs and associated funding for each of the last five years. It took over two months and multiple discussions with staff at various ministries and Treasury Board Secretariat to obtain the information. As noted in **Section 2.2**, for 2018/19, the Ministries identified 249 discretionary grant programs totalling $3.9 billion.

RECOMMENDATION 1

To improve transparency in government reporting and allow the members of the legislative assembly to have better information with which to make informed funding allocation decisions, we recommended that the Treasury Board Secretariat:

- show time-limited discretionary grants separately from government funding for ongoing programs in the Estimates of the Province and the Public Accounts of Ontario; and
- compile and maintain a central list of all time-limited discretionary grant programs.

SECRETARIAT RESPONSE

The Treasury Board Secretariat (Secretariat) will endeavour to strengthen transparency through public reporting, and assess highlighting discretionary grants as part of the Estimates and the Public Accounts.

The Secretariat will examine the feasibility of enhancing key sections of the Public Accounts to facilitate the identification of discretionary and ongoing grants.

Through the Transfer Payment Consolidation initiative, we will continue to ensure there is a central list of all transfer payment programs, including specific references to time-limited discretionary grant programs. We will make this

list available to all ministries and relevant provincial agencies through the enterprise intranet to help inform funding allocation decisions.

RECOMMENDATION 2

To inform the public about all grant programs available, we recommend that the Ministry of Government and Consumer Services disclose on the Grants Ontario System details on current and upcoming grant opportunities.

MINISTRY RESPONSE

The Ministry of Government and Consumer Services (Ministry) will engage with ministry program areas beginning in the fourth quarter of 2019/20 to disclose all current and forthcoming grant programs with approved launch dates on Transfer Payment Ontario.

4.1.2 Time-Limited Discretionary Grant Recipients Not Always Publicly Disclosed or Linked to the Grant Program

Grant recipients receiving more than $120,000 are annually disclosed in Volume 3 of the Public Accounts, but they are not identified with the respective grant program.

Of the 15 grant programs we reviewed, only five publicly disclosed all grant recipients and their related funding. For two grant programs (Celebrate Ontario and the Ontario Municipal Partnership Fund) recipients were disclosed on the Transfer Payment Ontario (formerly Grants Ontario) website. Recipients of the other three programs (the Jobs and Prosperity Fund, the Age-Friendly Community Planning Grant, and the Great Lakes Guardian Community Fund) were disclosed in the Ontario Data Catalogue portal, which is a government database that permits searches of various types of government data. However, the data was not always up to date. For example, for the Job Prosperity Fund the public information on the Ontario Data Catalogue was for July 1, 2009, to March 31, 2017. In this case, 19 recipients that had received in total $79 million in funding over the last two years had not been added to the portal. Another limitation of this database is that it does not allow the user to conduct searches by grant recipient to identify all funding a single recipient receives from any provincial grant program.

4.1.3 Recipients of Time-Limited Discretionary Grants Funded Indirectly by the Government Are Not Disclosed in Public Accounts

Based on our review of 2018/19 Public Accounts, we identified at least eight organizations that acted as flow-through entities because they received approximately $402 million in funding that was further disbursed to other recipients. Some of this funding was for the cost of administering the grants. For grants provided by flow-through organizations, only the name of the flow-through organization is listed in Volume 3 of the Public Accounts, not the final recipients of the funds. See **Figure 4** for a list of these organizations and related ministries.

We found that most of these flow-through organizations disclosed the names of grant recipients and amounts awarded, by grant program, on their individual websites. However, in most cases, the total funding disclosed was less than the amount of grant expenditures recorded in their audited financial statements, even after we took into consideration funding used by the organization for operating expenditures. In many cases, the latest available list of grant recipients was for 2017/18. Some specific observations we made were as follows:

- The Ontario Arts Council had not disclosed on its website the names of organizations that were awarded grants totalling $9.9 million in 2018/19. The Council disclosed an additional $7.5 million in grants following our inquiry about the discrepancy between the information on the website and the

Figure 4: List of Flow-Through Organizations and Amount of Funding Provided, 2018/19

Source of data: 2018/19 Public Accounts, Agencies'/Funds' Financial Statements and Websites

	Organizations	Amount of Funding Provided to Flow-Through Agencies/ Funds ($ million)
Ministry of Tourism, Culture and Sport		
1	Ontario Trillium Foundation	131.3
2	Ontario Arts Council	64.9
3	Ontario Media Development Corporation	45.3
4	Ontario Cultural Attractions Fund	2.0
Ministry of Energy, Northern Development and Mines		
5	Northern Ontario Heritage Fund Corporation	100.0
Ministry of Economic Development, Job Creation and Trade		
6	Ontario Centres of Excellence	37.4
7	MaRS Discovery District	19.3
Ministry of Agriculture, Food and Rural Affairs		
8	Greenbelt Fund	2.2
Total		**402.4**

amount of grants expensed on their financial statements for the year. Recipients of an additional $2.4 million in grants were still undisclosed on their website.

- The Ontario Media Development Corporation provided grants totalling $37 million in 2018/19; however, on its website it disclosed the names of about 400 organizations that were awarded grants totalling only $11.1 million.
- The Ontario Trillium Foundation received $131 million in funding in 2018/19 from two ministries for three grant programs and awarded $121 million to grant recipients; the remaining funding went toward operating costs. For the grants it awarded in 2018/19, the Foundation disclosed on its website only $94.1 million to grant recipients for one of the three grant programs it administered. For the other two grant programs, the latest list of grant recipients disclosed was for 2017/18.
- The Northern Ontario Heritage Fund Corporation does not disclose the recipients to which it provides financial assistance. In its latest financial statements, it reported grants totalling $105.9 million in 2018/19 and 94 million in 2017/18.
- The Ontario Centres of Excellence and the MaRS Discovery District do not disclose the recipients to which they provide grants. In 2018/19 they were provided with $37.4 million and $19.3 million respectively to allocate to recipients.

In contrast, we found that the then Ministry of Health and Long-Term Care did list all of the recipients in Volume 3 of the Public Accounts paid through its four flow-through agencies. In 2017/18, the then Ministry of Health and Long-Term Care provided funding to 127 recipients for a total amount of $245.7 million through four flow-through agencies. The Ministry publicly disclosed each of the 127 recipients and their corresponding amount of funding.

The federal government also makes flow-through grant information available on one common platform (Open Canada). The details include the recipient, the granting ministry or agency, the funding amount and in some cases additional detail such as the purpose of the grant and expected timelines for the use of the funds or the project start/end date.

RECOMMENDATION 3

To increase transparency and greater accountability for government funding, we recommend that the Treasury Board Secretariat, in conjunction with granting ministries, publicly disclose on one platform all recipients of government funding received directly through a ministry or indirectly through a flow-through organization, by granting program.

SECRETARIAT RESPONSE

The Treasury Board Secretariat (Secretariat) will support granting ministries to publicly

report in the Public Accounts of Ontario the recipients of government funding received directly through a ministry or indirectly through a flow-through organization, by granting program. To achieve this, the Secretariat will revise instructions provided to ministries to expand reporting requirements.

4.2 Grants Ontario System

4.2.1 Some Ministries Are Still Not Using the Grants Ontario System and Most Ministries Are Not Using All Key System Components

As of September 2019, more than three years after the government-wide Grants Ontario system was made mandatory, not all ministries were using the system for all of their time-limited/project-based discretionary grants. According to the information provided by the Transfer Payment Ontario Branch, only 53% of all time-limited discretionary grants were recorded on the Grants Ontario system.

For example, as of September 2019, the Cabinet Office and the Ministry of Long-Term Care were not using the Grants Ontario system for their time-limited discretionary grants. The Cabinet Office stated that the volume of grants and the limited number of recipients does not justify the costs associated with using the Grants Ontario System. In 2018/19, Cabinet Office provided $432,000 in grant funding under two grant programs. The Ministry of Health and the Ministry of Long-Term Care stated that the Grants Ontario system was designed to receive applications from many different potential applicants that are relatively small. In contrast, the grant activity of both the Ministry of Health and the Ministry of Long-Term Care is to provide ongoing funding to a relatively stable and unchanging number of recipients (that is, hospitals and long-term care homes) for which time-limited discretionary funding is generally provided in conjunction with ongoing funding.

Other ministries, like the Ministry of Natural Resources and Forestry, are using the system for some but not all their time-limited discretionary grant programs. The Ministry of Natural Resources and Forestry stated that it does not have the funding required to transition its remaining programs onto the system. While the other remaining ministries told us that they were in the process of transitioning all of their time-limited grants on to the system.

The Grants Ontario system includes six life cycle stages with 23 modules in total. As shown in **Figure 5**, not all grant programs on the system use all of the modules. A very high number of grant programs do not use the risk assessment module (97%), the performance measures module (72%), or the standardized contracts (100%) contained in the system. All these modules were designed to help capture relevant data and meet the requirements of the Transfer Payment Accountability Directive discussed in **Section 2.5.1**.

Most ministries we contacted were not using all modules to manage their time-limited grants within the system. The reasons they provided for not using the modules included:

- the system modules were too complicated and staff did not receive sufficient training on these modules;
- the budget module does not allow recipients of multi-component grants to input multiple budgets within one application, but instead forces recipients to create new applications for each budget component (an example of a multi-component grant is the Agricultural Drainage Infrastructure Program that includes grants for supervision, maintenance and construction);
- they were still in the process of implementing the system and have not yet started to use certain modules; and
- one ministry stated that it believed its internal risk assessment process is better than the risk assessment module in the system, which cannot accommodate all phases of the ministry's process.

Figure 5: Percentage of Grant Programs Using Grants Ontario Modules for Managing Grants, 2017/18[1]

Source of data: Transfer Payment Ontario Branch, Ministry of Government and Consumer Services

Life Cycle	Module Components	Yes[2] (%)	No (%)
Set-up and Design	Process Mapping	38	62
	Form Setup	68	32
	Web Portal	33	67
Intake	Electronic Submission	75	25
	Offline Applications and Reports	95	5
	Multi-tier Customer Support	100	0
Screening	Completeness Verification	91	9
	Eligibility Assessment	91	9
	Evaluation Scoring	77	23
	Risk Management	3	97
Approval	Funding Recommendation	100	0
	Approval Workflow	100	0
	Contract Generation	0	100
	Correspondence	99	1
Payments	Scheduling	100	0
	Authorization	100	0
	Credit Memos	69	31
	Recoveries/Repayments	72	28
	Payment integration with IFIS	100	0
Monitoring	Performance Measures	28	72
	Reporting (Report Backs)	50	50
	Corrective Action	38	62
	Notifications	100	0

1. Based on grant programs approved for funding in the Grants Ontario system in 2017/18. According to the information provided by the Transfer Payment Ontario Branch (formerly Grants Ontario Business Office), only 53% of total time-limited grants had been transferred to the Grants Ontario system.
2. Module components used by less than 50% of programs in the Grants Ontario system are noted in grey.

Incomplete Data in the Grants Ontario System Does Not Facilitate Province-Wide Analysis of Time-Limited Discretionary Grants

Since most ministries are not using all components of the system (especially the performance measures module), the province is missing out on one of the intended benefits of the centralized system—that is, sharing information to support better decision-making across government. Instead, the information coming from the centralized system is incomplete or unreliable for provincial-level or government-wide analysis.

Ministries not using the system are also at risk of making payments to recipients that may be in default for misuse of funds with another ministry, since the system allows ministries to flag any recipient for violating the terms of the agreement and this flag is accessible to all ministries using the system. If ministries are performing their own risk assessments and tracking performance measures outside of the system, this leads to inefficiencies and an inability to share critical information with other ministries that are considering providing grants to the same recipients.

While the Transfer Payment Ontario Branch has implemented a business intelligence tool to help ministries generate grant-level or ministry-level reports, it noted that most provincial-level reporting is not useful because the ministries are not using all available modules and data is not being collected in a consistent manner. For example, instead of storing information in a manner that is easily transferable to the Grants Ontario System, some ministries simply attach a scanned file or email attachment that the system cannot read or use to generate reports.

Based on our discussion with the Transfer Payment Ontario Branch, its goal is to get all ministries to use all applicable modules of the system. However, the Branch can only encourage ministries to use the modules because its role is to support the ministries and not to enforce use.

4.2.2 Expected Benefits of Implementing Grants Ontario System Not Achieved

In 2016, when the Treasury Board approved the Grants Ontario System as the mandatory government-wide system for grants, the system implementation was expected to lead to efficiencies and other benefits for the ministries using the system.

As noted in **Figure 6**, a few key benefits of implementing the system were to create efficiencies and reduce workload for ministries through standardization of the granting process, and by providing a common platform for ministries to share recipient funding and performance information for improved oversight and evidence-based decision-making across provincial grant programs. However, most of these benefits have not been achieved because not all ministries are using the system and those that are using the system are not using its full capability.

The Ministry of Government and Consumer Services has not developed performance measures for the Grants Ontario system. Appropriate performance measures, such as the percentage of grant programs on the system and using all available modules in the system, and the decrease in ministries' administrative costs, would help the Ministry and the Transfer Payment Ontario Branch assess whether the implementation of the system has achieved the expected benefits contained in the 2016 business case.

4.2.3 User Satisfaction with the Grants Ontario System Not High for Ministries That Are Using the System

At the time of our audit, the Transfer Payment Ontario Branch was collecting performance-related information through voluntary surveys of both external and internal users of the system (that is, registered grant recipients and ministry staff, respectively). Areas assessed by the survey included the following:

- frequency of use of the Grants Ontario system;
- ease of use when navigating the system;
- reasons for difficulties experienced while using the system;
- client satisfaction with customer service;
- overall effectiveness of the onboarding and program setup process;
- overall effectiveness of the training to prepare users; and
- suggestions for improvements.

The latest survey of ministry users was conducted in November 2018, and for external users it was conducted in August 2018. The response rate was low—only 16% for ministry users, and only 30 to 59 external users, depending on the survey question. According to the surveys, 41% of ministry users and 51% of external users found the Grants Ontario system difficult to navigate.

Most difficulties encountered by external users related to finding their way around the system (70%); downloading or uploading an application (57%); downloading or uploading a report (50%); attaching documents (50%); and uploading organization profile information (37%).

Most difficulties encountered by ministry staff involved querying the system (28%); case views

Figure 6: Status of Key Expected Benefits of Implementing the Grants Ontario System

Prepared by the Office of the Auditor General of Ontario

Expected Benefit	Status	Explanation
Establishment of common business processes for program administration.	Complete	Standardized grant modules, as identified in **Figure 5**.
Increase customer satisfaction.	Incomplete	Administrative burden for potential applicants has been reduced according to a government study called the *2018 Burden Reduction Report*. But user surveys indicate users still find it difficult to use the system.
Improved stewardship of public funds, allowing government to assess ministry and program performance.	Incomplete	Most ministries are not entering all grant information into the system. As of March 2019, there were 26 other transfer payment systems in use by Ontario ministries. These systems cost $45 million in total to operate.
Improved evidence-based decision-making by linking financial and grant program information through unique identifiers.	Incomplete	Each applicant must use their business number as a unique identifier. Lack of recipient risk analysis and performance results make evidence-based decisions difficult.
Improved accessibility to information through a single, consistent record system across the government.	Incomplete	Not all programs are using the system.
Improved risk management and transparency of funding relationship between province and recipient.	Incomplete	Funding relationship is transparent for programs that use the system. 97% of grant programs using the Grants Ontario System do not input risk management information in the system.
Consistent and on-demand reporting across programs and ministries.	Incomplete	Ministries do not input all relevant grant information into the system, therefore they are unable to generate useful monitoring reports.
Improved resource management by automating common grant management functions to reduce administrative costs.	Incomplete	To date, no analysis has been conducted on whether cost savings have been realized or workloads reduced.
Incorporation of best practices from existing policies and directives for transfer payment administration.	Incomplete	System provides the tools for implementing best practices, but they are not being used by all ministries.

(22%); payments (22%); and reports (22%). The exact nature of ministries' concerns was not known because users were not asked to provide details when checking off specific categories in which they were encountering problems.

In late August 2019, the Transfer Payment Ontario Branch implemented a system update that is expected to make the system more user-friendly. The update includes an interactive funding dashboard, task-based navigation and a simplified design.

We also surveyed several ministries that were using the Grants Ontario system to obtain their feedback on the system. They raised several issues, mainly to do with intake of applications, payment processing, training, technical support, and general usability of the system. Some of the issues are summarized in **Figure 7**.

One issue raised by ministries was external users having trouble uploading information. In particular, the most common complaint was that applicants had trouble saving an application in progress because the system would indicate an error in the application without identifying the source of the error. When the applicant tried to save the application, the system would appear to the user to delete partially completed applications rather than saving them, but in fact the incomplete applications remained in the system. This led to many applicants partially filling out grant applications multiple times before they successfully submitted an application.

Figure 7: Issues with the Grants Ontario System Noted by Ministries[1]

Prepared by the Office of the Auditor General of Ontario

System Issues Noted	# of Ministries Impacted
Recipients have trouble getting assistance from the system helpline with long wait times during peak periods. (From April 2018 to September 2019, over 1,900 user-reported system disruptions.)	8
Recipients that receive cheques without description.[2]	8
System implementation training is not sufficient.	7
Budget template in system is not practical and cannot be customized.	7
Downloading files from the system is difficult.	6
Recipients have trouble uploading/submitting reports prior to the deadline or Grants Ontario staff fail to input application received offline prior to the deadline.	3
Payments have to be approved individually instead of allowing batch approval for large number of recipients. (In 2017/18, 13 grant programs paid over 100 recipients.)	2
The system feature that flags recipients who perform poorly or don't comply with contract requirements, does not provide enough information and is not used effectively by ministries.	2

1. Based on survey results from 13 ministries that use the system.
2. Staff at Transfer Payment Ontario Branch informed us that grant recipients can access payment information details on their account with the Grants Ontario System.

The system does not differentiate between complete and partially complete applications, and therefore the ministries had to review all of the draft applications to ensure no applications were missed. The ministries also noted that some grant recipients had difficulty submitting final reports.

One of the key features of the Grants Ontario system is to allow ministries to share concerns about problematic recipients. The system allows the granting ministry to flag grant recipients who perform poorly or do not comply with contract requirements, and to inform other ministries who might have granted, or are considering granting funding to the same recipient. However, the flagging feature only identifies the ministry that flagged the recipient without providing any additional details or contact information for the individual or organization within the ministry that first issued the flag. The Ministry of Indigenous Affairs told us that it was difficult to find the cause for each flag because it must contact the other ministry to try to track down details on the flag. In some cases, the Ministry eventually found out that the cause for the flag was no longer relevant. At the time of the audit, there was no requirement to remove the flag once the flagged condition had been resolved.

RECOMMENDATION 4

To encourage more ministries to use the government-wide Grants Ontario system and all relevant and applicable modules available in the system for the administration of their grants, we recommend that the Transfer Payment Ontario Branch within the Ministry of Government and Consumer Services:

- develop a plan with specific timelines to address concerns with the system raised by ministry staff and external users in its user satisfaction surveys; and
- implement practical solutions that will make the Grants Ontario system user-friendly, effective and efficient.

MINISTRY RESPONSE

The Ministry of Government and Consumer Services will work to respond to user needs identified through satisfaction surveys and other sources, by updating the system on a regular basis for ongoing improvements.

RECOMMENDATION 5

To maximize the benefits of a complete government-wide grants database that produces comparable, consistent and reliable reporting, we recommend that the Treasury Board Secretariat, in conjunction with the Transfer Payment Ontario Branch:

- reinforce the communication that all ministries are to use the government-wide Grants Ontario system and all relevant and applicable modules available in the system for the administration of their grants once the concerns raised by ministry staff and external users with respect to the system have been addressed;
- clearly define all key inputs to be entered into the Grants Ontario system and ensure all ministries are entering information consistently; and
- monitor utilization of the system.

RESPONSE FROM SECRETARIAT AND MINISTRY

The Treasury Board Secretariat (Secretariat) and the Ministry of Government and Consumer Services (Ministry) agree with the Auditor General's recommendation, and will use the observations to help inform the transformational initiatives that are underway.

Towards that end, the Ministry will continue to engage ministries on transitioning all transfer-payment programs onto the Transfer Payment Ontario system, including the development of work plans and associated timelines. The Ministry will work directly with ministries to expand usage of modules that support program delivery, and to adopt best practices for transfer payment contract management and administration.

The Ministry will continue to work with ministries to build knowledge and capacity using the Transfer Payment Ontario modules to provide data driven insights to better support evidence-based decision-making.

The Secretariat will also support ministries on plans outlining how they and their provincial agencies who have a mandate to provide discretionary grants, will move to the Transfer Payment Ontario system.

The Ministry and the Secretariat will work with ministries on education and awareness of good data practices to improve data integrity, including clear understanding of data elements and consistency with data reporting and collection.

4.2.4 Grants Ontario System Costs

The Grants Ontario system was built in 2012 at a cost of $8.3 million to manage time-limited grants across all provincial ministries.

We reviewed the annual cost of operating the system over the last four years (2015/16–2018/19) in relation to the number of grant programs using the system at each year-end, as shown in **Figure 8**. We noted that the operating costs of the system have increased by over 120%, from $4.0 million to $8.9 million, and the number of staff has grown 228%, from 17.5 to 57 full-time-equivalent positions. At the same time, the number of grant programs on the system has increased by 268%, from 88 to 324 programs. These grant programs include time-limited and ongoing grants. Often, these grants may be recorded in the system multiple times by their individual components or various rounds of funding.

In 2018/19, the Transfer Payment Ontario Branch spent around $8.9 million in operating costs and to provide technical support for the Grants Ontario system. The initial cost of developing the system is less than its ongoing costs because of the high number of full-time-equivalent staff in the Transfer Payment Ontario Branch.

The staff are divided into two major groups. The Business Support Team provides support to ministries through the implementation process, onsite training, and ongoing data requests and operation of the system. The Digital Solution Team consists

Figure 8: Grants Ontario System—Operating Costs, Staffing and Number of Programs, 2015/16 to 2018/19
Source of data: Ministry of Government and Consumer Services

Operating Expenses	2015/16	2016/17	2017/18	2018/19
Salaries and Wages	2,0152,63	2,911,255	4,290,951	5,066,241
Employee Benefits	–	352,568	586,749	626,624
Services	625,000	3,040,170	4,130,690	3,198,875
Supplies and Equipment	1,379,829	48,200	232,946	7,885
Transportation/Communications	–	80,300	51,985	43,325
Total	**4,020,092**	**6,432,493**	**9,293,321**	**8,942,950**
Grants Ontario Staffing (Full-Time Equivalents)*				
Digital Solution Delivery	11	32	32	32
Business Support	6.5	19	25	25
Total FTEs	**17.5**	**51**	**57**	**57**
Grant Programs Managed by Grant Ontario*				
Grant Programs (time-limited and ongoing)	88	226	313	324

* As of March 31 of each fiscal year end.

of IT programmers that focus on integration and innovations within the system based on ministry feedback, run queries for ministry data requests, and provide tech support for system issues. The Branch does not have workload statistics on the two groups. Based on the number of programs managed by the Business Support Team, over the last three fiscal years, the average number of grant programs managed per staff ranged from 17.2 to 19.3 per full-time equivalent.

At the time of our audit, there were no plans to deploy implementation staff elsewhere once all ministries have transferred onto the Grants Ontario system. The Ministry told us that implementation staff also support ongoing program changes that occur annually, and the level of support needed by ministries throughout program changes is similar to first-time implementation. In addition, the changes in government priorities are leading to major program changes across the government. The Ministry also told us that level of staffing required depends on the complexity of the grant program, length of grant application, number of applicants per program, and its expended mandate to implement recurring programs. However, we could not confirm the need for the staffing complement because the Transfer Payment Ontario Branch does not have workload and efficiency measures needed to assess if its staffing levels are appropriate.

Costs of maintaining the system are recovered from the participating ministries. For 2018/19, the cost per ministry user of the Grant Ontario system was $2,900 per year.

RECOMMENDATION 6

To manage the Grants Ontario system cost-efficiently, we recommend that the Transfer Payment Ontario Branch within the Ministry of Government and Consumer Services develop workload and efficiency measures and review its staffing model on an ongoing basis.

MINISTRY RESPONSE

The Ministry of Government and Consumer Services (Ministry) will continue to review the staffing model on an annual basis to ensure it supports the extensive business requirements and the complexity of the large number of programs that will be managed on the Transfer Payment Ontario System. As part of this analysis, the Ministry will develop metrics to ensure

efficient and cost-effective services are delivered to clients in early 2020/21.

The Ministry's Transfer Payment Ontario Branch has expanded its mandate significantly over the last 3 years, and now provides support and services to 20 ministries and more than 300 programs. Over the next 2 years this will increase by an additional 500 new programs, including those that are recurring.

4.2.5 Most Ministries Do Not Check if Grant Applicants and Recipients Have Outstanding Environment or Labour Violations That Have Not Been Resolved

Prior to awarding grants, most granting ministries do not check whether grant applicants (that is, businesses) are in violation of any provincial legislation (such as those relating to environmental protection or occupational health and safety) or whether applicants are under investigation for such. Granting ministries also do not ensure whether the applicant has provincial taxes owing.

We noted two exceptions. The Jobs and Prosperity Fund under the Ministry of Economic Development, Job Creation and Trade, completes a compliance check with the relevant ministries to ensure that the applicants do not have any tax liabilities, environmental violations, or labour law violations, before awarding a grant to an applicant. However, the funding agreements under this program are for terms of between five and nine years, and ministry staff do not perform subsequent compliance checks or monitor compliance with provincial laws throughout the term of the agreement. The Ministry of the Environment, Conservation and Parks also performs compliance checks to confirm that grant applicants are in good standing with environmental requirements.

None of the other ministries from which we selected grants for review (Ministry of Heritage, Sport, Tourism and Culture Industries, Ministry for Seniors and Accessibility, and Ministry of Indigenous Affairs) or other grant programs at the Ministry of Economic Development, Job Creation and Trade perform a similar compliance check for environmental or labour violations or outstanding provincial taxes.

RECOMMENDATION 7

In order that government funding is provided only to grant applicants in good standing with provincial statutes when the grant constitutes a significant monetary amount, we recommend that the Treasury Board Secretariat require ministries to verify an applicant's status with respect to outstanding environmental and labour violations and any outstanding taxes before making a grant payment.

SECRETARIAT RESPONSE

The Treasury Board Secretariat (Secretariat), with support from the Ministry of Government and Consumer Services (Ministry) and the Ministry of Finance, will determine ways to leverage existing tax compliance tools and processes currently used for the purpose of government procurement, and identify how the tax-compliance verification processes could be applied in the context of discretionary grants. Alternative mechanisms will be developed where existing tools and processes are not sufficient to address the recommendation.

In addition, the Secretariat and the Ministry will determine the best means to access information on a potential recipient's status with respect to environmental and labour violations.

4.3 Grant Programs Tested—Selection and Funding of Grant Recipients

4.3.1 Some Grants Awarded to Recipients by the Ministry of Heritage, Sport, Tourism and Culture Industries Not Based on Evaluation Criteria

We noted that for three programs we selected for review, administered by the Ministry of Tourism, Culture and Sport, some grant recipients were selected at the discretion of the Minister, even though they did not meet minimum evaluation criteria established for the particular grant programs. We noted that the Ministry of Tourism, Culture and Sport has allocated about 10% of grant funding to events at the discretion of the Minister over the last few years.

The Transfer Payment Accountability Directive provides direction on determining a recipient's eligibility and requirements for documenting funding decisions. A ministry that wants an exemption from part or all of the directive, only for exceptional circumstances, must seek Treasury Board/Management Board of Cabinet approval. In addition, the ministry must set out the rationale for the exemption in a business case. We noted the Ministry did not request an exemption from Treasury Board for any of the grant programs we tested where grants were awarded under ministerial discretion.

Celebrate Ontario Grants

Since its inception in 2007, the Celebrate Ontario grant program of the Ministry of Heritage, Sport, Tourism and Culture Industries has provided financial support to festivals across the province.

All applications for funding are evaluated by the Ministry. Most small- and medium-sized events, for applicants with an operating budget less than $1 million, are evaluated by regional staff. Large events with operating budgets of at least $1 million are evaluated by the Ministry's corporate office. Senior ministry staff present to the Minister a listing of all assessed events sorted by their evaluation scores and multiple funding options. These options identify different combinations of small, medium and large events for funding. Under all funding options, an amount ($2.3 to $3.8 million in 2017/18) is set aside to fund other priority events identified by the Minister.

Funding to festivals over the last three years ending March 31, 2019, has totalled $55.2 million, of which $5.9 million (or 10% of funding) to 132 recipients was awarded under ministerial discretion to applicants that did not achieve the minimum evaluation score required for funding approval, as seen in **Figure 9**. For 2018/19, the minimum score required for funding was 56/100 for small- or medium-sized organizations and 65/100 for large organizations. Another $15.2 million was awarded in 2019/20, of which $2.5 million (or 16%) was

Figure 9: Celebrate Ontario Grant Approvals for Festivals, 2016/17 to 2018/19

Source of data: Ministry of Tourism, Culture and Sport

	2016/17	2017/18	2018/19	Total	2019/20[1]
# of grant applications	465	427	441	**1,333**	412
# of applications approved	200	304	328	**832**	275
# of applications approved via Minister's discretion[2]	35	56	41	**132**	73
Overall grant funding approved ($ million)	15.3	19.6	20.2	**55.2**	15.2
Funding awarded to recipients approved via Minister's discretion ($ million)	1.6	2.4	1.9	**5.9**	2.5
% of grant funding awarded through Minister's discretion	10	12	9	**10**	16

1. For grants awarded as of August 2, 2019, in the 2019/20 fiscal year.
2. The total number of unique events funded via Minister's discretion was 159.

in grants made under ministerial discretion to 73 recipients. In fact, 30% of funding awarded through ministerial discretion over the last four years was for applicants that scored at least 15 points below the minimum evaluation score. When we asked Ministry staff if they agreed with the events approved through the Minister's discretion, they told us that they put forward their best advice based on their evaluations of each applicant.

For funding under this grant program, Ministry staff review each applicant and score the event out of 100. For 2018/19, the evaluation criteria were as follows:

- Performance measurement, impact and marketing—25 points.
- Financial position and organizational capacity—20 points.
- Project information and sustainability—15 points.
- Tourism packages offered and event partnerships—15 points.
- Tourism analysis and support for tourist demand—10 points.
- Event budget analysis (forecast surplus/breakeven)—10 points.
- Accessibility for Ontarians with disabilities—5 points.

For the period 2016/17 to 2018/19, funding for recipients who scored below the minimum required score but were approved for funding under ministerial discretion was justified based on the fact that they fell under a certain priority category, such as supporting regional, multicultural, francophone or Indigenous/northern events. Aside from noting the priority category for each approved applicant, there was no other documented justification on file explaining why the Minister chose to fund a certain applicant over another applicant in the same category that had scored higher. For 2018/19, we identified 24 unsuccessful applicants that scored below the minimum required, but had a higher score than at least one recipient in the same region and for a similar-sized event who was awarded funding through ministerial discretion.

In 2019/20, 36 applicants that achieved the minimum score were not approved for funding, while 73 other recipients that scored below the threshold were approved for funding under ministerial discretion. In contrast, from 2016/17 to 2018/19, all applicants that achieved the minimum required score were approved for funding. When we asked the Ministry why applicants who met the minimum required score were not approved for funding in 2019/20, we did not receive a satisfactory answer. For applicants that did not achieve the minimum score but were approved for funding by the Minister in 2019/20, no justification was provided for their selection. In this case, there was no indication of what priority area the applicants were selected to address.

Over the last four years, this Ministry has had five different Ministers. Of the 159 unique projects approved through ministerial discretion over the last four years, we noted that 36 were approved through ministerial discretion at least twice and by different ministers. Twelve of these events were funded by ministers representing two different political parties.

Ontario 150 Grants

Similarly, two other grant programs of the Ministry of Heritage, Sport, Tourism and Culture Industries provided funding to low-scoring applicants based solely on ministerial discretion. These programs were short-term in nature as they were intended to celebrate Canada's 150th anniversary.

The Ontario 150 Partnerships grant program provided 13 grant recipients (15%) about $700,000 in total under ministerial discretion, including seven recipients that scored at least 15 points below the minimum required score. As well, the Ontario 150 Community Celebration grant program provided another 15 grant recipients (4%) about $520,000 in total funding under ministerial discretion even though their evaluation score was also below the minimum required. There was no rationale documented for any of these funding decisions.

RECOMMENDATION 8

To provide funding to grant recipients in an objective and transparent manner based on their applications submitted, we recommend that:

- the Ministry of Heritage, Sport, Tourism and Culture Industries follow the Transfer Payment Accountability Directive in selecting grant recipients and seek Treasury Board/Management Board of Cabinet approval prior to awarding grant funding to recipients that did not meet eligibility criteria and were selected under the Minister's discretion; and
- Treasury Board Secretariat reinforce the requirements of the Transfer Payment Accountability Directive with ministries, with respect to the use of exemptions and the need to document the rationale for funding decisions.

RESPONSE FROM THE MINISTRY OF HERITAGE, SPORT, TOURISM AND CULTURE INDUSTRIES

The Ministry of Heritage, Sport, Tourism and Culture Industries supports the recommendation for greater transparency in decision-making and will seek Treasury Board/Management Board of Cabinet approval prior to awarding grant funding to recipients under the Minister's discretion in the future.

SECRETARIAT RESPONSE

The Treasury Board Secretariat accepts the recommendation and will work with ministries to support awareness and reinforce the requirements of the rules in the Transfer Payment Accountability Directive, including the requirements related to selection and eligibility criteria, documentation and any exemptions to the rules.

4.3.2 Grant Criteria Not Consistently Applied to All Applicants

Under the Ministry of Economic Development, Job Creation and Trade's Jobs and Prosperity Fund—New Economy Stream, three organizations did not receive funding despite having a higher overall assessment score than 17 projects that did receive funding, as shown in **Figure 10**. The three recipients collectively were eligible for $18 million in funding, if approved. For this grant program, applicants did not have to achieve a minimum score.

According to the Ministry, these three organization were not funded because the organizations had significant resources to complete the projects without government funding. However, the same criteria were not consistently applied to other applicants. For example, we noted that only two of the 36 successful applicants had stated that their projects would not go ahead without government funding. The other 34 organizations stated that the lack of government funding would not deter the projects from being completed.

4.3.3 Correct Amount Awarded to Approved Applicants, but Need for Funding Is Not Always Considered

Overall, grant programs that we reviewed had set clear criteria for determining the amount of funding per recipient, as seen in **Figure 11**. Of the 15 grant programs we reviewed, the funding for

Figure 10: Evaluation Scores for the Jobs and Prosperity Fund—New Economy Stream, January 2015–March 2019

Source of data: Ministry of Economic Development, Job Creation and Trade

Applicant Score Range (Phase 1)	# of Applicants	# of Applicants Approved	# of Applicants Not Approved
85–90	7	7	0
80–84	15	12	3
70–79	17	17	0
Total	**39**	**36**	**3**

Figure 11: Grant Funding Details and Whether Need for Funding is Considered by Grant Program

Source of data: Ministry of Economic Development, Job Creation and Trade

Name of Grant	What is Being Funded?	How is Funding Amount Determined?*	Maximum Funding per Recipient*	% of Points Awarded Based on Applicant's Need for Funding
Jobs and Prosperity Fund—New Economy Stream	Project-related costs including research, labour, facility modification, materials, equipment and machinery	Up to 20% in grants or up to 40% in loans or combination of grants and loans	No maximum	5
Campus linked accelerator/ Ontario Campus Entrepreneurship Activities	Operating costs for post-secondary entrepreneurship programs	33% of eligible operating costs	No maximum	0
Campus linked accelerator/ Ontario Campus Entrepreneurship Activities—GlobalStart Voucher program	Travel costs, networking events, conferences, etc.	50% of eligible costs	$15,000	0
Youth Skills Connections—Industry Partnerships	Training staff, equipment, facilities, and advertising	50% of program cost	$1.5 million	0
College Applied Research and Development Fund	Research and development project costs (e.g., experimental design, lab testing)	50% of eligible costs	$20,000–$1 million	0
Ontario Scale-Up Vouchers Program	Executive leadership and training and other growth activities	Up to 50% of eligible costs depending on applicant's revenues and private investments	$150,000–$1 million, depending on applicant revenues and private investments	0
Celebrate Ontario	New additions or enhancements to events	Lesser of: 25% of regular event expenses or 50% of any new additions or enhancements	$50,000–$300,000, depending on operating costs of event	0
Ontario 150—Community Celebrations	Costs for additions or enhancements to events focused on 150th anniversary	75% of eligible costs	$10,000–$70,000, depending on applicant's operating budget	0
Ontario 150—Partnerships	Eligible project costs for youth-focused programs	75% of eligible cost	$100,000	0
Ontario Games	Cost to host sporting events (venues, equipment, accommodations)	$110,000–$1 million, depending on the type of games (Parasport, 55+ games, youth games)	$110,000–$1 million, depending on the type of games	n/a
Ontario Municipal Partnership Fund	Municipal operating costs	Based on five grant component calculations	No maximum	n/a (Funding formula accounts for need)

Name of Grant	What is Being Funded?	How is Funding Amount Determined?*	Maximum Funding per Recipient*	% of Points Awarded Based on Applicant's Need for Funding
New Relationship Fund	Consultation coordinator related costs	100% of eligible costs	$90,000	0
Great Lakes Guardian Community Fund	Eligible environmental project costs	100% of eligible costs not covered by other sources	$25,000	0
Age-Friendly Community Planning Grant	Costs of community planning work to make it more age-friendly and accessible (capital projects are not eligible)	100% of eligible costs	$25,000–$50,000, based on population of municipality	0
Response to violence in the Rakhine State of Myanmar	International disaster relief efforts	Cabinet Office decision	No maximum	n/a

Note: n/a = not applicable

* Based on the last funding year for the grant.

12 of them was based on a percentage of eligible costs. For the other three, one program (Ontario Municipal Partnership Fund) provided funding to municipalities using a pre-determined funding formula, another program (Ontario Games) provided a fixed amount of funds to municipalities based on the type of games being hosted, and in the third case (funding for international disaster-relief efforts) did not document how the level of funding was determined.

We calculated the funding amounts awarded to a sample of grant recipients in these programs to determine if the amount of funding awarded was accurate according to funding criteria. Our testing showed that the amounts awarded were accurate, did not exceed the amount requested by the applicant, and did not exceed the maximum funding allowed per recipient as established by each grant program, except for instances identified in **Sections 4.4.2** and **4.4.3**.

Most Grant Programs Do Not Consider an Applicant's Need for Government Funding during Selection

Recipients' need for funding was considered in the selection criteria for only two of the 15 grant programs we reviewed. The percentage of points awarded to applicants based on their need for funding under the Jobs and Prosperity Fund—New Economy Stream was 5%. For the Ontario Municipal Partnership Fund, the need for funding was built into the funding formula. Based on our review, we noted that the Ontario Scale-Up Vouchers Program, whose objective is to accelerate the growth of start-up technology companies, provided funding to businesses that had a significant amount of resources available to them already. Prior to receiving support from the program, 27 recipients combined had raised $491 million in capital ranging from $700,000 to $70 million each.

Under the New Relationship Fund (Ministry of Indigenous Affairs), the Ministry provides First Nation and Metis communities with funding for one consultation co-ordinator, without considering their workload (based on the number of requests received for consultation) or need for funding. For 2018/19, the funding per community was $90,000 (to cover the costs of one consultation co-ordinator and related expenses for training, travel and administration) regardless of the amount of consultation activity undertaken by each First Nation. According to expense reports submitted by First Nations to the Ministry over the last five years, the number of consultation requests ranged from 14 for one First

Nation to 1,177 for another. Both First Nations were eligible for the same amount of funding.

In our 2015 audit report of Economic Development and Employment Programs, based on a review of other grant programs, we recommended that the Ministry establish evaluation criteria that better assesses whether funding for projects is needed in order for the project to proceed. According to the Ministry's response in 2015, the new Jobs and Prosperity Fund (which was not audited in 2015) was to address this recommendation. However, in our review of the Jobs and Prosperity Fund, we noted that the need for government support only accounts for 5% of the evaluation criteria. Since this program started in 2015, only two of 31 grant recipients indicated that their projects would not go ahead without provincial funding.

RECOMMENDATION 9

In order to provide funding where most needed, we recommended that the granting ministries provide grant funding to recipients based on need and establish evaluation criteria that better assess whether funding for projects is needed in order for the project to proceed.

RESPONSE FROM GRANTING MINISTRIES

The granting ministries generally agreed that the design of grant programs should include elements and criteria to direct funds where financial support or incentives are needed for projects to proceed.

The Ministry of Economic Development, Job Creation and Trade noted in their response that in a number of their programs, a recipient's need for funding is one of several key criteria that are used to assess if funding is warranted.

The Ministry of the Environment, Conservation and Parks noted that it does not specifically award grants based on need; rather, it is focused on the likelihood for environmental benefits, community engagement and collaboration, and sound project design.

Ministries committed to assess developing and implementing appropriate criteria in future program design to better assess funding needs in conjunction with recipients' capacity to successfully deliver on the objectives of the program.

4.4. Monitoring of Grant Recipients

4.4.1 Ministries Rely Primarily on Self-Reported Information to Assess Use of Grant Funding

According to the Transfer Payment Accountability Directive, ministries must monitor recipients throughout the term of the grant agreement to ensure they are spending the funds as intended and progressing toward achieving the intended goal. As seen in **Figure 12**, based on our review of 15 grant programs, ministries were receiving segregated, project-specific financial information to assess the use of funding for 13 grants (the two exceptions were grants for international disaster-relief efforts and under the Ontario Municipal Partnership Fund). However, only three programs required recipients to provide independent verification by submitting audited financial information. The other 10 grant programs only required unverified spending information; of these, the ministries verified spending through invoice testing for only five grant programs.

4.4.2 Some Grant Recipients We Visited Were Reimbursed for Ineligible Expenses and Projects

The Ministry of Heritage, Sport, Tourism and Culture Industries did not request invoices from grant recipients funded under the Celebrate Ontario, Ontario 150—Community Celebrations, and Ontario 150—Partnerships grant programs. Although the Ministry provides recipients with a list

Figure 12: Monitoring of Grant Programs by Ministries

Prepared by the Office of the Auditor General of Ontario

Name of Grant	Segregated, Project-Specific Financial Information Provided?		Ministry Verification		
	Audited[1]	Unaudited	Invoice Testing of Expenses?[2]	Performance Data Reported is Verified?[3]	Site Visit Conducted?[4]
Jobs and Prosperity Fund—New Economy Stream	✓		✓	×	✓
Campus linked accelerator/ Ontario Campus Entrepreneurship Activities		✓	✓	×	✓
Campus linked accelerator/ Ontario Campus Entrepreneurship Activities—Global Start Voucher Program		✓	✓	×	×
Youth Skills Connections—Industry Partnerships		✓	✓	×	✓
College Applied Research and Development Fund		✓	✓	×	✓
Ontario Scale-Up Vouchers Program		✓	✓	×	×
Celebrate Ontario	✓		×	×	✓
Ontario 150—Community Celebration		✓	×	×	✓
Ontario 150—Partnerships	✓		×	×	×
Ontario Games		✓	×	×	✓
Ontario Municipal Partnership Fund[5]	n/a	n/a	n/a	n/a	n/a
New Relationship Fund		✓	×	×	×
Great Lakes Guardian Community Fund		✓	×	×	×
Age-Friendly Community Planning Grant		✓	×	×	×
Response to violence in the Rakhine State of Myanmar		×	×	×	×

Note: n/a = not applicable

1. The Jobs and Prosperity Fund—New Economy Stream's segmented financial information was audited at project end. For Celebrate Ontario and Ontario 150—Partnerships, grantees receiving over $75,000 provided an audit opinion on their event expenses.
2. Most of the invoice testing was done on a sample basis, except for the Ontario Scale-Up Vouchers Program, where all invoices were reviewed.
3. Performance data reported to ministries is not typically verified, except in certain instances (e.g., the number of jobs retained and created at project-end is verified for the Jobs and Prosperity Fund—New Economy Stream, and the economic impact of Ontario Games is measured for that event).
4. In the cases of Celebrate Ontario and Ontario 150—Community Celebration, we noted that only a small percentage of recipients were visited, most of which had been assessed as low-risk (as detailed in **Section 4.4.4**).
5. The Ontario Municipal Partnership Fund is an unconditional grant to 389 of more than 400 municipalities with no monitoring.

of eligible expenses in the application guide, it said this list is not exhaustive, and staff use their best judgment to determine eligible expenses related to its grant programs. We contacted a sample of recipients from these three grant programs to assess if the expenses they claimed were eligible for funding. Based on our limited sample, we found the following instances associated with 45% of grant recipients where the recipients had been reimbursed for ineligible expenses:

- For Celebrate Ontario, we selected for testing a sample of recipients that received about $345,000 in funding combined over the last two years. Based on our testing, we found that all the recipients we sampled had claimed ineligible expenses totalling almost

$87,000, and had been overpaid by about $42,000. For example, one street festival in Toronto claimed $67,600 in ineligible expenditures such as $19,000 for hanging flower baskets that remained in place for the whole season, $17,400 for HST, $11,500 for the payroll from April to August 2018, and $4,800 for office expenses (including, for example, rent and utilities). Ministry funding was intended to cover only enhancements to the event; therefore, regular costs, such as payroll for permanent staff, were not eligible. In addition, three other events we tested had reported ineligible expenses, such as $6,000 for an event in the previous year.

- Under the Ontario 150—Partnerships program, the Ministry provides support of up to 75% of eligible project costs up to a maximum of $100,000. For example, the Ministry provided $75,000 in funding to an organization to promote women's engagement in politics and to host an event at Queen's Park. The recipient claimed $115,000 in expenses. When we asked for supporting documentation for the amount claimed, the recipient submitted to us $135,000 in expenses. However, based on our review, we noted that only $17,200 were eligible or directly related to the project. The majority of the other expenditures claimed (about $85,000) were related to consulting work performed by the organization's executive director at a rate of $675 per day. Furthermore, the consulting invoices did not always outline the nature of the work performed. In some cases, the consulting charges were for other projects not related to the funded project. When we asked for more details on consulting expenses, the recipient was not able to provide any further information to substantiate the expenditures. In addition, the recipient claimed more than $16,000 in hotel expenses in Ottawa even though the event occurred in Toronto. When we inquired as to why this expense was incorrectly claimed, we were told that the members of staff that were involved with the expense claims no longer worked at the organization; hence, explanations for these expenses could not be provided.
- Under the Ontario 150—Community Celebrations program, we found two recipients that were funded for ineligible projects. One organization received $7,500 for its annual scholarship gala. However, events that occur annually were not eligible for funding unless the event added an Ontario 150–specific enhancement. Based on the recipient's application, this was a regular, annual event and there was no description of any enhancement. Similarly, another organization received funding for its annual religious meals. The Ministry was unable to substantiate that an event held at a religious location after nightly religious services was cultural rather than religious. Events that were primarily religious were not eligible for funding.

Based on our review of the New Relationship Fund, we noted that a First Nation's chief was receiving a salary as a consulting co-ordinator under the program (in the amount of about $60,000 in 2018/19), while also receiving a salary as the chief from the federal government (in the amount of about $126,000 in 2018/19). The program guidelines indicated that the consulting co-ordinator could not be drawing a salary from other sources. Although the chief had told the Ministry that they would not be drawing a salary from two sources, the Ministry had not followed up to confirm this.

4.4.3 Instances Where Grant Recipients Were Overpaid

Under the Celebrate Ontario grant program, funding for each event/recipient is based initially on the budget submitted by the applicant, but is to be adjusted once the actual expenditures are known. The final payment is to follow. Staff at the Ministry

of Heritage, Sport, Tourism and Culture Industries are expected to review each applicant's final report, which outlines use of funds (including summary of invoices) and performance results, before releasing the final payment.

For a sample of events funded from 2016/17 to 2018/19, we noted that the Ministry was not reviewing reports of the actual expenditures submitted by recipients and making adjustments to the grant amount based on the review. Based on our review and recalculation of the grant amount using actual expenditures submitted, we noted that 42% of events sampled were overpaid by $63,700 in total. This is in addition to overpayments we identified in **Section 4.4.2** by testing actual invoices.

We also found that 30% of events we sampled from the same three-year period received their final payment without ever submitting a final report of actual expenditures and performance results. One of these recipients, who also happened to be awarded funding under ministerial discretion, told us that they had not heard of the final reporting requirement for performance results and therefore had not submitted one for each of the past three years. The recipient had received their payment in full.

This issue had also been noted by an internal audit in May 2013. At that time, the Ministry responded that it was committed to holding back funds until a satisfactorily completed final report was received and approved.

4.4.4 Ministry Staff Not Visiting Recipients to Monitor Compliance with Agreement Terms

As mentioned in **Section 4.4.1**, ministries generally rely on self-reported information from funding recipients to ensure compliance with funding agreements. For seven of 15 grant programs we tested, granting ministries did not visit any recipients to confirm that the funded activities were taking place effectively. For example, the Great Lakes Guardian Fund under the Ministry of Environment, Conservation and Parks has provided over $7.6 million over the last four years to over 350 organizations to complete various environmental projects, such as tree planting, clean-up and others. Although the Ministry visited a few sites for promotional purposes and relationship-building, it was not to verify whether the approved grant activities were completed according to the terms of the funding agreement. Similarly, over the last five years, the Ministry of Indigenous Affairs, which has provided about $67 million in grants to First Nations from the New Relationship Fund, has not visited any First Nations to ensure funded activities were taking place, such as developing consultation protocols or processes, consulting with private sector, or municipal or provincial government staff, and training to improve consultation capacity.

According to the Transfer Payment Accountability Directive, ministries must exercise greater oversight for activities and recipients deemed to be higher risk. In our audit, we noted some cases where only a small percentage of grant program recipients/events were visited by ministry staff, and that those that were visited were not selected based on risk. For example:

- For the Celebrate Ontario grant, ministry staff (regional tourism advisors) visited 35 of 832 events (or 4%) over the last three years. However, 21 (60%) of the events visited had been rated as low-risk in terms of the recipient's ability to hold successful events. The risk rating was based on the application score given to the organization's financial position or organizational capacity. Ministry staff confirmed that the risk level of the recipient is not taken into consideration when selecting which events should be visited. Instead, ministry staff attended events based on their availability and their proximity to the event. In this regard, we noted a staff member who had visited the same event for five consecutive years (a theatre that hosts Canadian plays and music concerts).

- For the Ontario 150—Community Celebration grant, ministry staff visited 20 of 359 (or 6%) grant recipients over the period 2016/17 and 2017/18. Again, most grant recipients who were visited had been assessed as low risk. We noted that site visit decisions were made by ministry staff without direction from their managers.

4.4.5 Ministry Staff Not Reviewing or Verifying Performance Results Reported by Recipients

The ministries rely on performance results reported by grant recipients to assess progress toward meeting public policy objectives. Without reliable performance results, the ministries are not able to assess whether the grant program has met its objectives. As seen in **Figure 12**, 14 of the 15 grant programs we reviewed relied on recipient-reported performance results without verifying these performance results.

The Ministry of Heritage, Sport, Tourism and Culture Industries (Ministry) uses attendance and visitor expenditures to assess the economic impact of Celebrate Ontario grants. Attendance numbers are also considered when determining whether to fund recipients in future years. In our review of 33 events, every event projected a year-over-year increase in attendance in their application for funding. However, for 2017/18, the Ministry had to exclude 50% of recipients' actual performance results because the information was deemed unreliable. For example, some recipients were reporting an increase in visitors to their events that exceeded the total attendance reported for the event, while some reported that new visitors spent more than all visitors combined. The Ministry did not follow up with recipients to update the performance results and did not exclude recipients/events from future grant funding.

For Celebrate Ontario, we contacted five recipients to find out how the recipients obtained their attendance and visitor expenditure information. Two recipients told us they used tickets sales to obtain their attendance numbers, two others used their own best estimates, while one recipient informed us that they consulted with police officers at the event to estimate attendance. One recipient we spoke with informed us that they simply guessed at the number of attendees and amount spent by visitors at their event. All five agreed that it is difficult to measure attendance at free events, such as street festivals, compared to events that sell tickets.

For the Campus Linked Accelerators and On-Campus Entrepreneurship Activities, a program that provided about $40 million in funding over five years, the performance results were based on surveys conducted by the Ontario Centres of Excellent of start-ups that took advantage of the services offered by the program. Over the same period, the companies reported generating over $475 million in investments and creating 9,000 jobs, but neither of these results were verified by the Ministry.

RECOMMENDATION 10

To help ensure grant recipients spend funds for the purposes intended, we recommend that the granting ministries improve the effectiveness of their monitoring processes by:

- recalculating funding based on final reported costs, where applicable;
- requiring recipients to submit audited segmented financial information, where appropriate given the amount of funding awarded;
- using a risk-based approach to select which grant recipients to visit and verify that funded activities are taking place as intended;
- selecting recipients for invoice testing using a risk-based approach;
- verifying performance results reported for reasonability; and
- taking timely corrective action, including recovery of funds, with those recipients that do not meet their obligations according to grant requirements.

RESPONSE FROM GRANTING MINISTRIES

The granting ministries, as part of their monitoring processes of grant recipients, generally agreed, where applicable, to further verify reported expenses as recommended.

The Ministry of Economic Development, Job Creation and Trade noted in its response that as part of the Open for Jobs Blueprint, announced in the 2019 Budget, it has created the Business Success Framework (BSF) and Business Success Metric (BSM) to assess and transform government business supports, which includes grant recipients. The BSF and BSM will require the Ministry to create a plan to improve the defensibility of self-reported data from grant recipients, especially in areas of higher-risk, including data verification and due diligence (e.g., site visits, physical counts etc.).

The Ministry of Heritage, Sport, Tourism, and Culture Industries noted in its response that it will build in additional controls to monitor the effective and efficient use of grant funding. Total Ministry funding will be recalculated based on final reported costs. Going forward, the Ministry will require recipients to provide third-party validated financial information or audited financial statements (depending on the value of funding), unless doing so would cause undue financial hardship to the recipient. Going forward, the Ministry will take a risk-based approach to site visits, where verification cannot be obtained through alternative means. The Ministry has already revised the site-visit template to be more prescriptive in the requirements for site visits, and it will develop parameters to support invoice testing a percentage of recipients identified as high-risk. The Ministry will also strive to enhance existing processes to verify and validate reported performance results. The standardized Ministry Transfer Payment Agreement template includes provisions for corrective actions. The Ministry has existing processes to recover funds from recipients in default in a timely manner. The Ministry will continue to improve on this process and the timeliness for recovery of funds.

The Ministry of the Environment, Conservation and Parks noted that, where feasible, it will work to implement the effectiveness of monitoring processes as recommended for the Great Lakes Guardian Community Fund as well as other grants it awards.

The Ministry of Indigenous Affairs noted in its response that, as recommended, it plans to select recipients for invoice-testing using a risk-based approach, and to verify reported performance results for reasonability. The Ministry will continue to implement its corrective-action strategies where there is non-compliance with the Transfer Payment Accountability Directive, depending on the circumstances of each situation and the risk level. The strategies range from regular follow ups by phone or emails at staff and senior management levels for low risk recipients, to withholding instalment payments, demanding repayment of partial or all funds, to termination of TPA upon notice for extreme cases. Before any of these actions are taken, the recipient may be given opportunity to remedy the default.

The Ministry for Seniors and Accessibility accepted the recommendation and agreed with the importance of ensuring that grant recipients spend funds for the purposes intended. In its response, the Ministry noted that it will develop risk-based business processes to support accountability and integrity in grant programs as recommended.

4.4.6 Long-Term Impact of Grant Funding Not Monitored After Contract Ends

For the Jobs and Prosperity Fund—New Economy Stream (Ministry of Economic Development, Job Creation and Trade), applicants to the program from January 2015 to March 2019 noted that

about 4,700 jobs in total were at risk if the projects for which they were requesting funding were not implemented. While these jobs would likely be retained for the duration of the funding agreement, it is unknown whether these jobs would be retained after the term of the agreement ends. The Ministry does not confirm that the jobs will be retained after the projects are completed. The Ministry funds these companies with the long-term expectation of increasing production, sales, and exports to benefit Ontario's economy. However, the Ministry does not have any contractual agreement to be able to monitor the long-term progress of recipients beyond the term of the funding agreement.

Under the Youth Skills Connections—Industry Partnerships (Ministry of Economic Development, Job Creation and Trade), the Ministry supports training and provides work experience for youth based on industry-identified skills gaps. However, the Ministry does not follow up beyond the term of the funding agreement to assess whether the grant recipients are still employing the individuals they trained.

RECOMMENDATION 11

To confirm that the province is receiving the expected long-term benefits from grant funding, we recommend that the Ministry of Economic Development, Job Creation and Trade implement a process to continue monitoring the progress of recipients after the completion of funding arrangements when providing funds with goals of long-term benefits.

RESPONSE FROM MINISTRY OF ECONOMIC DEVELOPMENT, JOB CREATION AND TRADE

In order to assess the expected long-term benefits from grant funding, the Ministry of Economic Development, Job Creation and Trade (Ministry) will collect common data on business supports (including grant recipients) and continuously review and transform business supports to ensure they are meeting long-term objectives of the government.

Performance evaluations of business-support initiatives will include metrics and analysis that are quantitative (for example, return on investment, value-for-money, target achievement and other measures that can be calculated using data such as company revenues, tax dollars received by the government, jobs created, etc.); qualitative (for example, success stories, innovative processes and ecosystem impacts that are best captured through means such as news items, anecdotal commentary and surveys); self-assessed by the business supports directly in a consistent manner to enable comparability; and independently assessed by the business supports and the Ministry to ensure consistency and comparability between business supports.

The Ministry has begun to implement requirements in new transfer-payment agreements (both with direct-funding arrangements and flow-through funding agreements) for some programs that require recipients to report economic impact indicators for at least 12 months after the completion of the project. The Ministry will determine which new transfer payment agreements should require this type of reporting. Specific reporting requirements will be determined based on program design and need.

The Ministry's Business Success Framework and Business Success Metric state that the Ministry should collect and provide data on core metrics for three years after the term of the business support.

4.5 Performance Results Not Measured or Reported Publicly

The grant programs we reviewed generally contained performance measures but lacked performance targets and results were not being reported publicly, as summarized in **Figure 13**.

For most of the grant programs we reviewed, we found that ministries had established performance measures that were aligned with the objectives of the program. One exception we noted was for the

Figure 13: Performance Measures and Results for Grant Programs Reviewed, 2018/19

Prepared by the Office of the Auditor General of Ontario

Grant	Performance Measures				Results	
	Established?	Align with Program Objectives?	Outcome-Based?	Have Program Targets?	Reported Publicly?	Examples
Economic Development, Job Creation and Trade						
Jobs and Prosperity—New Economy Stream	✓	✓	Partially	×	×	• 13% increase in sales • 12% increase in export sales • 3,337 jobs created
Campus Linked Accelerator and On-Campus Entrepreneurship Activities[1]	✓	✓	Partially	×	×	• 3,035 students involved in start-ups • $17 million in incremental sales • 2,409 jobs created
Global Start Voucher Program[1]	✓	✓	Partially	×	×	• $840,000 in incremental sales • $3.3 million in private investment • 38 jobs created
Youth Skills Connections—Industry Partnerships[1]	✓	✓	Partially	×	×	• 2,370 youth completed training • 2,067 work placements • 1,222 industry jobs filled
College Applied Research and Development Fund	✓	✓	✓	×	×	• $3 million in Canadian incremental sales • $4.3 million in international incrermental sales • 568 trained undergraduate students (or equivalent) • 94 jobs created
Ontario Scale-Up Vouchers	✓	✓	Partially	×	×	• $15 raised by private equity for every $1 awarded • 527 jobs created • 430 Ontario jobs created
Tourism, Culture and Sport						
Celebrate Ontario	✓	✓	One only	×	×	• $1.5 million total enhancement tourists • $227 million in enhancement visitor expenditures
Ontario 150 Community Celebration[1]	✓	✓	×	×	×	• 26,428 diverse communities engaged
Ontario 150 Partnership[1]	✓	×	×	×	×	• 87 events hosted • 37,771 youth participants

Grant	Performance Measures				Results	
	Established?	Align with Program Objectives?	Outcome-Based?	Have Program Targets?	Reported Publicly?	Examples
Ontario Games[1]	✓	Partially	Partially	Partially	×	• $2 million in revenue from 55+ summer games • $6 million in revenue from summer games • $4.2 million in revenue from winter games • survey respondents rating satisfaction as excellent or good: 72% for 55+ summer games; 95% for summer games; 91% for winter games
Other (indicated in parentheses)						
Ontario Municipal Partnership Fund (Finance)[2]	✓	✓	×	✓	×	• 40% increase in fund from 2012 to the top 100 municipalities with the most challenging fiscal circumstances
New Relationship Fund (Indigenous Affairs)	✓	✓	×	×	×	• 6,044 consultations completed
Great Lakes Guardian Community Fund (Environment, Conservation and Parks)[1]	×	n/a	n/a	n/a	n/a	• 2,800 bags of garbage collected • 760 km of trail created or enhanced • $15 million in additional funding generated
Age Friendly Community Planning Grant (Seniors and Accessibility	×	n/a	n/a	n/a	n/a	None
Response to violence in the Rakhine State of Myanmar (Cabinet Office)	×	n/a	n/a	n/a	n/a	None

1. Information is for the latest year available prior to 2018/19.
2. No performance measures for the unconditional municipal grant.

Ontario Games program. One of the objectives of this program is to provide athletes with a developmental and competitive opportunity to prepare for national and international competitions. However, the Ministry of Heritage, Sport, Tourism and Culture Industries does not track the number of young athletes that go on to national or international competitions. Instead, the performance measures look at the economic impact the games have on the hosting municipality and whether athletes view the experience as positive.

For the majority of grant programs tested, the measures were primarily activity-based rather than outcome-based. Activity-based measures count actions, but not whether those actions were effective in achieving the desired outcomes. To illustrate, the Youth Skills Connection Program is meant to address skills gaps through industry partnerships and improve competitiveness in key sectors of Ontario's economy. The Ministry of Economic Development, Job Creation and Trade measures

the number of industry partners, youths trained, and work placements and jobs filled, but it does not measure and report whether the skills gap is closing in various sectors, or closing to an acceptable level.

In some cases, it is difficult to determine outcome-based measures because program goals may be too broad. For example, the Community Celebration Program aims to support communities with impactful initiatives; and the Global Start Voucher Program aims to develop strong business relations.

As noted in **Section 4.4.5**, the data used to assess program performance was frequently based on a summation reported by individual grant recipients, with little verification by the ministries.

RECOMMENDATION 12

To monitor the impact of grant funding and provide transparency, we recommend that the Treasury Board Secretariat, in conjunction with granting ministries, develop outcome-based performance measures for all discretionary grant programs as applicable, set reasonable targets to measure progress and report this information publicly.

SECRETARIAT RESPONSE

As part of the ongoing Transfer Payment Consolidation initiative, the Treasury Board Secretariat (Secretariat) and the Ministry of Government and Consumer Services (Ministry) will support granting ministries to develop stronger outcome-based performance measures for discretionary grant programs. The Ministry will also determine how these measures could be incorporated into the Transfer Payment Ontario system (formerly, the Grants Ontario system).

The Secretariat and the Ministry will also determine ways for granting ministries to publicly report on the performance measures.

4.6 Overlap between Ministries

4.6.1 Overlap in Grant Funding between Ministries with Little Co-ordination

The objective of the New Relationship Fund ($13.7 million in 2018/19) provided by the Ministry of Indigenous Affairs is to contribute to improved consultation and engagement with government and the private sector and support long-term planning related to lands and resources for indigenous communities.

There is potential overlap between this program and others offered by the same ministry and another ministry. Similar grant programs offered by the Ministry of Indigenous Affairs to support negotiations and consultations are as follows:

- The Support for Community Negotiations Fund ($5.2 million in 2018/19) provides annual financial support for Indigenous communities participating in land claim and land-related negotiations with Ontario.
- The Participation Fund ($2.7 million in 2018/19) provides financial support for Indigenous communities to build relationships and partnerships with the province in order to improve economic and social outcomes and respond to social emergencies.

The Ministry of Energy, Northern Development and Mines also has a grant with the same name (Participation Fund). This fund was developed to help support Indigenous communities and organizations participating in regulatory processes under the Mining Act and in economic development activities associated with mineral exploration and development.

The Ministry of Indigenous Affairs told us that the funding through the Ministry of Energy, Northern Development and Mines is to build capacity beyond what is supported by the New Relationship Fund. However, the Ministry of Energy, Northern Development and Mines acknowledged that there is overlap with other programs and has directed its staff to be mindful of this when reviewing applications for funding.

4.6.2 Reporting Process Not Streamlined for Recipients Receiving Funding from Multiple Programs

According to the Transfer Payment Operational Policy, effective May 1, 2018, if program areas within one ministry are funding the same recipient, the ministry must investigate opportunities to streamline and consolidate reporting, and do so where opportunities exist.

We analyzed recipient data within the Grants Ontario system and identified about 1,500 recipients that received funding from more than one grant program in 2018/19. 66% received funding from different programs administered by the same ministry and the remaining 34% received funding from grants administered by different ministries.

Based on the programs we selected for review, we noted two ministries (Ministry of Indigenous Affairs and Ministry of Heritage, Sport, Tourism and Culture Industries) that are funding the same recipient through multiple grant programs within their own ministry, but that have not yet streamlined the reporting for these recipients. Similarly, for recipients receiving grants from multiple ministries for a similar activity—as in the case of First Nations receiving grants from both the Ministry of Indigenous Affairs and the Ministry of Energy, Northern Development and Mines (see **Section 4.6.1**)—reporting requirements have also not been streamlined.

RECOMMENDATION 13

To minimize the risk of multiple ministries funding the same entity for the same or similar activities and to streamline reporting where justified, we recommend that:

- the Treasury Board Secretariat, along with granting ministries, consolidate grant programs that support similar initiatives for a particular sector into one grant program under one ministry; and
- where consolidation of funding into one program is not possible, that granting ministries streamline reporting activities, in accordance with the Transfer Payment Operational Policy.

SECRETARIAT RESPONSE

The government's Transfer Payment Consolidation initiative is focused on streamlining how the government funds programs and services. As part of this initiative, the Treasury Board Secretariat (Secretariat) and the Ministry of Government and Consumer Services (Ministry) will work with ministries on plans outlining how they and their provincial agencies who have a mandate to provide discretionary grants, will move to the Transfer Payment Ontario system (formerly the Grants Ontario system).

The Ministry and Secretariat are collaborating on a new training curriculum that will help ensure awareness of the rules in the Transfer Payment Operational Policy, which will increase compliance. In addition, the information available to ministries from existing tools such as the Transfer Payment Inventory, as well as increased usage of Transfer Payment Ontario, will support knowledge of transfer payment programs across ministries.

As part of the Transfer Payment Consolidation initiative, the Secretariat and the Ministry will monitor ministries' efforts to consolidate grant programs and streamline reporting.

Appendix 1: Discretionary Grants by Category, 2014/15–2018/19 ($ million)

Source of data: Ontario Ministries

Purpose of Support	2014/15	2015/16	2016/17	2017/18	2018/19	% 4-Year Change
Support for northern/rural communities	591.2	554.2	536.3	539.5	787.2	33
Industry support	465.8	604.4	593.0	575.5	631.7	36
Education support[1]	790.5	501.2	500.7	564.1	587.8	-26
Environmental initiatives[2]	52.7	50.2	185.0	320.8	426.6	710
Research and Innovation	336.0	354.4	408.5	429.8	394.1	17
Culture, tourism and sporting events/Organizations	379.5	393.9	372.8	396.1	364.3	-4
Farming/Agricultural support	140.9	139.9	171.3	143.5	172.6	23
Start-up/scale-up support	141.0	179.1	401.9	258.0	169.2	20
Skills training and employment	381.4	322.2	226.1	299.3	114.6	-70
Other (<$100 million)	233.7	202.3	298.6	304.6	243.2	4
Aboriginal support	52.5	59.4	79.0	148.8	88.1	68
Social Services	113.6	83.0	151.4	69.4	70.8	-38
Newcomer support	11.3	14.1	18.1	27.2	30.2	166
Health and wellness	28.0	24.3	30.2	26.6	28.4	1
Community Safety	25.3	18.5	18.6	28.6	25.7	2
International disaster relief support	3.0	3.0	1.3	4.0	–	
Total	**3,512.7**	**3,301.8**	**3,694.2**	**3,831.2**	**3,891.3**	**11**

1. The decrease is due to certain time-limited grants becoming permanent and provided through the Grant For Student Needs, a legislated funding program.
2. The increase is due to the introduction of the Green Investment Fund to provide financial support for projects that will fight climate change, grow the economy and create jobs; the increased demand for the Electrical and Hydrogen Vehicle Program; and the government's decision to cover the cost of Drive Clean test fee starting April 1, 2017, until the program ended in March 31, 2019.

Appendix 2: Guiding Principles of the Transfer Payment Accountability Directive

Source: Transfer Payment Accountability Directive

Principle	Description
Accountability	Ministries are accountable for protecting the public interest. Ministries hold recipients responsible for delivering the activities for which the funds were received.
Value for money	Ministries are efficient and effective in using public resources when providing grants.
Risk-based approach	Grant oversight is in proportion to any risks associated with the activity and the recipient.
Fairness, integrity and transparency	The decision to provide grant payments and their oversight is fair, impartial and transparent and conforms to applicable legislation and corporate policy direction.
Focus on outcomes	Grant activities are clearly defined and contribute to the achievement of public policy objectives.
Common Processes	Ministries use common processes, tools and templates as appropriate to create administrative efficiencies and support consistency in the oversight of grants.
Information sharing	Relevant and appropriate information and data are collected, managed and shared across the Ontario government.
Communication	There is respectful, open and ongoing communication between ministries and grant recipients.

Appendix 3: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Ministries should establish clearly defined goals and objectives for their discretionary grant programs that are aligned with the ministries' mandates and the government's overall strategic direction.
2.	Discretionary grant programs have eligibility criteria that are clearly communicated to stakeholders. The criteria are consistently and objectively assessed by qualified staff in a timely manner and funding amounts approved are based on the needs demonstrated by the applicant, the grant criteria and available funding.
3.	Discretionary grant agreements have clear accountability provisions to ensure that grant recipients are using funds as intended. Ministries are monitoring and holding grant recipients accountable for the funds they receive and are taking corrective actions against and/or recovering funds from those who fail to use grants as intended.
4.	Ministries are formally evaluating each discretionary grant program regularly to ensure that the grant continues to align with ministry objectives and, where necessary, corrective action is taken.
5.	The government-wide system (Grants Ontario), developed to act as a central repository to track all discretionary grant programs, is being used by all ministries and provides a secure and reliable platform for ministries to receive and assess grant applications, track payments and recoveries, and monitor recipients' use of funds and performance.
6.	Performance measures and targets are established for discretionary grant programs and the Grants Ontario system. Results are publicly reported against stated goals.

Appendix 4: Description of Grant Programs Selected for Detailed Testing

Prepared by the Office of the Auditor General of Ontario

	Grant Program	Description
Ministry of Economic Development, Job Creation and Trade		
1.	Jobs and Prosperity Fund—New Economy Stream	Introduced in July 2014, the program funds private sector projects that cost at least $10 million and focus on advanced manufacturing, financial services, information technologies and communications technologies, and life sciences. The goal of the program is to increase productivity leading to job creation/retention, support innovation through research and development, and increase exports. The program reimburses eligible project expenditures (e.g. equipment, materials, and labour). From January 2015 to June 2019, the program has funded 31 grant recipients (33 projects) for a total of $272 million.
2.	Campus-Linked Accelerator and On-Campus Entrepreneurship Activities	Introduced in April 2013, the program aims to facilitate the development of entrepreneurial activity in Ontario's universities and colleges. Between 2014/15 and 2018/19, the program provided $39 million in funding to 44 universities and colleges. The Ontario Centres for Excellence, a not-for-profit organization, manages the program on behalf of the Ministry. The universities and colleges provide innovation hubs and start-up incubators to youth entrepreneurs. Youth entrepreneurs receive the services offered, but do not receive direct funding, except for covering costs to transport entrepreneurs to other international innovation hubs for three to six months to increase their global reach.
3.	Global Start Voucher Program	Introduced in 2015/16, the program was a subset of the Campus-Linked Accelerator and On-Campus Entrepreneurship Activities (CLA/OCEA) program. The program aimed to support youth-led start-ups in accessing international markets that are too difficult to break into without significant connections and/or knowledge of the market, or due to language and cultural barriers. Start-ups received funding to support them for up to four months, as they were hosted in a foreign jurisdiction incubator. Between 2015/16 and 2017/18, the program provided $800,000 in funding to 59 grant recipients that were hosted by incubators in 19 different countries. The program ended in 2017/18.
4.	Youth Skills Connection—Industry Partnerships	Announced in August 2013, the grant funds educational institutions to run training programs aimed at solving the skills gap identified by Ontario companies by developing Ontario's youth to meet industry needs through experiential learning and work placements. For the three-year period (2015/2016 to 2017/2018) the program operated, it funded 32 recipients for a total of $18 million. The educational institutions developed training through consultation with businesses who identified the skills gap.
5.	College Applied Research and Development Fund	Introduced in January 2017, the program funds colleges with a goal of increasing industry/post-secondary collaboration, while providing industry access to research resources at colleges. The program provides learning opportunities for college students as they work on industry-led research projects to facilitate productivity improvements. Over the last 3 years (2016/17 to 2018/19) the program has funded 127 recipients and committed around $16.6 million.
6.	Ontario Scale-Up Vouchers Program	Introduced in November 2016, the program's objective was to accelerate the growth rate of high-potential, Ontario-based technology and innovation-based companies into global leaders. Recipient companies were eligible to receive a financial voucher of up to $1 million to offset costs for various direct and indirect scale-up expenses. In addition, the program provided companies with access to mentors with expertise in growth planning. The Ministry contracted with MaRS Discovery District to run the grant program. From November 2016 to April 2019, the program costs were about $24 million (including $2.2 million for administration costs totalling $11.3 million) and supported 95 companies (35 companies received financial vouchers). In April 2019, the Ministry terminated the program.

Grant Program		Description
Ministry of Tourism, Culture and Sport		
7.	Celebrate Ontario	Introduced in 2007, the program offers funding to festivals, events, and cultural organizations that will host tourism-focused events in the province. The program supports the operating expenses and/or promotional costs of new and existing events with the expectation that the funding will lead to long-term improvements and sustainability of the event and attract additional tourists. Over the last three years (2016/17 to 2018/19), the program has funded 832 event organizers for a total of $55.2 million.
8.	Ontario 150—Community Celebration	Introduced in July 2016, the program funded not-for-profits, municipalities, and indigenous organizations to celebrate and commemorate the 150th anniversary of Ontario and Canada in 2017. The goal of the program was to support communities in the creation and delivery of impactful, participatory and inclusive initiatives. All projects had to be aligned with one of four themes: supporting celebration; commemorating success and highlighting talent; supporting equal opportunity; and empowering people and communities. The two-year program ran in 2016/2017 and 2017/2018 and funded 359 recipients for a total of $7 million.
9.	Ontario 150—Partnership	Introduced in July 2016, the program funded not-for-profits, municipalities, Indigenous communities and organizations, and businesses. The goal of the program was to engage and empower Ontario's youth. All projects were to align with one of six priorities: supporting young artists; promoting diversity and inclusion; environmental stewardship; supporting youth entrepreneurship; promoting active and healthy living; and youth civic engagement. The two-year program ran in 2016/2017 and 2017/2018 and funded 87 recipients for a total of $5 million.
10.	Ontario Games	Introduced in 1970, the program funds municipalities to host five multi-sport games (Summer and Winter Games for youth, Summer and Winter Games for 55+, Parasport Games) every two years around the province. The aim of youth games is to prepare athletes for national and international competitions as well as future multi-sport games. The Ministry spends $2.6 million every two years to support municipalities in hosting the five games.
Ministry of Finance		
11.	Ontario Municipal Partnership Fund	Introduced in March 2005, the program is the province's main general unconditional assistance to municipalities. The program primarily supports northern and rural municipalities with limited property assessment and those with more challenging financial circumstances, while assisting municipalities that are adjusting to year-over-year funding changes. Over the past five years, from 2015/2016 to 2019/2020, the program has allocated around $2.5 billion to Ontario municipalities.
Ministry of Indigenous Affairs		
12.	New Relationship Fund	Introduced in 2008, the program funds First Nations, Métis communities, and Indigenous organizations to support them in their efforts to build consultation and engagement capacity, create jobs, develop business partnerships, and improve economic opportunities. Over the last five years (2014/15 to 2018/19), the program has funded 113 recipients for a total of about $67 million.
Ministry of the Environment, Conservation and Parks		
13.	Great Lakes Guardian Community Fund	Introduced in 2012, the program funds not-for-profit, Indigenous organizations, Conservation Authorities and municipalities (with a community-based partner). The goal of the program is to protect water quality for human and ecological health; and protect and restore watersheds, wetlands, beaches, shorelines, coastal areas, natural habitats, and biodiversity of the Great Lakes-St. Lawrence River Basin. Over the last five years (2013/14 to 2017/18), the program has funded 354 recipients for a total of $7.6 million.

Grant Program		Description
Ministry of Seniors and Accessibility		
14.	Age-Friendly Community Planning Grant	Introduced in November 2014, the program funds municipalities and community organizations with the goal of undertaking strategic planning to help communities become age-friendly and ensuring that the needs of seniors are considered at every stage of community planning and development. During the life of the program (June 15, 2015 to March 31, 2017), it funded 56 recipients for a total of $1.9 million.
Cabinet Office		
15.	Response to violence in the Rakhine State of Myanmar	Cabinet Office, with approval of Treasury Board, donates funding towards disaster relief efforts in other countries. In 2017/18, the Cabinet Office provided $4 million to agencies providing disaster relief to international communities, including $1 million in response to violence in the Rakhine State of Myanmar.

Appendix 5: Summary of Grant Testing Results

Prepared by the Office of the Auditor General of Ontario

Grant Name (Active Period Over Last 5 Years)	Application Type	# of Applicants	# of Recipients	Total Funds Disbursed[1] ($)	Results of Audit Testing				
					Selection Process Appropriate?	Funding Reasonable?	Effective Monitoring?[2]	Spending Appropriate?	Performance Reporting Appropriate?
Section Reference					**4.3.1** and **4.3.2**	**4.3.3**	**4.4.3** to **4.4.6**	**4.4.1** and **4.4.2**	**4.5**
Ministry of Economic Development, Job Creation, and Trade									
Jobs Prosperity Fund[3]—New Economy Stream (Jan 2015–Mar 2019)	Businesses	46	31	271,570,558	×	×	×	✓	× (not specific to Ontario)
Campus-Linked Accelerators and On-Campus Entrepreneurship Activities (Apr 2014–Mar 2019)	Post-Secondary Institutions	44	44	39,132,222	✓	✓	×	✓	×
Campus-Linked Accelerators and On-Campus Entrepreneurship Activities—Global Start Voucher Program (Apr 2015–Mar 2018)	Businesses	64	59	799,961	✓	✓	×	✓	×
Youth Skills Connection—Industry Partnerships[4] (Sep 2015–Mar 2018)	Post-Secondary Institutions	45	32	17,856,579	✓	✓	×	✓	✓
College Applied Research and Development Fund (Jan 2017–Mar 2019)	Post-Secondary Institutions	152	127	16,595,653	✓	✓	×	✓	✓
Ontario Scale-Up Vouchers Program (Apr 2015–Mar 2019)	Businesses	173	35	11,325,000	✓	✓	×	✓	✓
Ministry of Tourism, Culture and Sport									
Celebrate Ontario (Apr 2016–Mar 2019)	Not for Profit, Municipalities, Businesses, First Nations	1,333	832	55,155,742	×	✓	×	×	✓

Grant Name (Active Period Over Last 5 Years)	Application Type	# of Applicants	# of Recipients	Total Funds Disbursed[1] ($)	Results of Audit Testing				
					Selection Process Appropriate?	Funding Reasonable?	Effective Monitoring?[2]	Spending Appropriate?	Performance Reporting Appropriate?
Ontario150—Community Celebrations (Jul 2016–Mar 2018)	Not for Profit, Municipalities, Businesses, First Nations	922	359	7,000,000	×	✓	×	✓	✓
Ontario150 Partnership (Jul 2016–Mar 2018)	Not for Profit, Municipalities, Businesses, First Nations	445	87	4,899,805	×	✓	×	×	✓
Ontario Games (2018/19)	Municipalities	7	5	2,580,000	✓	✓	×	✓	✓
Other (indicated in square brackets)									
Ontario Municipal Partnership Fund (Apr 2014–Mar 2019) [Finance]	Municipalities	Based on pre-set eligibility criteria	389	2,525,000,000	✓	✓	n/a	n/a	n/a
New Relationship Fund (Apr 2014–Mar 2019) [Indigenous Affairs]	First Nations	115	113	67,325,642	✓	×	×	×	×
Great Lakes Communities Fund (Apr 2014–Mar 2018) [Environment, Conservation and Parks]	Not for Profit, Municipalities, First Nations	562	354	7,571,635	✓	✓	×	✓	×
Age Friendly Community Grant (Apr 2015–Mar 2017) [Seniors and Accessibility]	Municipalities	139	56	1,904,953	✓	✓	×	✓	×
Response to violence in the Rakhine State of Myanmar (Oct 2017–Jun 2018) [Cabinet Office]	Not for Profit	2	2	1,000,000	n/a[5]	n/a	n/a	✓	✓

Note: n/a = not applicable

1. During active period.
2. For most grants, we note that monitoring was not risk-based (for example, sites visits were not selected based on a recipient's risk score). Monitoring was not applicable for the Ontario Municipal Partnership Fund because this was an unconditional grant.
3. In total 36 grant applicants were approved for funding. By March 31, 2019 only 31 recipients had received funding.
4. The Youth Skills Connection—Industry Partnerships grant is by invitation only. Other grants are open to all to apply.
5. Funding approved by a Treasury Board order.

Ministry of Finance

Provincial Support to Sustain the Horse Racing Industry

1.0 Summary

The province has been supporting the horse racing industry through various initiatives since 1996. Ontario's 15 racetracks currently rely on annual government funding of close to $120 million to subsidize the horse racing industry in the province. In addition, 11 of these racetracks host provincial slot facilities, and receive about $140 million in annual lease revenues from OLG and private operators to host slot machines, and, in some cases, for valet parking and food services. Current government agreements do not require that these annual lease revenues be used to support horse racing operations.

Horse racing as a gaming operation has been in decline in Ontario since the legalization of lotteries in 1969. The introduction of slot machines and other electronic games in 1985 further impacted the industry. Over the last 10 years, from 2008/09 to 2018/19, Ontarians' wagering on Ontario races, and races outside the province, has decreased by 44% and 15% respectively. Wagering by other Canadians on Ontario races has also decreased by 48%.

The racetracks offer Thoroughbred, Standardbred and Quarter horse racing, and two of Ontario's tracks are home to the three races that make up Canada's Triple Crown. A race takes place almost every day somewhere in the province. According to a study commissioned by the industry, as of September 2017, the horse racing industry provided the equivalent of 45,000 full-time jobs. The industry employs racetrack owners and operators, breeders and their employees, racehorse owners, groomers, trainers and jockeys.

In 2018/19, gross wagering on horse racing in Ontario totalled $1.6 billion, including bets on Ontario races placed from outside Ontario and bets placed inside the province on races held elsewhere. Of the $1.6 billion total, Ontario racetracks paid out 87.3% to winning bettors and kept 12.7% or $203 million in gross commissions, before taxes and operating costs. However, these wagering commissions have not been sufficient for the industry to cover racetrack operating costs and purses, the prize money paid to horse owners. The largest racetrack operator in Ontario is the Woodbine Entertainment Group (Woodbine), which owns and operates both the Woodbine Racetrack and the Mohawk Racetrack. Together, these tracks accounted for about 90% or $1.47 billion of all wagering in the province in 2018/19.

As of April 2016, the Ontario Lottery and Gaming Corporation (OLG) assumed responsibility for administering funding and monitoring, as well as supporting the horse racing industry with its gaming and marketing expertise, with the goal of making the industry financially self-sustaining.

In March 2018, the province announced a new 19-year funding commitment to support the horse racing industry. Starting April 2019, the new

long-term agreement provides about $120 million to the industry annually for the first two years and is expected to drop to about $65 million in the fifth year and to $63.4 million by the eighth year. However, the latest funding agreement does not encourage the industry to become self-sustaining.

Oversight for the industry is divided between two provincial agencies and one federal agency. OLG is responsible for oversight of government funding through the 19-year funding agreement. The Alcohol and Gaming Commission of Ontario (AGCO) is responsible for licensing all participants in horse racing, including racetracks, and regulating the conduct of horse racing. A federal agency, the Canadian Pari-Mutuel Agency, is responsible for oversight of wagering.

Although the horse racing industry receives a significant amount of public funding, it lacks transparency and public accountability. Of the 15 racetracks, only one posts its financial statements on its website. There is no public reporting of gross wagers collected and wagering commissions by racetrack, how the provincial tax reduction on wagering is shared between the various racetracks and horse people, purses paid by racetracks, revenue and expenses related to racing operations separate from other operations, and key statistics such as the current number of people working in the industry.

Our audit found these significant concerns:

- **The horse racing industry is no closer to self-sustainment after a history of various government funding programs.** The goal of the five-year, $500 million Horse Racing Partnership Funding Program in existence from 2014/15 to 2018/19 was to support racetracks in becoming more self-sustaining. However, the industry is not significantly closer to that goal than it was in 2013. Over the last five years, total wagering has remained relatively unchanged, while purses have slightly increased. Between 2014/15 and 2018/19, about 60% of total purses was funded through provincial support. All key stakeholders we spoke with agreed that the horse racing industry would not be sustainable without the current level of provincial support now being provided by OLG.
- **Despite OLG's horse racing awareness campaign, wagering in Ontario on horse racing continues to decline.** Specifically, wagering in Ontario on races in and outside Ontario has decreased from $882 million in 2016/17 to $833 million in 2018/19. As part of its marketing strategy in 2015, OLG created a new horse racing brand under the Ontario Racing name in consultation with the industry association. It was launched in 2016. Based on the findings from a third-party researcher contracted by OLG to measure the effectiveness of OLG's marketing initiatives for the horse racing industry, awareness of horse racing by the Ontario adult population has grown from 13% in 2016 to 22% in 2018. However, although awareness increased, wagering did not. At the time of our audit, OLG had not set a target for the level of awareness it wanted to achieve or the level of wagering growth it wanted to result from the increased awareness.
- **Focus of provincial funding shifts from self-sustainment to sustaining the industry.** With the introduction of the new 19-year funding agreement on April 1, 2019, the objective of government funding changed from transitioning the industry to become self-sustaining to sustaining the industry for a long period of time. Although one of the key objectives of the new long-term agreement continues to be to reduce reliance on government funding, with 19 years of guaranteed funding until the end of fiscal 2037/38, it is difficult to see how the new agreement will reduce the industry's reliance on provincial support. For 2018/19, provincial funding covered 60% (or $84.8 million) of total purses paid of $142.3 million to winning horse owners.

- **Provincial support is guaranteed for 19 years.** The new long-term funding agreement does not include any clauses that would allow the province to terminate the agreement without cause. Furthermore, the total annual funding will not be reduced if a racetrack closes down. Because the funding levels are not tied to the number of racetracks, the money would be redistributed amongst the remaining racetracks.
- **Provincial funding reductions in the new long-term funding agreement related to wagering increases are likely unattainable.** Total funding over the 19-year term of the agreement is likely to reach $1.4 billion. According to the terms in the new long-term funding agreement between OLG, Ontario Racing (horse racing's industry association) and Woodbine, the industry (including racetracks and horse people) could receive almost $120 million in annual funding from OLG for two years. After that, funding would be reduced if wagering revenue increases significantly. For this reduction to occur, wagering within Ontario would need to increase by 44%, and wagering outside of Ontario would need to increase by 30%. Since overall wagering has increased by only 1% over the last 10 years, it appears unlikely that funding will be reduced due to wagering increases. However, OLG's funding obligations are more likely to decrease by $51.4 million when Woodbine receives incremental casino lease revenues from its racetracks.
- **Lack of federal government oversight to guard against money laundering at Ontario racetracks.** For a sector that is vulnerable to money laundering, the horse racing industry in Canada is not accountable to any regulatory body to monitor its operations for this type of crime. In contrast, the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* has covered the casino sector since 2007. All Canadian casinos are required to report transactions over $10,000 and any suspicious transactions to the Financial Transactions and Reports Analysis Centre of Canada (FINTRAC). As part of our review, we noted some deficiencies in Woodbine's record-keeping of suspicious transactions, including payments to customers over $10,000.
- **Ontario has more racetracks than comparable jurisdictions, without sufficient wagering income to support them.** Ontario currently has 15 racetracks—two that race Thoroughbred horses, 12 that race Standardbred horses, and one that races Quarter horses. When compared to racetracks in the United States, Ontario serves fewer people per racetrack than the states of California, Florida, New York, Pennsylvania and Ohio. Ontario has nine more racetracks than Pennsylvania, and six more than Florida, which has a 46% higher population than Ontario. For 2018/19, revenues totalled about $200 million, including wagering commission for racetracks, while racetrack expenses and purses totalled about $370 million. This leaves an estimated operating shortfall of about $170 million before considering any government support (including lease revenue for hosting provincial slot facilities).
- **The Woodbine Entertainment Group (Woodbine) has a significant role in the latest long-term funding agreement with OLG.** The funding agreement negotiated between OLG and Woodbine includes language that effectively cancels the agreement if Woodbine's role is changed or eliminated. Specifically, the funding agreement ceases to be valid if Woodbine ceases to be a member of Ontario Racing; Woodbine's subsidiary (Ontario Racing Management) ceases to be owned 100% by Woodbine; or Woodbine's subsidiary ceases to be responsible for the management of Ontario Racing. Woodbine holds two of the five racetrack representative positions on the 11-member Ontario Racing

Board, which is responsible for administering the new long-term funding agreement, setting race days and distributing funding to racetracks. Ontario Racing Management, which supports operations for the Ontario Racing's Board, is a wholly owned subsidiary of Woodbine. It will be paid $3.4 million annually to help the Ontario Racing Board administer the new long-term funding agreement. Key members of the management team of Ontario Racing Management are also employees of Woodbine.

This report contains nine recommendations, with 16 action items, to address our audit findings.

Overall Conclusion

Provincial funding to the horse racing industry has not helped the industry become self-sustaining as historically intended in various funding agreements. Income from wagering continues to decline and is not sufficient to cover racetrack operating costs and purses. Specifically, over the last ten years, wagering on Ontario horse races by Ontarians and other Canadians has dropped by 44% and 48%, respectively. In contrast, foreign wagering on Ontario races has seen a significant increase of 108% over the same period. However, since commissions are significantly lower on foreign wagering, overall wagering commissions have not increased. Government funding continues to support about 60% of total purses paid. In fact, the objective of the new 19-year funding agreement that came into effect April 1, 2019, is to sustain the industry. Critical decisions about how provincial funding is to be allocated amongst racetracks and which racetracks to close, if any, are in the hands of the industry.

Although the horse racing industry is licensed, regulated and receives a significant amount of public funding, it lacks transparency and public accountability. Ontario Racing publicly reports on how much wagering is collected in total and how provincial funding is distributed among industry parties or industry groups, there is no public reporting of gross wagers collected and wagering commissions by racetrack, how the provincial tax reduction on wagering is shared between the various racetracks and horse people, purses paid by racetracks, revenue and expenses related to racing operations separate from other operations, and key statistics regarding people working in the industry. As well, racetracks receiving government funding are no longer required to disclose the salaries of employees making more than $100,000.

After taking over the oversight of government funding of the horse racing industry in 2016, the Ontario Lottery and Gaming Corporation implemented a marketing strategy to help increase awareness of the industry. Although awareness of horse racing by Ontario adults has increased from 13% in 2016 to 22% in 2018, wagering by Ontarians and other Canadians on races in Ontario has continued to decline as noted above.

Based on our sample testing of the Horse Racing Partnership Funding Program which ended on March 31, 2019, we confirmed that provincial funding provided for purses was spent on purses, and that the provincial tax break to the industry of 6.9% was shared with specific industry parties in the correct amounts as intended by the program.

OVERALL RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) thanks the Office of the Auditor General for its review of public funding of the horse racing industry.

For a number of years, the province has funded live horse racing in support of a strong horse racing industry that creates jobs, investments and economic development in rural communities throughout Ontario.

In 2016/17, the province directed OLG to administer transfer payments to the industry, in addition to the provision of marketing and responsible gambling support. The province also asked OLG to develop a long-term funding

agreement to replace the transfer payment program. The goal was to foster a sustainable industry that would be less reliant on public funds. For two years, OLG worked closely with all areas of the horse racing sector to create an agreement that achieved these objectives. This agreement garnered buy-in from most industry stakeholders, and secured governance with broad representation from racetracks, breeders, and horse people.

Effective April 1, 2019, the long-term funding agreement provides funding stability for horse racing, including racetracks that lost or would lose slots, in exchange for a reduction in public funding over time. After the first year of the agreement, OLG will review 12 months of industry data and reports to help inform fact-based decisions in future years. Overall, the long-term funding agreement provides a framework for the industry to manage its own affairs in the marketplace, grow wagering and quality horse supply, while being held accountable for the public funds it receives.

The intent of the long-term funding agreement is to ensure the vitality of the horse racing industry in Ontario for generations to come. OLG welcomes the work and advice of the Office of the Auditor General of Ontario as we continue to build a sustainable future for horse racing in Ontario.

2.0 Background

2.1 Overview of Horse Racing Industry

The horse racing industry provided the equivalent of 45,000 full time jobs in September 2017, the latest date for which data is available, based on a study commissioned by the Ontario Racing Association on the economic impacts of horse racing and breeding in Ontario. The industry employs racetrack owners and operators, breeders and their employees, racehorse owners and horse people like grooms, jockeys, and trainers. According to the study, racetrack employees accounted for 21% (9,500) of horse racing jobs, while the other 79% (35,900) were in breeding, training, etc. Ontario is one of the few areas in North America that races three breeds – Thoroughbred, Standardbred and Quarter horses. Two of Ontario's tracks are home to the three Thoroughbred races that make up Canada's Triple Crown. The Queen's Plate and the Breeders' Stakes have been run at Woodbine since 1860 and 1889 respectively. Fort Erie's track began hosting the Prince of Wales Stakes in 1929.

Ontario has 15 licensed horse racing tracks; 11 of these are co-located with provincial slot facilities. For the locations of racetracks, see **Appendix 2**.

In 2018/19, about half (48%) of industry revenues were generated from non-government sources. These revenue sources include gross commissions on wagering before taxes ($203.5 million) and food sales at racetracks ($75.4 million). The province provided the remaining 52% ($299.4 million), including funding for purses, racetrack operating costs and breeding programs ($100.3 million), a tax reduction on wagering ($57.5 million), and lease revenue ($141.6 million) provided by OLG and its service providers to racetracks for hosting casino and slot machines. **Figure 1** shows the types of government support to the horse racing industry for the period 2012/13 to 2018/19. **Section 2.2** details the evolution of recent government support for the horse racing industry.

Horse racing in Ontario has been in decline for more than a decade. **Figure 2** shows that the number of race horses and scheduled race days, as well as the amounts of wagering in Ontario and purses have all declined from 2008/09 to 2018/19.

2.2 History of Provincial Support to the Horse Racing Industry

Over the years, various government financial support programs have been put in place to provide

Figure 1: Government Funding to Support the Horse Racing Industry in Ontario, by Provider and Program, 2012/13–2018/19 ($ million)

Source of data: Public Accounts, the Audited Financial Statements of the Ontario Racing Commission, Ontario Ministry of Agriculture, Food and Rural Affairs (OMAFRA), and Ontario Racing

Provider	Program/Support	Direct Recipient	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Ontario Lottery and Gaming Corporation (OLG)	Slots at Racetracks Program	Racetracks	333.1						
OLG[1] and gaming service providers	Lease and other payments	Racetracks	36.5	147.9	150.8	152.7	150.2	157.3	141.6
OMAFRA	Horse Racing Industry Transition Program	Racetracks		61.6	0.2				
OMAFRA	Horse Racing Partnership Funding Program[2] (HRPFP)	Racetracks			99.8	100.0			
Ministry of Finance	Horse Racing Partnership Funding Program[2] (HRPFP)	Racetracks					93.4	91.6	94.4
Ministry of Finance	Pari Mutuel Tax Reduction[3] (forgone taxes)	Racetracks	63.3	57.9	58.4	59.9	60.9	59.0	57.5
OMAFRA	Horse Racing Industry Development Program (HRIDP)[4]	Breeders Association					6.5	5.9	5.9
Total Provincial Support			**432.9**	**267.4**	**309.2**	**312.6**	**311.0**	**313.8**	**299.4**

1. OLG lease payments: Rent paid to host slot machines and payments to cover the costs of valet parking and food services. OLG has paid racetrack operators rent to host OLG slot machines since 2014 after the Slots at Racetracks Program was cancelled. OLG sold gaming sites to private operators starting primarily in 2017/18. These operators pay lease payments directly to racetracks. The lease payments include an estimate of lease payments to be paid by private operators to racetracks in 2017/18 ($19.8 million) and 2018/19 ($83.9 million). As of March 2019, 12 racetracks were hosting OLG slot machines and were receiving lease payments.
2. Horse Racing Partnership Funding Program: Government support payments to help cover racetrack operating costs and increase purses (prize money for horse owners) since 2014/15.
3. Pari-mutuel tax reductions: Provincial tax reduction. Racetrack operators are required by law to collect provincial taxes on all bets placed in Ontario on horse races. The tax rate was 7.4% until 1996 when it was reduced to 0.5%. This 6.9% reduction is shared between racetracks and horse people under the 2014 Horse Racing Partnership Funding Program as follows:
   - 3.00% to the Horse Improvement Program for horse breeding
   - 0.40% to horse people and associations
   - 1.25% to racetracks for operations
   - 1.50% to racetracks to provide customer benefits
   - 0.75% to the Alcohol and Gaming Commission of Ontario regulatory levy
4. Program is comprised of the Enhanced Horse Improvement Program (EHIP) and Race Horse Welfare.
   The Enhanced Horse Improvement Program
   - provides awards and incentives to promote the breeding of quality Ontario racehorses and ownership of Ontario-produced racehorses; there is a separate program for each type of racehorse.
   - supports research related to the racing and breeding of racehorses.

   Racehorse Welfare
   - encourages industry leadership in racehorse lifecycle planning, and responsibility in preventing racehorse cruelty and neglect.

Figure 2: Comparison of Key Statistics from 2008/09 to 2018/19 for Ontario's Horse Racing Industry

Source of data: Ontario Lottery and Gaming Corporation and the Alcohol and Gaming Commission of Ontario

	2008/09	2018/19	Increase/ (Decrease) (%)
# of race horses	7,809	6,834	(13)
# of scheduled race days[1]	1,613	929	(42)
Gross wagering (Ontario and non-Ontario customers)[2]	$1,585 million	$1,601 million	1
Amount wagered in Ontario on Ontario races	$404 million	$226 million	(44)
Amount wagered in Ontario on races outside Ontario	$715 million	$606 million	(15)
Total purses[1] (prize money)	$273 million	$142 million	(48)

Note: Ten-year trend in wagering is provided in **Figure 10**.

1. Calendar years 2008 and 2018.
2. Wagering by Ontario customers on races anywhere and wagering by non-Ontario customers on Ontario races only.
3. Wagering by Ontario customers on races anywere.

support to the horse racing industry in Ontario. Since 2012, however, the province has communicated that the overall goal of these programs was industry self-sustainability through the growth of marketplace revenues.

In 1998, OLG started to place slot machines at racetracks through the Slots at Racetracks Program. Each racetrack received 20% of the gross revenues from the slots at their premises, split evenly between the racetrack and the horse people based at that racetrack. By 2012/13, the program was providing the horse racing industry with almost $335 million annually.

In March 2012, OLG announced that the Slots at Racetracks Program was ending effective March 31, 2013 as part of OLG's modernization plan. The initiative followed a recommendation by the 2012 Commission on the Reform of Ontario's Public Services, also known as the Drummond Report, to discontinue provincial government subsidization of the horse racing industry through the Slots at Racetracks Program. The goal of OLG's modernization plan was to increase provincial revenues through the privatization and relocation of gaming facilities, including slots, closer to where customers live. However, OLG did not receive the municipal approvals required to relocate slot facilities closer to the downtown cores of major cities, as they had planned.

After receiving negative feedback from the horse racing industry, the government appointed a Horse Racing Transition Panel in June 2012, three months after the cancellation of the Slots at Racetracks Program, and announced $50 million in transition funding over three years. In October 2012, the panel, comprised of three former Ontario cabinet ministers from three political parties, found that $50 million was insufficient to transition the industry to self-sustainability and recommended an investment up to $179.4 million over three years. As a result, the provincial government increased the transitional funding to $180 million (or $60 million per year) over three years. However, this funding only lasted one year, as a new funding program was announced.

In October 2013, the government announced a five-year Horse Racing Partnership Funding Program that provided up to $400 million to support the horse racing industry through transfer payments to racetracks. The funding was increased to $500 million in April 2014, and the Ontario Racing Commission, a government agency that reported to the Ministry of Agriculture, Food and Rural Affairs, signed five-year transfer payment agreements with 15 racetracks. The funding had two components: the Horse Racing Partnership Funding Program and the Horse Racing Industry Development Program. The first component was intended for racetrack operations and purses,

depending on the needs of the racetrack. The second component was intended to improve the quality and value of Ontario bred racehorses, and to promote ownership of Ontario produced racehorses.

For a comparison of government funding to the industry before the cancellation of the Slots at Racetracks Program and after, see **Figure 3**.

In 2015/16, the government restructured horse racing regulation in Ontario. Regulatory responsibilities were transferred from the Ontario Racing Commission to the Alcohol and Gaming Commission of Ontario. *The Ontario Lottery and Gaming Corporation Act, 1999* was also amended to make the OLG responsible for supporting live horse racing in Ontario and for the Horse Racing Partnership Funding Program, starting April 1, 2016. In March 2016, Treasury Board extended the program until March 2021, two years past its original five-year term, and provided OLG with additional funding for industry development activities ($900,000 per year) and administration costs to oversee the provincial funding program ($1.1 million in 2016/17 and $1.8 million in 2017/18).

2.3 New Long-Term Funding Agreement beginning April 1, 2019

In March 2016, Treasury Board directed the Ontario Lottery and Gaming Corporation (OLG) to work with the horse racing industry on a long-term funding arrangement. Based on industry consultations, in January 2018, OLG, Ontario Racing (a private industry association described in **Section 2.4**) and Woodbine reached an agreement-in-principle. The long-term funding agreement received Treasury Board approval in March 2018 and a public announcement of the agreement was made.

On May 7, 2018, the new 19-year long-term funding agreement was signed, and came into effect on April 1, 2019. The agreement has an initial seven-year term, plus two six-year extensions.

The objectives of the new long-term agreement are to reduce reliance on government funding, increase support for racetracks not operated by Woodbine, improve access to revenue streams (for example, off-track betting) for all parts of the industry, provide a unified industry voice and improve industry transparency.

As a result of this new agreement, the previous two-year extension of the Horse Racing Partnership Funding Program (discussed in **Section 2.2**) was cancelled.

Provincial funding under the new agreement will be provided through OLG's gaming revenues and, therefore, will not be recorded in the province's Public Accounts as a transfer payment expense. It will likely be recorded as an expense in OLG's financial statements.

Over the 19-year term of the new agreement, OLG will provide up to $120 million in annual payments to the industry from OLG revenues for the first two years (which includes $3 million in annual transition payments to supplement purse and operating shortfalls), $117 million per year for the next two years and approximately $63-$65 million per year after that. The maximum funding in each category (excluding the $3 million in transition payments) is as follows:

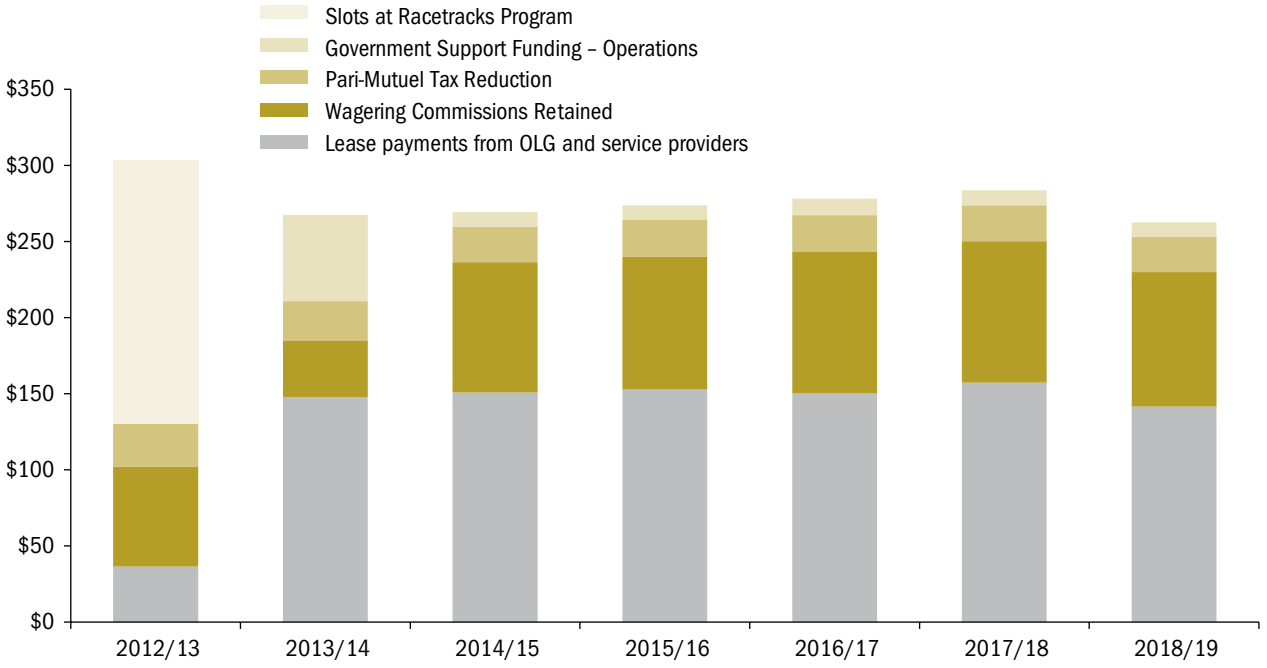
- $91.4 million to support purses and operating costs at racetracks (only $9.1 million can be used to support operating costs after 2020/21);
- $10 million to breeders to improve the quality and value of Ontario-bred horses;
- $6 million for capital improvements at non-Woodbine racetracks;
- $4 million to supplement purses at non-Woodbine racetracks;
- $3.4 million to a subsidiary of Woodbine to administer the payments;
- $2 million to provide financial assistance to Fort Erie and Dresden under the Optional Slots at Racetracks Program.

Under the Optional Slots at Racetracks Program, five racetracks that lost or were about to lose slot facilities were given the option to have slot machines and receive rental income, or to receive additional annual funding. Three tracks chose to

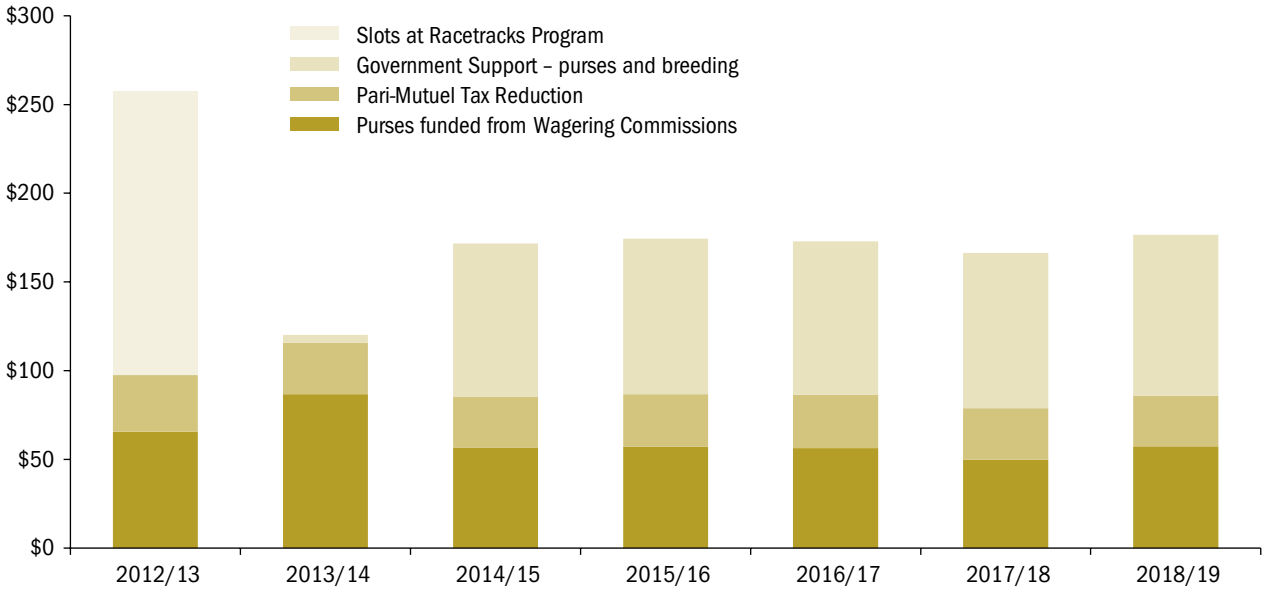
Figure 3: Trend in Revenues to Racetrack Owners and Horse People

Source of data: Ontario Lottery and Gaming Corporation and the Ministry of Agriculture, Food and Rural Affairs

Racetracks



Horse People



have slot machines, and the other two (Fort Erie Racetrack and Dresden Raceway) elected to receive additional financial support for horse racing operations totalling $2 million. The Fort Erie Racetrack will receive this funding in 2019/20, but Dresden will not receive its $250,000 share until the Chatham Casino opens.

The new long-term funding agreement provides a 17% annualized funding increase from $100 million provided by the former Horse Racing Partnership Funding Program, to $117 million. See **Appendix 3** for the 2019/20 approved funding allocation (including $3 million in transition payments). See **Appendix 4** for projected annual funding over the term of the agreement.

By 2021/22, OLG could reduce the maximum annual funding under the long-term agreement from $117 million if certain wagering and lease revenues are achieved. This is described more fully in **Section 4.1.8**.

Leasing Revenue for Woodbine Entertainment Group

As part of the OLG's modernization process for land-based gaming, the OLG combined all slots at racetracks and casino operations into eight regional gaming "bundles" throughout the province. Where procurement processes were completed, OLG transferred the bundles to private-sector service providers. Each transfer involved a formal, signed agreement between OLG and the service provider that won the bid, committing the provider to acquire assets and assume liabilities related to the sites in the bundle. The provider then signed a Casino Operating and Service Agreement with OLG to operate the casino and other services at the site. OLG continues to oversee the sites for the duration of the agreement, and the service provider has taken on the day-to-day operations.

In order to provide lease cost certainty to potential bidders for the GTA gaming bundle, OLG reached a long-term lease agreement with the Woodbine Entertainment Group (Woodbine) for space at the Woodbine Racetrack to develop gaming and non-gaming operations prior to the bidding process. The lease agreement eliminated the risk of Woodbine affecting the bidding process by either participating in the bidding itself and thereby creating an unfair competitive procurement process, or by creating uncertainty in the future lease costs for the winning bidder who would have to negotiate these costs with Woodbine. The long-term leasing agreement allows the successful bidder for the GTA bundle (Ontario Gaming GTA LP) access to the Woodbine Racetrack site to develop a predetermined number of acres.

Under the long-term funding agreement, when the additional casino leasing revenues from the new gaming expansions at Woodbine and Mohawk racetracks reach $51.4 million, both racetracks owned by Woodbine would no longer receive purse funding for horse racing from the government.

2.4 Ontario Racing: Horse Racing's New Private Industry Association

In April 2018, Horse Racing Ontario, operating as Ontario Racing, was incorporated as a not-for-profit corporation to represent the horse racing industry. Ontario Racing is responsible for setting an annual program of races for all racetracks, attracting new horse owners, implementing breed improvement programs (including horse improvement programs), growing the fan base and connecting the industry with the government and the general public. The goals of Ontario Racing are to attract competitive fields of high quality horses; to maximize the audience for live horse racing in Ontario, both on track and off track; and to increase wagering on the Ontario racing product, both domestically and internationally. The provincial government recognizes Ontario Racing as the authority for horse racing in Ontario.

Ontario Racing is the result of the government's initiative to transition responsibility for the industry from government to the industry itself. In 2016, the industry had set up the Ontario Racing Association

as a not-for-profit organization to represent the horse racing industry after signing an agreement with the now-defunct Ontario Racing Commission (a government agency under the Ministry of Agriculture, Food and Rural Affairs). The association's board included former directors of the previous industry association, and was provided operational funding of $1.8 million for two years by the Ministry of Finance through the Alcohol and Gaming Commission of Ontario (AGCO). In June 2018, Horse Racing Ontario purchased the assets and liabilities of the Ontario Racing Association and began operating as Ontario Racing.

There are 11 seats on Ontario Racing's Board of Directors—five from industry associations, five from racetracks, and an independent chair. The Board is responsible for setting race dates (subject to approval from OLG and the AGCO), allocating industry funds (subject to approval from OLG), marketing and promotion, and identifying opportunities for operational efficiencies. See **Figure 4** for a list of the current board members.

Ontario Racing Management, a wholly-owned subsidiary of Woodbine under contract with Ontario Racing, now provides all material management and operational services for Ontario Racing. According to OLG, Woodbine was made the administrator for Ontario Racing because it was a logical choice given its expertise in gaming and how well it managed the Standardbred Alliance.

2.5 Responsibility for the Horse Racing Industry

The responsibilities for the horse racing industry have changed significantly in the last five years since the dissolution of the Ontario Racing Commission. **Appendix 5** illustrates the governance model of the industry prior to April 1, 2016 and **Appendix 6** illustrates the current governance model as of April 2019. **Figure 5** lists the parties responsible for various functions in the horse racing industry.

- **Industry regulation, licensing and licensing appeals.** Before its dissolution, the

Figure 4: Ontario Racing Board of Directors as of September 2019
Source of data: Ontario Racing

Board Member		Position	Repesenting
1.	John Hayes (Chair)	(Industry-related experience) • former and most recently, an At-Large Director of Ontario Racing • former Gaming Director with OLG • Standardbred race horse owner	Independent
2.	Jim Lawson	CEO, Woodbine Entertainment Group	Premier Thoroughbred Racetracks
3.	Jessica Buckley	CEO, Woodbine Mohawk Park	Premier Standardbred Racetracks
4.	Ian Fleming	General Manager, Clinton Raceway	Grassroots Standardbred Racetracks
5.	Bruce Barbour	Executive Director, Flamboro Downs and Georgian Downs	Signature Standardbred Racetracks
6.	Jim Thibert	CEO, Fort Erie Live Racing Consortium	Signature Thoroughbred Racetracks
7.	Bob Broadstock	President, Quarter Racing Owners of Ontario Inc. (QROOI)	Quarter horse Horse people
8.	Sue Leslie	President, Horsemen's Benevolent and Protective Association (HBPA) of Ontario	Thoroughbred Horse people
9.	Bill O'Donnell	President, Central Ontario Standardbred Association (COSA)	Standardbred Horse people
10.	Walter Parkinson	President, Standardbred Breeders of Ontario Association (SBOA)	Standardbred Breeders
11.	David Anderson	Anderson Farms	Thoroughbred Breeders

Figure 5: Change in Responsibility for the Horse Racing Industry, 2015/16–2019/20

Prepared by the Office of the Auditor General of Ontario

Responsibility	2015/16	2016/17	2017/18	2018/19	2019/20
Industry regulation, licensing and licensing appeals	Ontario Racing Commission	Alcohol and Gaming Commission of Ontario			
Marketing, performance metrics and responsible gambling	Various industry associations*	Ontario Lottery and Gaming Corporation			
Purse and Operational Support for Racetracks	Ontario Racing Commission	Ontario Lottery and Gaming Corporation			Ontario Racing
Horse Improvement Program — Thoroughbreds	Canadian Thoroughbred Horse Society				Ontario Racing
Horse Improvement Program — Standardbreds	Ontario Racing Commission	Ontario Racing			
Horse Improvement Program — Quarter horses	Ontario Racing Commission	Ontario Racing			

Government agency, crown corporation or regulatory agency

Private industry association

* Includes associations such as the Canadian Thoroughbred Horsepersons Society, Standardbred Canada and Standardbred Breeders of Ontario.

Ontario Racing Commission was responsible for horse racing industry regulation, licensing and licensing appeals. Starting April 1, 2016, the Alcohol and Gaming Commission of Ontario took over the industry regulation and licensing responsibilities and the Licence Appeal Tribunal became responsible for licensing appeals.

- **Horse Improvement Programs.** Before April 1, 2016, the Ontario Racing Commission administered the Horse Improvement Programs for Standardbred and Quarter horses and delegated the responsibilities for administering the Thoroughbred Horse Improvement Program to the Canadian Thoroughbred Horse Society (a private industry association). Starting in April 2016, Ontario Racing assumed the administration of the Quarter horse and Standardbred Horse Improvement Programs, and the Canadian Thoroughbred Horse Society continued to be responsible for the Thoroughbred Horse Improvement Program. Starting April 1, 2019, Ontario Racing also assumed responsibility for all horse improvement programs.
- **Marketing, performance metrics and responsible gambling.** Before April 1, 2016, various industry associations were responsible for marketing and performance metrics for the horse racing industry. Starting April 1, 2016, the Ontario Lottery and Gaming Corporation became responsible for marketing, performance metrics and responsible gambling for the horse racing industry.
- **Purse and operational support.** Before April 1, 2016, the Ontario Racing Commission administered the Horse Racing Partnership Funding Program. Starting April 1, 2016, the Ontario Lottery and Gaming Corporation has administered funding to racetracks. With the end of the Horse Racing Partnership Funding Program, and the start of the new 19-year, long-term funding agreement on April 1, 2019, Ontario Racing became responsible for administering purse and operational support to racetracks. Ontario Racing was expected to represent the interests of all key stakeholders and allow the industry to manage itself.

2.6 Alliance of Standardbred Racetracks

In its final report in October 2013, the Horse Racing Transition Panel included a recommendation that an alliance of willing tracks formed to collectively set race dates and purses would be beneficial for industry self-sustainability. On January 14, 2014, a group of racetracks entered into an alliance of Standardbred racetracks known as the Standardbred Alliance. The alliance racetracks included Woodbine, Mohawk, Clinton, Grand River, Flamboro Downs, Georgian Downs, Hanover and Western Fair. Rideau-Carleton joined in October 2017.

These racetracks entered into a revenue-sharing agreement. All wagering income was shared based on each racetrack's share of live, on-track wagering revenues. The alliance chose the Woodbine Entertainment Group (Woodbine) to operate wagering for all alliance tracks by collecting all wagers on behalf of the member tracks and redistributing their shares to them.

Woodbine agreed to incur racing and wagering costs for all alliance tracks; for completing and submitting race date applications; race secretary duties related to scheduling races; accepting horse entries; and drawing post positions (i.e. selecting the gate from which each horse starts the race); processing purse payments; and on-track wagering related costs.

Woodbine also guaranteed purse funding for all alliance racetracks, if the government funding of purses and the track's wagering commission was not sufficient to support purses. Woodbine told us it has supported these tracks in order to maintain a reasonable supply of horses in the province and to increase provincial wagering. In 2018/19, Woodbine covered about $10 million in purse shortfalls to other alliance racetracks using the provincial funds Woodbine receives for purses.

3.0 Audit Objective and Scope

Our audit objective was to assess whether provincial funding provided to the horse racing industry is:

- achieving the communicated public policy objective of helping the industry become self-sustainable through growth in marketplace revenue; and
- being administered with clear accountability provisions to ensure that intended recipients within the industry receive and use provincial funding for the purposes intended in accordance with agreements.

In planning for our work, we identified the audit criteria (see **Appendix 7**) we would use to address our audit objective. These criteria were established based on a review of applicable agreements, and best practices. Senior management at the Ministry of Finance and OLG reviewed and agreed with the suitability of our objectives and associated criteria.

We conducted our audit between December 2018 and August 2019. We obtained written representation from management at the Ministry of Finance and the Ontario Lottery and Gaming Corporation that, effective November 12, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

Our audit work was conducted mainly at the Ontario Lottery and Gaming Corporation (OLG) and the Woodbine Entertainment Group (Woodbine), which owns and operates the only two premiere racetracks in Ontario (Woodbine Racetrack and Mohawk Racetrack) and received about 60% of government funding over the last five years under the Horse Racing Partnership Funding Program.

We focused on three key areas of the horse racing industry: growth and sustainment of the industry, allocation of government funding, and use of government funding. Our work included:

- Interviewing senior management and staff at OLG, Ministry of Finance and Woodbine, including Ontario Racing Management;
- Reviewing applicable agreements, policies and procedures;
- Reviewing reports provided by racetracks to OLG to assess the use of funding;
- Visiting Woodbine to assess the use of government funding by Woodbine tracks through detailed testing of supporting documents;
- Reviewing Woodbine's anti-money laundering controls; and
- Visiting three other racetracks (Fort Erie, Flamboro Downs and Grand River) to review their operating costs.

We also contacted the Ontario Ministry of Agriculture, Food and Rural Affairs to obtain information on the history of funding for the industry including the Horse Improvement Program. We met with the Alcohol and Gaming Commission of Ontario (AGCO) to gather information on the oversight of government funding and regulation of the horse racing industry.

We met with key stakeholder groups representing horse people. These groups include the Canadian Thoroughbred Horse Society (representing Thoroughbred breeders), the Standardbred Breeders of Ontario Association, the Central Ontario Standardbred Association (representing Standardbred horse people), and the Ontario Harness Horse Association (also representing Standardbred horse people).

We contacted the Canadian Pari-Mutuel Agency to discuss oversight over horse racing wagering, and we contacted the Financial Transactions and Reports Analysis Centre of Canada (FINTRAC) to discuss potential risks of money laundering in the industry.

Disclosure Limitation

As part of our report, we wanted to provide members of the Legislature with information about the net financial position (revenues less expenses) for 2018/19 for each racetrack, with and without government support, to present more complete and transparent information about racetrack sustainability. However, to disclose this information for racetracks owned and operated by Woodbine Entertainment Group (Woodbine), we required the written consent of Woodbine under section 10.6 of the provincially negotiated funding agreement for the Horse Racing Partnership Funding Program. Woodbine did not provide its consent. According to Woodbine, its financial statements are prepared on the understanding that they are for limited distribution. As Woodbine accounts for about 90% of wagering income and over 70% of purses, presenting information without including Woodbine would not be informative.

4.0 Detailed Audit Observations

4.1 Self-Sustainment of Horse Racing Through Marketplace Revenues

4.1.1 Ontario Has More Tracks Per Capita than Comparable Jurisdictions

Ontario currently has 15 racetracks across the province—two that race Thoroughbred horses, 12 that race Standardbred horses, and one that races Quarter horses. When we compared the number of racetracks to a sample of U.S. states and other Canadian provinces as shown in **Appendix 8**, we noted that each racetrack in Ontario serves fewer people than racetracks in the states of California, Florida, New York, Pennsylvania and Ohio. For example, Ontario has nine more racetracks than Pennsylvania, and six more than Florida, which has a 46% higher population than Ontario.

Also, despite the smaller number of racetracks in Pennsylvania, the total number of race days is similar to those in Ontario. However, race days are divided among many more tracks in Ontario then Pennsylvania. On average, Ontario has 61 race days

per track while Pennsylvania has 151 race days per track. In fact, the number of approved race days for seven Ontario racetracks range from 11 to 25 days per year, as shown in **Appendix 3**.

4.1.2 Only one or two racetracks operating on most days

A horse race is run somewhere in Ontario 363 days of the year. However, when we analyzed the number of racetracks operating on a single day by type of horse race, we noted that on most days, only one or two racetracks are scheduled to hold races. For example, for the 12 racetracks that race only Standardbred horses, we noted that only one or two were scheduled to hold races on the same day on almost 300 (83%) of race days in 2019.In addition, the highest number of Standardbred racetracks scheduled to run races on the same day was five of the 12 tracks. This occurred on only 15 days in 2019 (4% of the year's race days). For all types of horse racing, the highest number of racetracks scheduled to be open on a single day in 2019 is seven of the 15 tracks. Currently, seven racetracks have races one day a week, and two others are opened in the summer months only. This shows that Ontario can support a similar number of races with fewer racetracks.

Three of the four horse people associations we met with were in favour of consolidating racetracks in Ontario. They believe that with fewer tracks, horses will be re-allocated between fewer tracks, which would increase the number of horses running in any race. According to these associations, the number of horses per race, or field size, has a positive impact on wagering. Even if the number of tracks decrease, they believe that wagering revenue would increase. However, one stakeholder mentioned that without rural tracks, the horse supply in Ontario would likely decrease, as the industry would become less attractive to rural horse owners if they have to travel long distances to race their horses.

4.1.3 Focus of Government Funding Shifts from Self-Sustainment to Sustaining the Industry

A government study recommended that the horse racing industry become self-sustaining. In February 2012, the Drummond Report stated that "Ontario's approach [of sharing slot revenues with racetracks] is unsustainable and it is time for the [horse-racing] industry to rationalize its presence in the gaming marketplace so that the industry is more appropriately sustained by the wagering revenues it generates." The report characterized sharing slot machine revenue as a subsidy to the horse racing industry. The Drummond Report also recommended allowing slots-only gaming facilities "at sites that are not co-located with horse racing venues."

As stated in our 2014 special report on the Ontario Lottery and Gaming Corporation's Modernization Plan, the government was fully aware in March 2012 that its decision to end the Slots at Racetracks Program would have a significant impact on the horse racing industry in Ontario, and would force it to downsize to a level that could be sustained solely by the revenues that horse racing could generate on its own. The government had sufficient information to know that without government funding, the number of racetracks could be reduced from 17 to as few as six. This would mean fewer race dates, less breeding, less employment and fewer economic benefits for the agricultural industry.

In June 2012, the province announced $50 million in transition funding over three years to "help the horse racing industry transition from the Slots at Racetracks Program to a more sustainable, self-sufficient model." The Minister of Finance at the time, clarified that the $50 million in transition funding was to help "the industry move toward greater self-sufficiency without government support." In addition to the transition funding, Employment Ontario was expected to help displaced workers in the industry to train for and find new jobs.

Similarly, the purpose of the five-year Horse Racing Partnership Funding Program, which ran

from 2014/15 to 2018/19, was to provide funding to allow racetracks to become more self-sustainable through the growth of marketplace revenues.

With the new 19-year, long-term funding agreement, effective April 1, 2019, the objective of government funding shifted from transitioning the industry towards self-sustainment to sustaining the industry. The objective of the long-term funding agreement, is to promote the sustainability of horse racing in Ontario by providing a stable, long-term source of funding for the horse racing sector. The agreement was expected to provide greater certainty and confidence to the horse racing industry, enabling long-term decisions about breeding and racing programs. The submission also states that funding demonstrates a commitment to rural Ontario, including dedicated support for local racetracks and for people behind Ontario-bred horses.

4.1.4 Without Government Funding Racetracks Would Not Be Sustainable

Wagering revenue is the largest income stream for the horse racing industry. A successful and self-sustaining industry should be able to generate sufficient income to fund purses and cover racetrack operating costs. Similar views were expressed by the Horse Racing Industry Transition Panel in August 2012 when it proposed a stronger link between racing product—the horse races—and consumer demand shown in wagering. The panel suggested that the size of purses and the number of race dates should be determined by the amount of wagering revenue. According to the panel, for greater self-sustainability, racing opportunities should increase or decrease in response to consumer demand.

The Alcohol and Gaming Commission of Ontario (AGCO) and the Ontario Lottery and Gaming Corporation (OLG) agree that for a self-sustaining horse racing industry, purse amounts should be reflected in wagering income. They stated that the health of the industry can be judged by the percentage of purses funded by wagering income.

However, as seen in **Figure 6**, a significant portion of purses is funded by government support. Between 2014/15 and 2018/19, about 60% of purses were funded by the government.

In Ontario, the government provides purse funding to racetracks without any direct link to wagering revenues or income.

Without government support for purses or operations, few racetracks can cover their expenses. The racetracks that can cover expenses are primarily those that receive lease revenue from OLG or private gaming operators for hosting slot machines. Without government support, most racetracks would either close or significantly reduce the number of race days and the size of purses.

One stakeholder noted that there are few horse racing jurisdictions in North America that do not receive some government support. Based on the jurisdictions we researched, only California's industry is being sustained without some sort of government support or other gaming revenue. Another stakeholder felt that for Ontario's industry to become self-sustaining, it would need to increase wagering and/or create new betting products.

Figure 6: Percentage of Purses (Prizes to Horse Owners) Funded by the Government, 2014/15–2018/19
Source of data: Ontario Lottery and Gaming Corporation and Ministry of Agriculutre, Food and Rural Affairs

Year	Total Purses Paid ($ million)	Government Funding for Purses ($ million)	Government Funding for Purses (%)
2014/15	137.0	80.3	59
2015/16	138.9	81.7	59
2016/17	136.4	80.1	59
2017/18	131.3	81.5	62
2018/19	142.3	84.8	60

4.1.5 Although the Level of Wagering has Stayed Relatively Constant in the Last 10 Years, Commissions from Wagering have Declined

Income from wagering is down because Ontarians, and Canadians in other provinces, are not wagering on Ontario horse races as much as they used to. As seen in **Figure 7**, over the last 10 years, from 2008/09 to 2018/19, Ontarians' wagering on Ontario races and non-Ontario races has decreased by 44% and 15% respectively. Wagering by other Canadians on Ontario races has also decreased by 48%. In contrast, over the same period, foreign wagering on Ontario races has seen a significant increase of 108%. According to some stakeholders, this increase is due to the advertising of Ontario races in the U.S., and foreign exchange rates. However, since commissions are significantly lower on foreign wagering, overall wagering commissions have not increased. For foreign wagering, the only income Ontario racetracks generate is the small fee (about 3%) that they charge the foreign racetracks to allow them to bet on Ontario races. It should also be noted that the number of race days also declined by 42% over the same 10-year period, as previously shown in **Figure 2**.

The portion of wagering dollars retained by Ontario racetracks is significantly different for wagering by Ontario bettors, versus wagering by bettors outside of Ontario. For wagering by Ontario bettors on Ontario races, racetracks retain about 13% as commissions, after taxes and regulatory payments. For wagering by Ontario bettors on non-Ontario races, the commission is reduced to about 10%, after 3% is provided to foreign racetracks to be able to bet on foreign races. For foreign wagering, Ontario racetracks only receive about 3% in commission from the racetrack that took the bet outside Ontario. Across the North American horse racing industry, it is common practice for racetracks that take bets on races occurring in other jurisdictions to pay the track where the race is held a 3% commission.

4.1.6 Provincial Funding for the Horse Racing Industry Guaranteed for 19 Years with No Effective Out Clause

One of the key objectives of the new long-term agreement is to reduce reliance on government

Figure 7: Wagering Customers at Ontario Tracks, How They Place Bets, and Effects on Wagering Commissions, Comparison of 2008/09–2018/19

Prepared by the Office of the Auditor General of Ontario using data from Ontario Racing

	Gross Wagering Retained by Ontario Tracks (%)[1] A, % of Gross	Gross Wagering 2008/09 ($ million) B	Gross Wagering 2018/19 ($ million) C	Gross Wagering 10-Year Change ($ million) D, C – B	Gross Wagering 10-Year Change (%)	Wagering Commission 10-Year Change ($ million) D × A
Ontario customers wagering on Ontario tracks	13	404	226	(178)	(44)	(23)
Ontario customers wagering on non-Ontario tracks[2]	10	715	606	(109)	(15)	(11)
Canadian customers from outside Ontario wagering on Ontario tracks	3	128	66	(62)	(48)	(2)
Foreign customers wagering on Ontario tracks	3	338	703	365	108	11
Net Change		**1,585**	**1,601**	**16**	**1**	**(25)**

1. Industry estimates for each type of wagering according to Woodbine Entertainment Group.
2. A licence is required from the Canada Pari-Mutuel Agency to take bets on races outside Ontario. The licensee must be operating a racetrack in Ontario. Woodbine Entertainment Group is the only such licensee in Ontario.

funding. However, with 19 years of guaranteed funding until the end of fiscal 2037/38, it is difficult to see how the new agreement will reduce the industry's reliance on provincial support. Furthermore, although some funding reductions are likely during the term of the agreement, such a long-term agreement locks in future governments that could have different priorities.

The new long-term funding agreement does not include any clauses to enable the province to terminate the agreement without cause. The agreement has an initial term of seven years, and two additional renewal terms of six years each, for a total of 19 years. The additional terms are automatically renewed, as long as the racetracks have races on their approved race days each year. In the event that a race cannot be held on an approved date (for example, due to bad weather) the racetrack can reschedule the race or increase the purses for races on other days. The agreement does not include clauses to end the contract after the first or second term.

The province can cancel the agreement if certain events or defaults occur. Examples of such events include: if any of the three major parties to the agreement (Ontario Racing, Woodbine Entertainment Group and its subsidiary Ontario Racing Management) become insolvent; if the parties misrepresent information to OLG that has a material adverse effect; or if the parties, or their respective directors or senior officers, are convicted of a criminal or regulatory offence that has material adverse effects. Other reasons for default are included in **Section 4.5.1**.

The 19-year agreement provides guaranteed funding, and does not provide OLG a way to terminate the agreement at its discretion. We understand that OLG discussed potential termination clauses, but the industry was strongly against it because they wanted certainty over the term of the agreement.

The 19-year term was chosen because it aligns with the contracts that OLG has with service providers who operate provincial casinos. OLG was directed to integrate gaming with horse racing, and the Ministry of Finance believed that the term of the agreement should be similar. However, these two agreements are different because private casino operators generate significant revenues for the province, while horse racing cannot cover its own operating costs without the financial support of the province, as shown in **Figure 8**.

Figure 8: Ontario's Racetracks' Ability to Sustain Purses and Operations Through Wagering Commissions and Other Revenues, with and without Government Support, 2018/19

Source of data: Ontario Lottery and Gaming Corporation and the Woodbine Entertainment Group

	($million)
Horse Racing–Related Revenues	
Wagering Commissions (net of taxes)	127.3
Other Revenue	75.4
Total	**202.7**
Disbursement Needs	
Eligible Racetrack Expenses	229.9
Total Purses Paid	142.2
Total	**372.1**
Net Position of Racetracks – without Government Support and Lease Revenue	**(169.4)**
Government Support and Lease Revenue	
Lease Revenue	141.5
Purse	84.8
Operating	9.6
Total	**235.9**
Net Position of Racetracks – with Government Support and Lease Revenue	**66.5**

We confirmed with OLG that total annual funding under the 19-year agreement will not be reduced if a racetrack closes down. Instead, the money would be redistributed amongst the remaining racetracks because funding is not tied to the number of racetracks. Although the contract includes provisions for certain reductions in funding (discussed in detail in **Section 4.1.8**), based on the most likely scenario over the 19-year period, total funding is likely to reach $1.4 billion.

4.1.7 No economic impact study prior to providing funding to industry

OLG is currently conducting a study on the economic impact, including jobs created by each racetrack, as well as the overall impact of the horse racing industry on Ontario's economy. The study is expected to be completed by March 31, 2020.

We noted that the justification in 2018 that secured funding for the industry for 19 years did not discuss the number of jobs being impacted or the economic activity generated by the horse racing industry, despite the emphasis on sustainability. We would have expected the province to have conducted an economic impact study before finalizing both the five-year funding agreement for $100 million a year, which took effect April 1, 2014, and the latest 19-year agreement for $120 million a year initially, which took effect April 1, 2019.

OLG told us that it had not conducted an economic impact study earlier because it did not have the internal capacity to do so. The Horse Racing Division at OLG was formed in 2016 with four staff. It had 10 staff by March 2019.

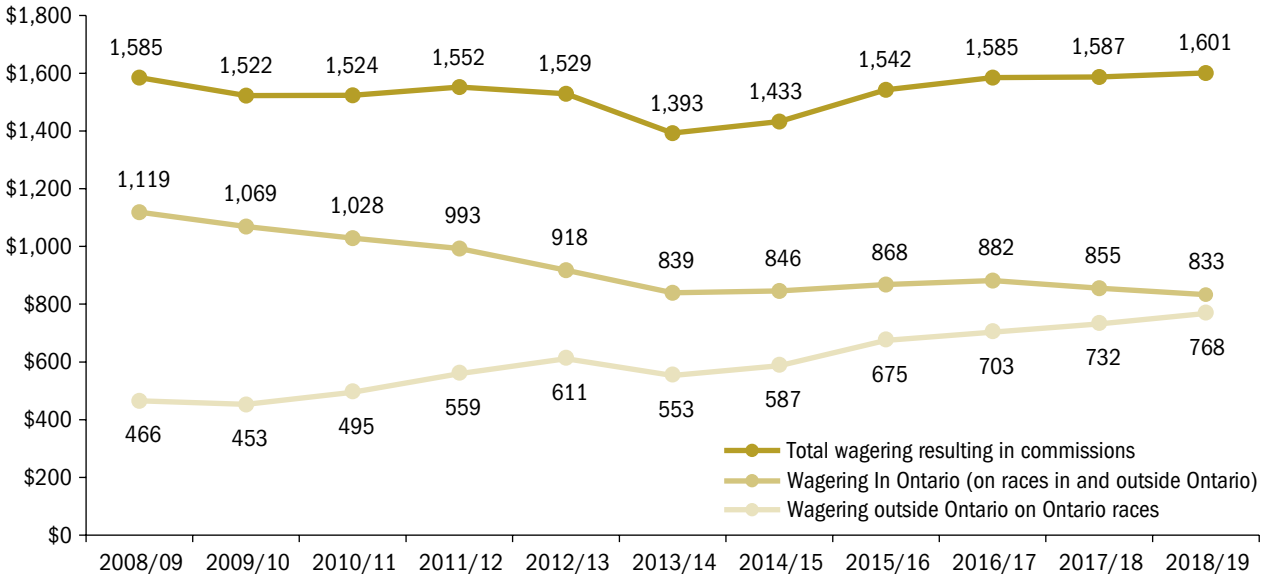
4.1.8 Not All Future Reductions in the Funding Agreement Likely to Materialize

In the new 19-year funding agreement effective April 2019, the government included provisions to reduce the level of funding. Funding could be decreased if there were increases in wagering revenue across the horse racing sector, and increases in leasing revenue to the Woodbine Entertainment Group (Woodbine) resulting from the expansion of its casino area. We expect leasing revenues from Woodbine's two racetracks to contribute to a reduction in government funding under the agreement. This reduction is expected to reach a maximum of $51.4 million per year starting in 2023/24. The Ministry of Finance noted that Woodbine is projected to become self-sustaining, however, total funding for tracks aside from Woodbine and Mohawk were not expected to decrease. The funding reduction provisions are as follows:

Funding reduction due to wagering in Ontario—For any funding year, if the total amount of revenues from wagering in Ontario is greater than $1.2 billion, then the amount of the payment to racetracks for the following year would be reduced by 5% of wagering revenues in excess of $1.2 billion. For example, if the gross wagering in Ontario reaches $1.4 billion, the amount of government funding would be reduced by $10 million ($200M x 5%) in the following year. This funding clawback is highly unlikely, as wagering from Ontarians on races in any jurisdiction has been declining. As of 2018/19, it was only $833 million (see **Figure 9**). Before any clawback occurs, the Ontario wagering would need to increase by 44%.

Funding reduction due to wagering outside Ontario—Similarly, for customers wagering on Ontario races from outside of Ontario, for any funding year, if the total amount of revenues from wagering on Ontario races from outside Ontario is greater than $1 billion, then payments to racetracks for the following year would be reduced by 1.5% of wagering revenues in excess of $1 billion. For example, if the gross wagering on Ontario races from outside of Ontario reaches $1.2 billion, the amount of government funding would be reduced by $3 million ($200M x 1.5%) in the following year. This funding clawback is also unlikely to happen, as wagering on Ontario races by non-Ontarians was only $768 million in 2018/19 (see **Figure 9**). Before any clawback occurs, the non-Ontario wagering on Ontario races would need to increase by 30%.

Figure 9: Trend in Wagering ($ million)
Source of data: Ontario Racing



Further funding reductions to the long-term funding exist if OLG chooses not to accept the industry's proposals for capital improvements and the horse improvement program beyond the 2025/26 fiscal year. The potential annual reduction in these areas is $16 million.

RECOMMENDATION 1

In order to reduce the horse racing industry's reliance on government funding and become self-sustaining, we recommend that the Ministry of Finance and the Ontario Lottery and Gaming Corporation:

- complete its impact study of the horse racing industry on Ontario's economy;
- based on the results of the study, construct a long-term plan toward self-sustainment of horse racing through wagering revenues and other options; and
- consider revisiting the latest agreement based on the results of the study.

OLG RESPONSE

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and recognizes the importance of reducing the horse racing industry's reliance on government funding. OLG recently launched a comprehensive study to quantify the economic impact of the Ontario horse racing sector. The objective of the study is to establish a credible baseline that can be relied upon by industry members to engage in fact-based discussions that drive sustainability. The study is currently scheduled for completion by the end of the 2019/20 fiscal year.

OLG will use inputs from this study to work with the industry body, Horse Racing Ontario (Ontario Racing), to develop an overarching long-term industry plan for enhanced stability and sustainability. Based on the results of the study and this plan, OLG will determine if there are amendments to the long-term funding agreement that could be explored with the other counterparties to the agreement and seek necessary approvals from the Minister of Finance.

MINISTRY RESPONSE

The Ministry of Finance will work with OLG to assess the outcome of the economic impact study and determine if there are amendments to the long-term funding agreement that could be explored.

4.2 OLG's Role in Horse Racing

4.2.1 Improvement Needed in OLG's Monitoring Efforts

OLG conducting audits of racetracks

Over the last two fiscal years (2017/18 and 2018/19), the Ontario Lottery and Gaming Corporation (OLG) audited seven racetracks (Hiawatha, Rideau-Carleton, Flamboro, Georgian, Fort Erie, Grand River and Ajax) to assess their compliance with the five-year Horse Racing Partnership Funding Agreement. The areas reviewed included: use of government funding for operations and purses, financial reporting, governance obligations, insurance coverage and public-sector salary disclosure. The issues in these audits noted below include:

- One racetrack took $12,000 from the purse account surplus to reimburse itself for a previous year's purse funding shortage instead of carrying the amount forward for the following year, as required under the agreement for the Horse Racing Partnership Funding Program.
- One racetrack had its financial statements reviewed by an external accountant rather than audited, as required by the funding agreement. In addition, it did not disclose significant accounting adjustments to OLG that were made after its initial submission. The funding agreement required that information submitted to OLG should be updated in the event of material change.
- Two racetracks did not deposit government funding received for operational support in a separate, interest-bearing account.
- Four racetracks' liability insurance policies did not meet transfer payment agreement requirements; for example, policies for one of the racetracks did not have minimum coverage of $2 million for third-party bodily injuries.
- Four racetracks lacked documented governance policies and procedures (such as code of conduct, prudent management of funds and risk management).

OLG requested that these racetracks submit action plans to address the exceptions noted during the audits and followed up to ensure corrective action had been taken.

OLG does not rely on racetracks' audited financial statements

OLG requires racetracks to submit unaudited information to monitor compliance with the terms of the Horse Race Funding Partnership Funding Agreement.

OLG relies mainly on self-reported information to assess whether the racetracks have used government funding according to the terms of the agreement. OLG gets audited financial statements from racetracks a few months after receiving the self-reported information, but much of the information OLG requires for monitoring purposes cannot be tied directly to the audited financial statements. We noted differences between the audited financial statements, and the information reported to OLG for two racetracks with the same year-end as OLG's reporting cycle.

With respect to the discrepancies noted, OLG informed us that it validates gross wagering amounts reported with information obtained from the Canadian Pari-Mutuel Agency, a federal agency that oversees horse racing wagering. However, OLG staff told us they do not verify expenses reported by racetracks and the amount of purses paid because the funding agreement does not explicitly require it. OLG also advised us that some racetracks have a different year-end, which makes it difficult to compare financial information.

We also noted a situation where salary expenses reported by a racetrack exceeded total racing expenses reported. This implies that either total racing expenses are understated or that salary expenses include salaries of persons in ancillary operations that are not part of horse racing operations. Another racetrack we visited told us that salary expenses included staffing costs for all operations, in addition to racing. OLG had never followed up with the racetracks to question the anomaly.

Based on our review of the racetracks' audited financial statements, we identified two tracks that made substantial donations to external parties.

- Ajax Downs made a $4.8 million donation to a charitable foundation. The racetrack operator told us that this was done to increase its corporate profile. It stated that this funding was received from a related party as a loan, which is expected to be paid back in full. This racetrack received $4.1 million in government support for purses and operations in 2018/19 and will receive $5.1 million in 2019/20.
- Clinton Raceway made a $150,000 donation to help the municipality build a splash pad at a nearby park. This raceway received $151,000 in government support for purses in 2018/19 and will receive $944,000 in 2019/20 for purse support and capital improvements.

In another instance, a racetrack paid $250,000 in severance, negotiated directly with the board of directors, to a retiring senior staff member.

It is unclear why OLG is allowing racetracks that receive government support to make such large donations and other discretionary payments.

Under the new long-term funding agreement, OLG can conduct audits and inspections of the racetracks, Ontario Racing and Ontario Racing Management. In addition, Ontario Racing is responsible for ensuring the proper use of provincial funding by racetracks, in accordance with the terms of the agreement and the approved annual business plans. If any misuse of funds is discovered by Ontario Racing or OLG (through audits or inspections), Ontario Racing is required to repay or have racetracks repay the funds to OLG.

Based on our sample testing of the Horse Racing Partnership Funding Program which ended on March 31, 2019, we confirmed that provincial funding provided for purses was spent on purses, and that the provincial tax break to the industry of 6.9% was shared with specific industry parties in the correct amounts as intended by the program.

RECOMMENDATION 2

In order to effectively monitor funding agreements with the horse racing industry, we recommend that the Ontario Lottery and Gaming Corporation:

- have racetracks submit audited financial statements with segmented information for horse racing operations;
- investigate significant differences or unusual items; and
- restrict racetracks from making large discretionary payments, such as donations or large severance payments.

OLG RESPONSE

OLG will determine if there are amendments to the long-term funding agreement that are necessary with respect to having racetracks submit audited financial statements with segmented information for horse racing operations and restricting racetracks from making large discretionary payments, such as donations or large severance payments. Any amendments to the long-term funding agreement will require agreement by the other counterparties to the agreement, and approval by the Minister of Finance. In addition, OLG agrees to investigate significant differences or unusual items in reporting.

4.2.2 Impact of OLG's Horse Racing Division on Industry not Clear

In 2015, the Minister of Finance instructed OLG to create a new line of business within the organization that focused on integrating horse racing activities into Ontario's gaming strategy. As a result, the horse racing division was created to:

- create effective stakeholder relationships to support the needs of the horse racing industry;
- contribute to the efficient and effective management of funding through performance measurements;
- develop a strong brand and marketing strategy with the industry; and
- share expertise to help the industry adopt its own Responsible Gambling Program.

OLG established a framework that focuses on the sustainability of the horse racing industry. The framework includes 11 key performance indicators to help monitor progress toward a more sustainable future.

As seen in **Figure 10**, data is reported for only five indicators. The remaining six are expected to be implemented by March 2020. Data related to the performance indicators is collected and reported quarterly on OLG's website. According to OLG, the five indicators for which reliable data could be obtained were implemented. The remaining indicators will be reported when data becomes available from reports by racetracks under the new long-term funding agreement, as well as the economic impact study being conducted by OLG at the time of our audit.

As part of its marketing strategy, OLG created a new horse racing brand under the Ontario Racing (OR) name. The OR brand was created in 2015 in consultation with the industry association, and launched in 2016. OR's marketing campaigns identify Ontario Racing as endorsed by OLG. This provides recognition and authenticity to OR advertising through brand association with OLG.

OLG measures the effectiveness of its advertising campaigns for specified target audiences through a third-party researcher. Based on the findings from the researcher, awareness of horse racing by the Ontario adult population has grown from 13% in 2016 to 22% in 2018. At the time of our audit, OLG had not set a target for the level of awareness it wanted to achieve.

Since 2016, OLG has created two horse-themed slot games that were released through OLG's iGaming website, PlayOLG. These games generated over 65,000-page views on a website that also hosted messaging about horse racing in Ontario and links to an online horse-betting site. In addition, OLG created and released two horse racing–themed instant lottery games, which sold a total of 3.9 million tickets. OLG's goal was to increase awareness and consideration of horse racing as a gaming option by creating new horse-themed products.

However, despite OLG's awareness campaign whose ultimate goal is to increase wagering revenue to help the industry become self-sustaining, wagering on horse racing by people in Ontario continues to decline. OLG has no data to assess whether the marketing initiatives generated increased wagering revenue for the industry overall.

The racetracks we visited confirmed that OLG runs marketing campaigns to attract customers to horse racing. However, none of them could say if OLG's marketing has had any impact on attendance or wagering at their tracks. For its 2019/20 marketing plan, OLG aims to continue to build awareness of horse racing via advertising on multiple media channels, event sponsorship, and supporting the broadcast of premier Canadian races.

Figure 10: Ontario Lottery and Gaming Corporation's Horse Racing Performance Indicators

Source of data: Ontario Lottery and Gaming Corporation

	Major Focus Area	Performance Indicator	Definition	2016/17 Results	2017/18 Results	2018/19 Results	2-Year Increase/ (Decrease) (%)
More Self-Sufficient Sector that Sustains Jobs							
1.	Grow fan base and enhance wagering revenue	Gross Bet on Ontario Races	Total gross wagering on Ontario races	$940 million	$967 million	$995 million	5.9
2.	Grow fan base and enhance wagering revenue	Gross Wagering Commissions (Revenue) to Racetracks	Sum of racetrack commissions from Ontario wagering on the Ontario product, Ontario wagering on the foreign product and foreign wagering on the Ontario product	*	*	*	
3.	Growth of live racing to grow new fan base	Total Count of Tickets Sold	Total number of wagering tickets sold	8.81 million	8.66 million	7.55 million	(14.3)
4.	Ontario breeding sector to breed quality Ontario horses	Average Ontario Yearling Sales Price	Average sales price of Ontario yearlings sold at all Thoroughbred and Standardbred yearling sales (Ontario and abroad) (A yearling is a horse less than two years old. This is the age at which horses are sold as race horses)	$41,384	$43,774	$47,784	15.5
5.	Balance supply and demand for race horses (breed-to-race model)	Wager to Purse	Amount of wagering revenue generated per purse	*	*	*	
6.	Balance supply and demand for race horses (breed-to-race model)	Average Field Size	Average number of starters (not unique) per race in Ontario	8.0	7.9	7.9	(1.3)
7.	Balance supply and demand for race horses (breed-to-race model)	Total # of Unique Starters	Total number of unique horses starting races in Ontario	7,086	6,782	6,840	(3.5)
8.	Balance supply and demand for race horses (breed-to-race model)	Total # of Registered Foals	Total number of foals produced and registered in a horse (breed) improvement program	*	*	*	
Appropriate Return on Investment to Taxpayers							
9.	Gov't support offset by resulting economic activity and jobs	Total FTEs Employed	Total FTEs involved in the horse racing	*	*	*	
10.	Gov't support offset by resulting economic activity and jobs	Racetrack Capital Reinvestment Rate	Total capital expenditures incurred by racetracks in support of horse racing operations as a % of total government funding	*	*	*	
11.	Reduced reliance on government funding over time	Total Other Racetrack Revenue	Revenue generated from non-racing activities at all Ontario racetracks	*	*	*	

* OLG does not report on these performance indicators.

RECOMMENDATION 3

In order to further support the horse racing industry to become self-sustainable, we recommend that the Ontario Lottery and Gaming Corporation:

- assess the impact of its marketing campaign in attracting customers to horse racing; and
- work with the industry to bring in new direct revenue streams and to increase wagering revenues.

OLG RESPONSE

OLG agrees with the recommendation and will work with third-party researchers to improve metrics that assess the impact of marketing campaigns, including in respect of attracting new customers and attendance. OLG will also work with the industry body, Ontario Racing, to support new industry driven revenue opportunities identified within Ontario Racing Business Plans, without increasing direct or indirect government funding.

4.3 Oversight by the Alcohol and Gaming Commission of Ontario is Reactive Rather Than Proactive

Over the past five fiscal years, AGCO has conducted limited accountability reviews and governance audits of racetracks in Ontario. An accountability review looks at compliance with terms and conditions contained in the licence to operate a racetrack. A governance audit looks at the overall effectiveness of the racetrack's governance structure (such as, the composition and role of the board and conflict of interest policies) and processes and controls related to revenues, expenditures, cash management and financial reporting cycles. The commission told us it only performs audits or investigations in response to allegations made against a racetrack.

Over the last five years, AGCO has conducted accountability reviews on five of the 15 racetracks (Ajax, Dresden, Flamboro, Lakeshore and Woodbine). Four reviews were completed in 2015 and the last review was completed in 2017. AGCO also conducted governance audits on two racetracks (Hanover and Woodbine). The audit of Hanover noted deficiencies with governance, including an undeclared conflict of interest incident by management, and poor controls over food and beverage sales, and other expenditures. At the time of our audit, AGCO had not followed up to confirm corrective action was taken. The Woodbine audit followed up on conditions placed on their operating licence in 2014 that resulted from governance issues identified in an earlier audit. The follow-up audit found that Woodbine had made progress in strengthening its governance framework, but noted that improvements were required in their anti-money laundering and risk-management policies. AGCO was satisfied that Woodbine had taken adequate action to address the concerns.

RECOMMENDATION 4

In order to provide comprehensive and efficient oversight of the racing industry, we recommend that Alcohol and Gaming Commission of Ontario (AGCO):

- conduct proactive oversight on racetracks on a regular basis; and
- follow up on deficiencies noted during audits or investigations to ensure corrective action has been taken.

AGCO RESPONSE

The AGCO agrees with the need for both proactive and reactive regulatory oversight of Ontario's racetracks. AGCO staff are present at all racetrack sites when racing occurs to verify that the rules of racing are followed; for example, racing participants are licensed and race horses are assessed for fitness by official veterinarians.

However, given the various sectors the AGCO is responsible for (that is, alcohol,

gaming, cannabis and horse racing) and finite resources, it is important for the AGCO to prioritize compliance activities, such as accountability reviews and governance audits, based on risk across all sectors. While resources remain finite, the AGCO will continue to improve its deployment moving forward to help ensure efficient and effective regulatory compliance across all sectors.

The AGCO's 2020/21 Audit Plan includes a review of Woodbine Entertainment Group properties that will follow up on higher risk areas and address many of the issues raised in the report.

4.4 Some Stakeholders Raised Concerns as Future Funding Decisions Shift from Province to Industry

The funding for the 15 racetracks under the new long-term funding agreement is expected to remain consistent for the first two years until the end of the 2020/21 fiscal year. There is no guarantee that all 15 racetracks will be funded beyond 2021, as the responsibility for deciding how funds are to be allocated and to which tracks has transferred from the province to the industry through Ontario Racing.

Some stakeholders we spoke with raised concerns that Woodbine Entertainment Group (Woodbine) had too much influence over key decisions made by Ontario Racing.

Woodbine is a significant player in the industry as it owns and operates the two largest racetracks in the province, and in 2018/19 generated about 90% of the industry's wagering revenue and paid out over 70% of the purses paid in Ontario.

In addition, Woodbine operates all of Ontario's wagering (on-track, off-track and online), because it holds the only wagering permit issued by the Canadian Pari-Mutuel Agency in Ontario, as recommended by the Horse Racing Industry Transition Panel in 2013. Before 2013, each racetrack owned its on-track and off-track wagering permit for the jurisdiction in which it operated. The wagering revenue generated was under the control of that racetrack.

The 19-year, long-term funding agreement was negotiated primarily between Woodbine and OLG, and Woodbine was made the administrator for Ontario Racing. In May 2018, a subsidiary of Woodbine (Ontario Racing Management) was contracted to provide all management and operational services on behalf of Ontario Racing. Key members of the management team of Ontario Racing Management are also employees of Woodbine.

Under the new long-term funding agreement, the amount paid to Woodbine's subsidiary to administer the funding has almost doubled to $3.4 million annually. Previously, the Ministry of Finance was funding OLG $1.8 million annually to administer and provide oversight over the Horse Racing Partnership Funding Program. OLG told us that the $3.4 million in administration costs was an amount negotiated with Woodbine. According to OLG, the additional funding was provided because the role of the administrator had expanded. For instance, the administrator now has to prepare an annual business plan, a three-year strategic plan and to perform racetrack office operations for all racetracks in the province, such as setting race days, processing purse payments, accepting wagers and allocating revenue and costs to racetracks. Many of these centralized functions were previously performed by Woodbine on behalf of the Standardbred Alliance tracks at Woodbine's expense.

As well, Woodbine, along with OLG, Ontario Racing, and Woodbine's subsidiary (Ontario Racing Management) are the only signatories to the new 19-year, long-term funding agreement. In addition, key events that would constitute a default of the agreement involve Woodbine. For example,

- Woodbine ceases to be a member of Ontario Racing;
- Woodbine's subsidiary (Ontario Racing Management) ceases to be a wholly-owned subsidiary of Woodbine; and
- Woodbine's subsidiary ceases to be responsible for the management of Ontario Racing.

Woodbine has two of eleven seats on the Ontario Racing Board. The Board is to be composed of 11 members (five racetrack representatives, five horse people representatives, and one independent chair). OLG told us that its intentions in structuring the Ontario Racing Board was to create an industry group with representation across all levels of racetracks and all breeds of racehorses.

Because the first two years of funding under the new long-term funding agreement was determined by OLG, the Board has yet to make any substantive funding decisions. Therefore, it is difficult to assess the Board's effectiveness and whether all parties to the horse racing industry continue to be fairly represented.

While OLG and AGCO have a role in approving annual business plans and race dates, the Ontario Racing Board makes the substantive decisions.

One decision made by the Ontario Racing Board was to transfer the administration of the Thoroughbred Horse Improvement Program from the Canadian Thoroughbred Horse Society to Woodbine's subsidiary, Ontario Racing Management. The society administered the horse improvement program for over 20 years. According to a member of Ontario Racing, the reason for transferring the program was to bring all funding under Ontario Racing, and to evaluate the best way to administer the Horse Improvement Program to maximize the benefits of the funding.

RECOMMENDATION 5

To ensure all parties to the horse racing industry are fairly represented, we recommend that the Ontario Lottery and Gaming Corporation periodically review feedback from members of Ontario Racing and the industry regarding the composition of the Ontario Racing Board and nominee selection processes, to assess the ongoing effectiveness of the Board and take corrective action if necessary.

OLG RESPONSE

OLG agrees with the recommendation and will review feedback from industry parties with respect to being fairly represented, and will work with Ontario Racing to take corrective action if necessary.

4.5 Public Reporting by Industry

4.5.1 Industry Discloses Little Public Information

For an industry that relies heavily on public funding for its sustainability, there is little public information available regarding its operations and financial health. Specifically, there is no public reporting of gross wagers collected and wagering commissions by racetrack, how the provincial tax reduction on wagering is shared between the various racetracks and horse people, purses paid by racetracks, revenue and expenses related to racing operations separate from other operations, and key statistics regarding people working in the industry. Only one of the 15 racetracks (Fort Erie) make its financial statements publicly available on its website.

In addition, under the new long-term funding agreement, racetracks are no longer required to publicly disclose the names and salaries of employees making over $100,000. This is because the new agreement is a commercial agreement rather than a transfer payment agreement and therefore, is not subject to the *Public Sector Salary Disclosure Act*.

Under the Horse Racing Partnership Funding Program which ended March 2019, the salaries and names of racetrack employees making over $100,000 were disclosed on OLG's website by racetrack. We noted that 69 racetrack employees made over $100,000 in 2018. Most of them (62 people or 90%) were Woodbine employees. The salaries of three Woodbine employees exceeded $350,000. In contrast, only five of the remaining 13 racetracks had staff that made more than $100,000 in salaries. The salaries of employees at these five tracks ranged from $110,000 to $160,000. Eight other tracks did not pay any employee more than $100,000.

Over a three-year period from 2016 to 2018, the number of Woodbine staff making more than $100,000 increased by 17%. Over the same period, the number of race days, amount of purses and wagering commissions remained relatively stable. According to Woodbine, during this period it revamped its core business to pursue real estate development, opened Mohawk Park year-round, opened new food and beverage outlets and expanded its simulcasting, innovation and technology network to world-class standards—these changes were specifically designed to generate additional revenue to support the horse industry and towards Woodbine's strategic goal of being self-sufficient and not rely on government support.

Furthermore, we noted that a review conducted by a third party engaged by the AGCO in 2012 identified excessive pay-outs to retired executives at Woodbine. At that time, the industry was sharing in revenues generated by slot machines at racetracks. Neither the AGCO nor OLG, which has been responsible since 2016 for ensuring the appropriate use of provincial funding by the horse racing industry, has performed any similar reviews since then, despite the government's millions of dollars in direct support payments to the industry. Without this support, racetracks would have to use their own funds to support purses, which would leave less money for salary-related expenditures and other operating costs.

Reporting Requirements Added to Long-Term Funding Agreement for Greater Transparency

We noted that non-Woodbine tracks indicated to the province in 2018 that they did not have sufficient information about how Woodbine deploys its resources for the benefit of the sector.

Reporting under the new long-term funding agreement is expected to increase transparency for people in the industry. The agreement requires Ontario Racing (the private industry association) to produce a strategic plan every three years, an annual business plan, audited financial statements, an annual attestation of its compliance with the terms of the agreement, and quarterly and semi-annual financial reporting. This information is expected to be shared with all board members. Ontario Racing is also expected to report publicly about how provincial funding is used.

RECOMMENDATION 6

In order for the horse racing industry to be transparent with horse people associations and the public, we recommend that the Ontario Lottery and Gaming Corporation work with racetracks to have them publicly disclose information on racetrack operations including wagering revenue and commissions, distribution of the provincial tax reduction, purses paid by racetracks, revenue and expenses related to racing operation separate from other operations, key statistics regarding people working in the industry, and their audited financial statements.

OLG RESPONSE

OLG recognizes the importance of transparency. The new funding agreement, implemented April 1, 2019, incorporates enhancements to industry reporting obligations. After completion of the first year of the agreement, OLG will determine if there are amendments to the long-term funding agreement that are necessary to address the auditor's recommendation. Any amendments to the long-term funding agreement will require agreement by the other counterparties to the agreement and approval by the Minister of Finance.

RECOMMENDATION 7

To ensure the transparency of salaries paid in the horse racing industry, we recommend that the Ontario Lottery and Gaming Corporation continue, under the new funding agreement, to require Ontario Racing Management and the racetracks that receive government funding to publicly disclose the names and salaries of employees making over $100,000, similar to the terms under the previous funding agreement.

RESPONSE FROM OLG AND AGCO

OLG agrees with this recommendation and will make amendments to the long-term funding agreement with respect to requiring Ontario Racing Management and racetracks that receive government funding to publicly disclose employees making over $100,000. Any amendments to the long-term funding agreement will require agreement by the other counterparties to the agreement and approval by the Minister of Finance.

4.5.2 Actual Wagering Payouts Not Reported Publicly

Due to declining attendance at horse races, all Ontario racetracks have stopped charging admission fees and no longer record attendance at racetracks. However, racetracks have stated that although increased attendance at racetracks would be preferred, it does not impact their success because most wagering happens off-track or online. In 2018/19, only 5% of gross wagering involved bettors going to the track to place a bet on a race happening at that racetrack.

We reached out to senior management at all racetracks to discuss opportunities to diversify their operations in order to generate additional revenue streams. Some racetracks hold wiener dog races, concerts or tractor competitions, but most of these events generate either insignificant income or losses. All racetracks we visited believe that horse racing needs support to operate, either through direct government funding or support from some other form of gaming (such as casinos, lotteries, slots and sportsbooks). Some other provinces and US states we researched provide support to horse racing either through direct funding or allowing them to share in other gaming revenues.

The Canadian Pari-Mutuel Agency (Federal Agency) regulates and supervises pari-mutuel betting in Canada on horse races to ensure that it is conducted fairly for the public. For example, it ensures no bets are made after the races start, and performs drug testing on horses both in and out of competition. It also ensures that no racetrack takes out more from the betting pool than the approved take-out rate of 35% of total wagers collected. (Racetracks established payout rates for their various betting pools which must be approved by the Federal Agency.) According to our discussions with the Federal Agency, the agency tests almost all of the wagering pools through its IT system to ensure that payout ratios are exactly as approved by the CPMA and publicly disclosed by racetracks. In addition, all racetracks are required to disclose to bettors their take-out percentage under the Canada's Criminal Code's *Pari-Mutuel Betting Supervision Regulations* (the percent of gross commissions racetracks keep for themselves from wagering). However, none of Ontario's racetracks publicly report the amount collected through bets, the amount paid out to winning bettors, or the amount won per bet for each betting pool.

According to Woodbine's public website, the take-out ratios for betting pools on races at the Woodbine racetrack in October 2019 were as follows: Win—11.65%, Place and Show—13.65%, Exacta—17.2%, Trifecta—19.7%, Pick 4 and Pick 5—21.7%, Double and Super High-5—11.7%, and all other wagers 23.0%. The take-out percentages are comparable to other Canadian and US tracks. **Figure 11** outlines the actual take-out for wagering on live races at Woodbine and Mohawk racetracks combined (including bets on non-Ontario races).

RECOMMENDATION 8

In order to increase confidence through greater transparency, we recommend that the Ontario Lottery and Gaming Corporation require racetracks to publicly provide wagering take-out and payout information by pool.

OLG RESPONSE

OLG recognizes the importance of transparency in this area to the customer. Regulation of the disclosure of wagering take-outs and payout

Figure 11: Woodbine Entertainment Group's Take Out on Live Racing at Woodbine and Mohawk Racetracks, 2018/19

Source of data: Woodbine Entertainment Group

Type of Betting Pool	Total Bets ($ million)	# of Bets*	Pay Out ($ million)	# of Winning Tickets*	% Kept By Racetrack
Double	23.1	2,467,551	19.3	359,642	16.4
Exacta	189.5	23,068,264	150.5	3,071,976	20.6
Pick 3	36.0	5,725,047	26.5	817,897	26.3
Pick 4	53.4	3,178,837	40.1	410,480	24.9
Pick 5	31.5	1,279,062	25.5	75,572	19.0
Place	62.3	8,741,915	51.2	2,611,706	17.7
Show	32.2	5,340,420	26.6	2,173,925	17.2
Super High-5	14.2	3,798,803	12.1	293,970	14.5
Superfecta	100.6	20,251,666	74.2	1,251,051	26.3
Trifecta	148.8	32,725,394	110.3	2,699,074	25.9
Win	180.5	17,722,198	151.4	3,074,065	16.1
Total	**872.1**	**124,299,157**	**687.8**	**16,839,357**	**21.1**

* Estimates for number of tickets based on average amount bet per ticket by betting pool and racetrack. Number of winning tickets is based on a percentage by betting pool and racetrack, taken from a sample of data and applied against the whole.

information is currently under the jurisdiction of the Canadian Pari-Mutuel Agency (CPMA) under the Pari-Mutuel Betting Supervision Regulations. OLG will work with the CPMA on possible reporting enhancements on wagering take-out and payout information.

4.6 Concerns over Money Laundering in the Horse Racing Industry

In February 2018, the federal Department of Finance began a review of Canada's Anti-Money Laundering and Anti-Terrorist Financing Regime. In the consultation document, the department outlined that the horse racing sector was vulnerable to money laundering similar to the casino sector. In response, the Woodbine Entertainment Group (Woodbine) and Racetracks of Canada, stated that the industry has controls in place to self-regulate. It also stated that the imposition of additional requirements on an industry that is already struggling would create an undue burden on the industry, and would pose challenges to those responsible for overseeing compliance. As of August 2019, no money laundering-related requirements have been placed on racetracks by the federal government.

Woodbine is the only racetrack licenced to conduct pari-mutuel wagering in Ontario. This means that it collects the bets for all racetracks in the province. We reviewed Woodbine's processes for preventing, detecting and deterring money laundering. Procedures included in its anti-money laundering policy included:

- Identifying customers who engage in suspicious activity, such as purchasing multiple cash cards without wagering, or placing a large amount of cash into their accounts but placing small bets or not betting at all, and then cashing out by converting a voucher into a cheque from the racetrack;
- Suspected money laundering activity is to be reported to management for investigation;
- Woodbine's board is to receive status reports on associated risk and related issues;

- regular audits are to be conducted by Woodbine's internal audit group on compliance with the internal anti-money laundering policy; and
- All wagering department employees are to receive training on the policy every two years.

We noted that internal audit had completed only one review on compliance with the anti-money laundering policy in early 2017. Woodbine was found to be in compliance with its policy.

We requested a list of all suspicious transactions and cheques over $10,000 at Woodbine's two racetracks for the period January 1, 2018, to July 31, 2019. Woodbine informed us that over the 19-month period, it issued 113 cheques in excess of $10,000 to customers totalling about $4 million. Woodbine informed us that management did not escalate these cheques to the subcommittee of the board for review, because it did not suspect any of these cheques to involve money laundering. One potential money laundering transaction was reported to the subcommittee. This involved a betting machine voucher worth $100,000 identified in May 2018, but the matter was not further reported to law enforcement. Woodbine confirmed that in the last ten years, no financial transactions have been reported to any law enforcement agency or government agency (such as the Alcohol and Gaming Commission of Ontario or the Canadian Pari-Mutuel Agency).

We reviewed the 113 cheques over $10,000 to confirm that the cheques were generated due to winning bets and that it was not a case of withdrawing cash deposits that may signal potential money-laundering transactions. There were 91 cheques to people that bet online and 22 cheques to people that placed their bets in person, either at the racetrack or teletheatre. As part of Woodbine's money laundering controls, wagering managers are required to sign-off on cheques and ensure the money is generated from winning wagers. However, for cheques generated through online wagers, no supporting documentation of the winning bets was attached. We followed-up on five online bettors that withdrew more than $100,000, accounting for 43% of the withdrawals over the last 19 months. We confirmed that in all cases, the withdrawals were directly attributable to a recent, large, winning bet. For the 22 cheques that were generated by people who placed their bets in person, Woodbine had only retained supporting documents for the winning bets related to ten of these cheques.

RECOMMENDATION 9

In order to reduce the risk of money laundering at racetracks, we recommend that the Alcohol and Gaming Commission of Ontario and the Ontario Lottery and Gaming Corporation work with racetracks to:

- collect and monitor all suspicious transactions, including withdrawals over $10,000 along with the necessary supporting documentation; and
- report the information to law enforcement, where necessary.

RESPONSE FROM OLG AND AGCO

The AGCO and OLG agree that the detection and prevention of money laundering is important in the racing industry. For all industries in Canada, anti-money laundering reporting is federally regulated under the *Proceeds of Crime (Money Laundering) and Terrorist Financing Act* by the Financial Transactions and Reports Analysis Centre of Canada (FINTRAC).

While OLG is responsible for compliance with FINTRAC regulation for gaming in Ontario given its role as the entity that 'conducts and manages' gaming on behalf of the province, OLG holds no such authority in the racing industry.

While the racing industry is not currently regulated by FINTRAC, the AGCO will work with FINTRAC and the CPMA on the provision of further anti-money laundering training and awareness to racetrack personnel on the identification and reporting of suspicious transactions.

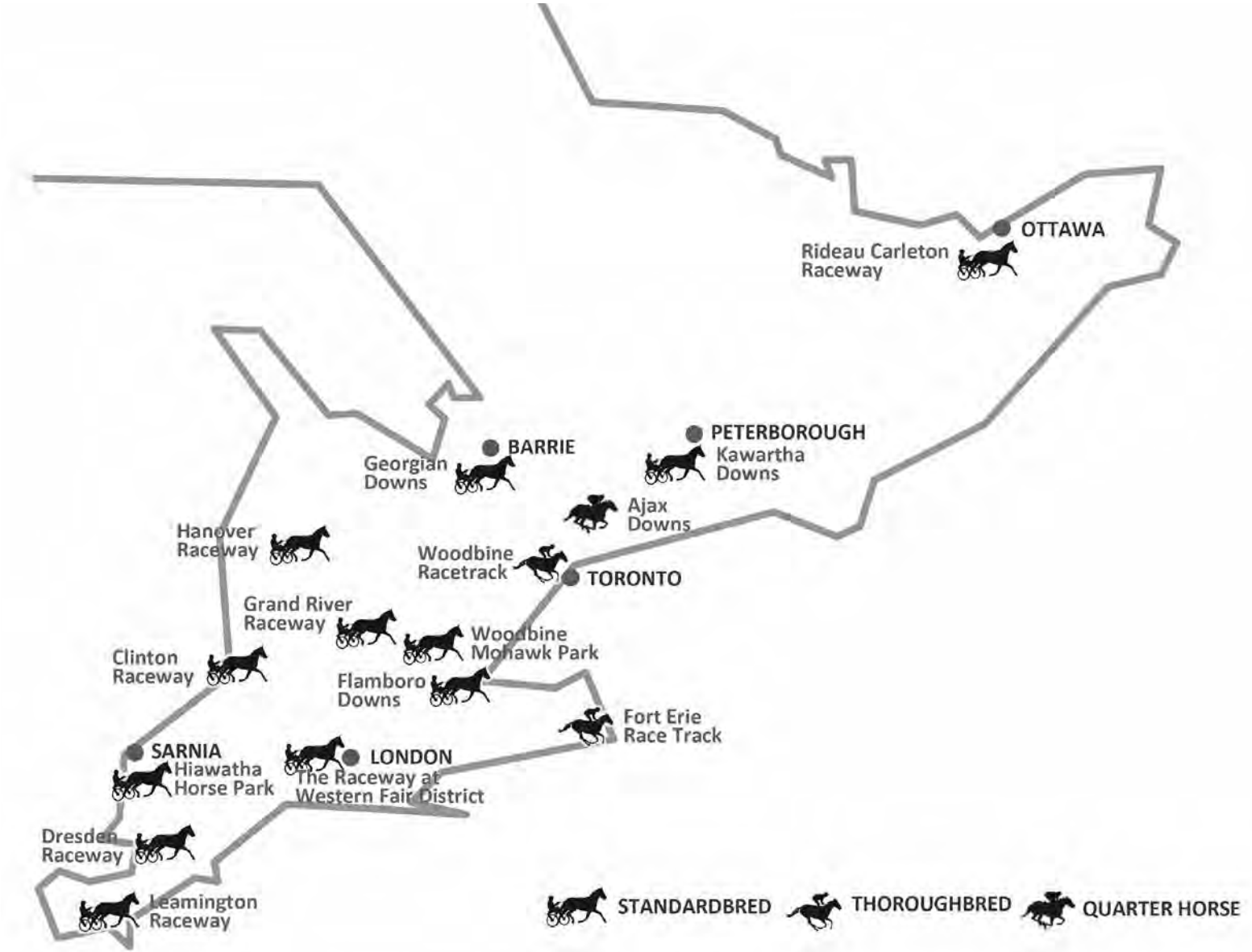
Appendix 1: Glossary of Terms

Prepared by the Office of the Auditor General of Ontario

Alcohol and Gaming Commission of Ontario: provincial government agency responsible for regulating Ontario's alcohol, gaming and horse racing sectors and cannabis retail stores.
Betting pool: gamblers place a bet into a pool and make a selection on an outcome; the pool is evenly divided between those that have made the correct selection; each winner's payoff depends on the number of gamblers and the number of winners.
Canadian Pari-Mutuel Agency (CPMA): a special federal government operating agency within Agriculture and Agri-Food Canada that regulates and supervises pari-mutuel betting in Canada on horse races, ensuring that pari-mutuel betting is conducted in a way that is fair to the public.
Gaming bundle: land-based gaming sites and operations, combined regionally; OLG introduced bundles to transfer day-to-day operations to private-sector service providers while retaining overall management.
Horse people: people involved in the horse racing industry including owners, breeders, groomers, trainers and jockeys.
Ontario Lottery and Gaming Corporation: the Ontario government agency that conducts and manages gaming facilities, the sale of province-wide lottery games, internet gaming, bingo and other electronic gaming products at Charitable Gaming Centres; responsible for marketing, performance metrics and oversight of government funding for the horse racing industry in Ontario, and for responsible gambling programs.
Ontario Racing: a non-profit horse racing industry association, recognized by the provincial government as the authority for horse racing in Ontario; directly responsible for setting an annual program of races, attracting new horse owners, implementing breed improvement programs.
Ontario Racing Commission: established in 1950 to govern, direct, control and regulate the horse racing industry in Ontario; the *Horse Racing Licence Act*, transferred regulatory responsibilities for horse racing from the ORC to the Alcohol and Gaming Commission of Ontario (AGCO).
Ontario Racing Management: provides all material management and operational services on behalf of Ontario Racing; a wholly owned subsidiary of Woodbine Entertainment Group.
Pari-mutuel taxes: a levy on each bet placed in Canada on horse races; in Canada, the CPMA levies 0.8% on each horse race.
Payouts: the amount of money a casino pays out in gambling winnings; the percentage of total money given back to the player who wins, or the amount of money a casino pays out relative to the amount that a player spends, is the payout percentage.
Purse: prize money for top finishers in a particular horse race; prize money goes to the horse owners.
Take outs: the amount of money that a racetrack will take for itself from betting pools; the maximum take out allowed is 35%, as stated under the Criminal Code of Canada, Pari-Mutuel Betting Supervision Regulations.
Teletheatres: off-track betting facilities in which horse races are viewed on television; they are operated by racetracks and licensed by the AGCO.
Wagering: making a bet, or betting.
Woodbine Entertainment Group: an Ontario corporation without share capital; runs horse racing, dining and entertainment venues, including Woodbine and Mohawk racetracks; founded in 1881 as the Ontario Jockey Club.

Appendix 2: Horse Racing Tracks in Ontario

Source of data: Ontario Racing



Appendix 3: Approved Funding per Racetrack and Other Program Recipients for 2019/20

Source of data: Ontario Racing

Racetracks	# of Race Days	Purse Support ($)	Operating Support ($)	Horse Retirement Aftercare ($)	Enhanced Purse Support ($)	Transition Allocation (Additional Support for Purses and Operations) ($)	Enhanced Operating Support (Relating to Optional Slots At Racetrack Program) ($)	Capital Improvement Funding ($)	Racetrack Totals ($)
Ajax Downs	25	650,000	2,000,000		183,900	1,500,000		745,250	**5,079,150**
Clinton	15	525,000			74,400	60,000		284,725	**944,125**
Dresden	11	385,000	286,000		54,500	44,000	125,000	352,660	**1,122,160**
Flamboro Downs	132	7,920,000			971,100	160,000		650,000	**9,701,100**
Fort Erie	40	3,500,000	5,214,000		294,200	500,000	1,800,000	1,500,000	**12,808,200**
Georgian Downs	40	2,400,000			287,000	46,000		188,500	**2,921,500**
Grand River	48	2,880,000			353,100	58,000		291,090	**3,582,190**
Hanover	15	525,000			74,400	60,000		508,990	**1,168,390**
Hiawatha	21	735,000	546,000		104,100	84,000			**1,469,100**
Kawartha Downs	21	630,000	432,000		89,300	200,000			**1,351,300**
Leamington	13	455,000	338,000		64,500	52,000			**909,500**
Mohawk and Woodbine (for Standardbred racing)[1]	221	19,729,430							**19,729,430**
Rideau-Carleton	72	4,320,000			530,000	86,000		728,545	**5,664,545**
Western Fair	125	7,500,000			919,500	150,000		650,000	**9,219,500**
Woodbine (for Thoroughbred racing)[1]	133	30,000,000		429,570					**30,429,570**
Total	**932**	**82,154,430**	**8,816,000**	**429,570**	**4,000,000**	**3,000,000**	**1,925,000**	**5,899,760**	**106,224,760**

Other Program Recipients[2]									
Thoroughbred Horse Improvement Program[3]	Standardbred Horse Improvement Program[3]	Long Run Retirement Society (Long Run)[3]	Ontario Standardbred Adoption Society (OSAS)[3]	Equine Guelph[3]	Canadian Thoroughbred Horse Society (CTHS)[4]	Standardbred Breeders of Ontario (SBOA)[3]	Quarter Racing Owners of Ontario Inc. (QROOI)[3]	Ontario Racing Management	Total (all other recipients)
2,375,000	2,375,000	75,000	75,000	100,000	2,000,000	2,000,000	1,000,000	3,400,000	**13,400,000**
Overall Total									**119,624,760**

1. Managed by Woodbine Entertainment Group.
2. All payments to Other Program Recipients are Horse Improvement Program payments, except for Ontario Racing Management (ORM). ORM payment is for administration.
3. Ontario Racing's approved business plan notes that it is in the process of conducting a value for money audit of the Horse Improvement Programs. The results of this audit would be incorporated within the allocations of the next fiscal year.
4. Ontario Racing's approved business plan notes that the Canadian Thoroughbred Horse Society has not signed the Membership Agreement. No funding would be provided to the Society until final execution of such an agreement.

Appendix 4: Projected Annual Funding to the Industry under 19-Year Long-Term Funding Agreement, 2019/20 –2037/38

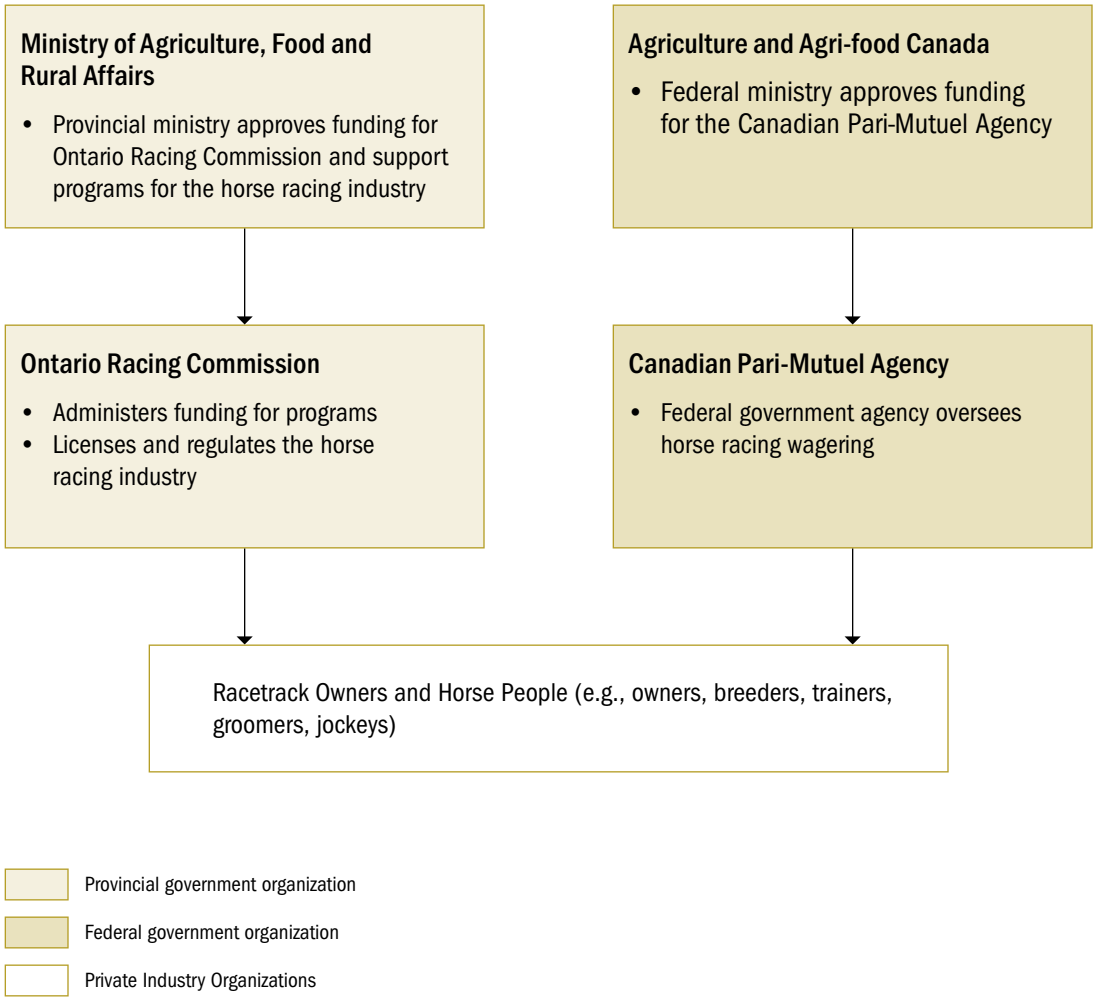
Source of data: Ontario Racing

Year of Agreement	Fiscal Year	Purse and Operational Support[1] ($)	Enhanced Purse Support ($)	Transition Support for Purses ($)	Enhanced Operating Support ($)	Capital Improvement Funding[2] ($)	Horse Improvement Programs[2] ($)	Ontario Racing Management ($)	Total ($)
1	2019/20	91,400,000	4,000,000	3,000,000	1,925,000	6,000,000	10,000,000	3,400,000	**119,725,000**
2	2020/21	91,400,000	4,000,000	3,000,000	1,988,500	6,000,000	10,000,000	3,400,000	**119,788,500**
3	2021/22	91,400,000	4,000,000	-	1,928,845	6,000,000	10,000,000	3,400,000	**116,728,845**
4	2022/23	91,400,000	4,000,000	-	1,870,979	6,000,000	10,000,000	3,400,000	**116,670,979**
5	2023/24	40,000,000	4,000,000	-	1,814,850	6,000,000	10,000,000	3,400,000	**65,214,850**
6	2024/25	40,000,000	4,000,000	-	1,760,405	6,000,000	10,000,000	3,400,000	**65,160,405**
7	2025/26	40,000,000	4,000,000	-	1,707,593	6,000,000	10,000,000	3,400,000	**65,107,593**
8	2026/27	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
9	2027/28	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
10	2028/29	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
11	2029/30	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
12	2030/31	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
13	2031/32	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
14	2032/33	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
15	2033/34	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
16	2034/35	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
17	2035/36	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
18	2036/37	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
19	2037/38	40,000,000	4,000,000	-	-	6,000,000	10,000,000	3,400,000	**63,400,000**
									1,429,196,172

1. Funding to Woodbine Entertainment Group to be reduced dollar for dollar up to a maximum of $51,400,000 in any year starting in 2021/22. Maximum reduction expected to be reached starting 2023/24.
2. Starting in 2026/27 the Ontario Lottery and Gaming Corporation can choose not to accept the industry's proposals for funding in these areas, potentially reducing total annual funding to $47.4 million.

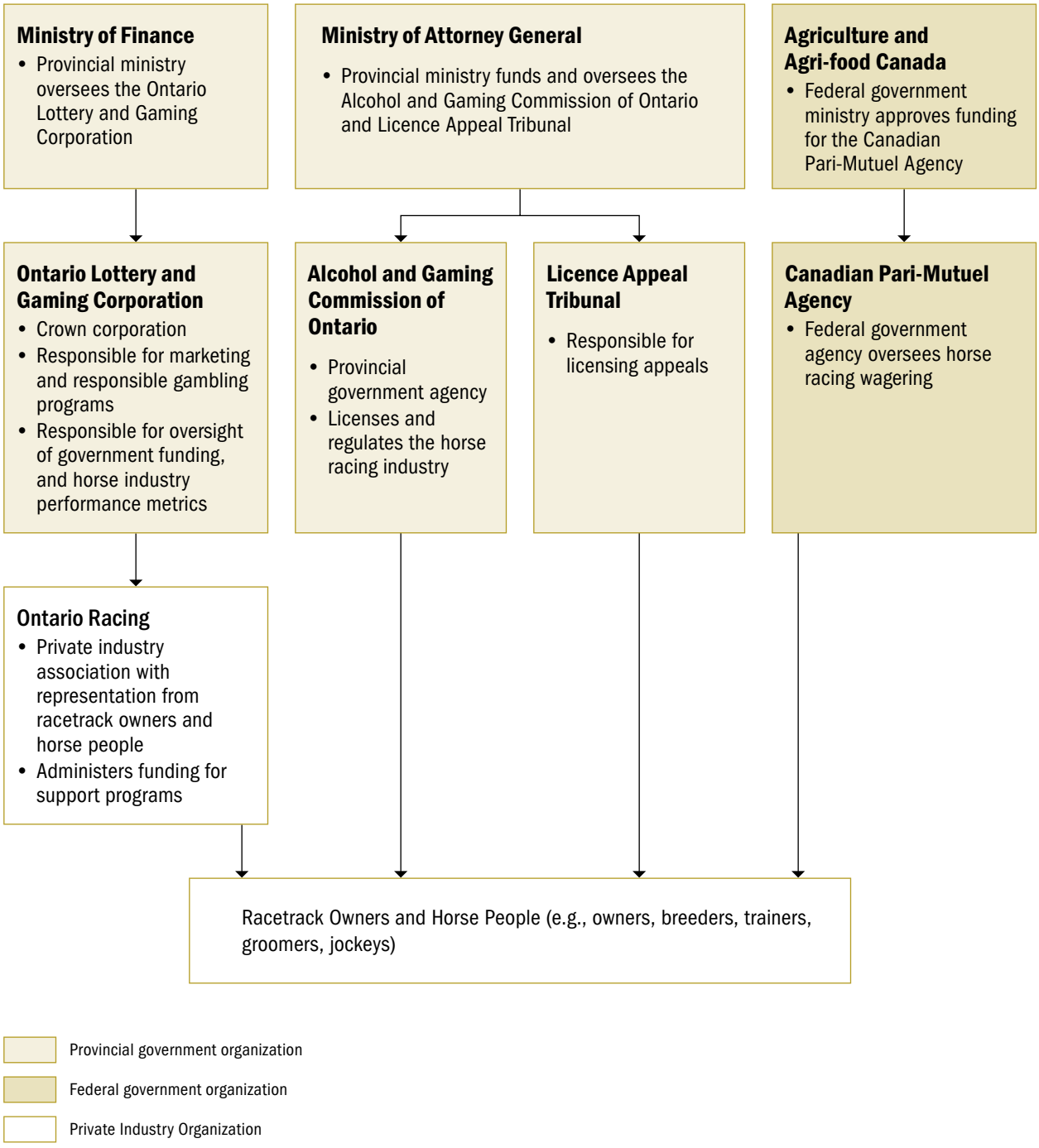
Appendix 5: Regulation, Administration and Oversight of Horse Racing Industry, April 2014 to March 2016

Prepared by the Office of the Auditor General of Ontario



Appendix 6: Regulation, Administration and Oversight of Horse Racing Industry, as of April 2019

Prepared by the Office of the Auditor General of Ontario



Appendix 7: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Provincial funding is helping increase the demand for live horse racing in Ontario, and in turn helping the industry become self-sustaining.
2.	There are clear accountability provisions and governance structures in place for allocating and administering government funding to intended recipients in the horse racing industry.
3.	Recipients are using the funding provided by the government for the purposes intended under the terms of agreements.

Appendix 8: Jurisdictional Research, 2018[1]

Source of data: OLG annual report, British Columbia Gambling Revenue Distribution Division, Government of Alberta population statistics, Horse Racing Alberta Annual Report, US Census Bureau, New York State Gaming Commission Annual Report, Pennsylvania Gaming Control Board Annual Report, individual racetrack websites of Ohio tracks, Kentucky Horse Racing Commission

	Canada			United States					
	Ontario	British Columbia	Alberta	California	New York	Pennsylvania	Ohio	Kentucky	Florida
Population (million) (2019)	14.6	5.1	4.4	39.6	19.5	12.8	11.7	4.5	21.3
# of race tracks	15	2[2]	6	9	11	6	7	8	9
Average population served by each racetrack	971,000	2,536,000	729,000	4,395,000	1,777,000	2,135,000	1,670,000	559,000	2,367,000
Total race days	922	109	251	560	1,258	906	895	235	498
Total Live On-Track Wagering ($ million)[3]	73.2	9.7	7.5	341.4	323.8	24.5	27.3	103.3	93.6
Total Other Wagering (off-track, simulcast, online, teletheatre, intertrack) ($ million)	1,528.0	138.0	100.6	2,840.5	1,041.1	644.4	131.3	2,426.1	372.6
Total Wagering ($ million)	1,601.2	147.7	108.1	3,181.6	1,364.9	668.9	158.6	2,529.4	466.2

1. Information is based on each jurisdiction's most recent financial statements available for our review. For Ontario and Kentucky, data was as of 2019, for New York, data was as of 2017. For all other jurisdictions, data was as of 2018.
2. British Columbia has three race tracks, but only two had races in 2017 – Hastings and Fraser Downs.
3. Total dollars wagered in person on races at the track.

Chapter 3
Section
3.13

Technology Systems (IT) and Cybersecurity at Ontario Lottery and Gaming Corporation

1.0 Summary

Ontario Lottery and Gaming Corporation (OLG) is responsible for conducting and managing the following four lines of business: province-wide lottery games (lottery), PlayOLG.ca Internet gaming (iGaming), Charitable gaming centres (cGaming), and 26 casinos currently operating in Ontario (casinos).

OLG develops and maintains the IT systems for its lottery games. However, IT systems for iGaming, cGaming and casinos are owned by IT vendors and used by OLG in accordance with licensing agreements. OLG oversees the operations of iGaming and cGaming and also oversees the casinos, but organizations under contract to OLG (that is, casino operators) manage the casinos' day-to-day operations.

Although OLG also administers the Ontario government's funding program for horse racing, the IT systems specifically used for the horse-racing industry are operated by private-sector operators.

OLG is regulated by the Alcohol and Gaming Commission of Ontario, which has set the minimum age for gambling at 19 and tests the design of OLG's games for the games' integrity and to ensure that players receive a fair payout.

OLG's website provides advice to its customers on its games and on issues around gambling. To fulfill its responsibility under the *Ontario Lottery Gaming Corporation Act, 1999*, "to promote responsible gambling," OLG administers the PlaySmart program, which lets players limit their exposure to gambling. Similarly, OLG sends out reminders to online players when they reach a certain limit in money wagered.

OLG contributed about 45% of the total $5.47 billion in non-tax revenue generated in 2018/19 by provincial government business enterprises, which also include the Liquor Control Board of Ontario, Ontario Power Generation Incorporated, Hydro One Limited and the Ontario Cannabis Retail Corporation.

In the past five years, OLG paid $651 million to 68 IT vendors that provide critical IT services to support its business operations. Any interruption to OLG's lines of business has the potential to reduce the province's revenue and impact OLG's gaming customers' experience. Outages and other incidents could negatively affect the experience of thousands of OLG customers—including purchasers of lottery tickets at any of Ontario's 10,000 lottery retailers, who expect the terminals and the OLG Lottery Mobile App to be working properly, scanning tickets accurately and displaying winning numbers and

coupons correctly—as well as casino customers and players of online games who want to be assured that the game they are playing is being run fairly.

We found that OLG needs to strengthen its oversight of IT vendors so that they deliver services and safeguard customer information more effectively and in accordance with the performance expectations in their contracts. OLG does not thoroughly review IT vendors' performance upon contract renewal to assess whether the vendor met OLG's performance expectations under its previous contract. As well, we found that casinos do not fully secure customers' personal information stored on their servers according to industry best practices.

There are opportunities to strengthen cybersecurity practices in the IT systems used in casinos, lottery and iGaming. For example, although OLG contracts with an external IT vendor to assess the technical controls behind the random number generator for its lottery system and evaluate the software formula to confirm that the system is able to generate suitable random numbers, we noted that OLG does not review the software source code for cybersecurity weaknesses using industry best practices. Although OLG conducts regular vulnerability assessments, OLG has not regularly performed security tests such as penetration testing for its lottery and iGaming lines of business to further identify potential vulnerabilities.

OLG has initiated major IT projects across its various lines of its business. OLG implemented 33 IT projects within budget; however, the remaining 11 were over budget, which account for almost half of all IT project expenses over the last five years ($91 million sampled over a total of $232 million spent), and had delays and cost overruns of over $10 million.

The following are some of our significant findings:

IT Vendor Performance

- **Critical IT performance indicators are not always incorporated in the service-level agreement with IT vendors.** Three out of the 10 service-level agreements we reviewed did not include key IT performance indicators. Depending on the service-level agreement, one or more critical performance indicators, such as system availability, service outages, incident resolution or response times, were not included, impacting (in various degrees) measurement of the customer experience, and, potentially, revenue and business operations.
- **Certain IT vendors are underperforming and not held accountable for meeting performance targets.** OLG does not consistently review the performance of all IT vendors against their service-level agreement and take remedial action where appropriate, such as imposing fines as per their service-level agreement. We found examples where IT vendors' performance was not reviewed by OLG. When we reviewed their performance, we noted that they did not meet their service-level-agreement performance targets, but remedial action was not taken by OLG because it had not reviewed their performance.

Cybersecurity, Encryption and Security Controls

- **OLG has not always kept up to date with its testing for security vulnerabilities on its IT systems.** Although OLG conducts regular vulnerability assessments, OLG has not regularly performed security tests such as penetration testing to further identify cybersecurity vulnerabilities. In November 2018, the OLG iGaming IT system was attacked by a hacker, making it unavailable for 16 hours and impacting customer experience. As well, three OLG casinos were subject to phishing email cyberattacks, a type of attack where sensitive information is compromised by the attacker. For example, at one casino, sensitive customer and employee data was stolen.

In the other two incidents, employee data was compromised.

- **Seven OLG staff have access to unencrypted confidential customer information.** Personal information of OLG customers is encrypted to prevent external access to it; however, seven OLG employees have access to the information in an unencrypted form, which increases the risk of customers' personal information being read for inappropriate purposes. In addition, we found that two casinos do not comply with OLG information security standards and do not encrypt OLG customer data within their IT systems.
- **Source code of critical IT systems is not assessed for cybersecurity risk.** We found that OLG does not follow industry best practices of reviewing the source code (the list of human-readable instructions that a programmer writes) for cybersecurity weaknesses within critical IT systems for its lottery, iGaming and casino operations.

Disaster Recovery

- **OLG has not developed and tested a comprehensive disaster recovery strategy for its entire IT system environment.** Although there are disaster recovery strategies developed and tested for IT systems for each individual line of business, we noted that OLG does not have a comprehensive strategy that incorporates all IT systems cohesively, even after it had a significant event occur that should have triggered OLG to prepare one. A significant outage of six hours in October 2018 affected key IT systems used for OLG's lottery. Because a comprehensive strategy was not in place, OLG was not able to promptly recover all its operations within OLG's targeted recovery times.

During the course of our audit, we noted that OLG began to act on some of our findings, such as improving its existing vendor management process, implementing an IT system to track contracts that are up for renewal and conducting better oversight of IT operations at the casino operators that manage day-to-day operations of casinos.

Overall Conclusion

Our audit concluded that the Ontario Lottery and Gaming Corporation (OLG) does not always exercise thorough oversight over IT vendors that provide services to OLG for its Internet gaming, charitable gaming and casino operations. This is especially significant because of how heavily OLG relies on these IT vendors. OLG's IT contracts do not always contain the necessary performance indicators needed to ensure operations are delivered efficiently. As a result, OLG cannot always hold vendors accountable through their contracts when they do not provide the level of contracted services it expects.

We also found that the personal information of OLG customers is not fully protected, because the information is not securely stored on OLG's servers and by certain casino operators. Although OLG conducts regular vulnerability assessments, OLG has not regularly performed security tests such as penetration testing for its lottery and iGaming lines of business to further identify potential vulnerabilities.

At the time of our audit, OLG had not performed a comprehensive disaster recovery exercise that incorporates all lines of business to assess whether it would be able to restore its business operations in the event of an actual disaster such as a power outage or a large-scale cyberattack.

Our audit also concluded that OLG had systems in place to ensure that all customers who played OLG's Internet games were the appropriate age. As well, based on sample testing of selected casinos, we noted that OLG has been reporting appropriately to the Financial Transactions and Reports Analysis Centre of Canada on a timely basis.

This report contains 14 recommendations, with 23 action items, to address our audit findings.

OVERALL OLG RESPONSE

The Ontario Lottery and Gaming Corporation (OLG) thanks the Auditor General and her team for this report on Technology Systems (IT) and Cybersecurity at OLG.

OLG strives for continuous improvement and is committed to secure delivery of operations that safeguards personal information, achieves value for money from external IT vendors and minimizes business interruption that may impact revenue to the province.

To help support our digital evolution, OLG has selected service providers through open, public procurements to launch an integrated player platform, including a new gaming website and mobile applications; and is replacing and upgrading our retail point-of-sale system, including a state-of-the-art network and new lottery terminals.

As part of this important work, OLG is strengthening its management of vendor performance by, among other things, centralizing and strengthening the management of key IT vendors to ensure consistency and effective performance monitoring. We are making continuous investments in the protection of personal information and are implementing further measures to strengthen security controls and practices. We are improving project management governance and performance by launching a new project control framework to strengthen oversight through rigorous standards and processes.

As OLG evolves, we are maintaining our commitment to strong governance and are ensuring that effective measures are in place to deliver value for money to the province. OLG will continue to work with service providers, vendors and the Alcohol and Gaming Commission of Ontario to implement the Auditor General's recommendations.

2.0 Background

2.1 Overview of Ontario Lottery and Gaming Corporation

Ontario Lottery and Gaming Corporation (OLG) is a Crown corporation and is the most significant source of non-tax revenue for Ontario. OLG accounted for 45% of the total $5.47 billion in non-tax revenue generated in 2018/19 by government business enterprises such as the Liquor Control Board of Ontario, Ontario Power Generation Incorporated, Hydro One Limited, the Ontario Cannabis Retail Corporation and OLG itself (see **Figure 1**).

In 2018/19, OLG business operations generated $8.3 billion in revenue and $2.47 billion in net profit to the province. **Figure 2** provides OLG's revenue and net profit from its four lines of business for the last five fiscal years.

Ontario established the Ontario Lottery Corporation (OLC) in 1975, approximately six years after the federal *Criminal Code* was amended to authorize provincial lotteries. Under

Figure 1: Government Business Enterprises' Contribution to Non-Tax Revenue for Ontario, 2018/19

Source of Data: Public Accounts of Ontario, *Volume 1, 2018–2019*

Government Business Enterprises	Contribution ($ million)	Contribution (%)
Ontario Lottery and Gaming Corporation	2,464	45
Liquor Control Board of Ontario	2,276	42
Ontario Power Generation Inc.	837	15
Ontario Cannabis Retail Corporation	(42)	(1)
Hydro One Limited	(65)	(1)
Total contribution to the province	**5,470**	**100**

Figure 2: Ontario Lottery and Gaming Corporation (OLG) Revenue and Net Profit to Province, 2014/15–2018/19 ($ million)

Source of data: Consolidated Financial Statements in the OLG *2018/19 Annual Report*

OLG Lines of Business	2014/15	2015/16	2016/17	2017/18*	2018/19*
Lottery	3,269	3,786	3,681	3,780	4,167
cGaming (Charitable gaming)	115	166	153	172	183
Casinos (Land-based gaming)	3,252	3,444	3,583	3,796	3,857
iGaming (Internet gaming)	8	49	58	73	92
Total revenue	**6,644**	**7,445**	**7,475**	**7,821**	**8,299**
Net profit to the province	**1,999**	**2,231**	**2,361**	**2,487**	**2,471**

* Starting in the 2018/19 fiscal year, OLG adopted International Financing Reporting Standards (IFRS) 15 and IFRS 9. Comparative figures in 2017/18 have been reclassified, where necessary.

the government's Northern Ontario Relocation Program, the lottery corporation moved its head office to Sault Ste. Marie in 1991. In 1993, OLC approved a framework for licensing charities to raise funds through gaming. The government established the Ontario Casino Corporation (OCC) in 1994 and opened its first casino, in Windsor, that same year. The government ran its first electronic bingo game in 1997. The following year, the Alcohol and Gaming Commission of Ontario was created, and in 2000 the province merged the two corporations, OLC and OCC, into OLG. Today, OLG operates one data centre in Sault Ste. Marie and one in Toronto.

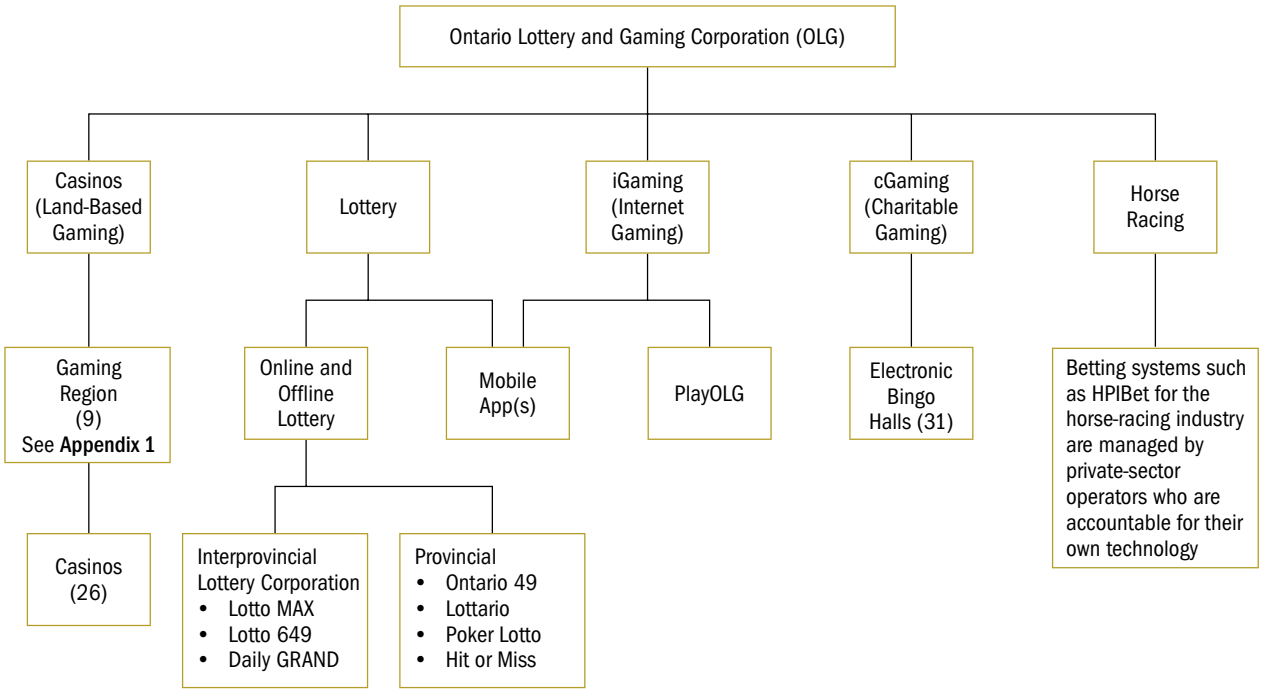
2.2 Lines of Business

OLG has four lines of business that are distinct revenue-generating divisions offering different products and services. These are land-based gaming (casinos), lottery, Internet gaming (iGaming) and charitable gaming (cGaming). OLG also has responsibility for funding the horse-racing industry on behalf of the province (see **Figure 3**).

- **Land-based gaming (casinos):** There are 26 "gaming sites"—we refer to them in this report as casinos—across the province (see **Appendix 1**), such as Casino Windsor, Casino Rama and Casino Niagara. These include slots and casinos operated by casino operators such as Caesars Entertainment, Windsor Limited, Gateway Casinos and Entertainment Limited. Casino operators report revenue to OLG through their IT gaming management systems, which are connected to the OLG central IT gaming management system. OLG validates revenue data and reviews audited financial statements provided by casino operators to ensure that revenues are complete and accurate.
- **Lottery:** Lottery games refer to national and regional lottery products where tickets are generated on a lottery terminal. Lottery products are sold by approximately 10,000 retailers across the province and through the OLG website PlayOLG.ca.
- **Internet gaming (iGaming):** PlayOLG.ca is the website-based gaming platform and was launched in January 2015. The website offers slots and electronic table games as well as sales of select lottery games—for example, Lotto MAX, Lotto 6/49 and Encore.
- **Charitable gaming (cGaming):** OLG operates electronic charitable games such as lottery, bingo and raffle tickets at registered charities and non-profit and service clubs across Ontario to support their communities. There are 31 charitable bingo and gaming centres that work with OLG to offer paper and electronic games.

Figure 3: Ontario Lottery and Gaming Corporation Key Lines of Business

Prepared by the Office of the Auditor General of Ontario



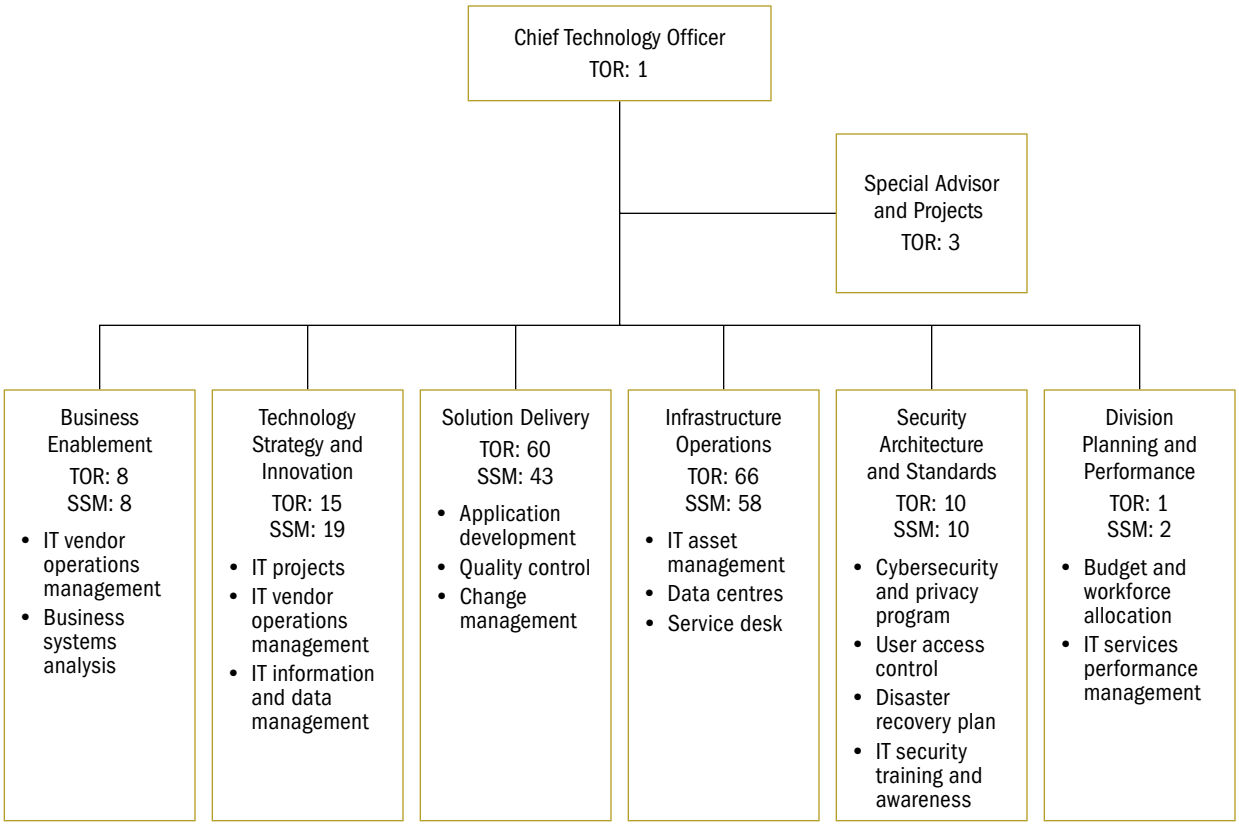
- **Horse racing:** OLG administers the Horse Racing Partnership Funding Program on behalf of the Ontario government and provides funding to the horse-racing industry in accordance with the administration agreement between the Minister of Finance and OLG. The OLG Technology Division has no resourcing involvement, support or oversight for technology systems in the horse-racing industry. Industry betting systems such as HPIBet are managed by private-sector operators who are accountable for their own technology. OLG informed us that its Horse Racing Division has approximately 12 staff who support the transfer payments to the industry. The horse-racing industry is not part of this audit, but it is the topic of **Section 3.12** in this chapter.

2.3 Information Technology Systems

The Corporate Services division of OLG, including Information Technology, Finance, Human Resources, Governance Legal and Compliance, and Audit Services, provides support services to all lines of business. OLG signs contract agreements with casino operators delegating to the operators the management of the day-to-day IT operations of casinos. It also signs contracts with IT vendors delegating IT management of the day-to-day IT operations of iGaming and cGaming to the IT vendors. However, OLG is still directly responsible for the day-to-day management of lottery IT operations.

IT systems are a critical component of OLG's core operations of casinos, lottery, iGaming and cGaming. OLG develops and maintains key IT systems for its lottery line of business. In addition, OLG has licensing agreements with IT software and hardware vendors to use their services for their other three lines of business. For example, OLG has contracted with the IT vendor Internet Gaming Technology (IGT) to develop and maintain

Figure 4: IT Division's Staff Allocation at Toronto (TOR) and Sault Ste. Marie (SSM), 2018
Source of data: Ontario Lottery and Gaming Corporation



its iGaming website. The IT system is hosted by the vendor. Also, IT systems such as Bally Gaming Management Systems and Casinolink, used at casinos for day-to-day business operations and to collect customer information, are owned by IT Vendors and operated by OLG through licensing agreements. The IT systems from IT vendors used for cGaming are licensed by OLG. See **Appendix 2** for a list of key IT systems.

2.4 IT Division

The IT division within OLG is responsible for the operation and maintenance of OLG's information systems and technology infrastructure for lottery operations. It is also responsible for exercising operational oversight over IT vendors' services delivered for iGaming and cGaming, as well as for oversight of casino operators' IT services at casinos.

The division spent $99 million on operating costs in 2017/18 (the most recent year that data was available). Operating costs have remained consistent, at 2% of OLG's total expenses, over the last five fiscal years.

The OLG IT division comprises six departments that help operate all four lines of business, with 304 full-time equivalent positions (costing $36.5 million) as of 2018, with 45% in Sault Ste. Marie and 55% in Toronto. **Figure 4** illustrates the IT division organization chart along with the budgeted IT staff allocation in the two offices.

The OLG Information and Technology Committee meets monthly to review IT projects, such as upgrading lottery terminals, and developing IT strategy to address risks and emerging trends.

2.5 Current Technology Projects

OLG is implementing a digital strategy that will let customers buy lottery tickets and play casino games through the OLG Lottery Mobile App. As part of this strategy, OLG will also offer more casino games on its Internet gaming website PlayOLG.ca. In addition, OLG is upgrading its existing lottery terminals at over 10,000 retail locations. OLG has spent a total of $232 million over the last five fiscal years for technology projects.

2.6 OLG Call Centre

The OLG call centre in Sault Ste. Marie offers customers and lottery retailers a 24/7 helpline. It is the first point of contact and supports all lines of OLG businesses: lottery, casinos, charitable gaming and online gaming. As of March 2019, the call centre had approximately 150 staff.

2.7 Cybersecurity

Cybersecurity is a critical measure to protect OLG from cyberattacks, privacy breaches, reputational damage, and the destruction of critical information and infrastructure, as well as from the negative financial impact that any of these could cause.

OLG has Information Security standards for its casinos that require them to protect the personal information of customers and staff. There has been a global increase in cyberattacks in the casino and lottery industry, such as the cyberattack in March 2016 against the River Cree Resort and Casino and in June 2016 against the Cowboys Casino, both located in Alberta. The National Lottery of the United Kingdom was hacked in November 2016 and September 2017, and twice more in March 2018.

We found that in the past five years, there have been thousands of unsuccessful cyberattack attempts at OLG. Examples of cybersecurity breaches at OLG are discussed in **Section 4.2**.

2.8 IT Procurement

OLG procurement is governed by external and internal policies and procedures. External policies and procedures include provincial legislation and directives, trade agreements and gaming regulations. Internally, OLG policies include financial approvals, a code of business conduct and a conflict-of-interest policy.

OLG uses the following procurement methods:

- an open competitive process involving the issuance of public procurement documents, such as requests for information, requests for prequalification and requests for proposal, using an electronic tendering system;
- an invitational process involving requests for a minimum of three qualified suppliers to submit a written proposal in response to OLG's requirements; and
- non-competitive procurement, which must be supported by a written business case that supports using a single or sole source and be approved by the appropriate authority:
  - single source selects one specific supplier even though several are capable of delivering the same goods or services; and
  - sole source selects a specific supplier based on the assessment that no other supplier is able to provide the required goods or services.

The Procurement Group within OLG is responsible for managing competitive evaluations to ensure IT procurement is performed consistently and in accordance with the evaluation criteria, ratings and methodology set out in the procurement documents that are issued to potential vendors by OLG. The documents identify the scope of work, evaluation criteria, terms of contracts and technology/solution specifications.

2.9 Responsible Gambling

Statutory requirements for OLG to "promote responsible gambling" were introduced in the

Ontario Lottery Gaming Corporation Act, 1999. OLG works with casinos to meet these standards and deliver the responsible-gaming program. OLG has a voluntary self-exclusion program, PlaySmart, that allows players to take a break from gambling at slots and casinos and on the Internet when they feel that gambling is no longer in their best interest. As of April 2019, 23,000 registered players were on the self-exclusion list across Ontario. At casinos, the program works through facial recognition technology, with the customer signing a contract with OLG. For Internet gaming, players have the option to set limits on how much money they spend. OLG also has controls such as disclaimers and reminders that it sends out when online players reach a certain limit in money wagered. OLG received the World Lottery Association's 2018 Best Overall Responsible Gambling Program award in recognition of its PlaySmart program.

Casinos also maintain a list of prohibited and excluded individuals, who are restricted from entering casinos due to various reasons, such as court orders, age limit (under 19 years) and improper dress.

2.10 Preventing Money Laundering at Casinos

Money laundering is the process used to hide the source of money or assets derived from criminal activity. Canadian casinos for many years have been used as "laundromats" for the proceeds of organized crime. Discovery of money laundering is difficult when the IT systems used to identify and report money laundering are ineffective and suspicious transaction reports are not reviewed regularly.

Casinos in Canada must fulfill specific obligations under federal regulations to help combat money laundering and terrorist financing. Although in Ontario casino operators are responsible for running casinos' daily operations, OLG is still responsible for the oversight of casinos and for ensuring compliance with federal regulations. For example, OLG is required to report to the Financial Transactions and Reports Analysis Centre of Canada (FinTRAC) any large cash transactions and other suspicious transactions. OLG has an Anti-Money Laundering Compliance Program whose purpose is to have all casinos in Ontario adhere to federal and provincial regulatory requirements.

2.11 Interprovincial Lottery Corporation

The Interprovincial Lottery Corporation (ILC) consists of five Canadian provincial lottery corporations, including OLG. The other members are British Columbia Lottery Corporation, Western Canada Lottery Corporation, Loto-Québec and Atlantic Lottery Corporation. ILC administers lotteries that are sold across Canada such as Lotto Max, Lotto 6/49 and Daily Grand. The provinces are paid revenue from the Canada-wide lotteries based on the proportion of ticket sales in their jurisdictions. OLG and the other four provincial lottery corporations oversee lotteries sold only within their provinces, like Lottario, where revenue remains within their jurisdictions.

2.12 Fairness of Gaming

The Alcohol and Gaming Commission of Ontario (Commission) ensures the integrity, security and fairness of gaming systems such as slots, electronic bingo machines and PlayOLG.ca games. As part of this, the Commission is responsible for the technical assessment and testing of all electronic gaming hardware and software and the associated equipment.

The Commission decides on the odds and payback percentages of OLG games, and OLG provides this information on its website. For example, the payback percentage of slot machines at casinos is a minimum 85%. The OLG website explains this as follows: "the payback percentage is representative of the machine's entire lifecycle, which can be many millions of spins. Thus, it does not mean that a player can expect to win back $85 if $100 was

gambled on that individual session." Such information is meant to inform customers openly and fairly of the game's risks and opportunities.

3.0 Audit Objective and Scope

Our audit objective was to assess whether Ontario Lottery and Gaming Corporation (OLG) has IT systems and processes in place for the:

- secure delivery of operations (including lottery operations) in an economic and efficient manner and in accordance with legislative, regulatory and contractual requirements;
- effective oversight of IT vendors who provide services to OLG for its Internet gaming, lottery, charitable gaming and casinos; and
- timely investigation and handling of cybersecurity incidents and fraudulent activities, such as money laundering and potential misuse of gaming systems.

In planning for our work, we identified the audit criteria we would use to address our audit objective (see **Appendix 3**). These criteria were established based on a review of applicable legislation, policies and procedures, internal and external studies, and best practices. Senior management at OLG reviewed and agreed with the suitability of our audit objective and related criteria.

We conducted our audit between January 2019 and September 2019. We obtained written representation from management that, effective November 18, 2019, they had provided us with all the information they were aware of that could significantly affect the findings or the conclusion of this report.

We conducted audit work primarily at OLG's Toronto and Sault Ste. Marie offices, which are responsible for the operation and maintenance of OLG's information systems and technology infrastructure, and for managing external technology vendors.

We also interviewed senior and front-line staff and reviewed documents. We were given a demonstration of lottery terminal machines used by retailers and the new lottery terminals that will be deployed in 2020. In Sault Ste. Marie and Toronto, we visited 20 retailers at gas stations, Gateway newsstands, casinos, convenience stores, shopping malls, cafés, grocery stores, drug marts and laundry services where OLG lottery terminals are deployed. We interviewed retailers regarding inventory count, IT-related incidents and training related to the use of terminals. We visited OLG's data centres in Toronto and Sault Ste. Marie to assess environmental and physical security controls. Environmental controls, which regulate such things as moisture, temperature and dust, protect IT equipment from damage and allow it to function optimally; physical security controls protect against risks such as tampering and theft. We were also given a demonstration of the IT asset disposal process at the Toronto office.

In addition, we met with staff at two casinos to review IT controls related to the prevention of money laundering, the collection and use of OLG's customer data, and the reporting of suspicious transactions to OLG and to the Financial Transactions and Reports Analysis Centre of Canada (FINTRAC).

We assessed IT systems and cybersecurity operations at OLG and reviewed governance oversight by OLG over its IT vendors and casino operators. We also assessed procurement practices at OLG and the protection and life-cycle management of critical IT assets and cybersecurity functions. We further reviewed whether casino operators and IT vendors deliver IT services to OLG as per service-level agreements.

In addition, we examined key IT projects implemented over the last five years that were in progress, as well as some projects that were planned as part of OLG's digital strategy. We reviewed project management (such as defined project requirements), the use of standard and consistent project

Figure 5: Assessment of IT Vendor Key Performance Indicators, January 2014–February 2019
Prepared by the Office of the Auditor General of Ontario

	Line of Ontario Lottery and Gaming Corporation (OLG) Business	Payments ($ million)	Vendor Classification	Performance Indicators in Contract	Performance Indicators Measured by OLG	Payment Clause in Contract	Payment Imposed (Poor Performance)
Section Reference				4.1.1	4.1.2	4.1.4	4.1.4
Vendor							
Avatar	Casino	0.9	Strategic	Yes	No	No	n/a
Bally	Casino	57.1	Strategic	No	Yes*	No	n/a
IGT Legacy (Casinolink/EZ Pay)	Casino	71.4	Strategic	No	Yes*	No	n/a
NRT	Casino	10.7	Tactical	Yes	No	No	n/a
Omnigo (iView)	Casino	3.0	Strategic	Yes	No	No	n/a
NCR Corporation	Lottery	34.2	Strategic	Yes	Yes	Yes	Yes
Plastic Mobile Inc.	Lottery	9.4	Tactical	No	n/a	No	n/a
Rogers Communications	Lottery	58.3	Strategic	Yes	Yes	Yes	No
Canadian Bank Note	Charitable Gaming	56.0	Strategic	Yes	Yes	Yes	No
IGT I-Gaming	I-Gaming	51.8	Strategic	Yes	Yes	Yes	Yes

* Performance indicators such as service availability are not established in the contract but are reviewed by OLG.

management frameworks, potential delays and under/over estimation of project costs.

We sampled 10 vendors (see **Figure 5**) from OLG's 68 IT vendors to examine whether performance metrics and IT services were delivered in line with the requirements included in their service-level agreements. The total amount spent on these 10 vendors from January 2014 to February 2019 was $353 million and accounts for over half of the IT expenses that provide critical IT services. These vendors were selected based on the payments they received, the different lines of business they served and the relevance of their operations to OLG's total revenues.

Based on the sample of OLG Internet customers we tested, we found that all customers who played OLG's Internet games were the appropriate age. We also tested names of lottery winners against names of OLG employees and found that, in accordance with OLG's policy, no employees had played the lottery and won a prize. We noted that there currently is an investigation to identify how suspects may have laundered money through the OLG casinos; however, based on sample testing of selected casinos, we noted that OLG has been reporting appropriately to FINTRAC on a timely basis.

4.0 Detailed Audit Observations

4.1 OLG Not Always Thoroughly Measuring and Monitoring IT Vendor Performance, which Can Impact Customer Experience

We found that Ontario Lottery and Gaming Corporation's (OLG's) oversight over its IT vendors can be improved. For example, OLG did not always

incorporate critical IT performance indicators into its service-level agreements with IT vendors, and where indicator targets were incorporated, IT vendors were not held accountable for meeting the related performance targets. The end result can be poor customer experience whenever casino gaming machines jammed, tickets and prizes were not processed, and system outages led to games and services not being available and casino operations being disrupted. See **Appendix 4** for information about the frequency of outages affecting key IT systems between January 2015 and May 2019.

4.1.1 Not All IT Vendor Contracts Contain Performance Indicators and Targets

Alcohol and Gaming Commission of Ontario standards, as well as industry best practices, advise that vendor contracts should include performance indicators that define the minimum performance targets for IT services and how the targets will be measured. In order to enforce vendor accountability and ensure IT system service quality expectations are clearly understood and met, performance indicators—such as for service availability, system capacity and IT incident resolution time—should be included in vendor contracts.

We found that three of the 10 contracts for IT vendors that we reviewed did not have the necessary performance indicators within their service-level agreements (see **Figure 5**). As such, OLG does not have a contractual mechanism for tracking vendor accountability in meeting service quality, as follows:

Plastic Mobile Inc. (line of business: lottery)

We found that performance indicators for service availability and capacity were not included in the contract for Plastic Mobile Inc. "Capacity" means meeting mobile users' peak volume (for example, during the peak day of Friday). Plastic Mobile Inc. is responsible for developing, testing, maintaining and hosting the OLG Lottery Mobile App for iOS (Apple) and Android, the operating system for Samsung, Motorola and other mobile models. The OLG Lottery Mobile App is used primarily for ticket scanning, jackpot information, displaying winning numbers and coupons. OLG paid Plastic Mobile over $9.4 million in the last five years. The contract was signed in January 2014 and has been amended three times since then; however, performance indicators for service availability and capacity have never been incorporated into the service-level agreement. The Alcohol and Gaming Commission of Ontario guidelines state that these performance indicators are minimum standard requirements to be incorporated in all service-level agreements.

We found that there were approximately 290 incidents impacting customer experience in the last five years pertaining to the OLG Lottery Mobile App ticket checker not being able to scan lottery tickets, and giving incorrect information regarding the displayed next jackpot draw date. We found there was no targeted turnaround time for resolving the IT issues; the time taken varied significantly, from one hour to 34 days. The average time taken was almost five days.

We noted that there is no requirement in the service-level agreement for Plastic Mobile Inc. to monitor its Lottery Mobile App's performance, and as a result, OLG is made aware of the app's outages and performance issues only when customers call the OLG call centre to complain.

IGT Casinolink and EZ Pay (line of business: casinos)

OLG paid IGT over $71.4 million in the last five years for the development and operational maintenance of the IT system used to connect games at casinos. The IT system is hosted by OLG, and IT support is provided by the vendor in accordance with the service-level agreement.

We found that the service-level agreement did not include a performance indicator for IT incident resolution time. We noted that approximately 3,000 IT incidents related to these IT systems

were recorded in OLG's call centre in the last five years. OLG assessed approximately 300 of these incidents as critical incidents that resulted in casino games not being available to customers, ultimately impacting their gaming experience and potentially impacting the casinos' revenue. Most of these incidents occurred during Fridays and Saturdays, which are generally peak days at casinos. The time to resolve the IT issues varied from one hour to 95 days; the average time was more than two days.

Bally Gaming Management System (GMS) (line of business: casinos)

We found that the service-level agreement with Bally did not include a performance indicator for IT incident resolution time. We noted that this system, which is used to collect casino gaming and customer information, had prolonged issue resolution times for recorded incidents relating to transferring customer and casino operational data from the casinos to OLG. We found that the Bally GMS had approximately 3,000 incidents in the last five years and that the vendor took as long as 600 days and an average of 26 days to resolve them. Among these incidents were business interruptions that primarily affected casino operations (not casino customers).

RECOMMENDATION 1

To improve oversight of the quality of the services provided by IT vendors, we recommend that Ontario Lottery and Gaming Corporation establish appropriate performance indicators and targets to be incorporated in all service-level agreements, monitor performance against the targets and, where necessary, take the necessary action to correct any concerns.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with this recommendation and will establish enhanced vendor performance management oversight to ensure greater quality and accountability. As a result of the audit, OLG has strengthened standard contract templates to ensure appropriate metrics are defined. OLG is also developing new IT category management oversight within IT procurements to enhance the development of requests for proposals and improve the articulation of requirements and expectations of proposed vendors. OLG has reviewed and strengthened its vendor management process and additional resources to apply appropriate oversight to the performance of its vendors.

4.1.2 Achievement of Performance Targets Not Always Monitored by OLG

The vendors of three IT systems to casinos—Omnigo (facial recognition), NRT (cash handling), and Avatar (the prevention of money laundering)—are not effectively monitored by OLG in accordance with their service-level agreements. For example, according to the service-level agreements, monthly and quarterly performance meetings should be taking place between OLG managers and the IT vendors. We found that OLG has not been holding meetings with these vendors or obtaining performance reports to know whether service standards were met. As noted in **Section 4.1.6**, many OLG IT managers we interviewed told us that they were not clear about their job requirements for measuring vendors' compliance with their service-level agreements.

Omnigo Software (line of business: casinos)

Omnigo Software is a facial recognition and self-exclusion IT system used by OLG to detect and remove self-excluded customers from Ontario casinos (see **Section 2.9**). Omnigo's IT system is hosted by OLG, and support is provided by Omnigo as per the service-level agreement. The agreement's target for incident response ranges from 30 minutes to 48 hours, depending on the incident type, and incident resolution ranges from two hours

for critical incidents to five business days for non-critical incidents. We noted that Omnigo's performance in this regard was not reviewed by OLG.

We found that approximately 1,500 incidents have occurred in the last five years where the facial recognition IT system was not performing optimally across all casinos in Ontario. Over 300 of these were assessed as critical incidents by OLG. The most frequent incidents were facial detection errors, such as flagging the wrong customer for exclusion or failing to flag self-excluded customers, and delays in the security surveillance team receiving facial recognition alerts. We found that the average time to resolve these critical incidents was over four days instead of two hours.

NRT Technology Corporation (line of business: casinos)

NRT provides the cash handling system for automated jackpot dispensing machines and customer ticket redemption kiosks at casino sites. According to its service-level agreement, NRT is required to respond to IT incidents and resolve them within four hours. During quarterly performance meetings, OLG is required to review the performance relating to NRT's response to and resolution of IT incidents; however, we noted that OLG has not conducted a performance review since the contract was established in 2008. We found that casinos had experienced approximately 2,900 incidents in the past five years. These incidents included bills jamming inside kiosks at casinos and the NRT system not processing ticket vouchers and jackpot prizes for cash disbursement, impacting the overall customer experience. The resolution time for such incidents ranged from a few hours up to seven days.

Avatar Software Creations Inc. (line of business: casinos)

The Avatar IT system is used by OLG and casinos for reporting on money laundering to the federal regulator. According to its service-level agreement, Avatar is required to respond to and resolve incidents within four hours and provide service-level summary reports for performance review during quarterly meetings. However, we noted that OLG does not have performance meetings or receive the required service-level reports from Avatar. In addition, we found approximately 680 incidents taking up to 23 days to be resolved by Avatar. Such delays affect casinos' ability to promptly and accurately report transactions to OLG.

RECOMMENDATION 2

To improve oversight of IT vendors, we recommend that Ontario Lottery and Gaming Corporation review vendors' performance regularly in accordance with their service-level agreements and take appropriate action when targets are not met.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) recognizes the importance of monitoring the performance of our IT vendors to maximize value for money. As a result of the audit, OLG has launched a comprehensive, enterprise review of its third-party management process and has established a revised management governance framework. This will result in more rigorous vendor reviews that assess performance against contracted standards and targets. In addition, OLG is improving its vendor classification, scorecards and management of service-level agreements.

4.1.3 Incorrect IT Vendor Classification Impacts OLG's Oversight

For its oversight purposes, OLG classifies IT vendors as strategic, tactical or commodity vendors, based on financial risk, significance of their operations to OLG's reputation, size of their contracts and the type of services they provide to OLG operations:

Figure 6: Categorization and Risk Level for Ontario Lottery and Gaming Corporation (OLG) Vendors
Source of data: Ontario Lottery and Gaming Corporation

Vendor Category	# of Vendors	Approximate Cumulative Annual Contract Values	Performance Meeting Frequency	Risk Level and Impact to OLG upon Supplier Failure
Strategic	17	>$1 million	Monthly	High
Tactical	51	$100,000–$1 million	Quarterly	Medium to high
Commodity	180	<$100,000	Not required	Low to medium

- **Strategic vendors** are subject to a higher level of oversight by OLG via monthly meetings where their performance is reviewed.
- **Tactical vendors** have quarterly performance meetings with OLG.
- **Commodity vendors** are not required to be reviewed for performance.

See **Figure 6** for further OLG guidelines regarding the three categories.

We found that although OLG has these three vendor categories and guidelines associated with them, there was no consistent approach for determining a vendor's classification. We noted that the classification was subjective and based on OLG IT operations' perception of its vendors. For instance, every IT vendor with an annual contract value of $1 million or more is to be classified as strategic; however, we found that 13 of 51 vendors classified as tactical (25%) were paid over $1 million each year in the past five years. As a result of being classified as tactical, these vendors were subject to less oversight—being reviewed quarterly instead of monthly.

According to IT industry best practices, such as those put forth in the Control Objectives for Information and Related Technology and by the Institute of Internal Auditors, organizations should have a standard approach for classifying IT vendors. IT vendors should be classified based on factors such as financial impact, type of information residing with the vendor, cost, operational impact, third-party reliance, risk of fraud, public reputation and customer satisfaction.

RECOMMENDATION 3

To enable the appropriate classification of IT vendors and enable them to be subject to the appropriate level of oversight, we recommend that Ontario Lottery and Gaming Corporation:

- establish consistent criteria for classifying existing and new vendors when it initiates contracts with them, using the selection factors identified by industry best practices; and
- review vendors' classifications at least annually and also when any significant changes to vendor operations occur.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and understands the importance of having a standard approach for classifying IT vendors. As a result of the audit, OLG has redeveloped its IT classification methodology to align with industry best practices and has applied this against its current list of vendors. OLG will adopt a more rigorous vendor-and-performance-standards-review process, including annual classification reviews.

4.1.4 IT Vendors Not Held Accountable when They Miss Performance Targets

Four of the 10 IT vendors we selected to review had a clause in their service-level agreements requiring them to pay a penalty to OLG if they did not provide IT services in accordance with their service-level

agreements. We noted that two out of the four vendors in our sample missed their performance targets, but OLG did not enforce the penalty payment (see **Figure 5**). When OLG does not enforce this requirement, its vendors may have less incentive to reach their performance targets.

Rogers Communications is one of OLG's most critical IT vendors because it is the sole vendor responsible for providing Internet network services to all 10,000 lottery retailers in Ontario. If OLG does not monitor whether Rogers resolves incidents in a timely manner, customer experience may be impacted. If Rogers' network is unavailable, customers are not able to buy tickets, and ticket-holders and retailers are not able to check for winning tickets.

OLG uses a "credit system" with Rogers in which OLG charges Rogers a specified sum when service requirements, such as not meeting network availability and incident response-time targets, are not met. We found that OLG does not review Rogers' performance reports to ensure that the correct charges are being applied and that the reports are correct.

Specifically:

- As shown in **Figure 7**, OLG's contract with Rogers identifies seven categories of services for which OLG can charge Rogers for not meeting service-level requirements. We found that no payments had been made to OLG for three of the seven service categories when performance targets were not met. We identified over 90 instances in the past five years where IT service performance did not meet contract obligations.
- We cross-checked Rogers' performance reports against OLG 's incident-tracking tool and found that certain incidents that had been tracked by OLG were not noted in the performance reports. For instance, according to Rogers' performance reports, Rogers met service-level requirements for

Figure 7: Service-Level Agreement (SLA) Categories and Results for Rogers Communications

Prepared by the Office of the Auditor General of Ontario

Categories	SLA Target	Penalty if Performance is Lower than SLA Target	Penalty Imposed	# of Instances[1] Penalty Not Imposed If Applicable
1. Core network availability	99.99%	1%–25% of monthly connection charges for all sites (depending on service level score)	Yes	n/a
2. Site (retailer) network availability	99.90%	1%–20% of monthly connection charges for all sites whether cable, DSL, or bonded DIAL Internet Service Provider (ISP) sites (depending on service level score)	n/a[2]	n/a[3]
3. Mean time to respond (data centres and retailer sites)	15 minutes	$250	No	49
4. Rogers site network time to repair	6 hours	$50–$250 (depending on exceeded time)	Yes	n/a
5. Rogers DSL mean time to repair	4 hours	$1–$10 per incident (if exceeded by one to 6 minutes)	No	39
6. Data centre time to repair	4 hours	$1,000–$5,000 (depending on wait time)	No	2
7. Installs, moves, adds and changes credits	Installation must not be billed to Ontario Lottery and Gaming Corporation if Rogers fails to meet the agreed upon installation date			

1. In the last five years.
2. No instance of not meeting service level requirements in Rogers' Service Level report.
3. OLG incident-tracking tool identified over 70,000 incidents over the past five years.

service Category 2 (see **Figure 7**). However, according to OLG's incident-tracking tool, over 70,000 Category 2 incidents occurred in the past five years. Some incidents took more than a year to resolve.

Another example involves Canadian Bank Note, OLG's IT vendor for charitable gaming sites. OLG charges Canadian Bank Note penalty payments when service levels are not met for requirements such as service availability, speed to answer, first call resolution and time taken to restore service. We found 51 incidents in the past five years where service levels were not achieved for two service categories—28 for first call resolution and 23 for time taken to restore service—but no payments were charged or collected.

We noted that the reason OLG did not impose a penalty for these categories was because the penalty clause is not clearly defined in OLG's contract with Canadian Bank Note. The contract states that penalties can be imposed for critical incidents, but it lacks a clear-cut definition of "critical." As a consequence, OLG reviews only the number of incidents not resolved within the required time rather than reviewing the degree to which an incident is critical. This service-level agreement was signed in 2012 and has not been amended since to clarify the definition of "critical."

OLG Has Only One Internet Provider Serving Lottery Retailers with No Backup

Rogers Communications is the sole provider of Internet network connectivity to all lottery retailers in Ontario and is OLG's primary Internet connectivity provider. In a scenario where Rogers is experiencing a province-wide outage, OLG does not have a backup Internet provider to support its day-to-day operations.

RECOMMENDATION 4

To continually confirm the importance of IT vendors meeting their contractual performance commitments, we recommend that Ontario Lottery and Gaming Corporation track vendors' performance and collect the payments specified in the service-level agreements.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and recognizes the importance of consistently enforcing the contractual obligations of its vendors. OLG is committed to establishing a robust process to identify and track underperformance, escalate its response to it, and apply appropriate penalties in accordance with vendor contracts.

RECOMMENDATION 5

To have a reliable backup for its primary Internet provider to help assure continuity of its business operations, we recommend that Ontario Lottery and Gaming Corporation analyze the costs and benefits of acquiring a secondary Internet provider.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation will analyze the costs and benefits of acquiring a secondary lottery network provider and take action as appropriate.

4.1.5 OLG Extended or Renewed Strategic IT Contracts without Thoroughly Assessing Vendor Performance

OLG extended IT contracts for four out of the 10 IT vendors we reviewed, with cumulative payments ranging from $1.5 million to $23.2 million, without thoroughly evaluating the vendors' performance. Effective governance over IT procurement and contracts requires that the overseer assess vendor performance—using such tools as performance scorecards, service and product quality reports, issue and problem logs and risk ratings—prior to renewing key IT contracts. Such assessments

provide assurance to organizations that the vendors successfully provided goods and services in accordance with the agreements.

Figure 8 shows a summary of IT contracts OLG renewed with four vendors without doing performance assessments: Avatar Software Creations Inc., Omnigo Software, OR Computer Solutions and Plastic Mobile Inc.

Specifically, we found the following:

Avatar Software Creations Inc. (line of business: casinos)

OLG initially procured a software solution from Avatar for reporting on money laundering in August 2009. OLG renewed the service-level agreement with Avatar multiple times without reviewing its performance in meeting its service-level-agreement requirements.

In addition, OLG used single-source procurement, indicating in its business case that only this vendor was able to meet the regulatory and business requirements and provide ongoing software services and support. OLG told us it did not conduct research to support the single-sourcing, such as comparing what tools other Canadian lottery corporations procured for reporting on money laundering. We found that there are various IT software systems available from well-known technology companies like ORACLE and SAS that provide money-laundering-reporting capability.

Omnigo Software (line of business: casinos)

In 2008, OLG contracted with this vendor to provide facial recognition systems at all casinos. This contract was extended two subsequent times without assessing the vendor's performance against its service-level agreement. There have been about 1,500 incidents where facial detection issues occurred, yet OLG did not assess Omnigo's performance prior to the contract extensions.

OR Computer Solutions (line of business: lottery)

OLG extended the initial three-year agreement with OR Computer for another two years. However, OLG did not assess OR Computer's performance before extending the contract. OR Computer provides lottery terminal supplies—that is, papers, inks and parts for terminals, printers and scanners.

Figure 8: IT Contracts Renewed by Ontario Lottery and Gaming Corporation (OLG) without Vendor Performance Assessment

Prepared by the Office of the Auditor General of Ontario

Vendor	Service	Start Date	Original End Date	Extended End Date	Payment Start Date–Original End Date ($ million)	Payment Original End Date–Sep 5, 2019 ($ million)
Avatar Software	Software solutions for anti-money laundering reporting	Aug 18, 2009	Aug 17, 2012	Nov 30, 2020	0.1	1.4
Omnigo Software (iView Systems)	Manages self-excluded customers and security incidents for OLG gaming sites and resort casinos	Oct 13, 2008	Dec 31, 2013	Dec 11, 2020	2.7	4.1
OR Computer	Provides lottery terminal supplies	Jan 1, 2016	Dec 31, 2018	Dec 31, 2020	19.3	3.9
Plastic Mobile	Provides OLG lottery mobile application	Jan 1, 2014	Sep 14, 2016	Mar 31, 2021	2.5	7.8

Plastic Mobile Inc. (line of business: lottery)

OLG extended the agreement with Plastic Mobile three times since the original contract in January 2014. Plastic Mobile supports the web applications, platforms and databases that it developed for OLG. These critical services are not being monitored and evaluated by OLG to ensure that intended service delivery is provided successfully during the contract period.

RECOMMENDATION 6

To improve oversight of IT vendors, we recommend that before extending or renewing an existing contract, Ontario Lottery and Gaming Corporation:

- perform thorough vendor performance assessments on its current vendors; and
- improve the existing procurement process by assessing whether a new tender for service is more appropriate than extending or renewing its contracts.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with this recommendation and will assess vendor performance prior to any contract renewal or extension. OLG is implementing thorough changes to its vendor management process, including establishing stronger performance management.

4.1.6 OLG Managers Not Clear on Responsibilities to Monitor IT Vendor Performance

OLG managers are responsible for monitoring that vendors adhere to performance requirements in their service-level agreements. One way they are to do this is to meet with vendors to review their performance at a specified frequency based on the vendor's classification (see **Figure 6**). We found that performance meetings were not taking place as required under contract. The 10 managers we interviewed told us that their roles and responsibilities are not well defined and they were not clear about their job requirements in this area. Clarifying their responsibilities is needed to ensure that they hold the performance meetings (by phone or in person) as required in vendors' contracts. In addition, information about vendors, such as past vendor contracts, vendor activities, meeting minutes and performance reports, is not stored in the central IT repository or readily available. As a result, we found that OLG managers did not have key information on past trends and activities relating to vendor performance.

RECOMMENDATION 7

To strengthen oversight of IT vendors, we recommend that Ontario Lottery and Gaming Corporation (OLG):

- clarify and communicate to OLG IT managers their roles and responsibilities for overseeing vendors' compliance with the contractual service commitments in their service-level agreements; and
- develop guidance for OLG managers on what constitutes effective monitoring of vendor performance.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and understands the importance of ensuring its vendor management team fully understands roles and responsibilities in managing vendor partners. In addition, OLG is in the process of strengthening its tools and training for managers to effectively monitor vendor performance.

4.2 Security over Personal Information of OLG Customers and Employees Can Be Strengthened

4.2.1 Need for Additional Penetration Testing to Reduce the Risk of Unauthorized Access to Personal Information

Organizations typically perform penetration testing on their IT systems to find security vulnerabilities. With respect to OLG, we found the following:

- Although OLG conducts regular vulnerability assessments, OLG has not regularly performed penetration testing to further identify cybersecurity vulnerabilities. Specifically, we noted that its iGaming website, PlayOLG.ca, had not been tested regularly since it was launched in January 2015. We noted that it was last tested in 2016 and 2017. According to industry best practices, such tests should be performed at least annually. In November 2018, the iGaming website was subject to a cyberattack causing PlayOLG.ca to be unavailable for approximately 16 hours. The attacker was never caught.
- OLG has also not performed a penetration test of the OLG Lottery Mobile App, which was developed by an IT vendor and stores customers' personal information. A potential breach via the app increases the risk that customer data, including customers' names, addresses and telephone numbers, could be compromised. In the past five years, there have been thousands of unsuccessful cyberattacks and attempts at OLG. Casino A was successfully attacked in November 2016.

RECOMMENDATION 8

In order for Ontario Lottery and Gaming Corporation (OLG) to more effectively protect itself from the risk of cyberattacks, safeguard personal information, and have continuity of services, we recommend that OLG regularly perform penetration testing of all critical IT systems.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) recognizes the critical importance of safeguarding personal and confidential information and utilizes a comprehensive security framework that includes regular vulnerability assessments. OLG is committed to continual investment and will perform regular penetration testing of all critical IT systems.

4.2.2 Sensitive Personal Information Not Fully Safeguarded

OLG collects the personal information of customers for business purposes and regulatory compliance. This information can include a customer's name, birth date, race, address, gender, height, eye colour, hair colour, credit card information, banking information and personal identification numbers such as a driver's licence. The information is stored in OLG databases and is encrypted to prevent attackers from accessing it. However, OLG currently has seven employees who have unrestricted access to databases that hold all OLG's customers' confidential information. This is not in line with best practices for security. Best practices would require a system privilege account (such as a Firecall ID) instead of these seven individual privileged accounts. A "Firecall ID" is a method established to provide temporary and monitored access to sensitive and secured information.

We also found that OLG has an overly narrow definition of personal data, so the personal information collected at casinos that does not meet this narrow definition is not safeguarded to the same extent as the personal information that does meet the definition. For example, OLG uses IT systems at casinos to identify restricted players: the IT system captures their images in photographs and compares them to a database of restricted players. These photographs are converted to mathematical formulae that are not classified as personal information by OLG. However, the Information and

Privacy Commissioner of Ontario advised us that these mathematical formulae describing a person's facial geometry should be considered personal information.

IT Division Does Not Keep Data Disposal Records as Required by Privacy Regulations

The personal information of OLG's customers is within the purview of the province's *Freedom of Information and Protection of Privacy Act* (Privacy Act). The Privacy Act requires that OLG must maintain a record of the types of personal data it disposes of and the date of disposal. However, we found that OLG's IT division does not maintain such a record for its disposal of the personal information of lottery players and casino customers.

RECOMMENDATION 9

So that personal information is safeguarded against breaches, we recommend that Ontario Lottery and Gaming Corporation:

- encrypt all personal information and restrict access using industry best practices;
- review and where needed update its definition and classification of personal information annually; and
- ensure that data is disposed of according to the requirements of the *Freedom of Information and Protection of Privacy Act*.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) recognizes the critical importance of safeguarding personal and confidential information, and utilizes a comprehensive security framework that includes regular vulnerability assessments. OLG will review its definition and classification of personal information annually and update as required. OLG will also ensure that data is disposed of according to the requirements of the *Freedom of Information and Protection of Privacy Act*. OLG currently uses a number of controls that govern the collection and access of personal information, including encryption. OLG will review and restrict administrative access.

4.2.3 Casino Operators Not in Compliance with OLG Information Security Standards

Casinos are contractually required to store OLG's customer information in accordance with OLG's information security standards. However, we found that the standards state only that the casinos must protect the information, but are silent on how that needs to be accomplished. When we visited two casinos, we found that neither casino encrypts OLG customer data within its IT systems.

Major lessons learned from cyber incidents are also not shared across different casinos. Attempted data breaches at casinos and at OLG have remained steady in the past five years with an average of 300 cybersecurity attempts every year.

A data breach occurred in November 2016, when Casino A was hit with a cyberattack in which customer and casino employee data was stolen. OLG and the Office of the Information and Privacy Commissioner of Ontario indicated that the incident was due to a phishing email sent to Casino A employees resulting in the theft of approximately 14,000 records, including financial reports, customer credit inquiries, collection and debt information, and payroll and other data.

Following the Casino A incident, OLG strengthened existing provisions in the agreements with its casino operators to ensure that data breaches are addressed and reported to OLG in accordance with OLG's information security practices. However, OLG has not confirmed that casinos are providing guidance to their employees, on an ongoing basis, to prevent a similar incident from occurring. We also noted that two more phishing attacks have happened since then:

- In May 2018, Casino B received a phishing email that became more targeted over three days as the unaware employees provided

information to the attacker. Accounts belonging to a total of six employees were compromised when user names and passwords were obtained by the hacker.

- In June 2019, Casino C received phishing emails. Ten employees from three affiliated casinos had their data compromised, which led to the attacker accessing confidential files in their email mailboxes.

These two incidents were similar to the Casino A incident, where employee awareness of these suspicious emails could have prevented the incident.

RECOMMENDATION 10

To be compliant with its own standards, we recommend that Ontario Lottery and Gaming Corporation (OLG):

- review and update its information security standards to specify how casinos are to protect personal information—for example, with encryption of personal information; and
- ensure that all casinos deliver their established formal training programs for their staff to reduce the risk of successful cyberattacks.

RESPONSE FROM OLG

Consistent with its business practices and contractual obligations, the Ontario Lottery and Gaming Corporation (OLG) holds all its service providers accountable for fulfilling high standards of information security. OLG agrees with the recommendation and will ensure that all gaming sites comply with obligations for encryption of personal information as stipulated in casino operator contracts and deliver its established training programs to their staff to reduce the risk of cyberattacks.

4.3 Additional Steps Could Be Taken to Further Reduce Cybersecurity Risks for Lottery, Casino and iGaming Systems

We noted OLG's IT team does not review the software source code of the critical IT systems that are used for its lottery, iGaming and casino operations. Software source code consists of instructions written by a programmer that can be read by humans.

Although the software source code from iGaming and casinos is reviewed by the vendor supporting these IT systems, OLG does not follow the industry best practice of identifying cybersecurity weaknesses by either performing an independent review of software source code or ensuring that vendors diligently perform such reviews.

OLG uses a random-number-generator algorithm, which is a software formula that creates a sequence of numbers, to ensure that winning numbers are random and cannot be entered into the system fraudulently or predicted in advance. OLG contracts with an external vendor, Gaming Laboratories International, to assess the technical controls behind the system and evaluate the software formula to determine whether the system is able to generate random numbers suitable for its lottery products. We noted that the last technical assessment was performed in 2015.

An incident where lines of code were altered occurred across state lotteries in the United States. The former information security director of the Multi-State Lottery Association confessed in 2015 to inserting minimal lines of code to generate specific winning numbers on a specific day. While written in plain form with no attempt to hide its presence, the code did not change the size of the file and went undetected for over 10 years of reviews performed by the same external vendor as OLG uses, Gaming Laboratories International. A total of $24 million had been paid to illegitimate winners by the time the fraud was discovered.

To prevent such insider threats from affecting critical software, code reviews are accepted as a

form of best practice. Programmers who were not involved in the writing of the original code perform a review of the code to find any defects, such as malicious code or unintended functions.

RECOMMENDATION 11

To improve the security over the generation of lottery numbers and identify cybersecurity weaknesses in the iGaming and casino IT systems, we recommend that Ontario Lottery and Gaming Corporation review its software source code in accordance with industry best practices.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and will ensure the practice of source code review is included in its software development lifecycle process.

4.4 Comprehensive Disaster Recovery and Testing Strategy Needed

Organizations conduct disaster recovery exercises to determine whether they are able to restore IT operations in the event of a natural or man-made disaster such as power outages, cyberattacks and earthquakes. In a disaster recovery exercise, organizations test the availability of their IT operations by making them unavailable and moving the operations to an alternative site known as a backup facility. It is a best practice to conduct these exercises at least once a year for the entire IT network, which typically includes the collective technology infrastructure, including switches, routers, servers, IT systems and databases.

OLG has data centres in Toronto and Sault Ste. Marie where its data is stored from IT systems across all lines of its business. Disaster recovery strategies have been developed and tested for IT systems for each individual line of business. However, we noted that OLG does not have a comprehensive disaster recovery plan that incorporates all IT systems cohesively. This became apparent when OLG experienced a major outage for six hours on October 29, 2018, resulting in key IT systems such as the lottery system and the gaming management system being unavailable. We found that a network switch at the Toronto data centre failed at 12:47 p.m., and services were not restored until almost six hours later, at 6:38 p.m. We noted that as of the time of our audit, OLG had yet to develop and test a comprehensive disaster recovery strategy that would allow OLG to recover operations within its set targets (see **Figure 9** for OLG's targeted recovery times).

Classifications Determine whether IT System Tested for Disaster Recovery

OLG classifies its 186 systems according to how critical they are to its business operations (see **Figure 9**). The classifications determine whether a disaster recovery test is required and, if so, how frequently tests should be done and how quickly OLG should be able to recover those systems. We noted

Figure 9: Disaster Recovery Classification for IT Systems and Test Frequency
Source of data: Ontario Lottery and Gaming Corporation

Classification	Test Frequency	Target Recovery Time	# of IT systems
Platinum	Annual	Less than 4 hours	34
Gold	Annual	4–24 hours	35
Silver	Annual	36 hours–7 days	42
Bronze	Not required	Best effort	9
Black/No profile	n/a	n/a	66
Total			**186**

that OLG has not reviewed the classifications for its systems to ensure the adequacy of their ability to meet their targeted recovery time is being tested.

Based on our review of a number of systems, we noted some areas for improvement in OLG's disaster recovery planning and testing. For example:

- The central gaming management system (GMS) at OLG is classified as Platinum, meaning the GMS system should be recovered within four hours. We noted that the disaster recovery exercise for the GMS on March 6, 2019, was unsuccessful: the IT team was unable to recover the system within four hours. The system was not retested to verify successful recovery.
- Another significant IT system is the casino site GMS, which sends casino data to the central GMS at OLG. We found that the disaster recovery classifications were inconsistent across all casinos' site GMSs. For example, the system at Casino B is classified as Black, which means no targeted recovery time is in place, while Casino C is classified as Platinum, with a targeted recovery time in the event of an outage of less than four hours.
- We found that the Onyx IT system, which is used for call centre operations to respond to customers and retailers, is classified at the level where no review is performed, and therefore there is no disaster recovery process in place for it. We noted that the Onyx system's classification was last reviewed over 10 years ago. Industry best practice is for critical IT systems such as Onyx to be reviewed at least on an annual basis.

RECOMMENDATION 12

To manage risks to key information technology systems at Ontario Lottery and Gaming Corporation (OLG), we recommend that OLG:

- establish a comprehensive disaster recovery plan to be approved and tested on an annual basis for its entire IT environment;
- review its information systems classification on a periodic basis for consistency across OLG and casino IT systems; and
- retest the disaster recovery plan for its IT systems following each failed disaster recovery test.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) is committed to business continuity to ensure revenue streams and services to customers are protected. OLG is in the process of conducting a comprehensive third-party review of its key information technology systems and associated recovery plans to better address complex scenarios, including site-level disasters. OLG will review the recovery objectives of its information systems annually to ensure alignment with the needs of the business. We will ensure consistent classification is applied, documented and regularly reviewed across service providers.

4.5 Certain IT Projects Have Experienced Delays in Implementation and About $10 Million in Cost Overruns

OLG has implemented 44 IT projects at a cost of $232 million across its various lines of business over the last five years, such as the introduction of the Internet gaming website PlayOLG.ca (iGaming) and OLG Lottery Mobile App, and has upgraded key IT systems at casinos and charitable gaming sites (cGaming). OLG implemented 33 IT projects within budget. However, the remaining 11 projects, which account for almost half of all IT project expenses over the last five years ($91 million sampled over a total of $232 million spent), experienced delays and cost overruns of over $10 million. We noted that there were multiple factors that contributed to the delays and cost overruns, such as weaker project oversight and monitoring. For example:

- As a result of significant delays, one project had a $2-million cost overrun, making it 36% over its $5.6 million initial budget. The delays were mainly due to issues with the vendor's availability to participate in the system integration test. This resulted in additional costs for retaining OLG contractors and vendor consulting to support the integration.
- Another project associated with OLG's Internet gaming site, PlayOLG.ca, launched in January 2015, had a cost overrun of $3.6 million, making it 9% over its total budget. The project encountered higher-than-anticipated legal fees and other costs, including testing/validation costs as a result of business requirements not being clearly defined by OLG in its planning phase.

RECOMMENDATION 13

In order to successfully implement its digital strategy and avoid the risk of delays in implementation and cost overruns, we recommend that Ontario Lottery Gaming Corporation implement a project management framework that tracks, monitors and reports on all IT projects on a timely basis.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) recognizes the importance of robust project management to ensure that initiatives are completed on time and on budget. As a result of the audit, OLG has launched a new project control framework to strengthen oversight. OLG is also in the process of enhancing project management practices to improve project scheduling, budgeting and delivery. As well, OLG plans to upgrade the tools available to staff to better estimate and track project deliverables.

4.6 OLG Internal Risk and Audit Division Not Performing Independent Audits of All Casinos to Reduce IT Risk

OLG has Casino Operating and Service Agreements (Agreements) with private-sector casino operators covering their administration and day-to-day operations of casino sites on OLG's behalf. In Ontario, 26 casinos in nine regions are operated by private-sector operators (see **Appendix 1**). Under the Agreements, OLG has the right to audit casinos to check if they are operating in compliance with contractual and regulatory requirements. The Agreements require casino operators to establish and monitor data regarding customers and gaming, IT security and cybersecurity of casino systems such as gaming management systems. Their operations are also subject to OLG's independent audits.

We found that OLG's Internal Risk and Audit Division has not performed the independent IT audits at all casinos as allowed under the Agreements. As shown in **Figure 10**, the Risk and Audit Division performed only 15 IT audits for the 26 casinos, and these audits had a limited scope. This does not provide sufficient assurance of casinos' compliance with their IT responsibilities under the Agreements.

We also found that where audits of casinos were performed by OLG's external auditors, OLG's Internal Risk and Audit Division did not review the audit reports to assess whether the audits identified system weaknesses and risks to IT operations impacting OLG. We reviewed these reports and noted that the audit reports identified weaknesses such as user access concerns and weak security controls for key systems.

Figure 10: Number of IT Audits Performed by Ontario Lottery and Gaming Corporation (OLG) Risk and Audit Division at Casinos

Source of data: Ontario Lottery and Gaming Corporation

Gaming Region	# of Casinos	# of IT Audits by OLG				
		2015	2016	2017	2018	2019
East	4	–	1	2	1	–
Southwest	6	–	–	1	2	–
North	3	1	–	–	1	–
Ottawa	1	–	–	–	–	1
Greater Toronto Area	3	–	–	1	–	3
West	4	1	–	–	–	–
Central	2	–	–	–	–	–
Niagara Falls	2	–	–	–	–	–
Windsor	1	–	–	–	–	–
Total	**26**	**2**	**1**	**4**	**4**	**4**

RECOMMENDATION 14

To improve the effectiveness of oversight of IT operations at casinos, we recommend that Ontario Lottery and Gaming Corporation's (OLG's) Risk and Audit Division:

- audit casino operators' performance of their IT responsibilities on a periodic basis to assess their compliance with contractual and regulatory requirements; and
- formally review external audit reports to identify IT risks impacting OLG's business operations and to confirm that corrective action has been taken.

RESPONSE FROM OLG

The Ontario Lottery and Gaming Corporation (OLG) agrees with the recommendation and will review the current scope and frequency of audits to assess casino operators' performance of their IT responsibilities and implement adjustments to enhance its assurance coverage. OLG will formalize the process to review external audit reports and confirm corrective action has been taken.

Appendix 1: Casinos by Region and Casino Operator

Source of data: Ontario Lottery and Gaming Corporation

Gaming Region	Gaming Sites	Casino Operator	Privatization Dates
East	Shorelines Slots at Kawartha Downs	Great Canadian Gaming Corporation	Jan 11, 2016
	Shorelines Casino Thousand Islands		
	Shorelines Casino Belleville		
	Shorelines Casino Peterborough		
Southwest	Gateway Casinos Point Edward	Gateway Casinos and Entertainment Limited	May 9, 2017
	Gateway Casinos Dresden		
	Gateway Casinos Clinton		
	Gateway Casinos Woodstock		
	Gateway Casinos Hanover		
	Gateway Casinos London		
North	Gateway Casinos Sault Ste. Marie	Gateway Casinos and Entertainment Limited	May 30, 2017
	Gateway Casinos Thunder Bay		
	Gateway Casinos Sudbury		
Ottawa	Hard Rock Casino Ottawa	Hard Rock Ottawa Limited Partnership	Sep 12, 2017
Greater Toronto Area	Casino Woodbine	Ontario Gaming Greater Toronto Area Limited Partnership/Great Canadian Gaming Corporation	Jan 23, 2018
	Casino Ajax		
	Great Blue Heron Casino		
West	Elements Casino Grand River	Ontario Gaming West Greater Toronto Area Limited Partnership /Great Canadian Gaming Corporation	May 1, 2018
	Elements Casino Brantford		
	Elements Casino Flamboro		
	Elements Casino Mohawk		
Central	Casino Rama	Gateway Casinos and Entertainment Limited	Jul 18, 2018
	Gateway Casinos Innisfil		
Niagara Falls	Fallsview Casino Resort	Mohegan Gaming and Entertainment	Jun 11, 2019
	Casino Niagara		
Windsor	Caesars Windsor	Caesars Entertainment Windsor Limited	Current agreement expires on Jul 31, 2020

Appendix 2: Ontario Lottery and Gaming Corporation (OLG) IT Systems by Lines of Business

Source of data: Ontario Lottery and Gaming Corporation

Line of Business	Key IT Systems	Description
Casinos (Land-Based Gaming)	Bally Central Gaming Management System (GMS)	Bally Central Gaming Management System (GMS) is the key IT system being used at land-based gaming sites/casinos for accounting, financial management, reporting, and management of player data for land-based games. The main system is located at OLG, and land-based gaming sites have the Service Provider system. Developed by: External vendor (OLG Licensed Software) In use for: Three years (Central GMS). Implementation in progress (SP Site GMS) Last major upgrade: June 2018 Technology: Windows/MS SQL Server
	CasinoLink (legacy GMS)	CasinoLink is the legacy IT system being used at the land-based gaming sites/ casinos that is currently being retired. The system will be replaced with the above mentioned Bally GMS IT System by 2020. Developed by: External vendor (OLG Licensed Software) In use for: 10+ years Last major upgrade: August 2015 Technology: Windows / MS SQL Server
	iTrak iGWatch IP Facial Recognition System	iGWatch IP Facial Recognition System is used to identify voluntary self-excluders through surveillance cameras and matching with the facial recognition database as part of the Responsible Gambling program. Images of patrons that do not match the database are automatically deleted. Developed by: External vendor (OLG Licensed Software) In use for: Five+ years Last major upgrade: January 2019 Technology: Windows/MS SQL Server
	ContractHub (CLM, SRM)	ContractHub is used by the Land-Based Gaming team to track and manage the performance and obligations of service providers. It includes the following: • enhanced contract management • supplier relationship management • advanced workflows • supplier community access • financial transactions • encryption of sensitive data to meet OLG and government standards Contract Hub is also used by OLG Procurement for: • vendor good and service contract housing • auto-generated renewal and expiration notifications • encryption of sensitive data to meet OLG and government standards Developed by: External vendor (OLG Licensed Software) In use for: Five+ years Last major upgrade: November 2018 Technology: Apttus Salesforce

Line of Business	Key IT Systems	Description
Lottery	Online Lottery Gaming System (OLGS)	Manages all business logic and transaction integrity in selling tickets, picking winners and the payment of prizes. The system supports approximately 10,000 retailers across the province that record lottery-based customer transactions in the main gaming engines. Developed by: In-house In use for: Five+ years Last major upgrade: November 2018 Technology: Windows / MS SQL Server
	OLG Lottery Mobile App	The OLG Lottery Mobile App is used for ticket scanning, jackpot information, displaying winning numbers and coupons. Developed by: External vendor (OLG Licensed Software) In use for: Two+ years Last major upgrade: January 2019
iGaming (Internet Gaming)	PlayOLG.ca Gaming website	PlayOLG is the internet gaming platform provided by International Gaming Technology (IGT) as the third-party service provider. IGT manages front-line customer service, day-to-day hosting and the iGaming Solution software.
cGaming (Charitable Gaming)	Charitable gaming systems	IT systems for the charitable gaming centres are operated and managed by Canadian Bank Note as the third-party service provider.

Appendix 3: Audit Criteria

Prepared by the Office of the Auditor General of Ontario

1.	Governance and accountability structure is in place for IT functions and provide sufficient oversight over service providers key to IT operations.
2.	Effective oversight is in place to ensure that IT procurement process is managed in an efficient and cost-effective manner, in accordance with applicable legislation, regulations, directives and trade agreements.
3.	IT assets including technology equipment, software and hardware are effectively managed in an economical manner throughout the life cycle of the IT asset management process.
4.	Critical IT services are being delivered effectively and monitored to ensure intended outcomes are achieved in an economical manner.
5.	IT systems are in place to detect, prevent and mitigate anomalies and threats to Ontario Lottery and Gaming Corporation operations in a timely manner including the safeguarding of legislatively protected personal identifiable information.
6.	IT controls are in place to ensure fraudulent activities are being monitored and investigated. Accurate and timely data reporting is being performed in accordance with legislative and regulatory requirements.

Appendix 4: Actual IT Systems Outages and Impacts to Ontario Lottery and Gaming Corporation (OLG) Operations, January 2015–May 2019

Prepared by the Office of the Auditor General of Ontario

Line of Business	Vendor Name and IT System	# of Incidents	Resolution Time	Description	Risk	Impact
Casinos (Land-Based Gaming)	Avatar FINTRAC RTMS	680	Few hours to 23 days	Application unavailable to log in or save transactions. Error messages generated when users create a report for patron information.	Wrong patron information, incomplete reporting and anti-money laundering transactions not reported in a timely manner.	Inaccurate reporting, regulatory fines and system unavailability due to unresolved problems and incidents.
	Bally Gaming Management System (GMS)	3,000	Few hours to 600 days	Various issues with GMS and interfacing applications where the system does not sign up new patrons or search existing patrons on Casino Marketplace. Data from various casinos is not reconciled with the centralized data.	Application unavailability and inconsistent data reconciliation.	Negative customer experience and disruption to casino operations. Inconsistent data reconciliation for transactions and patron information resulting in inaccurate data reporting.
	IGT Casinolink and EZPay	3,000	Few hours to 95 days	Performance, capacity and availability controls are not adequately established and implemented. As a result, customers experience major delays in jackpot processing and ticket validation.	Inconsistent performance, capacity and availability with the system.	Negative customer experience and disruption to casino operations.
	NRT Cash Handling System for Automated Jackpot Dispensing Machines (AJM) and Customer Ticket Redemption (CTR)	2,900	Few hours to 7 days	AJM issues with processing jackpots. CTR bills jamming and cash dispense errors.	Inconsistent performance and availability with the system.	Negative customer experience and disruption to casino operations.
	Omnigo (iView) Facial Recognition System iTrak	1,500	Few hours to 200 days	Casinos not receiving facial recognition alerts.	Inability to prevent self-excluded patrons from entering casinos.	Litigation issues, revenue loss and public distrust.
Lottery	Plastic Mobile Lottery mobile application	290	Few hours to 34 days	Ticket checker failures.	Inability to check winning numbers.	Negative customer experience.

Chapter 4

Review of Government Advertising

Government Advertising Spend at Record Low

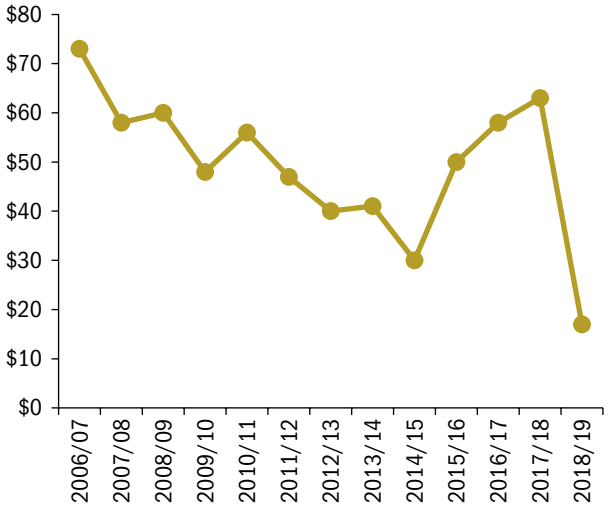
In the fiscal year ended March 31, 2019, the government spent the lowest amount on advertising since our Office began reviewing and approving government advertising in 2005. In the past year, our Office reviewed 614 advertisements in 77 submissions. The government spent $12.55 million producing and running these items. It also spent $3.84 million running digital advertising on social media and using search services that are exempt from our review. In total, the government spent $16.39 million on advertising for the 2018/19 fiscal year. See the **Appendix** for a breakdown of reviewable advertising costs by each government ministry.

This total is in sharp contrast to the previous fiscal year, when we reviewed 2,595 advertisements in 292 submissions, totalling $55.0 million. Another $7.60 million was spent on excluded digital advertising for an overall total of $62.60 million in the fiscal year ending March 31, 2018. See **Figure 1** for expenditure comparisons over the last 13 years since the original *Government Advertising Act* (Act) was proclaimed. It is worth noting that just over 30% of the expenditure in the 2016/17 and 2017/18 fiscal years were for advertisements we believe had as their primary objective to foster a positive impression of the governing party.

Last fiscal year (2018/19), for the first time since certain 2015 amendments to the Act came into effect, our Office would have passed every advertisement submitted by the government under the criteria we used to assess partisanship under the old Act.

Figure 1: Advertising Expenditures Since Proclamation of the Original *Government Advertising Act, 2004*, 2006/07–2018/19* ($ million)

Source of data: Office of the Auditor General/Advertising Review Board



* Yearly expenditures include all digital advertising costs, including social media.

The original *Government Advertising Act, 2004* (Act) which took effect in late 2005, required the government to submit advertisements to the Auditor General for review to ensure, among other things, that they were not partisan. Only advertisements that passed this review could run.

The original Act gave the Auditor General discretionary authority to determine what is partisan.

Under this system, although our Office took issue with a very small proportion of ads (less than 1%), we approved the overwhelming majority of the thousands of advertisements submitted to us. When significant amendments to the Act were introduced in 2015, we cautioned that these would weaken the Act and open the door to publicly funded partisan and self-congratulatory government advertisements on television and radio, in print and online.

The amendments imposed a specific and narrow definition of "partisan" as the only measure we can use in our reviews. Essentially, as long as the government avoids using the name or image of an elected official or the logo of a political party in an advertisement, the Auditor General cannot find it partisan under the Act. Our approval is still required under the amended Act before an advertisement can run. However, this approval is almost always automatic. The only other condition that must be met is the requirement for the ad to say it was paid for by the government of Ontario.

Advertising Activity during 2018/2019

The amendments made in 2015 to the *Government Advertising Act, 2004* stipulate that the government can no longer advertise as of the day when an election writ is issued. As well, changes made in 2016 to election financing rules placed further limits by prohibiting government advertising for the 60 days before the writ is issued. In the period leading up to the June 7, 2018, election, the government observed these new statutory requirements. However, these prohibitions do not apply to advertising that the government determines relates to a revenue-generating activity, is time-sensitive, or meets any other criteria that it may prescribe. Our Office reviewed and approved 33 submissions, consisting of 112 ads, which ran in the blackout period (March 10, 2018, to May 9, 2018) and/or the writ period (May 10, 2018, to June 7, 2018). Examples of submissions included international advertisements aimed at attracting investment to Ontario and notices about relocation of ServiceOntario offices. In contrast, during the same period the year before (March 10, 2017 to June 7, 2017), our Office reviewed 66 submissions, consisting of 407 ads. **Figure 2** shows the volume of advertising submitted over the past five fiscal years.

The period between election day and when a new government is officially sworn-in is one of preparing for the transition to a new government. In this case, very few submissions were made to our office between election day and swearing-in on June 29, 2018. As well, on June 18, 2018, the government- elect announced its expenditure management strategy which would freeze discretionary spending for ministries, including non-essential communications, such as advertising. In the following period, up to the end of the fiscal year, the government made only 53 advertising submissions to our Office.

The top five advertising campaign expenditures are listed in **Figure 3**. These campaigns accounted for almost 70% of the total reviewable expenditure on advertisements that our Office reviewed in the past fiscal year.

Digital Advertising on the Rise

Our authority to review digital advertising came into effect with other changes made to the Act in June 2015. This type of advertising includes video, text, images, or any combination of these that a government office proposes to pay to have

Figure 2: Volume and Value of Government Advertising Submitted for Auditor General Review

Source of data: Office of the Auditor General of Ontario

Fiscal Year	# of Submissions	# of Ads
2018/19	77	614
2017/18	292	2,595
2016/17	318	2,669
2015/16*	229	1,384
2014/15	182	653

* Digital advertising (except social and search services) was added as a reviewable medium under the *Government Advertising Act* in June 2015.

Figure 3: Top Five Campaigns for the 2018/19 Fiscal Year

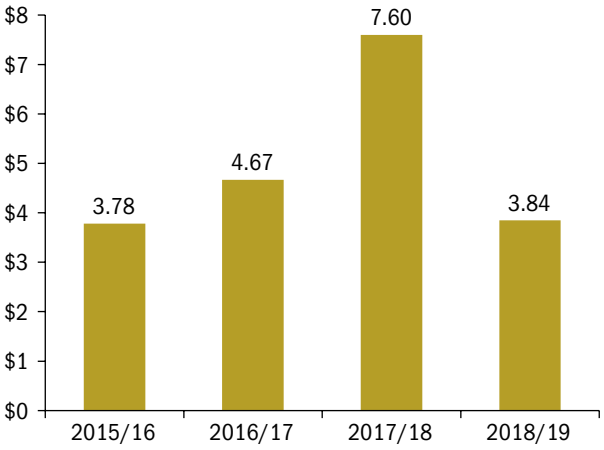
Source of data: Ontario government ministries

Topic	Ministry	Expenditure ($ million)
Ontario Cannabis Legalization	Attorney General	3.31
Prescription Painkillers	Health and Long-Term Care	1.68
Where Amazing Lives/Where the World is Going*	Economic Development, Job Creation and Trade	1.53
Foodland Ontario	Agriculture, Food and Rural Affairs	1.32
Flu Campaign	Health and Long-Term Care	0.82
Total		**8.66**

* This campaign was aimed at attracting international investment to Ontario. Due to its revenue-generating nature, it was able to run during the blackout periods for government advertising prior to the June 2018 election.

Figure 4: Government Spending on Digital Advertising Exempt from Auditor General Review ($ million)*

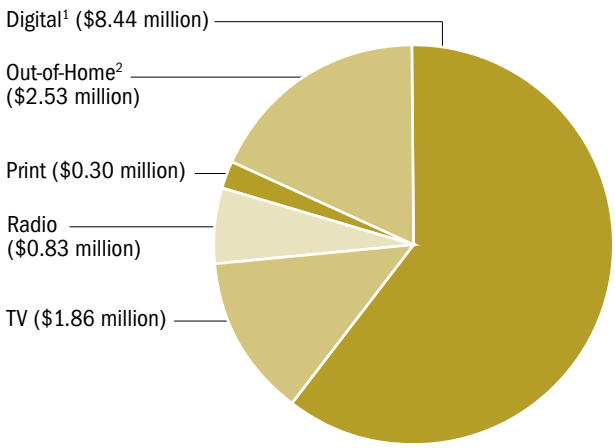
Source of data: Advertising Review Board



* Types of excluded digital advertising include those that appear on a social media website such as Facebook or Twitter, or are displayed on a website as a result of the government using a search-marketing service.

Figure 5: Advertising Expenditure by Medium, 2018/19

Source of data: Office of the Auditor General/Advertising Review Board



Note: Agency fees and production costs of $2.43 million are not included in this chart.

1. Includes costs of all digital advertising and search marketing services (including those types that are exempt from our review).
2. Includes billboards, transit posters, digital screens, etc.

displayed on a website. However, at the same time, a regulation came into force that limited which digital advertising we could review. Regulation 143/15 says that our Office can review digital ads displayed on a website "*other than* a social media website such as Facebook or Twitter" (emphasis added). As well, ads displayed as a result of the government using "a search-marketing service, such as Google AdWords," would not be subject to review.

In the 2018/19 fiscal year, the government spent $3.8 million on digital ads that were excluded from our review. This includes $2.9 million on social media websites and $940,000 on search services. See **Figure 4** for a comparison over the last four fiscal years. While this expenditure is about half of what it was last year, when combined with the cost of other digital ads submitted to our Office, it represents just over half of the government's total media buy last fiscal year, as shown in **Figure 5**.

As the use and importance of digital advertising becomes more important, it also becomes more important for our Office to be able to review all of the digital ads the government is paying for, without exception.

One Violation under Amended Act

Only one advertising submission was found in violation of the revised Act in the past year. Preliminary versions of eight Ministry of the Attorney General multilingual television ads violated Section 6(1)1 of the Act by failing to include a statement saying the ads were paid for by the government of Ontario. The items, part of a larger campaign called "Ontario Cannabis Legalization," were about laws around cannabis usage. The Ministry resubmitted amended versions that included the required statement, and we found them in compliance with the Act.

Campaigns We Took Issue With in 2019/20 Fiscal Year

We had concerns with three campaigns submitted to our Office in the current fiscal year. Under the previous version of the Act, these campaigns would not have passed our review. However, we had to find them in compliance with the revised legislation. When we issued our compliance opinions, we noted our reservations to the responsible ministry.

- **A campaign about the government's Environment Plan**. The Ministry of Environment, Conservation and Parks ran an estimated $4-million campaign named "One Little Nickel." This campaign, which included radio, digital and TV ads in 22 languages, was about Ontario's environmental plan. A campaign description, submitted with the advertisements, said that, "Ontarians need to understand that the Ontario government has a plan that will protect the environment, but not at the cost of making life unaffordable in Ontario." The "nickel" references related to paying a nickel more per litre of fuel, along with higher costs for heating and food because, as the voice-over in the TV ad tells viewers, the "Federal Government is charging you a carbon tax."

  We took the view that a primary objective of this campaign was to foster a negative impression of the federal government and its carbon pricing policy. We also believed that it aimed to foster a positive impression of the provincial governing party by saying that Ontario has a "better" plan for the environment.
- **A campaign about Ontario's debt and how the government will address it**. The Ministry of Finance submitted a campaign, called "Financial Literacy Public Education Campaign," which consisted of digital ads and videos. At an estimated cost of $1.4 million, the stated objective of the campaign was to educate Ontarians on Ontario's finances and debt, and how it affects them, as well as to build understanding around the government's plan to protect critical public services. Our Office concluded that the campaign's primary objective was to portray the government in a positive light. The use of music in the digital video—downbeat and concerning when referencing the debt, and upbeat when referencing how the government is "protecting what matters most"—is an example of this portrayal. As well, the ads offered no detail about how the government will address the debt, and sent viewers to a website for more information. We found the website provided only a few examples of early actions taken, and then predictions of results with no details about how they will be achieved.
- **A campaign about Ontario's public education system**. The Ministry of Education submitted English and French radio advertisements as part of a campaign called "Education for Tomorrow." These ads, which portray government changes to education as "improving" children's educational journey to "better prepare" them to "succeed every step of the way," would not have passed our review under the former version of the Act. We found these qualitative value judgments to be unsubstantiated and that led us to conclude that a primary objective of the ads

was to foster a positive impression of the governing party. We note that in a subsequent submission that included multi-ethnic radio ads, the Ministry made changes that addressed our comments, and we approved those ads without qualification.

Other Issues of Interest

Private Members' Bills Call for Reinstatement of Original GAA

In April 2019 a private members' bill was introduced called *End the Public Funding of Partisan Advertising Act, 2019* (Bill 101). This bill would have restored the Act to its pre-2015 version, including the discretionary authority of the Auditor General to determine partisanship. This bill was identical to one introduced in a preceding session of Parliament by another opposition member in March 2018. The earlier bill died on the Order Paper when the Legislature was dissolved. The current version, Bill 101, is currently referred to the Standing Committee on Finance and Economic Affairs for debate.

Overview of Our Compliance Function

What Falls under the Act

The Act applies to advertisements that government offices—specifically, government ministries, Cabinet Office and the Office of the Premier—propose to pay to have published in a newspaper or magazine, displayed on a billboard, displayed digitally in a prescribed form or manner, or broadcast on radio or television, or in a cinema. It also applies to printed matter that a government office proposes to pay to have distributed to households in Ontario by unaddressed bulk mail or another method of bulk delivery. Advertisements meeting any of these definitions are known as "reviewable" items and must be submitted to our Office for review and approval under the amended Act before they can run.

In addition, all proposed television and cinema commercials, along with bulk-distributed printed materials (householders) must be submitted in early versions for preliminary review in each language the government intends to run them. After receiving a preliminary approval, these proposed advertisements must be resubmitted to our Office in their final form for approval. (Under the old Act, preliminary reviews were voluntary, and were usually submitted in a single language. This was a more efficient process.)

The Act requires government offices to submit reviewable items to our Office. They cannot publish, display, broadcast, or distribute the submitted item until the head of that office (usually the deputy minister) receives notice, or is deemed to have received notice, that the advertisement has been found in compliance with legislation.

If our Office does not render a decision within the five business days set out in regulation, then the government office is deemed to have received notice that the item is in compliance with the Act, and may run it.

If our Office notifies the government office that the item is not in compliance with the Act, the item may not be used. However, the government office may submit a revised version of the rejected item for another review. Compliance approvals are valid for the life of the proposed media campaign.

The Act excludes from our review advertisements for specific government jobs (but not generic recruitment campaigns) and notices to the public required by law. Also exempt are advertisements on the provision of goods and services to a government office, and those regarding urgent matters affecting public health or safety.

The advertising done by government agencies is also exempt from the Act and thus our review. However, agencies' ads could be captured by the Act under a 2005 agreement with the government that gives us the authority to review third-party advertising if all three of the following criteria apply:

- a government office provided the third party with funds intended to pay part or all of the

cost of publishing, displaying, broadcasting or distributing the item;
- the government office approved the content of the item; and
- the government granted the third party permission to use the Ontario logo or another official provincial visual identifier in the item.

Revised Criteria for Proposed Advertisements

In conducting its review, the Auditor General's Office now only determines whether the proposed advertisement is in compliance with the amended Act. The following are the areas with which the advertisement must be in compliance:

1. It must include a statement that it is paid for by the government of Ontario.
2. It must not be partisan. The revised Act says an item is "partisan" only if it:
   - includes the name, voice or image of a member of the Executive Council or of a member of the Assembly (unless the item's primary target audience is located outside of Ontario);
   - includes the name or logo of a recognized party;
   - directly identifies and criticizes a recognized party or a member of the Assembly; and/or
   - includes, to a significant degree, a colour associated with the governing party.

We have no authority to consider any other factors, such as factual accuracy, context or tone, to determine whether an item is partisan.

Other Review Protocols

Since assuming responsibility for the review of government advertising in 2005, our Office has worked with the government to clarify procedures to cover areas where the Act is silent. In April 2019, our Office posted updated Government Advertising Review Guidelines. These Guidelines are intended to help government staff comply with the Act. They detail the submission, review and approval process, and reflect legal requirements, practices and conventions. The Guidelines can be found at **www.auditor.on.ca/en/content/adreview/adreview.html**.

What follows is a brief description of the significant areas that have required such clarification over the years.

Websites Used in Advertisements

Although government websites were not specifically reviewable in the original Act, we took the position that a website or similar linkage used in an advertisement is an extension of the advertisement. Following discussions, our Office came to an agreement with the government soon after the legislation was passed that the first page, or "click," of a website cited in a reviewable item would be included in our review.

We continue to consider the content only of the first click, unless it is a gateway page or lacks meaningful content, in which case we review the next page. We examine the page for any content that does not meet the standards of the amended Act. For example, the page must not include a minister's name or photo, or the name or logo of a recognized party.

Social Media Used in Advertisements

The government has significantly increased its presence on social-media platforms over the last decade. Our Office receives advertisements for approval that at times use icons leading the user to the government's presence on various social media, such as Facebook and Twitter.

Although the original Act was silent on the use of social media, we reached an agreement with the government in 2012 that we would perform an initial scan of any social-media page cited in an ad to ensure that the standards of the Act are being followed, in the same way we examine websites

referenced in ads. We recognize that content changes frequently and can be beyond the control of the government office, so our limited review focuses only on the content that the government office controls.

However, the government's social-media accounts and any content that its administrators post to it do not constitute reviewable advertising under the Act.

The Future of Our Office's Role in Government Advertising

Amendments to the Act in 2015 did away with our Office's discretionary authority to determine what constitutes partisan advertising. These amendments weakened the Act and paved the way for publicly paid partisan advertising by government. We will continue to identify those advertisements that would not have passed our review under the former version of the Act.

RECOMMENDATION 1

We recommend that the previous version of the *Government Advertising Act, 2004* as it appeared on June 3, 2015, be reinstated, while leaving in the amendment that added digital advertising as a reviewable medium.

TREASURY BOARD SECRETARIAT RESPONSE

The government continues to explore options for the review of government advertising.

The government reviews all advertising paid for by the province to ensure it is delivered in the most efficient and cost-effective manner, to maximize value for taxpayers.

Appendix: Expenditures for Reviewable Advertisements under the *Government Advertising Act, 2004*, April 1, 2018–March 31, 2019*

Source of data: Ontario government ministries

Ministry[1]	# of Submissions	# of Items	Agency Fees and Production Costs ($)	Media Costs ($)					Total ($)
				TV	Radio	Print	Digital	Out-of-Home[2]	
Agriculture, Food and Rural Affairs	2	41	92,826	724,118	507,159	–	–	–	**1,324,103**
Attorney General	9	106	416,800	1,055,604	–	2,259	190,428	1,652,420	**3,317,511**
Children, Community and Social Services	1	1	–	–	–	11,370	–	–	**11,370**
Economic Development, Job Creation and Trade	7	78	761,898	–	–	95,028	1,114,871	224,027	**2,195,824**
Finance	1	6	18,735	–	–	–	248,853	–	**267,588**
Government and Consumer Services	5	10	193	–	–	2,975	–	–	**3,168**
Health and Long-Term Care	24	204	564,403	–	137,620	18,334	2,606,503	661,042	**3,987,902**
Indigenous Affairs	2	2	167	–	–	528	–	–	**695**
Natural Resources and Forestry	4	54	–	80,153	20,817	37,312	–	–	**138,282**
Solicitor General	1	1	–	–	–	568	–	–	**568**
Tourism, Culture and Sport	19	78	494,209	–	49,097	128,405	429,597	–	**1,101,308**
Training, Colleges and Universities	2	33	80,800	–	119,130	–	–	–	**199,930**
Total	**77**	**614**	**2,430,031**	**1,859,875**	**833,823**	**296,779**	**4,590,252**	**2,537,489**	**12,548,249[3]**

* The *Auditor General Act* requires our Office to report annually on expenditures for advertising and printed matter reviewable under the *Government Advertising Act, 2004*. In order to verify completeness and accuracy, we may review selected payments and supporting documentation. We can also examine compliance relating to the sections of the Act dealing with submission requirements and use of ads during the Auditor General's review.

1. Ministry names as of June 29, 2018. The ministries of Education; Energy, Northern Development and Mines; Environment, Conservation and Parks; Francophone Affairs; Infrastructure; Labour; Municipal Affairs and Housing; Seniors and Accessibility; Transportation; and Treasury Board Secretatiat did not incur any advertising costs under the Act.
2. Includes billboards, transit posters, digital screens, etc. Media costs associated with cinema advertising are included in TV column.
3. An additional $3.84 million was spent on digital advertising and search services that were exempt from our review.

Chapter 5

Standing Committee on Public Accounts

Role of the Committee

The Standing Committee on Public Accounts (Committee) is empowered to review and report to the Legislative Assembly its observations, opinions and recommendations on reports from the Auditor General and on the Public Accounts. These reports are deemed to have been permanently referred to the Committee as they become available. The Committee examines, assesses and reports to the Legislative Assembly on a number of issues, including the economy and efficiency of government and broader-public-sector operations, and the effectiveness of government programs in achieving their objectives.

Under sections 16 and 17 of the *Auditor General Act*, the Committee may also request that the Auditor General examine any matter in respect of the Public Accounts or undertake a special assignment on its behalf.

The Committee typically holds hearings throughout the year when the Legislature is in session relating to matters raised in our Annual Report or in our special reports and may present its observations and recommendations to the Legislative Assembly.

Appointment and Composition of the Committee

Members of the Committee are typically appointed by a motion of the Legislature. The number of members from any given political party reflects that party's representation in the Legislative Assembly. All members except the Chair may vote on motions, while the Chair votes only to break a tie. The Committee is normally established for the duration of the Parliament, from the opening of its first session immediately following a general election to its dissolution.

In accordance with the Standing Orders of the Legislative Assembly and following the June 2018 election, Committee members were appointed on July 26, 2018. The Chair and prior Vice-Chair were elected on August 8, 2018, at the Committee's first meeting of the 42nd Parliament. There was a membership change on November 28, 2018, and on May 2, 2019, two new members were added. On October 28, 2019, a government motion replaced five members on the Committee. On October 31, 2019, one additional member was replaced. As of October 31 2019, the Committee membership was as follows:

- Catherine Fife, Chair, New Democrat (effective August 8, 2018)
- France Gélinas, Vice-Chair, New Democrat (effective October 30, 2019)

- Jill Andrew, New Democrat (appointed October 28, 2018)
- Toby Barrett, Progressive Conservative (appointed November 28, 2018)
- Stan Cho, Progressive Conservative (appointed October 28, 2019)
- Stephen Crawford, Progressive Conservative (appointed October 28, 2019)
- John Fraser, Liberal (appointed October 31, 2019)
- Goldie Ghamari, Progressive Conservative (appointed July 26, 2018)
- Norman Miller, Progressive Conservative (appointed July 26, 2018)
- Michael Parsa, Progressive Conservative (appointed July 26, 2018)
- Nina Tangri, Progressive Conservative (appointed October 28, 2019)

Auditor General's Advisory Role with the Committee

In accordance with Section 16 of the *Auditor General Act*, at the request of the Committee, the Auditor General, often accompanied by senior staff, attends Committee meetings to assist with its reviews and hearings relating to our Annual Report, Ontario's Public Accounts and any special reports issued by our Office.

Committee Procedures and Operations

The Committee meets weekly when the Legislative Assembly is sitting and, with the approval of the House, at any other times of its choosing. All meetings are generally open to the public except for those dealing with setting the Committee's agenda and the preparation of its reports. All public Committee proceedings are recorded in Hansard, the official substantially verbatim report of debates, speeches and other Legislative Assembly proceedings.

The Committee identifies matters of interest from our Annual Report and our special reports and conducts hearings on them. It typically reviews reports from the value-for-money chapter, the Public Accounts chapter, and follow-up chapters of our Annual Report. Normally, each of the political parties annually selects a minimum of three audits or other sections from our Annual Report for Committee review.

At each hearing, the Auditor General, senior staff from her Office and a Research Officer from the Legislative Research Service brief the Committee on the applicable section from our Report. A briefing package is prepared by the Research Officer that includes the responses of the relevant ministry, Crown agency or broader-public-sector organization that was the subject of the audit or review. The Committee typically requests senior officials from the auditee(s) to appear at the hearings and respond to the Committee's questions. Because our Annual Report deals with operational, administrative and financial rather than policy matters, ministers are rarely asked to attend as witnesses. Once the Committee's hearings are completed, the Research Officer may prepare a draft report pursuant to the Committee's instructions, as the Committee typically reports its findings to the Legislative Assembly.

In addition, the Clerk, at the direction of the Committee, may also request those auditees that were not selected for hearings to provide the Committee with an update of the actions taken to address our recommendations and other concerns raised in our reports.

Meetings Held

The Committee held 18 meetings between November 2018 and October 2019. Topics addressed at these meetings included settlement and integration

services for newcomers, the Darlington Nuclear Generating Station refurbishment project, Ontario Works, the Public Accounts of Ontario, the Fair Hydro Plan, the construction of the LRT by Metrolinx, government advertising, Public Health: chronic disease prevention, cancer treatment services and real estate services. Many of these meetings included hearings in which government and broader-public-sector witnesses were called to testify before the Committee and respond to questions regarding observations contained in our reports. Other meetings were spent on Committee business, writing the Committee's reports or hearing briefings from the Auditor General.

Reports of the Committee

The Committee issues reports on its work for tabling in the Legislative Assembly. These reports summarize the information gathered by the Committee during its meetings and include the Committee's comments and recommendations. Once tabled, all committee reports are publicly available through the Clerk of the Committee or online at **www.ola.org**, as well as on our website at **www.auditor.on.ca**.

Committee reports typically include recommendations and a request that management of the ministry, agency or broader-public-sector organization provide the Committee Clerk with responses within a stipulated time frame. As of October 31, 2019, the Committee had tabled three reports in the Legislature since we last reported on its activities in our *2018 Annual Report* (Volume 1, **Chapter 5**):

- February 19, 2019: Settlement and Integration Services for Newcomers
- October 28, 2019: Cancer Treatment Services
- October 28, 2019: Real Estate Services

These reports addressed audits from our *2017 Annual Report*. The writing of seven other reports is in progress.

In our Follow-Up Volume this year, we include follow-ups on the recommendations the Committee made in the final five reports that were tabled in 2018 (Immunization, Independent Electricity System Operator—Market Oversight and Cybersecurity, Metrolinx—Public Transit Construction Contract Awarding and Oversight, Public Accounts, and Government Advertising). In each of these sections, you will find:

- the recommendations contained in the Committee's report;
- the auditee's responses to the Committee's recommendations; and
- a table summarizing the status of each action from the Committee's recommendations (for example, fully implemented, or in the process of being implemented).

Special Reports

Two sections of the *Auditor General Act* authorize the Auditor General to undertake additional special work. Under Section 16, the Standing Committee on Public Accounts may resolve that the Auditor General must examine and report on any matter respecting the Public Accounts. Under Section 17, the Legislative Assembly, the Standing Committee on Public Accounts or a minister of the Crown may request that the Auditor General undertake a special assignment. However, these special assignments are not to take precedence over the Auditor General's other duties, and the Auditor General can decline such an assignment requested by a minister if he or she believes that it conflicts with other duties.

In recent years, our normal practice when we have received a special request has been to obtain the requester's agreement that the special report will be tabled in the Legislature on completion and made public at that time.

On March 21, 2018, the Committee passed a motion for our Office to conduct an audit of the Tarion Warranty Corporation. On October 24,

2018, the Committee passed a motion for our Office to "conduct an audit of the costs associated with illegal border crossers as it relates to all services provided through the government of Ontario and its municipalities for the three years ending July 31, 2018." Our special report on Tarion was tabled in the Legislature on October 30, 2019, and our work on the irregular boarder crossers remains ongoing.

Canadian Council of Public Accounts Committees

The Canadian Council of Public Accounts Committees (CCPAC) consists of delegates from federal, provincial and territorial public accounts committees across Canada. CCPAC holds a joint annual conference with the Canadian Council of Legislative Auditors to discuss issues of mutual interest.

The 40th annual conference was hosted in Niagara-on-the-Lake here in Ontario, from August 18 to 20, 2019. Next year, the 41st annual conference will be held in Victoria, British Columbia, from August 16 to 18, 2020.

Chapter 6

Office of the Auditor General of Ontario

The Office of the Auditor General of Ontario (Office) serves the Legislative Assembly and the citizens of Ontario by conducting value-for-money, financial, information technology, governance and special audits, reviews and investigations, and reporting on them. In so doing, the Office helps the Legislative Assembly hold the government, its administrators, government agencies and Crown-controlled corporations and grant recipients accountable for how prudently they spend public funds, and for the value they obtain for the money spent on behalf of Ontario taxpayers.

The work of the Office is performed under the authority of the *Auditor General Act*. In addition, under the amended *Government Advertising Act, 2004*, the Auditor General is responsible for reviewing and approving certain types of proposed government advertising for compliance with the amended *Government Advertising Act* (see **Chapter 4** for more details on the Office's advertising-review function). Also, in a year in which a regularly scheduled election is held, the Auditor General is required under the *Fiscal Transparency and Accountability Act, 2004* to review and deliver an opinion on the reasonableness of the government's pre-election report on its expectations for the financial performance of the province over the next three fiscal years.

All three Acts can be found at **www.e-laws.gov.on.ca**.

On April 1, 2019, the *Restoring Trust, Transparency and Accountability Act* was proclaimed. This Act transferred many of the responsibilities of the former Office of the Environmental Commissioner of Ontario to the Auditor General's Office. On July 8, 2019, the Auditor General appointed a Commissioner of the Environment who, as an employee of the Office, shall work as an Assistant Auditor General, reporting directly to the Auditor General. The Office will conduct audits of the environment under the same processes as the Office's value-for-money audits and now has additional reporting responsibilities with respect to compliance with the *Environmental Bill of Rights, 1993*. The Office is also able to report on energy conservation, greenhouse gas emissions reductions and any other environmental subjects that the Auditor General considers appropriate to conduct work on and report on to the Legislative Assembly.

General Overview

Value-for-Money Audits

More than two-thirds of the Office's work relates to value-for-money auditing, which assesses how well a given "auditee" (the entity that we audit) manages and administers its programs or activities. Value-for-money audits delve into the auditee's underlying operations to assess the level of service being delivered to the public and the relative cost-effectiveness of the service. The Office has the authority to conduct value-for-money audits of the following entities:

- Ontario government ministries;
- Crown agencies;
- Crown-controlled corporations; and
- organizations in the broader public sector that receive government grants (for example, agencies that provide mental-health services, children's aid societies, community colleges, hospitals, long-term-care homes, school boards and universities).

The *Auditor General Act* (Act) [in subclauses 12(2)(f)(iv) and (v)] identifies the criteria to be considered in a value-for-money audit:

- Money should be spent with due regard for economy.
- Money should be spent with due regard for efficiency.
- Appropriate procedures should be in place to measure and report on the effectiveness of programs.

The Act requires that the Auditor General report on any instances she may have observed where these three value-for-money criteria have not been met. More specific criteria that relate directly to the operations of the particular ministry, program or organization being audited are also developed for each value-for-money audit.

The Act also requires that the Auditor General report on instances where the following was observed:

- Accounts were not properly kept or public money was not fully accounted for.
- Essential records were not maintained or the rules and procedures applied were not sufficient to:
  - safeguard and control public property;
  - effectively check the assessment, collection and proper allocation of revenue; or
  - ensure that expenditures were made only as authorized.
- Money was expended for purposes other than the ones for which it was appropriated.

Assessing the extent to which the auditee complies with the requirement to protect against these risks is generally incorporated into both value-for-money audits and "attest" audits (discussed in a later section). Other compliance work that is also typically included in value-for-money audits includes determining whether the auditee adheres to key provisions in legislation and the authorities that govern the auditee or the auditee's programs and activities.

Government programs and activities are the result of government policy decisions. Thus, our value-for-money audits focus on how well management is administering and executing government policy decisions. It is important to note, however, that in doing so we do not comment on the merits of government policy. Rather, it is the Legislative Assembly that holds the government accountable for policy matters by continually monitoring and challenging government policies through questions during legislative sessions and through reviews of legislation and expenditure estimates.

In planning, performing and reporting on our value-for-money work, we follow the relevant professional standards established by the Chartered Professional Accountants of Canada. These standards require that we have processes for ensuring the quality, integrity and value of our work. Some of the processes we use are described in the following sections.

Selecting What to Audit

The Office audits significant ministry programs and activities, organizations in the broader public sector, Crown agencies and Crown-controlled corporations. Audits are selected using a risk-based approach. Since our mandate expanded in 2004 to allow us to examine organizations in the broader public sector, our audits have covered a wide range of topics in sectors such as health (hospitals, long-term-care homes, Community Care Access Centres, and mental-health service providers), education (school boards, universities and colleges), and social services (children's aid societies and social-service agencies), as well as several large Crown-controlled corporations.

In selecting what program, activity or organization to audit each year, we consider how great the risk is that an auditee is not meeting the three value-for-money criteria, plus environmental considerations, resulting in potential negative consequences for the public it serves. The factors we consider include the following:

- the impact of the program, activity or organization on the public;
- the total revenues or expenditures involved;
- the complexity and diversity of the auditee's operations;
- the results of previous audits and related follow-ups;
- recent significant changes in the auditee's operations;
- the impact of the program, activity or organization on the environment;
- the significance of the potential issues an audit might identify; and
- whether the benefits of conducting the audit justify its costs.

We also consider work that has been done by the auditee's internal auditors, and may rely on, or reference, that work in the conduct of our audit. Depending on what that work consists of, we may defer an audit or change our audit's scope to avoid duplication of effort. In cases where we do not reduce the scope of our audit, we still use and reference the results of internal audit work in our audit report.

Setting Audit Objectives, Audit Criteria and Assurance Levels

When we begin an audit, we set an objective for what the audit is to achieve. We then develop suitable audit criteria to evaluate the design and operating effectiveness of key systems, policies and procedures to address identified risks. Developing criteria involves extensive research on work done by recognized bodies of experts; other organizations or jurisdictions delivering similar programs and services; management's own policies and procedures; applicable criteria used in other audits; and applicable laws, regulations and other authorities.

To further ensure their suitability, the criteria we develop are discussed with the auditee's senior management at the planning stage of the audit.

The next step is to design and conduct tests so that we can reach a conclusion regarding our audit objective, and make relevant and meaningful observations and recommendations. Each audit report has a section titled "Audit Objective and Scope," in which the audit objective is stated and the scope of our work is explained. As required under our Act, we also report on circumstances where information was either difficult to obtain or not available for our review.

We plan our work to be able to obtain and provide assurance at an "audit level"—the highest reasonable level of assurance that we can obtain. Specifically, an audit level of assurance is obtained by interviewing management and analyzing information that management provides; examining and testing systems, procedures and transactions; confirming facts with independent sources; and, where necessary because we are examining a highly technical area, obtaining independent expert assistance and advice. We also use professional judgment in much of our work.

Standard audit procedures are designed to provide "a reasonable level of assurance" (rather than an "absolute level") that the audit will identify significant matters and material deviations. Certain factors make it difficult for audit tests to identify all deviations. For example, we may conclude that the auditee had a control system in place for a process or procedure that was working effectively to prevent a particular problem from occurring, but that auditee management or staff might be able to circumvent such control systems, so we cannot guarantee that the problem will never arise.

With respect to the information that management provides, under the Act we are entitled to access all relevant information and records necessary to perform our duties.

The Office can access virtually all information contained in Cabinet submissions or decisions that we deem necessary to fulfill our responsibilities under the Act. However, out of respect for the principle of Cabinet privilege, we do not seek access to the deliberations of Cabinet.

Infrequently, the Office will perform a review rather than an audit. A review provides a moderate level of assurance, obtained primarily through inquiries and discussions with management; analyses of information provided by management; and only limited examination and testing of systems, procedures and transactions. We perform reviews when:

- it would be prohibitively expensive or unnecessary to provide a higher level of assurance; or
- other factors relating to the nature of the program or activity make it more appropriate to conduct a review instead of an audit.

Communicating with Management

To help ensure the factual accuracy of our observations and conclusions, staff from our Office communicate with the auditee's senior management throughout the value-for-money audit or review. Early in the process, our staff meet with management to discuss the objective, criteria and focus of our work in general terms. During the audit or review, our staff meet with management to update them on our progress and ensure open lines of communication.

At the conclusion of on-site work, management is briefed on our preliminary results. A conditional draft report is then prepared and provided to and discussed with the auditee's senior management, who provide written responses to our recommendations. These are discussed and incorporated into the draft report, which the Auditor General finalizes with the deputy minister or head of the agency, corporation or grant-recipient organization, after which the report is published in **Chapter 3** of **Volume 1** of the Auditor General's Annual Report.

In compliance with CPA Canada Standards, letters of representation are signed by senior management confirming that they have provided and disclosed to our Office all relevant information pertaining to the audit.

Special Reports

As required by the Act, the Office reports on its audits in an Annual Report to the Legislative Assembly. In addition, under section 12(1), the Office may make a special report to the Legislature at any time, on any matter that, in the opinion of the Auditor General, should not be deferred until the Annual Report.

Two other sections of the Act authorize the Auditor General to undertake additional special work. Under section 16, the Standing Committee on Public Accounts may resolve that the Auditor General must examine and report on any matter respecting the Public Accounts. Under section 17, the Legislative Assembly, the Standing Committee on Public Accounts or a minister of the Crown may request that the Auditor General undertake a special assignment. However, these special assignments are not to take precedence over the Auditor General's other duties, and the Auditor General can decline such an assignment requested by a minister if he or she believes that it conflicts with other duties.

When we receive a special request under section 16 or 17, our normal practice is to obtain the requester's agreement that the special report will be tabled in the Legislature on completion and made public at that time.

On March 21, 2018, the Committee passed a motion for our Office to conduct an audit of Tarion Warranty Corporation. On October 24, 2018, the Committee also passed a motion for our Office to "conduct an audit of the costs associated with illegal border crossers as it relates to all services provided through the government of Ontario and its municipalities for the three years ending July 31, 2018." Our special report on Tarion was tabled in the Legislature on October 30, 2019. We are continuing to

work with the Ministry of Children, Community and Social Services—the Ministry designated to compile the costs associated with irregular border crossers incurred by the province and its municipalities—on the Committee's second motion.

Attest Audits

Attest audits are examinations of an auditee's financial statements. In such audits, the auditor expresses his or her opinion on whether the financial statements present information on the auditee's operations and financial position in a way that is fair and that complies with certain accounting policies (in most cases, with Canadian generally accepted accounting principles). Compliance audit work is also often incorporated into attest-audit work. Specifically, we assess the controls for managing risks relating to improperly kept accounts; unaccounted-for public money; lack of record keeping; inadequate safeguarding of public property; deficient procedures for assessing, collecting and properly allocating revenue; unauthorized expenditures; and not spending money on what it was intended for.

The Auditees

Every year, we audit the financial statements of the province and the accounts of many agencies of the Crown. Specifically, the Act [in subsections 9(1), (2), and (3)] requires that:

- the Auditor General audit the accounts and records of the receipt and disbursement of public money forming part of the province's Consolidated Revenue Fund, whether held in trust or otherwise;
- the Auditor General audit the financial statements of those agencies of the Crown that are not audited by another auditor;
- public accounting firms appointed as auditors of certain agencies of the Crown perform their audits under the direction of the Auditor General and report their results to the Auditor General; and
- public accounting firms auditing Crown-controlled corporations deliver to the Auditor General a copy of the audited financial statements of the corporation and a copy of the accounting firm's report of its findings and recommendations to management (typically contained in a management letter).

Chapter 2 discusses this year's attest audit of the province's consolidated financial statements.

We do not typically discuss the results of attest audits of agencies and Crown-controlled corporations in this report unless a significant issue arises and it would be appropriate for all Members of the Legislature to be aware of this issue. Agency legislation normally stipulates that the Auditor General's reporting responsibilities are to the agency's board and the minister(s) responsible for the agency. Our Office also provides copies of our independent auditors' reports and of the related agency financial statements to the deputy minister of the associated ministry, as well as to the Secretary of the Treasury Board.

We identify areas for improvement during the course of an attest audit of an agency and provide our recommendations to agency senior management in a draft report. We then discuss our recommendations with management and revise the report to reflect the results of our discussions. After the draft report is cleared and the agency's senior management have responded to it in writing, we prepare a final report, which is discussed with the agency's audit committee (if one exists). We bring significant matters to the attention of the Legislature by including them in our Annual Report.

Part 1 of **Exhibit 1** lists the agencies that were audited during the 2018/19 audit year. The Office contracts with public accounting firms to serve as our agents in auditing a number of these agencies. Part 2 of **Exhibit 1** and **Exhibit 2** list the agencies of the Crown and the Crown-controlled corporations, respectively, that were audited by public accounting firms during the 2018/19 audit year. **Exhibit 3** lists significant organizations in the broader public sector whose accounts are also audited by public

accounting firms and included in the province's consolidated financial statements.

Other Stipulations of the *Auditor General Act*

The *Auditor General Act* came about with the passage of the *Audit Statute Law Amendment Act* (Amendment Act) on November 22, 2004. The Amendment Act received royal assent on November 30, 2004. The purpose of the Amendment Act was to make certain changes to the Audit Act to enhance our ability to serve the Legislative Assembly. The most significant of these changes was the expansion of our Office's value-for-money audit mandate to organizations in the broader public sector that receive government grants.

In June 2015, the *Building Ontario Up Act* (Budget Measures), 2015 received royal assent. Schedule 3 amended section 13(1) of our Act, removing our ability to conduct value-for-money audits of Hydro One Inc. However, as per sections 13(2) and 13(3), Hydro One Inc. must still provide us with the information we need for our audit of the Public Accounts of Ontario. Section 13(4) states that Hydro One Inc. is not required to provide us with information relating to a period for which Hydro One Inc. has not yet publicly disclosed its financial statements.

In December 2018, the *Restoring Trust, Transparency and Accountability Act, 2018* received royal assent. Schedule 15 of the Act amended the *Environmental Bill of Rights, 1993* and transferred the duties associated with the position of the Environmental Commissioner to either the Environment Minister or the Auditor General. Schedule 15 also stated that the Auditor General shall appoint a Commissioner of the Environment who shall be an employee of the Office of the Auditor General, and shall exercise the powers and perform the duties delegated to him or her by the Auditor General under our Act. Sections 3, 27(1) and 27.1(1) of our Act were amended to include the Commissioner of the Environment as part of the Office of the Auditor General.

Schedule 15 also stated that the Auditor General shall report annually to the Speaker of the Assembly with regard to the operations of the *Environmental Bill of Rights Act, 1993* and the Speaker shall lay the report before the Assembly as soon as reasonably possible. The annual report may include a) a review of progress on activities to promote energy conservation; b) a review of progress on activities to reduce greenhouse gas emissions; and c) any other matter that the Auditor General considers appropriate. The approved report may in the Auditor General's discretion be included in the Auditor General's annual report prepared under Section 12 of the *Auditor General Act*.

Appointment of the Auditor General

Under our Act, the Auditor General is appointed as an Officer of the Legislative Assembly by an order of the Legislative Assembly. This means that the appointee must be approved by the Legislative Assembly. The order appointing the Auditor General shall be made only after a) unless decided otherwise by unanimous consent of the Assembly, the person to be appointed has been selected by unanimous agreement of a panel composed of one member of the Assembly from each recognized party, chaired by the Speaker who is a non-voting member; and b) the chair of the Standing Committee on Public Accounts of the Assembly has been consulted. The Chair of the Standing Committee on Public Accounts, under the Standing Orders of the Legislative Assembly, is a member of the official opposition (for more information about the Standing Committee on Public Accounts, see **Chapter 5**).

Independence

The Auditor General and staff of the Office are independent of the government and its administration. This independence is an essential safeguard that enables the Office to fulfill its auditing and reporting responsibilities objectively and fairly.

The Auditor General is appointed to a 10-year, non-renewable term, and can be dismissed only for cause by the Legislative Assembly. Consequently, the Auditor General maintains an arm's-length distance from the government and the political parties in the Legislative Assembly and is thus free to fulfill the Office's legislated mandate without political pressure.

The Board of Internal Economy, an all-party legislative committee that is independent of the government's administrative process, reviews and approves the Office's budget, which is subsequently laid before the Legislative Assembly. As required by the Act, the Office's expenditures in the 2018/19 fiscal year have been audited by a firm of chartered professional accountants, and the audited financial statements of the Office have been submitted to the Board and subsequently must be tabled in the Legislative Assembly. The audited statements and related discussion of expenditures for the year are presented at the end of this chapter.

Confidentiality of Working Papers

In the course of our reporting activities, we prepare draft audit reports and findings reports that are considered an integral part of our audit working papers. Under section 19 of the Act, these working papers shall not be laid before the Legislative Assembly or any of its committees. As well, our Office is exempt from the *Freedom of Information and Protection of Privacy Act* (FIPPA). This means that our draft reports and audit working papers, including all information obtained from an auditee during the course of an audit, are privileged, and cannot be accessed by anyone under FIPPA, thus further ensuring confidentiality.

Code of Professional Conduct

The Office has a Code of Professional Conduct to ensure that staff maintain high professional standards and keep up a professional work environment. The Code is intended to be a general statement of philosophy, principles and rules regarding conduct for employees of the Office. Our employees have a duty to conduct themselves in a professional manner, and to strive to achieve in their work the highest standards of behaviour, competence and integrity.

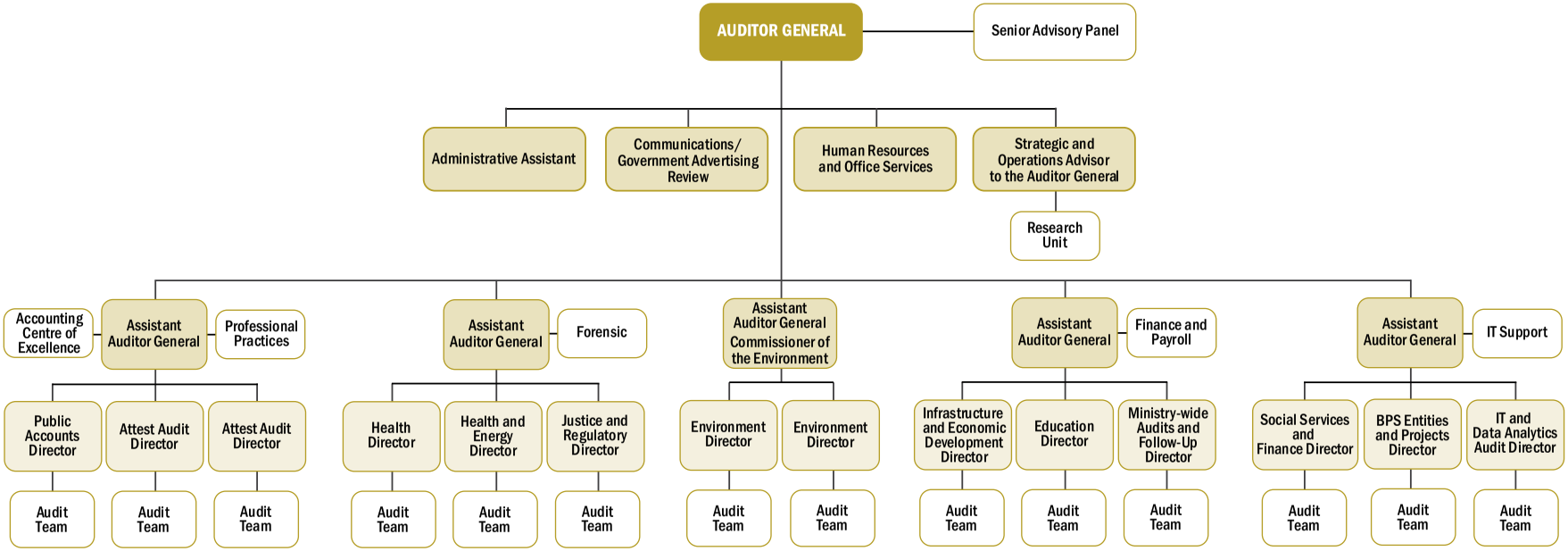
The Code explains why these expectations exist, and further describes the Office's responsibilities to the Legislative Assembly, the public and our auditees. The Code also provides guidance on disclosure requirements and the steps to be taken to avoid conflicts of interest. All employees are required to complete an annual conflict-of-interest declaration and undergo a police security check upon being hired and every five years thereafter.

Office Organization and Personnel

The Office is organized into portfolio teams to align with related audit entities and to foster expertise in the various areas of audit activity. The portfolios, somewhat based on the government's own ministry organization, are each headed by a Director, who oversees and is responsible for the audits within the assigned portfolio. Directors report to Assistant Auditors General, who report to the Auditor General. Reporting to the Directors and rounding out the teams are Audit Managers and various other audit staff, as illustrated in **Figure 1**.

The Auditor General and the Assistant Auditors General make up the Office's Executive Committee. The Auditor General, the Assistant Auditors General, the Audit Directors, the Director of Human Resources and Office Services, the Director of Communications and Government Advertising Review, and the Strategic and Operations Advisor to the Auditor General make up the Office's Senior Management Committee.

Figure 1: Office Organization, November 30, 2019



The Auditor General's Panel of Senior External Advisors

The Auditor General's Panel of Senior External Advisors (Panel) was established in early 2017 to provide strategic advice to the Auditor General on her Office's work. The Panel is governed by Terms of Reference that outline the Panel's mandate, objective, membership, scope of work, and other terms and conditions. The members of the Panel meet at least twice per year and may meet on other occasions when necessary. During 2019, the Panel met two times, reviewing material prior to those meetings.

The Panel comprises a broad cross-section of professionals and experts outside of the Office. Members are selected by the Auditor General based on their capacity to provide the Auditor General with the highest-quality advice in matters pertaining to the Panel's mandate. Members of the Panel are appointed for a term of three years and are eligible for reappointment at the discretion of the Auditor General. There are currently 11 members on the Panel:

- Tim Beauchamp, Former Director, Public Sector Accounting Board
- Deborah Deller, Former Clerk of the Legislative Assembly of Ontario
- Burkard Eberlein, Professor, Public Policy, York University (Schulich)
- Sheila Fraser, Former Auditor General of Canada
- Julie Gelfand, Former federal Commissioner of the Environment and Sustainable Development in the Office of the Auditor General of Canada
- Peter Mansbridge, Former Chief Correspondent for CBC News and Anchor of *The National*
- David Marshall, Former President, Workplace Safety and Insurance Board
- William Robson, President and CEO, C.D. Howe Institute
- Carmen Rossiter, Program Director, Centre for Governance, Risk Management and Control, York University (Schulich)
- Wayne Strelioff, Former Auditor General of British Columbia and Former Provincial Auditor of Saskatchewan
- Christopher Wirth, Lawyer, Keel Cottrelle LLP

Quality Assurance Review Process

Professional standards require that auditors establish and maintain a system of quality controls to help ensure that professional and legal standards are met and that audit reports are appropriate in the circumstances. Quality assurance reviews form an essential component of this system by providing a basis for determining whether quality control policies are appropriately designed and applied. The Office has implemented a system of internal quality assurance reviews and is also subject to external quality assurance reviews both by the Chartered Professional Accountants (CPA) of Ontario and by the Canadian Council of Legislative Auditors.

The internal quality assurance review process consists of reviews of completed audit files on a cyclical basis by individuals within the Office. Individuals chosen for this role are conversant with and have up-to-date knowledge of the application of professional accounting and assurance standards and have no other involvement with the audit. The selection of audit files for quality assurance review is based on criteria designed to provide the Office with reasonable confidence that professional standards and Office policies are being met. The selection criteria include, but are not limited to, the risk associated with the engagement (such as complexity or public sensitivity) and the results of previous quality assurances reviews.

In addition to internal file reviews, audit challenge teams are established for each value-for-money audit conducted and include the Auditor

General, all Assistant Auditors General, and a Director and Manager from a separate audit portfolio. They review and question audit teams' audit planning reports and final reports.

The Office is also subject to review by CPA Ontario, which conducts a triennial practice inspection of our Office to assess whether, as practitioners of public accounting, we are adhering to the professional standards set out in the *CPA Canada Handbook* and CPA Ontario's *Member's Handbook*. Practice inspection involves an assessment of the Office's quality controls and a review of a sample of completed audit files selected by CPA Ontario.

As well, through our participation in the Canadian Council of Legislative Auditors, our Office undergoes external quality assurance reviews on a regular basis. These reviews are conducted by experienced professional auditors from other jurisdictions across Canada. In addition to providing assurance that quality control systems are well designed and effective, this process also facilitates the sharing and exchange of information and experience, and encourages and supports continued development of auditing methodology, practices, and professional development.

Canadian Council of Legislative Auditors

The Canadian Council of Legislative Auditors (CCOLA) shares information and supports the continued development of auditing methodology, practices and professional development among legislative audit offices at the federal and provincial levels. Its membership consists of the federal Auditor General and Auditors General of each of the 10 Canadian provinces. Legislative auditors from outside of Canada can have either "Associate Member" status with full voting rights, or "Observer Member" status, which does not afford voting rights. The CCOLA currently has one associate member—the Auditor General of Bermuda, and one observer member—the Auditor General of the Cayman Islands.

This year, Ontario hosted the 40th annual meeting of the CCOLA in Niagara-on-the Lake from August 18 to 20, 2019. This annual conference is held jointly with the annual meeting of the Canadian Council of Public Accounts Committees (CCPAC). It brings together legislative auditors and members of the Standing Committees on Public Accounts from the federal government, provinces and territories, and provides an excellent opportunity for sharing ideas, exchanging information and learning about best practices for Standing Committees on Public Accounts in Canada. In 2020, the 41st annual conference will be hosted in Victoria, British Columbia, from August 16 to 18.

International Visitors

As an acknowledged leader in value-for-money auditing, the Office frequently receives requests to meet with visitors and delegations from abroad to discuss the roles and responsibilities of our Office, and to share our value-for-money and other audit experiences. During the last year, our Office hosted delegations from China, Guyana, Mongolia and Rwanda.

Results Produced by the Office This Year

This was another productive year for the Office. In total, while operating within our budget, we completed 17 value-for-money audits, three reports on the environment as part of the transfer of the responsibilities of the former Office of the Environmental Commissioner, one special report, 16 follow-ups on previous value-for-money reports, one follow-up on a previous special report, and five follow-ups on reports issued by the Standing

Committee on Public Accounts. We also expanded our tracking of the status of previous recommendations made by following up on the 1,306 actions we recommended in our annual reports of 2012, 2013, 2014, 2015 and 2016. The Audit Recommendations Follow-Up Team that did this work has put in place a system for ongoing follow-ups on our audit recommendations and those of the Standing Committee on Public Accounts.

As mentioned in the Attest Audits section earlier, we are responsible for auditing the province's consolidated financial statements (further discussed in **Chapter 2**), as well as the statements of more than 40 Crown agencies. We met all of our key financial statement audit deadlines while continuing to invest in training to ensure adherence to accounting and assurance standards and methodology for conducting attest audits.

We also met our review responsibilities under the *Government Advertising Act, 2004*, as further discussed in **Chapter 4** and met our responsibility under the *Environmental Bill of Rights* (EBR) through the issuance of our environment-focused report, which included prescribed ministries' compliance with the EBR.

The results produced by the Office this year would not have been possible without the hard work and dedication of our staff, as well as that of our agent auditors, contract staff and our Panel of Senior External Advisors.

Public Inquiries

The Office of the Auditor General receives inquiries from the public, Members of Provincial Parliament and the civil service through letter, fax, email and phone. Each inquiry is reviewed on a case-by-case basis and is logged to ensure that the information is recorded, and that we can track inquiries received and responses provided. The Office has one central intake of public inquiries. The Office conducts an annual overall review of public inquiries to assess actions taken and for consideration as part of the audit selection process. During the 2018/19 fiscal year, the Office received over 1,000 public inquiries.

Financial Accountability

The following discussion and our financial statements present the Office's financial results for the 2018/19 fiscal year. Our financial statements have been prepared in accordance with Canadian Public-Sector Accounting Standards. In accordance with these standards, we have presented a breakdown of our expenses by the main activities our Office is responsible for: value-for-money and special audits, financial-statement audits, pre-election report and the review of government advertising. This breakdown is provided in **Note 9** to the financial statements and indicates that 69% of our time was used to perform value-for-money and special audits, a stated priority of the Standing Committee on Public Accounts, and 28% to completing the audits of the annual financial statements of the province and over 40 of its agencies. The remaining time was devoted to the pre-election report and our statutory responsibilities under the *Government Advertising Act* and the *Fiscal Transparency and Accountability Act*.

Figure 2 provides a comparison of our approved budget and expenditures over the last five years. **Figure 3** presents the major components of our spending during the 2018/19 fiscal year, and shows that salary and benefit costs for staff accounted for 72% (70% in 2017/18), while professional and other services, along with rent, comprised most of the remainder. These proportions have been relatively stable in recent years. **Figure 4** presents the year-over-year percentage change of actual expenditures. Overall, our expenses increased by 3% in 2018/19 from the previous year.

In November 2018, the Board of Internal Economy of the Legislature approved our request to increase our staffing complement from 116 to 129. In April 2019, the Board also approved an increase

Figure 2: Five-Year Comparison of Spending (Accrual Basis) ($ 000)

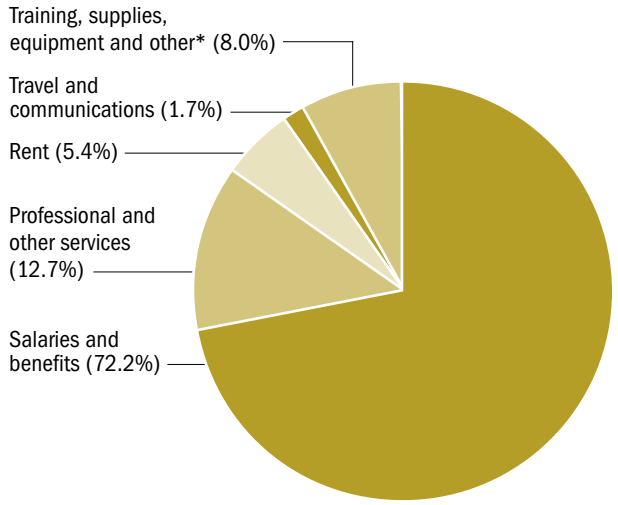
Prepared by the Office of the Auditor General of Ontario

	2014/15	2015/16	2016/17	2017/18	2018/19
Approved budget	**16,520**	**18,083**	**18,566**	**19,547**	**20,613**
Actual expenses					
Salaries and benefits	11,201	11,504	12,830	13,568	14,269
Professional and other services	2,352	2,268	2,538	2,683	2,510
Rent	1,008	1,059	1,090	1,097	1,080
Travel and communications	336	354	312	374	337
Training, supplies, equipment and other[1]	1,305	1,415	1,328	1,536	1,575
Total	**16,202**	**16,600**	**18,098**	**19,258**	**19,771**
Unused appropriations[2]	**160**	**974**	**42**	**32**	**612**

1. "Other" includes amortization and statutory expenses.
2. These amounts are typically slightly different than the excess of appropriation over expenses as a result of non-cash expenses (such as amortization of capital assets, deferred lease inducements and employee future benefit accruals).

Figure 3: Spending by Major Expenditure Category, 2018/19

Prepared by the Office of the Auditor General of Ontario



* "Other" includes amortization and statutory expenses.

Figure 4: Actual Expenses for 2018/19 and 2017/18 ($ 000)

Prepared by the Office of the Auditor General of Ontario

Actual Expenses	2018/19	2017/18	% Change
Salaries and benefits	14,269	13,568	5
Professional and other services	2,510	2,683	(6)
Rent	1,080	1,097	(2)
Travel and communications	337	374	(10)
Training, supplies, equipment and amortization	945	875	8
Statutory expenses	630	661	(5)
Total	**19,771**	**19,258**	**3**

in our staffing complement by 16 to enable us to hire staff from the former Office of the Environmental Commissioner and a new Assistant Auditor General, Commissioner of the Environment, which brought our approved complement to 145. As of March 31, 2020, we expect that we will be at full complement.

A more detailed discussion of the changes in our expenses and some of the challenges we face follows.

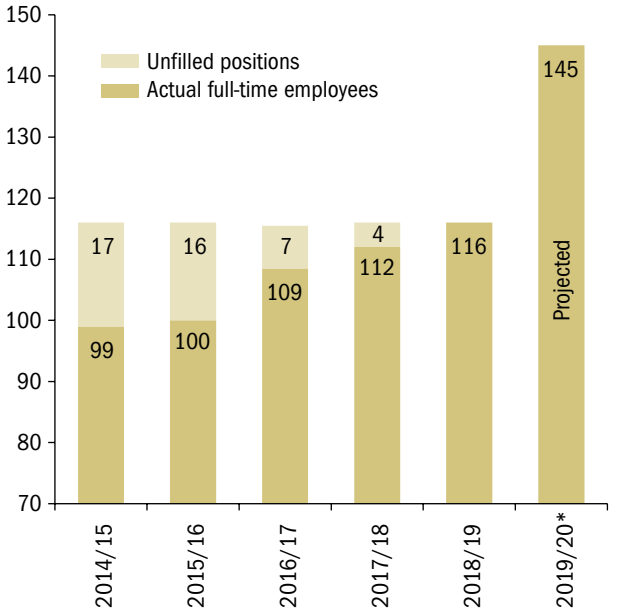
Salaries and Benefits

Our salary and benefit costs were 5% higher than in 2017/18. Salary increases were a result of the annualized cost of 2017/18 hires, promotions and implementing changes to staff compensation to align with increases to those working in the Ontario government. Benefit costs increased accordingly.

In 2018/19, our average full-time equivalents (FTEs) was 116 (112 in 2017/18), as shown in **Figure 5**. Most students who earned their professional

Figure 5: Staffing, 2014/15–2019/20

Prepared by the Office of the Auditor General of Ontario



* Includes staff from the transfer of responsibilities of the former Office of the Environmental Commissioner of Ontario.

accounting designation during the year remained with us and were promoted to Senior Auditor positions.

Staff turnover was low and, where experienced, was due mainly to the market for professional accountants remaining fairly robust. The growing complexity of our audits requires highly qualified, experienced staff.

Professional and Other Services

These services include both contracted CPA firms and contract specialists that assisted in our value-for-money audits, pre-election report and various projects. These services account for about 13% of total expenses and decreased by 6% compared to the previous year.

Given the more complex work and peak period deadlines for finalizing the financial statement audits of Crown agencies and the province, we continue to rely on contract professionals to assist us in meeting our legislated responsibilities. As such, we prudently engage contract staff when necessary to cover for special assignments and parental or unexpected leaves, as well as to help us manage peak workloads during the late spring and summer months.

Contract costs for the CPA firms with which we work remain high because of the higher salaries they pay their staff. We continue to competitively test the market for such services as contracts expire.

Rent

Our costs for accommodation decreased by 2% compared with last year, as 2017 year-end credit adjustments were applied for property taxes and utility costs billed under our 10-year lease.

Travel and Communications

Our travel and communications costs decreased by 10% as the audits selected required less travel compared with the prior year.

Training, Supplies and Equipment (Including Amortization)

Our training, supplies and equipment costs increased by 8% compared with the prior year due mainly to higher amortization expense as a result of past information technology expenditures.

The Office's training program enables staff to progress and meet their professional obligations to maintain and enhance their competencies. The program consists of a combination of in-house and external courses.

Statutory Expenses

These expenses include the Auditor General's salary and fees for contracted experts. Statutory expenses were 5% lower this year. Specialized accounting advisory services were required in 2017/18 for our special report on the Fair Hydro Plan, which we tabled in October 2017.

Financial Statements

MANAGEMENT'S RESPONSIBILITY FOR FINANCIAL STATEMENTS

The accompanying financial statements of the Office of the Auditor General of Ontario are the responsibility of management of the Office. Management has prepared the financial statements to comply with the *Auditor General Act* and with Canadian public sector accounting principles.

Management maintains a system of internal controls that provides reasonable assurance that transactions are appropriately authorized, assets are adequately safeguarded, appropriations are not exceeded, and the financial information contained in these financial statements is reliable and accurate.

The financial statements have been audited by the firm of Adams & Miles LLP, Chartered Professional Accountants. Their report to the Board of Internal Economy, stating the scope of their examination and opinion on the financial statements, appears on the following page.

Bonnie Lysyk, MBA, FCPA, FCA, LPA
Auditor General
September 25, 2019

Gus Chagani, CPA, CA
Assistant Auditor General
September 25, 2019

Adams & Miles LLP
Chartered Professional Accountants

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INDEPENDENT AUDITOR'S REPORT

To the Board of Internal Economy of
Legislative Assembly of Ontario

Opinion
We have audited the accompanying financial statements of The Office of the Auditor General of Ontario (the Office), which comprise the statement of financial position as at March 31, 2019, and the statement of operations and accumulated deficit, changes in net financial debt, and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

In our opinion, the financial statements present fairly, in all material respects, the financial position of The Office of the Auditor General of Ontario as at March 31, 2019, and the results of its financial performance and its cash flows for the year then ended in accordance with Canadian public sector accounting standards.

Basis for Opinion
We conducted our audit in accordance with Canadian generally accepted auditing standards. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are independent of the Office in accordance with the ethical requirements that are relevant to our audit of the financial statements in Canada, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of Management and Those Charged with Governance for the Financial Statements
Management is responsible for the preparation and fair presentation of the financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, management is responsible for assessing the Office's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Auditor General Act is repealed, the government intends to cease operations, or the government has no realistic alternative to do so.

Those charged with governance are responsible for overseeing the Office's financial reporting process.

INDEPENDENT AUDITOR'S REPORT – cont'd

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with Canadian generally accepted auditing standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements. As part of an audit in accordance with Canadian generally accepted auditing standards, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Office's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by management.
- Conclude on the appropriateness of management's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Office's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the Office to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.

We communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

Adams & Miles LLP

Chartered Professional Accountants
Licensed Public Accountants

Toronto, Canada
September 25, 2019

Adams & Miles LLP

Office of the Auditor General of Ontario

Statement of Financial Position
As at March 31, 2019

	2019 $	2018 $
Financial assets		
Cash	1,947,157	2,100,303
Harmonized sales taxes recoverable	194,295	176,167
	2,141,452	2,276,470
Financial liabilities		
Accounts payable and accrued liabilities [Notes 4 and 5(B)]	1,982,161	2,748,021
Accrued employee benefits obligation [Note 5(B)]	1,806,000	1,763,000
Due to Consolidated Revenue Fund	820,960	209,118
Deferred lease inducement (Note 10)	83,241	115,463
	4,692,362	4,835,602
Net financial debt	(2,550,910)	(2,559,132)
Non-financial assets		
Tangible capital assets (Note 3)	1,605,897	1,383,654
Accumulated deficit	(945,013)	(1,175,478)

Commitments (Note 6)
Measurement uncertainty [Note 2(F)]

See accompanying notes to financial statements.

Approved by the Office of the Auditor General of Ontario

Bonnie Lysyk, MBA, FCPA, FCA, LPA
Auditor General

Gus Chagani, CPA, CA
Assistant Auditor General

Office of the Auditor General of Ontario

Statement of Operations and Accumulated Deficit
For the Year Ended March 31, 2019

	2019 Budget (Note 12) $	2019 Actual $	2018 Actual $
Expenses			
Salaries and wages	12,721,100	11,781,407	10,735,203
Employee benefits (Note 5)	3,228,800	2,487,975	2,833,195
Professional and other services	2,033,300	2,510,123	2,683,033
Office rent	1,140,000	1,079,405	1,097,261
Amortization of tangible capital assets	—	636,037	566,467
Travel and communication	409,100	337,409	373,636
Training and development	124,000	139,300	123,168
Supplies and equipment	459,800	169,921	185,622
Statutory expenses: *Auditor General Act*	315,400	319,034	316,636
Government Advertising Act	10,000	—	—
Statutory services	171,700	310,282	343,794
Total expenses (Notes 8 and 9)	20,613,200	19,770,893	19,258,015
Revenue			
Consolidated Revenue Fund – Voted appropriations [Note 2(B)]	20,613,200	20,613,200	19,547,000
Excess of revenue over expenses		842,307	288,985
Less: returned to the Province [Notes 2(B) and 11]		611,842	31,528
Net operations surplus		230,465	257,457
Accumulated deficit, beginning of year		(1,175,478)	(1,432,935)
Accumulated deficit, end of year		(945,013)	(1,175,478)

See accompanying notes to financial statements.

Office of the Auditor General of Ontario

Statement of Changes in Net Financial Debt
For the Year Ended March 31, 2019

	2019 Budget (Note 12) $	2019 Actual $	2018 Actual $
Net operations surplus	-	230,465	257,457
Purchase of tangible capital assets	-	(858,280)	(621,342)
Amortization of tangible capital assets	-	636,037	566,467
Decrease in net financial debt	-	8,222	202,582
Net financial debt, beginning of year	(2,559,132)	(2,559,132)	(2,761,714)
Net financial debt, end of year	(2,559,132)	(2,550,910)	(2,559,132)

See accompanying notes to financial statements.

Office of the Auditor General of Ontario

Statement of Cash Flows
For the Year Ended March 31, 2019

	2019 $	2018 $
Operating transactions		
Net operations surplus	230,465	257,457
Amortization of tangible capital assets	636,037	566,467
Amortization of deferred lease inducement	(32,222)	(32,223)
Accrued employee benefits obligation [Note 5(B)]	24,000	4,000
	858,280	795,701
Changes in working capital		
Increase in harmonized sales taxes recoverable	(18,128)	(1,486)
Increase in due to Consolidated Revenue Fund	611,842	31,527
Increase (decrease) in accounts payable and accrued salaries (Note 4)	(746,860)	646,629
	(153,146)	676,670
Cash provided by operating transactions	705,134	1,472,371
Capital transactions		
Purchase of tangible capital assets	(858,280)	(621,342)
Increase (decrease) in cash	(153,146)	851,029
Cash, beginning of year	2,100,303	1,249,274
Cash, end of year	1,947,157	2,100,303

See accompanying notes to financial statements.

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

1. Nature of Operations

In accordance with the provisions of the *Auditor General Act* and various other statutes and authorities, the Auditor General, through the Office of the Auditor General of Ontario (the Office), conducts independent audits of government programs, of institutions in the broader public sector that receive government grants, and of the fairness of the financial statements of the Province and numerous agencies of the Crown. In doing so, the Office promotes accountability and value-for-money in government operations and in broader public sector organizations.

Additionally, under the *Government Advertising Act, 2004*, the Office is required to review specified types of advertising, printed matter or reviewable messages proposed by government offices to determine whether they meet the standards required by the Act.

Under both Acts, the Auditor General reports directly to the Legislative Assembly.

Under the *Fiscal Transparency and Accountability Act, 2004*, in an election year the Office is also required to report on the reasonableness of a Pre-Election Report prepared by the Ministry of Finance.

2. Summary of Significant Accounting Policies

The financial statements have been prepared in accordance with Canadian public sector accounting standards. The significant accounting policies are as follows:

(A) ACCRUAL BASIS

These financial statements are accounted for on an accrual basis whereby expenses are recognized in the fiscal year that the events giving rise to the expense occur and resources are consumed.

(B) VOTED APPROPRIATIONS

The Office is funded through annual voted appropriations from the Province of Ontario. Unspent appropriations are returned to the Province's Consolidated Revenue Fund each year. As the voted appropriation is prepared on a modified cash basis, an excess or deficiency of revenue over expenses arises from the application of accrual accounting, including the capitalization and amortization of capital assets, the deferral and amortization of the lease inducement and the recognition of employee benefits expenses earned to date but that will be funded from future appropriations.

The voted appropriation for statutory expenses is intended to cover the salary of the Auditor General as well as the costs of any expert advice or assistance required to help the Office meet its responsibilities under the *Government Advertising Act* and the *Fiscal Transparency and Accountability Act*, or to conduct special assignments under Section 17 of the *Auditor General Act*.

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

2. Summary of Significant Accounting Policies (Continued)

(C) TANGIBLE CAPITAL ASSETS

Tangible capital assets are recorded at historical cost less accumulated amortization. Amortization of tangible capital assets is recorded on the straight-line method over the estimated useful lives of the assets as follows:

Computer hardware	3 years
Computer software	3 years
Furniture and fixtures	5 years
Leasehold improvements	The remaining term of the lease

(D) FINANCIAL INSTRUMENTS

The Office's financial assets and financial liabilities are accounted for as follows:

- Cash is subject to an insignificant risk of change in value so carrying value approximates fair value.
- Due from Consolidated Revenue Fund is recorded at cost.
- Accounts payable and accrued liabilities are recorded at cost.
- Accrued employee benefits obligation is recorded at cost based on the entitlements earned by employees up to March 31, 2019. A fair value estimate based on actuarial assumptions about when these benefits will actually be paid has not been made as it is not expected that there would be a significant difference from the recorded amount.

It is management's opinion that the Office is not exposed to any interest rate, currency, liquidity or credit risk arising from its financial instruments due to their nature.

(E) DEFERRED LEASE INDUCEMENT

The deferred lease inducement is being amortized as a reduction of rent expense on a straight-line basis over the 10-year lease period that commenced November 1, 2011.

(F) MEASUREMENT UNCERTAINTY

The preparation of financial statements in accordance with Canadian public sector accounting standards requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements, and the reported amounts of revenue and expenses during the reporting period. Items requiring the use of significant estimates include: useful life of capital assets and accrued employee benefits obligation.

Estimates are based on the best information available at the time of preparation of the financial statements and are reviewed annually to reflect new information as it becomes available. Measurement uncertainty exists in these financial statements. Actual results could differ from these estimates. These estimates and assumptions are reviewed periodically, and adjustments are reported in the Statement of Operations and Accumulated Deficit in the year in which they become known.

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

3. Tangible Capital Assets

	Computer hardware $	Computer software $	Furniture and fixtures $	Leasehold improvements $	2019 Total $
Cost					
Balance, beginning of year	1,088,225	364,712	392,030	986,863	2,831,830
Additions	497,664	150,982	119,634	90,000	858,280
Write-off of fully amortized assets	(1,551)	(39,977)	(5,128)	-	(46,656)
Balance, end of year	1,584,338	475,717	506,536	1,076,863	3,643,454
Accumulated amortization					
Balance, beginning of year	543,709	168,346	202,986	533,135	1,448,176
Amortization	306,269	132,281	67,852	129,635	636,037
Write-off of fully amortized assets	(1,551)	(39,977)	(5,128)	-	(46,656)
Balance, end of year	848,427	260,650	265,710	662,770	2,037,557
Net Book Value, March 31, 2019	735,911	215,067	240,826	414,093	1,605,897

	Computer hardware $	Computer software $	Furniture and fixtures $	Leasehold improvements $	2018 Total $
Cost					
Balance, beginning of year	857,637	271,198	308,429	986,863	2,424,127
Additions	426,035	101,995	93,312	-	621,342
Write-off of fully amortized assets	(195,447)	(8,481)	(9,711)	-	(213,639)
Balance, end of year	1,088,225	364,712	392,030	986,863	2,831,830
Accumulated amortization					
Balance, beginning of year	468,793	78,919	144,136	403,500	1,095,348
Amortization	270,363	97,908	68,561	129,635	566,467
Write-off of fully amortized assets	(195,447)	(8,481)	(9,711)	-	(213,639)
Balance, end of year	543,709	168,346	202,986	533,135	1,448,176
Net Book Value, March 31, 2018	544,516	196,366	189,044	453,728	1,383,654

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

4. Accounts Payable and Accrued Liabilities

	2019 $	2018 $
Accounts payable	459,012	916,116
Accrued salaries and benefits	809,149	1,098,905
Accrued employee benefits obligation	714,000	733,000
	1,982,161	2,748,021

Accounts payable relates largely to normal business transactions with third-party vendors and is subject to standard commercial terms. Accruals for salaries and benefits and employee benefits obligation are recorded based on employment arrangements and legislated entitlements.

5. Obligation for Employee Future Benefits

Although the Office's employees are not members of the Ontario Public Service, under provisions in the *Auditor General Act*, the Office's employees are entitled to the same benefits as Ontario Public Service employees. The future liability for benefits earned by the Office's employees is included in the estimated liability for all provincial employees that have earned these benefits and is recognized in the Province's consolidated financial statements. In the Office's financial statements, these benefits are accounted for as follows:

(A) PENSION BENEFITS

The Office's employees participate in the Public Service Pension Fund (PSPF) which is a defined benefit pension plan for employees of the Province and many provincial agencies. The Province of Ontario, which is the sole sponsor of the PSPF, determines the Office's annual payments to the fund. As the sponsor is responsible for ensuring that the pension funds are financially viable, any surpluses or unfunded liabilities arising from statutory actuarial funding valuations are not assets or obligations of the Office. The Office's required annual payment of $1,008,433 (2018 - $881,061), is included in employee benefits expense in the Statement of Operations and Accumulated Deficit.

(B) ACCRUED EMPLOYEE BENEFITS OBLIGATION

The costs of legislated severance, compensated absences and unused vacation entitlements earned by employees during the year amounted to $70,000 (2018 –$601,000) and are included in employee benefits in the Statement of Operations and Accumulated Deficit. The total liability for these costs is reflected in the accrued employee benefits obligation, less any amounts payable within one year, which are included in accounts payable and accrued liabilities, as follows:

5. Obligation for Future Employee Benefits (Continued)

(B) ACCRUED EMPLOYEE BENEFITS OBLIGATION

	2019 $	2018 $
Total liability for severance and vacation credits	2,520,000	2,496,000
Less: Due within one year and included in accounts payable and accrued liabilities	714,000	733,000
Accrued employee benefits obligation	1,806,000	1,763,000

(C) OTHER NON-PENSION POST-EMPLOYMENT BENEFITS

The cost of other non-pension post-retirement benefits is determined and funded on an ongoing basis by the Ontario Ministry of Government Services and accordingly is not included in these financial statements.

6. Commitments

The Office has an operating lease to rent premises which expires on October 31, 2021. In August 2019, the Office extended its lease agreement to October 31, 2031. The minimum rental commitment for the next 5 years is as follows:

	$
2019/20	527,100
2020/21	534,600
2021/22	613,600
2022/23	724,200
2023/24	724,200

The Office is also committed to pay its proportionate share of realty taxes and operating expenses for the premises amounting to approximately $602,000 during 2019 (2018 - $632,000).

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

7. Public Sector Salary Disclosure Act, 1996

Section 3(5) of this Act requires disclosure of the salary and benefits paid to all Ontario public-sector employees earning an annual salary in excess of $100,000. This disclosure for the 2018 calendar year is as follows:

Name	Position	Salary $	Taxable Benefits $
Lysyk, Bonnie	Auditor General	320,077	20,747
Chagani, Gus	Assistant Auditor General	192,336	288
Chiu, Rudolph	Assistant Auditor General	192,336	288
Klein, Susan	Assistant Auditor General	192,336	288
Stavropoulos, Nick	Assistant Auditor General	178,090	266
Bell, Laura	Director	164,925	247
Blair, Jeremy	Director	133,707	196
Carello, Teresa	Director	141,402	211
Chadha, Kartik	Director	130,936	196
Chan, Ariane	Director	134,564	196
Chan, Sandy	Director	152,719	228
Cho, Kim	Director	152,719	228
Cumbo, Wendy	Director	141,402	211
Gotsis, Vanna	Director	164,925	247
Pelow, William	Director	145,228	217
Sin, Vivian	Director	141,402	211
Tsikritsis, Emanuel	Director	134,603	196
Yip, Gigi	Director	152,719	228
MacDonald, Cindy	Director, Human Resources and Office Services	152,719	228
Yosipovich, Rebecca	Director, Professional Practices	121,238	181
Bove, Tino	Audit Manager	130,610	189
Budihardjo, Audelyn	Audit Manager	128,135	184
Catarino, David	Audit Manager	111,608	167
Dimitrov, Dimitar	Audit Manager	106,798	160
Exaltacion, Katrina	Audit Manager	114,684	171
Gill, Rashmeet	Audit Manager	111,554	171
Herberg, Naomi	Audit Manager	128,594	194
Martino, Mary	Audit Manager	116,009	173
Muhammad, Shariq	Audit Manager	125,667	187
Parmar, Gurinder	Audit Manager	103,433	154
Rogers, Fraser	Audit Manager	124,471	186
Sarkar, Christine	Audit Manager	103,589	159
Shilton, Georgegiana	Audit Manager	124,294	178
Stonell, Alice	Audit Manager	114,684	171
Tso, Cynthia	Audit Manager	111,875	167
Wang, Jing	Audit Manager	113,101	169
Wong, Nancy	Audit Manager	108,145	161
Yarmolinsky, Michael	Audit Manager	113,101	169

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

7. Public Sector Salary Disclosure Act, 1996 (Continued)

Name	Position	Salary $	Taxable Benefits $
Young, Denise	Audit Manager	130,610	189
Gosse, Scott	Information Technology Manager	101,973	153
Krishnamurthy, Varkala	Manager, Financial Accounting and Reporting	137,741	207
Pedias, Christine	Manager, Corporate Communications and Government Advertising Review	130,610	189
Randoja, Tiina	Editorial and Communications Coordinator	123,013	179
Beben, Izabela	Audit Supervisor	120,124	178
Chatzidimos, Tom	Audit Supervisor	120,124	178
DeSouza, Marcia	Audit Supervisor	116,703	174
Liang Fletcher, Kandy	Audit Supervisor	103,666	155
Munroe, Roger	Audit Supervisor	110,289	165
Sidhu, Pasha	Audit Supervisor	120,690	179
Tepelenas, Ellen	Audit Supervisor	122,438	178
Thomas, Zachary	Audit Supervisor	103,666	155
Ulisse, Dora	Audit Supervisor	120,124	178
Wanchuk, Brian	Audit Supervisor	120,124	178

8. Reconciliation to Public Accounts Volume 1 Basis of Presentation

The Office's Statement of Expenses presented in Volume 1 of the Public Accounts of Ontario was prepared on a basis consistent with the accounting policies followed for the preparation of the Estimates submitted for approval to the Board of Internal Economy, under which purchases of computers and software are expensed in the year of acquisition rather than being capitalized and amortized over their useful lives. Volume 1 also excludes the accrued obligation for employee future benefits and deferred lease inducement recognized in these financial statements. A reconciliation of total expenses reported in Volume 1 to the total expenses reported in these financial statements is as follows:

	2019 $	2018 $
Total expenses per Public Accounts Volume 1	20,001,358	19,341,113
purchase of tangible capital assets	(858,280)	(621,342)
amortization of tangible capital assets	636,037	566,467
change in accrued employee benefits obligation	24,000	4,000
amortization of deferred lease inducement	(32,222)	(32,223)
	(230,465)	(83,098)
Total expenses per the Statement of Operations and Accumulated Deficit	19,770,893	19,258,015

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

9. Expenses by Activity

	2019				
	Salaries and benefits	Other operating expenses	Statutory expenses	Total	%
Value for money and special audits	10,487,996	2,778,813	465,464	13,732,273	69.4
Financial statement audits	3,467,460	2,029,035	52,644	5,549,139	28.1
Pre-Election Report	185,502	36,199	95,256	316,957	1.6
Government advertising	128,424	28,148	15,952	172,524	0.9
	14,269,382	4,872,195	629,316	19,770,893	100.0
%	72.2	24.6	3.2	100.0	

	2018				
	Salaries and benefits	Other operating Expenses	Statutory expenses	Total	%
Value for money and special audits	8,833,027	2,748,221	264,758	11,846,006	61.5
Financial statement audits	4,653,961	2,262,658	354,395	7,271,014	37.8
Pre-Election Report	13,568	2,719	25,445	41,732	0.2
Government advertising	67,842	15,589	15,832	99,263	0.5
	13,568,398	5,029,187	660,430	19,258,015	100.0
%	70.5	26.1	3.4	100.0	

Expenses have been allocated to the Office's four (2018 – four) main activities based primarily on the hours charged to each activity as recorded by staff in the Office's time accounting system, including administrative time and overhead costs that could not otherwise be identified with a specific activity. Expenses incurred for only one activity, such as most travel costs and professional services, are allocated to that activity based on actual billings.

10. Deferred Lease Inducement

As part of the lease arrangements for its office premises (Note 6), the Office negotiated a lease inducement of $322,225 to be applied to future accommodation costs. This deferred lease inducement is being amortized as a reduction of rent expense on a straight-line basis over the 10-year lease period that commenced November 1, 2011. The Office received payment for the lease inducement in 2015.

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

11. Unused Appropriations

	2019 $	2018 $
Consolidated Revenue Fund – Voted appropriations [Note 2(B)]	20,613,200	19,547,000
Less: Appropriations received from the Province	20,001,358	19,515,472
Unused Appropriations	611,842	31,528
Cash returned to the Province	611,842	205,887
Adjustment for deferred lease inducement	-	(174,359)
	611,842	31,528

12. Budgeted Figures

The budget as presented in the financial statements was prepared on the Public Accounts Volume 1 basis of accounting as described in Note 8. Following are the adjustments required to restate the budget using Canadian public sector accounting standards:

	$
Total expenses per the budget approved by the Board of Internal Economy	20,613,200
purchase of tangible capital assets	(205,000)
amortization of tangible capital assets	621,149
amortization of deferred lease inducement	(32,222)
	383,927
Total budgeted expenses restated using Canadian public sector accounting standards	20,997,127

Office of the Auditor General of Ontario

Notes to Financial Statements
For the Year Ended March 31, 2019

13. Subsequent Event

On April 1, 2019, Schedule 15 of the *Restoring Trust, Transparency and Accountability Act* (the "Act") was proclaimed. The Act amends the *Environmental Bill of Rights, 1993* to transfer some of the responsibilities of the former Office of the Environmental Commissioner of Ontario (ECO) to the Office. The Office's expanded responsibilities include reporting annually on the government's compliance with the Environmental Bill of Rights.

The Act also transfers the rights, obligations, assets and liabilities of the ECO, as they exist immediately before April 1, 2019 to the Office, except for any rights, obligations, assets or liabilities relating to former ECO employees for service immediately before April 1, 2019.

ECO has a lease agreement for its current premises expiring on February 28, 2023. The minimum lease payments over the remaining term of the lease is $610,200 plus the proportionate share of realty taxes and operating expenses. The lease payments are the responsibility of the Office as of April 1, 2019. The Office intends to sublet the premises on approximately the same terms and conditions as the head lease.

The office is assessing the financial impact of this legislated transfer on its financial statements for the year ended March 31, 2020.

Exhibit 1

Agencies of the Crown

1. Agencies and Offices of the Legislature whose accounts are audited by the Auditor General

Agricorp
Algonquin Forestry Authority
Cancer Care Ontario
Centennial Centre of Science and Technology (Ontario Science Centre)
Chief Electoral Officer, Election Act
Deposit Insurance Corporation of Ontario (Dec 31)[1]
Election Fees and Expenses, Election Finances Act
Financial Accountability Office of Ontario
Financial Services Commission of Ontario[2]
Financial Services Regulatory Authority of Ontario
Grain Financial Protection Board, Funds for Producers of Grain Corn, Soybeans, Wheat and Canola
Independent Electricity System Operator (Dec 31)[1]
Legal Aid Ontario
Liquor Control Board of Ontario
Livestock Financial Protection Board, Fund for Livestock Producers
Motor Vehicle Accident Claims Fund, Financial Services Commission of Ontario
Northern Ontario Heritage Fund Corporation
Office of the Assembly
Office of the Children's Lawyer
Office of the Environmental Commissioner[3]
Office of the French Language Services Commissioner[4]
Office of the Information and Privacy Commissioner
Office of the Ombudsman
Ontario Cannabis Retail Corporation
Ontario Clean Water Agency (Dec 31)[1]
Ontario Climate Change Solutions Deployment Corporation (Green Ontario Fund)
Ontario Educational Communications Authority (TVO)
Ontario Electricity Financial Corporation
Ontario Energy Board
Ontario Financing Authority
Ontario Food Terminal Board
Ontario Heritage Trust
Ontario Immigrant Investor Corporation
Ontario Media Development Corporation
Ontario Mortgage and Housing Corporation
Ontario Northland Transportation Commission
Ontario Place Corporation (Dec 31)[1]
Ontario Securities Commission
Pension Benefits Guarantee Fund, Financial Services Commission of Ontario
Province of Ontario Council for the Arts (Ontario Arts Council)
Provincial Advocate for Children and Youth[4]
Provincial Judges Pension Fund, Provincial Judges Pension Board
Public Guardian and Trustee for the Province of Ontario

2. Agencies whose accounts are audited by another auditor under the direction of the Auditor General

Niagara Parks Commission
St. Lawrence Parks Commission
Workplace Safety and Insurance Board (Dec 31)[1]

1. Dates in parentheses indicate fiscal years ending on a date other than March 31.
2. Operating under the Financial Services Regulatory Authority of Ontario as of June 8, 2019.
3. Became part of the Office of the Auditor General as of April 1, 2019.
4. Became part of the Office of the Ombudsman as of May 1, 2019.

Exhibit 2

Crown-Controlled Corporations

Corporations whose accounts are audited by an auditor other than the Auditor General, with full access by the Auditor General to audit reports, working papers and other related documents as required

Alcohol and Gaming Commission of Ontario
Agricultural Research Institute of Ontario
Central East Local Health Integration Network
Central Local Health Integration Network
Central West Local Health Integration Network
Champlain Local Health Intgration Network
Education Quality and Accountability Office
eHealth Ontario
Erie St. Clair Local Health Integration Network
Forest Renewal Trust
General Real Estate Portfolio
Hamilton Niagara Haldimand Brant Local Health Integration Network
HealthForceOntario Marketing and Recruitment Agency
Health Shared Services Ontario (HSSOntario)
Higher Education Quality Council of Ontario
Human Rights Legal Support Centre
Hydro One Inc. (Dec 31)*
Investment Management Corporation of Ontario (Dec 31)*
McMichael Canadian Art Collection
Metrolinx
Metropolitan Toronto Convention Centre Corporation
Mississauga Halton Local Health Integration Network
Municipal Property Assessment Corporation
North East Local Health Integration Network
North Simcoe Muskoka Local Health Integration Network
North West Local Health Integration Network
Ontario Capital Growth Corporation
Ontario College of Trades
Ontario French-language Educational Communications Authority (TFO)
Ontario Health Quality Council
Ontario Infrastructure and Lands Corporation (Infrastructure Ontario)
Ontario Lottery and Gaming Corporation
Ontario Pension Board (Dec 31)*
Ontario Power Generation Inc. (Dec 31)*
Ontario Tourism Marketing Partnership Corporation
Ontario Trillium Foundation
Ottawa Convention Centre Corporation
Owen Sound Transportation Company Limited
Ontario Agency for Health Protection and Promotion (Public Health Ontario)
Royal Ontario Museum
Science North
South East Local Health Integration Network
South West Local Health Integration Network
Toronto Central Local Health Integration Network
Toronto Islands Residential Community Trust Corporation
Toronto Waterfront Revitalization Corporation (Waterfront Toronto)
Trillium Gift of Life Network
Walkerton Clean Water Centre
Waterloo Wellington Local Health Integration Network
Waterfront Regeneration Trust Agency

* Dates in parentheses indicate fiscal years ending on a date other than March 31.

Exhibit 3

Organizations in the Broader Public Sector

Broader-public-sector organizations whose accounts are audited by an auditor other than the Auditor General, with full access by the Auditor General to audit reports, working papers and other related documents as required[1]

PUBLIC HOSPITALS (MINISTRY OF HEALTH AND LONG-TERM CARE)

Alexandra Hospital Ingersoll
Alexandra Marine & General Hospital
Almonte General Hospital
Anson General Hospital
Arnprior Regional Health
Atikokan General Hospital
Baycrest Centre for Geriatric Care
Bingham Memorial Hospital
Bluewater Health
Brant Community Healthcare System
Brockville General Hospital
Bruyère Continuing Care Inc.
Cambridge Memorial Hospital
Campbellford Memorial Hospital
Carleton Place and District Memorial Hospital
Casey House Hospice
Chatham-Kent Health Alliance
Children's Hospital of Eastern Ontario—Ottawa Children's Treatment Centre
Clinton Public Hospital
Collingwood General and Marine Hospital
Cornwall Community Hospital
Deep River and District Hospital Corporation
Dryden Regional Health Centre
Englehart and District Hospital Inc.
Erie Shores Healthcare
Espanola Regional Hospital and Health Centre
Four Counties Health Services
Georgian Bay General Hospital
Geraldton District Hospital
Grand River Hospital
Grey Bruce Health Services
Groves Memorial Community Hospital
Guelph General Hospital
Haldimand War Memorial Hospital
Haliburton Highlands Health Services Corporation
Halton Healthcare Services Corporation
Hamilton Health Sciences Corporation
Hanover and District Hospital
Headwaters Health Care Centre
Health Sciences North
Holland Bloorview Kids Rehabilitation Hospital
Hôpital Général de Hawkesbury and District General Hospital Inc.
Hôpital Glengarry Memorial Hospital
Hôpital Montfort
Hôpital Notre Dame Hospital (Hearst)
Hornepayne Community Hospital
Hospital for Sick Children
Hôtel-Dieu Grace Healthcare
Hôtel-Dieu Hospital, Cornwall
Humber River Regional Hospital
Joseph Brant Hospital
Kemptville District Hospital
Kingston Health Sciences Centre
Kirkland and District Hospital

1. This exhibit only includes the more financially signficiant organizations in the broader public sector.

Lady Dunn Health Centre
Lady Minto Hospital, Cochrane
Lake of the Woods District Hospital
Lakeridge Health
Lennox and Addington County General Hospital
Listowel Memorial Hospital
London Health Sciences Centre
Mackenzie Health
Manitoulin Health Centre
Markham Stouffville Hospital
Mattawa General Hospital
Muskoka Algonquin Healthcare
Niagara Health System
Nipigon District Memorial Hospital
Norfolk General Hospital
North Bay Regional Health Centre
North Shore Health Network
North of Superior Healthcare Group
North Wellington Health Care Corporation
North York General Hospital
Northumberland Hills Hospital
Orillia Soldiers' Memorial Hospital
Ottawa Hospital
Pembroke Regional Hospital Inc.
Perth and Smiths Falls District Hospital
Peterborough Regional Health Centre
Providence Care Centre (Kingston)
Queensway-Carleton Hospital
Quinte Healthcare Corporation
Red Lake Margaret Cochenour Memorial Hospital Corporation
Religious Hospitallers of St. Joseph of the Hotel Dieu of St. Catharines
Renfrew Victoria Hospital
Riverside Health Care Facilities Inc.
Ross Memorial Hospital
Royal Victoria Regional Health Centre
Runnymede Healthcare Centre
Salvation Army Toronto Grace Health Centre
Santé Manitouwadge Health
Sault Area Hospital
Scarborough Health Network
Seaforth Community Hospital
Sensenbrenner Hospital
Services de santé de Chapleau Health Services
Sinai Health System
Sioux Lookout Meno-Ya-Win Health Centre
Smooth Rock Falls Hospital
South Bruce Grey Health Centre
South Huron Hospital Association
Southlake Regional Health Centre
St. Francis Memorial Hospital
St. Joseph's Care Group
St. Joseph's Continuing Care Centre of Sudbury
St. Joseph's General Hospital, Elliot Lake
St. Joseph's Health Care, London
St. Joseph's Health Centre (Guelph)
St. Joseph's Healthcare Hamilton
St. Mary's General Hospital
St. Marys Memorial Hospital
St. Thomas-Elgin General Hospital
Stevenson Memorial Hospital
Stratford General Hospital
Strathroy Middlesex General Hospital
Sunnybrook Health Sciences Centre
Temiskaming Hospital
Thunder Bay Regional Health Sciences Centre
Tillsonburg District Memorial Hospital
Timmins and District Hospital
Toronto East Health Network
Trillium Health Partners
Unity Health Network[2]
University Health Network
University of Ottawa Heart Institute
Weeneebayko Area Health Authority
West Haldimand General Hospital
West Nipissing General Hospital
West Park Healthcare Centre
West Parry Sound Health Centre
William Osler Health System
Winchester District Memorial Hospital
Windsor Regional Hospital
Wingham and District Hospital
Women's College Hospital
Woodstock General Hospital Trust

2. Providence Healthcare, St. Joseph's Health Centre (Toronto) and St. Michael's Hospital formed Unity Health Network on August 1, 2017.

SPECIALTY PSYCHIATRIC HOSPITALS (MINISTRY OF HEALTH AND LONG-TERM CARE)

Centre for Addiction and Mental Health
Ontario Shores Centre for Mental Health Sciences
Royal Ottawa Health Care Group
Waypoint Centre for Mental Health Care

CHILDREN'S AID SOCIETIES (MINISTRY OF CHILDREN AND YOUTH SERVICES)

Bruce Grey Child and Family Services
Catholic Children's Aid Society of Hamilton
Catholic Children's Aid Society Toronto
Chatham-Kent Children's Services
Children and Family Services for York Region
Children's Aid Society of Algoma
Children's Aid Society of Hamilton
Children's Aid Society of London and Middlesex
Children's Aid Society of Ottawa
Children's Aid Society of Oxford County
Children's Aid Society of the City of Sarnia and the County of Lambton
Children's Aid Society of the District of Nipissing and Parry Sound
Children's Aid Society of the District of Sudbury-Manitoulin
Children's Aid Society of the Region of Peel
Children's Aid Society of the Regional Municipality of Halton
Children's Aid Society of the United Counties of Stormont-Dundas-Glengarry
Children's Aid Society of Thunder Bay
Children's Aid Society of Toronto
Draagdawenmag Binnoojiiyag Child and Family Services
Dufferin Child and Family Services
Durham Children's Aid Society
Family and Children's Services of St Thomas and Elgin
Family and Children's Services of Frontenac Lennox and Addington
Family and Children's Services of Guelph and Wellington
Family and Children's Services of Lanark Leeds and Grenville
Family And Children's Services of Renfrew County
Family and Children's Services of the Waterloo Region
Highland Shores Children's Aid Society
Huron-Perth Children's Aid Society
Jewish Family and Child Service of Greater Toronto
Kawartha-Haliburton Children's Aid Society
Kenora-Rainy River Districts Child and Family Services
North Eastern Ontario Family and Children's Services
Simcoe Muskoka Child, Youth and Family Services
The Children's Aid Society of Brant
The Children's Aid Society of Haldimand and Norfolk
The Children's Aid Society of the Niagara Region
Valoris Pour Enfants Et Adultes De Prescott-Russell/Valoris for Children and Adults of Prescott-Russell
Windsor-Essex Children's Aid Society
Akwesasne Child and Family Services
Anishinaabe Abinoojii Family Services
Dilico Anishinabek Family Care
Kina Gbezhgomi Child and Family Services
Kunuwanimano Child and Family Services
Native Child And Family Services of Toronto
Nogdawindamin Family and Community Services
Payukotayno James and Hudson Bay Family Services
Six Nations of the Grand River
Tikinagan Child and Family Services
Weechi-it-te-Win Family Services

SCHOOL BOARDS (MINISTRY OF EDUCATION)

Algoma District School Board
Algonquin and Lakeshore Catholic District School Board
Avon Maitland District School Board
Bloorview MacMillan School Authority
Bluewater District School Board

Brant Haldimand Norfolk Catholic District School Board
Bruce-Grey Catholic District School Board
Campbell Children's School Authority
Catholic District School Board of Eastern Ontario
Conseil des écoles publiques de l'Est de l'Ontario
Conseil scolaire catholique MonAvenir
Conseil scolaire catholique Providence
Conseil scolaire de district catholique de l'Est ontarien
Conseil scolaire de district catholique des Aurores boréales
Conseil scolaire de district catholique des Grandes Rivières
Conseil scolaire de district catholique du Centre-Est de l'Ontario
Conseil scolaire de district catholique du Nouvel-Ontario
Conseil scolaire de district catholique Franco-Nord
Conseil scolaire de district du Nord-Est de l'Ontario
Conseil scolaire public du Grand Nord de l'Ontario
Conseil scolaire Viamonde
District School Board of Niagara
District School Board Ontario North East
Dufferin-Peel Catholic District School Board
Durham Catholic District School Board
Durham District School Board
Grand Erie District School Board
Greater Essex County District School Board
Halton Catholic District School Board
Halton District School Board
Hamilton-Wentworth Catholic District School Board
Hamilton-Wentworth District School Board
Hastings and Prince Edward District School Board
Huron-Perth Catholic District School Board
Huron-Superior Catholic District School Board
James Bay Lowlands Secondary School Board
John McGivney Children's Centre School Authority
Kawartha Pine Ridge District School Board
Keewatin-Patricia District School Board
Kenora Catholic District School Board
KidsAbility School Authority
Lakehead District School Board
Lambton Kent District School Board
Limestone District School Board
London District Catholic School Board
Moose Factory Island District School Area Board
Moosonee District School Area Board
Near North District School Board
Niagara Catholic District School Board
Niagara Peninsula Children's Centre School Authority
Nipissing-Parry Sound Catholic District School Board
Northeastern Catholic District School Board
Northwest Catholic District School Board
Ottawa Catholic District School Board
Ottawa-Carleton District School Board
Peel District School Board
Penetanguishene Protestant Separate School Board
Peterborough Victoria Northumberland and Clarington Catholic District School Board
Rainbow District School Board
Rainy River District School Board
Renfrew County Catholic District School Board
Renfrew County District School Board
Simcoe County District School Board
Simcoe Muskoka Catholic District School Board
St. Clair Catholic District School Board
Sudbury Catholic District School Board
Superior North Catholic District School Board
Superior-Greenstone District School Board
Thames Valley District School Board
Thunder Bay Catholic District School Board
Toronto Catholic District School Board
Toronto District School Board
Trillium Lakelands District School Board
Upper Canada District School Board
Upper Grand District School Board
Waterloo Catholic District School Board
Waterloo Region District School Board
Wellington Catholic District School Board
Windsor-Essex Catholic District School Board
York Catholic District School Board
York Region District School Board

COLLEGES (MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES)

Algonquin College of Applied Arts and Technology
Cambrian College of Applied Arts and Technology
Canadore College of Applied Arts and Technology
Centennial College of Applied Arts and Technology
Collège Boréal d'arts appliqués et de technologie
Collège d'arts appliqués et de technologie La Cité collégiale
Conestoga College Institute of Technology and Advanced Learning
Confederation College of Applied Arts and Technology
Durham College of Applied Arts and Technology
Fanshawe College of Applied Arts and Technology
George Brown College of Applied Arts and Technology
Georgian College of Applied Arts and Technology
Humber College Institute of Technology and Advanced Learning
Lambton College of Applied Arts and Technology
Loyalist College of Applied Arts and Technology
Mohawk College of Applied Arts and Technology
Niagara College of Applied Arts and Technology
Northern College of Applied Arts and Technology
Sault College of Applied Arts and Technology
Seneca College of Applied Arts and Technology
Sheridan College Institute of Technology and Advanced Learning
Sir Sandford Fleming College of Applied Arts and Technology
St. Clair College of Applied Arts and Technology
St. Lawrence College of Applied Arts and Technology

Exhibit 4

Treasury Board Orders

Under subsection 12(2)(e) of the *Auditor General Act*, the Auditor General is required to annually report all orders of the Treasury Board made to authorize payments in excess of appropriations, stating the date of each order, the amount authorized and the amount expended. These are outlined in the following table. Although ministries may track expenditures related to these orders in more detail by creating accounts at the sub-vote and item level, this schedule summarizes such expenditures at the vote and item level.

Ministry	Date of Order	Authorized ($)	Expended ($)
Accessibility Directorate of Ontario	Mar 19, 2019	400,000	304,978
		400,000	**304,978**
Advanced Education and Skills Development	Dec 11, 2018	500,000	500,000
	Dec 11, 2018	208,000,000	140,189,289
	Jan 14, 2019	49,000,000	–
	Mar 19, 2019	20,137,800	2,032,784
	Mar 19, 2019	50,149,600	–
	Apr 11, 2019	6,109,200	–
		333,896,600	**142,722,073**
Agriculture, Food and Rural Affairs	Mar 5, 2019	2,200,000	2,200,000
	Apr 11, 2019	6,640,800	37,265
		8,840,800	**2,237,265**
Attorney General	Dec 11, 2018	3,000,000	3,000,000
	Dec 11, 2018	1,585,000	1,410,000
	Dec 11, 2018	33,303,100	14,680,476
	Mar 5, 2019	82,925,400	55,876,269
	Mar 5, 2019	3,671,700	–
	Mar 19, 2019	2,204,000	2,204,000
	Apr 11, 2019	16,019,100	3,535,907
		142,708,300	**80,706,652**
Cabinet Office	Mar 5, 2019	168,700	168,700
	Apr 11, 2019	158,400	–
		327,100	**168,700**

Ministry	Date of Order	Authorized ($)	Expended ($)
Children and Youth Services	Dec 11, 2018	40,000,000	27,875,614
	Mar 19, 2019	6,000,000	–
	Mar 19, 2019	6,000,000	–
	Apr 11, 2019	5,414,900	–
	Apr 11, 2019	7,949,100	–
		65,364,000	**27,875,614**
Citizenship and Immigration	Mar 19, 2019	3,000,000	467,222
	Mar 19, 2019	898,300	–
	Apr 11, 2019	657,000	–
	Apr 11, 2019	456,900	–
	Apr 11, 2019	202,300	–
		5,214,500	**467,222**
Community and Social Services	Dec 11, 2018	16,916,900	14,156,574
	Jan 23, 2019	15,850,000	15,744,301
	Mar 19, 2019	42,400,000	8,662,510
	Apr 11, 2019	10,925,800	1,168,375
	Apr 11, 2019	2,265,100	227,118
		88,357,800	**39,958,878**
Community Safety and Correctional Services	Dec 11, 2018	2,019,400	2,019,400
	Dec 11, 2018	2,706,700	1,455,700
	Mar 19, 2019	105,239,300	79,707,826
	Apr 11, 2019	16,612,900	880,809
	Jun 19, 2019	21,964,600	380,206
		148,542,900	**84,443,941**
Economic Development and Growth/ Research, Innovation and Science	Feb 12, 2019	41,329,000	–
	Mar 19, 2019	2,500,000	2,500,000
	Apr 11, 2019	1,050,000	757,086
		44,879,000	**3,257,086**
Education	Dec 11, 2018	1,000,000	500,000
	Dec 11, 2018	200,000	200,000
	Mar 19, 2019	41,198,800	18,721,300
	Apr 2, 2019	3,500,000	3,478,652
	Apr 11, 2019	4,748,000	3,459,500
	Apr 11, 2019	100,000,000	–
	Jun 19, 2019	130,000,000	77,025,777
		280,646,800	**103,385,229**
Energy	Dec 11, 2018	2,224,000,000	2,224,000,000
	Mar 5, 2019	600,000,000	410,787,305
	Mar 19, 2019	233,650,000	208,798,530
	Apr 11, 2019	169,200	–
		3,057,819,200	**2,843,585,835**

Ministry	Date of Order	Authorized ($)	Expended ($)
Environment and Climate Change	Mar 5, 2019	18,799,900	4,086,263
	Apr 11, 2019	13,568,400	1,532,532
	Jun 19, 2019	7,890,000	7,692,000
		40,258,300	**13,310,795**
Finance	Dec 11, 2018	35,000,000	29,539,261
	Mar 5, 2019	3,146,600	–
	Apr 11, 2019	5,903,200	–
		44,049,800	**29,539,261**
Francophone Affairs	Apr 2, 2019	**148,800**	**–**
Government and Consumer Services	Mar 5, 2019	39,894,400	39,750,324
	Apr 11, 2019	22,138,200	3,610,322
		62,032,600	**43,360,646**
Health and Long-Term Care	Mar 5, 2019	6,185,500	4,297,479
	Mar 19, 2019	150,000	–
	Mar 19, 2019	680,079,100	558,757,047
	Apr 11, 2019	7,204,000	–
		693,618,600	**563,054,526**
Indigenous Relations and Reconciliation	Mar 5, 2019	52,586,400	42,173,539
	Jun 19, 2019	150,000,000	149,998,000
		202,586,400	**192,171,539**
Infrastructure	Feb 19, 2019	16,296,900	11,975,815
	Mar 5, 2019	3,750,000	2,780,636
	Apr 11, 2019	497,500	497,500
	Jun 19, 2019	3,000,000	2,535,349
		23,544,400	**17,789,300**
International Trade	Mar 5, 2019	**971,000**	**945,014**
Labour	Feb 19, 2019	3,121,000	2,288,385
	Apr 11, 2019	8,921,600	2,339,934
		12,042,600	**4,628,319**
Municipal Affairs and Housing	Dec 11, 2018	350,000	–
	Feb 12, 2019	81,971,800	65,967,190
	Feb 16, 2019	200,000,000	197,243,459
	Apr 11, 2019	1,488,900	–
		283,810,700	**263,210,649**

Ministry	Date of Order	Authorized ($)	Expended ($)
Natural Resources and Forestry	Dec 11, 2018	10,200,000	10,200,000
	Dec 11, 2018	100,000,000	100,000,000
	Dec 11, 2018	42,000,000	35,197,166
	Mar 5, 2019	10,270,200	8,937,376
	Mar 19, 2019	156,800	151,500
	Apr 11, 2019	12,302,700	4,053,899
		174,929,700	**158,539,941**
Northern Development and Mines	Dec 11, 2018	7,670,000	3,827,575
	Dec 11, 2018	15,900,000	–
	Dec 11, 2018	50,000,000	–
	Feb 19, 2019	6,792,500	–
	Mar 19, 2019	53,113,800	44,920,450
	Mar 19, 2019	435,000	–
	Apr 11, 2019	440,700	–
		134,352,000	**48,748,025**
Status of Women	Mar 19, 2019	200,000	–
	Apr 11, 2019	90,700	–
	Apr 11, 2019	198,500	–
		489,200	**–**
Tourism, Culture and Sport	Mar 5, 2019	15,000,000	5,531,975
	Mar 5, 2019	180,000	–
	Mar 19, 2019	99,055,900	99,055,879
	Apr 11, 2019	1,913,500	129,306
		116,149,400	**104,717,160**
Transportation	Mar 5, 2019	89,100,000	69,007,280
	Mar 19, 2019	11,000,000	–
	Apr 11, 2019	16,815,000	4,492,591
	Jun 19, 2019	350,500,000	–
		467,415,000	**73,499,871**
Treasury Board Secretariat	Mar 5, 2019	6,266,400	388,185
	Mar 19, 2019	1,216,668,200	–
	Apr 11, 2019	7,279,100	–
	Apr 11, 2019	3,331,000	2,748,288
		1,233,544,700	**3,136,473**
Total Treasury Board Orders		**7,666,940,200**	**4,845,764,992**

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