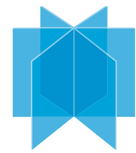

OFFICE OF THE
AUDITOR GENERAL
MANITOBA

Follow-up of Recommendations

March 2018

Our vision

The Office of the Auditor General is an accessible, transparent and independent audit office, serving the Manitoba Legislature with the highest standard of professional excellence.

Our mission

To provide the Legislative Assembly with high quality audits and recommendations, and to focus our resources on areas of strategic importance to the Assembly.

Our values

- Respect
- Honesty
- Integrity
- Openness

Our priorities

- Strengthen the management systems and practices of government organizations
- Provide Members of the Legislative Assembly with relevant and useful information on the performance of government entities
- Support the Public Accounts Committee in its efforts to improve the performance of government organizations
- Manage our internal business efficiently, effectively and economically

Our critical success factors

- Independence from government
- Reliable audit opinions and conclusions
- Relevance of audit work performed
- Knowledge, skills and abilities of our staff

March 2018

The Honourable Myrna Driedger
Speaker of the House
Room 244, Legislative Building
450 Broadway
Winnipeg, Manitoba R3C 0V8

Honourable Ms. Driedger:

It is an honour to provide you with my report titled, *Follow-up of Recommendations*, to be laid before Members of the Legislative Assembly in accordance with the provisions of Section 28 of *The Auditor General Act*.

Respectfully submitted,

Norm Ricard, CPA, CA
Auditor General

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Auditor General's comments

Auditor General's comments

In this report we present the statuses of 224 recommendations as at September 30, 2017. We note that 96 (43%) have been implemented. We believe that significant progress has been made on 15 of the 119 recommendations that remain in progress.

We follow-up the status of recommendations for 3 consecutive years, beginning a year to 18 months after issuance. As such, this is the final follow-up for the 98 recommendations included in our March 2014 Report to the Legislature (comprised of 9 chapters) and the 2 recommendations included in the August 2013 Report to the Legislature. With respect to these 100 recommendations, we note that only 67 have been implemented. Of the 31 recommendations still in progress, significant progress is only evident on 4. Of particular note is that several recommendations that I believe are very important remain largely unimplemented. These recommendations deal with:

- conducting independent quality assurance reviews on STARS clinical operations.
- developing a long-term capital plan for adult correctional facilities.
- developing a values and ethics policy or code of conduct for all civil servants.
- monitoring how well government departments are implementing ethics-related policies and providing support to those with less-developed implementation processes.
- providing public servants with a vehicle to anonymously report concerns of ethical misconduct.

I encourage the Public Accounts Committee to continue monitoring the status of these recommendations by requesting detailed action plans from each of the relevant government organizations and critically assessing the adequacy of planned actions and the appropriateness of the planned timeframe. The Committee should also consider which of the other in-progress recommendations, if any, it should continue monitoring.

I would like to take this opportunity to thank the many public servants we met with during our follow-up reviews for their cooperation and assistance, and for providing progress reports and support documentation by the requested dates. This made it possible for us to conduct our work and to issue this report within the planned timeframes.

Norm Ricard, CPA, CA
Auditor General

Follow-up process

Follow-up process

A follow-up review begins when we request a status update from management. The implementation status is to be determined as at the forthcoming September 30. When status updates are received we conduct review procedures (see Nature of a review on page 8) to assess the plausibility of the recommendation statuses provided. We do not re-perform audit procedures from the original audit.

A follow-up review is scheduled 12 to 18 months after an audit report is released, and annually thereafter for 2 more years (for a total of 3 years).

Status categories

The implementation status of each recommendation is described using one of the following categories:

Implemented/resolved
The recommendation has been implemented or an alternate solution has been implemented that fully addresses the risk identified in the original report.

Action no longer required
The recommendation is no longer relevant due to changes in circumstances.

Do not intend to implement
Management does not intend to implement our recommendation or to otherwise address the risk identified in our original report.

Work in progress
Management is taking steps to implement our recommendation.

Report format

This report includes 13 follow-up reports. We have organized the follow-up reports into 2 sections:

- No additional follow-up reviews scheduled.
- At least one more follow-up review scheduled.

For each follow-up report we identify who is responsible for implementing our recommendations. The Public Accounts Committee (PAC) will be able to use this information to identify the appropriate witnesses to call to their meetings.

Follow-up reports include a chart indicating the current implementation status of our recommendations as at September 30, 2017, as well as tables listing all the recommendations made, organized by implementation status.

For select recommendations we have added an "OAG comment" to clarify implementation status and/or to highlight select actions or planned actions.

OAG comments included in prior year(s) follow-up reports for recommendation considered implemented/resolved at that time are reprinted in this report.

Nature of a review

In conducting our recommendation follow-ups, we perform a review rather than an audit.

In a review, we provide a moderate level of assurance. Our review consists primarily of inquiry, analytical procedures and discussion related to information supplied. The evidence obtained through these procedures enables us to conclude on whether the matter is **plausible** in the circumstances. We do not re-perform audit procedures from the original audit.

In an audit, we provide a high, though not absolute, level of assurance. We achieve this high level of assurance by gathering sufficient appropriate audit evidence. Audit procedures would include: inspection, observation, enquiry, confirmation, analysis and discussion. Use of the term "high level of assurance" refers to the highest reasonable level of assurance auditors provide on a subject. Absolute assurance is not attainable because much of the evidence available to us is persuasive rather than conclusive, as well as, the inherent limitation of control systems, and the use of testing and professional judgment.

Results of our follow-up reviews

Results of our follow-up reviews

Review comments

Our follow-up reviews were conducted in accordance with Canadian generally accepted standards for assurance engagements, and accordingly consisted primarily of inquiry, analytical procedures and discussion related to information supplied.

A review does not constitute an audit and consequently we do not express an opinion on these matters.

Our follow-up reviews assessed the implementation status of our recommendations as at September 30, 2017.

With respect to the implementation status of the recommendations followed-up, nothing has come to our attention to cause us to believe that the status representations made by entity management do not present fairly, in all significant respects, the progress made in implementing the recommendations.

Summary of implementation status

In this report we note the implementation status of 224 recommendations issued since August 2013. As detailed in **Figure 1**, we concluded that:

- 96 have been implemented/resolved.
- 5 were no longer relevant due to changed circumstances.
- 4 will not be implemented.
- 119 remain in progress.

Many factors must be considered when assessing whether the implementation rate is satisfactory including: complexity of the recommendations, the operating priorities of the entity, the significance of the underlying issues, resourcing implications, and capacity of the entity.

In conducting our follow-up reviews we generally do not assess the reasonableness of an entity's decisions regarding the efforts applied to fully implement our recommendations. We believe this is a role best played by the Public Accounts Committee. As such, we continue to encourage the Committee to request appropriately detailed action plans for some or all of the recommendations that remain in progress, particularly in relation to those reports that we have followed up for 3 years and for which we do not intend to continue following up.

Figure 1: Implementation status, as at September 30, 2017

Report	Total recommendations	Recommendations considered cleared			Work in progress
		Implemented/ resolved	Action no longer required	Do not intend to implement	
No additional follow-up reviews scheduled					
August 2013					
Rural Municipality of Lac du Bonnet	**2**	**1 (50%)**			**1 (50%)**
March 2014					
Accounts and Financial Statements	7	1	1	1	4
Citizen Concerns – Manitoba Hydro Funding of the Keeyask Centre	(Note 2)				
– Town of Lac du Bonnet – Bulk Water Sales (Note 1)	1	1			
Helicopter Ambulance Program	5	1			4
Lake Manitoba Financial Assistance Program: Parts C and D	(Note 3)				
Managing the Province's Adult Offenders	29	23			6
Manitoba's Framework for an Ethical Environment	20	13			7
Manitoba Hydro – Managing Cyber Security Risk Related to Industrial Control Systems	8	7			1
Northern Airports and Marine Operations (Note 1)	3	3			
Waiving of Competitive Bids	25	17			8
Total	**98**	**66 (67%)**	**1 (1%)**	**1 (1%)**	**30 (31%)**
At least one more follow-up review scheduled					
July 2015					
WRHA's Management of Risks Associated with End-user Devices	12	3			9
Manitoba Home Care Program	46	17			29
Total	**58**	**20 (34%)**			**38 (66%)**
January 2016					
Improving Educational Outcomes for Kindergarten to Grade 12 Aboriginal Students	**19**	**2 (11%)**		**1 (5%)**	**16 (84%)**
July 2016					
Management of Provincial Bridges	**20**				**20 (100%)**
September 2016					
Keeyask Process Costs and Adverse Effects Agreements with First Nations (Note 2)	3	1			2
Manitoba East Side Road Authority	24	6	4	2	12
Total	**27**	**7 (26%)**	**4 (15%)**	**2 (7%)**	**14 (52%)**
Grand Total	**224**	**96 (43%)**	**5 (2%)**	**4 (2%)**	**119 (53%)**

Notes to Figure 1

Note 1: All recommendations in these Reports were implemented as at June 30, 2015. They are noted here in order to list all the chapters included in our March 2014 Report to the Legislature.

Note 2: The recommendation noted in the March 2014 Report to the Legislature under Citizen Concerns - Manitoba Hydro Funding of the Keeyask Centre was followed up as part of our September 2016 report on Keeyask Process Costs and Adverse Effects Agreements with First Nations. It is noted here in order to list all the chapters included in our March 2014 Report to the Legislature.

Note 3: Because Lake Manitoba Financial Assistance Program is not an ongoing project, the 21 recommendations included in the Report are considered lessons learned for future programs. It is noted here in order to list all the chapters included in our March 2014 Report to the Legislature.

No additional follow-up reviews scheduled

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Manitoba Hydro – Managing Cyber Security Risk Related
to Industrial Control Systems 41
Waiving of Competitive Bids 44

No additional follow-up reviews scheduled

Rural Municipality of Lac du Bonnet

Our recommendations were originally directed to the Department of Local Government and the Rural Municipality of Lac du Bonnet. Due to a government reorganization, government of Manitoba recommendations are now directed to the Department of Municipal Relations.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – August 2013	January 13, 2014 May 21, 2015 (Passed)
First follow-up – May 2016	May 8, 2017 (Passed)
Second follow-up – March 2017	May 8, 2017 (Passed)

What our original report examined

In March 2008, we began receiving allegations about poor administrative practices in the Rural Municipality of Lac du Bonnet (RM). We reviewed the more significant allegations relating to the RM's administrative practices.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 1 of our 2 recommendations has been implemented as at September 30, 2017.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**1**	**-**	**-**	**1**	**2**

Because we have followed up on the *Rural Municipality of Lac du Bonnet* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	-	-	-
March 2017	1	-	-
May 2016	-	-	-
Total	**1**	-	-

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. We have added an "OAG comment" to highlight select actions and planned actions by the Department.

Work in progress

We recommended that:

2. The Province follow-up on the property taxes written off at the tourist camp.

   OAG comment: *The Department of Municipal Relations (the Department) advised us that a committee within the Department of Sustainable Development continues to review The Crowns Land Act. The Department of Municipal Relations is represented on the committee. The review includes determining how to strengthen enforcement of Crown Land leases where property taxes owing have not been paid by the lessee.*

   The Department advised us that they have completed their review of other provinces' practices on writing off uncollectible taxes and assessed their applicability to Manitoba. They noted that legislative changes would be required to implement similar practices.

   They also indicated that given that the loss of property tax revenues impacts all other property owners in the municipality, careful consideration of any new authority for tax cancellation would be required.

   The Department noted that it will continue to provide individual municipalities with advisory supports to address concerns about non-payment of property taxes, if requested.

Considered cleared

March 2017 – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

1. The RM and the Planning District improve their overall administrative practices and the Province monitor progress.

Accounts and Financial Statements

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report - March 2014 (Chapter 1) *(relates to our audit of the Public Accounts and other financial statements for the year ended March 31, 2013)*	September 3, 2014 January 28, 2015 November 4, 2015 (Passed)
First follow-up – May 2016	November 30, 2016 (Passed)
Second follow-up – March 2017	December 19, 2017 (Passed)

The Auditor General Act (the Act) requires that the Auditor General report to the Assembly by December 31st each year on the examinations and audits conducted under Section 9 of the Act. This section of the Act relates to audits of the Public Accounts and other financial statements included in the Province of Manitoba's Public Accounts. Section 10(2) of the Act requires that the Auditor General report anything resulting from this work that the Auditor General considers should be brought to the Assembly's attention.

In this follow-up report we note the status of all recommendations issued as a result of our audit of the Public Accounts and other financial statements included in the Government Reporting Entity (GRE) for the year ended March 31, 2013. No new recommendations were issued as a result of our audit for the Public Accounts and other financial statements for the years ended March 31, 2014, 2015 and 2016.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Recommendations directed to Finance - Status as at September 30, 2017

As shown in the table below, one of our 6 recommendations directed to Finance has been implemented as at September 30, 2017. The Department does not intend to implement Recommendation 4 and Recommendation 5 is no longer relevant (see comments below).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**1**	**1**	**1**	**3**	**6**

In our *May 2016 Follow-up* report, we noted that the Department did not intend to implement Recommendation 1. The Department has reconsidered its position on this recommendation. As such the recommendation is included in "Work in Progress".

Also in our *May 2016 Follow-up* report, we noted that the Department did not intend to implement Recommendation 4 which dealt with fixed dates for quarterly reports. The Department noted that the release dates for quarterly reports must consider a balance between timely information versus more accurate information and that set release dates may not provide sufficient time to ensure the accuracy of certain quarterly reports.

The status of Recommendation 5, which dealt with communications between Finance, Manitoba Infrastructure and the East Side Road Authority (ESRA) is now reported as Action no longer required. As of May 2016, Manitoba Infrastructure assumed responsibility for the operations of ESRA.

Below we list the recommendations that remain in progress and the recommendations considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status and to highlight select actions or planned actions.

Work in progress

We recommended that:

1. The Department of Finance account for seconded employees consistently – regardless of the cost recovery process.

   ***OAG comment**: The Province has revised its note disclosure in the Public Sector Compensation Disclosure report to include more information on the inclusion or exclusion of seconded employees and self-employed contractors in the report. However, increased note disclosure does not eliminate the inconsistent treatment of employees under secondment or interchange agreements to or from organizations for which the province administers the payroll. The Department has indicated that they will review their policy of using the method of cost recovery in determining whether a seconded employee is included or excluded from the report.*

3. The Province provide disclosure of vendor payments by all entities in the government reporting entity.

   ***OAG comment**: The Province has not yet determined whether it will implement this recommendation.*

6. The Province specify in a policy or regulation the type of expenses to include in the *Report of Amounts Paid or Payable to Members of the Legislative Assembly* for expenses that the *Members' Allowance Regulation* does not cover.

   ***OAG comment**: The Province developed a policy to include in the Report expenses coded as "processed on account of a member". But there is no policy on the type of expenses that must be "processed on account of a member". The Province has indicated they will review whether a policy or regulation is required. In our view, a policy, regulation or change in legislation is needed, as there is no clarity on what expenses should be recorded as "processed on account of a member". This may result in inconsistent reporting of expenses between members.*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

We recommended that:

2. The Province increase the threshold for the *Statement of Payments in Excess of $5,000* to reflect the Province's objectives of the disclosure. We also recommend that the Province set up a mechanism to regularly adjust the threshold.

   OAG comment*: We note that the threshold has been increased to $50,000. The Minister has approved the intent to index the threshold to inflation to permit periodic revisions to the threshold. It is unclear when this will result in amendments to the threshold.*

March 2017 report – *status as at September 30, 2016*

Action no longer required

5. Finance, Manitoba Infrastructure and Transportation (MIT) and the Manitoba Floodway and East Side Road Authority (MFESRA) improve their communication with each other to ensure information is promptly reported and reviewed by all parties to prevent errors.

May 2016 report – *status as at June 30, 2015*

Do not intend to implement

We recommended that:

4. The Province set fixed dates to release its quarterly reports.

Recommendation directed to another entity - Status as at September 30, 2017

The one recommendation directed to another entity remains in progress.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**-**	**-**	**-**	**1**	**1**

Below we list the recommendation that remains in progress.

Work in progress

We recommended that:

7. The Northern Affairs Fund complete its financial statements in compliance with the Act.

   OAG comment*: The Northern Affairs Fund issued its audited 2014 financial statements on June 1, 2017.*

   As at September 30, 2017, the Fund's financial statements for the years ended March 31, 2015, 2016 and 2017 had not yet been finalized. We continue to wait for these statements to be presented for audit.

Helicopter Ambulance Program

Our recommendations were originally directed to the Department of Health. An amended Service Provider Agreement (SPA) between the Shock Trauma Air Rescue Society (STARS) and the Winnipeg Regional Health Authority (WRHA) took effect on August 1, 2014. As a result, Recommendations 2 - 5 are now directed to the WRHA. Recommendation 1 is directed to both Health and the WRHA.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – March 2014 (Chapter 4)	July 9, 2014
First follow-up – May 2016	-
Second follow-up – March 2017	-

What our original report examined

Our audit objectives were:

- To assess if procurement of the helicopter ambulance program was in compliance with provincial tendering principles, polices, and legislation.
- To assess if the Department of Health has an appropriate oversight process to ensure compliance with key elements of the SPA.

During the course of the audit other matters were brought to our attention regarding quality of patient care concerns.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 1 of our 5 recommendations has been implemented as at September 30, 2017.

Of the 4 recommendations that remain in progress, we note that significant progress has been made on one (Recommendation 4).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**1**	**-**	**-**	**4**	**5**

Because we have followed up on the *Helicopter Ambulance Program* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	-	-	-
March 2017	-	-	-
May 2016	**1**	-	-
Total	**1**	**-**	**-**

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status and to highlight select actions or planned actions.

Work in progress

We recommended that:

1. Health develop and implement an ongoing quality assurance process to oversee STARS clinical operations.

OAG comment:

Manitoba Health

Manitoba Health has put forward legislation entitled The Emergency Medical Response and Stretcher Transportation Amendment Act. This Act would provide the Provincial Medical Director with authority to receive and independently review Air, Land, or Stretcher transport reports. The proposed Act would also provide the Provincial Medical Director with authority over general oversight of emergency medical response systems; establishing quality assurance program requirements; and other duties as assigned.

Winnipeg Regional Health Authority (WRHA)

WRHA has developed an integrated quality assurance program for STARS within an overall clinical and quality oversight framework. WRHA advised that the clinical and quality oversight framework includes three components:

1. *Internal: STARS internal quality assurance processes.*
2. *Collaborative: WRHA/STARS joint quality assurance processes.*
3. *Independent: Oversight through the Provincial Medical Director quality assurance processes. (See above.)*

Work in progress (cont'd)

Three subcommittees/working groups reporting to the Joint Operating Committee (JOC) support the quality assurance plan:

- *The Performance Metrics Sub-committee is responsible for operational, clinical and financial performance metrics and reporting schedules.*
- *The Clinical Sub-committee is responsible for establishing the WRHA/STARS integrated quality framework, reviewing STARS' training curriculum and clinical protocols, and making associated recommendations to JOC.*
- *The Dispatch Working Group is responsible for ensuring evidence informed criteria for dispatching STARS to scene calls and inter-facility transfers.*

Although the Provincial Medical Director office is currently operating, we note that the Act has not yet been proclaimed and that the office has yet to directly conduct a quality assurance review. Independent quality assurance is a best practice for overseeing the performance of a third-party provider. This is all the more vital in this situation given the quality of care concerns noted in the initial report.

2. Health conduct a risk assessment to identify key performance areas. We also recommend that Health develop a performance management framework for key areas, including performance metrics, assignment of responsibility for information, timing requirements and corrective actions.

   OAG comment: *Our original report noted that: "Many sections of the SPA set operational requirements for STARS. But many of these requirements lack performance indicators or metrics for management to assess STARS' performance." This recommendation deals with our finding of a lack of operational and administrative oversight. A comprehensive analysis of all key performance areas and associated risks has yet to be produced. To date the WHRA has identified a number of clinical risks, but these do not respond to the key element of this recommendation, which would answer the question of how well the contract is working.*

3. Health differentiate performance expectations for inter-facility transport and scene call chute times.

   OAG comment: *We note that the contract between WRHA and STARS states: "at all times while it is required hereunder to provide Services, deal with all requests for its services within 15 minutes of receipt of a dispatch request..." This does not differentiate performance expectations for inter-facility transport and scene call times. WRHA officials have stated they are working towards standards based on patient needs.*

4. Health review operational issues, including manifests, stand downs, referral emergency physician (REP) access, and landing zones. We also recommend that Health develop policies to monitor and track operational issues and prescribe corrective actions for breaches of these policies.

   OAG comment: *<u>Significant progress</u> - In 2016 we commented that the JOC addressed the operational issues noted except for monitoring flight manifests. Flight manifests are an excellent tool for the WRHA to verify vendor compliance for provisions of the SPA dealing with staff compliment (e.g. one paramedic and one nurse or doctor and that they are licensed in Manitoba).*

Considered cleared

May 2016 report – *status as at June 30, 2015*

Implemented/resolved

We recommended that:

5. Health develop a process to ensure that certificates of insurance are updated annually.

Managing the Province's Adult Offenders

Our recommendations are directed to the Department of Justice.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – March 2014 (Chapter 6)	August 27, 2014 October 31, 2016
First follow-up – May 2016	October 31, 2016
Second follow-up – March 2017	-

What our original report examined

We examined how adequately the Department managed adult correctional centre capacity, adult offenders in the community, adult rehabilitation programs, and related public performance reporting.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 23 of our 29 recommendations have been implemented as at September 30, 2017.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**23**	*	*	**6**	**29**

* Action is no longer required on Recommendation 14(a). The Department does not intend to implement Recommendations 27(b), 28(a) and (d). The other components of Recommendations 14, 27 and 28 have been implemented.

In our *March 2017 Follow-up* report, the Department advised that it does not intend to implement Recommendation 27(b) with regards to tracking and monitoring the use of Department workbooks and agency referrals as it does not feel that this information would be useful in assessing the offender programming being offered.

In our *May 2016 Follow-up* report, the Department advised that Recommendation 14(a) is no longer required as the automated curfew calling has been discontinued. The Department also advised that it does not intend to implement Recommendation 28(a) and (d). Officials are satisfied with the current method of calculating recidivism and do not believe that additional recidivism information and the extra work required to obtain it will be of any added benefit to the Department.

Because we have followed up on the *Managing the Province's Adult Offenders* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared

Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**3**	-	-
March 2017	**10**	-	-
May 2016	**10**	-	-
Total	**23**	-	-

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status and to highlight select actions or planned actions. OAG comments included in a prior year follow-up report, for recommendations considered implemented/ resolved, are reprinted below.

Work in progress

We recommended that:

2. The Department set system-wide, clearly defined accommodation standards for all correctional centres.

   OAG comment: *The Department has started developing accommodation standards to be applied to new facilities and plans to work on accommodation standards on existing facilities through the development of a master capital plan. (See Recommendation 7).*

4. The Department formally assess the likely costs, risks, and benefits - particularly the potential reduction in bed demand and related capital and operating cost savings - of expanding and improving the following: bail support programs, drug and mental health courts and related treatment programs, electronic monitoring, and initiatives to reduce the time to trial and case disposition.

   OAG comment: *The Department is currently in the process of implementing a number of restorative justice, reintegration and intensive case assessment initiatives designed to decrease time in custody. These will help address overcrowding issues in general, but do not directly focus on the remand population (those charged, but not yet tried or convicted) or case velocity (time to trial). Our original March 2014 report showed the remand population accounted for 64% of all adult offenders in custody and this percentage has remained constant.*

Work in progress (cont'd)

7. The Province have the Department work with Manitoba Infrastructure and Transportation to prepare a comprehensive, long-term capital plan that:
   a. responds to any bed shortfall identified by updated adult custody population forecasts, as well as the Department's plans to reduce bed demand.
   b. identifies and responds to the significant repairs, maintenance, and replacement work required to properly upgrade and maintain aging adult correctional centre infrastructure.
   c. includes future capital and operating cost estimates, as well as an estimated cost of deferred maintenance.

   OAG comment: *The Department has completed the first stage of a planned 2-stage project to develop a master capital plan. Approval for the second stage is awaiting government's overall review of capital projects.*

16. The Department make its custody release planning more meaningful and helpful for offenders transitioning to community living.

    OAG comment: *The Department's Quality Assurance and Evaluation Unit plans to complete its review of applicable current best practices in the near future. In addition, the Department intends to soon launch a new reintegration program that will be incorporated into its custody release planning.*

21. The Department:
    a. clarify the quality assurance roles of coach trainers and area directors.
    b. ensure that the quality assurance activities are conducted on an on-going basis throughout the year, results reviewed, plans for improvement developed, and progress against plans regularly monitored.
    c. ensure that templates used for quality assurance processes cover all key standards.

    OAG comment: *The Department has implemented 21(a) and (c). The Quality Assurance and Evaluation Unit continues to work on fully implementing 21(b).*

29. The Department expand its public performance reporting to include information on overcrowding levels and impacts, and rehabilitation programs offered and their outcomes.

    OAG comment: *The Department is working on its public performance measures and expects them to be available March 2018.*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

We recommended that:

1. The Department track and monitor key overcrowding trends and impacts in adult correctional centres, including the average number of offenders double-bunked in formerly single cells, triple-bunked, in dorm style accommodation in gym space, and in other types of less-preferred arrangements.

19. The Department regularly monitor whether the training and security-check requirements for probation officers are being met and properly documented, and remedy any gaps.

Considered cleared (cont'd)

26. The Department improve coordination of inter-agency case management activities by working with:
    a. the Addictions Foundation of Manitoba and other addictions organizations to ensure offenders' needs are being met.
    b. the Addictions Foundation of Manitoba, Employment and Income Assistance, and Regional Health Authority staff to develop more integrated case management planning for very-high-risk offenders and information-sharing protocols for common clients.

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

10. The Department:
    a. investigate why a significant number of offender risk assessments are late and not properly updated, develop a plan for improvement, and regularly monitor progress.
    b. ensure that all staff clearly document the specific risk-assessment information verified and the details of the verification work performed, including the names and dates of any collateral contacts.

11. The Department take steps to ensure that probation officers schedule first in-person contacts with offenders within the one-month timeframe specified in Department policy.

13. The Department develop risk-based guidelines to help probation officers decide when court-ordered conditions require active monitoring, when self-reported compliance requires collateral or other verification, and the level of file documentation required for monitoring activities.

15. The Department:
    a. ensure staff properly apply its policy on offender non-compliance.
    b. improve the quality of documentation supporting decisions not to charge offenders who breach their conditions.

17. The Department prioritize the development of case management plans by offenders' risk levels, regularly monitor the timeliness and quality of the plans, and develop strategies to improve them.

18. The Department review the quality of case management progress notes after implementing its planned system changes and correct any remaining deficiencies.

22. The Department better assess the reasonableness of probation caseloads by:
    a. developing active and non-active file flags.
    b. examining the feasibility of assigning workloads indexes to offender files.
    c. tracking the time each probation officer spends monthly preparing pre-sentence reports, travelling, and delivering group programming.

    OAG March 2017 comment: *The Department assessed the reasonableness of probation caseloads by conducting a workload analysis, rather than through the steps outlined above. This resulted in a rebalancing of probation caseloads.*

24. The Department better align programming and offenders' needs by:
    a. completing the series of workbooks addressing criminogenic needs.
    b. regularly extracting and analyzing relevant data from its databases to more fully identify and understand offenders' profiles and needs.
    c. working with Aboriginal stakeholders to ensure that all programs and materials are culturally appropriate and recognize the unique needs of Aboriginal offenders.

Considered cleared (cont'd)

25. The Department:
    a. centrally direct its rehabilitation programming.
    b. determine the core programming to be consistently offered in all correctional centres, all community supervision offices, and all centres and offices.
    c. ensure that all community supervision offices have up-to-date directories of the external agency programming available in the local community for offenders.
    d. compare the programming available internally and externally to offenders' needs to identify programming gaps and develop plans for improvement.

    OAG March 2017 comment: *With respect to 25(d), the Department advised that its comparison of available programming to offender's needs has identified no gaps. We noted that some desirable programming is not consistently offered in all correctional centres (such as the Winding River addictions program, which is offered only at Headingley Correctional Centre).*

27. The Department:
    a. track and monitor the number of times each program is offered, the number of offenders waiting for programs to be offered, enrolments, completions, and participant outcomes.
    b. track and monitor use of Department workbooks and agency referrals.
    c. ensure that program evaluation recommendations are dealt with promptly.

    OAG March 2017 comment: *The Department does not intend to implement 27(b) because it does not feel that tracking and monitoring the use of Department workbooks and agency referrals would be useful in assessing the offender programming being offered.*

May 2016 report – *status as at June 30, 2015*

Implemented/resolved

We recommended that:

3. The Department develop clear guidelines and a reasonable timeframe for deciding when temporary alterations to accommodate more beds are permanent enough to increase a centre's rated capacity.
5. The Department work with the Manitoba Bureau of Statistics to see if cost-effective improvements can be made to the methodology and assumptions used to forecast offender populations, and update its forecasts for any significant changes.
6. The Department:
    a. prepare a range of adult custody population forecasts using best-case, worst-cast, and most-likely-case scenarios.
    b. forecast separately all significant adult sub-populations with differing accommodation needs.
8. The Province publicly release the full report prepared by the Adult Corrections Capacity Review Committee to allow legislators and the public to better understand the recommendations and monitor their implementation.
9. The Department publicly call for proposals and develop selection criteria to evaluate and select all future adult correctional centre sites.
12. The Department resolve the workload problems preventing probation officers from scheduling meeting with offenders as often as Department policy requires for the offender's risk profiles.

Considered cleared (cont'd)

14. The Department:
    a. ensure probation officers arrange automated curfew monitoring promptly.
    b. develop curfew-monitoring alternatives to deal with the increased use of cell phones and gradual elimination of landline phones.

    OAG May 2016 comment: *Action is no longer required on Recommendation 14(a) because automatic curfew calling has been discontinued.*

20. The Department remind staff of their responsibilities for declaring and managing actual and potential conflicts of interest as files are being assigned, and require all declared conflicts and their resolution to be documented.

23. The Department investigate the costs and benefits of using more probation officer assistants.

28. The Department measure:
    a. longer-term (3 to 5 years) recidivism rates and compare them to 2-year rates to see if they are significantly different.
    b. separate recidivism rates for low, medium, high, and very high risk offenders to assess the on-going validity of its risk scoring process.
    c. recidivism rates for offenders completing significant rehabilitation programs.
    d. an overall provincial recidivism rate.

    OAG May 2016 comment: *The Department does not intend to implement Recommendation 28(a) and (d) because it is satisfied with the current method of calculating recidivism.*

Manitoba's Framework for an Ethical Environment

Our recommendations were originally directed to the Civil Service Commission, the Department of Finance and the Department of Infrastructure and Transportation – Procurement Services Branch. Due to a government reorganization, the Department of Finance is responsible for implementing the recommendation originally directed to the Department of Infrastructure and Transportation - Procurement Services Branch.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – March 2014 (Chapter 7)	September 8, 2014
First follow-up – May 2016	-
Second follow-up – March 2017	-

What our original report examined

A well-constructed values and ethics program or framework is a key element in ensuring a strong ethical environment within the public service. We focused on the framework put in place by Manitoba's Civil Service Commission (CSC) and examined:

1. Whether policies and guidelines, with specified standards and procedures, are in place to foster an ethical environment within the public service.
2. Whether the policies and guidelines are clearly communicated to all civil servants, with ongoing education and training.
3. Whether the policies are being monitored to ensure implementation across all government departments.
4. Whether systems are in place to identify, mitigate and report any incidents of an ethical/fraudulent nature which may arise.
5. Whether the policies and guidelines are reviewed and updated periodically.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

Our report made 20 recommendations. Civil Service Commission is responsible for 14 of the recommendations and the Department of Finance is responsible for 6.

As shown in the table below, 13 of our 20 recommendations have been implemented as at September 30, 2017 and 7 remain in progress.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017					
Civil Service Commission	**8**	**-**	**-**	**6**	**14**
Finance	**4**	**-**	**-**	**1**	**5**
Procurement Services Branch	**1**	**-**	**-**	**-**	**1**
Total	**13**	**-**	**-**	**7**	**20**

We are concerned with the lack of progress on the 7 outstanding recommendations, all of which we consider foundational to ensuring a strong ethical framework throughout government.

We found limited progress on Recommendation 1, which is to develop an ethics policy or code of conduct that would include expectations of all civil servants, and of senior management in overseeing implementation and compliance with the policy. This is an important building block for a strong ethical framework in government. Without it, progressing further on the other elements of an ethics program becomes difficult, or fragmented at best. A strong central policy ensures consistent expectations across government. Departments can then implement needed processes and procedures that suit their unique activities, and the associated levels of risk.

Little progress has been made on Recommendation 11, which deals with periodic reports to the CSC from departments on their implementation of ethics-related policies. This recommendation envisions an engaged role for CSC in providing proactive support to those departments with less-developed implementation processes.

We also note that no action has been taken with respect to Recommendation 14, which is to develop and implement a process to enable employees to report concerns of ethical misconduct, including anonymous disclosures. This is in addition to the disclosure procedures under *The Public Interest Disclosure (Whistleblower Protection) Act,* which is limited to only dealing with the serious issues defined by the Act, and does not deal with administrative or operational matters.

We continue to stress that employees need to be aware of where and how to report ethical issues and fraudulent activity that they become aware of within their workplace. Most importantly, employees need to feel safe in doing so. At the time of our audit, our survey of department employees indicated that a third of respondents are personally aware of ethical misconduct or fraudulent activity within their workplace, yet only half of these instances have been reported to management. Leading practices for ethics programs emphasize the importance of allowing anonymity and confidentiality in reporting suspected misconduct or fraud, either through a

reporting hotline, or a designated Ethics Officer (which in some organizations is delegated to Internal Audit).

Ethical lapses in politics, business and society around the world are currently making almost daily headlines in Canada. Higher ethical expectations are being placed on every sector of society. And Manitoba's public sector is certainly not immune; many of our office's past audits and investigations have found ethical and conflict of interest concerns within departments.

We believe that more has to be done centrally to build and reinforce a workplace culture where the focus is on maintaining the highest possible standards of ethical behavior, and where ethical issues are appropriately dealt with. Especially in times of fiscal restraint and workforce reductions, ensuring that appropriate corporate values and ethics are embedded within the workplace culture is critical to fostering a strong ethical environment and maintaining the integrity of internal controls throughout government.

Our 2014 report was aimed at strengthening Manitoba's ethical framework overall, based on leading practices for an effective ethics program and the key elements that must be in place to ensure a strong ethical framework throughout government. A well-constructed and implemented ethics program helps to build a corporate culture that fosters ethical behaviour; that recognizes and avoids potential conflicts of interest; and that reduces the risk of loss due to fraud. Hence, we believe the CSC, in conjunction with all Deputy Ministers, must adopt a more proactive approach to instill a strong ethical culture within all departments. The mandate and direction for implementing a strong ethics program within the public service must come from its most senior leaders - this constitutes 'tone at the top'.

We encourage the Public Accounts Committee to actively engage the CSC in considering the best course of action regarding the outstanding recommendations.

Because we have followed up on the *Manitoba's Framework for an Ethical Environment* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared

Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**1**	-	-
March 2017	**6**	-	-
May 2016	**6**	-	-
Total	**13**	-	-

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status and to highlight select actions or planned actions. OAG comments included in prior year follow-up reports, for recommendations considered implemented/resolved, are reprinted below.

Work in progress

Directed to the Civil Service Commission

We recommended that:

1. The CSC develop a policy on values and ethics, or a code of conduct, which includes expectations of:
    a. all civil servants.
    b. senior management in overseeing implementation and compliance with the policy.

    OAG comment: *We were advised by CSC that they support this recommendation and have researched approaches to codes of conduct and policies related to values and ethics, and that they are continuing to assess opportunities to convert the Values and Ethics Guide into a policy or code of conduct.*

    We are concerned with the lack of progress on this recommendation. A strong policy is a critical first step in building a robust ethical framework that helps ensure a consistent approach and expectations across government. Departments can then implement processes and procedures within that policy that make sense for their environment, and the level of risk within any particular departmental activity. Without it, progressing further on the other elements of an ethics program becomes difficult or fragmented at best.

10. The CSC include fraud awareness training in its strategy for providing ethics-related training to all employees.

    OAG comment: *CSC does not currently provide training that is focused on fraud awareness, nor is any significant action planned for this recommendation. As we noted in our March 2017 Follow-up Report, we believe fraud awareness training should be provided periodically to employees within workplaces perceived to be at high risk for fraudulent activity.*

    CSC should work proactively with departments to identify the need for fraud awareness training, and tailor such training to the unique aspects of each department and to specific employee roles and responsibilities.

    We believe fraud awareness training is further strengthened if it can be aligned within an overall ethics policy for civil servants. Our 2014 survey of department employees found that 34% of respondents would like to have more training with respect to fraud awareness and identification of risk within their department. Further, 25% of respondents indicated the type of work done in their workplace is at a high risk for misconduct or fraudulent activity.

Work in progress (cont'd)

11. The CSC require periodic reports from departments on their implementation of ethics-related policies, including the Values and Ethics Guide. Upon receipt of the reports, we recommend that the CSC proactively provide support to those departments with less-developed implementation processes.

    OAG comment: *In our March 2017 Follow-up Report, we indicated that CSC was finalizing a Values and Ethics Checklist to remind departments of ethics-related requirements throughout the year. However, as of September 30, 2017, the Values and Ethics Checklist was not in place. We note that the Checklist as currently drafted is only intended for a department's use and will not be submitted to CSC.*

    Our recommendation envisions a more engaged role for CSC in providing proactive support to those departments with less-developed implementation processes. We believe that formalized reporting from the departments will enable CSC to better support departments in their implementation of ethics-related policies, and assist as needed, or develop enhanced tools when required.

12. The CSC amend the Conflict of Interest Policy to require that all employees update their conflict of interest declaration forms on a periodic basis, preferably annually.

    OAG comment: *In 2015, CSC updated their Conflict of Interest Policy and developed guidance and procedures for managers to follow. Since 2016, CSC has been sending an annual memo to Deputy Ministers entitled "Supporting a Trusted and Ethical Civil Service", which includes a reminder of the Conflict of Interest Policy.*

    Only Deputy Ministers and Assistant Deputy Ministers are required to submit annual declarations. CSC advised that they have implemented a compliance mechanism, in conjunction with the Clerk of Executive Council's office, to ensure these conflict of interest declarations are submitted annually. As part of our follow-up procedures we tested the pay and benefits files for these positions, and found 100% compliance of current Deputy Ministers and 84% compliance of current Assistant Deputy Ministers.

    While no amendments have been made to the Conflict of Interest policy with respect to this recommendation, CSC indicated that some departments have extended this practice across their executive team, but this is currently at each department's discretion. CSC also advised that they are recommending annual renewals be considered for positions where there is a more significant risk of a conflict of interest occurring.

    Ensuring employees periodically review and sign conflict of interest declaration forms is a leading practice to monitor and continually reinforce high ethical standards within the workplace. As noted in our March 2017 Follow-up Report, we believe, at a minimum, those employees in significant decision-making roles, or departmental positions with an elevated risk for conflict of interest, should be required to submit declarations on a periodic basis, preferably annually.

Work in progress (cont'd)

14. In addition to the disclosure procedures under *The Public Interest Disclosure (Whistleblower Protection) Act*, the CSC develop and implement a process to enable employees to report concerns of ethical misconduct, including anonymous disclosures.

    OAG comment: *In our March 2017 Follow-up Report, we indicated that CSC had been exploring the feasibility of an internal Ethics Officer position to receive and address ethical concerns, however they now indicate they are no longer pursuing this option. CSC advised they are currently exploring the development of a more defined process and templates for employees to anonymously disclose complaints of wrongdoing that fall outside the scope of The Public Interest Disclosure (Whistleblower Protection) Act (PIDA).*

    Our 2014 survey of department employees noted that 32% of respondents are personally aware of fraudulent activity/ethical misconduct in their workplace within the last year, but only about half (53%) reported the instance to management. Of those that did not report the misconduct to management, the most common reasons were that they did not feel it would be appropriately dealt with and fear of retaliation from management.

    As noted in our original report, we believe more has to be done to reinforce a workplace culture that is not afraid to bring issues forward and that sees that ethical issues are taken seriously and appropriately dealt with.

15. The CSC and departments track and report all disclosures of ethics-related matters that do not fall under the scope of *The Public Interest Disclosure (Whistleblower Protection) Act*, and are investigated through other means.

    OAG comment: *Since its 2015/16 annual report, CSC reports the overall number of HR investigations conducted across government under the activities of its Human Resource Operations. This provides the breakdown of how many were and were not substantiated, and includes those that do not fall under PIDA. However, the information does not include the corrective action taken for substantiated allegations. Further, this information is not categorized by department, nor is each department reporting their own specific number of investigations within their annual reports, as was envisioned by this recommendation (in conjunction with Recommendation 17 below to the Department of Finance).*

    We believe that each department's annual report should provide the overall number of investigations and the outcomes, similar to the reporting of investigations occurring under PIDA. In responding to Recommendation 17 below, the Department of Finance has drafted instructions that reflect this approach.

    Leading practices specify that ensuring employees are made aware of the consequences for violating ethics-related policies is a key deterrent to fraud in the workplace. Our 2014 survey of the civil service noted that only half of respondents perceive that those who violate ethical standards will be caught or subject to appropriate consequences.

Work in progress (cont'd)

Directed to the Department of Finance

We recommended that:

17. The Department of Finance include in its Departmental Annual Report Instructions the requirement to provide information and consequences regarding not only disclosures under *The Public Interest Disclosure (Whistleblower Protection) Act*, but all investigations conducted in the department over the year, including department-related investigations conducted by the Manitoba Ombudsman's Office.

    OAG comment: *In our March 2017 Follow-up Report, we noted that Finance has drafted comprehensive instructions for departments to report on all investigations conducted in the department over the year (including those conducted by the Manitoba Ombudsman), and corrective action taken. However, we have been advised that the disclosure requirement remains unissued, pending concurrence by CSC and the Provincial Comptroller.*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

Directed to the Civil Service Commission

We recommended that:

16. The CSC and departments track investigations by type.

    OAG comment: *CSC has enhanced the tracking of the investigations it does within each Service Centre of Human Resource Operations and has included the overall information in CSC's Annual Report since 2015/16. However, the information is not currently compiled in a consistent manner across Service Centres. As noted in our original report, it is good practice for an organization to maintain a database of allegations of fraudulent conduct that enables trends, patterns or systemic weaknesses to be identified and changes made to processes and controls, as required. The current tracking of investigations by CSC does not facilitate producing this type of analytical information for management's use.*

    We believe that not tracking investigations by consistent category/type results in a missed opportunity to identify ethics-related trends or systemic issues that may exist or arise. (For example, are sexual harassment complaints increasing or decreasing? Or have issues of intoxication increased or decreased after the legalization of cannabis? Or has a particular fraud type such as theft of government property been increasing or decreasing in a particular area?). Such information would allow CSC and departments to make changes to policy and practices in order to mitigate future issues, or to develop training to address current concerns. It could also be used to direct the activities of Internal Audit

Considered cleared (cont'd)

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

Directed to the Civil Service Commission

We recommended that:

7. The CSC develop and implement follow-up procedures to ensure that all new employees complete the online corporate orientation program as required.

 OAG March 2017 comment: *CSC has developed a biannual report to Deputy Ministers advising them of employees hired since October 2015 that have and have not completed the online corporate orientation program. The onus is on the Deputies to follow up with employees who have not yet completed the orientation module. Going forward, CSC should ensure employees that have not completed the program are retained in each biannual report so that continued non-compliance can be addressed.*

9. The CSC, in conjunction with departments, develop and implement a strategy for providing ethics-related training to all employees. The strategy should require that ethics-related training be provided to employees on an ongoing and periodic basis, and that training be provided to management in how to handle any ethical issues or violations brought forward by employees.

20. The CSC assess the effectiveness of their ethics-related policies and procedures by following up on the key indicators measuring ethical climate and workplace culture, which could be incorporated into their employee engagement survey, currently conducted every three years.

Directed to the Department of Finance

We recommended that:

13. The Department of Finance require that departments conduct internal fraud exposure evaluations and use the results to assess the sufficiency of existing controls and management oversight to prevent fraud.

19. The Department of Finance update the Fraud Prevention and Reporting Policy on a periodic basis.

Directed to the Procurement Services Branch

We recommended that:

5. The Procurement Services Branch of Manitoba Infrastructure and Transportation develop and implement the "Ethics in Procurement" chapter of the Procurement Administration Manual.

May 2016 report – *status as at June 30, 2015*

Implemented/resolved

Directed to the Civil Service Commission

We recommended that:

2. The CSC strengthen the Conflict of Interest Policy by including:
   a. specific expectations of civil servants for a broad array of conflict situations and for the submission of conflict of interest declarations.
   b. the responsibilities of senior management in overseeing implementation and compliance with the policy.

Considered cleared (cont'd)

6. The CSC develop and implement procedures to better insure employees submit conflict of interest declaration forms as required.
8. The CSC and departments utilize more communication methods to ensure employees throughout the civil service are aware of and understand the ethical requirements.

   OAG May 2016 comment: *While CSC has enhanced its communication of the updated policies to employees, communication efforts will need to be sustained to reflect their commitment to an effective ethics program on an ongoing basis.*

18. The CSC update all its ethics-related policies on a periodic basis.

    OAG May 2016 comment: *CSC has prepared a review schedule for updating policies. It will require ongoing commitment by CSC to ensure this is fulfilled in the future.*

Directed to the Department of Finance

We recommended that:

3. The Department of Finance conduct a comprehensive review of the Fraud Prevention and Reporting Policy and update the policy as needed.
4. The Department of Finance develop and implement a communication plan to better educate civil servants on the purpose of the Fraud Prevention and Reporting Policy and their related obligations.

   OAG May 2016 comment: *The Department of Finance has held several fraud awareness sessions with senior managers in departments and agencies. We suggest that fraud awareness training also be provided periodically to employees within workplaces perceived to be at high risk for fraudulent activity. This fraud training should be tailored to the unique aspects of each department so that it is relevant to specific employee roles and responsibilities.*

Manitoba Hydro – Managing Cyber Security Risk Related to Industrial Control Systems

Our recommendations are directed to Manitoba Hydro.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – March 2014 (Chapter 8)	February 25, 2015 (Passed)
First follow-up – May 2016	-
Second follow-up – March 2017	-

What our original report examined

Our objective was to determine whether Manitoba Hydro's risk management practices ensure the design of security controls over Industrial Control Systems (ICS) and related Information Technology (IT) reasonably mitigate identified cyber risks.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 7 of our 8 recommendations have been implemented as at September 30, 2017.

We note that significant progress has been made on the remaining recommendation.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**7**	**-**	**-**	**1**	**8**

Because we have followed up on the *Manitoba Hydro – Managing Cyber Security Risk Related to Industrial Control Systems* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	-	-	-
March 2017	**3**	-	-
May 2016	**4**	-	-
Total	**7**	-	-

Below we list the recommendation that remains in progress and the recommendations that are considered cleared. We have added an "OAG comment" to highlight select actions and planned actions. OAG comments included in a prior year follow-up report, for recommendations considered implemented/resolved, are reprinted below.

Work in progress

We recommended that:

1. Manitoba Hydro identify, assess and mitigate all Industrial Control Systems (ICS) cyber security risks and that this be performed on a priority basis for assets critical to operations.

    ***OAG comment**: Significant Progress - Manitoba Hydro has developed a Risk Management Program for ICS cyber security risks. They have identified the sites with critical assets based on established criteria. Further, Manitoba Hydro identified the existing Cyber security controls at these sites and assessed them against baseline security controls (CIPv5 standards, NIST and Manitoba Hydro policy).*

    Using an acquired risk assessment tool, Manitoba Hydro will review the control discrepancies and develop a mitigation plan. They plan to prioritize the conduct of ICS cyber security risk assessments to identify any remaining potential control discrepancies.

Considered cleared

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

4. Manitoba Hydro develop and implement ICS cyber security policy instruments and make them applicable to all ICS systems.
6. Manitoba Hydro develop and implement physical security policy instruments to control physical access to ICS systems.
7. Manitoba Hydro develop and deliver a comprehensive ICS cyber security training and awareness program for all staff responsible for operation, maintenance and security of ICS systems.

Considered cleared (cont'd)

May 2016 report – *status as at June 30, 2015*

Implemented/resolved

We recommended that:

2. Once ICS cyber security risks have been assessed, Manitoba Hydro include cyber security as a corporate risk profile in the annual risk management report that is presented to the Board.

    OAG May 2016 comment: *The November 2014 Corporate Risk Management Report included cyber security as a new and separate corporate risk profile. As new ICS cyber security risks are identified through the implementation of Recommendation 1, we encourage Manitoba Hydro to ensure a comprehensive discussion of these risks is included in the annual corporate risk management report to the board.*

3. Manitoba Hydro assign responsibility for corporate-wide cyber security to one executive.

5. Manitoba Hydro assign responsibility for corporate-wide physical security to one executive.

    OAG May 2016 comments for #3 and #5: *The Vice President Human Resources and Corporate Services assumed responsibility for both corporate wide cyber and physical security effective April 1, 2014. Given both cyber and physical security spans several business units across the organization, an Enterprise Security Council comprising 5 Vice Presidents and chaired by the Vice President Human Resources and Corporate Services was formed. In addition, 2 key subcommittees (Physical and Technology Security) have been formed. Terms of References for each of the noted committees have been approved.*

8. Manitoba Hydro develop a strategy to converge Information Technology (IT) and Operational Technology (OT) management, including IT security.

    OAG May 2016 comment: *Manitoba Hydro has developed a strategy regarding IT and OT management that contains several initiatives and projects related to operational efficiencies, ICS cyber security best practices and NERC CIP Version 5 compliance. The strategy document has been endorsed by the Technology Security Advisory Committee and approved by the Enterprise Security Council.*

Waiving of Competitive Bids

Our recommendations were directed to the Province, Treasury Board Secretariat (TBS), Department of Finance-Provincial Comptroller, Department of Infrastructure and Transportation-Procurement Services Branch (PSB), Departments with SOAs, and the Vehicle and Equipment Management Agency (VEMA). As a result of a government reorganization in June 2015, the Procurement Services Branch and the Vehicle and Equipment Management Agency are now part of the Department of Finance.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – March 2014 (Chapter 10)	October 5, 2015 December 14, 2015 August 17, 2016 (Passed)
First follow-up – November 2015	December 14, 2015 August 17, 2016 (Passed)
Second follow-up – March 2017	-

What our original report examined

Our objectives were to determine whether departments and special operating agencies (SOAs):

- Ensured fair access to government contracts by waiving competitive bids only when "acceptable circumstances" identified in the government's Procurement Administration Manual (PAM) were demonstrated.
- Assessed quoted prices on untendered contracts for consistency with fair market value.
- Publicly disclosed untendered contracts over $1,000.

We examined untendered contracts in 5 departments and 3 SOAs.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 17 of our 25 recommendations have been implemented as at September 30, 2017.

Of the 8 recommendations that remain in progress, we note that significant progress has been made on 2 (Recommendations 18 and 23).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ Resolved	Action no longer required	Do not intend to implement		
September 30, 2017					
Procurement Services Branch	**10**	**-**	**-**	**3**	**13**
TBS/Province	**3**	**-**	**-**	**2**	**5**
Departments/SOAs	**1**	**-**	**-**	**3**	**4**
Finance	**3**	**-**	**-**	**-**	**3**
Total	**17**	**-**	**-**	**8**	**25**

When we conducted our audit in 2013 Section 80 of the Financial Administration Act required the public disclosure of untendered contracts over $1,000. In our audit we assessed compliance with this requirement but recommended "that the Province periodically review whether the threshold for the reporting on untendered contracts is consistent with its disclosure objections and adjust it if necessary" (Recommendation 13). On November 30, 2015 the Contract Disclosure Regulation was registered. Section 6 of the Regulation states that "a contract for which the total expenditures from the Consolidated Fund will be less than $10,000;" is exempt from the reporting requirement in Section 80 of the Financial Administration Act. As a result, untendered contracts issued subsequent to November 30, 2015 with total values between $1,000 and $9,999 are no longer required to be publicly disclosed.

Because we have followed up on the *Waiving of Competitive Bids* report for 3 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**4**	-	-
March 2017	**5**	-	-
November 2015 & May 2016	**8**	-	-
Total	**17**	-	-

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status, to highlight select actions or planned actions, or to identify opportunities to further enhance Department actions. OAG comments included in prior year follow-up reports, for recommendations considered implemented/resolved, are reproduced below.

Work in progress

Directed to the Procurement Services Branch

We recommended that:

14. The PSB improve guidance on the documentation for untendered procurement transactions in the PAM by clearly specifying which documents are mandatory and requiring reasons for waiving discretionary documents.

    ***OAG comment**: The PSB has updated Chapter 13 of the PAM on Contract Planning – Record of Procurement. The information on documents to be included that was in the chapter at the time of our audit has been removed and instead refers to the "Procurement Services Branch website for a procurement checklist that may be used as a guide for the Record of Procurement". The use of the checklist is not required and does not have specific guidance on mandatory documents for untendered procurement. For example, it does not include the PSB Sole Source Validation Request form that is required to be completed on contracts with an estimated value greater than $10,000. This form requires signoff from PSB. We do not consider the recommendation implemented as:*

    - *the reference to a checklist that "may" be used reduces the likelihood of a complete record of procurement.*
    - *the checklist should have a section dedicated to a record of procurement for untendered transactions.*
    - *we would expect a checklist to be included in the PAM and not referenced to a website, as it makes it more difficult for users, and therefore less likely to be followed.*

18. The PSB develop and implement a communication strategy to ensure that department and SOA officials know and understand the PAM requirements.

    ***OAG comment**: <u>Significant Progress</u> - PSB has taken steps to improve communication of PAM requirements, but has not yet developed a communication strategy. PSB developed communication tools on procurement policies and practices (for example, the Governing Principles of Procurement document) and has developed a webinar and delivered presentations on procurement practices.*

23. The PSB develop and implement a plan to promptly complete the PAM.

    ***OAG comment**: <u>Significant Progress</u> - PSB has finalized its Governing Principles of Procurement document, developed some new sections for the PAM and has amended various other sections. However, to date a plan to complete the PAM has not been prepared.*

Directed to the Treasury Board Secretariat and the Province

We recommended that:

17. Treasury Board Secretariat develop an administrative policy development framework.

    ***OAG comment**: TBS has developed an Administrative Policy Review Framework which outlines the process for revisions to the General Manual of Administration (GMA) policies. TBS also has a document titled "Developing Policy Proposals", however, this guide is aimed at departments developing policy which will directly affect the public. In section 4.3 of our report we stated "the province lacks an administrative policy <u>development</u> framework" which would provide guidance to departments when developing internal policies. We indicated that this guidance would include how to properly communicate new policies and how to evaluate the results of this communication.*

Work in progress (cont'd)

22. Treasury Board Secretariat develop a list of organizations that need to comply with the PAM.

    ***OAG comment**: Treasury Board indicated that PSB has agreed to prepare the list of organizations that need to comply with the PAM.*

Directed to Departments and SOAs

We recommended that:

16. Department executive financial officers randomly review higher-risk procurement transactions to ensure internal controls function properly.

    ***OAG comment**: The department advised us that updates to the PAM "will require executive financial officers (EFOs) to closely monitor procurement activity through monthly reporting requirements" and that "the new purchase order (PO) threshold of $1,000, as well as the requirement to identify the nature and terms of the PO in SAP in advance, will enable departments to monitor and identify any higher risk procurement transactions through our SAP system, and to address any issues in a timely manner". We note, however, that at the time of our original audit the use of SAP purchase orders was required for goods over $2,500 and services over $5,000, yet significant purchases were still being made without purchase orders. In addition, when reviewing purchase order use in SAP we found some instances of incorrect "nature and terms" used in the SAP POs.*

20. Departments enforce the requirement to use a purchase order in SAP for all purchases of goods over $2,500 and services over $5,000. We also recommend that the reasons for not tendering a contract be properly documented in the Business Case tab of the purchase order.

    ***OAG comment**: See comment under Recommendation 16. In addition, in our view, to increase compliance, EFOs will need to actively enforce purchase order use.*

25. Departments with SOAs review and update the operating charters yearly.

    ***OAG comment**: We have been advised that SOAs, along with their operating charters are currently under review.*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

Directed to Procurement Services Branch

We recommended that:

1. The Procurement Services Branch (PSB) assess whether procurement practices that departments and Special Operating Agencies (SOAs) use instead of obtaining competitive bids are reasonable.
    - If the PSB finds the practices are reasonable, we recommend it amend the Procurement Administration Manual (PAM) as needed.
    - If the PSB finds that the practices are not reasonable, we recommend that it work with the department to develop acceptable procurement practices for the situation in question.

Considered cleared (cont'd)

12. The PSB ensure its public internet access to untendered information has a comprehensive search engine. We also recommend that, in the interim, the PSB improve the search and reporting capabilities of the existing public access database so users can:
    - search by data range and by all fields in the database.
    - extract large quantities of data.
    - display all outstanding contracts for a department at a specific time.

Directed to the Treasury Board Secretariat and the Province

We recommended that:

4. Treasury Board Secretariat:
    - develop guidelines for delegating purchasing authorities for untendered contracts and related extensions during emergency events (in particular the purchasing authorities for Treasury Board, ministers and deputy ministers).
    - require comprehensive reporting after an emergency event on how the delegated authority was used.
9. Treasury Board Secretariat amend the General Manual of Administration's (GMA's) definition of contract to match the PAM definition.

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

Directed to the Procurement Services Branch

We recommended that:

3. The PSB amend the PAM to require that departments make public their intent to award a contract over a set amount.
6. The PSB update the PAM to require that departments and SOAs analyze and document how the price quoted on an untendered contract represents fair market value. The analysis should be conducted prior to contract signing.
8. The PSB amend the PAM to require that contracts be kept in the public access database for as long as they are active.
15. The PSB implement a risk based process to monitor department and SOA compliance with policies on the waiving of competitive bids (including the policy on public disclosure). We also recommend that the PSB report compliance issues to the department's deputy minister.

Directed to the Treasury Board Secretariat and the Province

We recommended that:

13. The Province periodically review whether the threshold for the reporting of untendered contracts is consistent with its disclosure objectives and adjust it if necessary.

Considered cleared (cont'd)

November 2015 report – *status as at October 30, 2015*

Implemented/resolved

Directed to the Procurement Services Branch

We recommended that:

2. The PSB amend the PAM to require that departments and SOAs:
   - consult with the PSB prior to directly awarding a service contract over a set amount.
   - include the PSB advisory notes in the procurement record and in any required Treasury Board submission.

   OAG November 2015 comment*: Alternate solution implemented - In 2014, TBS began requiring that a Financial Overview Form be completed and signed by departmental Executive Financial Officers and that it accompany all Treasury Board submissions. This form contains a section on competitive procurement which must be completed when goods and services requiring TB approval are not competitively tendered. The section requires the documentation of consultations with PSB, including any related outcomes.*

7. The PSB amend the PAM to include the *Financial Administration Act* (FAA) disclosure requirement for contracts with uncertain values.

   OAG November 2015 comment*:* Alternate solution implemented - *PSB now requires that purchase orders for contracts greater than $1,000 (with a few exceptions) be entered into SAP. Doing this necessitates inputting a contract amount. SAP is used to generate the Proactive Disclosure Report on all contracts greater than $10,000 and as such all contracts will contain a value.*

10. The PSB amend the PAM to add disclosure requirements of untendered contracts in foreign currencies.

11. The PSB make public access to untendered contract information available on the internet.

    OAG November 2015 comment: *As at September 2015, disclosure information on contracts greater than $10,000 (included untendered contracts) is available on the government's website under "Proactive Disclosure".*

Directed to the Department of Finance

We recommended that:

19. The Department of Finance, consulting with PSB, use SAP to generate the untendered contract information for public disclosure. In the interim, we recommend that department finance staff directly enter their information in the public access database and ensure the information is complete and accurate.

    OAG November 2015 comment*: See our comment related to Recommendation 7.*

21. The Department of Finance amend the purchase category fields in SAP to include the acceptable circumstances for waiving competitive bids, from the PAM.

    OAG November 2015 comment*: The purchase category fields in SAP have been changed to reflect the changes to Chapter 9 of the PAM (SAP Procurement). As of the follow-up date, Chapter 13 (Contract Planning) of the PAM on Waiving of Competitive Bids has not been amended to ensure consistency between the "acceptable circumstances" for waiving competitive bids and the purchase category fields reflected in Chapter 9. As such, there is still a disconnect between SAP categories for purchases and Chapter 13 of the PAM.*

Considered cleared (cont'd)

24. The Provincial Comptroller amend the control self-assessment questionnaire on procurement processes (part of the Comptrollership Framework document) to include the PAM requirements for waiving of competitive bids, including SAP requirements discussed in Recommendation 20.

Directed to Departments and SOAs

We recommended that:

5. VEMA amend its policies to require the documentation of proper contract approvals (before payment).

At least one more follow-up review scheduled

WRHA's Management of Risks Associated with End-user Devices 53
Manitoba Home Care Program 56
Improving Educational Outcomes for Kindergarten to Grade 12 Aboriginal Students 64
Management of Provincial Bridges 68
Keeyask Process Costs and Adverse Effects Agreements with First Nations 71
Manitoba East Side Road Authority 73

WRHA's Management of Risks Associated with End-user Devices

Our recommendations were originally directed to the Winnipeg Regional Health Authority (WRHA) and the Department of Health, Healthy Living and Seniors (HHLS). Due to a government reorganization, the Department of Health, Seniors and Active Living is now responsible for implementing the recommendations originally directed to the Department of HHLS.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – July 2015	May 8, 2017 (Passed)
First follow-up – March 2017	May 8, 2017 (Passed)

What our original report examined

The mobility and power of end-user devices create operating efficiencies while transforming business processes. Their proliferation within the healthcare industry is understandable given the need of healthcare professionals to access critical information quickly. However, there is a risk that health organizations, in their desire to meet the demands of healthcare professionals for such technology, may inadvertently compromise the cybersecurity over sensitive and confidential information and systems accessed by these end-user devices.

We wanted to know how vulnerable the WRHA was to confidential personal health information falling into wrong hands. As such, we looked at whether the WRHA properly managed the risks associated with personal health information being stored on, and accessed by, end-users devices. We focused our efforts on assessing the adequacy of management policies and practices and not on whether they were operating as intended.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 3 of our 12 recommendations have been implemented as at September 30, 2017.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017					
WRHA	**3**	**-**	**-**	**7**	**10**
Department	**-**	**-**	**-**	**2**	**2**
Total	**3**	**-**	**-**	**9**	**12**

Because we have followed up on the *WRHA's Management of Risks Associated with End-user Device* report for 2 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**2**	-	-
March 2017	**1**	-	-
Total	**3**	-	-

Below we list the recommendations that remain in progress and the recommendation that is considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status and to highlight select actions or planned actions.

Work in progress

Directed to the WRHA

We recommended that:

2. Upon completion of risk assessments associated with end-user devices, eHealth communicate the results of the risk assessments to the WRHA Chief Executive Officer (CEO) and that the CEO document the acceptance of residual risks.
3. Upon completing end-user device risk assessments, the WRHA implement the controls needed to reduce (to an appropriate level) the risks associated with end-user devices (including the areas of concern noted in our letter to management).
4. eHealth develop a strategic plan for the delivery of ICT (Information and Communication Technology) services to the WRHA, including plans for remote access through end-user devices.
5. The WRHA define and implement a structured information classification scheme that includes multiple classifications based on the sensitivity of information.

Work in progress (cont'd)

8. The WRHA Internal Audit branch develop and implement a risk-based audit program that would satisfy the requirements of the WRHA's Audit of Security Safeguards policy.
9. Upon the completion of risk assessments, WRHA update the PHIA (Personal Health Information Act) and information security awareness training sessions to:
   a. Communicate a complete and consistent set of risks, expectations and requirement pertaining to personal health information residing on or accessed by end-user devices.
   b. Develop training that specifically targets users in higher risk positions.
   c. Outline incident handling procedures.
11. The WRHA require that associated individuals (e.g. physicians and medical staff, contractors, students, researchers and employees) using WRHA information assets attend the information security awareness training upon hiring and periodically thereafter.

Directed to the Department of Health, Seniors and Active Living

We recommended that:

6. The Department develop guidance for PHIA (Personal Health Information Act) trustees on how to audit their security safeguards.

   ***OAG comment**: Department of Health, Seniors and Active Living officials noted that draft guidelines are in the latter stages of development and review.*

7. The Department monitor trustees' compliance with PHIA's audit of security safeguards requirements.

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

Directed to the WRHA

We recommended that:

1. eHealth identify and assess the risks associated with end-user devices used within the WRHA environment.
12. eHealth implement other information security awareness techniques to complement and reinforce the messages communicated in its awareness training courses and intranet site.

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

Directed to the WRHA

We recommended that:

10. The WRHA update the Confidentiality of Personal Health Information policy to require that associated individuals (e.g. physicians and medical staff, contractors, students, researchers and employees) periodically attend PHIA awareness training.

Manitoba Home Care Program

Our recommendations were directed to the Department of Health, Healthy Living and Seniors, Winnipeg Regional Health Authority and Southern Health-Santé Sud. Due to a government reorganization, the Department of Health, Seniors and Active Living is now responsible for implementing the recommendations originally directed to the Department of Health, Healthy Living and Seniors.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – July 2015	-
First follow-up – March 2017	-

What our original report examined

The Manitoba Home Care Program (the Program) provides healthcare, personal care, and household services to people living at home and needing support—but not necessarily the level of care provided in a hospital or a personal care home. The Department of Health, Seniors and Active Living (the Department) funds and oversees the Program. Manitoba's 5 Regional Health Authorities (RHAs) manage and deliver Program services.

We examined the adequacy of the Department's oversight of the Program, including its strategic planning, standards, and monitoring of RHA performance.

We also examined the adequacy of the management and delivery of home care services by Southern Health-Santé Sud and Winnipeg Regional Health Authority (WRHA). This included their processes for identifying people needing home care, assessing client needs and developing care plans, delivering services, and ensuring qualified staff. It also included their quality assurance processes and management information.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

Many of the 28 recommendations from our 2015 report were directed to more than one organization. For follow-up purposes, the recommendations were followed-up with each entity named, resulting in a total of 46 recommendations.

As shown in the table below, 17 of our 46 recommendations (1 of 9 for Health, 9 of 19 for WRHA, and 7 of 18 for Southern Health-Santé Sud) have been implemented as at September 30, 2017.

Of the 29 recommendations that remain in progress, we note that significant progress has been made on 8 (WRHA Recommendations 12, 15, 17 and 27; Southern Health-Santé Sud Recommendations 8, 9, 15 and 28).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017					
Department of Health	**1**	**-**	**-**	**8**	**9**
WRHA	**9**	**-**	*	**10**	**19**
Southern Health-Santé Sud	**7**	**-**	*	**11**	**18**
Total	**17**	**-**	**-**	**29**	**46**

* The WRHA and the Southern Health-Santé Sud do not intend to implement Recommendation 21(a). The other components of Recommendation 21 have been implemented.

Both the WRHA and the Southern Health-Santé Sud do not intend to implement Recommendation 21(a). WRHA indicated that their systems were not able to separate out travel time from overall task times. Southern Health-Santé Sud noted concerns over IT system limitations and also that documenting travel time and client-specific task time would overburden the home care scheduling system.

Because we have followed up on the *Manitoba Home Care Program* report for 2 years, we have prepared the following table that summarizes when recommendations were considered cleared. Recommendations that are considered cleared are excluded from subsequent follow-ups.

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**15**	-	-
March 2017	**2**	-	-
Total	**17**	-	-

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status or to highlight select actions or planned actions.

Work in progress

Directed to the Department

We recommended that:

2. The Department:
   a. specify which direct services (if any) RHAs must make available to home care clients, no matter where they live.
   b. make it clear in all their published materials describing home care services which services RHAs must provide (if any) and which are optional.
3. The Department make its home care standards and policies public, as done in other provinces.
4. The Department identify key provincial home care standards and require RHAs to review their compliance with these standards and report the results to the Department.

Work in progress (cont'd)

5. The Department:
   a. review the home care monthly statistics it requires from RHAs to ensure the statistics will provide all key information needed to effectively monitor and analyze Manitoba Home Care Program performance.
   b. monitor all key home care information it receives for completeness and reasonableness, particularly information being publicly disclosed in its annual statistics report.
   c. analyze RHAs' statistical reports, in conjunction with their financial reports, to identify and follow-up variances from expected results, anomalies, and longer-term trends for the Manitoba Home Care Program.
6. The Department, in consultation with RHAs, define and monitor performance measures for service timeliness, service reliability, and key client outcomes for the Manitoba Home Care Program.
7. The Department work with RHAs to expand and improve public performance reporting on the Manitoba Home Care Program.
14. The Department develop a plan for province-wide implementation of the RAI-HC client assessment tool.
24. The Department, in collaboration with RHAs, develop an approach to identify and manage nurse-delegated tasks in the Manitoba Home Care Program consistently, efficiently, and in accordance with acceptable professional practice.

Directed to the WRHA

We recommended that:

9. WRHA develop plans to improve the timeliness of at-home client needs assessments and monitor progress in meeting their timeliness standards.
12. WRHA ensure that case coordinators have the training and tools to:
    a. assess and negotiate, as consistently as possible in similar circumstances, the support that family members can realistically be expected to provide for home care clients.
    b. identify all possible third-party providers so coordination of home care services and cost recoveries can be arranged and properly documented.
    c. adequately support and document the reasons for Program non-admissions.

    OAG comment: *Significant Progress - WRHA has implemented Recommendation 12(b) and (c) and has taken some steps towards providing case coordinators with training to assess and negotiate the support family members can be expected to provide.*
15. WRHA ensure that client care plans:
    a. meet all clients' assessed needs, and only those needs.
    b. clearly state the frequency or amount of service to be delivered.
    c. specify a reliable back-up plan that can be actioned as required.
    d. are signed by clients or their designates to show they reviewed and discussed them.
    e. are updated at least annually, using a formal reassessment process that prioritizes higher-risk clients.

    OAG comment: *Significant Progress - WRHA has implemented an audit tool for files managed by community-based coordinators. This tool is to be used annually to assess client care plans. The results of these annual reviews indicate that 15(b) and (e) have been implemented.*

Work in progress (cont'd)

16. WRHA ensure that file documentation for client care plans includes:
    a. supervisory approval when planned services exceed established protocols.
    b. a copy of the paper care plan signed by clients or their designates.
17. WRHA develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:
    a. more collaborative discharge planning between hospital and home care staff.
    b. reasons for delays in initial service start-ups and service adjustments for clients in the community.
    c. staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

    ***OAG comment**: Significant Progress - WRHA has implemented Recommendation 17(a) and (c).*
18. WRHA develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.
20. WRHA review the reasonableness and consistency of their standard task time allotments to ensure they are appropriate.
25. WRHA require staff to document reviews of sign-off sheets and related follow-up actions.
26. WRHA monitor whether the mandatory training and security-checks for home care staff are being done and properly documented, and remedy any gaps.
27. WRHA:
    a. ensure that they receive and keep signed conflict-of-interest forms for all staff.
    b. require all declared conflicts and their resolution to be documented.
    c. periodically remind staff of their responsibilities to declare and manage actual and potential conflicts of interest as clients are assigned.

    ***OAG comment**: Significant Progress - WRHA has implemented Recommendations 27(b) and (c). And WRHA has advised us it has implemented a process for ensuring conflict of interest forms are completed by all direct service staff, and will be implementing a process for non-direct service staff in 2018.*

Directed to the Southern Health-Santé Sud

We recommended that:

8. Southern Health-Santé Sud work with the Department to strategically promote greater awareness of Manitoba Home Care Program services to doctors and the public.

    ***OAG comment**: Significant Progress - Southern Health-Santé Sud has taken several steps including: a) developing and launching a public website with information about home care services and b) developing, and have begun distributing, a pamphlet.*
9. Southern Health-Santé Sud develop plans to improve the timeliness of at-home client needs assessments and monitor progress in meeting their timeliness standards.

    ***OAG comment**: Significant Progress - In 2016 Southern Health-Santé Sud had taken several steps including: developing a process map, conducting 22 audits of case coordinators to see how long it is taking for the initial assessment and development of the care plan, completing 3 focus groups, and developing a clinical audit tool that is used biannually. In 2017, Southern Health-Santé Sud approved a revised referral/intake process with shorter timelines for completing assessments.*

Work in progress (cont'd)

12. Southern Health-Santé Sud ensure that case coordinators have the training and tools to:
    a. assess and negotiate, as consistently as possible in similar circumstances, the support that family members can realistically be expected to provide for home care clients.
    b. identify all possible third-party providers so coordination of home care services and cost recoveries can be arranged and properly documented.
    c. adequately support and document the reasons for Program non-admissions.
13. Southern Health-Santé Sud work with the Department to:
    a. clearly define "available community resources" and clarify if client ability to pay is relevant when assessing the availability of a community resource.
    b. develop processes to verify client ability to pay if it is relevant in assessing the availability of a community resource.
15. Southern Health-Santé Sud ensure that client care plans:
    a. meet all clients' assessed needs, and only those needs.
    b. clearly state the frequency or amount of service to be delivered.
    c. specify a reliable back-up plan that can be actioned as required.
    d. are signed by clients or their designates to show they reviewed and discussed them.
    e. are updated at least annually, using a formal reassessment process that prioritizes higher-risk clients.

    ***OAG comment**: Significant Progress - Southern Health-Santé Sud has developed and implemented a file review process that addresses Recommendations 15(c), (d), and (e), and will be expanded to include (a) and (b).*
17. Southern Health-Santé Sud develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:
    a. more collaborative discharge planning between hospital and home care staff.
    b. reasons for delays in initial service start-ups and service adjustments for clients in the community.
    c. staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.
18. Southern Health-Santé Sud develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.
19. Southern Health-Santé Sud monitor the number and consistency of workers assigned to individual clients and assess progress.
22. Southern Health-Santé Sud enhance their oversight of the EFT (Equivalent Full-Time) initiative by:
    a. developing plans and targets for better matching guaranteed hours to client assignments.
    b. monitoring the cost and percentage of total EFT hours unmatched to client assignments.
    c. evaluating if the EFT initiative is improving staff recruitment and retention.

    ***OAG comment**: Southern Health-Santé Sud has implemented Recommendation 22(b) and (c).*
25. Southern Health-Santé Sud require staff to document reviews of sign-off sheets and related follow-up actions.

Work in progress (cont'd)

28. Southern Health-Santé Sud improve their quality assurance processes by:
    a. completing the client file reviews and home visits required, particularly for higher-risk clients.
    b. developing standard templates to ensure client file reviews and home visits are done consistently and cover all key areas.
    c. compiling the results of file reviews and home visits to discern trends and identify areas where staff may need more training or guidance.

    OAG comment*: Significant Progress - Southern Health-Santé Sud has implemented Recommendation 28(a) and (b).*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

Directed to the Department

We recommended that:

1. The Department forecast the increased demand for home care services likely to result from the expected growth in the senior population so that, within the context of its planning for the healthcare system as a whole, it can understand the staff and financial resources needed to sustain Program services over the long term.

Directed to the WRHA

We recommended that:

8. WRHA work with the Department to strategically promote greater awareness of Manitoba Home Care Program services to doctors and the public.

    OAG comment*: In 2016, WRHA developed a WRHA Home Care ad for the WAVE Magazine to promote awareness of services. This magazine is published every 2 months and is distributed to all hospitals, community doctors' offices, and to the community at large. WRHA had now also added a link on its website to the Department's Home Care website. In June 2017 a working group was formed and has since developed a Home Care and Primary Care Integration work plan.*

10. WRHA review its central intake processes to ensure staff flag all urgent referrals and avoid unnecessarily duplicating the needs assessments done by case coordinators.

11. WRHA investigate why required client needs assessments are not always done or fully completed, and remedy this.

13. WRHA work with the Department to:
    a. clearly define "available community resources" and clarify if client ability to pay is relevant when assessing the availability of a community resource.
    b. develop processes to verify client ability to pay if it is relevant in assessing the availability of a community resource.

    OAG comment*: Recommendation 13(b) was no longer applicable because the Department has clarified that a client's ability to pay is not relevant in assessing available community resources.*

Considered cleared (cont'd)

19. WRHA monitor the number and consistency of workers assigned to individual clients and assess progress.

21. WRHA require resource coordinators to:
    a. clearly explain and document scheduled travel time (for which RHAs may choose to establish standards) and adjustments to standard task times that are made to accommodate client-specific needs.
    b. avoid scheduling multiple visits in the same time slot, as well as shifts where the total task time exceeds the time available.

    ***OAG comment**: WRHA does not intent to implement 21(a). They indicated that their systems were not able to separate out travel time from overall task times.*

23. WRHA centrally track and document the receipt, investigation, and resolution of all complaints, and regularly compile complaint statistics for management review.

    ***OAG comment**: In implementing this recommendation, WRHA has limited the tracking of complaints to those which are elevated to middle or senior management. As a result, very few complaints are logged. We continue to be concerned that the failure to log complaints handled by the direct service workers and case coordinators is a missed opportunity to understand service delivery issues.*

28. WRHA improve their quality assurance processes by:
    a. completing the client file reviews and home visits required, particularly for higher-risk clients.
    b. developing standard templates to ensure client file reviews and home visits are done consistently and cover all key areas.
    c. compiling the results of file reviews and home visits to discern trends and identify areas where staff may need more training or guidance.

    ***OAG comment**: WRHA is compiling the results of file reviews and discerning trends for staff training ideas. Although they are conducting home visits and recording results, we continue to encourage WRHA to compile this information to discern trends for home visits.*

Directed to the Southern Health-Santé Sud

We recommended that:

11. Southern Health-Santé Sud investigate why required client needs assessments are not always done or fully completed, and remedy this.

16. Southern Health-Santé Sud ensure that file documentation for client care plans includes:
    a. supervisory approval when planned services exceed established protocols.
    b. a copy of the paper care plan signed by clients or their designates.

21. Southern Health-Santé Sud require resource coordinators to:
    a. clearly explain and document scheduled travel time (for which RHAs may choose to establish standards) and adjustments to standard task times that are made to accommodate client-specific needs.
    b. avoid scheduling multiple visits in the same time slot, as well as shifts where the total task time exceeds the time available.

    ***OAG comment**: Southern Health-Santé Sud does not intent to implement 21(a). This is due in part to IT system limitations and also due to the concern that documenting travel time and client-specific task time would overburden the home care scheduling system.*

Considered cleared (cont'd)

23. Southern Health-Santé Sud centrally track and document the receipt, investigation, and resolution of all complaints, and regularly compile complaint statistics for management review.

    OAG comment*: In implementing this recommendation, Southern Health-Santé Sud has limited the tracking of complaints to those which warrant documentation in the client's health care record. As a result, very few complaints are logged. We continue to be concerned that the failure to log complaints handled by the direct service workers and case coordinators is a missed opportunity to understand service delivery issues.*

26. Southern Health-Santé Sud monitor whether the mandatory training and security-checks for home care staff are being done and properly documented, and remedy any gaps.

27. Southern Health-Santé Sud:
    a. ensure that they receive and keep signed conflict-of-interest forms for all staff.
    b. require all declared conflicts and their resolution to be documented.
    c. periodically remind staff of their responsibilities to declare and manage actual and potential conflicts of interest as clients are assigned.

March 2017 report – *status as at September 30, 2016*

Implemented/resolved

Directed to the WRHA

We recommended that:

22. WRHA enhance their oversight of the EFT (Equivalent Full-Time) initiative by:
    a. developing plans and targets for better matching guaranteed hours to client assignments.
    b. monitoring the cost and percentage of total EFT hours unmatched to client assignments.
    c. evaluating if the EFT initiative is improving staff recruitment and retention.

Directed to the Southern Health-Santé Sud

We recommended that:

20. Southern Health-Santé Sud review the reasonableness and consistency of their standard task time allotments to ensure they are appropriate.

Improving Educational Outcomes for Kindergarten to Grade 12 Aboriginal Students

Our recommendations were directed to the Department of Education and Advanced Learning. Due to a government reorganization, the Department of Education and Training is now responsible for implementing the recommendations.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – January 2016	August 17, 2016 (Passed)

What our original report examined

Aboriginal students' educational outcomes can be affected by factors outside the control of Manitoba's provincial school system. For example, students may find it much more difficult to succeed academically if they and their families are facing the housing, health, financial, and other challenges associated with poverty. Manitoba's education system must nonetheless strive to meet the educational needs of Aboriginal students.

The Department of Education and Training (the Department) is responsible for ensuring all children in Manitoba have access to an appropriate, relevant, and high quality Kindergarten to Grade 12 (K-12) education. We examined whether the Department effectively:

- planned, monitored, and reported on its K-12 Aboriginal education initiatives and efforts to improve educational outcomes for Aboriginal students.
- supported the delivery of Aboriginal education initiatives in school divisions and schools with targeted funding, assistance to help smooth student transitions from on-reserve to provincial schools, and teacher resources and training.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 2 of our 19 recommendations have been implemented as at September 30, 2017. The Department does not intend to implement Recommendation 5 (see comments below).

Of the 16 recommendations that remain in progress, we note that significant progress has been made on one (Recommendation 13).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**2**	**-**	**1**	**16**	**19**

The Department has chosen not to implement Recommendation 5. Recommendation 5 deals with setting short and long-term targets for improving educational outcomes for K-12 Aboriginal students. The Department has stated that it disaggregates student achievement data in order to be able to provide school divisions with data specific to Indigenous student achievement, and that this allows each division to reflect on and plan for increased student achievement. The Department believes that the uniqueness of each division means that targets for Indigenous student achievement in literacy and numeracy need to be set at the division level, not the provincial level. We continue to support the value of this recommendation because setting provincial targets enables the measurement of overall provincial progress and the adequacy of provincial initiatives aimed at improving outcomes.

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status or to highlight select actions or planned actions.

Work in progress

We recommended that:

1. The Department adopt a unified and coordinated approach to improving educational outcomes for K-12 Aboriginal students, ensuring that it engages all key partners and prevents any unnecessary duplication of effort across the Province's different plans and initiatives.
2. The Department provide leadership and develop mechanisms to ensure a greater focus on planning and implementing initiatives to improve educational outcomes for K-12 Aboriginal students, and that it clearly define and communicate responsibilities and accountabilities for achieving results to all parties, including the Directorate and school divisions.
3. The Department ensure that its implementation plan for improving educational outcomes for K-12 Aboriginal students is based on a comprehensive understanding of the related key initiatives already underway in government departments and school divisions, both to avoid possible duplication of effort and to identify gaps where additional supports are needed.
4. The Department identify the key barriers to success faced by Aboriginal students in Manitoba, assess whether each of these barriers and the Department's objectives and intended outcomes for Aboriginal students are being sufficiently addressed by current initiatives, and take steps to remedy gaps.
6. The Department align the total funding for improving educational outcomes for K-12 Aboriginal students with the Department's stated goals, objectives, intended outcomes, and targets for these students.
7. The Department monitor and report on the results of key initiatives related to improving educational outcomes for K-12 Aboriginal students using quantified output and outcome measures (whenever possible), and that it regularly review and update its implementation plans to reflect what is found to be effective.

Work in progress (cont'd)

8. The Department conduct more evidence-based evaluations of the programs and projects designed to improve educational outcomes for K-12 Aboriginal students, and use the results to inform planning and funding decisions.
10. The Department disaggregate and analyze Aboriginal student achievement data by First Nation, Métis, and Inuit student identifiers to better understand trends and to develop appropriate student supports.
11. The Department analyze Aboriginal student achievement data by school division in order to identify those with better results and the underlying successful practices that could be applied more broadly across all divisions.
13. The Department take steps to ensure that all schools give parents an annual opportunity to declare their children's Aboriginal identity.

    OAG comment: *Significant Progress - The Department is now requiring all school divisions to include Aboriginal Identity Declaration as part of the school registration/verification package. As well, promotional material has been developed and posted on the Department's website. In early 2018, the Department plans to provide a course on identity declaration to front-line school staff.*

14. The Department allocate Aboriginal education funding to school divisions where it is most needed, using a process that considers measured outcomes for Aboriginal student achievement and the estimated Aboriginal student population.
15. The Department communicate all Aboriginal Academic Achievement (AAA) and Building Student Success with Aboriginal Parents (BSSAP) funding requirements to school divisions, and that it demonstrate through a documented review that all requirements are met before funding is released.
16. The Department issue guidance detailing best practices for achieving successful transitions for First Nations students.
17. The Department issue guidance to help school divisions and First Nations develop education agreements that support First Nations students transitioning from on-reserve to provincial schools.
18. The Department promote use of its Manitoba Professional Learning Environment (MAPLE) website to share resources and practices found to be effective in improving educational outcomes for K-12 Aboriginal students.
19. The Department develop a process to ensure that all curricula documents include ideas to help teachers incorporate Aboriginal perspectives into lesson plans and teaching methods.

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

We recommended that:

9. The Department regularly monitor performance data showing the level of progress being made towards all of its publicly stated intended outcomes for K-12 Aboriginal students and that it share this data with those accountable for achieving results.
12. The Department publicly report annual measured results showing its progress in achieving its stated goals and intended outcomes for K-12 Aboriginal students.

Do not intend to implement

We recommended that:

5. The Department set specific and measurable short- and long-term targets for improving educational outcomes for K-12 Aboriginal students.

Management of Provincial Bridges

Our recommendations are directed to the Department of Infrastructure.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – July 2016	September 15, 2016 (Passed)

What our original report examined

The Department of Infrastructure manages about 3,000 bridges and large (bridge-sized) culverts on the Provincial road and water control networks. We examined the Department's management of these structures, including its processes for:

- inspecting bridges and large culverts, and implementing related maintenance recommendations.
- bridge inventory planning and performance reporting.
- ensuring quality assurance in bridge construction.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, none of our 20 recommendations have been implemented as at September 30, 2017.

Of the 20 recommendations that remain in progress, we note that significant progress has been made on 2 (Recommendations 3 and 17).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**-**	*****	**-**	**20**	**20**

*Action is no longer required on Recommendation 15(c).

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status or to highlight select actions or planned actions.

Work in progress

We recommended that:

1. The Department review and update its bridge inspection policy so that it is comprehensive, risk-based, and reflects intended Department practice.
2. The Department identify all the bridges and large culverts that the Province is responsible for and ensure they all receive Level 1 and Level 2 inspections in accordance with risk-based inspection frequency standards.
3. The Department amend its process for selecting external service providers to include an assessment of any recent experience with their bridge inspection work.

   ***OAG comment**: Significant Progress - The Department has developed forms for assessing the performance of its current external service providers and plans to use these assessments in its next annual selection process.*
4. The Department improve the consistency and quality of bridge element ratings and inspection documentation, and that it assess whether more guidance, training, photographs, and supervisory review are needed to achieve this.
5. The Department improve the appropriateness and pricing of all bridge inspectors' maintenance recommendations, and that it assess whether additional guidance, training, supervisory review, and centralization are needed to achieve this.
6. The Department verify that all internal and external bridge inspection staff have the training and experience the Department currently requires them to have, and that it assess if currently required training adequately meets its needs.
7. The Department track scheduled bridge inspection dates so that it will know when related inspection reports are due, and follow-up promptly on all overdue reports.
8. The Department develop risk-based and documented management processes to monitor the quality of all inspectors' fieldwork and inspection reports, and that it assess the feasibility of obtaining documentation that would allow it to place some reliance on the quality assurance processes it requires all external service providers to have in place.
9. The Department strengthen management oversight of bridge inspectors' recommendations by developing systems and processes that let senior engineering staff:
   a. track recommendations through to final disposition.
   b. monitor and approve staff decisions to waive inspectors' recommendations, or to alter inspectors' recommended timeframes for implementing recommendations, after considering documented reasons for such decisions.
   c. monitor whether scheduled work is completed on time.
   d. monitor the total amount of deferred basic maintenance, as well as deferred rehabilitation or replacement work, considered necessary.
10. The Department use documented risk considerations and Bridge Condition Index information to support its capital planning decisions for bridges and large culverts.
11. The Department ensure that its bridge inventory system has all the information needed to maximize use of the Department's planned bridge management system.

Work in progress (cont'd)

12. The Department provide integrated summary information on all Provincial bridges and large culverts in its road and water-infrastructure capital budget requests to Treasury Board, and that this include:
    a. the total capital spending proposed for bridges and large culverts, plus the percentage proposed for new structures versus rehabilitation or replacement of existing structures.
    b. the dollar amount of maintenance, rehabilitation, and replacement work that it considers necessary, but has deferred, and the number of affected structures.
    c. measured trends in the condition of the bridge inventory, including changes in the Bridge Condition Index and the percentage of structures in poor condition.
13. The Department annually measure and monitor the percentage of required Level 1 and Level 2 inspections actually completed and the overall condition of its bridge inventory.
14. The Department set a specific and measurable target for the condition of its bridge inventory.
15. The Department ensure that the bridge-related information in its annual public report is accurate and that it include:
    a. a measure of the overall condition of Provincial bridges, and whether the condition is improving, declining, or stable.
    b. the percentage of required Level 1 and Level 2 bridge inspections completed.
    c. progress in meeting the Province's commitment to invest over $700M in bridges over five years.

    ***OAG comment**: The Department has implemented 15(b). With respect to (c), Department officials told us that there is no longer a 5 year capital investment commitment, therefore no further action is required. We noted the Department now reports capital expenditures on Bridges and other structures (2016/17 - $173.9 million, 2015/16 - $155 million).*
16. The Department periodically review and update the submittals required in its bridge construction specifications to ensure they are current and reflect better practices.
17. The Department require staff to track all required bridge submittals using standardized logs that show due dates, waived submittals and their rationale, receipt dates for all originally submitted and re-submitted information, review comments, identified concerns and their resolution, and approval dates.

    ***OAG comment**: Significant Progress - The Department is in the process of implementing a new submittal log and will assess the need for further amendments as implementation progresses.*
18. The Department require supervisors to regularly review bridge submittal logs and a sample of related submittals to ensure staff are tracking and handling submittals appropriately.
19. The Department ensure that its bridge construction inspectors receive documented notice of all submittals that are outstanding or unapproved at their due dates so that they can decide if construction needs to be delayed until this is rectified.
20. The Department require its bridge construction inspectors to use the bridge-construction inspection checklists it has developed.

Keeyask Process Costs and Adverse Effects Agreements with First Nations

Our recommendations are directed to Manitoba Hydro.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – September 2016	-

What our original report examined

Manitoba Hydro (Hydro) development projects can adversely impact First Nations communities. As a result, discussions are held with First Nations to identify potential impacts. These discussions can result in changes to the Hydro development project and to payments to the First Nations.

Payments to First Nations with respect to Hydro development projects can be made for process costs and for adverse effects. Process cost payments are intended to reimburse First Nations for the costs incurred to negotiate a partnership agreement with Hydro. As part of the negotiations process, Hydro and First Nations identify adverse effect on communities. Adverse effects agreements include programs to mitigate or offset the effects.

Our audit objectives were:

- To determine whether Keeyask process cost are reimbursed in accordance with Hydro's approved polices.
- To determine whether Hydro was properly monitoring compliance with key provisions of the 4 Keeyask adverse effects agreements and the *Ratification Protocol*.
- To determine if Hydro met its financial obligations for each of the 4 Keeyask adverse effects agreements.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 1 of our 3 recommendations has been implemented as at September 30, 2017.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**1**	**-**	**-**	**2**	**3**

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status or to highlight select actions or planned actions.

Work in progress

We recommended that:

2. Hydro conduct periodic risk assessments for each First Nations and tailor claim review procedures accordingly.
3. Any future ratification protocol include a mechanism to provide all parties to the agreement with independent assurance that agreed to procedures were adhered to in all significant respects.

   OAG comment: *Management advised that no project ratification protocol agreements have been entered into since the audit.*

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

We recommended that:

1. Hydro require certification that expenses were paid and, for significant expenses, require proof of payment.

   OAG comment: *The certification statement required still states that amounts were incurred and has not changed to ensure that expenses were paid. However, the Reimbursement Policy was changed to state that amounts be "paid or will be paid" and now requires receipts to support all expenses.*

Manitoba East Side Road Authority

Our recommendations are directed to the Department of Infrastructure.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 19, 2017)
Original report – September 2016	May 25, 2017 (Passed)

On May 27, 2016 the Manitoba Government announced the dissolution of the Manitoba East Side Road Authority and the transfer of its operations to Manitoba Infrastructure (MI). As assented to on June 2, 2017, The Manitoba East Side Authority Act was repealed. While the recommendations included in the report were directed to the Manitoba East Side Road Authority, we believed that they would be equally valuable to MI if they continued to manage the east side road project using the same framework.

In conducting this follow-up, MI advised us of the following matters regarding the integration of ESRA operations into MI:

- The road from Bloodvein to Berens River was announced complete on December 12, 2017. Construction is currently underway on the road between Wasagamack and St. Theresa Point and future plans for the project are being developed.
- The Aboriginal Engagement Strategy is no longer in force. As a result:
    - MI is applying their mandatory clause for Indigenous involvement for construction near Indigenous communities. The percentage, which varies depending on the construction ability of the community, averages about 10%.
    - MI will no longer be assessing the ongoing viability of the community corporations.
- The Community Benefits Agreements (CBAs) continue to be in force, but MI advised that it is exploring alternative delivery models to achieve their goal of economic development in the region. In the meantime, as a result of the lack of any new planned construction projects, and in consultation with the Chiefs of the communities with construction work currently underway, MI suspended acting on the provisions related to:
    - Including a capacity building allowance on untendered pre-construction contracts.
    - Providing training.
    - Providing mentoring.
        - MI will not require joint venture partners to provide mentoring, preferring to leave it up to the community corporations to ensure they get what they need from their joint venture agreements.
        - MI will limit its mentoring to advice regarding financial accounting and will consider opportunities to have some level of training and mentoring in consultations with each community and as part of actual construction work.
    - Supporting an equipment maintenance program.

Given that MI, in consultation with the Indigenous communities, has not yet decided on a service delivery model to replace the ESRA model, the potential applicability of many of our recommendations remain unresolved. These are reflected below as in progress.

What our original report examined

The Manitoba East Side Road Authority (ESRA) was mandated to construct and maintain the east side road project (the project) and ensure that the construction was carried out in a matter that provided increased benefits for east side communities.

Once completed, the project would replace the region's winter road network with over 1,000 km of gravel surfaced roads and water crossings connecting 13 communities. It was projected to cost $3 billion over 30 years.

To act on its mandate of ensuring the project provided increased benefits, ESRA developed an Aboriginal Engagement Strategy (AES). This strategy included the signing of Community Benefits Agreements (CBAs) with Indigenous Communities. Benefits provided by CBAs included training and mentoring by ESRA, as well as access to untendered pre-construction work contracts. Untendered contracts for pre-construction work were awarded to newly established community owned construction corporations (community corporations) which were created as a requirement of the CBA.

Benefits to the east side communities were also provided through ESRA's tendered construction contracts. Tendered contracts made up a majority of the construction costs of the project and included benefits to communities in the form of local procurement, employment and training opportunities.

The benefits provided under the Aboriginal Engagement Strategy represented approximately 35% of the overall road construction cost.

We examined whether ESRA adequately managed the Aboriginal Engagement Strategy, and whether it had effective processes for ensuring compliance with the requirements of the Community Benefits and related agreements.

This follow-up report should be reviewed in conjunction with our original report to obtain an understanding of the issues which underlie the recommendations. All of our reports are available at our website: oag.mb.ca

Status of recommendations as at September 30, 2017

As shown in the table below, 6 of our 24 recommendations have been implemented as at September 30, 2017. Four recommendations have been classified as Action no longer required due to changes in how the east side road project is being managed.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2017	**6**	**4**	**2**	**12**	**24**

Because capacity building allowances will no longer be distributed, MI has indicated that they do not intend to implement Recommendations 4 and 5. These recommendations dealt with determining the total amount of the allowances distributed to date and assessing how the community corporations benefitted from the allowances. MI indicated that it would be too expensive, time consuming, and very difficult to determine what, if any, value the capacity building allowance achieved. They further noted that gathering the information to fulfill these recommendations would be significantly problematic as the key ESRA staff involved are no longer available and some of the community owned construction companies have been shuttered. We continue to support the value of Recommendations 4 and 5 but acknowledge the logistical challenge noted by the Department. This highlights the need for strong oversight, management, and record keeping processes when implementing public policy initiatives.

Below we list the recommendations that remain in progress and the recommendations that are considered cleared. For certain recommendations we have added an "OAG comment" to clarify implementation status or to highlight select actions or planned actions.

Work in progress

We recommended that:

2. ESRA conduct comprehensive risk assessments for all aspects of their operations including but not limited to:
   - The Aboriginal Engagement Strategy.
   - Community Benefits Agreements in general, and specific to each First Nation.

     OAG Comment: *The Aboriginal Engagement Strategy is no longer in place. As a result this recommendation now only relates to the CBAs.*
3. ESRA develop a policy and related practices for calculating capacity building allowances. The policy should include guidance for reducing the capacity building allowance as the community corporations mature.
6. ESRA determine the extent and nature of mentoring provided by joint venture partners and other subcontractors, and whether any compensation provided through the capacity building allowance is reasonable.
11. ESRA develop mentoring plans, including measurable objectives, for each of its divisions that detail how they will fulfill the mentoring obligations outlined in the CBAs.
12. Each ESRA division document the performance of key mentoring activities noted in their mentoring plans. (See Recommendation 11).
13. ESRA ensure all staff responsible for mentoring have the required skills to carry out mentoring obligations outlined in the CBA.
14. ESRA develop performance measures to assess how well each division is meeting their mentoring objectives.
15. ESRA periodically provide government with information on the progress made in achieving mentoring objectives.
16. ESRA monitor training provided against the CBA training targets.
17. ESRA track whether training participants are able to secure related employment within a set time after being trained.
18. ESRA establish a plan for meeting their equipment maintenance program obligation.

Work in progress (cont'd)

21. ESRA assign a senior official overall responsibility for the administration of CBAs and related contracts.

Considered cleared

This follow-up report – *status as at September 30, 2017*

Implemented/resolved

We recommended that:

7. ESRA, on a test basis, verify the employment information received from contractors.

   OAG Comment: *Recommendations 7, 8, 19, 20, 22, and 24 are considered cleared because ESRA operations are now included in the Department of Infrastructure. Based on our previous audit work, we note that the Department has policies and controls in place to address these recommendations.*

8. ESRA monitor whether contractors are complying with the requirement to purchase goods from local suppliers.
19. ESRA Finance obtain proper support for goods or services received, and ensure this support is attached to the payment request.
20. ESRA revise their holdback release process to ensure that payments are compliant with the terms of the contract.
22. ESRA develop and implement contract administration policies and procedures.
24. ESRA develop and implement a centralized contract administration filing system as well as documentation standards that identify key records that should be created and retained in either electronic or paper format.

Action no longer required

We recommended that:

1. ESRA set measurable objectives for the AES including short and long term targets.
9. ESRA develop a comprehensive process for assessing the ongoing financial viability of each community corporation during the term of their CBA**.**
10. Once measurable performance objectives, measures and targets and timelines are set, we recommend that ESRA report appropriately detailed performance information in its annual report in relation to each of its AES objectives.
23. Once contract administration policies and procedures are in place, we recommend that related training workshops be developed and delivered to all pertinent staff.

Do not intend to implement

We recommended that:

4. ESRA track the total amount of capacity building allowances paid overall and to each Community corporation.
5. ESRA track how community corporations benefited from the capacity building allowances they received.

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