Auditor General
MANITOBA

Report to the Legislative Assembly

Follow-up of Recommendations

Independent Auditor's Report

Website Version

March 2019

Our Vision

To be valued for positively influencing public sector performance through impactful audit work and reports.

Our Mission

To focus our attention on areas of strategic importance to the Legislative Assembly, and to provide Members of the Legislative Assembly (MLAs) with reliable and efficient audits.

Our mission includes easy-to-understand audit reports that include discussions of good practices within audited entities, and recommendations that, when implemented, will have a significant impact on the performance of government.

Our Values | Accountability | Integrity | Trust | Collaboration | Innovation | Growth

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Auditor General
MANITOBA

March 2019

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,

Original Signed by:
Norm Ricard

Norm Ricard, CPA, CA
Auditor General

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Auditor General's comments

As declared in my Office's new vision statement, we strive to be "Valued for positively influencing public sector performance through impactful audit work and reports." But what makes for an impactful audit? I believe a measure of audit impact relates to the improvements entities make to their practices that are influenced, at least in part, by the recommendations we include in our audit reports.

Looking at the subject matters of our recommendations provides a high-level picture of how our audits can help improve the operations of government organizations. The recommendations included in this follow-up report cover a broad range of subject matters including:

- Operational effectiveness
- Operational efficiency
- Documentation
- Security management
- Performance monitoring and reporting
- Strategic planning/risk management

In my view, an unimplemented recommendation represents lost potential. I am therefore pleased to note that a "Do not intend to implement" status is rarely used.

In this report we present the statuses of 196 recommendations as at September 30, 2018. These recommendations were issued between July 2015 and July 2017. We follow-up the status of recommendations for 3 consecutive years, beginning a year to 18 months after issuance.

Some of our recommendations can be difficult and time consuming to implement, and efforts to implement the recommended changes must be made amid other operating priorities. That said, I think 3 years is sufficient time to implement most of the recommendations included in our performance audit reports.

This is the third and final follow-up for the 58 recommendations included in the 2 reports to the Legislature that were issued in July 2015. With respect to these 58 recommendations, we note that 59% (34) have been implemented. While this number is low, I find it encouraging that of the 23 recommendations still in progress, significant progress was evident on 13. As such, 3 years after issuance 81% (47) are either implemented or are close to being fully implemented.

I believe that an implementation rate below 85% after our third follow-up, as we have seen every year since 2013, is concerning.

Since 2014, when we began limiting our follow-ups to 3, the number of recommendations reported as in-progress after our third and final follow-up, and for which progress has not since been reassessed by the Public Accounts Committee, continues to grow. These recommendations now total 173. I encourage the Committee to actively monitor the status of recommendations it judges as significant from among these 173. The Committee should do so 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 may wish to 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.

I would especially like to thank all my audit teams for their excellent work.

Original Signed by:
Norm Ricard

Norm Ricard, CPA, CA
Auditor General

This report: 196 recommendations made between July 2015 and July 2017

Third and final follow-up by the Auditor General

58 Recommendations

81% Implemented, or significant progress, after 3 years

59% IMPLEMENTED

22% SIGNIFICANT PROGRESS

85% **What we believe would be a reasonable implementation rate after 3 years**

Potential impact

Topics covered by recommendations include

- Operational effectiveness
- Operational efficiency
- Documentation
- Security management
- Performance monitoring and reporting
- Strategic planning/risk management

3 **The number of consecutive years we follow-up recommendations**

173 **in-progress recommendations** since 2013 not re-assessed by Public Accounts Committee

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Follow-up process

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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 our review" on page 10) 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 8 follow-up reports. We have organized the follow-up reports into 3 sections:

- Third and final follow-up review
- Second follow-up review
- First follow-up review

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, 2018. In addition, the reports include a list by implementation status of all recommendations made.

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 our review

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

In a review, we provide a limited 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. The procedures performed in a review engagement are less extensive than for an audit, and consequently, the level of assurance provided in a review engagement is substantially lower than the assurance that would have been provided had an audit been performed. We do not re-perform audit procedures from the original audit.

In an audit, we provide a reasonable, though not absolute, level of assurance. We achieve this reasonable level of assurance by gathering sufficient appropriate audit evidence. Audit procedures would include: inspection, observation, enquiry, confirmation, analysis and discussion. Use of the term "reasonable level of assurance" refers to the highest 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.

Our follow-up reviews assessed the implementation status of our recommendations as at September 30, 2018.

With respect to the implementation status of the recommendations followed-up, nothing has come to our attention to cause us to believe that the recommendation statuses included in this report do not present fairly, in all significant respects, the progress made in implementing the recommendations.

Implementation status

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Implementation status

In this report we note the implementation status of 196 recommendations issued between July 2015 and July 2017. As detailed more fully in **FIGURE 4,** we report the following implementation statuses:

Recommendations subject to:	Total	Recommendations considered cleared			Work in progress
		Implemented/ resolved	Action no longer required	Do not intend to implement	
Third and final follow-up	58	34		1	23
Second follow-up	66	17	5	2	42
First follow-up	72	3		1	68
Total	**196**	**54**	**5**	**4**	**133**

MANAGEMENT GENERALLY AGREES WITH OUR RECOMMENDATIONS

For every performance audit report we issue, we provide management with the opportunity to comment on each of our recommendations and/or the report overall. In drafting their comments we ask that management indicate whether they agree with the recommendations, and what action they have taken, or will take, to implement the recommendations. In this regard we note that management generally agrees with, or will consider or explore, the value of the recommendations. One of our follow-up statuses is "Do not intend to implement." We use this category when, after due consideration, the entity chooses not to implement a recommendation. We highlight the entity's rational in each of our follow-up reports. We are pleased to note that this category is rarely used.

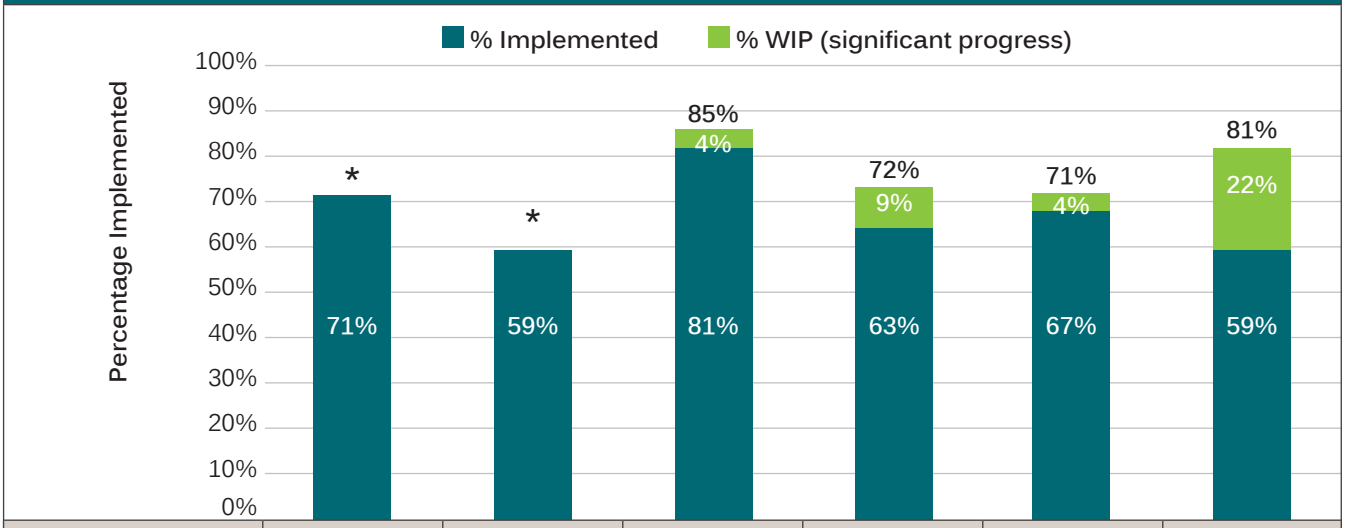
IMPLEMENTATION RATE OF 85% AFTER 3 YEARS WOULD INDICATE REASONABLE ACCEPTANCE AND PROGRESS

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. As such we typically do not comment on the overall progress made by an entity after the first and second follow-ups. We believe, however, that 3 years is a sufficient amount of time to implement most of the recommendations included in a performance audit report. To this end, in our view, an implementation rate of 85% after our third follow-up would indicate reasonable acceptance and progress by the audited entities.

ACTUAL IMPLEMENTATION RATE AFTER 3 YEARS WELL BELOW 85%

In **FIGURE 1** we present a 6-year summary of the implementation rates after our third follow-up. It shows that, except for 2015, these implementation rates were well below 85%. In **FIGURE 1**, we also note the number of recommendations where significant progress was made. When we consider both implemented and significant progress, we note that as at September 2018 a rate of 81% was achieved.

Figure 1: Implementation rate for recommendations included in third follow-up



As of date	June 2013	June 2014	June 2015	September 2016	September 2017	September 2018
Total number of recommendations	225	51	141	104	100	58
Total implemented and significant progress	159*	30*	120	75	71	47
Action no longer required	–	3	4	–	11	–
Do not intend to implement	–		9	2	1	1

* *Assessment of significant progress did not begin until June 2015*

A MEASURE OF AUDIT IMPACT IS IMPROVED ENTITY PRACTICES

As noted in our Vision statement, we strive to influence public sector performance through impactful audit work and reports. The value or impact of our audits can be assessed in part by the perceived usefulness of the information we provide the Legislature on the adequacy of an audited entity's management practices. We believe this information helps the Legislature hold these government organizations accountable for the use of public resources entrusted to them. In addition, audits can be impactful if they influence entities to improve their practices. Our recommendations are designed to guide entities in this regard.

As noted in **FIGURE 2**, the recommendations included in this follow-up report cover a broad range of potential impact areas. These impact areas reflect how the results of our audit work can help improve the operations of government organizations. The areas of greatest frequency deal with operational effectiveness and efficiency, performance monitoring, documentation, quality assurance and strategic planning.

Figure 2: Areas of potential impact and the related recommendation statuses

Areas of potential impact (in descending order of frequency of occurrence)	Recommendations		
	Total	Implemented/ resolved	Work in progress
Operational effectiveness	57	18	39
Operational efficiency	33	7	26
Performance monitoring	32	5	27
Documentation	19	7	12
Quality assurance	14	3	11
Strategic planning	11	1	10
Communication and transparency	9	3	6
Performance reporting	6	1	5
Security management	7	3	4
Risk management	6	2	4
Contract management	4	3	1
Operational training	4	1	3
Administrative policy	2		2
Managing conflicts of interest	2	1	1
Budgeting	1		1
Capital planning	1	1	
Compliance	1		1
Information management	1		1
Total	**218***	**56 (25%)**	**154 (71%)**

* *The total number of recommendations followed-up is 196 but some recommendations dealt with more than one potential impact, and some recommendations are excluded from this figure because their status was either "Action no longer required" or "Do not intend to implement" resulting in a different total.*

UNIMPLEMENTED RECOMMENDATIONS REPRESENT LOST POTENTIAL (i.e. improved entity practice)

Because our recommendations are, in essence, an indicator of potential impact, recommendations left unimplemented represent lost potential. FIGURE 3 notes the potential impact areas for the recommendations issued in July 2015 that remain in progress after the third follow-up. Many of these recommendations deal with matters of operational effectiveness and efficiency, as well as, security and risk management.

Figure 3: Areas of potential impact for in progress recommendations no longer being followed up

Areas of potential impact (in descending order of frequency of occurrence)	Work in progress
Operational effectiveness	5
Operational efficiency	4
Documentation	2
Security management	4
Communication and transparency	1
Performance monitoring	2
Risk management	3
Managing conflicts of interest	1
Operational training	1
Strategic planning	1
Compliance	1
Information management	1
Performance reporting	1
Total	**27* (43%)**

* *This is the final follow-up for 23 recommendations, but some of these recommendations dealt with more than one potential impact, resulting in a different total.*

STATUS OF IN-PROGRESS RECOMMENDATIONS AFTER OUR THIRD FOLLOW-UP IS UNKNOWN

We adopted our 3-year follow-up approach in 2014. Since then, the cumulative number of recommendations that we reported as still in progress after our third follow-up, and for which progress has not since been reassessed by the Public Accounts Committee, continues to grow, as noted below:

Year	# of Recommendations
2014	66
2015	4
2016	13
2017	36
2018	31
2019	23
Total	**173**

We continue to encourage the Public Accounts 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 4: Implementation status, as at September 30, 2018					
Report	Total recommendations	Recommendations considered cleared			Work in progress
		Implemented/ resolved	Action no longer required	Do not intend to implement	
Third and final follow-up review					
July 2015					
WRHA's Management of Risks Associated with End-user Devices	12	4			8
Manitoba Home Care Program	46	30		1	15
Third and final follow-up review total	**58**	**34 (59%)**		**1 (2%)**	**23 (39%)**
Second follow-up review					
January 2016					
Improving Educational Outcomes for Kindergarten to Grade 12 Aboriginal Students	19	3			16
July 2016					
Management of Provincial Bridges	20	5			15
September 2016					
Keeyask Process Costs and Adverse Effects Agreements with First Nations	3	2			1
Manitoba East Side Road Authority	24	7	5	2	10
Second follow-up review total	**66**	**17 (26%)**	**5 (7%)**	**2 (3%)**	**42 (64%)**
First follow-up review					
April 2017					
Management of MRI Services	52	2			50
July 2017					
Management of Manitoba's Apprenticeship Program	20	1		1	18
First follow-up review total	**72**	**3 (4%)**		**1 (1%)**	**68 (95%)**
Grand Total	**196**	**54 (28%)**	**5 (2%)**	**4 (2%)**	**133 (68%)**

Third and final follow-up review

Website Version

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 restructuring of Manitoba's health care system, eHealth will be moving from the WRHA into the newly created Shared Health organization. As a result, Shared Health will be jointly responsible with the WRHA for implementing the recommendations originally directed to the WRHA. Also, due to a government reorganization, the Department of Health, Seniors and Active Living is now responsible for implementing the recommendations originally directed to the HHLS.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 4, 2018)
Original report – July 2015	May 8, 2017 (Passed)
First follow-up – March 2017	May 8, 2017 (Passed)
Second follow-up – March 2018	–

What our original report examined

The mobility and power of end-user devices create operating efficiencies while transforming business processes. Their proliferation within the health-care industry is understandable given the need of health-care professionals to access critical information quickly. However, there is a risk that health organizations, in their desire to meet the demands of health-care 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, 2018

As shown in the table below, 4 of our 12 recommendations have been implemented as at September 30, 2018.

Of the 8 recommendations that remain in progress, we note that significant progress has been made on 6 (Recommendations 2, 3, 4, 5, 6 and 9).

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018					
WRHA	4			6	10
Department of Health	–			2	2
Total	**4**	**0 (0%)**	**1 (1%)**	**8**	**12**

Because we have followed up on the WRHA's *Management of Risks Associated with End-user Device* 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 2018	2	–	–
March 2017	1	–	–
Total	**4**	**–**	**–**

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

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.

   OAG comment: Significant Progress **- eHealth has conducted end-user devices risk assessments and communicated the results to the WRHA CEO on October 30, 2018. The decision on risk acceptance is pending.**

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).

   OAG comment: Significant Progress **- The risk assessments identified a number of needed controls, many of which have been implemented. In addition, out of the 6 control issues noted in our letter to management, 5 have been resolved.**

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.

   OAG comment: Significant Progress **- eHealth developed a strategic plan for the delivery of information and communication technology services to the WRHA. However, no documented evidence of approval of the strategic plan was available.**

5. The WRHA define and implement a structured information classification scheme that includes multiple classifications based on the sensitivity of information.

   OAG comment: Significant Progress **- WRHA has developed a policy classifying non-medical information into 3 categories: restricted, protected and public. However, the needed controls for each of the categories have not yet been defined.**

   Medical and personal information is classified as confidential. The needed controls for this category have been defined.

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.

   OAG comment: Significant Progress **- A PHIA training course has been developed and launched both online and in person. WRHA expects to provide PHIA training to all staff by the summer of 2019. An online information security awareness course has been developed but not launched.**

11. 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.

    OAG comment: **An online information security awareness training course has been developed. Pending the course launch, no training has been provided.**

Directed to the Department

We recommended that:

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

   OAG comment: Significant Progress **- Department of Health, Seniors and Active Living has developed the guidelines but has not yet made them available to the trustees.**

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

   OAG comment: **Department of Health, Seniors and Active Living has not begun monitoring trustees' compliance.**

Considered cleared

This follow-up report – *status as at September 30, 2018* — Implemented/resolved

Directed to the WRHA

We recommended that:

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.

March 2018 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 4, 2018)
Original report – July 2015	–
First follow-up – March 2017	–
Second follow-up – March 2018	–

What our original report examined

The Manitoba Home Care Program (the Program) provides health care, 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, 2018

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, 30 of our 46 recommendations (2 of 9 for the Department, 13 of 19 for WRHA, and 15 of 18 for Southern Health-Santé Sud) have been implemented as at September 30, 2018.

Of the 15 recommendations that remain in progress, we note that significant progress has been made on 7 (Department Recommendation 24; WRHA Recommendations 15, 16, 26 and 27; Southern Health-Santé Sud Recommendations 19 and 28).

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018					
Department of Health	2	–	1	6	9
WRHA	13	–	*	6	19
Southern Health-Santé Sud	15	–	*	3	18
Total	**30**	**–**	**1**	**15**	**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.*

The Department has chosen not to implement Recommendation 2. Recommendation 2 deals with determining what specific home care services all RHAs must provide, and communicating this in all public home care materials. The Department told us that with the creation of Shared Health, the Department will be moving to a role focused on policy, planning, funding and oversight and that the task may be delegated to the provincial clinical teams of Shared Health in the future.

Both the WRHA and the Southern Health-Santé Sud do not intend to implement Recommendation 21(a) which deals with documenting scheduled travel times and the related rationale. WRHA indicated that their systems are 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 additional client-specific task times (from standard task times) would overburden the home care scheduling system. In our view, given that the WRHA and Southern Health-Santé Sud have implemented Recommendation 20 and 21(b), our concern regarding Recommendation 21(a) is diminished.

Because we have followed up on the *Manitoba Home Care 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	13	–	1
March 2018	15	–	–
March 2017	2	–	–
Total	**30**	**–**	**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 or to highlight select actions or planned actions.

Work in progress

Directed to the Department

We recommended that:

3. The Department make its home care standards and policies public, as done in other provinces.

   OAG comment: **The Department told us it provides provincial home care policies to the public upon request. They also noted that through the health system transformation the Department will be considering what policies should remain at the provincial level and whether to post existing and new policies on its website.**

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.

   OAG comment: **The Department advises that a steering committee is working on identifying key standards.**

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.

   OAG comment: **The Department advises it is working on implementing the Electronic Home Care Record (EHCR) project. This project included defining the home care data needed to oversee management of the 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.

   OAG comment: **The Department told us that in the EHCR project various data fields were created to enable monitoring of home care performance including: service timeliness (wait times) and service reliability.**

7. The Department work with RHAs to expand and improve public performance reporting on the Manitoba Home Care Program.

   OAG comment: **The Department told us that work on this recommendation has not yet begun because they continue to implement Recommendation #5. They plan to develop a home care services dashboard for public consumption.**

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.

   OAG comment: Significant Progress **- The RHAs are taking the lead on implementing this recommendation. They have designated which tasks must remain as "nurse-delegated". This clarified which tasks can be subject to group training and those which require client-specific training (nurse-delegated). Implementation is planned to be done by the RHAs in 2019.**

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.

   OAG comment: **In 2017 WRHA identified barriers to timely assessments and some related actions to address those barriers. WRHA told us they have begun recording in each client's file the data required to determine the timeliness of at-home client needs assessments, but that statistics on whether timeliness of client needs assessments was improving were not yet available.**

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 (b) and (e) have been implemented. Audit tool results for 2017 and 2018 for (a), (c), and (d) showed little improvement had occurred.**

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.

    OAG comment: Significant Progress **- WRHA has implemented Recommendation 16 (a). Audit tool results for 2017 and 2018 for (b) showed little improvement had occurred.**

18. WRHA develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.

    OAG comment: **WRHA is tracking the frequency of cancelled visits and told us it is currently working towards finding ways to increase flexibility of how staff are scheduled.**

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

    OAG comment: Significant Progress **- The WRHA is now tracking mandatory training for all staff and ensures attendance. In 2017 WRHA ensured security checks were on file for direct service staff. In 2018 WRHA told us a new system was implemented to track receipt of security checks for non-direct service staff, but they had not monitored whether all required security checks were in place.**

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). WRHA told us it is working on improving its processes for ensuring conflict-of-interest forms are received and kept on file for all staff, including home care staff.**

Directed to the Southern Health-Santé Sud

We recommended that:

19. Southern Health-Santé Sud monitor the number and consistency of workers assigned to individual clients and assess progress.

    OAG comment: Significant Progress **- A management report has been developed to monitor the number of workers assigned to individual clients. In addition, new questions were added to its client satisfaction survey related to the number of workers providing services and the related impact. These 2 monitoring tools are planned to be implemented in October 2018 and November 2018 respectively.**

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). With regards to 22 (a), Southern Health-Santé Sud is conducting Health Care Aide (HCA) staffing reviews of its 19 offices. They advised us that they are reviewing client needs, identifying available HCA resources and then matching client needs to HCA resources. They anticipate this process will decrease the number of HCAs assigned to individual clients, align clients geographically and cascade visits to remove unassigned time.**

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). With respect to 28 (c), it has begun compiling the results of file reviews, but not home visits, and has not begun to discern trends to identify possible training ideas.**

Considered cleared

This follow-up report – *status as at September 30, 2018* | Implemented/resolved

Directed to the Department

We recommended that:

14. The Department develop a plan for province-wide implementation of the RAI-HC client assessment tool.

    OAG comment: **We note that RAI-HC was upgraded in WRHA in 2018 and is in the process of being implemented in PMH, with completion scheduled for February 2019. Implementing RAI-HC in the other 3 RHAs is included in a global plan. The Department is currently working on a detailed rollout plan.**

Directed to the WRHA

We recommended that:

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.

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: **While the WRHA has taken a number of steps to improve the timeliness of service start-ups consistent with our recommendation, to date service start-up data does not yet show a trend towards an overall improvement.**

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.

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.

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.

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.

    OAG comment: **Recommendation 13 (b) was not required because the Department views a client's ability to pay as not relevant in accessing program services and assessing available community resources.**

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.

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.

25. Southern Health-Santé Sud require staff to document reviews of sign-off sheets and related follow-up actions.

Do not intend to implement

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.

March 2018 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 March 2018 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 has 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 March 2018 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.**

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 March 2018 comment: **WRHA does not intend 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 March 2018 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 March 2018 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 March 2018 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.

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 March 2018 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.

Second follow-up review

Website Version

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 4, 2018)
Original report – January 2016	August 17, 2016 (Passed)
First follow-up – March 2018	–

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, 2018

As shown in the table below, 3 of our 19 recommendations have been implemented as at September 30, 2018.

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

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018	3	–	–	16	19

In our *March 2018 Follow-up* report we noted that the Department had chosen not to implement Recommendation 5. We are pleased that the Department has reconsidered and is now working on implementing this recommendation.

The Department advised that it will implement Recommendations 1, 6, 8 and 14 through the planned broad review of the K-12 education system. While we have not been provided with the planned scope of this review, given its purported broad nature, we are concerned that the specific issues giving rise to the recommendations will not be sufficiently examined. We encourage the Department to ensure these issues are specifically included in the planned review.

Because we have followed up on the *Improving Education Outcomes for Kindergarten to Grade 12 Aboriginal Students* 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	1	–	–
March 2018	2	–	1*
Total	**3**	**–**	**–***

* *Recommendation 5 was reported as Do Not Intend to Implement in our 2018 progress report, but the Department has since reconsidered and is working on implementing the recommendation.*

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.

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

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.

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.

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. The Department plans to provide a course in early 2019 on identity declaration.**

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, 2018*	Implemented/resolved

We recommended that:

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.

March 2018 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.

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 4, 2018)
Original report – July 2016	September 15, 2016 (Passed)
First follow-up – March 2018	–

What our original report examined

The Department of Infrastructure (the Department) 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, 2018

As shown in the table below, 5 of our 20 recommendations have been implemented as at September 30, 2018.

Of the 15 recommendations that remain in progress, we note that significant progress has been made on one (Recommendation 17).

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018	5	*	–	15	20

In our *March 2018 Follow-up* report, the Department advised that Recommendation 15(c) is no longer required as there is no longer a 5 year capital investment commitment. We noted the Department now reports capital expenditures on Bridges and other structures (2017/18 - $129.7 million, 2016/17 - $173.9 million, 2015/16 - $155 million).

Because we have followed up on the *Management of Provincial Bridges* 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	5	–	–
March 2018	–	–	–
Total	**5**	**–**	**–**

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.

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.

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.

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 (2017/18 - $129.7 million, 2016/17 - $173.9 million, 2015/16 - $155 million).**

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 has developed a new submittal log and is formalizing the process to ensure consistent implementation across the Department.**

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.

Considered cleared

This follow-up report – *status as at September 30, 2018*	Implemented/resolved

We recommended that:

3. The Department amend its process for selecting external service providers to include an assessment of any recent experience with their bridge inspection work.

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.

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.

16. The Department periodically review and update the submittals required in its bridge construction specifications to ensure they are current and reflect better practices.

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 4, 2018)
Original report – September 2016z	May 16, 2018
First follow-up – March 2018	May 16, 2018

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, 2018

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018	2	–	–	1	3

Because we have followed up on the *Keeyask Process Costs and Adverse Effects Agreements with First Nations* 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	1	–	–
March 2018	1	–	–
Total	**2**	**–**	**–**

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:

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, 2018*	Implemented/resolved

We recommended that:

2. Hydro conduct periodic risk assessments for each First Nations and tailor claim review procedures accordingly.

March 2018 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 March 2018 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 4, 2018)
Original report – September 2016	May 25, 2017 (Passed)
First follow-up – March 2017	–

On May 27, 2016 the Manitoba Government announced the dissolution of the Manitoba East Side Road Authority (ESRA) and the transfer of its operations to Manitoba Infrastructure (MI). As assented to on June 2, 2017, The *Manitoba East Side Road Authority Act* was repealed. While the recommendations included in the report were directed to ESRA, 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 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 ment
  - MI will not require joint venture partners to provide mentoring, preferring to leav 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.
- MI will provide advice in establishing a plan for an equipment maintenance program upon request.

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

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 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 AES represented approximately 35% of the overall road construction cost.

We examined whether ESRA adequately managed the AES, 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, 2018

As shown in the table below, 7 of our 24 recommendations have been implemented as at September 30, 2018. Five 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 Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018	7	5	2	10	24

Recommendation 3, which deals with developing a policy and related practices for capacity building allowances, is classified as action no longer required because capacity building allowances will no longer be distributed.

As in 2017, Recommendations 4 and 5 remain categorized as "Do not intend to implement". These recommendations dealt with determining the total amount of 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.

Because we have followed up on the *Manitoba East Side Road Authority* 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	1	1	–
March 2018	6	4	2
Total	**7**	**5**	**2**

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.**

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.

Considered cleared

This follow-up report – *status as at September 30, 2018* — Implemented/resolved

We recommended that:

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

    OAG comment: **A senior official with the Department of Infrastructure has been assigned this responsibility.**

Action no longer required

We recommended that:

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.

March 2018 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 March 2018 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.

Website Version

First follow-up review

Website Version

Management of MRI Services

Our recommendations were directed to the Department of Health, Seniors and Active Living, Diagnostic Services Manitoba, Prairie Mountain Health and Winnipeg Regional Health Authority. Due to a restructuring of Manitoba's health care system, Shared Health was created and is now responsible for implementing the recommendations originally directed to Diagnostic Services Manitoba.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 4, 2018)
Original report – April 2017	–

What our original report examined

Magnetic Resonance Imaging (MRI) is a non-invasive procedure that uses a strong magnetic field and radio waves to create detailed images of organs and structures inside the body—most commonly the brain, spine, heart, abdomen, pelvis, and soft tissues in joints. This advanced imaging helps clinicians diagnose, monitor, and treat patients' medical conditions. The Department of Health, Seniors and Active Living (the Department) funds and oversees MRI services. Two Regional Health Authorities (RHAs) and Diagnostic Services Manitoba (now called Shared Health Manitoba) manage and deliver these services.

We examined the adequacy of processes in the Department, Diagnostic Services Manitoba (DSM), Prairie Mountain Health (PMH), and Winnipeg Regional Health Authority (WRHA) for ensuring:

- timely and efficient MRI services.
- patient safety and quality of MRI scans and reports.

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, 2018

Many of the 24 recommendations from our 2017 report were directed to more than one organization. For follow-up purposes, recommendations directed to more than one organization were followed-up with each organization named. This results in a total of 52 recommendations.

Recommendations that require multiple organizations to "work together" were followed-up as one recommendation rather than by each organization named in the recommendation.

As shown in the table below, 2 of our 52 recommendations (1 of 13 for PMH and 1of 14 for WRHA) have been implemented as at September 30, 2018.

Of the 50 recommendations that remain in progress, we note that significant progress has been made on 3 (WRHA Recommendations 2 and 4; and multiple organizations working together on Recommendation 8).

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018					
Department of Health, Seniors and Active Living	–	–	–	5	5
Shared Health	–	–	–	13	13
Prairie Mountain Health	1	–	–	12	13
Winnipeg Regional Health Authority	1	–	–	13	14
Multiple organizations working together	–	–	–	7	7
Total	**2**	**–**	**–**	**50**	**52**

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:

5. The Department make it clear on their website that, following consultation with their health care providers, patients may have their MRI scans done at different facilities and in different regions.

15. DSM, PMH, and WRHA develop and monitor scanner productivity measures that can help assess efficiency and drive process improvement, and that over the long-term the Department require the regions to develop standardized productivity measures.

17. The Department provide government decision-makers considering new additional MRI scanners with more comprehensive data, such as data on the:

    - volume of MRI demand from the different geographic areas of the province.
    - various proposed scanner locations and their related costs, benefits, and risks; clinical environments; transportation impacts; and impacts on provincial, regional and facility wait-times.
    - costs and benefits of expanding the operating hours of existing scanners as opposed to adding new scanners.
    - rationale of proposed operating hours and throughput for new scanners.

20. The Department enhance public information on MRI wait times and volumes by:

    a. accurately explaining the information.
    b. reporting a greater variety of wait-time information to better meet users' needs (such as percentile information; both average and median wait times; and, as systems allow, wait times by priority level against established targets).

22. The Department ensure there is a qualified service provider in place to continue accrediting MRI facilities beyond June 2017.

    OAG comment: **The Department has taken steps to ensure there is a service provider to continue accrediting MRI facilities in Manitoba beyond 2017. A one-year service purchase agreement was signed with the College of Physicians and Surgeons of Manitoba (CPSM) accepting responsibility for accreditation through the continued operation of the Manitoba Quality Assurance Program (MANQAP). The Department is now determining what other options are available to provide independent accreditation services.**

Directed to Shared Health (formerly directed to DSM)

We recommended that:

3. DSM evaluate the costs and benefits of sharing centralized MRI intake services within or across regions.

   OAG comment: **Shared Health, WRHA, and PMH advise that the success of the pilot on the mandatory use of Central Intake in WRHA indicates the likely benefit of expanding centralized intake provincially. The Diagnostic Imaging Joint Council has approved a phased approach to implementation, subject to resourcing. Full-costing estimates of centralized intake expansion have not yet been conducted.**

4. DSM monitor the length of time it is taking to book MRI appointments and promptly remedy any significant booking backlogs.

5. DSM make it clear on their website that, following consultation with their health care providers, patients may have their MRI scans done at different facilities and in different regions.

9. DSM assign priority codes to all MRI scan requests based solely on medical considerations and then schedule all scans—including those where a third party is paying for them—based on assigned codes.

10. DSM track and monitor MRI wait times by priority level, and that they adjust their scheduling processes when monitoring shows a significant number of the more urgent scans are not being scheduled so as to meet wait-time targets.

12. DSM identify and implement facility scheduling practices that can increase the number of MRI scans done daily at each facility.

13. DSM implement further strategies for reducing no-show rates for MRI appointments and monitor their effectiveness.

14. DSM provide all patients with the option to be placed on a cancellation list.

15. DSM develop and monitor scanner productivity measures that can help assess efficiency and drive process improvement, and that over the long-term the Department require the regions to develop standardized productivity measures.

16. DSM track and monitor MRI report turnaround times using policies and targets that take clinical urgency into consideration, and that DSM develop processes to identify and promptly follow-up overdue reports.

21. DSM implement processes to ensure patient safety screening forms are fully completed and properly signed.

23. DSM have a medical physicist assess their MRI quality control programs each year, as required by Manitoba Quality Assurance Program standards.

24. DSM:

    a. regularly complete all required peer reviews for MRI technologists.
    b. implement a formal and documented annual peer review process for radiologists that includes assessing how they prioritize, read, and interpret MRI scans.

    OAG comment: **Shared Health has implemented Recommendation 24(a).**

Directed to Prairie Mountain Health

We recommended that:

3. PMH evaluate the costs and benefits of sharing centralized MRI intake services within or across regions.

   OAG comment: **See our comment on Recommendation 3 under Shared Health.**

5. PMH make it clear on their website that, following consultation with their health care providers, patients may have their MRI scans done at different facilities and in different regions.

9. PMH assign priority codes to all MRI scan requests based solely on medical considerations and then schedule all scans—including those where a third party is paying for them—based on assigned codes.

10. PMH track and monitor MRI wait times by priority level, and that they adjust their scheduling processes when monitoring shows a significant number of the more urgent scans are not being scheduled so as to meet wait-time targets.

12. PMH identify and implement facility scheduling practices that can increase the number of MRI scans done daily at each facility.

13. PMH implement further strategies for reducing no-show rates for MRI appointments and monitor their effectiveness.

14. PMH provide all patients with the option to be placed on a cancellation list.

15. PMH develop and monitor scanner productivity measures that can help assess efficiency and drive process improvement, and that over the long-term the Department require the regions to develop standardized productivity measures.

16. PMH track and monitor MRI report turnaround times using policies and targets that take clinical urgency into consideration.

21. PMH implement processes to ensure patient safety screening forms are fully completed and properly signed.

23. PMH have a medical physicist assess their MRI quality control programs each year, as required by Manitoba Quality Assurance Program standards.

24. PMH:

    a. regularly complete all required peer reviews for MRI technologists.
    b. implement a formal and documented annual peer review process for radiologists that includes assessing how they prioritize, read, and interpret MRI scans.

    OAG comment: **PMH has implemented Recommendation 24(a).**

Directed to the WRHA

We recommended that:

2. WRHA make central intake of MRI requests mandatory.

    OAG comment: Significant Progress **- WRHA implemented a 3-month pilot making central intake of MRI requests mandatory as of September 19, 2017. The region indicated they intend to extend the pilot permanently due to success in reducing patient no-shows for appointments, and has advised that additional communication to referring practitioners is planned in coming months.**

3. WRHA evaluate the costs and benefits of sharing centralized MRI intake services within or across regions.

    OAG comment: **See our comment on Recommendation 3 under Shared Health.**

4. WRHA monitor the length of time it is taking to book MRI appointments and promptly remedy any significant booking backlogs.

   OAG comment: Significant Progress **- WRHA has begun to track MRI booking times. Its tracking to-date shows a reduction in the length of time it takes to book MRI appointments over what we found in our audit.**

9. WRHA assign priority codes to all MRI scan requests based solely on medical considerations and then schedule all scans—including those where a third party is paying for them—based on assigned codes.

10. WRHA track and monitor MRI wait times by priority level, and that they adjust their scheduling processes when monitoring shows a significant number of the more urgent scans are not being scheduled so as to meet wait-time targets.

12. WRHA identify and implement facility scheduling practices that can increase the number of MRI scans done daily at each facility.

13. WRHA implement further strategies for reducing no-show rates for MRI appointments and monitor their effectiveness.

14. WRHA provide all patients with the option to be placed on a cancellation list.

15. WRHA develop and monitor scanner productivity measures that can help assess efficiency and drive process improvement, and that over the long-term the Department require the regions to develop standardized productivity measures.

16. WRHA track and monitor MRI report turnaround times using policies and targets that take clinical urgency into consideration, and that WRHA develop processes to identify and promptly follow-up overdue reports.

21. WRHA implement processes to ensure patient safety screening forms are fully completed and properly signed.

23. WRHA have a medical physicist assess their MRI quality control programs each year, as required by Manitoba Quality Assurance Program standards.

24. WRHA:

    a. regularly complete all required peer reviews for MRI technologists.
    b. implement a formal and documented annual peer review process for radiologists that includes assessing how they prioritize, read, and interpret MRI scans.

    OAG comment: **WRHA has implemented Recommendation 24(a).**

Directed to multiple organizations working together

We recommended that:

1. The Department, DSM, PMH, and WRHA (working together and collaboratively with Choosing Wisely Manitoba and other stakeholders) develop specific initiatives to improve the appropriateness of MRI requests, and that in doing so they assess the costs and likely benefits of:

    - developing and implementing ordering guidelines and stricter requirements for the MRI requests most often inappropriately ordered.
    - educating the public on inappropriate scan demands.
    - providing targeted education to clinicians with unusually high ordering rates.
    - altering radiologists' fee structure to recognize time spent dealing with inappropriate orders.
    - embedding ordering guidelines in order-entry software.

6. The Department, DSM, PMH, and WRHA work together to develop a specific initiative (or initiatives) to remind clinicians that MRI scans can be requested at facilities in different regions.

7. DSM, PMH, and WRHA work together to finish standardizing MRI request forms across the province in the short-term and work with the Department to implement an electronic MRI request form in the long-term.

8. The Department, DSM, PMH, and WRHA work together to develop a single province-wide method of prioritizing MRI requests that includes a clear definition and standard wait-time target for each priority level, at minimum meeting the Canadian Association of Radiologists' guidelines.

    OAG comment: Significant Progress **- PMH, Shared Health and WRHA have agreed to use the Canadian Association of Radiologists' (CAR) priority category definitions and national maximum wait time targets for MRI. PMH has formally communicated this new method of prioritizing MRI requests in the organization. Shared Health and WRHA plan to create documentation formalizing this decision in the future. The Department advised that it is supportive of the decision to adopt CAR guidelines.**

11. DSM, PMH, and WRHA work together to harmonize MRI scan protocols across all facilities in the province, and that they adjust the standard length of scan appointments to reflect any resulting time savings.

18. The Department work collaboratively with DSM, PMH, and WRHA to ensure there is comprehensive strategic planning for MRI services in the province that holistically considers demand, productivity, supply, safety, and quality assurance issues.

    OAG comment: **Shared Health has accepted the lead on this recommendation and will report on its efforts to the Department going forward.**

19. The Department work collaboratively with DSM, PMH, and WRHA to:

    a. review and clarify how it expects MRI scan volumes and wait-times to be calculated and reported (both short-term and long-term).
    b. include wait-time information by priority level, including comparisons to targets, in its reporting requirements, as systems allow.
    c. include productivity measures (other than scan volumes) in its reporting requirements.
    d. ensure the accuracy and consistency of reported data.

Considered cleared

This follow-up report – *status as at September 30, 2018* | Implemented/resolved

Directed to Prairie Mountain Health

We recommended that:

4. PMH monitor the length of time it is taking to book MRI appointments and promptly remedy any significant booking backlogs.

Directed to the WRHA

We recommended that:

5. WRHA make it clear on their website that, following consultation with their health care providers, patients may have their MRI scans done at different facilities and in different regions.

Management of Manitoba's Apprenticeship Program

Our recommendations are directed to the Department of Education and Training.

Summary of reports and PAC discussion dates	
Reports issued	Discussed at PAC (in meetings up to December 4, 2018)
Original report – July 2017	August 31, 2017

What our original report examined

Apprenticeship Manitoba, a branch of the Department of Education and Training, is responsible for administering Manitoba's apprenticeship program. Its stated mission is "to provide access to training, supports, and certification of skilled workers to help meet the needs of Manitoba industry," and its stated vision is "to be the model for training and certification of workers." It also assists the Apprenticeship and Certification Board, a group of people appointed by the Minister to provide advice and help the Province coordinate Manitoba's apprenticeship system.

An apprentice typically obtains about 80% of his or her training on the job and 20% in school to obtain a certificate of qualification in a trade. We examined the adequacy of Apprenticeship Manitoba's processes for overseeing in-school training, workplace training, and apprentice progress. We also examined the adequacy of planning and performance reporting for Manitoba's apprenticeship system. We chose these areas for examination because they support Apprenticeship Manitoba's stated mission and vision. They also reflect the requirements of *The Apprenticeship and Certification Act* and regulations.

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, 2018

As shown in the table below, 1 of our 20 recommendations has been implemented as at September 30, 2018.

Of the 18 recommendations that remain in progress, we note that significant progress has been made on 2 (Recommendations 1 and 15).

Status date See Nature of our review on page 10	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2018	1	–	1	18	20

Apprenticeship Manitoba has chosen not to implement Recommendation 11. Recommendation 11 deals with having employers track and verify their apprentices' practical experience. Apprenticeship Manitoba told us that implementing this recommendation would have a negative impact on industry engagement, which could in turn limit opportunities for future apprentices and challenge the Apprenticeship and Certification Board to advance its mandate. While we acknowledge Apprenticeship Manitoba's concerns, we continue to support the value of this recommendation. Understanding the breadth and depth of an apprentice's practical experience is critical to ensuring they are properly qualified. We note that part (b) of Recommendation 11 speaks to the need to, in effect, work with employers and apprentices to gain their support for such a revised logbook.

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. Apprenticeship Manitoba obtain documented evidence that all legislative and policy requirements are met before it accredits training courses, and that it assess the need for increased supervisory review, staff training, and checklists in order to achieve this.

   OAG comment: Significant Progress **- Apprenticeship Manitoba has developed revised procedures to ensure better support for accreditation decisions. In subsequent follow-ups, we will review compliance with these revised procedures.**

2. Apprenticeship Manitoba annually remind training institutions that they must immediately report any significant changes to their accredited training courses, and that this includes all instructor changes.

3. Apprenticeship Manitoba use a risk-based accreditation process.

4. Apprenticeship Manitoba obtain documented evidence that the quality of each block-release training course is consistent with accreditation standards, and then use a risk-based approach to periodically assess on-going quality.

5. Apprenticeship Manitoba conduct and document a comprehensive lessons learned analysis for the E-Apprenticeship Alternative Delivery Development Initiative, and then develop an updated strategy for offering online training courses to apprentices.

6. Apprenticeship Manitoba:
   a. clarify in policy the information and verification needed in order for staff to conclude that an employer registering an apprentice will provide suitable experience and proper supervision, and comply with applicable legislation.
   b. periodically monitor staff compliance with the policy.

7. Apprenticeship Manitoba improve its employer database so that it tracks the following information for each employer:

   a. number and names of journeypersons, designated trainers, and apprentices.
   b. ratio adjustments.
   c. all actions related to ensuring the employer is providing suitable experience and properly supervising apprentices.
   d. all instances of non-compliance with apprenticeship legislation.

8. Apprenticeship Manitoba require all individuals applying for designated-trainer status to provide evidence supporting their self-declarations.

9. Apprenticeship Manitoba perform the following work before approving ratio adjustments:

    a. ensure the adjustments are for reasons allowed by the General Regulation.
    b. verify or assess the reasonableness of employer-reported information, including the safety steps proposed to mitigate the reduced level of supervision.
    c. evaluate the employer's compliance history.
    d. document all work performed, including how information was weighed to arrive at a decision.

10. Apprenticeship Manitoba develop a regimen for visiting workplaces to assess the quality of workplace training that includes:

    a. coverage of both voluntary and compulsory trades.
    b. consideration of partnerships with other parts of government to avoid any potential duplication of effort.
    c. risk-based selection criteria that consider industry and employer history with respect to compliance issues and complaints.
    d. specified procedures for assessing whether apprentices are receiving suitable experience and proper supervision, plus specified documentation requirements.
    e. specified procedures and guidance for following-up and resolving all instances of noted or alleged non-compliance with apprenticeship legislation.

13. Apprenticeship Manitoba develop a policy for recognizing prior workplace training and experience, similar to its policy for recognizing prior in-school training, and then take steps to ensure staff comply with both policies.

14. Apprenticeship Manitoba keep copies of employers' certification of apprentices' work hours to support the information recorded in its database.

15. Apprenticeship Manitoba develop a policy setting out formal processes for conducting and documenting the prior learning assessments that exempt people from the practical exams otherwise required.

    OAG comment: Significant Progress **- Apprenticeship Manitoba has developed a draft prior learning assessment policy related to exempting individuals from practical exams, and are waiting for approval from the Executive Director of Apprenticeship.**

16. Apprenticeship Manitoba develop a documented quality assurance process to ensure that staff:

    a. identify apprentices failing to progress and follow-up to ascertain the reasons for the lack of progression.
    b. develop plans and provide supports for apprentices needing help for continued progression, and regularly monitor the effectiveness of the supports being provided.
    c. cancel apprenticeship agreements when apprentices no longer wish to remain in the apprenticeship program.

    OAG comment: **Apprenticeship Manitoba has implemented recommendation 16 (a) and (c).**

17. Apprenticeship Manitoba evaluate the adequacy and effectiveness of the essential-skills support services it offers to apprentices, and then take steps to remedy any identified gaps.

18. Apprenticeship Manitoba develop:

    a. mechanisms for forecasting supply and demand for apprenticeship trades.
    b. goals and objectives related to the quality of both in-school and workplace training.
    c. risk management processes.
    d. specific and measurable performance targets tied to stated goals and objectives.

19. Apprenticeship Manitoba:

    a. take steps to ensure the accuracy of the reported number of active apprentices.
    b. regularly measure completion rates.
    c. periodically measure apprentice and employer satisfaction.

    OAG comment: **Apprenticeship Manitoba has implemented recommendation 19 (a) and (c).**

20. Apprenticeship Manitoba improve its public reporting on Manitoba's apprenticeship program *to include information about training results and the quality of training (for example, program completion rates and the results of course accreditation and workplace monitoring).*

Considered cleared

This follow-up report – *status as at September 30, 2018* | Implemented/resolved

We recommended that:

12. Apprenticeship Manitoba evaluate the costs and benefits of making the workplace mentoring resources developed by other provinces and the Canadian Apprenticeship Forum available to Manitoba employers and journeypersons.

Do not intend to implement

We recommended that:

11. Apprenticeship Manitoba:

    a. work with employers to develop a logbook that records the types of tasks performed by apprentices, as well as the hours worked.
    b. develop a strategy for communicating the value of the revised logbook to both employers and apprentices.