Health Canada and the Public Health Agency of Canada
Santé Canada et l'Agence de la santé publique du Canada
Canada

Audit of Health Facilities Program at Health Canada

March 2017

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Executive summary

The objective of the audit was to assess: the management control framework in place to ensure that health facilities are planned, constructed and maintained to support First Nation and Inuit Health Branch (FNIHB) health programs delivery; and, whether contribution agreements comply with the Treasury Board *Policy on Transfer Payments*.

The Health Facilities Program (HFP) is the FNIHB umbrella transfer payment program that supports on-reserve recipient communities in the management of capital planning, capital projects and facilities, including operations and maintenance (O&M), for the provision of health-related services. Health Canada does not own the First Nations health facilities and associated buildings; this infrastructure is not considered federal real property.

In 2014-15, HFP spent approximately $79.5 million, of which $71 million was transferred to recipients through contribution agreements. Direct departmental spending of about $6 million relates to operating expenditures such as health facility maintenance, utilities expenses and staff travel.

Why is the management of the Health Facilities Program important?

FNIHB-supported health facilities serve approximately 515,000 First Nations individuals residing on reserve and in communities. Quality construction and timely maintenance are essential for safety and effective program delivery. Health facilities require significant funding for ongoing operations and maintenance and for retrofit or replacement.

What was found?

The audit found that the transfer of the funding is in compliance with the Treasury Board *Policy on Transfer Payments*. As well, there is a governance structure that oversees the management of the program; however, some regions have stronger governance practices than others. Evidence of corporate and branch level risk identification and mitigation was found to be documented as well as some informal risk practices for individual projects; however, individual project risks should be systematically documented and managed. Planning and allocation of O&M funding is not based on current data or a current allocation methodology, and there is inconsistent coding of funding. Also, the alignment of human resources may not be meeting actual requirements.

The Program has policies and guidance to support the project delivery; however, these tools need to be updated and communicated. Based on sampling 35 project files, the audit found the policy and guidance for administering the capital projects is applied inconsistently across the regions and between similar project files. Specific inconsistencies were found in tendering practices; requesting of technical feasibility studies; functional plans with inadequate information for space requirements; limited understanding on how to manage environmental assessment results; and project administration fees that ranged from 2% to 10% of the overall project costs without justification or consistent application.

The audit also found that the project files need to be monitored by headquarters to ensure adherence to the expectations of the policies and to minimize regional variation. Given the recent influx of Social Infrastructure Funding ($164 million over two years), it will be important that controls are strengthened.

The audit makes the following recommendations to address the challenges and other opportunities identified to further strengthen the management control framework of the HFP:

- Enhance the effectiveness of the committee structures by updating and adhering to the terms of reference for the Capital Project Review Committee and ensure each region has a robust governing committee;

- Adopt a systematic process to collect and analyse current data related to facility O&M requirements and ensure funding provided to recipients is consistently coded, develop more detailed regional operation plans to support program delivery and the alignment of internal resources;

- Update and communicate policy, guidance and directives for project implementation and monitoring, and ensure that applicable roles and responsibilities are clarified;

- Replace the program's current information management system while ensuring that an interim mitigation strategy is put in place to capture information; and,

- Develop a national quality assurance function to ensure regional activities follow project management expectations.

A - Introduction

1. Background

The Health Facilities Program (HFP) is the First Nations and Inuit Health Branch (FNIHB) umbrella transfer payment program that supports on-reserve recipient communities in the management of capital planning, capital projects and facilities, including operations and maintenance, for the provision of health-related services.

Financial support to recipient communities is provided through funding arrangements (contribution agreements), pursuant to requirements of the Treasury Board *Policy on Transfer Payments*. In 2014-15, the program spent approximately $79.5 million (see Appendix A and Appendix B), of which approximately $71 million was transferred to recipients through contribution agreements in support of the construction, recapitalization and operation and maintenance of health facilities. Direct departmental spending of approximately $6 million relates to operating expenditures such as health facility maintenance, utilities expenses and staff travel.

Table 1: Program Expenditures by Area

Expenditure Area	Expenditure
Grants and Contributions	$71,000,000
O&M	$6,000,000
Salaries and Wages	$2,500,000
Total	**$79,500,000**

Program funding supports a portfolio of 841 buildings, including 377 health facilities with an estimated replacement value of over $800 million. These health facilities consist of hospitals, nursing stations, health centres, health stations, health offices and housing for health personnel (see Appendix C). The facilities provide the physical space and environment to enable over 435 First Nation communities to deliver a range of health programs and services, from primary care to health promotion and prevention. The type of facility required by a community is based on the nature of the health services it is intended to support. The factors that are considered include population size, isolation of the community and proximity to a provincial or other First Nations health facility.

Projects funded through the HFP are governed by the Terms and Conditions for Health Infrastructure Support Authority, First Nations and Inuit Health Program. The authority outlines the types of projects and project-related activities that are eligible to receive funding.

In 2016 FNIHB was successful in obtaining $164 million over two years through the Social Infrastructure Fund umbrella, to invest in capital and maintenance projects that will improve the conditions of health facilities on reserve.

Ownership of First Nations Health Facilities

FNIHB does not own or have other legal interests in any capital assets (health facilities) funded through the HFP; as such, these assets are not considered federal real property. The control, management and usage rights to First Nations health facilities constructed on reserve lands rest with the host First Nations community, subject to any permit, designation or surrender of the facility, as described within the *Indian Act*. It is the First Nations funding recipient's obligation to operate, maintain and manage the infrastructure, as per the requirements of the funding agreement.

Rationale for the audit

Health facilities are essential for the delivery of FNIHB programs. Any delays in their construction or deficiencies in maintenance could jeopardize employee safety or the effectiveness of program delivery. Capital assets require significant funding for ongoing operations and maintenance and for retrofit or replacement.

Compounding this, there are multiple stakeholders involved in ensuring that the facilities are operational and meet applicable standards and building codes. They include the First Nations communities, FNIHB and the Corporate Services Branch (CSB). The degree of Health Canada's involvement varies considerably, depending on the capacity of First Nations and Inuit communities to perform the work themselves.

Authority

The Office of Audit and Evaluation (OAE) has the authority and the responsibility to carry out the audit of the FNIHB Health Facilities Program, as approved in the 2015-16 Annual Update to the Multi-Year Risk-Based Audit Plan. The Plan was recommended for approval by the Departmental Audit Committee in December 2014 and approved by the Deputy Head in March 2015. The project was collaborative in nature and the findings were cleared with the parties concerned.

2. Audit objective

The objective of this audit was to:

- Assess the management control framework in place to ensure that health facilities are planned, constructed and maintained to be available to support FNIHB health program delivery; and
- Determine whether the contribution agreements comply with the Treasury Board *Policy on Transfer Payments* and related directives.

3. Audit scope

The audit covered HFP management activities undertaken and processes in place from April 2014 to the end of October 2016, including major construction projects that were either completed or started during this period. Financial and non-financial aspects of program management and related support services and processes were examined within FNIHB and the Corporate Services Branch (CSB) related to both capital construction and facilities operations and maintenance (O&M) funding. Site visits included HFP headquarters and three regional offices (Manitoba, Ontario and Saskatchewan). As well, there were interviews and a review of documentation from the other regions where the HFP is delivered.

The audit did not include the British Columbia Region because in that province the HFP is delivered through the British Columbia Tripartite Agreement.

The lines of enquiry and audit criteria are presented in Appendix D.

4. Audit approach

The audit was conducted at Health Canada's headquarters and in three regional offices. The principal audit procedures included:

- A review and analysis of policy frameworks, planning documents, service delivery and performance-related documentation.
- Interviews with key program personnel at headquarters and in the regional offices.
- A sampling strategy was developed to ensure that sufficient evidence was obtained for the criteria being addressed:
    - detailed testing of 35 project files to determine compliance with FNIHB policy and guidance expectations;
    - testing of 15 contribution agreements for compliance to Treasury Board (TB) Policy.

5. Statement of conformance

In the professional judgment of the Chief Audit Executive, sufficient and appropriate procedures were performed and evidence gathered to support the accuracy of the audit conclusion. The audit findings and conclusion are based on a comparison of the conditions that existed as of the date of the audit against established criteria that were agreed upon with management. Further, the evidence was gathered in accordance with the Internal Auditing Standards for the Government of Canada and the International Standards for the Professional Practice of Internal Auditing. The audit conforms to the Internal Auditing Standards for the Government of Canada, as supported by the results of the quality assurance and improvement program.

B - Findings, recommendations and management responses

1. Governance

1.1 Governance Framework

Audit criterion: An effective governance framework is in place within FNIHB and horizontally across Health Canada for achieving the objectives of the FNIHB Health Facility Program.

A governance framework is a set of rules and practices by which an organization ensures accountability, fairness and transparency with all its stakeholders. Ultimately, the application of good governance serves to realize organizational goals effectively and efficiently.

In 2012, the First Nations and Inuit Health Branch (FNIHB) developed the Accountability Framework, which describes how core horizontal and program functions apply in the context of the Headquarters and Regional structures and clearly outlines responsibilities by function for all FNIHB programs. Core horizontal and program functions include, among others: Operations, Risk Management, Planning and Performance, Program Policy and Program Operational Support.

Committees

FNIHB is governed by a Senior Management Committee (SMC) structure, comprising two principal committees, the SMC-Policy and Planning and the SMC-Operations Committee.

The **SMC-Operations Committee** is responsible for the oversight and management of the Health Facilities Program (HFP). It is the key forum for discussion and decision-making within the Branch on operational planning and performance measurement issues as they relate to the program. Committee members review and approve the Branch Operational Plan and key planning and reporting documents such as the Long Term Capital Plan.

At the HFP level, there is a committee structure in place, comprised of national and regional level committees to support effective governance of the program – the Capital Project Review Committee (CPRC) and the Capital Allocation Review Committee (CARC) respectively.

The **Capital Project Review Committee** is responsible for reviewing and making recommendations to the SMC-Operations Committee on matters pertaining to resource requirements and allocations for capital and operations and maintenance (O&M) funding, as well as other issues with major implications for health facilities. The CPRC is co-chaired by the Executive Director of the Capacity, Infrastructure and Accountability Division (CIAD) and the FNIHB Regional Liaison for HFP. Membership includes regional and national managers from both FNIHB and CSB.

The audit expected to find that the CPRC's terms of reference identify the minimum quorum requirements, including both minimum attendance requirements and management level participation, to ensure effective decision-making to support the senior management committee (SMC-Operations Committee). The audit also expected to see formalized information requirements and processes to support regular reporting from the CPRC to the SMC.

The audit found that while issues were identified and actions were stated at CPRC meetings, there was no evidence of tracking or status updates in subsequent meetings, as would be the case with a 'forward agenda' mechanism to track completed actions of the committee. As well, while the terms of reference noted the requirement for four to six teleconferences and two face-to-face meetings annually, in fiscal year 2015-16 only, two teleconferences were held and there was one face-to-face meeting.

The **Capital Allocation Review Committee's** purpose is to provide advice and recommendations on the delivery of the Program at the regional level and to support regional executive decisions related to the prioritization of projects and allocation of funds through the long-term planning process through the CPRC.

The audit found that not all regions have this committee. In some regions, the function is exercised through senior regional executive management boards or committees. Where committees were found, the audit examined terms of reference, agendas and meeting minutes and held related interviews with regional representatives. The audit found that capital committee structure and implementation varied from one region to another. In one region, a robust committee function related specifically to health facility management has been implemented, including regular meetings, pertinent agenda items, the identification of specific actions, the assignment of responsibilities and timely follow-up. In comparison, in another region, there has been no committee activity in the last five years. In a third region, it was found that allocation review decisions were made at a regional management committee. However, whereas in the other regions there was CSB representation, in this region there was no representation from CSB. In yet another region, it was noted that only two meetings were held in the last 20 months, with no mechanism in place to follow up on identified issues and actions.

In conclusion, the audit found a governance structure in place for committees; however, operating effectiveness should be strengthened by updating and implementing requirements as described in the committees' terms of reference and by more consistent application across regions. Measures to strengthen operating effectiveness, as noted above, will minimize risks potentially arising from inadequately informed and supported decisions, the inadequate or untimely implementation of identified actions, and regional variability in program delivery.

Recommendation 1

It is recommended that the Senior Assistant Deputy Minister and the Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch, enhance the effectiveness of the committee structures by updating and adhering to the terms of reference for national and regional capital review committees.

Management response

At the national level, FNIHB will update and distribute the Capital Program Review Committee terms of reference (ToR) to all committee participants and ensure the ToR is followed. FNIHB will also communicate to the regions the expected outcomes of their regional capital committees and ensure that regions update the terms of reference for their committees to reflect the expected outcomes. Going forward, regions will attest annually that regional committees are following their ToR as part of their annual attestation questionnaire that they are required to complete.

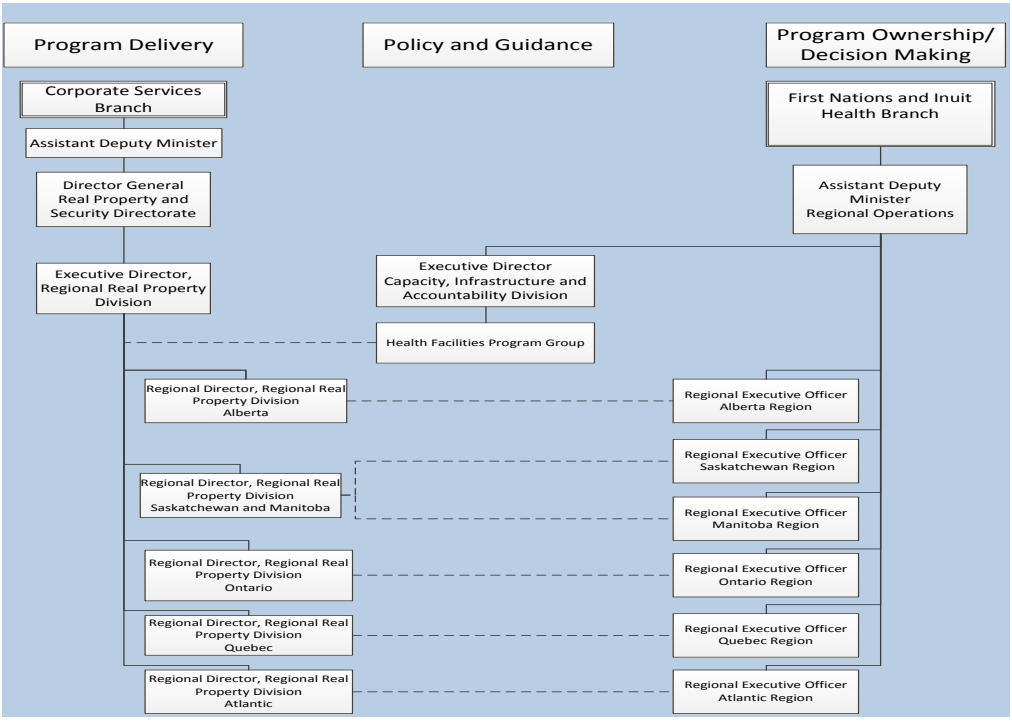
1.2 Roles and Responsibilities

Audit criterion: Roles and responsibilities for the delivery of the Health Facilities Program are clearly defined, documented and functioning as defined.

Roles and responsibilities are a key element of governance. A clear definition of roles and responsibilities supports accountability for decisions and effective and efficient undertaking of activities. Delivery of the HFP is a responsibility shared by FNIHB Headquarters, the regional offices, CSB and the contribution agreement recipients (see Figure 1).

Roles and Responsibilities

Figure 1: Organizational Chart Related to the Delivery of the HFP



At the regional level, **FNIHB Regional Executives** (RE) are accountable for delivery of the program and are the decision-makers with regard to the allocation of investments and funds within their respective regions.

- The **CSB Regional Directors,** Real Property Division, provide subject-matter expertise in capital project delivery. They are primarily responsible for activities that support the delivery of capital projects and O&M related to health facilities.

- **Capital officers** (also called facilities managers or zone managers) are part of the CSB Regional Real Property Division. They are primarily responsible for supporting and monitoring project implementation and status.

Guidance on Roles and Responsibilities

The roles and responsibilities of the various key stakeholders within the organizational units identified above, as well as roles and responsibilities of funding recipients, are defined and documented in a suite of guidance and business process documents (these were applicable at the time of the audit).

- The *FNIHB Framework for Planning and Managing Capital Contributions* (March 2016) outlines the governance structure for the HFP and the general accountabilities and responsibilities associated with the planning, management and delivery for the Senior ADM, the ADM of Regional Operations, regional executives, CIAD, CSB and contribution agreement recipients.

- *Knowledge in a Book* (February 2012) is a guidance document that specifically describes business processes for managing FNIHB capital contributions. This document also outlines the roles and responsibilities of the key players.

- In 2015, the *Health Infrastructure and Capital Protocol* (the Protocol) was developed to align with the implementation of the new single contribution arrangement approach and the introduction of the Grants and Contributions Information Management System (GCIMS).

A review of the documents and subsequent interviews with staff revealed that certain references and processes in the *Knowledge in a Book (KIAB)* are dated and no longer reflect the funding arrangement environment or the business processes and organizational structure. Management noted that it intends to update and disseminate new guidance replacing the *KIAB* document, in April 2017.

The auditors also conducted interviews with capital officers and other staff, who confirmed that their general roles are fairly clear and that there is effective communication and cooperation between FNIHB and CSB. However, an analysis of the documentation and subsequent interviews with staff found that the regions have implemented differing organizational structures and certain capital-related responsibilities may be exercised by different positions from one region to another. This can lead to unclear roles at an individual level if there are no clearly documented roles and responsibilities in place.

In conclusion, regional variations in organizational structures and operational environments, as well as expected new hires in support of delivery of the Social Infrastructure Fund (SIF) stimulus funding, increase the risk associated with the discharging of responsibilities. Documenting regional-specific roles and responsibilities for FNIHB and CSB staff implicated in the delivery of the HFP will minimize potential risks associated with unclear understanding of roles and uneven discharging of responsibilities (see recommendation 3 in section 3.2 related to updating policy and guidance).

2. Risk management

2.1 Risk management

Audit criterion: Risks associated with the delivery of the FNIHB Health Facilities Program are identified, assessed and managed.

The Treasury Board of Canada Secretariat's *Guide to Integrated Risk Management* (May 2016) notes the importance of risk management as a core element of effective public administration. The effective management of risk contributes to improved decision-making and better allocation of resources. The Guide states that a cohesive and integrated set of mechanisms for identifying, assessing, responding to, communicating and monitoring risk in the form of a risk management process can enable programs to manage risks more systemically.

Corporate Risk Management

The FNIHB Accountability Framework identifies headquarters' responsibilities to identify program operational risks, and in collaboration with the regions, develop risk mitigation strategies. Adhering to the requirements of the Accountability Framework would provide for a level of detail consistent with an operationalizing of risk management.

Health Canada's 2016-17 Corporate Risk Profile (CRP) identifies a risk to the Department's ability to ensure continuous delivery of health services due to a lack of quality maintenance and timely repairs of health facilities as a risk priority area for the department. The only branch identified to address this risk is FNIHB. The risk responses to address equipment and aging physical infrastructure are the following:

- address resource requirements through the reallocation of funds to address priority repairs and renovations;
- evidence-based planning to support the expansion and replacement of facilities according to the Capital Management Framework;
- innovation through the use of alternative capital funding approaches on reserve (this response strategy has been postponed due to Social Infrastructure funding); and
- partner engagement through increased First Nations follow-up to facility inspections.

The 2016-17 mid-year review of the CRP identifies progress made to date by CIAD in implementing and measuring the effectiveness of the mitigating strategy. For example, for the reallocation of funding to address priority repairs and renovations, FNIHB reports that 135 minor projects were approved with funding. For the expansion and replacement of facilities according to the Capital Management Framework, 37 of 42 projects are on schedule. And for the refinement of capital program practices to increase engagement of First Nations communities in the follow-up to facility inspections, there is a new action plan to have facilities inspected on a three-year cycle.

FNIHB's draft 2016-17 Branch Risk Register aligns with the CRP and identifies two key mitigating responses. The first is to implement an inspection schedule for nursing stations in First Nations communities; the second is to support the construction, renovation and repair of First Nations community health facilities. The targets identified include 100 inspections to be completed by March 31, 2019; the renovation of eight existing buildings to meet health and safety needs by March 31, 2018; and the replacement of 24 existing buildings by March 31, 2018.

The identification of risks and the associated risk responses documented in the corporate and branch level risk documents, as outlined above, are linked to strategic outcomes of the department and the Branch overall. This approach to corporate risk management is sound and in line with Treasury Board expectations.

Project risk management

The auditors tested 35 project files and conducted interviews with CSB and FNIHB regional management and found that individual project risks are discussed and considered when undertaking program delivery and management activities. Examples include the participation of facility officers and managers on major project management teams, the requirement to set up separate bank accounts for major capital project funding and the classification of capital cash flows as essential so that they are not held up due to outstanding reporting related to other programs. This last issue would put the capital projects at risk because of tight completion timelines, especially in remote locations with limited access.

The audit concluded that while project risks are informally considered, as described in the previous paragraph, when undertaking program activities, a formal, documented risk management process at this level is not in place to enhance the development, implementation and monitoring of specific risk management activities and help focus the efforts, effectiveness and efficiency of resources. (Recommendation 5 in this report, which relates to monitoring and reporting, addresses this issue).

3. Internal controls

3.1 Health Facilities Program investment and operational planning

Audit criterion: The Health Facilities Program funding allocation plans are developed based on adequate information and are risk-based.

Investment planning

Investment planning in the context of the Health Facilities Program (HFP) refers to the processes related to making decisions for the allocation of funds to address capital project and operational and maintenance needs. In this context, investment planning provides the framework to ensure well informed, prioritized and risk-based decision making in the allocation of capital funds.

Capital project funding

Capital investment funding under the HFP is supported by the long-term capital planning process. The national Long Term Capital Plan (LTCP) consolidates regional plans with a five-year horizon. The regional plans are prepared and refreshed annually, using standard templates, and are approved by the FNIHB regional executives. LTCPs are based on national and regional priorities focusing on health and safety projects and on facilities providing primary care. They present key information including: age of the facility; cost estimate and estimated cash flows; status on projects under way; and comments providing context for the need for the project. LTCPs also include prioritized regional listings of unfunded projects and thus serve as an inventory of identified projects for future years, or in the current year should funding become available.

In conclusion, there is an established investment planning process for capital projects that is based on addressing the most urgent requirements within individual regions. It is supported by a transparent and agreed-upon methodology of allocating funds to regions, and the national committees present an adequate forum for further discussions and reallocations.

Operations and Maintenance funding

Operations and Maintenance (O&M) funding is allocated to regions based on long-established methodologies and formulas. The regions in turn, provide the O&M funding to recipients with health facilities through consolidated agreements.

There is a significant shortfall of funding to adequately address recapitalization and current O&M requirements. This was acknowledged by FNIHB and CSB program management. For example actual overall funding provided by the HFP in the past two fiscal years has been well in excess of planned spending, the variance being funded via reallocations from other programs to address capital and O&M priorities.

A costing model exercise was undertaken in 2012-13 by the program. This exercise collected costing data related to the operating of nursing stations and health centres in remote and isolated First Nations communities in Ontario and Manitoba. However, there was insufficient data collected in this exercise for it to be useful in identifying trends or to update O&M funding formulas and it was not shared with the regions.

Since 2012-13, there has not been any systematic effort to obtain required information and ascertain O&M costs by facility, even for the larger components of O&M such as fuel and electricity. While some regions are beginning to solicit such information from recipients, this is currently an ad hoc effort. In order to more accurately identify the extent of this shortfall, the program needs to make a concerted effort to obtain such information from the First Nations communities.

Review of funded projects across different regions also identified inconsistencies in how project expenditures are coded in SAP. For example, one region classified as O&M, certain recapitalization projects that included the renovation of existing space and a new sewage treatment system, involving a significant expenditure of $250,000 and more. In another region, minor expenditures related to the installation of de-icing cable on a roof and minor floor re-tiling costing $10,000 or less were coded as capital projects[1].

In conclusion, planning and allocation of O&M funding is not based on an up-to-date allocation methodology and the current data, which the allocation has been based upon, has not been updated since 2005. Also, the audit noted inconsistencies in coding which may increase the risk that O&M funding is not being equitably or optimally aligned with actual requirements due to reporting inconsistencies. (see recommendation 2 below related to investment and management operational planning).

Audit criterion: FNIHB has sufficient capacity and resources to manage the program and develops operational plans to support the effective and efficient use of resources for the delivery of key program activities.

Management operational planning

Operational management refers to the business practices in place that serve as controls to support the effective and efficient use of resources in delivering program activities and achieving pre-defined milestones.

The audit confirmed that there is an established, standardized annual Branch planning process that includes the preparation of the management operational plans MOPs at the regional level. MOPs are reviewed and approved by senior management at both the regional and national levels. A refresh process during the year serves as an effective means for requesting and re-allocating resources among projects and regions.

[1] Minor capital expenditures are categorized as the construction or repairs to a facility, valued at a certain dollar threshold. O&M expenditures cover minor repairs to existing facilities.

A review of the regional MOPs identified that they incorporate all programming delivered by the regions, including the HFP, and present high-level program information for each program in two or three lines. However, the financial resources allocated through the long-term Capital Plan are not included in the MOPs. The auditors noted that the MOPs do not include sufficient detail to serve as an effective tool for directing and managing operational efforts and to support the alignment of resources with operational activities.

The HFP component of the MOPs focuses on the identification and allocation of contribution funding for capital purposes, O&M for maintenance of the facilities on reserve as well as an operations budget for items such as travel. Although the planning documents are structured to identify deliverables and milestones for each quarter, this is also done at a very high level using general terminology to describe deliverables and milestones. In certain cases, quarterly milestones have not been identified. Further details would enhance the usefulness of the documents for operational planning including more specific activities to be undertaken and milestones to be achieved, the identification of resources dedicated to the undertaking of individual activities, and adequate indicators for the measurement of performance against planned operational activities.

Such detail could be developed in another operational document; however, while requests were made for more detailed operational plans that would support the MOPs, no documentation was provided to the auditors.

Resource utilization

Decisions related to human and financial resources dedicated to program management and delivery are made at the regional level. Regions are provided with an overall budget and regional executives make decisions on resource allocation within their region. Resources related to the delivery and management of the HFP primarily fund the activities of the CSB offices in the regions, to the extent that they support capital project delivery and O&M related activities.

The audit found that the allocation of funds to the regions for delivery of the HFP is not supported by an analysis by Headquarters to determine regional resource requirements. Resource allocation to the regions has been based, to a large degree, on legacy methodologies and historical allocations.

A comparative analysis of resource information identified that there is regional disparity in the allocation of human resources relative to capital budgets and health facilities. For example:

- One region with program expenditures of $3.4 million (2014-15), no nursing stations and facilities that are concentrated close to urban centres has four Engineering and Scientific Support (EG) capital manager and officer positions staffed.

- Another region with seven times the capital expenditures in the same year (approximately $25 million) and with more facilities, including nursing stations in remote and isolated communities, has only two EGs on staff.

- A third region with twice the expenditures ($7.7 million) has only one facility manager at the Administrative Services Group (AS) classification.

Furthermore, the latter two regions have been sharing a regional CSB director, while other regions each have a dedicated resource in the position.

Interviews were conducted with regional FNIHB and CSB management to determine the operational planning and resource allocation processes in place and to identify potential challenges and risks. Regional capital officers noted that resourcing has been an issue, especially in the regions where capital expenditures are large, communities are remote and isolated, and assistance to First Nation communities is most required. This has impacted the ability to plan and undertake capacity-building activities and facility inspections and to perform adequate file administration and documentation review.

The audit was also informed that the regions are in the process of addressing the need for additional resources for delivery through stimulus funding from the Social Infrastructure Fund (SIF). However, they are at various stages of preparation. While some have either staffed or are at the final stages of staffing processes, others indicated that the process had not yet been started.

In conclusion, the absence of detailed operational plans and analysis for the program, based on capital construction and O&M activities planned in the regions, has contributed to an allocation of resources that may not meet actual requirements. The stimulus funding and the associated increase in capital construction activity increases the importance of a more robust operational planning process and review of the regional allocation of resources specific to the HFP.

Recommendation 2

It is recommended that the Senior Assistant Deputy Minister and the Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch, ensure that:

- **A systematic process to collect and analyze current data related to facility O&M requirements is implemented and that O&M funding provided to recipients is consistently and accurately recorded to support decision-making; and,**

- **A resource review is undertaken in collaboration with the Assistant Deputy Minister, Corporate Services Branch, to ensure that regional operational plans for the HFP are developed that optimally reflect the best alignment and allocation of human resources to adequately support program delivery activities.**

Management response

FNIHB will use 2016-17 GCIMS data along with data from SAP to determine O&M allocations and conduct a quantitative analysis. The analysis will include identification of miscoded transactions and recommendations for correction, and will be used to plan for the implementation of O&M planning and reporting.

FNIHB will implement an O&M planning, analysis, and reporting component into the long term capital planning process. The template for data collection and input will be developed and implemented to coincide with the next LTCP planning cycle in the fall of 2017.

FNIHB, in collaboration with CSB, will develop an MOU including the expected level of service to be delivered and based upon an analysis of the regional supports to ensure proper alignment.

3.2 Policy/guidance, processes and systems

Audit criterion: FNIHB has current policies, guidance manuals and systems for the delivery of the FNIHB Health Facilities Program.

Effective policies and guidance support management and staff in discharging their responsibilities according to expectations. Effective systems allow for the capture, analysis and reporting of information that facilitates and enhances decision-making, performance measurement and accountability.

Policies and guidance

The development of standards, policies and guidelines is a national-level responsibility that resides within CIAD at the FNIHB headquarters. The suite of documents that has been developed and is in place to set standards and provide guidance for the delivery and management of the HFP is outlined in section 1.2 of this report and includes the FNIHB Framework for Planning and Managing Capital Contributions (March 2016), *Knowledge in a Book* (*KIAB*) (February 2012), and the *Health Infrastructure and Capital Protocol* (February 2015).

Other related protocols and guides include a protocol for conducting integrated facility audits (IFA), planning and design guidelines for FNIHB-funded health facilities, and guides for conducting recipient audits and for recipient reporting.

A review of the documents identified that sections of certain documents are dated or do not reflect the current funding arrangement environment, business processes and organizational structure; they offer inconsistent guidance that may be subject to varying interpretations by capital officers.

Project Processes

The audit sampled 35 capital files that included projects that were completed or started during the April 2014 to October 2016 time period in three regions, and conducted interviews with program officials to test the processes related to capital project implementation in the area of technical feasibility studies, functional plans, environmental assessments, tendering, project administration fees, and the demonstration of due diligence and file administration.

Technical feasibility studies are studies prepared by professional architects or engineers examining the relative merit and feasibility of one or more design and construction or renovation options for proposed projects. The Protocol states that the capital officer may request that a feasibility study be carried out at any time.

File testing and interviews found that that there are regional variations in this practice. While in one region, capital officers stated that feasibility studies were always considered and conducted on a regular basis, in another region the capital officer responsible for two major capital files tested stated that feasibility studies were not undertaken as a rule because there was no value in them because the need and scope of the project were known to the Department.

Functional plans outline the rationale for space requirements for new facilities based primarily on the types of funded health programs delivered in those facilities. The *KIAB* states that "to ensure program requirements are met, the functional plan and routing slip is signed off by all applicable programs".

A review of project files found that there were some with complete functional plans, others with multiple versions, and some where the actual facility space did not match the space in the functional plan. Capital officers confirmed that programs were consulted, and in some cases related email evidence was provided. However, of the applicable files tested, only 40 percent contained formal sign-offs on the functional plans by the various health program representatives to indicate input or concurrence with the plan.

In addition, the audit found inconsistencies in how the determination of space requirements is interpreted and applied. In one region it was stated that, in designing facilities, they do not "build in" space for future growth of the community. Two other regions indicated that future growth is taken into consideration in determining space requirements and designing health facilities.

Environmental assessments are a tool used by the federal government to evaluate the potential environmental effects from proposed projects. It ensures that any negative environmental effects are identified and measures developed to mitigate those effects. Ideally, environmental assessments are initiated as early as possible in a project's planning process.

A review of project files and interviews with capital officers established that there were inconsistencies in the understanding of how to go about addressing environmental concerns and in documenting related decisions. Where environmental concerns were addressed by consultants on behalf of the recipient, there was no evidence of documentation review or guidance on the role of the capital officers or environmental authority/officer within FNIHB or CSB. The officers interviewed stated that it is the responsibility of the recipient and the project consultant to determine the need for, and the extent of, an environmental review. However, given that the requirements for environmental reviews are not clearly understood and documented, there is a risk that environmental concerns may not have been consistently or adequately addressed and may not be on future projects.

Tendering (competitive contracting) is a sound comptrollership practice that demonstrates the application of fairness and best value in the procurement of goods and services. The *Knowledge in a Book* guidance states it is a best business practice and a condition of funding

for recipients to competitively award contracts for the services of a consultant (architect) and contractor. It further states that competitive tendering should always be the best practice by First Nations for contracts exceeding $100,000 and that where the competitive process is bypassed, the decision should be supported by a written rationale.

Of the projects sampled for construction services, the audit found that 60 percent of projects were awarded in line with requirements; however, documentation was found to be weak.

Of the files sampled for architectural services, 64 percent did not contain evidence of following a tender process, and for project management services only eight percent of files contained evidence of tendering.

Capital officers confirmed these observations and stated that although recipients may solicit advice or suggestions from the capital officers related to competitive tendering, the decision is ultimately that of the recipient, and often depends on the level of prior association between recipient and project manager or consultant and/or on the availability of the service in the area.

Project administration fees

The Terms and Conditions of the Health Infrastructure Support Authority that governs the Program state that: “generally, eligible expenditures will include administration of the programs, staff salaries and benefits”. Administrative fees/costs are not addressed as an eligible expense for the program and this lack of guidance has caused a wide range of practice in this area.

The testing of project files found that Administration fees to recipient First Nations or related Tribal Councils/Health Authority organizations are part of funded project budgets. These fees ranged from two percent to 10 percent of the overall project costs and in some cases involved more than one level of administration; that is, budgets allocated the costs to administration by the First Nations community, a related tribal council or technical authority organization.

Capital officers stated that the administration fees are determined on a project-by-project basis, taking into consideration the degree of administration that would be required depending on the nature of the project. However, there was no documented evidence in the files justifying or indicating how the amount of an administration fee was derived. For example, for two seemingly identical projects sampled, managed by the same regional office under the oversight of the same facility manager, administration fees for one project were approximately $41,000 while for the other they were $11,000, and overall soft (non-construction) costs were $100,000 and $30,000 respectively.

Demonstration of due diligence and file administration

A capital project self-assessment checklist is required to support a consistent file structure for each facility project from initiation to completion. Review of project files found that checklists were not used.

Checklists assist in documenting the extent of the capital officer’s due diligence in monitoring the project to ensure that key documentation requirements are identified and maintained in a

consistent file structure. The audit revealed that change orders and documentation related to contractor tender were not consistently on file.

Capital officers confirmed that while they did not always have certain documents on file, they expected them to be with the Project Manager, as it was primarily the Project Manager's responsibility. For all regions visited, capital officers stated that there was no specific regional guidance related to demonstrating their due diligence in regard to capital project delivery or specific expectations for file documentation, and that no such guidance had been received from CSB, Headquarters.

In conclusion, the above noted observations may indicate that capital officers do not have a clear or common understanding of what the specific expectations are with regard to certain aspects of capital project implementation. Not following all required steps increases the risk that projects may not be undertaken in accordance with program requirements, and that inconsistencies in implementation may result in inefficiencies in project delivery and/or inequitable project funding. The lack of a common understanding of the expectations to demonstrate due diligence in supporting and monitoring of the capital projects, as outlined in the policies and guidance manuals, increases the risk to the program. Finally, it is necessary to ensure that all steps undertaken are documented to demonstrate that they have been completed for due diligence purposes.

Recommendation 3

It is recommended that the Senior Assistant Deputy Minister and Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch, ensure that:

- **Policy, guidance documents and directives for project implementation and monitoring are updated and communicated, and that applicable roles and responsibilities are clarified.**

Management response

Clear and up-to-date documentation is critical for the sound operation of a program such as HFP. In 2015-16, FNIHB updated the FNIHB Framework for Planning and Managing Capital Contributions and the FNIHB Health Infrastructure and Capital Protocol.

FNIHB will review and update, including strengthening roles and responsibilities, all key documents (as outlined below) related to the delivery of the Health Facilities Program. This will include updating the Framework and Protocol documents, and completing a draft Project Brief document that was developed in 2016-17, and as well as a project Business Case document. Finally, FNIHB will revise the Property Planning and Management Manual (PPMM) to reflect policy changes.

Systems

There are two key information management systems in place to support delivery and management of the HFP.

The **Real Property Management Information System (RPMIS)** is in place to capture and manage health facility-related information. The program recognizes that there has been a long standing need for a system replacement, which was identified as early as 2010, and was noted in the Health Canada *FNIHB Facilities and Capital Program – Cluster Evaluation* report in 2012. Interviews with program representatives at the regional and national levels confirmed that: the system is based on an unsupported Lotus-based platform, lacks the required functionality, and there is a risk that the information may not be accurate or complete. Concerns were also expressed that there is a significant risk of malfunction and data loss due to the instability of the system. The noted concerns and the lack of functionality have necessitated the development of databases/spreadsheets by individual regions, resulting in potential inefficiencies and inconsistencies in data capture.

It is noted that the program has to work within the constraints of the departmental Information Management/Information Technology investment process and related priorities. HFP management at Headquarters has stated that this has thus far inhibited procurement of a replacement system in a timely manner.

The 2016-17 FNIHB Management Operational Plan has earmarked $250, 000 and to implement a new data management system to replace the RPMIS. To date, HFP has been working with the Information Management Services Division and SSC to develop detailed business requirements as well as options analysis.

The **Grants and Contributions Information Management System (GCIMS)** was adopted for use by the department at the beginning of fiscal year 2015-16. The system automates the Department's transfer payment business processes and manages funding agreements and funding agreement information. Its functionality offers key benefits that are intended to improve overall accountability, including:

- creation and management of funding agreements, amendments and adjustments, including built-in controls related to the use of CA templates and tracking of the approval processes;
- financial transaction management and reporting; and
- submission, review, and approval of recipient reporting requirements.

Interviews with users resulted in some mixed opinions. While users said that there were challenges related to the system, they attributed these primarily to its novelty, and noted that the challenges were resolved as experience with the system was gained.

In conclusion, GCIMS has been adopted and incorporated to support the management of HFP contribution funding. However, due to its limited functionality and unsustainability, the RPMIS presents significant risks related to loss of data and to the effective and efficient management of facility-related information. In addition, the creation of spreadsheets in the regions to capture data poses a risk of unreliability of data and inefficiencies in rolling up data, which may be inconsistently captured from region to region.

Recommendation 4

It is recommended that the Senior Assistant Deputy Minister and Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch, ensure that:

- **A system to replace the current legacy real property management information system is obtained; and,**
- **In the absence of a fully functional real property management information system, an interim mitigation strategy is put in place to capture business information by region.**

Management response

FNIHB recognizes the need to have a fully functional real property management information system and work has been underway to advance a solution, while also recognizing the need to work within the Health Canada – Shared Services Canada priority list (as of March 2016, the project was ranked 42 out of 59 on the priority list).

FNIHB will continue to work through the departmental Investment Planning process for an appropriate replacement system for the existing Real Property Management Information System (RPMIS). Efforts will focus on developing options and a Business Case that will reflect a project scope which has evolved to include different types of assets from different program areas [e.g. Aboriginal Head Start On Reserve, National Native Alcohol & Drug Abuse Program]. This will require a consistent reporting approach across different programs and regions. The Government of Canada IT funding requirements have changed since the project was originally started, which will have implications on the steps and timing required to complete the project depending on the option chosen.

In the interim, FNIHB will continue to implement mitigation measures to ensure business processes can be followed and information of value is collected. A formal strategy will be developed to consider 1) using appropriate components of the existing system to the extent possible, including the following applications: main building information database, FCES, and asset management; and, 2) implement regionally consistent processes and templates, related to: Project Brief, Long Term Capital Plan (LTCP) and audit and inspection follow-up. Work around solutions mainly include the use of excel spreadsheets (e.g. LTCP) and Word templates (e.g. Project Brief).

Please note: While no new development can occur on RPMIS (development platform is no longer supported), the System will be supported and remain active until a replacement solution is implemented.

3.3 Transfer payments

Audit criterion: Contribution agreements comply with the Treasury Board *Policy on Transfer Payments* and related directives and include appropriate clauses to enable the management or mitigation of program and project-related risks at the recipient level.

The contribution agreement is a key accountability document and control for managing the transfer of funding from Health Canada to recipients. Accordingly, agreements must contain appropriate clauses to allow for the effective management of funds while complying with requirements for agreements and related clauses, as set out by the Treasury Board Secretariat (TBS).

Effective April 2015, FNIHB adopted a single funding agreement approach for its First Nations recipients. Under this approach, funding to recipients that was formerly provided through specific capital contribution agreements is now provided through the single consolidated agreement with the recipient through an amendment to the agreement.

The Regional Support and Coordination Unit, Health Funding Arrangements (HFA) Division, at Headquarters has developed common agreement templates for use by all regions. A detailed review and comparison of the clauses in the template agreements and those outlined in the TBS *Policy on Transfer Payments*, and the supporting Directive established that the template agreements comply with requirements of the TBS Directive.

Within each region, there is an HFA function that supports the preparation and implementation of the funding agreements. This involves an extensive review and quality assurance process for agreement and amendment execution, including various review stages by peers, program managers, CSB and HFA representatives prior to signature of agreements and amendments by the regional executives. Since the implementation of GCIMS in 2015-16, deviations from the template agreements can be controlled because GCIMS has the capability to identify any text deviations from the approved templates. These deviations require the approval of the HFA Division at Headquarters.

A sample of 15 agreements was tested. It was found that they all contain the required clauses to facilitate effective monitoring and reporting related to capital funding. During interviews, FNIHB officers indicated that they communicate with the capital officers prior to issuing capital payments. However, they confirmed that there are currently no formal sign-off requirements. This increases the risk that while project funds may be provided based on the agreed cashflow schedule, they may be provided in advance of need in cases where the project is not progressing at the originally anticipated pace. Both FNIHB and CSB officers in the regions indicated that they are currently working on implementing a formal sign-off process to address this risk.

In conclusion, the migration to a single funding agreement is consistent with the overall government initiative to simplify, to the extent possible, the overall funding processes and to minimize the administrative burden on recipients and departments. Furthermore, the template

agreements developed are consistent with the requirements of the TB *Policy on Transfer Payments*, and the process in place for their implementation is well controlled.

3.4 Monitoring and Reporting

Audit criterion: A systematic process is in place to monitor, assess and report on the status of capital projects and the condition of the health facilities funded by FNIHB.

Monitoring and reporting is a key component of any management framework. It enables management to assess the activities undertaken and the attainment of related milestones in relation to plans, standards and expectations. It also facilitates the adjustment of plans and strategies and supports the effective reallocation of resources.

Project monitoring

Capital officers and regional CSB directors are closely involved throughout the life cycle of major projects. They are informed of project progress and potential issues through:

- participation as non-voting members of the project management team;
- the review of key documentation including facility design documents, cost estimates and budgets;
- the review of scope change and change order reports provided by the project manager;
- monthly progress reports provided by the project manager itemizing actual costs in relation to the budget and a qualitative description of the status of project; and
- interactions with regional FNIHB officers visiting the communities, as well as maintenance technicians, environmental health officers and Health Canada nursing staff residing in the community.

Capital officers review the required capital project and O&M reports. GCIMS provides effective functionality and control for capturing and providing an adequate audit trail for the status of reporting required under the contribution agreements.

Reporting on project status at the regional level is accomplished through project status updates that are provided by the Regional Real Property Division (RRPD) regional director to FNIHB regional executives, formally and informally through bilateral meetings, at the regional executive management table or at the Capital Allocation Review (or equivalent) Committees. At the national level, senior management at the SMC-Operations Committee table is provided with status updates on projects through the Long Term Capital Plan (LTCP) refresh process.

Condition of health facilities

The condition of health facilities is assessed informally when visits are undertaken by FNIHB representatives such as environmental officers and program staff or by capital officers. They are also evaluated using two more formalized inspection activities.

Integrated facilities audits are independent, third-party audits coordinated by HQ that focus on auditing the condition and performance of health facility infrastructure and buildings, the performance of the facility's operations (including health and safety elements and environmental performance), and maintenance practices. A small sample of health facilities from across the regions are audited annually based on a regional risk based identification process. A protocol for conducting these audits has been developed to guide qualified contractors in undertaking the audits. It includes a framework for determining the priority of findings and a reporting template. Final reports are reviewed by HFP Headquarters for consistency and completeness and distributed to the regional offices for communication to the recipients and follow-up. The regions prioritize capital elements of the reports and include them, as appropriate, in their LTCPs.

Facility condition reports (FCR) are the outputs of inspections of health facilities. They focus solely on facility condition and not on the additional areas covered in the IFAs such as facility operations, environmental performance, and health and safety elements. These inspections are coordinated at the regional level and undertaken by First Nations, associated technical authorities, regional capital officers or contractors engaged by the regional office.

The Office of the Auditor General's (OAG) Report Four, *Access to Health Services for Remote First Nations Communities,* dated Spring 2015, noted that Health Canada did not fully adhere to its schedule for conducting inspections of nursing stations. The present audit found that the HFP has responded to the related recommendations of the OAG report by:

- Establishing a three-year cycle for the completion of inspections of all facilities;
- Communicating explicit requirements through the FNIHB Framework for Planning and Managing Capital Contributions and the *Health Infrastructure and Capital Protocol*; and
- Implementing an 'Attestation' mechanism using a self-assessment questionnaire, whereby regional executives attest to the process in place in their region relative to standards. Through responses to the 10 questions and comments providing relevant context, the regional executives indicate the extent to which their region is compliant with the standards.

The regions have set schedules and are working on completing the FCRs and meeting the three-year cycle. However, some interviewees expressed concern that resource restrictions will present a challenge. The HPF has made a commitment and taken steps to partner with Indigenous and Northern Affairs Canada to jointly conduct facility inspections where possible.

Areas for improvement

The above notwithstanding, the following audit findings offer opportunities to improve the monitoring of capital projects and facility conditions.

- Inconsistent file documentation demonstrating the due diligence of capital officers in monitoring and supporting capital projects (see section 3.2).
- Approximately two Integrated Facility Audits are conducted per region annually, leaving the prioritization at the regional level, which may not reflect national level priorities.
- Reservations were expressed that the three-year cycle for conducting FCRs may be overly ambitious (the largest region, Ontario, has recently started to catalogue, prioritize and provide estimated costs for the over 4,000 identified deficiencies stemming from over 70 inspections reports carried out three years ago through the FCR process).

- An analysis of integrated facility audit findings has not been undertaken by HFP management, thus limiting HFP management's ability to maintain, track and analyze recommendations from these audits to identify common themes or challenges as well as to provide additional direction if required. Information related to building conditions and tracking of audit findings has been left up to individual regions.
- Regional capital officers are creating and updating their own regional databases to capture information related to building conditions, which may not be consistently maintained and tracked.
- The regions confirmed that it is not known how many First Nations recipients have established and implemented O&M plans specific to their facilities.

O&M plans do not currently form part of the integrated facility audit or facility inspection criteria. HFP management stated that, as capacity of recipients in this area improves, there is a longer term view of refocussing and transitioning the integrated facility audit process to an O&M audit process, with an emphasis on specific aspects of the facility O&M plans.

Suggested improvements and recommendations made in this audit report pertain to managing project risks in a more formal manner; effectively communicating more prescriptive guidance for capital officers; capturing and analyzing actual facility O&M costs; and replacing the current facility management information system to support more effective monitoring and reporting. However, in light of these findings, there remains a risk that the regions may not be effectively or consistently undertaking monitoring activities and follow-up related to capital project implementation and O&M activities.

The audit concludes that in addressing the identified areas related to monitoring, and as part of the suggestion to formally implement project risk management (section 2.1) and in support of the update of guidance (recommendation 3), the HFP would benefit from the establishment of an active monitoring, follow-up and quality assurance role at the national level to provide oversight of regional practices. This would ensure that guidelines and expectations are consistently understood and equitably applied across regions and across recipients for this national program.

Recommendation 5

The Senior Assistant Deputy Minister and the Assistant Deputy Minister, Regional Operations, First Nations and Inuit Health Branch should ensure that a national quality assurance function is established to monitor regional capital facility funding and monitoring activities, including project risk management, to support consistent and equitable regional practices and to enable effective and timely adjustments to program policies when required.

Management response

FNIHB will incorporate a year-end follow-up process for the long term capital plan, including a direct review of project files (random sample of five minor and two major capital files for every region that has this volume of projects), and develop a capital project checklist to better support file management and decrease risks to the Program.

3.5 Recipient capacity building

Audit criterion: FNIHB provides training and support to recipients to increase their capacity to manage the maintenance, security and environmental issues in their facilities.

Capacity building has been identified as one of the key components or themes in the HFP's logic model and draft Performance Measurement Strategy. The stated activities associated with this theme include the provision of information and training related to the management, administration and delivery of capital projects and facility operations.

The audit confirmed that a certain level of support is provided to recipients. At the national level, the *Guide to Developing and Implementing an Operations and Maintenance Plan for Your Health Facility* has been developed for use by recipients. At the regional level, facility managers, capital officers and maintenance technicians provide support through participation on project management teams and advice when visiting communities or if otherwise requested by the recipients. However, interviews with these regional representatives also confirmed that although ad hoc advice may be provided, capacity-building activities are not systemically undertaken. Furthermore, there are no related plans or specific initiatives, associated resources are not identified or allocated and there is no mechanism to adequately measure progress or results.

Regional capital managers and officers stated that the level of capacity varies greatly among recipients. Many face challenges in contracting for relatively straightforward services and to address very basic O&M requirements, necessitating that in certain cases, O&M technicians within CSB undertake such services or contract on their behalf.

An Evaluation report on the HFP found evidence of direct capacity-building activities in the regions visited. However, it was noted that smaller, more remote communities tend to face the greatest challenges with respect to increasing their capacity related to capital projects and for the management of O&M activities.

In conclusion, the HFP is at risk of not meeting its objective, outlined in its draft Performance Measurement Strategy, to enhance the capacity of First Nations recipients in the management, administration and delivery of capital projects and facility operations in order to support safe health facilities. The audit acknowledges that due to the vast differences in qualified resources available in each community and their various capacities to undertake capital projects or appropriately maintain the health facilities, a one-size-fits-all capacity-building strategy may not be feasible. Accordingly, a more systematic approach to capacity-building activities and measurement of related results will enhance the HFP's ability to manage the identified risk.

At the time of the audit, the HFP was in the process of updating its Performance Measurement Strategy and related logic model. The HFP stated that the alignment of future expectations related to capacity building with the logic model would be addressed through this update exercise.

3.6 Performance measurement

Audit criterion: Relevant performance data exists and is used to support decision-making.

Performance measurement is a key process and control in support of accountability and in providing relevant information to support decision-making. It ensures that strategies and operational plans continue to be relevant and effective in the attainment of the overall program objective(s).

The Health Facilities Program (HFP) has a draft 2016-17 logic model and a supporting Performance Measurement Strategy (PMS) that is designed to be a sustainable and repeatable process for the systematic collection and analysis of performance information. The logic model identifies three key components or themes with associated activities, outputs and expected immediate, intermediate and long-term outcomes. The supporting performance measurement strategy identifies 18 expected results and associated performance indicators.

In its 2015-16 Departmental Performance Report, Health Canada reported on two performance indicators for the program, namely: a) the number of high priority recommendations stemming from integrated facility audits that are addressed on schedule; and b) the number of recipients who signed contribution agreements starting in 2011-12 and who have developed plans for managing the operations and maintenance of their health infrastructure. At the time of the audit, Health Canada undertook a revision of the Performance Measurement Framework including health facility indicators, and implemented a new requirement to track inspections and resolution of deficiencies. However, the first reporting cycle was not completed during the scope of this audit. For these reasons, the audit was not able to assess evidence of systematic performance indicator collection and reporting.

During the audit, some regional management and staff stated that they do not undertake performance measurement activities of their own, but try to provide information to headquarters who request information on an ad hoc basis. The provision of information has not been a formalized and consistent process to date.

In conclusion, although the HFP is currently not monitoring all outcomes on a regular basis, it is in the process of updating its Performance Management Strategy and aligning it with the overall program objectives. At the time of writing this report, the HFP was working closely with the Evaluation Office of the Office of Audit and Evaluation (OAE) to update its Performance Management Strategy. The revised strategy is expected to be approved in 2017.

C - Conclusion

The audit concludes that, although there is a management control framework in place for the support and monitoring of construction and maintenance of health facilities in First Nation communities, opportunities exist to improve the functioning of the program's governance structure, the provision of clear and current guidance, and the consistent implementation of some internal controls.

The HFP would benefit from reviewing the existing governance committees to strengthen their operational effectiveness; adopting a systematic process to collect and analyze current data related to facilities O&M requirements and ensuring funding provided to recipients is consistently coded. More detailed regional operation plans should be developed to support program delivery and the alignment of internal resources.

To address the challenges that exist related to the national scope of the program and the regional delivery model, the program would further benefit from updating and consistently communicating policy and guidance documents as well as applicable roles and responsibilities. The program should continue its work to replace the program's current real property information management system, and ensure that an interim mitigation strategy is put in place to capture information. As well, an active quality assurance function over regional practices at the national level should be put in place.

Contribution agreements governing HFP funding provided to recipients, and the processes in place to manage the funding agreements comply with the requirements of the Treasury Board *Policy on Transfer Payments*.

The areas for improvement that have been noted in this audit report will collectively strengthen the effectiveness of the management controls for the Health Facilities Program.

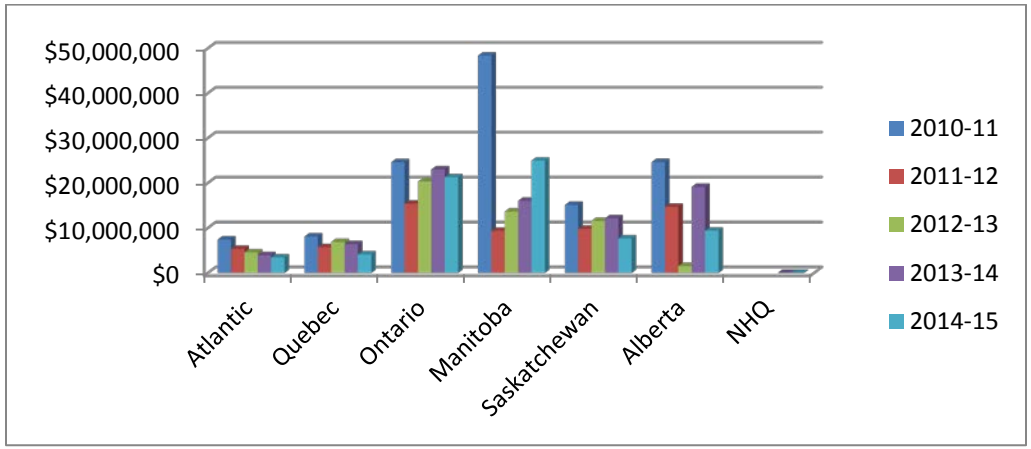
Appendix A – FNIHB Health Facilities Program expenditures, by region[2]

FY2014-15	# of Cases	Grants and Contribution	Operating	Salaries and Wages	Total	%
Manitoba	82	$24,982,164	1,033,747	$137,409	**$26,153,320**	**32.9%**
Ontario	152	$21,268,708	2,811,565	$894,714	**$24,974,987**	**31.4%**
Alberta	59	$9,410,046	$1,389,017	$98,316	**$10,897,379**	**13.7%**
Saskatchewan	73	$7,692,068	$97,215	$104,944	**$7,894,227**	**9.9%**
Quebec	38	$4,143,222	$90,848	$100,352	**$4,334,422**	**5.5%**
Atlantic	58	$3,436,079	$55,518	$97,632	**$3,589,229**	**4.5%**
Headquarters	1	$36,441	$482,297	$ 927,658	**$1,446,396**	**1.8%**
Northern			$39,979	$146,612	**$186,591**	**0.2%**
Total	**463**	**$70,968,728**	**$6,000,186**	**$2,507,637**	**$79,476,551**	
		89%	**8%**	**3%**		

* This amount includes $12,875 of Vote 5 expenditures in Manitoba

[2] These are figures from SAP. They include the new codes KM00, KM01, and KM10. The totals are aligned with the DPR and the financials provided to Evaluation.

Appendix B – FNIHB Health Facilities Program contributions, by region, from 2010-11 to 2014-15



Region	2010-11*	2011-12	2012-13	2013-14	2014-15	5-yr Total
Atlantic	$7,432,627	$5,367,592	$4,562,181	$3,933,881	$3,436,079	$24,732,360
Quebec	$8,105,667	$5,728,530	$6,896,887	$6,417,788	$4,143,222	$31,292,094
Ontario	$24,637,255	$15,401,486	$20,346,523	$23,023,039	$21,268,708	$104,677,011
Manitoba	$48,383,928	$9,373,359	$13,673,950	$16,051,302	$24,982,164	$112,464,703
Saskatchewan	$14,692,897	$9,809,763	$11,607,370	$12,144,097	$7,692,068	$55,946,195
Alberta	$24,660,157	$14,692,897	$15,556,034	$19,152,349	$9,410,046	$83,471,483
NHQ[3]				$17,774	$36,441	$54,215
Totals[4]	$127,912,531	$60,373,627	$72,642,945	$80,740,230	$70,968,728	$412,638,061

[3] Health Canada Funding for Self-Governing First Nations in British Columbia, three year Interdepartmental Letter of Agreement for funding to be transferred to the First Nation's via Indigenous Affairs and Northern Development Canada (ending 2015-16)
[4] BC Region has been removed for comparison purposes. BC Region was transferred to the First Nations Health Authority (FNHA) in 2013-14.
*Increased expenditures due to Economic Action Plan activities

Appendix C – Health Facilities[5]

At the time of writing this document, the classification of facilities was still based on aspects of remoteness and isolation as follows:

Nursing stations

- Located in an isolated or remote community with no year-round road access to other health facilities.
- Staff: two or more community health nurses, support staff and other primary care staff.
- Services: 24-hour access to urgent care, short-term in-patient care and public health.
- Visiting services: physician and dental care.

Health centres

- Located in non-isolated and semi-isolated communities.
- Staff: two or more community health nurses and support staff.
- Services: disease prevention, health promotion.
- Primary and urgent care provided by area physicians or on a visiting basis.

Health stations

- Located in isolated or semi-isolated communities.
- Staff: community health nurses and support staff.
- Services: disease prevention, health promotion; may also include primary care services for urgent health needs but only on weekdays.
- Visiting services: physician and dental care.

Health offices

- Leased space within a multi-purpose building.
- Supports the work of Community Health Representatives, visiting community health nurses and other visiting health care providers.

National Native Alcohol and Drug Abuse Centres

The Centres for the National Native Alcohol and Drug Abuse Program (NNADAP) provide a range of services, including prevention, treatment, training and research.

Housing for health personnel

Accommodation for nurses and visiting health personnel is provided in remote areas where commercial housing is not available.

[5] Framework for FNIHB Capital Planning and Management (March 2005), p. 16.

Appendix D – Lines of enquiry and criteria

Audit of the Health Facilities Program	
Criteria Title	**Audit Criteria**
Line of Enquiry 1: Governance	
1.1 Governance framework[1]	An effective governance framework is in place within FNIHB and horizontally across Health Canada for achieving the objectives of the FNIHB Health Facility Program.
1.2 Roles and responsibilities[1,4]	Roles and responsibilities for the delivery of the Health Facilities Program are clearly defined, documented and communicated.
Line of Enquiry 2: Risk management	
2.1 Risk management[1]	Risks associated with the delivery of the FNIHB Health Facilities Program are identified, assessed and managed.
Line of Enquiry 3: Internal controls	
3.1 Health Facilities Program investment planning[4] Operational management[3,4]	The Health Facilities Program funding allocation plans are developed based on adequate information and are risk-based. FNIHB has sufficient capacity and resources to manage the program and develops operational plans to support the effective and efficient use of resources for the delivery of key program activities.
3.2 Policy, guidance and systems[4]	FNIHB has current policies, guidance manuals and systems for the delivery of the FNIHB Health Facilities Program.
3.3 Transfer payments[2]	Contribution agreements comply with the Treasury Board *Policy on Transfer Payments* and related directives and include appropriate clauses to enable the management or mitigation of program and project-related risks at the recipient level.
3.4 Monitoring and reporting[1]	A systematic process is in place to monitor, assess and report on the status of capital projects and the condition of the health facilities funded by FNIHB.
3.5 Recipient capacity building[4]	FNIHB provides training and support to recipients, to increase their capacity to manage the maintenance, security and environmental issues in their facilities.
3.6 Performance measurement[4]	Relevant performance data exists and is used to support decision-making.

[1]Office of the Comptroller General Internal Audit Sector's *Audit Criteria Related to the Management Accountability Framework: A Tool for Internal Auditors* (March 2011);
[2]Treasury Board *Directive* and *Policy on Transfer Payments*;
[3]*Financial Administration Act*; and
[4]HFP's policies and guidelines.

Appendix E – Scorecard

Audit of the Health Facilities Program			
Criterion	**Rating**	**Conclusion**	**Rec #**
Governance			
1.1 Governance		An established governance framework is in place. Opportunity exists to strengthen operating effectiveness.	1
1.2 Roles and responsibilities		Roles and responsibilities are generally outlined in national level documents and staff are aware. Opportunities exist to clarify and formalize regional roles and responsibilities to address the regional variations in organizational structures and operating environments.	3
Risk Management			
2.1 Risk management		A formal HFP project risk management process would help mitigate project risks.	5
Internal Controls			
3.1 Program investment planning		Operations and maintenance funds allocated in the Investment Plan are based on a long-standing methodology and are not adequately supported by current data.	2
Operational management		There is insufficient detail in operational plans to effectively direct and monitor activities and to support the allocation and alignment of resources.	2
3.2 Policy and Guidance		Updating of certain guidance documents is required to provide more prescriptive guidance related to capital project implementation and monitoring.	3
Systems		The information management system for Health Facilities (RPMIS) lacks sufficient functionality; is unsupported; and, information stored therein may not be current or complete.	4
3.3 Transfer payments		Contribution agreements are in compliance and there is a control framework in place for implementing and managing agreements.	-
3.4 Monitoring and Reporting		Opportunities exist for improvement in the following areas: documentation in support of due diligence related to monitoring of implementation of capital projects (see 3.2); more direct monitoring and assessment of O&M activities and related expenditures; and, processes for more effective and efficient capture and analysis of facility audit / inspection results and follow-up.	5
3.5 Recipient Capacity Building		Capacity building activities are not undertaken in a systemic, planned manner, and there is no mechanism to adequately measure progress in this area.	-
3.6 Performance measurement		HFP has not monitored outcomes on a regular basis. It is in the process of updating its Performance Management Strategy and aligning it with the overall program objectives.	-

Satisfactory	Needs Minor Improvement	Needs Moderate Improvement	Needs Improvement	Unsatisfactory	Unknown; Cannot Be Measured

Appendix F – List of acronyms

ARRAT	Agreement Recipient Risk Assessment Tool
CA	Contribution Agreement
CARC	Capital Allocation Review Committee
CCA	Capital Contribution Agreement
CIAD	Capacity, Infrastructure and Accountability Division
CPRC	Capital Project Review Committee
CRP	Corporate Risk Profile
CSA	Canadian Standards Association
CSB	Corporate Services Branch
FCR	Facility Condition Reports
FNIHB	First Nations and Inuit Health Branch
GCIMS	Grants and Contributions Information Management System
HFA	Health Funding Arrangements
HFP	Health Facilities Program
KIAB	Knowledge in a Book
LTCP	Long Term Capital Plan
MOP	Management Operational Plans
OAG	Office of the Auditor General
O&M	Operations and Maintenance
PMS	Performance Measurement Strategy
RE	Regional Executive
RPMIS	Real Property Management Information System
RRPD	Regional Real Property Division
SIF	Social Infrastructure Fund
SMC	Senior Management Committee
SSC	Shared Services Canada