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MANITOBA

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Follow-up of Recommendations

March 2017

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

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- Honesty
- Integrity
- Openness

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

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

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March 2017

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

Honourable Ms. Driedger:

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

Respectfully submitted,

Norm Ricard, CPA, CA
Auditor General

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Auditor General's comments

In this report we present, as at September 30, 2016, the statuses of 262 recommendations. We note that 127 (48%) have been implemented. We believe that significant progress has been made on 27 of the 130 recommendations that remain in progress.

We follow-up the status of recommendations for 3 consecutive years, beginning a year to 18 months after issuance. As such, this is the final follow-up for the 104 recommendations included in our January 2013 Report to the Legislature (comprised of 7 audit reports). With respect to these recommendations, we note that 66 (63%) have been implemented. Of particular note is that all of the recommendations in only 3 of the 7 audit reports were fully implemented (Citizen Concerns – North Portage Development Corporation – 4 recommendations, Manitoba eHealth Procurement of Contractors – 10 recommendations, and Provincial Nominee Program for Business – 13 recommendations). The least progress in implementing our recommendations occurred with respect to our audit report on Information Technology Security Management Practices where 23 of 47 recommendations remain in progress. For the Manitoba Early Learning and Child Care Program 10 of 25 recommendations remain outstanding but significant progress is evident for 7 of the 10.

We encourage the Public Accounts Committee to consider which of the in progress recommendations, if any, it should continue to monitor and to request appropriately detailed action plans from the relevant government organizations.

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.

Norm Ricard, CPA, CA
Auditor General

Follow-up process

Follow-up process

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

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

Status categories

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

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

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

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

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

Report format

This report includes 15 follow-up reports. We have organized the follow-up reports into two sections:

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

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

Follow-up reports include a chart indicating the current implementation status of our recommendations as at September 30, 2016, as well as tables listing all the recommendations made, organized by implementation status.

Nature of a review

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

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

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

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Results of our follow-up reviews

Results of our follow-up reviews

Review comments

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

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

Our follow-up reviews assessed the implementation status of our recommendations as at September 30, 2016 (except for the one outstanding recommendation from our report on the *Citizen Concerns – North Portage Development Corporation* which was assessed as at October 17, 2016).

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

Summary of implementation status

In this report we note the implementation status of 262 recommendations issued since January 2013. As detailed in **Figure 1**, we concluded that:

- 127 have been implemented/resolved
- 1 no longer required the recommended action
- 4 will not be implemented
- 130 remain in progress

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

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

Figure 1: Implementation status, as at September 30, 2016

Report	Total recommendations	Recommendations considered cleared			Work in progress
		Implemented/ resolved	Action no longer required	Do not intend to implement	
No additional follow-up reviews scheduled					
January 2013					
Annual Report to the Legislature					
Citizen Concerns – North Portage Development Corporation (Note 4)	4	4			
Information Technology Security Management Practices	47	22		2	23
Manitoba Early Learning and Child Care Program	25	15			10
Manitoba eHealth Procurement of Contractors (Note 1)	10	10			
Office of the Fire Commissioner	4	2			2
Provincial Nominee Program for Business	13	13			
Senior Management Expense Policies	1				1
Total	**104**	**66 (63%)**		**2 (2%)**	**36 (35%)**
At least one more follow-up review scheduled					
August 2013					
Rural Municipality of Lac du Bonnet	**2**	**1 (50%)**			**1 (50%)**
March 2014					
Annual Report to the Legislature					
Accounts and Financial Statements	7		1	2	4
Citizen Concerns – Manitoba Hydro Funding of the Keeyask Centre	(Note 2)				
– Town of Lac du Bonnet – Bulk Water Sales (Note 1)	1	1			
Helicopter Ambulance Program	5	1			4
Lake Manitoba Financial Assistance Program: Parts C and D	(Note 3)				
Managing the Province's Adult Offenders	29	20			9
Manitoba's Framework for an Ethical Environment	20	12			8
Manitoba Hydro – Managing Cyber Security Risk Related to Industrial Control Systems	8	7			1
Northern Airports and Marine Operations (Note 1)	3	3			
Waiving of Competitive Bids	25	13			12
Total	**98**	**57 (58%)**	**1 (1%)**	**2 (2%)**	**38 (39%)**
July 2015					
WRHA's Management of Risks Associated with End-user Devices	12	1			11
Manitoba Home Care Program	46	2			44
Total	**58**	**3 (5%)**			**55 (95%)**
Grand Total	**262**	**127 (48%)**	**1 (1%)**	**4 (2%)**	**130 (49%)**

Notes to Figure 1

Note 1: All recommendations in these Reports were implemented as at June 30, 2015. They are noted here in order to list all the chapters included in our January 2013 and March 2014 Reports to the Legislature.

Note 2: The recommendation noted in the March 2014 Report to the Legislature under Citizen Concerns - Manitoba Hydro Funding of the Keeyask Centre has not been included in this Follow-up report. The recommendation was followed up as part of our audit on Manitoba Hydro: Management of Keeyask Process Costs and Adverse Effects Agreements with First Nations. This report was released in September 2016. The follow-up on the status of recommendations in this report will begin in September 2017.

Note 3: Because Lake Manitoba Financial Assistance Program is not an ongoing project, the 21 recommendations are considered lessons learned for future programs.

Note 4: In our May 2016 Follow-up report, one recommendation from our report on Citizen Concerns – North Portage Development Corporation remained in progress. The implementation status of this recommendation is as of October 17, 2016.

No additional follow-up reviews scheduled

Citizen Concerns – North Portage Development Corporation

Our recommendations were originally directed to the North Portage Development Corporation and the Department of Local Government. Due to a government reorganization, the government of Manitoba recommendations are now directed to the Department of Indigenous and Municipal Relations.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 2)	May 21, 2015 (passed)
First follow-up – May 2015	-
Second follow-up – May 2016	-

What our original report examined

We examined governance issues at the North Portage Development Corporation (NPDC) including term limits for Directors, availability of public information and accountability to shareholders. We also examined the salary levels of executives and expense reports submitted by employees.

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 October 17, 2016

As shown in the table below, all of our recommendations have been implemented as at October 17, 2016.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
October 17, 2016	**4**	**-**	**-**	**-**	**4**

Because we have followed up on the *Citizen Concerns – North Portage Development Corporation* 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**	-	-
May 2016	**1**	-	-
May 2015	**2**	-	-
Total	**4**	-	-

Below we list our recommendations. For certain recommendations we have added an "OAG comment" to clarify the implementation status. An OAG comment included in our *May 2015 Follow-up* report, for a recommendation considered implemented/resolved, is also reproduced below.

Considered cleared

This follow-up report – *status as at October 17, 2016*

Implemented/resolved

We recommended that:

1. The Corporation amend its bylaws to limit the number of terms that directors can serve.

   OAG comment: *On October 17, 2016 the Shareholders approved the amendment to By-law No. 1 limiting the number of terms that directors can serve to two consecutive terms, of which each term is three years, for a maximum total of six years.*

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

Implemented/resolved

We recommended that:

2. The Provincial government enter into a discussion with the City and the Federal government to find a mechanism for the public to access detailed information.

May 2015 report – *status as at June 30, 2014*

Implemented/resolved

We recommended that:

3. The Provincial government assess the reasonability of the salary levels at NPDC.

   OAG May 2015 comment: *The Department advised that it reviewed the process by which comparable economic development organizations in Winnipeg set salaries for the Chief Executive Officers. The Department concluded the process is comparable to other similar organizations. Documentation of the analysis was not prepared or retained.*

4. The Corporation prepare formal written procedures for purchases and employee expenses.

Information Technology Security Management Practices

Our recommendations were originally directed to the Department of Innovation, Energy and Mines (IEM), the Treasury Board Secretariat (TBS), the Department of Finance, and the Civil Service Commission (CSC). Due to a government reorganization, the Department of Finance is now responsible for implementing the recommendations originally directed to the Department of IEM.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 3)	August 8, 2013 June 26, 2014 (Passed)
First follow-up – May 2015	-
Second follow-up – May 2016	-

What our original report examined

Our audit objective was to determine whether Business Transformation & Technology (BTT) designed and implemented adequate Information Technology (IT) security management practices and controls.

We looked at whether BTT:

- had processes to identify, assess, mitigate, and accept IT security risks.
- had information security strategies that support IT and organizational objectives.
- had policies that address significant IT security risks.
- periodically updated and communicated IT security policies.
- classified and safeguarded information assets.
- ensured that adequate security controls were in place in outsourced services.
- secured system and network operations to protect against threats and vulnerabilities.

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, 2016

Our report made 47 recommendations (41 to BTT, 4 to TBS, 1 to CSC and 1 to the Provincial Comptroller's Office (Department of Finance)).

As shown in the table below, 22 of our 47 recommendations have been implemented as at September 30, 2016. BTT does not intend to implement recommendations 14 and 41.

Review date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**22**	**-**	**2**	**23**	**47**

Given the value and sensitivity of the information located in the Province's information systems, coupled with accelerating cyber threats (frequency and impact), we continue to stress the importance of information security management.

Overall, we are concerned with the progress made towards implementing the recommendations. Upon issuing our report in 2013, BTT engaged an independent third party to assess the risks associated with our recommendations and to develop an implementation roadmap. The roadmap broke down the recommendations directed to BTT by implementation timeframes (see table below). The table highlights that BTT has missed, or will miss, many of the identified target completion dates.

Timeframe	Number of BTT Recommendations	Implemented as at			Work in progress	Do Not Intend to Implement
		June 2014	June 2015	September 2016		
By September 30, 2013 (noted as "Quick Wins")	**11**	**8**	**-**	**1**	**1**	**1**
By March 31, 2014	**7**	**1**	**-**	**1**	**5**	**-**
By March 31, 2015	**11**	**-**	**4**	**2**	**4**	**1**
Beyond March 31, 2015	**12**	**-**	**1**	**2**	**9**	**-**
Totals	**41**	**9**	**5**	**6**	**19**	**2**

In particular, the 2013 roadmap highlighted recommendation 2 ("BTT complete, on a priority basis, a comprehensive IT risk assessment, which would include an assessment of IT security risks") as a high priority with a targeted implementation date of "beyond March 31, 2015". However, BTT has made little progress with this recommendation. Without such assessments, progress towards implementing many of our recommendations is delayed. We are concerned with BTT's continued lack of progress in commencing these risk assessments and continue to highlight their importance.

In our *May 2016 Follow-up* report BTT indicated that it did not intend to implement recommendation 14. As noted in our original audit report, users are asked if they wish to read the Electronic Network Usage policy (ENUP) each time they log into the network. We encourage BTT to consider requiring users to periodically acknowledge their review and understanding of the ENUP. Without such acknowledgement, BTT cannot ensure that users have read the policy or that they understand their responsibility to comply with its expectations.

Also, BTT indicated that it did not intend to implement recommendation 41. In our January 2013 report we found that the Information Protection Centre (IPC) was not fully using available encryption methods for their laptops and emails. However, BTT assessed the implications of various laptop encryption methods and determined that they would accept the risks associated with not strengthening their existing controls. BTT has also accepted the risks associated with

their current email encryption methods, but without conducting a similar assessment. We continue to stress to BTT the importance of strengthening their encryption methods.

Because we have followed up on the *Information Technology Security Management Practices* 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	**6**	-	**1**
May 2016	**5**	-	-
May 2015	**11**	-	**1**
Total	**22**	-	**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 the implementation status and to highlight select actions or planned actions. OAG comments included in prior year follow-up reports, for recommendations considered implemented/resolved, are reproduced below.

Work in progress

We recommended that:

2. BTT complete, on a priority basis, a comprehensive IT risk assessment, which would include an assessment of IT security risks.

   OAG comment: *In June 2016, BTT issued a Request For Information "seeking advice and recommendations on developing a comprehensive approach and roadmap, including high level effort requirements and budget estimate, as a fixed fee, for a government-wide information and communications technology (ICT) risk assessment."*

3. BTT complete an assessment of the risks related to the operations of the Legislative Building Information System.

   OAG comment: *BTT advised that a Request For Proposal for an operational review of the Legislative Building Information System unit, including a risk assessment will be issued.*

4. BTT develop an IT strategic plan and a properly aligned IT security plan.

   OAG comment: *BTT advised that they are continuing to develop their IT Strategic Plan and IT Security Plan.*

5. BTT and IPC identify performance measures for the management of IT security operations, and that a specific target be set for each measure. Once an IT security plan is in place, performance measures and targets should align with the noted security goals and objectives.

   OAG comment: *BTT advised that the metrics will be reviewed and adjusted in light of the new plans that will be created by the end of fiscal 2016/17 (see recommendation 4).*

Work in progress (cont'd)

We recommended that:

6. BTT and IPC provide senior management with quarterly reports that focus on:
   a. key performance measures (as agreed to by senior management).
   b. performance in relation to the defined targets.
   c. actions to address any performance shortfalls in meeting objectives.

   OAG comment: *Little progress has been made on this recommendations as it is dependent on recommendations 4 and 5.*

7. BTT obtain, at regular intervals, independent third party audits of its IT security practices, and that progress reports on the implementation of recommendations be provided to senior management.

   OAG comment: *BTT advised that they intend to include a funding request in their 2017/18 estimates process for a third party to audit their security practices.*

11. Upon the completion of IT security risk assessments, BTT implement additional IT policy instruments needed to mitigate IT security risks.

    OAG comment: *BTT advised that upon the completion of recommendation 2, they will review the identified risks against potential policy requirements.*

17. The government:
    a. assign responsibility for information management to an appropriate department.
    b. develop and implement an information management framework.

    OAG comment: *TBS advised that a letter was sent to all Deputy Ministers on September 16, 2013 advising them of the new ICT Security Policy that was coming into effect on January 1, 2014. But no progress has been made in developing an Information Management Framework.*

18. The government implement a data classification standard.

    OAG comment: *TBS sent a letter to all Deputy Ministers on January 8, 2014 asking departments to determine whether IT systems contain highly-sensitive data. To assist Deputy Ministers, TBS provided a Guideline for Applying Data Classification in Information Systems Review. The guide, while useful, does not represent a Data Classification Standard. As such, we continue to stress the need for the government to implement a data classification standard.*

19. Upon the implementation of data classification standards, BTT develop standards and procedures for properly handling electronic media during use.

    OAG comment: *Until recommendation 18 is implemented, BTT does not have further plans to implement standards and procedures for properly handling electronic media.*

20. The CSC amend their *Security Check* policy to:
    a. require periodic statutory declarations from employees in designated positions.
    b. once a data classification system is in place, require periodic security checks on employees in designated higher risk positions.

    OAG comment: *CSC stated that they have created an initial report in SAP to track positions requiring periodic checks. CSC also noted that they are developing a policy regarding periodic statutory declarations and checks.*

Work in progress (cont'd)

We recommended that:

25. IPC establish standard IT security requirements. Once these are in place, we recommend that IPC assess whether the security practices of contractors meet the standard requirements and, if there are gaps, that IPC ensure security practices are strengthened.

    OAG comment (for recommendations 25 and 26): *BTT developed a Baseline Security Controls document that took effect on June 28, 2016 and intends to use it to support their Information Security Program. The document notes that Government departments are responsible for developing internal processes and procedures consistent with the Baseline Security Controls. BTT advised that all future outsourcing agreements for ICT services are to include the requirement to comply with the Baseline Security Controls. BTT stated that they intend to include a funding request in their 2017/18 estimates process for a third party to assess whether the security practices of existing contractors comply with the Baseline Security Controls and that they are operating effectively.*

26. BTT periodically obtain independent assurance that the IT security practices used by its contractors are operating effectively.

    OAG comment: *See recommendation 25.*

29. BTT implement a configuration management database with updated network diagrams.

    OAG comment (for recommendations 29, 30, 31 and 32): *BTT advised that they are in the planning stage with respect to all four recommendations dealing with configuration management. They noted that they intend to include a funding request in their 2017/18 estimates for the purchase of configuration management database (CMDB) tools and software, along with hiring two resources to manage the CMDB.*

30. BTT implement a configuration management process.

    OAG comment: *See recommendation 29.*

31. IPC establish baseline configuration standards for all of its information systems and network components.

    OAG comment: *See recommendation 29.*

32. BTT establish a configuration control board or oversight committee.

    OAG comment: *See recommendation 29.*

34. IPC conduct authenticated vulnerability scans on high risk components within the environment.

    OAG comment: *BTT advised that while they are conducting unauthenticated scans, authenticated scans are conducted only on a limited basis (not based on high risk systems). They stated that they will continue to evaluate tools and approaches to conduct authenticated scans.*

37. IPC periodically review firewall design and test operating effectiveness.

    OAG comment: *BTT advised that some third-party managed firewalls have had a security test conducted against them and that other third-party contracts that were recently negotiated include requirements for such testing. BTT also advised that testing of the remaining firewalls will occur by the end of the fiscal 2016/17.*

38. IPC update their zoning standards and network diagrams.

    OAG comment: *BTT advised that they are currently updating their Zoning Standard document.*

Work in progress (cont'd)

We recommended that:

39. IPC contact system owners to develop a plan to migrate highly sensitive information assets into the high security zone.

    OAG comment: *In 2014, BTT requested that departments classify their IT systems using BTT's Data Classification Guide. Departments were provided with guidance in a booklet titled Guideline for Applying Data Classification in Information Systems Review. BTT however, received minimal responses from departments. In 2016, responsibility for implementing this recommendation was moved from BTT to TBS.*

40. Upon completion of IT security risk assessments and the implementation of data classification standards, BTT implement a data loss prevention strategy.

    OAG comment: *BTT advised that upon completion of recommendation 2, BTT will request funding for a Data Loss Prevention Strategy.*

44. BTT establish an after business hours response program.

    OAG comment: *To date BTT has established an on-call program for operations staff, but not for IPC security staff.*

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

8. BTT annually determine the total costs associated with IT security.

16. IPC enhance the security awareness program by:
    a. incorporating the use of IT security incident trends and documented risks.
    b. developing additional security awareness training specifically targeting users in higher risk positions.
    c. using additional awareness techniques.

    OAG comment: *BTT has implemented 16(b) and (c). With respect to (a), IPC has been reviewing and updating their security awareness program annually to incorporate trends and risks. However, the risks are not identified through a systematic ICT risk assessment process (see recommendation 2).*

28. BTT obtain periodic assurance over the operating effectiveness of the IT security practices employed at the Department of Health data centre.

36. IPC monitor the implementation of security patches within the environment.

43. BTT enhance the *Incident Management Guide* by:
    a. developing standard operating procedures and workflows.
    b. defining escalation procedures.

46. IPC routinely test information security incident management processes and make improvements as required.

Considered cleared (cont'd)

Do not intend to implement

We recommended that:

41. IPC implement email and laptop hard drive encryption methods that appropriately protect all levels of data sensitivity.

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

Implemented/resolved

We recommended that:

22. BTT develop logical access control requirements.
23. BTT develop and implement minimum physical security requirements for data centres.
35. BTT implement security patch management processes for databases and applications.
45. IPC document, track, and analyze all information security events and incidents.
47. BTT implement a comprehensive Disaster Recovery Plan framework for critical IT services and systems.

May 2015 report – *status as at June 30, 2014*

Implemented/resolved

We recommended that:

1. BTT enhance the *ICT Risk Management Model* by requiring consultation with relevant stakeholders within government on their risk tolerances and their willingness to accept residual IT risks.

   OAG May 2015 comment: *BTT enhanced their ICT Risk Management Model to ensure tolerances are understood and residual risk accepted, but BTT has not yet clearly determined who is responsible for accepting IT risks as well as how IT risks are to be accepted within the Government of Manitoba.*

9. BTT strengthen its *Policy Management Framework* by requiring that IT risk assessments and strategic objectives support the need for new or updated policy instruments.

   OAG May 2015 comment*: BTT strengthened their ICT Policy Management Framework to note that policies are to be driven by risk assessments and strategic objectives. However, they have not yet updated any existing policies and have only created one new policy, the IT Security Policy (see recommendation 10). Because recommendation 2 has not been implemented, we could not determine if risk assessments and strategic objectives will result in new or updated policy instruments.*

10. BTT implement an over-arching IT Security Policy.
12. BTT strengthen its *Policy Management Framework* by defining the frequency of IT policy instrument review.

    OAG May 2015 comment*: BTT strengthened their ICT Policy Management Framework to require that the entire body of their policy instruments be reviewed on a regular basis and that planned review dates be noted within each individual policy instrument. However, it does not specifically define the frequency by individual instrument or by type of instrument (i.e. policy, standard, guideline, procedure).We noted that only the IT Security Policy has since been created and that it states its next planned review date.*

Considered cleared (cont'd)

We recommended that:

13. BTT develop a prioritized schedule or plan for the review and update of all existing IT policy instruments and that progress against the plan be actively monitored.

15. The government make security awareness training mandatory for government employees with access to the electronic network and systems, immediately upon hiring and periodically thereafter.

    OAG May 2015 comment: *In May 2013, the Secretary to Treasury Board communicated to Deputy Ministers the expectation that all new and existing employees attend the Information Security Awareness training sessions, as well as a refresher course approximately four to five years thereafter. The communication also requests that Deputy Ministers develop a plan for ensuring all staff, both new and existing, attend this training and track staff attendance.*

    We encourage TBS to periodically follow-up on the request and track government-wide uptake of the BTT security awareness training.

21. BTT obtain periodic assurance that contractors are obtaining security checks on employees with access to government information assets.

    OAG May 2015 comment: *BTT deals with 3 major vendors and obtained confirmation from 2 that security checks had been performed. The other major vendor stated that they were able to confirm that security checks were performed on only new employees after 2008, but not before. This vendor stated that they are establishing a process to ensure that all employees required to undergo security clearances do so.*

24. The Provincial Comptroller's Office, in collaboration with BTT, create a standard procedures checklist for use when employees are suspended or fired.

27. BTT develop a new Memo Of Understanding that clearly defines IT security requirements and the relationship between BTT, the Information Systems Branch and the Department of Health.

33. IPC develop and implement a vulnerability assessment methodology.

    OAG May 2015 comment: *IPC developed a Vulnerability Management Standard. We are concerned, however, that the scope, frequency and cycles noted in the standard are not based on documented risk assessments.*

42. IPC implement a security event monitoring plan, highlighting a Security Information & Event Management system utilization.

Do not intend to implement

We recommended that:

14. BTT amend the Employee Network Usage Policy (ENUP) to require new and existing users of the government network, systems, and information assets to acknowledge, either through signature or digital means, their responsibility to comply with the expectations included in the ENUP.

Manitoba Early Learning and Child Care Program

Our recommendations were originally directed to the Department of Family Services and Labour. Due to a government reorganization, the Department of Families is now responsible for implementing our recommendations.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 4)	October 30, 2013 November 26, 2013 June 26, 2014 (Passed)
First follow-up – May 2015	August 17, 2016 (Passed)
Second follow-up – May 2016	August 17, 2016 (Passed)

What our original report examined

We examined the Department's management of the Manitoba Early Learning and Child Care Program, including its systems and practices for planning and performance measurement, ensuring compliance with child care standards, and providing financial support to eligible child care facilities and families.

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, 2016

As shown in the table below, 15 of our 25 recommendations have been implemented as at September 30, 2016.

Of the 10 recommendations that remain in progress, we note that significant progress has been made on 7 (recommendations 1, 7, 14, 16, 19, 20 and 22).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**15**	**-**	*****	**10**	**25**

***** The Department does not intend to implement certain aspects of recommendation 3.

In our *May 2015 Follow-up* report we noted that the Department did not intend to implement recommendation 3(a). The recommendation deals with measuring and publicly reporting on wait times for child care. The Department noted that a system review found that its current information system lacked the capacity to do this.

Because we have followed up on the *Manitoba Early Learning and Child 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	**3**	-	-
May 2016	**6**	-	-
May 2015	**6**	-	-
Total	**15**	-	-

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 the implementation status.

Work in progress

We recommended that:

1. The Department regularly include the following in its internal child care strategic planning:
   a. information compiled from its Online Child Care Registry on wait times and the levels of demand for different types of child care spaces.
   b. trends in facility compliance with all key standards.
   c. summary results from quality assessments of centers' learning and development activities.

   OAG comment: *Significant Progress - The Department has implemented 1(a) and (c). With respect to (b), the Department is still not in a position to track trends in facility compliance. It has implemented a key standards comment sheet to be used during non-relicensing visits to track facility compliance. The Department also said it intends to track compliance results from re-licensing inspections once an upgrade of the IT system is done.*

3. The Department improve publicly reported child care information by:
   a. measuring and reporting wait times for child care.
   b. determining the most significant child care standards and then reporting the province-wide level of facility compliance with these key standards.
   c. ensuring facility licences clearly communicate all legislated standards not being met.

   OAG comment: *The Department does not intend to implement 3(a). With respect to (b), the Department has not begun exploring options for public reporting of province-wide facility compliance with key standards. With respect to (c), the Department plans to improve how licences communicate facility non-compliance with standards once an upgrade of the IT system is done.*

Work in progress (cont'd)

We recommended that:

5. The Department enhance its facility database by:
   a. expanding it to include facility inspection results.
   b. verifying the accuracy and completeness of database information during annual facility inspections.

      OAG comment: *The Department has implemented 5(b). With respect to (a), the Department plans to include facility inspection results in its facility database once an upgrade of the IT system is done.*

7. The Department improve its processes for ensuring that family home providers operating over the 4-child (at any given time) limit are properly licensed by:
   a. further educating stakeholders about family home provider licensing requirements.
   b. periodically searching for unlicensed facilities that should be licensed.

      OAG comment: *Significant Progress - The Department has implemented 7(a). With respect to (b), in June 2016 it proposed a pilot process for searching for unlicensed child care providers caring for more than 4 children, but the pilot process did not receive ministerial approval to proceed, at that time.*

10. The Department link the frequency of regular facility inspections and monitoring visits to underlying risk factors, such as facility inspection history and licence type, and then ensure that all required visits are conducted.

      OAG comment: *The Department has drafted a 4-tiered licensing system for child care centres that ties the frequency and type of inspection to each facility's assessed risk factors. It plans to begin applying this system for the 2017 centre licensing year. The new tiered system does not apply to school age centres, nursery schools or family child care homes.*

14. The Department:
   a. ensure that monitoring and enforcement activities are escalated when consecutive provisional licences show repeated or serious violations.
   b. comply with the Department's policy requiring all ordered actions to be properly addressed before licensing orders are removed.
   c. ensure all escalated monitoring and enforcement actions, including those related to licensing orders, are fully documented.

      OAG comment: *Significant Progress - The Department has implemented 14(b) and (c). With respect to (a), it is now implementing a new process for identifying facilities with consecutive provisional licences. The Department indicates they plan to work with these facilities to help bring them into compliance with standards.*

16. The Department:
   a. regularly update licensing and policy and procedures manuals to ensure they reflect current standards and practices.
   b. give sufficient guidance to coordinators to ensure greater consistency in conducting inspections and providing correction timeframes.
   c. develop criteria for assessing the adequacy of documents submitted for initial licensing.

      OAG comment: *Significant Progress - The Department has implemented 16(b) and (c). With respect to (a), it updated and publicly released the licensing manual for family child care providers, and updated the licensing manual for centres but has not released it.*

Work in progress (cont'd)

We recommended that:

19. The Department ensure that operating grant calculations are accurate and consistent by:
    a. providing tools (such as Excel templates) to help with complex manual calculations.
    b. providing further guidance as to when adjustments for space utilization may be overridden for "low attendance for a short period of time", and making this guidance available to all facilities.
    c. reconciling existing funding policy with actual funding practice for extended care spaces, and ensuring funding is consistent with the Child Care Regulation.
    d. linking the funding for an extended care space to the number of extended care hours being provided.
    e. implementing a documented quality assurance process for grant calculations.

    OAG comment: *Significant Progress - The Department has implemented 19(a), (b), (c), and (d). With respect to (e), in 2014 it developed a documented quality assurance process for grant calculations, but it has not been implemented.*

20. The Department improve its financial monitoring of facilities by:
    a. requiring nursery schools receiving larger dollar grants to submit operating budgets.
    b. documenting reviews of facility financial statements that include variance analysis, as well as monitoring of facility compliance with parent fee maximums, base minimum wage rates where a wage adjustment grant is being provided, and all pension plan financial requirements.

    OAG comment: *Significant Progress - The Department has implemented 20(b). With respect to (a), the Department said it has conducted a review of enhanced nursery schools (typically in receipt of large dollar grants), and is considering whether to require such nursery schools to submit budgets.*

22. The Department improve the Inclusion Support Program by developing policies and processes to more fully and consistently assess and document:
    a. children's inclusion support needs.
    b. facilities' inclusion support capabilities.
    c. cost-effective options for bridging gaps between children's support needs and facilities' capabilities, together with an approved rationale for the nature, level, and period of funding support selected, or a rationale for denying funding.

    OAG comment: *Significant Progress - The Department has implemented 22(a) and (b). With respect to (c), it is now assessing what facilities can do to meet a child's needs with existing resources before approving additional funding but is not yet documenting rationales for funding decisions.*

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

12. The Department investigate all complaints that a family home provider is caring for more than 4 children (at any given time) without a licence promptly, thoroughly, and in accordance with its recently revised policy for handling complaints about unlicensed facilities.

Considered cleared (cont'd)

We recommended that:

21. The Department ensure that parents are made aware of parent fee limits, and provided with a means of determining whether or not their child care facility is required to comply with the fee limits, by including this information in its *Parent Guide to Quality Child Care*.

23. The Department develop a documented quality assurance process to ensure that all inclusion support payments over amounts originally approved are properly explained and authorized.

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

Implemented/resolved

We recommended that:

4. The Department develop processes to improve communication and accountability reporting between the service delivery and policy/administration arms of the Early Learning and Child Care Program.

6. The Department develop processes to ensure that it does not issue initial or renewed licences when departmental policy prohibits it, or issue initial licences before it has received all the information the *Child Care Regulation* requires.

13. The Department follow up all standards violations promptly and verify the corrective actions facilities report by obtaining supporting documentation or re-visiting the facilities.

15. The Department implement structured, consistent and ongoing orientation and training processes for child care coordinators and their supervisors.

17. The Department develop checklists to help supervisors assess the quality and consistency of child care coordinator work, including the level of compliance with the Department's inspection and licensing policies, when reviewing licensing packages.

24. The Department improve its processes for verifying child care subsidy eligibility by:
    a. regularly sharing information between provincial income assistance and child care programs when applicants' eligibility for subsidy depends on their eligibility for income assistance.
    b. periodically requesting tax information from the Canada Revenue Agency for a sample of subsidy applicants and recipients.
    c. documenting all verification activities performed.

May 2015 report – *status as at June 30, 2014*

Implemented/resolved

We recommended that:

2. The Department clearly state progress towards its $37 million capital commitment and its commitment to an overall funding increase of 20% to support a stronger workforce when publicly reporting on its 5-year child care agenda.

8. The Department direct coordinators to:
    a. refrain from overly preparing facilities for inspections.
    b. schedule family home inspections when children will be present.
    c. comply with its policy requiring some monitoring visits to be during evenings and weekends for facilities with extended hours.
    d. document whether inspections and other visits were unannounced or scheduled.

9. The Department pilot-test doing some family home inspections on an unannounced basis, and then reconsider the need to schedule all family home inspections with providers.

Considered cleared (cont'd)

We recommended that:

11. The Department improve inspection documentation so that:
    a. all checklist questions are answered and answers are consistent with accompanying comments.
    b. expected completion dates are provided for all corrective actions required.

18. The Department provide facilities with the criteria and priorities being used to allocate new funding to previously unfunded spaces, and fully document the rationale for all its decisions to approve or defer funding.

25. The Department improve the accuracy of subsidy payments by:
    a. providing related staff training to subsidy advisors and their supervisors.
    b. requiring supervisors to regularly conduct and document detailed reviews of subsidy calculations.

Office of the Fire Commissioner

Our recommendations are directed to the Civil Service Commission (CSC), Treasury Board Secretariat and the Department of Finance.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 6)	October 30, 2013 June 30, 2016 (Passed)
First follow-up – May 2015	-
Second follow-up – May 2016	-

What our original report examined

On July 29, 2011, the Minister of Finance requested that the Office of the Auditor General perform a Special Audit of the Office of the Fire Commissioner (OFC) under Section 16 of *The Auditor General Act*. This request was made after financial irregularities were found by the Provincial Comptroller.

We examined expense claims, accountable advances, corporate credit card transactions, purchasing card transactions, and other travel related documentation, concerning 5 employees of the OFC. We also examined emails, fleet vehicle and attendance 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, 2016

As shown in the table below, 2 of our 4 recommendations have been implemented as at September 30, 2016.

We note that significant progress has been made on both recommendations that remain in progress.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**2**	**-**	**-**	**2**	**4**

Because we have followed up on the *Office of the Fire Commissioner* 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	-	-	-
May 2016	**1**	-	-
May 2015	**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 and to highlight select actions or planned actions.

Work in progress

Directed to the Civil Service Commission

We recommended that:

3. *The Public Interest Disclosure (Whistleblower Protection) Act* be assessed, and revised if necessary.

   OAG comment: *Significant Progress - The Civil Service Commission (CSC) retained a consultant to undertake a review of the Public Interest Disclosure Act (PIDA). The resulting report dated April 2014 included 10 recommendations. 4 of the consultant's 10 recommendations have been implemented. The remaining 6 will require legislative amendments in order to address the recommendation.*

Directed to the Department of Finance

We recommended that:

4. The Internal Audit and Consulting Services (Internal Audit) report recommendations on strengthening the oversight role of the Procurement Services Branch be implemented, as appropriate.

   OAG comment: *Significant Progress - In 2010, Internal Audit completed an audit on purchasing card processes and, in 2014, completed an audit of travel card and business travel account compliance. These audits resulted in a number of recommendations to improve the oversight role of the Procurement Services Branch and departments. In response, updated purchasing card policies and guidelines were developed and communicated.*

   In our May 2016 Follow-up Report we noted that new travel card guidelines were being developed to improve monitoring of travel card and business travel account activity and use. The Department of Finance noted that the guidelines will prescribe the methods and frequency for department staff to periodically monitor travel card activity for personal use and overdue accounts. In addition the guidelines will include a quarterly process whereby departments must report to the Procurement Services Branch indicating that their Executive Financial Officer has reviewed the summary of their quarterly activity and must note any areas of concern and action plans for addressing.

   As of September 30, 2016, the Department of Finance indicated that the Procurement Services Branch was still in the process of developing operating guidelines, procedures, and roles and responsibilities for Manitoba's Travel Card program.

Considered cleared
May 2016 report – *status as at June 30, 2015*
Implemented/resolved
We recommended that: 2. The Special Operating Agency governance model be assessed, and revised if necessary.
May 2015 report – *status as at June 30, 2014*
Implemented/resolved
We recommended that: 1. The Minister of Finance forward our detailed audit findings to Civil Legal Services.

Other matter followed-up

Our original report noted that Internal Audit and Consulting Services (Internal Audit) had made recommendations to improve the comptrollership function and control environment at OFC. We indicated that we would be reviewing the status of Internal Audit's recommendations when we followed-up on our recommendations. The July 2011 Internal Audit report on OFC included 57 recommendations. In July 2015, Internal Audit reported that 52 of the recommendations were implemented by OFC, and that 3 were substantially completed. 2 recommendations remained as work in progress. The July 2015 follow-up report noted that overall, the OFC had made it a priority to establish clear policies and directives and to also monitor compliance in areas where this was previously lacking. As at September 30, 2016 no subsequent follow-up report has been issued.

Provincial Nominee Program for Business

Our recommendations were originally addressed to the Department of Entrepreneurship, Training and Trade. Due to a government reorganization, the Department of Education and Training is now responsible for implementing our recommendations.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 7)	October 9, 2013 August 17, 2016 (Passed)
First follow-up – May 2015	August 17, 2016 (Passed)
Second follow-up – May 2016	August 17, 2016 (Passed)

What our original report examined

We examined the Program's policies and procedures for the assessment of applications, the functions of the business settlement office, and the measurement of Program outcomes. We also examined the processes in place for the detection of and response to false documentation.

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, 2016

As shown in the table below, all 13 recommendations have been implemented as at September 30, 2016.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**13**	**-**	**-**	**-**	**13**

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

Timing of recommendations considered cleared			
Follow-up report date	Implemented/ resolved	Action no longer required	Do not intend to implement
This follow-up	**3**	-	-
May 2016	**2**	-	-
May 2015	**8**	-	-
Total	**13**	-	-

Below we list our recommendations. OAG comments included in prior year follow-up reports, for recommendations considered implemented/resolved, are reproduced below.

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

10. The Program:
    a. monitor nominees to ensure they comply with the Deposit Agreement, including semi-annual reporting.
    b. develop a process to follow up on nominees who do not comply with the Deposit Agreement.
11. The Program formalize arrangements with other departments and agencies to obtain and share personal information on landed nominees.
12. The Program assess its long-term performance by developing a tracking mechanism and regularly monitoring whether nominees continue to live and operate a business in Manitoba after their deposit is returned.

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

Implemented/resolved

We recommended that:

1. The Program:
    a. develop a risk matrix.
    b. complete the risk matrix for all files.
    c. perform additional due diligence procedures or use third party verification if the risk matrix indicates they are necessary.
9. The Program:
    a. create a database of all indicators of false documentation identified during the verification process and regularly update it.
    b. develop procedures to ensure that application documentation is compared to the indicators of false documentation in the database.

Considered cleared (cont'd)

May 2015 report – *status as at June 30, 2014*

Implemented/resolved

We recommended that:

2. If the assessment process finds false documentation or misrepresentation of a significant nature, the Business Immigration Officer stop processing the application and recommend that the Assessment Review Team reject it.

   OAG May 2015 comment: *The Department has moved to a one step application process. Applications will now be immediately rejected if significant false documentation or misrepresentation is found.*

3. The Program require applicants to submit all required information once—at the initial application stage.
4. The Program revise its current information release forms to ensure that applicants consent to the collection and verification of their information by the Program or its agents in the applicant's home country. Alternatively, we recommend that the Program require applicants to submit their key documents directly to third-party contractors the Program has accepted for verification.
5. The Program remove references to the Selection Committee from the Policy and Procedures Manual.
6. The Program update the Policy and Procedures Manual to the same time period referred to in the acceptance letter.
7. The Program update the Policy and Procedures Manual to the same time period referred to in the *Certificate of Nomination*.
8. Program employees complete conflict-of-interest forms annually and that management review them.

   OAG May 2015 comment: *We found that program employees had completed conflict-of-interest disclosures for 2013 and 2014. Management advised us that it intends to update its policy to reflect the annual declaration requirement.*

   Our March 2014 Report to the Legislature includes the results of our audit on Manitoba's Framework for an Ethical Environment. In that report we recommend that the Civil Service Commission's conflict of interest policy be amended to require periodic, preferably annual, updates of conflict of interest declarations (Recommendation 12).

13. The Program clarify policies and procedures for site visits.

Senior Management Expense Policies

Our recommendations are directed to the Treasury Board Secretariat.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – January 2013 (Chapter 8)	August 8, 2013 June 26, 2014 (Passed)
First follow-up – May 2015	-
Second follow-up – May 2016	-

What our original report examined

We examined whether expense policies were in place for senior management in 113 provincial agencies, boards and commissions and the degree to which policies varied across government.

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

Status of our recommendation as at September 30, 2016

As shown in the table below, our recommendation has not been implemented as at September 30, 2016.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**-**	**-**	**-**	**1**	**1**

Below we list our recommendation. We have added an "OAG comment" to highlight planned actions.

Work in progress

We recommended that:

1. Treasury Board Secretariat monitor whether all agencies, boards and commissions have appropriate expense policies in place, consistent with the General Manual of Administration (GMA) or applicable legislation.

   OAG comment: *The Treasury Board Secretariat indicated that they intend to develop a plan to implement the recommendation.*

At least one more follow-up review scheduled

Rural Municipality of Lac du Bonnet

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

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – August 2013	January 13, 2014 May 21, 2015 (Passed)
First follow-up – May 2016	-

What our original report examined

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 1 of our 2 recommendations has been implemented as at September 30, 2016.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**1**	**-**	**-**	**1**	**2**

Because we have followed up on the *Rural Municipality of Lac du Bonnet* 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**	-	-
May 2016	-	-	-
Total	**1**	-	-

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

Work in progress

We recommended that:

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

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

   The Department noted that it will continue to examine other provinces' practices on how best to support municipalities in collecting tax arrears. The Department advised that it will also examine other province's practices on writing off uncollectible taxes and assess the applicability to Manitoba.

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

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

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

Accounts and Financial Statements

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report - March 2014 (Chapter 1) *(relates to our audit of the Public Accounts and other financial statements for the year ended March 31, 2013)*	September 3, 2014 January 28, 2015 November 4, 2015 (Passed)
First follow-up – May 2016	November 30, 2016 (Passed)

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

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

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

Recommendations directed to Finance - Status as at September 30, 2016

As shown in the table below, none of our 6 recommendations have been implemented as at September 30, 2016. The Department does not intend to implement recommendation 1 and 4 and recommendation 5 is no longer required (see comments below).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**-**	**1**	**2**	**3**	**6**

In our *May 2016 Follow-up* report, we noted that the Department did not intend to implement recommendation 1. The Department noted that it is not readily possible to identify all the secondment agreements where the employee is paid by another entity and collect or gain access

to the related pay records from those other entities. Thus they believe the cost of implementing this recommendation would outweigh the benefits.

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

The status of recommendation 5 is now reported as Action no longer required. As of May 2016, Manitoba Infrastructure has assumed responsibility for the operations of the Manitoba East Side Road Authority.

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

Work in progress

We recommended that:

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

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

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

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

   ***OAG comment**: The Province revised its "Basis of Accounting" note in the Report of Amounts Paid or Payable to Members of the Assembly. The Province will review whether a policy or regulation is required beyond the legislation and policy currently in effect.*

Considered cleared

This follow-up report – *status as at September 30, 2016*

Action no longer required

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

Considered cleared (cont'd)

May 2016 report – *status as at June 30, 2015*
Do not intend to implement
We recommended that: 1. The Department of Finance account for seconded employees consistently – regardless of the cost recovery process. 4. The Province set fixed dates to release its quarterly reports.

Recommendations directed to other entities - Status as at September 30, 2016

The one recommendation included in this report remains in progress.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**-**	**-**	**-**	**1**	**1**

Below we list the recommendation that remains in progress.

Work in progress
We recommended that: 7. The Northern Affairs Fund complete its financial statements in compliance with the Act. ***OAG comment**: Our audit of the March 31, 2014 financial statements is in progress. The March 31, 2015 and March 31, 2016 financial statements have not yet been finalized.*

Helicopter Ambulance Program

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

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – March 2014 (Chapter 4)	-
First follow-up – May 2016	-

What our original report examined

Our audit objectives were:

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

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 1 of our 5 recommendations has been implemented as at September 30, 2016.

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

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**1**	**-**	**-**	**4**	**5**

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

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

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

Work in progress

We recommended that:

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

   OAG comment: *The WRHA advised us that it intends to use a collaborative approach with STARS for quality assurance. Reliance would be placed on STARS's quality assurance process, augmented by requests from the Joint Operations Committee (JOC). The JOC consists of up to 19 individuals from STARS, WRHA, Health and other health organizations and is mandated to, among other responsibilities "ensure oversight of STARS quality assurance processes for clinical operations". The JOC will receive quality assurance reports conducted by STARS officials.*

   The intent of our recommendation is that an independent quality assurance program to oversee STARS be established. Quality assurance reviews of STARS operations conducted by STARS personnel are not independent reviews. Independent quality assurance is a best practice for overseeing the performance of a third-party provider. This is all the more vital in this situation given the quality of care concerns noted in the initial report.

   The Department's original response to recommendation 1 (included in our March 2014 report) recognized the value of an independent quality assurance review process. The Department stated that:

   > *"As part of the Emergency Medical Services (EMS) review of 2013 the need for a quality assurance program (QAP) across the system was identified. Manitoba Health prioritized this recommendation for implementation and it is expected early in 2014 that The Office of the Medical Director (OMD) will be established. The OMDs role is to ensure consistency of medical training and practice across the EMS system in Manitoba. To ensure this consistency, monitoring and evaluation of the system's medical performance will be essential. This will be accomplished through a QAP. The QAP will be led by an Assistant Medical Director specifically tasked to the QAP. QAP reviews will be conducted based on reported concerns, requests to investigate as well as randomly, and will utilize dispatch records and electronic medical/patient*

Work in progress (cont'd)

care records. Findings from these reviews will be provided to medical professionals involved and will be used if necessary to develop remedial actions, alter treatment practices and create/enhance educational programs."

In our view, it is important that this commitment to independent quality assurance be pursued. The Office of the Medical Director was established in March 2014. Health is currently drafting legislation which will provide the Medical Director, as a delegate of the Minister, the authority over air medical response systems. The draft legislation contains a provision for the Medical Director's responsibilities which includes establishing quality assurance program requirements for air medical response systems.

We note that Health has yet to develop and implement an ongoing independent quality assurance process.

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

   OAG comment: *We found that some key performance areas and associated risks were identified and mitigating actions taken. However, a documented comprehensive analysis of all key performance areas and associated risks has yet to be produced.*

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

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

   OAG comment: *Significant progress - We found that the JOC addressed the operational issues noted except for monitoring flight manifests to confirm the required staff complements. We were told the JOC identifies, monitors and resolves operational issues.*

Considered cleared

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

Implemented/resolved

We recommended that:

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

Managing the Province's Adult Offenders

Our recommendations are directed to the Department of Justice.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – March 2014 (Chapter 6)	August 27, 2014 October 31, 2016
First follow-up – May 2016	October 31, 2016

What our original report examined

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 20 of our 29 recommendations have been implemented as at September 30, 2016.

Of the 9 recommendations that remain in progress, we note that significant progress has been made on 3 (recommendations 2, 21 and 26).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**20**	*****	*****	**9**	**29**

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

The Department advised that it does not intend to implement recommendation 27(b) with regards to tracking and monitoring the use of Department workbooks and agency referrals as it does not feel that this information would be useful in assessing the offender programming being offered.

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

Because we have followed up on the *Managing the Province's Adult Offenders* report for 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	**10**	-	-
May 2016	**10**	-	-
Total	**20**	-	-

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

Work in progress

We recommended that:

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

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

   OAG comment: *Significant Progress - In 2015, consultants hired by the Department conducted a pre-architectural planning study for a new correctional facility in Dauphin. This included the development of accommodation standards to be used for all future construction. As of September 30, 2016, the Department had not upgraded existing facilities to these standards.*

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

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

Work in progress (cont'd)

We recommended that:

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

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

    OAG comment: *The Department advised that it is monitoring whether training and security-check requirements are being met, but the recently implemented training database is not yet fully reflecting all probation officer training.*

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

    OAG comment: *Significant Progress - The Department has implemented 21(a) and (c). The Area Director's quality assurance review of probation files has started and the Quality Assurance and Evaluation Unit reviews will begin in January 2017.*

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

    OAG comment: *Significant Progress - The Department advised that it has developed processes for inter-agency case management. We also found increased inter-agency communication and coordination in the files reviewed, but this could occur more regularly.*

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

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

10. The Department:
    a. investigate why a significant number of offender risk assessments are late and not properly updated, develop a plan for improvement, and regularly monitor progress.
    b. ensure that all staff clearly document the specific risk-assessment information verified and the details of the verification work performed, including the names and dates of any collateral contacts.
11. The Department take steps to ensure that probation officers schedule first in-person contacts with offenders within the one-month timeframe specified in Department policy.
13. The Department develop risk-based guidelines to help probation officers decide when court-ordered conditions require active monitoring, when self-reported compliance requires collateral or other verification, and the level of file documentation required for monitoring activities.
15. The Department:
    a. ensure staff properly apply its policy on offender non-compliance.
    b. improve the quality of documentation supporting decisions not to charge offenders who breach their conditions.
17. The Department prioritize the development of case management plans by offenders' risk levels, regularly monitor the timeliness and quality of the plans, and develop strategies to improve them.
18. The Department review the quality of case management progress notes after implementing its planned system changes and correct any remaining deficiencies.
22. The Department better assess the reasonableness of probation caseloads by:
    a. developing active and non-active file flags.
    b. examining the feasibility of assigning workloads indexes to offender files.
    c. tracking the time each probation officer spends monthly preparing pre-sentence reports, travelling, and delivering group programming.

    OAG comment: *The Department assessed the reasonableness of probation caseloads by conducting a workload analysis, rather than through the steps outlined above. This resulted in a rebalancing of probation caseloads.*
24. The Department better align programming and offenders' needs by:
    a. completing the series of workbooks addressing criminogenic needs.
    b. regularly extracting and analyzing relevant data from its databases to more fully identify and understand offenders' profiles and needs.
    c. working with Aboriginal stakeholders to ensure that all programs and materials are culturally appropriate and recognize the unique needs of Aboriginal offenders.

Considered cleared (cont'd)

We recommended that:

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

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

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

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

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

Implemented/resolved

We recommended that:

3. The Department develop clear guidelines and a reasonable timeframe for deciding when temporary alterations to accommodate more beds are permanent enough to increase a centre's rated capacity.

5. The Department work with the Manitoba Bureau of Statistics to see if cost-effective improvements can be made to the methodology and assumptions used to forecast offender populations, and update its forecasts for any significant changes.

6. The Department:
    a. prepare a range of adult custody population forecasts using best-case, worst-cast, and most-likely-case scenarios.
    b. forecast separately all significant adult sub-populations with differing accommodation needs.

8. The Province publicly release the full report prepared by the Adult Corrections Capacity Review Committee to allow legislators and the public to better understand the recommendations and monitor their implementation.

9. The Department publicly call for proposals and develop selection criteria to evaluate and select all future adult correctional centre sites.

12. The Department resolve the workload problems preventing probation officers from scheduling meeting with offenders as often as Department policy requires for the offender's risk profiles.

Considered cleared (cont'd)

We recommended that:

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

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

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

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

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

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

Manitoba's Framework for an Ethical Environment

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

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

What our original report examined

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

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 12 of our 20 recommendations have been implemented as at September 30, 2016.

Of the 8 recommendations that remain in progress, we note that significant progress has been made on one (recommendation 17).

The nature of the public service demands that civil servants consistently maintain the highest possible standards of ethical behaviour. A strong ethical framework in government ensures that the corporate culture of the civil service fosters ethical behaviour in all employees, recognizes and avoids potential conflicts of interests, and that the risks of loss due to fraud are mitigated. Strong ethical frameworks contribute to the public maintaining confidence and trust in the institutions of government, and being assured there is good value and probity in the expenditure of taxpayer dollars.

We believe a proactive approach is required to instill a strong ethics program throughout the civil service. This is a critical function that deserves focused attention by the CSC, and by senior leadership in all departments.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**12**	**-**	**-**	**8**	**20**

Because we have followed up on the *Manitoba's Framework for an Ethical Environment* 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	**6**	-	-
May 2016	**6**	-	-
Total	**12**	-	-

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

Work in progress

Directed to the Civil Service Commission

We recommended that:

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

   OAG comment: *We were advised by CSC that the Values and Ethics Guide is currently under review with the intent of updating and converting it to a policy applicable to all staff.*

Work in progress (cont'd)

We recommended that:

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

    OAG comment: *While Finance and CSC have developed a 5 module e-learning course on comptrollership available as of September 2015, these do not specifically reference fraud nor provide awareness training. Fraud awareness training should be provided periodically to employees within workplaces perceived to be at high risk for fraudulent activity. Departments are in the best position to identify the need for such training as they best understand their operating environment and how to mitigate the risk of fraud. CSC should work with these departments to implement fraud awareness training tailored to the unique aspects of each department and relevant to specific employee roles and responsibilities.*

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

    OAG comment: *We were advised that CSC is currently finalizing a Values and Ethics Checklist to remind departments of ethics-related requirements throughout the year. In addition, on a biannual basis, CSC provides Deputy Ministers with information on department staff that have completed the Values and Ethics, Respectful Workplace, and Corporate Orientation e-learning-modules. However, there is no formalized reporting from departments back to CSC on their implementation of ethics-related policies. We believe this information would enable CSC to provide proactive support to those departments with less-developed implementation processes.*

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

    OAG comment: *Only Deputy Ministers and Assistant Deputy Ministers continue to be required to submit annual declarations. In 2015, CSC updated their Conflict of Interest Policy and developed guidance and procedures for managers to follow.*

    For newly-hired employees, CSC advised that they have implemented an audit process to verify that signed conflict of interest forms are in employee files. The initial audit result showed 74% compliance.

    In April 2016, the CSC Commissioner circulated a memo to Deputy Ministers entitled Supporting a Trusted and Ethical Civil Service, and asked that it be shared with all staff in the department. As well as other values and ethics requirements, the memo reminded employees of their ongoing responsibilities with respect to conflicts of interest, and to complete a Conflict of Interest Declaration Form if required. However, we believe, at a minimum, those employees in specific roles or departments with an elevated risk for conflict of interest should be required to submit declarations on a periodic basis, preferably annually.

Work in progress (cont'd)

We recommended that:

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

    OAG comment: *While no specific actions have been taken on this recommendation, CSC advises they are exploring: a process that would allow employees to anonymously disclose complaints of wrongdoing that fall outside the scope of PIDA; and the feasibility of an internal Ethics Officer position to receive and address ethical concerns*.

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

    OAG comment: *In its 2015/16 annual report, CSC reported under the activities of its Human Resource Operations, the number of investigations across government that they have conducted that do not fall under PIDA, and the breakdown of how many were and were not substantiated. However, this information is not categorized by department, nor is each department reporting their own specific number of investigations within their annual reports.*

    We believe that each department's annual report should provide the overall number of investigations and the outcomes, similar to the reporting of investigations occurring under PIDA. Leading practices specify that ensuring employees are made aware of the consequences for violating ethics-related policies is a key deterrent to fraud in the workplace. Our survey of the civil service found that only half of respondents perceive those who violate ethical standards will be caught or subject to appropriate consequences.

    This recommendation is linked to Recommendation 17 below to the Department of Finance.

16. The CSC and departments track investigations by type.

Directed to the Department of Finance

We recommended that:

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

    OAG comment: *<u>Significant Progress</u> – Finance has drafted comprehensive instructions for departments to report on all investigations conducted in the department over the year, including those conducted by the Manitoba Ombudsman. These are to be reported in conjunction with the PIDA disclosures. However it has not yet been issued.*

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

Directed to the Civil Service Commission

We recommended that:

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

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

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

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

Directed to the Department of Finance

We recommended that:

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

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

Directed to the Procurement Services Branch

We recommended that:

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

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

Implemented/resolved

Directed to the Civil Service Commission

We recommended that:

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

Considered cleared (cont'd)

We recommended that:

6. The CSC develop and implement procedures to better insure employees submit conflict of interest declaration forms as required.

8. The CSC and departments utilize more communication methods to ensure employees throughout the civil service are aware of and understand the ethical requirements.

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

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

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

Directed to the Department of Finance

We recommended that:

3. The Department of Finance conduct a comprehensive review of the Fraud Prevention and Reporting Policy and update the policy as needed.

4. The Department of Finance develop and implement a communication plan to better educate civil servants on the purpose of the Fraud Prevention and Reporting Policy and their related obligations.

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

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

Our recommendations are directed to Manitoba Hydro.

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – March 2014 (Chapter 8)	February 25, 2015 (Passed)
First follow-up – May 2016	-

What our original report examined

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 7 of our 8 recommendations have been implemented as at September 30, 2016.

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

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**7**	**-**	**-**	**1**	**8**

Because we have followed up on the *Manitoba Hydro – Managing Cyber Security Risk Related to Industrial Control Systems* 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	**3**	-	-
May 2016	**4**	-	-
Total	**7**	-	-

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

Work in progress

We recommended that:

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

   ***OAG comment**: Significant Progress - Manitoba Hydro has developed an ICS risk management process.*

   Manitoba Hydro advised that the risks associated with ICS assets identified as North American Electric Reliability Corporation (NERC) critical assets were being mitigated based on NERC physical and network guidelines.

   Manitoba Hydro also created a high priority asset listing of locations they deem critical to operations and selected sites to conduct initial assessments using risk criteria (that were developed with the assistance from an independent ICS cyber security firm). Manitoba Hydro advised that these initial assessments were used to determine which assets at each location required attention first and were beginning to take steps to address the associated risks. Manitoba Hydro also advised that they are in the process of beginning to triage the risks associated with ICS assets at the other sites (not critical to operations).

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

We recommended that:

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

Considered cleared (cont'd)

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

Implemented/resolved

We recommended that:

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

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

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

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

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

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

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

Waiving of Competitive Bids

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

Summary of reports and PAC discussion dates

Reports issued	Discussed at PAC (in meetings up to December 7, 2016)
Original report – March 2014 (Chapter 10)	October 5, 2015 December 14, 2015 August 17, 2016 (Not passed)
First follow-up – November 2015	December 14, 2015 August 17, 2016 (Passed)

What our original report examined

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

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

We examined untendered contracts in 5 departments and 3 SOAs.

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

Status of recommendations as at September 30, 2016

As shown in the table below, 13 of our 25 recommendations have been implemented as at September 30, 2016.

Of the 12 recommendations that remain in progress, we note that significant progress has been made on 4 (recommendations 4, 9, 18 and 23).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ Resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**13**	**-**	**-**	**12**	**25**

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

Because we have followed up on the *Waiving of Competitive Bids* report for 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**	-	-
November 2015 & May 2016	**8**	-	-
Total	**13**	-	-

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

Work in progress

Directed to the Procurement Services Branch

We recommended that:

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

   ***OAG comment**: PSB is in the process of identifying departmental practices. We note that the alternative procurement practices identified in our audit are included in this review.*

Work in progress (cont'd)

We recommended that:

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

    OAG comment: The new on-line system for disclosing contracts greater than $10,000 (see recommendation 11) organizes contracts by department and by month. For each selected month the contract information can be sorted by date, vendor, purpose, value or purchase category. The system, however, does not allow a user to query by vendor or date. To find a specific vendor, the user must know which department issued the contract they are looking for and in which month the contract was issued. To find all contracts issued to a specific vendor government wide, a user needs to go to each department's page and then to each month. In our view, because of these limitations the new system does not have a "comprehensive search engine".

    We appreciate that building sophisticated search capabilities may have significant cost implications. Accepting that costs should be minimized, we encourage the PSB to explore how best to provide users with the ability to extract vendor focused contract information.

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

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

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

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

    ***OAG comment**: Significant Progress - PSB has added a new section on Ethical Procurement and has amended various other sections. PSB notes that it is finalizing a Governing Principles of Procurement document and that this is the first step in a more comprehensive update of the PAM. Once the governing principles are approved, PSB advised that a detailed plan for updating the PAM will be prepared.*

Work in progress (cont'd)

Directed to the Treasury Board Secretariat and the Province

We recommended that:

4. Treasury Board Secretariat:
   - develop guidelines for delegating purchasing authorities for untendered contracts and related extensions during emergency events (in particular the purchasing authorities for Treasury Board, ministers and deputy ministers).
   - require comprehensive reporting after an emergency event on how the delegated authority was used.

   ***OAG comment**: Significant Progress - Treasury Board Secretariat has completed a jurisdictional review of untendered contracts for emergency expenditures and is working toward refining authorities and determining when an event is deemed an emergency.*

9. Treasury Board Secretariat amend the General Manual of Administration's (GMA's) definition of contract to match the PAM definition.

   ***OAG comment**: Significant Progress - Treasury Board has developed a draft update to the GMA section on Contracts and has incorporated references to the PAM.*

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

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

Directed to Departments and SOAs

We recommended that:

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

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

    ***OAG comment**: PSB now requires purchase orders for all contracts greater than $1,000 (with a few exceptions) to be entered into SAP and is currently monitoring the use of the Business Case Tab. At the time of our audit, use of SAP purchase orders was required for all purchases of goods over $2,500 and services over $5,000 yet significant purchases were still being made without purchase orders. In our view, to increase compliance, Executive Financial Officers will need to actively enforce purchase order use.*

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

    ***OAG comment**: The amendment of an SOA's operating charter previously required approval by Order in Council. Legislation has been amended to require the Minister of Finance's approval of any changes to an SOA's operating charter. We note that current operating charters in use by some SOAs continue to contain references to General Manual of Administration sections that are out of date. The Treasury Board Secretariat advises that it will oversee the implementation of this recommendation.*

Considered cleared

This follow-up report – *status as at September 30, 2016*

Implemented/resolved

Directed to the Procurement Services Branch

We recommended that:

3. The PSB amend the PAM to require that departments make public their intent to award a contract over a set amount.

6. The PSB update the PAM to require that departments and SOAs analyze and document how the price quoted on an untendered contract represents fair market value. The analysis should be conducted prior to contract signing.

8. The PSB amend the PAM to require that contracts be kept in the public access database for as long as they are active.

15. The PSB implement a risk based process to monitor department and SOA compliance with policies on the waiving of competitive bids (including the policy on public disclosure). We also recommend that the PSB report compliance issues to the department's deputy minister.

Directed to the Treasury Board Secretariat and the Province

We recommended that:

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

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

Implemented/resolved

Directed to the Procurement Services Branch

We recommended that:

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

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

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

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

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

Considered cleared (cont'd)

We recommended that:

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

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

Directed to the Department of Finance

We recommended that:

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

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

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

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

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

Directed to Departments and SOAs

We recommended that:

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

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

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

Summary of reports and PAC discussion dates	
Reports issued	**Discussed at PAC** (in meetings up to December 7, 2016)
Original report – July 2015	-

What our original report examined

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

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

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

Status of recommendations as at September 30, 2016

As shown in the table below, 1 of our 12 recommendations has been implemented as at September 30, 2016.

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016	**1**	**-**	**-**	**11**	**12**

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

Work in progress

Directed to the WRHA

We recommended that:

1. eHealth identify and assess the risks associated with end-user devices used within the WRHA environment.

   ***OAG comment**: eHealth has conducted risk assessments on their smartphones and various remote access methods. However, they have not yet completed risks assessments on laptops, desktops or USB Flash Drives.*

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**: eHealth advised that they are developing formal procedures to communicate risk to the WRHA.*

3. Upon completing end-user device risk assessments, the WRHA implement the controls needed to reduce (to an appropriate level) the risks associated with end-user devices (including the areas of concern noted in our letter to management).

4. eHealth develop a strategic plan for the delivery of ICT (Information and Communication Technology) services to the WRHA, including plans for remote access through end-user devices.

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

8. The WRHA Internal Audit branch develop and implement a risk-based audit program that would satisfy the requirements of the WRHA's Audit of Security Safeguards policy.

9. Upon the completion of risk assessments, WRHA update the PHIA (Personal Health Information Act) and information security awareness training sessions to:

   a. Communicate a complete and consistent set of risks, expectations and requirement pertaining to personal health information residing on or accessed by end-user devices.
   b. Develop training that specifically targets users in higher risk positions.
   c. Outline incident handling procedures.

11. The WRHA require that associated individuals (e.g. physicians and medical staff, contractors, students, researchers and employees) using WRHA information assets attend the information security awareness training upon hiring and periodically thereafter.

12. eHealth implement other information security awareness techniques to complement and reinforce the messages communicated in its awareness training courses and intranet site.

Work in progress (cont'd)

Directed to the Department of Health, Seniors and Active Living

We recommended that:

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

   ***OAG comment**: Department of Health, Seniors and Active Living officials noted that a draft guideline has been developed and is under review.*

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

Considered cleared

This follow-up report – *status as at September 30, 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 7, 2016)
Original report – July 2015	-

What our original report examined

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

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

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

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

Status of recommendations as at September 30, 2016

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, 2 of our 46 recommendations (0 of 9 for Health, 1 of 19 for WRHA, and 1 of 18 for Southern Health-Santé Sud) have been implemented as at September 30, 2016.

Of the 44 recommendations that remain in progress, we note that significant progress has been made on 8 (WRHA recommendations 8, 10, 17, 19, 21 and 28; Southern Health-Santé Sud recommendations 11 and 16).

Status date See Review comments on page 11	Recommendations considered cleared			Work in progress	Total
	Implemented/ resolved	Action no longer required	Do not intend to implement		
September 30, 2016					
Department of Health	-	-	-	**9**	**9**
WRHA	**1**	-	-	**18**	**19**
Southern Health-Santé Sud	**1**	-	-	**17**	**18**
Total	**2**	-	-	**44**	**46**

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:

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.
2. The Department:
   a. specify which direct services (if any) RHAs must make available to home care clients, no matter where they live.
   b. make it clear in all their published materials describing home care services which services RHAs must provide (if any) and which are optional.
3. The Department make its home care standards and policies public, as done in other provinces.
4. The Department identify key provincial home care standards and require RHAs to review their compliance with these standards and report the results to the Department.
5. The Department:
   a. review the home care monthly statistics it requires from RHAs to ensure the statistics will provide all key information needed to effectively monitor and analyze Manitoba Home Care Program performance.
   b. monitor all key home care information it receives for completeness and reasonableness, particularly information being publicly disclosed in its annual statistics report.
   c. analyze RHAs' statistical reports, in conjunction with their financial reports, to identify and follow-up variances from expected results, anomalies, and longer-term trends for the Manitoba Home Care Program.
6. The Department, in consultation with RHAs, define and monitor performance measures for service timeliness, service reliability, and key client outcomes for the Manitoba Home Care Program.
7. The Department work with RHAs to expand and improve public performance reporting on the Manitoba Home Care Program.

Work in progress (cont'd)

We recommended that:

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

24. The Department, in collaboration with RHAs, develop an approach to identify and manage nurse-delegated tasks in the Manitoba Home Care Program consistently, efficiently, and in accordance with acceptable professional practice.

Directed to the WRHA

We recommended that:

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

   ***OAG comment**: Significant Progress - WRHA advised us that it has developed a WRHA Home Care ad for the WAVE Magazine to promote awareness of services. This magazine is published every two months and is distributed to all hospitals, community doctors' offices, and community at large. WRHA has also added a link on its website to the Department's website. WRHA told us they also planned to work with WRHA Primary Care to develop strategies to communicate with primary physicians.*

9. WRHA develop plans to improve the timeliness of at-home client needs assessments and monitor progress in meeting their timeliness standards.

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.

    ***OAG comment**: Significant Progress - WRHA advised us that it has implemented a new electronic screening tool to help central intake staff assess the urgency of assessment by case coordinators. WRHA plans to evaluate the effectiveness of this new process in the near future.*

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

12. WRHA:
    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. 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.

Work in progress (cont'd)

We recommended that:

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: WRHA has developed and begun implementing a new audit tool for reviewing community coordinated files. This review includes a review of care plans.

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

17. WRHA develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:
    a. more collaborative discharge planning between hospital and home care staff.
    b. reasons for delays in initial service start-ups and service adjustments for clients in the community.
    c. staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

    ***OAG comment**: Significant Progress - WRHA has implemented recommendation 17(c) and has taken some steps towards improving scheduling processes to better enable the discharge planning of home care clients in hospital.*

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

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

    ***OAG comment**: Significant Progress - WRHA advised us that for both community care and nursing care information is now being tracked and monitored that will allow them to assess the consistency of workers, but progress was not being assessed.*

20. WRHA review the reasonableness and consistency of their standard task time allotments to ensure they are appropriate.

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

    ***OAG comment**: Significant Progress - WRHA has implemented recommendation 21(b).*

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

25. WRHA require staff to document reviews of sign-off sheets and related follow-up actions.

Work in progress (cont'd)

We recommended that:

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

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

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

    ***OAG comment**: Significant Progress - WRHA has implemented recommendation 28(b) and has begun the implementation of a quality assurance client file review process. WRHA was also in the process of rolling out a new direct service staff performance appraisal system, which includes home visits.*

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.

    ***OAG comment**: Southern Health-Santé Sud advised us it has taken several steps including: developing a process map, conducting 22 audits of case coordinators to see how long it is taking for the initial assessment and development of the care plan, completing three focus groups, and developing a clinical audit tool that is used biannually.*

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

    ***OAG comment**: Significant Progress - Southern Health-Santé Sud has developed a draft guideline for completing client needs assessments requiring all fields to be completed (even if not applicable). Southern Health Santé-Sud has also implemented a biannual clinical audit process that includes checking whether staff met set standards (e.g. was the care plan created within 7 days of referral).*

12. Southern Health-Santé Sud:
    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.

Work in progress (cont'd)

We recommended that:

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

15. Southern Health-Santé Sud ensure that client care plans:
    a. meet all clients' assessed needs, and only those needs.
    b. clearly state the frequency or amount of service to be delivered.
    c. specify a reliable back-up plan that can be actioned as required.
    d. are signed by clients or their designates to show they reviewed and discussed them.
    e. are updated at least annually, using a formal reassessment process that prioritizes higher-risk clients.

    OAG comment: Southern Health-Santé Sud has implemented recommendation 15(c).

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.

    ***OAG comment**: Significant Progress - Southern Health-Santé Sud has implemented recommendation 16(a).*

17. Southern Health-Santé Sud develop plans to improve the timeliness of service start-ups and service adjustments, and monitor progress and compliance with any related standards. These plans should explore:
    a. more collaborative discharge planning between hospital and home care staff.
    b. reasons for delays in initial service start-ups and service adjustments for clients in the community.
    c. staffing both case and resource coordinators on evenings and weekends to facilitate service start-ups.

18. Southern Health-Santé Sud develop plans to improve service reliability and monitor how frequently clients have to use their back-up plans.

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

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.

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(c).*

Work in progress (cont'd)

We recommended that:

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.

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

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.

    ***OAG comment**: Southern Health-Santé Sud has implemented recommendation 27(a).*

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**: Southern Health-Santé Sud has implemented recommendation 28(a).*

Considered cleared

This follow-up 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.

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