Investigation Report

Brant Community Healthcare System

Submitted to:

The Honourable Dr. Eric Hoskins
Minister of Health and Long-Term Care

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Executive Summary

The Brant Community Healthcare System (BCHS) has been struggling in recent years with performance issues, significant financial difficulties, and declining staff and physician morale. With concerns regarding BCHS's operational and financial performance, the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN) Board held a meeting with the BCHS Board in January 2017. The HNHB LHIN assessment of the BCHS Board was that, although it was comprised of an impressive group of committed people, the Board members did not yet have the right complement of skills, knowledge and experiences to deal with the complex issues facing BCHS. In response to a recommendation from the HNHB LHIN, the Minister of Health and Long-Term Care appointed Dr. Tim Rutledge as Investigator for BCHS, to "examine and report on issues related to the governance and management at Brant Community Healthcare System."

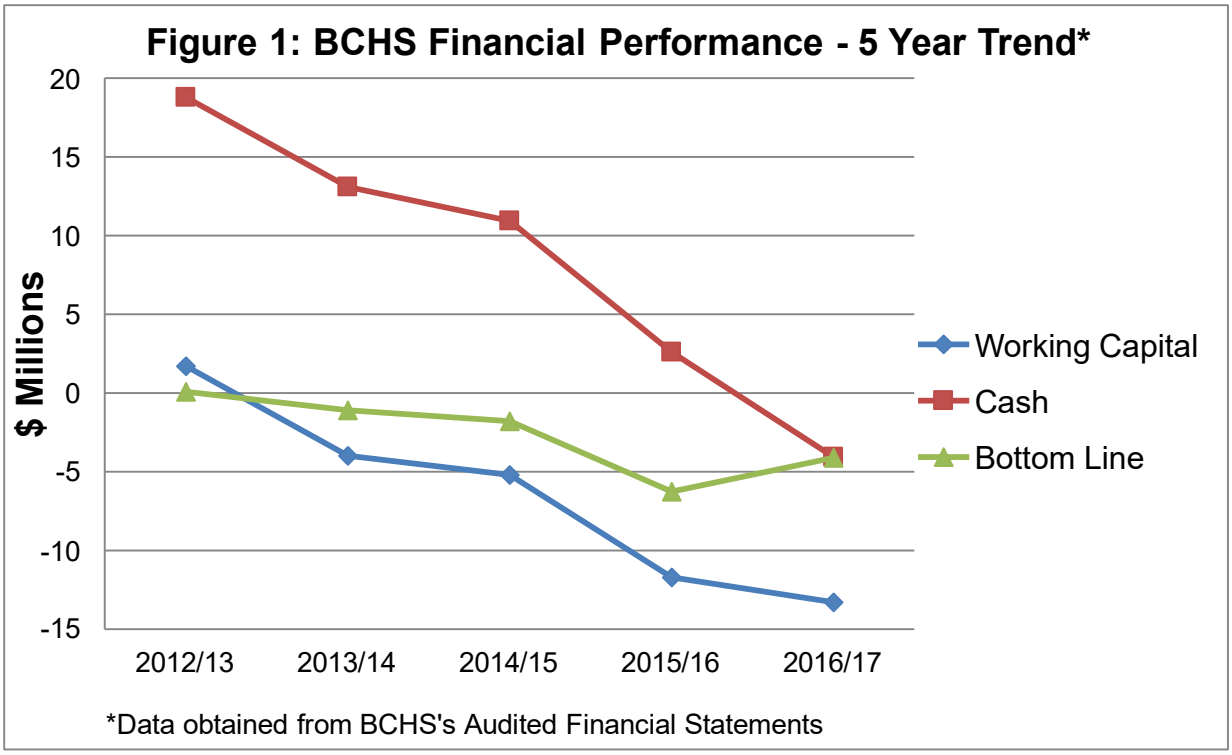
BCHS has undergone extensive change over the past five years. Although there have been important changes in the healthcare environment, much of the change at BCHS has been internally driven, including a new strategic direction, a major change in organizational structure with multiple leadership role changes, and model of care changes in many of its inpatient units. As a result of deteriorating operational and financial performance, BCHS has also had two major external reviews, each with a substantial set of recommendations. Unfortunately, the execution of these large-scale changes has not been well led. As a result, numerous skilled and experienced personnel have left the organization, and the culture and morale at BCHS have deteriorated significantly.

There is a clear commitment to quality and safety throughout the organization. The Investigation Team was impressed with the passion, ability and commitment of the front-line staff and physicians to deliver high quality and safe care. Many of those interviewed remain very dedicated to BCHS. There is also strength at the middle management level in most areas of the organization.

Unfortunately, the leadership style at BCHS has resulted in increasingly frustrated and disenfranchised staff and physicians. The increasing level of disengagement of the staff and physicians at BCHS is clearly illustrated in third-party workplace culture surveys conducted in 2013 and 2016. Words used to describe the current culture of BCHS included: a culture of fear, intimidation, lack of trust and transparency, uncertainty, instability, and toxic.

BCHS has been underperforming on all key performance indicators in its Hospital Service Accountability Agreement (HSAA) with the HNHB LHIN. Wait times have been particularly long for certain services.

The financial health of BCHS began to decline in 2013-14. This was the first of four consecutive fiscal years where BCHS failed to achieve a balanced position, and was the beginning of a steady decline in key financial indicators. Factors leading to the decline in cash reserves include 4 years of deficits and capital equipment spend beyond funding. The organization has not met its HSAA financial performance indicators. Figure 1 illustrates the continued erosion of BCHS's financial position.



Despite the material decline in key aspects of BCHS's performance, a review of the Board and its committee minutes provides evidence that the Board was not properly monitoring the decline in performance and the related risks. As a result, appropriate steps were not taken by the Board to mitigate or respond to the decline.

In consideration of the above findings, the Investigation Team has concluded that in recent years there has been an unacceptable failure in both governance and executive leadership at BCHS. Collectively, the findings of this Investigation reflect that the BCHS Board has failed to discharge its governance responsibilities, including the exercise of reasonable care, diligence and skill, at a level that the Investigator believes BCHS's stakeholders would reasonably expect of a large community public hospital Board in Ontario. The Board's failure to discharge its oversight responsibilities was exacerbated by its failure to ensure that BCHS's executive leadership established a "tone at the top" that is aligned with the culture of accountability and transparency that is required of public hospitals in Ontario today.

Summary of Key Recommendations

- The Lieutenant Governor in Council should appoint a Supervisor for Brant Community Healthcare System with the full powers of a Supervisor under the Public Hospitals Act of Ontario.
- The Supervisor should oversee a Board renewal process for the BCHS Board of Directors founded on governance best practices.
- The Supervisor should undertake a review of the senior leadership and the organizational structure of BCHS.
- The Supervisor should identify a process to renew the physician leadership at BCHS, and develop processes for the selection, appointment, and evaluation of BCHS's Chiefs of Departments who are integral to the Board's ability to discharge its oversight of BCHS's professional staff as contemplated by the Public Hospitals Act (Ontario).
- When renewed governance and leadership are in place, the organization should undergo a full strategic planning exercise. This should involve early and meaningful engagement of internal and external stakeholders, and lead to the development of a renewed shared vision for the future of BCHS.
- An organization-wide plan for improving the morale and culture at BCHS must be developed by the refreshed Board of Directors and leadership team.
- A robust communication plan should be developed to regularly update internal and external stakeholders on progress with the transition and the development of a new direction to meet the needs of the communities served by BCHS.
- BCHS should continue to develop the role of the Patient and Family Advisory Council to support improvements in the patient experience and advance patient and family centred care. This committee should have input on process improvements, policies, design of care environments and hospital planning.
- BCHS should immediately review and recalibrate staffing on units where the IPC model has been implemented. The staff qualifications and patient ratios should align with accepted standards of practice for the acuity level of each unit.
- A multi-year plan for BCHS's existing facility must be developed and advanced. The Ministry should review and prioritize the pre-capital submission for the redevelopment of the Emergency Department, and should consider the urgent need

for capital redevelopment of BCHS's mental health inpatient unit, following a complete proposal from BCHS.

- Board oversight of the establishment and monitoring of quality and safety priorities must be enhanced. This should include patient and family centred indicators, as well as those in BCHS's HSAA and QIP.
- BCHS should undertake a comprehensive multi-year recovery plan and develop a financial strategy. This should be led by the Executive Team and be overseen by the Board.
- BCHS needs to redesign its current operational and financial planning processesto create an integrated and transparent operating plan. This should include strengthening the financial and decision support teams.
- BCHS should adopt more rigorous financial reporting processes and practices. The Board must receive much more detailed and complete financial and operational reports to discharge its fiduciary duties.
- The role and responsibilities, scope of practice, recruitment and retention,and remuneration of Hospitalists requires urgent review and intervention. Detailed recommendations are listed in the Physician Relations and Medical Leadership section.
- The roles of specialist physicians with regards to Most Responsible Physician for inpatient care needs to be reviewed and clarified. Detailed recommendations are listed in the Physician Relations and Medical Leadership section.
- Contracts must be developed for all physicians that receive remuneration from the hospital.

Introduction

The Brant Community Healthcare System (BCHS) hospital corporation includes the Brantford General Hospital (BGH), which is a full-service community hospital, and the Willett ambulatory care facility, which hosts an Urgent Care Centre, outpatient medical imaging, and leases space to other organizations including a Family Health Team. BCHS operates 262 beds and serves a population of approximately 120,000 in the cities of Brantford and Paris and the surrounding area of Brant County. Over 2300 staff, physicians and volunteers work at BCHS. There has been a long history of quality healthcare in this region. In 2010, BGH celebrated 125 years of community service.

In recent years, BCHS has experienced significant financial difficulties, with operating deficits in each of the last four years and a steadily growing working capital deficit. In addition, BCHS has been underperforming on all key performance indicators in its Hospital Service Accountability Agreement with the Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN).

BCHS has undergone significant change over the past few years, including a new strategic direction, a major change in organizational structure with multiple leadership role changes, and model of care changes in many of its inpatient units. Concerns related to the new model of care have been raised by nursing, allied health and physicians at the hospital. These concerns led to an external review of the model in 2014-15, which led to more changes.

The financial difficulties at BCHS led to an external operational review in 2016 that identified a list of opportunities for improvement in operations and management. However, implementation of the recommended initiatives has been challenging, and in some cases, disruptive.

Despite the external reviews, BCHS continues to struggle achieve its performance targets, and has not achieved financial stability. In addition, there are growing concerns about deteriorating staff and physician morale at the hospital.

The HNHB LHIN has been concerned about the performance of BCHS for some time. In January 2017, the HNHB LHIN Board of Directors decided to follow an escalation protocol and met with the BCHS Board of Directors to ascertain their ability to manage the situation. Following this meeting, the HNHB LHIN Board of Directors made a recommendation to the Minister of Health and Long-Term to appoint an Investigator for BCHS.

The Investigation Team

On February 15, 2017, Dr. Tim Rutledge was appointed by Cabinet as Investigator to examine and report on issues related to the governance and management at BCHS. The Terms of Reference for the Investigator are provided in Appendix A.

Due to the broad scope of the Investigation, Dr. Rutledge retained a team of experts (the Investigation Team) to assist with specific areas of the investigation. A short biography of each of the Investigation Team members appears in Appendix B.

Review Process

The Investigation Team conducted a comprehensive engagement strategy to collect feedback from various stakeholder groups in BCHS, including the Board of Directors and executive of the hospital, staff, physicians, key stakeholders and community members, including members of the Indigenous communities in the region. In total the Investigation Team interviewed 64 individuals and conducted 10 focus groups (71 participants) for a total of 135 unique individuals providing feedback in-person.

As per the advice of local experts on community engagement, two online surveys were developed and promoted. One was for hospital staff, volunteers and physicians and the other was a survey of community members who use the hospital's services. In total, 296 responses were received from the BCHS hospital survey, and 423 responses were received from the community survey. Additionally, 36 individuals provided feedback to a confidential email address. More detail on the engagement strategy is provided in Appendix C.

The Investigation Team attended several meetings as guests, including the Project Management Office Executive, Board Committee meetings, and one Board of Directors meeting. The Investigation Team also toured the BCHS facilities (the Brantford General Hospital and the Willett ambulatory care facility) both formally (guided by staff or physicians) and informally.

The Investigation Team conducted an extensive review of relevant documentation that was provided by BCHS and the HNHB LHIN. A list of documents that were reviewed as part of this investigation is provided in Appendix D.

The Investigation Team met regularly to discuss the key findings from the review, develop recommendations and write the final report. The key findings and recommendations are grouped into five main categories: Governance, Leadership and Management, Quality and Safety, Operational and Financial Performance, and Physician Relations and Medical Leadership.

Background and Context

A significant change in leadership occurred at BCHS in 2010 when the President and CEO since 1982 stepped down. The new (and current) President and CEO brought a leadership and management style that was very different from that of his predecessor. For over 25 years, the hospital had been led with an approach that was described by many as traditional and hierarchical. In contrast, the current CEO described his preferred leadership style as team-based and bottom-up.

The Executive Team in 2010 consisted of the new CEO, and four VPs: VP Medical/Chief of Staff, VP Patient Services/CNE, VP Corporate Services/CFO/CIO/CPO, VP Resources and Development. Having come from Saskatchewan where the healthcare system was undergoing a large-scale Lean transformation, the current CEO was keen to implement Lean methodologies, structures and processes at BCHS.

In the initial years under the new leadership, Lean methodologies were introduced and a few personnel with Lean expertise were recruited. In 2013, the organization was completely restructured, moving from a structure with traditional roles and reporting relationships to a "Value Stream" structure, which was described as "flatter" with more distributed leadership. The clinical programs were grouped into "Value Streams" intended to cluster activities required for patients as they flowed through the hospital's services while ensuring that all components of care added value from the patients' perspective. Other Value Streams were clusters of support and corporate services. Role titles were changed from Directors and Managers to Value Stream Leaders, Group Leaders and Team Leads. Role descriptions, responsibilities and accountabilities were all modified.

The restructuring in 2013 was a highly disruptive experience according to many remaining in the organization, and to this day, the Value Stream structure is poorly understood by most internal personnel interviewed. A number of experienced leaders have left the organization since, some by choice, others were restructured out. Within a year of the restructuring, the VP Corporate Services/CFO/CIO/CPO and VP Resources and Development had left the organization and were not replaced. The VP Patient Services/CNE was promoted to the additional role of COO. The Executive Team currently consists of three individuals; the CEO, the VP Patient Services/CNE/COO, and the Chief of Staff.

Another major change at BCHS was an initiative called "Inter-Professional Care" (IPC), which was implemented in phases beginning in 2012. This was a shift in the hospital's model of care that was intended to improve quality of care, patient and provider satisfaction and system sustainability. The IPC model involved significantly decreasing the number of Registered Nurses (RNs) on inpatient units and increasing the number of Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs). While

shifts in models of care have been implemented in many hospitals in Ontario, the degree of reduction in the number of regulated health professionals at BCHS was extraordinary and led to significant quality and safety concerns from both nursing staff and physicians. This prompted a formal external review in 2014-15 that resulted in a number of recommendations to improve the model.

Both the organizational restructuring and the move to the IPC model of care were related to the introduction of a new strategic plan for BCHS in 2012-13, entitled "True North." The True North Strategy has three components: (1) A Great Place to Work, (2) Patient's First, and (3) Using Resources Wisely, and it continues to frame BCHS's annual planning. According to the strategy, the restructuring was intended to simplify the organizational structure and allocate more resources to support front-line care, and the IPC model was part of the journey of improving patient care.

In 2013-14, BCHS began to demonstrate significant financial difficulties. This was the first of four consecutive fiscal years where BCHS failed to achieve a balanced position, running bottom line deficits of $1.1M in 2013-14, $1.8M in 2014-15, $6.3M in 2015-16 and $4.1M in 2016-17. Cash availability at the BCHS plummeted from $18.9M in 2012-13 to bank indebtedness of $4M in 2016-17, and the Current Ratio has steadily declined from 1.14 in 2012-13 to 0.4 in 2016-17. In response, BCHS procured an external consultant to conduct an operational review of the entire organization in 2016.

Ernst and Young (EY) conducted the operational review from January to April 2016. The intention of the review was to identify operational efficiencies that would help BCHS recover from a then-projected deficit of $3.8M in 2015-16, $6M in 2016-17 and $9M in 2017-18. In their May 2016 report, the EY review identified opportunities for potential savings of over $22.8M, most of which was based on management of inpatient beds and length of stay ($11.2M) and organization enablers ($7.2M). The report recommended establishing a Project Management Office to support the implementation of operational improvement.

A Project Management Office (PMO) was established in June 2016 as per the recommendations of the EY report, replacing a "Cost Improvement Program" structure that was in place from March to June 2016. The PMO had an executive committee that was to be led by the CFO, reporting to the Executive Team and Board of Directors. A consultant from EY was retained to support the leadership team and the PMO in implementing the recommendations. A Physician Advisory Committee (PAC) was also established in July 2016 to advise the PMO from the perspective of physicians. Due to lack of engagement, the PAC disbanded in November 2016. As a result of a prolonged absence of the CFO, the PMO was led by two physicians in recent months. The PMO is the only group at BCHS currently driving cost-saving initiatives, which are focused on opportunities identified by EY. There has been only moderate success in curbing the deficit in 2016-17, which is $2.9M at the operating line and $4.1M bottom line.

Governance

The process of governance review for this investigation included a review of the Corporate By-law of June 1, 2016, Board policies and processes, Board minutes, the results of Board surveys, the results of performance reviews of the President and Chief Executive Officer (CEO) and Chief of Staff (CoS), letters written to the Board and responses from the Board. The lead Investigator also interviewed each of the thirteen elected members of the Board individually, and observed one Board meeting, including the in-camera and Board-only components of that meeting.

Board Structure and Composition

The BCHS Board of Directors is a skills-based Board made up of thirteen independent Directors and seven ex-officio non-voting Directors as listed below.

Brant Community Healthcare System Board Composition

13 elected, independent voting Directors

Ex-officio non-voting:

- Hospital President & CEO
- President of the Medical Staff Association
- Vice-President of the Medical Staff Association
- Chief of Staff
- Chief Nursing Executive and Chief Operating Officer
- President of the Volunteers Association
- Chair of the Foundation

The Board has eight subcommittees, which are listed below along with brief descriptions of their major functions.

Brant Community Healthcare System Board Subcommittees

Governance Committee: manages Board objectives, plans and implements Board performance evaluation practices, makes recommendations to the Board regarding Board effectiveness, Board member recruitment, orientation, education and committee appointments

Audit Committee: oversight of the annual external audit process

Corporate Resources Committee: oversight of fiscal, property and human resources

Executive Compensation & Development Committee: oversight of performance evaluation, succession planning and development of the President and CEO and the Chief of Staff, and compensation of the executives

Quality Committee: oversight of the hospital's quality programs and its Quality Improvement Plan

Medical Advisory Committee: advisory to the Board on credentialing and quality of care provide by the medical, dental, midwifery, and extended-class nursing staff – required by Ontario's Public Hospital's Act

Fiscal Advisory Committee: to make recommendations to the Board with respect to the operation, use and staffing of the hospital – includes medical and nursing staff – required by Ontario's Public Hospital's Act

Joint Conference Committee: a venue to discuss points of mutual interest to the Board and the Medical Staff

The BCHS Hospital Corporation, reflective of best practices, has a closed membership, with the Members being the voting and non-voting members of the Board.

The term for elected members of the BCHS Board is three years, with eligibility for re-election twice, for a maximum term of nine years. There are three exceptions to this maximum term in the June 1, 2016 bylaw:

1) A Director's maximum term may be extended when they become Chair or Past Chair.
2) One individual had served a nine-year term and was brought back onto the Board after one year off. This individual is named in the bylaw with the stipulation that the maximum term applies to when he was reappointed. Thus, he could potentially serve on the Board for eighteen years. Since his reappointment, the bylaw has been changed such that the maximum number of years a member can serve is a total of nine years in aggregate.
3) The bylaw indicates that another individual may be reappointed annually, with no term limit. He is the great grand-nephew of the founder of the Brantford General Hospital, which was opened in 1885. A number of members of that family have served on the Board over the years, and some have chaired the Board. The current family member is in his eighteenth year on the BCHS Board.

The two individuals named in the bylaw with exceptions to the nine-year term limit (referred to in 2 and 3 above) are considered valuable contributors to the Board by all of the members. That stated, most agreed with the importance of continuous board renewal and rejuvenation. Better governance practice is to set a maximum number of years of service, with the usual maximum term being in the range of six to nine years. The maximum term of service should apply to all elected governors without exception. There needs to be a balance of continuity with fresh thinking. Mandated turnover helps to avoid historical inertia and allows regular opportunities to recruit new members.

The Board's skills matrix in 2017 consists of 21 areas of expertise that are pertinent to the governance of BCHS, and are based on the inventory suggested by the Governance Centre of Excellence's *Guide to Good Governance*. Each year, the members of the Board are asked to rank their level of knowledge, skills and experience on a 3-point scale in each of the 21 areas. This information facilitates the identification of areas of need, which in turn, informs the process of recruiting new members to the Board.

The annual Board recruitment process is carried out by the Governance Committee. The opportunity is advertised in local newspapers, on the hospital's website, and through social media (Facebook and Twitter). While these postings make the opportunity known, directly approaching individuals has historically been the most effective way to recruit people with the required expertise according to several Board members. To date this year, there have been five applicants for three available positions.

Diversity is listed on the skills matrix, which is certainly appropriate given the growing diversity of the communities served by BCHS. Five of the thirteen independent Directors are women. However, none of the current Directors comes from a visible minority or an Indigenous background.

Engagement of Indigenous Peoples

BCHS serves a large and diverse Indigenous population, and thus it would be valuable to have perspectives from the Indigenous community on the Board. Efforts have been made to recruit from the Indigenous communities in the past; however, previous attempts have not been successful. Members of the Investigation Team held two focus groups with representatives from the Six Nations of the Grand River and the Mississaugas of the New Credit First Nation. It was evident from these focus groups that there would be people from those communities who would be willing to serve on the BCHS Board and who would offer a variety of the other skills in the skills matrix. However, because of the difficult history the people of these communities have experienced, as well as the ongoing challenges they continue to experience, recruiting a Director from the Indigenous community will likely take some extra focused effort. It would need to be made clear that participation would be valued and meaningful, and it may be necessary to do some preparatory work; for example, with initiatives to build relationships and demonstrate a commitment to patient and family centered care that is sensitive to the needs and preferences of Indigenous peoples.

To enhance understanding of the healthcare needs and preferences of the Indigenous people in the region, it would be valuable for the BCHS Board members to receive occasional educational sessions on these topics. Considerable insight and understanding could also be gained by arranging a Board tour of the Mohawk Institute Residential School, one of the oldest and longest running residential schools in Canada.

The BCHS Board's mandate to engage with Indigenous peoples should not be solely reliant on an Indigenous person being recruited to serve on the Board. Such a strategy relies on one individual to appropriately represent varied communities with many different interests and perspectives. The goal of Indigenous engagement should be obtained through a variety of strategies including for example, the development of a formal communications process between BCHS and the Councils of the Six Nations of the Grand River and the Mississaugas of New Credit First Nation to:

- Identify the unique health care needs of Indigenous people and the related deficiencies of existing services;
- Improve the services BCHS can provide to the Indigenous populations it serves;
- Provide more culturally sensitive healthcare services; and
- Work together to identify and remove systemic barriers to providing culturally appropriate care the Indigenous populations served by BCHS.

The intent would be to develop formal and ongoing communications between BCHS and the Indigenous Councils to ensure that the services provided by BCHS to Indigenous peoples continually improve.

Board Processes

The BCHS Board normally meets monthly except for July and August. Each meeting consists of an open session, which is open to the public, followed by an *in camera* session. The *in camera* session includes the Independent Directors, CEO, CoS, and the President and Vice-President of the Medical Staff Association. Those excluded from the *in camera* session are the public, the CNE/COO, other staff, and representatives of the BCHS Foundation and Volunteer Association.

The Board does not routinely have an independent director meeting immediately following each meeting. Independent director meetings have been held approximately 2 weeks following the Board meetings, although until recently, these “Board-only” meetings have occurred infrequently. Such meetings allow independent Directors to ask difficult questions, discuss the effectiveness of senior management, and consider the role of the Board in various issues the hospital is facing. They are also an opportunity to reflect on the effectiveness of meetings in contributing to the discharge of the Board’s role. Optimally, *in camera* meetings with only the independent directors should occur after each Board meeting, while the participants are present and the items are fresh in their minds.

Board meeting effectiveness was discussed with each of the Board members. A sense of frustration was expressed by a significant majority of the independent directors. There was a recurring theme that meetings have consisted largely of a number of presentations that have not been engaging. While the information provided has usually been interesting and valuable, it was often information that could have been circulated with the board package and read prior to the meeting. Reports from management and staff have been dominated by good news stories, and when performance issues have come up, reassurances have been provided on corrective actions being planned or underway. Most independent directors indicated in their interviews that they felt there has not been sufficient engagement in generative discussions at Board meetings, particularly with respect to some of the most important issues facing BCHS.

A few examples were cited by Directors in which it was felt that the Board was not made aware of how things were going at the hospital. In one example, the Board was under the impression that the implementation of the IPC model of care launched in 2012-13 was proceeding quite successfully. The Board was very surprised when they received a letter from the Medial Staff Association in May 2014 that raised significant quality and safety concerns related to the model. This led to a formal external review in 2014-15 that resulted in a number of recommendations to improve the model.

On January 3, 2017, the BCHS Board met with the HNHB LHIN Board to discuss the financial and operational challenges facing BCHS. During this meeting, BCHS Board members were surprised to learn how poorly the hospital was performing on key performance indicators in the BCHS's Hospital Service Accountability Agreement (HSAA). Further, they did not feel adequately informed about the hospital's fiscal situation to respond to questions from the HNHB LHIN Board.

A consent agenda is part of the open session of each BCHS Board meeting to enhance efficiency by expediting the approval of routine matters or motions where no debate is anticipated. However, the Investigation Team had concerns with the appropriateness of some of the items included in the consent agenda. For example, BCHS's Hospital Accountability Planning Submission (HAPS) was simply part the Corporate Resources Committee report within the consent agenda of the February 2017 Board meeting. The minutes of the Corporate Resources Committee were attached to the Board package and included a resolution to recommend that the HAPS budget be approved by the Board. Items included in consent agendas must be accompanied by sufficient supporting materials to allow the Board members to fulfill their fiduciary duties. In this case, the materials consisted of the Corporate Resources Committee minutes, which had a very brief (2 paragraph) description of what the HAPS is and factors considered in its preparation. The HAPS plan was not included in the Board materials, and it was not specifically mentioned in the minutes of the February 2017 Board meeting.

Given that the HAPS is the hospital's detailed annual operating plan, including financial and statistical budgets and performance indicators that inform the hospital's HSAA, it should not be considered a routine matter. It warrants discussion by the Board prior to its approval, including a review of the details of the plan, associated risks and mitigation strategies.

The HSAA, a public document, is a legal agreement between the hospital and the LHIN, which commits to hospital to accountability for financial and service performance. It also merits discussion by the Board prior to its approval. On review of the Board meeting minutes over the last 3 years, the HSAA has only been mentioned during indicator reviews. There has apparently been no discussion of the overall HSAA, and no approval of the HSAA by the BCHS Board in the last 3 years. The HSAA amending agreement was signed by the Board Chair in 2015, and the Vice Chair in 2016 and 2017.

The Investigation Team did note improvement of the financial packages to the Board in recent months, including narratives and indicators. Since March 2017, HSAA performance indicators have been included. Considering that performance targets have not been met for a number of years, these indicators should have been reviewed regularly.

The Excellent Care for All Act, which came into law in 2010, requires hospitals in Ontario to develop annual Quality Improvement Plans (QIPs) and make them available to the public. One of the main responsibilities of the Quality Committee is to oversee the preparation of BCHS's annual QIP. Given its significance and the important role of the Board in oversight of quality, the formulation of the QIP warrants understanding and engagement of the full Board. Approval of the annual QIP has not been a focused agenda item for the full Board in recent years. Rather, QIP targets have been recommended to the Board as part of the Quality Committee report within the consent agenda.

The BCHS Board reviews the hospital's performance on a number of indicators each meeting during a session entitled "Huddle – Mission, Vision, Values and Corporate Priorities." Metrics monitored include HSAA and QIP indicators. However, concerns were expressed by Board members about a lack of follow up on the effectiveness of action plans where performance has been below target or deteriorating.

A key role for the Board is oversight of the formulation of the organization's strategy. The last comprehensive strategic planning exercise conducted at BCHS occurred in 2012-13, and it resulted in the "True North" strategy with its 3 pillars: Patients First, A Great Place to Work, and Using Resources Wisely. Each year since then, strategic planning has involved deciding on areas of focus, determining metrics and setting targets under each of the 3 pillars. Staff, physicians and Board members are engaged in this process. In spite of this process, there is only a vague awareness of the hospital's strategy among staff, physicians and Board members. On detailed review of the Board minutes over the past 3 years, there has been no agenda item focused on reviewing or refreshing the organization's strategy. The strategy has only been mentioned when indicators within the pillars are reviewed. The Board should be highly engaged in strategic planning and hold management accountable for executing the strategy with predetermined goals and timeframes.

While the Board agendas are meant to be planned by the Chair in consultation with the CEO, in practice, the agendas have generally been set by the CEO. The BCHS Board and its committees have not used the practice of developing annual work plans, although this is currently being considered. Work plans are highly recommended as a means of ensuring that work gets done in a timely and coordinated way, and help to optimize Board effectiveness. Work plans enable consistent and connected flow of information, deliverables, and decision making from subcommittees to the Board.

Substantial items such as the hospital's HAPS plan, HSAA, QIP, CEO and CoS evaluations, and Board evaluation, should be placed in the Board's annual work plan, and each should be allotted sufficient time for discussion by the Board. Other items to incorporate into the work plans of the Board and its committee include periodic updates on strategy, quality performance, risk management, human resources, capital projects, financial performance, and stakeholder relations.

Minutes of standing committee meetings tend to be high level summaries of discussions and the content often lacks depth. On review of the Committee packages, there are many operational level approvals requested by management which are unnecessary and remove focus from the key issues. There is lack of oversight in certain critical areas, such as cash advances, and too much oversight in others, such as a new human resources form. This suggests a lack of role clarity on the roles of the Board and management.

It was noted that internal financial statements are shared at the Corporate Resource Committee but are not approved by that committee, nor are they shared with the Board. Given the current financial concerns, it is surprising that the statements are not reviewed regularly at the Board level, along with a forecast and cash flow. A budget recovery action plan, complete with risk assessments of the various proposed strategies, should be developed under the oversight of the Corporate Resources Committee and presented to the Board.

Work plans, agendas, meeting packages and minutes of the Board and Committees should be a collaborative effort between the Chairs and the management resource to ensure that both Directors and management have a shared understanding of the key priorities. Ultimately the work plans, agendas, materials, and outcomes of the committees are the responsibility of the Chairs, with appropriate support from management and staff.

It was noted that several Board policies were missing or outdated. Board policy review should be on the work plans of the pertinent committees, with for example a 3-year cycle to ensure policies remain current and relevant.

The Board often receives unapproved minutes of the standing committees in the package rather than reports from the committees. While committee minutes could be made available to the Board members for reference, a more effective approach to informing the full Board of the activities of each committee is to pre-circulate a briefing note highlighting the most substantive issues discussed at each meeting. These notes can be elaborated on when appropriate with a verbal report of the Committee Chair during the Board meeting. Important items put forward by the committees for Board approval should be considered as specific Board agenda items, encouraging discussion of key elements prior to approval. This could occur in an "Items for Approval" section, which could be included in either the open or *in camera* sessions of the Board meetings.

Such a practice is important for key approvals such as the HAPS plan, HSAA, QIP and annual updates to the hospital's strategic plan.

BCHS lacks a robust Enterprise Risk Management (ERM) program that spans the risk universe in the hospital and allows early identification of risks all in one dashboard. The current reporting of patient safety and quality risk is an important part of this endeavor. In addition, other operational and business risks must be part of a comprehensive ERM program.

The Board processes outlined above, as evidenced in the Board and its committee minutes, do not properly record the Board's exercise of its business judgement in making good faith decisions in the best interests of BCHS as per paragraph 4.09(a) of the BCHS By-law.

Board Effectiveness

The By-law requires that the Board evaluate its own effectiveness together with the effectiveness of its committees, individual Directors and Board officers. This responsibility, together with the responsibility for the nominating processes and the ongoing orientation and education program for the Board is delegated to the Governance Committee.

Board and committee meetings are not regularly evaluated. Some of the frustrations and concerns expressed by governors in the course of this investigation could have been addressed with regular feedback on the effectiveness of the Board meetings. In addition to reflecting on meeting effectiveness during Board-only *in camera* sessions, it is valuable to gather anonymous feedback from e-surveys immediately following each meeting.

The process for Board member evaluation involves each Board member being evaluated with a survey sent to four other Board members. The results are collated, and feedback is meant to be provided during one-on-one interviews between each member and the Chair. The process for selecting evaluators has not been transparent, and few have received feedback on these evaluations from the Chair. There has not been a formal evaluation process for the Chair of the Board. The Board's evaluation process needs to be improved to address the above concerns and, in particular, the results of the performance assessments need to be shared, as may be applicable, in order to stimulate a governance culture that is continuously striving to improve and reflect best practices.

The HNHB LHIN assessment of the BCHS Board was that, although it was comprised of an impressive group of committed people, the Board members did not yet have the right complement of skills, knowledge and experiences to deal with the complexities of some of the issues facing BCHS. These deficiencies, which were confirmed by the Investigation Team, combined with weak governance structures and processes, resulted in BCHS having a Board of Directors that was not effective in providing

independent oversight of BCHS's operations. As a result, the BCHS Board has failed to discharge its governance responsibilities and accountabilities to its stakeholders relating to the Board's oversight of the BCHS operations as BCHS's performance materially declined in regards to key provincially identified performance indicators relating to quality and financial performance.

BCHS's difficulties began following the Board's approval of the new True North and Strategic Plan, the CEO's related Lean transformation, and the new IPC model of care in fiscal year 2012-13. The combination of these significant changes created what EY described in its report as cultural clash. This cultural clash, together with the Executive Team's lack of skills required to successfully lead the transformational changes, resulted in a declining organization whose culture was described to the Investigation Team as "toxic."

The result is that BCHS's key performance indicators that measure quality and financial performance compared to its peer hospitals in Ontario have been materially declining since 2012-13. These are the indicators that are used by the Board, the LHIN and the Ministry of Health and Long-Term Care to monitor BCHS's performance. Of concern is that many of the key performance indicators have continued to trend in the wrong direction despite the LHIN's close monitoring and BCHS hiring external consultants. The decline in performance in the various realms is detailed under separate headings in this report and is summarized in the Executive Summary.

Despite the material decline in key aspects of BCHS's performance, a review of the Board and its committee minutes provides evidence that the Board was not properly monitoring the decline in performance and the related risks. As a result, appropriate steps were not taken by the Board to mitigate or respond to the decline.

The lack of capacity of BCHS's Executive Team to make improvements in spite of the support of consultants, and their lack of meaningful engagement of staff and physicians in planning and implementation of initiatives, has led to significant morale and cultural issues at the hospital. Widespread loss of confidence in the CEO and the Board led to the Medical Staff Association President's letter of December 2016 to the Minister of Health and Long-Term Care that expressed "grave concerns with regards to the serious decline in quality of care, patient safety, staff morale, staff engagement and workplace values" at BCHS.

Board Independence

BCHS was responsible for establishing appropriate policies and procedures to enable the Board, its committees and individual Directors to function independently of management to the extent necessary to be able to provide independent oversight of the CEO and the hospital's operations. Independence requires that the Board be provided appropriate information to monitor BCHS performance indicators; that the Board members have the necessary skills and expertise to discharge the Board member

duties; that the Board members have an inquiring mind and the confidence to hold the CEO and Senior Management Team accountable when and if the Board member has concerns.

The Board members acknowledged in the Board surveys and in the interviews with the Investigator that the Board allowed the CEO to largely determine the Board and committee agendas and the information presented. The information presented to the Board and its committees did not provide the Board the necessary information required to discharge its duties and accountabilities to its stakeholders, including its accountability to the LHIN as set out in the HSAA.

The Board is required to satisfy itself as to the "tone at the top." The CEO's integrity is essential in setting the appropriate "tone at the top," and is critical to the Board's ability to discharge its oversight of BCHS's operations. The CEO needs to proactively and conscientiously put the Board in a position to be able to provide independent and meaningful oversight of BCHS's operations and the CEO's performance. This requires the CEO to work with the Board Chair, Board committee Chairs and Executive Team to develop agendas, reports and performance metrics that allow the Board to objectively oversee BCHS's operations and benchmark its performance against its peer hospitals. Without the CEO's proactive steps in putting the Board in a position to independently oversee BCHS's operations, BCHS's Board was put in an impossible position to provide meaningful oversight of BCHS's operations as the Board members were unable to close the gap between their knowledge of BCHS's complex operations and that of the CEO, Executive Team and physician leaders.

In our view, the following reflects the Board's failure to ensure that the appropriate procedures were in place to guarantee independent oversight of the CEO: the CEO's management of the Board agendas and reports; the deficiency of such agendas and reports; the acknowledgement by the CEO and the Board of the CEO's weak financial skill set combined with the CEO's recommendation not to replace the VP Chief Financial Officer in 2014; together with the red flags regarding the CEO's management style set out in his performance reviews. Collectively, these facts reflect the Board's failure of its responsibility to ensure that BCHS's leadership established a "tone at the top" that aligned with the culture of accountability and transparency that is required of a public hospital in Ontario today.

Oversight and Performance Evaluation of CEO

In the view of the Investigation Team, the Board's most significant failure was in regard to its oversight of the CEO. The Board did not demonstrate the appropriate independent oversight and required skepticism of the CEO performance and recommendations.

The By-law requires that the Board evaluate the performance of the CEO on an annual basis to ensure that, among other things, the CEO's performance is closely aligned with the Corporation meeting its performance metrics targets. The Board created an

“Executive Compensation & Development Committee” to assist the Board in discharging its responsibilities including reviewing annually for the CEO:

(A) Performance for the previous year against performance targets and the proposed incentive payments, if any;

(B) Performance targets and evaluation criteria for the ensuing year;

(C) Proposed compensation for the ensuing year.

The evaluation process undertaken by the Board includes a 360° survey. The results of the survey are compiled via Survey Monkey and are confidential to the CEO, the Board Chair and the HR Administrator. Strong concerns regarding the CEO’s performance were clearly identified in the 2015 and 2016 annual performance evaluation surveys that in our view, are closely aligned to BCHS’s material decline in performance. However, the results of the CEO evaluation process do not appear to have been shared with, or more importantly, acted upon by, the Executive Compensation & Development Committee or the Board. The length of tenure of the Board Chair, who was the only Director who had visibility into the findings of the CEO’s performance evaluations, may have been prejudicial to the Chair’s ability to demonstrate the required independence to act upon the negative findings.

As a final note, despite BCHS’s poor performance, the CEO was still authorized to receive a percentage of his at risk pay in each of the years reviewed.

Oversight and Performance Evaluation of the Chief of Staff

The Board’s oversight of the Professional Staff starts with the appointment and evaluation of its Chief of Staff and Chiefs of Departments as contemplated by the Public Hospitals Act (Ontario) and the By-law.

The performance evaluation of the Chief of Staff is also conducted by the Board’s Executive Compensation Committee. Our comments regarding the Board’s full participation in the CEO’s evaluation process apply equally to the CoS’s evaluation process.

There is no record of a performance evaluation of the current Chief of Staff since he began in the role in 2015.

The Investigation Team’s review of the Medical Advisory Committee’s reports is consistent with the Board survey and Investigator’s interviews of the Board members that there appears to be very little in the way of strategic or quality of care recommendations or input being brought to the Board from the Medical Advisory Committee.

In consideration of the above facts, and in particular the Board and committee minutes, the Investigator has concluded that the Board members have failed to exercise

reasonable due diligence that would be expected of the Board of a public hospital in Ontario.

Governance Recommendations

1. The Lieutenant Governor in Council should appoint a Supervisor for Brant Community Healthcare System with the full powers of a Supervisor under the Public Hospitals Act of Ontario.

2. The Supervisor should oversee a Board renewal process for the BCHS Board of Directors founded on governance best practices that should include attention to:

    a. Board and Board Committee structures and processes, including work plans and agenda setting based on the key roles and functions of the Board;

    b. Board size and composition;

    c. Recruitment process for new Directors;

        This process needs to be more robust than it has been, given its importance and the challenges of recruiting Board members from diverse backgrounds with the right skills, diversity and experience. Strategies could include advertising more widely, for example, posting on LinkedIn, the Institute of Corporate Directors' website and higher profile advertising in the local communities. An additional option would be to enlist the services of a recruitment agency.

    d. Director terms and renewal;

        There should be a maximum term of service that applies to all Directors, with the one possible exception of a member that takes on the office of the Chair when it is necessary to extend the maximum term to complete the term of Chair.

    e. Board and Director evaluation process;

    f. Board orientation and ongoing education;

    g. Quality of meeting packages and meeting documentation;

    h. The process for CEO and CoS evaluations, which should ensure that the full Board is responsible for approving the results of the annual performance evaluations before they are finalized.

3. The Supervisor should identify a process to renew the physician leadership at BCHS, and develop processes for the selection, appointment, and evaluation of BCHS's Chiefs of Departments who are integral to the Board's ability to discharge its oversight of BCHS's professional staff as contemplated by the Public Hospitals Act (Ontario).

4. The Supervisor should establish a process for the BCHS Medical Advisory Committee to review and adopt Medical Advisory Committee best practices, including orientation and ongoing education.
5. The Supervisor should establish a process to have BCHS's By-law and Governance Charters and Policies reviewed, benchmarked and updated.
6. The Supervisor should implement a whistleblower policy and process which uses public sector best practices to receive and appropriately vet and escalate the complaints that are brought forward that have merit.
7. A robust Enterprise Risk Management program must be developed to include all risks to the hospital. The ERM program, including risk mitigation strategies, should be summarized by the Executive Team and presented to the Board of Directors at intervals as part of the Board's annual work plan.
8. When renewed governance and leadership are in place, the organization should undergo a full strategic planning exercise. This should involve early and meaningful engagement of internal and external stakeholders, and lead to the development of a renewed shared vision for the future of BCHS.

Leadership and Management

Brant Community Healthcare System underwent significant changes in leadership and management approaches with the change in the CEO in 2010. The previous CEO had been in the position for over 25 years and had in place a conventional organizational structure with four VPs: Patient Services/CNE, Medical/CoS; Corporate Services/CFO/CIO/CPO; and Resources/Development. Below the executive level, there were a stable group of directors and managers with many long-term, dedicated staff who had considerable pride in the organization at that time. Under the former CEO, BCHS was known as a fiscally sound organization that rarely closed the year in a deficit position.

The new and current CEO is a proponent of Lean management in healthcare and led a Lean transformation at BCHS in which leadership was intended to be more distributed throughout the organization. By 2013, the organization was completely restructured, with clinical programs clustered horizontally into three value streams, and support functions grouped into five vertically oriented value streams to support each of the clinical value streams.

The restructuring process was highly disruptive. While education was provided on Lean methodologies in the period leading up to the transformation, the restructuring process was sudden and upsetting for many. Directors and Managers were terminated from their existing positions and had to apply for the new roles of the new structure. Some were offered positions in areas outside of their core expertise and were given minutes to accept the new role or leave the organization. There is a perception by many of those interviewed that the process weakened the organization because many skilled and experienced managers left or were restructured out.

Four years later, the value stream structure continues to be poorly understood throughout the organization. The clinical value streams were intended to reflect patient process pathways. However, in practice, they are clusters of clinical services with shared characteristics (e.g. ambulatory services, acute inpatient care). The traditional roles of Directors, Managers and Coordinators were changed to Value Stream Leads, Group Leads and Team Leads. Despite adjustments to roles and responsibilities since the transformation, the accountabilities of the new roles remain vaguely defined and ambiguous. In May 2016, the final report of the operational review conducted by EY called for structural realignment to establish clearer reporting relationships and accountabilities. A new draft value stream structure is being considered in June 2017.

Within a year of the implementation of the value stream structure, the VP Corporate Services, CFO, CIO and CPO and VP Resources and Development left the organization and were not replaced. The VP Patient Services and Chief Nursing Executive, who had been a Clinical Program Director prior to joining BCHS in 2009, was promoted to the role of Chief Operating Officer. Since then, the Value Stream Leaders all reported to the

Executive Team, which consisted of three individuals; the CEO, the VP CNE/COO, and the CoS. The leadership group consisting of the Executive Team, the Value Stream Leaders and the Value Stream Medical Leaders is referred to as the Senior Management Team. Initially a group of 18, the Senior Management Team was eventually decreased to 12 members.

The Lean transformation was related to the hospital's new Lean-based "True North" strategy, which was launched in 2012-13. Since then, strategic and operational planning has consisted of setting annual goals and targets within the three pillars of the strategy, which are (1) A Great Place to Work, (2) Patient's First, and (3) Using Resources Wisely. Among the many staff and physicians interviewed, there was a notable lack of understanding of, and commitment to this strategy. There were concerns about the pace of change with frequent reshuffling of priorities and a lack of clear focus.

Another major change was ongoing during the restructuring process at BCHS. Phase 1 of the Inter-Professional Care model (IPC) was implemented on three inpatient units in 2012. With the decreases in nursing coverage and shifts to increasing numbers of unregulated care providers, quality concerns were raised by nurses, allied health professionals and physicians. These concerns intensified in 2013 as the model continued to be rolled out to additional units. The external review conducted by Corpus Sanchez International completed in April 2015 made a number of recommendations including increasing nursing staffing on all units and all shifts, and improving the planning and implementation of a revised IPC model.

With the departure of the Chief Financial Officer in 2014, a Value Stream Leader with no accounting designation was promoted to Chief Financial Officer. While the Board expressed concerns at the time about the organization's capacity in financial management, the CEO was confident in the promoted individual's ability to lead the financial portfolio of the hospital. Since 2013-14, BCHS has had consecutive budget deficits. An experienced Interim CFO was recruited in December 2016, and a permanent VP Corporate Affairs and CFO is now in place as of June 2017.

Anticipating a significant deficit in 2015-16, BCHS engaged EY to conduct an operational review in January 2016. The final EY report of May 2016 report identified opportunities for potential savings of $22.8M. Since the report, an EY consultant has been retained to support the work of the Project Management Office (PMO), which is the group charged with prioritizing, planning and implementing the operational improvements identified by EY to achieve financial stability and sustainability. Two physicians were hired to participate in the PMO who liaise with senior managers and physician leaders as cost saving initiatives are planned and implemented. A number of significant operational changes have been implemented in the year since the inception of the PMO. However, the financial health of BCHS remains very concerning.

Leading Change

With the Lean transformation, the shifts in models of care, and implementation of PMO operational changes, the breadth, scope and pace of change at BCHS has been extraordinary in the last five years. Leading change in complex organizations like hospitals is challenging at the best of times. Organizational change of this magnitude requires careful planning with attention to well-established principles of change management. Undertaking this amount of change can be overwhelming, and even traumatic for an organization. Without excellent planning and execution, there is a risk of failure and anguish.

Because major change is so difficult to accomplish, a critical mass of influential people among those affected by the change are needed to guide and sustain the process. Early and meaningful engagement of key stakeholders is critical to success. This allows for the development of a shared vision that can be communicated widely. It leads to a more robust plan and identification of barriers, risks and mitigation strategies. Early and meaningful stakeholder engagement builds trust, leads to shared objectives, and helps to anchor the change into the organization's culture. People commit to what they create.

The Investigation Team was struck by the consistency with which people throughout BCHS described stakeholder engagement during the planning and implementation of organizational changes in recent years. In spite of the stated intent to have a bottom-up approach, those interviewed consistently described change as being driven from the top. In virtually all cases, people described initiatives as being driven by the Executive Team, or being required as a result of a report from an external consulting firm. Both the CEO and VP/CNE/COO described heavy reliance on external reports and saw their success as acting on those recommendations. This description of priorities is concerning because it reflects a lack of organizational ownership. Consequently, there is often no passion or commitment regarding the work required to achieve the expected results.

Stakeholder engagement was often described as "window dressing." Stakeholders were brought together to discuss a change and asked for input, and the perception was that input was largely ignored, and that decisions had already been made to implement the change. Changes have been made without addressing concerns raised about unintended clinical or financial consequences resulting in the need to make further changes. Stakeholder engagement is now seen as meaningless by many in the organization, and as result, some have decided that they will no longer participate.

The Investigation Team heard repeated accounts of staff coming together to make recommendations on operational or structural changes to achieve identified priorities only to have the work disregarded and alternate decisions made at the senior leadership table. Staff and physicians have had concerns that decisions have not appropriately considered clinical issues raised and that certain changes have led to quality or safety risks.

A very concerning theme that came up in a number of interviews with staff and physicians is that a culture of fear and intimidation has developed at BCHS. Staff, physicians and managers have been afraid to speak up about concerns for fear of retribution or losing their jobs. It is apparent to many that loyalty is very important to the Executive Team, and it has been communicated either directly or indirectly that “you’re either on the bus, or off the bus.”

These features of change leadership are not conducive to successful and sustainable change. Further, they are not consistent with the BCHS’s core values of Quality, Respect and Accountability. In spite of good intentions, the existing Executive Team has demonstrated lack of effectiveness in leading change. The amount and pace of change has been overwhelming and fundamental principles of change management have not been applied. Scoping, planning, implementation and analysis has been flawed, and perhaps most importantly, there has been a failure to meaningfully engage internal personnel with the required expertise.

Culture

Peter Drucker’s famous quote, “Culture eats strategy for breakfast,” emphasizes that success with strategy is dependent on an aligned and supportive culture. While culture can be difficult to measure, it is usually evident when one spends time within an organization. Direct exposure to staff below the level of senior management can provide valuable insights into behavioral norms and how employees feel about an organization. Engagement surveys help to understand an organization’s culture by measuring employees’ alignment and commitment to the organization, and the extent to which they feel valued. Exit interviews and an effective whistleblower process can also be valuable means of getting unfiltered views of an organization.

Culture is very much impacted by “tone at the top,” which is largely determined by the leadership style of the CEO, and can also be influenced by other members of the Executive Team and the Board. When a new CEO is brought into an organization that is functioning well, it is wise for that CEO to take time to understand the culture, and build on what is working well. On the other hand, when an organization requires significant improvements in performance, evolving the culture is an important focus.

In many of the interviews conducted by the Investigation Team, staff and physicians were asked to describe the evolution of the culture at BCHS over the past several years. The hospital’s culture in 2010 was often described as positive, collaborative, safe, and there was a general sense of pride in the organization. In contrast, the words most often used to describe the current culture of BCHS were: a culture of fear, intimidation, lack of trust, unsafe environment, lack of transparency, uncertainty, instability, and the word toxic was used by several of those interviewed.

The leadership style at BCHS has resulted in an increasingly frustrated and disenfranchised staff and physicians. The increasing level disengagement of the staff at

BCHS was clearly illustrated in third-party workplace culture surveys conducted by Metrics@Work in 2013 and 2016. A sample of results of key drivers from the Metrics@Work analysis is shown in Table 1. Note: physician engagement survey data can be seen in Table 2 in the Physician Relations and Medical Leadership section.

Table 1: Sample of Staff Results from Metrics@Work Analysis in 2016

Driver*	2016 Average	2013 Average	Difference 2013 > 2016	External Benchmarking**	
				Average	Highest
Workload is reasonable	48.6%	53.4%	-4.8%	57.7%	71.5%
Org Communication (satisfied with communications at BCHS)	47.4%	55.1%	-7.7%	56.0%	70.2%
Learning and Development	53.4%	62.0%	-8.6%	Not available	
Satisfaction with Senior Leadership	35.5%	45.0%	-9.5%	48.3%	69.1%
Resources and Supplies (satisfied with availability of resources)	50.8%	61.0%	-10.2%	64.1%	78.8%
Alignment with True North	46.7%	57.3%	-10.6%	Not available	
Continuous Improvement	47.1%	58.0%	-10.9%	Not available	
Understand Performance Assessment	56.8%	68.5%	-11.7%	60.5%	67.4%

* A Driver is a survey element that is most highly related to, and predictive of overall engagement and can include one or a group of questions on a similar topic.

** External benchmarking data is from the Metrics@Work hospital sector database - Average and Highest Scores from external organizations are shown.

There were 24 Drivers in the BCHS staff survey. Comparing the 2013 to 2016 data, the 2016 results were lower in 22 of the 24 scores. The largest decrease was in "Understanding Performance Assessment." The average of all driver scores decreased from 61.8% in 2013 to 56.2% in 2016, an overall decrease of 5.6%. This is a significant decrease that demands an effective response from the Executive Team and the Board.

The consistent themes of disengagement and deteriorating culture that emerged during interviews and focus groups prompted the Investigation Team to conduct a short online survey to gather further qualitative information on BCHS's culture and the morale of the staff and physicians. The survey was completed by 296 individuals, primarily identifying as nursing staff (104), support staff ranging from unit clerks to nutrition (76), allied health (56) and physicians (34). 55.6% of respondents indicated working at BCHS for

over 10 years. Details regarding staff and physician survey questions and responses are provided in Appendix E.

There were several prominent themes in the responses from the online staff and physician survey. There was a strong feeling of teamwork and camaraderie within teams, which is sometimes compromised because of work-related stressors. The overall morale of the organization is low and has decreased over time due in part to change fatigue and a loss of confidence in senior leadership. There is a strong perception that staffing levels are too low given the number and complexity of patients. Staff and physicians want to be part of the solution but do not feel adequately engaged.

Significant concern exists in the organization about the level of dysfunction of the Executive Team. Given the culture that has evolved and the lack of trust and confidence in the hospital's current leadership, a significant change in leadership will be necessary for BCHS to make required functional and operational improvements.

Recommendations

9. The Supervisor should undertake a review of the senior leadership and the organizational structure of BCHS.
10. An organization-wide plan for improving the morale and culture at BCHS must be developed by the refreshed Board of Directors and leadership team.
11. The values of BCHS should be reviewed and refreshed with deep engagement of the staff, physicians and volunteers of the hospital. Together with the Patient Values, these shared values should be communicated widely. Concerted efforts should be made by the staff, physicians, volunteers and leaders of the organization to hold each other accountable to live these shared values.
12. A robust communication plan should be developed to regularly update internal and external stakeholders on progress with the transition and the development of a new direction to meet the needs of the communities served by BCHS.

Quality and Safety

The provision of quality hospital services requires the co-operation and co-ordination of all providers across the continuum of care. The competing expectations of quality care, efficiency, responsive service, ready access, equity and fairness and provider morale are a reality in all hospitals. These expectations provide significant challenges for health care providers and hospital Boards who need structures, policies, processes and clear accountabilities to succeed in delivering an exceptional patient experience.

In reviewing Quality and Safety at BCHS, the Investigation Team reviewed a wide spectrum of materials related to the planning and monitoring of quality of care and safety. Areas of focus included patient and family centred care, community perceptions, meeting the needs of Indigenous people, models of care, care environments, and working with community partners.

There is a clear commitment to quality and safety throughout the organization. The Investigation Team found that there is strength at the middle management and Value Stream Lead level in most areas of the organization. The passion and commitment of the front-line staff and physicians to deliver high quality and safe care was very evident.

A number of quality and safety improvements have been made at BCHS with the support of the Patient Experience and Quality Team. Examples include:

- BCH has been very successful in implementing initiatives promoted by Choosing Wisely Canada. Unnecessary testing has been significantly reduced in the pre-operative clinic while maintaining a high standard of care.
- A Patient Safety Program was initiated in 2015 that involved staff training, senior leadership walkabouts and patient safety presentations to hospital teams.
- A medication reconciliation initiative has improved medication reconciliation on admission (a QIP Indicator) from 48.6% in 2015-16 to 80% in 2016-17, and the goal for 17/18 is to sustain or increase above 80%. The medication reconciliations are all completed by pharmacists to ensure the best quality reconciliation for patient safety.

Patients First

There is a growing recognition that a key dimension of quality in health care is patient and family centred care; care that is focused on the needs and priorities of individual patients and their families. “Patients First” is one of the three pillars of BCHS’s True North Strategy. This has involved setting patient focused goals and indicators each year. In 2016-17, the goals of the “Patients First” strategy include decreasing adverse events, improving patient satisfaction, improving wait times and implementing leading practices.

Many hospitals in Ontario have established Patient and Family Advisory Councils that bring the perspectives of patients and family members to advance patient and family centred care throughout their organizations. Patient and Family Advisors and councils provide valuable perspectives that can lead to significant improvement in the patient experience in hospitals and other health care settings. Patient and family input can be leveraged to enrich many hospital processes including recruitment of leaders, strategic planning, quality and safety improvement initiatives and design of care environments.

BCHS has only recently began to formulate a Patient and Family Advisory Council (PFAC). To date, 18 volunteer patient and family advisors have been recruited, with a goal to eventually recruit 30. Terms of Reference for the PFAC were established in June 2017, and the first meeting was recently held. The current Terms of Reference stipulate a maximum of 4 Patient and Family Advisors among the 19 members of the PFAC. The proportion of Patient and Family Advisors should be significantly higher. As a final point, it is important to consider diversity in recruiting Patient and Family Advisors in order to bring in perspectives from the range of populations served.

Recommendations

13. BCHS should continue on its path to recruit Patient and Family Advisors, and develop the role of the new Patient and Family Advisory Council to support improvements in the patient experience and advance patient and family centred care. This committee should have input on process improvements, policies, design of care environments and hospital planning.

14. Diversity should be an important consideration in the recruitment of Patient and Family Advisors.

Community Perceptions of Quality

The Investigation Team collected feedback from the community via an online survey and through a confidential email address. The online survey was intended to capture community perceptions of quality of care as well as satisfaction with services provided using a five point Likert scale from “Very Poor” to “Excellent,” and allowing the opportunity to provide open-ended responses. This survey was completed by 423 individuals. Over 70% of the respondents were from Brantford; 82% have lived in the region for longer than 10 years; and in the past two years, 19.0% have had 2 or more visits to the Willett Urgent Care Centre and 51.5% have had two or more visits to the Brantford General Hospital.

The rating for quality of care at their most recent hospital or urgent care visit was rated as “Excellent” or “Good” by 50% of respondents. Specific feedback related to quality of care was provided by 248 individuals, with more expressing negative feelings (69.4%) than positive (16.5%) or neutral (13.7%). The most frequent concerns listed were a lack of access to services or long wait times by 101 respondents (40.7%), and that staff appeared to be too busy and overworked (18.5%). The rating for satisfaction with their

most recent hospital or urgent care visit was rated as “Very satisfied” or “Satisfied” by 53.8% of respondents. Specific comments for patient satisfaction closely mirrored those provided for quality of care.

Finally, an open-ended question on additional comments and concerns yielded 195 responses. Lack of access and long wait times and the understaffing of clinical staff were expressed and reiterated by 16.8% and 14.6% of respondents, respectively. Additionally, 12.4% commented negatively on administration (too top heavy, lack of trust, and poor decision making) and 11.4% complained about the environment (physical space, cleanliness, etc.).

The results of these surveys conducted by the Investigation Team are subject to several biases and should be interpreted with caution. Because of the difference in methodology, the results are not comparable with the patient satisfaction results collected by BCHS. What is clear from these surveys is that there are a number of unsatisfied individuals in the community who wanted to provide feedback to this investigation.

Meeting the Needs of Indigenous People

BCHS is located in a geographic region with a large and diverse population of Indigenous people, many of whom live on-reserve at either Six Nations of the Grand River or Mississaugas of the New Credit First Nation. There are also many Indigenous people who live off-reserve in communities that are served by BCHS, particularly in the City of Brantford. BCHS has a tremendous opportunity to be a leader in providing patient-centered care to Indigenous people.

The Investigation Team gained some valuable insights in meetings with Indigenous stakeholders of BCHS. Key themes of these discussions are as follows:

- Presence of systemic racism at the societal level towards Indigenous people, which can impact their experience across our health care system.
- Importance of traditional medicine and the need for space within the hospital setting to support its practice.
- There are many talented and passionate people from the Indigenous community that could be recruited as hospital staff, physicians, patient and family advisors, or to be members of the Board at BCHS. However, individuals tend to avoid these roles because of a perceived intimidating, unwelcoming culture, as well as the feeling that they are filling a token role rather than having their input valued.
- Some valuable services, such as the Aboriginal Patient Navigator, exist but are not full time in the hospital setting and therefore do not fully meet the demand.

BCHS has processes in place for receiving and responding to complaints from all patients, and the Investigation Team heard some examples of the hospital

accommodating the needs of Indigenous people. However, there were some examples of negative experiences at BCHS. One opportunity identified is to improve the discharge planning process, ensuring that adequate supports are organized in the community prior to sending patients home.

An initiative that may help to shift the BCHS culture to be more receptive to the needs of Indigenous people is cultural competency training. Such training is available through the HNHB LHIN.

Recommendations

15. BCHS should work with the Indigenous community including Six Nations of the Grand River and Mississaugas of the New Credit, to develop strategies for recruitment of staff, physicians, patient and family advisors, and Board members with Indigenous backgrounds.
16. The Patient Family Advisory Committee should include representation from the Indigenous community.

Models of Care

The Inter-Professional Care (IPC) model launched in 2012, was based on discussions that were happening across LHIN partners with respect to Complex Continuing Care (CCC). A model that had been proposed for CCC was adopted and implemented in the acute care medicine units. This model was a radical departure from the existing model and saw the introduction of Personal Support Workers (PSWs) taking the place of RNs as part of the core staffing model. Significant concerns around quality and safety were expressed by nurses, allied health staff, physicians and leaders (including Value Stream Leaders) during the planning and implementation of the IPC model.

The change in the model resulted in significant turnover of seasoned nursing staff across the organization. At the same time, clinical educators were disbanded as new, more novice staff as well as PSWs were brought into the organization. According to numerous interviewees, there was no engagement of physicians, allied health staff, lab or diagnostic imaging personnel, or pharmacy staff during the planning and implementation of IPC, in spite of the fact that the model had significant impacts on all of them. The response from senior leadership to concerns raised was that the change was required to manage expenses.

According to staff reports, there was no design team or opportunity for input on the model, nor any analysis related to benchmarking or current models of care for acute care units. A decision and direction to implement was given by the VP Patient Services.

During the first phase in 2012, IPC was implemented on 3 inpatient units; CCIP, B7 and B5. The skills mix change on the units was significant. Teams of nearly all RNs with some RPNs were switched to rotations of one RN per shift on the 24 - 26 patient units,

with the remaining staff comprised of RPNs and PSWs with patient assignments. One unit had no RNs at all.

In 2013, a multidisciplinary IPC steering committee was established to address concerns. However, reports from multiple staff involved in this committee stated their advice and recommendations did not seem to be considered or acted on by senior leadership.

Comments from interviewees included:

> *"My feedback hasn't been well received. Staff aren't happy. I haven't seen improvements. The committee has been held back by fiscal restraint. We recommend proper nursing staff ratios and to not put in PSWs as RPNs, because that has been happening."*

> *"Most of the RPNs were right out of school. The PSWs were introduced in a very bad way. They were thrown onto the floor with no guidance and no one giving them direction. They weren't assigned to a head nurse. The nurses couldn't tell them what needed to be done."*

By 2014, the IPC model was implemented on nine units. As a result of concerns raised by staff and physicians, and eventually a letter written to the Board signed by 80 physicians, and external review of the IPC model was conducted by Corpus Sanchez International (CSI). The final CSI report of April 2015 included a number of recommendations to improve the model. Since then, an additional RN has been added to each unit. However, staff remain very concerned with the patient ratios and acuity on the units. The RNs are often carrying patient loads of 1:8 on the acute medicine units, which is in excess of what is commonly considered standard in acute care areas.

Several of the significant CSI recommendations have yet to be addressed. A forum for patient and family input has been implemented; however feedback from participants has indicated that the suggestions made have not been acted on. Integration of allied health teams has not been demonstrated. The introduction of the CRN role has failed to address what was recommended to ensure sufficient team level supports. The report noted that the level of RN staffing was below CNO standards on six of the nine units, including a minimum of one RN each shift for Rehab and CCC. This has only been partially addressed for Rehab and CCC. Reports from staff on the other units confirm that the only change has been with the CRN role. Chronic staff shortages have created further challenges.

Interviews with staff and leadership revealed significant ongoing quality concerns and a lack of response from senior leadership to address the issues.

Below are comments that capture recurring themes heard by the Investigation Team.

> *"Being under-staffed is the norm."*

"Nurses are distressed that we can't meet any of the College of Nursing standards because we don't have time. It's not acceptable."

Recommendations

17. BCHS should immediately review and recalibrate staffing on units where the IPC model has been implemented. The staff qualifications and patient ratios should align with accepted standards of practice for the acuity level of each unit.

Care Environments

There are some significant infrastructure deficiencies at BCHS. The physical care environments of some departments are not suitable to accommodate the volume and/or type of care required. To address these deficiencies, BCHS has developed four pre-capital submissions since 2014.

A master plan for the redevelopment of the Brantford site was submitted to and endorsed by the LHIN in 2014. Some minor updates to this pre-capital plan were made in 2017. BCHS and the LHIN are awaiting confirmation of Ministry review of these proposals.

Given the long time-frame for master plan development, and at the suggestion of the Ministry, a pre-capital submission was developed by BHCS for Emergency Department (ED) Redevelopment. The ED has seen significant increases in volume relative to the physical space available. There are now over 50,000 visits per year in a space that was last expanded in 1980 to accommodate approximately half that volume. This creates significant challenges to maintain quality of care, patient safety and privacy. The target volume for the pre-capital submission is to accommodate 52,000 visits per year. The pre-capital submission for the ED was received and endorsed by the LHIN in 2016. BCHS and the LHIN are also awaiting confirmation of Ministry review.

The mental health inpatient unit is also in urgent need of redevelopment. Located in the oldest section of the hospital, it is a poor physical environment to provide care to patients, particularly those with acute mental health conditions. A pre-capital submission has yet to be developed for this inpatient unit.

Recommendations

18. The Ministry should review and prioritize the pre-capital submission for the redevelopment of the Emergency Department at BCHS.

19. BCHS should prioritize the development of plans to address the immediate and long-term needs of its mental health inpatient unit. This should be encouraged and supported by the HNHB LHIN and the Ministry.

20. BCHS must continue to develop and advance its Master Plan. The Ministry should conclude the pre-capital review of the existing Brantford Site Redevelopment

proposal, and together with the HNHB LHIN, support progress on a multi-year plan to address BCHS's aging infrastructure.

Working with System Partners

The Ontario government's "Patients First" agenda aims to improve health care delivery in the province by putting patients first, improving access, and providing care that is coordinated and integrated across the continuum of providers. Strong relationships and collaboration with community and system partners have never been more important to hospitals than in today's healthcare system. As a result, quality frameworks are being expanded to include metrics that monitor transitions in care

Hospitals are increasingly challenged to decrease length of stay in order to optimize capacity and meet growing demands for acute care. This requires strong linkages with community and system partners to ensure that, once it is safe to leave the hospital, patients are supported appropriately in the community. The right care in the community can avoid readmissions, which further reduces pressures on acute care resources.

BCHS has implemented a number of LHIN-wide initiatives to improve length of stay and readmissions to hospital. However, with ongoing financial challenges, BCHS has increasingly focused on internal processes in order to achieve cost saving objectives. This has resulted in examples of BCHS reducing support and collaborations with system partners. For example, the Investigation Team heard examples of poor outcomes associated with inappropriate or incomplete discharge plans or referrals. The most vulnerable patients impacted by lack of collaboration from hospital to the community are seniors and those with mental health challenges.

The path towards quality improvement and financial sustainability for BCHS should be accomplished in collaboration with community and system partners.

Recommendations

21. BCHS should refresh relationships with community and system partners to ensure that transitions from hospital to the community are well supported.

22. BCHS should work closely with the HNHB LHIN and other system partners in the development and implementation of the of the Brant sub-region strategy.

Leveraging Quality as a Primary Organizational Driver

There are a multitude of quality measures reported by the various departments and clinical programs throughout the organization. While teams endeavor to track appropriate quality measures, the senior leadership seems to be focused mainly on the hospital's annual Quality Improvement Plan, which is relatively limited subset of the broader spectrum of quality measures being tracked. There is a lack of clarity in the organization on how quality goals are prioritized.

There has been little emphasis on the quality indicators that are part of the BCHS's Hospital Service Accountability Agreement (HSAA). These indicators are monitored by the LHIN to ensure that BCHS is providing quality care that is important at the system level. As of Q3 2016-17, ten of eleven of BCHS's HSAA indicators are categorized as "red" (i.e. more than 10% below the provincial target). Seven of the eleven indicators showed a worsening trend from the previous reporting quarter.

Quality should be embedded in BCHS's strategic planning and operational processes. It should be foundational platform for a refreshed strategic plan, and attention should be given to creating a culture of quality and safety throughout BCHS. While the Lean transformation was meant to be a framework for quality improvement and efficiency, it has failed to create a culture of quality and safety at BCHS. A refreshed framework with a primary focus on the needs and priorities of patients would help to create such a culture.

The Institute for Healthcare Improvement has delineated six realms of quality of care that matter to patients, which are: Care that is Effective, Safe, Timely, Patient and Family Centred, Equitable and Efficient. Aligning quality metrics to these dimensions is helpful in creating a quality framework that put patients first.

Leveraging quality as a primary strategic focus has a positive impact on culture, and helps to clarify priorities. Decisions on resource allocation, equipment purchasing and capital redevelopment projects should also be made with a patient-centred quality lens.

Recommendations

23. BCHS should review its spectrum of quality and safety metrics to ensure they are focused on the needs and priorities of patients.

24. Board oversight of the establishment and monitoring of quality and safety priorities must be enhanced. This should include patient and family centred indicators, as well as those in BCHS's HSAA and QIP.

Operational and Financial Performance

As public organizations, all Ontario hospitals have a fiduciary responsibility to have balanced budgets. Hospitals are held financially accountable by Local Health Integration Networks through their Hospital Sector Accountability Agreements (HSAA) which are reviewed, negotiated, and renewed annually. The HSAA contains financial performance targets for a balanced position, current ratio and operating margin. The financial position of BCHS has substantively declined since 2013-14, manifested by consecutive operating deficits and a deteriorating current ratio and operating margin. As a result, BCHS has relied on the HNHB LHIN to flow $2M cash as an interest-free loan to help them manage their short-term obligations.

Financial information is closely monitored by public organizations of this magnitude and there are multiple reporting obligations of BCHS quarterly and annually. The Investigation Team reviewed several years of audited financial statements, reports submitted to the HNHB LHIN, and internal reporting, budgets, cash flow statements, contracts and numerous other financial documents. These, combined with multiple interviews with the finance team, select Board members, executive, and other departments of the hospital that are closely linked with finance as well as financial managers, provided the Investigation Team with significant evidence of financial mismanagement. The major financial issues identified can be categorized under leadership, strategy, reporting and clinical expenses.

Financial Leadership

As noted in the Background and Context section, there has been a significant gap in financial leadership and competency at BCHS that can be traced back to 2014. At this time BCHS was in the midst of significant change to the organization structure as well as models of care. A Chief Financial Officer (CFO) is a vitally important role within Ontario hospitals to ensure strong financial stewardship. BCHS has been without such leadership since 2014.

Prior to the change in organizational structure, a CFO role was in place and was held by a designated and experienced individual. Following a short period of time without leadership in place, another internal leader with no prior CFO experience and without an accounting designation was promoted internally to take this role. From 2014 onwards, BCHS has experienced suboptimal cash management, internal policies, internal controls, procedures and forecasting, and a breakdown in the communication of financial issues to the Executive Team and Board of Directors. Despite Board encouragement, a properly credentialed Interim CFO was not appointed until December 2016, and the search for a permanent CFO was not commenced until February 2017. The permanent CFO began in June 2017.

Financial health can be measured by the working capital (current assets less current liabilities), cash position and operating margin. Since 2013 there has been continued

decline in all these financial indicators. Factors leading to the decline in cash reserves include 4 years of deficits and capital equipment spend beyond funding. The organization has not met its HSAA financial performance indicators. Figure 1 in the Executive Summary illustrates the continued erosion of financial position.

Another consequence of weak financial leadership and stewardship at BCHS is in capital budgeting and planning. Part of the role of hospital leadership is to assure the integrity of the facility to support the delivery of high quality care, present and future. BCHS has only recently submitted a pre-capital submission for the construction of a new emergency department, and has undergone an exercise in master planning. Both of these activities are important, but should have been initiated several years ago. BCHS is in need of capital improvements, especially in the area of inpatient mental health, which currently is located in an antiquated space not purpose-built to meet the needs of mental health patients. This portion of the facility should be immediately considered for redesign, relocation and/or expansion. The risk to patients and staff is of high concern to the leadership team but there is no interim strategy in place on addressing the significant facility issues at BCHS.

In additional to capital planning for the physical plant, financial constraints have affected the purchase and/or maintenance of necessary equipment. The 2016-17 Capital Plan was referred to in multiple interviews as a “die & fry” program, which means that, with no approved capital planned for the year, key equipment items at BCHS were not replaced until they completely failed. The reduced capital spend was a result of the cash constraints due to the erosion of capital from $18M cash, to bank indebtedness of $4.1M (as reported in the 2012/13 and 2016/17 audited financial statements). The capital equipment spend for 2016/17 was $2.8M, which was largely funded by Foundation donations. There remains a pent-up need for capital as evidenced by recent capital budgeting requests front-loading the 5-year ask all in the first year. The lack of necessary equipment is a risk to operations and patient care and has been a significant source of frustration for physicians and hospital staff across the organization.

Recently, the capital equipment spend was again managed within the funded equipment depreciation and Foundation support. However, the 3 years of capital spends that were more than double funded levels not only eroded the cash reserves, but also raised the expectations of staff and physicians. The capital equipment spend in excess of funded levels accounts for approximately 75% of the cash erosion, with the remaining 25% being drawn down by operating deficits. There is a need for transparent communication and prioritization by management to work with the programs to ensure that capital equipment needs are addressed in a proactive and controlled manner, while not further increasing bank debt.

The investigation also uncovered a lack of integration of capital information technology (IT) needs in the financial plan. This may be a result of the organization letting go of the Chief Information Officer within the past year, leaving the IT team without effective

leadership. This has led to delays in renewals and inflated costs. For example, software licenses and servers require a substantial investment and are currently not optimized for cost efficiency because this investment has been delayed. Another example is the purchase of a computerized physician order entry (CPOE) system for $400K that has not been installed due to financial constraints. A shared CIO has been hired in recent months.

Finance leaders are responsible to uphold the reputation of the organization. There is evidence that the financial leaders at BCHS have compromised relationships with external stakeholders, notably banking institutions. For example, the investigation identified that management had requested that the bank not provide additional operating line credit without a due diligence so that they could request a cash advance from the HNHB LHIN (interest free). Management subsequently requested an additional longer term loan for capital, only to be stalled and denied. This was unprofessional and further compromised an already financially unstable organization.

Over the past few months under the Interim CFO's leadership a number of initiatives have been undertaken that should have been in place and may have prevented further financial deterioration. The finance team has been integrated with decision support and personnel changes have occurred to strengthen the team. Reporting continues to improve. With the hiring of a qualified and experienced VP of Corporate Affairs and CFO, continued improvement efforts should result in financial stabilization.

Recommendations

25. A fully qualified and experienced Chief Financial Officer is an essential member of the executive team of an organization the size of BCHS. The CFO should be structured to report directly to the CEO. The permanent CFO should continue to restructure and rebuild strong finance and decision support teams building on the work begun by the Interim CFO.

26. BCHS must have a plan for support teams such as IT, before eliminating leadership positions. BCHS must re-establish leadership within the IT department, which could involve working with the LHIN and other partner organizations.

27. BCHS must include capital equipment and capital projects in the hospital's annual budget and cash flow planning. This needs to include facility improvements, IT systems, and should include an equipment contingency budget. Multi-year capital plans need to be developed with programs and tied to cash flow projections.

28. Management needs to develop a proactive strategy to fund the local share component of planned redevelopment projects such as the expansion of the Emergency Department.

29. Management should report to the Board on a regular basis on financial performance, cash flow, and strategies to mitigate unfavorable variances.

Financial Strategy

Rather than engage internal resources to identify issues, and develop and operationalize improvement plans, BCHS has relied almost exclusively on consultant reports for financial strategy in recent years. Consultants appear to be procured in place of Senior Management and other internal personnel performing any analysis and there is insufficient evidence to suggest that the Senior Management Team conducts or leads any internal validation of any proposed recommendations. Thus, it is unclear that there is a full understanding of the proposed changes and their potential unintended consequences. Further, there is uncertainty about the internal capacity to lead the proposed changes.

Given the weakening financial position of BCHS in recent years, the Investigation Team expected to uncover a comprehensive organization-wide recovery plan, as well as a financial strategy with a long-term outlook. However, there was no evidence of such a recovery plan or long-term financial strategy. For the past 4 years, BCHS has reported deficits which have accumulated to a deterioration of working capital by $13.3M. The decline in cash reserves and erosion in working capital and net assets is a result of accumulated deficits and overages in capital spending. Prior to 2013/14, the capital equipment spend correlated to the equipment depreciation. It is a common accounting practice to spend funded equipment depreciation on replacement equipment and new technology. Often the total spend is augmented by donations from the Foundation. It appears that there were a few years where the capital equipment spend more than doubled under the new leadership. BCHS has decreased their capital spend to meet operating demands. The accountability for the capital budget and cash management resides with the hospital's executive and the Board. As the Board observed the depletion of cash, increased capital spend and operating deficits, it should have intervened and challenged management to recast budgets and mitigate losses with a multi-year recovery plan. There is no documented evidence that the Board explicitly approved or disapproved of such financial plans.

The operational review conducted by EY is used as a recovery plan, although it was not thoroughly validated by an internal team and does not address all performance and financial issues. Based on the EY review, a Project Management Office (PMO) was established and tasked with using the recommendations in the report as a work plan.

Structurally, the PMO was intended to be led by the Executive Team, supported by a group of staff with ongoing engagement with a physician advisory group. Functionally, this structure has evolved into being led by two physicians with the ongoing guidance of a retained consultant from EY. The PMO has had some success in implementing cost-savings approaches at BCHS and is largely responsible for curbing the operating deficit in 2016-17 to an estimated $2.9M. However, the existing structure is not appropriate or sustainable as it currently exists. It is alienating well-intentioned physicians from their peers, further straining the relationship between the Executive Team and physicians

and hospital staff, and does not have appropriate accountability to the Executive Team and, by extension, the Board of Directors.

There has been an overreliance on the EY report, which has contributed to several suboptimal and short-sighted financial decisions. The EY report should be incorporated into a more comprehensive organization-wide recovery plan.

Recommendations

30. BCHS should undertake a comprehensive multi-year recovery plan and develop a financial strategy. This should be led by the Executive Team and be overseen by the Board.
31. The PMO should be restructured and redesigned, led by the new CFO. The PMO team should be reviewed, and personnel with business and analytic skills should be added.
32. All current project work plans should be reviewed to confirm their priority, impact, associated risks and mitigation strategies, and alignment to the hospital's strategy. Project deliverables and critical milestones should be established.
33. It is critical that leaders throughout the organization be engaged in financial planning within their portfolios with the support of finance personnel, and empowered to manage the resultant projects with appropriate support. Leaders can then be reasonably held accountable to achieve their results. Any changes in scope, timelines or expected results should be reviewed and remediated where possible.

Budgeting

Budgeting is an essential component of strong financial management and is especially important in challenging fiscal environments. BCHS currently does not have the decision support capacity to predict their funding with a reasonable degree of accuracy and consequently has not implemented a strategy to mitigate decreases in total funding for services in the past two years. For example, Health System Funding Reform (HSFR) established a competitive environment for efficiency among Ontario hospitals. Since the announcement of HSFR, many hospitals have dedicated resources to understanding the funding formulas and developed operational plans to maximize efficiencies. BCHS has not kept up with the new efficiency standards.

In the past few years, BCHS has received less funding from Ministry revenue sources such as the Post-Construction Operating Plan (PCOP), and Quality-Based Procedures (QBPs), as well as Cancer Care Ontario. These fluctuations in revenue sources for the hospital, and lack of ability to predict them, have had adverse impacts on budget planning at BCHS.

Other deficiencies in budget planning relate to timing and assumptions. Budget timing has been delayed to late in the year and has relied heavily on the EY recommendations and the PMO. Because of the timing of their implementation, certain projects will not yield a full year of savings. There have been no multi-year budgets.

Some assumptions included in recent budgets have been unrealistic. For example, there was an assumption for 2017-18 that there would be no increase in costs of supplies and other expenses, and a reduction in salaries for medical remuneration and staffing. There is concern that cost savings planned around physician remuneration and bed management may not be achievable due to morale and recruitment and retention issues.

In addition to the regular quarterly updates provided to the HNHB LHIN, monthly meetings have been held recently between the LHIN CEO and Hospital CEO to monitor and support BCHS in performance improvement in clinical wait times and finances. BCHS has requested waivers for the past 2 years and will need to do so again this year as performance targets for operating margin and current ratio have not been met. The LHIN has requested a Performance Improvement Plan from BCHS, which includes financial performance. A comprehensive multi-year recovery plan would serve to address this. Once developed, operational readiness for planned changes will need to be carefully gauged and execution excellence will be required for success and sustainability.

Recommendations

34. With the development of a comprehensive multi-year recovery plan, performance indicators should be developed that include both financial and quality metrics. Performance should be shared with a transparent synopsis of the efficiencies and effectiveness of the organization. Progress can thus be monitored and communicated to staff, physicians, the Board, the LHIN and other stakeholders.

35. A process for internal validation of consultant reports should occur. This should include early and meaningful engagement of hospital staff and physicians as changes are being considered.

36. BCHS needs to redesign its current operational and financial planning processes to create an integrated and transparent operating plan. This should include strengthening the financial and decision support teams.

Financial Reporting and Monitoring

Due to the multiple financial reporting requirements of Ontario hospitals, there must be a set of clear and consistent reporting processes in place. Deficiencies in reporting can lead to downstream impacts on decision-making and strategy. This Investigation identified several financial reporting issues, including:

- Internal financial statements are not approved by the Executive Team, Corporate Resources Committee, or the Board of Directors.
- Cash flows are not regularly reported to Senior Management, the Executive Team, or the Board, and are sent to the LHIN in advance of Board receipt and approval.
- Financial materials provided to the Board and Board Committees regularly lack completeness and sufficient detail to clarify potential implications of decisions.
- Financial statements are not included in the Board packages. Only brief minutes of the Corporate Resources Committee meetings are circulated.
- Basic Board financial policies and internal hospital financial policies are absent or antiquated, which add to the lack of accountability that exists in a Value Stream management framework. Some examples of absent Board Policies include: operating plan, capital plan, asset protection, borrowing, investment and financial condition. A signing authority policy with dollar threshold levels was only added in recent months. Many areas have been superficially addressed in By-laws which need to be enhanced with formal and living policies.
- Financial performance indicators that are measured by the LHIN as per the HSAA are not regularly presented to the Board.

Benchmarking is a process for comparing performance across a variety of indicators to peer hospitals. This provides information that enables management to develop strategies for quality improvement and efficiency. Regular benchmarking has not been done at BCHS in recent years. Benchmarking yields findings for further internal review, such as:

- BCHS Executive Administration costs have been below the province, large community and LHIN hospital averages for the past 5 years
- Total Expenses related to medical staff & nurse practitioner remuneration has been higher than the province, large community and LHIN hospital averages for the past 5 years. There is a large variance, with BCHS expenses in this area almost double the LHIN average.
- Non-Ministry of Health and Long-Term Care revenues have been below provincial, large community and LHIN hospital averages in the past 5 years. Revenue generation is a key strategy in budget planning that can mitigate pressures to decrease services.

Recommendations

37. BCHS should adopt more rigorous financial reporting processes and practices. The Board must receive much more detailed and complete financial and operational reports to discharge its fiduciary duties.

38. Expertise should be developed internally to understand hospital funding reform methodologies in order to optimize operational planning.

39. Benchmarking should be undertaken to highlight opportunities in budget planning and to support the comprehensive recovery plan.

Physician Relations and Medical Leadership

The Investigation Team had the opportunity to engage with many current and past physician leaders, as well as front line physicians from almost every department in the hospital. It is clear that there is a critical mass of dedicated, passionate and highly skilled physicians practicing at BCHS who are very committed to the organization and the patients it serves. That stated, the Investigation Team identified a number of medical manpower, cultural and leadership opportunities for improvement that, if not addressed, will pose important risks to the ongoing operation of the hospital.

Physician Relations

The relationship between the medical staff and those responsible for the management and governance of BCHS has unfortunately been deteriorating with since the recruitment of the current CEO. The areas of concern were highly consistent among the majority of physicians interviewed.

From their perspective, major structural and operational changes have been made at BCHS with little to no meaningful physician engagement. Many stated that when they were invited to meetings to discuss significant changes, their input was largely ignored. Non-clinical leaders were empowered to make changes that failed to appreciate the significance of clinical concerns raised. It seemed apparent that decisions had already been made and engagement was an illusion. There were several examples in which important clinical concerns were raised with proposed changes (e.g. staffing models, changes impacting infection prevention and control), and in spite of those concerns, management forged ahead with their original plans. In some cases, subsequent alterations to initiatives were required in order to address quality issues that arose which had been previously anticipated by the clinical experts.

There was a commonly held view among the physicians interviewed, as well as other staff, that the culture at BCHS has become increasingly negative. Many expressed apprehension that they were no longer comfortable raising concerns, as those who had done so were belittled or intimidated. Several of those interviewed stated that they had felt bullied. Leaders have apparently stated that you're either on the bus or off the bus, and the Investigation Team heard in more than one interview that certain leaders have made disparaging remarks about staff and physicians with contrary views.

While the culture at BCHS, under the previous regime was described as hierarchical, it was also generally seen as positive. People understood their accountabilities and felt secure and valued, for the most part. When asked to describe the current culture of BCHS, recurring themes were a culture of fear and intimidation, lack of trust, where loyalty is rewarded and dissent is quashed. Recognizing that these are subjective descriptions, the consistency among those interviewed was remarkable, with very few opposing opinions regarding the culture among all of those interviewed.

Discontent was so prevalent among the physicians that in May 23, 2014, a letter was written to the BCHS Board expressing concerns in three areas: patient safety and quality of care, staff engagement and morale, and respectful workplace values. This was sent on behalf of the physicians by the then President of the Medical Staff, Dr. McNeil. This letter was signed by 80 physicians, although the signatures were not submitted as some feared reprisal. The Investigation Team has confirmed that there was widespread support for this letter.

The quality and safety concerns included the IPC model of care, which was apparently developed and implemented *"in the absence of meaningful consultation with key clinical stakeholders."* Deficiencies in the clinical coverage of the inpatient units were becoming *"progressively more glaring."* A motion was put forward to the Board by the Medical Advisory Committee (MAC) to halt implementation of the IPC model as physicians had serious concerns about the safety of implementing the model on a higher acuity unit. The May 2014 letter, at least in part, led to a formal third party review of the IPC model, which led to enhancements in the clinical coverage of the units.

Other quotes from the May 2014 letter include the following:

> *"Staff engagement and morale are at all-time lows. Physicians who have worked at BCHS for 25 years or more have never experienced this degree of dissatisfaction and disengagement."*
>
> *"Communications from senior staff routinely lack appropriate professionalism and respect. These communications continued unchecked by senior administration. A culture of intimidation has developed with BCHS."*

The letter ended with a request for the Board, with or without senior administration, to meet with representatives from the medical staff to discuss their concerns and explore potential solutions. The Board received the letter and communicated with the MSA leadership. The letter was interpreted by the Board as an "end run" by the physician in an attempt to undermine the executive. While the Chair of the Board at the time stated that the Board wanted engaged physicians, he made it very clear that the Board supported the executive team and their approach to management.

A recent indication of the fractured relationship between the medical staff and management and governors of BCHS is a letter written by the current President of the MSA on behalf of the MSA to the Minister of Health and Long-Term Care in December 2016. The letter was written to express *"grave concerns with regards to the serious decline in quality of care, patient safety, staff morale, staff engagement and workplace values at Brantford General Hospital."* A number of specific areas of concern are raised in the letter that include lack of clarity in roles and accountabilities, financial management, high attrition rate of skilled personnel, and ineffective leadership.

This letter was the culmination of several unsuccessful attempts of the MSA to communicate their concerns, and those of their colleagues, to the executive leadership

and Board of Directors of BCHS. This Investigation uncovered several letters outlining similar concerns that were written by either the MSA or individual departments to the executive leadership and/or Board of Directors of BCHS. During the many interviews conducted in the course of this investigation, it became clear that the concerns expressed in the December 2016 letter to the Minister were carefully considered and, in general terms, accurately reflected the views of many of the BCHS physicians and employees, and were aligned with many of the Investigation Team's and consultants' findings.

Workplace culture surveys, conducted at BCHS by Metrics@Work in 2013 and 2016, provide quantitative evidence of the declining morale and disengagement of the physicians at BCHS. Table 2 is a summary of physician results from a sample of questions related to engagement from the most recent survey in 2016, compared to the 2013 results and benchmark scores.

Table 2: Sample of Physician Results from Metrics@Work Analysis in 2016

Driver*	2016 Average	2013 Average	Difference 2013 > 2016	External Benchmarking**	
				Average	Highest
Alignment with BCHS's Strategy (e.g., "I have a clear understanding of the BCHS Mission, Values and True North")	47.6%	55.2%	-7.6%	69.1%	74.9%
Satisfaction with the Board of Directors (e.g., "the Board of Directors can be trusted to perform its role competently)	38.3%	51.6%	-13.3%	Not available	
Quality Improvement at BCHS	39.3%	64.4%	-25.1%	55.3%	70.0%
I would recommend BCHS as good place to practice to other physicians	58.9%	83.3%	-24.4%	71.4%	83.9%
Involvement in organizational decision making	39.3%	64.0%	-24.7%	53.9%	65.0%
Satisfaction with Executive Team (e.g., "the Executive Team is trusted by physicians")	30.3%	57.5%	-27.2%	53.1%	70.1%

* A Driver is a survey element that is most highly related and predictive of organizational engagement and can include one or a group of questions on a similar topic.

** External benchmarking data is from the Metrics@Work physician database - Average and Highest Scores from external organizations are shown.

There was a total of 14 Drivers in the BCHS physician survey. Comparing the 2013 to 2016 data, the 2016 results were lower in all 14 scores, with a range of decreases in absolute percentage points of -7.8% to -27.2%. The largest absolute decrease was in satisfaction with the Executive Team. The Grand Average (average driver score) decreased from 64.4% in 2013 to 46.9% in 2016, a decrease of 17.5%. A decrease of this magnitude over three years is very concerning.

Another concern raised by a number of physicians is the way the “Risk Pro” system is being used. Risk Pro is a software system used at BCH for reporting and tracking incidents as part of the organization’s quality and risk management program. Events tracked include adverse drug reactions, falls, medical errors, surgical site infections, etc. It is also used to document and track breaches in maintaining a respectful workplace or the code of conduct, or behaviors that pose a risk to self or others. Unfortunately, the threshold for submitting reports has become quite low for some, such that “Risk Pro” has evolved into a verb at BCHS. That is, when conflicts arise, people are “Risk Proed,” meaning that their behavior is documented in the system as possibly inappropriate or disruptive. The system is now viewed by some as a tool for intimidation of those who speak out.

There is clearly need for rebuilding relationships between the management and physicians at BCHS. It will take a sustained and concerted effort to develop collaboration and build trust among the stakeholders. One step in this process would involve revisiting the organization’s values and perhaps developing a statement of behavioral norms based on these values. While a Code of (Business) Conduct Policy exists and the physicians are required to sign-off on it annually as part of the credentialing process, it is focused on ethical, legal and professional standards rather than day-to-day collaborative and collegial behaviors.

A process of developing shared values and co-creating a statement of behavioral norms would help align the stakeholders to a common set of principles of behavior. This should be done with a multidisciplinary approach such that the behavioral expectations would pertain to all in the organization. Once developed, it would be important for all stakeholders to hold each other accountable to these norms and to live the shared values of the organization.

To address the impasse in relations, an effort was made by management to work together to develop an agreement (a charter or compact) between physicians and administration that would outline expectations and accountabilities for both parties. Several templates were shared. However, the physicians did not engage in the discussions. It is clear that more fundamental work needs to be done to build trust before such an undertaking.

Recommendations

40. Fundamental work needs to be done to repair the fractured relations that currently exist between the BCHS leadership and the medical staff. This may need to be facilitated with external expertise.

41. The organization should set out to refresh its values with broad stakeholder engagement. The current value words, which are Respect, Quality and Accountability, do not seem to be resonating widely in the organization. The highly engaging process of developing renewed shared values will help to establish more positive and collaborative behavioral norms.

42. The culture at BCHS needs immediate attention, with sustained efforts to evolve a more positive and collegial work environment. One component of this work to consider is the development of a statement delineating a set of principles of behavior. While this could take the form of a compact with physicians, another approach would be to develop a statement that pertains to all stakeholders in the organization. The process for development of such a statement would be very important, and once developed, it would be key for all stakeholders to hold each other accountable to the agreed upon principles.

43. Going forward, fundamental principles of physician engagement need to be consistently applied in the planning of any processes that are pertinent to physicians and clinical care. These principles are well documented in the change management literature and are consistent with engagement strategies for any stakeholder group. Key strategies include: meaningful engagement early in planning, being respectful of their time, building trust with each initiative, communicating candidly and often, clarifying principles for decision making (while all input will be considered, not all will be implemented), recognizing contributions and celebrating successes.

Medical Leadership

The physicians of BCHS clearly have some ownership of the rift that exists between them and the senior management. There have been numerous examples of physician representatives being asked to participate in planning or quality improvement initiatives where the physicians have refused to be involved. The various reasons for such refusals include not enough time, poor scheduling, feeling that their input will not be seriously considered, and some simply don’t feel it is their job. And notwithstanding the relationship issues between the medical staff and the administration, there are additional challenges that exist within and between physician groups and departments.

According to the by-law of BCHS (June 1, 2016), oversight of the quality of care provided by the medical, dental, midwifery and extended class nursing staff is the responsibility of the Chiefs. Chiefs are appointed by the Board to supervise the clinical care in their Department, Division or Clinical Service. The process for the appointment

of Chiefs is defined as follows: the Board considers the recommendation of the CoS who, in turn, consults with the members of the Department or Division. According to the bylaw, the term of Chiefs of Departments and Divisions is 2 years, once renewable.

The role of the Chiefs is thus a solemn responsibility for the quality and safety of care provided by the professional staff that report to them. The bylaw delineates other important duties of the Chiefs including orientation of new members, oversight of appropriate utilization of resources, making recommendations on medical human resource needs, performing annual performance evaluations of the members of their department, establishing and maintaining effective working relationships, and participating on committees as requested by the Board or CoS.

There are ten Chiefs of Departments and nine Chiefs of Services at BCHS, and most of these were interviewed by the Investigation Team. It was striking how consistently they each described the process for their appointment as Chief; it was either their "turn," or they "drew the short straw." In some Departments, there is apparently a rotation in which each member takes their 2-year turn to be the Chief. In others, certain individuals take on the role because no one else will. Under the bylaw provision that "the Chief of each Department/Division shall hold office until a successor is appointed," some Chiefs have been in the role long past the 2-year, once renewable term. If no one else is willing to apply for the role, the incumbent carries on indefinitely.

While the bylaw stipulates that the CoS will conduct an annual performance evaluation of each Departmental Chief, there did not seem to be a regular evaluation process in place.

The practice of medicine occurs in interprofessional teams. The performance of the Chiefs as members of interdisciplinary leaders of services and programs is highly variable. While some are quite engaged, others rarely attend meetings of their interdisciplinary teams. When it comes to important process or financial planning sessions, some Chiefs say they are not invited to participate. In other situations, Chiefs have been asked to participate and have not.

It was interesting that some of the Chiefs seemed to see themselves as advocates for the members of their departments rather than having a core fiduciary responsibility to assure that the services provided by their departments are meeting the needs of the patients and communities served by the hospital. It is actually the role of the Medical Staff Association (MSA) to advocate the interests and support the rights and privileges of the medical staff. Yet it has been the MSA that has been raising concerns about the quality of care at the hospital. This may be a result of ineffectiveness of the Medical Advisory Committee and the Board in prevailing upon the Chiefs to fulfill their responsibilities.

For their services, the Chiefs of Departments receive an annual stipend of $15,000, with one exception who now receives an annual stipend of $30,000. The Chiefs of Services receive annual stipends of $5,000.

There are other medical administrative positions at BCHS that report through the management structure to the hospital executives. There are 14 such positions and their annual stipends range from approximately $10,000 to $65,000.

It cannot be overstated that high-caliber physician leadership is essential to the smooth functioning of a hospital. Physicians are key members of hospital teams. They are appointed by the Board with a responsibility to provide high standards of medical care. Much of the clinical activity in hospitals is derivative of their decisions or recommendations, and they are key drivers of the utilization of hospital resources. While physician leadership should go well beyond those with formal leadership positions, certainly those with formal positions need to have proven leadership skills.

Given the importance of physician leadership, the recruitment process for Chiefs at BCHS needs to be much more robust. The roles and responsibilities of Chiefs need to be clarified and the Chiefs must be held accountable to these roles. The physician organization structure should to be reviewed, possibly resulting in some rationalization of leadership positions. It will likely be necessary to fund more protected time for medical leaders to fulfill their responsibilities.

Recommendations

44. All Chief positions should be reviewed, clarifying roles and accountabilities.

45. In the context of a broader organization structure review, the organization of the medical departments should be reviewed. There should be limited number of Chiefs with expanded roles. Consideration should be given to establishing the combined role of Chief (reporting through the MAC to the Board) and Medical Director (reporting to the Executive Team).

46. The terms for Chiefs should be extended to 3 years renewable up to 3 times, or 5 years with the opportunity for renewal once after a departmental review.

47. The bylaw delineating the Chief selection process needs to be significantly revised and updated. Department Chief searches should be open to external and internal candidates, and when they arise, these opportunities should be advertised widely early in the process. The selection process should involve a multidisciplinary selection committee that includes a Board member, the CEO, CoS or designate, the CNE or designate, only 2 or 3 physicians from the department, physician leaders from other departments, managers and directors, and a patient representative.

48. The remuneration of Chiefs should be reviewed in a fair and transparent way. The remuneration should protect dedicated time, measured in half days per week, to conduct the leadership and administrative duties expected of the role.

49. There should be a formal annual performance review process for every Chief. This should include input from the CoS, physician colleagues from within and outside of their department, as well as nursing and other pertinent staff.

50. Chiefs and Medical Directors should be expected to work collaboratively with their Administrative counterparts. They should function as a dyad, working together on clinical, operational, capital and financial planning.

The Hospitalist Program

As the Hospitalist program at BCHS is experiencing significant difficulties, it was a specific focus in this investigation. At BCHS, Hospitalists are clinically involved with the majority of inpatients, and are the Most Responsible Physician (MRP) for many of these patients. As a group, they are generally demoralized and disillusioned. As a result, many have left for other opportunities, leaving BCHS with a looming medical staffing crisis. It is imperative that the Hospitalist program be stabilized at BCHS.

The Hospitalists, by all accounts from their physician colleagues, are providing a level of service that approaches that of a General Internist (GIM). The complexity of the patients under their care as the Most Responsible Physician is very high. That being said, the Hospitalists are trained in Family Medicine and have essentially undergone an apprenticeship in Internal Medicine at BCHS, being mentored by their more senior colleagues. While this is an admirable system and speaks to the educational commitment and sense of team spirit amongst the group, it is a “workaround” for a model that has expanded well outside the bounds of its original concept or intent.

From a clinical perspective, there are a number of fundamental problems with the current Hospitalist system:

- The number of patients each Hospitalist is caring for is too high. The industry standard would expect no more than 25 patients on an individual’s list with the optimal number closer to 20.

- The complexity of the patients is often outside the Hospitalists’ clinical experience or abilities. The term “acuity creep” refers to the gradual increase in the complexity of patients under their care for the past decade or so. Internists should have significantly more involvement with Internal Medicine patients.

- Hospitalists are providing MRP duties for surgical patients. The Hospitalists essentially provide a “free” house staff service for most of the surgeons who then have off-loaded much of their clinical responsibilities for inpatient care onto the Hospitalists. The Hospitalists do not have the training to be the MRP on newly admitted or recent post-operative surgical patients. Hospitalists can provide valuable advice and care for surgical patients, in a supportive role as a consultant, but not as the MRP, until such time in the patient’s care that it falls into the scope of the Hospitalists’ scope and comfort zone.

- Consultants are often not responsive enough to requests from the Hospitalists to consult and/or to assume MRP duties for patients. This contrary to existing BCHS by-laws.
- Consultants sometimes transfer patients to the Hospitalists' care without contacting and/or seeking the agreement of the Hospitalists. This practice is also contrary to existing hospital by-laws.
- Some of the newer and less experienced Hospitalists are uncomfortable with the clinical responsibilities they must shoulder. This issue is based on the volume of patients they are asked to carry, as well as the clinical complexity some of those patients. While in the past, the existing Hospitalists would "groom" new physician recruits, the departure of many veteran Hospitalists along with the recruitment of so many new Hospitalists, has stressed the legacy group's ability to mentor and supervise the newly recruited physicians.

Recommendations

51. Hospitalists should have a maximum of 25 patients on their lists. In 6 months, this number should be revisited and adjusted accordingly.
52. Internal Medicine should be responsible (MRP) for patients in ICU, CCU, any step-down units, as well as for any patients the Hospitalists refer to Internal Medicine, accompanied with a request to transfer care to the Internists. This may require recruiting more physicians to the Department of Internal Medicine.
53. Any request, for transfer of care, of any patient, to the Hospitalists' service should be communicated by the referring physician to the Hospitalist along with a written notation in the patient's chart made with respect to the transfer (as per current BCHS bylaws). Each Hospitalist has the right and obligation to either accept or decline the transfer based on the patient's clinical condition and/or the number of patients already under the care of the Hospitalist.
54. Patients admitted through the Emergency Department by Internal Medicine should be triaged, with a subset of appropriate patients referred to the Hospitalists' service with conditions of transfer as noted above.
55. All surgical patients should have a Surgeon as MRP. Hospitalists or Internists can be consulted for supportive care with respect to medical issues outside the Surgeons' scope of practice. However, the Surgeon should remain as MRP until transfer of care is agreed to as noted above.
56. Issues and disputes arising from the transfer of care and consulting models described above should be referred to the respective Departmental Chiefs involved. If still unresolved, the issue can be escalated to the CoS, if necessary.

57. Palliative Care should be part of the Hospitalists' service, working collaboratively with any Family Physician who wishes to continue to assist in the care of these patients.

58. Hospitalists can serve as a resource to the Psychiatry service, in a supportive model, as described above for the surgical service.

59. The clinical services to be provided by Hospitalists should be drafted as Departmental Rules and Regulations that would be congruent with those of other Departments. This document should be presented to MAC for approval. An alternative approach would entail a clinical services agreement or MOU that would detail clinical expectations for the Hospitalists.

60. Any monetary support from BCHS for the Hospitalists' service should be separate from the clinical services provided in their Departmental rules and regulations.

The reduced scope and volume of practice outlined in these recommendations would translate into the need for fewer full time equivalent Hospitalists than currently required.

Financial and Administrative Considerations

The current OHIP fee for service system cannot support a Hospitalist service in Ontario, due to the historical inadequacies of the fee schedule for inpatient care provided by physicians. Until an alternate funding arrangement is instituted across Ontario for Hospitalists, Ontario hospitals will continue to be forced to use their operating budgets to support Hospitalist programs.

Many Hospitals have leveraged the unique skill sets Hospitalists bring (education, administrative skills, flow initiatives) and financially reimburse their Hospitalists for their knowledge, time, interest and commitment to their organizations. BCHS's remuneration system for Hospitalists, while adequate in terms of net income to these physicians, is neither creative nor "main stream" any longer. A different model for reimbursement of BCHS Hospitalists is necessary to ensure that the hospital maintains its requirement for fiscal sustainability.

According to the Healthcare Indicator Tool (HIT), medical staff and nurse practitioner remuneration as a percent of total expenses are approximately 14% in comparison to the average of large community hospitals and average for the Province at 9% and average of the HNHB LHIN at 7.5%. The medical remuneration is $4M greater than revenues and recoveries. Overages are largely in the areas of Hospitalists ($1.4M stipends greater than billings), the emergency department ($0.9M stipends and salaries greater than billings) and administrative stipends ($1M). The historical method of addressing medical attendance has been to increase stipends. A review of hospitalist payments suggests that the capture of visits by doctors is not always reflected correctly. In addition, it was suggested that the rate of recovery has dropped in past years with a change in personnel preparing and submitting the OHIP billing.

BCHS should move to a Hospitalist remuneration system that, as part of individual consulting contracts, provides an administrative stipend for providing administrative support and consultative advice to BCHS regarding matters such as patient flow, patient safety, attendance at “bullet rounds”, education, participating in Hospital committees, etc. This system more clearly defines the Hospitalists as independent contractors, receiving fee for service remuneration directly from OHIP as well as on call remuneration from the HOCC program. Each Hospitalist would be responsible for their own OHIP billings as well as the cost of a billing service, which would obviate the need for BCHS to pay for that clerical function and account for concerns with the accuracy and completeness of coding that has been questioned by some physicians and data drivers.

Any fees received by the Hospitalists from BCHS should fulfill the conditions of a contract that does not include any fees received for direct patient care. By defining a daily cost per Hospitalist, BCHS would have the added benefit of predictable costs of the Hospitalist Program and remove the uncertainty inherent that exists in the current system. The Hospitalists may need to charge BCHS HST with this arrangement.

The Hospitalists are currently working at BCHS without existing contracts, which is a situation that needs to be resolved as soon as possible.

Recommendations

61. Contracts for the Hospitalists should be developed as a priority. These contracts should be developed in a cooperative manner between the Hospitalists and administration. The ongoing management of contracts must be planned.
62. The Hospitalist remuneration system should be revised to provide an administrative stipend with the associated responsibilities clearly delineated. Hospitalists should bill OHIP directly for the fee for service component of their income and receive HOCC funding as appropriate.
63. Given the amount of clinical work done by the Hospitalists, consideration should be given to creating a Department of Hospital Medicine. A Chief of Hospital Medicine should be selected as per the recommended process for all Department Chiefs.
64. A review of coding and data quality should be conducted to ensure accuracy for both most responsible physicians and in general to promote the sharing of knowledge around charting and reporting to potentially increase funding.

The Willett Site

The future of the Willett ambulatory care site (formerly the Willett Hospital) has been the subject of much debate in recent years. It is the site of BCHS's Urgent Care Centre (UCC) and some outpatient medical imaging services. BCHS also leases space at the site to a few other organizations including a Family Health Team. The building is old and in need of significant capital investment if it is to continue to be used as an active health care facility. Much of the building is currently vacant.

The UCC volumes have been low and as a result, it has been necessary for the hospital to supplement the incomes of the emergency physicians who cover the shifts there. The majority of the patients who attend the UCC present with low-acuity conditions that are more appropriately managed by primary care providers.

The EY report came to the conclusion that continuing to operate the Willett facility is not sustainable and recommended closure and divestment of the facility. Selling the property would provide significant capital funds; however, this is complicated by the fact that the Foundation has legacy funds that were designated specifically for projects at the Willett site.

Many of those who live in Paris are quite attached to the Willett facility and have lobbied to keep it open. Most recently, a community group has advocated for the creation of a Community Health Hub. The proposal is for BCHS to partner with other health service providers, public and private, to create a hub that offers a spectrum of services.

While it is clear that the current status of the Willett ambulatory care site is not sustainable, a recommendation on the optimal strategy for the future of the facility is beyond the scope of this investigation. A thorough assessment of the options is required, which the Investigation Team understands is underway. This should involve a thorough business case assessment, ample community engagement, and exploration of potential partnerships to meet the health care needs of the community. Plans for the Willett site should be part of BCHS's broader strategic and capital development plans.

Recommendation

65. Plans for the future of the Willett site should involve a thorough assessment of options and should be part of BCHS's broader strategic and capital development plans.

Appendices

Appendix A – Terms of Reference

INVESTIGATOR FOR BRANT COMMUNITY HEALTHCARE SYSTEM

INVESTIGATE AND REPORT

1. The investigator will examine and report on issues related to the governance and management at Brant Community Healthcare System (BCHS).

2. The investigator will examine, evaluate and make recommendations on the quality of care, performance and capabilities, financial position, and governance and management of BCHS.

3. In conducting this investigation, the investigator will also:

    - Review the status of recommendations from all pertinent studies, reviews, strategies and reports regarding governance and operations of the BCHS;

    - Consider pertinent recommendations arising from the reports and changes that resulted from these reports; and

    - Review the pertinent recommendations of any other consultant, hospital or Local Health Integration Network (LHIN) studies that have been completed that are relevant to the current situation.

4. The investigator will liaise with the Hamilton Niagara Haldimand Brant (HNHB) LHIN and other stakeholders as deemed appropriate by the investigator.

5. The investigator may retain external resources as the investigator deems appropriate.

6. The investigator will report to the Minister of Health and Long-Term Care (the “Minister”) as required by the Minister.

7. The Ministry may, from time to time, ask the Appointee to provide updates on the progress of the investigation work. As appropriate, the Appointee will discuss issues related to the investigation with the Minister, Deputy Minister, Associate Deputy Minister (Delivery and Implementation), and Assistant Deputy Minister. The Appointee may also provide updates to the LHIN CEO and Board Chair as the Appointee deems appropriate.

8. The investigator will provide a final written report to the Minister no later than June 15, 2017, which the Minister shall make public after redacting any personal health information, and the investigator shall notify parties interviewed that the report shall be made public. The final report shall also be provided to the Chair of the Board of BCHS.

Appendix B - Investigation Team Biographies

Dr. Tim Rutledge – Lead Investigator

Dr. Rutledge has been President and CEO of North York General Hospital since 2010, and has held several management and leadership roles over the course of his career. With a background in Emergency Medicine, he has also served as Chief of Emergency Services, Vice President of Medical and Academic Affairs, and Medical Advisory Committee Chair at North York General Hospital. In addition, Dr. Rutledge serves on several health care boards and advisory tables, is an Associate Professor in the Department of Family and Community Medicine at the University of Toronto and is a member of the Canadian College of Health Leaders.

Dale Clement – Nursing/Professional Practice and Models of Care Expert

Dale has more than 20 years of experience in the healthcare sector and, since January 2015, has been the CEO of the Waterloo Wellington CCAC. Prior to this role, Dale served as the Chief Operating Officer for the Oakville hospital site of Halton Healthcare Services, ER/ALC Lead for the Mississauga Halton LHIN, and held positions with the Mississauga Halton CCAC, the HNHB CCAC, St. Peter's Health System and Bayshore Health Services. Dale is the Board Chair for the OakMed Family Health Team, Board member for the Canadian Home Care Association and OACCAC, as well as the Chair of the Rural Welling Health Alliance Operations Committee.

Dr. Keith Greenway – Medical Expert

Dr. Greenway is a recognized leader in Hospital Medicine and is currently the Lead Hospitalist at Joseph Brant Hospital. Past leadership roles held by Dr. Greenway include the Regional Chief of Hospital Medicine at Niagara Health System, the Chief of Emergency Medicine at William Osler Medical Centre and the Program Director for the Emergency Medicine Residency Program at McMaster University. He is currently a Clinical Associate Professor in the Department of Family Medicine at McMaster University. Dr. Greenway is the co-founder and Managing Director of Emergency Solutions Incorporated, a firm specializing in medical legal matters and consulting services to health care organizations.

Ingrid Suurmann – Finance Expert

Ingrid is a health care executive that has worked in a number of Ontario hospitals, and consulted for private industry, government and healthcare while at Deloitte and PwC. She was the Vice-President of Corporate Services and CFO for St. Mary's Hospital in Kitchener Ontario from 2011- 2015. While at St. Mary's, she worked with the Board and Board Committees on strategic planning and the introduction and adaption of ERM. Ingrid's leadership experience includes human capital, finance, occupational health, engineering and redevelopment, risk management, procurement, strategic planning and

business development. For over 6 years, she served on the Audit and Finance Committee of Holland Bloorview Kids Rehab.

Michael Watts – Legal Counsel

Michael is a Partner and Chair of Osler, Hoskin & Harcourt's Health Industry Group. He is general counsel to many of the firm's public and private health industry clients in respect of a wide spectrum of matters. Michael also has extensive experience in providing complex regulatory opinions that ensure statutory compliance with federal and provincial health statutes. He has assisted a number of hospitals across Ontario in reviewing and updating their governance structures and by-laws, including providing best practice governance advice to Supervisors of ten hospital corporations. Michael has been granted the ICD.D designation by the Institute of Corporate Directors. He has been recognized yearly by Best Lawyers in Canada since 2008 and, in 2014, as the Toronto Health Care "Lawyer of the Year." In 2015 and 2016 Michael was recognized by Chambers Global for his expertise in Canadian health law.

Ben Deignan – Project Manager

Ben is the Director, Sub-region Planning and Integration for Brant and Haldimand-Norfolk at the Hamilton Niagara Haldimand Brant Local Health Integration Network. Recently, he led the provincial implementation of the PSS Regulatory Amendments & Policy Implementation. Ben holds a Master of Science in Health Studies and Gerontology from the University of Waterloo and is an MBA candidate at McMaster University (Finance and Health Services Management). Ben has a diverse background in quantitative and qualitative research and has published multiple peer-reviewed journal articles in the field of health communication and health literacy.

Appendix C - Interviews and Focus Groups Conducted

Type	Unique Participants*	Notes
Interviews	64	• All active Board Members • Hospital management (executive, value stream leaders, group leaders, team leaders) • Physician leaders (Medical leads, Department Chiefs, MSA Executive) • Local Politicians (Mayors, MPP) • Past and present third party consultants • HNHB LHIN leadership

Focus Groups (10 total)	71	• "Internal"
		  ○ Physicians
		  ○ Group Leads/Team Leads
		  ○ Nurses
		  ○ Allied Health
		  ○ Support Staff
		• "Community"
		  ○ Six Nations of the Grand River
		  ○ Mississaugas of the New Credit First Nations

Online Survey – BCHS Hospital Staff, Volunteers, Physicians	296	• Open May 19 to June 2, 2017
Online Survey – Community Members	423	• Open May 19 to June 2, 2017
Confidential Email	36	• Open April 1 to May 31, 2017
Total Individuals Providing Feedback**	**890**	

*Some individuals were interviewed more than once.

**Some individuals who were interviewed may have also completed an online survey.

Appendix D - Documents Reviewed

Accreditation Reports
Annual General Meeting Packages
Annual Reports
Audited Financial Statements
Board Meeting Packages
Board Orientation Package
Board Recruitment Documents
Board Skills Matrices
Board Sub-Committee Packages
By-laws as appropriate
Capital Planning
Consultant Reports (EY, CSI, Marsh)
Emergency Department Data
Hospital Budget Strategy
Hospital Improvement Plans
Hospital Policies (e.g., Code of Conduct)
Hospital Strategic Plans
HSAA and HAPS Submissions
HSFR Reports and Recommendations
Job Descriptions
LHIN Documents – ABP, IHSP, SHSP
LHIN Performance Indicators
Medical Advisory Committee Minutes and Policies
Medical Staff Rules
Medication Incident Data
Organizational Charts
Physician Compensation/Contracts
Physician Letters
Physician Satisfaction Survey Results
Project Management Office documents
Quality Improvement Plans
Quality Scorecards
Senior Leadership Team Meeting Materials
SRI Reports
Staff Satisfaction Survey Results
BCHS external website
Whistleblower policy

Appendix E - Results from the Online BCHS Staff and Physician Survey 2017

Question	Top 3 Themes Identified*	Prevalence of Theme in responses	Example
In the last year or two, what are you most proud of in your value stream, department or service? 263 responses	Teamwork/Co-workers	52.1%	"Staff dedication to continued excellent patient care despite lack of resources"
	Continuous Quality Improvement	14.8%	"I am very proud of our ability to manage the increasing acuity of patients that are being admitted to our floor"
	Nothing or not sure	12.2%	"I cannot say I am proud of any one thing in the past 4 years on this unit"
What are the current challenges? 288 responses	Short Staff/High Workload	42.9%	"Not having enough staff. Having to spread ourselves too thin and give the bare minimum"
	Executive Team lack of decision making, support or vision	13.9%	"The constant change. Management is always changing and don't really understand my role and work"
	Morale	12.5%	"Being able to continue under such adverse conditions"
What quality initiatives have been undertaken in the last couple of years? What indicators do you measure? 210 responses	Nothing/Unsure	47.1%	"I am not sure what we currently measure. We're trying to keep our heads above water, and it is hard to keep tabs on the "nice to do" things like quality initiatives when we're struggling to provide adequate patient care"
	"Continuous Improvement"	5.3%	"the ongoing review of organizational standard in almost all aspect of care"
	Identified one or more specific quality initiatives	47.6%	"Far too many quality initiatives to list—QIP measures, PMO projects, IPC, QBPs, clinically sensitive measures, engagement survey"

Question	Top 3 Themes Identified*	Prevalence of Theme in responses	Example
How would you describe the functioning and the culture of the team you work with? 279 responses	Positive or work well as a team	40.9%	"We function very well together. We are like family"
	Neutral (positive and negative together)	26.1%	"Work well together but staff is disgruntled with heavy workload and constant sick calls"
	Negative or do not work well as a team – most common reason for negativity is stress and low morale	32.7%	"very unhappy and down-trodden staff"
How has the organization changed since you have been here? 279 responses	Reduced morale, recognition, satisfaction of staff	34.4%	"Staff don't feel valued by the organization, especially those on evening and night shifts"
	Large-scale changes not well planned or implemented	20.7%	Introduction of the value streams - management is let go and then re-hired under a new title…has caused lowered morale. Also, no one seems to know on the front line just what all these group leads, team leads, value stream leads do"
	Ineffective management	12.7%	"The hospital seems to have been mismanaged with regards to funding"
What opportunities do you see for improvement at BCHS? 269 responses	Proper staffing levels	30.5%	"appropriate, safe staffing levels must be addressed"
	Need to build confidence in executive team/Board	19.3%	"There is no confidence in the current Executive team or the Board internally and externally to the organization"
	Better planning and engagement across the organization	16.4%	"Management needs to…really listen to staff if figuring out how to meet those priorities, and then implement… a few successes…will start to reverse the deteriorating culture"

* Method: A thematic analysis identified the core theme in each qualitative response. In cases where more than one issue was listed, the first was assumed to be the highest priority and therefore assigned to that category. The frequency of each key theme was then counted and scored as a percentage of total responses.