Governance, Budgeting, and Fiscal Management Review – Shared Health

Shared Health

Prepared for the Government of Manitoba

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SUITE 1200, 242 HARGRAVE STREET, WINNIPEG, MB, R3C 0T8

T. 204.775.4531 F: 204.783.8329 **MNP.ca**

Executive Summary

Under the Health System Governance and Accountability Act, and the terms of the accountability agreements, the Health Service Delivery Organizations (SDOs) are expected to operate within the annual budget allocated to them by the minister. Over the last several years, SDO's have not been able to achieve balance and have been reporting operating deficits. The accumulated deficits have reached the level where it has become unsustainable for the SDOs on their own and government intervention may be required. Deficits impede the ability of organizations to make the best decisions for patient care, plan effectively for future health care needs and support front line staff. In addition, the ongoing deficits of the SDOs are incompatible with the Government of Manitoba's overall goal of a balanced summary budget by the end of its current term.

The report contained herein provides a detailed review of the governance, budgeting, and fiscal management practices of Shared Health. The time examined included fiscal 2019/2020 to fiscal 2023/2024. It should be noted that a new board chair was appointed in early 2024 and there have also been several other new board members added to Shared Health's board.

MNP began this review with the development of a detailed evaluation matrix including review questions, indicators, and evidence factors which was circulated and approved by Manitoba Health, Seniors and Long-Term Care (MHSLTC). The primary methods used for data collection and analysis consisted of document reviews and interviews with key Shared Health representatives. The resulting report identifies gaps in practice and provides recommendations and a plan of action for the consideration of the department to mitigate the identified gaps.

We would like to express our gratitude and appreciation to those individuals at Shared Health who sourced documents, participated in interviews, and who made time available for follow-up discussions and clarifications. We acknowledge the time this took and appreciate their cooperation and willingness to identify areas for improvement with a shared goal of improving health care for Manitobans.

The following sections highlight some of the most noteworthy and significant findings and recommendations from this report. A complete summary of findings is found in Appendix 5 along with a complete summary of recommendations in Appendix 6.

Key Findings

Governance

At the time of the audit, board members indicated that historical budgeting processes did not allow for a collaborative effort between the board, management and the government. Management and board member turnover impacted the consistency of the information they received.

During the time reviewed, the board has been frustrated by the perceived removal of their decision-making authority over some budgetary decisions. They have expressed a need to be closer to the budgeting process, with the ability to contemplate better service delivery and cost trade-offs alongside management, to make independent judgements on resourcing levels.

During the time reviewed, the board did not adequately mitigate identified financial risks. There is a disconnect between some risks, drivers of the risks and the steps taken to mitigate the risks. In some cases, the board has not taken proactive action to mitigate identified risks and reduce their likelihood, severity or impact.

Budgeting

Shared Health has not used the annual operating plan to link ongoing service needs and demands to change in the operating budget. It is unable to change course and adapt quickly when funding allocations differ significantly from budget guidance.

The AOP framework provides flexibility for managing volume pressures in various healthcare categories however, Shared Health has not historically used it to integrate analytical data to accurately reflect and address the actual demand and needs for all service lines. Their current financial reporting structure makes it challenging to directly link the use of funds to the list of core services outlined in their accountability agreement with government. Their annual report has limited information on whether it has achieved the minimum service levels established in the agreement.

The Annual Operating Plan framework does provide room for Shared Health to innovate service delivery in both operating and capital budgets. The 2023/24 Annual Operating Plan Guidelines introduced a new section for new initiatives (like a new service, program or expansion of a program) that have measurable cost savings and allow for the reallocation of current funds.

The budgetary components of the Annual Operating Plan process have not necessarily facilitated better compliance or budgeting by Shared Health. The AOP does have a mechanism for the SDO to provide narrative explanation regarding variances, that then become a part of the AOP that the SDO is held accountable to.

Fiscal Management

Shared Health is regularly operating in a deficit as defined by the Annual Operating Plan budget, and as a result, is not in compliance with the Accountability Agreement.

Historically, extraordinary changes in demand have not been managed in a proactive manner and incorporated into financial forecasts once the related costs become apparent. The acceptance of increased service demands, and the related costs, has not resulted in significant efforts to offset these costs or to identify corresponding savings that can be implemented in other areas.

Shared Health has not provided adequate visibility to MHSLTC on their projected cash position as part of its standard reporting requirements.

The budget component of the Annual Operating Plan is currently designed as a static document with budgeting based on the funding guidance provided by MHSLTC. If the approved funding is different from the budgeted funding guidance, the SDO is given an opportunity to update their AOP. Further, the SDO's are expected to advise MHSLTC of the impacts of receiving different funding than originally forecast in the AOP, providing MHSLTC an opportunity to provide additional advice to the SDO.

Key Recommendations

Governance

1. The SDO should consider adopting zero-based budgeting and scenario planning approaches in their budgeting process that allow for increased granularity, more fulsome planning, and increased flexibility.
2. The impact of mid-year service delivery standard changes should be tracked if they result in an additional unfunded financial obligation to better enable analysis of SDO's ability to manage to budget.
3. A policy should be implemented by the SDO, so that any additional mid-year service requirements are not implemented unless they can be funded through internal reallocation.

Budgeting

1. The Annual Operating Plan should incorporate a scenario-based planning element to enable a better understanding of potential budget changes and greater flexibility to respond to change. Scenario-based budgeting is described in the body of the report
2. MHSLTC should consider adopting a zero-based budgeting approach for all SDO's to justify expenses annually.
3. Shared Health should be mandated to propose a list of cost-saving measures equal to three-times the reported deficit within 90 days when a deficit is reported on Shared Health's quarterly reporting.
4. Shared Health should be required to carry a pre-determined contingency in its annual budgeting to prepare for unexpected costs.
5. MHSLTC should direct the immediate procurement of a single budgeting and forecasting software across all SDOs, and expedite implementation to improve the speed, accuracy, and reliability of reporting, and significantly reduce manual effort.

Fiscal Management

1. MHSLTC should require all SDOs to provide quarterly cash position statements and include cash position planning in the Annual Operational Plans.

2. If cash position shortfalls are projected in the Annual Operating Plan, MHSLTC should consider adjusting the timing of payments to Shared Health and providing more front-loaded cashflow to offset the effects of delays in implementing the approved increase to annual funding.

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Introduction

Manitoba Health, Seniors and Long-Term Care (MHSLTC) administers the most complex and visible social program provided by the government. The program is delivered partially by the department and partially through grant agencies, arm's length health authorities, independent physicians, or other service providers paid through fee-for-service or alternate means.

Under the Health System Governance and Accountability Act, and the terms of the accountability agreements, the Health Service Delivery Organizations (SDOs) are expected to operate within the annual budget allocated to them by the minister. Over the last several years, SDO's have not been able to achieve balance and have been reporting operating deficits. The accumulated deficits have reached the level where it has become unsustainable for the SDOs on their own and government intervention may be required. In addition, the ongoing deficits of the SDOs are jeopardizing Government of Manitoba's overall goal of a balanced summary budget by the end of its current term (2026/27).

MNP was engaged to support MHSLTC by employing a consultative approach to evaluate the governance, budgeting, and fiscal management practices of the selected SDOs, identifying gaps, and providing recommendations to address them.

Accurate budgeting, forecasting, accounting, and analysis are always important, but are particularly critical to making informed decisions about healthcare transformation and the allocation of resources to meet citizen needs and achieve desired outcomes.

Scope

The engagement is a critical review of the governance, budgeting, and fiscal management practices of Shared Health (SH) in order to identify gaps in practice and provide recommendations to address those gaps with best practices.

Development of a plan of action for the consideration and approval of the department to mitigate the identified gaps. The plan needs to be practical and achievable within the prevailing broad economic and human resources challenges in the province.

Specifically, the scope of the review included:

Governance: Shared Health is governed by a board of directors who provide oversight to the organization. The review focuses specifically on the governance role of the board of directors as it relates to budgeting and fiscal management, rather than a broad review of all board activities.

Budgeting: The review evaluates whether Shared Health is compliant with the required annual planning processes, and whether the current budgeting processes enable Shared Health to meet its obligations under the Accountability Agreement.

Fiscal management: The review identifies whether Shared Health is managing its finances as budgeted and planned, and whether appropriate processes are in place for communication of variances and delegation of authority.

Report Format

To guide the review, a review matrix was prepared that outlines the three review areas. Each area has a set of questions with associated indicators that are used to evaluate that specific question. The review matrix is provided in Appendix 1. The report is structured as follows:

Detailed Findings - for each of the three review areas.

- Governance
- Budgeting
- Fiscal Management

Summary of Recommendations - A summary of all the recommendations.

Implementation Plan – A plan that details a strategy for implementing the recommendations.

Appendices – Including:

- Review Matrix
- Documents reviewed
- Actual vs. budget expense analysis
- Key deficit drivers – a section that details analysis of elements identified as the most significant drivers of the deficit
- Summary of findings
- Summary of recommendations

Methodology

The primary methods used for data collection and analysis included financial statement review, document review, and interviews. The data and information obtained through financial statement and document review were further explored through focused interviews with key representatives from the SDO.

Document reviews: A full list of the statements and documents reviewed is provided in Appendix 2.

Interviews: Interviews were conducted with key representatives including:

- Members of the SDO's Finance department
- Executive team
- Board of Directors
- Members of Board committees

Limitations of this Review

MNP has relied upon the completeness, accuracy, and fair presentation of all information and data that were made available by June 28, 2024. The accuracy and reliability of the findings and opinions expressed in this report are conditional upon the quality of this same information.

Additionally, the findings and expressed opinions constitute judgments as of the date of the report and are subject to change without notice. MNP is under no obligation to advise of any such change brought to its attention which would alter those findings or opinions.

Disclaimer

In preparing this report, MNP relied upon the completeness, accuracy, and fair presentation of all information and data that was made available by the Government of Manitoba and Shared Health by June 28, 2024. The accuracy and reliability of the findings and opinions expressed in this report are conditional upon the quality of this same information. MNP did not audit or independently verify the accuracy or completeness of the supporting information. Accordingly, MNP expresses no opinion or other forms of assurance in respect to the supporting information and does not accept any responsibility for errors or omissions, or any loss or damage because of any persons relying on this Report for any purpose other than that for which it has been prepared.

The findings and expressed opinions constitute judgments as of the date of the report and are subject to change without notice. MNP is under no obligation to advise of any such change brought to its attention which would alter those findings or opinion. MNP reserves the right to revise any analysis, observations or comments referred to in this Report, if additional supporting information becomes available to us after the release of this Report.

Acknowledgements

We would like to express our gratitude and appreciation to those individuals at Shared Health who sourced documents, participated in interviews, and were always available for follow-up discussions and clarifications. We acknowledge the time this took and appreciate their input.

Governance Findings and Recommendations

The following sections provide governance findings and recommendations based on the questions listed in the review matrix. Each question from the review matrix is listed first, followed by the corresponding findings and recommendations.

Shared Health is governed by a board of directors who provide oversight to the organization. MNP interviewed Shared Health's board members and members of the executive leadership, with the summary of our findings and recommendations presented below. MNP notes this section focuses specifically on the governance role of the board of directors as it relates to budgeting and fiscal management, rather than a broad review of all board activities.

Question #1

Do board members in key roles possess the necessary skills and experience to provide appropriate financial oversight given the scale and complexity of the SDOs?

Findings

Finding #1

Given the complexities and financial oversight required, we found a majority of board members in key roles do not possess the necessary skills and experience to provide appropriate financial oversight.

- One person on Shared Health's board of directors has a CPA designation and one person has a MPA degree.
    - The CPA chairs the Audit and Finance Committee, and the MPA chairs the Finance Committee.
    - Other board members in key roles such as the chair role, and finance and audit committee member roles have other areas of expertise and limited, if any, financial training and experience.
- There is an ex-officio member of the Audit and Finance Committee with an accounting designation, however this ex-officio member is not a part of ongoing board discussions and information.
- Eight of ten board members have experience in senior management or board roles at large, complex organizations.
- The Chair and one of three members of the Finance and Audit Committee have indirect experience overseeing the finances at large, complex organizations, including health-care

organizations. One Finance and Audit Committee member has direct experience overseeing the finances of a large, complex organization.

- One of ten board members has experience in a key financial role (Controller, CFO, etc.).
- Four of ten board members have experience serving on boards of large, complex organizations with a high level of impact and accountability. Three of these member's experiences include sitting on national boards.

Finding #2

Turnover of board members has recently been high with many board members not fulfilling their term.

- The board is seeking the appointment of at least one more CPA and one person with significant IT credentials and experience.

Finding #3

Shared Health has an orientation process for onboarding new board members and ongoing training is a regular board agenda item.

- Board member education includes an orientation process for the onboarding of new board members and an educational component has been included in each board meeting for ongoing board member education.
- At least two board members have the Institute of Corporate Directors Director's Education Program certification.

Finding #4

Board compensation for Shared Health is among the lowest paid for large, complex public sector entities in Manitoba.

- The board has indicated to the Minister that board member compensation should be evaluated to ensure it is comparable to other large, public boards in Manitoba.
- With a baseline total estimated compensation of $1,600 and an assumed 90 hours of time spent in preparation for and at meetings, board members are compensated at the equivalent of $17 per hour, only slightly more than the $15.30 minimum wage in Manitoba.
- Shared Health board members are paid less than board members at other Manitoba public entities, such as Manitoba Hydro-Electric Board, Manitoba Liquor and Lotteries Corp., and Manitoba Public Insurance. Shared Health board members receive the same estimated baseline annual compensation as WRHA board members MNP found that while Shared Health is comparable to some of the largest Manitoba public entities in revenue and complexity, its board members are paid at the lowest levels as shown below (Table 1).

Table 1: @Board Member Compensation Comparison

Entity Name	Annual Revenue	Baseline Annual Number of Board Meetings	Baseline Estimated Annual Compensation
Manitoba Hydro-Electric Board	$3,835,000,000	6	$7,500
Manitoba Liquor and Lotteries Corp.	$985,143,000	4	$7,500
Manitoba Public Insurance	$1,519,748,000	9	$7,500
Shared Health	$1,780,032,000	10	$ 1,600 ($4,000 maximum)
Winnipeg Regional Health Authority	$2,319,521,000	10	$ 1,600 ($4,000 maximum)

Recommendations

Based on the principal findings outlined above, MNP developed five recommendations to strengthen the SDO's financial governance.

Recommendation #1

A desired skills matrix should be developed and used to evaluate existing board members.

- Skills gaps should be identified, and recommendations for skills required should be communicated to the cabinet minister when a position is to be appointed to ensure appropriate balance of skills and that board member's skills align with the needs of the organization.

Recommendation #2

Open board positions should be posted publicly.

- Transparency regarding the specific skills required would help ensure the broadest pool of candidates are available for consideration.

Recommendation #3

Compensation for Shared Health board members should be reviewed and increased.

- Remuneration of board members is at the lowest level paid when compared to 17 Manitoba not-for-profit or crown corporations and may contribute to the reduction in quality appointments and high turnover rate.
- Given the workload and visibility of these positions, higher remuneration is believed to be warranted and appropriate.

Recommendation #4

The SDO should introduce staggered board terms.

- Staggering terms would provide continuity and preserve institutional knowledge.

Recommendation #5

Formal board governance education should be reinstated and required of all board members.

- Governance education would ensure board members are aware of their responsibilities and that their actions are aligned with government and other stakeholder expectations.

Question #2

Are board members provided with fulsome, accurate, timely, and actionable information regarding the financial position of the organization and material changes as they occur?

Findings

Finding #1

Board members receive communication that provides them with an understanding of the organization's financial position. Management and board member turnover has impacted the consistency of the information.

- Committee and Board meeting materials – including financial statements and related information - are posted on a secure, online portal prior to meetings. The board chair can see if board members have reviewed materials.
- An information template has recently been implemented for the CEO's report to the board. There have been three CFOs in the last two years. It is felt, in part, because of the turnover, consistency in regular reporting to the board has been lacking but has recently been improving with initiatives like the template.
- Financial information is received by the Finance and Audit Committee prior to its distribution at board meetings. The board and the Audit and Finance committee meet monthly. The Board Chair and CEO have standing weekly meetings.
- The current CEO keeps the board updated on important information including challenges with unfunded announcements and unfunded demands. Management alerts board members to upcoming high profile news events, staff departures, etc.

Finding #2

While the board is well-informed during the annual budgeting process and are aware of the cost and service delivery trade-offs incorporated in the proposed budgets, board members feel that they are not close enough to the budgeting process to provide effective oversight.

- The Audit & Finance Committee has focused on cost reduction and will be building a tracker to monitor and track initiatives taken. It is felt Management is good at listening to the guidance provided by the committee and actioning requests.
- MNP found management is in a tough place with two leaders. The board and government might agree in principle to the budget, but after the government requests and receives more details, it may change its position.
- At times, information received from the chair's conversations with the Minister of Health may differ from the information the CEO receives from the Deputy Minister of Health.

Finding #3

Board members indicated that the historical budgeting process did not allow for as collaborative an effort between management, the board, and the government as would be beneficial.

- The Annual Operating Plan (AOP) submission cycle, and the manner with which this cycle has historically been implemented, has reduced opportunities for timely collaboration. For example, while the SDO receives budget guidance at the outset of the cycle, the actual budget number may come later in the cycle once issued by the Treasury Board. Accordingly, the SDO's AOP submission has been based on a set of assumptions that quite often change and lead to increased financial pressures that can have significant impact on performance against the budget.

Finding #4

Board members receive additional information or clarification when requested.

- The board is engaged and actively works to understand the information received. For example, the board recently requested management include full year forecast numbers along with the actual and budgeted numbers being reported. The additional information allows the board to provide details to the government on the forecasted affects of unfunded requirements and changes in service levels.

Finding #5

Management provides timely information and updates when material changes affect the organization's ability to meet its established budget.

- Board members stated that the drivers of the deficit are openly discussed at board meetings.

Finding #6

The board understands government's desire to reduce corporate services costs.

- MNP heard that the government's listening tours have not included representation from finance or other administrative functions and heard several comments from Shared Health

representatives that when internal processes such as administration are described as red tape, it has detrimental effects on administrative staff morale.[1]

Recommendations

Based on the principal findings outlined above, MNP developed one recommendation to strengthen the SDO's communication of the financial position of the organization.

Recommendation #1

The SDO and MHSLTC should mutually explore opportunities to reduce the time that elapses between AOP draft delivery and approval, and the process for development of, and making changes to the AOP.

Question #3

Does the board exercise independence from management and provide sufficient oversight of the annual budget development process before approving the budget?

Findings

Finding #1

Board members expressed that they are not close enough to the budgeting process to be able to make independent judgements on resourcing levels.

- While board members indicated that they come to independent judgements on financial matters based on available information, they feel there is a disconnect in the budgeting process
- Board members indicated that the budgeting process should start with management's forecast of expected service levels to determine associated costs.

Finding #2

The board is aware of service delivery and cost trade-offs proposed in the budget. However, the board has at times been frustrated by their lack of decision-making authority over budgetary decisions.

Finding #3

The board indicated its ability to contemplate service delivery and cost trade-off options with management is at times limited by the realities that to achieve savings a reduction in patient service delivery may be required, and this is often not perceived as a viable option.

[1] https://news.gov.mb.ca/news/index.html?item=62437&posted=2024-03-12.

Finding #4

The SDO board attempts to ensure compliance with accountability agreements are met but has historically struggled with this.

- Given the realities of unplanned insertions being likely, and the potential receipt of lower than assumed funding (as has been the case historically), it would have been reasonable to expect that SDO's would consider these realities and have adjusted their budgeting process accordingly. Similarly, it would have been reasonable to expect that MHSLTC acknowledge these realities and work with the SDO collaboratively to identify new budget planning guidance and process. For example, utilizing a scenario planning approach to budget development would allow both the SDO and MHSLTC to understand and be prepared for "what if" scenarios more fully. What if our budget was reduced by "x" dollars in the coming year? What if we do not receive inflationary increases?

Recommendations

Based on the principal findings outlined above, MNP developed two recommendations to strengthen the SDO's oversight of the annual budget development process.

Recommendation #1

The SDO should consider adopting zero-based budgeting and scenario planning approaches in their multi-year budgeting process that allows for increased granularity, more fulsome planning, and increased flexibility.

Recommendation #2

The Accountability Agreement should clearly define the roles and responsibilities of Government and the Board in the oversight of Shared Health.

Question #4

Does the board approve material changes to the budget or variances from budget as they become apparent?

Findings

Finding #1

The board is aware of material changes and variances from budget as they occur during the fiscal year.

- The board requests and receives full year forecasts with each monthly report so that unfunded amounts are more easily viewable as early as possible.

Finding #2

The board authorizes significant variances or revised budgets as information on the variances becomes available.

- The board receives monthly financial statements with a comparison to the budget and an end of year forecast. The board feels that they are required to authorize variances since they see the alternative as operating to funded activity, which would require closing beds and turning patients away.
- With recent changes to board membership, there appears to be increased willingness and openness to discuss variances with MHSLTC in a proactive manner.

Finding #3

Current year financial obligations and the timing of those obligations have led to cash flow challenges for Shared Health.

- Already tight budgets combined with cash transfer timing issues and expectations and/or decisions by Shared Health to add services that are unfunded or underfunded have all contributed to Shared Health's current cash flow challenges and deficit situation.

Recommendations

Based on the principal findings outlined above, MNP developed four recommendations to enhance the SDO's oversight of material changes to the budget or variances from budget as they become apparent.

Recommendation #1

The impact of mid-year service delivery standard changes should be tracked if they result in an additional unfunded financial obligation to better enable analysis of SDO's ability to manage to budget.

- Unbudgeted items in budget updates should be separately stated to ensure the reader is aware that there has been a change made by the SDO or government in required services offered, service levels, or general service requirements of the SDO.

Recommendation #2

- **A policy should be implemented by the SDO, so that any additional mid-year service requirements are not implemented unless they can be funded through internal reallocation.**

Recommendation #3

A comprehensive analysis should be completed to understand why staffing positions are not being filled.

- Filling vacancies would reduce overtime pay requirements, prevent staff burn-out, and, ultimately, reduce budget variances for wages.

Recommendation #4

Shared Health and MHSLTC should jointly explore alternate cash transfer timing options to mitigate the risks associated with the current transfer timing.

Question #5

Does the board identify the financial risks facing the organization and ensure they are well-informed on the impacts?

Findings

Finding #1

Shared Health has identified financial risks facing the organization by preparing a risk register and completing an annual assessment of risk.

- The results are documented and published annually in the Shared Health Corporate Risk Assessment. The risks are reviewed on an annual basis.
- Members of the board have indicated that there should be a shift to an enterprise risk management program to better evaluate the risks and build criteria for evaluation. Management indicated this will be an ongoing project over the coming months.

Finding #2

Key financial risks are identified in the risk assessment along with their potential impacts.

- Of the fourteen risks identified, two were focused directly on financial sustainability and the need for capital planning and infrastructure needs.
- The risks identified in the Financial Sustainability risk area seem to reasonably reflect the financial risks facing the organization and include key financial risks such as the impacts of an inflationary environment and staffing vacancies.
- The format used does not align the individual risks with their controls, actions, and gaps and potential issues.
- There are no timelines for completion of the mitigation actions.

Recommendations

Based on the principal findings outlined above, MNP developed two recommendations to strengthen the SDO's ability to identify the financial risks facing the organization and ensure they are well-informed on the impacts to the SDO.

Recommendation #1

Risk register should include the status of actions to be taken for further mitigation and the person/department responsible for these actions.

- Mitigation accountability would improve with timelines and the status of actions to be taken.

Recommendation #2

A standardized enterprise risk register format should be used to report to the board.

- Register should include a clear description of each risk, the risk rating, the risk owner, the mitigating actions to be taken, the current mitigation actions taken, and the status of each of those actions.

Question #6

Does the board act adequately to mitigate the financial risks identified?

Findings

Finding #1

The board does not adequately mitigate the financial risks identified. There is a disconnect between some risks, drivers of the risks and the steps taken to mitigate the risks. Timelines for implementation of mitigation steps are not provided.

- As mentioned in the findings and recommendations for Question #5, the format of the risk register does not lend itself to a direct correlation and flow between the individual risks, drivers, impacts, key controls, mitigation/action plans, and timelines for implementation.

Finding #2

In some cases, the board has not taken proactive action to mitigate identified risks and reduce their likelihood, severity, or impact.

- Two of the ten Critical or High Risk rated risks' Mitigation/Action Plans have not been acted on indicating that either the mitigating strategy is either not effective or not feasible. Alternative actions have not been documented.
- Of the ten risks rated Critical or High, six risks seem to have mitigation plans that either mostly cover or cover identified risks.
- Four of ten have mitigation/action plans considered to be incomplete or weak. For example, when addressing the risks resulting from the SDO realignment, gaps in processes, lack of communication and clarity of roles, the following points were identified as a mitigation/action plan:
    - "Not a control but many are wearing multiple hats to keep the business / operations going however this is not sustainable."

Recommendations

Based on the principal findings outlined above, MNP developed two recommendations to strengthen the SDO's ability to act adequately to mitigate the financial risks identified.

Recommendation #1

Shared Health should involve the MHSLTC directly in its risk and mitigation identification process to ensure mitigating factors are realistic given government mandates.

Recommendation #2

The existing risk register should be further developed and include the status of the implementation of mitigation strategies.

Budgeting Findings and Recommendations

The following sections provide budgeting findings and recommendations based on the questions listed in the review matrix. Each question from the review matrix is listed first, followed by the corresponding findings and recommendations. The questions evaluate whether Shared Health is compliant with the required annual planning processes, and whether the current budgeting processes enable Shared Health to meet its obligations under the Accountability Agreement.

Question #1

Is the SDO compliant with the required planning frameworks?

Findings

Finding #1

Shared Health generally follows deadlines and requirements to submit annual planning documentation and reporting.

Shared Health follows the established deadlines for submitting required documents as part of the planning framework including:

- Annual Operational Plan
- Annual Report
- Summary Forecast Reports
- Monthly Forecast Reports
- Accounts Receivable and Accounts Payable Templates
- Debt held by the Department of Finance Treasury Division
- Medical Remuneration Templates
- Bad Debt Reports
- Fiscal Year-End Reporting Requirements

No concerns were identified with the planning templates and reporting reviewed and Shared Health was found to have completed the required planning templates and subsequent reporting as expected.

Finding #2

In past years, Shared Health has lacked a robust multi-year strategic plan to guide its internal planning processes and priorities but developed a draft strategic plan in 2023 and is working toward finalizing the strategic plan in Fall 2024.

Since its formation, Shared Health has been operating without a finalized standalone multi-year strategic plan that is approved by its board and aligned with MHSLTC's strategic plan. This has been a requirement of past accountability agreements and an area of weakness in Shared Health's past annual planning responses. For example, a strategic plan was a requirement of the accountability agreement with a submission due date of November 1, 2022.

While Shared Health has lacked a standalone strategic plan, it was noted that the Overview of Direction section of 2022/23 Strategic and Operational Plan lists the initiatives currently underway to address the four provincial goals of MHSLTC, demonstrating efforts to align Shared Health's actions with provincial strategic priorities. Further, Shared Health's mission, vision, and values are noted to be in alignment with those of MHSLTC as shown in Table 2.

Table 2: Mission, Vision, and Values Alignment between MHSLTC and Shared Health

MHSLTC	Shared Health	Aligned
MISSION		
To ensure Manitoban patients, families and seniors have access to quality, timely health care wherever they live through a health care system that is sustainable and accountable.	To bring Manitobans together to create equitable, safe, accessible, trusted and sustainable pathways to care. Leading provincial planning. Delivering provincial services. Valuing all voices.	Yes
VISION		
Working together toward excellent whole person integrated healthcare for all Manitobans.	Our Manitoba. Healthier. Together.	Yes
VALUES		
Champion Quality: We cultivate a collaborative environment and have the courage to drive continuous improvement, evidence-based solutions,	**Learn and Innovate:** Nurturing continuous improvement and innovation, sharing knowledge, learning with others and creating an environment where	Yes

MHSLTC	Shared Health	Aligned
and innovation for sustainable and excellent healthcare delivery. **Foster Adaptability**: We are nimble and react with urgency to an ever-changing environment. **Be Accountable**: We practice strong oversight, due diligence and fiscal responsibility, acting as effective stewards of the health care system. **Respect the Workforce**: We are committed to building an inclusive, diverse, engaged, resilient, caring, and supportive environment that fosters personal development and professional growth. **Value the Community**: We are committed to equitable people-centered service planning and delivery for all. We are dedicated to the advancement of Indigenous reconciliation.	every experience is an opportunity for growth. **Be Inclusive:** Valuing diversity, honouring dignity, and creating connections, trust and shared vision. Accepting, recognizing and respecting differences, understanding that each individual is unique. **Be Accountable**: Upholding organizational values, professional ethics and the prudent use of public resources to continuously achieve improved outcomes and ensure sustainable delivery of safe and high-quality services. **Act with Compassion**: Demonstrating genuine attention, care and respect. Building trusting relationships. Building constructive and collaborative engagement with others.	

In 2023, Shared Health executive developed a draft strategic plan with input from the board of directors. At the time of writing, the strategic plan remains in draft format and is being updated to a new format that aligns with MHSLTC requirements. Shared Health intends to complete these updates in time for submission in Fall 2024.

Recommendations

Based on the findings outlined above, MNP developed one recommendation to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

Shared Health should prioritize completion of a multi-year strategic plan to serve as a standalone, guiding document for the organization.

- Shared Health currently operates using a draft strategic plan developed in 2023. Work is underway to update this draft strategic plan ahead of the Fall 2024 submission for the annual planning process. Going forward, it is important for Shared Health to finalize the strategic plan in a timely way to provide concrete guidance on Shared Health's priorities to all levels of the

organization. While a draft strategic plan is beneficial, the nature of a draft document is that its distribution is more limited, and it does not carry the same impact as a tool for prioritization. Further, the draft strategic plan provides limited benefits as an accountability tool as it can be perceived as still subject to change and has less visibility for others to hold the organization to account to its stated priorities.

Question #2

Does the AOP planning framework and related processes enable compliance with the accountability agreements?

Findings

Finding #1

The budgetary components of the Annual Operating Plan process have not necessarily facilitated better compliance or budgeting by Shared Health. The AOP does have a mechanism for the SDO to provide narrative explanation regarding variances, that then become a part of the AOP that the SDO is held accountable to

- The annual planning process provides important budgeting visibility to MHSLTC and serves as a gathering point for funding requests relating to new initiatives and potential cost saving measures. The value in the annual planning process to Shared Health, however, is currently as a communication tool rather than as a tool to enable better planning. The SDOs, including Shared Health, must undertake separate internal budgeting exercises to plan for the upcoming year. Several reasons necessitate the separation of the annual planning process from internal budgeting activities:
    - The Shared Health internal budget categorizes its revenue and expenses using different category labels and groupings than required in the Annual Operating Plan. This is driven by the internal structure and needs of Shared Health while the Annual Operating Plan is organized based on the reporting needs of MHSLTC.
    - Funding guidance provided by MHSLTC during the annual planning process is not binding and actual funding approved by MHSLTC may differ from the guidance provided.
    - The AOP can change both prior to and during the planned fiscal year. These changes can include additional service delivery directives and may also include funding for separate initiatives throughout the year in addition to the annual funding letter.

Recommendations

Based on the finding outlined above, MNP developed one recommendation to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

The Annual Operating Plan should incorporate a scenario-based planning element to enable a better understanding of potential budget changes and greater flexibility to respond to change.

- The budget component of the AOP is currently designed as a static document with budgeting based on the funding guidance provided by MHSLTC. If the approved funding is different from the budgeted funding guidance, the SDO is given an opportunity to update their AOP. Shared Health did not update their AOP last year. Further, the SDO's are expected to advise MHSLTC of the impacts of receiving different funding than originally forecast in the AOP, providing MHSLTC an opportunity to provide additional advice to the SDO.
- A scenario-based approach would continue to identify a primary funding guidance target but also ask SDO's to identify how they would plan to meet a "worst-case" scenario with a lower funding target. This additional scenario should include the specific initiatives and related service delivery impacts that would be required to meet the lower funding level. As a result, MHSLTC would gain greater visibility on any potential service delivery impacts of funding being approved below the primary guidance target, and the SDO's would already have plans in place that can be implemented if additional budget savings are required.

Question #3

Does the SDO use funding received pursuant to the Accountability Agreement to provide the services outlined unless otherwise agreed to by Manitoba in writing and approved by Manitoba?

Findings

Finding #1

Shared Health maintains a funding transfer policy, delegation of authority policy, and position control policy, which together ensure appropriate oversight so that funding is allocated as outlined in the Accountability Agreement unless approved by Shared Health executive.

- The Shared Health Funding Transfer Policy specifies that transferring funds from non-global to global or global to non-global categories is not allowed without specific approval from Shared Health Finance and the affected Program Team, where applicable. This policy aligns with the Accountability Agreement Funding Directives.
- The policies ensure that funding is in place before hiring for positions and ensure that staff operate within their appropriate authorities.
- Policy exceptions must be approved by the executive level.
- All deficit transfer proposals must have a strong operating rationale and be approved by Shared Health Senior Management.

Finding #2

The current financial reporting formats make it challenging to directly link the use of funds to the list of core services outlined in the Accountability Agreement schedules.

- The core services listed in the Accountability Agreement differ from the categories used in the Annual Operating Plan core financial schedules and the reporting categories used in the financial statements. This creates a situation where it is challenging to compare how funds are used between each type of service schedule or reporting tool.

  The Accountability Agreement outlines the following core services to be delivered by Shared Health:

  - Provincial tertiary hospital and referral hub - Health Sciences Centre
  - Pharmacy Services
  - Dentistry and Oral Health
  - Diagnostic Services
  - Emergency Response Service
  - Provide provincial Medical Assistance in Dying (MAID) services
  - Provincial Blood Services
  - Provincial design and implementation oversight for Primary Health and Community Services
  - Provincial Mental Health and Addictions Services
  - Provincial care coordination
  - Provincial Health System Integration and Quality
  - Lead and coordinate provincial patient flow
  - Lead and coordinate French Language Services
  - Lead, coordination, and delivery of Indigenous Services
  - Lead and coordinate Quality, Patient Safety and Infection Prevention and Control
  - Provide Digital Health, Supply Chain, and Human Resource services

  The Annual Operating Plan (AOP), Section 3 (Core Financial Schedules - Volume Pressures) provides an estimate for the following categories which are different from the above core service groupings:

  - Acute Care
  - Long Term Care
  - Home Care
  - Mental Health
  - Community
  - EMS and Land Ambulance
  - Other

The Shared Health financial statements utilize different categories than the AOP categories and the list of core services. These categories also differ from other SDO's such as the WRHA, in part, due to Shared Health's unique shared services mandate. The expense categories on Shared Health's financial statements include:

- Acute care
- Diagnostic services
- Emergency response services
- Digital health
- Medical remuneration
- Mental health services
- Non-insured service expenses

The Shared Health financial statements also break down expenses by the following expense types:

- Salaries and benefits
- Medical supplies
- Equipment expense
- Contracted out services
- Drug supplies
- Laboratory & diagnostic supplies
- Housekeeping supplies
- Laundry and linen supplies
- Rent and utilities
- External consulting
- Buildings & grounds
- Travel
- Bad debt
- Food and dietary supplies
- Facility fee
- Telecommunications
- Courier and postage
- Staff training and development
- Insurance
- Printing, paper, and office supplies
- Legal & audit fees
- Miscellaneous
- Amortization of capital

- Accretion Expense
- Capital infrastructure
- Minor equipment
- Interest on capital debt
- Grant funding
- Grants to agencies
- Insured service expenses Non-insured service expenses
- Compensation
- Supplies
- Utilities and miscellaneous
- Interest on capital debt
- Amortization of capital assets
- Non-insured service expenses

Annual reports prepared by Shared Health provide key statistics regarding the services delivered, including:

- Critical Incidents
- Diagnostic Imaging Exams
- Emergency Response Services
- Hospital Statistics (e.g., number of beds, average occupancy, emergency department visits, etc.)
- Mental Health & Addictions Statistics

Finding #3

The Shared Health funding transfer policy requires updating to fully align with the Accountability Agreement funding directives.

- The Shared Health Funding Transfer Policy specifies that transferring funds from non-global to global or global to non-global programs or items is not allowed without specific approval from Shared Health Finance and the affected Program Team, where applicable. This policy aligns with the Accountability Agreement Funding Directives. However, there are inconsistencies between the list of global-protected programs and non-global items in the Shared Health policy and the list in the Accountability Agreement Funding Directives (See Accountability Agreement, Exhibit A1). Most notably, as shown in Table 3, the Shared Health Funding Transfer Policy does not specifically reference capital costs and capital operating as non-global items.

Table 3: Comparison of Global-Protected Programs and Non-Global Items between Accountability Agreement Funding Directives and Shared Health Funding Transfer Policy

Accountability Agreement Funding Directives	Shared Health Funding Transfer Policy
GLOBAL-PROTECTED PROGRAMS:	
• Laboratory and Imaging Services • Northern Patient Transportation Program • Chemotherapy • Dialysis (Includes Staff Training) • Digital Health (Shared Health) • Bone and Marrow Transplant (CCMB) • Healthy Together Now	• Laboratory and Diagnostic Imaging Services • Defibrillators • Cardiac Services (date to be specified) • Finance (Acute Care only) • Human Resources (Acute Care only) • e-Health Services (Acute Care only)
NON-GLOBAL ITEMS:	
• Medical Remuneration/Medical Sessional Payments/PARIM • Capital Costs • Capital Operating, ICT, Operating and Medical Operating • Public Health Initiatives • SDO Billings for Ambulance Responses Related to Childbirth Events • Provincial Oncology Drug Program (CCMB)	• Orthopaedic Funding • Interest on Long Term Debt • Medical Remuneration • Dialysis (MB Renal Program) • Authorized/Residential Charge Income • Chronic Care Income

Recommendations

Based on the findings outlined above, MNP developed two recommendations to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

Shared Health should consider preparing an annual reconciliation or statement, reporting the budgeted and actual revenue and expense amounts using statement categories which are aligned with the AOP.

- Annual financial statements currently categorize revenue and expenses in different categories than those used in the AOP. This makes it challenging to easily compare past performance in each AOP category against the budget.
- An annual reconciliation or statement presenting Shared Health's revenue and expenses using the same categories as the AOP would enable better evaluation of Shared Health performance against the AOP.

Recommendation #2

Shared Health should review its Funding Transfer Policy and update the policy to ensure full alignment with the Accountability Agreement Funding Directives.

- Shared Health's funding transfer policy currently includes different lists of global-protected programs and non-global items than listed in the Accountability Agreement Funding Directives.
- The Funding Transfer Policy functions as a key tool to ensure Shared Health alignment with the Funding Directives.
- Shared Health should review and update its Funding Transfer Policy to ensure that all current global-protected programs and non-global items align with the Funding Directives to ensure that the Funding Transfer Policy fully prevents any unauthorized transfers of funds.

Question #4

Is there a clear link between expected service need and demand and the budgeting process?

Findings

Finding #1

The SDO has not used the annual operating plan process to link ongoing service needs and demands to changes in the operating budget.

- The annual operating plan is developed using the prior year's budget as a starting point and assumes the status quo service delivery as a baseline starting point before incorporating proposals for new service delivery and cost savings. New initiatives and cost saving measures contain strong analyses of their merits, the related needs, and their benefits. In contrast, ongoing service delivery does not receive the same level of analysis both to ensure that resources are still deployed in the best way possible, and to ensure that adequate resources are still in place to meet changing levels of demand since a program was initiated. Thus, the needs relating to increased demand for services are often not recognized at a budgeting level until additional resources are proposed as a new initiative or itemized funding request.

Finding #2

Shared Health's Annual Report contains limited information to analyze whether it has achieved the minimum service levels established in the Accountability Agreement.

- Schedule A to AA of the Accountability Agreement states that within the funding provided in Schedule B, Shared Health is expected to meet certain minimum performance levels for services. These are baseline expectations, and Shared Health has the discretion to allocate additional resources within its global budget to increase service volumes throughout the year. Service levels are not capped by Manitoba, and no service delivery site should consider these as maximum levels set by the province.

- Shared Health's Annual Report for 2022/23 indicates that it exceeded the minimum service levels for bone density, CT, and ultrasound, but did not meet the required volume for MRI. Information for other services was not provided in the report.

Table 4: Comparison of Minimum and Actual Service Levels for 2022/23

Service	Minimum Service Levels as per AA	Actual Service Levels as per Annual Report 2022/23	Outcome
Bone density	8,802	9,755	Met +953
Cardiac Catheterization (Pediatric Cases)	25	No information	No information
CT	230,074	270,512	Met +40,438
Echocardiography	33,000	No information	No information
Hip and Knee (elective)	60	No information	No information
MRI	101,664	91,497	Not met (10,167)
Myocardial Perfusion	4,860	No information	No information
Pain Management Clinic	13,784	No information	No information
Pediatric Dental Surgery	1,645	No information	No information
Sleep Studies	145	No information	No information
Ultrasound	205,603	214,316	Met +8,713

Finding #3

The Annual Operating Plan framework provides flexibility for managing volume pressures in various healthcare categories; however, Shared Health has not used it to integrate analytical data to accurately reflect and address the actual demand and needs for all service lines.

- The AOP Master Template provides flexibility to accommodate volume pressures for Health Care Sectors, including:
    - Acute Care
    - Long Term Care
    - Home Care
    - Mental Health
    - Community

- Emergency Services and Land Ambulance
- Other

It addresses current volume but excludes emerging volume trends, unique program enhancements, and annualization of previously approved projects.

However, these volume pressures are not clearly linked to the actual demand for all service lines and appear to represent only a portion of the true demand and requirements. Analytical data on actual needs and demands for service lines, including the percentage of programs meeting or failing to meet this demand, have historically not been incorporated into the AOP framework by the SDO

Recommendations

Based on the findings outlined above, MNP developed three recommendations to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

MHSLTC should consider adopting a zero-based budgeting approach for all SDO's to justify expenses annually.

- The historical budgeting approach which assumes the prior year's budget as a starting point has not inherently led to SDO's evaluating their expenditures in a dynamic fashion that would allow them to adjust and reallocate funds, within the guidelines articulated by MHSLTC.
- Zero-based budgeting will better reflect service delivery demands in the budgeting process as service delivery demands will support budget allocations.
- Zero-based budgeting will ensure better alignment with strategic planning as status quo programs will be monitored for continuing alignment with organizational objectives.

Recommendation #2

Implement a mid-year and year-end report with a comparison between minimum and actual service levels.

- The Accountability Agreement currently lacks clear reporting requirements comparing actual results against minimum service levels.
- Implementing a mid-year and year-end report comparing minimum and actual service levels will help to identify areas for improvement and ongoing monitoring.

Recommendation #3

Incorporate demand projections in the budgeting process to ensure an appropriate level of resourcing and to respond proactively to developing needs.

- The current annual planning process is isolated from the projected level of demand and can result in Shared Health being one or two years behind demand trends since the budgeting process is largely based on past costs and demand. To mitigate this risk, it is recommended that

the planning process include a submission from Shared Health outlining historical and projected demand for key services. This submission should also include an analysis of key demographic drivers (population count, age, etc.) and their expected impact on service demand in the coming years.

It is recommended that the demand analysis correspond with the key service delivery areas in the Annual Operating Plan to enable a better understanding of demand pressures when evaluating budgeted expenses in each category.

Question #5

Does the budgeting process fully capture the trade-offs inherent in having limited funds available?

Findings

Finding #1

The budgeting process fails to fully capture the impact of the service delivery trade-offs associated with cost savings including impacts on Shared Health's strategic goals and key performance indicators.

- The current annual budgeting process partially reflects the trade-offs inherent in limited funding by allowing for narrative explanation of the trade-offs in the AOP submission. While it enables Shared Health to prioritize spending, it fails to fully capture the true impact of these trade-offs on achieving the strategic goals and objectives of both Shared Health and MHSLTC, as well as how they will affect Shared Health's key performance indicators.
- Under the historical budgeting process, the SDO's assumption of status quo as the starting point for budget development appears to have led to an avoidance of analysis of service delivery and cost trade-offs for existing programs and services unless a specific proposal has been put forward for cost savings that impacts service delivery. This approach can potentially allow services with escalating costs or declining utility or value to continue without the SDO having weighed the trade-offs between cost and service delivery benefits.
- The current planning process requires Shared Health to submit a balanced budget using the status quo current-year budget amounts combined with guidance on an overall percentage increase as the base scenario.

  Key elements of the planning process include:[2]

  a. SDO must present balanced budget scenarios.

[2] AOP Guidelines for 2023/2024, Schedule 6: Strategies to Balance

b. SDO is required to recommend strategies or proposals to achieve the projected balance, including new expenditure reduction and cost-saving ideas not previously implemented.
c. Strategies must be listed in order of priority, highlighting the necessity of making tough decisions about which initiatives to fund first based on their impact and alignment with organizational goals.
d. Ensures that limited funds are directed towards the correct mix of health services, aligning with the preferences of those funding the services (i.e., doing the right things).
e. Focuses on securing the minimum cost for the maximum quality in delivering agreed outputs, assessing operational performance, and minimizing resource wastage (i.e., doing things right).

Recommendations

No new recommendations are noted in connection with Question #5 as the recommendations associated with Questions #2 and #4 are sufficient to address the findings in connection with Question #5.

Question #6

Do current budget processes support service delivery innovation and improvement?

Findings

The AOP template was viewed as an important part of the SDOs budget process, and accordingly, two findings are provided below related to how the AOP supports service delivery, innovation, and improvement.

Finding #1

The AOP framework provides room for service delivery innovation and improvement initiatives in capital projects.

- The AOP framework consolidates health authority infrastructure requests into a master list which is ranked by priority. A provincial prioritization is than completed and forwarded to Treasury Board for review and potential approvals. If approved, the selected projects are incorporated into the Provincial Health Capital Plan. The Provincial Health Capital Plan is made up of the following components:
    - Safety and Security Projects
    - Major Capital Projects
    - Medical Equipment (specialized capital)
    - Health System ICT

- The capital prioritization process allows for the most important and urgent projects to be prioritized and receive funding first, which in turn supports service delivery improvement. While innovation is not specifically prioritized, innovation which leads to cost savings or better service delivery will likely be recognized as a higher priority through the current process.

Finding #2

The AOP supports service delivery innovation in operating programs if the proposed innovation is cost-neutral or results in cost savings within the year the innovation is implemented.

The 2023/24 Annual Operational Plan Guidelines 2023/24 introduced a new section for New Program Initiatives. This section supports new initiatives that have measurable cost savings that could offset the associated expenses and allow for reallocation of current funds. Health authorities had the option of submitting a prioritized list of proposed new program initiatives.

A new initiative was defined as:

- A new service, program, or expansion of an existing program to an additional catchment area
- An additional service to an existing program
- Implementing a new program or service that currently does not exist

There was no budget allocated for new initiatives in 2023/24; it was explained that any proposed initiative would need to have measurable cost savings that could offset the expenses and allow for reallocation of current funds before it could be considered.

Shared Health included 37 new program initiatives in its 2023/24 AOP submission. It provided detailed descriptions for each and links to relevant planning documents including the MHSLTC Strategic Plan, Manitoba's Clinical and Preventative Services Plan (MCPSP), and the Provincial Health Capital Plan.

Recommendations

No recommendations are noted in connections with Question #6.

Question #7

Does the SDO have access to clear, accurate, timely and relevant information to enable the development of accurate budgets?

Findings

Finding #1

Shared Health receives adequate information for development of the Annual Operating Plan (AOP) but key elements remain open to change which can impact the accuracy of the AOP.

- MHSLTC provides guidance on a projected annual increase to global funding to guide budget development. This guidance provides the basis for planning but is also subject to change.

- Capital projects are prioritized but must be assessed and approved prior to authorization. The capital planning process provides sufficient information and SDO's anticipate that projects will be assessed, and only selected projects approved.
- AOP development guidelines are available in advance and provide sufficient detail on planning expectations.

Recommendations

No new recommendations are made in connection with Question #7. The recommendation connected to Question #2 to incorporate a scenario-planning element into the budgeting process will mitigate some of the uncertainty connected to the current budgeting process.

Question #8

Are the budgeting and planning processes and timelines of the SDO effectively integrated with MHSLTC processes and timelines?

Findings

Finding #1

Shared Health's budgeting processes and timelines are compatible and integrate with the AOP.

- Shared Health begins its annual budgeting process at least a year in advance and undertakes several iterations of budget planning. Its internal budgeting processes are compatible with the AOP requirements and Shared Health can meet the AOP timelines and requirements.
- The integration of budgeting processes does require effort, however, as the AOP requires a manual approach to budgeting inputs with an Excel workbook format. Additionally, the AOP requires different budget categories than Shared Health uses for its internal budgeting which requires budget subcategories to be rolled up into different line items for the AOP than internal budgets.

Finding #2

The AOP process has a generally defined cadence but does not have an annual schedule of milestones and due dates for submissions, because of its dependency on government timelines.

- The annual financial planning cycle for the Shared Health fiscal year begins in March and includes the following elements as laid out by Shared Health:
    - Strategic and Operating Plans
        - March: Call letter
        - April: Executive review
        - May: Board approval
        - June: Submit

- Summary Budget Submission
    - July: Call letter
    - August: Identify spending reductions; Executive review
    - September: Board approval and submission
- Shared Health Annual Planning
    - October: Set priorities and performance targets
    - November to February: Communicate priorities, risk assessments, site/sectors submit plans
    - March: Executive review
- Shared Health Budget Plan
    - November: Site/sectors provide initial forecasts
    - December: Sustainability targets and initiatives applied
    - January and February: Corporate finance develops budget using SBS, site forecasts
    - March: Executive review
    - April: Board approval

- While the above activities have a similar cadence each year, there is not a consolidated document that lays out the specific due dates for each step in the process on an annual basis. Rather, Shared Health is notified of individual due dates several weeks or months in advance while maintaining the past cadence of other years. MNP, notes that detailing specific due dates will be challenging given the reality that Treasury Board and government decision-making timelines are as one would expect, a fluid process.
- A lack of clear due dates at an annual calendar level can make it more challenging than otherwise necessary to align certain activities that need to occur in sequence. For example, budget submissions require discussion and approval at a committee level, before receiving approval by the board and the dates of these meetings need to be aligned before submission due dates.
- Shared Health finance and budgeting staff have seen significant turnover in recent years, leading to less familiarity among staff as to the typical timelines and cadence. As a result, there is a need for more prescriptive timelines to clearly communicate when items are due far in advance.

Finding #3

Confirmation of funding allocations is typically received at the start of the fiscal year or after the fiscal year has already begun which can lead to a need for sudden budget adjustments if allocations differ from prior guidance.

- Funding letters with approval of the funding allocations typically arrive at the start of the fiscal year or after the fiscal year has already started.

- If the approved funding is significantly different than the budget guidance provided during the AOP development process, SDOs will need to make sudden budget adjustments to immediately align their budget plans with the confirmed funding.

Finding #4

Shared Health is unable to change course and adapt quickly when funding allocations differ significantly from budget guidance.

- If actual budget allocations are approved at levels below the budget guidance given, Shared Health currently requires time to change course, or it will inherently run a deficit during the adjustment period. Given the current processes, budget adjustments require time for several activities including:
    - To identify and submit cost-saving proposals to meet the approved budget
    - For MHSLTC to review and respond to cost-saving proposals
    - For resubmission or submission of additional cost-saving proposals if the submitted cost-saving proposals are not approved as submitted
    - For implementation of the approved proposals for cost savings to take effect

Recommendations

As outlined under the Budgeting, Question #2 recommendations, scenario-based planning will have a key role in enabling the identification of cost-saving initiatives in advance and shortening the response time to unanticipated budget changes. Three additional recommendations are outlined in the sections below.

Recommendation #1

Shared Health should be mandated to propose a list of cost-saving measures equal to three-times the reported deficit within 90 days when a deficit is reported on Shared Health's quarterly reporting.

- A deficit is an indication that Shared Health has been unable adapt quickly enough to the current service demand and funding available. Quick action is required following the identification of a deficit to mitigate the accrual of further deficits throughout the year.
- Shared Health should be mandated to propose three-times the required value of cost-saving measures so that MHSLTC can review and approve the measures with impacts that are most in line with provincial priorities.

Recommendation #2

Shared Health should be required to carry a pre-determined contingency in its annual budgeting to prepare for unexpected costs.

- In any given year, there will most likely be unexpected expenses which need to be accommodated by Shared Health. Examples include:

- Unexpected demand for specific services
- Department directives to undertake new services
- Unanticipated supplier cost increases

- A budget contingency prepares Shared Health to respond to a certain level of unexpected costs without entering a deficit and provides funds to cover expenses during adjustment periods if sudden changes in funding expectations or service demand occur.
- A budget contingency could be self-directed by Shared Health or mandated at a specific level by MHSLTC.

Recommendation #3

MHSLTC and Shared Health should maintain regular informal communication throughout AOP development cycle, with MHSLTC providing advance communication, where possible, as to potential changes to funding guidance.

- While MHSLTC may not be able to provide formal approval of funding prior to the start of the fiscal year, informal indications as to whether there is a likelihood of approved funding aligning with the funding guidance would be beneficial and allow for additional advance planning by Shared Health.

Question #9

Are the SDO service delivery needs and financial trade-offs clearly communicated and visible to decision-makers?

Findings

Finding #1

Shared Health clearly communicates the service delivery trade-offs associated with identified cost-saving measures in the AOP.

- The 2022/23 AOP (Schedule 6: Strategies to Balance) lists the strategies to balance in order of priority and provides a description of each. Further details can be found in the SH 2022/23 Strategic and Operating Plan submission paper, which includes an Impact Statement. The 2022/23 template includes details such as:
  - Expense Category
  - Projected Savings for five years ahead
  - Description and rationale for requested increase / proposed decrease
  - Assumptions/calculations used to determine change
  - Impact on service delivery and clients
  - Alternatives within proposal
  - Other financial impacts, including future years

- Implementation strategy
- Workforce impact

- Shared Health provided a thorough response in its AOP submission, enabling an understanding of how savings will be achieved and the related impacts.
- Shared Health also highlighted the need for collaborative discussions about the proposed trade-offs to ensure all parties understand the true outcomes and impacts on SDO performance and the achievement of MHSLTC and Shared Health strategic goals and priorities.

Recommendations

Based on the finding outlined above, MNP developed one recommendation to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

Establish regular, structured discussions between Shared Health and MHSLTC to review quarterly forecasts, and if a deficit is forecast, to present deficit mitigation strategies to MHSLTC and agree on next steps for addressing that deficit.

- While there are indications that some meetings focused on reviewing forecasts are taking place, further steps should be taken to institute a regular cadence for these meetings following quarterly reports.
- The outcomes of these meetings should be documented by the SDO with action items reflected in the monthly forecast reports to provide a clearer understanding of the decision-making process and mutual agreements, and to enable monitoring of outcomes against these agreements in future reporting.
- At a minimum, the action steps being taken to address any projected deficits should be documented with reporting against these action items included in subsequent monthly reports.

Question #10

Are changes in service delivery and budget expectations effectively communicated and supported between budget cycles?

Findings

Finding #1

The AOP is considered a high-level planning document that needs to be updated dynamically to reflect the changing environment. There is a procedure in place to communicate and address such changes, however it does not guarantee timely and adequate funding.

- The AOP is acknowledged as a high-level plan and summary of activities that will guide the organization. It represents the organization's plan at a specific point in time but is also

recognized as a dynamic, living document that will evolve with the changing environment (AOP Guidelines 2022-23, Introduction).

- To address changes to the budget, the following mechanism is in place:
    - The historical practice has been that during the year, when a need for additional funding is identified for new programs, expansion of programs, or unexpected cost increases, a briefing note and related detailed costing schedules are prepared by the affected sites/programs and provided to Shared Health Executive for review and approval. The costing schedule includes detailed information on staffing requirements, supplies needed, medical remuneration (if applicable) and capital equipment needs and is reviewed by Corporate Finance prior to consideration by Shared Health Executive. If approved internally, the briefing note is then sent to MHSLTC and/or HAH.
    - If MHSLTC and/or HAH approve the additional funding requests, and a funding letter is issued, Shared Health will issue a funding letter to the related site or program, authorizing the program to hire staff or to start the program expansion. Funding requests are approved at the discretion of the department and are typically reserved for select unexpected cost increases and not new programs or expansions.

Finding #2

Monthly forecast reports adequately inform MHSLTC on performance to date and on projected year-end variances, but more proactive communication is needed from Shared Health to MHSLTC around forecasts and related assumptions, as well as proactive planning and communication of change impacts.

- Shared Health submits monthly and quarterly forecast reports based on updated financial and statistical data from the current year's operations. Each quarterly report is accompanied by a forecast submission letter explaining the changes impacting the budget and planning assumptions.
- Forecasts capture current assumptions, but projected deficits may continue to grow in subsequent forecast periods if further changes occur.
- There is a need for Shared Health to develop more open and proactive communication with MHSLTC regarding forecasts, assumptions, funding impacts, and expected deliverables, and to take a more proactive approach to the planning and communication of change impacts.

Recommendations

No new recommendations are made in connection with Question #10.

Question #11

Are the current SDO finance tools and staffing adequate to fully meet the budgeting needs and financial reporting obligations of the organization?

Findings

Finding #1

Shared Health lacks appropriate budgeting and forecasting software leading to resource-intensive, manual budgeting processes and a lack of standardization.

- Shared Health uses SAP software for all internal budgeting and financial management activities but lacks a dedicated budgeting and forecasting module.
- Budgeting, forecasting, and reporting processes are highly manual and resource intensive.
- Separate reports are currently being created for different purposes (board information requests, AOP submissions, monthly forecasts, etc.).
- AOP, budget, and forecast schedules are prepared separately using Excel workbooks and templates provided by MHSLTC.
- Manual data entry increases risk of errors and creates significant re-work if adjustments are needed to reflect changes or perform a scenario analysis.
- Manual processes reduce time that can be devoted to investigative analysis to support operational decision-making, scenario analysis, and identifying efficiencies.

Finding #2

The use of different accounting software and manual processes between SDO's leads to inconsistencies and less comparability between SDO's reporting.

- Different methods of reporting and recording financial information across SDOs creates comparison challenges
- Reporting to MHSLTC is less standardized as a result, as SDOs undertake different manual processes to compile information from financial systems into MHSLTC reporting templates in an Excel workbook format.

Finding #3

Evidence suggests that Shared Health has sufficient staffing for current budget processes.

The Finance and Accounting department is one of five major streams reporting to the CFO, and is divided into two main branches, Financial Reporting and Financial Planning. The Financial Planning Branch is the smaller of the two branches with 30 staff as compared to 109 Financial Reporting staff and is responsible for conducting forecasting and budgeting activities across Shared Health. The branch includes a director, four managers, and 25 other staff members organized as shown below:

- Financial Planning Director
- Manager of Financial Planning (+ 3 employees)
- Manager of Medical Remuneration (+ 7 employees)
- Manager of Financial Planning Provincial (+ 2 employees)
- Manager of Budgets & Funding (+ 13 employees)

- Current budget development and consolidation processes require sufficient staffing given the number of sites and programs, and complexity of Shared Health.
- Staffing numbers are structured around the current budgeting model. A move to another budgeting system such as zero-based budgeting will increase the workload on Shared Health's staff involved in the budgeting processes. This could be counteracted, at least in part, by an adoption of a software with a finance and budgeting module which would reduce some currently manual and labor-intensive processes.

Finding #4

Shared Health's average corporate services expense is not comparable to other SDOs and other jurisdictions nationally.

- The Canadian Institute for Health Information (CIHR) tracks and defines the Corporate Services Expense Ratio (CSER). According to the CIHR, the CSER "measures the percentage of the legal entity's total expenses that were spent in administrative departments such as finance and human resources. A high percentage indicates that administrative costs are a large portion of total expenses; a low percentage indicates that administrative costs are a small portion of total expenses.[3]"
- Shared Health carries a unique role relative to other SDOs as it provides coordinated administrative and support services (health human resources, supply chain management, capital planning, etc.)[4] to Manitoba's other SDOs. A direct comparison of administrative costs with other SDOs is not reflective of the differences in responsibilities and the provincial 5-year average expense ratios (Table 6) should also be considered. In addition, Shared Health's total administration costs included a one-time capital gain in 2022/23.

[3] Canadian Institute for Health Information, https://www.cihi.ca/en/indicators/corporate-services-expense-ratio-cser

[4] Shared Health Inc., https://sharedhealthmb.ca/services/

Table 5: 2022/23 Provincial Health System Administrative Costs and Percentages (WRHA Annual Report 2022/23, p. 52)

Region	Corporate	Patient Care Related	Human Resources & Recruitment	Total Administration	Above / Below Provincial Average
CancerCare Manitoba	2.05%	0.61%	0.60%	3.26%	Below Average
Prairie Mountain Health	2.71%	0.37%	0.77%	3.85%	Below Average
Winnipeg Regional Health Authority	2.60%	0.50%	0.80%	3.90%	Below Average
Southern Health Santè- Sud	2.96%	0.26%	1.16%	4.38%	Below Average
Northern Regional Health Authority	3.51%	0.99%	1.20%	5.70%	Above Average
Interlake-Eastern Regional Health Authority	3.12%	0.77%	1.83%	5.72%	Above Average
Shared Health	5.41%	1.15%	1.78%	8.34%	Above Average
Provincial – Percent	3.37%	0.67%	1.12%	5.16%	

- Using a 5-year average, Manitoba's CSER ranks 8th of 12 reported provinces and territories (Nunavut excluded). In the most recent year available (2021-22), Manitoba's CSER matches the national average.

Table 6: Corporate Services Expenses Ratio Ranked by 5-Year Average (2017-2021)[5]

	Rank	2017-18	2018-19	2019-20	2020-21	2021-22	5-Year Average
Alberta	1	3.3%	3.5%	3.0%	2.9%	2.7%	3.1%
New Brunswick	2	3.3%	3.3%	3.2%	3.1%	3.4%	3.3%
British Columbia	3	3.5%	3.7%	3.4%	3.3%	3.3%	3.4%
Prince Edward Island	4	3.4%	3.4%	3.6%	3.9%	3.8%	3.6%
Newfoundland and Labrador	5	3.8%	4.1%	3.7%	3.5%	3.5%	3.7%
Quebec	6	4.6%	4.5%	4.3%	4.2%	4.0%	4.3%

[5] Canadian Institute for Health Information, https://www.cihi.ca/en/indicators/corporate-services-expense-ratio-cser

Canada	n/a	4.5%	4.4%	4.3%	4.4%	4.3%	4.4%
Nova Scotia	7	4.6%	4.7%	4.3%	4.4%	4.3%	4.5%
Manitoba	8	4.6%	4.7%	4.5%	4.5%	4.3%	4.5%
Saskatchewan	9	4.5%	4.7%	5.0%	5.1%	4.9%	4.8%
Ontario	10	6.1%	6.0%	5.9%	6.5%	5.9%	6.1%
Northwest Territories	11	5.9%	6.7%	7.0%	7.5%	7.3%	6.9%
Yukon	12	9.0%	9.1%	9.3%	8.1%	8.5%	8.8%

Recommendations

Based on the findings outlined above, MNP developed one recommendation to strengthen the SDO's budgeting process and outcomes.

Recommendation #1

MHSLTC should direct the immediate procurement of a single budgeting and forecasting software across all SDOs, and expedite implementation to improve the speed, accuracy, and reliability of reporting, and significantly reduce manual effort.

- It is understood that MHSLTC is in the process of implementing a S/4Hana software solution which could provide the required standardization of budgeting and forecasting. However, it is also noted that the installation of this software is likely a multi-year process so appropriate interim measures such as adding a budgeting module should also be considered. Note, it will be important that any interim measures taken do not result in excessive costs or barriers to the implementation of the S/4Hana software.
- The use of a single system across all SDOs will increase transparency, enable standardized reporting to MHSLTC, and facilitate better comparison across SDOs.
- SDOs will receive better access to financial information to enable management decisions.
- Integrated budgeting and forecasting tools will reduce manual processes, enable greater scenario analysis, and provide increased time available for finance staff to focus on analysis.

Fiscal Management Findings and Recommendations

The following sections provide fiscal management findings and recommendations based on the questions listed in the review matrix. Each question from the review matrix is listed first, followed by the corresponding findings and recommendations. The questions evaluate whether Shared Health is managing its finances as budgeted and planned, and whether appropriate processes are in place for communication of variances and delegation of authority.

Question #1

Is the SDO compliant with its AOP?

Findings

Finding #1

Shared Health is regularly operating in a deficit as defined by the Annual Operating Plan budget, and as a result, is not in compliance with the Accountability Agreement.

- The Accountability Agreement requires prudent financial management of resources (Section 5.A.) and that Shared Health operate within the annual budget allocated to it by MHSLTC and HAH (Section 5.F.).
- Operating deficits occur early in the fiscal year, with a forecasted deficit projected for year-end being identified within the first quarter.

Table 7: Operating deficit forecasted for year-end based on quarterly results

Fiscal Year	Q1 (June actuals)	Q2 (Sept. Actuals)	Q3 (Dec. actuals)
2019-20	$9.3	$16.2	$4.0
2020-21	$52.6	$32.6	*
2021-22	$16.6	$22.7	$11.7
2022-23	$21.5	$27.5	$27.5
2023-24	*	$55.0	$112.9

* Data not available

- Quarterly deficits for capital costs also tend to occur early in the fiscal year, but generally don't see as large a variance as the operating costs.

Table 8: Capital deficit forecasted for year-end based on quarterly results

Fiscal Year	Q1 (June actuals)	Q2 (Sept. Actuals)	Q3 (Dec. actuals)
2019-20	$0	$0	$4.6
2020-21	$2.6	$2.2	*
2021-22	$2.7	$2.0	$4.5
2022-23	$0.8	$29.5	$29.6
2023-24	*	$56.4	$57.2

Finding #2

A combination of deficits early in the fiscal year, and the timing of cashflow payments contributes to a reliance on a line of credit for operating needs.

- Shared Health continues to receive funding twice monthly based the previous year's core funding levels until several months into the new fiscal year. Discussions indicate that in past years it has taken until September or October for core funding to be increased to the new year's approved funding level and for the difference between the previous and current year's core funding over those months to be paid as a lump sum.
- To account for the delay in providing the approved increase to Shared Health, MHSLTC has typically provided three monthly payments in April instead of the standard two monthly payments so that Shared Health has additional operating funds until the catch-up payment and increased monthly payments. This equates to approximately 4% of the previous year's budget that is front-loaded in the new year to account for six or seven months of operating without any funding increases.
- If Shared Health is expected to roll out new programs or initiatives, or budget for a significant funding increase in the new year, this cashflow structure can constrain Shared Health and necessitate Shared Health using a line of credit to manage cashflow timing differences.
- The presence of deficits starting in the first quarter of recent fiscal years has also contributed to cashflow pressures in the first half of the fiscal year. Further, cost-saving measures have typically taken months to compile, approve, and implement in the past which has resulted in deficit cash outflows continuing before the effects of the cost-saving measures are fully realized.
- The reliance on a line of credit has led to interest charges that could potentially be avoided with a different timing of payments and a quicker response to implement cost-saving measures once deficits are identified.

Finding #3

Shared health has not provided adequate visibility to MHSLTC on their projected cash position as part of its standard reporting requirements.

- The Annual Operational Plan and quarterly reporting templates do not include a requirement to provide a cash position forecast.
- Cashflow management discussions currently take place in a reactive way as SDOs communicate separately through meetings and letters to MHSLTC when they anticipate cashflow challenges.
- MHSLTC does not have adequate information to proactively anticipate SDO cashflow constraints using the current reporting.

Recommendations

Based on the findings outlined above, MNP developed two recommendations to strengthen the SDO's fiscal management practices.

Recommendation #1

MHSLTC should require all SDOs to provide quarterly cash position statements and include cash position planning in the Annual Operational Plans.

- SDOs should be asked to identify in their AOP submissions whether the number of new programs or the annual funding increase planned for the year will result in cashflow shortfalls in the first half of the fiscal year given the standard timing of payments.
- The inclusion of a quarterly cash position statement would provide MHSLTC with visibility on anticipated cashflow shortfalls and enable proactive conversations to identify the shortfall drivers.

Recommendation #2

If cash position shortfalls are projected in the Annual Operating Plan, MHSLTC should consider adjusting the timing of payments to Shared Health, providing more front-loaded cashflow to offset the effects of delays in implementing the approved increase to annual funding.

- If a cash position shortfall is projected in the AOP due to the size of the annual funding increase or the number of new initiatives which are being funded, MHSLTC should consider increasing the amount of the additional April payment to cover the projected shortfall.
- Other recommendations in this report are expected to mitigate the potential cashflow or position impacts related to deficits in future years.

Question #2

Are the financial impacts of unexpected changes in demand identified in a timely way and incorporated into ongoing planning and operations?

Findings

Finding #1

Unexpected changes in demand are incorporated into financial forecasts once the related costs become apparent but are managed on a reactive basis.

- SDOs can identify unexpected changes in demand but it takes time to quantify the financial impacts.
- Monthly forecasts reflect the impact of unexpected demand increases once the related costs flow or are known.
- In the past, large, unexpected increases in demand have led to additional funding requests from MHSLTC with no guarantee of whether the request will be approved.
- Shared Health has maintained a policy of not reducing service levels or turning anyone away due to increase demand for services, leading to an acceptance of higher costs as a result.
- The acceptance of increased service demands, and the related costs, has not resulted in significant efforts to offset these costs or to identify corresponding savings that can be implemented in other areas.

Finding #2

The budget articulated in the Annual Operating Plan is static and is not updated to reflect any changing needs or demand, per central government directives

- While the budget amounts contained in the AOP are static, SDO's have been provided opportunity to modify the narrative explanations for the 2024/2025 fiscal year.

Recommendations

MNP has not developed any new recommendations based on the findings above. Previous recommendations will enable SDOs to better respond to unexpected changes in demand including the practice of carrying a budget contingency, budget scenario planning, and the rapid identification and implementation of cost saving measures when a budget deficit is first identified.

Question #3

Are budget shortfalls and variances identified and communicated to MHSLTC and MHCW in a timely way?

Findings

Finding #1

Financial reporting and forecasting are supplied on a regular basis, and identifies variances compared to the budget defined in the AOP.

- MNP found monthly and quarterly reports accurately identify when variances occur throughout the fiscal year. These reports are being submitted on a timely basis, ensuring any variances are being communicated. The reports highlight the drivers of a variance, including information such as unexpected or unbudgeted for changes in specific service demand.
- MNP found budgets are maintained on a regular basis and continually incorporate changes that occur throughout the year. A variety of budget forecasting tools are utilized to identify where the changes in demand occur. Budgets are updated to include the new forecasts through to the end of the year.
- MNP found - at times - new programs are added by government or the SDO themselves that are not fully funded and the SDO must find a way to cover the additional costs. This is not always possible and can lead to an increase in the budget deficit.
- When necessary, mitigation strategies and initiatives are developed to offset the financial challenges due to demand changes.

Recommendations

No recommendations were noted in connection with the above finding as communication of budget variances is sufficient and timely. Other recommendations in this report address the causes of budget deficits and propose solutions for prevention and mitigation.

Question #4

Does the SDO have an effective process for the delegation of authority?

Findings

Finding #1

A clearly defined Delegation of Authority policy is in place which provides an effective process for purchasing approvals.

- Shared Health's "Agreement Execution and Authorization of Expenditures" policy includes a Delegation of Authority policy that provides clear definitions of maximum dollar amounts for specific definitions and calculation examples for a clear understanding. The policy clearly indicates who can sign for each of the spending levels and provides detail on when exceptions can be made.

  The signing authority limits include levels one through seven, and includes detailed requirements on who has the authority to approve at that level:

  Table 9: Shared Health Signing Authority Limits

Level	Allowable Amount
Level 1	> $5,000,000
Level 2	< $5,000,000
Level 3	< $2,000,000
Level 4	< $1,000,000
Level 5	< $250,000
Level 6	< $100,000
Level 7	< $10,000

  Information is also provided for temporary delegation of signing authority when the required party isn't available to sign.

  Dollar limits and commitment limits for the following specific roles our outlined:

  - Shared Health Chair of Boards of Directors
    - The Shared Health CEO
    - The Shared Health CFO
    - The Shared Health CMO
    - The Shared Health CHRO
    - The Shared Health COO
    - HWL (i.e., provincial lead, health workforce of shared health)

The policy also speaks to non-financial commitments, such as NDA's, data-sharing, and more. The requirements and expectations of those who have authority to sign are outlined as are the consequences of not adhering to the policy.

Finding #2

Current procurement processes provide safeguards to ensure appropriate approvals are granted.

- MNP found safeguards in place to help ensure the Delegation of Authority policies are followed. The spending control process is managed withing Shared Health's SAP finance software, which reduces the chances for human error and interference. Feedback indicates this process works well.

  It is understood that multi-year contracts cannot be broken up into smaller amounts to make them fall under the $5 million threshold. Difficulties can arise when contracts do not have a specific dollar value assigned to them. When staff are unsure, they typically reach out to the CEO for clarification.

Recommendations

No recommendations are noted in connection with the above findings.

Implementation Plan

MNP has developed a high-level implementation plan articulating the advised timelines for implementing each of the recommendations. MNP notes, given the urgency of addressing the financial challenges being faced by the SDO, we are advising that all recommendations be fully implemented by the end of fiscal 2026.

	Recommendation	2024/25				2025/26											
		D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
	Governance																
1	A desired skills matrix should be developed and used to evaluate existing board members.	■	■	■	■												
2	Open board positions should be posted publicly.	■	■	■	■												
3	Compensation for Shared Health board members should be reviewed and increased.	■	■	■	■												
4	The SDO should introduce staggered board terms.	■	■	■	■												
5	Formal board governance education should be reinstated and required of all board members.					■	■	■	■								
6	The SDO and MHSLTC should mutually explore opportunities to reduce the time that elapses between AOP draft delivery and approval, and the process for development of, and making changes to the AOP.	■	■	■	■	■	■	■	■								

	Recommendation	2024/25 D	J	F	M	2025/26 A	M	J	J	A	S	O	N	D	J	F	M
	Governance																
7	The SDO should consider adopting zero-based budgeting and scenario planning approaches in their multi-year budgeting process that allow for increased granularity, more fulsome planning, and increased flexibility.																
8	The Accountability Agreement should clearly define the roles and responsibilities of Government and the Board in the oversight of Shared Health.																
9	The impact of mid-year service delivery standard changes should be tracked if they result in an additional unfunded financial obligation to better enable analysis of SDO's ability to manage to budget.																
10	A policy should be implemented by the SDO, so that additional mid-year service requirements are not implemented unless they can be funded through internal reallocation.																
11	A comprehensive analysis should be completed to understand why staffing positions are not being filled.																
12	Shared Health and MHSLTC should jointly explore alternate cash transfer timing options to mitigate the risks associated with the current transfer timing.																
13	Risk register should include the status of actions to be taken for further mitigation and the person/department responsible for these actions.																

	Recommendation	2024/2025				2025/2026											
		D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
	Governance																
14	A standardized enterprise risk register format should be used to report to the board.																
15	Shared Health should involve the MHSLTC directly in its risk and mitigation identification process to ensure mitigating factors are realistic given government mandates.																
16	The existing risk register should be further developed and include the status of the implementation of mitigation strategies.																

	Recommendation	2024/2025 D J F M	2025/2026 A M J J A S O N D J F M
	Budgeting Recommendations		
17	Shared Health should prioritize completion of a multi-year strategic plan to serve as a standalone, guiding document for the organization.		
18	The Annual Operating Plan should incorporate a scenario-based planning element to enable a better understanding of potential budget changes and greater flexibility to respond to change.		*
19	Shared Health should consider preparing an annual reconciliation or statement, reporting the budgeted and actual revenue and expense amounts using statement categories which are aligned with the AOP.		*
20	Shared Health should review its Funding Transfer Policy and update the policy to ensure full alignment with the Accountability Agreement Funding Directives.		
21	MHSLTC should consider adopting a zero-based budgeting approach for all SDO's to justify expenses annually.		
22	Implement a mid-year and year-end report with a comparison between minimum and actual service levels.	*	
23	Incorporate demand projections in the budgeting process to ensure an appropriate level of resourcing and to respond proactively to developing needs.		*

* Indicates recurring task.

	Recommendation	2024/2025 D	J	F	M	2025/2026 A	M	J	J	A	S	O	N	D	J	F	M
	Budgeting Recommendations																
24	Shared Health should be mandated to propose a list of cost-saving measures equal to three-times the reported deficit within 90 days when a deficit is reported on Shared Health's quarterly reporting.					*											
25	Shared Health should be required to carry a pre-determined contingency in its annual budgeting to prepare for unexpected costs.					*											
26	MHSLTC and Shared Health should maintain regular informal communication throughout AOP development cycle, with MHSLTC providing advance communication, where possible, as to potential changes to funding guidance.																
27	Establish regular, structured discussions between Shared Health and MHSLTC to review quarterly forecasts, and if a deficit is forecast, to present deficit mitigation strategies to MHSLTC and agree on next steps for addressing that deficit.																
28	MHSLTC should direct the immediate procurement of a single budgeting and forecasting software across all SDOs, and expedite implementation to improve the speed, accuracy, and reliability of reporting, and significantly reduce manual effort.																

* Indicates recurring task.

	Recommendation	2024/2025				2025/2026											
		D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M
	Fiscal Management Recommendations																
29	MHSLTC should require all SDOs to provide quarterly cash position statements and include cash position planning in the Annual Operational Plans.					*											
30	If cash position shortfalls are projected in the Annual Operating Plan, MHSLTC should consider adjusting the timing of payments to Shared Health, providing more front-loaded cashflow to offset the effects of delays in implementing the approved increase to annual funding.					*											

* Indicates recurring task.

Appendices

Appendix 1: Review Matrix

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
Governance					
Board Composition	1. Do board members in key roles possess the necessary skills and experience to provide appropriate financial oversight given the scale and complexity of the SDOs?	• Board members in key roles such as chair roles, and finance and audit committee roles possess accounting or finance designations, or have other training or backgrounds in finance • Board members in chair roles, and finance and audit committee roles possess experience overseeing the finances of large, complex organizations,	• Board member experience in senior management or board roles of large, complex organizations including those in healthcare • Board member experience in key financial roles (Controller, CFO, etc.) • Board member experience serving on boards of large, complex organizations with a high level of impact and accountability • Onboarding training provided for each board member.	• Percentage of board and committee members with accounting or finance designations (CPA, CMA, MBA, etc.)	• Board member resumes and bios • Public source information • Board policies and bylaws

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		including health-care organizations	• Board members have completed Manitoba Agency, Board or Commission orientation session training.		
Board Communication	2. Are board members provided with fulsome, accurate, timely, and actionable information regarding the financial position of the organization and material changes as they occur?	• Board members receive regular communication that provides them with a thorough understanding of the organization's financial position • Board members are well-informed during the annual budgeting process and are aware of the cost and service delivery trade-offs incorporated in the proposed budgets • Board members receive additional information or	• Meeting materials for the board and finance / audit committee are provided with sufficient time to review prior to meetings • Board and finance / audit committee members have sufficient access to information to support their informed approval of the annual budget • Communication to the board relating to material financial changes closely aligns with the timing of when these changes took place • Material changes in financial position are disclosed and discussed in finance/audit	• Frequency of board meetings • Frequency of finance / audit committee meetings • Timing of communication to board members relative to information availability • Frequency and timing of board briefings	• Board meeting minutes • Finance / audit committee meeting minutes • Board and audit / finance committee briefings • Internal and public source information on timing of material changes • Communication from MB Health providing budget and service delivery directives

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		clarification when requested • Management provides timely information and updates when material changes affect the organization's ability to meet its established budget	committee and general board meetings • The impacts and risks of material financial changes are fully communicated to committee and board members		
Board Budget Approval Process	3. Does the board exercise independence from management and provide sufficient oversight of the annual budget development process before approving the budget?	• The board comes to independent judgements on financial matters based on the available information • The board is aware of the service delivery and cost trade-offs proposed in the budget • The board provides direction to management on	• Evidence of board and finance / audit committee members asking probing questions and verifying management assertions • Evidence of board and finance / audit committee members ensuring budget alignment with the mandate of the organization • Evidence of a thorough review of financial	• Budget compliance with accountability agreements	• Board meeting minutes • Finance / audit committee meeting minutes • Board policies and bylaws • AOP Guidelines • Accountability Agreements

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		navigating budget trade-offs • The board ensures that the organization's obligations under the accountability agreement are met	materials by board members such as well-informed lines of questioning, healthy debate, non-unanimous decisions, or board disagreement with management positions. • Evidence of the board providing guidance on service delivery and cost trade-offs		
	4. Does the board approve material changes to the budget or variances from budget as they become apparent?	• The board is aware of material changes and variances from budget as they occur during the fiscal year • The board authorizes significant variances or revised budgets as information on the variances becomes available	• Evidence of board and finance / audit committee review of variances as they develop	• Board and finance / audit committee votes relating to budget and variance approvals	• Board meeting minutes • Finance / audit committee meeting minutes • Board policies and bylaws • Quarterly and monthly forecast reports • Board briefings

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
Risk Management	5. Does the board identify the financial risks facing the organization and ensure they are well-informed on the impacts?	• Risk register maintained and updated regularly by board • Key financial risks are identified in the risk register along with their potential impacts • The board identifies new risks as circumstances change	• Evidence of risks being added to the risk register, or the risk register being reviewed and updated • The risks identified accurately reflect the risks facing the organization and include key financial risks • Decision-making processes take the associated risks into account when deciding on a course of action	• Existence of risk register and regular review process	• Board meeting minutes • Finance / audit committee meeting minutes • Data requests to SDOs • Board briefings
	6. Does the board act adequately to mitigate the financial risks identified?	• Effective risk mitigation strategies have been developed for financial risks identified in the risk register • The board takes proactive action to mitigate identified risks and reduce their	• Evidence of proactive risk mitigation measures taken by the board • Risks are acted on in a timely way after being identified • Mitigation strategies are effective and appropriate	• Time between risk identification and implementation of mitigation measures	• Board meeting minutes • Finance / audit committee meeting minutes • Data requests to SDOs

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		likelihood, severity, or impact.			
Budgeting					
Compliance with Planning Frameworks	1. Is the SDO compliant with the required planning frameworks?	• The SDO follows the AOP planning process • AOP is approved by MHSLTC • AOP complies with the cross-referenced strategic plans and mandate letters • The outlined plan is realistic and achievable	• Resource allocation is compliant with AOP requirements, ministerial directives, and strategic priorities • The identified cost saving measures are viable and achievable • MH approval of AOP	• All required AOP documentation is accurate and complete • The allocated budget matches the available funds • AOP submission timelines have been adhered to	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • MH Five-Year Strategic Plan • Ministerial mandate letters • Board mandate letters • Mental Health and Community Wellness ("MHCW") strategic plan • SDO strategic plan • Annual planning cycle

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
					• Commissioning and accountability tools
	2. Does the AOP planning framework and related processes enable compliance with the accountability agreements?	• The AOP process produces an achievable plan based on the current environment • The AOP planning process adequately prepares the SDOs to respond to normal service delivery demand fluctuations • The AOP planning process enables communication between MH and MHCW and the SDOs	• Variances from budget can be directly attributed to circumstances which were unforeseen at the start of the fiscal year (e.g., restructuring initiated mid-year, pandemics, etc.) • SDO communicates adequately with MH and MHCW during planning process • SDOs have adequate visibility on upcoming service delivery directives	• Analysis of actual results indicates that budget assumptions in AOP were reasonable	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • Financial statements • Forecast summaries • Ministerial mandate letters • Board meeting minutes • Finance / audit committee meeting minutes • Annual planning cycle • SDO Data requests • Interviews with MH and SDO Finance staff

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
	3. Does the SDO use funding received pursuant to the Accountability Agreement to provide the services outlined unless otherwise agreed to by Manitoba in writing and approved by Manitoba?	• Funding from MB Health is used in alignment with the Accountability Agreement and the stated funding allocation purposes	• Written approvals for funding used for purposes that are not approved within the Agreement or the stated funding allocations	• Expenditures reflect the approved funding uses and allocations	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • Financial statements • Forecast summaries • Ministerial mandate letters • Board meeting minutes • Finance / audit committee meeting minutes
Budgeting for Service Need and Demand	4. Is there a clear link between expected service need and demand and the budgeting process?	• The AOP process adequately captures expected demand and anticipated changes to service delivery • The AOP process can adapt to changes during the planning process including	• Demand forecasts are made in advance and adequately reflected in the resulting budgets and operational plans • Variances from budget can be directly attributed to circumstances which were unforeseen at the start of the fiscal year	• Analysis of actual results indicates that anticipated demand was adequately incorporated in financial planning	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • Financial statements • Forecast summaries

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		changes in demand or changes in service delivery directives	(e.g., restructuring initiated mid-year, pandemics, etc.) • Final AOP incorporates changes in environment that occurred during planning process		• Ministerial mandate letters • Board meeting minutes • Finance / audit committee meeting minutes • Annual planning cycle • SDO Data requests • Interviews with MH and SDO Finance staff
	5. Does the budgeting process fully capture the trade-offs inherent in having limited funds available?	• An effective process exists for identifying tradeoffs between service levels and budget • An effective process exists for reviewing tradeoffs and determining the appropriate level of funding and service provided	• Proposed changes to service delivery articulate the related service delivery and financial impacts • Actual service delivery impacts closely align with projected service delivery impacts • Board discussion of trade-offs • MH and MHCW review of the financial and	• Actual cost savings closely match proposed cost savings • Actual expenditures for increased service delivery closely match proposed costs for increased service delivery	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • Ministerial mandate letters • Board meeting minutes • Finance / audit committee meeting minutes

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
			service delivery trade-offs involved		• Financial statements • Forecast summaries • Interviews with MH and SDO staff
	6. Do current budget processes support service delivery innovation and improvement?	• Whole-of-system costs and multi-year timeframes are considered when developing a case for innovation or improvement • Projects with a positive net present value that also improve service delivery are prioritized for investment • Innovation and improvement are incentivized as part of the planning process	• Funding is allocated for projects with a net positive return over a multi-year time horizon, not only those with a single-year payback • Planning and project selection recognizes whole-of-system benefits and cost savings from innovation • Projects are identified in AOP that result in savings and service delivery improvements, not simply trade-offs between cost and service delivery	• Quantified cost savings from investment in innovation and improvement	• Annual Operational Plan Guidelines • SDO Annual Operational Plans • Board meeting minutes • Finance / audit committee meeting minutes • Finance staff interviews

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
Communication with External Partners	7. Does the SDO have access to clear, accurate, timely and relevant information to enable the development of accurate budgets?	• MH and MHCW provide clear guidance on available funding and expected changes to service delivery in a timely way • Health Care Organizations (HCO) provide clear, timely, and accurate budgets or cost estimates for their expected services in the planned year	• MH and MHCW guidance are provided at an appropriate time in the planning cycle • MH and MHCW guidance are clear and accurate and reflect the expected service delivery changes for the planned year • Health Care Organizations provide clear, accurate budgets at an appropriate time during the planning cycle	• HCO projections closely align with actual expenditures	• SDO Annual Operational Plans • Ministerial mandate letters • Board meeting minutes • Finance / audit committee meeting minutes • Financial statements • Forecast summaries • Finance staff interviews
	8. Are the budgeting and planning processes and timelines of the SDO effectively integrated with MHSLTC processes and timelines?	• MH has visibility on the AOP planning process at the appropriate times • The current AOP process effectively integrates into the separate budgeting and planning processes of the SDO and MH	• Sufficient budget guidance is provided in a timely way by MH and MHCW • SDO communicates information on trade-offs between service delivery and cost to MH and MHCW in a timely way • Communication takes place between SDO and		• Annual Operational Plan Guidelines • Commissioning and Accountability tools • SDO Annual Operational Plans • Ministerial mandate letters

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		• There is effective and responsive communication between MH and MHCW and the SDO to support the planning process	MH and MHCW at key points throughout the AOP development process • Questions and requests for information between MH, MHCW, and the SDO are responded to in a timely and fulsome way		• Board meeting minutes • Finance / audit committee meeting minutes • Interviews with Finance staff • Interviews with MH
	9. Are the SDO service delivery needs and financial trade-offs clearly communicated and visible to decision-makers?	• Clear communication is provided on the financial costs of providing status quo service • Clear communication is provided on the financial and service delivery impacts associated with increased or decreased service delivery from status quo • Appropriate decision-makers have access to comprehensive	• Proposed service delivery changes are described with sufficient detail on expected patient impacts and SDO operational impacts • Rationale for proposed service delivery changes are clearly articulated • SDO executives, board members, MH and MHCW have access to information on the rationale, patient impacts, and operational impacts in a timely way.	• Status quo budget costs • Budget allocations for service delivery changes	• Annual Operational Plan Guidelines • Commissioning and Accountability tools • SDO Annual Operational Plans • Board meeting minutes • Finance / audit committee meeting minutes • Interviews with Finance staff • Interviews with MH

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		information on these trade-offs including SDO management, board members, MH, and MHCW			
	10. Are changes in service delivery and budget expectations effectively communicated and supported between budget cycles?	• MH and MHCW communicate changes in service delivery expectations in a timely way • Where appropriate, MH and MHCW consult the SDOs to understand the full service delivery and financial impacts of proposed changes • SDO-led changes in service delivery between budget cycles are communicated to MH and MHCW in a timely way along with their financial impacts	• Communication and coordination of planning for new or increased services between budget cycles • Appropriate funding is allocated by MH and MHCW for service delivery changes initiated by the department(s) between budget cycles • SDO-led service delivery changes are communicated to MH and/or MHCW prior to implementation where they present material financial impacts	• Government funding to support new department announcements for increased services	• Board meeting minutes • • • Finance / audit committee meeting minutes • Interviews with Finance staff • Interviews with MH • MH, MHCW, and SDO press releases

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
Resources	11. Are the current SDO finance tools and staffing adequate to fully meet the budgeting needs and financial reporting obligations of the organization?	• SDO Finance departments have the necessary number of staff to effectively meet the needs of the organization • SDO Finance departments have the appropriate software and tools available to meet their budgeting, planning, and financial reporting obligations	• Finance department capacity to meet necessary deadlines and reporting requirements • Individual finance staff member workloads • Current software and tools offer appropriate features and integration with other systems	• Number and type of finance staff • Number and type of staff mandated to work on budgeting • Type and functionality of finance software • Availability and use of software tools	• SDO Finance Organizational Structure • Interviews with Finance Staff • Interviews with MH
Fiscal Management					
Compliance with Annual Operating Plans (AOP)	1. Is the SDO compliant with its AOP?	• The SDO meets its defined budget in the AOP • The SDO executes its operational plan outlined in the AOP	• Actual service delivery closely aligns with planned service delivery	• Financial actuals closely align with the AOP budget	• SDO Annual Operational Plans • Financial statements • Quarterly and monthly forecast reports • Board meeting minutes

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
					• Finance / audit committee meeting minutes • Interviews with Finance staff • Interviews with MH
Managing Financial Changes	2. Are the financial impacts of unexpected changes in demand identified in a timely way and incorporated into ongoing planning and operations?	• Unexpected changes in demand are identified as they occur • The financial impacts of unexpected service delivery demands are quantified in a timely way • Financial impacts are incorporated into ongoing reporting and operational plans • Monthly and quarterly reports accurately identify when variances occur throughout the fiscal year	• The AOP process maintains flexibility to incorporate changes in demand throughout the planning process prior to AOP approval • Material changes in demand which occur mid-year are quantified including their expected impact on the remaining part of the fiscal year • An updated internal budget is maintained incorporating mid-year changes and any additional measures taken to meet the increased demand	• Monthly and quarterly reporting accurately captures actual results to date compared to budgeted	• SDO Annual Operational Plans • Board meeting minutes • Finance / audit committee meeting minutes • Interviews with Finance staff • Financial statements • Monthly and Quarterly Forecast Reports

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
			and/or offset the related financial impacts • The timing of variance reporting aligns with the occurrence of the events driving the same variances		
	3. Are budget shortfalls and variances identified and communicated to MHSLTC and MHCW in a timely way?	• MH and MHCW are notified of budget shortfalls in a timely way following internal identification by the SDO • Current reporting methods sufficiently capture the up-to-date financial picture of the SDO as it evolves throughout the year • Ongoing communication takes place between MH and/or MHCW and the SDO when	• Significant mid-year variances are quantified and communicated to MH and MHCW as soon as they are identified • Ongoing communication takes place between the SDO and departments to identify mitigation strategies and funding sources for variances prior to year-end	• Monthly and quarterly forecasts accurately capture the projected year-end results based on the current levels of service delivery and demand	• Board meeting minutes • Finance / audit committee meeting minutes • Interviews with Finance staff • Interviews with MH staff • Financial statements • Monthly and Quarterly Forecast Reports

Area of Review	Questions	Indicators	Qualitative Evidence	Quantitative Evidence	Method/ Information Source
		significant variances become apparent			
Delegation of Authority	4. Does the SDO have an effective process for the delegation of authority?	• The SDO has a clearly defined Delegation of Authority policy and authorization limits • The delegation of authority policy and authorization limits are effectively communicated throughout the organization • Invoices are approved in accordance with the delegation of authority	• Invoices are approved in accordance with the delegation of authority • Relevant staff are aware of and consistently follow the delegation of authority policy and authorization limits	• A clear delegation of authority policy exists • Clear authorization limits have been established	• SDO Policies • Interviews with SDO staff

Appendix 2: Documents Reviewed

- Accountability Agreements
- Monthly briefing notes
- Monthly forecasts
- ORE Quarterly Reports
- Quarterly forecasts
- Quarterly briefing notes
- Agreement Execution and Authorization of Expenditures policy
- Annual Operating Plan
- Planning guidelines
- Board, finance committee, and audit committee meeting agendas and minutes
- Financial statements
- Commissioning and accountability tools
- Mandate letters
- MHSLTC Strategic plan
- The Health System Governance and Accountability Act
- Organizational structure
- Financial policies
- Risk assessment

Appendix 3: Actual vs Budget Expense Analysis

	2020/2021	2021/2022	2022/2023	2023/2024
Expenses Total				
Budget	$1,278,582	$1,398,181	$1,297,108	$1,320,587
Actual	$1,276,295	$1,419,879	$1,645,429	$1,839,687
Variance, $	($2,287)	$21,698	$348,321	$519,100
Variance, %	(0.2%)	1.6%	26.9%	39.3%
Expenses by Sector				
Acute care				
Share of Total Expenses	49%	50%	52%	50%
Budget	$624,933	$606,732	$600,013	$605,877
Actual	$629,382	$715,503	$861,554	$924,074
Variance, $	$4,449	$108,771	$261,541	$318,197
Variance, %	0.7%	17.9%	43.6%	52.5%
Diagnostic Services				
Share of Total Expenses	22%	21%	22%	19%
Budget	$279,339	$276,293	$285,914	$293,651
Actual	$275,794	$303,546	$365,161	$340,492
Variance, $	($3,545)	$27,253	$79,247	$46,841
Variance, %	(1.3%)	9.9%	27.7%	16.0%
Emergency Response Services				
Share of Total Expenses	12%	11%	11%	9%
Budget	$152,602	$156,787	$162,661	$173,036
Actual	$152,173	$155,880	$172,827	$174,112
Variance, $	($429)	($907)	$10,166	$1,076
Variance, %	(0.3%)	(0.6%)	6.2%	0.6%
Digital Health				
Share of Total Expenses	11%	10%	9%	12%
Budget	$142,390	$145,741	$145,548	$145,280
Actual	$139,567	$147,336	$143,073	$215,646

	2020/2021	2021/2022	2022/2023	2023/2024
Variance, $	($2,823)	$1,595	($2,475)	$70,366
Variance, %	(2.0%)	1.1%	(1.7%)	48.4%
Medical Remuneration				
Share of Total Expenses	5%	6%	5%	5%
Budget	$67,536	$199,084	$88,277	$88,277
Actual	$66,894	$84,021	$87,343	$87,901
Variance, $	($642)	($115,063)	($934)	($376)
Variance, %	(1.0%)	(57.8%)	(1.1%)	(0.4%)
Mental health services				
Share of Total Expenses	1%	1%	1%	5%
Budget	$11,782	$13,544	$14,695	$14,466
Actual	$12,485	$13,593	$15,471	$97,462
Variance, $	$703	$49	$776	$82,996
Variance, %	6.0%	0.4%	5.3%	573.7%

Appendix 4: Key Deficit Drivers

Shared Health is expected to operate within the Minister's annual operating budget. In the last five years, Shared Health - and other SDOs - have struggled to achieve financial balance. The accumulated deficits have now reached an unsustainable level. Understanding the deficit and the corresponding drivers of the deficit is integral information to help evaluate the fiscal management of Shared Health and provides an understanding of the financial results of Shared Health. The following section outlines Management's assertions of the risks that are impacting financial sustainability and the results of MNP's analysis of the fiscal years ended 2021 to 2023.

Management's Assertions

Shared Health's management team has outlined the following risks that are impacting financial sustainability:

- Overtime cost and management challenges from being short-staffed
- Inflationary impacts on supplies, food, and drugs
- Supply chain disruptions ultimately increasing costs
- COVID pandemic costs that are no longer funded
- Funding limitations combined with cost escalations
- Ability to meet patient flow targets for revenue generation
- Ability to influence regulation change to enhance the ability to collect key revenues

Deficit Drivers

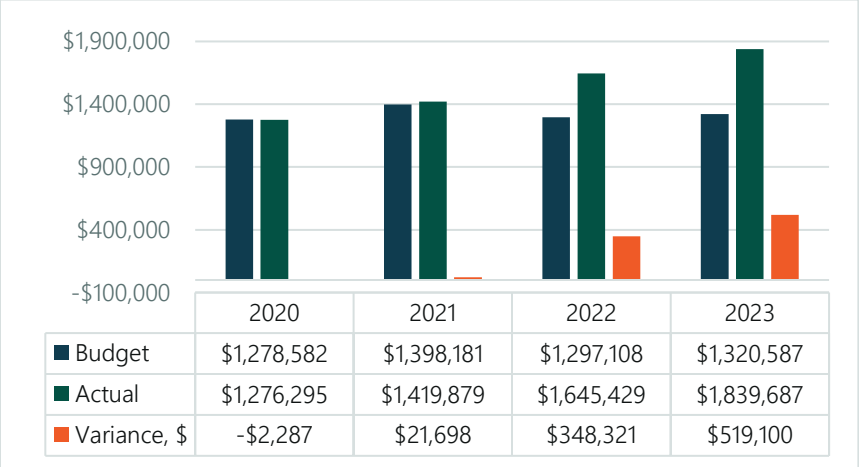
MNP found that Shared Health's actual expenses consistently exceed the budgeted amounts in the fiscal years ended 2021 to 2023, and yet, the budgeted amounts were not adjusted to take the experienced increases into account.

- Starting in 2021, SH's budget overspends increased significantly: 1.6% in 2021, 26.9% in 2022, and 39.3% in 2023.
- From 2020 to 2023, SH's budgeted expenses increased by 3.3%, rising from $1.28 billion to $1.32 billion. However, actual expenses surged by 44.1%, increasing from $1.28 billion to $1.8 billion. This resulted in a total expense budget overage of $519 million in 2023.
    - Acute care consistently had the largest share of expenses and regularly exceeded budgeted amounts.
    - Salaries and benefits were the primary budget drivers, accounting for 66%-69% of total expenses.

- Specifically, regarding Salaries, and Benefits, during this time period several collective agreements were negotiated and settled resulting in variances to budget for both expenditures and revenues.

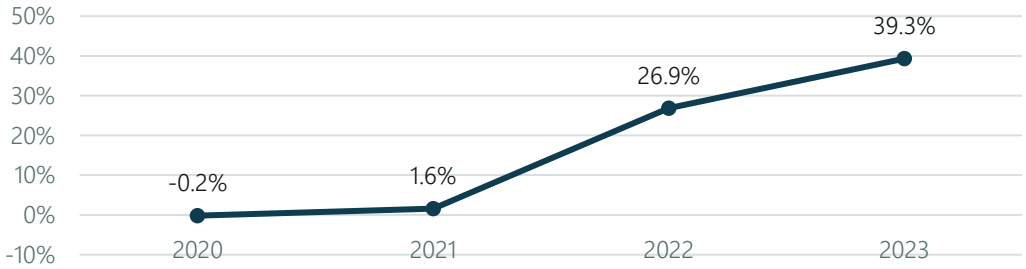
Figure 1 and Figure 2 illustrate the SH budget and actual expenses change from 2020 to 2023, along with the budget variance.

Figure 1: SH Expenses vs Budget, 2020-2023, (in thousands of CAD)



	2020	2021	2022	2023
Budget	$1,278,582	$1,398,181	$1,297,108	$1,320,587
Actual	$1,276,295	$1,419,879	$1,645,429	$1,839,687
Variance, $	-$2,287	$21,698	$348,321	$519,100

Figure 2: SH Expense variance from budget, %, 2020-2023

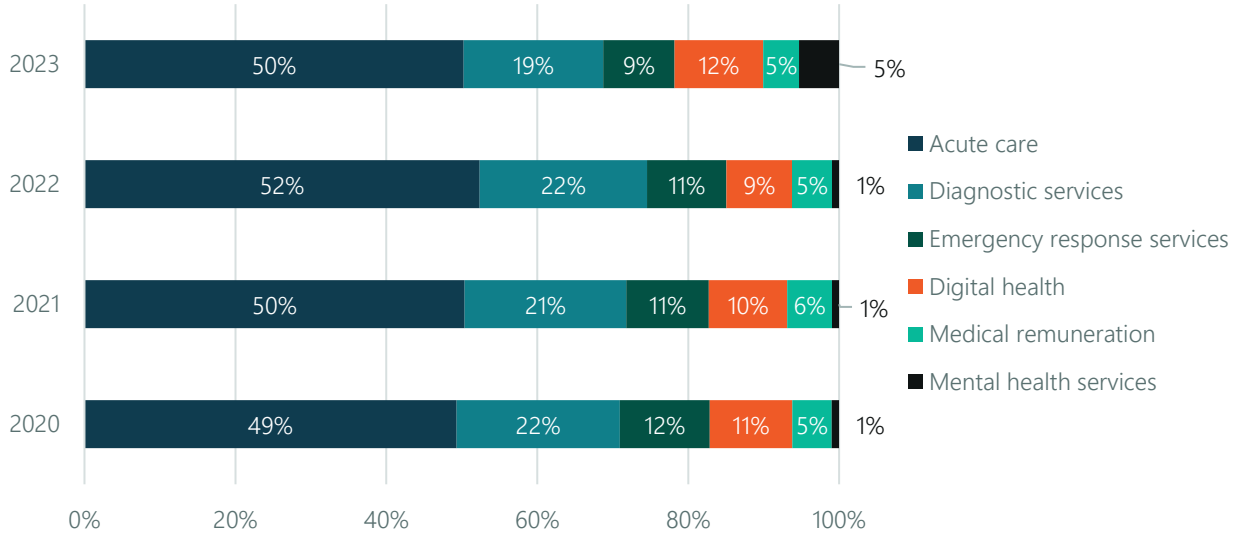


The share of major expense categories in total expenses remained relatively stable from 2020 to 2023 except for mental health services.

- The largest change was in the share of mental health services with expenses increasing significantly, rising from 1% in 2020-2022 to 5% in 2023. Note, that this increase was in large part due to the transfer of the Selkirk Mental Health Centre and the Manitoba Adolescent Treatment Centre from MHSLTC and the WRHA respectively to Shared Health.
- Acute care represented the largest share, accounting for 49-50% of total expenses.
- Diagnostic services were the second largest sector, comprising 19-22% of expenses.
- Emergency response services and digital health each accounted for 9-12% of the total expenses.

- Medical remuneration made up 5-6% of total expenses.

Figure 3: SH Share of Expense by Sectors, 2020-2023

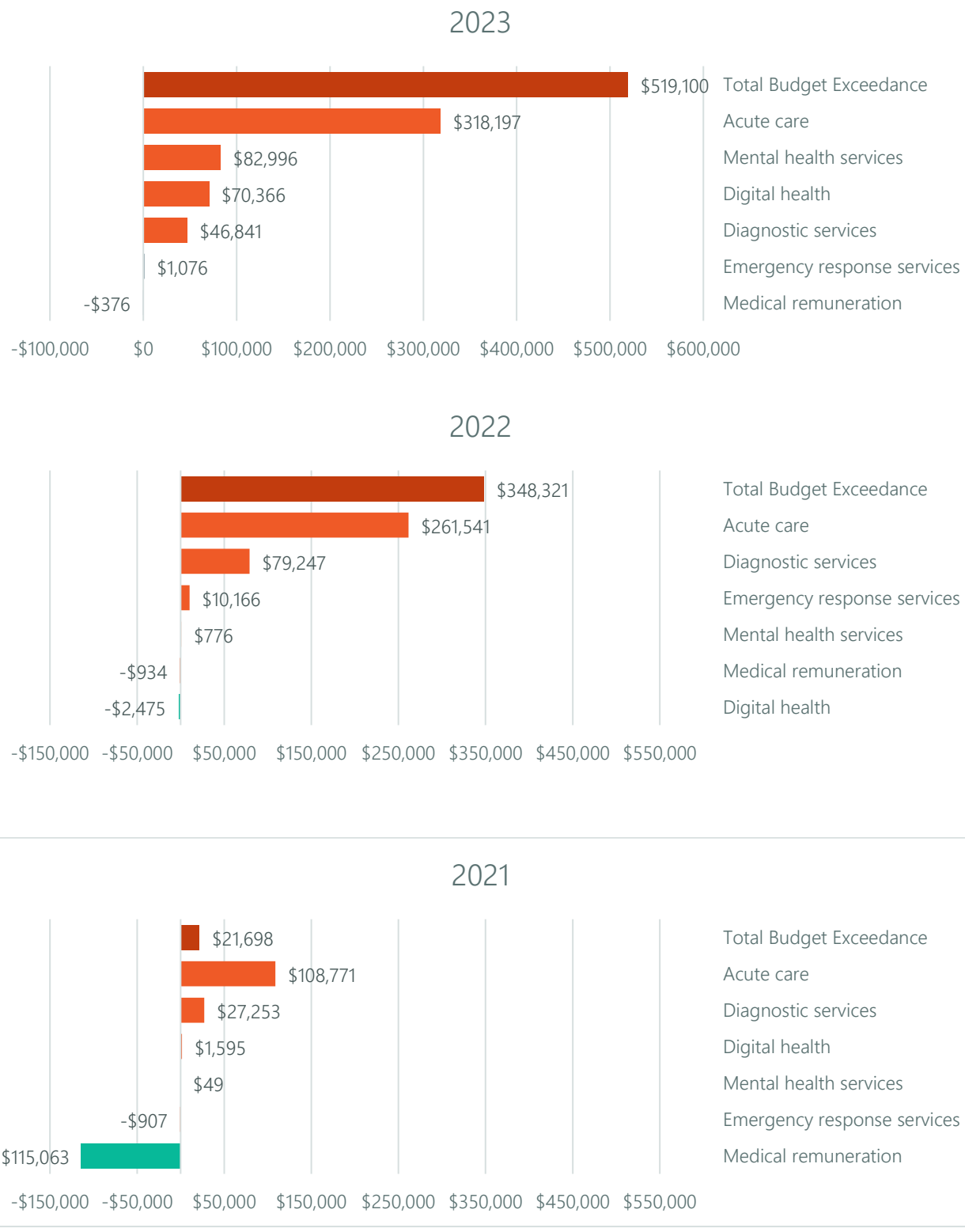


Note: More details regarding analysis by expense sector are available in Appendix 3.

Overspending in Acute Care has been the primary driver of total budget overages, while Medical Remuneration consistently underspent, helping to mitigate overall budget variances.

- In 2023, overspending in Acute Care accounted for the largest portion of the total budget overage, representing 61.3% ($318 million of the $519 million budget variance). Similarly, in 2022, Acute Care overspending comprised 75% of the total budget exceedance ($262 million of the $348 million budget variance).
- Conversely, actual expenses for Medical Remuneration were consistently lower than budgeted from 2021 to 2023. In 2021, the budget for this category was overestimated by 57.8%, resulting in a variance of -$115 million. This overestimation offset the Acute Care overspend of $108 million (17.9% higher than planned), balancing the overall budget to just a 1.6% variance. In the subsequent years, budgeting for Medical Remuneration has been more accurate, with actual expenses being 1.1% lower than budgeted in 2022 and 0.4% lower in 2023.

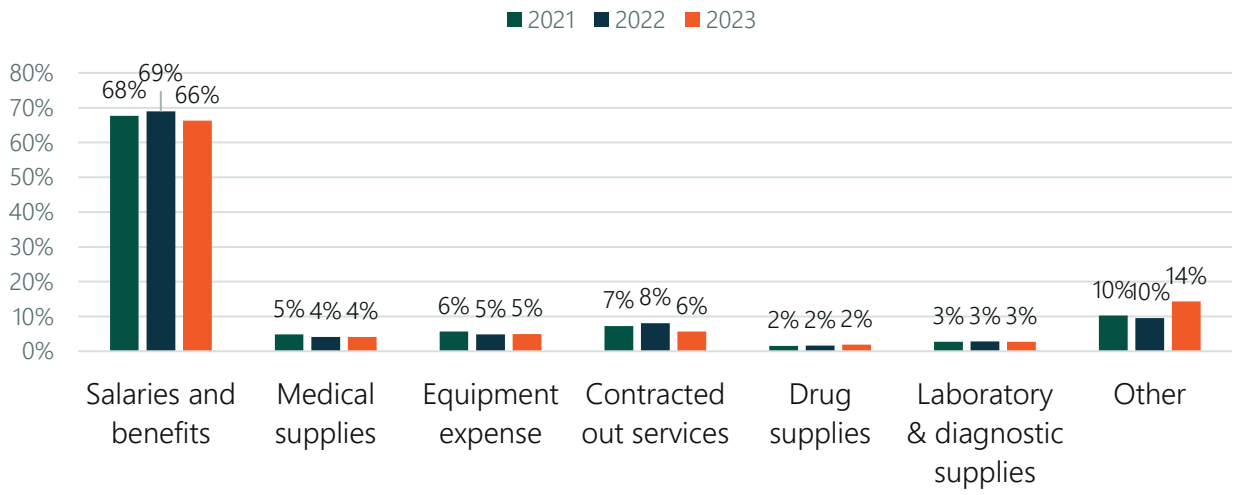
Figure 4: Total budget exceedance and each sector's contribution, 2021-2023



Salaries and benefits constitute the largest share of expenses, accounting for 66-69% of the total. This expense category saw a significant increase of 27% in 2023 compared to 2021.

- Shared Health's largest expenses by type are salaries and benefits, medical supplies, equipment expenses, contracted services, drug supplies, and laboratory & diagnostic supplies.
- The expense structure remained relatively stable from 2021 to 2023, with salaries and benefits comprising 66-69% of total expenses, contracted services 6-8%, equipment expenses 5-6%, medical supplies 4-5%, laboratory & diagnostic supplies 3%, and drug supplies 2%.

Figure 5: Share of key expenses by type in total SH insured services expense, 2021-2023



Note: Budgeted figures for expenses by type were not available in Shared Heath's Financial Statements.

The largest expense categories have faced significant year-over-year increases that are not sustainable without corresponding significant increases in revenue.

- Salaries and benefits, the primary budget driver, increased by 27% in 2023 compared to 2021. Additionally, drug supplies saw a significant increase of 63%, and laboratory & diagnostic supplies increased by 31% over the same period.

  Table 10 shows the increase in key expenses for insured services by type for 2021-2023.

Table 10: Year over year increases (decreases) in key expenses for insured services, 2021-2023

Expense type	2022 vs 2021	2023 vs 2022	2023 vs 2021
Salaries and benefits	18%	7%	27%
Medical supplies	(2%)	12%	9%
Equipment expense	(2%)	13%	11%
Contracted out services	29%	(22%)	1%
Drug supplies	20%	36%	63%
Laboratory & diagnostic supplies	19%	9%	31%

Appendix 5: Summary of Findings

Governance Findings	
Question #1 **Do board members in key roles possess the necessary skills and experience to provide appropriate financial oversight given the scale and complexity of the SDOs?**	
1	Given the complexities and financial oversight required, we found a majority of board members in key roles do not possess the necessary skills and experience to provide appropriate financial oversight.
2	Turnover of board members has recently been high with many board members not fulfilling their term.
3	Shared Health has an orientation process for onboarding new board members and ongoing training is a regular board agenda item.
4	Board compensation for Shared Health is among the lowest paid for large, complex public sector entities in Manitoba.
Question #2 **Are board members provided with fulsome, accurate, timely, and actionable information regarding the financial position of the organization and material changes as they occur?**	
1	Board members receive communication that provides them with an understanding of the organization's financial position. Management and board member turnover has impacted the consistency of the information.
2	While the board is well-informed during the annual budgeting process and are aware of the cost and service delivery trade-offs incorporated in the proposed budgets, board members feel that they are not close enough to the budgeting process to provide effective oversight.
3	Board members indicated that the historical budgeting process did not allow for as collaborative an effort between management, the board, and the government as would be beneficial.
4	Board members receive additional information or clarification when requested.
5	Management provides timely information and updates when material changes affect the organization's ability to meet its established budget.
6	The board understands government's desire to reduce corporate services costs.
Question #3 **Does the board exercise independence from management and provide sufficient oversight of the annual budget development process before approving the budget?**	
1	Board members expressed that they are not close enough to the budgeting process to be able to make independent judgements on resourcing levels.

Governance Findings	
2	The board is aware of service delivery and cost trade-offs proposed in the budget. However, the board has at times been frustrated by the perceived removal of their decision-making authority over some budgetary decisions.
3	The board indicated its ability to contemplate service delivery and cost trade-off options with management is at times limited by the realities that to achieve savings a reduction in patient service delivery may be required, and this is often not perceived as a viable option.
4	The SDO board attempts to ensure compliance with accountability agreements are met but has struggled with this.
Question #4 **Does the board approve material changes to the budget or variances from budget as they become apparent?**	
1	The board is aware of material changes and variances from budget as they occur during the fiscal year.
2	The board authorizes significant variances or revised budgets as information on the variances becomes available.
3	Current year financial obligations and the timing of those obligations have led to cash flow challenges for Shared Health.
Question #5 **Does the board identify the financial risks facing the organization and ensure they are well-informed on the impacts?**	
1	Shared Health has identified financial risks facing the organization by preparing a risk register and completing an annual assessment of risk.
2	Key financial risks are identified in the risk assessment along with their potential impacts.
Question #6 **Does the board act adequately to mitigate the financial risks identified?**	
1	The board does not adequately mitigate the financial risks identified. There is a disconnect between some risks, drivers of the risks and the steps taken to mitigate the risks. Timelines for implementation of mitigation steps are not provided.
2	In some cases, the board has not taken proactive action to mitigate identified risks and reduce their likelihood, severity, or impact.

Budgeting Findings	
Question #1 **Is the SDO compliant with the required planning frameworks?**	
1	Shared Health generally follows deadlines and requirements to submit annual planning documentation and reporting.
2	In past years, Shared Health has lacked a robust multi-year strategic plan to guide its internal planning processes and priorities but developed a draft strategic plan in 2023 and is working toward finalizing the strategic plan in Fall 2024.
Question #2 **Does the AOP planning framework and related processes enable compliance with the accountability agreements?**	
1	The budgetary components of the Annual Operating Plan process have not necessarily facilitated better compliance or budgeting by Shared Health. The AOP does have a mechanism for the SDO to provide narrative explanation regarding variances, that then become a part of the AOP that the SDO is held accountable to.
Question #3 **Does the SDO use funding received pursuant to the Accountability Agreement to provide the services outlined unless otherwise agreed to by Manitoba in writing and approved by Manitoba?**	
1	Shared Health maintains a funding transfer policy, delegation of authority policy, and position control policy, which together ensure appropriate oversight so that funding is allocated as outlined in the Accountability Agreement unless approved by Shared Health executive.
2	The current financial reporting formats make it challenging to directly link the use of funds to the list of core services outlined in the Accountability Agreement schedules.
3	The Shared Health funding transfer policy requires updating to fully align with the Accountability Agreement funding directives.
Question #4 **Is there a clear link between expected service need and demand and the budgeting process?**	
1	The SDO has not used the annual operating plan process to link ongoing service needs and demands to changes in the operating budget.
2	Shared Health's Annual Report contains limited information to analyze whether it has achieved the minimum service levels established in the Accountability Agreement.
3	The Annual Operating Plan framework provides flexibility for managing volume pressures in various healthcare categories; however, Shared Health has not used it to integrate analytical data to accurately reflect and address the actual demand and needs for all service lines.

Budgeting Findings	
Question #5 **Does the budgeting process fully capture the trade-offs inherent in having limited funds available?**	
1	The budgeting process fails to fully capture the impact of the service delivery trade-offs associated with cost savings including impacts on Shared Health's strategic goals and key performance indicators.
Question #6 **Do current budget processes support service delivery innovation and improvement?**	
1	The AOP framework provides room for service delivery innovation and improvement initiatives in capital projects.
2	The AOP supports service delivery innovation in operating programs if the proposed innovation is cost-neutral or results in cost savings within the year the innovation is implemented.
Question #7 **Does the SDO have access to clear, accurate, timely and relevant information to enable the development of accurate budgets?**	
1	Shared Health receives adequate information for development of the Annual Operating Plan (AOP) but key elements remain open to change which can impact the accuracy of the AOP.
Question #8 **Are the budgeting and planning processes and timelines of the SDO effectively integrated with MHSLTC processes and timelines?**	
1	Shared Health's budgeting processes and timelines are compatible and integrate with the AOP.
2	The AOP process has a generally defined cadence but does not have an annual schedule of milestones and due dates for submissions, because of its dependency on government timelines.
3	Confirmation of funding allocations is typically received at the start of the fiscal year or after the fiscal year has already begun which can lead to a need for sudden budget adjustments if allocations differ from prior guidance.
4	Shared Health is unable to change course and adapt quickly when funding allocations differ significantly from budget guidance.
Question #9 **Are the SDO service delivery needs and financial trade-offs clearly communicated and visible to decision-makers?**	
1	Shared Health clearly communicates the service delivery trade-offs associated with identified cost-saving measures in the AOP.

Budgeting Findings	
Question #10 **Are changes in service delivery and budget expectations effectively communicated and supported between budget cycles?**	
1	The AOP is considered a high-level planning document that needs to be updated dynamically to reflect the changing environment. There is a procedure in place to communicate and address such changes, however it does not guarantee timely and adequate funding.
2	Monthly forecast reports adequately inform MHSLTC on performance to date and on projected year-end variances, but more proactive communication is needed from Shared Health to MHSLTC around forecasts and related assumptions, as well as proactive planning and communication of change impacts.
Question #11 **Are the current SDO finance tools and staffing adequate to fully meet the budgeting needs and financial reporting obligations of the organization?**	
1	Shared Health lacks appropriate budgeting and forecasting software leading to resource-intensive, manual budgeting processes and a lack of standardization.
2	The use of different accounting software and manual processes between SDO's leads to inconsistencies and less comparability between SDO's reporting.
3	Evidence suggests that Shared Health has sufficient staffing for current budget processes.
4	Shared Health's average corporate expense is not comparable to other SDOs and other jurisdictions nationally.

Fiscal Management Findings	
Question #1 **Is the SDO compliant with its AOP?**	
1	Shared Health is regularly operating in a deficit as defined by the Annual Operating Plan budget, and as a result, is not in compliance with the Accountability Agreement.
2	A combination of deficits early in the fiscal year, and the timing of cashflow payments contributes to a reliance on a line of credit for operating needs.
3	Shared Health has not provided adequate visibility to MHSLTC on their projected cash position as part of its standard reporting requirements.
Question #2 **Are the financial impacts of unexpected changes in demand identified in a timely way and incorporated into ongoing planning and operations?**	
1	Unexpected changes in demand are incorporated into financial forecasts once the related costs become apparent but are managed on a reactive basis.
2	The budget articulated in the Annual Operating Plan is static and is not updated to reflect any changing needs or demand, per central government directives.
Question #3 **Are budget shortfalls and variances identified and communicated to MHSLTC and MHCW in a timely way?**	
1	Financial reporting and forecasting are supplied on a regular basis, and identifies variances compared to the budget defined in the AOP.
Question #4 **Does the SDO have an effective process for the delegation of authority?**	
1	A clearly defined Delegation of Authority policy is in place which provides an effective process for purchasing approvals.
2	Current procurement processes provide safeguards to ensure appropriate approvals are granted.

Appendix 6: Summary of Recommendations

Governance Recommendations	
Question #1 **Do board members in key roles possess the necessary skills and experience to provide appropriate financial oversight given the scale and complexity of the SDOs?**	
1	A desired skills matrix should be developed and used to evaluate existing board members.
2	Open board positions should be posted publicly.
3	Compensation for Shared Health board members should be reviewed and increased.
4	The SDO should introduce staggered board terms.
5	Formal board governance education should be reinstated and required of all board members.
Question #2 **Are board members provided with fulsome, accurate, timely, and actionable information regarding the financial position of the organization and material changes as they occur?**	
1	The SDO and MHSLTC should mutually explore opportunities to reduce the time that elapses between AOP draft delivery and approval, and the process for development of, and making changes to the AOP.
Question #3 **Does the board exercise independence from management and provide sufficient oversight of the annual budget development process before approving the budget?**	
1	The SDO should consider adopting zero-based budgeting and scenario planning approaches in their multi-year budgeting process that allows for increased granularity, more fulsome planning, and increased flexibility.
2	The Accountability Agreement should clearly define the roles and responsibilities of Government and the Board in the oversight of Shared Health.
Question #4 **Does the board approve material changes to the budget or variances from budget as they become apparent?**	
1	The impact of mid-year service delivery standard changes should be tracked if they result in an additional unfunded financial obligation to better enable analysis of SDO's ability to manage to budget.
2	A policy should be implemented by the SDO, so that any additional mid-year service requirements are not implemented unless they can be funded through internal reallocation.
3	A comprehensive analysis should be completed to understand why staffing positions are not being filled.

Governance Recommendations	
4	Shared Health and MHSLTC should jointly explore alternate cash transfer timing options to mitigate the risks associated with the current transfer timing.
Question #5 Does the board identify the financial risks facing the organization and ensure they are well-informed on the impacts?	
1	Risk register should include the status of actions to be taken for further mitigation and the person/department responsible for these actions.
2	A standardized enterprise risk register format should be used to report to the board.
Question #6 Does the board act adequately to mitigate the financial risks identified?	
1	Shared Health should involve the MHSLTC directly in its risk and mitigation identification process to ensure mitigating factors are realistic given government mandates.
2	The existing risk register should be further developed and include the status of the implementation of mitigation strategies.

Budgeting Recommendations	
Question #1 **Is the SDO compliant with the required planning frameworks?**	
1	Shared Health should prioritize completion of a multi-year strategic plan to serve as a standalone, guiding document for the organization.
Question #2 **Does the AOP planning framework and related processes enable compliance with the accountability agreements?**	
1	The Annual Operating Plan should incorporate a scenario-based planning element to enable a better understanding of potential budget changes and greater flexibility to respond to change.
Question #3 **Does the SDO use funding received pursuant to the Accountability Agreement to provide the services outlined unless otherwise agreed to by Manitoba in writing and approved by Manitoba?**	
1	Shared Health should consider preparing an annual reconciliation or statement, reporting the budgeted and actual revenue and expense amounts using statement categories which are aligned with the AOP.
2	Shared Health should review its Funding Transfer Policy and update the policy to ensure full alignment with the Accountability Agreement Funding Directives.
Question #4 **Is there a clear link between expected service need and demand and the budgeting process?**	
1	MHSLTC should consider adopting a zero-based budgeting approach for all SDO's to justify expenses annually.
2	Implement a mid-year and year-end report with a comparison between minimum and actual service levels.
3	Incorporate demand projections in the budgeting process to ensure an appropriate level of resourcing and to respond proactively to developing needs.
Question #5 **Does the budgeting process fully capture the trade-offs inherent in having limited funds available?**	
1	No new recommendations are noted in connection with Question #5 as the recommendations associated with Questions #2 and #4 are sufficient to address the findings in connection with Question #5.
Question #6 **Do current budget processes support service delivery innovation and improvement?**	
1	No recommendations are noted in connections with Question #6.

Budgeting Recommendations	
Question #7 **Does the SDO have access to clear, accurate, timely and relevant information to enable the development of accurate budgets?**	
1	No new recommendations are made in connection with Question #7. The recommendation connected to Question #2 to incorporate a scenario-planning element into the budgeting process will mitigate some of the uncertainty connected to the current budgeting process.
Question #8 **Are the budgeting and planning processes and timelines of the SDO effectively integrated with MHSLTC processes and timelines?**	
1	Shared Health should be mandated to propose a list of cost-saving measures equal to three-times the reported deficit within 90 days when a deficit is reported on Shared Health's quarterly reporting.
2	Shared Health should be required to carry a pre-determined contingency in its annual budgeting to prepare for unexpected costs.
3	MHSLTC and Shared Health should maintain regular informal communication throughout AOP development cycle, with MHSLTC providing advance communication, where possible, as to potential changes to funding guidance.
Question #9 **Are the SDO service delivery needs and financial trade-offs clearly communicated and visible to decision-makers?**	
1	Establish regular, structured meetings between budget decision-makers and SDO stakeholders to discuss the trade-offs indicated in the AOP Core Financial Schedules.
Question #10 **Are changes in service delivery and budget expectations effectively communicated and supported between budget cycles?**	
1	Establish regular, structured discussions between Shared Health and MHSLTC to review quarterly forecasts, and if a deficit is forecast, to present deficit mitigation strategies to MHSLTC and agree on next steps for addressing that deficit.
Question #11 **Are the current SDO finance tools and staffing adequate to fully meet the budgeting needs and financial reporting obligations of the organization?**	
1	MHSLTC should direct the immediate procurement of a single budgeting and forecasting software across all SDOs, and expedite implementation to improve the speed, accuracy, and reliability of reporting, and significantly reduce manual effort.

Fiscal Management Recommendations	
Question #1 **Is the SDO compliant with its AOP?**	
1	MHSLTC should require all SDOs to provide quarterly cash position statements and include cash position planning in the Annual Operational Plans.
2	If cash position shortfalls are projected in the Annual Operating Plan, MHSLTC should consider adjusting the timing of payments to Shared Health, providing more front-loaded cashflow to offset the effects of delays in implementing the approved increase to annual funding.
Question #2 **Are the financial impacts of unexpected changes in demand identified in a timely way and incorporated into ongoing planning and operations?**	
1	MNP has not developed any new recommendations based on the findings above. Previous recommendations will enable SDOs to better respond to unexpected changes in demand including the practice of carrying a budget contingency, budget scenario planning, and the rapid identification and implementation of cost saving measures when a budget deficit is first identified.
Question #3 **Are budget shortfalls and variances identified and communicated to MHSLTC and MHCW in a timely way?**	
1	No recommendations were noted in connection with the above finding as communication of budget variances is sufficient and timely. Other recommendations in this report address the causes of budget deficits and propose solutions for prevention and mitigation.
Question #4 **Does the SDO have an effective process for the delegation of authority?**	
1	No recommendations are noted in connection with the above findings.


MNP