

# **Building the New Quinte Health Care**

**Report of the Supervisor,**

**Quinte Health Care**

**Graham W. S. Scott, C.M., Q.C.**

**Submitted to**

**The Honourable Deb Matthews**

**Minister of Health and Long-Term Care**

March 12, 2010

## Table of Contents

Report Highlights.....	3
Preface.....	8
Section 1: QHC Governance Renewal.....	11
Section 2: QHC Financial Recovery .....	22
Section 3: QHC Management Review .....	26
Section 4: Renewing the Collaboration & Support of the Community .....	28
Section 5: Community Consultation and Communication Activities .....	33
Section 6: Relationship with SELHIN and the MOHLTC .....	37
Section 7: QHC - Foundations Relationship .....	38
Section 8: Conclusion.....	40
Appendix 1: Terms of Reference for Supervisor for the Board of Directors of Quinte Health Care Corporation.....	41
Appendix 2: QHC - Administrative and Clinical Accomplishments .....	42
Appendix 3: Community Advisory Council (CAC) .....	44
Appendix 4: Notes for Remarks to the QHC Board Open Session (January 26, 2010).....	45
Appendix 5: Quinte Health Care - Reflections of the Supervisor on Past and Future: Notes for Presentation by Graham W. S. Scott, C.M; Q.C. Scott to the Rotary Club of Brighton (November 27, 2009) .....	51
Acknowledgements & Thanks .....	62

## Report Highlights

### *Context & Supervisor Appointment*

The first Board of Quinte Health Care (QHC) was composed primarily of representatives of the amalgamating hospitals. At the time of the amalgamation, the Belleville General Hospital had been owned by the Municipality of Belleville and in the negotiations the municipality insisted on maintaining representation on the Board. This led to other municipalities insisting on equal representation so that the amalgamating hospitals had both representatives from their hospitals and local municipal Mayors or counsellors delegated by the Mayors on the Board. While the expectation was clear that Directors owed their first responsibility to QHC as a single corporation and should not act in a representative capacity, the concept of representation of the interests of different parts of the region became a major factor in decision making when realignment of services became an issue. This concept of representation of different parts of Quinte clashed with the dynamics of necessary realignment and reached a point that the government appointed an Investigator for QHC in 2005. The Investigator's subsequent report identified that the Board was focused more on representation than on the need to provide the best service to the whole region. The solutions provided in the Investigator's Report were never fully addressed. As a result, the Board continued to operate divided in its interests and over time became less able to provide clear direction and oversight to the management of the hospital. This situation culminated in my appointment as Supervisor for the Board of Directors of the Quinte Health Care Corporation in April 2009.

### *QHC Governance Renewal*

My first priority as Supervisor was to commence the governance renewal process. Following dismissal of the Board of Directors, I appointed a Community Advisory Council (CAC) to provide me with advice on the size and composition of the Board of Directors and to lead the selection process for the new Board of Directors. As part of their work, the CAC developed the key elements of a new Governance Policy Framework including the new corporate membership structure, which was approved and incorporated in a new Administrative by-law.

As a result of the work of the CAC, twelve (12) new elected Directors were appointed and received extensive orientation (October 2009 - January 2010) in preparation for assuming responsibility on January 26, 2010. During this time, the Board of Directors

was also provided with draft policies, work plans and processes to facilitate the effective governance of QHC aligned with best practices.

The final component of QHC governance renewal was the implementation of the new corporate membership structure. This model represents a variation of the corporate membership structure that was proposed by the QHC Governance Task Force in 2006. It establishes a two-tiered structure of 16 voting members (the Board of Directors) and 54 non-voting Advisory Members, which builds upon recent corporate membership structures that have been implemented in other hospitals under Supervision. In addition to the corporate membership structure, mechanisms have been established to ensure effective communication with the Municipalities and to fulfill the requirements for community engagement required under the Local Health Systems Integration Act.

### *QHC Financial Recovery*

In the 11 years since the creation of QHC, no operational reviews had been undertaken to determine the financial impact of the amalgamation on the corporation. Between 2003-04 and 2007-08 the hospital carried out a number of activities to address its growing deficit. These efforts resulted in the hospital achieving a total savings of \$ 16M during this period. Despite this success, management advised the Board in October 2008 that the hospital was still facing a deficit and without a recovery plan would accumulate a debt of approximately \$15M by the end of 2010-11. Several options were developed as part of the proposed recovery plan; however, the hospital experienced difficulties obtaining approval of the proposal plan from the Board and the LHIN.

Upon assuming my responsibilities as Supervisor, I supported the need for QHC's management team to proceed with the recovery plan as an interim step. At the same time, however, I decided to convene a small team to undertake a more thorough review of the proposed recovery plan to confirm whether or not additional efficiencies could be achieved. The team was led by Bonnie Adamson, CEO of North York General Hospital (Toronto). The findings arising from Ms. Adamson's review confirmed support for the proposed recovery process (which had identified potential deficit reduction initiatives of \$4.7M), and recommended that the LHIN and MOHLTC revisit the funding base of some of the provincial programs offered by QHC and proceed with the proposed expansion of the ICU (a priority initiative previously identified by the LHIN and QHC). Furthermore, it was also confirmed that the hospital was being impacted by 'inefficiencies' arising from funding formula definitions that were related to the large number of alternate level of care (ALC) patients. In brief, The Adamson review removed any doubt as to the need to proceed with the recovery plan. Consequently, the

review formed the basis for the QHC recovery process that was submitted to the LHIN. As a result, QHC was provided with a \$3.5M adjustment to its funding base. This adjustment included support for the \$1.7M expansion of the ICU program as well as an additional \$1.8M primarily to address corrections related to provincial priority programs funding. Further bridging funding was also requested to maintain the employment of hospital employees that could be subject to lay-off as part of the recovery plan but that would subsequently need to be rehired with the scheduled opening of new beds in the Sills wing at the beginning of fiscal 2010-11.

### *QHC Management Review*

The management team at QHC has been an effective steward of the hospital and has managed well in spite of challenging circumstances. External reviewers have confirmed the competence of the management of the hospital while noting that the senior team “appeared to be understaffed.”

The principal weakness of the management team (and the Board) has been its failure to adequately communicate developments unfolding in the broader health care sector and the impact of these changes on the delivery of hospital services in Quinte. That being said, it is clear that efforts to communicate externally were continually hampered by Board division and negative political commentary that made it difficult for senior staff to speak out in a credible manner.

Going forward it is critical that the leadership of the hospital (including the Board, the CEO and clinical leaders) maintain strong and regular communication with the communities QHC serves not just through the media, but through planned community speaking engagements.

### *Renewing the Collaboration & Support of the Community*

Recognizing QHC as a single hospital with four interdependent sites serving all Quinte patients continues to be a challenge. Fears about the future have prohibited each of the four communities from supporting the absolute need for services to be reorganized among hospital sites to realize needed efficiencies and improve the delivery of patient care. There are many examples that demonstrate the benefits that amalgamation has had on the delivery of health care services within the region. On the administrative side virtually all of the back room services at QHC have been rationalized and efficiencies achieved. Significant achievements have also been made to improve clinical care.

During my Supervisory period I met with representatives in Quinte West and Prince Edward County to facilitate activities that I am hopeful will be successful in fostering greater coordination and integration among these sites in strengthening their programs and position them as critical components of the overall plan for building QHC as a single hospital operating on four sites.

### *Community Consultation & Communication Activities*

During the course of my supervision I engaged a broad group of individuals in a series of community consultation and communication activities. I also chose to deliver a series of speeches at local Rotary Clubs to address some of the misperceptions about QHC within the community. Having met with and spoken to six clubs in the region, I firmly believe that these meetings helped clarify the imperative for change in the Quinte region as well as across the hospital system more generally.

I believe hospital Boards would be able to govern more effectively with closed meetings and provide access to the media immediately after the meeting to report on all significant matters. The onus would still remain on the Board to keep its community informed of issues of public significance. In Quinte, this level of communication combined with the public meetings with the corporate membership and the municipal councils would ensure that the public was fully and accurately informed. As there is no government or OHA policy on open/closed meetings there is an opportunity to revisit this with the opening of the Public Hospitals Act and I have written the OHA governance council suggesting they review this issue.

### *Relationships between QHC and the Foundations*

It is important to be clear that the Supervisor has no authority with regard to the Foundations as they are independent entities. I have decided to comment on the Foundations as I believe that their role is of critical importance to the future success of QHC in meeting the needs of the residents of the Quinte region.

The continuation of the independent hospitals Foundations within the Quinte region and their reluctance to accept the vision of a single hospital working to enhance services on all of its sites is based largely on fears that there are ulterior motives to “strip and close” the Trenton and Picton sites. As programs continue to be strengthened at particular sites and the visions for those sites unfold, suspicions will hopefully disappear.

One Foundation serving the whole QHC catchment area would be preferable both from the perspective of engaging in best fundraising practices and economies of scale. This is unlikely to happen until the respective leaderships accept the reality that QHC is one hospital with four interdependent sites serving all the patients in Quinte. In meantime it is in the interests of the patients in Quinte that the Foundations voluntarily work together to do their best to ensure all residents across the region have access to the best equipment and capital innovations.

### *Conclusion*

A major message emerging from my work as Supervisor for QHC has been the need to re-establish the confidence of the Quinte community and convince the residents of the region that:

- QHC is being governed according to best practices;
- QHC is well managed and in a financially secure position;
- QHC is a single corporation operating on four sites committed to providing quality care to the whole of the Quinte catchment area.

These assurances were necessary to rebuild public confidence that residents could rely on QHC to continue to provide them with quality health care.

QHC is well poised for the future with a new qualified and energetic Board, a new CEO, a full Accreditation award and a stable financial position. There is clear evidence that the amalgamation of the four hospital sites that are part of QHC has led to opportunities that would not have been possible had these predecessor organizations remained separate. QHC provides the region with opportunities to collaborate – rather than compete with one another – to recruit scarce human resources, attract physician specialists, and build the critical mass of programs needed to ensure the delivery of quality care.

It is time for all of the communities within the region to embrace the opportunities that lie ahead and replace fears with pride in the unique contributions that each can bring to building a successful high quality health service delivery system for the entire region. The most important aspect of a new beginning for QHC lies in the commitment of all the players to acknowledge issues and concerns and work cooperatively to find solutions to them.

## **Preface**

On April 16<sup>th</sup> 2009 I was appointed Supervisor of QHC by Order in Council under subsection 8 (1) of the *Public Hospitals Act*. My appointment was made following a number of events that had unfolded within the Quinte region that raised concerns about the effectiveness of the governance of QHC. The most recent event related to the failure of the hospital to convince the South East Local Health Integration Network (SELHIN) that it was positioned to address a growing deficit situation.

My role as Supervisor was guided by Terms of Reference that included the task of addressing governance issues, and taking actions that are appropriate and necessary for the proper functioning of the hospital. This included re-establishing a Board with appropriate skills and competencies and an understanding of the diverse needs of the communities served by the hospital.<sup>1</sup>

This report summarizes the key findings arising from my work as Supervisor undertaken during the period April 16, 2009 to March 12, 2010.

### ***Background and Context***

Quinte Health Care Corporation (QHC) was created in 1998 by the amalgamation of Belleville General Hospital (which included the hospital in Bancroft), Prince Edward Memorial Hospital (Picton), and Trenton Memorial Hospital (Trenton) as directed by the Ontario Health Services Restructuring Commission (HSRC). At the time, the combination of traditional community rivalry and local support for each hospital sparked substantial opposition to the merger of the hospitals – a situation not unique to the Quinte region.

In 1998, Maureen Quigley, Maureen Quigley & Associates and I were retained by the hospitals to assist them in the amalgamation negotiations. During that time I became familiar with the history of each of the organizations that became part of the QHC. Upon my return to Quinte over a decade later, I was surprised by many of the negative attitudes and lack of support for the QHC that continued to exist across the region.

During my tenure as Supervisor, it became clear that much of the opposition that existed about QHC and the perceived “insensitivity of management and leadership” within the hospital were rooted in public misunderstandings about the rationale for change and the lack of appreciation of the need for change. The community at large

---

<sup>1</sup> See Appendix 1 for the full terms of reference

viewed any changes that were made as an attempt to 'erode' services rather than considering the complex forces at work that necessitated changes in program delivery and design to respond to quality and access issues.

The misunderstanding that existed within the community related primarily to two issues:

1. *That changes occurring across QHC with respect to program realignment and consolidation were 'unique' to the region.* In fact, changes that were unfolding at QHC are consistent with those occurring at other hospitals across the province and country and are a response to economic challenges as well as new innovations in program delivery and design. There was, for example, little appreciation of such universal developments that are unfolding with respect to the changing and evolving roles of hospitals and LHINs in the planning and delivery of health services [see Figure below and Appendix 5].

### **Characteristics of the changing and evolving role of hospitals**

- Less invasive surgery with shorter hospital stays
- Growth of day surgery
- Decline in Inpatient surgery
- Development of PACS (Picture Archiving and communications systems)
- Evolution of hospital systems as opposed to stand alone entities.
- Professional human resource shortages requiring some consolidation of service
- Sufficient patient volume and professional staff to support new complex technology
- Critical mass of patients and professionals required to meet growing quality and safety standards
- Sufficient patient volumes to support physician income

2. *That QHC was not seen as one hospital with four interdependent sites, but rather as one hospital (centrally located in Belleville) with a hidden agenda to "erode and eliminate programs and people" at the Quinte West site (Trenton Memorial) and the Prince Edward site (Prince Edward Memorial).* The lack of trust, suspicion, and laying of blame was astounding. The fear of change in the delivery of services had not only translated into criticism of proposed changes but also more damaging strong perceptions within the community that management was driven solely by the

The lack of awareness of the global trends and changes unfolding in hospital care combined with fears about the future of care delivery in certain parts of the region provided fertile ground for controversy and opposition to the actions of QHC. Fears were further stoked by colourful (but often uninformed) political commentary which over time damaged the reputation of this hospital. The realization of the extent of misunderstanding and the damage caused as a result of it prompted me to initiate a community consultation and communication strategy as part of my work as Supervisor (see below).

Against this background, I embarked on a number of actions during the course of my Supervision. A summary of the activities undertaken is summarized in the sections below.

---

<sup>2</sup> See Appendix B Administrative and Clinical Accomplishments

## Section 1: QHC Governance Renewal

### *Context for Governance Renewal*

The role of the Mayors on the Board had been the focus of much of the concern around inappropriate representation of parochial interests within the Board. Unquestionably the Mayors were in a legal position of conflict of interest between their hospital and municipal responsibilities. If they placed their duty to the hospital corporation first, they could find themselves in certain circumstances approving something that disadvantaged their local site which would draw local criticism by their municipal electorate, even if the final result would have been better health care for the whole region. In contrast to their duty as hospital Directors, they also had a duty to their local communities as elected representatives. It is not surprising that given a choice they would put the perceived interest of their constituents first even though that would put them in a position of not meeting their other duty as a Director. It is, for example, not possible to be acting in the best interest of the hospital while providing support to any group wishing to break up the hospital. Rather than face this conflict it would have been appropriate to resign. However, once they found themselves on the Board the exit strategy became difficult as having established themselves as champions for their local interest they obviously had difficulty being seen to voluntarily walk away.

The rationale for establishing a new Board without Municipal representatives (while sound in law and in governance practice) unfortunately tended to single out the participation of the Mayors as the only problem. In fact, there were other Directors who also adopted a representational approach with the result that discussions about service realignment were frequently being converted into local “win/lose” decisions leading to negative attitudes toward QHC management and seriously impacting on their credibility to defend the need for necessary change.

### *The Approach to Governance Renewal*

The first step in my appointment was to address Board governance. Simply put: the Board was not working and a quick solution was needed to remedy the situation. My choices were limited: I could dismiss the entire Board or I could attempt to “assess” which members should be retained to participate in a ‘renewed’ Board. The latter option would have been an almost impossible task. All Directors were dedicated to serving their community. There really was no reasonable way to “assess” contributions to the Board and/or single out particular directors as being responsible for the overall poor functioning of the Board.

My decision to remove the whole Board was really the only reasonable option. The removal of the entire Board limited the potential for individual finger pointing and provided an opportunity for the organization to put the past behind them and look ahead. The removal of all Directors did not prevent the ensuing focus of attention that was placed on the participation of the local Mayors. This issue had been the subject of tremendous debate and controversy and was addressed in the Report of Scott Rowand when he was appointed as Investigator of QHC in 2005. While it would be unfair to characterize all the problems of the Board as a result of the presence of the Mayors, there is no doubt that they became the focus of the debate between the concept of a Board based on “local representation” and a Board where all members owed their primary responsibility to the hospital corporation.

Governance renewal was achieved through a multi phased process:

Phase 1: Establishment of a Community Advisory Council to develop a Governance Policy Framework and recommend the new Board of Directors

Phase 2: Board Orientation

Phase 3: Implementation of Board and Committee Policies and Processes

Phase 4: Implementation of the Corporate Membership Structure

### ***Governance Renewal Phase 1: The Community Advisory Council (CAC)***

The process for the selection of a new Board to oversee management of a \$175M operation required individuals committed to both the best interests of QHC in serving the patients across the region and to the principles of good governance. The selection process was supported by the creation of a Community Advisory Council (CAC).<sup>3</sup> As part of the debriefing process, members of the previous Board were asked to suggest individuals that they thought would make good appointees to the CAC. This plus other inquiries resulted in the appointment of the following as members of the CAC: Gord Allen retired businessman and former QHC Director and Treasurer; Ross McDougall, businessman and former Mayor of Belleville; Maureen Piercy, President of Loyalist College; Glenn Rainbird, O.C., businessman; Dr. Michael Shannon, former Deputy Surgeon General of the Armed Forces and health science consultant; and the Honourable Lyle Vanclief, businessman and former federal Minister of the Crown.

---

<sup>3</sup> See Appendix 3 for Terms of Reference of the CAC

In the first phase of their work, the CAC established the framework for the recruitment of the Board which involved extensive discussion of the following:

- Principles of Governance and Board accountabilities;
- Roles and responsibilities of the Board as a whole and individual Directors,
- Composition of the Board of Directors,
- Guidelines and process for the selection of Directors and mechanisms for engagement of the broader community with QHC including the corporate membership structure and other advisory and communications mechanisms.

This work was informed by the 2006 governance renewal process arising from the Rowand Report on QHC governance, current approaches to governance in a wide range of multi-site hospitals in Ontario and external sources of governance best practice in the corporate and not-for-profit sectors. I was fortunate to have this process guided by Maureen Quigley. Her previous experience in advising the QHC Board Committee that was established following the release of the Rowand Report and her extensive governance work undertaken in support of the Supervisions of Stevenson Memorial Hospital (Alliston) and Kingston General Hospital (Kingston) was invaluable.

The Phase 1 report of the CAC was released on July 24, 2009 and included nine recommendations related to Board size and composition, guidelines and process for the selection of Directors and mechanisms to engage the broader community with QHC.

### **Board Size and Composition**

The CAC recommendations for the future size and composition of the QHC Board of Directors were grounded in two overarching principles:

- QHC is one hospital corporation with four interdependent sites
- The Board and its committees should have members who collectively possess a range of specific skills and expertise needed for the Board to fulfill its governance roles and responsibilities.

The CAC recommended that the overall size of the Board of Directors be reduced from 21 to 16 Directors including 12 elected (independent) Directors and 4 ex-officio Directors consisting of the positions required under the Public Hospitals Act and the President and CEO. The CAC also recommended that the elected members of the Board of Directors be selected based solely on possession of the personal attributes,

professional skills and experience which were outlined in the Guidelines and Process for Selection of Directors included in their report. The recommended composition of the new Board of Directors was a significant change from the previous Board structure which had been representative of specific geographic communities through a formula for selecting elected Directors and through the participation of five Mayors as ex-officio Directors. The CAC's rationale for change was as follows:

- it is essential to recruit a skills-based Board, recognizing the increasing complexity of hospital governance and significant challenges that are facing hospital Boards across Ontario;
- rather than individual Directors being expected to represent specific communities, all Directors must have an appreciation of the diverse needs of the community served by QHC;
- in order to avoid any potential conflict between their obligation under the Municipal Act to advance the municipal causes or interest of their respective municipalities and those who elected them and their obligation under the Corporations Act to act in the best interest of the hospital corporation, municipal elected officials should not serve on the Board of Directors;
- the reduction in the size of the Board of Directors is appropriate to align QHC with the best governance practice in both the corporate and not-for-profit sectors and to maximize the effective functioning of the Board;
- a Board of sixteen (16) Directors will allow a diversity of perspectives and provide a practical size for effective dialogue and participation and a sufficient number of Directors to fulfill the responsibilities of the Board Committees;
- all Directors must share responsibility for regular attendance and engagement in the work of the Board.

### **Process for Selection of the Elected Directors**

Following release of their report on July 24, 2009 the CAC initiated the process for recruitment of elected Directors and recommendation of candidates to the Supervisor for approval. This included:

- posting a notice on the QHC website and advertisement in each of the local community newspapers inviting applications from interested individuals for the 12 elected Director positions;

- provide supporting documents on the QHC website including Principles of Governance and Board Accountability, Board of Director Roles and Responsibilities, Responsibilities as an Elected and Ex-Officio Director and Guidelines for the Selection of Directors;
- notifying former members of the Board of Directors and the individuals who were nominated by the former Governance Committee for election in June 2009 of the application process; and
- CAC review of applications and structured interviews with a short list of candidates.

Following a six-week period of advertising and extensive outreach by the CAC members to build awareness of the recruitment process, the CAC received 43 applications. A short-list of 19 candidates was selected for interview with 12 final candidates being recommended for appointment. Appointments of these 12 candidates (four Directors of the previous Board and eight new Directors) were subsequently confirmed on October 1, 2010.

### **Appointment of Board Officers**

The final task of the CAC in relation to the selection of the Board of Directors was to advise me on the appointment of the first Board Chair, Vice-Chair and Treasurer. Following the Board orientation process (see discussion below), in early November, 2009, the elected Directors were invited to express interest in assuming leadership positions within the Board and to identify their preferences for assignment to Board Standing Committees. Based on this information and the previous interviews, I accepted the recommendation of the CAC and announced the appointment of the first Board officers on November 17, 2009. I then worked with the Board Chair to finalize the appointment of Standing Committee Chairs and members.

### **Corporate Membership**

The second major issue addressed by the CAC in their Phase 1 report was corporate membership. In approaching this issue and in light of the Local Health System Integration Act requirements for community engagement in hospital planning and priority setting, the CAC positioned the issue of community engagement in the broader context of mechanisms for engaging the broader community with QHC.

Arising from its earlier position that the QHC Board of Directors is not the place for representation of any specific interests or communities served by QHC, the CAC was

acutely aware of the keen interest of the public in their health and health care and the need to ensure that mechanisms are available to the public to voice their perspectives and be informed about the services of QHC.

In order to respond appropriately to this legitimate community interest, the CAC recommended a three-pronged approach:

- First, to establish a model of corporate membership which provides for an appropriate balance between community engagement with the hospital and stability at the Board level, whereby the Board of Directors would be free to act in the best interest of the corporation and discharge its multiple accountabilities and responsibilities without the risk of destabilizing member action;
- Second, to undertake an open and transparent process for Board of Directors recruitment and selection that aims to achieve a skills based Board;
- Finally, initiate new advisory mechanisms to enable QHC to meet its accountabilities for engaging the community served (as required by the Local Health System Integration Act) and to enable the broader community to be informed about and offer input on current activities and future directions of QHC on a timely and ongoing basis.

At the time of amalgamation, QHC established an open membership structure in which the Board of Directors annually approved corporate members on receipt of an application and payment of a nominal annual fee. At the time of my appointment as Supervisor, QHC had approximately 600 corporate members, primarily residents of Prince Edward County.

Following review of the “constituency model” of governance which was approved by the QHC Board of Directors in 2007 (but not implemented) and the two-tier model of voting and Advisory Members which has been recently implemented in several Ontario hospitals under Supervision, the CAC recommended that I establish a new corporate membership structure which was a hybrid between these models. The new QHC corporate membership model includes 16 voting members who are comprised of the elected and ex-officio members of the QHC Board of Directors and 54 non-voting Advisory Members appointed for a defined term including 18 nominated by the six municipalities within QHC, 18 nominated by the Foundations and Auxiliaries and 18 members at large.

The voting members are the only members eligible to vote for the election of Directors, approve by-law amendments, special resolutions and changes to the letters patent, appoint the auditor and request a special meeting of the membership.

The Advisory Members are entitled to receive notice and attend the Annual Meeting, receive annual financial statements, receive the annual report of the Auditor, nominate candidates and apply for appointment to the Board of Directors and non-Director members of the Board Standing Committees and serve as an advisory group for the Board of Directors and CEO to provide periodic advice (at a minimum semi-annually) in relation to QHC planning and priority setting and receive updates on hospital activities.

In addition to the new corporate membership structure, I approved the recommendation of the CAC to establish additional mechanisms to ensure ongoing engagement of the community with QHC. These included:

- an ongoing transparent process for recruitment and selection of Directors by a Nominations and Communications sub-committee of the Board of Directors comprised of a majority of Advisory Members of the Corporation;
- potential establishment of community advisory committees in addition to the corporate membership structure, following consultation by the Board of Directors with the Advisory Members of the Corporation
- the establishment of a policy and process for ongoing dialogue with the Municipal/County Councils on the strategic directions, priorities and challenges of QHC and other matters of mutual interest.

### ***Governance Renewal Phase 2: Board Orientation***

The objectives of the Board orientation program were to provide all Directors with a shared opportunity to become familiar with –

- each other as individuals as a foundation for building an effective governance team;
- the four interdependent sites of QHC;
- the QHC Governance Policy Framework;
- current expectations and issues related to each of the responsibilities of the Board of Directors

The Board of Directors orientation program included two modules, which were provided over two weekends in October and November 2009. The first module (held October 17-18) included a full-day bus tour to each of the four sites of QHC and briefing by the Management team en route regarding the overall QHC structure and operations, the respective services at each site and priority issues. This was followed on the second day by a series of briefings including:

- QHC in the context of the broader health system including the national, provincial, regional and multi-site hospital environments;
- the QHC Governance Policy Framework by the members of the CAC;
- Fiduciary Duty by Carol Hansell, a noted legal expert in corporate governance, Trustee, Toronto East General Hospital and Chair, OHA Governance Leadership Council.

The second module on November 13-14 included presentations related to each of the Board's responsibilities by an external faculty of Board and executive leaders from within the Southeast LHIN and from other multi-site hospitals in the province. This module was intended to share the governance challenges and experiences and best practices and to provide a network of peer support for the QHC Board of Directors in the future.

### ***Governance Renewal Phase 3: Implementation of Board and Committee Policies and Processes***

In order to prepare the Board of Directors to assume its responsibilities, a series of four informal meetings of the Board of Directors were held on November 2, 2009, December 3, 2009, January 12 and January 26, 2010. While the Board of Directors remained in an advisory capacity to the Supervisor, these meetings provided an opportunity to implement a new Board agenda format aligned with the responsibilities of the Board of Directors. It also enabled the Board to become familiar with the types of issues that they would be expected to address during the course of the Board annual work plan and to begin to receive reports from the Board Standing Committees.

During this period, most of the new Board Standing Committees also began to meet to review their terms of reference, establish a work plan and receive initial briefings and recommendations from management related to their respective areas of responsibility.

Arising from the phase 1 Governance Policy Framework developed by CAC, I authorized the preparation of a draft Board of Directors Policy Manual and detailed

work plans for the Board of Directors and each of the Board Standing Committees. I approved the Policy Manual as a starting point for ensuring that the Board had basic policies in place. I also made an explicit expectation that the Board would undertake a review of the policies and confirm and/or amend them later in the spring of 2010 following review and revision by the Board Standing Committees and management team.

Finally, I retained the QHC legal counsel to prepare a new administrative by-law to reflect the changes to Board of Directors and corporate membership structure which were made in the governance renewal process. I approved this by-law by resolution in December 2009 on the understanding that the Board of Directors may wish to introduce amendments for approval by the membership over time.

In addition to the need to amend the Administrative by-laws and develop new Board policies as part of the Governance Renewal process, it was appropriate to revisit the Professional Staff By-laws to ensure that they reflected the contemporary expectations of hospital governance and accountability in such areas as privileges and responsiveness to the Dupont-Daniel Inquiry recommendations.<sup>4</sup>

The Professional Staff Association (PSA) established a team to work with the Chief of Staff, the CEO, the Supervisor and legal counsel of the hospital to examine and amend the by-laws. In addition to having the benefit of the opinion of hospital counsel, the PSA sought advice from counsel of the Ontario Medical Association. In general, the by-laws were deemed to be in good shape with the bulk of changes being made for purposes of simplification and clarification. The Professional By-laws were approved in early February, 2010

#### ***Governance Renewal Phase 4: Implementation of the Corporate Membership Structure (Advisory Members of the Corporation)***

The final phase of the governance renewal process was the implementation of the corporate membership structure that was recommended by the CAC in Phase 1. The approach to this process was to provide some initial parameters but leave the actual selection of the designated Advisory Members to the sponsoring organizations (i.e., the municipalities, Foundations and auxiliaries) and then actively engage the 36 designated Advisory Members in the selection of the 18 at large members.

---

<sup>4</sup> Dupont Inquest: Ontario Coroner's Jury Recommendations, released December 11, 2007

Given that this was a new structure, the implementation process was phased over several months from October 2009 – April 2010 and included:

- Development of the Board of Directors policy on the terms and conditions for appointment of the initial and future Advisory Members of the corporation;
- Invitation to the six Municipalities, three Foundations and four auxiliaries to nominate individuals to fill the 36 designated positions within the Advisory Membership structure based on the terms and conditions outlined above;
- Appointment of the 36 designated Advisory Members by the Supervisor on the recommendation of the Board of Directors;
- Initial meeting of the 36 Advisory Members to receive an initial orientation and to select an Interim Nominations Committee from within their membership to implement a process for the selection of the remaining 18 at large Advisory Members;
- Appointment of the 18 at large Advisory Members by the Board of Directors;
- Invitation to the 54 Advisory Members for expressions of interest to serve in the Advisory member positions on Board Standing Committees;
- Meeting of the 54 Advisory Members with the Board of Directors to select the five Advisory Members to serve on the Nominations and Communications Sub-Committee;
- Recommendation by the Nominations and Communications sub-committee of the Advisory Members for appointment by the Board of Directors to serve on Board Standing Committees

### ***Lessons Learned***

The major learnings from the QHC governance renewal process that may be of benefit to others going forward are as follows:

- ***Establishing the Community Advisory Council:*** The establishment of an arms-length Community Advisory Council to undertake the initial phase of the governance renewal process was essential to the credibility of the recommendations. These individuals were highly regarded within the QHC catchment area and brought the appropriate balance of objectivity, insight and experience to their task, ensuring that

- ***Board flexibility to address membership of the Board and membership of the corporation:*** While the recent OHA Prototype By-law is helpful in that it provides guidance to the hospital sector on best practices arising from supervision and other recent governance renewal experiences, implementation of these measures is still at the discretion of the individual hospital and the practices are extremely variable across Ontario. The experience of the QHC supervision builds on that of previous supervisions and reinforces the need to update the Public Hospitals Act to restrict the appointment of ex-officio Directors and to provide for the Board of Directors as the only voting members of the corporation. The recent Speech From the Throne on March 8, 2010 indicating that the Public Hospitals Act will be opened provides an opportunity to consider amendments to address these issues and to align public policy on hospital governance structure and process with current expectations of good governance practices and the legislated accountability of hospital Boards in Ontario.

## Section 2: QHC Financial Recovery

### *Context*

Over the past few years, QHC had been slowly moving toward a deficit situation. In 2007-08, the SE LHIN (MOHLTC) provided a one-time loan of \$ 2.5M to assist the hospital in reaching a balanced position for the year and strongly encouraged the hospital to retain the services of E. C. Murphy Walsh (ECMW) to assist in identifying opportunities to achieve major administrative efficiencies. While the loan 'balanced the books' for the year it did little more than buy a one-time reprieve for the hospital.

In the 11 years since the creation of QHC, there had been no operational reviews to determine the impact of the amalgamation. When the hospital began to feel pressures on its budget it carried out a number of steps during the period of 2003-04 to 2007-08 to enhance both its revenues and efficiencies. These efforts resulted in total saving of \$16M during this period. The ECMW proposal had identified the potential for additional savings in a number of areas; however, upon further reflection many of these were deemed to be theoretical and therefore not feasible. Subsequently, a team (including representation from ECMW) was established to estimate the realistic potential savings flowing from the report. During this time (October 2008), management advised the Board that without a recovery plan to address the growing deficit, QHC could have accumulated a debt of roughly \$15M by the end of fiscal 2010-11. This meant that QHC had to develop a recovery plan to enable it to return to a balanced budget position and avoid building up a serious debt.

The Local Health Services Integration Act requires hospitals to undertake public consultation when contemplating major changes in service delivery. Although there was no LHIN-wide accepted definition of the type and level of consultation required, the LHIN advised QHC that they must (as part of the public consultation process) provide the community with a number of options to reach a balanced budget. The Board subsequently decided that these options should be advanced through a number of large town hall meetings.

The combination of developing options and tabling them for discussion at large town hall meetings proved to be destructive. The options created a situation that had the effect of inviting each community within the region to oppose any options which appeared might negatively impact their local site. This put QHC in the impossible position of being seen as threatening services in one community to the detriment and/or benefit of another. The strong representative approach imbedded within the

membership of the Board and the differential impact of the proposed options on the sites made Board consensus difficult if not impossible in light of the different community reactions to the various proposals. In retrospect, QHC would have better met the requirements of the legislation by establishing a preferred plan and taking it to the public for advice and comment. Throughout this period of community engagement the deficit continued to grow.

Following the unsuccessful and divisive consultation process, management prepared a fourth recovery option which was approved by the Board albeit with significant opposition. The recovery plan was presented to the LHIN which subsequently rejected it and advised the Minister that an appointment of a Supervisor was necessary to address the overall concerns related to both governance and the recovery plan.

### *Assessing the Financial Situation*

Prior to my appointment as Supervisor, the LHIN and QHC agreed to invite Ken Tremblay, the CEO of the Chatham Kent Health Alliance, to undertake a quick review of the operations of QHC. This request was made in January 2009. One of Mr. Tremblay's observations was that QHC appeared to be generally well managed but was compromised in its work by the division among members of the Board.

The Tremblay Report was helpful. However, I concluded that it would be advisable to bring in a team to undertake a more thorough review of the proposed recovery plan and identify additional efficiencies that might be achieved. In the interim I agreed with QHC's management of the need to proceed with the recovery plan as an interim step and, at the same time, imposed some additional actions including an immediate hiring restraint.

The team, established in May 2009, consisted of Bonnie Adamson, CEO of North York General Hospital (Toronto), Corrine Wong, former CFO of North York General Hospital and Nan Brooks of Consulting Cadre. The findings arising from Ms. Adamson's review confirmed support for the proposed recovery process (which had identified potential deficit reduction initiatives of \$4.7M), and recommended that the LHIN and MOHLTC revisit the funding base of some of the provincial programs offered by QHC and proceed with the proposed expansion of the ICU (a priority initiative previously identified by the LHIN and QHC).

The review also identified a key 'inefficiency' related to the funding formula definitions arising primarily from the large number of alternate level of care (ALC) patients which increased the number of conservable days and lowered the overall level of acuity of care

in the hospital. This inefficiency was not a reflection of the failure of management but rather on the large number of occupied ALC beds. This situation was viewed largely as being beyond the ability of the hospital to manage given the lack of opportunities to move patients to more appropriate care settings in light of the shortage in the availability of long term care beds within the region.

The Adamson review removed any doubt as to the need to proceed with the recovery plan. In order to ensure that implementation of the plan moved ahead expeditiously, I instructed QHC to appoint Corinne Wong as Interim VP, Financial Recovery Plan. She undertook this assignment until December 2009.

The findings in the Adamson review formed the basis for the QHC recovery process that was submitted to the LHIN. The LHIN Board made a submission to the Ministry. Subsequently, QHC was provided with a \$3.5M adjustment to its funding base. This adjustment included support for the \$1.7M expansion of the ICU program as well as an additional \$ 1.8M primarily to address corrections related to provincial priority programs funding. Further bridging funding was requested to maintain the employment of nurses that would be laid off as part of the recovery plan but that would subsequently need to be rehired with the scheduled opening of new beds in the Sills wing.

### *Balancing the Budget*

In late summer 2008, management estimated that failure to take significant action to address the increasing costs at QHC would result in an accumulated debt of approximately \$15M by the end of fiscal 2010-11. This estimate assumed a QHC budgeted deficit of \$ 6.5M in 2008-09 and 8.1 for 2009-10.

QHC finished 2008-09 with an actual deficit of \$6.4M. The projected deficit for 2009-10 was lowered to \$ 4.1M in anticipation of the results arising from the implementation of the recovery plan.

The recovery plan was implemented faster than anticipated as a result of two key events:

- i. the early opening of a number of new long term care beds in the region during July and August 2009; and
- ii. the unexpected resignation of privileges by some of the Trenton area physicians in June 2009 that prompted the earlier than planned closure of acute care beds in this community.

These two events – accompanied by early success on other initiatives – resulted in the projected 2009-10 deficit to once again be lowered (from \$4.1 to \$3.6M).

In summary, the combination of the earlier than expected implementation of the recovery plan and the \$3.5M base adjustment<sup>5</sup> provided by the LHIN resulted in QHC ending the year with a positive financial position and with base funding that should provide future financial stability. QHC was also provided with \$1.3 M in funding to bridge employees that would have been laid off in the recovery plan process in order to retain their services in the opening of the beds in the new Sills wing.

---

<sup>5</sup> The MOHLTC and the SELHIN announced other funding for the QHC during the supervision period. This funding was linked to the operation of the new Sills wing, not issues directly related to the supervision.

### **Section 3: QHC Management Review**

In the controversy surrounding governance and the financial issues at QHC prior to the appointment of a Supervisor it is hardly surprising that the management of QHC was exposed to considerable criticism. For more than a decade, management had been caught between the tugs and pulls of the duelling areas within Quinte and at times found itself having to defend routine business decisions publicly. Ongoing conflict and tensions within the region caused decisions that normally would not have fallen within the purview of the Board to become public issues and the subject of debate at the governance level.

Notwithstanding the criticism aimed at the CEO and his Senior Management Team, there is considerable evidence that the management team operated QHC with a high level of competence and managed to maintain a positive atmosphere within the hospital throughout a number of controversial periods.

It is notable that almost all of the multi-site hospitals that were created by directions issued by the Health Services Restructuring Commission have struggled with issues arising from the merger of different cultures and the traditional rivalries that accompanied the transition. This has taken a toll on the many of the first CEOs charged with leading these hospitals. It is notable that the CEO of QHC has successfully led the management team for 11 years and during this time has managed ongoing 'conflict' across the region while simultaneously working to maintain financial stability, realign and grow the services available to residents across the Quinte region.

The results of a positive three-year accreditation of the hospital from Accreditation Canada, the Tremblay Report and the work of the Adamson team confirmed that QHC has a competent management team which is well led and, if anything, maybe understaffed at the senior management level. Compared with organizations of similar size, QHC is lean in terms of its senior management structure and has had to grapple with considerable work pressures arising from the demands of a multi-site hospital. It is my belief that the management team have served the residents of Quinte well – a perception that is reflected in the high level of satisfaction expressed by patients of the hospital. In fact, it is noteworthy that there is a disconnect between the general public perception about the hospital and the actual high level of satisfaction reported by those that have made use of the hospitals services.

While high patient satisfaction ratings are the result of the combined work of the whole QHC team of doctors, nurses, other professional staff, support staff, and front line

managers, the simple reality is that these individuals work in and are strongly impacted by a positive environment established by the leadership of the hospital.

While I believe that the hospital has been well managed internally, I also believe that the lack of effective ongoing external communication has contributed to some of the problems. The responsibility for external communication rests primarily with the CEO and the Board Chair. Going forward it is critical that the leadership of the hospital (including the Board, the CEO and clinical leaders) maintain strong and regular communication with the communities QHC serves not just through the media, but through planned community speaking engagements. A key objective of communication should be to raise understanding of the importance of each of the sites, their different roles and the collective interplay among them required to make QHC a better and stronger organization.

## Section 4: Renewing the Collaboration & Support of the Community

Recognizing QHC as a single hospital with four interdependent sites serving all of Quinte patients continues to be a challenge. Fears about the future have prohibited each of the four communities from supporting the absolute need for services to be reorganized among hospital sites to improve the delivery of patient care. There are many examples that demonstrate the benefits that amalgamation has had on the delivery of health care services within the region.

On the administrative side virtually all of the back room services at QHC have been rationalized and efficiencies achieved. Significant achievements have also been made to improve clinical care. Examples include:

- **The redevelopment of an improved ICU at the QHC- Belleville General site:** As a merged entity QHC used to operate two Special Care Units and an ICU. In particular the Trenton Memorial SCU was constantly challenged with providing comprehensive and reliable critical care given human resource shortages and the lack of 24/7 oncall coverage at that site. The hospital and the LHIN aspired to address this issue and at the same time position QHC as a key player in the critical care arena in the Southeast by building an improved ICU at the Belleville General site. As a merged entity the hospital was able to realize this goal by consolidating critical care patient volumes at a single site. This has allowed for the critical mass needed to offer a significantly improved ICU model available to residents of all of the communities served by QHC.
- **The development of a state of the art diagnostic imaging program:** Only a few years ago the hospital was in crisis with outdated equipment, a film environment and a serious shortage of radiologists. The success of a joint fundraising campaign raised money for a complete PACS environment and a complete replacement of all of the imaging equipment with state-of-the-art digital technology. The equipment was configured to support the array of services at the four sites. This was coupled with the province's approval of a new CT scanner at the Trenton Memorial site and funding for a MRI in Belleville. By creating a four site "workplace of choice" environment QHC has been able to successfully recruit the professionals needed to work in what is now a leading edge imaging environment. Subsequently, in February 2010, the hospital announced that all of its previous radiologist vacancies had been filled.

### *Quinte West/Brighton*

In May 2009 I attended a public meeting of the Quinte West/Brighton Health Integration Committee (a standing committee of the Quinte West Council) held at the Quinte West City Hall. This meeting provided me with an early introduction to the depth of misunderstanding that existed in the community with respect to the role of QHC and, in particular, the failure of those in the community to understand the importance of the Trenton Memorial site within QHC. The tendency to dwell on the loss of services that had taken place in the past resulted in very little recognition of the substantial investment that had been made to 'upgrade' the hospital in terms of the new emergency department, the development of a highly-regarded day surgery program and the ongoing planning to further develop growth in ambulatory care at the TMH site as part of QHC's overall vision for the future. The crucial role of all of these realities in servicing the needs of all the residents of the Quinte area should have effectively eliminated any concerns that the site was at risk of possible closure.

Those in the community that advocated for de-amalgamation of the site from QHC did not appreciate that returning to a 'stand alone' site would jeopardize the hospital in being able to provide its residents with the broad range of hospital services that are currently available within the region. Shortages of physicians (Internists and others) have made it impossible for the site to safely sustain even limited ICU (Special Care Unit) capacity. The lack of consistent, sustainable physician coverage at the Trenton site has placed pressures on the remaining family doctors working at the site. It is interesting that one of the most common arguments I heard to support the belief that "QHC was stripping services from the Trenton community" related to the transfer of paediatrics, obstetrics and orthopaedics from the Trenton to Belleville site. In fact, these decisions were not made by QHC but were transferred to the Belleville General by the Board of the Trenton Memorial prior to the creation of QHC.

My discussions in the community quickly confirmed that one of the biggest problems in Quinte West that needed to be addressed was the need to improve the provision of family medicine and primary care. In response to this – and in cooperation with Quinte West, the Town of Brighton, CFB Trenton, and the Brighton Family Health Team (BFHT) – we agreed to establish the Quinte West/Brighton Health Integration Committee. The role of this Committee was to participate in planning the future expansion of ambulatory services at the Trenton site and strengthen the provision of primary care at that site. I served as the temporary Chair of this Committee. Our initial efforts were focused on the expansion of the ambulatory care program which will result

in the transfer and/or establishment of a number of QHC programs at the TMH site [see Figure below].

**Phase 1: Ambulatory Program Development at QHC (Trenton site)**

- Surgical Preadmission Clinic: Assessment; Teaching; Discharge Planning/Screening
- Urodynamics Clinic (part of pre-admission program): Assessment; Teaching; Discharge Planning; Screening
- Domestic Violence and Sexual Assault Response Program (DVSARP)
- Comprehensive Breast Assessment (CBA) Program
- Minor Surgery

Following these discussions, the committee quickly turned its attention to the problems in the delivery of family and primary care and following an assessment of the needs for the community decided to support the building of a larger team on the already established BFHT that would work with the hospital similar to the more advanced planning model in Prince Edward County. The committee proposed a plan to strengthen the growth of family medical care by providing space for the Brighton Family Health Team (BFHT) on the third floor of the TMH site. This latter move while approved by QHC still requires funding approval from the Foundation as well as support from the Ministry and the SELHIN to carry out necessary renovations. The establishment of the family health team at the QHC-TM site would considerably enhance the access of the residents of Brighton, CFB Trenton and Quinte West to family practice as well as reinforcing the vision of QHCTM as an ambulatory care centre of excellence.

In January 19, 2010 Councillor Sally Freeman undertook the role of Chair of the Committee. The cooperation of Mayor Williams of Quinte West and Mayor Herrington of Brighton, Councillor Freeman, the BFHT, QHC physicians, and CFB Trenton on the committee provided an excellent example of what progress can be made in an environment of collaboration.

***Prince Edward County (The Prince Edward Health Alliance)***

On May 7<sup>th</sup> 2009 I attended the Prince Edward County Health Care Advisory Committee public meeting at Shire Hall in Picton. The purpose of the meeting was to introduce the establishment of the Prince Edward Health Alliance (PEHA) – a not-for-profit corporation whose purpose is to coordinate community involvement in the future design of health care delivery in the region. PEHA’s work is focused on utilizing the Prince Edward Memorial Hospital (PEMH) site of the QHC as the base for building an

integrated health care delivery system for residents of the county. Central to the concept is the vision of co-locating the Prince Edward Family Health Team (PEFHT) and other community based health services on the land occupied by the QHC- PEMH site. Obtaining the support of QHC and engaging the PEFHT and other service providers in the county in planning for the redevelopment of the site were seen as critical success factors for pursuing this endeavour.

At the meeting, I confirmed that QHC would support the establishment of PEHA as a coordinating body responsible for engaging partners in planning for the redevelopment of the PEMH site and also agreed that QHC would participate as one of the partners in PEHA. Shortly thereafter, we began the process of working with the PEHA to develop a submission to the Minister of Health and Long Term Care to outline how QHC and PEHA intended to work on a redevelopment plan for the site. While QHC would remain accountable for the expenditure of the monies, the other members of PEHA would work in full collaboration with QHC in the planning process. The principle reason for the submission to the Minister was to seek assurance that the Minister saw merit in the proposed organizational integration being sought between QHC, the PEFHT and other community based health partners. Minister Matthews has indicated her support for the potential merit of forging a more integrated partnership between the PEFHT and the QHC-PEMH site and has confirmed the importance of completing the redevelopment plan prior to making any further commitments with respect to redevelopment of the site.

A key aspect of the concept is related to the desirability of building the PEFHT offices on the same property to advance patient accessibility to health services. Consequently the plan has to consider the feasibility of location on the same site and the impact on service delivery systems of having the PEFHT collocated on the hospital site. The PEFHT requires office space to be established very quickly as they are currently without sufficient office space. One of the early key questions was, assuming that their offices could share the site with the hospital, would they be able to build on hospital owned land independently from timing for approval for the hospital's redevelopment construction?

I confirmed with the Ministry that acquisition of additional land for the PEFHT, if necessary, and construction of PEFHT offices need not be tied to the timing of reconstruction of the hospital building. Any space utilized on the hospital site would be made available to the PEFHT at market rents.

The concept of cooperation through the PEHA is a welcome form of collaboration and the commitment of all parties to work together provides important opportunities for QHC, the PEFHT and the community agencies to deliver to the community greater access to health services. The support of Mayor Finnegan and Councillor Sandy Latchford in working with the PEHA has been of considerable importance.

The business case which includes the master plan and the functional program should be complete by spring 2010.

### *Lessons Learned*

The major learnings that may be of benefit to others going forward are as follows:

- **Commitment and close collaboration between a hospital, Municipality and family health team have the potential to substantially improve patient care:** Community multi- site hospitals will generally have sites that rely on family physicians to provide some or all of inpatient services. In Prince Edward County the cooperation between the FHT and the hospital has resulted in an enhancement of the quality of care. Although the hospital has no direct accountability for the local provision of family medicine, close cooperation and coordination between the hospital and FHTs provides opportunities to enhance patient care and is of mutual benefit. This success stands in stark contrast to the longstanding situation of uncoordinated delivery of family medicine in Quinte West (Trenton) that has worked to the significant disadvantage of residents in that community.
- **Development of strong partnerships between FHTs and multi site hospital corporation can result in significant improvements to patient care and improved access to care:** Prince Edward County is an example of a community where partnerships between the local hospital and the PEFHT have helped to facilitate and support discussions regarding the inevitable integration processes needed to improve access to quality patient care.

## Section 5: Community Consultation and Communication Activities

### *Community Education*

During the course of my supervision I engaged a broad group of individuals in a series of community consultation and communication activities. For internal stakeholders, I held two series of meetings for staff and physicians: the first during the second week of my supervision and the second in January 2010. I also provided regular written updates to internal groups throughout the process.

Two news conferences were arranged with members of local media to keep the community apprised of the status of activities.<sup>6</sup> Between April 2009 and January 2010 a total of eight news releases were distributed to local media providing updates on the governance review process and the appointment of the Board and the Advisory Members. In addition, I participated in dozens of media interviews by phone and in person.

I also chose to deliver a series of speeches at local Rotary Clubs to address some of the misperceptions about QHC within the community. The speeches provided an overview of the intent of the supervisory process as well as an overview of the rationale for changes in the delivery of hospital services provincially, nationally and internationally to help provide a context for changes in the local hospital system. Having met with and spoken to six clubs in the region, I firmly believe that these meetings helped clarify the imperative for change in the Quinte region as well as across the hospital system more generally.<sup>7</sup> All of the communication information including the internal updates, news releases, the Rotary Club speeches, etc. was made available to members of the general public through the QHC website.<sup>8</sup>

As previously mentioned, one of QHC's major weaknesses has been its failure to adequately communicate developments unfolding in the broader health care sector and

---

<sup>6</sup> The first of these was held immediately following my arrival at QHC and the second in July 2009 in conjunction with the members of the hospital's Community Advisory Council (CAC)

<sup>7</sup> Rotary speeches were given on the following dates: Quinte Sunrise Rotary - September 17, 2009; Belleville Rotary - September 21, 2009; Trenton Rotary - October 19, 2009; Picton Rotary - October 20, 2009; Brighton Rotary - November 27, 2009. Appendix 2 includes a copy of the speech given to the Brighton Rotary Club

<sup>8</sup> [www.qhc.on.ca](http://www.qhc.on.ca)

their impact on the delivery of hospital services in Quinte. Effective communication does not eliminate contentious issues but it does result in better informed debate and decision making. It is with this in mind that the CAC established clear expectations for communication activities to be undertaken by the new Board. Regular communication with the corporate membership, meetings with municipal councils, greater clarity related to processes for consultation with Foundations, and stronger communication with external stakeholders (e.g., service clubs and other community groups) will improve understanding of needed changes and engage the community in constructive dialogue.

### *Open Board Meetings*

The Board has a duty to provide quality oversight of hospital operations which involves both diligence and care in carrying out their duties. The complex environment of a hospital places great demands on Directors and they need to be free to address difficult and delicate issues without prematurely triggering controversies before establishing the facts that can give rise to intelligent debate. The Board should be free to explore all issues and pursue difficult questions without unintentionally creating external debate prematurely.

The QHC Board of Directors has had a longstanding practice of encouraging and attracting media and public attendance at its meetings through public advertisement and other means. I have serious reservations about the effectiveness of these open meetings and addressed some changes during my extensive remarks in open session to the board On January 26, 2010. I have appended those remarks (Appendix 4).

While the positive result of the QHC approach to open meetings is the effect of demonstrating openness and transparency, it does result in the Board operating in a “fishbowl” for most of its deliberations and can significantly impede the full and frank discussion and debate on issues, which is afforded to those hospitals which do not open their board meetings to the media or the public.

The media should be provided with the opportunity to keep the public informed. However, it is not constructive if the Board is constrained from full discussion and exploration of any issue during a Board meeting due to the fear that it that may be misinterpreted or misunderstood thus creating unnecessary and premature public debate before there is factual information available to facilitate meaningful external communication.

Recognition of this problem has led many Boards that retain open meetings to extend their closed meetings to address all the difficult issues leaving open meetings that provide little information. This is not the right answer either as it creates a fictitious environment of openness with resultant credibility issues. I believe hospitals should hold closed meetings and provide access to the media immediately after the meeting to report on all significant matters. The onus would still remain on the Board to keep its community informed of issues of public significance. In Quinte, this level of communication combined with the public meetings with the corporate membership and the municipal councils would ensure that the public was fully and accurately informed.

There is no official government or OHA policy on this issue. It is interesting to note that most of the external faculty who participated in the Board of Directors orientation program were surprised to learn of the QHC experience of high media and public attendance at its open Board meetings as it is a substantial departure from the norm of officially closed or effectively closed (because no one ever attends) meetings in many Ontario hospitals.

In reviewing the QHC experience, while supporting the continuation of open Board meetings, I have worked with the Board and management team to implement measures which provide more discipline in this process. Also based on this experience, I have requested the OHA Governance Leadership Council to review the practices related to open Board meetings to ensure that these enable hospital Boards to meet their accountabilities and responsibilities. A review of open/closed meeting policy is timely given the announced review of the Public Hospitals Act.

### *Lessons Learned*

The major learnings from the community consultation and communication activities that may be of benefit to others going forward are as follows:

- **An annual communication plan is important and essential:** Communication is not just about controversy, it is also about continuing education and keeping the community informed about changes and developments unfolding in the hospital and broader health care sector.
- **Hospital Board Chairs and CEOs need to give greater attention to the importance of communication and engaging their communities in discussions about change:** All multi-site hospitals as part of their strategic plans should place importance on regularly communicating the broader environment impacting on health delivery

- **Open public meetings of hospital Board business are of little real value.** Few of the public attend and media attendance could be better organized to provide the media with value added without them attending the whole meeting. While I firmly believe in the need for transparency and accountability at the Board level, I am convinced that open QHC Board meetings have contributed to perpetuating (and indeed fuelling) the lack of trust that exists between the QHC and the communities it serves by too often exposing issues prematurely before there were adequate facts to sustain a constructive debate. Inaccurate, incomplete information while perhaps 'colourful' does not contribute to constructive communication of issues. This does not relieve the Board from its responsibility to ensure full and complete communication to the public and work toward clear and transparent forms of communication.

## Section 6: Relationship with SELHIN and the MOHLTC

Large hospitals are very complex in their operations and no two hospitals are the same. Given the corporate independence of hospitals, it is not a simple task for the LHIN to assess the impact on patient care when considering hospital performance and what potential improvement may be realized through reforms to bring about efficiencies.

My first meeting with the SE LHIN following my appointment included a review of the LHIN's concerns about QHC's governance and finances. The combination of these concerns, created uncertainty at the LHIN and Ministry level about the ongoing performance of the hospital as well as the will and ability of the leadership within the hospital to undertake the necessary changes. As the supervision progressed, I was able to validate some of the concerns identified by the LHIN and challenge the validity of others.

As the facts became clearer as the supervision process progressed, both the Ministry and LHIN responded constructively and quickly to the findings. While there were 'hiccups' in obtaining various approvals the core issues that needed to be addressed were resolved to the satisfaction of all parties. I would like to express my appreciation to the Ministry, the Chair and CEO of the SE LHIN for being available to consult and work through the issues as they arose.

### *Lessons Learned*

- *Clarify the most effective method of intervention to address operational and governance concerns that arise at the hospital level:* By the time most supervisors are appointed one or more of a number of interventions have been exercised: peer reviews, operational reviews, appointment of an Investigator. There is little clarity in the field as to when, how and in what order these interventions can or should be applied. Given the importance of both the MoHLTC and LHINs in assessing and taking action to address concerns about the financial, management, or governance health of hospitals it would be appropriate to provide greater clarity on the application of the various methods of intervention.

## Section 7: QHC - Foundations Relationship

It is important to be clear that the supervisor has no authority with regard to the Foundations as they are independent entities. I have decided to comment on the Foundations as I believe that their role is of critical importance to the future success of QHC in meeting the needs of the residents of the Quinte region.

QHC has three Foundations: Prince Edward County Memorial, Belleville General Hospital, and Trenton Memorial Hospital and a fund development committee (North Hastings as a part of the Belleville General Foundation) representing all of the sites. There is also an overarching *Imagine Foundation* which has the sole responsibility of dispersing funds successfully raised for the purpose of upgrading the diagnostic imaging equipment at QHC. The latter Foundation is germane to this discussion only because it was created as necessary to advance the health needs of the community as a whole in the absence of a cooperative joint initiative among the existing Foundations.

The Foundations are a product of the previous hospitals which they served prior to amalgamation 11 years ago and have tended to remain focused on support of their local sites regardless of where the patients in their immediate area require services. Over a decade after the merger QHC is still treated by the Foundations as if it was four different hospitals, rather than one hospital serving the whole of Quinte on four interdependent sites.

With the exception of the Belleville General Hospital Foundation which supports the Belleville site and the regional programs it operates, the other two Foundations are very much focussed on traditional turf protection and raising funds for the sole use of their local site. The restriction of funding to purely local uses is clearly at odds with the mission of QHC as it has to focus on the health needs of the whole community. The hardest sell is in trying to convince the Trenton and Prince Edward County groups to also provide support for clinical activities at the Belleville General site which serve all QHC communities.

The reluctance to accept the vision of a single hospital with a vision to enhance services on all of its sites is based largely on fears that there are ulterior motives to “strip and close” sites. As programs are strengthened on particular sites and the visions for those sites unfold, suspicions will hopefully disappear.

Supporting changes across QHC will require greater coordination between the Foundations if donated funds are to be effectively and efficiently used to meet patient

needs across the region. The ultimate goal should be to have a single Foundation serving the whole QHC catchment area both from the perspective of engaging in best fundraising practices and economies of scale. There are, for example, huge opportunities to achieve significant efficiencies if the three Foundations were to simply agree to operate with a single administration. Consolidated administration would permit the individual Foundations to retain independent governance while advancing cooperation among them to better serve residents of Quinte.

I have urged the Foundations to meet together with QHC to plan for future capital requirements with the hope of the Foundations being able to resolve any differences and work together to advance their collective efforts to meet the needs of all patients relying on QHC. I firmly believe that many of the past issues can be easily and adequately addressed with good will and direct communication on both sides. This should result in initiatives that more effectively serve the community. An optimal relationship is unlikely to exist until the respective leaderships accept the reality that QHC is one hospital with four interdependent sites serving all the patients in Quinte. It is essential, in the interests of the patients in Quinte, that the Foundations find a way to voluntarily work together to ensure that patients have access to the best equipment and facilities affordable.

### *Lessons Learned*

- **Close collaboration among Foundations and the hospital:** Where there is more than one Foundation supporting a multi-site hospital it is in the interest of the residents of the communities served that there be close cooperation among the Foundations and between the Foundations and the hospital in establishing capital priorities. Anything less will result in less than acceptable support for patient care. Stated another way it is essential that the hospital and the Foundation share a common vision.
- **Regular communication between the Foundations and the hospital:** There is too much room for misunderstanding if communication is not maintained. While the Foundations are legally independent of each other, in the interests of the communities served, it is hoped that the Foundations will work as a team to advance patient care opportunities with the hospital.

## Section 8: Conclusion

A major message emerging from my work as Supervisor for QHC has been the need to re-establish the confidence of the Quinte community and convince the residents of the region that:

- QHC is being governed according to best practices;
- QHC is well managed and in a financially secure position;
- QHC is a single corporation operating on four sites committed to providing quality care to the whole of the Quinte catchment area.

These assurances were necessary to rebuild public confidence that residents could rely on QHC to continue to provide them with quality health care.

QHC is well poised for the future with a new qualified and energetic Board, a new CEO, a full Accreditation award and a stable financial position. There is clear evidence that the amalgamation of the four hospital sites that are part of QHC has led to opportunities that would not have been possible had these predecessor organizations remained separate. QHC provides the region with opportunities to collaborate – rather than compete with one another – to recruit scarce human resources, attract physician specialists, and build the critical mass of programs needed to ensure the delivery of quality care.

It is time for all of the communities within the region to embrace the opportunities that lie ahead and replace fears with pride in the unique contributions that each can bring to building a successful high quality health service delivery system for the entire region. The most important aspect of a new beginning for QHC lies in the commitment of all the players to acknowledge issues and concerns and work cooperatively to find solutions to them.

## Appendix 1: Terms of Reference for Supervisor for the Board of Directors of Quinte Health Care Corporation

### TERMS OF REFERENCE FOR SUPERVISOR FOR THE BOARD OF DIRECTORS OF THE QUINTE HEALTHCARE CORPORATION ("QUINTE ")

1. The supervisor will fulfill all the responsibilities of the Quinte Healthcare Corporation board, the corporation, its officers and members in governing the hospital in accordance with the *Public Hospitals Act*, its regulations and all other applicable legislation.
2. The supervisor will address governance issues, and take actions that are appropriate and necessary for the proper functioning of the hospital, including re-establishing a Board with appropriate skills and competencies that is reflective of the communities served by the hospital.
3. The supervisor will create a community advisory group to assist in establishing the Board of Directors.
4. The supervisor will ensure development and implementation of a best practices education plan for Board members, specifically including a review of their fiduciary and legal responsibilities as members of the Board.
5. The supervisor will develop a clinical service and operating plan that balances the fiscal position of the hospital, and that is acceptable to the South East Local Health Integration Network (SE LHIN). Such a plan shall include local and regional considerations in its development.
6. The supervisor will develop and oversee the implementation of policies and procedures to ensure hospital operations provide safe, high quality care within the existing resource allocation and are sustainable in future years.
7. The supervisor will retain external resources as appropriate.
8. The supervisor will provide direction to the senior management team as appropriate during the term of the involvement of the supervisor and to ensure the management structure facilitates program and service integration, patient safety and program continuity, and performance management across sites.
9. The supervisor will provide regular updates to the Deputy Minister of Health and Long-Term Care or his delegate and the Chief Executive Officer of the SE LHIN.
10. The supervisor will report to the Minister of Health and Long-Term Care as required by the Minister. The supervisor will provide a written report to the Minister of Health and Long-Term Care upon completion of duties.

## **Appendix 2: QHC – Administrative and Clinical Accomplishments**

### **Capital and Operational**

- Tri County campaign, DI Renewal and successful recruitment of Radiologists;
- \$6.3 Million Capital Infrastructure Renewal Grant from the MOHLTC, which helped us significantly revive aging building infrastructure;
- Canada Health Infoway Grant and the development of a regional PACS strategy
- Creation of 3SO in partnership with Ontario Buy
- Implementation of a fully integrated support service model including food preparation and distribution, materials management, housekeeping, portering, engineering and maintenance
- Implementation of a single Call Centre based at Trenton Memorial
- Implementation of an organization wide IT strategic plan
- Implementation of the development of QHC electronic health record including Electronic Nursing documentation and Emergency Department Information System.
- Complete Human Resources Integration
- Complete integration of the finance and business office functions
- Implementation of “one” medical staff with all credentialing QHC wide
- Implementation of a QHC wide balanced scorecard
- Implementation of a revised nursing staffing model across all of the sites
- Implementation of a QHC focused capital equipment planning process Implementation of a Strategic Communication Plan
- Implementation of a QHC wide major construction and minor renovation process.
- The implementation of QHC wide support programs has paid off during major incidents and emergencies permitting programs and services to be easily transferred.
- Numerous corporation wide contracts (security, snow removal, occupational health and safety etc., general and medical procurement) achieving economies of scale.

### **Clinical**

- Establishment of all Inpatient Surgery at QHC- Belleville General
- Rationalization of Colonoscopy Services from three sites to two

- Rationalization of all Critical Care to the QHC- Belleville General Site
- Plans in place to transfer major QHC wide ambulatory programs to the QHC=TM Site
- Progressive organization wide Infection Prevention & Control service
- QHC wide Decision Support Service
- Progressive Pharmacy Service- implemented Omnicell technology very early on in all sites

## **Appendix 3: Community Advisory Council (CAC)**

### **Terms of Reference**

1. To advise the Supervisor on the following:
  - the optimal size and composition of the Board of Directors
  - guidelines for selection of the new Board of Directors including generic qualities of all Directors and specific skills and expertise of individual Directors
  - the approach to a systematic, open and transparent process for recruitment and selection of the new Board of Directors
  
2. To assist the Supervisor in the selection of candidates for the Board of Directors arising from the recruitment process.

### **Selection Criteria**

CAC members were selected by the Supervisor based on the following criteria:

- commitment to the future of Quinte Health Care as one corporation with four sites
- knowledge of the communities served by Quinte Health Care
- ability to provide independent and wise counsel to the Supervisor
- understanding of governance

## **Appendix 4: Notes for Remarks to the QHC Board Open Session (January 26, 2010)**

First, I want to thank you for the time and dedication you have given to the Director Orientation Program.

I am sure you appreciated that the position of QHC Director would be demanding when you applied but I suspect you did not know just how much we were going to keep you occupied in the run up to assuming the stewardship of QHC.

I believe that the program has been thorough and that you are well prepared in terms of systems and processes to get the job done.

Indeed, adherence to clearly understood governance principles and practices should guarantee that the fundamentals of good governance are followed.

It is particularly important that you can rely on such processes to maintain a strong, open and collegial environment that will sustain QHC and maintain and enhance it's credibility when you face the inevitable tough decisions and even the decisions that are easy to make from a patient care perspective but are not so easily communicated to vocal interest groups who claim to speak on behalf of a public.

You are for the most part knowledgeable in leadership and management and well positioned to oversee, challenge and hold management accountable to provide the highest quality advice and leadership to the operation of the hospital but I want to take a moment to address some of the major issues that lie ahead.

### Communication

The Community Advisory Council underlined the need for you to communicate effectively. In your interviews and subsequently you all repeated the mantra of the importance of good communication.

The CAC wisely did not attempt to spell out your communication strategy beyond establishing the need for you to meet annually with the Municipal councils of Quinte West, Brighton, Prince Edward County, Belleville, and Bancroft and meeting a least twice with the Advisory members of the corporation. That is a minimum of seven meetings a year! Exactly how you do it and when you do it is your decision but it is important you have something to say.

You should use the opportunity to engage them in both the educational and advisory roles so as to encourage a constructive perspective that will guide you in the difficult decisions that lie ahead.

It is important to keep the community informed through these meetings and to make sure you don't just engage them when you have nothing to offer but difficult, controversial decisions.

Probably the most immediate constructive opportunity will arise to engage them when you begin your strategic planning process with your new CEO. While that is some months away you will need to take some initiatives in the meantime to engage and get the communication process underway.

In the above context I have a few thoughts that I will share with you for your consideration.

### Patient Care

Your Chair has been working with the importance of looking at all the issues from the perspective of patient care. This is a common pledge heard in the system and as Brian knows it is forgotten more often than remembered. It is a wonderful starting point and I wish you well in truly making it your mantra.

The welfare of patients provides an important backdrop for guiding decision making in the utilization of scarce resources.

It will be important for you to bear in mind that doing the best for patients and their families also means being strong stewards of your financial resources.

Ultimately a bad financial position will breed diminished quality.

### The Financial Position

I regret that I am unable to provide you with detail as to the financial position of QHC as we must await formal communication from the SELHIN. I can however say that QHC will be in a secure financial position as a result of the Ministry and the LHIN thoroughly reviewing our success in pursuing the recovery plan and responding positively to some needed enhancement of existing programs.

### Beds

I want to say something about "beds" as the word too often defines in the public mind what hospitals are all about. Beds are a crucial part of the hospital but they do not define the hospital in 2010.

Beds are important professional tools for physicians to do their jobs whether they are for medicine patients or for recovery from surgery.

It will be no small part of your oversight responsibility to understand the importance of beds, their distribution and use and also the need to design hospital care to address those growing needs that are independent of beds.

Beds are important to the high profile role of acute care but QHC is about a lot more. In the current context of hospital care beds are a resource much the same as equipment, technology and human resources.

You would never in any enterprise, most of all a hospital, expect to leave all resources the same regardless of shifts in patient demands and care. So you will have to shift resources, including beds, as this dynamic environment in the Southeast and in Ontario evolves.

It is also the reality that there has been a sharp decline in Beds across the western world and that hospitals and their work have become more and more ambulatory and much more focused on chronic illness, and illness prevention management that does not require as many beds.

If you become captured by measuring success by the number of beds and succumb to the bias that hospital care is synonymous with beds then you will not be serving the community in too many areas of quality health care. This goes against the grain of much public perception and will be a challenge but it should be an ongoing part of your education/communication to the public.

#### LHINs and the SE LHIN

You as a board, in partnership with your CEO have an obligation to your patients, your staff and your communities to support the LHIN Integrated Health Services Plan. But support is not blind obedience and support in my mind is also constructive and informed criticism and debate.

I am a strong supporter of the need for well defined integration.

This about partnership and I was gratified to see the report of the last SE LHIN Chairs meeting.

You as a board should be an advocate for integration and support the SE LHIN to achieve their vision but at the same time hold them responsible to take unequivocal responsibility for their chosen directions.

That leads me to the matter of community engagement. It is an expectation of boards and LHINs under legislation. To say it is misunderstood is an understatement. Back to my previous comments around communication there is no substitute for strong ongoing communication. Issue specific or HSAA specific community engagement will not suffice in the absence of regular substantive communication.

#### The Mayors and Municipalities

There has been an unfortunate degree of controversy with regard to the past relationship between the Municipalities and QHC. Hopefully that is behind us as there is so much that can be accomplished going forward.

There has been a great deal of cooperation between the Municipality of Prince Edward County and QHC in advancing Community and Family health care and between Quinte West and QHC both with regard to expansion at the Trenton site and in advancing community and family health planning.

In both cases the personal involvement of the Mayors and their councils was crucial. There will, of course be differences on some issues but I believe that close communication and cooperation will result in better care for Quinte residents.

### Community and Family Health Care

The single most positive thing I feel I have advanced while Supervisor is to have advanced potential for the delivery of a strong Community and Family health care program in both Prince Edward County and in Quinte West/Brighton.

The future vision for health care in Prince Edward lies not in more acute beds and resident specialists, if for no other reason than it is not possible. There is however a tremendous opportunity to develop a real community health campus at the PECM site which will be much more relevant to quality care and could provide a base for 90% of the health needs of the residents of PE.

The establishment of the PEHA and our enthusiastic participation, particularly through community involvement in our planning grant, has launched a process that should see the eventual development of a model of coordinated community care that could well be the envy of small community rural health in Ontario.

The unique alignment of the QHCPEM, Family Health team, allied community health services and the Municipality provides the special ingredients for success.

I have authorized the full commitment of QHC and believe that your ongoing support is not only crucial but it could be the initiative that will make you most proud of your service on this board.

In the same vein to address concerns in Quinte West/Brighton I established the Quinte West/Brighton Health Care Integration Committee. The objective was twofold first to address the concern in the area that the future of the TMH site was in doubt.

Although not widely recognized the future of the site was already well secure and plans were being worked on to advance the services on the site.

The object was to gain a broader understanding not only that the site was safe from closing but it was in an expansion mode particularly with regard to ambulatory care and women's health.

I have authorized the expansion of health programs at the TMH site which have the full support of the committee and now await the completion of our discussions with the Trenton Foundation to support capital requirements.

The second objective was to assist in the development of family and community health care. Family physicians in the Trenton area are on average older, maintaining full practices and without hospital privileges.

This results in too many orphan patients, exacerbated by the unavoidably transient nature of our forces at CFB Trenton and poor coordination of care.

The committee involving QHC, Quinte West and the Family Health Team has developed a proposal to renovate the empty third floor to serve as an office base for a growing family health team to begin to advance the concept already in progress in PEC. We have developed a charter with the Foundation to guide construction of the 3<sup>rd</sup> floor and currently await a formal request from the FHT for the space and will shortly have a meeting with the Foundation to review the cost estimates.

There is an irony that in both these community based initiatives we are reaching out beyond our normal realm of traditional hospital responsibility. FHTs and family medicine are not direct hospital responsibilities but obviously the better they work the better it is for the hospital in serving our patients.

Our involvement is in the community interest as well as in our interest of providing better care.

I'll now address the members of the media and public in attendance. Firstly, thank you for your continued interest in Quinte Health Care. You heard me earlier confirm this Board's commitment to good communications and we recognize the important role you play in allowing us to easily reach the community we serve. The Board and management team will continue to provide the information you need for accurate coverage about QHC to your readers and listeners.

Secondly, you will notice that future meetings will be in a different format than in the past. For example in keeping with good governance:

- The agendas have been reformatted to allow the Board to focus on their governance responsibilities and ensure adequate time to discuss important issues.
- The Board Chair will endeavour to keep all meetings to two hours, including the closed session
- Board members will openly debate matters at the Board table, but will have a unified voice once they have made a decision
- Although Board Members will speak out during the Board Meetings, the official spokesperson for QHC will normally be the Chair and CEO following the meetings
- Directly following each Board Meeting there will be an organized media scrum with the Chair, CEO and any other relevant Committee Chairs where you can ask questions.

Following these media sessions, the elected members of the Board will sometimes hold informal board sessions without ex-officio Directors. There is nothing to read into these sessions, they are simply an opportunity to let the elected Directors assess the effectiveness of the meeting and the quality of information provided. There can be no discussion of specific meeting agenda items and no decisions can be made.

In between Board Meetings, we encourage you to contact the Chair or CEO through Susan Rowe if you have any questions about QHC. Of course you can also expect to receive timely news releases and media advisories on a range of hospital-related matters.

### Conclusion

As I turn over to you the day to day responsibility for the continued evolution of this fine organization I would make the following points.

1. You have a fine medical staff. I have worked with these folks and can tell you that these professionals work relatively well with the management and the board and are deeply concerned for the care they provide to our communities.
2. For the nursing, other professional and general staff and management that I have come in contact with I have been nothing short of impressed with their dedication and creativity.
3. Based on my experience as an investigator or supervisor I found QHC to be fundamentally well managed and this was confirmed by several external sources. The problems in governance cohesion and between governance and management obscured the fact that QHC was well run.
4. The financial recovery plan that we have fully implemented was largely the one developed by management over the last few years. I strengthened the plan, sought validation of the plan and I caused the plan to be implemented. Some of the key elements of this plan are just now being picked up by other hospitals in the province and QHC management clearly was ahead of the curve.
5. Now as we move forward with the new board and the new CEO we are well positioned in the short term but as I forecast above change will be the bellwether as the province struggles to deal with regionalization, lack of funds and scarcity of human resources.
6. With its four interdependent sites QHC has a bright future and the communities can look forward to a more stable hospital system than many areas of the province.
7. Significant change is inevitable and if I have accomplished one thing as supervisor I have hopefully positioned you to manage these forces as they inevitably confront you.

I know I will not be disappointed.

## **Appendix 5: Quinte Health Care – Reflections of the Supervisor on Past and Future: Notes for Presentation by Graham W. S. Scott, C.M; Q.C. Scott to the Rotary Club of Brighton (November 27, 2009)**

Thank you very much for inviting me to speak to you about QHC. I will address aspects of the past but they are primarily to set the stage for the future of QHC.

Let me begin by telling you about what motivates me:

- I am a strong believer in Universal health care in Canada
- We must focus on continuous improvement to ensure sustainability
- I have always been a health policy critic (except during the time I was deputy minister) and believe there remains much to be done to sustain the system
- Most politicians support our system and when in government struggle with the same issues
- Health care is seen as a local issue but is driven by Universal realities
- Some times the emphasis on local access can trump quality and safety in the provision of care
- Health care reform is not just about money, often it is about how we use our human and physical resources
- We need to better understand our system and what drives it

My perspective comes from being a Supervisor for three hospitals, appointed by two governments, two investigations and fact finding assignments and other special assignments involving three governments

11 years ago I was hired with Maureen Quigley by the committee established by the hospitals, not the government, based in Belleville, Picton and Trenton to co-chair the amalgamation to create what became QHC. (I did not mention Bancroft as it was a subset of the Belleville General)

On returning Quinte in April, I was surprised by many of the negative attitudes to the hospital that I encountered when I returned.

While not unique to Quinte, I believe that much of the negative assessment arises from a lack of understanding of the larger provincial and national forces impacting the delivery of hospital services.

Before I address these larger issues, a word about the economic relevance of QHC to the community.

QHC spent \$175m last year in operations and directly employs over 1500 staff. This makes it a very important economic force in Quinte.

Consequently, any shift or change in a service has both health service and financial impacts for the community. While QHC must be sensitive to these financial impacts on the communities our principal concern must be the delivery of quality and safe health care to all of Quinte.

The combined impact of both these financial and health service forces has driven many of the attitudes that have influenced how people react toward QHC.

It is easy to misunderstand and misrepresent the influences behind these forces. And that results in the laying of blame for change on perceived insensitive leadership rather on recognition of the more complex forces at work.

Fear of change in the delivery of services usually translates into criticism of proposed changes and a suspicion that they are driven by motives to save money rather than to maintain or improve quality care.

While I can understand how these misunderstandings grow, much of the criticism I have heard in some quarters is neither justified nor constructive.

QHC is seen by some as one hospital centrally located in Belleville with a hidden objective of stripping down and eventually eliminating the other hospital sites to save money.

These suspicions combined with some rewriting of history and public options that were floated for dealing with deficits early this year, further fuelled the fire. Please allow me to address some misconceptions important to the future, then move to what I believe will provide a positive future for QHC as it enters the next decade.

Much media controversy revolves around the Quinte West site and the suggestion there is an intention to close it. The facts fly in the face of such rumours.

Let me first address historical inaccuracy for a moment. One of the first stories I heard from Quinte West was that QHC had moved paediatrics, obstetrics and orthopaedics to Belleville, thus providing crucial evidence that QHC was in the process of hollowing out the Trenton Memorial site. I am sure many of you have heard that.

Well, it simply isn't true. The decision to move those services was made by the board of the Trenton Memorial Hospital before the amalgamation that created QHC. This was an unhappy,

but intelligent decision taken by that board no doubt influenced by some of the realities I will discuss that have influenced changes in hospital services. Unfortunately, it has been recast to discredit subsequent appropriate changes undertaken by QHC.

Today far from being in danger of closing, the Quinte West site has a new renovated emergency and is the centre for most QHC day surgery and is growing into the role of the ambulatory surgery centre for Quinte and a centre of excellence for ambulatory care serving the whole Quinte area.

This is a significant role.

Better appreciating the forces influencing the reorganization of hospitals and their services is not about re-debating the past but instead putting past realities in context in laying the groundwork for a positive future for QHC with a new board, a new CEO and sound finances.

To begin with, the face of health care continues to change at a rapid rate. I cannot emphasize enough that:

- what is done in hospitals
- who does it, and indeed
- whether it needs to be done in hospitals

has been and continues to go through a massive transition.

To begin with the number of acute care hospital facilities in Canada has dropped over 20% in a period of 10 years and that in itself requires a realignment of services. In addition there has been considerable realignment of services in sites in provinces that have gone from individual governance to regional health authorities.

Today we have less invasive surgery which results in shorter stays in hospitals and faster recovery which also means we need fewer beds than a few years ago. These new surgery techniques while a boon for patients also often require expensive equipment and very highly trained surgeons.

The growth of day surgery is another example. The Trenton site will be the QHC centre for day surgery and is in the process of becoming the main centre for our ambulatory surgery. This concentration of surgeons is basic to quality care, efficiency and effectiveness.

According to the Canadian Institute for Health Information, 4 of 5 surgeries are now done on an ambulatory basis. In the last 10 years, day surgery has grown 31% while inpatient surgery has dropped 17%. Indeed this is a growth opportunity for the Trenton site.

e-Health has also had a considerable impact. PACS (Picture archiving and Communications systems) allow clinicians to examine patient images from anywhere in the province by simply logging into a computer network.

We have computerized laboratory work that limits the need for maintaining laboratories at every site while speeding up the results and their accuracy.

This complexity, much of it unknown 20 years ago, has also changed the requirements to run a modern, full service acute care hospital. At a minimum you need:

- Sufficient physician coverage
- Sufficient allied professional services – nursing, diagnostics etc.
- Quality equipment
- Sufficient patient flow to support physician income
- Sufficient patient volume to maintain professional skills and physician coverage.

This also raises considerations other than costs, that cannot be ignored, particularly if we are to continue to have universal health care coverage. It is important to recognize that to run a modern acute care organization a great deal more than cost is at issue.

Consider some of the other non cost issues that impact on health service and coverage:

- There is a shortage of physicians
- There is a shortage of registered nurses
- There is a shortage of highly skilled technicians
- There is an aging professional work force retiring at a faster rate than replacements are being trained
- Physicians require an adequate volume of patients to maintain their income and there must be a sufficient number of physicians in the practice area to maintain adequate on call coverage
- There is an expectation that specialists must perform a minimum number of procedures in order to ensure and maintain quality.
- Rural populations are not growing; attracting and retaining all healthcare professionals in this environment is particularly challenging

- There are few education institutions preparing healthcare professionals for the diverse practice challenges in rural settings.

So while cost is an important factor, the quality of service, the human resources and the critical mass required to ensure safety, quality and quantity are also paramount factors.

The impact of these changing influences has repositioned how health care is delivered in Quinte, the province, nationally and internationally.

Depending on the alignment of these forces, some degree of consolidation becomes both desirable and inevitable in the delivery of appropriate patient care and we have seen some of this take place in Quinte.

Clearly, the provision of high quality acute care services in many practice areas requires some degree of consolidation—a move that involves change and therefore the potential for controversy. Let me provide a current example.

Recently, the state-of-the-art Intensive Care Unit that was opened in Belleville. This was preceded by the closure of the Special Care Unit in Trenton. Even though the closure of the special care unit at Trenton was part of the announced cuts in the QHC recovery plan, critics were quick to cite this change as further evidence of QHC's intent to downgrade and possibly close Trenton.

It is important to note that while these changes involved some savings, the principal motive was to better address patient care. Notwithstanding the presence of some able support at the Trenton site, it was not possible to maintain the unit there, as there was insufficient physician and nursing resource depth to continue to provide a proper service or coverage.

Indeed, it is hard to find sufficient professionals period, but at least there is a sufficient volume of patients and cases in the total Quinte region to attract the professionals to one site, in this case of the ICU service, based in this case in Belleville. In the case of Day Surgery, Trenton and in the case of the Prince Edward site as a model service provider for ambulatory and inpatient primary care service offerings.

I understand and admire the great loyalty people have to the community hospitals they helped to build. I also appreciate the natural desire to have all services in the nearest site. But it is not possible and throwing money or rhetoric at QHC for its decisions around unavoidable, consolidation will not solve the issues.

This is not an easy message to convey but it is up to people like me to continue trying to explain why hospitals do what they do.

Does this suggest that consolidation of all services on one hospital site is the answer and that the other sites have no future role and are living on borrowed time? While it may seem that way as we tend to focus most of our attention on the more dramatic, complex acute care matters the answer is absolutely not!

Those who jump to the conclusion that there is no role for sites other than Belleville are also ignoring other very important considerations and changes in health care delivery that speak to the value of community hospitals as centres for integrated community health care.

In the first instance not all consolidation can or will occur in the same site.

The growth of Day surgery is an example. The Quinte West site is becoming the QHC centre for Day surgery for the region.

All four sites provide good emergency services that ensure local residents can be triaged and stabilized. That local assessment will determine whether further intervention is required beyond the services provided at the site so they can be transported on an urgent or non urgent basis to another QHC site that is equipped to handle the issues or in situations that cannot be handled at QHC, to a tertiary hospital such as KGH in Kingston or UHN in Toronto.

The Quinte West site has the potential for more surgical activity. The proposal for capital equipment to support growth in surgery in orthopedic and urology procedures is under review by the TMH Foundation. Further, minor surgery and urodynamic procedures and the preadmission clinic for all Quinte will be located at the Trenton site. A full Women's Health Centre is in planning stages, beginning with the Domestic Violence and Sexual Abuse Program to be centred at the TMH.

In addition, there is a great deal of community based care that can and should be established around each of our sites in conjunction with our hospital facilities. This is a major consideration in the discussions between the Brighton Family Health Centre, Quinte West and QHC.

These family and community health services properly developed will result in a greater volume of care being provided more efficiently and effectively closer to home and will provide the potential for much greater access for residents. This will be a major growth area in Quinte West. Primary care visits to the physician, specialist appointments, health maintenance, and support for those with chronic disease problems far outnumber the small volumes of inpatient care.

One hundred years ago life expectancy was little better than 50 years and today it is over 80 years. This longevity has resulted in some new trends that speak yet again to how we use our hospitals. More people now survive strokes and heart surgery but require special monitoring and medication, poor diets will have a greater impact on our need for support, and we are seeing growth in diabetes, obesity, blood pressure, dialyses etc. Indeed the growth of the

obesity problem suggests that the current generation may actually have a life span shorter than their parents!

QHCTM site has a great potential to be developed as a strong community medicine centre and this is being advanced by the Quinte West/Brighton/QHC Health Integration Committee made up of local politicians (Councilor Sally Freeman from Quinte West, Mayor Herrington from Brighton and when possible Mayor Williams also attends), physicians, administrators, and QHC. This initiative should help the city in its struggle to recruit adequate numbers of family physicians and see the Memorial site strengthened as a centre for strong community health services. A recent discussion at the Quinte West Healthcare Advisory Committee confirmed the mutual benefit to the Brighton Family Health Team and QHCTMH to locate the FHT at the Trenton site. Support for necessary renovations are being presented to the TMH Foundation for their consideration.

Beyond the services located in QHCTM, QHC offers stronger and better support to the residents of the Quinte Region at other sites. The Belleville site which is the largest and provides the most complex acute care will shortly be opening the new Sills Wing.

This new wing will house complex continuing care to serve all of QHC, rehabilitation, a much overdue Children's Treatment Centre and several allied health services. Its design makes it very adaptable to meeting future needs in serving patients in Quinte.

Under the leadership of Lyle Vanclief and Dr. Matt Downey, QHC embarked on the Imagine Campaign and the Diagnostic imaging Renewal strategy. QHC has installed both a 64 slice CT in Belleville and 16 slice CT in Trenton, an MRI and substantial other new equipment. This has truly been a "build it and they will come". The department is now fully staffed by a team of energetic young radiologists and is the envy of other hospitals in the region and the province.

- QHC is one of 22 hospitals that partnered in the Diagnostic Imaging Repository strategy (for people like me a big computer that stores all of the digital images) which will allow us to share images with all of the other 22 hospitals. This makes easy the transfer of images from referring hospitals or from teaching centres back to the referring hospital. It permits images that can be read by a radiologist and reported on from a multitude of locations.
- QHC has just signed an affiliation agreement with the Psychiatry Department at Queen's University whereby this hospital will work closely with the Kingston psychiatrists to ensure adequate coverage for mental health patients based at Belleville General.
- QHC is actively working with the provincial government and the SE LHIN to advance the last phase of the Belleville site redevelopment which will include the new emergency

- QHC continues to perform with the best in surgical wait times, which is a huge priority with the provincial government.

It should come as no surprise that these kinds of positive accomplishments often get lost in controversy. Controversy is natural to all hospitals where:

- different professional groups guard their turf and complain to the public that services will suffer if any part of their turf is occupied by another profession
- the most influential and important group in the hospital consists of independent contractors with their own financial and relationship issues
- life and death decisions are made every day
- finite resources are up against heightened expectations and demands for new technology and drugs
- changes in technology or new learning about quality and safety dictate instant changes in cultural behaviours that have been entrenched over the years

That is just the beginning of a list that makes it very hard to manage modern hospitals and poses communications challenges to hospital boards here or elsewhere. It is therefore crucial that communities have confidence that they have a hospital board that is up to the job.

So there are a lot of positive initiatives in QHC but of course it is crucial that you be assured of good governance of QHC going forward.

The decision to establish a new board at QHC, particularly against the history of controversy that has dogged the development of the corporation, called for the creation of a highly skilled and respected board. A board that could concentrate its energy on ensuring that QHC with its four interdependent sites could meet the reasonable expectations of the residents of the Quinte region.

The first step was to appoint an advisory committee of prominent citizens who, without any reward other than undertaking a controversial public service, would work to devise a strong new board. Based on consultations locally, I was blessed with such a committee:

- Gord Allan
- Glenn Rainbird

- Ross McDougall
- Maureen Piercy
- Dr. Michael Shannon, and
- Lyle Vanclief

Their meetings were facilitated by Maureen Quigley, with expert credentials in hospital and health care governance.

Following a number of meetings, the Committee made a series of unanimous recommendations that will result in more open and accountable governance of QHC.

There will be substantially greater opportunity for the community to scrutinize the policies and practices of the board while at the same time the board will be able to focus its efforts on building a strong vision for the future while overseeing the effective operation of the hospital.

The highlights of the report are:

- A 12 person board joined by the three statutory members and the CEO for a total of 16.
- The process for the selection of Board Directors remains open and transparent
- The membership of the corporation will consist of the Directors who are voting members and 54 non voting members consisting of:
  - 18 appointed by the 6 Municipal/county councils
  - 10 appointed by the Foundations
  - 8 appointed by the Auxiliaries/Volunteer Associations, and
  - 18 at large selected by the 36 other appointed members in an open process
  - Corporate non-voting members may serve on board committees where they will have a vote and will have a voting majority on the board nomination committee

The board will no longer simply meet with the membership once a year at a set piece annual meeting but will meet more often to hear the advice of the membership and take advantage of their knowledge.

Further, the board will be expected to meet with the Municipal and County Councils at least annually. This will ensure that there is effective communication and feedback.

This process of open meetings should meet the expectations of the Local Health Integration legislation and ensure that residents of Quinte will have the opportunity to be well informed on hospital matters.

The work of the Community Advisory Council was more than vindicated by the large number of strong Director applications. The Community Advisory Council had to choose the 12 directors from 43 impressive applications. It is a tribute to the Quinte region that so many qualified applicants are prepared to volunteer for the onerous and usually thankless task of overseeing the management and operations of QHC.

Last week many of the new board members met with the Quinte West City Council and I announced that I had accepted the CAC recommendations that Brian Smith be appointed Chair, Steve Blakely, Vice Chair and John Embregts as Treasurer. The Board has been involved in substantial orientation and has commenced the process for selection of the new CEO.

All this should result in the new board undertaking its full responsibility and selecting the new CEO early in the New Year.

This is an exciting time here in Quinte. I believe it is important that Quinte embrace the potential of the vision of one hospital with four interdependent sites.

However strong that vision may be, it will be tested.

Future investments will continue and other new innovative developments will occur in the future. The new board will certainly see these as opportunities to improve the care but they will also see in such changes the need to reconfigure QHC to meet the service and fiscal accountability obligations. They cannot be expected to make their decisions simply to avoid controversy.

All change is marked with some controversy.

Constructive criticism is both necessary and desirable but destructive and uninformed criticism channels energy away from urgent priorities and in the end it diverts attention from the fundamentals of your health care. For example, it dampens the enthusiasm required to help foundations raise the funds necessary to ensure the provision of equipment and support so necessary to acquire quality, modern technology essential to acute care the end it diverts attention from the fundamentals of your health care.

2010 will see a number of changes in QHC:

- A new board
- A new CEO

- A much stronger financial base
- A strong community based corporate membership

QHC will see growth in the number, quality, and coordination of health services. This will include the high quality hospital based care, deeper partnership with family health teams and other health providers to deliver better community and coordinated care to the region.

The residents of Quinte also have a role to play. They must embrace QHC as their hospital, provide constructive advice, support the foundations and understand that, notwithstanding the traditional rivalries in the region, that all sites have important integrated roles to play in QHC and, most importantly, that together they provide the resource to residents for better and more sophisticated services than would otherwise be available.

Being proud and supportive of QHC will make it stronger and help it continually enhance its services to meet the current and future needs of the people of Quinte.

Thank you for the opportunity to speak with you today.

## **Acknowledgements & Thanks**

Supervision is not a one person task. Being successful requires the active input and involvement of many, people who are committed to work together in the interest of building a stronger hospital in their community. It is with sincere appreciation that I acknowledge the special efforts of the many individuals who were of considerable assistance in advancing various aspects of my work:

### **Volunteers**

- Members of the Community Advisory Council: Gord Allen, Ross McDougall, Maureen Piercy, Glenn Rainbird, Michael Shannon, and Lyle Vanclief not only for the wise advice and assistance they provided to me purely on a voluntary basis but also for ongoing and consistent efforts to put the needs of their community first.
- The Chair and Members of the Prince Edward Health Alliance
- Members of the Quinte West/Brighton Health Integration Committee
- The Rotary Clubs of Belleville, Trenton, Picton, Brighton and the Rotary Sunrise Club which provided me with a forum to discuss the changes unfolding in the broader health sector and the impact of these changes on the role of QHC.

### **QHC Management and Staff**

- Members of the QHC management team including Bruce Laughton, CEO, Dr. Mohammad Gaber, Chief of Staff, Mike Prociw, Vice-President, Informatics & Diagnostic Services, Finance & Chief Financial Officer, Jan Richardson, Vice-President, Human Resources, Medical Affairs & Support Services, Katherine Stansfield, Vice-President, Patient Care Services & Chief Nursing Executive. All of these individuals worked tirelessly to meet and, in fact, exceed my expectations.
- Professional Staff who were open and helpful in addressing complex clinical issues
- The members of the Medical Advisory Committee
- Dr. Sylvain Duchaine, President, Dr. Dan Stinitz, Vice-President and the Members of the Professional Staff Association Executive
- Senior staff at all sites. Thanks to each and every one of you for going out of your way to ensure that I was well prepared for all meetings and for providing me with you ideas on how to make things better.
- Susan Rowe, Director of Communications who provided valuable advice on communication issues
- Kathryn Noxon, Executive Assistant to the CEO who generously and tirelessly provided important and invaluable administrative support to the Supervisor and team throughout the supervision process

## **Municipal Leadership**

- Municipal Council members who worked with me in Prince Edward County and Quinte West: Mayor Leo Finnegan; Councillor Sandy Latchford; Mayor Chris Herrington; Mayor John Williams; Councillor Sally Freeman

- **External Faculty of the Board Orientation Program**

Carol Hansell, Davies, Phillip, Vineberg LLP, Trustee, Toronto East General Hospital and Chair, Ontario Hospital Association Governance Leadership Council

Georgina Thompson, Chair and Paul Huras, CEO of Southeast LHIN

Betty- Lou Souter, Board Chair and Debbie Sevenpifer, CEO, Niagara Health System

Scott Campbell, Past Chair and Janet Davidson, CEO, Trillium Health Centre

Dr. Chris Carruthers, former Chief of Staff, Ottawa Hospital

Jim Nininger, Trustee, The Ottawa Hospital and Chair, Centre for Excellence in Health Governance

Kevin Empey, CEO, Lakeridge Health

Bill Richard, Board Chair, and Leslee Thompson, CEO Kingston General Hospital

Valerie Jackson, Board Chair and David Marshall, CEO, Southeast CCAC

Dr. Greg Higgins, President and Duff Sprague, Executive Director, Prince Edward Family Health Team.

## **The Supervisor's Team**

The Adamson team (Bonnie Adamson, Corrine Wong, Nan Brooks) which responded quickly to my request for a review of the operations of QHC and provided valuable guidance in the eventual resolution

Maureen Quigley, Maureen Quigley & Associates, facilitator of governance renewal, for quality work in advancing governance and accountability and, creating an extensive customized orientation program that was well received by the Board and management.