NEW BEGINNINGS:

AN ASSESSMENT OF GOVERNANCE AND RELATED MATTERS AT QUINTE HEALTH CARE CORPORATION

FOR THE

MINISTER OF HEALTH AND LONG-TERM CARE

GOVERNMENT OF ONTARIO

R. Scott Rowand

JANUARY 31, 2006

Letter of Transmittal

Private and Confidential

January 31, 2006

Honourable George Smitherman
Minister of Health and Long-Term Care
10th Floor, Hepburn Block
80 Grosvenor Street
Toronto ON, M7A 2C4

RE: Review of Governance at Quinte Health Care Corporation

Dear Minister:

Further to your request, and in accordance with the Terms of Reference and instructions received from your Assistant Deputy Minister, I am pleased to table my report in the above matter. The process used, the results of my investigation, and recommendations are contained in the attached report. It is sent to you in confidence at this time, for release in whole or part, as you see fit.

I have been as objective, factual, balanced, and fair as possible in this assignment; these communities for which health services are such a vital part of their history and social fabric deserve nothing less.

Subject to your wishes, I am prepared to remain seized with this matter to assist you, your officials, and QHC in whatever manner you so determine. Thank you for the opportunity to serve.

Sincerely,

R. Scott Rowand
c.c. Chair, South East LHIN

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REVIEW OF GOVERNANCE AND RELATED MATTERS AT QUINTE HEALTH CARE CORPORATION

1. Background

Quinte Health Care Corporation (QHC) was created by amalgamation of predecessor corporations by way of Letters Patent on November 26, 1998 pursuant to Final Directions issued by the Health Services Restructuring Commission in April, 1998. Graham W. S. Scott C.M. Q.C. and Maureen Quigley assisted the Boards of the legacy corporations in reaching an amalgamation agreement in their roles as Facilitators appointed by HSRC.

QHC has made considerable progress in reaching or exceeding the goals set for it by HSRC although, like many restructured Ontario hospital corporations, it has had challenges since amalgamation meeting its budget targets with a history of small operating deficits (after amortization) in each of the seven years since amalgamation in 1998/1999.

The mandated amalgamation of the legacy hospital corporations was not embraced by many in Trenton, Picton and Belleville, just as similar amalgamations directed by HSRC in other parts of Ontario were met with community opposition. Nonetheless, QHC forged on and despite some occasional controversies has continued to serve the communities providing high quality health care services, just as the predecessor hospitals did before the formation of QHC.

With the advent of the Government's policies aimed at increased accountability and the introduction of MoHLTC's Hospital Annual Planning Submission (HAPS) process, the situation at QHC has deteriorated. The QHC Board initially approved its HAPS submission which contained an extensive plan to balance its budget and then, following a motion at a subsequent Board meeting, advised the Minister in a letter dated September 20, 2005 that it wished to amend its submission by replacing all of the previous strategies with a request for an increase to its Ministry base budget of $6.8 million predicated on "business cases" that alleges under funding by that amount due to operation of a four site entity serving a population of in predominantly rural areas experiencing aging and growth. Minister Smitherman responded noting that the amendment was not consistent with the "Hospital Annual Planning Submission Completion Guide", encouraged that the strategies contained in steps one through five be further developed for implementation in conjunction with Ministry officials, noting his intention to revisit the proposals in step six after receiving advice from JPPC early in 2006, and advising of the appointment of an Investigator to review governance at QHC. The Minister's letter and the Terms of Reference for the review are contained in Appendix 1.

Since that time, there have been many community meetings and considerable interest by local politicians and the media. Some, apparently taking a cue from the Government's decision to reverse the amalgamation of Sunnybrook Health Sciences Centre and

Women's College Hospital in Toronto, have urged that the "de-amalgamation" of QHC be pursued.

The objective of this review is to assess the capacity of the Board of QHC to govern effectively and make recommendations to the Minister of Health and Long Term Care through the Assistant Deputy Minister – Acute Services Division designed to improve governance and organizational effectiveness, bearing in mind, key Government policy directions including:

- Health services integration;
- Accountability; and,
- Openness and transparency.

2. Process

As Investigator I reviewed materials provided in confidence by the Ministry and met with the Assistant Deputy Minister on November 28th, 2005 to receive instructions. I subsequently met with the Board Chair, another senior Board member, the CEO, and the Chief of Medical Staff on December 2nd to obtain further background and to get things organized.

QHC provided extensive documentation (contained in Appendix 2) and responded to every request I made completely and without hestitation.

On January 7th, I met with Graham Scott and Maureen Quigley for the purposes of reviewing the amalgamation history, facilitation process, and to obtain other relevant detail and observations.

During the week of January 9th, I attended at all four sites and in Kingston for the purposes of conducting interviews with key informants and stakeholders (Appendix 3) with subsequent meetings in the weeks following. People interviewed were selected by me, after consultation with QHC officials. A semi-structured interview process, based in part on the Terms of Reference, was used for the interviews to assure consistency and comprehensiveness. Requests to meet with the general public or interested citizens were declined in the interests of time but they were encouraged to write and express their views. Any requests for information or interviews by media were declined and referred to the Minister's Office.

3. Setting and Context

QHC serves over 150,000 residents in a 7000 square kilometer area including Hasting, Prince Edward, and some portions of Northumberland Counties. While somewhere around 80% of the population lives south of Highway 401, 60% of the catchment area's land mass is north of the 401. There is no organized transportation system between the communities in the catchment areas. On average, the population is older and has a lower annual income than the rest of Ontario. Agriculture including serving as an emerging

wine region, tourism, and manufacturing of construction materials are primary industries. In addition, Trenton is home to 8 Wing/CFB Trenton of the Canadian Forces with about 3000 military and civilian personnel - probably the largest air defense installation in Canada. It has a proud history of service in international deployment and search and rescue operations at home and is the base of operations for the Canadian Parachute Centre, the Skyhawks and the high profile Disaster Assistance Response Team.

Rates of population growth in the region based on 1996-2001 census data have been modest with a rate of only 1.1% growth for Southeastern Ontario as compared with the Provincial average of 6.1%. More recently, there have been reports of accelerated growth in some areas such as Prince Edward and North Hastings due to an influx of retirees from metropolitan centres and potential growth in Quinte West as a result of consolidation of Canadian Forces Bases elsewhere in Canada.

It is worth noting that two largest communities, Belleville and Quinte West (Trenton) have historically been keen (some would say bitter) competitors for decades. Each has vied for location of every new development in their community such as the air force base, Loyalist College, or the School for the Deaf just to name three examples. This historical competitiveness colors interaction of all kinds involving Trenton and Belleville, not just health care, and may well be one of the root causes of the current controversy.

QHC operates four sites for the delivery of health services with 657,000 square feet of buildings: Belleville General, North Hastings in Bancroft, Prince Edward County in Picton and Trenton Memorial. Belleville General serves as the regional referral centre providing a comprehensive spectrum of secondary hospital and health care services with all other sites offering emergency, some inpatient acute, ambulatory and complex continuing care services. Travel time between the Belleville and other sites is estimated at 20-30 minutes to Trenton, 30-40 minutes to Picton, and 90 minutes to Bancroft. Re-development has been on going since 1999 and the implementation of current plans will continue through to 2011.

The Belleville General facility includes 446,000 sq. ft of building area. There are three interconnected buildings constructed between 1939 and 1973. The central plant infrastructure was recently renovated but most distribution systems are original to the building and are in poor condition. The oldest wing of the building, the 1939 WCA Wing, is scheduled for demolition within a few years.

Trenton Memorial includes approximately 138,000 sq. ft of building space, which was constructed between 1949 and 2000. The Acute Care Wing was constructed in 2000 and renovations of all other patient areas will be completed in 2006. A portion of the original building, covering approximately 55,000 sq. ft and constructed from 1949 through the late 1950's, is used for clinics and offices is in generally poor condition.

The Picton site, occupies 53,000 sq. ft, constructed in two phases in 1956 and 1964. The central heating plant is new and the physical building has been generally well maintained.

The internal infrastructure, however, has not been well maintained and is in poor condition. Renovations to some of the systems are currently in progress.

The North Hastings includes approximately 20,000 sq. ft, newly constructed in 2002. The building and systems are in good condition.

With the exception of Prince Edward County, like other regions in the Province and across Canada, physicians are in short supply and there is a need for an estimated 27 family physicians, three ER, two paediatric, and three psychiatry specialist physicians.

4. HSRC Directions

A reasonable starting point for the review was the basis upon which the Health Services Restructuring Commission directed the formation of QHC in the first place.

Consistent with the process used by HSRC in all of its reports, its initial report in February of 1998 and the Final Directions contained its report of April 1998 considered the existing configuration of health services in the region, examined geography and demographic factors (noting aging and other factors influencing health status), utilization patterns, etc. It reviewed the work of the Hastings/Prince Edward Counties District Health Council and their proposal for restructuring issued in June, 1997. Finally, it took into account the history and prior efforts in the region to integrate health services including merger discussions between Belleville General and Trenton Memorial Hospitals and efforts at creating a regional academic health network with Queen's University. After examining a variety of options, it selected the current configuration which today comprises QHC.

Several aspects of the HSRC reports are germane to this review of governance:

- Bellville General Hospital owned and operated the North Hasting District Hospital in Bancroft (the most remote part of the region) for a considerable period prior to restructuring.

- Prior to amalgamation, the Belleville General and North Hastings District Hospitals were jointly owned, including land, buildings and the operating entity in partnership by the City of Belleville and the County of Hastings – this unique situation was the primary reason for the inclusion of municipal ex officio representation on the Board of QHC.

- The June 1997 DHC review recommended the configuration of hospitals amalgamated into a single corporation that today forms QHC.

- Discussions were underway prior to HSRC beginning its work with a view to effecting a merger between Belleville General and Trenton Memorial Hospitals which "came to a stalemate over the issue of a majority vote required for service elimination or closure of facilities at any hospital site of the merged corporation."

- Prince Edward County Memorial Hospital never supported the vision of a single hospital corporation for the region.

- Even in the absence of restructuring or merger, progress was made in the region to rationalize services appropriately.

In the end HSRC concluded, as did the DHC before it, that consolidation of all four hospitals sites and the three corporations into a single entity was the preferred option to facilitate regional health services planning, assure quality of patient care through critical mass and clinical coherence, inhibit service duplication and reduce costs while maintaining and strengthening the benefits and linkages with other parts of the district and regional health system.

As in its other reports, HSRC noted that the governance structure should be reflective of the community, assure fairness and equity in the election of community members to the Board, facilitate the movement of patients, programs, staff, and physicians, and other resources across the Corporation, and assure that staff realignment occurs in a fair and equitable manner. HSRC specifically declined to set conditions for the governance structure related to representation by population at QHC, or anywhere else for that matter.

Graham Scott and Maureen Quigley were appointed Facilitators by HSRC to assist the parties to develop and implement a plan for amalgamation. Notwithstanding obvious opposition and disagreement, they succeeded admirably and brought the parties together to create QHC. As noted above, the ownership of the two amalgamated hospitals jointly by two municipalities including the operating entity – a situation unique in Ontario – drove the decision to include municipal representatives on the Board of the amalgamated corporation. That is to say, with two municipalities having a joint ownership interest in two of the predecessor hospitals and insisting on representation as a condition precedent to amalgamation, equity demanded that there also be representation by Quinte West and Prince Edward County. Curiously, Brighton was excluded from representation even though an overwhelming portion of the Brighton population uses Trenton Memorial Hospital as “their hospital”.

An option not apparently considered by HSRC but raised by several people interviewed was replacement of both the Belleville and Trenton facilities with a new hospital on the dividing line between the two communities near Loyalist College and Highway 401 (the Coburg-Port Hope solution). While this may have eased tensions between the communities, it would have been expensive and, given recent capital upgrades and those now approved/underway at the two sites, such an option is simply not reasonable especially given the demand for hospital facilities redevelopment elsewhere in Ontario. There is little to be gained by further discussion of this idea.

5. Governance Structure and Bylaws

The Amalgamation Agreement and Bylaws provide for 12 elected trustees and nine ex officio trustees including the Chief of Medical Staff; the President and Vice President of the Professional Staff Association; a representative of the Auxiliaries; the Mayors of Belleville, County of Prince Edward and the City of Quinte West and the Warden of the County of Hastings or their designates; and the Chief Executive Officer. This makes for a Board of 21. Members of the Corporation were initially to be the Trustees and such others admitted to membership pursuant to the Bylaws.

Article 2 of the QHC Bylaws sets out membership requirements in the QHC Corporation including the right to vote at Annual and Special Meetings of Members. Admission to membership requires approval of the Board, payment of a prescribed fee, residency requirements and not be an excluded person (primarily hospital or medical staff members or their families or contractors). There is a requirement that the Board advertise in local newspapers for Annual Members. Non-voting members include excluded persons, Foundation and Volunteer Association members plus Life and Honorary Members. Beyond a wide canvass, there is no requirement to assure that members of the Corporation are reflective of the community. There are currently 101 annual members of the Corporation including the 21 Directors and no Honorary or Life Members.

The Bylaws are consistent with the Letters Patent as to the composition of the Board with matters related to the Board set out in Article 4. Nomination as a Director for election at the Annual Meeting may only be made by the Board. The Bylaws also provide that at least two Directors shall reside is each of QHC's catchment areas (Belleville, North Hastings, Prince Edward County and Quinte West areas) with not more than five elected Directors coming from any one part of the catchment area. In addition to providing for officers of the Corporation and the Board's committee structure, Article 4 also contains attendance requirements and an extensive conflict of interest policy covering pecuniary or financial interests, undue influence benefiting a wide variety of entities including municipalities, and where a Director is party to a claim adverse to the interests of the Corporation.

Beyond those provisions, the Bylaws are generally consistent with bylaws of others hospital corporations in Ontario.

While not a focus of this review, it is worth noting that Article 10 relating to Professional Staff (commonly referred to as the Medical Staff Bylaws) provides for a somewhat unusual structure with four Departments of Family Medicine pertaining to each of the sites and a surgical departmental structure wherein each discipline is a department on its own rather the more common approach of a single Department of Surgery with a divisional structure. This not only creates an excessively large and unwieldy Medical Advisory Committee but perpetuates site specific professional practice. This issue was raised in a review of emergency care by external consultants who recommended

appointment of a single chief for each medical department and elimination of site specific representation on the Medical Advisory Committee.

6. Volumes, Funding and Performance

A variety of statistical and financial data pertaining to QHC are contained in Appendix 4. These data are revealing in the light of criticism of QHC.

Although there seems to be a widely held view that services are being taken away from the region that is not the case. Since amalgamation (1998/99) there has been an increase in beds from 325 to 348 and an increase in total patient days although separations (discharges) are down slightly. As at other hospitals in Ontario and across Canada, inpatient surgical procedures and emergency visits have also shown a slight decline but ambulatory surgical procedures have increased by over 20%.

Total operating expense has grown from April 1, 1998 to March 31, 2005 by over 50%. QHC has sustained small operating deficits, after depreciation, every year since amalgamation but these deficits have been 1% or less of total revenue. More significantly, cost per weighted case – probably the best measure of operating efficiency and performance – has fallen from 9% above expected cost per weighted case to about break even (1% below in 2003/04 and 1% above in 2004/05). This is a significant achievement and all associated with QHC deserve considerable credit. It is also worth noting that administrative expense at QHC is in the bottom quartile of Ontario hospitals demonstrating a clear preference for maximizing funding for front line patient care.

Annual operating funding from the Ministry of Health and Long Term Care increased during the same period by over $35 million or over 40% (average annual increase 6.7%). The Ministry has also invested just over $28 million in facilities upgrading and renewal at QHC, almost half of which has gone to the Trenton Memorial site and it has committed to providing the majority of funding for the $68 million Belleville redevelopment. The Picton site has received only modest support for infrastructure renewal, notwithstanding a facility which is showing its age. While all Ontario hospitals have funding challenges and could use more support for hospital care, on balance, the region has done well by the Ministry.

Comparing service statistics and financial performance at QHC to Ontario hospitals as a whole, it is performing at an above average level. Moreover, QHC and the citizens it serves in the South East region of Ontario have benefited from generous support from MoHLTC. That said, annual expenditure increases of the magnitude seen in the past at QHC or other Ontario hospitals are not sustainable over the long term. Hard decisions will need to be made regarding the level of health care which is affordable and tough choices will need to be made in patient care service offerings and delivery approaches. QHC needs to prepare itself to confront that reality. The citizens of communities served by QHC must also understand and accept that changes to the health care delivery system they have enjoyed in the past are inevitable.

7. Governance Best Practices

There can be no doubt about the increasing interest in governance practices and processes both in investor-owned and not-for-profit corporations. This is especially true with respect to governance of health care organizations in Ontario as a result of the Governments focus on accountability and health system integration.

It is beyond the scope of this report and inconsistent with its purpose to comprehensively review best practices in the governance of health care organizations. Moreover, excellent resources exist elsewhere such as reports available from the Ontario Hospital Association such as ***Hospital Governance and Accountability*** (Maureen Quigley and Graham Scott, April, 2004) and ***Guide to Good Governance*** (Anne Corbett et al, November 2005); Toronto Stock Exchange. ***Where were the Directors? Guidelines for Improved Corporate Governance in Canada: Report of the Toronto Stock Exchange Committee on Corporate Governance in Canada*** (Toronto Stock Exchange Committee on Corporate Governance in Canada, 1994); and ***Getting to Great: Principles of Health Care Organization Governance*** (Dennis Pointer and James Orlikoff, 2002).

Certain themes or contemporary best practices emerge from these works that serve as useful benchmarks for evaluation of a hospital Board and its ability to effectively discharge it key responsibilities in strategic direction and formulating policy, decision-making, and oversight. Briefly, these include a Board:

- Composed of individuals unencumbered by conflicts able to act in the best interests of all stakeholders including patients, government, and the broader community and with the range of requisite skills, knowledge and experience to assure that the hospital fulfils its mission and vision, within the limit of available resources.

- Capable of defining organizational ends including integration with the broader health system, engaging and holding accountable management and clinical leadership, effectively overseeing clinical and operational performance, ensuring financial viability, and able to continuously improve its own performance.

- Of a size and with a structure designed to accomplish its work efficiently, promote cohesion, engagement and participation of all Directors in discussion and decision-making.

- Elected by a corporate membership structure reflective of stakeholders interested in and committed to furthering the hospital, using open and transparent processes, which provides effective governance.

In addition to the above principles it is essential that Directors of corporations, whether in the private or public sector, understand their statutory and common law obligation to exercise diligence in identifying and acting in the best interests of **ALL** shareholders/stakeholders **ALL** of the time. To function effectively, a Board must be

composed of individuals who respect and trust one another. This demands that confidences are respected, differing perspectives are appreciated, conflicts are resolved, and, once decisions are taken, the Board is unified in execution of its decisions. Members must be prepared to make time available to attend board and committee meetings and to be sufficiently informed and prepared to make knowledgeable contributions.

Finally in regard to management, effective governance requires appreciation by the Board of the different roles and responsibilities of governance and management but also of their partnership. Hospital boards in Ontario have only two employees – the Chief Executive Officer and the Chief of Medical Staff – and their selection, evaluation and ongoing development, given the centrality of the roles to organizational performance, warrant priority for Board attention.

A useful way of thinking about Boards and their responsibilities is contained in the excellent monograph by Quigley and Scott cited above. In addition to commenting on QHC generally, its Board structure, composition and committees, as well as corporate membership and the recent HAPS process, their framework of defining ends, providing for excellent management, ensuring quality and effectiveness, ensuring financial viability, board effectiveness, and relationship building will be used to review and make recommendations and suggestions pertaining to various aspects of governance at QHC contained in the Terms of Reference for this review.

8. Observations and Conclusions about Governance at QHC

With the above background and introduction, I now turn to a summary of observations and conclusions based on the materials reviewed, interviews conducted, submissions made and evidence available to me. In doing so, I want to acknowledge the importance of QHC and/or of its component parts to those who contributed to this review. It is obvious that the hospital sites which compose QHC are associated with deep feelings – joy, sadness, great anxiety. These facilities have not only been shelters in their communities from the winds of illness, but also integral parts of their history and economy. I appreciate fully and respect the attachment, pride, and protectiveness expressed to me about their hospitals.

Quinte Health Care Corporation

- This is an organization with four unique and valued sites: excellent facilities and an example of unparalleled health services vertical integration in Bancroft; a highly regarded, collegial model of comprehensive family medicine care in Picton; a busy emergency care and ambulatory surgical facility (QHC's area of program growth) with a mix of acute medical and complex continuing care services utilizing a facility nearing completion of comprehensive renewal in Trenton; and a full service, secondary care facility in Belleville on the cusp of comprehensive facility renewal and upgrading.

- I could detect **no evidence whatsoever that there is any intention on the part of QHC to close any of its facilities** in spite of suggestions, motivated by whatever reason, that there is a covert agenda to do so. While what type of care and services are provided and where they are provided may change over time, the four hospital sites will continue to exist and as more than "first aid stations".

- Historical competitiveness between communities and opposition to the amalgamation mandated by HSRC to form QHC are regrettably still very much present, coloring QHC's relationships with its communities which may take generations to overcome and is crowding out recognition of the significant achievements in health services delivery in the region and the accomplishments of QHC.

- Given Government policy that favors health services integration, recognizing the reality of advances in technology and medical practice, and resources challenges of all kinds (professional staff, funding, etc.), the communities served and the individual facilities that comprise QHC are better off together than apart. **There was no persuasive evidence found or tendered that would support de-amalgamation or "unbundling" of QHC.**

- The real potential of QHC as a merged, integrated entity has yet to be realized. **Instead, it functions as a "federation" of community hospitals with common governance and administration but is not truly integrated or merged.** The compromises and decisions taken preserving site representation and a measure of independence at every level of the organization are inhibiting progress towards integration and consuming time, energy and attention needed to make QHC a high performing organization**. Three themes are evident from top to bottom of QHC: site-based protectionism; confusion of representation with governance; and, a history of decision-making based on consensus/compromise to "keep peace in the family" rather than clinical coherence, evidence-based practice and financial viability.**

- Funding realities aside, **there is not the critical mass of patients or the availability of physician, nursing and other health professional manpower to support more than one full service, acute care, secondary level hospital in this region.** Medicine today is a "team sport" and evidence supports that as a general principle, quality and outcomes improve with increased clinical volumes. For example, while much has been made of the recent departure of the sole general surgeon in Quinte West, in reality to have a viable inpatient general surgical service, Trenton Memorial would require five general surgeons supported by a like number of fellowship trained anesthesiologists and other medical and health professional personnel. Similarly, the wisdom of maintaining a single ventilated critical care bed in Trenton or a low volume obstetrical service in Picton are questionable for quality of care and risk management reasons alone, to say nothing about their impact on QHC's cost profile.

2006/07 HAPS Process

- The recent controversy surrounding QHC's HAPS submission to the Ministry is the only the most recent example of more fundamental issues which have surfaced at least twice before in the past (shortly after amalgamation and in 2000/2001). At its core, the issue is the unwillingness or inability for some to accept the reality of health services integration and service realignment and the very formation of QHC itself.

- Out of a total of just over $5 million in revenue generation efficiency, and service realignments, the latest conflagration involves just $500,000 of service changes (step six) with the remainder (steps one through five) for the most part being non-controversial. For context, this amounts to less than 1% of QHC's base budget.

- The new Ministry process was imposed on hospitals with very tight timelines during the summer holiday period and with mixed messages around expectations regarding community consultation leaving QHC management with the erroneous understanding that proposals were to be developed with minimal consultation/ input from stakeholders.

- Management, in developing proposals, failed to consult or engage physicians or other stakeholders adequately in proposal development, presented the Board with a single option instead of a range of choices, and communicated them in a manner that led to unnecessary misunderstanding.

- The Board of QHC dealt with the proposals in a way that inhibited meaningful discussion and full consideration both at the Finance Committee and at the Board level and failed to direct management to present alternative proposals for its consideration.

- However well intentioned, the conduct of some members of the Board in relation to the HAPS proposals was prejudicial to the good order and management of QHC violating confidences and their obligation to consider the best interests of the Corporation and ALL stakeholders, not just those they believe they "represent".

- This has led to misinformation, community controversy, and added to the mistrust of QHC, which was at a significant level prior to the events of the fall of 2005. It is common ground between all parties that this cannot continue as it is negatively affecting the ability to recruit needed professional resources, contributing to declining staff morale, and is or will make QHC an unattractive organization for volunteers or donors, including future Board members. As a result of the negative, unproductive atmosphere which now exists and destructive behavior on the part of some, competent, credible QHC leaders are considering other, more professionally fulfilling career options.

- I have concluded that the controversy regarding QHC's HAPS process is symptomatic of more basic issues: **a Board which as a result of its composition is unstable, conflicted, divided, and excessively political and therefore unable to govern effectively; an amalgamated organization which is merged only to the extent that it has common governance and administration but operates as four independent sites instead of an integrated whole with common standards and processes; suffers from a strategic plan that, while appropriate and well developed at the time, is out of date and fails to adequately delineate the role of each its component parts or to serve as a benchmark against which proposals can be evaluated; and finally, an organization that, for whatever reason, is ineffective in communicating with the communities it serves.**

- More positively, the people interviewed demonstrated insight and expressed readiness for change, and for the most part, are united in their resolve to do what ever it takes to reposition QHC in a way that deals once and for all with its core problems and prepare it to be an accountable contributor to local health services integration. **It is also important that it be clearly understood that I could detect no compromise to patient care or safety at this time resulting from the current state of affairs**; were it otherwise, my recommendations regarding implementation provided later would be different. The reports of the quality of care and service I received and patient satisfaction survey data are generally positive. Notwithstanding controversy and unproductive criticism of QHC, the high quality, compassionate care provided by QHC staff is a testament to their professionalism.

Board Composition and Structure

- The current Board is too large (21) and has too many ex officio members (nine) to be effective. The inclusion of municipal representatives has outlived its usefulness and they suffer from conflicts between their obligation to those who elected them and to act in the best interest of all QHC stakeholders. The driver of the their inclusion on the Board, the City of Belleville, has signaled its willingness to accept elimination of municipal representation if that contributes to a more effective, stable governance structure. Best governance practice and the trend across the Province has been to reduce the size of hospital boards (12 to 18 members) and to reduce ex officio membership. This has occurred in communities like Hamilton, Sudbury, Thunder Bay and at urban hospitals such as University Health Network in Toronto and Credit Valley Hospital in Mississauga where the size of boards has been reduced and municipal representation eliminated. Although not unanimous, the overwhelming majority of people interviewed suggested this as an essential first step to improving governance at QHC. ***Accordingly, it is recommend QHC change its Board to one consisting of not more than 16 members and with ex officio representation limited to the Chief of Staff, President and Vice President of the Medical Staff Association and the Chief Executive Officer.***

- There is confusion over the concept of governance with representation leading to advocacy for board representation by population or public election of hospital board members. Boards are about governance, however, and best practice is to populate them with people who bring the range of knowledge, skills, and experience necessary to effectively govern complex organizations. This can rarely be achieved through elections or other methods of trustee selection as has been the experience in jurisdictions where this method has been tried (e.g. regional health authorities in Alberta, where after one round of elections, the process was abandoned). Ideally, a "skill-based" board is also balanced taking into account other factors such as geography, language, ethnicity, and gender. QHC uses elements of these ideas. The Bylaws provide for a minimum of two nominees from each of its four principal geographic service regions (although not Brighton which is now formally part of the South East Ontario LHIN). Its Board election policy calls balancing a variety of factors to "reflect" the community and makes passing reference to required skills. **It is recommended that QHC amend its Bylaws to provide for election of at least one Director from each of its primary service areas (Belleville, West Quinte, Prince Edward County, Hastings County, and Brighton).** It must be clearly understood that while these individuals are recruited from across the catchment area, they do not "represent" that area. **It is further recommended that QHC review its policy on Board nomination procedures to emphasize recruitment of Directors with the necessary <u>skills</u> for effective governance while, at the same time, seeking balance to reflect the characteristics of the population.**

- There has been criticism by some that QHC's nomination process is closed and self-perpetuating. Their process involves Local Recruitment Committees for each of the four principal service communities composed of a preponderance of non-Board members, requires advertisement of vacancies in local media, an application process, interview by the Local Recruitment Committee, recommendation thereon to the Governance Committee and ultimately the Board, who in turn, recommends a slate of Directors for election at the annual meeting. As with most other hospitals in the Province, nominations from the floor at the Annual meeting are not accepted. On the other hand, the Board attempts to put forward a slate of candidates larger than the number of vacancies to assure members choice in selection. In fact, compared to other Ontario hospitals, QHC has gone out of its way to implement open and transparent processes for nomination of Directors – indeed, one which may be too open and democratic to effectively recruit a skill-based Board. Moreover, the use of Local Recruitment Committees is an example why QHC operates as more of a federated than integrated organization. **It is recommended that QHC review its Board member recruitment process and adopt procedures that continue to require a broad canvass of communities for nomination of candidates for election to the Board who have the skills and background to fill identified gaps in the Board's preferred skill matrix but that the nomination process be conducted by a Nominating Subcommittee of the Governance Committee without the**

use of Local Recruitment Committees. (See later recommendations regarding committees.)

- Recognizing community interest in QHC and the changes proposed above, there may be some apprehension that mechanisms no longer exist for direct input to the Board. After the last major controversy in 2000/01, Quinte West Council established a Health Services Advisory Committee which was subsequently replicated in Prince Edward County. The problem with these Advisory Committees, however, is that they are creatures of, and accountable to, the municipal councils that established them and while they invite QHC to participate, the Committees have no formal relationship to QHC. In addition, they are also specific to their communities, contribute to site protectionism and detract from organizational integration. Some hospitals such as the Centre for Addiction and Mental Health have found that members of the Corporation can be an effective resource to assure community input to the Board directly. (See recommendations below related to membership).

- Generally speaking there is a reasonable mix of skills amongst the elected Directors on the Board at QHC although there are some obvious deficiencies. For example, a lawyer, a communications/public relations professional, perhaps someone with construction experience, and a social worker/human services professional would be useful additions to round out the skill mix. The elected Directors all have previous Board experience, seem to be engaged, have a reasonable understanding of their responsibilities and obligations, and demonstrated an above average understanding of, and support for, Provincial health policy directions. There will be significant turnover in the Board at this year's Annual Meeting providing an opportunity for Board renewal. Unfortunately, the current environment of criticism and controversy will not make recruitment easy. Indeed, many of the current Directors seemed to be ready to leave the Board because of the constant criticism to which they have been subjected by community leaders.

- Directors are elected for three year terms and may serve for a total of up to nine consecutive years after which they may not be re-elected without a break in service.

Board Committees

- QHC currently has the following standing committees of the Board: Executive; Finance/Resource Planning (and a Property subcommittee); Audit; Governance (and a Bioethics subcommittee); Quality Service/Assurance and Medical Advisory Committees. This mix of committees is not unusual for Ontario hospitals. Members of the Board serve on one or two committees and there is provision for two community members on most committee who are not Directors which is supported as an excellent way to develop future Directors and provide additional community input to the Board. They are usually selected

from individuals who stood for election to the Board and were not successful. Terms of Reference exist for each committee, are comprehensive, and are reviewed annually.

- The Executive Committee does not seem to be overly active. Some Boards conduct primary business of importance through the Executive Committee creating a "board within a board" which is not the case at QHC. Both the Governance Committee and the Executive Committee seem to have responsibilities related to performance evaluation of the CEO and the Chief of Staff which should be clarified.

- Given the recommendations above related to election of Directors and specifically elimination of Local Recruitment Committees, creating a Nominating Sub-committee of the Governance Committee with enhanced community would contribute to preservation of openness and transparency in the electoral process. As Directors govern on behalf of stakeholders as represented through corporate membership (similar to shareholders in an investor-owned entity), community members on the Nominating Sub-committee should be drawn from the members of the Corporation. **It is recommended that QHC revise the Terms of Reference for the Governance Committee and create a Nominating Sub-committee which is chaired by the Board Chair and composed of three additional elected Directors and three members of the Corporation who are not Directors.** The CEO and an ex officio Director representing the Professional Staff Association should also be members of the Committee but without vote. The primary functions of the Committee should be to review and recommend policies to the Board related to recruitment and election of Directors including maintenance of a matrix of skills required for effective governance, annually review Board membership and recruit a slate of candidates for election as Directors to fill vacancies and identified gaps in required skills, recruit community members to serve on Board Committees, and cause the Directors to regularly engage in a self-evaluation performance process.

Corporate Membership

- Currently, QHC has an "open membership" model of corporate membership with no limitation on numbers of members. The Bylaws require QHC to annually advertise for membership in the Corporation which is open to all residents of the catchment area who meet certain criteria such as age, are not bankrupt or excluded persons, and pay the prescribed fee for membership and include the Directors. Although there are provisions for Honorary and Life members without vote, there are currently no such members. Given the centrality of the role of corporate members in electing board members, the problem with this approach is that membership can be "stacked" to achieve certain desired outcomes such as has occurred elsewhere and may result in over representation by one constituency to the detriment of others. Some hospitals have adopted the model of the directors being the only members of the corporation but this runs the opposite risk of

lending credence to allegations of a board being closed and self-perpetuating. If the board is about governance, the proper place for representation is in the corporate membership and the members should ideally be reflective of the communities served.

- While there is no best practice for defining corporate membership, an approach worth considering given its history and the environment in which QHC operates is an "electoral college" approach to corporate membership which has been used successfully by some Ontario hospitals. This model fixes the number of corporate members and includes the directors plus representatives named by key constituencies or communities to assure openness and equity in representation of interests. **It is recommended that QHC consider revising its Bylaws to define corporate membership as being the Directors plus representatives named by the five primary municipalities served by QHC, the four Foundations and the Auxiliaries/Volunteer associations associated with QHC, and its academic partners such as Loyalist College and Queen's University.** In addition to its role in electing Directors and selecting community non-Board members to serve on Board committees via its representative Nominating Sub-committee, QHC should undertake to communicate regularly with Members on issues of interest to the community to assure Members are fully informed on issues related to QHC. **More specifically, QHC should hold a minimum of two meetings per year of the Members, in addition to the Annual Meeting, to update Members on QHC activities, obtain their input and perspective on key issues such as strategic directions, proposed operating plans, and capital requirements, and to facilitate increased understanding by Members and the community on health policy directions and trends**

Defining Ends

- QHC currently defines its vision as "Healthy communities with accessible health care through partnership and innovation." Its mission speaks to collaboration and partnership to provide care close to home, health education for professionals and the public, and advocacy for needed resources. Its values include compassion, dignity, respect, fairness, teamwork, collaboration, flexibility, a positive attitude to change, continuous improvement, empowerment of staff and volunteers, and accountability for clinical, ethical and fiscal decisions. All statements include admirable platitudes.

- QHC's commitment to collaboration and partnership with others, while laudable, has not been fully realized internally across its sites. The notion of care close to home, unqualified by quality or evidence-based practice considerations, has been used by some as an argument favoring four independent full service hospitals with common administration. Finally, this review suggests it has a long way to go if it is to live up to its espoused value of positively embracing change.

- QHC's strategic plan, approved in 2002 with apparent extensive community consultation, was well done at the time and includes several key goals, most of which have been met. QHC is poised to engage in a new strategic planning exercise to "move the yard sticks" and account for environmental changes and new directions which respond to realities and Government health policy.

- The "acid-test" of a good plan is its ability to help the Board and management make allocation decisions. That is to say: "If QHC has an extra dollar to spend, where should it be invested and conversely, if it needs to reduce expenditures by a dollar, where should the dollar be taken from?" The 2002 plan is weak in this respect. Moreover its general nature does not speak adequately to the key consideration of what role each of its facilities will play in QHC's future or the South East LHIN in order to serve as a benchmark against which changes in service offerings and program siting can be evaluated. With the advent of Local Health Integration Networks with broad responsibilities for services integration across the region and accountability for performance, these concepts will need to be factored into future strategic planning processes and outcomes.

- **It is recommended that the Board of QHC mandate the development of a new strategic plan in collaboration with the South East Local Health Integration Network that, amongst other things, defines as concretely as possible, the role each of its facilities is to play in the future of QHC and the South East health services network.** In developing a new strategic plan, the work of the Joint Policy and Planning Committee and their upcoming report defining core services for rural hospitals will be a useful resource and should figure prominently in the process. Once approved, the Board needs to assure that it has processes in place to operationalize the strategic plan through its use as a driver of annual operational, financial, human resources, and capital planning processes and to monitor progress towards achievement of key strategic objectives.

Provide for Excellence in Management

- The Board of QHC appears to take seriously its responsibilities with regard to recruitment and retention of competent leadership and has annual performance evaluation processes in place for the CEO and the Chief of Staff. Through QHC's "balanced scorecard", it is able to monitor completion of performance appraisals of staff throughout the organization. The performance appraisal process for the CEO and the Chief of Staff would be strengthened by comparing performance against predetermined annual personal and corporate objectives and obtaining additional inputs to the evaluation process using a "360 degree" approach soliciting comment from peers and subordinates in addition to members of the Board. Evaluation processes and development of compensation policies and recommendations should be a responsibility of the Board Executive Committee and the Board Executive should engage in ongoing discussion and feedback on performance with the CEO and the Chief of Staff.

- Most Board members interviewed commented favorably on their relationship with the CEO and the leadership team of QHC. Comments received indicate that the majority of Directors find that the CEO and his direct reports are available, responsive, and competent and there seems to be a high degree of mutual respect. Areas for improvement in the performance of the CEO relate to communication, political sensitivity, and visibility. Without exception, comments about the performance of the Chief of Staff were favorable and all saw him as competent, committed, concerned, honest, ethical professional and a valuable asset to QHC. A worry expressed by some was that the current environment of negativity may result is key members of the leadership team looking for other career opportunities that are more positive, productive and less stressful.

- Given controversy concerning compensation provided to the senior leadership team in the community, the Executive Committee would find use of the services of an external compensation consultant are helpful in assuring fairness and objectivity in designing management compensation programs and development of compensation recommendations for key personnel, including approaches to link compensation to performance.

- QHC, notwithstanding suggestions that it has too many administrators, actually performs in the bottom quartile of peer hospitals with respect to administrative expense, as noted above. Stated another way, QHC devotes relatively more of its resources to delivery of patient care and services and less to administrative and support services than over three-quarters of Ontario hospitals. This comes with a price – the span of control of managers is large, leaders have to devote the majority of their time to responding to urgent problems and issues rather than having time to do needed tasks that would help QHC improve performance and prepare for the future, and are burning out key leadership personnel. It is little wonder that a frequent complaint is a lack of visibility of management personnel across the four sites of QHC.

- The current model of site-based administrators contributes to the atmosphere of "sitedness" which detracts from QHC's ability to function as an integrated organization. While having a "go to" person on site at each QHC facility is certainly supported, there are other ways to achieve this such as basing members of the senior leadership team at different QHC sites. Additionally, several interviewees expressed concern about QHC's silo-based functional structure. Contemporary hospital organizational architecture utilizes a programmatic approach to assure optimal allocation of leadership responsibility and accountability across patient programs and services, facilitates common standards and processes across sites, and helps assure continuity of the patient experience across inpatient, day program, outpatient, and rehabilitation services and sites.

- **It is recommended that the CEO, after completion of the update to QHC's strategic plan, review the adequacy of investment in administrative and**

management resources and the design of QHC's leadership structure with a view to implementation of a leadership model that contributes to integration of services across programs and sites, continuity of patient care, and organizational effectiveness.

- Chiefs of medical departments must be seen as representatives of the Board and responsible to it, through the Chief of Staff, for the quality of medical care and professional services delivered by a hospital. It seems that at QHC department Chiefs are essentially elected by departmental members and then recommended to the Board for appointment. Most hospitals employ search committees composed of departmental, Board, and administrative representatives to recruit and make recommendations to the Board on appointment of chiefs of medical departments QHC's Bylaws for Professional Staff are highly unusual in that they provide for a structure with four separate departments of Family Medicine and separate departments for each surgical specialty. There is no divisional structure. **It is recommended that the Board and Professional Staff leadership of QHC review and amend the Bylaws with respect the process for recruitment of chiefs of medical departments and consider changes to the Professional Staff structure that reduce the number of chiefs of departments and where appropriate, create divisions within the smaller number of departments to deal with issues unique to that specialty.**

Ensuring Program Quality and Effectiveness

- A key responsibility of any hospital board is effectiveness and fairness in the appointment, reappointment and discipline of members of the professional staff and oversight, through the Medical Advisory Committee, of the quality of professional practice. A goal of HSRC in the creation of multi-site hospitals was to facilitate integration, continuity, and common standards in the delivery of health care services. While QHC makes appointments to its Professional Staff corporately, it awards privileges according to site. This approach not only detracts from achievement of the original HSRC goals for QHC but, at a time when physician and other professional resources are in short supply, makes shifting of professional expertise to where it is most required more cumbersome that it should be. If communities with separate hospital corporations such as Hamilton, London or Edmonton to cite three examples can credential professional staff and award appointments and privileges on a community-wide basis, surely so can QHC across its own facilities.

- The Board of QHC has a Quality Service/Assurance Committee that meets regularly and receives reports on hospital programs and services, provides oversight of risk management, quality assurance, and utilization management activities, and reviews performance data. It appears to function well. With the recommended changes to the Governance Committee, QHC should consider making its Bioethics Committee a subcommittee of its Quality Committee.

- QHC has developed an on-line balanced scorecard with key performance indicators which is unique and impressive. It was not always apparent from a review of QHC's Board Minutes how much use is made or attention paid to this tool but it is a valuable resource to assist the whole Board to to fulfill its responsibilities to ensure quality and effectiveness and should feature prominantly.

Ensuring Financial Viability

- QHC does appear to have a good mix of Directors who are financially literate with professional backgrounds in accounting and business, appropriate policies relating to financial management and control, good performance indicators, etc.

- Directors expressed a commitment to the concepts of stewardship and accountability for use of resources. Evidence is present that the Board and its Finance/Resource Planning Committee pays attention to results and exercises diligence in use of operating and capital funding.

- While QHC has a history of small deficits, it appears to be in better shape financially than many Ontario hospitals. It currently has no debt but its working capital position at year-end is forecasted to be - $1.9 million. Its current ratio (current assets divided by current liabilities) is about 0.80 compared to a Provincial avearge forecasted by OHA for the year ending March 31, 2004 of 0.53. Major reasons for decline of QHC's working capital position, in addition to the small operating deficits in past years, are related to up front costs associated with acquistion of medical equipment, renewal of diagnostic imaging equipment, and investment in facilties renewal, all of which are expected to be supported with grants from the Foundations associated with QHC. QHC's cost per weighted case has shown a trend towards steady improvement and is essentially break-even with expected cost per case data.

- The recent reversal from a reasonable HAPS submission, especially in regards to steps one through five, to one which simply calls on the Ministry to provide more funding, appears to be motivated primarily by a call for help to deal with other issues related to governance and is not a true reflection of the Board's culture or beliefs and is out of character with past practices of the QHC Board.

- The over-riding concern with QHC's approach to resource management relates to its lack of a current strategic plan to assist in making decisions that contribute its preferred future, its failure to require management to table a range of options from which it can select, and its contribution to a culture that favors decision making based on a desire to satisfy everyone or minimize controversy, rather than exercise leadership in doing what is right based on best available evidence. That said, the Board's current structure and composition combined with the present political atmosphere at the local level underpin these deficiencies. Insight was evident amongst a majority of Directors and therefore, there is every prospect that

correction of its core problems will play a major role in improving Board performance and accountability.

- Given the state of facilities of the Prince Edward County Hospital, **it is recommended that after completion of a new strategic plan taking into account core services for rural hospital defined by JPPC, the Board should seek and MoHLTC should consider providing financial support to develop plans for replacement or redevelopment of facilities to carry out its defined role in serving the needs of local residents.** A functional program was completed some years ago which may be a helpful starting point. As well, recent interest in utilizing hospital facilities for Family Health Teams has been under consideration. Vertical integration of health services in a single facility such as now exists in Bancroft may be a useful model for QHC to consider in Prince Edward County.

- An issue affecting QHC operating performance and stability is physician remuneration. Policies of the Ministry of Health and Long Term Care strongly discourage additional payments to physicians by hospitals for patient care services where the physicians also receive funding from OHIP either on a fee-for-service or alternative funding plan arrangement. Total physician-related expense at QHC is almost $2 millions and climbing with "top-ups" paid to physicians in departments such as emergency and paediatrics to assure coverage. While QHC has a full time physician recruitment officer who has been quite successful in attracting new doctors to the areas served by QHC, there are deficencies. Redirection of this money to where it is intended by the Ministry, and not to physicians, would go along way to helping QHC resolve its budget challenges. **It is recommended that the Board of QHC review physician remuneration for clinical coverage and patient services on a monthly basis with a view to effecting changes that would faciltate use of this funding for its intended purpose.**

Ensuring Board Effectiveness

- The QHC Board annually evaluates its own performance and identifies areas for improvement. It also has a program of "Breakfast with the Chair" where Board effectiveness is discussed in an informal setting and also serves as a tool for Director education and development.

- There is a well developed Director orientation program, educational materials are provided to Directors on relevant topics related to governance and health policy, educational presentations are made regularly to the Board and resources are available for Directors who wish to avail themselves of extramural development opportunities.

- Board policies are generally well done and there is evidence of regular review and updating.

- Director were generally happy with information provided by management. Most commented that the Board package is usually comprehensive, included the appropriate level of detail, and received in time to permit review in advance of meetings. Management personnel are accessible, open and responsive to inquiries from Directors for additional information.

- A review of attendance by Directors at Board meetings contained in Appendix Four suggests elected Directors are diligent in attending meetings. Some ex officio Directors, however, have attendance records that, at least in the past, were unacceptable. In a similar vein, public statements have been made by some ex officio Directors injurious to QHC and public confidence in QHC, in contravention to the Bylaws. These behaviors provide evidence of the potential conflicts inherent in such ex officio appointments and lend weight to recommendations to change Board composition. To be clear, these observations do not apply to all ex officio Directors. Some have been model Directors who have made very positive contributions to QHC's Board. Moreover, nothing should preclude the individuals who occupy ex officio positions recommended for elimination from the Board, if they wish, from seeking election as Directors in their personal capacities.

- The Board does have a policy which calls on it to be open and transparent and to do business in open session. Notice of the date, time and location of meetings is given to media and the general public. In camera or closed sessions of the Board are reserved for discussion of patient information, legal matters, personnel matters, issues pertaining to employee relations, contracts and property acquisition. This conforms to common practice for hospital boards across the Province of Ontario. To assure additional openness and transparency, the general nature of matters discussed in closed session should be reported in open session obviously using discretion as to the level of detail provided.

- The current rather large size of the Board of QHC inhibits discussion and debate. Reducing the size of the Board should help to alleviate this concern while still assuring Board business can be conducted within a reasonable time period. Every effort should be taken to assure that all Directors have the opportunity to speak to issues of concern or interest and to engage actively in debate and decision-making.

Building Relationships

- A final key responsibility of hospital Boards is relationship building with the key stakeholders including the Ministry of Health and Long Term Care, donors, volunteers, community and political leaders, and the general public. Here QHC's performance is mixed. While QHC generally appears have good relations with the Ministry, some community and political leaders, and other stakeholders, its relations with others are generally poor. Responsibility for relationship

management has too often been left to management alone and this is an area where the Board needs to significantly improve its performance.

- **It is strongly recommended that Board develop a program of regular briefings for area MPPs by the Chair, Vice Chair, CEO, and Chief of Staff and especially assure that they are briefed in advance on upcoming issues likely to create community controversy or concern. A similar program of briefings for municipal leaders and Foundation leadership should be part of the Board's work plan. The Board should develop a policy on communication with key stakeholders and hold regular meetings of Members to improven relationship management.**

- Ontario's new Local Health Integration Networks will usher in a new era demanding collaborative governance and planning. In addition to engaging the South East LHIN as a partner in its strategic planning process, **it is recommended that Board of QHC engage its LHIN counterparts in discussion of ways and means of effecting a collaborative approach to governance between the two organizations and with other providers of health services in south east Ontario.**

- QHC's relationships with local media appear to be ineffective and even hostile. **It is recommended that the Board assign responsibility for public affairs and communication to one of its committees, direct management to review the adequacy of its resources for communications and public relations, and engage the services of a skilled, external communications consultant to assist it in developing an effective strategic communications plan and program.** This is not about "spin" but rather a vital component of health care organizational governance and management which will assist QHC in explaining decisions and directions to the public and contributing to public understanding of required changes to assure the continued delivery of high quality health services at the local level within the context of the realities of contemporary clinical best practice, availability of professional, financial, and capital resources and Provincial policy.

- Many interviewed commented on the distances between sites operated by QHC, the absence of public transportation and the hardships imposed on people with fixed incomes traveling between QHC sites for necessary care or to visit loved ones admitted to a facility distant from their local community. This represents an ideal opportunity for QHC to partner with municipalities to develop, at a minimum, an inter-site transportation system to rectify this deficiency. Without a public transportation system, these municipalities have not received a share of gas tax revenue from the Province of Ontario. While QHC could develop such a system as other multi-site hospitals have done and especially those in large cities like Toronto or Mississauga, it would require funds now used for patient care or other needs. Working collaboratively with elected Provincial MPPs, the municipalities and QHC should be able to develop a plan and program where

everyone wins and especially local residents. Moreover, it represents an opportunity where the respective talents of all parties can be put to good use instead of unproductive complaining about one another.

9. Implementation

- Given an expressed broad consensus regarding the need for change to the governance structure and processes at QHC and for the type of change required, **it is recommended that QHC be given the opportunity to implement key recommendations to its governance structure and processes on its own, within 90 days, but with an independent third party appointed by the Minister to monitor progress.** The Board would be well advised to engage the services of a facilitator experienced in governance processes to assist it in implementing the recommendations contained in this review. While QHC should be allowed some latitude in making changes recommended in this review, the expectation should be clear that the spirit and direction of the recommendations, once accepted by the Minister, are not negotiable.

- Should it become evident that the Board or Members of the QHC Corporation are either unable or unwilling to implement the recommended governance changes proposed in this review or make substantive progress within the 90 day period proposed, **it is recommended that the Lieutenant Governor in Council appoint a Supervisor pursuant to s. 9 of the *Public Hospitals Act* to assume the powers of the Board, the Corporations, Members and Officers of QHC to implement recommended changes.**

10. Setting the Record Straight

Throughout this review, matters were brought to my attention that have been the subject of community comment, controversy, and contribute to community concern about QHC and its performance. Many of these are covered above. In a spirit of openness, fairness, and transparency, I have included in Appendix 6, my observations about the facts on other issues of controversy as best as I have been able to determine the truth. These are offered not to challenge anyone but rather to set the record straight in the hope that it "turns down the temperature" and assists stakeholders to rebuild trust and confidence in QHC.

11. Conclusion

The observations and conclusions reached through this review resulted from an objective assessment of available information obtained from a variety of sources and the recommendations and suggestions offered are intended to assist QHC, its Board, and stakeholders begin a new day in local health services delivery. This new beginning will hopefully provide a foundation for progress and stability.

All who participated in the process were forthright, engaged, and demonstrated interest in making progress and their input, observations, and advice were received with gratitude. Board leadership and management at QHC were open, generous with their time, and responded to every request made openly and in a very timely way.

Appreciation is especially expressed to Kathryn Noxon at QHC for her responsive and cheerful assistance with logistics and in obtaining documents and information. I would also like to express my appreciation to Maureen Quigley, Graham W.S. Scott C.M., Q.C., Kate Jackson of MoHLTC, and Georgina Thompson and Paul Huras of the South East LHIN for reviewing earlier drafts of the report and Moshe Greengarten and Mark Hundert of HayGroup Health Care Consulting for their review of the CEO's compensation.

I am absolutely certain that with goodwill, effort, and willingness to focus on the best interests of all stakeholders in south eastern Ontario who rely of Quinte Healthcare Corporation, the future will be positive and productive for regional health services delivery.

APPENDICES

1. Final Terms of Reference and Minister's Letter
2. Documents Reviewed
3. Interviews
4. Financial Data
5. Director Attendance Records
6. Setting the Record Straight

APPENDIX ONE

TERMS OF REFERENCE AND MINISTER'S LETTER

Quinte Health Care Corporation Governance Review

Final Terms of Reference

Scope of Review

- Review the hospital's governance structure and practices, conformance to statutory and bylaw requirements and contemporary governance best practices, and its ability to provide strategic leadership generally and with reference to the 2006/07 HAPS process.

Objectives

Review the governance of Quinte Health Care Corporation (QHC) including:

- Mission, vision, values of QHC;
- QHC Bylaws focusing on corporate membership structure and structure, nomination and election of the Board of Directors;
- Appropriateness of the skill set mix/governance experience of the current Board;
- Board guidelines and policies relating to conflict of interest, confidentiality, openness and transparency, etc.
- Information flow to and from the Board and between Directors with emphasis on accountability processes to assure effective operational and clinical performance and risk oversight;
- Board involvement with, and processes for, strategic planning;
- Effectiveness of mechanisms for Board communication to and from stakeholders;

- Appropriateness of processes for orientation, education and development of Directors and an assessment of their understanding of their responsibilities and accountabilities;

- Effectiveness of evaluation processes for Board and Management performance;

- Understanding by Directors of the role and purpose of LHINs and the appropriateness of the governance structure and processes for effective participation in the South East LHIN;

- Any other matter affecting governance of QHC.

Review Process

The review will be conducted by an objective third party appointed by the Minister under s. 8 of the *Public Hospitals Act.*

The review will include:

- Key documents such as Bylaws, policies, minutes, correspondence, planning documents, accreditation reports, service agreements, etc.

- Interviews with all Directors, selected hospital officials and physicians, South East LHIN leadership, and key community stakeholders.

- Documentation of observations and findings and recommendations.

Reporting Structure

The reviewer will report and make recommendations to the Minister through the Assistant Deputy Minister, Acute Services Division and with a copy to the Chair of the South East LHIN.

Timelines

The reviewer will submit the final report on or before January 31, 2006.

APPENDIX TWO

DOCUMENTS REVIEWED

- Letters Patent and Amalgamation Agreement
- Bylaws
- Board Policies
- Board Minutes for the last three years
- Director attendance records
- Annual reports
- Audited financial statements
- Misc. financial data
- Balanced scorecard
- Accreditation report
- Leadership and Partnership component of accreditation questionnaire
- HSRC reports
- LHIN publications
- Misc data related to characteristics of catchment area population
- Various news clippings, media reports, and QHC communications materials
- HAPS submission
- QHC web site
- CEO salary history
- Materials related to Aramark contract
- Selected consultant reports
- Submissions and materials supplied by stakeholders

APPENDIX THREE

PERSONS INTERVIEWED

QHC Board of Directors
George Beer
Rick Belanger, Treasurer
Lloyd Churchill, Chair
Janet de Groot, Auxiliary representative
Ron Emond
Jack Gibbons
Dan Holland
John Inwood
Jack Moore, Vice Chair
Ted Reid
Susan Scarborough
June Surgey

QHC Physicians
Dr. Michael Courtland
Dr. Barry Guppy
Dr. Jack Hilton
Dr. David Seybold

Local Politicians (Mayors and MPPs)
Mayor Bob Campney
Mayor Leo Finnegan
Mayor Chris Herrington
Mayor Charles Mullett

Mayor Mary-Anne Sills
Ernie Parsons, MPP
Lou Rinaldi, MPP

Ministry of Health and Long Term Care
Carolyn Beatty
Henry de Souza
Jan Hansen
Kate Jackson
Mary Kardos Burton
Brad Sinclair (Telephone)
Scott Lovell (Telephone)

South East Ontario Local Health Integration Network
Paul Huras
Georgina Thompson

Community Leaders
Gord Allan
Joe de Mora
John Hudson
Lyle Vanclief
Jim Alyea and Lee Pierce
Bob Bird and Wayne Drake
John Williams

Others
Graham W.S. Scott C.M. Q.C.
Maureen Quigley

APPENDIX FOUR

FINANCIAL AND PERFORMANCE DATA

APPENDIX FIVE

DIRECTOR ATTENDANCE RECORDS

	2005/06 (4 months – Sept to Dec)	**2004/05**	**2003/04**
Elected Directors			
George Beer	4/4	9/10	8/10
Rick Belanger	4/4	8/10	8/10
Lloyd Churchill (elected June 05)	4/4		
Ron Emond (elected in Nov 05)	2 /2		
Jack Gibbons	4/4	9/10	8/10
Dan Holland (elected June 04)	3 /4	9/10	
John Inwood	4/4	9 /10	9/10
Jack Moore	4/4	10/10	9/10
Ted Reid (elected June 04)	3 /4	8 /10	
Susan Scarborough	4/4	8 /10	10/10
June Surgey	3 /4	10/10	10/10
Richard Taylor (elected June 05)	3 /4		
Gord Allan (term expired June 05)		9/10	9/10
Shirley Brett (term expired June 05			7/10
Susan Strelioff (resigned Oct 05)		6/10	
Ex-officio			
Mayor Campney	3 /4	6 /10	2/10
Mayor Finnegan (elected Nov 03)	2 /4	7/10	3/7

Mayor Sills (elected Nov 03)	4/4	8/10	5/7
Mr. Mullett (or warden rep)	3 /4	8/10	7/10
Dr. Courtland	2/4	6/10	6/10
Dr. Seybold (replaced Dr. Kaladeen)	3 /4	8/10	
Dr. Kaladeen (PSA)			3/10
Dr. Guppy (hired Oct 04)	4/4	9/10	
Bruce Laughton	4/4	10/10	10/10
Janet de Groot	2 /4	6/10	n/a

APPENDIX SIX

SETTING THE RECORD STRAIGHT

Throughout conduct of this review, certain issues were raised that have been the subject of community controversy. Most are covered in the main body of my report. For the sake of completeness, I have included my observations about others matters here in the hopes that the information below helps to set the record straight in order that the community can focus on more substantive matters.

Closing Hospital Sites

While covered in the main body of the report, its importance bears repeating here. Despite fears of some in the communities served by QHC that management and the Board have an overt or covert agenda to close one or more sites it operates, I could detect no such plan or even suggestion. In fact, the evidence goes in the opposite direction. The North Hasting facilities are new and too distant from Belleville and must remain in operation to serve the vast northern component of the catchment area; half the dollars spent on facilities upgrading since amalgamation have been spent at Trenton Memorial which seems to be emerging as the primary site for ambulatory surgery and QHC's principal area of growth (20% increase in outpatient surgery volumes compared to static or declining volumes for other acute care); Prince Edward County Hospital supports a model of comprehensive primary care which is well regarded across the Province and recognizing that current facilities are time-expired, QHC has sought Ministry funding support to do a comprehensive facilities redevelopment plan for Picton and has already completed a functional program; and finally, QHC is starting on a major renewal program for facilities at the Belleville General site. **QHC is not planning to close any of its hospital sites.**

QHC Financial Performance Compared to Performance at Individual Hospitals before Amalgamation

People have questioned why the individual hospitals ran operating budget surpluses and QHC has had small operating deficits since amalgamations. Such comparisons, however, are dubious for a number of reasons. Although I was not able to review the financial statements of the legacy hospitals, there are several likely explanations. First, it is understood that when program changes occurred before amalgamation (e.g. elimination of obstetrical services at Trenton Memorial), funding was retained by the hospital and not transferred to the hospital that assumed the patient care volume. Second, while amalgamation was underway, the former Progressive Conservative government cut budgets to Ontario hospitals with the new entity having to deal with the full impact of the reductions. Thirdly, the full real costs of amalgamation at Ontario hospitals were not recognized or funded (e.g. leveling salaries of staff groups with different collective agreements, merging information systems, etc.). Finally, the acuity and complexity of patients has increased at all Ontario hospitals – patients in hospital today are sicker, more

complex, use more expensive drugs and technology in their treatment, and stays are shorter and more intense.

CEO and Administrative Salaries at QHC

Hospital executives in Ontario, rightly or wrongly, are often the highest paid in the broader public sector (municipalities, universities, schools, hospitals, and crown corporations) and the level of hospital administration salaries is a controversial issue in many communities. My own review of salaries at QHC and particularly the CEO's salary, compared to salaries paid to hospital executives in similar sized hospitals across Ontario, based on public disclosure data maintained by the Ministry of Finance, suggests that QHC salaries are either comparable or low. To be sure, I asked HayGroup Health Care Consulting, an international firm with vast experience in compensation consulting, to review the CEO's salary and to compare it to the Ontario market. Based on a review of data from OHA and their own database for community hospital leadership compensation, they also concluded that the salary was "consistent with the market or a bit low" considering the size of organization, budget, and number of employees or complexity.

Aramark Contract

QHC contracts with Aramark, a multinational firm headquartered in the US with subsidiaries in 19 countries, provides QHC with a variety of support services such as housekeeping, building maintenance, materiel management, security, switchboard, and food services. The firm provides similar services to many other hospitals across Ontario and Canada as well as to non health care clients. Aramark was selected through a "request for proposal" process to which Aramark and two other firms responded. All front line employees belong to and are paid by QHC. Aramark managers (many of whom were previously QHC employees) are paid at rates comparable to other QHC managers. Financial arrangements involve reimbursement of Aramark's direct expenses that are invoiced at cost and subject to audit and a set, fixed management fee. All invoices are paid in Canadian dollars to Aramark's Canadian subsidiary whose head office is located in the Greater Toronto Area. The management fee in my opinion, based on my personal experience with similar contracts at other hospitals I have been associated with, is reasonable. Moreover, comparing QHC's performance against benchmarks for similar services at other hospitals, including direct costs and the management fee, is favorable. There is a non-disclosure clause in QHC's contract with Aramark which is a standard industry practice for such contracted services regardless of which firm was selected or whether the client is a hospital, school, municipality, prison, university, ski resort, arena (e.g. Corel Centre in Ottawa), etc. QHC's contract with Aramark was recently renewed for another term, without tendering, but involved a comprehensive review of the proposal for renewal with a variety of internal stakeholders and a community Board member. I could find nothing in QHC's arrangement with Aramark which is unusual or different compared to similar arrangements at other Ontario hospitals or of concern to me.