



Office of the Auditor General of Ontario

To the Honourable Speaker
of the Legislative Assembly

I am pleased to transmit my Special Report on
Consultant Use in Selected Health Organizations,
which the Standing Committee on Public Accounts
requested pursuant to Section 17 of the *Auditor
General Act*.

A handwritten signature in black ink, appearing to read 'Jim McCarter'.

Jim McCarter
Auditor General

October 2010

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Consultant Use in Selected Health Organizations

Background

The Ministry of Health and Long-Term Care (Ministry) is working to establish a patient-focused, results-driven, integrated, and sustainable publicly funded health system. The Ministry views its primary role as establishing the health system's overall strategic direction and priorities, and guiding resources to bring value to the system. During the 2009/10 fiscal year, the Ministry incurred \$42 billion in operating expenses and almost \$1.5 billion in capital expenses.

In 2005, the Ministry created 14 Local Health Integration Networks (LHINs) to plan, fund, and integrate health-care services in their communities. LHINs are Crown agencies with provincially appointed boards of directors that are accountable to the Minister of Health and Long-Term Care. With ministry funding, the LHINs allocated approximately \$21.7 billion in the 2009/10 fiscal year to various health-care service providers, including hospitals.

Ontario's public hospitals are governed by boards of directors that are responsible for their hospital's operations and for determining their hospital's priorities in addressing patient needs. In the 2009/10 fiscal year, the total operating expenditures for Ontario's 155 public and specialty psychiatric hospitals was approximately \$18.9 billion, of

which approximately 85% was funded directly by the Ministry, primarily through the LHINs.

The Ministry, LHINs, and hospitals spend a portion of their budgets on engaging private-sector consultants. The Ministry and LHINs are required to follow the policies laid out in the Management Board of Cabinet's Procurement Directive (Directive), as amended in November 2007 and July 2009, for planning, acquiring, and managing consulting services. At that time, organizations in the broader public sector, such as hospitals, were not required to follow the Directive and were responsible for establishing their own administrative policies. Effective April 1, 2010, however, the government required certain health and education broader-public-sector organizations to comply with a recently issued Supply Chain Guideline and the procurement policies and code of ethics contained therein.

Audit Objective and Scope

On October 21, 2009, the Standing Committee on Public Accounts requested that the Auditor General of Ontario, "at his discretion, conduct spot audits on the use of consultants by the Ministry of Health and Long-Term Care, the 14 LHINs, and Ontario's hospitals."

Section 17 of the *Auditor General Act* states that the Standing Committee on Public Accounts can request us to perform such special assignments and, accordingly, we accepted this assignment. Our audit objective was to assess whether the Ministry and a selection of Ontario's LHINs and hospitals had adequate systems and procedures in place to ensure that consulting services were acquired and managed in accordance with sound public-sector business practices.

Our Special Report on Ontario's Electronic Health Records Initiative was issued in October 2009 and included a review of procurement practices involving private-sector consultants at the Ministry of Health and Long-Term Care and at the eHealth Ontario agency. As a result, we excluded from this audit additional consulting-services engagements that the Ministry may have entered into for that initiative. We did, however, consider the observations made in our 2009 audit as well as several previous audits involving consulting services.

The Ministry's use of consulting services was examined by the Ontario Internal Audit Division for the 2008/09 fiscal year, and it issued a report in September 2009. Its audit work included a review of a large sample of contracts issued during the period under review. We reviewed the internal auditors' work and concluded that we could rely on the results of their audit. In addition, we selected and reviewed another sample of consulting-services contracts for the 2009/10 fiscal year. Both the internal audit and our work included assessing processes, approvals, and the documentation available for engaging and managing consultants. Our work included discussions with ministry staff in nine different program areas on their decisions and actions taken.

We selected three LHINs for audit primarily on the basis of size and location, excluding the three LHINs that the Ontario Internal Audit Division was separately auditing at the time for the Ministry. During our field visits, we learned that some consulting services assignments paid for by the LHINs

were actually procured and managed by other LHINs, which we also contacted for additional information. We also visited the LHIN Shared Services Office (LSSO), which provides some corporate and common services and programs to all LHINs.

We selected 16 hospitals at which to conduct our work, choosing on the basis of size, location, and other operational characteristics, in order to examine a diverse range of institutions.

Our audit followed the professional standards of the Canadian Institute of Chartered Accountants for assessing value for money and compliance. We set an objective for what we wanted to achieve in the audit and developed audit criteria that covered the key systems, policies, and procedures that should be in place and operating effectively. These criteria were accepted by senior management at the Ministry and at the LHINs and hospitals we visited. We then designed and conducted tests and procedures to address our audit objective and criteria.

Our audit work at the LHINs and hospitals included interviews, reviews, and analyses of policies, procedures, approvals, and documentation with respect to the use of consultants in the 2007/08, 2008/09, and 2009/10 fiscal years. Figure 1 shows the LHINs and hospitals we selected for this audit.

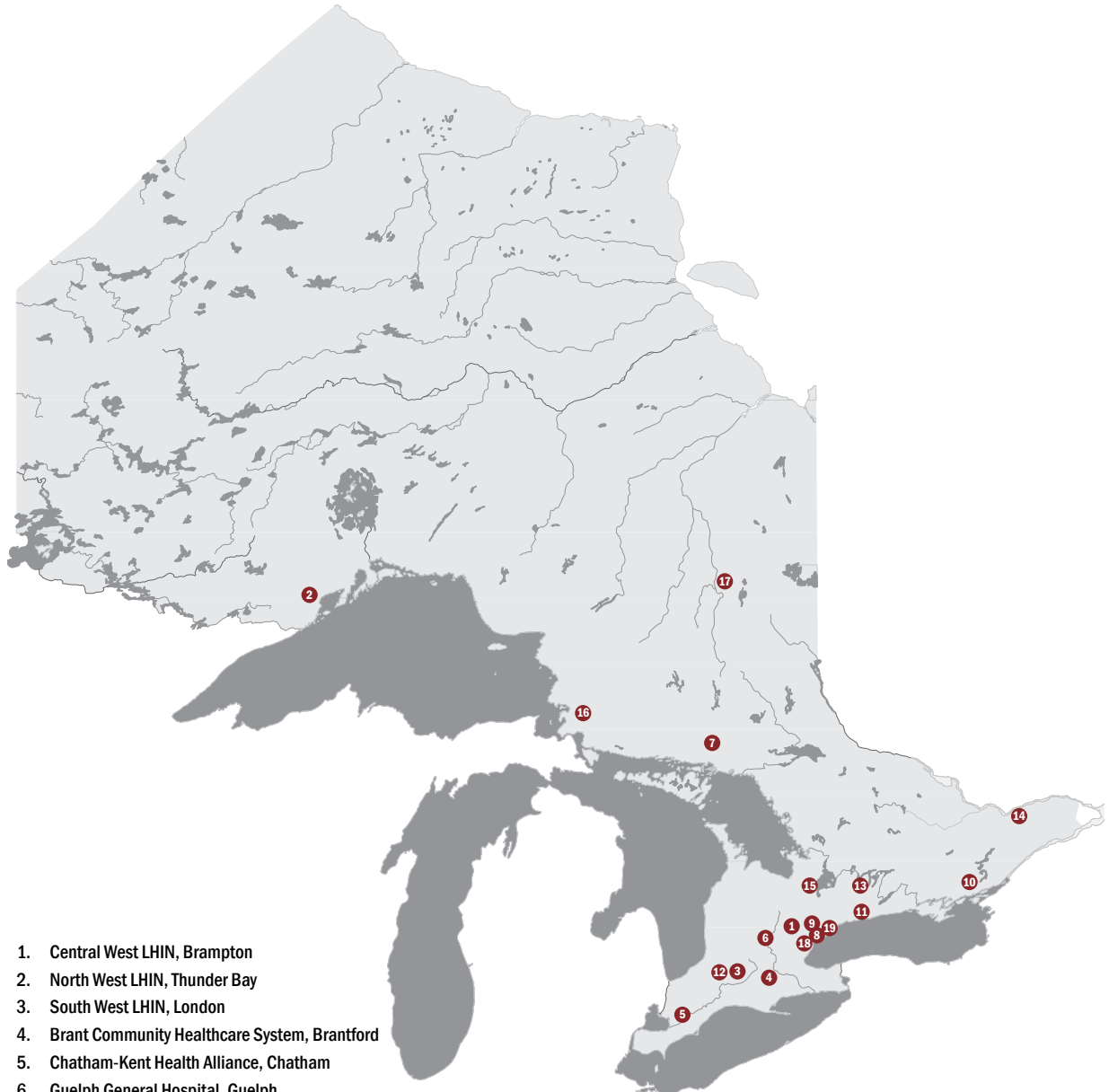
Summary

In summary, our spot audits on the use of consultants by the Ministry of Health and Long-Term Care, three LHINs, and 16 Ontario hospitals indicated the following:

- *Ministry*: On the basis of our work and the work done by Internal Audit, we found that the Ministry complied with most, but not all, of the established requirements of the Management Board of Cabinet's Procurement Directive (Directive). For instance, insufficient time was allowed for consultants to respond to tender requests, and we noted instances

Figure 1: LHINs and Hospitals We Selected for Our Audit

Prepared by the Office of the Auditor General of Ontario



1. Central West LHIN, Brampton
2. North West LHIN, Thunder Bay
3. South West LHIN, London
4. Brant Community Healthcare System, Brantford
5. Chatham-Kent Health Alliance, Chatham
6. Guelph General Hospital, Guelph
7. Hôpital régional de Sudbury Regional Hospital, Sudbury
8. Hospital for Sick Children, Toronto
9. Humber River Regional Hospital, Toronto
10. Kingston General Hospital, Kingston
11. Lakeridge Health Corporation, Oshawa
12. London Health Sciences Centre, London
13. Ross Memorial Hospital, Lindsay
14. Royal Ottawa Health Care Group, Ottawa
15. Royal Victoria Hospital, Barrie
16. Sault Area Hospital, Sault Ste. Marie
17. Timmins and District Hospital, Timmins
18. Trillium Health Centre, Mississauga
19. University Health Network, Toronto

where the underlying documentation indicated that a competitive process had been followed but we believed that the process favoured a particular consultant.

- *LHINs*: We noted that before mid-2009, the LHINs often did not follow established requirements in the Directive designed to ensure the sound procurement and use of consulting services. However, our examination of the more recent procurements did indicate that some improvement is under way.
- *Hospitals*: We noted far too many instances at the hospitals we visited where sound public-sector business practices were not followed in the selection and oversight of consulting services. While the Ministry has since mandated specific policies and procedures that must be followed for the procurement of goods and services effective April 1, 2010, it will be incumbent on hospital senior management and boards of directors, the LHINs, and the Ministry to establish appropriate oversight roles to ensure that hospitals consistently comply with these requirements.

More specifically, with respect to the Ministry:

- Internal audit reported that for consulting services acquired during the 2008/09 fiscal year, many elements of the Directive were being complied with, but there were still deficiencies that needed to be addressed.
- Our work indicated that the Ministry was, for the most part, in compliance with the requirements of the revised Directive that came into effect in July 2009. We did note, however, two recent cases where the Ministry's new oversight controls were ineffective, and higher-priced consultants were given preferred treatment in the procurement process used.

With respect to the LHINs:

- Procurements examined to mid-2009 indicated that processes and practices used by the LHINs we visited were inadequate to ensure that the use of consultants was planned for, acquired, and managed in accordance with

the requirements of the Directive then in effect. For example, at least 75% of the single-sourced contracts that we reviewed did not meet the specific requirements for exemptions provided for at the time by the Directive, and they lacked the required supporting documentation and/or prior approval.

- As many as two-thirds of the consulting contracts we examined had follow-on agreements, and most were awarded without a separate competitive process or documented justification for the additional work. At the three LHINs we visited, we noted that consultants' invoices did not provide sufficient information on work done or other billing details, including receipts for expenses, to support the amount paid in about 40%, 50%, and 35%, respectively, for invoices of contracts we examined.
- A recent audit of three other LHINs by the Ministry's internal auditors identified similar control weaknesses in their sampling of contracts awarded between April 2008 and August 2009. We did note some improvement in processes used by all three LHINs following both the government's introduction of the amended July 2009 Directive and the Ministry's instructions to LHINs to improve their compliance with the Directive.

With respect to the hospitals:

- At the time of our audit, the hospitals were not required to follow the government's Directive on procurement. However, because the Directive constitutes sound, common-sense public-sector business practices, we benchmarked the hospitals against its principles. We noted that, although procurement policies established by each hospital generally required an open competitive process for procurements of goods and services that cost over \$100,000, policies were neither as robust nor as comprehensive as those in the Directive. For instance, they did not require:

- assignments to be well defined and properly justified before consultants were engaged;
- adequate contractual arrangements with fixed ceiling prices to be established;
- payments to be tied to specified deliverables; and
- consultant performance to be properly managed.
- Most hospitals did not require that their boards of directors approve either large contracts with consultants or single-sourced contracts, or that senior management regularly report to the board on their use of consultants.
- Most hospitals we visited had deficiencies with respect to their planning, acquisition, approval, payment, and/or contract management of consultants. Non-competitive procurement practices and follow-on assignments to extend existing contracts were used extensively to acquire and retain consultants, and fair, open, and transparent procurement practices were often not followed. Consultants were frequently engaged without establishing comprehensive contractual arrangements.
- Many operational and capital-related consulting-services engagements were single-sourced and allowed to grow from small assignments to ongoing projects totalling several million dollars without sound competitive procurement practices.
- Controls over payments were often inadequate to ensure that payment was made in accordance with agreements and key deliverables, and expenses were often not supported by details and receipts. In some cases, consultants charged for expensive meals, alcohol, and accommodations, and for conferences and unauthorized fees, without questioning by hospital staff. Hospitals also prepaid for services in some cases.
- Eight of the 16 hospitals we visited had engaged consultants to lobby the provincial

government, and in some cases the federal government, using funding provided by the Ministry for clinical and administrative activities. While the more than \$1.6 million spent by the eight hospitals was relatively small in comparison to these hospitals' overall funding, we questioned the appropriateness of using government funds to pay lobbyists to help obtain more government funding.

In our discussions with the hospitals, they acknowledged that they needed to pay more attention to ensuring that their procurement of consultants was open, transparent, and better documented. A number of the hospitals did indicate that they had recently made improvements to their consultant-procurement practices and noted that this was not necessarily reflected given the time frame of our audit. As well, several hospitals indicated that the issues we raised with respect to consultants would not be applicable to their procurement processes for other goods and services, which "were much more mature" and which would "cover the vast majority of annual (non-salary) spending in the hospital."

OVERALL RESPONSE FROM THE MINISTRY, LHINs AND HOSPITALS

The Ministry of Health and Long-Term Care informed us that "The Ministry fully supports the recommendations in the Auditor General's report. Ontarians expect the government, its agencies, and its institutions to use public funds responsibly. It is imperative that we ensure taxpayer dollars are spent wisely, that we are accountable for our decisions, and that our investments improve patient care."

The Ministry further noted that our report clearly demonstrates that more needs to be done, and that the Ministry is taking actions consistent with the report's recommendations. It has already taken and will be taking additional concrete steps to strengthen accountability and transparency in procurement and the

use of public funds within the Ministry, LHINs, and hospitals.

The LHINs agreed with our recommendation on the need to report to both their Boards of Directors and the Ministry on compliance with the Management Board of Cabinet's July 2009 Procurement Directive for their use of consultants. The LHINs also noted that they have made significant improvements to their administrative practices recently to ensure ongoing compliance with the Directive.

In general, the hospitals recognized that they needed to improve their practices around consultant use. They are committed to implementing the procurement policy contained in the new broader-public-sector Supply Chain Guideline.

Detailed Observations

MINISTRY OF HEALTH AND LONG-TERM CARE

Provincial Procurement Policy

The Management Board of Cabinet's Procurement Directive (Directive) establishes comprehensive policies for the planning, acquisition, and management of consulting services in ministries and Crown agencies, and is designed to ensure that procurement practices achieve value for money and comply with interprovincial and national trade agreements. The Directive defines consulting services as the provision of expertise or strategic advice for consideration and decision-making in such areas as management, information technology, technical activities, research and development, policy, and communications.

The Directive was updated in November 2007 and again in July 2009, and applies to all ministries and most Crown agencies, including LHINs. It does

not, however, apply to Ontario's broader-public-sector organizations, which include hospitals.

The principles in the Directive cover vendor access, transparency, fairness, value for money, responsible management, geographic neutrality, and non-discrimination. It sets out mandatory requirements in five major areas—procurement planning, value establishment, source of supply, procurement method, and approvals—involving such matters as research and consultation, document retention, bid evaluation, and contract management.

In addition, Management Board of Cabinet issued a Procurement Operating Policy in November 2007 to promote consistency in the management of procurement practices and decisions. The policy provided additional operational requirements to supplement the mandatory requirements in the Directive.

The Directive distinguishes between single-sourcing and sole-sourcing for a non-competitive procurement process. Single-sourcing means acquiring goods or services from a specific supplier non-competitively even though there may be more than one supplier capable of delivering the same goods or services. Sole-sourcing means acquiring goods or services from the only available supplier of the goods or services. Before using either of these non-competitive procurement processes, ministry or Crown agency staff are required to prepare a formal documented rationale to justify its use and obtain approval from a higher level of management.

Changes to the Directive in July 2009 as they applied to consulting services included making more Crown agencies subject to the Directive, requiring a business case and a competitive process for all engagements irrespective of value, and imposing more senior-level management and ministerial approval requirements. Figure 2 shows the type of procurement method and approval level required for ministry and Crown agency consulting-services contracts.

The Directive clearly states that decisions to use consultants must be adequately documented and

Figure 2: Procurement Method and Approval Levels Required by the Directive as of July 2009

Source of data: Management Board of Cabinet Procurement Directive, July 2009

	Total Value of Contract	Level of Approval (Ministry Contracts Only) ¹
Procurement Method		
invitational competitive	<\$100,000	ministry management as delegated by deputy minister
open competitive	<\$1 million	ministry management as delegated by deputy minister
	more than \$1 million but less than \$10 million	Supply Chain Leadership Council of the Ministry of Government Services
	\$10 million or more	Treasury Board/Management Board of Cabinet
non-competitive ²	<\$500,000	deputy minister and minister
	more than \$500,000 but less than \$1 million	Supply Chain Leadership Council of the Ministry of Government Services
	\$1 million or more	Treasury Board/Management Board of Cabinet
Ceiling Price Increases		
	more than \$750,000 but less than \$1 million	deputy minister and minister
	\$1 million or more	Treasury Board/Management Board of Cabinet

1. Crown agencies establish their own levels of approval.

2. The Directive limits allowable non-competitive procurements to certain cases of urgency, limited availability of suppliers, and the need for confidentiality and security.

properly approved. It also requires that ministries track their use and report on it annually. The required records include the number and type of contracts tendered, the names of consultants engaged, the procurement method used, the contract ceiling amounts, and start and end dates of the engagements. The Ministry was in compliance with this requirement and as a result was able to provide us with records of its use of consultants.

We are generally satisfied that the Directive provides ministries and Crown agencies with sufficient guidance to acquire and manage consulting services in a cost-effective manner.

Compliance with the Directive

The Ministry spent \$86.1 million on consulting services in the 2007/08 fiscal year, \$102.2 million in 2008/09, and \$35.4 million in 2009/10. The Ontario Internal Audit Division’s review of the Ministry’s procurement of consulting services commenced in mid-June 2009 and focused on a selection of consulting contracts signed during the 2008/09 fiscal year.

The objective of the internal audit review was to assess whether the Ministry had maintained appropriate procurement processes and controls for consulting services that were compliant with the November 2007 Directive. In their September 2009 report, the internal auditors concluded that the Ministry had complied with many elements of the Directive. Specifically, they noted that in the majority of files reviewed:

- Ministry program areas had appropriately justified the acquisition of consultants, assessed the available resources, and sought prior approvals.
- Signed written contracts were in place with acquired consultants, with the exception of two instances of single-source procurement of services totalling approximately \$573,000.
- The appropriate procurement method had been used for the type and value of the procurement.
- Proper approval had been obtained for subsequent amendments to extend the contract and increase its value.

The internal auditors also noted that:

- The Ministry should improve corporate monitoring controls by ensuring that its consulting-services reports include all contracts and expenses incurred; by conducting spot audits for compliance with documentation requirements and oversight of vendor performance; and by conducting formal vendor-performance reviews and maintaining them centrally.
- Procurement files should contain sufficient detail to demonstrate compliance with requirements such as contractor reference checks and security clearances, completion of Tax Compliance Declaration Forms, and post-assignment evaluations.
- In several instances, contract files did not include justification or authorization for setting the minimum bid response time at less than the required 15 calendar days.
- The rationales for some single-sourced contracts were not consistent with the allowable exceptions noted in the Directive.
- The Ministry brought to the attention of the Ontario Internal Audit Division two single-sourced contracts, totalling approximately \$950,000, where the Ministry had paid consultants using transfer-payment funding paid to a non-profit corporation to acquire consulting services for the Ministry.
- Strategies are needed to improve general knowledge and understanding of the Directive and related procedures.

The Ministry responded that it had already taken action to address the weaknesses identified in the internal audit report, including the introduction of controls to enhance oversight capacity and guidance for all procurement within the Ministry. It had also implemented mandatory training for all managers and enhanced quarterly reviews and reporting.

Notably, the Ministry had used a non-competitive, single-source procurement method for about 80% of consulting contracts under \$25,000 and 15% of contracts greater than \$25,000 in the fiscal year preceding the July 2009 Directive. In contrast,

from July 2009 to March 31, 2010, ministry records indicate that it did not hire any consultants using single-source procurement.

Our review of a sample of consulting-services engagements from April 2009 to February 2010 confirmed that, for the most part, the Ministry was complying with requirements. However, we did note some areas where improvements to the Ministry's processes and oversight were needed to ensure that contracts were awarded fairly and in accordance with both the spirit and requirements of the Directive.

In two cases, higher-priced consultants were given preferential treatment in the procurement process used:

- In November 2009, the Ministry awarded a \$495,000 contract to a consultant using an open competitive process for completing the third stage of a project to support the creation of a government-wide 10-year strategic plan on mental health and addiction. The Ministry had previously awarded this consultant the first two stages of the project (November 2008 through July 2009) without competition at a cost of \$365,000. In awarding the first two stages, the Ministry single-sourced the consultant in accordance with certain exemptions to competitive procurement permitted by the November 2007 Directive that were no longer permitted in the July 2009 Directive. For the third stage of the contract, the consultant originally submitted a bid of \$819,000, the highest of 12 bids. Following their review of the submissions in August 2009, ministry staff decided to negotiate exclusively with the incumbent consultant. The scope of the consultant's work was then reduced by eliminating key areas of the original project, thereby lowering the bid price to \$495,000 to match a revised project budget set in September 2009. The original project budget, set in July 2009, had been valued at \$375,000. No other bidders were given the opportunity to negotiate. Negotiations with the bidder and

senior management approvals delayed the contract signing until mid-November 2009, even though the consultant commenced work on the project in mid-September 2009.

- Before issuing a request for services in July 2009 to consultants on the vendor-of-record list, the Ministry had estimated through an approved business case that “change management services” would cost \$200,000. Four pre-qualified firms were invited to provide proposals and were given only four days to develop a submission, contrary to the Directive’s mandatory minimum requirement of 15 days. In our view, four days was not adequate time to give all the invited firms a fair opportunity to prepare their proposals. The Ministry received proposals from only two firms: one for \$151,000 based on 80 days’ work at \$1,850 per day, and another at \$307,000 based on 190 days’ work at \$1,600 per day. Ministry staff evaluated the proposals and determined that the higher-priced bidder should be awarded the contract. They then negotiated directly with this bidder to reduce its price from \$307,000 to \$199,800. Both consultants scored similarly on work experience, proposal, and interview, with the higher-priced consultant scoring 71.5 out of 90 and the other scoring 70.5. Although both firms quoted a per diem rate and the number of days required to complete the project, ministry staff considered the per diem rates rather than the total price. As a result, even though the higher bidder estimated that it needed more than twice as many days as the other bidder to complete the work, it scored better in the Ministry’s evaluation of the price component because its per diem rate was about 15% lower. Further, if one bidder was allowed to revise its bid, we questioned why the other bidder was not allowed the same opportunity.
- We noted two other examples in spring 2009 in which the Ministry allowed only seven and nine days for pre-qualified firms to provide

proposals for the competitive procurement process; as in the previous case, one bidder chose not to submit a proposal.

We also noted a case in which the amount paid for a single-sourced contract was not properly justified. In May 2009, the Ministry awarded a single-sourced contract for \$749,000 to a consultant to undertake a review of the pharmaceutical sector. The consultant’s statement of work, signed by the Ministry, listed project deliverables but had no breakdown of how the contract price had been arrived at, the hours assigned to individual tasks, or per diem rates. Instead, the contract price was a lump sum, which in our view did not provide the Ministry with sufficient information to assess whether the amount was reasonable; nor could the Ministry justify the project’s cost, because by single-sourcing the procurement it obtained no competing bids for comparison. We also noted that this contract had been approved by the then Deputy Minister of Health and the Ministry of Government Services’ Supply Chain Leadership Council, despite the lack of details explaining how the amount of \$749,000 had been arrived at. Invoices from the consultant did not provide any breakdown of the work completed or deliverables met that could account for the costs incurred. We also noted from our visits to hospitals that this consultant provided no detail on its invoices to the hospitals that engaged it for other assignments, including one contract for \$1.7 million in 2007.

RECOMMENDATION 1

To ensure that its consulting services are acquired and managed appropriately and economically, the Ministry of Health and Long-Term Care should make certain that its processes, decisions, and actions comply with the formal requirements as well as the spirit of the Management Board of Cabinet’s Procurement Directive.

MINISTRY RESPONSE

The Ministry of Health and Long-Term Care fully supports the Auditor General's recommendation and is committed to continuing to implement effective and compliant practices for the procurement of consulting services. The Ministry has also undertaken a number of initiatives to strengthen its oversight capacity and provide guidance on procurement.

Further, the Ministry has centralized all transfer-payment activities to provide greater assurance that the Transfer Payment Directive is followed. All managers have received procurement training and the Ministry has strengthened its reporting and quarterly review processes.

LOCAL HEALTH INTEGRATION NETWORKS

Compliance with the Directive

Local Health Integration Networks (LHINs) are required by their Memorandum of Understanding with the Ministry to comply with certain government directives, policies, and guidelines, including the Management Board of Cabinet's Procurement Directive. For the 2007/08 to 2009/10 fiscal years, the three LHINs we visited had annual expenditures on consultants ranging from \$224,000 to \$1.4 million per year.

We concluded that all three LHINs we selected had inadequate processes and practices for most of the period we examined for ensuring that consulting services were planned for, acquired, and managed in accordance with the requirements of the Directive. We recognize that LHINs were established only four years ago and have since been required to quickly implement their key systems and procedures. However, the extent of non-compliance with the mandatory requirements in the Directive that we found was significant. We did

note some improvement with recent contracts we sampled following the introduction of the updated Procurement Directive in July 2009. Figure 3 summarizes our observations from our visits to the three LHINs.

In addition, in April 2010, the Ontario Internal Audit Division reported the results of its audit of three other LHINs' compliance with the Directive between April 2008 and August 2009. The internal auditors identified weak control over consulting-services contracts, noted the absence of business cases, found contracts that were single-sourced with insufficient documentation or justification, noted a lack of signed contracts and proper approvals, found consecutive and follow-on engagements that were awarded without competition, and identified consultants that had not been selected from the Ministry's mandatory vendor-of-record listing. The internal auditors informed us that they were planning to review the remaining 11 LHINs by the end of the 2013/14 fiscal year.

Tracking, Monitoring, and Reporting on Use of Consultants

The Directive requirement that ministries must track and annually report on their use of consultants does not apply to LHINs and other Crown agencies. We noted that the three LHINs had no standard process to track and report on their use of consultants. Consequently, at our request, each of the LHINs we visited provided us with a list of expenditures on consultants over the last three years prepared from its financial records, which indicated payments made to each consultant and totals paid by each LHIN.

Procurement Planning

According to the Directive, procurement planning must be undertaken as an integral part of the procurement process. Procurement planning includes early identification of needs, a clear definition of requirements, and a justification for the acquisition.

Figure 3: Observations on Key Controls over Consulting Services Engagements at Three LHINs*

Source of data: Procurement Directive, November 2007 and July 2009; and the Office of the Auditor General of Ontario

Key Requirements of the Procurement Directive	LHIN A	LHIN B	LHIN C
Justification for the use of consultants is documented and proper approval is obtained prior to the engagement.			
Large contracts are procured with a minimum of three quotations or open tendering, as required. Any exceptions to the competitive procurement are formally documented and properly approved.			
All bid proposals and related evaluation summaries are documented to support the bid award decision.			
Formal, signed written contracts are in place before work begins.			
Follow-on contracts are awarded using a separate competitive process; if not, the justification for not doing so is properly documented and approved.			
Invoice payments are tied to specific deliverables, expenses reimbursed are reasonable, and detailed receipts are made available upon request.			
Total payments to consultants are within a pre-set contract ceiling price. Additional payments are justified with proper documentation and approval.			
Consultants make a formal declaration of possible conflict of interest.			

Note: The order in which the LHINs are listed in Figure 1 has no bearing on the order in which they are listed here.

* At the time of our visit to one LHIN, it had made no recent procurements to which the July 2009 Directive would have applied. As a result, we were unable to review any recent consulting-services arrangements at that LHIN to which the Directive applied.

	key requirements were generally met
	deficiencies were noted and Directive requirements were not consistently met

In addition, before it conducts a procurement, the LHIN must identify an appropriate supply source for the required services, first taking into consideration the availability of internal resources.

We found that between 45% and 83% of the consulting contracts reviewed at the three LHINs we visited were prepared without proper prior written justification for the use of consultants; nor did the LHIN management obtain documented approval prior to the engagement.

Competitive Procurement and Follow-on Engagements

Given that most of the consulting engagements we examined occurred before the revised Directive came into force in July 2009, it was the November 2007 Directive that applied to them. In general, it stated the following requirements:

- Quotations from vendors are not mandatory for amounts below \$25,000; a minimum of three vendors must submit proposals for services with an estimated value between \$25,000 and \$99,999; and an open competitive procurement process must be used for services valued at \$100,000 or more.
- Allowable exceptions for non-competitive procurement can include unforeseen situations of urgency, instances where an open tendering process could reasonably be expected to compromise government confidentiality, or occasions when only one supplier is known to meet the requirements.
- Appropriate procurement approval authority in writing must be sought for all non-competitive procurements valued at \$100,000 or more.

As well, before entering into a follow-on engagement to a related agreement that has already been completed, the LHIN must obtain appropriate approval authority for the combined value of the original work and the follow-on engagement. In addition, it may not reduce the value of the procurement to avoid the Directive's requirements regarding competition, approvals, or reporting. Such actions could include subdividing projects or contracts and awarding multiple consecutive follow-on engagements for the same assignment to the same consultant.

We found that the LHINs did not meet the Directive's requirements most of the time. For example, at least 75% of the single-sourced contracts did not meet the specific exemptions allowed for in the Directive, and they lacked formal documentation and/or prior approval. The three LHINs had made follow-on engagements to about 25%, 65%, and 35%, respectively, of the consulting contracts we reviewed. Of the contracts with follow-on engagements, at least 85% were awarded without a separate competitive process, proper approval, and/or documented justification. For example:

- A LHIN engaged a consulting firm to develop a hospital Emergency Department human-resources project, which resulted in two contracts totalling \$184,000 between November 2008 and May 2009. The Directive required that a minimum of three vendors be invited. However, both contracts were single-sourced without documented justification or proper approvals. This LHIN had a policy that required board approval for these contracts because their total value exceeded \$100,000, but the approvals had not been obtained.

Similarly, the same LHIN engaged another consultant in 2008 for \$90,000 to review the financial operating position of two hospitals. The LHIN did not use a competitive selection process and did not properly document the justification and approval for using a single-source procurement method for this consultant.

- A LHIN we visited single-sourced a contract to a health-care service provider to establish and operate an eHealth project-management office. The project costs were shared with another LHIN and totalled \$716,000 for the 2007/08 and 2008/09 fiscal years. The provider had been engaged by the Ministry (prior to the creation of the LHIN) to develop an eHealth strategic plan. A business case to support the decision to single-source this contract was provided to the LHIN board for approval in June 2008 for the second year of the contract's term. The LHIN explained that the exception to competitive tendering was due to the consultant's knowledge of the office, the tight timelines associated with the project, the one-time nature of the funding from the Ministry, and the work that was already under way. Nonetheless, the reasons cited by the LHIN did not meet the specific requirements for allowable exemptions in the Directive. The arrangement was discontinued in the spring of 2009 when ongoing funding was provided by the Ministry and the LHIN brought the function of the project management office in-house.

The same LHIN had assumed the lead on behalf of other LHINs and engaged a consultant without competition to develop a decision-making and priority-setting process and to provide a series of workshops. The five contracts related to these projects amounted to \$94,000 between May 2007 and March 2009. The costs of two of the contracts were shared with other LHINs. Each contract lasted between two weeks and five months, and cost between \$17,750 and \$24,999—just below the Directive's minimum threshold for a competitive process. We noted that the LHIN's internal documents indicated that from the very start of the project it had intended to continue acquiring these services from the same consultant. To comply with the Directive, the LHIN should have considered this as

a single project and thus invited at least three consultants to bid.

Signed Contracts

The Directive requires both the LHIN and the consultant to define their contractual responsibilities in a signed written agreement before the provision of services commences. Two of the LHINs we visited generally complied with this requirement, but at the third LHIN, formal contracts were not in place before work commenced for about half of the contracts we sampled. For instance, the LHIN had entered into three related engagements with a consulting firm regarding the eHealth strategic plan for total payments of \$249,000 from 2006/07 to 2008/09. The LHIN could not provide us with signed contracts for any of the three engagements.

The same LHIN engaged a consulting firm to provide governance-related seminars and research assignments. No contracts were in place for nine of the 11 assignments awarded to the firm. The LHIN's board of directors reviewed and approved the proposals submitted by the firm. However, without a contract there is a risk that the specific terms of assignment, key deliverables, ceiling price, timing, and other provisions will not be formally established and enforceable. In addition, at the time of our audit, \$198,000 had been paid since November 2008 for the 11 assignments, each of which cost just below \$25,000. The LHIN told us that because each segment of the project fell below \$25,000, none required a competitive selection process. We questioned this rationale, because each assignment was not unique and all the services were related to each other, effectively making them a single project that should have been tendered and contracted as such.

Documentation

The Directive also requires that all decisions in the procurement process are to be recorded so that the path to an award decision can be traced. We found

that at one of the LHINs, proper documentation supporting the award decisions was absent even when we were advised that a competitive selection had taken place. For example, at this LHIN:

- In addition to having no signed contract for a \$94,000 assignment, the LHIN informed us that many of the key procurement documents, such as unsuccessful consultants' proposals, evaluations of the bids summary to support the award decision, and formal approvals, were not available. Moreover, the LHIN could not confirm the procurement methods it used for two subsequent contracts valued at \$155,000 relating to the project in the 2007/08 and 2008/09 fiscal years and awarded to the same consultant, or whether they were properly approved, because no supporting documentation was available and the employee who managed this assignment had since left the LHIN.

We also noted that the same consultant invoiced the LHIN on the basis of hourly rates that ranged between \$180 and \$300, and payments for one of the follow-on contracts exceeded the contract price of \$56,000 by almost \$30,000 without any supporting documentation.

- Similarly, the LHIN awarded a four-month contract for nearly \$287,000 in December 2007 to a consulting firm to establish a community health-system plan. The procurement process included inviting five consultants selected from the Ministry's vendor-of-record list. Four submitted proposals, but the LHIN was unable to locate certain key documents used in the process, such as the consultant proposals and the evaluations made by the selection committee.

Controls over Payments to Consultants

Our audit identified weaknesses in financial controls over payments to consultants at all three LHINs that we visited. We expected that payments

to consultants would be directly tied to specific deliverables, and expense claims would contain detailed descriptions of the nature of the expense and copies of receipts. However, many of the invoices we examined did not provide sufficient details of the work performed or did not have receipts for expenses claimed and paid. At the three LHINs we visited, we therefore questioned the approval process for about 40%, 50%, and 35%, respectively, of the consultants' invoices for contracts we examined. For example:

- The firm that was awarded the December 2007 contract to establish a health-system plan was paid \$19,000 over the contract ceiling price of \$287,000, without any documented justification.

The LHIN also made a payment of over \$23,000 to a consultant in March 2009, before any work had commenced. Although the payment had been made in anticipation of the completion of the work before the end of the same month, no work had been completed at the time of our visit, nine months later. Subsequently, the LHIN cancelled the project and initiated efforts to recover the payment. However, as of July 2010, the payment had not been recovered.

- A second LHIN paid a non-profit service organization almost \$20,000 in 2009, mainly for travel and meals, in addition to its fee of nearly \$33,000 for a project that involved visits to health-care providers in 18 communities. The organization provided a list of travel expenses incurred, but the LHIN did not request receipts to substantiate the large amount claimed, although this was a requirement in the agreement.
- A third LHIN reimbursed about \$4,000 of expenses without pre-approval or receipts, although the contract required pre-approval of the consultant's expenses. In 2008, the same LHIN paid a consultant an administration fee of almost \$5,000 above the agreed-

upon consulting fee of nearly \$60,000, even though the additional fee was not part of the contract and it was unusual to allow consultants to charge such fees.

Conflict-of-interest Declarations

The November 2007 Procurement Operating Policy required that procurements include documents with sufficient detail to fairly compare vendor submissions. A conflict-of-interest statement is to be among these documents. The provision requires consultants to declare any actual or potential conflict of interest, circumstance, or relationship that could give the consultant an unfair advantage during a procurement process or compromise its ability to meet its obligations under the agreement.

However, we found that all three LHINs did not consistently obtain separate, signed conflict-of-interest declarations from consultants at the proposal submission stage, although conflict-of-interest provisions were generally contained in contracts, where a contract existed.

Contracts Managed by Shared Services Arrangements

The LHINs have established a LHIN Shared Services Office (LSSO) to provide some corporate and common services and programs to all LHINs. Our audit included several consulting-services contracts in which costs were shared by LHINs and managed by the LSSO. We noted the following deficiencies:

- The LSSO entered into two contracts with the same executive-search consulting firm. The first contract engaged the firm to search for and supply an interim executive director for the LSSO. The second was to conduct a search for a permanent executive director and was later expanded to search for and supply a temporary manager to oversee implementation of an information-system project. A total of nearly \$370,000 was paid to the consultant

for both contracts from February to December 2009. The Directive required the LSSO to use an open competitive procurement process for services valued at \$100,000 or more. Nevertheless, although the LSSO obtained proposals from three firms, the proposals were based on a verbal invitation to the firms, no evaluation of the proposals was prepared, and there was no documented justification for selecting the winning firm.

- The LSSO spent \$133,000 from February to April 2009 and \$122,000 from March to November 2009, respectively, on consultants for two information technology projects. We noted that the LSSO could not provide us with business cases that would have been used to define the upfront project-planning requirements before these engagements. However, both consultants were engaged using satisfactory competitive-procurement processes and the government's vendor-of-record list. The LSSO determined prior to the projects' completion that time requirements and costs for both projects had been underestimated and both projects were poorly managed and documented. The LSSO then hired one new consultant in January 2010 to complete the first project at a cost of \$24,995, and a second new consultant in February 2010 to complete the second project at a cost of \$85,000. We noted that the first of these consultants was engaged on a sole-source basis using the vendor-of-record list, which was permitted for amounts less than \$25,000. The second consultant was engaged after the LSSO invited three consultants on the vendor-of-record list to provide proposals, but consultants were given only four days to respond instead of the required minimum of 15 days, and only two submitted proposals.

Changes Following the Updated July 2009 Procurement Directive

Following the introduction of the July 2009 Directive, the Ministry advised the LHINs to comply with the new requirements and required each LHIN to provide it with written confirmation by August 14, 2009, that it was in compliance. We noted that the LHINs we visited had recently taken some initiatives to improve their adherence to the Directive.

In late 2009, one LHIN conducted a review of its consulting contracts and found that the most common deviations from the Directive were single-sourcing of contracts above \$25,000 and awarding of follow-on contracts to consultants without competition. The LHIN reported to its board in January 2010 that it had since established a new control that required all future procurements be reviewed by its business manager to ensure compliance with the Directive.

We reviewed a few of this LHIN's recent procurements and found that the procedures generally complied with the revised Directive. Only one minor exception was noted: for one consulting-services contract awarded in November 2009 and valued at \$75,000, the bidders were permitted only 10 days to respond instead of the 15 days required by the Directive.

While we were unable to review recent consulting-services contracts at another LHIN because of the timing of our visit, we did note that in September 2009, it had prepared a report for its board of directors on its use of consultants over the last three years that listed project names, consulting firms, value of the contracts, procurement methods used, and project descriptions.

We also reviewed a small sample of contracts awarded after July 2009 at the third LHIN and at the LSSO. We found that the third LHIN had generally complied with the Directive and that there was some opportunity for improvement at the LSSO, as described in the previous section. In addition, we noted that the LSSO has engaged a procurement

specialist to provide a centralized support function to LHINs, including strategic and technical procurement advice and training on procurement best practices.

RECOMMENDATION 2

To ensure that LHINs consistently comply with the requirements of Management Board of Cabinet's Procurement Directive as it pertains to the engagement and use of consultants, the Ministry of Health and Long-Term Care should consider requiring each LHIN to provide its board of directors and the Ministry with a comprehensive annual report on its procurement and use of consultants similar to the reports required by ministries. To help demonstrate compliance with the Directive, this report should include information on the nature and timing of the assignments, the ceiling amounts of the contracts, the extent of follow-on contracts, the total amount paid, and how the consultants were procured.

LHIN RESPONSE

All three LHINs agreed that an annual reporting mechanism similar to the one that applies to ministries will assist in their ensuring not only compliance with Management Board of Cabinet's July 2009 Procurement Directive, but also openness and transparency in their procurement processes. Each LHIN informed us that it had made changes to its administration practices to ensure that they are compliant with the Directive. The LHINs now regularly report to their boards of directors on the use of consultants.

The LHIN Shared Services Office (LSSO) indicated that it has hired a procurement specialist to provide support to all LHINs. To help LHINs to fully comply with the new Directive, the LSSO plans to launch an extranet site in October 2010 that will provide comprehensive

information on procurement guidelines and support tools for all aspects of the planning, acquisition, and management of consultants.

MINISTRY RESPONSE

The Ministry of Health and Long-Term Care fully supports this recommendation and will require the LHINs to report regularly on procurement and consulting services. This reporting is to be in addition to the current declarations of compliance that are submitted by LHIN boards on a quarterly basis. The Ministry will take action to ensure that reporting requirements for LHINs similar to those that apply to government ministries are implemented.

HOSPITALS

Policies on Consultant Use

Each hospital we visited was responsible for establishing its own administrative policies, such as those for procuring goods and services. In general, hospital policies relating to procuring consulting services were neither as robust nor as comprehensive as those in the Management Board of Cabinet's Procurement Directive; although the Directive does not apply to hospitals, we consider its requirements to be best practices for public-sector organizations. Each hospital we visited had policies requiring competitive procurement practices that met the requirements of interprovincial and national trade agreements. However, most policies lacked specific requirements designed to promote the cost-effective use of consultants. For instance, policies did not require assignments to be well defined or properly justified before consultants were engaged; nor did they require adequate contractual arrangements with fixed ceiling prices, payments tied to specified deliverables, or proper management of consultant performance. Most of the policies we reviewed also

lacked the requirement to document and retain the records of procurement decisions.

Most hospitals had a policy in place to avoid any real or perceived conflict of interest when acquiring consultants, although further guidance was typically not provided to managers on how to administer a conflict-of-interest declaration. Generally, the hospitals we visited did not ensure that conflict-of-interest declarations were obtained from the consultants they engaged. Only a few of the hospitals we visited had established standardized document templates for such declarations from consultants and they were not consistently used.

Each hospital's procurement policies generally required competitive bidding for contracts of \$25,000 or more and a formal open-tender process for amounts of \$100,000 or more. Situations involving urgency or sole- or single-source suppliers were permissible exceptions to the requirement, but guidelines or restrictions were not in place to prevent excessive or inappropriate reliance on these provisions. A best practice at a few of the hospitals was the requirement for higher-level approvals for procurements that were non-competitively sourced or for large amounts. For example, one hospital required board approval for single- or sole-sourced service contracts over \$250,000, and for all service contracts over \$500,000; another required approval from a higher-than-normal level for single- or sole-sourced contracts.

In addition, the hospitals had no policies or processes that required senior management to report to the board of directors on their use of consultants, and most boards were not aware of hospitals' procurement practices, since their approvals were required only for total operating and capital budgets on a departmental basis. For example, management at most of the hospitals we visited informed us that they were not required to report back to the board on their use of funds, including large transactions, unless actual overall expenditures exceeded the approved budget.

Hospitals used various non-standardized services accounts to record consulting-services

expenditures in their accounting systems, making it impractical to obtain accurate information on each hospital's total annual payments to consultants.

Recognizing the inconsistencies in procurement policies existing in the broader public service, the Treasury Board of Cabinet directed in March 2008 that a Supply Chain Guideline be prepared and, as of April 1, 2009, be incorporated into the Ministry's funding agreements with organizations receiving more than \$10 million per fiscal year. Two key documents were prepared: the Supply Chain Code of Ethics setting out overarching principles of conduct for organizations, their suppliers, advisers, and other stakeholders for acceptable behaviours and standards; and Procurement Policies and Procedures governing how organizations are to conduct their sourcing, contracting, and purchasing. The areas covered include competitive and non-competitive procurement, approval limits, and conflict of interest. The key aims of the procurement policies and procedures were accountability, standardized process, transparency, and value for money. Treasury Board announced that the code and procurement policy were to be implemented by April 1, 2010.

The hospitals we visited were all aware of the new requirements and acknowledged that the new supply-chain policies were an improvement. However, as of April 1, 2010, some hospitals had not yet fully implemented the policies and were still carrying out analyses to assess their policies against the new requirements and determining their training needs. We also noted that the new policy did not require regular reporting by hospitals to their boards to demonstrate hospital management's adherence to the new policy.

Controls over Consultant Use

As Figure 4 shows, there were significant weaknesses in key controls over the use of consultants at most hospitals we visited. Deficiencies were noted across all aspects of planning, acquisition, approval, payment, and management oversight of consult-

Figure 4: Observations on Key Controls over Consulting Services Engagements at 16 Hospitals

Source of data: Procurement Directive, November 2007 and July 2009; and the Office of the Auditor General of Ontario

Key Controls for Best Practices*	Hospitals															
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P
Justification for the use of consultants is documented and proper approval is obtained prior to the engagement.																
Large contracts are procured with a minimum of three quotations or open tendering, as required. Any exceptions to the competitive procurement are formally documented and properly approved.																
All bid proposals and related evaluation summaries are documented to support the bid award decision.																
Formal, signed written contracts are in place before work begins.																
Follow-on contracts are awarded using a separate competitive process; if not, the justification for not doing so is properly documented and approved.																
Invoice payments are tied to specific deliverables, expenses reimbursed are reasonable, and detailed receipts are made available upon request.																
Total payments to consultants are within a pre-set contract ceiling price. Additional payments are justified with proper documentation and approval.																
Consultants make a formal declaration of possible conflict of interest.																

Note: The order in which the hospitals are listed in Figure 1 has no bearing on the order in which they are listed here.

* Hospitals are responsible for establishing their own administrative policies, which we determined were neither as comprehensive as the requirements of the Procurement Directive that applies to the Ministry and LHINs. Although hospitals are not subject to the requirements of the Directive listed in this figure, the Directive nevertheless constitutes a public-sector standard for best practices in key controls for consulting services engagements.

key controls for best practices were generally met

some deficiencies were noted and key controls for best practices were sometimes not met

significant deficiencies were noted and key controls for best practices were consistently not met

not tested since not encountered in our sample selection, or insufficient information

ants. Procurement processes that were fair, open, and transparent to all potential bidders were often not followed. Non-competitive procurement practices and follow-on assignments to existing contracts were used extensively. Oversight was inadequate to ensure that existing policies and proper procedures had been followed before hospitals authorized consultant engagements, and to prevent overpayment of consultants' invoices. Often, documentation that could support decisions was not prepared, was lacking, or had been discarded. Consultants were engaged without comprehensive contractual arrangements. Even recent procurements had significant shortcomings and showed only limited improvements over earlier years' practices.

Without proper documentation, it is impossible to demonstrate accountability and value for money. This problem was particularly evident with single-sourcing procurement methods. For the most part, there was no documentation to explain why a competitive process was not followed. In other cases, where a competitive process was followed, documentation to justify the selection of the winning candidate or the evaluation criteria used was lacking. We noted that written contracts, if they had been established, omitted key deliverables, had been misplaced, or had not been formally approved or signed by all necessary parties before the work commenced. Documentation of subsequent changes to services to be provided and of proper approvals was also absent. For example:

- One hospital single-sourced the engagement of a consultant between June 2007 and June 2008 to speed its development and adoption of electronic health records. However, we found no documentation or justification to indicate why an external consultant was necessary, or outlining the preliminary scope or budget of the project prior to the engagement. In addition, when a contract was finally established, the key deliverables and expectations were not specified and, consequently, the contract was based only on a per diem rate of \$1,100 instead of on the key deliverables

for the project. Also, the contract was never signed by the consultant, and it was signed by a hospital employee who did not have signing authority for a contract over \$100,000. The hospital's records indicated that payments to the consulting firm were more than \$58,000 higher than the contract ceiling price of \$264,000, but there was no evidence that the additional billing was questioned or properly approved. In addition, the hospital had no documentation on hand to explain the extra billing.

- Another hospital initially engaged a consultant as a clinical network co-ordinator for April 2007 to March 2008. The engagement was based on a proposal by the consultant, and no other consultants were invited to compete on a contract. The initial price of this assignment was \$94,000; the assignment was later extended for another year with payments totalling almost \$210,000. During the term of the first assignment, the consultant was awarded another, different engagement for \$77,000 to provide consulting services to a surgery support unit between September 2007 and April 2008. There were no formal contracts in place for these two engagements, and all key requirements, such as the scope of the project, key deliverables, remuneration, ceiling price, and timing, were absent. No documentation was available to explain the need to engage an external consultant or why the engagements were single-sourced.
- In September 2009, a hospital tendered a contract for consulting services to carry out a utilization review of the operating and ambulatory-care rooms. Nine consultants submitted proposals. The hospital's evaluation team short-listed three proposals, but internal documents did not clearly explain how the three were selected. Subsequently, the hospital awarded the contract to the consultant that submitted the highest bid of the three, which, at over \$83,000, was almost double

the lowest bid. The available documentation did not justify the selection of this consultant. Hospital management advised us that it had used a detailed selection process and had based its decision on the quality of the successful consultant's proposal and on the fact that this consultant had more experience than the other bidders. Management acknowledged, however, that the documentation did not provide sufficient information on how it had made its decision.

- In March 2008, a hospital awarded a consulting firm a multi-year contract at a potential cumulative value of nearly \$700,000 to prepare a development and succession-planning program and training for its leadership staff. We noted that, despite the large value of this assignment, the hospital did not develop the normal competitive procurement documents for the project, such as a detailed description of the services needed, deliverables, and time frames. Instead of conducting a tender process, it invited three firms for interviews. Two firms provided written proposals based on their preliminary discussions with the hospital, although they were not required to do so. Hospital staff acknowledged that the two unsuccessful candidates had difficulty understanding the assignment because the hospital had not clearly identified its requirements. As of March 31, 2010, approximately \$300,000 had been spent on this contract.
- A hospital informed us that in August 2007, it asked several consulting firms to submit proposals to manage a detailed request for proposal for an information technology project. Although this was a major project costing over \$170,000, hospital staff were unable to provide the request for proposal, the names and number of firms invited to bid, the bidders' proposals, or any evaluation documentation or criteria used in making the award decision. The project ran from September 2007 to April 2008, and the hospital subsequently

engaged the same consulting firm to provide project-management services costing nearly \$430,000 from May 2008 to May 2009. The hospital paid the consultant \$600,000 for the two assignments without maintaining any documentation relating to the competitive selection process. Hospital staff informed us that only the statement of work submitted by the winning bidder is ever retained. All documentation relating to the unsuccessful bidders and the bidding process is discarded.

The new supply-chain procurement policy now requires hospitals to retain all procurement documents, as well as other pertinent information, for seven years.

Continuous Reliance on Consultants

According to the Directive, "access for qualified vendors to compete for government business must be open and the procurement process must be conducted in a fair and transparent manner, providing equal treatment to vendors. Conflicts of interest, both real and perceived, must be avoided during the procurement process and the ensuing contract, and relationships must not be created which result in continuous reliance on a particular vendor for a particular kind of work." This policy helps ensure that there is equal opportunity for consultants to bid on assignments, and can help reduce an organization's dependence on specific consultants.

Although the Directive does not apply to hospitals, the intent of the policy—that the spending of public funds should be done in a fair, transparent, and open manner—is applicable to them. This is reinforced in the new supply-chain procurement policy. As Figure 4 shows, we found many instances where significant contracts were not tendered, or included no documented justification and/or formal approvals. These contracts often started with the consultant providing its expertise for a short period of time, usually three to six months, but the engagements were extended into continuous agreements with little or no change to the original

deliverables. In other cases, further contracts were provided to the consultants without competition because they had done work for the hospital previously. For instance:

- A hospital awarded at least 15 contracts ranging from a few days to a year between 2007 and early 2010 to a consulting firm to provide various information technology services, including systems upgrades, support and implementation, training, consulting, and other ad hoc services. Only two of the contracts had an established ceiling price, and almost all were based on an hourly rate of \$100. As of February 2010, total payments made to the firm amounted to over \$650,000. There was no documented justification for the contracts or the competitive process used in initially selecting this consultant, and the consultant was not required to submit periodic quotations. The hospital maintained that few local firms could provide this service, resulting in its continued reliance on this one firm.
- A hospital engaged an engineering firm on a single-source basis to provide consulting for a facility assessment in 2008, at a cost of \$165,000. The reasons for single-sourcing the assignment were not documented and no contract for the project specifying the terms of the engagement was signed. We were informed that this engineering firm was selected primarily on the basis of its technical knowledge of the hospital, gained from having been used by the hospital for 20 years.
- One hospital is responsible for administering a province-wide electronic network established in 1999. The Ministry provides funding to the hospital for operating the network. In early 1999, the hospital single-sourced a contract, which has been in continued operation since that time, with a firm for developing, managing, and providing ongoing IT technical services to support the network. Total costs paid to this firm have amounted to about \$60 million since 1999. Over the past three fiscal years, the

firm has been paid approximately \$8.3 million per year. This amount includes the \$180,000 per year the firm charges the hospital for each consultant provided by the firm. The hospital has informed us that these services will be tendered competitively at the end of the current contract term in February 2011.

We also noted that hospitals relied extensively on continuous arrangements for professional services related to construction and capital-related projects. For example:

- A hospital engaged a consulting firm to provide project-management services for a hospital redevelopment project that started in 2002 and was completed in early 2009. Approximately \$3.7 million was paid to the firm in two separate contracts. We were advised that both contracts were single-sourced with neither formal documentation nor board approval because the firm had prior experience with the hospital. The first contract's ceiling price was exceeded by \$180,000; hospital staff could not locate the second contract, valued at \$2.3 million.
- A hospital single-sourced a contract to a facility support firm to provide project management services. At the time of our audit, total payments amounted to \$259,000—\$110 per hour over three years—and had been ongoing since February 2007 without a signed contract. Informal approvals were obtained from the hospital's CEO in 2006, but subsequent cost increases amounting to almost \$140,000 above the \$120,000 original ceiling price had not been formally approved.

Follow-on Engagements

We noted numerous examples in addition to those above where hospitals gave consultants additional work as a result of a previous engagement, often without documenting the rationale for the addition, thereby avoiding having to open the non-competitive

selection process to other potential bidders. For example:

- A hospital engaged a consulting firm on a single-source basis to provide project management in implementing a new information reporting system. The consultant's initial statement of work covered the period from February to April 2008 at a cost of \$163,000. For April 2008 to March 2009, the hospital authorized six follow-on contracts with the firm totalling an additional \$1.1 million.
- A hospital single-sourced an information technology project for \$18,000 to a consulting firm in January 2008. Following completion of the initial work, the hospital then awarded the same firm a related second project for \$150,000. Shortly afterwards, the hospital awarded a third assignment for \$20,000 to complete the overall project. In total, the consulting firm received more than \$195,000 for services that were acquired with no competitive process.
- At one hospital, the Ministry appointed a provincial supervisory team that issued a report in June 2008 including recommendations for "renewal" of board governance. To help implement these recommendations, in August 2008 the hospital engaged on a single-source basis a consultant who had been a member of the provincial supervisory team. The consultant was paid \$60,000 as a member of the provincial supervisory team and approximately \$120,000 in fees and expenses for this assignment. No contract was established specifying the deliverables or specific services to be provided, or the cost of the work.
- A hospital single-sourced a contract to an engineering firm for \$21,000 in early 2007 for assessing its facilities' heating and cooling systems. The consultant presented a report to the hospital in May 2007. The hospital then awarded the next stage of the project to the same consultant at a cost of \$150,000 in

December 2007 with no competitive process. This phase of the project was completed in May 2009. The final phase was awarded to the consultant in January 2010 for \$26,000. If all three phases of the contract totalling \$197,000 had been included in the original procurement, the hospital's policy would have required the work to be tendered competitively.

Controls over Payments to Consultants

When a hospital makes a payment for a consulting service, normal business practices require controls to be in place to ensure that payments are in accordance with original terms of the agreement, that proper approvals are in place before payments are made, and that there is evidence that key deliverables were received and consultant out-of-pocket expenses properly supported. Hospitals should also ensure that invoices from consultants provide sufficient details on the work performed and how the amounts billed, such as the number of hours worked and the billing rates, were arrived at. As Figure 4 indicates, we found that these controls were often lacking. In addition, by compensating consultants on a per diem basis instead of on the basis of a fixed price and fixed deliverables, the hospitals assume the risk and cost of missed deadlines and cost overruns, even when the cause may be the consultants' unsatisfactory performance and inefficiencies.

The following examples illustrate our concerns:

- In April 2006, a hospital single-sourced the engagement of a consulting firm to develop and implement a health information management system. During the first three years, the firm was paid \$398 per hour—\$2.6 million in total—and no fixed ceiling price or specific project deliverables were established. The invoices provided no detail on services rendered or any project accomplishments. Effective April 2009, the hospital required the firm to provide detailed invoices for work

completed, and it paid the firm an additional \$975,000 up to February 2010. We noted that it was the firm that prepared the budgets for this project, and the appropriate hospital authority had not signed the agreements with the firm. Following our visit, a new agreement between the hospital and firm was established, without a competitive process, covering the period March 2010 to October 2010; future payments were fixed at over \$735,000 and based on project deliverables.

- A consultant engaged by a hospital to fill a senior management position was paid approximately \$275,000 annually. From April 2007 to December 2009, this consultant also claimed \$97,000 in fees for other consultants and \$50,000 in administrative support services fees, neither of which was in his contract. The consultant billed the hospital twice for over \$7,000 relating to a salary bonus, foreign exchange fees, and a Christmas luncheon. The hospital also paid this consultant questionable business-related expenses, including accommodation costs of \$400 per night for three nights in Chicago along with \$500 in hotel phone charges; accommodations of \$510 per night on a second four-night trip to Chicago; accommodations of \$700 per night for five nights in Singapore; and dinners in the greater Toronto area, one costing \$300 for three people (including \$140 for alcohol) and another costing \$350 for three people (including \$215 for alcohol).
- Another hospital awarded a consultant three single-sourced contracts and three follow-on contracts from 2007 to 2009, totalling \$608,000, to review the hospital's finances in order to address a budget shortfall and implement recommendations made in the consultant's earlier work. None of the invoices we sampled from this consultant included detailed receipts or justification for the \$170,000 in expenses claimed. As a result of our audit, the hospital asked the consult-

ant for additional details regarding these expenses. The hospital did not get the receipts because the consultant intended to charge a \$3,000 service fee for providing them.

- A hospital single-sourced a contract to a consulting firm to enhance "employee leadership skills." The leadership training consisted of four one-day sessions in June, September, December, and March, and coaching, at a cost of \$3,000 to \$4,000 per employee. Even though the training was provided throughout the year, the hospital paid the total fees up front upon the signing of the contract. The hospital prepaid the consultant \$170,000 in April 2007 and \$210,000 in March 2008.
- A hospital single-sourced a contract of over \$170,000 to a consulting firm to provide Workplace Safety and Insurance Board claims-management services from June 2007 to May 2009. There was no documentation supporting the single-sourcing of the contract, and at the time of our audit the hospital could not locate a signed copy of the contract. We noted that the consulting firm continued to provide services to the hospital after the contract expired. As a result, total payments to date have amounted to \$235,000, or \$65,000 over the original contract price of \$170,000, without any supporting documentation or proper contract renewals.

In other single-sourced contracts, one hospital engaged a former management employee as a consultant within one month of the employee leaving the hospital at fees that totalled about \$240,000 annually, which was \$100,000 more than his previous salary; he was paid for expenses greater than those permitted in his signed contract but provided no supporting receipts. Another hospital prepaid the full contract fee of \$34,000 to a consultant engaged to develop an accountability framework for hospital staff and a related communication plan. When the consultant failed to provide a component of the assignment, the hospital had to request a refund of \$16,500 from the fee it had prepaid.

Employment Arrangements as Consulting Contracts

Several employment arrangements were structured as consulting services contracts, typically for senior management positions. As a result, the arrangements often provided consultants with certain employee salary provisions and benefits. For example:

- One hospital used consulting-services arrangements to engage three individuals between 2003 and 2009, 2004 and 2009, and 2007 and 2008, respectively, to fill three executive staff positions—two vice presidents and a chief financial officer. The two vice-president positions paid approximately \$300,000 and \$220,000 annually, and the chief financial officer position paid \$210,000 annually for a four-day work week. No competitive process was followed to engage these consultants. The hospital provided them with remuneration packages similar to those offered to salaried executive hospital staff. They were paid bonuses, termination settlements, and vacation entitlements, and reimbursed for conference-related expenses. On their departure, one vice president received termination payouts of \$170,000, and the second received \$105,000. In contrast, our experience has been that in typical consulting-services contracts, the termination clauses often provide 30 days' notice with no payout required. In addition, the consultants signed large capital and supplier contracts on behalf of the hospital, even though they were deemed in their contracts not to be the hospital's agents or employees. We have been advised that the hospital has since discontinued its practice of using consultants to fill senior roles.
- At one hospital, a consultant has been engaged since 1999 as the chief executive officer of a provincially funded initiative it administers involving many hospitals and

other health providers. The hospital originally single-sourced the position to this consultant, a former ministry employee. Over the three fiscal years that we reviewed, the consultant had been paid approximately \$275,000 plus taxes annually. The consultant's remuneration is based on a per diem rate of \$1,100 for eight hours of work. We noted that the consultant billed for 250 days worked each year, meaning that every weekday was billed for the last three years, excluding statutory holidays. The hospital informed us that the consultant had not taken any vacations where he was out of contact with the business during this time. This consultant was also reimbursed for travel expenses and fees for several conferences over this time. In May 2008, he received approval from the hospital for a one-week trip to Hong Kong to attend a business-related conference as an invited guest speaker. However, he added a personal one-week trip to Japan as part of the excursion. We noted that the hospital paid the consultant's airfare claim of \$7,800, which included the airfare for his personal trip to Japan, and also paid his fees billed for every work day during the month, which included the two-week trip to both Hong Kong and Japan. Following our inquiries, the hospital has informed us that the consultant has reimbursed half of the airfare. The hospital also informed us that the contract had been poorly drafted and did not accurately reflect the intent of the parties, although the execution of the contract did reflect the intent. The hospital further informed us that it will be revising the contract substantially to better reflect the business arrangements.

- A hospital engaged a consultant as a project manager shortly after he retired from the hospital in January 2008. We were informed that the main reason for not tendering this contract was the consultant's previous knowledge of an ongoing major capital project, gained

while the consultant was employed by the hospital. There was no formal documentation justifying the single-sourcing of this work; the consultant was engaged on an hourly basis with no specific deliverables in his contract. He worked part-time from January 2008 to September 2009 and was paid approximately \$179,000 on the basis of invoices that detailed only the hours worked. At the time of our audit, we were informed that the hospital was exercising an option for an additional two years of services from this consultant.

Procurement Practices for Recent Contracts

The new mandatory supply chain policies did not become effective until April 1, 2010, which was after the period of our review. Our discussions with senior hospital managers revealed that they generally had been aware of the increased emphasis on good procurement practices since mid-2009, about the same time as the revised Directive began to apply to LHINs. Nonetheless, our review of a number of recent consulting-services contracts entered into by hospitals did not indicate that they had yet made any significant systemic improvements to their practices. For instance:

- In the fall of 2009, a hospital initiated an internal review of 14 information technology contracts after it learned that these contracts might not have been awarded in accordance with hospital policy. The review resulted in the termination of 12 contracts. The hospital did not renew one contract because it determined that it had the internal staff to do the work; at the time of our visit, three contracts had been newly tendered using an open-tender process. While one of the contracts was awarded to the lowest bidder, the other two were awarded to the incumbent consultants even though their bids, at \$105,000 and \$88,000, were nearly double the lowest bids. The hospital selected the incumbent firms primarily on the basis of

their technical expertise and prior experience with the hospital. We noted that in one successful bid, the consultant gave as a reference a director of the hospital who was also a member of the selection committee.

- A hospital single-sourced a contract to provide information technology staffing resources beginning in March 2009 at the hourly rate of \$110. We were advised that the consultant was used to replace an employee on temporary leave due to illness. No ceiling price was included in the contract, which was signed by the consultant but not the hospital. The initial contract term was from March 2009 to October 2009, but the hospital extended it verbally to the end of July 2010. The hospital has paid the consultant \$130,000 so far for this assignment. The consultant has submitted no supporting documentation for about \$10,500 in expenses claimed.

Acquisition of Consultants to Lobby Government

The *Local Health System Integration Act, 2006* (Act) provides a framework for the Ministry to fund services provided by hospitals through transfer payments to the LHINs. Under the Act, the Ministry is to enter into an accountability agreement detailing the funding arrangements with each LHIN. The 2007/08 fiscal year was the first year such agreements were created. The Ministry provides each LHIN with multi-year funding targets for both its operating and transfer payment budgets. In turn, each LHIN is to advise and discuss its multi-year funding targets with the hospitals that are party to its services agreements. The Ministry, LHINs, and hospitals are to review these funding targets and allocations annually. The LHIN–Hospital Service Accountability Agreement requires the hospital to ensure that government funding is used to provide clinical services or activities to support these services.

Although the funding frameworks and mechanisms that apply to all hospitals are intended to

provide fair and equitable operating and capital funding for each hospital, eight of the 16 hospitals we visited had engaged consultants to lobby the provincial government and, in some cases, the federal government, using hospital funding that included funds acquired from the Ministry. The services were typically referred to as “providing advocacy, representation, and government relations communications services” to the hospitals. Payment arrangements varied from a fixed monthly retainer to ad hoc fees. Our discussions with hospitals’ senior management noted that these services were often helpful in lobbying for capital funding or to bring more attention to their funding needs.

These eight hospitals spent over \$1.1 million on lobbying firms over the three-year period we examined, ranging from about \$11,000 to almost \$100,000 per year. Some of these hospitals had lobbyist arrangements dating back several years; we are aware of a further \$550,000 paid by these hospitals as far back as 2002. Three of these eight hospitals had terminated the contracts with their lobbyists over the previous two years, but five had ongoing arrangements at the time of the completion of our audit. For example:

- In 2002, a hospital single-sourced a contract valued at about \$51,000 to a lobbying firm for a six-month term. The firm continued to receive a monthly retainer for seven years until the hospital’s new chief executive officer terminated the arrangement in September 2009. In total, the firm received fees amounting to \$675,000. We were informed that this firm was engaged mainly due to its experience and political relationships. Its invoices generally lacked an itemized account of the specific services provided, the personnel who provided the services, or the number of consulting hours it incurred.
- Another hospital engaged a lobbying firm at a total cost of \$130,000 over the past three fiscal years. In addition, the hospital engaged a second firm to lobby the government to provide funding for a provincially funded

initiative. Over the past three fiscal years, the second firm has charged a monthly retainer of \$4,000, at a total cost of \$159,000.

- A hospital and a lobbying firm signed a letter of proposal in 2006 for a one-year contract costing \$72,000. We were advised that three firms had been interviewed, but no documentation was available. The initial arrangement has been renewed annually on an informal basis and was in place at the completion of our audit. Between 2006 and March 31, 2010, the hospital paid the firm a total of \$275,000. Its invoices lacked specifics on the deliverables provided to the hospital.
- In 2009, a hospital engaged a lobbying firm at cost of \$50,000. The hospital was unable to provide documentation on the assignment, other than invoices from the firm, and said that the firm provided “general lobbying services.” Hospital senior management later clarified that the lobbying was directed at federal funding opportunities. This purpose could be ascertained from only about half of the invoices we reviewed, as the remaining invoices did not have details of the specific lobbying activities.
- Another hospital contracted with a firm to lobby the government on funding and capital project approvals from 2005 to August 2009. The hospital paid the firm \$3,000 per month, approximately \$157,000 over the life of the agreement. In August 2009, the hospital engaged a different lobbying firm on an ongoing basis at a cost of \$7,000 per month.

Although the amounts spent on consultants for lobbying activities were relatively small in comparison to hospitals’ overall funding, engaging firms with provincial government funding to lobby the provincial and federal governments for more funds is a questionable use of funds provided to hospitals for clinical and administrative activities. Also, lobbying by some hospitals could disadvantage other hospitals that do not engage firms to lobby the Ministry and LHINs in connection with the funding-allocation process.

Hospitals Acting as Paymasters for the Ministry or LHINs

As discussed earlier in this report, the Ministry brought to the attention of the Ontario Internal Audit Division two single-sourced contracts totalling approximately \$950,000, where the Ministry paid consultants using transfer-payment funding paid to a non-profit corporation to acquire consulting services for the Ministry. We also noted several similar instances of this during our visits to hospitals. In these cases, the consultants were selected, contracted, and managed by the Ministry or the LHIN, but the hospitals paid the consultants' invoices using funding that flowed from the Ministry or LHIN. The payments in these cases were recorded as transfer payments to the hospital instead of consulting-services payments, and thus the hospital, the Ministry, and the LHIN were not accountable for the consulting-services contractual arrangements and for following the Directive. For example:

- In 2008, the Ministry signed an agreement with a university to undertake a study of the critical-care nursing workforce from April 2008 to March 2012, at a cost of \$300,000. The hospital's role was to pay the university's invoices, once they were approved by the Ministry, with specific Ministry-provided funding. In this instance the hospital was not actually paying the university listed in the contract, but rather an individual who worked for the university; the hospital was unaware of this. The hospital informed us that it subsequently contacted the university in April 2010 and learned that the individual receiving payments from the hospital had been endorsing the cheques and forwarding them to the university since 2008.
- One hospital received \$150,000 in November 2008 from its LHIN. The LHIN then single-sourced a consulting firm to undertake a review of area emergency departments at a cost of \$84,000. All consultant invoices, once approved by the LHIN, were forwarded

to the hospital for payment. The LHIN then instructed the hospital to pay other consultants engaged by the LHIN using the unspent balance of \$66,000.

RECOMMENDATION 3

To ensure that hospitals implement the necessary policies, procedures, and processes for the cost-effective planning, acquisition, and management of consulting services:

- hospital boards of directors should ensure that recent mandatory supply-chain procurement policies for goods and services are implemented and enforced, and that open, fair, and competitive procurement processes are in place; and
- hospitals should track and regularly report to Local Health Integration Networks (LHINs) on their use of consultants in a manner that demonstrates their compliance with required policies and sound public-sector business practices.

The Ministry of Health and Long-Term Care should discontinue the use of transfer-payment funding to acquire consulting services for either its own or LHIN use and should assess the appropriateness of hospitals' use of government funds to engage consultants to lobby the Ministry and their LHINs for increased operating and capital funding.

HOSPITAL RESPONSE

The hospitals acknowledged the issues we raised regarding the need for improvement in the planning, procurement, and management of consultants. They agreed with our recommendations with perhaps one exception, in that a number questioned the need for detailed reporting to their respective LHINs on consultant use. As an alternative, several suggested that incorporating the requirement in the LHIN-Hospital Service Accountability Agreement that

hospitals comply fully with the new broader-public-sector Supply Chain Guideline covering mandatory requirements for procurement and the code of ethics would provide assurance to the LHINs that hospitals were complying with the new policies.

We are pleased to note that almost all the hospitals indicated to us that they had initiated regular reporting to their boards of directors on their use of consultants. A number of hospitals also indicated that they had improved their practices since the completion of our audit work.

Several hospitals commented on the Ministry and the LHINs' use of hospital transfer-payment funding to acquire consulting services for their own use and agreed that this practice should be discontinued. One hospital commented that past practices lacked transparency and often involved organizations over which it had little control in terms of the services provided and how the funds were used.

With respect to the use of lobbyists, we received a variety of responses. Most of the hospitals that commented on this issue agreed it was either an inappropriate use of funds or, at the very least, that it was a practice that the Ministry should review. Two hospitals advised us that their lobbying efforts were directed at finding federal funding opportunities, and another hospital informed us that, following our audit, it no longer had any consultants engaged in lobbying. One hospital informed us that it engages "government relations" consultants on an as-needed basis to provide strategic advice

and direction only on complex processes and policy issues, and that it did not engage consultants to lobby the government for increased funding. Another hospital stated, "Our decision to selectively use lobbyists, we firmly believe, provides excellent value for money in facilitating the appropriate and timely access to decision-makers who can support our corporate health-care goals within the provincial health-care system. In the case of [our hospital], the lobbyists we used were for the sole purpose of our capital project."

MINISTRY RESPONSE

The Ministry of Health and Long-Term Care agrees with this recommendation and confirms that hospitals need to have supply-chain codes of ethics, procurement policies, and procedures in place that are consistent with the mandatory broader-public-sector Supply Chain Guideline. The Ministry will work with the LHINs and hospitals to implement this recommendation.

The Ministry agrees that the use of transfer payment funding for ministry procurement should be discontinued and that funding should be provided directly by the Ministry to the appropriate transfer-partner recipient. The Ministry has strengthened its processes and controls to end this practice.

The Ministry also recognizes that ministry funding should not be used for lobbying activities and it will address this issue with the hospitals.